

MEDI-CAL
NOVEMBER 2021
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2021-22 *and* 2022-23



The Great Seal

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

**MEDI-CAL
NOVEMBER 2021
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2021-22 and 2022-23**

- ERRATA -

Management Summary, Page 16
Current Year, Pages 26 and 28
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Caseload, Pages A, C - E

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NOVEMBER 2021 MEDI-CAL ESTIMATE

TABLE OF CONTENTS

The November 2021 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 2021 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 Number</u>	<u>PC Name</u>	<u>Estimate Section</u>	<u>Page</u>
29	1% FMAP INCREASE FOR PREVENTIVE SERVICES	Regular PC	59
142	10% PROVIDER PAYMENT REDUCTION	Regular PC	338
118	2020 MCO ENROLLMENT TAX MANAGED CARE PLANS	Regular PC	272
119	2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	Regular PC	275
96	2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	Regular PC	235
126	AB 1629 ANNUAL RATE ADJUSTMENTS	Regular PC	289
267	AB 97 ELIMINATIONS	Regular PC	622
31	ACA OPTIONAL EXPANSION MLR RISK CORRIDOR	Regular PC	64
9	ACCELERATED ENROLLMENT FOR ADULTS	Regular PC	25
17	ACTUARIAL COSTS FOR RATE DEVELOPMENT	Other Admin	69
33	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	Regular PC	70
112	AIDS HEALTHCARE CENTERS (OTHER M/C)	Base PC	72
221	ALAMEDA WELLNESS CAMPUS	Regular PC	548
254	AMERICAN RESCUE PLAN INCREASED FMAP FOR HCBS	Regular PC	605
265	ANNUAL COGNITIVE ASSESSMENTS	Regular PC	619
230	ARRA HITECH - PROVIDER PAYMENTS	Regular PC	566
13	ARRA HITECH INCENTIVE PROGRAM	Other Admin	57
240	AUDIT SETTLEMENTS	Regular PC	583
250	BASE RECOVERIES	Base PC	102
59	BCCTP DRUG REBATES	Regular PC	140
275	BEHAVIORAL HEALTH BRIDGE HOUSING	Regular PC	638
74	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE	Regular PC	176
32	BEHAVIORAL HEALTH TREATMENT	Regular PC	66
2	BREAST AND CERVICAL CANCER TREATMENT	Regular PC	10
76	CALAIM - BH QUALITY IMPROVEMENT PROGRAM	Regular PC	184
207	CALAIM - DENTAL INITIATIVES	Regular PC	524
260	CALAIM - LTC BENEFIT TRANSITION	Regular PC	613
105	CALAIM - MEDI-CAL PATH	Regular PC	252
114	CALAIM - MSSP CARVE-OUT OF CCI	Regular PC	266
47	CALAIM - ORGAN TRANSPLANT	Regular PC	105
7	CALAIM - POPULATION HEALTH MANAGEMENT	Other Admin	42
102	CALAIM - TRANSITIONING POPULATIONS	Regular PC	246
86	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES	Regular PC	215
14	CALAIM INMATE PRE-RELEASE PROGRAM	Regular PC	29
65	CALHEERS DEVELOPMENT	Other Admin	184
40	CALIFORNIA COMMUNITY TRANSITIONS COSTS	Regular PC	87
38	CALIFORNIA HEALTH INTERVIEW SURVEY	Other Admin	117
74	CALIFORNIA SMOKERS' HELPLINE	Other Admin	205
268	CALIM - DESIGNATED STATE HEALTH PROGRAMS	Regular PC	624
4	CALWORKS APPLICATIONS	County Admin	15
160	CAPITAL PROJECT DEBT REIMBURSEMENT	Regular PC	402
116	CAPITATED RATE ADJUSTMENT FOR FY 2022-23	Regular PC	268
21	CAPMAN	Other Admin	77
5	CASE MANAGEMENT FOR OTLICP	County Admin	17
206	CCI IHSS RECONCILIATION	Regular PC	522
22	CCI-ADMINISTRATIVE COSTS	Other Admin	81
95	CCI-MANAGED CARE PAYMENTS	Regular PC	232
113	CCI-QUALITY WITHHOLD REPAYMENTS	Regular PC	264
3	CCS CASE MANAGEMENT	Other Admin	29
42	CCS DEMONSTRATION PROJECT	Regular PC	94
51	CCT FUND TRANSFER TO CDSS	Regular PC	114
42	CCT OUTREACH - ADMINISTRATIVE COSTS	Other Admin	125

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17	CDCR RETRO REPAYMENT	Regular PC	35
66	CDDS ADMINISTRATIVE COSTS	Other Admin	188
81	CDPH I&E PROGRAM AND EVALUATION	Other Admin	216
82	CHART REVIEW	Regular PC	200
14	CHDP COUNTY ALLOCATION	Other Admin	60
78	CHHS AGENCY HIPAA FUNDING	Other Admin	212
24	CHIP PREMIUMS	Regular PC	51
238	CIGARETTE AND TOBACCO SURTAX FUNDS	Regular PC	579
73	CLPP CASE MANAGEMENT SERVICES	Other Admin	203
237	CLPP CASE MANAGEMENT SERVICES (MISC. SVCS.)	Base PC	101
239	CLPP FUND	Regular PC	581
245	CMS DEFERRED CLAIMS	Regular PC	596
47	CMS DEFERRED CLAIMS - OTHER ADMIN	Other Admin	138
26	COMMUNITY FIRST CHOICE OPTION	Regular PC	53
39	COMMUNITY HEALTH WORKER	Regular PC	84
191	CONTINUOUS CHIP COVERAGE DURING THE COVID-19 PHE	Regular PC	498
46	CONTINUOUS GLUCOSE MONITORING SYSTEMS BENEFIT	Regular PC	101
120	COORDINATED CARE INITIATIVE RISK MITIGATION	Regular PC	277
5	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	Other Admin	35
1	COUNTY ADMINISTRATION ALLOCATION	County Admin	8
262	COUNTY BH RECOUPMENTS	Regular PC	615
11	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM	Base PC	14
44	COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE	Other Admin	130
93	COUNTY ORGANIZED HEALTH SYSTEMS	Base PC	45
249	COUNTY SHARE OF OTLICP-CCS COSTS	Regular PC	601
2	COUNTY SPECIALTY MENTAL HEALTH ADMIN	Other Admin	26
188	COVID-19 - SICK LEAVE BENEFITS	Regular PC	490
192	COVID-19 BASE RECOVERIES	Regular PC	500
186	COVID-19 BEHAVIORAL HEALTH	Regular PC	484
182	COVID-19 CASELOAD IMPACT	Regular PC	470
189	COVID-19 ELIGIBILITY	Regular PC	492
187	COVID-19 FFS DME RESPIRATORY RATES	Regular PC	487
185	COVID-19 FFS REIMBURSEMENT RATES	Regular PC	481
194	COVID-19 INCREASED FMAP - DHCS	Regular PC	502
46	COVID-19 INCREASED FMAP - OTHER ADMIN	Other Admin	134
272	COVID-19 INCREASED FMAP EXTENSION	Regular PC	631
87	COVID-19 INCREASED FMAP EXTENSION - OTHER ADMIN	Other Admin	224
190	COVID-19 TESTING IN SCHOOLS	Regular PC	495
83	COVID-19 VACCINATION INCENTIVE PROGRAM ADMIN	Other Admin	220
184	COVID-19 VACCINE ADMINISTRATION	Regular PC	477
163	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	Regular PC	414
16	CS3 PROXY ADJUSTMENT	Regular PC	33
25	CYBHI - BH SERVICES AND SUPPORTS PLATFORM	Other Admin	89
225	CYBHI - CALHOPE STUDENT SUPPORT	Regular PC	556
53	CYBHI - DYADIC SERVICES	Regular PC	121
236	CYBHI - EVIDENCE-BASED BH PRACTICES	Regular PC	577
103	CYBHI - INCREASE ACCESS TO STUDENT BH SERVICES	Regular PC	248
208	CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY	Regular PC	527
60	DENTAL ASO ADMINISTRATION 2016 CONTRACT	Other Admin	172
61	DENTAL FI ADMINISTRATION 2016 CONTRACT	Other Admin	175
108	DENTAL MANAGED CARE (OTHER M/C)	Base PC	66
202	DENTAL SERVICES	Base PC	87
71	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	Other Admin	199
69	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	Other Admin	194
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13	DISABLED ADULT CHILDREN PROGRAM CLEANUP	Regular PC	27
50	DOULA BENEFIT	Regular PC	112
145	DPH INTERIM & FINAL RECONS	Regular PC	351
137	DPH INTERIM RATE	Regular PC	324
129	DPH INTERIM RATE COVID-19 INCREASED FMAP ADJUST	Regular PC	304
125	DPH INTERIM RATE GROWTH	Regular PC	287
156	DPH PHYSICIAN & NON-PHYS. COST	Regular PC	388
70	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	Regular PC	168
8	DRUG MEDI-CAL COUNTY ADMINISTRATION	Other Admin	44
69	DRUG MEDI-CAL MAT BENEFIT	Regular PC	165
66	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	Base PC	20
31	DRUG MEDI-CAL PARITY RULE ADMINISTRATION	Other Admin	101
71	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	Regular PC	173
67	DRUG MEDI-CAL STATE PLAN SERVICES	Base PC	25
152	DSH PAYMENT	Regular PC	374
141	DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT	Regular PC	335
30	ELECTRONIC ASSET VERIFICATION PROGRAM	Other Admin	99
197	ELECTRONIC VISIT VERIFICATION FED PENALTIES	Regular PC	516
133	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	Regular PC	312
39	ENCRYPTION OF PHI DATA	Other Admin	119
258	END-OF-FY 2-WEEK CHECKWRITE HOLD BUYBACK	Regular PC	611
7	ENHANCED FEDERAL FUNDING	County Admin	21
266	EQUITY & PRACTICE TRANSFORMATION PAYMENTS	Regular PC	620
257	EVIDENCE-BASED DENTAL PRACTICES	Regular PC	609
48	EXPANSION TO SCREENING FOR ADDITIONAL SUBSTANCES	Regular PC	108
115	FAMILY MOSAIC CAPITATED CASE MGMT. (OTH. M/C)	Base PC	75
61	FAMILY PACT DRUG REBATES	Regular PC	146
34	FAMILY PACT PROGRAM	Regular PC	72
40	FAMILY PACT PROGRAM ADMIN.	Other Admin	121
65	FEDERAL DRUG REBATES	Regular PC	158
72	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG	Other Admin	201
70	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	Other Admin	196
158	FFP FOR LOCAL TRAUMA CENTERS	Regular PC	394
270	FPACT HPV VACCINE COVERAGE	Regular PC	628
3	FPL INCREASE FOR AGED AND DISABLED PERSONS	Regular PC	13
130	FQHC/RHC/CBRC RECONCILIATION PROCESS	Regular PC	306
176	FREE CLINICS AUGMENTATION	Regular PC	455
242	FUNDING ADJUST.—ACA OPT. EXPANSION	Regular PC	589
243	FUNDING ADJUST.—OTLICP	Regular PC	591
3	FUNDING FOR COUNTY REDETERMINATIONS	County Admin	13
135	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	Regular PC	319
136	GDSP PRENATAL SCREENING PROGRAM FEE INCREASE	Regular PC	322
175	GEMT SUPPLEMENTAL PAYMENT PROGRAM	Regular PC	451
94	GEOGRAPHIC MANAGED CARE	Base PC	51
84	GLOBAL PAYMENT PROGRAM	Regular PC	207
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127	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	Regular PC	294
18	HCBA WAIVER ADMINISTRATIVE COST	Other Admin	71
227	HCBS SP - ASSISTED LIVING WAIVER EXPANSION	Regular PC	560
211	HCBS SP - CALBRIDGE BH PILOT PROGRAM	Regular PC	533
203	HCBS SP - COMM BASED RESIDENTIAL CONTINUUM PILOT	Regular PC	518
68	HCBS SP - CONTINGENCY MANAGEMENT	Regular PC	162
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223	HCBS SP - NON-IHSS CARE ECONOMY PMTS	Regular PC	552
269	HCBS SP CDDS	Regular PC	626
86	HCBS SP CDDS - OTHER ADMIN	Other Admin	222
58	HCO COST REIMBURSEMENT 2017 CONTRACT	Other Admin	168
59	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	Other Admin	170
57	HCO OPERATIONS 2017 CONTRACT	Other Admin	166
9	HEALTH ENROLLMENT NAVIGATORS	Other Admin	48
107	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS	Regular PC	257
11	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	Other Admin	51
68	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	Other Admin	192
63	HEALTH-RELATED ACTIVITIES - CDSS	Other Admin	180
43	HEARING AID COVERAGE	Regular PC	97
235	HIPP PREMIUM PAYOUTS (MISC. SVCS.)	Base PC	99
205	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER	Regular PC	520
199	HOME & COMMUNITY-BASED SVCS.-CDDS (MISC.)	Base PC	80
134	HOSPICE RATE INCREASES	Regular PC	315
157	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	Regular PC	391
27	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	Regular PC	55
28	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	Regular PC	57
244	HOSPITAL QAF - CHILDREN'S HEALTH CARE	Regular PC	593
147	HOSPITAL QAF - FFS PAYMENTS	Regular PC	356
148	HOSPITAL QAF - MANAGED CARE PAYMENTS	Regular PC	360
233	HPSM DENTAL INTEGRATION PILOT PROGRAM	Regular PC	573
224	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	Regular PC	554
209	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	Regular PC	529
181	IGT ADMIN. & PROCESSING FEE	Regular PC	468
241	IMD ANCILLARY SERVICES	Regular PC	585
219	INDIAN HEALTH SERVICES	Regular PC	544
248	INDIAN HEALTH SERVICES FUNDING SHIFT	Regular PC	599
213	INFANT DEVELOPMENT PROGRAM	Regular PC	539
83	INTERIM AND FINAL COST SETTLEMENTS - SMHS	Regular PC	202
1	INTERIM AND FINAL COST SETTLEMENTS-SMHS	Other Admin	22
217	KEDREN COMMUNITY HEALTH & ACUTE PSYCHIATRIC HOSP.	Regular PC	541
75	KIT FOR NEW PARENTS	Other Admin	207
19	LA COUNTY PUBLIC HEALTH NURSING PILOT	Other Admin	73
144	LABORATORY RATE METHODOLOGY CHANGE	Regular PC	346
215	LAWSUITS/CLAIMS	Base PC	93
26	LITIGATION RELATED SERVICES	Other Admin	91
58	LITIGATION SETTLEMENTS	Regular PC	138
35	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	Regular PC	75
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6	LOS ANGELES COUNTY HOSPITAL INTAKES	County Admin	19
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7	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	Base PC	11
8	MEDI-CAL COUNTY INMATE PROGRAMS	Regular PC	22
19	MEDI-CAL COUNTY INMATE REIMBURSEMENT	Regular PC	39
256	MEDI-CAL COVID-19 VACCINATION INCENTIVE PROGRAM	Regular PC	607
56	MEDI-CAL DRUG REBATE FUND	Regular PC	131
27	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	Other Admin	93
51	MEDICAL FI BO & IT CHANGE ORDERS	Other Admin	149
49	MEDICAL FI BO & IT COST REIMBURSEMENT	Other Admin	142
55	MEDICAL FI BO HOURLY REIMBURSEMENT	Other Admin	162
56	MEDICAL FI BO MISCELLANEOUS EXPENSES	Other Admin	164
52	MEDICAL FI BO OTHER ESTIMATED COSTS	Other Admin	153
53	MEDICAL FI BO TELEPHONE SERVICE CENTER	Other Admin	157
54	MEDICAL FI BUSINESS OPERATIONS	Other Admin	159
48	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	Other Admin	140
50	MEDICAL FI IT INFRASTRUCTURE SERVICES	Other Admin	147
77	MEDI-CAL INPATIENT SERVICES FOR INMATES	Other Admin	210
49	MEDICAL INTERPRETERS PILOT PROJECT	Regular PC	110
34	MEDI-CAL NONMEDICAL TRANSPORTATION	Other Admin	108
23	MEDI-CAL RECOVERY CONTRACTS	Other Admin	83
170	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	Regular PC	436
173	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	Regular PC	447
60	MEDI-CAL RX - ADDITIONAL SAVINGS FROM MAIC IN FFS	Regular PC	143
6	MEDI-CAL RX - ADMINISTRATIVE COSTS	Other Admin	38
54	MEDI-CAL RX - MANAGED CARE PHARMACY BENEFIT TO FFS	Regular PC	123
57	MEDI-CAL RX- ADDITIONAL SUPPLEMENTAL REBATES	Regular PC	135
5	MEDI-CAL STATE INMATE PROGRAMS	Regular PC	17
62	MEDICAL SUPPLY REBATES	Regular PC	149
216	MEDI-CAL TCM PROGRAM	Base PC	96
41	MEDICALLY TAILORED MEALS PILOT PROGRAM	Regular PC	92
45	MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM	Other Admin	132
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201	MEDICARE PAYMENTS - PART D PHASED-DOWN	Base PC	84
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271	MHSF - PROVIDER ACES TRAININGS	Regular PC	630
226	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	Regular PC	558
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24	MITA	Other Admin	86
229	MLK JR. HOSPITAL IMPROVEMENT	Regular PC	565
41	MMA - DSH ANNUAL INDEPENDENT AUDIT	Other Admin	123
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162	NDPH IGT SUPPLEMENTAL PAYMENTS	Regular PC	411
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16	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	Other Admin	65
79	OUT OF STATE YOUTH - SMHS	Regular PC	193
232	OUTREACH & ENROLLMENT ASSIST. FOR DUAL BENES	Regular PC	571
100	PACE (OTHER M/C)	Base PC	61
33	PACES	Other Admin	105
29	PASRR	Other Admin	97
20	PAVE SYSTEM	Other Admin	75
30	PAYMENTS TO PRIMARY CARE PHYSICIANS	Regular PC	62
222	PEER SUPPORT SPECIALIST SERVICES	Regular PC	550
62	PERSONAL CARE SERVICES	Other Admin	178
200	PERSONAL CARE SERVICES (MISC. SVCS.)	Base PC	82
64	PHARMACY RETROACTIVE ADJUSTMENTS	Regular PC	154
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155	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	Regular PC	383
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NOVEMBER 2021 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.

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

Permanent reference number, does not change each November.

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

If Full Year Cost is an accrual number, this adjusts an accrual estimate downward to account for payments that will fall outside of each fiscal year, resulting in a cash estimate. A lag of 1.0000 represents no adjustment.

To avoid double counting impacts of policy changes, this row identifies the portion of the cash impact that is estimated to be included in base data and in base trends. 0.00% represents no impact estimated in the base.

These are the amounts added to the Medi-Cal budget for this item after adjusting downward to remove costs estimated to already be reflected in the base data/trends.

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

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NOTE: FOR THE NOVEMBER 2021 ESTIMATE:

- CURRENT YEAR = FY 2021-22
- BUDGET YEAR = FY 2022-23
- APPROPRIATION = MAY 2021 ESTIMATE + BUDGET ACT CHANGES, FY 2021-22

November 2021 Medi-Cal Estimate

Current Year (FY 2021-22) Projected Expenditures Compared to the Appropriation

(Dollars in Millions)

Medical Care Services	FY 2021-22 Appropriation	Nov 2021 Estimate	Change	
			Amount	Percent
Total Funds	\$117,672.4	\$117,868.9	\$196.5	0.2%
Federal Funds	\$80,307.6	\$81,664.8	\$1,357.2	1.7%
General Fund	\$27,077.3	\$25,698.3	(\$1,379.0)	-5.1%
Other Non-Federal Funds	\$10,287.5	\$10,505.8	\$218.3	2.1%

County Administration	FY 2021-22 Appropriation	Nov 2021 Estimate	Change	
			Amount	Percent
Total Funds	\$5,178.3	\$5,532.3	\$354.0	6.8%
Federal Funds	\$4,220.1	\$4,523.2	\$303.1	7.2%
General Fund	\$940.0	\$991.0	\$51.0	5.4%
Other Non-Federal Funds	\$18.2	\$18.1	(\$0.1)	-0.5%

Fiscal Intermediary	FY 2021-22 Appropriation	Nov 2021 Estimate	Change	
			Amount	Percent
Total Funds	\$426.7	\$443.3	\$16.6	3.9%
Federal Funds	\$274.0	\$285.7	\$11.7	4.3%
General Fund	\$152.6	\$157.6	\$5.0	3.3%
Other Non-Federal Funds	\$0.1	\$0.0	(\$0.1)	n/a

Total Expenditures	FY 2021-22 Appropriation	Nov 2021 Estimate	Change	
			Amount	Percent
Total Funds	\$123,277.3	\$123,844.5	\$567.2	0.5%
Federal Funds	\$84,801.7	\$86,473.7	\$1,672.0	2.0%
General Fund	\$28,169.9	\$26,846.9	(\$1,323.0)	-4.7%
Other Non-Federal Funds	\$10,305.8	\$10,523.9	\$218.1	2.1%

Note: Totals may not add due to rounding.

November 2021 Medi-Cal Estimate

Budget Year (FY 2022-23) Projected Expenditures Compared to Current Year (FY 2021-22)

(Dollars in Millions)

Medical Care Services	FY 2021-22 Estimate	FY 2022-23 Estimate	Change	
			Amount	Percent
Total Funds	\$117,868.9	\$126,719.4	\$8,850.5	7.5%
Federal Funds	\$81,664.8	\$79,953.8	(\$1,711.0)	-2.1%
General Fund	\$25,698.3	\$33,570.4	\$7,872.1	30.6%
Other Non-Federal Funds	\$10,505.8	\$13,195.2	\$2,689.4	25.6%

County Administration	FY 2021-22 Estimate	FY 2022-23 Estimate	Change	
			Amount	Percent
Total Funds	\$5,532.3	\$5,491.3	(\$41.0)	-0.7%
Federal Funds	\$4,523.2	\$4,300.2	(\$223.0)	-4.9%
General Fund	\$991.0	\$1,177.2	\$186.2	18.8%
Other Non-Federal Funds	\$18.1	\$13.9	(\$4.2)	-23.2%

Fiscal Intermediary	FY 2021-22 Estimate	FY 2022-23 Estimate	Change	
			Amount	Percent
Total Funds	\$443.3	\$448.9	\$5.6	1.3%
Federal Funds	\$285.7	\$310.5	\$24.8	8.7%
General Fund	\$157.6	\$138.5	(\$19.1)	-12.1%
Other Non-Federal Funds	\$0.0	(\$0.1)	(\$0.1)	\$0.0

Total Expenditures	FY 2021-22 Estimate	FY 2022-23 Estimate	Change	
			Amount	Percent
Total Funds	\$123,844.5	\$132,659.6	\$8,815.1	7.1%
Federal Funds	\$86,473.7	\$84,564.4	(\$1,909.3)	-2.2%
General Fund	\$26,846.9	\$34,886.0	\$8,039.1	29.9%
Other Non-Federal Funds	\$10,523.9	\$13,209.0	\$2,685.1	25.5%

Note: Totals may not add due to rounding.

Medi-Cal Local Assistance Estimate
Management Summary
November 2021 Estimate

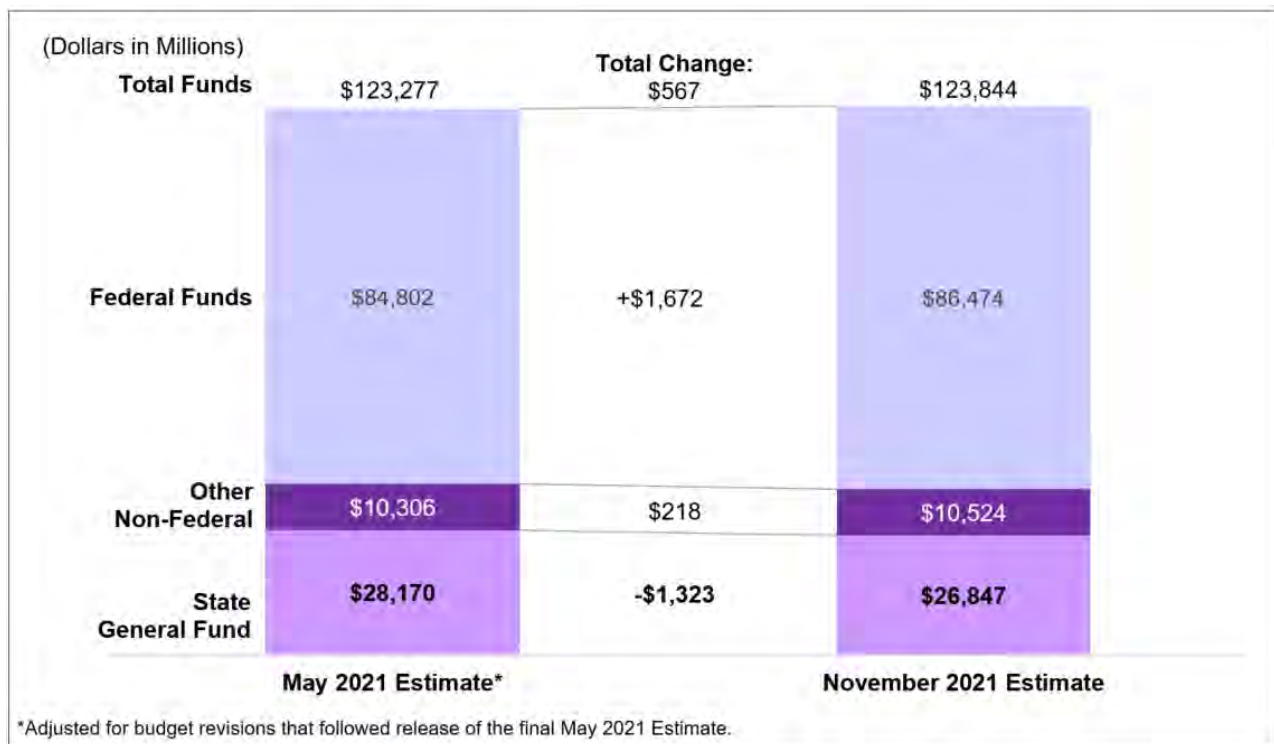
This document is intended to provide a high-level overview of the November 2021 Medi-Cal Local Assistance Estimate (Estimate).

The Department of Health Care Services (DHCS) estimates Medi-Cal local assistance spending to be \$123.8 billion total funds (\$26.8 billion General Fund) in Fiscal Year (FY) 2021-22 and \$132.7 billion total funds (\$34.9 billion General Fund) in FY 2022-23. This does not include Certified Public Expenditures of local governments or General Fund expenditures in 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:

- FY 2021-22 Comparison
- Discussion of Major Drivers of Changes from Prior Estimate
- FY 2021-22 to FY 2022-23 Year-Over-Year Comparison
- Discussion of Major Drivers of Changes Year Over Year
- Caseload Projections
- Detail Tables

FY 2021-22 Comparison



As displayed above, the November 2021 Estimate for FY 2021-22 projects a \$567 million increase in total spending (a \$1.3 billion decrease in General Fund spending) compared to the FY 2021-22 Budget Act appropriation, including revisions. This reflects a 0.5 percent increase in estimated total spending and a 4.7 percent decrease in estimated General Fund spending for FY 2021-22. Excluding revisions to the 2021-22 appropriation, the decrease is \$1.1 billion General Fund.

The major drivers of the change in estimated General Fund spending in FY 2021-22 between the May 2021 Estimate and the November 2021 Estimate are listed below:

FY 2021-22 Fiscal Year Comparison – Major Drivers of Changes in Estimated General Fund Spending

(Dollars in Millions)	Change in State General Fund from M21 to N21
Changes in COVID-19 impacts	(\$1,044)
Shift of funding for multiyear spending into later years	(\$553)
Increased funding from Hospital Quality Assurance Fee (HQAF) for children’s health care coverage	(\$189)
Reduced projected one-time impact from CalAIM transitioning populations	(\$170)

(Dollars in Millions)	Change in State General Fund from M21 to N21
Increased costs related to state-only claiming	\$548
Other impacts	\$85
Total	(\$1,323)

Discussion of Major Drivers of Changes from Prior Estimate

This section describes the major factors that drive changes in estimated spending in FY 2021-22 compared to the previous Estimate.

- **Changes in COVID-19 Impacts.** The Estimate reflects total net COVID-19 impacts of \$13.5 billion total funds (\$45.7 million General Fund) in FY 2021-22. This represents an increase of \$1 billion total funds but a reduction of \$1 billion General Fund compared to the FY 2021-22 Budget Act appropriation. The main drivers of this change include:
 - **Additional Increased Federal Medical Assistance Percentage (FMAP).** The Estimate assumes that the federal public health emergency (PHE) will continue through June 2022. This results in additional federal funding of \$1.6 billion and an additional General Fund savings of \$1.4 billion in FY 2021-22 compared to the previous Estimate.
 - **Revised Caseload Impact.** The projected monthly growth in caseload due to COVID-19 has been revised downward slightly compared to the previous Estimate. However, the Estimate now assumes that the federal PHE will continue through June 2022, and that the Medi-Cal caseload will continue to grow through that time. On net, the Estimate reflects additional costs of \$1.1 billion total funds (\$415 million General Fund) in FY 2021-22 compared to the previous Estimate.
 - **Testing in Schools.** The previous Estimate included \$575 million total funds (\$265 million General Fund) in FY 2021-22 for the estimated costs of COVID-19 testing in schools, after adjusting to remove the impacts of increased FMAP. Since that time, the Department has learned that schools have utilized direct federal funding for COVID-19 testing and there has been little to no Medi-Cal claiming activity related to COVID-19 testing in schools. The November 2021 Estimate assumes schools will continue using direct federal funding through June 2022, resulting in General Fund savings of \$265 million in FY 2021-22 compared to the previous Estimate.
 - **Vaccine Administration.** The Medi-Cal COVID-19 vaccine administration costs are estimated to be \$348 million total funds (\$38 million General Fund, not accounting for the impact of increased FMAP) in FY 2021-22. The November 2021 Estimate changes reflect a decrease of \$382 million total funds (increase of \$26 million General Fund) in FY 2021-22 from the prior Estimate. The reasons for the changes include: (1) updated

assumptions on the vaccinations administered and paid in Medi-Cal, (2) updated assumptions for the quarterly funding adjustments, (3) an estimate of the Medi-Cal beneficiaries, age 65 and older, that may qualify to receive a third booster dose, and (4) estimated costs for retroactive and prospective payments to Federally Qualified Health Centers (FQHCs) that were not able to bill Medi-Cal for vaccine administration-only encounters.

- **Fee-For-Service (FFS) Utilization Impact.** The COVID-19 PHE has affected medical and dental FFS utilization in multiple ways, such as reduced overall service utilization due to stay-at-home orders. The previous Estimate assumed net savings in FFS of about \$99 million total funds (\$51 million General Fund) in FY 2021-22, with impacts generally persisting through early fall 2021.

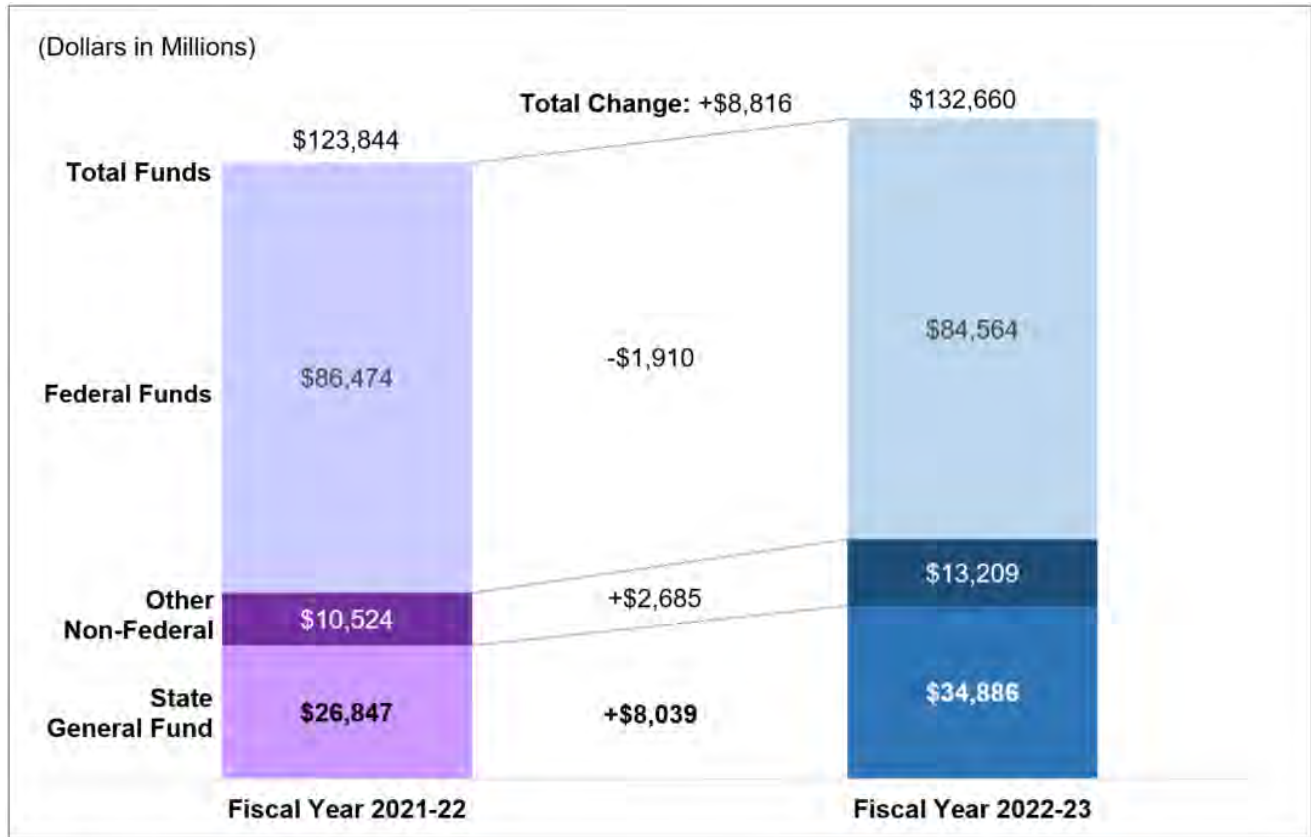
In more recent months, the COVID-19 impact on most FFS utilization appears to have declined and there is no longer significant evidence of a COVID-19 impact in FY 2021-22, other than that related to COVID vaccinations. Accordingly, the Estimate no longer separately scores any COVID-related impact FFS, other than what is captured in the COVID-19 Vaccine Administration policy change. This results in a net cost of \$99 million total Funds (\$51 million GF) in FY 2021-22 compared to the previous Estimate.

- **COVID-19 Vaccination Incentive Program.** Consistent with actions taken following enactment of the FY 2021-22 budget, \$350 million total funds (\$175 million General Fund) was added in FY 2021-22 for the Vaccination Incentive Program. These amounts are included in FY 2021-22 appropriation totals.
- **Shift of Multiyear Spending into Later Years.** The FY 2021-22 budget agreement included a number of large funding items with multiyear appropriation authority. In general, these items were budgeted entirely in FY 2021-22 in the previous Estimate. The November 2021 Estimate moves some of this funding into later years. This results in General Fund savings of \$553 million in FY 2021-22 compared to the previous Estimate. Specifically:
 - \$443 million General Fund for the Behavioral Health Continuum Infrastructure Program (BHCIP) was previously reflected in FY 2021-22. The November 2021 Estimate updates FY 2021-22 costs to reflect a decrease of \$277 million General Fund due to moving a portion of the FY 2021-22 General Fund to be spent in FY 2022-23 based on more developed project timelines and estimated expenditures.
 - \$389 million total funds (\$194 million General Fund) to increase access to student behavioral health services (part of the Children and Youth Behavioral Health Initiative, or CYBHI) was previously reflected in FY 2021-22. Of this amount, \$65 million total funds (\$32 million General Fund) remains in FY 2021-22, with the rest shifted to later years.
 - \$200 million total funds (\$100 million General Fund) for the CalAIM – PATH program, related to justice-involved initiatives, was assumed for FY 2021-22 in the previous

Estimate. Of this amount, \$106 million total funds (\$53 million General Fund) remains in FY 2021-22, with the rest shifted to later years.

- \$300 million total funds (\$30 million General Fund) for the CalAIM – Population Health Management Service item was previously reflected in FY 2021-22. Of this amount, \$75 million total funds (\$7.5 million General Fund) remains in FY 2021-22, with the rest shifted to later years.
- \$45 million, all General Fund, for CalHOPE Student Support (also part of CYBHI) was previously reflected in FY 2021-22. Of this amount, \$11 million remains in FY 2021-22, with the rest shifted to later years.
- \$12 million, all General Fund, for outreach and enrollment assistance for dual beneficiaries was previously reflected in FY 2021-22. Of this amount, \$2 million remains in FY 2021-22, with the rest shifted to later years.
- ***Additional Funding from the Hospital Quality Assurance Fee (HQAF) for Children’s Health Care Coverage.*** As a result of a delayed fee collection cycle and General Funds transfer in FY 2020-21, an additional \$189 million General Fund savings for children’s health care coverage is included in FY 2021-22.
- ***Reduced Projected One-Time Impact from CalAIM Transitioning Populations.*** The FY 2021-22 impact of the transitioning populations is estimated to be \$12 million total funds (\$4 million General Fund). This reflects a reduction of \$390 million total funds (\$170 million General Fund) based on shifts in the timing of transitions and refined policy and methodology assumptions for the populations transitioning in January 2022.
- ***Increase in State-Only Claiming Costs.*** In FY 2021-22, there is a net increase of \$548 million General Fund for the state-only claiming policy changes. The increase is mainly from (1) \$249 million General Fund increase related to updated managed care cost estimates based on CMS direction applicable to rating periods beginning July 2019, (2) \$102 million General Fund increase due to a decreased estimate of the additional federal claiming available related to immigration status change, (3) \$190 million General Fund shifting to FY 2021-22 due to the delay of the retroactive dental repayment, and (4) \$7 million General Fund net increase from other updated program estimates in FY 2021-22.

Year-Over-Year Change from FY 2021-22 to FY 2022-23



After the adjustments described previously, the Estimate projects that total spending will increase by \$8.8 billion total funds (7.1 percent) and General Fund spending will increase by \$8 billion (30 percent) between FY 2021-22 and FY 2022-23. The major factors that drive the increase in state General Fund costs are listed below:

FY 2021-22 to FY 2022-23 Year-Over-Year Comparison – Major Drivers of Changes in Estimated General Fund Spending

(Dollars in Millions)	Change in State General Fund from 2021-22 to 2022-23
Additional drug rebates	(\$478)
Reduction in deferrals compared to previous year	(\$415)
Savings from a full year of implementation of Medi-Cal Rx	(\$327)
Extend provider adverse childhood experiences (ACEs) using Mental Health Services Act funding	\$0
Human papillomavirus (HPV) coverage in Family Planning, Access, Care and Treatment (PACT) program	\$5

(Dollars in Millions)	Change in State General Fund from 2021-22 to 2022-23
Eliminate certain AB 97 provider rate reductions	\$9
Medi-Cal dental policy evidence-based practices	\$13
Implement mobile crisis benefit	\$16
Reduce Medi-Cal premiums to zero	\$19
Nursing facility financing reform	\$46
Impact of managed care organization (MCO) tax expiration	\$77
Full year of postpartum care extension costs	\$134
General Fund support for Proposition 56 payments	\$176
Equity and Practice Transformation Payments	\$200
Discontinue end-of-year two-week checkwrite hold	\$309
Managed care rate growth	\$340
Growth in Medicare costs	\$348
Increased costs for a full year implementing coverage for undocumented older Californians	\$454
Increased costs for a full year implementing CalAIM	\$547
Increased costs from state only claiming	\$813
Behavioral Health Bridge Housing funding	\$1,000
Increased state costs related to COVID-19	\$2,271
Children and Youth Behavioral Health Initiative and Behavioral Health Continuum Infrastructure Program	\$2,353
Other impacts	\$129
Total	\$8,039

Discussion of Major Drivers of Changes Year Over Year

This section describes the major factors that drive changes in estimated spending in FY 2022-23 compared to FY 2021-22.

- **Additional Drug Rebates.** Drug rebate savings are estimated to increase based on updated rebate collections data through the quarter ending June 30, 2021. However, consistent with the purpose of the Medi-Cal Drug Rebate Fund, the FY 2021-22 transfer from the Drug Medi-Cal Rebate Fund to the General Fund is kept at \$1.474 billion, which is the level assumed in the appropriation for FY 2021-22. Instead, additional savings are brought forward to FY 2022-

23. Taken together with a projected increase in drug rebates in FY 2022-23, this results in additional General Fund savings of \$478 million in FY 2022-23 compared to FY 2021-22. This projection assumes the reserve balance of \$222 million is maintained at the end of FY 2022-23.

- **Reduction in Deferrals Compared to Previous Year.** Deferrals are estimated to be \$182 million General Fund costs in FY 2021-22 and \$233.2 million General Fund savings in FY 2022-23. The change from FY 2021-22 to FY 2022-23 is \$415 million General Fund savings, mainly due to the assumption that \$438 million is returned to the General Fund with the full resolution of the remaining state only claiming deferrals in FY 2022-23.
- **Savings from a Full Year of Implementation of Medi-Cal Rx.** The overall annual impact of the Medi-Cal Rx is estimated to be \$827 million total funds (\$307 million General Fund) savings, reflecting increased costs of \$32 million total funds (\$2 million General Fund) from the prior Estimate. The Estimate assumes net savings of \$414 million total funds (\$178 million General Fund) in FY 2022-23. This reflects savings of \$850 million total funds (\$327 million General Fund) compared to FY 2021-22. The main driver of the GF savings in FY 2022-23 is due to including additional supplemental rebates totaling \$670 million total funds (\$224 million General Fund) savings; and a full year of the 340B, Maximum Allowable Ingredient Cost (MAIC) benchmark, and medical supply rebate savings.
- **Extend Provider Adverse Childhood Experiences (ACEs) Trainings.** The Estimate includes \$22 million in state Mental Health Services Act funding and an additional \$22 million in federal funding in FY 2022-23 to extend provider ACEs trainings to additional Medi-Cal providers.
- **Human Papillomavirus (HPV) Coverage in Family Prevention Planning, Access, Care and Treatment (PACT) Program.** The Estimate includes \$8 million total funds (\$5 million General Fund) to make HPV vaccination a covered benefit for individuals age 19 through 45.
- **Eliminate Certain AB 97 Provider Rate Reductions.** The Department proposes to eliminate provider rate reductions for nurses, alternative birthing centers, audiologists/hearing aid dispensers, respiratory care providers, durable medical equipment oxygen and respiratory services, chronic dialysis clinics, non-emergency medical transportation (by converting the existing Proposition 56 supplemental payment to an ongoing rate increase, costs budgeted with other Proposition 56 changes), and emergency air medical transportation. The Estimate reflects costs of \$20 million total funds (\$9 million General Fund) to eliminate these reductions effective July 2022.
- **Medi-Cal Dental Policy Evidence-Based Practices.** The Department proposes to update coverage requirements via trailer bill language in Medi-Cal to include evidence-based dental practices consistent with the American Association of Pediatric Dentists and the American Dental Association. Specifically, laboratory-processed crowns for posterior teeth will be available for adult Medi-Cal beneficiaries, in place of stainless-steel crowns. The budget

includes \$37 million total funds (\$13 million General Fund) in FY 2022-23 to implement this change.

- **Implement Mobile Crisis Benefit.** The Estimate includes \$108 million total funds (\$16 million General Fund) to implement a mobile crisis response services to Medi-Cal beneficiaries in need of behavioral health services. Under the American Rescue Plan Act, this benefit qualifies for 85 percent federal funding.
- **Reduce Medi-Cal Premiums to Zero.** The Estimate includes \$53 million total funds (\$19 million General Fund) to reduce premiums in Medi-Cal to zero, effective July 2022.
- **Nursing Facility Financing Reform.** Under current law, the rate-setting methodology for most nursing facilities sunsets effective December 31, 2022. The Department proposes to extend and reform the funding framework to move from a primarily cost-based methodology to one that incentivizes value and quality. The Estimate includes \$96 million total funds (\$46 million General Fund) for this change.
- **Expiration of Managed Care Organization (MCO) Enrollment Tax.** The Estimate reflects savings to the General Fund of \$1.6 billion in FY 2021-22 and \$1.5 billion in FY 2022-23. The decrease in General Fund savings of \$77 million (exclusive of any increased FMAP) is reflective of the estimated timing of MCO Tax payments and savings assuming the MCO tax expires December 31, 2022.
- **Full Year of Postpartum Care Extension.** The Estimate includes \$291 million total funds (\$134 million General Fund) in FY 2022-23. These expenditures assume the COVID-19 PHE ends June 30, 2022.
- **General Fund Support for Proposition 56 Payments.** Beginning FY 2022-23, certain Proposition 56 payments are proposed to be transitioned to ongoing General Fund support as ongoing rate increases, at an estimated cost of \$147 million General Fund. These payments include:
 - Adverse Childhood Experiences Screenings
 - AIDS Waiver
 - Community-Based Adult Services
 - Developmental Screenings
 - Freestanding Pediatric Subacute
 - Home Health
 - Intermediate Care Facilities for the Developmentally Disabled
 - Nonemergency Medical Transportation
 - Pediatric Day Health Care

Additionally, Proposition 56 revenue is projected to be insufficient to fully cover remaining Proposition 56 payments in FY 2022-23, such that an additional \$29 million of General Fund is estimated to be needed to fully cover costs for remaining Proposition 56 payments not being shifted in full to the General Fund. Taken together, General Fund costs to support current

Proposition 56 payments (both those proposed to transition to ongoing General Fund support and those proposed to remain funded by Proposition 56) is \$176 million in FY 2022-23.

- **Equity and Practice Transformation Payments.** The Estimate includes one-time \$400 million total funds (\$200 million General Fund) to support practice transformation and COVID-19 recovery payments to qualifying Medi-Cal providers focused on advancing equity and improving quality in children’s preventive, maternity, and integrated behavioral health care.
- **Discontinue End-of-Year Two-Week Checkwrite Hold.** Currently, the last two weeks of fee-for-service (FFS) checkwrite payments in June are held until the following July. This practice was instituted as a way to obtain one-time budgetary savings and has negatively impacted FFS providers and introduced administrative complexity. The Department proposes to discontinue this checkwrite hold for FY 2022-23, resulting an estimated one-time cost of \$796 million total funds (\$309 million General Fund).
- **Regular Growth in Costs.** As is typical, the Estimate includes growth in certain costs from year to year. Specifically, General Fund costs related to Medicare payments made on behalf of Medi-Cal beneficiaries are projected to grow by approximately \$348 million in FY 2022-23 compared to FY 2021-22. General Fund costs related to increases in the managed care base (due to factors such as rate increases, but excluding the impact of removing the pharmacy benefit effective January 2022) are estimated to be approximately \$340 million.
- **Increased Costs for a Full Year of Costs Related to Undocumented Older Californians Expansion.** The Estimate includes \$53 million total funds (\$42 million General Fund) in FY 2021-22 and \$590 million total funds (\$496 million General Fund) in FY 2022-23. The increase of \$454 million General Fund is due to including a full year of impact in FY 2022-23.
- **Growth in CalAIM Costs, Largely Due to a Full Year of Implementation.** The total cost of CalAIM initiatives in the Estimate is projected to grow from \$1.2 billion total funds (\$436 General Fund) to \$2.8 billion total funds (\$983 billion General Fund) in FY 2022-23. Major factors in this growth include:
 - **Enhanced Care Management, Community Supports, and Managed Care Plan Incentives.** The Estimate includes \$1.3 billion total funds (\$546 million General Fund) for these items in FY 2022-23. This represents an increase of \$774 million total funds (\$308 million General Fund). The reason for the year over year growth is a full year of implementation and incentive payments.
 - **CalAIM Inmate Pre-Release.** The Estimate includes \$50 million total funds (\$16 million General Fund) in FY 2022-23 for Mandatory County-Pre-Release Applications, “In Reach” Services up-to-90 days prior to release, and Behavioral Health Referrals/Linkages. This policy assumes implementation of January 1, 2023.
 - **CalAIM – Medi-Cal PATH.** The Estimate includes \$390 million total fund (\$134 million General Fund) in FY 2021-22. The Estimate includes \$707 million total fund (\$253 General Fund) in FY 2022-23. Major changes for PATH since the previous Estimate

include: (1) adding additional PATH funding requested in the 1115 waiver, to be matched with local funds, and (2) adding PATH funds connected with the home and community-based services (HCBS) spending plan.

- **CalAIM Population Health Management Service.** \$225 million of the \$300 million proposed for population health management has shifted from FY 2021-22 to FY 2022-23. This results in growth in General Fund costs for CalAIM of \$15 million in FY 2022-23 compared to FY 2021-22.
- **CalAIM Long-Term Care Benefit Transition.** Effective January 1, 2023, under the CalAIM Initiative, all Managed Care Plans (MCP) will be required to authorize and cover institutional long term care (LTC) facility services. In addition, effective January 2023, FFS beneficiaries receiving LTC facility services will be transitioned to mandatory managed care enrollment. The LTC benefit and population transition from the Fee-for-Service (FFS) to managed care delivery system is estimated to be budget neutral, but will reflect a costs until the annual FFS savings are fully lagged in against the estimated managed care costs. The Estimate includes \$116 million total funds (\$55 million General Fund) in FY 2022-23 for these costs.
- **State Only Claiming Costs.** In FY 2022-23, there is a net increase of \$813 million General Fund costs related to state only claiming. The increased General Fund is due to including approximately \$1 billion General Fund costs for retroactive managed care costs to be paid in FY 2022-23, decreased General Fund savings from immigration status change, and changes between the prospective pharmacy rebate and pharmacy claims estimate . The increased costs is offset by decreased General Fund in FY 2022-23 from completing the dental retroactive repayments in FY 2021-22.
- **Behavioral Health Bridge Housing.** The Estimate includes \$1 billion from the General Fund in FY 2022-23 to address the needs of people experiencing homelessness with serious and persistent behavioral health conditions by providing additional beds for county mental health departments and other housing types including tiny homes and existing assisted living settings.
- **COVID-19 Impacts.** The Estimate includes \$11.1 billion in total spending related to COVID-19 in FY 2022-23 (consisting of \$9.2 billion in federal funding, \$2.3 billion General Fund costs, with offsetting savings of \$413 million in special funds). In general, impacts due to COVID-19 are assumed to decline in 2022-23, largely in connection with the assumed end of the PHE at the end of June 2022. This results in a net reduction in federal funds associated with COVID-19 of \$4.6 billion going from FY 2021-22 to FY 2022-23. General Fund costs related to COVID-19 are estimated to increase by \$2.3 billion from FY 2021-22 to FY 2022-23. For details on funding changes to COVID-19 policy changes, see the COVID-19 section in the Detail Tables section at the end of this document. Major changes in COVID-19 impacts from FY 2021-22 to FY 2022-23 include:
 - **Significantly Reduced Federal Funding Under Families First Coronavirus Response Act (FFCRA).** The FFCRA provides increased federal medical assistance

percentage (FMAP) through the quarter following the end of the federal PHE. Consistent with the assumption that the PHE ends at the conclusion of June 2022, significantly less increased FMAP is assumed in FY 2022-23 than in FY 2021-22. Specifically, the Estimate projects \$5.3 billion in increased federal funding, with \$3.7 billion in General Fund savings in FY 2021-22. For FY 2022-23, the Estimate projects only \$1.5 billion in increased federal funding, with \$641 million in General Fund savings. (Some increased FMAP is assumed to be received in FY 2022-23 due to claim lag.) These assumptions result in increased General Fund costs of \$3.1 billion in FY 2022-23 compared to FY 2021-22.

- **Reduced Estimated Caseload Impact.** The Estimate includes \$10 billion total funds (\$2.8 billion General Fund) for COVID-19 caseload impacts in FY 2022-23. Projected COVID-19 caseload costs rely on an assumption that the federal public health emergency (PHE) and related continuous enrollment requirement will continue through the end of June 2022, after which counties will gradually redetermine eligibility for all cases over a 12-month period. The estimate assumes that, following this redetermination period, the caseload will approximately reach levels observed in mid-2020. There is considerable uncertainty about how low the Medi-Cal caseload will go following this redetermination period.
- **Testing in Schools.** As previously noted, schools are assumed to continue using direct federal funding for testing costs through FY 2021-22. Medi-Cal payments for testing in schools are estimated to begin in FY 2022-23 with estimated costs of \$405 million total funds (\$102 million General Fund). The FY 2022-23 estimate also assumes that a portion of tests will be reimbursed through the Local Educational Agency Billing Option Program.
- **Vaccine Administration.** Vaccine administration costs are estimated to be \$155 million total funds (\$1.5 million General Fund) in FY 2022-23. This reflects a decrease of \$193 million total funds (\$36 million General Fund) from FY 2021-22. From year to year, fewer first round vaccine doses and booster doses are projected to be administered in FY 2022-23, and there are no further FQHC payment corrections assumed in FY 2022-23.
- **Savings from Winding Down Various COVID-19 Items.** Consistent with assumed end of the PHE, FY 2022-23 reflects net reduced spending on a variety of other items, totaling roughly \$1.5 billion total funds (about \$761 million General Fund). Examples of this include the end of temporary rate increases, the end of one-time initiatives such as direct grants to designated public hospitals and the vaccination incentive program, and the end of other flexibilities such as paid sick leave for home care workers.
- **Multiyear Funding Items—Children and Youth Behavioral Health Initiative (CYBHI) and Behavioral Health Continuum Infrastructure Program (BHCIP).** The FY 2021-22 budget agreement included funding for a number of major initiatives as part of the CYBHI, as well as the BHCIP. The November 2021 Estimate makes a number of changes consistent with the multiyear plan. Together, these items result in \$2.4 billion in additional General Fund costs in FY 2022-23 compared to FY 2021-22.

- **Dyadic Services.** Existing law requires a new dyadic services benefit effective no sooner than July 1, 2022. The Estimate assumes an effective date for the benefit of January 1, 2023. The estimated impact in FY 2022-23 is \$87 million total funds (\$41 million General Fund).
- **Evidence-Based Behavioral Health Practices.** Consistent with the multiyear budget agreement, \$429 million from the General Fund is included in FY 2022-23 for evidence-based behavioral health practices.
- **Additional Funding for School Behavioral Health Partnerships and Capacity.** On top of the \$100 million one-time funding provided in FY 2021-22, the Estimate includes an additional \$450 million from the General Fund in FY 2022-23.
- **Behavioral Health Services and Supports Platform.** \$120 million from the General Fund are added to the existing \$10 million for the Behavioral Health Services and Supports Platform item in FY 2021-22 under the multiyear agreement. In addition, the multiyear agreement provides \$110 million from the General Fund for e-Consult service as well as provider training, for a total of \$230 million from the General Fund in FY 2022-23.
- **Additional Funding for BHCIP.** On top of one-time funding provided in the 2021-22 budget agreement, an additional \$1.4 billion, including \$218.5 million from the Coronavirus Fiscal Recovery Fund and \$1.2 billion from the General Fund for BHCIP is included in FY 2022-23. From the funding mentioned above, the CYBHI portion of the FY 2022-23 BHCIP funding is \$480.5 million General Fund.
- **Home- and Community-Based Services (HCBS) Spending Plan.** The Estimate includes a number of new PCs related to the enhanced HCBS funding under the American Rescue Plan (ARP) Act. These include a new policy change to budget enhanced HCBS funding claiming of \$3 billion, to be deposited in the new HCBS ARP Fund and several policy changes to reflect local assistance expenditures from the HCBS ARP Fund for programs administered by DHCS. HCBS Fund expenditures for other departments are reflected in their respective budgets. Expenditures from the HCBS ARP Fund are projected to draw down an additional \$1.6 billion in regular federal financial participation. See the detail table at the end of this document for more information.

Caseload Projections

This section provides an overview of Medi-Cal caseload projections included in the Estimate. Projected caseload levels are summarized in the tables and plot below:

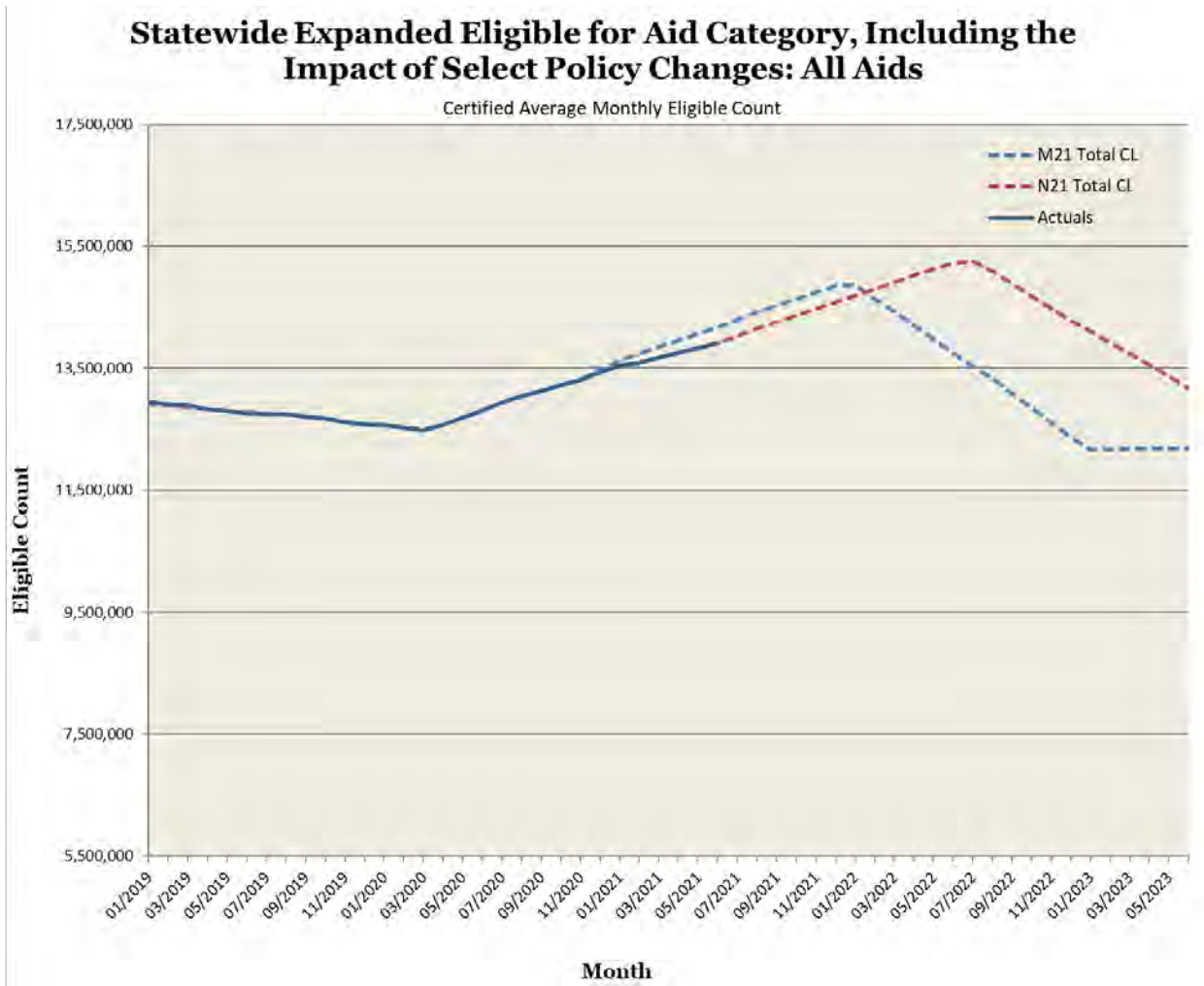
Estimated Average Monthly Certified Eligibles

November 2021 Estimate

	2020-21	2021-22	2022-23	Year over Year Change	
				2020-21 to 2021-22	2021-22 to 2022-23
Seniors	1,056,400	1,130,700	1,168,500	7.03%	3.34%
Persons with Disabilities	1,109,300	1,103,400	1,113,500	-0.53%	0.92%
Families and Children	7,137,300	7,689,400	7,479,900	7.74%	-2.72%
Optional Expansion	4,131,100	4,703,200	4,445,100	13.85%	-5.49%
Miscellaneous	56,900	60,700	60,900	6.68%	0.33%
Total	13,491,000	14,687,400	14,267,900	8.87%	-2.86%

Change from May 2021 Estimate

	Eligibles		Percent	
	2020-21	2021-22	2020-21	2021-22
Seniors	(6,800)	16,600	-0.64%	1.49%
Persons with Disabilities	(1,600)	400	-0.14%	0.04%
Families and Children	(71,600)	83,400	-0.99%	1.10%
Optional Expansion	(28,100)	90,600	-0.68%	1.96%
Miscellaneous	(2,000)	(100)	-3.40%	-0.16%
Total	(110,100)	190,900	-0.81%	1.32%



The overall Medi-Cal caseload is projected to continue to grow steadily through June 2022, consistent with the Estimate’s assumption that the federal public health emergency, and related restrictions on disenrolling beneficiaries, continue through that time. Consistent with recent actuals, this growth is assumed to be concentrated among the Affordable Care Act (ACA) Optional Expansion population and families with children.

Detail Table

The table below provides policy change-level detail on certain key program areas, including:

- COVID-19
- CalAIM
- CYBHI/BHCIP
- HCBS Spending Plan
- Proposition 56
- Other New Proposals

PC Type	PC #	Policy Change Title	November 2021 Estimated Amount (In Thousands)				Change from May 2021 Estimate (In Thousands)		Nov 2021 Estimate Year- over-Year Change (In Thousands)	
			2021-22 (CY)		2022-23 (BY)		2021-22 (CY)		2021-22 to 2022-23	
			TF	GF	TF	GF	TF	GF	TF	GF
COVID-19										
Reg.	182	COVID-19 CASELOAD IMPACT	\$10,464,267	\$2,942,532	\$9,981,882	\$2,815,274	\$1,075,409	\$414,947	-\$482,385	-\$127,258
Reg.	190	COVID-19 TESTING IN SCHOOLS *	\$0	\$0	\$404,591	\$102,449	-\$575,466	-\$264,690	\$404,591	\$102,449
County Admin.	3	FUNDING FOR COUNTY REDETERMINATIONS	\$73,015	\$36,508	\$73,015	\$36,508	\$0	\$0	\$0	\$0
Reg.	186	COVID-19 BEHAVIORAL HEALTH	\$274,809	\$17,657	\$10,351	\$1,534	\$201,126	\$13,543	-\$264,458	-\$16,122
Reg.	184	COVID-19 VACCINE ADMINISTRATION *	\$348,435	\$37,703	\$155,348	\$1,451	-\$382,009	\$25,570	-\$193,087	-\$36,252
Reg.	183	DESIGNATED PUBLIC HOSPITAL DIRECT GRANTS	\$300,000	\$300,000	\$0	\$0	\$0	\$0	-\$300,000	-\$300,000
Reg.	185	COVID-19 FFS REIMBURSEMENT RATES	\$378,526	\$180,548	\$0	\$0	\$185,713	\$84,141	-\$378,526	-\$180,548
Reg.	187	COVID-19 FFS DME RESPIRATORY RATES	\$35,203	\$16,453	\$0	\$0	\$28,898	\$13,516	-\$35,203	-\$16,453
Reg.	188	COVID-19 - SICK LEAVE BENEFITS *	\$7,249	\$58	\$0	\$0	-\$1,088	\$0	-\$7,249	-\$58
Reg.	189	COVID-19 ELIGIBILITY	\$159,769	\$39,405	\$0	\$0	\$129,682	\$18,450	-\$159,769	-\$39,405
Reg.	191	CONTINUOUS CHIP COVERAGE DURING THE COVID-19 PHE	\$0	\$39,794	\$0	\$0	\$0	\$23,794	\$0	-\$39,794
Reg.	192	COVID-19 BASE RECOVERIES	-\$14,026	-\$5,906	\$0	\$0	-\$49,198	-\$20,715	\$14,026	\$5,906
Reg.	N/A	COVID-19 UTILIZATION CHANGE	\$0	\$0	\$0	\$0	\$99,270	\$51,255	\$0	\$0
Reg.	256	MEDI-CAL COVID-19 VACCINATION INCENTIVE PROGRAM	\$250,000	\$125,000	\$0	\$0	\$0	\$0	-\$250,000	-\$125,000
Other Admin.	83	COVID-19 VACCINATION INCENTIVE PROGRAM ADMIN	\$100,000	\$50,000	\$0	\$0	\$0	\$0	-\$100,000	-\$50,000

DHCS Medi-Cal Local Assistance Estimate
Management Summary - November 2021

			November 2021 Estimated Amount (In Thousands)				Change from May 2021 Estimate (In Thousands)		Nov 2021 Estimate Year- over-Year Change (In Thousands)	
			2021-22 (CY)		2022-23 (BY)		2021-22 (CY)		2021-22 to 2022-23	
PC Type	PC #	Policy Change Title	TF	GF	TF	GF	TF	GF	TF	GF
	Var.	COVID-19 INCREASED FMAP	\$1,164,990	-\$3,734,009	\$500,277	-\$640,585	\$342,342	-\$1,403,401	-\$664,713	\$3,093,424
Totals			\$13,542,238	\$45,743	\$11,125,464	\$2,316,631	\$1,054,679	-\$1,043,590	-\$2,416,774	\$2,270,888
* Adjusted to remove impact of increased FMAP to avoid double counting.										
** Reflects adjustments to the FY 2021-22 Budget Act following release of the final May 2021 Estimate.										
CalAIM										
Reg.	86	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES	\$564,241	\$237,642	\$1,338,593	\$545,563	\$28,824	-\$30,066	\$774,352	\$307,920
Reg.	105	CALAIM – MEDI-CAL PATH	\$389,650	\$134,400	\$706,650	\$253,100	\$189,650	\$34,400	\$317,000	\$118,700
Reg.	207	CALAIM - DENTAL INITIATIVES	\$120,700	\$58,489	\$243,216	\$117,674	\$4,487	\$1,502	\$122,516	\$59,185
Reg.	260	CALAIM - LTC BENEFIT TRANSITION	\$0	\$0	\$115,809	\$55,468	\$0	\$0	\$115,809	\$55,468
Reg.	102	CALAIM - TRANSITIONING POPULATIONS	\$11,771	\$4,348	\$101,037	\$50,269	-\$389,826	-\$170,412	\$89,266	\$45,921
Reg.	76	CALAIM - BH QUALITY IMPROVEMENT PROGRAM	\$21,750	\$21,750	\$45,396	\$45,396	\$0	\$0	\$23,646	\$23,646
Other Admin.	7	CALAIM - POPULATION HEALTH MANAGEMENT	\$75,000	\$7,500	\$225,000	\$22,500	-\$225,000	-\$22,500	\$150,000	\$15,000
Reg.	14	CALAIM INMATE PRE-RELEASE PROGRAM	\$0	\$0	\$50,232	\$15,534	\$0	\$0	\$50,232	\$15,534
Reg.	47	CALAIM - ORGAN TRANSPLANT	\$4,789	\$1,394	\$1,061	\$309	\$133	\$39	-\$3,728	-\$1,084
Reg.	114	CALAIM - MSSP CARVE-OUT OF CCI	\$1,600	\$800	\$0	\$0	\$0	\$0	-\$1,600	-\$800
Reg.	N/A	CALAIM - MANAGED CARE SMHS CARVE-OUT	\$0	\$0	\$0	\$0	\$4,773	\$2,290	\$0	\$0
Reg.	268	CALAIM- DESIGNATED STATE HEALTH PROGRAMS	\$0	-\$30,800	\$0	-\$123,200	\$0	-\$30,800	\$0	-\$92,400
Totals			\$1,189,501	\$435,523	\$2,826,994	\$982,613	-\$386,959	-\$215,547	\$1,637,493	\$547,090
Children and Youth Behavioral Health Initiative / Behavioral Health Continuum Infrastructure Program										
Reg.	74	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE	\$466,000	\$166,000	\$1,659,749	\$1,441,249	-\$277,499	-\$277,499	\$1,193,749	\$1,275,249
Reg.	208	CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY	\$100,000	\$100,000	\$450,000	\$450,000	\$0	\$0	\$350,000	\$350,000
Reg.	236	CYBHI - EVIDENCE-BASED BH PRACTICES	\$0	\$0	\$429,000	\$429,000	\$0	\$0	\$429,000	\$429,000
Other Admin.	25	CYBHI - BH SERVICES AND SUPPORTS PLATFORM	\$10,000	\$10,000	\$230,000	\$230,000	\$0	\$0	\$220,000	\$220,000
Reg.	103	CYBHI - INCREASE ACCESS TO STUDENT BH SERVICES	\$64,831	\$32,416	\$129,662	\$64,831	-\$324,155	-\$162,077	\$64,831	\$32,416
Reg.	53	CYBHI - DYADIC SERVICES	\$0	\$0	\$87,444	\$40,790	\$0	\$0	\$87,444	\$40,790
Reg.	225	CYBHI - CALHOPE STUDENT SUPPORT	\$11,000	\$11,000	\$17,000	\$17,000	-\$34,000	-\$34,000	\$6,000	\$6,000
Totals			\$651,831	\$319,416	\$3,002,855	\$2,672,870	-\$635,654	-\$473,576	\$2,351,024	\$2,353,455

DHCS Medi-Cal Local Assistance Estimate
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PC Type # Policy Change Title			November 2021 Estimated Amount (In Thousands)				Change from May 2021 Estimate (In Thousands)		Nov 2021 Estimate Year- over-Year Change (In Thousands)	
			2021-22 (CY)		2022-23 (BY)		2021-22 (CY)		2021-22 to 2022-23	
			TF	GF	TF	GF	TF	GF	TF	GF
Home and Community Based Services Spending Plan										
Reg.	104	HCBS SP - HOUSING AND HOMELESSNESS INCENTIVE PROG	\$161,059	\$0	\$644,236	\$0	\$161,059	\$0	\$483,177	\$0
Reg.	203	HCBS SP - COMM BASED RESIDENTIAL CONTINUUM PILOT	\$0	\$0	\$287,197	\$0	\$0	\$0	\$287,197	\$0
Reg.	269	HCBS SP CDDS	\$43,593	\$0	\$231,796	\$0	\$43,593	\$0	\$188,203	\$0
Reg.	227	HCBS SP - ASSISTED LIVING WAIVER EXPANSION	\$10,819	-\$6,819	\$32,375	-\$20,492	\$10,819	-\$6,819	\$21,556	-\$13,673
Reg.	68	HCBS SP - CONTINGENCY MANAGEMENT	\$3,638	\$0	\$23,086	\$0	\$3,638	\$0	\$19,448	\$0
Other Admin.	86	HCBS SP CDDS - OTHER ADMIN	\$1,167	\$0	\$2,521	\$0	\$1,167	\$0	\$1,354	\$0
Reg.	254	AMERICAN RESCUE PLAN INCREASED FMAP FOR HCBS	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Reg.	223	HCBS SP - NON-IHSS CARE ECONOMY PMTS	\$12,250	\$0	\$0	\$0	\$12,250	\$0	-\$12,250	\$0
Other Admin.	64	HCBS SP - IHSS HCBS CARE ECONOMY PMTS	\$137,275	\$0	\$0	\$0	\$137,275	\$0	-\$137,275	\$0
Reg.	211	HCBS SP - CALBRIDGE BH PILOT PROGRAM	\$40,000	\$0	\$0	\$0	\$40,000	\$0	-\$40,000	\$0
Totals			\$409,801	-\$6,819	\$1,221,211	-\$20,492	\$409,801	-\$6,819	\$811,410	-\$13,673
Proposition 56										
Reg.	149	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	\$1,222,805	\$440,668	\$1,215,755	\$485,871	-\$14,561	\$26,781	-\$7,050	\$45,203
Reg.	167	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	\$493,663	\$170,374	\$507,946	\$199,843	\$37,604	\$87	\$14,283	\$29,469
Reg.	153	PROP 56 - MEDI-CAL FAMILY PLANNING	\$422,419	\$69,692	\$407,214	\$67,271	-\$15,603	\$25,890	-\$15,205	-\$2,421
Reg.	139	PROP 56 - HOME HEALTH RATE INCREASE	\$123,645	\$54,060	\$123,645	\$61,467	\$30,891	\$10,728	\$0	\$7,407
Reg.	109	PROP 56-BEHAVIORAL HEALTH INCENTIVE PROGRAM	\$75,998	\$33,286	\$90,136	\$42,739	-\$2	-\$2	\$14,138	\$9,453
Reg.	164	PROP 56 - DEVELOPMENTAL SCREENINGS	\$60,811	\$24,287	\$60,079	\$27,366	-\$954	-\$1,241	-\$732	\$3,079
Reg.	166	PROP 56 - ADVERSE CHILDHOOD EXPERIENCES SCREENINGS	\$47,900	\$17,591	\$48,035	\$20,009	-\$78	-\$1,034	\$135	\$2,418
Reg.	171	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS	\$26,264	\$11,204	\$27,361	\$13,238	-\$9	-\$781	\$1,097	\$2,035
Reg.	174	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	\$67,144	\$12,298	\$70,366	\$12,842	-\$26,460	-\$3,711	\$3,222	\$544

DHCS Medi-Cal Local Assistance Estimate
 Management Summary - November 2021

PC Type	PC #	Policy Change Title	November 2021 Estimated Amount (In Thousands)				Change from May 2021 Estimate (In Thousands)		Nov 2021 Estimate Year- over-Year Change (In Thousands)	
			2021-22 (CY)		2022-23 (BY)		2021-22 (CY)		2021-22 to 2022-23	
			TF	GF	TF	GF	TF	GF	TF	GF
Reg.	168	PROP 56 - CBAS SUPPLEMENTAL PAYMENTS	\$26,552	\$11,630	\$23,702	\$11,851	-\$2,785	-\$1,995	-\$2,850	\$221
Reg.	177	PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS	\$8,173	\$3,454	\$8,206	\$3,958	-\$644	-\$494	\$33	\$504
Reg.	178	PROP 56 - NEMT SUPPLEMENTAL PAYMENTS	\$7,158	\$3,319	\$7,158	\$3,729	-\$767	-\$577	\$0	\$410
Reg.	154	PROP 56 - VALUE-BASED PAYMENT PROGRAM	\$363,684	\$117,326	\$30,595	\$3,548	-\$1,793	\$0	-\$333,089	-\$113,778
Reg.	138	PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE	\$6,371	\$2,786	\$6,371	\$3,168	-\$7,875	-\$3,870	\$0	\$382
Reg.	180	PROP 56 - AIDS WAIVER RATE INCREASE	\$4,274	\$1,872	\$4,274	\$2,137	-\$2,526	-\$1,371	\$0	\$265
Reg.	210	PROP 56 - PROVIDER ACES TRAININGS	\$56,592	\$28,296	\$1,468	\$734	\$0	\$0	-\$55,124	-\$27,562
Reg.	121	PROP 56 - DIRECTED PAYMENT RISK MITIGATION	-\$235,000	-\$74,547	\$0	\$0	-\$235,000	-\$74,547	\$235,000	\$74,547
Reg.	218	PROP 56 PHYSICIANS & DENTISTS LOAN REPAYMENT PROG	\$28,477	\$0	\$41,400	\$0	\$0	\$0	\$12,923	\$0
Reg.	179	PROPOSITION 56 FUNDING	\$0	-\$927,595	\$0	-\$783,879	\$0	\$26,083	\$0	\$143,716
Totals			\$2,806,930	\$0	\$2,673,711	\$175,890	-\$240,562	\$0	-\$133,219	\$175,890
Other New Proposals										
Reg.	275	BEHAVIORAL HEALTH BRIDGE HOUSING	\$0	\$0	\$1,000,000	\$1,000,000	\$0	\$0	\$1,000,000	\$1,000,000
Reg.	258	END-OF-FY 2-WEEK CHECKWRITE HOLD BUYBACK	\$0	\$0	\$795,755	\$309,410	\$0	\$0	\$795,755	\$309,410
Reg.	266	EQUITY & PRACTICE TRANSFORMATION PAYMENTS	\$0	\$0	\$400,000	\$200,000	\$0	\$0	\$400,000	\$200,000
Reg.	263	NURSING FACILITY FINANCING REFORM	\$0	\$0	\$96,480	\$45,732	\$0	\$0	\$96,480	\$45,732
Reg.	274	PREMIUMS REDUCTION	\$0	\$0	\$53,163	\$18,879	\$0	\$0	\$53,163	\$18,879
Reg.	252	QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES	\$0	\$0	\$108,483	\$16,272	\$0	\$0	\$108,483	\$16,272
Reg.	267	AB 97 ELIMINATIONS	\$0	\$0	\$20,191	\$8,986	\$0	\$0	\$20,191	\$8,986
Reg.	257	EVIDENCE-BASED DENTAL PRACTICES	\$0	\$0	\$37,110	\$12,915	\$0	\$0	\$37,110	\$12,915
Reg.	270	FPACT HPV VACCINE COVERAGE	\$0	\$0	\$8,040	\$4,581	\$0	\$0	\$8,040	\$4,581
Reg.	271	MHSF - PROVIDER ACES TRAININGS	\$0	\$0	\$44,100	\$0	\$0	\$0	\$44,100	\$0
Totals			\$0	\$0	\$2,563,322	\$1,616,775	\$0	\$0	\$2,563,322	\$1,616,775

Medi-Cal Funding Summary
November 2021 Estimate Compared to Appropriation
Fiscal Year 2021 - 2022

TOTAL FUNDS

<u>Benefits:</u>	<u>Total Appropriation</u>	<u>Nov 2021 Estimate</u>	<u>Difference Incr./(Decr.)</u>
4260-101-0001/0890 Medi-Cal General and Federal Funds	\$97,202,114,000	\$95,298,499,000	(\$1,903,615,000)
4260-101-0080 CLPP Funds	\$916,000	\$916,000	\$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	\$97,987,000	\$97,987,000	\$0
4260-101-0233 Prop 99 Physician Srvc. Acct	\$27,831,000	\$27,831,000	\$0
4260-101-0236 Prop 99 Unallocated Account	\$49,196,000	\$49,196,000	\$0
4260-101-3085 Mental Health Services	\$0	\$0	\$0
4260-101-3168 Emergency Air Transportation Fund	\$4,351,000	\$4,351,000	\$0
4260-101-3305 Healthcare Treatment Fund	\$803,065,000	\$776,982,000	(\$26,083,000)
4260-101-3375 Prop 56 Loan Repayment Program	\$28,477,000	\$28,477,000	\$0
4260-101-8507 Home & Community Based Services (101)*	\$930,814,000	\$152,251,000	(\$778,563,000)
4260-611-0001/0890 Home & Community Based Services(611) ^d	\$3,026,795,000	\$5,085,402,000	\$2,058,607,000
4260-698-0001 Home & Community Based Services (698-0001) ^d	(\$3,026,795,000)	(\$2,542,701,000)	\$484,094,000
4260-698-8507 Home & Community Based Services (698-8507) ^d	(\$3,026,795,000)	(\$2,542,701,000)	\$484,094,000
4260-102-0001/0890 Capital Debt	\$71,005,000	\$67,179,000	(\$3,826,000)
4260-102-3305 Prop 56 Loan Forgiveness Program ¹	\$15,200,000	\$0	(\$15,200,000)
4260-103-3305 Prop 56 Value-Based Payment	\$150,613,000	\$150,613,000	\$0
4260-104-0001 NDPH Hosp Supp	\$1,900,000	\$1,900,000	\$0
4260-601-3096 NDPH Suppl	\$891,000	\$5,558,000	\$4,667,000
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	\$143,647,000	\$139,910,000	(\$3,737,000)
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 ¹	\$13,663,000	\$13,000,000	(\$663,000)
4260-112-0001 GF Support for Prop 56 Payments*	\$0	\$0	\$0
4260-695-3305 Health Care Treatment Fund (Less GF)	\$0	\$0	\$0
4260-113-0001/0890 Children's Health Insurance Program	\$3,936,394,000	\$3,507,040,000	(\$429,354,000)
4260-162-8506 State Fiscal Recovery Fund of 2021	\$300,000,000	\$300,000,000	\$0
4260-601-0942142 Local Trauma Centers	\$68,225,000	\$53,616,000	(\$14,609,000)
4260-601-0942 Health Homes Program Account	\$10,453,000	\$15,526,000	\$5,073,000
4260-601-0995 Reimbursements	\$1,149,691,000	\$1,316,348,000	\$166,657,000
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	\$0	\$0	\$0
4260-601-3213 LTC QA Fund	\$550,334,000	\$447,165,000	(\$103,169,000)
4260-601-3311 Healthcare Service Fines and Penalties	\$0	\$0	\$0
4260-601-3323 Medi-Cal Emergency Transport Fund	\$64,328,000	\$57,425,000	(\$6,903,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	\$1,474,916,000	\$1,474,916,000	\$0
4260-601-3334 MCO Tax (HCS Special Fund)	\$2,517,458,000	\$2,517,457,000	(\$1,000)
4260-601-7502 Demonstration DSH Fund	\$273,781,000	\$283,951,000	\$10,170,000
4260-601-7503 Health Care Support Fund	\$434,000	\$42,430,000	\$41,996,000
4260-601-8107 Whole Person Care Pilot Fund	\$297,649,000	\$309,811,000	\$12,162,000
4260-601-8108 Global Payment Program Fund	\$1,518,616,000	\$1,481,349,000	(\$37,267,000)
4260-601-8113 DPH GME Special Fund	\$188,599,000	\$223,567,000	\$34,968,000
4260-602-0309 Perinatal Insurance Fund	\$14,694,000	\$12,266,000	(\$2,428,000)
4260-605-0001 SNF Quality & Accountability	\$47,523,000	\$47,523,000	\$0
4260-605-3167 SNF Quality & Accountability (Non-GF) Only	(\$13,750,000)	\$0	\$13,750,000
4260-605-3167 SNF Quality & Accountability	\$42,000,000	\$42,000,000	\$0
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	(\$47,523,000)	(\$47,523,000)	\$0
4260-606-0834 SB 1100 DSH	\$105,495,000	\$84,284,000	(\$21,211,000)
4260-607-8502 LIHP IGT (Non-GF)	\$0	\$0	\$0
4260-611-3158/0890 Hospital Quality Assurance	\$8,660,067,000	\$8,886,971,000	\$226,904,000
Total Benefits	\$117,672,359,000	\$117,868,872,000	\$196,513,000
County Administration:			
4260-101-0001/0890 Medi-Cal General and Federal Funds ¹	\$5,074,678,000	\$5,430,300,000	\$355,622,000
4260-102-3305 Prop 56 Loan Forgiveness Program	\$0	\$0	\$0
4260-106-0890 Money Follow Person Fed. Grant	\$340,000	\$340,000	\$0
4260-113-0001/0890 Children's Health Insurance Program	\$73,129,000	\$68,888,000	(\$4,241,000)
4260-117-0001/0890 HIPAA	\$11,972,000	\$14,645,000	\$2,673,000
4260-162-8506 State Fiscal Recovery Fund of 2021	\$0	\$0	\$0
4260-601-0942 Health Homes Program Account	\$162,000	\$161,000	(\$1,000)
4260-601-0995 Reimbursements	\$13,917,000	\$13,793,000	(\$124,000)
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	\$0	\$0	\$0
4260-605-3167 SNF Quality & Accountability Admin.	\$4,007,000	\$4,007,000	\$0
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	\$100,000	\$149,000	\$49,000
Total County Administration	\$5,178,305,000	\$5,532,283,000	\$353,978,000
Fiscal Intermediary:			
4260-101-0001/0890 Medi-Cal General and Federal Funds	\$403,295,000	\$422,437,000	\$19,142,000
4260-111-0001 CHDP State Only	\$0	\$0	\$0
4260-113-0001/0890 Children's Health Insurance Program	\$21,999,000	\$19,503,000	(\$2,496,000)
4260-117-0001/0890 HIPAA	\$1,373,000	\$1,388,000	\$15,000
4260-601-0995 Reimbursements	\$0	\$0	\$0
Total Fiscal Intermediary	\$426,667,000	\$443,328,000	\$16,661,000
Grand Total - Total Funds	\$123,277,331,000	\$123,844,483,000	\$567,152,000

¹ Reflects mid-year adjustments to the Appropriation

Medi-Cal Funding Summary
November 2021 Estimate Compared to Appropriation
Fiscal Year 2021 - 2022

STATE FUNDS

<u>Benefits:</u>	<u>State Funds</u> <u>Appropriation</u>	<u>Nov 2021</u> <u>Estimate</u>	<u>Difference</u> <u>Incr./(Decr.)</u>
4260-101-0001 Medi-Cal General Fund* ¹	\$25,839,835,000	\$24,606,372,000	(\$1,233,463,000)
4260-101-0080 CLPP Funds	\$916,000	\$916,000	\$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	\$97,987,000	\$97,987,000	\$0
4260-101-0233 Prop 99 Physician Srvc. Acct	\$27,831,000	\$27,831,000	\$0
4260-101-0236 Prop 99 Unallocated Account	\$49,196,000	\$49,196,000	\$0
4260-101-3085 Mental Health Services	\$0	\$0	\$0
4260-101-3168 Emergency Air Transportation Fund	\$4,351,000	\$4,351,000	\$0
4260-101-3305 Healthcare Treatment Fund	\$803,065,000	\$776,982,000	(\$26,083,000)
4260-101-3375 Prop 56 Loan Repayment Program	\$28,477,000	\$28,477,000	\$0
4260-101-8507 Home & Community Based Services (101) ¹	\$930,814,000	\$152,251,000	(\$778,563,000)
4260-611-0001 Home & Community Based Services(611)* ¹	\$3,026,795,000	\$2,542,701,000	(\$484,094,000)
4260-698-0001 Home & Community Based Services (698-0001)* ¹	(\$3,026,795,000)	(\$2,542,701,000)	\$484,094,000
4260-698-8507 Home & Community Based Services (698-8507) ¹	(\$3,026,795,000)	(\$2,542,701,000)	\$484,094,000
4260-102-0001 Capital Debt *	\$19,575,000	\$18,840,000	(\$735,000)
4260-102-3305 Prop 56 Loan Forgiveness Program ¹	\$15,200,000	\$0	(\$15,200,000)
4260-103-3305 Prop 56 Value-Based Payment	\$150,613,000	\$150,613,000	\$0
4260-104-0001 NDPH Hosp Supp *	\$1,900,000	\$1,900,000	\$0
4260-601-3096 NDPH Suppl	\$891,000	\$5,558,000	\$4,667,000
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	\$143,647,000	\$139,910,000	(\$3,737,000)
4260-698-3097 Private Hosp Supp (Less Funded by GF)	(\$118,400,000)	(\$118,400,000)	\$0
4260-112-0001 GF Support for Prop 56 Payments*	\$0	\$0	\$0
4260-695-3305 Health Care Treatment Fund (Less GF)	\$0	\$0	\$0
4260-113-0001 Childrens Health Insurance Program *	\$1,050,029,000	\$905,231,000	(\$144,798,000)
4260-601-0942142 Local Trauma Centers	\$68,225,000	\$53,616,000	(\$14,609,000)
4260-601-0942 Health Homes Program Account	\$10,453,000	\$15,526,000	\$5,073,000
4260-601-0995 Reimbursements	\$1,149,691,000	\$1,316,348,000	\$166,657,000
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	\$0	\$0	\$0
4260-601-3213 LTC QA Fund	\$550,334,000	\$447,165,000	(\$103,169,000)
4260-601-3311 Healthcare Service Fines and Penalties	\$0	\$0	\$0
4260-601-3323 Medi-Cal Emergency Transport Fund	\$64,328,000	\$57,425,000	(\$6,903,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	\$1,474,916,000	\$1,474,916,000	\$0
4260-601-3334 MCO Tax (HCS Special Fund)	\$2,517,458,000	\$2,517,457,000	(\$1,000)
4260-601-8107 Whole Person Care Pilot Fund	\$297,649,000	\$309,811,000	\$12,162,000
4260-601-8108 Global Payment Program Fund	\$1,518,616,000	\$1,481,349,000	(\$37,267,000)
4260-601-8113 DPH GME Special Fund	\$188,599,000	\$223,567,000	\$34,968,000
4260-602-0309 Perinatal Insurance Fund	\$14,694,000	\$12,266,000	(\$2,428,000)
4260-605-0001 SNF Quality & Accountability *	\$47,523,000	\$47,523,000	\$0
4260-605-3167 SNF Quality & Accountability (Non-GF) Only	(\$13,750,000)	\$0	\$13,750,000
4260-605-3167 SNF Quality & Accountability	\$42,000,000	\$42,000,000	\$0
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	(\$47,523,000)	(\$47,523,000)	\$0
4260-606-0834 SB 1100 DSH	\$105,495,000	\$84,284,000	(\$21,211,000)
4260-607-8502 LIHP IGT (Non-GF)	\$0	\$0	\$0
4260-611-3158 Hospital Quality Assurance Revenue	\$3,240,401,000	\$3,746,518,000	\$506,117,000
Total Benefits	\$37,364,741,000	\$36,204,062,000	(\$1,160,679,000)
Total Benefits General Fund *	\$27,077,262,000	\$25,698,266,000	(\$1,378,996,000)
County Administration:			
4260-101-0001 Medi-Cal General Fund * ¹	\$922,651,000	\$974,440,000	\$51,789,000
4260-102-3305 Prop 56 Loan Forgiveness Program	\$0	\$0	\$0
4260-113-0001 Childrens Health Insurance Program *	\$15,313,000	\$13,694,000	(\$1,619,000)
4260-117-0001 HIPAA *	\$2,078,000	\$2,840,000	\$762,000
4260-601-0942 Health Homes Program Account	\$162,000	\$161,000	(\$1,000)
4260-601-0995 Reimbursements	\$13,917,000	\$13,793,000	(\$124,000)
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	\$0	\$0	\$0
4260-605-3167 SNF Quality & Accountability Admin.	\$4,007,000	\$4,007,000	\$0
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	\$100,000	\$149,000	\$49,000
Total County Administration	\$958,228,000	\$1,009,084,000	\$50,856,000
Total County Administration General Fund *	\$940,042,000	\$990,974,000	\$50,932,000
Fiscal Intermediary:			
4260-101-0001 Medi-Cal General Fund *	\$145,875,000	\$152,066,000	\$6,191,000
4260-111-0001 CHDP State Only *	\$0	\$0	\$0
4260-113-0001 Childrens Health Insurance Program *	\$6,459,000	\$5,287,000	(\$1,172,000)
4260-117-0001 HIPAA *	\$294,000	\$295,000	\$1,000
4260-601-0995 Reimbursements	\$0	\$0	\$0
Total Fiscal Intermediary	\$152,628,000	\$157,648,000	\$5,020,000
Total Fiscal Intermediary General Fund *	\$152,628,000	\$157,648,000	\$5,020,000
Grand Total - State Funds	\$38,475,597,000	\$37,370,794,000	(\$1,104,803,000)
Grand Total - General Fund*	\$28,169,932,000	\$26,846,888,000	(\$1,323,044,000)

¹ Reflects mid-year adjustments to the Appropriation

Medi-Cal Funding Summary
November 2021 Estimate Compared to Appropriation
Fiscal Year 2021 - 2022

FEDERAL FUNDS

	<u>Federal Funds Appropriation</u>	<u>Nov 2021 Estimate</u>	<u>Difference Incr./(Decr.)</u>
<u>Benefits:</u>			
4260-101-0890 Federal Funds ¹	\$71,362,279,000	\$70,692,127,000	(\$670,152,000)
4260-102-0890 Capital Debt	\$51,430,000	\$48,339,000	(\$3,091,000)
4260-106-0890 Money Follows Person Federal Grant	\$13,663,000	\$13,000,000	(\$663,000)
4260-113-0890 Childrens Health Insurance Fund	\$2,886,365,000	\$2,601,809,000	(\$284,556,000)
4260-162-8506 State Fiscal Recovery Fund of 2021	\$300,000,000	\$300,000,000	\$0
4260-601-7502 Demonstration DSH Fund	\$273,781,000	\$283,951,000	\$10,170,000
4260-601-7503 Health Care Support Fund	\$434,000	\$42,430,000	\$41,996,000
4260-611-0890 Home & Community Based Services 100% FF	\$0	\$2,542,701,000	\$2,542,701,000
4260-611-0890 Hospital Quality Assurance	\$5,419,666,000	\$5,140,453,000	(\$279,213,000)
Total Benefits	<u>\$80,307,618,000</u>	<u>\$81,664,810,000</u>	<u>\$1,357,192,000</u>
<u>County Administration:</u>			
4260-101-0890 Federal Funds	\$4,152,027,000	\$4,455,860,000	\$303,833,000
4260-106-0890 Money Follows Person Fed. Grant	\$340,000	\$340,000	\$0
4260-113-0890 Childrens Health Insurance Fund	\$57,816,000	\$55,194,000	(\$2,622,000)
4260-117-0890 HIPAA	\$9,894,000	\$11,805,000	\$1,911,000
4260-162-8506 State Fiscal Recovery Fund of 2021	\$0	\$0	\$0
Total County Administration	<u>\$4,220,077,000</u>	<u>\$4,523,199,000</u>	<u>\$303,122,000</u>
<u>Fiscal Intermediary:</u>			
4260-101-0890 Federal Funds	\$257,420,000	\$270,371,000	\$12,951,000
4260-113-0890 Childrens Health Insurance Fund	\$15,540,000	\$14,216,000	(\$1,324,000)
4260-117-0890 HIPAA	\$1,079,000	\$1,093,000	\$14,000
Total Fiscal Intermediary	<u>\$274,039,000</u>	<u>\$285,680,000</u>	<u>\$11,641,000</u>
Grand Total - Federal Funds	<u>\$84,801,734,000</u>	<u>\$86,473,689,000</u>	<u>\$1,671,955,000</u>

¹ Reflects mid-year adjustments to the Appropriation

Medi-Cal Funding Summary
November 2021 Estimate Comparison of FY 2021-22 to FY 2022-23

TOTAL FUNDS

	FY 2021-22	FY 2022-23	Difference
	Estimate	Estimate	Incr./(Decr.)
Benefits:			
4260-101-0001/0890 Medi-Cal General and Federal Funds	\$95,298,499,000	\$102,849,663,000	\$7,551,164,000
4260-101-0080 CLPP Funds	\$916,000	\$916,000	\$0
4260-101-0232 Prop 99 Hospital Svc. Acct.	\$97,987,000	\$89,639,000	(\$8,348,000)
4260-101-0233 Prop 99 Physician Svc. Acct	\$27,831,000	\$25,769,000	(\$2,062,000)
4260-101-0236 Prop 99 Unallocated Account	\$49,196,000	\$39,512,000	(\$9,684,000)
4260-101-3085 Mental Health Services	\$0	\$22,050,000	\$22,050,000
4260-101-3168 Emergency Air Transportation Fund	\$4,351,000	\$3,811,000	(\$540,000)
4260-101-3305 Healthcare Treatment Fund	\$776,982,000	\$812,849,000	\$35,867,000
4260-101-3375 Prop 56 Loan Repayment Program	\$28,477,000	\$41,400,000	\$12,923,000
4260-101-8507 Home & Community Based Services (101)	\$152,251,000	\$484,590,000	\$332,339,000
4260-611-0001/0890 Home & Community Based Services(611)	\$5,085,402,000	\$968,188,000	(\$4,117,214,000)
4260-698-0001 Home & Community Based Services (698-0001)	(\$2,542,701,000)	(\$484,094,000)	\$2,058,607,000
4260-698-8507 Home & Community Based Services (698-8507)	(\$2,542,701,000)	(\$484,094,000)	\$2,058,607,000
4260-102-0001/0890 Capital Debt	\$67,179,000	\$76,257,000	\$9,078,000
4260-102-3305 Prop 56 Loan Forgiveness Program	\$0	\$0	\$0
4260-103-3305 Prop 56 Value-Based Payment	\$150,613,000	\$0	(\$150,613,000)
4260-104-0001 NDPH Hosp Supp	\$1,900,000	\$1,900,000	\$0
4260-601-3096 NDPH Suppl	\$5,558,000	\$1,900,000	(\$3,658,000)
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	\$139,910,000	\$144,823,000	\$4,913,000
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	\$13,000,000	\$8,420,000	(\$4,580,000)
4260-112-0001 GF Support for Prop 56 Payments*	\$0	\$28,970,000	\$28,970,000
4260-695-3305 Health Care Treatment Fund (Less GF)	\$0	(\$28,970,000)	(\$28,970,000)
4260-113-0001/0890 Children's Health Insurance Program	\$3,507,040,000	\$3,694,537,000	\$187,497,000
4260-162-8506 State Fiscal Recovery Fund of 2021	\$300,000,000	\$218,500,000	(\$81,500,000)
4260-601-0942142 Local Trauma Centers	\$53,616,000	\$75,915,000	\$22,299,000
4260-601-0942 Health Homes Program Account	\$15,526,000	\$0	(\$15,526,000)
4260-601-0995 Reimbursements	\$1,316,348,000	\$2,039,422,000	\$723,074,000
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	\$0	\$0	\$0
4260-601-3213 LTC QA Fund	\$447,165,000	\$592,657,000	\$145,492,000
4260-601-3311 Healthcare Service Fines and Penalties	\$0	\$0	\$0
4260-601-3323 Medi-Cal Emergency Transport Fund	\$57,425,000	\$54,586,000	(\$2,839,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	\$1,474,916,000	\$1,852,874,000	\$377,958,000
4260-601-3334 MCO Tax (HCS Special Fund)	\$2,517,457,000	\$2,065,534,000	(\$451,923,000)
4260-601-7502 Demonstration DSH Fund	\$283,951,000	\$203,016,000	(\$80,935,000)
4260-601-7503 Health Care Support Fund	\$42,430,000	\$123,749,000	\$81,319,000
4260-601-8107 Whole Person Care Pilot Fund	\$309,811,000	\$0	(\$309,811,000)
4260-601-8108 Global Payment Program Fund	\$1,481,349,000	\$1,280,725,000	(\$200,624,000)
4260-601-8113 DPH GME Special Fund	\$223,567,000	\$234,177,000	\$10,610,000
4260-602-0309 Perinatal Insurance Fund	\$12,266,000	\$22,917,000	\$10,651,000
4260-605-0001 SNF Quality & Accountability	\$47,523,000	\$0	(\$47,523,000)
4260-605-3167 SNF Quality & Accountability(Non-GF) Only	\$0	\$0	\$0
4260-605-3167 SNF Quality & Accountability	\$42,000,000	\$14,750,000	(\$27,250,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	(\$47,523,000)	\$0	\$47,523,000
4260-606-0834 SB 1100 DSH	\$84,284,000	\$109,652,000	\$25,368,000
4260-607-8502 LIHP IGT (Non-GF)	\$0	\$0	\$0
4260-611-3158/0890 Hospital Quality Assurance	\$8,886,971,000	\$9,534,790,000	\$647,819,000
Total Benefits	\$117,868,872,000	\$126,719,400,000	\$8,850,528,000
County Administration:			
4260-101-0001/0890 Medi-Cal General and Federal Funds	\$5,430,300,000	\$5,392,337,000	(\$37,963,000)
4260-102-3305 Prop 56 Loan Forgiveness Program	\$0	\$0	\$0
4260-106-0890 Money Follow Person Fed. Grant	\$340,000	\$340,000	\$0
4260-113-0001/0890 Children's Health Insurance Program	\$68,888,000	\$66,084,000	(\$2,804,000)
4260-117-0001/0890 HIPPA	\$14,645,000	\$18,577,000	\$3,932,000
4260-162-8506 State Fiscal Recovery Fund of 2021	\$0	\$0	\$0
4260-601-0942 Health Homes Program Account	\$161,000	\$0	(\$161,000)
4260-601-0995 Reimbursements	\$13,793,000	\$13,793,000	\$0
4260-602-3311 Healthcare Svc. Plans Fines and Penalties Fund	\$0	\$0	\$0
4260-605-3167 SNF Quality & Accountability Admin.	\$4,007,000	\$0	(\$4,007,000)
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	\$149,000	\$150,000	\$1,000
Total County Administration	\$5,532,283,000	\$5,491,281,000	(\$41,002,000)
Fiscal Intermediary:			
4260-101-0001/0890 Medi-Cal General and Federal Funds	\$422,437,000	\$425,693,000	\$3,256,000
4260-111-0001 CHDP State Only	\$0	\$0	\$0
4260-113-0001/0890 Children's Health Insurance Program	\$19,503,000	\$20,137,000	\$634,000
4260-117-0001/0890 HIPAA	\$1,388,000	\$3,104,000	\$1,716,000
4260-601-0995 Reimbursements	\$0	\$0	\$0
Total Fiscal Intermediary	\$443,328,000	\$448,934,000	\$5,606,000
Grand Total - Total Funds	\$123,844,483,000	\$132,659,615,000	\$8,815,132,000

Medi-Cal Funding Summary
November 2021 Estimate Comparison of FY 2021-22 to FY 2022-23

STATE FUNDS

	FY 2021-22 Estimate	FY 2022-23 Estimate	Difference Incr./(Decr.)
Benefits:			
4260-101-0001 Medi-Cal General Fund*	\$24,606,372,000	\$32,352,950,000	\$7,746,578,000
4260-101-0080 CLPP Funds	\$916,000	\$916,000	\$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	\$97,987,000	\$89,639,000	(\$8,348,000)
4260-101-0233 Prop 99 Physician Srvc. Acct	\$27,831,000	\$25,769,000	(\$2,062,000)
4260-101-0236 Prop 99 Unallocated Account	\$49,196,000	\$39,512,000	(\$9,684,000)
4260-101-3085 Mental Health Services	\$0	\$22,050,000	\$22,050,000
4260-101-3168 Emergency Air Transportation Fund	\$4,351,000	\$3,811,000	(\$540,000)
4260-101-3305 Healthcare Treatment Fund	\$776,982,000	\$812,849,000	\$35,867,000
4260-101-3375 Prop 56 Loan Repayment Program	\$28,477,000	\$41,400,000	\$12,923,000
4260-101-8507 Home & Community Based Services (101)	\$152,251,000	\$484,590,000	\$332,339,000
4260-611-0001 Home & Community Based Services(611)*	\$2,542,701,000	\$484,094,000	(\$2,058,607,000)
4260-698-0001 Home & Community Based Services (698-0001)*	(\$2,542,701,000)	(\$484,094,000)	\$2,058,607,000
4260-698-8507 Home & Community Based Services (698-8507)	(\$2,542,701,000)	(\$484,094,000)	\$2,058,607,000
4260-102-0001 Capital Debt *	\$18,840,000	\$25,504,000	\$6,664,000
4260-102-3305 Prop 56 Loan Forgiveness Program	\$0	\$0	\$0
4260-103-3305 Prop 56 Value-Based Payment	\$150,613,000	\$0	(\$150,613,000)
4260-104-0001 NDPH Hosp Supp *	\$1,900,000	\$1,900,000	\$0
4260-601-3096 NDPH Suppl	\$5,558,000	\$1,900,000	(\$3,658,000)
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	\$139,910,000	\$144,823,000	\$4,913,000
4260-698-3097 Private Hosp Supp (Less Funded by GF)	(\$118,400,000)	(\$118,400,000)	\$0
4260-112-0001 GF Support for Prop 56 Payments*	\$0	\$28,970,000	\$28,970,000
4260-695-3305 Health Care Treatment Fund (Less GF)	\$0	(\$28,970,000)	(\$28,970,000)
4260-113-0001 Childrens Health Insurance Program *	\$905,231,000	\$1,042,638,000	\$137,407,000
4260-601-0942142 Local Trauma Centers	\$53,616,000	\$75,915,000	\$22,299,000
4260-601-0942 Health Homes Program Account	\$15,526,000	\$0	(\$15,526,000)
4260-601-0995 Reimbursements	\$1,316,348,000	\$2,039,422,000	\$723,074,000
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	\$0	\$0	\$0
4260-601-3213 LTC QA Fund	\$447,165,000	\$592,657,000	\$145,492,000
4260-601-3311 Healthcare Service Fines and Penalties	\$0	\$0	\$0
4260-601-3323 Medi-Cal Emergency Transport Fund	\$57,425,000	\$54,586,000	(\$2,839,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	\$1,474,916,000	\$1,852,874,000	\$377,958,000
4260-601-3334 MCO Tax (HCS Special Fund)	\$2,517,457,000	\$2,065,534,000	(\$451,923,000)
4260-601-8107 Whole Person Care Pilot Fund	\$309,811,000	\$0	(\$309,811,000)
4260-601-8108 Global Payment Program Fund	\$1,481,349,000	\$1,280,725,000	(\$200,624,000)
4260-601-8113 DPH GME Special Fund	\$223,567,000	\$234,177,000	\$10,610,000
4260-602-0309 Perinatal Insurance Fund	\$12,266,000	\$22,917,000	\$10,651,000
4260-605-0001 SNF Quality & Accountability *	\$47,523,000	\$0	(\$47,523,000)
4260-605-3167 SNF Quality & Accountability (Non-GF) Only	\$0	\$0	\$0
4260-605-3167 SNF Quality & Accountability	\$42,000,000	\$14,750,000	(\$27,250,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	(\$47,523,000)	\$0	\$47,523,000
4260-606-0834 SB 1100 DSH	\$84,284,000	\$109,652,000	\$25,368,000
4260-607-8502 LIHP IGT (Non-GF)	\$0	\$0	\$0
4260-611-3158 Hosp. Quality Assurance Revenue	\$3,746,518,000	\$3,818,157,000	\$71,639,000
Total Benefits	\$36,204,062,000	\$46,765,623,000	\$10,561,561,000
Total Benefits General Fund *	\$25,698,266,000	\$33,570,362,000	\$7,872,096,000
County Administration:			
4260-101-0001 Medi-Cal General Fund *	\$974,440,000	\$1,158,074,000	\$183,634,000
4260-102-3305 Prop 56 Loan Forgiveness Program	\$0	\$0	\$0
4260-113-0001 Childrens Health Insurance Program *	\$13,694,000	\$15,144,000	\$1,450,000
4260-117-0001 HIPAA *	\$2,840,000	\$3,949,000	\$1,109,000
4260-601-0942 Health Homes Program Account	\$161,000	\$0	(\$161,000)
4260-601-0995 Reimbursements	\$13,793,000	\$13,793,000	\$0
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	\$0	\$0	\$0
4260-605-3167 SNF Quality & Accountability Admin.	\$4,007,000	\$0	(\$4,007,000)
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	\$149,000	\$150,000	\$1,000
Total County Administration	\$1,009,084,000	\$1,191,110,000	\$182,026,000
Total County Administration General Fund *	\$990,974,000	\$1,177,167,000	\$186,193,000
Fiscal Intermediary:			
4260-101-0001 Medi-Cal General Fund *	\$152,066,000	\$130,936,000	(\$21,130,000)
4260-111-0001 CHDP State Only *	\$0	\$0	\$0
4260-113-0001 Childrens Health Insurance Program *	\$5,287,000	\$6,808,000	\$1,521,000
4260-117-0001 HIPAA *	\$295,000	\$723,000	\$428,000
4260-601-0995 Reimbursements	\$0	\$0	\$0
Total Fiscal Intermediary	\$157,648,000	\$138,467,000	(\$19,181,000)
Total Fiscal Intermediary General Fund *	\$157,648,000	\$138,467,000	(\$19,181,000)
Grand Total - State Funds	\$37,370,794,000	\$48,095,200,000	\$10,724,406,000
Grand Total - General Fund*	\$26,846,888,000	\$34,885,996,000	\$8,039,108,000

Medi-Cal Funding Summary
November 2021 Estimate Comparison of FY 2021-22 to FY 2022-23

FEDERAL FUNDS

	FY 2021-22 Estimate	FY 2022-23 Estimate	Difference Incr./(Decr.)
Benefits:			
4260-101-0890 Federal Funds	\$70,692,127,000	\$70,496,713,000	(\$195,414,000)
4260-102-0890 Capital Debt	\$48,339,000	\$50,753,000	\$2,414,000
4260-106-0890 Money Follows Person Federal Grant	\$13,000,000	\$8,420,000	(\$4,580,000)
4260-113-0890 Childrens Health Insurance Fund	\$2,601,809,000	\$2,651,899,000	\$50,090,000
4260-162-8506 State Fiscal Recovery Fund of 2021	\$300,000,000	\$218,500,000	(\$81,500,000)
4260-601-7502 Demonstration DSH Fund	\$283,951,000	\$203,016,000	(\$80,935,000)
4260-601-7503 Health Care Support Fund	\$42,430,000	\$123,749,000	\$81,319,000
4260-611-0890 Home & Community Based Services 100% FF	\$2,542,701,000	\$484,094,000	(\$2,058,607,000)
4260-611-0890 Hospital Quality Assurance	\$5,140,453,000	\$5,716,633,000	\$576,180,000
Total Benefits	\$81,664,810,000	\$79,953,777,000	(\$1,711,033,000)
County Administration:			
4260-101-0890 Federal Funds	\$4,455,860,000	\$4,234,263,000	(\$221,597,000)
4260-106-0890 Money Follows Person Fed. Grant	\$340,000	\$340,000	\$0
4260-113-0890 Childrens Health Insurance Fund	\$55,194,000	\$50,940,000	(\$4,254,000)
4260-117-0890 HIPAA	\$11,805,000	\$14,628,000	\$2,823,000
4260-162-8506 State Fiscal Recovery Fund of 2021	\$0	\$0	\$0
Total County Administration	\$4,523,199,000	\$4,300,171,000	(\$223,028,000)
Fiscal Intermediary:			
4260-101-0890 Federal Funds	\$270,371,000	\$294,757,000	\$24,386,000
4260-113-0890 Childrens Health Insurance Fund	\$14,216,000	\$13,329,000	(\$887,000)
4260-117-0890 HIPAA	\$1,093,000	\$2,381,000	\$1,288,000
Total Fiscal Intermediary	\$285,680,000	\$310,467,000	\$24,787,000
Grand Total - Federal Funds	\$86,473,689,000	\$84,564,415,000	(\$1,909,274,000)

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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.

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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>
I. BASE ESTIMATES				
A. C/Y FFS BASE	\$18,690,158,100	\$9,345,079,050	\$9,345,079,050	\$0
B. C/Y BASE POLICY CHANGES	\$50,776,384,990	\$33,631,800,940	\$17,003,276,050	\$141,308,000
C. BASE ADJUSTMENTS	(\$1,620,603,000)	(\$1,304,226,800)	(\$316,376,200)	\$0
D. ADJUSTED BASE	\$67,845,940,090	\$41,672,653,190	\$26,031,978,900	\$141,308,000
II. REGULAR POLICY CHANGES				
A. ELIGIBILITY	\$243,360,230	(\$869,432,370)	\$1,110,885,600	\$1,907,000
B. AFFORDABLE CARE ACT	\$5,982,537,000	\$6,035,146,850	(\$52,609,850)	\$0
C. BENEFITS	\$2,250,957,510	\$1,614,687,650	\$610,516,870	\$25,753,000
D. PHARMACY	(\$501,032,250)	(\$1,380,257,100)	(\$595,691,150)	\$1,474,916,000
E. DRUG MEDI-CAL	\$3,983,190	\$285,300	\$59,880	\$3,638,000
F. MENTAL HEALTH	\$88,764,000	(\$129,783,000)	\$218,347,000	\$200,000
G. WAIVER--MH/UCD & BTR	\$4,622,205,140	\$2,565,280,820	\$251,132,310	\$1,805,792,000
H. MANAGED CARE	\$9,066,396,040	\$5,435,896,450	\$19,580,100	\$3,610,919,500
I. PROVIDER RATES	\$1,077,980,340	\$1,136,130,900	(\$590,917,910)	\$532,767,350
J. SUPPLEMENTAL PMNTS.	\$13,671,007,400	\$9,141,888,800	\$360,914,610	\$4,168,204,000
K. COVID-19	\$12,494,020,590	\$12,424,830,580	\$132,683,010	(\$63,493,000)
L. STATE ONLY CLAIMING	(\$19,391,000)	(\$747,632,000)	\$728,241,000	\$0
M. OTHER DEPARTMENTS	(\$52,868,000)	(\$53,629,000)	\$761,000	\$0
N. OTHER	\$1,095,010,590	\$4,818,742,280	(\$2,527,615,270)	(\$1,196,116,410)
O. TOTAL CHANGES	\$50,022,930,780	\$39,992,156,160	(\$333,712,810)	\$10,364,487,440
III. TOTAL MEDI-CAL ESTIMATE	\$117,868,870,870	\$81,664,809,350	\$25,698,266,090	\$10,505,795,440

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2021-22

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>ELIGIBILITY</u>					
2	BREAST AND CERVICAL CANCER TREATMENT	\$59,142,000	\$35,845,150	\$23,296,850	\$0
3	FPL INCREASE FOR AGED AND DISABLED PERSONS	\$57,662,580	\$28,831,290	\$28,831,290	\$0
4	UNDOCUMENTED OLDER CALIFORNIANS EXPANSION	\$52,532,000	\$10,921,000	\$41,611,000	\$0
5	MEDI-CAL STATE INMATE PROGRAMS	\$52,275,000	\$46,375,000	\$5,900,000	\$0
6	UNDOCUMENTED YOUNG ADULTS FULL SCOPE EXPANSION	\$41,081,030	\$13,058,140	\$28,022,890	\$0
8	MEDI-CAL COUNTY INMATE PROGRAMS	\$15,001,830	\$14,527,060	\$474,770	\$0
9	ACCELERATED ENROLLMENT FOR ADULTS	\$12,281,790	\$6,140,900	\$6,140,900	\$0
13	DISABLED ADULT CHILDREN PROGRAM CLEANUP	\$1,616,000	(\$1,308,000)	\$2,924,000	\$0
16	CS3 PROXY ADJUSTMENT	\$0	\$53,950,300	(\$53,950,300)	\$0
17	CDCR RETRO REPAYMENT	\$0	(\$11,000)	\$11,000	\$0
18	REFUGEE MEDICAL ASSISTANCE	\$0	\$0	(\$282,000)	\$282,000
19	MEDI-CAL COUNTY INMATE REIMBURSEMENT	\$0	\$0	(\$1,625,000)	\$1,625,000
20	MEDICARE OPTIONAL EXPANSION ADJUSTMENT	\$0	(\$962,400)	\$962,400	\$0
21	NON-OTLICP CHIP	\$0	\$86,166,900	(\$86,166,900)	\$0
22	NON-EMERGENCY FUNDING ADJUSTMENT	\$0	(\$1,205,139,600)	\$1,205,139,600	\$0
23	SCHIP FUNDING FOR PRENATAL CARE	\$0	\$73,523,700	(\$73,523,700)	\$0
24	CHIP PREMIUMS	(\$48,232,000)	(\$31,350,800)	(\$16,881,200)	\$0
	ELIGIBILITY SUBTOTAL	\$243,360,230	(\$869,432,370)	\$1,110,885,600	\$1,907,000
<u>AFFORDABLE CARE ACT</u>					
26	COMMUNITY FIRST CHOICE OPTION	\$5,995,155,000	\$5,995,155,000	\$0	\$0
27	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	\$20,385,000	\$20,385,000	\$0	\$0
28	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	\$0	\$46,552,850	(\$46,552,850)	\$0
29	1% FMAP INCREASE FOR PREVENTIVE SERVICES	\$0	\$4,242,000	(\$4,242,000)	\$0
30	PAYMENTS TO PRIMARY CARE PHYSICIANS	(\$3,000)	(\$3,000)	\$0	\$0
31	ACA OPTIONAL EXPANSION MLR RISK CORRIDOR	(\$33,000,000)	(\$31,185,000)	(\$1,815,000)	\$0
	AFFORDABLE CARE ACT SUBTOTAL	\$5,982,537,000	\$6,035,146,850	(\$52,609,850)	\$0
<u>BENEFITS</u>					
32	BEHAVIORAL HEALTH TREATMENT	\$1,058,853,000	\$595,647,450	\$463,205,550	\$0
33	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	\$532,400,000	\$532,400,000	\$0	\$0
34	FAMILY PACT PROGRAM	\$352,260,000	\$268,270,800	\$83,989,200	\$0
35	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	\$109,512,000	\$109,512,000	\$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
<u>BENEFITS</u>					
36	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	\$51,506,000	\$26,552,000	(\$799,000)	\$25,753,000
37	TELEHEALTH	\$50,593,960	\$32,746,110	\$17,847,840	\$0
38	REMOTE PATIENT MONITORING	\$27,135,340	\$17,222,310	\$9,913,030	\$0
39	COMMUNITY HEALTH WORKER	\$7,375,000	\$4,847,600	\$2,527,400	\$0
40	CALIFORNIA COMMUNITY TRANSITIONS COSTS	\$12,310,000	\$7,859,000	\$4,451,000	\$0
41	MEDICALLY TAILORED MEALS PILOT PROGRAM	\$10,491,000	\$0	\$10,491,000	\$0
42	CCS DEMONSTRATION PROJECT	\$8,591,000	\$4,513,640	\$4,077,360	\$0
43	HEARING AID COVERAGE	\$8,560,000	\$0	\$8,560,000	\$0
45	MFP/CCT SUPPLEMENTAL FUNDING	\$5,000,000	\$5,000,000	\$0	\$0
46	CONTINUOUS GLUCOSE MONITORING SYSTEMS BENEFIT	\$7,243,640	\$4,715,690	\$2,527,950	\$0
47	CALAIM - ORGAN TRANSPLANT	\$4,789,000	\$3,395,350	\$1,393,650	\$0
48	EXPANSION TO SCREENING FOR ADDITIONAL SUBSTANCES	\$2,787,910	\$1,766,860	\$1,021,050	\$0
49	MEDICAL INTERPRETERS PILOT PROJECT	\$1,260,000	\$0	\$1,260,000	\$0
51	CCT FUND TRANSFER TO CDSS	\$150,000	\$150,000	\$0	\$0
52	DIABETES PREVENTION PROGRAM	\$139,670	\$88,840	\$50,840	\$0
	BENEFITS SUBTOTAL	\$2,250,957,520	\$1,614,687,650	\$610,516,870	\$25,753,000
<u>PHARMACY</u>					
54	MEDI-CAL RX - MANAGED CARE PHARMACY BENEFIT TO FFS	\$2,990,390,000	\$2,066,322,450	\$924,067,550	\$0
55	MEDICATION THERAPY MANAGEMENT PROGRAM	\$7,197,750	\$4,677,850	\$2,519,900	\$0
56	MEDI-CAL DRUG REBATE FUND	\$0	\$0	(\$1,474,916,000)	\$1,474,916,000
58	LITIGATION SETTLEMENTS	(\$105,000)	\$0	(\$105,000)	\$0
59	BCCTP DRUG REBATES	(\$4,276,000)	(\$4,276,000)	\$0	\$0
60	MEDI-CAL RX - ADDITIONAL SAVINGS FROM MAIC IN FFS	(\$6,629,000)	(\$4,304,700)	(\$2,324,300)	\$0
61	FAMILY PACT DRUG REBATES	(\$7,524,000)	(\$7,524,000)	\$0	\$0
62	MEDICAL SUPPLY REBATES	(\$15,423,000)	(\$7,711,500)	(\$7,711,500)	\$0
63	STATE SUPPLEMENTAL DRUG REBATES	(\$96,906,000)	(\$96,906,000)	\$0	\$0
64	PHARMACY RETROACTIVE ADJUSTMENTS	(\$99,854,000)	(\$62,632,200)	(\$37,221,800)	\$0
65	FEDERAL DRUG REBATES	(\$3,267,903,000)	(\$3,267,903,000)	\$0	\$0
	PHARMACY SUBTOTAL	(\$501,032,250)	(\$1,380,257,100)	(\$595,691,150)	\$1,474,916,000
<u>DRUG MEDI-CAL</u>					
68	HCBS SP - CONTINGENCY MANAGEMENT	\$3,638,000	\$0	\$0	\$3,638,000
69	DRUG MEDI-CAL MAT BENEFIT	\$517,690	\$418,180	\$99,510	\$0
70	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	\$229,500	\$214,120	\$15,380	\$0
71	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	(\$402,000)	(\$347,000)	(\$55,000)	\$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
	DRUG MEDI-CAL SUBTOTAL	\$3,983,190	\$285,300	\$59,880	\$3,638,000
	<u>MENTAL HEALTH</u>				
74	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE	\$466,000,000	\$300,000,000	\$166,000,000	\$0
75	MHP COSTS FOR FFPSA	\$34,124,000	\$23,307,000	\$10,817,000	\$0
76	CALAIM - BH QUALITY IMPROVEMENT PROGRAM	\$21,750,000	\$0	\$21,750,000	\$0
77	MHP COSTS FOR CONTINUUM OF CARE REFORM	\$20,725,000	\$10,057,000	\$10,668,000	\$0
78	MHP STRTP GRANTS	\$7,478,000	\$0	\$7,478,000	\$0
79	OUT OF STATE YOUTH - SMHS	\$1,760,000	\$880,000	\$880,000	\$0
80	SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS	\$0	(\$712,000)	\$712,000	\$0
81	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	\$0	\$0	(\$200,000)	\$200,000
82	CHART REVIEW	(\$50,000)	(\$50,000)	\$0	\$0
83	INTERIM AND FINAL COST SETTLEMENTS - SMHS	(\$463,023,000)	(\$463,265,000)	\$242,000	\$0
	MENTAL HEALTH SUBTOTAL	\$88,764,000	(\$129,783,000)	\$218,347,000	\$200,000
	<u>WAIVER--MH/UCD & BTR</u>				
84	GLOBAL PAYMENT PROGRAM	\$3,227,712,000	\$1,731,731,000	\$0	\$1,495,981,000
85	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS	\$707,330,000	\$397,519,000	\$0	\$309,811,000
86	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES	\$564,241,000	\$326,598,700	\$237,642,300	\$0
87	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	\$124,793,140	\$67,272,120	\$57,521,010	\$0
88	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	\$637,000	\$637,000	\$0	\$0
89	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM	\$0	\$13,231,000	(\$13,231,000)	\$0
90	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL	(\$270,000)	(\$270,000)	\$0	\$0
91	MH/UCD—SAFETY NET CARE POOL	(\$2,238,000)	(\$2,238,000)	\$0	\$0
268	CALAIM- DESIGNATED STATE HEALTH PROGRAMS	\$0	\$30,800,000	(\$30,800,000)	\$0
	WAIVER--MH/UCD & BTR SUBTOTAL	\$4,622,205,140	\$2,565,280,820	\$251,132,310	\$1,805,792,000
	<u>MANAGED CARE</u>				
95	CCI-MANAGED CARE PAYMENTS	\$2,958,819,040	\$1,479,409,520	\$1,479,409,520	\$0
96	2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	\$2,565,371,000	\$1,633,523,900	\$931,847,100	\$0
98	MANAGED CARE PUBLIC HOSPITAL EPP	\$1,201,593,000	\$895,791,490	\$305,801,510	\$0
99	MANAGED CARE HEALTH CARE FINANCING PROGRAM	\$1,007,531,000	\$698,914,460	\$308,616,540	\$0
101	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	\$962,082,000	\$709,549,960	\$252,532,040	\$0
102	CALAIM - TRANSITIONING POPULATIONS	\$11,771,000	\$7,423,100	\$4,347,900	\$0
103	CYBHI - INCREASE ACCESS TO STUDENT BH SERVICES	\$64,831,000	\$32,415,500	\$32,415,500	\$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
<u>MANAGED CARE</u>					
104	HCBS SP - HOUSING AND HOMELESSNESS INCENTIVE PROG	\$161,059,000	\$80,530,000	\$0	\$80,529,000
105	CALAIM – MEDI-CAL PATH	\$389,650,000	\$194,825,000	\$134,400,000	\$60,425,000
106	RETRO MC RATE ADJUSTMENTS	\$178,253,000	(\$12,093,900)	\$190,346,900	\$0
107	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS	\$118,180,000	\$87,336,500	\$15,318,000	\$15,525,500
109	PROP 56-BEHAVIORAL HEALTH INCENTIVE PROGRAM	\$75,998,000	\$42,712,000	\$33,286,000	\$0
111	SAN MATEO HEALTH PLAN REIMBURSEMENT	\$10,000,000	\$0	\$10,000,000	\$0
113	CCI-QUALITY WITHHOLD REPAYMENTS	\$10,571,000	\$5,285,500	\$5,285,500	\$0
114	CALAIM - MSSP CARVE-OUT OF CCI	\$1,600,000	\$800,000	\$800,000	\$0
117	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	\$0	\$0	(\$936,983,000)	\$936,983,000
118	2020 MCO ENROLLMENT TAX MANAGED CARE PLANS	\$0	\$0	(\$1,691,653,000)	\$1,691,653,000
119	2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	\$0	\$0	(\$825,804,000)	\$825,804,000
120	COORDINATED CARE INITIATIVE RISK MITIGATION	(\$111,260,000)	(\$55,630,000)	(\$55,630,000)	\$0
121	PROP 56 - DIRECTED PAYMENT RISK MITIGATION	(\$235,000,000)	(\$160,452,880)	(\$74,547,120)	\$0
122	MANAGED CARE EFFICIENCIES	(\$304,653,000)	(\$204,443,700)	(\$100,209,300)	\$0
	MANAGED CARE SUBTOTAL	\$9,066,396,040	\$5,435,896,450	\$19,580,100	\$3,610,919,500
<u>PROVIDER RATES</u>					
124	RATE INCREASE FOR FQHCS/RHCS/CBRCS	\$293,148,860	\$184,087,300	\$109,061,550	\$0
125	DPH INTERIM RATE GROWTH	\$161,321,000	\$108,290,900	\$53,030,100	\$0
126	AB 1629 ANNUAL RATE ADJUSTMENTS	\$194,494,960	\$102,304,550	\$92,190,400	\$0
127	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	\$179,077,360	\$124,922,950	(\$6,016,960)	\$60,171,370
128	LTC RATE ADJUSTMENT	\$155,550,770	\$79,645,370	\$75,905,400	\$0
129	DPH INTERIM RATE COVID-19 INCREASED FMAP ADJUST	\$59,177,000	\$59,177,000	\$0	\$0
130	FQHC/RHC/CBRC RECONCILIATION PROCESS	\$52,717,000	\$33,451,150	\$19,265,850	\$0
131	PP-GEMT PROGRAM	\$58,613,550	\$38,830,330	(\$1,296,760)	\$21,079,980
133	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	\$7,720,000	\$4,694,000	(\$1,325,000)	\$4,351,000
134	HOSPICE RATE INCREASES	\$6,867,520	\$3,589,890	\$3,277,630	\$0
135	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	\$5,275,000	\$3,168,860	\$2,106,140	\$0
137	DPH INTERIM RATE	\$0	\$485,649,800	(\$485,649,800)	\$0
138	PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE	\$0	\$0	\$0	\$0
139	PROP 56 - HOME HEALTH RATE INCREASE	\$0	\$0	\$0	\$0
140	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	\$0	\$0	(\$447,165,000)	\$447,165,000

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
<u>PROVIDER RATES</u>					
141	DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT	(\$420,000)	(\$258,180)	(\$161,820)	\$0
142	10% PROVIDER PAYMENT REDUCTION	(\$8,819,810)	(\$5,416,850)	(\$3,402,960)	\$0
143	REDUCTION TO RADIOLOGY RATES	(\$12,524,060)	(\$7,130,070)	(\$5,394,000)	\$0
144	LABORATORY RATE METHODOLOGY CHANGE	(\$870,800)	(\$5,528,110)	\$4,657,310	\$0
145	DPH INTERIM & FINAL RECONS	(\$73,348,000)	(\$73,348,000)	\$0	\$0
	PROVIDER RATES SUBTOTAL	\$1,077,980,340	\$1,136,130,900	(\$590,917,910)	\$532,767,350
<u>SUPPLEMENTAL PMNTS.</u>					
146	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	\$3,278,827,000	\$2,211,765,000	\$0	\$1,067,062,000
147	HOSPITAL QAF - FFS PAYMENTS	\$2,859,969,000	\$1,658,733,000	\$0	\$1,201,236,000
148	HOSPITAL QAF - MANAGED CARE PAYMENTS	\$1,797,400,000	\$1,264,639,000	\$0	\$532,761,000
149	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	\$1,162,398,430	\$743,499,430	\$418,899,000	\$0
150	PRIVATE HOSPITAL DSH REPLACEMENT	\$807,830,000	\$434,117,000	\$373,713,000	\$0
151	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	\$761,754,000	\$535,295,000	\$0	\$226,459,000
152	DSH PAYMENT	\$477,375,000	\$390,082,000	\$25,535,000	\$61,758,000
153	PROP 56 - MEDI-CAL FAMILY PLANNING	\$404,888,610	\$338,088,930	\$66,799,690	\$0
154	PROP 56 - VALUE-BASED PAYMENT PROGRAM	\$363,684,000	\$246,357,850	\$117,326,150	\$0
155	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	\$312,253,000	\$170,821,000	\$118,400,000	\$23,032,000
156	DPH PHYSICIAN & NON-PHYS. COST	\$382,101,000	\$382,101,000	\$0	\$0
157	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	\$225,884,000	\$225,884,000	\$0	\$0
158	FFP FOR LOCAL TRAUMA CENTERS	\$132,735,000	\$79,119,000	\$0	\$53,616,000
159	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	\$115,613,000	\$70,852,000	\$2,872,000	\$41,889,000
160	CAPITAL PROJECT DEBT REIMBURSEMENT	\$84,670,000	\$65,563,500	\$19,106,500	\$0
161	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	\$84,000,000	\$42,000,000	\$47,523,000	(\$5,523,000)
162	NDPH IGT SUPPLEMENTAL PAYMENTS	\$67,330,000	\$46,067,000	(\$2,477,000)	\$23,740,000
163	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	\$61,392,000	\$61,392,000	\$0	\$0
164	PROP 56 - DEVELOPMENTAL SCREENINGS	\$59,363,700	\$35,654,530	\$23,709,160	\$0
165	NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS	\$52,500,000	\$26,250,000	\$26,250,000	\$0
166	PROP 56 - ADVERSE CHILDHOOD EXPERIENCES SCREENINGS	\$46,683,340	\$29,539,010	\$17,144,330	\$0
167	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	\$45,417,000	\$29,742,590	\$15,674,400	\$0
168	PROP 56 - CBAS SUPPLEMENTAL PAYMENTS	\$26,546,690	\$14,919,020	\$11,627,670	\$0
169	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	\$14,013,000	\$14,013,000	\$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
<u>SUPPLEMENTAL PMNTS.</u>					
170	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	\$10,000,000	\$5,310,000	\$4,690,000	\$0
171	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS	\$8,078,810	\$4,632,520	\$3,446,290	\$0
172	NDPH SUPPLEMENTAL PAYMENT	\$8,007,000	\$2,449,000	\$1,900,000	\$3,658,000
173	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	\$8,000,000	\$4,248,000	\$3,752,000	\$0
174	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	\$4,619,510	\$3,773,400	\$846,100	\$0
175	GEMT SUPPLEMENTAL PAYMENT PROGRAM	\$4,034,000	\$4,034,000	\$0	\$0
176	FREE CLINICS AUGMENTATION	\$2,000,000	\$0	\$2,000,000	\$0
177	PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS	\$1,640,320	\$947,020	\$693,300	\$0
178	PROP 56 - NEMT SUPPLEMENTAL PAYMENTS	\$0	\$0	\$0	\$0
179	PROPOSITION 56 FUNDING	\$0	\$0	(\$927,595,000)	\$927,595,000
180	PROP 56 - AIDS WAIVER RATE INCREASE	\$0	\$0	\$0	\$0
181	IGT ADMIN. & PROCESSING FEE	\$0	\$0	(\$10,921,000)	\$10,921,000
	SUPPLEMENTAL PMNTS. SUBTOTAL	\$13,671,007,400	\$9,141,888,800	\$360,914,600	\$4,168,204,000
<u>COVID-19</u>					
182	COVID-19 CASELOAD IMPACT	\$10,464,267,000	\$7,521,735,160	\$2,942,531,840	\$0
183	DESIGNATED PUBLIC HOSPITAL DIRECT GRANTS	\$300,000,000	\$0	\$300,000,000	\$0
184	COVID-19 VACCINE ADMINISTRATION	\$348,435,000	\$314,688,850	\$33,746,150	\$0
185	COVID-19 FFS REIMBURSEMENT RATES	\$346,995,010	\$181,486,940	\$165,508,070	\$0
186	COVID-19 BEHAVIORAL HEALTH	\$274,809,000	\$257,152,250	\$17,656,750	\$0
187	COVID-19 FFS DME RESPIRATORY RATES	\$34,967,140	\$18,624,130	\$16,343,010	\$0
188	COVID-19 - SICK LEAVE BENEFITS	\$7,249,000	\$7,198,500	\$50,500	\$0
189	COVID-19 ELIGIBILITY	\$3,163,440	\$2,383,210	\$780,230	\$0
191	CONTINUOUS CHIP COVERAGE DURING THE COVID-19 PHE	\$0	(\$39,794,000)	\$39,794,000	\$0
192	COVID-19 BASE RECOVERIES	(\$14,026,000)	(\$8,120,450)	(\$5,905,550)	\$0
194	COVID-19 INCREASED FMAP - DHCS	(\$120,408,000)	\$2,023,648,000	(\$2,144,056,000)	\$0
256	MEDI-CAL COVID-19 VACCINATION INCENTIVE PROGRAM	\$250,000,000	\$125,000,000	\$125,000,000	\$0
272	COVID-19 INCREASED FMAP EXTENSION	\$598,569,000	\$2,020,828,000	(\$1,358,766,000)	(\$63,493,000)
	COVID-19 SUBTOTAL	\$12,494,020,590	\$12,424,830,580	\$132,683,010	(\$63,493,000)
<u>STATE ONLY CLAIMING</u>					
195	STATE ONLY CLAIMING ADJUSTMENTS	(\$13,371,000)	(\$727,136,000)	\$713,765,000	\$0
196	STATE ONLY CLAIMING ADJUSTMENTS - SMHS and DMC	(\$6,020,000)	(\$20,496,000)	\$14,476,000	\$0
	STATE ONLY CLAIMING SUBTOTAL	(\$19,391,000)	(\$747,632,000)	\$728,241,000	\$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
<u>OTHER DEPARTMENTS</u>					
197	ELECTRONIC VISIT VERIFICATION FED PENALTIES	(\$52,868,000)	(\$53,629,000)	\$761,000	\$0
	OTHER DEPARTMENTS SUBTOTAL	(\$52,868,000)	(\$53,629,000)	\$761,000	\$0
<u>OTHER</u>					
205	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER	\$223,231,940	\$111,615,970	\$111,615,970	\$0
206	CCI IHSS RECONCILIATION	\$135,495,000	\$0	\$0	\$135,495,000
207	CALAIM - DENTAL INITIATIVES	\$120,700,000	\$62,210,900	\$58,489,100	\$0
208	CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY	\$100,000,000	\$0	\$100,000,000	\$0
209	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	\$106,523,000	\$106,523,000	\$0	\$0
210	PROP 56 - PROVIDER ACES TRAININGS	\$56,592,000	\$28,296,000	\$28,296,000	\$0
211	HCBS SP - CALBRIDGE BH PILOT PROGRAM	\$40,000,000	\$0	\$0	\$40,000,000
212	QAF WITHHOLD TRANSFER	\$37,846,000	\$21,962,000	\$15,884,000	\$0
213	INFANT DEVELOPMENT PROGRAM	\$38,319,000	\$38,319,000	\$0	\$0
217	KEDREN COMMUNITY HEALTH & ACUTE PSYCHIATRIC HOSP.	\$30,000,000	\$0	\$30,000,000	\$0
218	PROP 56 PHYSICIANS & DENTISTS LOAN REPAYMENT PROG	\$28,477,000	\$0	\$0	\$28,477,000
219	INDIAN HEALTH SERVICES	\$20,071,140	\$13,347,480	\$6,723,660	\$0
220	SELF-DETERMINATION PROGRAM - CDDS	\$22,085,000	\$22,085,000	\$0	\$0
221	ALAMEDA WELLNESS CAMPUS	\$15,000,000	\$0	\$15,000,000	\$0
223	HCBS SP - NON-IHSS CARE ECONOMY PMTS	\$12,250,000	\$6,125,000	\$0	\$6,125,000
224	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	\$17,085,000	\$9,271,000	\$7,814,000	\$0
225	CYBHI - CALHOPE STUDENT SUPPORT	\$11,000,000	\$0	\$11,000,000	\$0
226	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	\$10,844,590	\$5,422,300	\$5,422,300	\$0
227	HCBS SP - ASSISTED LIVING WAIVER EXPANSION	\$10,818,970	\$7,855,330	(\$6,818,940)	\$9,782,590
228	SECTION 19.56 LEGISLATIVE PRIORITIES	\$10,330,000	\$0	\$10,330,000	\$0
229	MLK JR. HOSPITAL IMPROVEMENT	\$10,000,000	\$0	\$10,000,000	\$0
230	ARRA HITECH - PROVIDER PAYMENTS	\$8,806,000	\$8,806,000	\$0	\$0
231	TRIBAL FEDERALLY QUALIFIED HEALTH CENTER	\$7,204,950	\$5,334,360	\$1,870,600	\$0
232	OUTREACH & ENROLLMENT ASSIST. FOR DUAL BENES	\$2,000,000	\$0	\$2,000,000	\$0
233	HPSM DENTAL INTEGRATION PILOT PROGRAM	\$606,000	\$361,650	\$244,350	\$0
234	WPCS WORKERS' COMPENSATION	\$682,000	\$341,000	\$341,000	\$0
238	CIGARETTE AND TOBACCO SURTAX FUNDS	\$0	\$0	(\$175,014,000)	\$175,014,000
239	CLPP FUND	\$916,000	\$0	\$0	\$916,000
240	AUDIT SETTLEMENTS	\$0	(\$9,427,000)	\$9,427,000	\$0

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

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

<u>NO.</u>	<u>POLICY CHANGE TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>GENERAL FUNDS</u>	<u>OTHER STATE FUNDS</u>
	<u>OTHER</u>				
241	IMD ANCILLARY SERVICES	\$0	(\$70,954,000)	\$70,954,000	\$0
242	FUNDING ADJUST.—ACA OPT. EXPANSION	\$0	\$1,935,296,400	(\$1,935,296,400)	\$0
243	FUNDING ADJUST.—OTLICP	\$0	\$83,277,900	(\$83,277,900)	\$0
244	HOSPITAL QAF - CHILDREN'S HEALTH CARE	\$0	\$0	(\$950,775,000)	\$950,775,000
245	CMS DEFERRED CLAIMS	\$0	(\$177,234,000)	\$177,234,000	\$0
248	INDIAN HEALTH SERVICES FUNDING SHIFT	\$0	\$12,103,000	(\$12,103,000)	\$0
249	COUNTY SHARE OF OTLICP-CCS COSTS	(\$25,466,000)	\$0	(\$25,466,000)	\$0
254	AMERICAN RESCUE PLAN INCREASED FMAP FOR HCBS	\$0	\$2,542,701,000	\$0	(\$2,542,701,000)
269	HCBS SP CDDS	\$43,593,000	\$43,593,000	\$0	\$0
273	URBAN INDIAN ORGANIZATIONS FUNDING SHIFT	\$0	\$11,510,000	(\$11,510,000)	\$0
	OTHER SUBTOTAL	\$1,095,010,590	\$4,818,742,280	(\$2,527,615,270)	(\$1,196,116,410)
	GRAND TOTAL	\$50,022,930,790	\$39,992,156,160	(\$333,712,810)	\$10,364,487,440

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
PROFESSIONAL	\$9,399,788,370	\$6,353,427,670	\$2,552,971,150	\$493,389,550
PHYSICIANS	\$1,383,198,050	\$1,068,520,270	\$299,578,950	\$15,098,840
OTHER MEDICAL	\$6,220,574,010	\$4,072,822,470	\$2,191,733,770	(\$43,982,230)
CO. & COMM. OUTPATIENT	\$1,796,016,310	\$1,212,084,940	\$61,658,430	\$522,272,950
PHARMACY	\$5,839,953,890	\$3,636,612,720	\$842,092,050	\$1,361,249,120
HOSPITAL INPATIENT	\$14,771,497,930	\$10,004,153,350	\$2,075,294,330	\$2,692,050,250
COUNTY INPATIENT	\$4,547,218,740	\$2,977,924,450	\$57,288,660	\$1,512,005,630
COMMUNITY INPATIENT	\$10,224,279,190	\$7,026,228,890	\$2,018,005,680	\$1,180,044,620
LONG TERM CARE	\$3,645,097,820	\$2,166,345,890	\$1,329,079,010	\$149,672,920
NURSING FACILITIES	\$3,092,992,550	\$1,852,474,300	\$1,114,125,090	\$126,393,160
ICF-DD	\$552,105,270	\$313,871,590	\$214,953,930	\$23,279,760
OTHER SERVICES	\$1,789,199,770	\$1,097,547,960	\$725,649,740	(\$33,997,920)
MEDICAL TRANSPORTATION	\$141,220,180	\$103,118,030	\$36,837,320	\$1,264,840
OTHER SERVICES	\$1,372,325,760	\$805,032,760	\$585,849,210	(\$18,556,210)
HOME HEALTH	\$275,653,840	\$189,397,170	\$102,963,210	(\$16,706,540)
TOTAL FEE-FOR-SERVICE	\$35,445,537,780	\$23,258,087,590	\$7,525,086,280	\$4,662,363,910
MANAGED CARE	\$56,235,864,390	\$38,047,913,300	\$12,721,791,640	\$5,466,159,460
TWO PLAN MODEL	\$33,365,992,780	\$22,588,676,750	\$7,478,941,310	\$3,298,374,720
COUNTY ORGANIZED HEALTH SYSTEMS	\$13,617,851,660	\$9,137,140,850	\$3,044,094,880	\$1,436,615,930
GEOGRAPHIC MANAGED CARE	\$6,068,398,410	\$4,097,722,140	\$1,364,343,440	\$606,332,840
PHP & OTHER MANAG. CARE	\$1,280,557,370	\$894,577,220	\$486,868,020	(\$100,887,880)
REGIONAL MODEL	\$1,903,064,170	\$1,329,796,330	\$347,543,990	\$225,723,840
DENTAL	\$2,146,063,910	\$1,287,460,220	\$869,629,750	(\$11,026,060)
MENTAL HEALTH	\$3,045,822,010	\$2,909,263,220	(\$32,118,940)	\$168,677,740
AUDITS/ LAWSUITS	\$39,876,000	(\$166,670,500)	\$206,546,500	\$0
EPSDT SCREENS	\$0	\$0	\$0	\$0
MEDICARE PAYMENTS	\$6,582,423,310	\$2,475,979,770	\$4,117,301,010	(\$10,857,480)
STATE HOSP./DEVELOPMENTAL CNTRS.	\$33,007,080	\$33,120,360	(\$90,030)	(\$23,260)
MISC. SERVICES	\$13,623,177,450	\$13,058,666,600	\$319,185,780	\$245,325,070
RECOVERIES	(\$411,666,010)	(\$240,616,860)	(\$171,049,150)	\$0
DRUG MEDI-CAL	\$1,128,764,960	\$1,001,605,650	\$141,983,260	(\$14,823,950)
GRAND TOTAL MEDI-CAL	\$117,868,870,870	\$81,664,809,350	\$25,698,266,090	\$10,505,795,440

**MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
NOVEMBER 2021 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2021-22**

<u>SERVICE CATEGORY</u>	<u>2021-22 APPROPRIATION</u>	<u>NOV. 2021 EST. FOR 2021-22</u>	<u>DOLLAR DIFFERENCE</u>	<u>% CHANGE</u>
PROFESSIONAL	\$9,767,219,580	\$9,399,788,370	(\$367,431,200)	-3.76%
PHYSICIANS	\$1,325,573,200	\$1,383,198,050	\$57,624,860	4.35%
OTHER MEDICAL	\$6,567,572,080	\$6,220,574,010	(\$346,998,080)	-5.28%
CO. & COMM. OUTPATIENT	\$1,874,074,300	\$1,796,016,310	(\$78,057,980)	-4.17%
PHARMACY	\$5,466,291,690	\$5,839,953,890	\$373,662,200	6.84%
HOSPITAL INPATIENT	\$14,648,754,130	\$14,771,497,930	\$122,743,790	0.84%
COUNTY INPATIENT	\$4,459,174,110	\$4,547,218,740	\$88,044,630	1.97%
COMMUNITY INPATIENT	\$10,189,580,020	\$10,224,279,190	\$34,699,160	0.34%
LONG TERM CARE	\$3,433,044,170	\$3,645,097,820	\$212,053,650	6.18%
NURSING FACILITIES	\$2,977,483,880	\$3,092,992,550	\$115,508,660	3.88%
ICF-DD	\$455,560,290	\$552,105,270	\$96,544,980	21.19%
OTHER SERVICES	\$1,875,957,550	\$1,789,199,770	(\$86,757,770)	-4.62%
MEDICAL TRANSPORTATION	\$228,352,180	\$141,220,180	(\$87,132,000)	-38.16%
OTHER SERVICES	\$1,375,367,300	\$1,372,325,760	(\$3,041,550)	-0.22%
HOME HEALTH	\$272,238,060	\$275,653,840	\$3,415,770	1.25%
TOTAL FEE-FOR-SERVICE	\$35,191,267,120	\$35,445,537,780	\$254,270,660	0.72%
MANAGED CARE	\$57,434,093,740	\$56,235,864,390	(\$1,198,229,350)	-2.09%
TWO PLAN MODEL	\$34,518,984,740	\$33,365,992,780	(\$1,152,991,960)	-3.34%
COUNTY ORGANIZED HEALTH SYSTEMS	\$13,755,159,230	\$13,617,851,660	(\$137,307,570)	-1.00%
GEOGRAPHIC MANAGED CARE	\$6,048,185,240	\$6,068,398,410	\$20,213,170	0.33%
PHP & OTHER MANAG. CARE	\$1,171,363,750	\$1,280,557,370	\$109,193,620	9.32%
REGIONAL MODEL	\$1,940,400,780	\$1,903,064,170	(\$37,336,610)	-1.92%
DENTAL	\$2,009,978,060	\$2,146,063,910	\$136,085,840	6.77%
MENTAL HEALTH	\$3,368,948,380	\$3,045,822,010	(\$323,126,370)	-9.59%
AUDITS/ LAWSUITS	\$32,350,000	\$39,876,000	\$7,526,000	23.26%
MEDICARE PAYMENTS	\$6,289,902,090	\$6,582,423,310	\$292,521,220	4.65%
STATE HOSP./DEVELOPMENTAL CNTRS.	\$37,454,500	\$33,007,080	(\$4,447,430)	-11.87%
MISC. SERVICES	\$13,355,960,850	\$13,623,177,450	\$267,216,600	2.00%
RECOVERIES	(\$364,642,000)	(\$411,666,010)	(\$47,024,010)	12.90%
DRUG MEDI-CAL	\$753,235,170	\$1,128,764,960	\$375,529,790	49.86%
GRAND TOTAL MEDI-CAL	\$118,108,547,910	\$117,868,870,870	(\$239,677,040)	-0.20%
GENERAL FUNDS	\$26,934,454,020	\$25,698,266,090	(\$1,236,187,930)	-4.59%
OTHER STATE FUNDS	\$12,368,258,580	\$10,505,795,440	(\$1,862,463,140)	-15.06%

**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2021 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2021-22**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2021-22 APPROPRIATION		NOV. 2021 EST. FOR 2021-22		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		ELIGIBILITY						
4	2	BREAST AND CERVICAL CANCER TREATMENT	\$62,792,000	\$24,874,200	\$59,142,000	\$23,296,850	(\$3,650,000)	(\$1,577,350)
1	3	FPL INCREASE FOR AGED AND DISABLED PERSONS	\$215,004,000	\$107,502,000	\$76,072,000	\$38,036,000	(\$138,932,000)	(\$69,466,000)
275	4	UNDOCUMENTED OLDER CALIFORNIANS EXPANSION	\$67,291,000	\$48,000,000	\$52,532,000	\$41,611,000	(\$14,759,000)	(\$6,389,000)
2	5	MEDI-CAL STATE INMATE PROGRAMS	\$76,467,000	\$5,500,000	\$52,275,000	\$5,900,000	(\$24,192,000)	\$400,000
3	6	UNDOCUMENTED YOUNG ADULTS FULL SCOPE EXPANSION	\$329,618,000	\$222,883,000	\$303,181,000	\$206,811,000	(\$26,437,000)	(\$16,072,000)
12	8	MEDI-CAL COUNTY INMATE PROGRAMS	\$54,058,000	\$2,078,400	\$50,699,000	\$1,604,500	(\$3,359,000)	(\$473,900)
251	9	ACCELERATED ENROLLMENT FOR ADULTS	\$14,347,200	\$7,173,600	\$12,281,790	\$6,140,900	(\$2,065,410)	(\$1,032,700)
8	13	DISABLED ADULT CHILDREN PROGRAM CLEANUP	\$1,616,000	\$2,924,000	\$1,616,000	\$2,924,000	\$0	\$0
18	16	CS3 PROXY ADJUSTMENT	\$0	(\$54,544,700)	\$0	(\$53,950,300)	\$0	\$594,400
--	17	CDCR RETRO REPAYMENT	\$0	\$0	\$0	\$11,000	\$0	\$11,000
19	18	REFUGEE MEDICAL ASSISTANCE	\$0	(\$282,000)	\$0	(\$282,000)	\$0	\$0
13	19	MEDI-CAL COUNTY INMATE REIMBURSEMENT	\$0	(\$1,824,000)	\$0	(\$1,625,000)	\$0	\$199,000
6	20	MEDICARE OPTIONAL EXPANSION ADJUSTMENT	\$0	\$477,600	\$0	\$962,400	\$0	\$484,800
14	21	NON-OTLIPC CHIP	\$0	(\$85,404,600)	\$0	(\$86,166,900)	\$0	(\$762,300)
15	22	NON-EMERGENCY FUNDING ADJUSTMENT	\$0	\$1,203,709,750	\$0	\$1,205,139,600	\$0	\$1,429,850
16	23	SCHIP FUNDING FOR PRENATAL CARE	\$0	(\$72,795,100)	\$0	(\$73,523,700)	\$0	(\$728,600)
21	24	CHIP PREMIUMS	(\$59,106,000)	(\$20,687,100)	(\$48,232,000)	(\$16,881,200)	\$10,874,000	\$3,805,900
10	--	MEDICARE PART B DISREGARD	\$1,911,000	\$1,911,000	\$0	\$0	(\$1,911,000)	(\$1,911,000)
11	--	PROVISIONAL POSTPARTUM CARE EXTENSION	\$11,544,000	\$11,544,000	\$0	\$0	(\$11,544,000)	(\$11,544,000)
22	--	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	(\$383,381,000)	(\$80,290,500)	\$0	\$0	\$383,381,000	\$80,290,500
262	--	POSTPARTUM CARE EXTENSION	\$90,546,000	\$45,273,000	\$0	\$0	(\$90,546,000)	(\$45,273,000)

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2021 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2021-22**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2021-22 APPROPRIATION		NOV. 2021 EST. FOR 2021-22		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		ELIGIBILITY SUBTOTAL	\$482,707,200	\$1,368,022,550	\$559,566,790	\$1,300,008,150	\$76,859,590	(\$68,014,400)
		<u>AFFORDABLE CARE ACT</u>						
23	26	COMMUNITY FIRST CHOICE OPTION	\$5,776,465,000	\$0	\$5,995,155,000	\$0	\$218,690,000	\$0
25	27	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	\$15,448,000	\$0	\$20,385,000	\$0	\$4,937,000	\$0
26	28	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	\$0	(\$47,732,800)	\$0	(\$46,552,850)	\$0	\$1,179,950
27	29	1% FMAP INCREASE FOR PREVENTIVE SERVICES	\$0	(\$3,493,000)	\$0	(\$4,242,000)	\$0	(\$749,000)
28	30	PAYMENTS TO PRIMARY CARE PHYSICIANS	(\$15,000)	\$0	(\$3,000)	\$0	\$12,000	\$0
--	31	ACA OPTIONAL EXPANSION MLR RISK CORRIDOR	\$0	\$0	(\$33,000,000)	(\$1,815,000)	(\$33,000,000)	(\$1,815,000)
		AFFORDABLE CARE ACT SUBTOTAL	\$5,791,898,000	(\$51,225,800)	\$5,982,537,000	(\$52,609,850)	\$190,639,000	(\$1,384,050)
		<u>BENEFITS</u>						
30	32	BEHAVIORAL HEALTH TREATMENT	\$1,075,439,000	\$484,582,850	\$1,058,853,000	\$463,205,550	(\$16,586,000)	(\$21,377,300)
31	33	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	\$501,857,000	\$0	\$532,400,000	\$0	\$30,543,000	\$0
32	34	FAMILY PACT PROGRAM	\$371,255,000	\$88,424,900	\$352,260,000	\$83,989,200	(\$18,995,000)	(\$4,435,700)
33	35	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	\$96,256,000	\$0	\$109,512,000	\$0	\$13,256,000	\$0
36	36	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	\$20,232,000	(\$10,743,000)	\$51,506,000	(\$799,000)	\$31,274,000	\$9,944,000
282	37	TELEHEALTH	\$54,332,000	\$19,167,000	\$50,593,960	\$17,847,840	(\$3,738,040)	(\$1,319,160)
239	38	REMOTE PATIENT MONITORING	\$94,785,420	\$33,145,950	\$27,135,340	\$9,913,030	(\$67,650,080)	(\$23,232,910)
256	39	COMMUNITY HEALTH WORKER	\$16,323,000	\$6,154,300	\$7,375,000	\$2,527,400	(\$8,948,000)	(\$3,626,900)
38	40	CALIFORNIA COMMUNITY TRANSITIONS COSTS	\$13,812,000	\$5,312,000	\$12,310,000	\$4,451,000	(\$1,502,000)	(\$861,000)
41	41	MEDICALLY TAILORED MEALS PILOT PROGRAM	\$10,600,000	\$10,600,000	\$10,491,000	\$10,491,000	(\$109,000)	(\$109,000)
37	42	CCS DEMONSTRATION PROJECT	\$7,503,000	\$3,589,200	\$8,591,000	\$4,077,360	\$1,088,000	\$488,160
46	43	HEARING AID COVERAGE	\$8,830,000	\$8,830,000	\$8,560,000	\$8,560,000	(\$270,000)	(\$270,000)

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2021 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2021-22**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2021-22 APPROPRIATION		NOV. 2021 EST. FOR 2021-22		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>BENEFITS</u>								
261	45	MFP/CCT SUPPLEMENTAL FUNDING	\$5,000,000	\$0	\$5,000,000	\$0	\$0	\$0
233	46	CONTINUOUS GLUCOSE MONITORING SYSTEMS BENEFIT	\$4,888,300	\$1,310,890	\$7,243,640	\$2,527,950	\$2,355,340	\$1,217,050
238	47	CALAIM - ORGAN TRANSPLANT	\$4,656,000	\$1,355,150	\$4,789,000	\$1,393,650	\$133,000	\$38,500
42	48	EXPANSION TO SCREENING FOR ADDITIONAL SUBSTANCES	\$3,040,150	\$1,098,710	\$3,017,540	\$1,105,150	(\$22,610)	\$6,440
43	49	MEDICAL INTERPRETERS PILOT PROJECT	\$2,000,000	\$2,000,000	\$1,260,000	\$1,260,000	(\$740,000)	(\$740,000)
44	51	CCT FUND TRANSFER TO CDSS	\$173,000	\$0	\$150,000	\$0	(\$23,000)	\$0
45	52	DIABETES PREVENTION PROGRAM	\$1,077,930	\$384,370	\$139,670	\$50,840	(\$938,250)	(\$333,540)
34	--	LEA EXPANSION	\$57,109,000	\$0	\$0	\$0	(\$57,109,000)	\$0
39	--	MSSP SUPPLEMENTAL PAYMENTS	\$4,933,000	(\$4,780,000)	\$0	\$0	(\$4,933,000)	\$4,780,000
265	--	DOULA BENEFIT	\$402,580	\$152,040	\$0	\$0	(\$402,580)	(\$152,040)
277	--	RAPID WHOLE GENOME SEQUENCING	\$6,000,000	\$3,000,000	\$0	\$0	(\$6,000,000)	(\$3,000,000)
BENEFITS SUBTOTAL			\$2,360,504,380	\$653,584,370	\$2,251,187,150	\$610,600,970	(\$109,317,230)	(\$42,983,400)
<u>PHARMACY</u>								
57	54	MEDI-CAL RX - MANAGED CARE PHARMACY BENEFIT TO FFS	\$239,901,000	\$72,597,850	\$2,990,390,000	\$924,067,550	\$2,750,489,000	\$851,469,700
250	55	MEDICATION THERAPY MANAGEMENT PROGRAM	\$12,595,500	\$4,418,830	\$7,197,750	\$2,519,900	(\$5,397,750)	(\$1,898,930)
48	56	MEDI-CAL DRUG REBATE FUND	\$0	(\$1,474,916,000)	\$0	(\$1,474,916,000)	\$0	\$0
--	58	LITIGATION SETTLEMENTS	\$0	\$0	(\$105,000)	(\$105,000)	(\$105,000)	(\$105,000)
49	59	BCCTP DRUG REBATES	(\$4,706,000)	\$0	(\$4,276,000)	\$0	\$430,000	\$0
55	60	MEDI-CAL RX - ADDITIONAL SAVINGS FROM MAIC IN FFS	(\$6,629,000)	(\$2,324,300)	(\$6,629,000)	(\$2,324,300)	\$0	\$0
51	61	FAMILY PACT DRUG REBATES	(\$11,041,000)	\$0	(\$7,524,000)	\$0	\$3,517,000	\$0
54	62	MEDICAL SUPPLY REBATES	(\$15,078,000)	(\$7,539,000)	(\$15,423,000)	(\$7,711,500)	(\$345,000)	(\$172,500)
56	63	STATE SUPPLEMENTAL DRUG REBATES	(\$96,437,000)	\$0	(\$96,906,000)	\$0	(\$469,000)	\$0

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2021 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2021-22**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2021-22 APPROPRIATION		NOV. 2021 EST. FOR 2021-22		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>PHARMACY</u>								
232	64	PHARMACY RETROACTIVE ADJUSTMENTS	(\$203,147,000)	(\$75,562,100)	(\$99,854,000)	(\$37,221,800)	\$103,293,000	\$38,340,300
58	65	FEDERAL DRUG REBATES	(\$1,608,901,000)	\$0	(\$3,267,903,000)	\$0	(\$1,659,002,000)	\$0
52	--	OTC ADULT ACETAMINOPHEN & COUGH/COLD PRODUCTS	(\$6,051,000)	(\$2,241,100)	\$0	\$0	\$6,051,000	\$2,241,100
53	--	BLOOD FACTOR REIMBURSEMENT METHODOLOGY	(\$37,797,000)	(\$13,253,150)	\$0	\$0	\$37,797,000	\$13,253,150
PHARMACY SUBTOTAL			(\$1,737,290,500)	(\$1,498,818,970)	(\$501,032,250)	(\$595,691,150)	\$1,236,258,250	\$903,127,820
<u>DRUG MEDI-CAL</u>								
--	68	HCBS SP - CONTINGENCY MANAGEMENT	\$0	\$0	\$3,638,000	\$0	\$3,638,000	\$0
64	69	DRUG MEDI-CAL MAT BENEFIT	\$383,960	\$72,560	\$517,690	\$99,510	\$133,720	\$26,950
63	70	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	\$962,580	\$75,240	\$229,500	\$15,380	(\$733,080)	(\$59,870)
--	71	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	\$0	\$0	(\$402,000)	(\$55,000)	(\$402,000)	(\$55,000)
59	--	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	\$732,479,000	\$72,735,050	\$0	\$0	(\$732,479,000)	(\$72,735,050)
DRUG MEDI-CAL SUBTOTAL			\$733,825,540	\$72,882,850	\$3,983,190	\$59,880	(\$729,842,350)	(\$72,822,970)
<u>MENTAL HEALTH</u>								
249	74	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE	\$743,499,000	\$443,499,000	\$466,000,000	\$166,000,000	(\$277,499,000)	(\$277,499,000)
240	75	MHP COSTS FOR FFPSA	\$14,580,000	\$4,622,000	\$34,124,000	\$10,817,000	\$19,544,000	\$6,195,000
231	76	CALAIM - BH QUALITY IMPROVEMENT PROGRAM	\$21,750,000	\$21,750,000	\$21,750,000	\$21,750,000	\$0	\$0
69	77	MHP COSTS FOR CONTINUUM OF CARE REFORM	\$21,335,000	\$10,608,000	\$20,725,000	\$10,668,000	(\$610,000)	\$60,000
--	78	MHP STRTP GRANTS	\$0	\$0	\$7,478,000	\$7,478,000	\$7,478,000	\$7,478,000
255	79	OUT OF STATE YOUTH - SMHS	\$17,511,000	\$8,755,500	\$1,760,000	\$880,000	(\$15,751,000)	(\$7,875,500)
75	80	SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS	\$0	\$1,795,000	\$0	\$712,000	\$0	(\$1,083,000)

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2021 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2021-22**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2021-22 APPROPRIATION		NOV. 2021 EST. FOR 2021-22		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		<u>MENTAL HEALTH</u>						
73	81	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	\$0	(\$200,000)	\$0	(\$200,000)	\$0	\$0
76	82	CHART REVIEW	(\$396,000)	\$0	(\$50,000)	\$0	\$346,000	\$0
--	83	INTERIM AND FINAL COST SETTLEMENTS - SMHS	\$0	\$0	(\$463,023,000)	\$242,000	(\$463,023,000)	\$242,000
71	--	PATHWAYS TO WELL-BEING	\$1,027,000	\$0	\$0	\$0	(\$1,027,000)	\$0
241	--	MHP COSTS FOR FFPSA - AFTERCARE SERVICES	\$19,889,000	\$6,305,000	\$0	\$0	(\$19,889,000)	(\$6,305,000)
		MENTAL HEALTH SUBTOTAL	\$839,195,000	\$497,134,500	\$88,764,000	\$218,347,000	(\$750,431,000)	(\$278,787,500)
		<u>WAIVER--MH/UCD & BTR</u>						
78	84	GLOBAL PAYMENT PROGRAM	\$3,276,280,000	\$0	\$3,227,712,000	\$0	(\$48,568,000)	\$0
80	85	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS	\$679,564,000	\$0	\$707,330,000	\$0	\$27,766,000	\$0
225	86	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES	\$535,417,000	\$267,708,500	\$564,241,000	\$237,642,300	\$28,824,000	(\$30,066,200)
81	87	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	\$185,186,000	\$85,321,000	\$196,370,000	\$90,513,000	\$11,184,000	\$5,192,000
82	88	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	\$434,000	\$0	\$637,000	\$0	\$203,000	\$0
--	89	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM	\$0	\$0	\$0	(\$13,231,000)	\$0	(\$13,231,000)
--	90	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL	\$0	\$0	(\$270,000)	\$0	(\$270,000)	\$0
--	91	MH/UCD—SAFETY NET CARE POOL	\$0	\$0	(\$2,238,000)	\$0	(\$2,238,000)	\$0
--	268	CALAIM- DESIGNATED STATE HEALTH PROGRAMS	\$0	\$0	\$0	(\$30,800,000)	\$0	(\$30,800,000)
		WAIVER--MH/UCD & BTR SUBTOTAL	\$4,676,881,000	\$353,029,500	\$4,693,782,000	\$284,124,300	\$16,901,000	(\$68,905,200)
		<u>MANAGED CARE</u>						
90	95	CCI-MANAGED CARE PAYMENTS	\$8,624,926,000	\$4,312,463,000	\$7,202,578,000	\$3,601,289,000	(\$1,422,348,000)	(\$711,174,000)

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2021 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2021-22**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2021-22 APPROPRIATION		NOV. 2021 EST. FOR 2021-22		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		MANAGED CARE						
89	96	2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	\$2,565,371,000	\$932,375,250	\$2,565,371,000	\$931,847,100	\$0	(\$528,150)
91	98	MANAGED CARE PUBLIC HOSPITAL EPP	\$1,208,317,000	\$310,918,740	\$1,201,593,000	\$305,801,510	(\$6,724,000)	(\$5,117,230)
92	99	MANAGED CARE HEALTH CARE FINANCING PROGRAM	\$1,061,465,000	\$327,762,650	\$1,007,531,000	\$308,616,540	(\$53,934,000)	(\$19,146,110)
93	101	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	\$962,754,000	\$223,239,500	\$962,082,000	\$252,532,040	(\$672,000)	\$29,292,540
235	102	CALAIM - TRANSITIONING POPULATIONS	\$401,597,000	\$174,759,600	\$11,771,000	\$4,347,900	(\$389,826,000)	(\$170,411,700)
248	103	CYBHI - INCREASE ACCESS TO STUDENT BH SERVICES	\$388,986,000	\$194,493,000	\$64,831,000	\$32,415,500	(\$324,155,000)	(\$162,077,500)
--	104	HCBS SP - HOUSING AND HOMELESSNESS INCENTIVE PROG	\$0	\$0	\$161,059,000	\$0	\$161,059,000	\$0
268	105	CALAIM – MEDI-CAL PATH	\$200,000,000	\$100,000,000	\$389,650,000	\$134,400,000	\$189,650,000	\$34,400,000
96	106	RETRO MC RATE ADJUSTMENTS	\$175,676,000	\$198,569,450	\$178,253,000	\$190,346,900	\$2,577,000	(\$8,222,550)
98	107	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS	\$118,180,000	\$20,391,000	\$118,180,000	\$15,318,000	\$0	(\$5,073,000)
242	109	PROP 56-BEHAVIORAL HEALTH INCENTIVE PROGRAM	\$76,000,000	\$33,288,000	\$75,998,000	\$33,286,000	(\$2,000)	(\$2,000)
--	111	SAN MATEO HEALTH PLAN REIMBURSEMENT	\$0	\$0	\$10,000,000	\$10,000,000	\$10,000,000	\$10,000,000
102	113	CCI-QUALITY WITHHOLD REPAYMENTS	\$16,822,000	\$8,411,000	\$10,571,000	\$5,285,500	(\$6,251,000)	(\$3,125,500)
234	114	CALAIM - MSSP CARVE-OUT OF CCI	\$1,600,000	\$800,000	\$1,600,000	\$800,000	\$0	\$0
108	117	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	\$0	(\$931,590,000)	\$0	(\$936,983,000)	\$0	(\$5,393,000)
106	118	2020 MCO ENROLLMENT TAX MANAGED CARE PLANS	\$0	(\$1,645,922,000)	\$0	(\$1,691,653,000)	\$0	(\$45,731,000)
107	119	2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	\$0	(\$871,536,000)	\$0	(\$825,804,000)	\$0	\$45,732,000
110	120	COORDINATED CARE INITIATIVE RISK MITIGATION	(\$111,260,000)	(\$55,630,000)	(\$111,260,000)	(\$55,630,000)	\$0	\$0
--	121	PROP 56 - DIRECTED PAYMENT RISK MITIGATION	\$0	\$0	(\$235,000,000)	(\$74,547,120)	(\$235,000,000)	(\$74,547,120)

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

**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2021 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2021-22**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2021-22 APPROPRIATION		NOV. 2021 EST. FOR 2021-22		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		MANAGED CARE						
112	122	MANAGED CARE EFFICIENCIES	(\$304,653,000)	(\$100,209,300)	(\$304,653,000)	(\$100,209,300)	\$0	\$0
105	--	CAPITATED RATE ADJUSTMENT FOR FY 2021-22	\$1,056,330,000	\$363,935,550	\$0	\$0	(\$1,056,330,000)	(\$363,935,550)
114	--	MANAGED CARE DRUG REBATES	(\$1,672,917,000)	\$0	\$0	\$0	\$1,672,917,000	\$0
		MANAGED CARE SUBTOTAL	\$14,769,194,000	\$3,596,519,440	\$13,310,155,000	\$2,141,459,580	(\$1,459,039,000)	(\$1,455,059,870)
		PROVIDER RATES						
117	124	RATE INCREASE FOR FQHC/RHCS/CBRC	\$180,681,250	\$69,438,850	\$294,178,480	\$109,444,610	\$113,497,230	\$40,005,760
115	125	DPH INTERIM RATE GROWTH	\$241,109,000	\$120,554,500	\$161,321,000	\$53,030,100	(\$79,788,000)	(\$67,524,400)
120	126	AB 1629 ANNUAL RATE ADJUSTMENTS	\$511,236,080	\$255,618,040	\$234,246,600	\$111,032,640	(\$276,989,480)	(\$144,585,400)
116	127	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	\$204,310,000	(\$14,255,000)	\$207,650,000	(\$6,977,000)	\$3,340,000	\$7,278,000
123	128	LTC RATE ADJUSTMENT	\$93,940,380	\$46,970,190	\$157,999,760	\$77,100,450	\$64,059,380	\$30,130,260
119	129	DPH INTERIM RATE COVID-19 INCREASED FMAP ADJUST	\$39,016,000	\$0	\$59,177,000	\$0	\$20,161,000	\$0
122	130	FQHC/RHC/CBRC RECONCILIATION PROCESS	\$36,935,000	\$14,194,700	\$52,717,000	\$19,265,850	\$15,782,000	\$5,071,150
254	131	PP-GEMT PROGRAM	\$45,393,330	(\$676,550)	\$58,613,550	(\$1,296,760)	\$13,220,230	(\$620,210)
124	133	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	\$9,500,000	(\$1,178,000)	\$7,720,000	(\$1,325,000)	(\$1,780,000)	(\$147,000)
125	134	HOSPICE RATE INCREASES	\$20,389,930	\$10,194,970	\$7,414,730	\$3,538,800	(\$12,975,200)	(\$6,656,170)
127	135	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	\$4,635,700	\$2,317,850	\$5,275,000	\$2,106,140	\$639,300	(\$211,710)
128	137	DPH INTERIM RATE	\$0	(\$485,916,300)	\$0	(\$485,649,800)	\$0	\$266,500
126	138	PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE	\$14,246,000	\$6,655,150	\$6,371,000	\$2,785,600	(\$7,875,000)	(\$3,869,550)
121	139	PROP 56 - HOME HEALTH RATE INCREASE	\$92,754,000	\$43,332,500	\$123,645,000	\$54,060,050	\$30,891,000	\$10,727,550
129	140	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	\$0	(\$550,334,000)	\$0	(\$447,165,000)	\$0	\$103,169,000
130	141	DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT	(\$2,762,000)	(\$1,191,800)	(\$420,000)	(\$161,820)	\$2,342,000	\$1,029,980

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2021 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2021-22**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2021-22 APPROPRIATION		NOV. 2021 EST. FOR 2021-22		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>PROVIDER RATES</u>								
132	142	10% PROVIDER PAYMENT REDUCTION	(\$166,215,000)	(\$83,107,500)	(\$166,726,000)	(\$64,328,150)	(\$511,000)	\$18,779,350
131	143	REDUCTION TO RADIOLOGY RATES	(\$12,873,690)	(\$6,436,850)	(\$12,524,060)	(\$5,394,000)	\$349,630	\$1,042,850
133	144	LABORATORY RATE METHODOLOGY CHANGE	(\$34,315,420)	(\$17,157,710)	(\$2,294,000)	\$12,269,000	\$32,021,420	\$29,426,710
118	145	DPH INTERIM & FINAL RECONS	(\$123,313,000)	\$0	(\$73,348,000)	\$0	\$49,965,000	\$0
270	--	UNFREEZE ICF/DD and FS-PSA RATES	\$45,443,000	\$21,606,000	\$0	\$0	(\$45,443,000)	(\$21,606,000)
279	--	CLINICAL LAB REIMBURSEMENT RATES	\$32,000,000	\$25,000,000	\$0	\$0	(\$32,000,000)	(\$25,000,000)
280	--	COMPLEX REHAB TECHNOLOGY REIMBURSEMENT RATES	\$4,000,000	\$2,000,000	\$0	\$0	(\$4,000,000)	(\$2,000,000)
PROVIDER RATES SUBTOTAL			\$1,236,110,560	(\$542,370,950)	\$1,121,017,060	(\$567,664,280)	(\$115,093,500)	(\$25,293,330)
<u>SUPPLEMENTAL PMNTS.</u>								
136	146	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	\$3,278,824,000	\$0	\$3,278,827,000	\$0	\$3,000	\$0
134	147	HOSPITAL QAF - FFS PAYMENTS	\$2,822,293,000	\$0	\$2,859,969,000	\$0	\$37,676,000	\$0
135	148	HOSPITAL QAF - MANAGED CARE PAYMENTS	\$1,797,400,000	\$0	\$1,797,400,000	\$0	\$0	\$0
138	149	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	\$1,237,366,000	\$413,887,050	\$1,222,805,000	\$440,668,000	(\$14,561,000)	\$26,780,950
139	150	PRIVATE HOSPITAL DSH REPLACEMENT	\$841,759,000	\$390,505,500	\$807,830,000	\$373,713,000	(\$33,929,000)	(\$16,792,500)
137	151	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	\$640,258,000	\$0	\$761,754,000	\$0	\$121,496,000	\$0
143	152	DSH PAYMENT	\$508,989,000	\$26,360,000	\$477,375,000	\$25,535,000	(\$31,614,000)	(\$825,000)
161	153	PROP 56 - MEDI-CAL FAMILY PLANNING	\$438,022,000	\$43,802,200	\$422,419,000	\$69,691,900	(\$15,603,000)	\$25,889,700
141	154	PROP 56 - VALUE-BASED PAYMENT PROGRAM	\$365,477,000	\$117,325,750	\$363,684,000	\$117,326,150	(\$1,793,000)	\$400
142	155	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	\$316,789,000	\$118,400,000	\$312,253,000	\$118,400,000	(\$4,536,000)	\$0
145	156	DPH PHYSICIAN & NON-PHYS. COST	\$328,488,000	\$0	\$382,101,000	\$0	\$53,613,000	\$0
144	157	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	\$245,815,000	\$0	\$225,884,000	\$0	(\$19,931,000)	\$0

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2021 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2021-22**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2021-22 APPROPRIATION		NOV. 2021 EST. FOR 2021-22		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		<u>SUPPLEMENTAL PMNTS.</u>						
146	158	FFP FOR LOCAL TRAUMA CENTERS	\$169,584,000	\$0	\$132,735,000	\$0	(\$36,849,000)	\$0
147	159	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	\$116,728,000	\$0	\$115,613,000	\$2,872,000	(\$1,115,000)	\$2,872,000
148	160	CAPITAL PROJECT DEBT REIMBURSEMENT	\$89,046,000	\$19,575,000	\$84,670,000	\$19,106,500	(\$4,376,000)	(\$468,500)
150	161	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	\$56,500,000	\$33,773,000	\$84,000,000	\$47,523,000	\$27,500,000	\$13,750,000
149	162	NDPH IGT SUPPLEMENTAL PAYMENTS	\$60,518,000	(\$2,408,000)	\$67,330,000	(\$2,477,000)	\$6,812,000	(\$69,000)
151	163	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	\$96,334,000	\$0	\$61,392,000	\$0	(\$34,942,000)	\$0
154	164	PROP 56 - DEVELOPMENTAL SCREENINGS	\$61,765,000	\$25,528,200	\$60,811,000	\$24,287,200	(\$954,000)	(\$1,241,000)
153	165	NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS	\$52,500,000	\$26,250,000	\$52,500,000	\$26,250,000	\$0	\$0
156	166	PROP 56 - ADVERSE CHILDHOOD EXPERIENCES SCREENINGS	\$47,978,000	\$18,625,350	\$47,900,000	\$17,591,150	(\$78,000)	(\$1,034,200)
140	167	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	\$456,059,000	\$170,287,150	\$493,663,000	\$170,373,950	\$37,604,000	\$86,800
155	168	PROP 56 - CBAS SUPPLEMENTAL PAYMENTS	\$29,337,000	\$13,624,500	\$26,552,000	\$11,630,000	(\$2,785,000)	(\$1,994,500)
157	169	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	\$12,327,000	\$0	\$14,013,000	\$0	\$1,686,000	\$0
158	170	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	\$10,000,000	\$4,690,000	\$10,000,000	\$4,690,000	\$0	\$0
160	171	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS	\$26,273,000	\$11,984,750	\$26,264,000	\$11,203,800	(\$9,000)	(\$780,950)
163	172	NDPH SUPPLEMENTAL PAYMENT	\$4,206,000	\$1,900,000	\$8,007,000	\$1,900,000	\$3,801,000	\$0
159	173	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	\$8,000,000	\$3,752,000	\$8,000,000	\$3,752,000	\$0	\$0
162	174	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	\$93,604,000	\$16,009,000	\$67,144,000	\$12,298,000	(\$26,460,000)	(\$3,711,000)
152	175	GEMT SUPPLEMENTAL PAYMENT PROGRAM	\$85,772,000	\$0	\$4,034,000	\$0	(\$81,738,000)	\$0
283	176	FREE CLINICS AUGMENTATION	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$0	\$0

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2021 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2021-22**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2021-22 APPROPRIATION		NOV. 2021 EST. FOR 2021-22		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>SUPPLEMENTAL PMNTS.</u>								
165	177	PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS	\$8,817,000	\$3,947,950	\$8,173,000	\$3,454,400	(\$644,000)	(\$493,550)
167	178	PROP 56 - NEMT SUPPLEMENTAL PAYMENTS	\$7,925,000	\$3,895,150	\$7,158,000	\$3,318,550	(\$767,000)	(\$576,600)
166	179	PROPOSITION 56 FUNDING	\$0	(\$953,678,000)	\$0	(\$927,595,000)	\$0	\$26,083,000
170	180	PROP 56 - AIDS WAIVER RATE INCREASE	\$6,800,000	\$3,189,000	\$4,274,000	\$1,872,000	(\$2,526,000)	(\$1,317,000)
169	181	IGT ADMIN. & PROCESSING FEE	\$0	(\$9,476,000)	\$0	(\$10,921,000)	\$0	(\$1,445,000)
		SUPPLEMENTAL PMNTS. SUBTOTAL	\$14,323,553,000	\$503,749,550	\$14,298,534,000	\$568,463,600	(\$25,019,000)	\$64,714,050
<u>COVID-19</u>								
172	182	COVID-19 CASELOAD IMPACT	\$9,388,858,000	\$2,527,584,800	\$10,464,267,000	\$2,942,531,840	\$1,075,409,000	\$414,947,040
271	183	DESIGNATED PUBLIC HOSPITAL DIRECT GRANTS	\$300,000,000	\$300,000,000	\$300,000,000	\$300,000,000	\$0	\$0
247	184	COVID-19 VACCINE ADMINISTRATION	\$730,444,000	\$12,390,000	\$348,435,000	\$33,746,150	(\$382,009,000)	\$21,356,150
174	185	COVID-19 FFS REIMBURSEMENT RATES	\$192,813,610	\$96,406,800	\$378,526,250	\$180,547,690	\$185,712,640	\$84,140,890
173	186	COVID-19 BEHAVIORAL HEALTH	\$73,683,000	\$4,113,850	\$274,809,000	\$17,656,750	\$201,126,000	\$13,542,900
252	187	COVID-19 FFS DME RESPIRATORY RATES	\$6,305,000	\$2,937,740	\$35,203,000	\$16,453,250	\$28,898,000	\$13,515,510
177	188	COVID-19 - SICK LEAVE BENEFITS	\$8,337,000	\$50,500	\$7,249,000	\$50,500	(\$1,088,000)	\$0
176	189	COVID-19 ELIGIBILITY	\$30,087,590	\$20,955,120	\$159,769,480	\$39,405,440	\$129,681,890	\$18,450,320
281	191	CONTINUOUS CHIP COVERAGE DURING THE COVID-19 PHE	\$0	\$16,000,000	\$0	\$39,794,000	\$0	\$23,794,000
175	192	COVID-19 BASE RECOVERIES	\$35,172,000	\$14,808,950	(\$14,026,000)	(\$5,905,550)	(\$49,198,000)	(\$20,714,500)
178	194	COVID-19 INCREASED FMAP - DHCS	(\$197,141,000)	(\$2,267,994,000)	(\$120,408,000)	(\$2,144,056,000)	\$76,733,000	\$123,938,000
--	256	MEDI-CAL COVID-19 VACCINATION INCENTIVE PROGRAM	\$0	\$0	\$250,000,000	\$125,000,000	\$250,000,000	\$125,000,000
--	272	COVID-19 INCREASED FMAP EXTENSION	\$0	\$0	\$598,569,000	(\$1,358,766,000)	\$598,569,000	(\$1,358,766,000)
179	--	COVID-19 UTILIZATION CHANGE	(\$99,270,000)	(\$51,254,550)	\$0	\$0	\$99,270,000	\$51,254,550
258	--	COVID-19 TESTING IN SCHOOLS	\$575,466,000	\$238,497,850	\$0	\$0	(\$575,466,000)	(\$238,497,850)

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2021 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2021-22**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2021-22 APPROPRIATION		NOV. 2021 EST. FOR 2021-22		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		COVID-19 SUBTOTAL	\$11,044,755,200	\$914,497,070	\$12,682,393,730	\$186,458,080	\$1,637,638,530	(\$728,038,990)
		STATE ONLY CLAIMING						
221	195	STATE ONLY CLAIMING ADJUSTMENTS	\$0	\$164,573,000	(\$13,371,000)	\$713,765,000	(\$13,371,000)	\$549,192,000
244	196	STATE ONLY CLAIMING ADJUSTMENTS - SMHS and DMC	(\$4,640,000)	\$15,856,000	(\$6,020,000)	\$14,476,000	(\$1,380,000)	(\$1,380,000)
245	--	STATE ONLY CLAIMING ADJUSTMENTS - TCM	(\$3,774,000)	\$0	\$0	\$0	\$3,774,000	\$0
		STATE ONLY CLAIMING SUBTOTAL	(\$8,414,000)	\$180,429,000	(\$19,391,000)	\$728,241,000	(\$10,977,000)	\$547,812,000
		OTHER DEPARTMENTS						
180	197	ELECTRONIC VISIT VERIFICATION FED PENALTIES	(\$52,264,000)	\$761,000	(\$52,868,000)	\$761,000	(\$604,000)	\$0
		OTHER DEPARTMENTS SUBTOTAL	(\$52,264,000)	\$761,000	(\$52,868,000)	\$761,000	(\$604,000)	\$0
		OTHER						
204	205	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER	\$289,203,000	\$144,601,500	\$263,774,000	\$131,887,000	(\$25,429,000)	(\$12,714,500)
187	206	CCI IHSS RECONCILIATION	\$100,000,000	\$0	\$135,495,000	\$0	\$35,495,000	\$0
226	207	CALAIM - DENTAL INITIATIVES	\$59,547,000	\$29,773,500	\$120,700,000	\$58,489,100	\$61,153,000	\$28,715,600
273	208	CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY	\$100,000,000	\$100,000,000	\$100,000,000	\$100,000,000	\$0	\$0
188	209	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	\$66,896,000	\$0	\$106,523,000	\$0	\$39,627,000	\$0
190	210	PROP 56 - PROVIDER ACES TRAININGS	\$56,592,000	\$28,296,000	\$56,592,000	\$28,296,000	\$0	\$0
--	211	HCBS SP - CALBRIDGE BH PILOT PROGRAM	\$0	\$0	\$40,000,000	\$0	\$40,000,000	\$0
202	212	QAF WITHHOLD TRANSFER	\$44,938,000	\$18,917,000	\$37,846,000	\$15,884,000	(\$7,092,000)	(\$3,033,000)
193	213	INFANT DEVELOPMENT PROGRAM	\$33,121,000	\$0	\$38,319,000	\$0	\$5,198,000	\$0
278	217	KEDREN COMMUNITY HEALTH & ACUTE PSYCHIATRIC HOSP.	\$30,000,000	\$30,000,000	\$30,000,000	\$30,000,000	\$0	\$0
199	218	PROP 56 PHYSICIANS & DENTISTS LOAN REPAYMENT PROG	\$28,477,000	\$0	\$28,477,000	\$0	\$0	\$0

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2021 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2021-22**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2021-22 APPROPRIATION		NOV. 2021 EST. FOR 2021-22		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
200	219	INDIAN HEALTH SERVICES	\$23,020,000	\$7,711,500	\$23,020,000	\$7,711,500	\$0	\$0
196	220	SELF-DETERMINATION PROGRAM - CDDS	\$15,616,000	\$0	\$22,085,000	\$0	\$6,469,000	\$0
284	221	ALAMEDA WELLNESS CAMPUS	\$15,000,000	\$15,000,000	\$15,000,000	\$15,000,000	\$0	\$0
--	223	HCBS SP - NON-IHSS CARE ECONOMY PMTS	\$0	\$0	\$12,250,000	\$0	\$12,250,000	\$0
197	224	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	\$11,015,000	\$5,039,000	\$17,085,000	\$7,814,000	\$6,070,000	\$2,775,000
272	225	CYBHI - CALHOPE STUDENT SUPPORT	\$45,000,000	\$45,000,000	\$11,000,000	\$11,000,000	(\$34,000,000)	(\$34,000,000)
194	226	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	\$65,722,980	\$32,861,490	\$73,373,410	\$36,686,710	\$7,650,440	\$3,825,220
222	227	HCBS SP - ASSISTED LIVING WAIVER EXPANSION	(\$45,291,000)	(\$22,645,500)	\$10,818,970	(\$6,818,940)	\$56,109,970	\$15,826,560
--	228	SECTION 19.56 LEGISLATIVE PRIORITIES	\$0	\$0	\$10,330,000	\$10,330,000	\$10,330,000	\$10,330,000
276	229	MLK JR. HOSPITAL IMPROVEMENT	\$10,000,000	\$10,000,000	\$10,000,000	\$10,000,000	\$0	\$0
201	230	ARRA HITECH - PROVIDER PAYMENTS	\$8,806,000	\$0	\$8,806,000	\$0	\$0	\$0
206	231	TRIBAL FEDERALLY QUALIFIED HEALTH CENTER	\$13,652,020	\$3,544,460	\$9,071,960	\$2,355,320	(\$4,580,050)	(\$1,189,140)
285	232	OUTREACH & ENROLLMENT ASSIST. FOR DUAL BENES	\$12,000,000	\$12,000,000	\$2,000,000	\$2,000,000	(\$10,000,000)	(\$10,000,000)
253	233	HPSM DENTAL INTEGRATION PILOT PROGRAM	\$697,000	\$280,950	\$606,000	\$244,350	(\$91,000)	(\$36,600)
205	234	WPCS WORKERS' COMPENSATION	\$3,325,000	\$1,662,500	\$682,000	\$341,000	(\$2,643,000)	(\$1,321,500)
211	238	CIGARETTE AND TOBACCO SURTAX FUNDS	\$0	(\$175,014,000)	\$0	(\$175,014,000)	\$0	\$0
215	239	CLPP FUND	\$0	(\$916,000)	\$916,000	\$0	\$916,000	\$916,000
209	240	AUDIT SETTLEMENTS	\$0	\$9,427,000	\$0	\$9,427,000	\$0	\$0
210	241	IMD ANCILLARY SERVICES	\$0	\$19,642,000	\$0	\$70,954,000	\$0	\$51,312,000
212	242	FUNDING ADJUST.—ACA OPT. EXPANSION	\$0	(\$1,875,918,800)	\$0	(\$1,935,296,400)	\$0	(\$59,377,600)
213	243	FUNDING ADJUST.—OTLICP	\$0	(\$91,946,850)	\$0	(\$83,277,900)	\$0	\$8,668,950

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

**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2021 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2021-22**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2021-22 APPROPRIATION		NOV. 2021 EST. FOR 2021-22		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
216	244	HOSPITAL QAF - CHILDREN'S HEALTH CARE	\$0	(\$761,550,000)	\$0	(\$950,775,000)	\$0	(\$189,225,000)
214	245	CMS DEFERRED CLAIMS	\$0	\$254,060,000	\$0	\$177,234,000	\$0	(\$76,826,000)
218	248	INDIAN HEALTH SERVICES FUNDING SHIFT	\$0	(\$11,062,500)	\$0	(\$12,103,000)	\$0	(\$1,040,500)
223	249	COUNTY SHARE OF OTLIPC-CCS COSTS	(\$25,466,000)	(\$25,466,000)	(\$25,466,000)	(\$25,466,000)	\$0	\$0
--	254	AMERICAN RESCUE PLAN INCREASED FMAP FOR HCBS	\$0	\$0	\$0	\$0	\$0	\$0
--	269	HCBS SP CDDS	\$0	\$0	\$43,593,000	\$0	\$43,593,000	\$0
--	273	URBAN INDIAN ORGANIZATIONS FUNDING SHIFT	\$0	\$0	\$0	(\$11,510,000)	\$0	(\$11,510,000)
203	--	CCS SAR EPC	\$6,166,000	\$5,897,000	\$0	\$0	(\$6,166,000)	(\$5,897,000)
227	--	CALAIM - DENTAL CARIES RISK ASSESSMENT	\$12,104,000	\$4,957,550	\$0	\$0	(\$12,104,000)	(\$4,957,550)
229	--	CALAIM - DENTAL SILVER DIAMINE FLUORIDE	\$1,071,000	\$511,050	\$0	\$0	(\$1,071,000)	(\$511,050)
230	--	CALAIM - DENTAL CONTINUITY OF CARE	\$43,491,000	\$21,745,500	\$0	\$0	(\$43,491,000)	(\$21,745,500)
286	--	RECONCILIATION	\$0	\$0	\$0	\$0	\$0	\$0
		OTHER SUBTOTAL	\$1,024,702,990	(\$2,163,591,650)	\$1,202,897,350	(\$2,474,607,260)	\$178,194,360	(\$311,015,610)
		GRAND TOTAL	\$55,485,358,370	\$3,884,602,460	\$55,621,526,030	\$2,347,951,010	\$136,167,650	(\$1,536,651,440)

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 2021 ESTIMATE

SERVICE CATEGORY	PA-OAS	NEWLY	PA-ATD	PA-AFDC	LT-OAS	H-PE
PHYSICIANS	\$8,889,960	\$226,651,380	\$84,153,660	\$55,174,060	\$1,779,600	\$58,099,790
OTHER MEDICAL	\$113,919,560	\$1,849,051,520	\$487,004,450	\$349,636,080	\$4,180,140	\$44,349,340
CO. & COMM. OUTPATIENT	\$4,367,080	\$186,650,660	\$111,669,170	\$28,127,800	\$507,520	\$54,790,980
PHARMACY	\$11,776,990	\$2,523,970,010	\$1,580,414,330	\$184,488,360	\$6,177,860	\$21,012,190
COUNTY INPATIENT	\$3,331,880	\$736,970,440	\$22,708,190	\$14,846,590	\$2,303,920	\$65,728,990
COMMUNITY INPATIENT	\$51,996,010	\$1,644,379,730	\$488,952,460	\$230,280,430	\$15,729,820	\$396,747,350
NURSING FACILITIES	\$203,070,210	\$245,422,280	\$531,299,610	\$4,334,920	\$1,283,516,350	\$1,748,930
ICF-DD	\$2,416,660	\$16,947,240	\$210,419,670	\$1,130,340	\$80,743,540	\$810
MEDICAL TRANSPORTATION	\$4,951,740	\$47,322,120	\$17,295,360	\$4,189,260	\$2,170,550	\$11,768,810
OTHER SERVICES	\$130,780,050	\$54,982,130	\$520,578,190	\$35,747,070	\$69,353,100	\$2,556,160
HOME HEALTH	\$3,423,140	\$2,501,810	\$132,104,300	\$7,256,550	\$46,240	\$229,900
FFS SUBTOTAL	\$538,923,260	\$7,534,849,330	\$4,186,599,390	\$915,211,470	\$1,466,508,630	\$657,033,230
DENTAL	\$37,290,020	\$543,196,080	\$92,683,460	\$160,654,350	\$7,442,270	\$1,485,050
MENTAL HEALTH	\$9,273,170	\$483,707,970	\$924,098,540	\$683,860,600	\$579,200	\$9,025,400
TWO PLAN MODEL	\$1,186,173,180	\$10,367,063,270	\$5,218,727,450	\$1,462,985,290	\$0	\$0
COUNTY ORGANIZED HEALTH SYSTEMS	\$345,866,930	\$4,186,983,460	\$1,441,415,210	\$337,964,490	\$836,455,120	\$0
GEOGRAPHIC MANAGED CARE	\$186,862,570	\$1,817,225,650	\$1,015,144,600	\$222,534,730	\$0	\$0
PHP & OTHER MANAG. CARE	\$340,513,690	\$43,241,780	\$223,878,100	\$13,015,410	\$13,976,810	\$0
MEDICARE PAYMENTS	\$1,867,603,090	\$0	\$1,672,715,460	\$0	\$157,498,790	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$1,596,540	\$0	\$3,449,090	\$3,903,870	\$140,340	\$0
MISC. SERVICES	\$1,020,849,250	\$41,100	\$8,483,464,790	\$6,913,090	\$120	\$0
DRUG MEDI-CAL	\$25,962,000	\$391,431,950	\$57,618,670	\$64,167,040	\$1,788,180	\$0
REGIONAL MODEL	\$15,456,200	\$631,441,750	\$284,930,460	\$75,121,770	\$0	\$0
NON-FFS SUBTOTAL	\$5,037,446,640	\$18,464,333,030	\$19,418,125,840	\$3,031,120,640	\$1,017,880,820	\$10,510,450
TOTAL DOLLARS (1)	\$5,576,369,900	\$25,999,182,360	\$23,604,725,240	\$3,946,332,110	\$2,484,389,450	\$667,543,690
ELIGIBLES ***	405,800	4,703,200	878,500	990,100	34,400	38,600
ANNUAL \$/ELIGIBLE	\$13,742	\$5,528	\$26,869	\$3,986	\$72,221	\$17,294
AVG. MO. \$/ELIGIBLE	\$1,145	\$461	\$2,239	\$332	\$6,018	\$1,441

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

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

Refer to page following for listing of excluded policy changes.

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

SERVICE CATEGORY	LT-ATD	POV 250	MN-OAS	MN-ATD	MN-AFDC	MI-C
PHYSICIANS	\$1,180,020	\$22,764,210	\$30,285,820	\$13,484,300	\$190,331,340	\$41,864,060
OTHER MEDICAL	\$2,843,280	\$235,817,620	\$237,982,990	\$121,905,600	\$1,483,613,190	\$122,381,030
CO. & COMM. OUTPATIENT	\$368,180	\$27,833,910	\$23,822,260	\$15,473,770	\$154,018,800	\$13,655,420
PHARMACY	\$6,501,680	\$153,951,680	\$65,738,740	\$117,771,500	\$776,321,480	\$99,482,740
COUNTY INPATIENT	\$1,405,930	\$2,562,850	\$43,799,570	\$9,936,900	\$120,351,550	\$7,531,630
COMMUNITY INPATIENT	\$8,948,420	\$73,743,560	\$156,014,980	\$58,364,560	\$911,223,710	\$85,457,330
NURSING FACILITIES	\$233,377,990	\$5,218,580	\$244,492,340	\$72,115,800	\$39,108,080	\$10,628,570
ICF-DD	\$208,223,290	\$4,947,190	\$3,179,830	\$16,369,620	\$2,339,090	\$3,492,890
MEDICAL TRANSPORTATION	\$800,240	\$575,160	\$12,372,350	\$8,291,100	\$11,873,640	\$3,305,600
OTHER SERVICES	\$9,526,200	\$24,069,750	\$169,723,670	\$140,538,050	\$107,427,060	\$25,877,060
HOME HEALTH	\$22,340	\$16,104,140	\$2,794,360	\$55,548,610	\$19,489,650	\$17,395,260
FFS SUBTOTAL	\$473,197,580	\$567,588,650	\$990,206,910	\$629,799,820	\$3,816,097,600	\$431,071,600
DENTAL	\$2,143,520	\$269,053,450	\$50,262,160	\$20,731,240	\$513,221,080	\$18,353,790
MENTAL HEALTH	\$1,511,710	\$62,977,240	\$14,730,260	\$92,609,150	\$636,402,830	\$65,633,570
TWO PLAN MODEL	\$0	\$651,316,050	\$1,808,959,290	\$838,641,350	\$4,619,771,130	\$33,241,370
COUNTY ORGANIZED HEALTH SYSTEMS	\$203,276,130	\$407,343,830	\$665,649,860	\$414,888,460	\$1,799,504,100	\$27,802,510
GEOGRAPHIC MANAGED CARE	\$0	\$124,785,750	\$282,239,850	\$174,897,750	\$833,402,950	\$4,125,120
PHP & OTHER MANAG. CARE	\$932,540	\$5,919,010	\$529,221,540	\$50,747,270	\$9,749,660	\$7,425,900
MEDICARE PAYMENTS	\$0	\$0	\$2,006,339,670	\$727,310,240	\$150,464,420	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$36,340	\$0	\$2,335,670	\$750,210	\$16,570,690	\$586,880
MISC. SERVICES	\$620	(\$35,863,320)	\$1,685,891,110	\$1,715,436,520	\$27,532,270	\$1,037,670
DRUG MEDI-CAL	\$559,390	\$56,112,290	\$47,513,520	\$14,095,890	\$327,293,620	\$9,585,990
REGIONAL MODEL	\$0	\$39,531,160	\$51,471,260	\$47,574,250	\$301,019,660	\$1,185,730
NON-FFS SUBTOTAL	\$208,460,250	\$1,581,175,460	\$7,144,614,190	\$4,097,682,330	\$9,234,932,420	\$168,978,530
TOTAL DOLLARS (1)	\$681,657,830	\$2,148,764,110	\$8,134,821,110	\$4,727,482,150	\$13,051,030,010	\$600,050,140
ELIGIBLES ***	8,900	873,900	699,100	221,800	4,026,000	142,400
ANNUAL \$/ELIGIBLE	\$76,591	\$2,459	\$11,636	\$21,314	\$3,242	\$4,214
AVG. MO. \$/ELIGIBLE	\$6,383	\$205	\$970	\$1,776	\$270	\$351

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

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

Refer to page following for listing of excluded policy changes.

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

SERVICE CATEGORY	MI-A	REFUGEE	OBRA	POV 185	POV 133	POV 100
PHYSICIANS	\$273,100	\$62,160	\$14,410	\$136,511,950	\$23,012,590	\$9,436,560
OTHER MEDICAL	\$554,310	\$374,120	\$6,870	\$380,567,960	\$306,121,820	\$121,023,540
CO. & COMM. OUTPATIENT	\$117,160	\$60,290	\$1,820	\$33,059,480	\$18,185,740	\$12,868,790
PHARMACY	\$1,575,980	\$148,610	\$12,920	\$48,339,750	\$133,793,120	\$80,742,830
COUNTY INPATIENT	\$1,487,530	\$560	\$19,370	\$77,012,420	\$1,689,560	\$1,545,730
COMMUNITY INPATIENT	\$1,145,820	\$56,060	\$70,230	\$937,494,710	\$94,736,480	\$33,839,130
NURSING FACILITIES	\$23,992,670	\$0	\$3,231,000	\$1,223,910	\$12,033,620	\$1,356,490
ICF-DD	\$1,498,640	\$0	\$37,300	\$57,220	\$250,570	\$41,830
MEDICAL TRANSPORTATION	\$69,180	\$6,230	\$4,290	\$2,713,080	\$839,990	\$300,120
OTHER SERVICES	\$793,040	\$2,870	\$21,510	\$13,180,370	\$20,557,900	\$10,079,410
HOME HEALTH	\$210	\$0	\$0	\$4,318,010	\$10,265,070	\$2,912,900
FFS SUBTOTAL	\$31,507,650	\$710,910	\$3,419,720	\$1,634,478,850	\$621,486,450	\$274,147,340
DENTAL	\$102,620	\$43,370	\$14,460	\$10,965,990	\$224,324,220	\$77,013,650
MENTAL HEALTH	\$0	\$147,950	\$1,473,490	\$2,377,860	\$27,425,220	\$35,732,860
TWO PLAN MODEL	\$12,130	\$408,930	\$0	\$300,532,660	\$674,199,480	\$328,157,170
COUNTY ORGANIZED HEALTH SYSTEMS	\$274,000	\$61,630	\$15,320	\$145,671,960	\$239,485,960	\$122,293,310
GEOGRAPHIC MANAGED CARE	\$3,350	\$327,730	\$0	\$62,461,110	\$113,049,780	\$53,768,480
PHP & OTHER MANAG. CARE	\$7,425,120	\$0	\$0	\$10,273,870	\$9,672,590	\$8,399,730
MEDICARE PAYMENTS	\$0	\$0	\$0	\$0	\$0	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$24,370	\$0	\$380	\$1,891,480	\$0	\$1,721,210
MISC. SERVICES	\$277,090	\$0	\$0	\$52,730	\$5,903,200	\$2,932,250
DRUG MEDI-CAL	\$207,460	\$37,250	\$0	\$30,312,220	\$71,745,620	\$30,831,020
REGIONAL MODEL	\$0	\$3,380	\$0	\$19,549,730	\$35,480,900	\$16,355,540
NON-FFS SUBTOTAL	\$8,326,140	\$1,030,240	\$1,503,650	\$584,089,620	\$1,401,286,970	\$677,205,210
TOTAL DOLLARS (1)	\$39,833,790	\$1,741,150	\$4,923,370	\$2,218,568,460	\$2,022,773,430	\$951,352,550
ELIGIBLES ***	3,100	500	100	366,600	869,400	421,000
ANNUAL \$/ELIGIBLE	\$12,850	\$3,482	\$49,234	\$6,052	\$2,327	\$2,260
AVG. MO. \$/ELIGIBLE	\$1,071	\$290	\$4,103	\$504	\$194	\$188

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

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

Refer to page following for listing of excluded policy changes.

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

SERVICE CATEGORY	TOTAL
PHYSICIANS	\$903,968,960
OTHER MEDICAL	\$5,861,333,420
CO. & COMM. OUTPATIENT	\$685,578,840
PHARMACY	\$5,812,220,780
COUNTY INPATIENT	\$1,113,233,610
COMMUNITY INPATIENT	\$5,189,180,790
NURSING FACILITIES	\$2,916,171,350
ICF-DD	\$552,095,730
MEDICAL TRANSPORTATION	\$128,848,850
OTHER SERVICES	\$1,335,793,580
HOME HEALTH	\$274,412,480
FFS SUBTOTAL	\$24,772,838,390
DENTAL	\$2,028,980,790
MENTAL HEALTH	\$3,051,567,010
TWO PLAN MODEL	\$27,490,188,770
COUNTY ORGANIZED HEALTH SYSTEMS	\$11,174,952,280
GEOGRAPHIC MANAGED CARE	\$4,890,829,440
PHP & OTHER MANAG. CARE	\$1,274,393,020
MEDICARE PAYMENTS	\$6,581,931,670
STATE HOSP./DEVELOPMENTAL CNTRS.	\$33,007,080
MISC. SERVICES	\$12,914,468,490
DRUG MEDI-CAL	\$1,129,262,120
REGIONAL MODEL	\$1,519,121,790
NON-FFS SUBTOTAL	\$72,088,702,450
TOTAL DOLLARS (1)	\$96,861,540,840
ELIGIBLES ***	14,683,400
ANNUAL \$/ELIGIBLE	\$6,597
AVG. MO. \$/ELIGIBLE	\$550

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

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

Refer to page following for listing of excluded policy changes.

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

EXCLUDED POLICY CHANGES: 92

	Base Adj for Late N21 Lawsuits/Claims PC change
2	BREAST AND CERVICAL CANCER TREATMENT
7	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
11	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM
12	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL
13	DISABLED ADULT CHILDREN PROGRAM CLEANUP
16	CS3 PROXY ADJUSTMENT
20	MEDICARE OPTIONAL EXPANSION ADJUSTMENT
21	NON-OTLICP CHIP
29	1% FMAP INCREASE FOR PREVENTIVE SERVICES
34	FAMILY PACT PROGRAM
43	HEARING AID COVERAGE
58	LITIGATION SETTLEMENTS
61	FAMILY PACT DRUG REBATES
71	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
74	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE
81	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT
84	GLOBAL PAYMENT PROGRAM
85	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS
86	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES
88	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG
89	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM
90	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL
91	MH/UCD—SAFETY NET CARE POOL
96	2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.
103	CYBHI - INCREASE ACCESS TO STUDENT BH SERVICES
105	CALAIM – MEDI-CAL PATH
115	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)
117	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND
118	2020 MCO ENROLLMENT TAX MANAGED CARE PLANS
119	2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ
121	PROP 56 - DIRECTED PAYMENT RISK MITIGATION
127	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF
133	EMERGENCY MEDICAL AIR TRANSPORTATION ACT

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

EXCLUDED POLICY CHANGES: 92

140	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
146	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS
147	HOSPITAL QAF - FFS PAYMENTS
148	HOSPITAL QAF - MANAGED CARE PAYMENTS
150	PRIVATE HOSPITAL DSH REPLACEMENT
151	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS
152	DSH PAYMENT
153	PROP 56 - MEDI-CAL FAMILY PLANNING
154	PROP 56 - VALUE-BASED PAYMENT PROGRAM
155	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
156	DPH PHYSICIAN & NON-PHYS. COST
157	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
158	FFP FOR LOCAL TRAUMA CENTERS
159	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS
160	CAPITAL PROJECT DEBT REIMBURSEMENT
161	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
162	NDPH IGT SUPPLEMENTAL PAYMENTS
163	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS
169	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
170	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
171	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS
172	NDPH SUPPLEMENTAL PAYMENT
173	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
174	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS
175	GEMT SUPPLEMENTAL PAYMENT PROGRAM
176	FREE CLINICS AUGMENTATION
177	PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS
178	PROP 56 - NEMT SUPPLEMENTAL PAYMENTS
179	PROPOSITION 56 FUNDING
180	PROP 56 - AIDS WAIVER RATE INCREASE
181	IGT ADMIN. & PROCESSING FEE
183	DESIGNATED PUBLIC HOSPITAL DIRECT GRANTS
189	COVID-19 ELIGIBILITY
192	COVID-19 BASE RECOVERIES

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

EXCLUDED POLICY CHANGES: 92

195	STATE ONLY CLAIMING ADJUSTMENTS
196	STATE ONLY CLAIMING ADJUSTMENTS - SMHS and DMC
207	CALAIM - DENTAL INITIATIVES
208	CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY
210	PROP 56 - PROVIDER ACES TRAININGS
215	LAWSUITS/CLAIMS
216	MEDI-CAL TCM PROGRAM
217	KEDREN COMMUNITY HEALTH & ACUTE PSYCHIATRIC HOSP.
218	PROP 56 PHYSICIANS & DENTISTS LOAN REPAYMENT PROG
221	ALAMEDA WELLNESS CAMPUS
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MEDI-CAL PROGRAM ESTIMATE SUMMARY FISCAL YEAR 2022-23

	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>GENERAL FUNDS</u>	<u>OTHER STATE FUNDS</u>
I. BASE ESTIMATES				
A. B/Y FFS BASE	\$18,369,824,050	\$9,184,912,020	\$9,184,912,020	\$0
B. B/Y BASE POLICY CHANGES	\$50,876,882,980	\$33,386,172,290	\$17,333,891,700	\$156,819,000
C. BASE ADJUSTMENTS	(\$398,897,000)	(\$509,151,500)	\$110,254,500	\$0
D. ADJUSTED BASE	\$68,847,810,030	\$42,061,932,810	\$26,629,058,220	\$156,819,000
II. REGULAR POLICY CHANGES				
A. ELIGIBILITY	\$1,273,962,590	(\$532,059,370)	\$1,794,801,960	\$11,220,000
B. AFFORDABLE CARE ACT	\$6,088,053,000	\$6,135,935,000	(\$47,882,000)	\$0
C. BENEFITS	\$2,403,869,810	\$1,676,435,390	\$695,458,430	\$31,976,000
D. PHARMACY	\$2,547,185,190	\$781,069,190	(\$186,440,000)	\$1,952,556,000
E. DRUG MEDI-CAL	\$23,963,880	\$12,314,300	\$106,580	\$11,543,000
F. MENTAL HEALTH	\$1,458,773,000	(\$69,185,500)	\$1,527,758,500	\$200,000
G. WAIVER--MH/UCD & BTR	\$3,979,843,000	\$2,237,130,500	\$461,987,500	\$1,280,725,000
H. MANAGED CARE	\$9,933,080,440	\$6,160,621,930	(\$395,961,490)	\$4,168,420,000
I. PROVIDER RATES	\$1,615,134,420	\$1,484,155,540	(\$573,644,290)	\$704,623,170
J. SUPPLEMENTAL PMNTS.	\$13,260,822,030	\$8,561,221,590	\$372,712,950	\$4,326,887,500
K. COVID-19	\$10,568,516,000	\$8,421,476,700	\$2,443,401,300	(\$296,362,000)
L. STATE ONLY CLAIMING	\$122,623,000	(\$1,418,334,000)	\$1,540,957,000	\$0
M. OTHER	\$4,595,762,490	\$4,441,062,620	(\$691,952,670)	\$846,652,550
N. TOTAL CHANGES	\$57,871,588,850	\$37,891,843,890	\$6,941,303,760	\$13,038,441,210
III. TOTAL MEDI-CAL ESTIMATE	\$126,719,398,890	\$79,953,776,700	\$33,570,361,980	\$13,195,260,210

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2022-23

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>ELIGIBILITY</u>					
1	POSTPARTUM CARE EXTENSION	\$290,975,000	\$147,362,000	\$134,459,000	\$9,154,000
2	BREAST AND CERVICAL CANCER TREATMENT	\$59,789,000	\$36,255,800	\$23,533,200	\$0
3	FPL INCREASE FOR AGED AND DISABLED PERSONS	\$81,374,000	\$40,687,000	\$40,687,000	\$0
4	UNDOCUMENTED OLDER CALIFORNIANS EXPANSION	\$589,846,000	\$93,785,000	\$496,061,000	\$0
5	MEDI-CAL STATE INMATE PROGRAMS	\$49,275,000	\$49,275,000	\$0	\$0
6	UNDOCUMENTED YOUNG ADULTS FULL SCOPE EXPANSION	\$84,245,590	\$27,449,580	\$56,796,010	\$0
8	MEDI-CAL COUNTY INMATE PROGRAMS	\$0	\$0	\$0	\$0
9	ACCELERATED ENROLLMENT FOR ADULTS	\$17,843,000	\$8,921,500	\$8,921,500	\$0
14	CALAIM INMATE PRE-RELEASE PROGRAM	\$50,232,000	\$34,698,000	\$15,534,000	\$0
15	PHASING IN THE MEDI-CAL ASSET LIMIT REPEAL	\$45,452,000	\$22,726,000	\$22,726,000	\$0
16	CS3 PROXY ADJUSTMENT	\$0	\$54,257,100	(\$54,257,100)	\$0
18	REFUGEE MEDICAL ASSISTANCE	\$0	\$0	(\$200,000)	\$200,000
19	MEDI-CAL COUNTY INMATE REIMBURSEMENT	\$0	\$0	(\$1,665,000)	\$1,665,000
20	MEDICARE OPTIONAL EXPANSION ADJUSTMENT	\$0	(\$962,400)	\$962,400	\$0
21	NON-OTLICP CHIP	\$0	\$86,166,900	(\$86,166,900)	\$0
22	NON-EMERGENCY FUNDING ADJUSTMENT	\$0	(\$1,205,139,600)	\$1,205,139,600	\$0
23	SCHIP FUNDING FOR PRENATAL CARE	\$0	\$69,726,800	(\$69,726,800)	\$0
24	CHIP PREMIUMS	(\$48,232,000)	(\$31,350,800)	(\$16,881,200)	\$0
274	PREMIUMS REDUCTION	\$53,163,000	\$34,082,750	\$18,879,250	\$201,000
	ELIGIBILITY SUBTOTAL	\$1,273,962,590	(\$532,059,370)	\$1,794,801,960	\$11,220,000
<u>AFFORDABLE CARE ACT</u>					
26	COMMUNITY FIRST CHOICE OPTION	\$6,068,888,000	\$6,068,888,000	\$0	\$0
27	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	\$19,168,000	\$19,168,000	\$0	\$0
28	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	\$0	\$43,640,000	(\$43,640,000)	\$0
29	1% FMAP INCREASE FOR PREVENTIVE SERVICES	\$0	\$4,242,000	(\$4,242,000)	\$0
30	PAYMENTS TO PRIMARY CARE PHYSICIANS	(\$3,000)	(\$3,000)	\$0	\$0
	AFFORDABLE CARE ACT SUBTOTAL	\$6,088,053,000	\$6,135,935,000	(\$47,882,000)	\$0
<u>BENEFITS</u>					
32	BEHAVIORAL HEALTH TREATMENT	\$866,319,000	\$455,478,000	\$410,841,000	\$0
33	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	\$523,841,000	\$523,841,000	\$0	\$0
34	FAMILY PACT PROGRAM	\$369,130,000	\$281,118,000	\$88,012,000	\$0

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

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2022-23

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>BENEFITS</u>					
35	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	\$122,305,000	\$122,305,000	\$0	\$0
36	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	\$63,951,000	\$31,975,500	(\$500)	\$31,976,000
37	TELEHEALTH	\$132,460,760	\$85,669,880	\$46,790,890	\$0
38	REMOTE PATIENT MONITORING	\$32,037,000	\$20,333,300	\$11,703,700	\$0
39	COMMUNITY HEALTH WORKER	\$47,046,000	\$30,099,050	\$16,946,950	\$0
40	CALIFORNIA COMMUNITY TRANSITIONS COSTS	\$13,052,000	\$8,255,000	\$4,797,000	\$0
41	MEDICALLY TAILORED MEALS PILOT PROGRAM	\$112,000	\$0	\$112,000	\$0
43	HEARING AID COVERAGE	\$9,990,000	\$0	\$9,990,000	\$0
46	CONTINUOUS GLUCOSE MONITORING SYSTEMS BENEFIT	\$4,919,550	\$3,648,590	\$1,270,960	\$0
47	CALAIM - ORGAN TRANSPLANT	\$1,061,000	\$751,750	\$309,250	\$0
48	EXPANSION TO SCREENING FOR ADDITIONAL SUBSTANCES	\$1,345,490	\$852,370	\$493,120	\$0
49	MEDICAL INTERPRETERS PILOT PROJECT	\$2,400,000	\$0	\$2,400,000	\$0
50	DOULA BENEFIT	\$941,210	\$580,080	\$361,120	\$0
51	CCT FUND TRANSFER TO CDSS	\$165,000	\$165,000	\$0	\$0
52	DIABETES PREVENTION PROGRAM	\$1,159,520	\$738,420	\$421,100	\$0
53	CYBHI - DYADIC SERVICES	\$87,444,280	\$46,653,900	\$40,790,390	\$0
260	CALAIM - LTC BENEFIT TRANSITION	\$115,809,000	\$60,341,050	\$55,467,950	\$0
265	ANNUAL COGNITIVE ASSESSMENTS	\$341,000	\$170,500	\$170,500	\$0
270	FPACT HPV VACCINE COVERAGE	\$8,040,000	\$3,459,000	\$4,581,000	\$0
	BENEFITS SUBTOTAL	\$2,403,869,820	\$1,676,435,390	\$695,458,430	\$31,976,000
<u>PHARMACY</u>					
54	MEDI-CAL RX - MANAGED CARE PHARMACY BENEFIT TO FFS	\$6,794,603,000	\$4,696,440,550	\$2,098,162,450	\$0
55	MEDICATION THERAPY MANAGEMENT PROGRAM	\$20,103,190	\$13,065,240	\$7,037,950	\$0
56	MEDI-CAL DRUG REBATE FUND	\$0	\$0	(\$1,952,556,000)	\$1,952,556,000
57	MEDI-CAL RX- ADDITIONAL SUPPLEMENTAL REBATES	(\$670,311,000)	(\$446,555,400)	(\$223,755,600)	\$0
59	BCCTP DRUG REBATES	(\$4,552,000)	(\$4,552,000)	\$0	\$0
60	MEDI-CAL RX - ADDITIONAL SAVINGS FROM MAIC IN FFS	(\$14,732,000)	(\$9,566,400)	(\$5,165,600)	\$0
61	FAMILY PACT DRUG REBATES	(\$10,600,000)	(\$10,600,000)	\$0	\$0
62	MEDICAL SUPPLY REBATES	(\$121,712,000)	(\$60,856,000)	(\$60,856,000)	\$0
63	STATE SUPPLEMENTAL DRUG REBATES	(\$97,572,000)	(\$97,572,000)	\$0	\$0
64	PHARMACY RETROACTIVE ADJUSTMENTS	(\$110,244,000)	(\$60,936,800)	(\$49,307,200)	\$0
65	FEDERAL DRUG REBATES	(\$3,237,798,000)	(\$3,237,798,000)	\$0	\$0
	PHARMACY SUBTOTAL	\$2,547,185,190	\$781,069,190	(\$186,440,000)	\$1,952,556,000

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

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2022-23

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>DRUG MEDI-CAL</u>					
68	HCBS SP - CONTINGENCY MANAGEMENT	\$23,086,000	\$11,543,000	\$0	\$11,543,000
69	DRUG MEDI-CAL MAT BENEFIT	\$350,110	\$279,090	\$71,010	\$0
70	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	\$527,780	\$492,210	\$35,560	\$0
	DRUG MEDI-CAL SUBTOTAL	\$23,963,880	\$12,314,300	\$106,580	\$11,543,000
<u>MENTAL HEALTH</u>					
74	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE	\$1,659,749,000	\$218,500,000	\$1,441,249,000	\$0
75	MHP COSTS FOR FFPSA	\$45,286,000	\$30,196,000	\$15,090,000	\$0
76	CALAIM - BH QUALITY IMPROVEMENT PROGRAM	\$45,396,000	\$0	\$45,396,000	\$0
77	MHP COSTS FOR CONTINUUM OF CARE REFORM	\$20,674,000	\$9,444,500	\$11,229,500	\$0
78	MHP STRTP GRANTS	\$7,478,000	\$0	\$7,478,000	\$0
79	OUT OF STATE YOUTH - SMHS	\$2,678,000	\$1,339,000	\$1,339,000	\$0
80	SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS	\$0	(\$6,017,000)	\$6,017,000	\$0
81	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	\$0	\$0	(\$200,000)	\$200,000
82	CHART REVIEW	(\$174,000)	(\$174,000)	\$0	\$0
83	INTERIM AND FINAL COST SETTLEMENTS - SMHS	(\$322,314,000)	(\$322,474,000)	\$160,000	\$0
	MENTAL HEALTH SUBTOTAL	\$1,458,773,000	(\$69,185,500)	\$1,527,758,500	\$200,000
<u>WAIVER--MH/UCD & BTR</u>					
84	GLOBAL PAYMENT PROGRAM	\$2,561,451,000	\$1,280,726,000	\$0	\$1,280,725,000
86	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES	\$1,338,593,000	\$793,030,500	\$545,562,500	\$0
87	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	\$79,250,000	\$39,625,000	\$39,625,000	\$0
88	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	\$549,000	\$549,000	\$0	\$0
268	CALAIM- DESIGNATED STATE HEALTH PROGRAMS	\$0	\$123,200,000	(\$123,200,000)	\$0
	WAIVER--MH/UCD & BTR SUBTOTAL	\$3,979,843,000	\$2,237,130,500	\$461,987,500	\$1,280,725,000
<u>MANAGED CARE</u>					
95	CCI-MANAGED CARE PAYMENTS	\$2,618,566,440	\$1,309,283,220	\$1,309,283,220	\$0
96	2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	\$1,532,243,000	\$975,669,950	\$556,573,050	\$0
98	MANAGED CARE PUBLIC HOSPITAL EPP	\$1,778,153,000	\$1,363,819,310	\$414,333,690	\$0
99	MANAGED CARE HEALTH CARE FINANCING PROGRAM	\$1,864,564,000	\$1,246,887,750	\$617,676,250	\$0
101	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	\$1,989,172,000	\$1,458,651,450	\$530,520,550	\$0
102	CALAIM - TRANSITIONING POPULATIONS	\$101,037,000	\$50,768,200	\$50,268,800	\$0
103	CYBHI - INCREASE ACCESS TO STUDENT BH SERVICES	\$129,662,000	\$64,831,000	\$64,831,000	\$0

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

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2022-23

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
MANAGED CARE					
104	HCBS SP - HOUSING AND HOMELESSNESS INCENTIVE PROG	\$644,236,000	\$322,118,000	\$0	\$322,118,000
105	CALAIM – MEDI-CAL PATH	\$706,650,000	\$353,325,000	\$253,100,000	\$100,225,000
106	RETRO MC RATE ADJUSTMENTS	\$193,016,000	\$102,514,250	\$90,501,750	\$0
109	PROP 56-BEHAVIORAL HEALTH INCENTIVE PROGRAM	\$90,136,000	\$47,397,000	\$42,739,000	\$0
113	CCI-QUALITY WITHHOLD REPAYMENTS	\$11,242,000	\$5,621,000	\$5,621,000	\$0
116	CAPITATED RATE ADJUSTMENT FOR FY 2022-23	(\$1,725,597,000)	(\$1,140,264,200)	(\$585,332,800)	\$0
117	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	\$0	\$0	(\$1,680,543,000)	\$1,680,543,000
118	2020 MCO ENROLLMENT TAX MANAGED CARE PLANS	\$0	\$0	(\$1,508,961,000)	\$1,508,961,000
119	2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	\$0	\$0	(\$556,573,000)	\$556,573,000
MANAGED CARE SUBTOTAL		\$9,933,080,440	\$6,160,621,930	(\$395,961,490)	\$4,168,420,000
PROVIDER RATES					
124	RATE INCREASE FOR FQHCS/RHCS/CBRCS	\$329,447,150	\$206,881,610	\$122,565,540	\$0
125	DPH INTERIM RATE GROWTH	\$246,132,720	\$166,805,190	\$79,327,520	\$0
126	AB 1629 ANNUAL RATE ADJUSTMENTS	\$247,714,450	\$130,297,760	\$117,416,680	\$0
127	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	\$153,592,900	\$104,465,600	(\$5,458,490)	\$54,585,790
128	LTC RATE ADJUSTMENT	\$200,449,690	\$102,634,620	\$97,815,070	\$0
130	FQHC/RHC/CBRC RECONCILIATION PROCESS	\$111,000,000	\$70,434,300	\$40,565,700	\$0
131	PP-GEMT PROGRAM	\$145,653,480	\$96,352,230	(\$4,217,130)	\$53,518,370
133	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	\$7,689,000	\$4,697,000	(\$870,000)	\$3,862,000
134	HOSPICE RATE INCREASES	\$9,658,950	\$5,049,020	\$4,609,930	\$0
135	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	\$2,637,000	\$1,583,950	\$1,053,050	\$0
136	GDSP PRENATAL SCREENING PROGRAM FEE INCREASE	\$5,290,530	\$3,177,830	\$2,112,700	\$0
137	DPH INTERIM RATE	\$0	\$481,535,000	(\$481,535,000)	\$0
138	PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE	\$0	\$0	\$0	\$0
139	PROP 56 - HOME HEALTH RATE INCREASE	\$0	\$0	\$0	\$0
140	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	\$0	\$0	(\$592,657,000)	\$592,657,000
141	DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT	(\$932,000)	(\$530,140)	(\$401,860)	\$0
142	10% PROVIDER PAYMENT REDUCTION	(\$6,819,530)	(\$4,188,330)	(\$2,631,200)	\$0
143	REDUCTION TO RADIOLOGY RATES	(\$12,514,490)	(\$7,112,270)	(\$5,402,220)	\$0
144	LABORATORY RATE METHODOLOGY CHANGE	(\$1,528,440)	(\$872,950)	(\$655,490)	\$0
145	DPH INTERIM & FINAL RECONS	\$60,992,000	\$60,992,000	\$0	\$0
263	NURSING FACILITY FINANCING REFORM	\$96,480,000	\$50,748,400	\$45,731,600	\$0

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

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2022-23

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>PROVIDER RATES</u>					
267	AB 97 ELIMINATIONS	\$20,191,000	\$11,204,700	\$8,986,300	\$0
	PROVIDER RATES SUBTOTAL	\$1,615,134,420	\$1,484,155,540	(\$573,644,290)	\$704,623,170
<u>SUPPLEMENTAL PMNTS.</u>					
146	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	\$3,403,178,000	\$2,328,183,000	\$0	\$1,074,995,000
147	HOSPITAL QAF - FFS PAYMENTS	\$3,358,212,000	\$1,977,802,000	\$0	\$1,380,410,000
148	HOSPITAL QAF - MANAGED CARE PAYMENTS	\$1,797,400,000	\$1,205,828,000	\$0	\$591,572,000
149	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	\$1,149,739,500	\$690,251,490	\$459,488,020	\$0
150	PRIVATE HOSPITAL DSH REPLACEMENT	\$634,392,000	\$317,196,000	\$317,196,000	\$0
151	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	\$542,183,000	\$333,690,000	\$0	\$208,493,000
152	DSH PAYMENT	\$430,468,000	\$316,742,000	\$25,000,000	\$88,726,000
153	PROP 56 - MEDI-CAL FAMILY PLANNING	\$389,703,800	\$325,325,070	\$64,378,730	\$0
154	PROP 56 - VALUE-BASED PAYMENT PROGRAM	\$30,595,000	\$27,047,150	\$3,547,850	\$0
155	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	\$310,343,000	\$165,520,000	\$118,400,000	\$26,423,000
156	DPH PHYSICIAN & NON-PHYS. COST	\$98,248,000	\$98,248,000	\$0	\$0
157	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	\$198,877,000	\$198,877,000	\$0	\$0
158	FFP FOR LOCAL TRAUMA CENTERS	\$177,122,000	\$101,207,500	\$0	\$75,914,500
159	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	\$118,535,000	\$68,888,000	\$719,000	\$48,928,000
160	CAPITAL PROJECT DEBT REIMBURSEMENT	\$95,602,000	\$67,574,000	\$28,028,000	\$0
161	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	\$29,500,000	\$14,750,000	\$0	\$14,750,000
162	NDPH IGT SUPPLEMENTAL PAYMENTS	\$43,948,000	\$24,378,000	(\$1,356,000)	\$20,926,000
163	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	\$84,205,000	\$84,205,000	\$0	\$0
164	PROP 56 - DEVELOPMENTAL SCREENINGS	\$58,631,100	\$31,924,370	\$26,706,720	\$0
165	NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS	\$105,000,000	\$52,500,000	\$52,500,000	\$0
166	PROP 56 - ADVERSE CHILDHOOD EXPERIENCES SCREENINGS	\$46,819,710	\$27,317,040	\$19,502,670	\$0
167	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	\$59,683,660	\$36,202,070	\$23,481,590	\$0
168	PROP 56 - CBAS SUPPLEMENTAL PAYMENTS	\$23,697,260	\$11,848,630	\$11,848,630	\$0
169	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	\$14,682,000	\$14,682,000	\$0	\$0
170	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	\$10,000,000	\$5,000,000	\$5,000,000	\$0
171	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS	\$9,176,880	\$4,736,750	\$4,440,130	\$0
172	NDPH SUPPLEMENTAL PAYMENT	\$4,219,000	\$2,319,000	\$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 2022-23

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>SUPPLEMENTAL PMNTS.</u>					
173	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	\$8,000,000	\$4,000,000	\$4,000,000	\$0
174	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	\$4,791,920	\$3,917,380	\$874,540	\$0
175	GEMT SUPPLEMENTAL PAYMENT PROGRAM	\$20,196,000	\$20,196,000	\$0	\$0
176	FREE CLINICS AUGMENTATION	\$2,000,000	\$0	\$2,000,000	\$0
177	PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS	\$1,673,200	\$866,140	\$807,070	\$0
178	PROP 56 - NEMT SUPPLEMENTAL PAYMENTS	\$0	\$0	\$0	\$0
179	PROPOSITION 56 FUNDING	\$0	\$0	(\$783,879,000)	\$783,879,000
180	PROP 56 - AIDS WAIVER RATE INCREASE	\$0	\$0	\$0	\$0
181	IGT ADMIN. & PROCESSING FEE	\$0	\$0	(\$11,871,000)	\$11,871,000
	SUPPLEMENTAL PMNTS. SUBTOTAL	\$13,260,822,030	\$8,561,221,590	\$372,712,940	\$4,326,887,500
<u>COVID-19</u>					
182	COVID-19 CASELOAD IMPACT	\$9,981,882,000	\$7,166,608,000	\$2,815,274,000	\$0
184	COVID-19 VACCINE ADMINISTRATION	\$155,348,000	\$153,897,200	\$1,450,800	\$0
186	COVID-19 BEHAVIORAL HEALTH	\$10,351,000	\$8,816,650	\$1,534,350	\$0
190	COVID-19 TESTING IN SCHOOLS	\$404,591,000	\$302,141,850	\$102,449,150	\$0
192	COVID-19 BASE RECOVERIES	\$0	\$0	\$0	\$0
194	COVID-19 INCREASED FMAP - DHCS	\$0	(\$6,764,000)	\$6,764,000	\$0
272	COVID-19 INCREASED FMAP EXTENSION	\$16,344,000	\$796,777,000	(\$484,071,000)	(\$296,362,000)
	COVID-19 SUBTOTAL	\$10,568,516,000	\$8,421,476,700	\$2,443,401,300	(\$296,362,000)
<u>STATE ONLY CLAIMING</u>					
195	STATE ONLY CLAIMING ADJUSTMENTS	\$128,643,000	(\$1,397,838,000)	\$1,526,481,000	\$0
196	STATE ONLY CLAIMING ADJUSTMENTS - SMHS and DMC	(\$6,020,000)	(\$20,496,000)	\$14,476,000	\$0
	STATE ONLY CLAIMING SUBTOTAL	\$122,623,000	(\$1,418,334,000)	\$1,540,957,000	\$0
<u>OTHER</u>					
203	HCBS SP - COMM BASED RESIDENTIAL CONTINUUM PILOT	\$287,197,000	\$181,080,000	\$0	\$106,117,000
205	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER	\$304,000,000	\$152,000,000	\$152,000,000	\$0
207	CALAIM - DENTAL INITIATIVES	\$243,216,000	\$125,541,650	\$117,674,350	\$0
208	CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY	\$450,000,000	\$0	\$450,000,000	\$0
209	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	\$60,914,000	\$60,914,000	\$0	\$0
210	PROP 56 - PROVIDER ACES TRAININGS	\$1,468,000	\$734,000	\$734,000	\$0
212	QAF WITHHOLD TRANSFER	(\$2,028,000)	(\$1,014,000)	(\$1,014,000)	\$0
213	INFANT DEVELOPMENT PROGRAM	\$28,784,000	\$28,784,000	\$0	\$0
218	PROP 56 PHYSICIANS & DENTISTS LOAN REPAYMENT PROG	\$41,400,000	\$0	\$0	\$41,400,000

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

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2022-23

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>OTHER</u>					
219	INDIAN HEALTH SERVICES	\$26,428,000	\$17,574,500	\$8,853,500	\$0
220	SELF-DETERMINATION PROGRAM - CDDS	\$36,377,000	\$36,377,000	\$0	\$0
222	PEER SUPPORT SPECIALIST SERVICES	\$31,305,000	\$31,305,000	\$0	\$0
224	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	\$10,471,000	\$5,681,000	\$4,790,000	\$0
225	CYBHI - CALHOPE STUDENT SUPPORT	\$17,000,000	\$0	\$17,000,000	\$0
226	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	\$40,780,100	\$20,390,050	\$20,390,050	\$0
227	HCBS SP - ASSISTED LIVING WAIVER EXPANSION	\$32,375,310	\$23,523,790	(\$20,492,020)	\$29,343,540
231	TRIBAL FEDERALLY QUALIFIED HEALTH CENTER	\$19,332,090	\$14,313,130	\$5,018,950	\$0
232	OUTREACH & ENROLLMENT ASSIST. FOR DUAL BENES	\$5,000,000	\$0	\$5,000,000	\$0
233	HPSM DENTAL INTEGRATION PILOT PROGRAM	\$78,000	\$46,400	\$31,600	\$0
234	WPCS WORKERS' COMPENSATION	\$682,000	\$341,000	\$341,000	\$0
236	CYBHI - EVIDENCE-BASED BH PRACTICES	\$429,000,000	\$0	\$429,000,000	\$0
238	CIGARETTE AND TOBACCO SURTAX FUNDS	\$0	\$0	(\$154,920,000)	\$154,920,000
239	CLPP FUND	\$916,000	\$0	\$0	\$916,000
241	IMD ANCILLARY SERVICES	\$0	(\$37,080,000)	\$37,080,000	\$0
242	FUNDING ADJUST.—ACA OPT. EXPANSION	\$0	\$1,883,833,600	(\$1,883,833,600)	\$0
243	FUNDING ADJUST.—OTLICP	\$0	\$84,073,950	(\$84,073,950)	\$0
244	HOSPITAL QAF - CHILDREN'S HEALTH CARE	\$0	\$0	(\$976,000,000)	\$976,000,000
245	CMS DEFERRED CLAIMS	\$0	\$233,240,000	(\$233,240,000)	\$0
248	INDIAN HEALTH SERVICES FUNDING SHIFT	\$0	\$13,391,000	(\$13,391,000)	\$0
249	COUNTY SHARE OF OTLICP-CCS COSTS	(\$25,337,000)	\$0	(\$25,337,000)	\$0
252	QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES	\$108,483,000	\$92,211,000	\$16,272,000	\$0
254	AMERICAN RESCUE PLAN INCREASED FMAP FOR HCBS	\$0	\$484,094,000	\$0	(\$484,094,000)
257	EVIDENCE-BASED DENTAL PRACTICES	\$37,110,000	\$24,194,200	\$12,915,800	\$0
258	END-OF-FY 2-WEEK CHECKWRITE HOLD BUYBACK	\$795,755,000	\$486,345,350	\$309,409,650	\$0
262	COUNTY BH RECOUPMENTS	(\$60,840,000)	\$0	(\$60,840,000)	\$0
266	EQUITY & PRACTICE TRANSFORMATION PAYMENTS	\$400,000,000	\$200,000,000	\$200,000,000	\$0
269	HCBS SP CDDS	\$231,796,000	\$231,796,000	\$0	\$0
271	MHSF - PROVIDER ACES TRAININGS	\$44,100,000	\$22,050,000	\$0	\$22,050,000
273	URBAN INDIAN ORGANIZATIONS FUNDING SHIFT	\$0	\$25,322,000	(\$25,322,000)	\$0
275	BEHAVIORAL HEALTH BRIDGE HOUSING	\$1,000,000,000	\$0	\$1,000,000,000	\$0

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

**SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2022-23**

<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>
	OTHER SUBTOTAL	\$4,595,762,490	\$4,441,062,620	(\$691,952,670)	\$846,652,540
	GRAND TOTAL	<u>\$57,871,588,860</u>	<u>\$37,891,843,890</u>	<u>\$6,941,303,760</u>	<u>\$13,038,441,210</u>

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

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY FISCAL YEAR 2022-23

SERVICE CATEGORY	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
PROFESSIONAL	\$10,166,316,650	\$6,284,097,110	\$3,076,835,250	\$805,384,290
PHYSICIANS	\$1,193,990,000	\$742,257,660	\$397,428,160	\$54,304,180
OTHER MEDICAL	\$6,941,847,590	\$4,265,776,990	\$2,547,738,490	\$128,332,110
CO. & COMM. OUTPATIENT	\$2,030,479,070	\$1,276,062,470	\$131,668,600	\$622,748,000
PHARMACY	\$9,201,483,370	\$5,583,942,670	\$1,613,435,030	\$2,004,105,670
HOSPITAL INPATIENT	\$14,039,190,870	\$9,123,064,650	\$2,169,545,970	\$2,746,580,250
COUNTY INPATIENT	\$3,908,710,910	\$2,521,705,390	\$91,197,100	\$1,295,808,420
COMMUNITY INPATIENT	\$10,130,479,960	\$6,601,359,260	\$2,078,348,870	\$1,450,771,830
LONG TERM CARE	\$2,190,089,610	\$1,175,498,790	\$839,314,350	\$175,276,470
NURSING FACILITIES	\$1,860,439,850	\$1,010,864,020	\$699,137,070	\$150,438,760
ICF-DD	\$329,649,760	\$164,634,770	\$140,177,280	\$24,837,710
OTHER SERVICES	\$2,541,747,630	\$1,495,705,250	\$865,150,420	\$180,891,950
MEDICAL TRANSPORTATION	\$163,324,110	\$111,288,650	\$47,032,530	\$5,002,930
OTHER SERVICES	\$2,105,401,930	\$1,235,097,490	\$694,875,160	\$175,429,280
HOME HEALTH	\$273,021,590	\$149,319,110	\$123,242,730	\$459,740
TOTAL FEE-FOR-SERVICE	\$38,138,828,140	\$23,662,308,480	\$8,564,281,030	\$5,912,238,630
MANAGED CARE	\$58,906,657,530	\$35,853,382,200	\$16,106,450,260	\$6,946,825,070
TWO PLAN MODEL	\$35,221,720,140	\$21,636,856,000	\$9,461,485,640	\$4,123,378,500
COUNTY ORGANIZED HEALTH SYSTEMS	\$14,025,960,630	\$8,411,837,320	\$3,827,660,320	\$1,786,462,990
GEOGRAPHIC MANAGED CARE	\$6,206,571,010	\$3,756,905,600	\$1,681,273,360	\$768,392,060
PHP & OTHER MANAG. CARE	\$1,498,263,140	\$827,438,800	\$682,930,410	(\$12,106,070)
REGIONAL MODEL	\$1,954,142,600	\$1,220,344,480	\$453,100,530	\$280,697,590
DENTAL	\$2,236,179,730	\$1,351,673,120	\$825,154,630	\$59,351,990
MENTAL HEALTH	\$2,969,096,460	\$2,647,905,250	\$119,992,800	\$201,198,410
AUDITS/ LAWSUITS	\$27,449,000	\$246,964,500	(\$219,515,500)	\$0
EPSDT SCREENS	\$0	\$0	\$0	\$0
MEDICARE PAYMENTS	\$7,059,655,030	\$2,119,897,870	\$4,990,946,710	(\$51,189,560)
STATE HOSP./DEVELOPMENTAL CNTRS.	\$29,259,490	\$28,514,780	\$931,300	(\$186,590)
MISC. SERVICES	\$16,674,811,600	\$13,368,749,900	\$3,183,333,320	\$122,728,380
RECOVERIES	(\$425,628,000)	(\$246,437,150)	(\$179,190,850)	\$0
DRUG MEDI-CAL	\$1,103,089,910	\$920,817,750	\$177,978,280	\$4,293,880
GRAND TOTAL MEDI-CAL	\$126,719,398,890	\$79,953,776,700	\$33,570,361,980	\$13,195,260,210

**MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2021-22 AND 2022-23**

<u>SERVICE CATEGORY</u>	<u>NOV. 2021 EST. FOR 2021-22</u>	<u>NOV. 2021 EST. FOR 2022-23</u>	<u>DOLLAR DIFFERENCE</u>	<u>% CHANGE</u>
PROFESSIONAL	\$9,399,788,370	\$10,166,316,650	\$766,528,280	8.15%
PHYSICIANS	\$1,383,198,050	\$1,193,990,000	(\$189,208,060)	-13.68%
OTHER MEDICAL	\$6,220,574,010	\$6,941,847,590	\$721,273,580	11.59%
CO. & COMM. OUTPATIENT	\$1,796,016,310	\$2,030,479,070	\$234,462,760	13.05%
PHARMACY	\$5,839,953,890	\$9,201,483,370	\$3,361,529,480	57.56%
HOSPITAL INPATIENT	\$14,771,497,930	\$14,039,190,870	(\$732,307,060)	-4.96%
COUNTY INPATIENT	\$4,547,218,740	\$3,908,710,910	(\$638,507,830)	-14.04%
COMMUNITY INPATIENT	\$10,224,279,190	\$10,130,479,960	(\$93,799,230)	-0.92%
LONG TERM CARE	\$3,645,097,820	\$2,190,089,610	(\$1,455,008,200)	-39.92%
NURSING FACILITIES	\$3,092,992,550	\$1,860,439,850	(\$1,232,552,700)	-39.85%
ICF-DD	\$552,105,270	\$329,649,760	(\$222,455,510)	-40.29%
OTHER SERVICES	\$1,789,199,770	\$2,541,747,630	\$752,547,860	42.06%
MEDICAL TRANSPORTATION	\$141,220,180	\$163,324,110	\$22,103,930	15.65%
OTHER SERVICES	\$1,372,325,760	\$2,105,401,930	\$733,076,170	53.42%
HOME HEALTH	\$275,653,840	\$273,021,590	(\$2,632,250)	-0.95%
TOTAL FEE-FOR-SERVICE	\$35,445,537,780	\$38,138,828,140	\$2,693,290,360	7.60%
MANAGED CARE	\$56,235,864,390	\$58,906,657,530	\$2,670,793,140	4.75%
TWO PLAN MODEL	\$33,365,992,780	\$35,221,720,140	\$1,855,727,360	5.56%
COUNTY ORGANIZED HEALTH SYSTEMS	\$13,617,851,660	\$14,025,960,630	\$408,108,970	3.00%
GEOGRAPHIC MANAGED CARE	\$6,068,398,410	\$6,206,571,010	\$138,172,600	2.28%
PHP & OTHER MANAG. CARE	\$1,280,557,370	\$1,498,263,140	\$217,705,780	17.00%
REGIONAL MODEL	\$1,903,064,170	\$1,954,142,600	\$51,078,430	2.68%
DENTAL	\$2,146,063,910	\$2,236,179,730	\$90,115,820	4.20%
MENTAL HEALTH	\$3,045,822,010	\$2,969,096,460	(\$76,725,550)	-2.52%
AUDITS/ LAWSUITS	\$39,876,000	\$27,449,000	(\$12,426,990)	-31.16%
MEDICARE PAYMENTS	\$6,582,423,310	\$7,059,655,030	\$477,231,720	7.25%
STATE HOSP./DEVELOPMENTAL CNTRS.	\$33,007,080	\$29,259,490	(\$3,747,590)	-11.35%
MISC. SERVICES	\$13,623,177,450	\$16,674,811,600	\$3,051,634,150	22.40%
RECOVERIES	(\$411,666,010)	(\$425,628,000)	(\$13,961,990)	3.39%
DRUG MEDI-CAL	\$1,128,764,960	\$1,103,089,910	(\$25,675,050)	-2.27%
GRAND TOTAL MEDI-CAL	\$117,868,870,870	\$126,719,398,890	\$8,850,528,010	7.51%
GENERAL FUNDS	\$25,698,266,090	\$33,570,361,980	\$7,872,095,890	30.63%
OTHER STATE FUNDS	\$10,505,795,440	\$13,195,260,210	\$2,689,464,770	25.60%

**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2021-22 AND 2022-23**

NO.	POLICY CHANGE TITLE	NOV. 2021 EST. FOR 2021-22		NOV. 2021 EST. FOR 2022-23		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
ELIGIBILITY							
1	POSTPARTUM CARE EXTENSION	\$0	\$0	\$290,975,000	\$134,459,000	\$290,975,000	\$134,459,000
2	BREAST AND CERVICAL CANCER TREATMENT	\$59,142,000	\$23,296,850	\$59,789,000	\$23,533,200	\$647,000	\$236,350
3	FPL INCREASE FOR AGED AND DISABLED PERSONS	\$76,072,000	\$38,036,000	\$81,374,000	\$40,687,000	\$5,302,000	\$2,651,000
4	UNDOCUMENTED OLDER CALIFORNIANS EXPANSION	\$52,532,000	\$41,611,000	\$589,846,000	\$496,061,000	\$537,314,000	\$454,450,000
5	MEDI-CAL STATE INMATE PROGRAMS	\$52,275,000	\$5,900,000	\$49,275,000	\$0	(\$3,000,000)	(\$5,900,000)
6	UNDOCUMENTED YOUNG ADULTS FULL SCOPE EXPANSION	\$303,181,000	\$206,811,000	\$350,731,000	\$236,453,000	\$47,550,000	\$29,642,000
8	MEDI-CAL COUNTY INMATE PROGRAMS	\$50,699,000	\$1,604,500	\$37,485,000	\$1,684,700	(\$13,214,000)	\$80,200
9	ACCELERATED ENROLLMENT FOR ADULTS	\$12,281,790	\$6,140,900	\$17,843,000	\$8,921,500	\$5,561,210	\$2,780,600
13	DISABLED ADULT CHILDREN PROGRAM CLEANUP	\$1,616,000	\$2,924,000	\$0	\$0	(\$1,616,000)	(\$2,924,000)
14	CALAIM INMATE PRE-RELEASE PROGRAM	\$0	\$0	\$50,232,000	\$15,534,000	\$50,232,000	\$15,534,000
15	PHASING IN THE MEDI-CAL ASSET LIMIT REPEAL	\$0	\$0	\$45,452,000	\$22,726,000	\$45,452,000	\$22,726,000
16	CS3 PROXY ADJUSTMENT	\$0	(\$53,950,300)	\$0	(\$54,257,100)	\$0	(\$306,800)
17	CDCR RETRO REPAYMENT	\$0	\$11,000	\$0	\$0	\$0	(\$11,000)
18	REFUGEE MEDICAL ASSISTANCE	\$0	(\$282,000)	\$0	(\$200,000)	\$0	\$82,000
19	MEDI-CAL COUNTY INMATE REIMBURSEMENT	\$0	(\$1,625,000)	\$0	(\$1,665,000)	\$0	(\$40,000)
20	MEDICARE OPTIONAL EXPANSION ADJUSTMENT	\$0	\$962,400	\$0	\$962,400	\$0	\$0
21	NON-OTLIPC CHIP	\$0	(\$86,166,900)	\$0	(\$86,166,900)	\$0	\$0
22	NON-EMERGENCY FUNDING ADJUSTMENT	\$0	\$1,205,139,600	\$0	\$1,205,139,600	\$0	\$0
23	SCHIP FUNDING FOR PRENATAL CARE	\$0	(\$73,523,700)	\$0	(\$69,726,800)	\$0	\$3,796,900
24	CHIP PREMIUMS	(\$48,232,000)	(\$16,881,200)	(\$48,232,000)	(\$16,881,200)	\$0	\$0
274	PREMIUMS REDUCTION	\$0	\$0	\$53,163,000	\$18,879,250	\$53,163,000	\$18,879,250
ELIGIBILITY SUBTOTAL		\$559,566,790	\$1,300,008,150	\$1,577,933,000	\$1,976,143,650	\$1,018,366,210	\$676,135,500

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 2021-22 AND 2022-23**

NO.	POLICY CHANGE TITLE	NOV. 2021 EST. FOR 2021-22		NOV. 2021 EST. FOR 2022-23		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>AFFORDABLE CARE ACT</u>							
26	COMMUNITY FIRST CHOICE OPTION	\$5,995,155,000	\$0	\$6,068,888,000	\$0	\$73,733,000	\$0
27	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	\$20,385,000	\$0	\$19,168,000	\$0	(\$1,217,000)	\$0
28	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	\$0	(\$46,552,850)	\$0	(\$43,640,000)	\$0	\$2,912,850
29	1% FMAP INCREASE FOR PREVENTIVE SERVICES	\$0	(\$4,242,000)	\$0	(\$4,242,000)	\$0	\$0
30	PAYMENTS TO PRIMARY CARE PHYSICIANS	(\$3,000)	\$0	(\$3,000)	\$0	\$0	\$0
31	ACA OPTIONAL EXPANSION MLR RISK CORRIDOR	(\$33,000,000)	(\$1,815,000)	\$0	\$0	\$33,000,000	\$1,815,000
	AFFORDABLE CARE ACT SUBTOTAL	\$5,982,537,000	(\$52,609,850)	\$6,088,053,000	(\$47,882,000)	\$105,516,000	\$4,727,850
<u>BENEFITS</u>							
32	BEHAVIORAL HEALTH TREATMENT	\$1,058,853,000	\$463,205,550	\$866,319,000	\$410,841,000	(\$192,534,000)	(\$52,364,550)
33	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	\$532,400,000	\$0	\$523,841,000	\$0	(\$8,559,000)	\$0
34	FAMILY PACT PROGRAM	\$352,260,000	\$83,989,200	\$369,130,000	\$88,012,000	\$16,870,000	\$4,022,800
35	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	\$109,512,000	\$0	\$122,305,000	\$0	\$12,793,000	\$0
36	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	\$51,506,000	(\$799,000)	\$63,951,000	(\$500)	\$12,445,000	\$798,500
37	TELEHEALTH	\$50,593,960	\$17,847,840	\$132,460,760	\$46,790,890	\$81,866,810	\$28,943,040
38	REMOTE PATIENT MONITORING	\$27,135,340	\$9,913,030	\$32,037,000	\$11,703,700	\$4,901,660	\$1,790,670
39	COMMUNITY HEALTH WORKER	\$7,375,000	\$2,527,400	\$47,046,000	\$16,946,950	\$39,671,000	\$14,419,550
40	CALIFORNIA COMMUNITY TRANSITIONS COSTS	\$12,310,000	\$4,451,000	\$13,052,000	\$4,797,000	\$742,000	\$346,000
41	MEDICALLY TAILORED MEALS PILOT PROGRAM	\$10,491,000	\$10,491,000	\$112,000	\$112,000	(\$10,379,000)	(\$10,379,000)
42	CCS DEMONSTRATION PROJECT	\$8,591,000	\$4,077,360	\$0	\$0	(\$8,591,000)	(\$4,077,360)
43	HEARING AID COVERAGE	\$8,560,000	\$8,560,000	\$9,990,000	\$9,990,000	\$1,430,000	\$1,430,000
45	MFP/CCT SUPPLEMENTAL FUNDING	\$5,000,000	\$0	\$0	\$0	(\$5,000,000)	\$0

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2021-22 AND 2022-23**

NO.	POLICY CHANGE TITLE	NOV. 2021 EST. FOR 2021-22		NOV. 2021 EST. FOR 2022-23		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>BENEFITS</u>							
46	CONTINUOUS GLUCOSE MONITORING SYSTEMS BENEFIT	\$7,243,640	\$2,527,950	\$4,919,550	\$1,270,960	(\$2,324,090)	(\$1,256,990)
47	CALAIM - ORGAN TRANSPLANT	\$4,789,000	\$1,393,650	\$1,061,000	\$309,250	(\$3,728,000)	(\$1,084,400)
48	EXPANSION TO SCREENING FOR ADDITIONAL SUBSTANCES	\$3,017,540	\$1,105,150	\$1,570,000	\$575,400	(\$1,447,540)	(\$529,750)
49	MEDICAL INTERPRETERS PILOT PROJECT	\$1,260,000	\$1,260,000	\$2,400,000	\$2,400,000	\$1,140,000	\$1,140,000
50	DOULA BENEFIT	\$0	\$0	\$941,210	\$361,120	\$941,210	\$361,120
51	CCT FUND TRANSFER TO CDSS	\$150,000	\$0	\$165,000	\$0	\$15,000	\$0
52	DIABETES PREVENTION PROGRAM	\$139,670	\$50,840	\$1,159,520	\$421,100	\$1,019,850	\$370,270
53	CYBHI - DYADIC SERVICES	\$0	\$0	\$87,444,280	\$40,790,390	\$87,444,280	\$40,790,390
260	CALAIM - LTC BENEFIT TRANSITION	\$0	\$0	\$115,809,000	\$55,467,950	\$115,809,000	\$55,467,950
265	ANNUAL COGNITIVE ASSESSMENTS	\$0	\$0	\$341,000	\$170,500	\$341,000	\$170,500
270	FPACT HPV VACCINE COVERAGE	\$0	\$0	\$8,040,000	\$4,581,000	\$8,040,000	\$4,581,000
	BENEFITS SUBTOTAL	\$2,251,187,150	\$610,600,970	\$2,404,094,320	\$695,540,710	\$152,907,170	\$84,939,740
<u>PHARMACY</u>							
54	MEDI-CAL RX - MANAGED CARE PHARMACY BENEFIT TO FFS	\$2,990,390,000	\$924,067,550	\$6,794,603,000	\$2,098,162,450	\$3,804,213,000	\$1,174,094,900
55	MEDICATION THERAPY MANAGEMENT PROGRAM	\$7,197,750	\$2,519,900	\$20,103,190	\$7,037,950	\$12,905,440	\$4,518,050
56	MEDI-CAL DRUG REBATE FUND	\$0	(\$1,474,916,000)	\$0	(\$1,952,556,000)	\$0	(\$477,640,000)
57	MEDI-CAL RX- ADDITIONAL SUPPLEMENTAL REBATES	\$0	\$0	(\$670,311,000)	(\$223,755,600)	(\$670,311,000)	(\$223,755,600)
58	LITIGATION SETTLEMENTS	(\$105,000)	(\$105,000)	\$0	\$0	\$105,000	\$105,000
59	BCCTP DRUG REBATES	(\$4,276,000)	\$0	(\$4,552,000)	\$0	(\$276,000)	\$0
60	MEDI-CAL RX - ADDITIONAL SAVINGS FROM MAIC IN FFS	(\$6,629,000)	(\$2,324,300)	(\$14,732,000)	(\$5,165,600)	(\$8,103,000)	(\$2,841,300)
61	FAMILY PACT DRUG REBATES	(\$7,524,000)	\$0	(\$10,600,000)	\$0	(\$3,076,000)	\$0
62	MEDICAL SUPPLY REBATES	(\$15,423,000)	(\$7,711,500)	(\$121,712,000)	(\$60,856,000)	(\$106,289,000)	(\$53,144,500)
63	STATE SUPPLEMENTAL DRUG REBATES	(\$96,906,000)	\$0	(\$97,572,000)	\$0	(\$666,000)	\$0

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2021-22 AND 2022-23**

NO.	POLICY CHANGE TITLE	NOV. 2021 EST. FOR 2021-22		NOV. 2021 EST. FOR 2022-23		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
PHARMACY							
64	PHARMACY RETROACTIVE ADJUSTMENTS	(\$99,854,000)	(\$37,221,800)	(\$110,244,000)	(\$49,307,200)	(\$10,390,000)	(\$12,085,400)
65	FEDERAL DRUG REBATES	(\$3,267,903,000)	\$0	(\$3,237,798,000)	\$0	\$30,105,000	\$0
	PHARMACY SUBTOTAL	(\$501,032,250)	(\$595,691,150)	\$2,547,185,190	(\$186,440,000)	\$3,048,217,440	\$409,251,150
DRUG MEDI-CAL							
68	HCBS SP - CONTINGENCY MANAGEMENT	\$3,638,000	\$0	\$23,086,000	\$0	\$19,448,000	\$0
69	DRUG MEDI-CAL MAT BENEFIT	\$517,690	\$99,510	\$350,110	\$71,010	(\$167,580)	(\$28,500)
70	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	\$229,500	\$15,380	\$527,780	\$35,560	\$298,280	\$20,190
71	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	(\$402,000)	(\$55,000)	\$0	\$0	\$402,000	\$55,000
	DRUG MEDI-CAL SUBTOTAL	\$3,983,190	\$59,880	\$23,963,880	\$106,580	\$19,980,690	\$46,690
MENTAL HEALTH							
74	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE	\$466,000,000	\$166,000,000	\$1,659,749,000	\$1,441,249,000	\$1,193,749,000	\$1,275,249,000
75	MHP COSTS FOR FFPSA	\$34,124,000	\$10,817,000	\$45,286,000	\$15,090,000	\$11,162,000	\$4,273,000
76	CALAIM - BH QUALITY IMPROVEMENT PROGRAM	\$21,750,000	\$21,750,000	\$45,396,000	\$45,396,000	\$23,646,000	\$23,646,000
77	MHP COSTS FOR CONTINUUM OF CARE REFORM	\$20,725,000	\$10,668,000	\$20,674,000	\$11,229,500	(\$51,000)	\$561,500
78	MHP STRTP GRANTS	\$7,478,000	\$7,478,000	\$7,478,000	\$7,478,000	\$0	\$0
79	OUT OF STATE YOUTH - SMHS	\$1,760,000	\$880,000	\$2,678,000	\$1,339,000	\$918,000	\$459,000
80	SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS	\$0	\$712,000	\$0	\$6,017,000	\$0	\$5,305,000
81	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	\$0	(\$200,000)	\$0	(\$200,000)	\$0	\$0
82	CHART REVIEW	(\$50,000)	\$0	(\$174,000)	\$0	(\$124,000)	\$0
83	INTERIM AND FINAL COST SETTLEMENTS - SMHS	(\$463,023,000)	\$242,000	(\$322,314,000)	\$160,000	\$140,709,000	(\$82,000)
	MENTAL HEALTH SUBTOTAL	\$88,764,000	\$218,347,000	\$1,458,773,000	\$1,527,758,500	\$1,370,009,000	\$1,309,411,500

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CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2021-22 AND 2022-23**

NO.	POLICY CHANGE TITLE	NOV. 2021 EST. FOR 2021-22		NOV. 2021 EST. FOR 2022-23		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>WAIVER--MH/UCD & BTR</u>							
84	GLOBAL PAYMENT PROGRAM	\$3,227,712,000	\$0	\$2,561,451,000	\$0	(\$666,261,000)	\$0
85	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS	\$707,330,000	\$0	\$0	\$0	(\$707,330,000)	\$0
86	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES	\$564,241,000	\$237,642,300	\$1,338,593,000	\$545,562,500	\$774,352,000	\$307,920,200
87	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	\$196,370,000	\$90,513,000	\$79,250,000	\$39,625,000	(\$117,120,000)	(\$50,888,000)
88	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	\$637,000	\$0	\$549,000	\$0	(\$88,000)	\$0
89	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM	\$0	(\$13,231,000)	\$0	\$0	\$0	\$13,231,000
90	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL	(\$270,000)	\$0	\$0	\$0	\$270,000	\$0
91	MH/UCD—SAFETY NET CARE POOL	(\$2,238,000)	\$0	\$0	\$0	\$2,238,000	\$0
268	CALAIM- DESIGNATED STATE HEALTH PROGRAMS	\$0	(\$30,800,000)	\$0	(\$123,200,000)	\$0	(\$92,400,000)
	WAIVER--MH/UCD & BTR SUBTOTAL	\$4,693,782,000	\$284,124,300	\$3,979,843,000	\$461,987,500	(\$713,939,000)	\$177,863,200
<u>MANAGED CARE</u>							
95	CCI-MANAGED CARE PAYMENTS	\$7,202,578,000	\$3,601,289,000	\$6,676,610,000	\$3,338,305,000	(\$525,968,000)	(\$262,984,000)
96	2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	\$2,565,371,000	\$931,847,100	\$1,532,243,000	\$556,573,050	(\$1,033,128,000)	(\$375,274,050)
98	MANAGED CARE PUBLIC HOSPITAL EPP	\$1,201,593,000	\$305,801,510	\$1,778,153,000	\$414,333,690	\$576,560,000	\$108,532,180
99	MANAGED CARE HEALTH CARE FINANCING PROGRAM	\$1,007,531,000	\$308,616,540	\$1,864,564,000	\$617,676,250	\$857,033,000	\$309,059,710
101	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	\$962,082,000	\$252,532,040	\$1,989,172,000	\$530,520,550	\$1,027,090,000	\$277,988,500
102	CALAIM - TRANSITIONING POPULATIONS	\$11,771,000	\$4,347,900	\$101,037,000	\$50,268,800	\$89,266,000	\$45,920,900
103	CYBHI - INCREASE ACCESS TO STUDENT BH SERVICES	\$64,831,000	\$32,415,500	\$129,662,000	\$64,831,000	\$64,831,000	\$32,415,500
104	HCBS SP - HOUSING AND HOMELESSNESS INCENTIVE PROG	\$161,059,000	\$0	\$644,236,000	\$0	\$483,177,000	\$0
105	CALAIM – MEDI-CAL PATH	\$389,650,000	\$134,400,000	\$706,650,000	\$253,100,000	\$317,000,000	\$118,700,000

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NO.	POLICY CHANGE TITLE	NOV. 2021 EST. FOR 2021-22		NOV. 2021 EST. FOR 2022-23		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
MANAGED CARE							
106	RETRO MC RATE ADJUSTMENTS	\$178,253,000	\$190,346,900	\$193,016,000	\$90,501,750	\$14,763,000	(\$99,845,150)
107	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS	\$118,180,000	\$15,318,000	\$0	\$0	(\$118,180,000)	(\$15,318,000)
109	PROP 56-BEHAVIORAL HEALTH INCENTIVE PROGRAM	\$75,998,000	\$33,286,000	\$90,136,000	\$42,739,000	\$14,138,000	\$9,453,000
111	SAN MATEO HEALTH PLAN REIMBURSEMENT	\$10,000,000	\$10,000,000	\$0	\$0	(\$10,000,000)	(\$10,000,000)
113	CCI-QUALITY WITHHOLD REPAYMENTS	\$10,571,000	\$5,285,500	\$11,242,000	\$5,621,000	\$671,000	\$335,500
114	CALAIM - MSSP CARVE-OUT OF CCI	\$1,600,000	\$800,000	\$0	\$0	(\$1,600,000)	(\$800,000)
116	CAPITATED RATE ADJUSTMENT FOR FY 2022-23	\$0	\$0	(\$1,725,597,000)	(\$585,332,800)	(\$1,725,597,000)	(\$585,332,800)
117	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	\$0	(\$936,983,000)	\$0	(\$1,680,543,000)	\$0	(\$743,560,000)
118	2020 MCO ENROLLMENT TAX MANAGED CARE PLANS	\$0	(\$1,691,653,000)	\$0	(\$1,508,961,000)	\$0	\$182,692,000
119	2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	\$0	(\$825,804,000)	\$0	(\$556,573,000)	\$0	\$269,231,000
120	COORDINATED CARE INITIATIVE RISK MITIGATION	(\$111,260,000)	(\$55,630,000)	\$0	\$0	\$111,260,000	\$55,630,000
121	PROP 56 - DIRECTED PAYMENT RISK MITIGATION	(\$235,000,000)	(\$74,547,120)	\$0	\$0	\$235,000,000	\$74,547,120
122	MANAGED CARE EFFICIENCIES	(\$304,653,000)	(\$100,209,300)	\$0	\$0	\$304,653,000	\$100,209,300
	MANAGED CARE SUBTOTAL	\$13,310,155,000	\$2,141,459,580	\$13,991,124,000	\$1,633,060,290	\$680,969,000	(\$508,399,280)
PROVIDER RATES							
124	RATE INCREASE FOR FQHCS/RHCS/CBRCS	\$294,178,480	\$109,444,610	\$330,504,770	\$122,959,010	\$36,326,290	\$13,514,400
125	DPH INTERIM RATE GROWTH	\$161,321,000	\$53,030,100	\$246,132,720	\$79,327,520	\$84,811,720	\$26,297,420
126	AB 1629 ANNUAL RATE ADJUSTMENTS	\$234,246,600	\$111,032,640	\$247,714,450	\$117,416,680	\$13,467,840	\$6,384,040
127	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	\$207,650,000	(\$6,977,000)	\$179,410,000	(\$6,376,000)	(\$28,240,000)	\$601,000
128	LTC RATE ADJUSTMENT	\$157,999,760	\$77,100,450	\$200,449,690	\$97,815,070	\$42,449,930	\$20,714,620
129	DPH INTERIM RATE COVID-19 INCREASED FMAP ADJUST	\$59,177,000	\$0	\$0	\$0	(\$59,177,000)	\$0

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NO.	POLICY CHANGE TITLE	NOV. 2021 EST. FOR 2021-22		NOV. 2021 EST. FOR 2022-23		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>PROVIDER RATES</u>							
130	FQHC/RHC/CBRC RECONCILIATION PROCESS	\$52,717,000	\$19,265,850	\$111,000,000	\$40,565,700	\$58,283,000	\$21,299,850
131	PP-GEMT PROGRAM	\$58,613,550	(\$1,296,760)	\$145,653,480	(\$4,217,130)	\$87,039,930	(\$2,920,370)
133	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	\$7,720,000	(\$1,325,000)	\$7,689,000	(\$870,000)	(\$31,000)	\$455,000
134	HOSPICE RATE INCREASES	\$7,414,730	\$3,538,800	\$10,264,560	\$4,898,970	\$2,849,830	\$1,360,180
135	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	\$5,275,000	\$2,106,140	\$2,637,000	\$1,053,050	(\$2,638,000)	(\$1,053,090)
136	GDSP PRENATAL SCREENING PROGRAM FEE INCREASE	\$0	\$0	\$5,290,530	\$2,112,700	\$5,290,530	\$2,112,700
137	DPH INTERIM RATE	\$0	(\$485,649,800)	\$0	(\$481,535,000)	\$0	\$4,114,800
138	PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE	\$6,371,000	\$2,785,600	\$6,371,000	\$3,167,600	\$0	\$382,000
139	PROP 56 - HOME HEALTH RATE INCREASE	\$123,645,000	\$54,060,050	\$123,645,000	\$61,467,050	\$0	\$7,407,000
140	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	\$0	(\$447,165,000)	\$0	(\$592,657,000)	\$0	(\$145,492,000)
141	DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT	(\$420,000)	(\$161,820)	(\$932,000)	(\$401,860)	(\$512,000)	(\$240,050)
142	10% PROVIDER PAYMENT REDUCTION	(\$166,726,000)	(\$64,328,150)	(\$164,723,000)	(\$63,555,500)	\$2,003,000	\$772,650
143	REDUCTION TO RADIOLOGY RATES	(\$12,524,060)	(\$5,394,000)	(\$12,514,490)	(\$5,402,220)	\$9,580	(\$8,220)
144	LABORATORY RATE METHODOLOGY CHANGE	(\$2,294,000)	\$12,269,000	(\$1,528,440)	(\$655,490)	\$765,560	(\$12,924,490)
145	DPH INTERIM & FINAL RECONS	(\$73,348,000)	\$0	\$60,992,000	\$0	\$134,340,000	\$0
263	NURSING FACILITY FINANCING REFORM	\$0	\$0	\$96,480,000	\$45,731,600	\$96,480,000	\$45,731,600
267	AB 97 ELIMINATIONS	\$0	\$0	\$20,191,000	\$8,986,300	\$20,191,000	\$8,986,300
	PROVIDER RATES SUBTOTAL	\$1,121,017,060	(\$567,664,280)	\$1,614,727,270	(\$570,168,940)	\$493,710,210	(\$2,504,660)
<u>SUPPLEMENTAL PMNTS.</u>							
146	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	\$3,278,827,000	\$0	\$3,403,178,000	\$0	\$124,351,000	\$0
147	HOSPITAL QAF - FFS PAYMENTS	\$2,859,969,000	\$0	\$3,358,212,000	\$0	\$498,243,000	\$0

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	<u>SUPPLEMENTAL PMNTS.</u>						
148	HOSPITAL QAF - MANAGED CARE PAYMENTS	\$1,797,400,000	\$0	\$1,797,400,000	\$0	\$0	\$0
149	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	\$1,222,805,000	\$440,668,000	\$1,215,755,000	\$485,870,800	(\$7,050,000)	\$45,202,800
150	PRIVATE HOSPITAL DSH REPLACEMENT	\$807,830,000	\$373,713,000	\$634,392,000	\$317,196,000	(\$173,438,000)	(\$56,517,000)
151	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	\$761,754,000	\$0	\$542,183,000	\$0	(\$219,571,000)	\$0
152	DSH PAYMENT	\$477,375,000	\$25,535,000	\$430,468,000	\$25,000,000	(\$46,907,000)	(\$535,000)
153	PROP 56 - MEDI-CAL FAMILY PLANNING	\$422,419,000	\$69,691,900	\$407,214,000	\$67,271,400	(\$15,205,000)	(\$2,420,500)
154	PROP 56 - VALUE-BASED PAYMENT PROGRAM	\$363,684,000	\$117,326,150	\$30,595,000	\$3,547,850	(\$333,089,000)	(\$113,778,300)
155	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	\$312,253,000	\$118,400,000	\$310,343,000	\$118,400,000	(\$1,910,000)	\$0
156	DPH PHYSICIAN & NON-PHYS. COST	\$382,101,000	\$0	\$98,248,000	\$0	(\$283,853,000)	\$0
157	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	\$225,884,000	\$0	\$198,877,000	\$0	(\$27,007,000)	\$0
158	FFP FOR LOCAL TRAUMA CENTERS	\$132,735,000	\$0	\$177,122,000	\$0	\$44,387,000	\$0
159	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	\$115,613,000	\$2,872,000	\$118,535,000	\$719,000	\$2,922,000	(\$2,153,000)
160	CAPITAL PROJECT DEBT REIMBURSEMENT	\$84,670,000	\$19,106,500	\$95,602,000	\$28,028,000	\$10,932,000	\$8,921,500
161	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	\$84,000,000	\$47,523,000	\$29,500,000	\$0	(\$54,500,000)	(\$47,523,000)
162	NDPH IGT SUPPLEMENTAL PAYMENTS	\$67,330,000	(\$2,477,000)	\$43,948,000	(\$1,356,000)	(\$23,382,000)	\$1,121,000
163	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	\$61,392,000	\$0	\$84,205,000	\$0	\$22,813,000	\$0
164	PROP 56 - DEVELOPMENTAL SCREENINGS	\$60,811,000	\$24,287,200	\$60,079,000	\$27,366,250	(\$732,000)	\$3,079,050
165	NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS	\$52,500,000	\$26,250,000	\$105,000,000	\$52,500,000	\$52,500,000	\$26,250,000
166	PROP 56 - ADVERSE CHILDHOOD EXPERIENCES SCREENINGS	\$47,900,000	\$17,591,150	\$48,035,000	\$20,008,900	\$135,000	\$2,417,750
167	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	\$493,663,000	\$170,373,950	\$507,946,000	\$199,843,300	\$14,283,000	\$29,469,350
168	PROP 56 - CBAS SUPPLEMENTAL PAYMENTS	\$26,552,000	\$11,630,000	\$23,702,000	\$11,851,000	(\$2,850,000)	\$221,000

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

**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2021-22 AND 2022-23**

NO.	POLICY CHANGE TITLE	NOV. 2021 EST. FOR 2021-22		NOV. 2021 EST. FOR 2022-23		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>SUPPLEMENTAL PMNTS.</u>							
169	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	\$14,013,000	\$0	\$14,682,000	\$0	\$669,000	\$0
170	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	\$10,000,000	\$4,690,000	\$10,000,000	\$5,000,000	\$0	\$310,000
171	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS	\$26,264,000	\$11,203,800	\$27,361,000	\$13,238,300	\$1,097,000	\$2,034,500
172	NDPH SUPPLEMENTAL PAYMENT	\$8,007,000	\$1,900,000	\$4,219,000	\$1,900,000	(\$3,788,000)	\$0
173	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	\$8,000,000	\$3,752,000	\$8,000,000	\$4,000,000	\$0	\$248,000
174	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	\$67,144,000	\$12,298,000	\$70,366,000	\$12,842,000	\$3,222,000	\$544,000
175	GEMT SUPPLEMENTAL PAYMENT PROGRAM	\$4,034,000	\$0	\$20,196,000	\$0	\$16,162,000	\$0
176	FREE CLINICS AUGMENTATION	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$0	\$0
177	PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS	\$8,173,000	\$3,454,400	\$8,206,000	\$3,958,150	\$33,000	\$503,750
178	PROP 56 - NEMT SUPPLEMENTAL PAYMENTS	\$7,158,000	\$3,318,550	\$7,158,000	\$3,728,550	\$0	\$410,000
179	PROPOSITION 56 FUNDING	\$0	(\$927,595,000)	\$0	(\$783,879,000)	\$0	\$143,716,000
180	PROP 56 - AIDS WAIVER RATE INCREASE	\$4,274,000	\$1,872,000	\$4,274,000	\$2,137,000	\$0	\$265,000
181	IGT ADMIN. & PROCESSING FEE	\$0	(\$10,921,000)	\$0	(\$11,871,000)	\$0	(\$950,000)
	SUPPLEMENTAL PMNTS. SUBTOTAL	\$14,298,534,000	\$568,463,600	\$13,897,001,000	\$609,300,500	(\$401,533,000)	\$40,836,900
<u>COVID-19</u>							
182	COVID-19 CASELOAD IMPACT	\$10,464,267,000	\$2,942,531,840	\$9,981,882,000	\$2,815,274,000	(\$482,385,000)	(\$127,257,840)
183	DESIGNATED PUBLIC HOSPITAL DIRECT GRANTS	\$300,000,000	\$300,000,000	\$0	\$0	(\$300,000,000)	(\$300,000,000)
184	COVID-19 VACCINE ADMINISTRATION	\$348,435,000	\$33,746,150	\$155,348,000	\$1,450,800	(\$193,087,000)	(\$32,295,350)
185	COVID-19 FFS REIMBURSEMENT RATES	\$378,526,250	\$180,547,690	\$0	\$0	(\$378,526,250)	(\$180,547,690)
186	COVID-19 BEHAVIORAL HEALTH	\$274,809,000	\$17,656,750	\$10,351,000	\$1,534,350	(\$264,458,000)	(\$16,122,400)
187	COVID-19 FFS DME RESPIRATORY RATES	\$35,203,000	\$16,453,250	\$0	\$0	(\$35,203,000)	(\$16,453,250)
188	COVID-19 - SICK LEAVE BENEFITS	\$7,249,000	\$50,500	\$0	\$0	(\$7,249,000)	(\$50,500)

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2021-22 AND 2022-23**

NO.	POLICY CHANGE TITLE	NOV. 2021 EST. FOR 2021-22		NOV. 2021 EST. FOR 2022-23		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>COVID-19</u>							
189	COVID-19 ELIGIBILITY	\$159,769,480	\$39,405,440	\$0	\$0	(\$159,769,480)	(\$39,405,440)
190	COVID-19 TESTING IN SCHOOLS	\$0	\$0	\$404,591,000	\$102,449,150	\$404,591,000	\$102,449,150
191	CONTINUOUS CHIP COVERAGE DURING THE COVID-19 PHE	\$0	\$39,794,000	\$0	\$0	\$0	(\$39,794,000)
192	COVID-19 BASE RECOVERIES	(\$14,026,000)	(\$5,905,550)	\$0	\$0	\$14,026,000	\$5,905,550
194	COVID-19 INCREASED FMAP - DHCS	(\$120,408,000)	(\$2,144,056,000)	\$0	\$6,764,000	\$120,408,000	\$2,150,820,000
256	MEDI-CAL COVID-19 VACCINATION INCENTIVE PROGRAM	\$250,000,000	\$125,000,000	\$0	\$0	(\$250,000,000)	(\$125,000,000)
272	COVID-19 INCREASED FMAP EXTENSION	\$598,569,000	(\$1,358,766,000)	\$16,344,000	(\$484,071,000)	(\$582,225,000)	\$874,695,000
	COVID-19 SUBTOTAL	\$12,682,393,730	\$186,458,080	\$10,568,516,000	\$2,443,401,300	(\$2,113,877,730)	\$2,256,943,220
<u>STATE ONLY CLAIMING</u>							
195	STATE ONLY CLAIMING ADJUSTMENTS	(\$13,371,000)	\$713,765,000	\$128,643,000	\$1,526,481,000	\$142,014,000	\$812,716,000
196	STATE ONLY CLAIMING ADJUSTMENTS - SMHS and DMC	(\$6,020,000)	\$14,476,000	(\$6,020,000)	\$14,476,000	\$0	\$0
	STATE ONLY CLAIMING SUBTOTAL	(\$19,391,000)	\$728,241,000	\$122,623,000	\$1,540,957,000	\$142,014,000	\$812,716,000
<u>OTHER DEPARTMENTS</u>							
197	ELECTRONIC VISIT VERIFICATION FED PENALTIES	(\$52,868,000)	\$761,000	\$0	\$0	\$52,868,000	(\$761,000)
	OTHER DEPARTMENTS SUBTOTAL	(\$52,868,000)	\$761,000	\$0	\$0	\$52,868,000	(\$761,000)
<u>OTHER</u>							
203	HCBS SP - COMM BASED RESIDENTIAL CONTINUUM PILOT	\$0	\$0	\$287,197,000	\$0	\$287,197,000	\$0
205	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER	\$263,774,000	\$131,887,000	\$304,000,000	\$152,000,000	\$40,226,000	\$20,113,000
206	CCI IHSS RECONCILIATION	\$135,495,000	\$0	\$0	\$0	(\$135,495,000)	\$0
207	CALAIM - DENTAL INITIATIVES	\$120,700,000	\$58,489,100	\$243,216,000	\$117,674,350	\$122,516,000	\$59,185,250
208	CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY	\$100,000,000	\$100,000,000	\$450,000,000	\$450,000,000	\$350,000,000	\$350,000,000

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2021-22 AND 2022-23**

NO.	POLICY CHANGE TITLE	NOV. 2021 EST. FOR 2021-22		NOV. 2021 EST. FOR 2022-23		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER						
209	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	\$106,523,000	\$0	\$60,914,000	\$0	(\$45,609,000)	\$0
210	PROP 56 - PROVIDER ACES TRAININGS	\$56,592,000	\$28,296,000	\$1,468,000	\$734,000	(\$55,124,000)	(\$27,562,000)
211	HCBS SP - CALBRIDGE BH PILOT PROGRAM	\$40,000,000	\$0	\$0	\$0	(\$40,000,000)	\$0
212	QAF WITHHOLD TRANSFER	\$37,846,000	\$15,884,000	(\$2,028,000)	(\$1,014,000)	(\$39,874,000)	(\$16,898,000)
213	INFANT DEVELOPMENT PROGRAM	\$38,319,000	\$0	\$28,784,000	\$0	(\$9,535,000)	\$0
217	KEDREN COMMUNITY HEALTH & ACUTE PSYCHIATRIC HOSP.	\$30,000,000	\$30,000,000	\$0	\$0	(\$30,000,000)	(\$30,000,000)
218	PROP 56 PHYSICIANS & DENTISTS LOAN REPAYMENT PROG	\$28,477,000	\$0	\$41,400,000	\$0	\$12,923,000	\$0
219	INDIAN HEALTH SERVICES	\$23,020,000	\$7,711,500	\$26,428,000	\$8,853,500	\$3,408,000	\$1,142,000
220	SELF-DETERMINATION PROGRAM - CDDS	\$22,085,000	\$0	\$36,377,000	\$0	\$14,292,000	\$0
221	ALAMEDA WELLNESS CAMPUS	\$15,000,000	\$15,000,000	\$0	\$0	(\$15,000,000)	(\$15,000,000)
222	PEER SUPPORT SPECIALIST SERVICES	\$0	\$0	\$31,305,000	\$0	\$31,305,000	\$0
223	HCBS SP - NON-IHSS CARE ECONOMY PMTS	\$12,250,000	\$0	\$0	\$0	(\$12,250,000)	\$0
224	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	\$17,085,000	\$7,814,000	\$10,471,000	\$4,790,000	(\$6,614,000)	(\$3,024,000)
225	CYBHI - CALHOPE STUDENT SUPPORT	\$11,000,000	\$11,000,000	\$17,000,000	\$17,000,000	\$6,000,000	\$6,000,000
226	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	\$73,373,410	\$36,686,710	\$80,434,120	\$40,217,060	\$7,060,700	\$3,530,350
227	HCBS SP - ASSISTED LIVING WAIVER EXPANSION	\$10,818,970	(\$6,818,940)	\$32,375,310	(\$20,492,020)	\$21,556,340	(\$13,673,080)
228	SECTION 19.56 LEGISLATIVE PRIORITIES	\$10,330,000	\$10,330,000	\$0	\$0	(\$10,330,000)	(\$10,330,000)
229	MLK JR. HOSPITAL IMPROVEMENT	\$10,000,000	\$10,000,000	\$0	\$0	(\$10,000,000)	(\$10,000,000)
230	ARRA HITECH - PROVIDER PAYMENTS	\$8,806,000	\$0	\$0	\$0	(\$8,806,000)	\$0
231	TRIBAL FEDERALLY QUALIFIED HEALTH CENTER	\$9,071,960	\$2,355,320	\$23,732,000	\$6,161,250	\$14,660,040	\$3,805,930
232	OUTREACH & ENROLLMENT ASSIST. FOR DUAL BENES	\$2,000,000	\$2,000,000	\$5,000,000	\$5,000,000	\$3,000,000	\$3,000,000
233	HPSM DENTAL INTEGRATION PILOT PROGRAM	\$606,000	\$244,350	\$78,000	\$31,600	(\$528,000)	(\$212,750)
234	WPCS WORKERS' COMPENSATION	\$682,000	\$341,000	\$682,000	\$341,000	\$0	\$0

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2021-22 AND 2022-23**

NO.	POLICY CHANGE TITLE	NOV. 2021 EST. FOR 2021-22		NOV. 2021 EST. FOR 2022-23		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
OTHER							
236	CYBHI - EVIDENCE-BASED BH PRACTICES	\$0	\$0	\$429,000,000	\$429,000,000	\$429,000,000	\$429,000,000
238	CIGARETTE AND TOBACCO SURTAX FUNDS	\$0	(\$175,014,000)	\$0	(\$154,920,000)	\$0	\$20,094,000
239	CLPP FUND	\$916,000	\$0	\$916,000	\$0	\$0	\$0
240	AUDIT SETTLEMENTS	\$0	\$9,427,000	\$0	\$0	\$0	(\$9,427,000)
241	IMD ANCILLARY SERVICES	\$0	\$70,954,000	\$0	\$37,080,000	\$0	(\$33,874,000)
242	FUNDING ADJUST.—ACA OPT. EXPANSION	\$0	(\$1,935,296,400)	\$0	(\$1,883,833,600)	\$0	\$51,462,800
243	FUNDING ADJUST.—OTLICP	\$0	(\$83,277,900)	\$0	(\$84,073,950)	\$0	(\$796,050)
244	HOSPITAL QAF - CHILDREN'S HEALTH CARE	\$0	(\$950,775,000)	\$0	(\$976,000,000)	\$0	(\$25,225,000)
245	CMS DEFERRED CLAIMS	\$0	\$177,234,000	\$0	(\$233,240,000)	\$0	(\$410,474,000)
248	INDIAN HEALTH SERVICES FUNDING SHIFT	\$0	(\$12,103,000)	\$0	(\$13,391,000)	\$0	(\$1,288,000)
249	COUNTY SHARE OF OTLICP-CCS COSTS	(\$25,466,000)	(\$25,466,000)	(\$25,337,000)	(\$25,337,000)	\$129,000	\$129,000
252	QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES	\$0	\$0	\$108,483,000	\$16,272,000	\$108,483,000	\$16,272,000
254	AMERICAN RESCUE PLAN INCREASED FMAP FOR HCBS	\$0	\$0	\$0	\$0	\$0	\$0
257	EVIDENCE-BASED DENTAL PRACTICES	\$0	\$0	\$37,110,000	\$12,915,800	\$37,110,000	\$12,915,800
258	END-OF-FY 2-WEEK CHECKWRITE HOLD BUYBACK	\$0	\$0	\$795,755,000	\$309,409,650	\$795,755,000	\$309,409,650
262	COUNTY BH RECOUPMENTS	\$0	\$0	(\$60,840,000)	(\$60,840,000)	(\$60,840,000)	(\$60,840,000)
266	EQUITY & PRACTICE TRANSFORMATION PAYMENTS	\$0	\$0	\$400,000,000	\$200,000,000	\$400,000,000	\$200,000,000
269	HCBS SP CDDS	\$43,593,000	\$0	\$231,796,000	\$0	\$188,203,000	\$0
271	MHSF - PROVIDER ACES TRAININGS	\$0	\$0	\$44,100,000	\$0	\$44,100,000	\$0
273	URBAN INDIAN ORGANIZATIONS FUNDING SHIFT	\$0	(\$11,510,000)	\$0	(\$25,322,000)	\$0	(\$13,812,000)
275	BEHAVIORAL HEALTH BRIDGE HOUSING	\$0	\$0	\$1,000,000,000	\$1,000,000,000	\$1,000,000,000	\$1,000,000,000
	OTHER SUBTOTAL	\$1,202,897,350	(\$2,474,607,260)	\$4,639,816,430	(\$670,983,370)	\$3,436,919,080	\$1,803,623,890
	GRAND TOTAL	\$55,621,526,030	\$2,347,951,010	\$62,913,653,090	\$9,412,781,720	\$7,292,127,070	\$7,064,830,700

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

FISCAL YEAR 2022-23 COST PER ELIGIBLE BASED ON NOVEMBER 2021 ESTIMATE

SERVICE CATEGORY	PA-OAS	NEWLY	PA-ATD	PA-AFDC	LT-OAS	H-PE
PHYSICIANS	\$9,181,970	\$223,679,530	\$90,686,700	\$60,942,860	\$1,628,490	\$58,320,720
OTHER MEDICAL	\$130,955,850	\$1,887,417,990	\$564,613,210	\$403,168,790	\$4,105,170	\$44,563,880
CO. & COMM. OUTPATIENT	\$4,159,250	\$183,431,570	\$109,180,460	\$26,084,930	\$438,240	\$54,557,670
PHARMACY	\$16,498,790	\$4,150,001,720	\$2,324,034,600	\$272,741,740	\$8,976,710	\$21,281,290
COUNTY INPATIENT	\$3,759,560	\$737,099,270	\$31,879,350	\$20,451,000	\$3,350,610	\$64,399,720
COMMUNITY INPATIENT	\$51,318,650	\$1,669,024,130	\$471,305,060	\$227,237,320	\$15,683,560	\$404,987,290
NURSING FACILITIES	\$117,145,910	\$169,489,280	\$306,663,940	\$3,555,400	\$612,318,630	\$1,602,700
ICF-DD	\$1,402,530	\$10,624,070	\$122,243,890	\$1,059,910	\$40,724,130	\$890
MEDICAL TRANSPORTATION	\$4,840,100	\$48,134,130	\$17,528,250	\$4,208,610	\$2,079,350	\$12,086,520
OTHER SERVICES	\$218,517,870	\$52,404,810	\$910,673,910	\$51,537,970	\$63,157,400	\$2,538,550
HOME HEALTH	\$3,481,250	\$2,541,800	\$129,062,830	\$7,058,450	\$46,480	\$220,340
FFS SUBTOTAL	\$561,261,750	\$9,133,848,310	\$5,077,872,190	\$1,078,046,990	\$752,508,770	\$664,559,550
DENTAL	\$36,066,480	\$546,339,150	\$89,418,820	\$155,912,720	\$6,517,040	\$1,414,090
MENTAL HEALTH	\$8,932,020	\$486,848,000	\$878,278,190	\$654,586,840	\$511,720	\$8,421,410
TWO PLAN MODEL	\$1,232,056,490	\$11,611,403,820	\$5,344,248,970	\$1,482,987,770	\$0	\$0
COUNTY ORGANIZED HEALTH SYSTEMS	\$352,398,690	\$4,626,783,450	\$1,472,102,890	\$329,357,690	\$757,553,270	\$0
GEOGRAPHIC MANAGED CARE	\$192,348,130	\$1,949,346,580	\$1,028,990,750	\$222,608,140	\$0	\$0
PHP & OTHER MANAG. CARE	\$393,855,920	\$47,135,240	\$257,056,820	\$10,704,240	\$15,101,320	\$0
MEDICARE PAYMENTS	\$1,995,726,900	\$0	\$1,783,426,540	\$0	\$154,561,910	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$1,387,800	\$0	\$2,991,540	\$3,403,490	\$112,050	\$0
MISC. SERVICES	\$1,236,151,010	\$295,190	\$9,142,429,370	\$5,697,290	\$160	\$0
DRUG MEDI-CAL	\$24,530,500	\$389,713,950	\$54,373,350	\$60,827,870	\$1,587,550	\$0
REGIONAL MODEL	\$16,184,340	\$655,715,680	\$295,176,610	\$73,337,540	\$0	\$0
NON-FFS SUBTOTAL	\$5,489,638,280	\$20,313,581,060	\$20,348,493,860	\$2,999,423,600	\$935,945,030	\$9,835,500
TOTAL DOLLARS (1)	\$6,050,900,020	\$29,447,429,360	\$25,426,366,060	\$4,077,470,580	\$1,688,453,800	\$674,395,060
ELIGIBLES ***	410,800	4,445,100	887,500	990,500	38,800	38,800
ANNUAL \$/ELIGIBLE	\$14,730	\$6,625	\$28,649	\$4,117	\$43,517	\$17,381
AVG. MO. \$/ELIGIBLE	\$1,227	\$552	\$2,387	\$343	\$3,626	\$1,448

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

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

Refer to page following for listing of excluded policy changes.

FISCAL YEAR 2022-23 COST PER ELIGIBLE BASED ON NOVEMBER 2021 ESTIMATE

SERVICE CATEGORY	LT-ATD	POV 250	MN-OAS	MN-ATD	MN-AFDC	MI-C
PHYSICIANS	\$1,137,120	\$22,043,640	\$33,371,200	\$13,877,230	\$201,101,080	\$45,421,030
OTHER MEDICAL	\$2,940,580	\$265,790,220	\$264,890,010	\$129,391,950	\$1,655,019,550	\$141,759,900
CO. & COMM. OUTPATIENT	\$350,230	\$26,537,120	\$24,377,210	\$14,846,770	\$152,175,910	\$13,085,740
PHARMACY	\$10,117,720	\$207,897,540	\$99,857,450	\$166,552,970	\$1,148,623,310	\$151,621,610
COUNTY INPATIENT	\$2,106,620	\$2,280,850	\$60,455,260	\$12,912,730	\$157,774,080	\$10,646,330
COMMUNITY INPATIENT	\$8,490,470	\$76,745,420	\$153,823,820	\$56,798,640	\$894,251,100	\$83,196,010
NURSING FACILITIES	\$128,802,640	\$5,946,650	\$142,544,280	\$43,942,780	\$26,319,060	\$9,423,420
ICF-DD	\$111,958,080	\$5,074,920	\$1,924,580	\$10,377,500	\$1,631,830	\$3,202,730
MEDICAL TRANSPORTATION	\$787,190	\$636,240	\$12,691,990	\$8,114,220	\$11,935,000	\$3,314,100
OTHER SERVICES	\$9,004,470	\$32,980,190	\$252,641,760	\$215,237,780	\$135,099,430	\$36,770,120
HOME HEALTH	\$4,090	\$16,410,730	\$2,872,600	\$55,183,650	\$19,334,310	\$16,960,000
FFS SUBTOTAL	\$275,699,220	\$662,343,520	\$1,049,450,160	\$727,236,220	\$4,403,264,650	\$515,400,990
DENTAL	\$1,995,610	\$231,835,370	\$50,604,950	\$20,419,500	\$520,718,740	\$17,242,250
MENTAL HEALTH	\$1,424,790	\$59,888,860	\$14,856,740	\$90,118,130	\$642,849,850	\$62,517,340
TWO PLAN MODEL	\$0	\$783,393,720	\$1,958,763,320	\$861,396,780	\$4,850,025,020	\$34,399,850
COUNTY ORGANIZED HEALTH SYSTEMS	\$191,882,880	\$413,297,180	\$716,778,490	\$427,063,010	\$1,843,960,930	\$27,258,710
GEOGRAPHIC MANAGED CARE	\$0	\$124,287,820	\$305,579,640	\$178,513,470	\$860,792,680	\$4,096,410
PHP & OTHER MANAG. CARE	\$1,059,070	\$6,107,610	\$636,808,260	\$59,252,060	\$10,465,300	\$7,609,050
MEDICARE PAYMENTS	\$0	\$0	\$2,167,971,040	\$790,829,010	\$165,884,290	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$30,560	\$0	\$2,032,130	\$656,750	\$14,854,900	\$511,650
MISC. SERVICES	\$50	(\$37,736,730)	\$1,141,584,360	\$1,915,503,200	\$22,465,220	\$854,660
DRUG MEDI-CAL	\$521,040	\$54,289,240	\$45,353,250	\$13,539,660	\$319,298,400	\$9,229,140
REGIONAL MODEL	\$0	\$38,990,790	\$56,474,280	\$50,008,530	\$308,536,110	\$1,154,620
NON-FFS SUBTOTAL	\$196,913,990	\$1,674,353,860	\$7,096,806,460	\$4,407,300,090	\$9,559,851,440	\$164,873,700
TOTAL DOLLARS (1)	\$472,613,200	\$2,336,697,370	\$8,146,256,610	\$5,134,536,310	\$13,963,116,090	\$680,274,690
ELIGIBLES ***	9,400	885,600	727,500	222,400	3,892,900	142,200
ANNUAL \$/ELIGIBLE	\$50,278	\$2,639	\$11,198	\$23,087	\$3,587	\$4,784
AVG. MO. \$/ELIGIBLE	\$4,190	\$220	\$933	\$1,924	\$299	\$399

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

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

Refer to page following for listing of excluded policy changes.

FISCAL YEAR 2022-23 COST PER ELIGIBLE BASED ON NOVEMBER 2021 ESTIMATE

SERVICE CATEGORY	MI-A	REFUGEE	OBRA	POV 185	POV 133	POV 100
PHYSICIANS	\$341,810	\$64,220	\$13,440	\$168,679,650	\$24,659,510	\$9,923,000
OTHER MEDICAL	\$732,680	\$375,370	\$7,330	\$487,052,490	\$342,848,780	\$136,202,110
CO. & COMM. OUTPATIENT	\$132,900	\$63,170	\$990	\$35,841,780	\$17,642,490	\$12,499,890
PHARMACY	\$2,445,520	\$320,830	\$19,120	\$77,292,110	\$225,435,950	\$114,470,740
COUNTY INPATIENT	\$2,962,680	\$630	\$27,770	\$115,108,850	\$2,199,820	\$2,032,230
COMMUNITY INPATIENT	\$1,325,620	\$58,960	\$62,930	\$1,096,196,700	\$100,027,050	\$34,667,220
NURSING FACILITIES	\$14,252,950	\$0	\$3,519,870	\$1,082,470	\$11,505,430	\$1,261,460
ICF-DD	\$850,420	\$0	\$41,080	\$22,990	\$263,860	\$7,690
MEDICAL TRANSPORTATION	\$79,190	\$7,450	\$4,450	\$3,190,230	\$889,030	\$294,010
OTHER SERVICES	\$905,840	\$3,130	\$3,020	\$18,864,020	\$27,556,490	\$14,601,730
HOME HEALTH	\$250	\$0	\$0	\$5,121,310	\$10,286,150	\$2,818,680
FFS SUBTOTAL	\$24,029,850	\$893,760	\$3,700,010	\$2,008,452,610	\$763,314,560	\$328,778,780
DENTAL	\$122,130	\$42,660	\$14,220	\$12,879,010	\$224,405,030	\$76,275,680
MENTAL HEALTH	\$0	\$162,730	\$1,627,220	\$2,830,640	\$26,705,530	\$34,281,440
TWO PLAN MODEL	\$17,020	\$445,100	\$0	\$347,809,280	\$677,894,940	\$332,355,620
COUNTY ORGANIZED HEALTH SYSTEMS	\$339,630	\$65,280	\$16,760	\$166,883,270	\$235,989,230	\$120,436,720
GEOGRAPHIC MANAGED CARE	\$4,090	\$333,300	\$0	\$72,722,960	\$112,529,720	\$53,806,740
PHP & OTHER MANAG. CARE	\$9,115,860	\$0	\$0	\$12,552,850	\$10,223,110	\$8,797,910
MEDICARE PAYMENTS	\$0	\$0	\$0	\$0	\$0	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$21,250	\$0	\$340	\$1,729,010	\$0	\$1,528,000
MISC. SERVICES	\$3,352,590	\$0	\$0	\$106,240	\$4,821,490	\$2,400,650
DRUG MEDI-CAL	\$199,720	\$37,130	\$0	\$30,151,490	\$69,950,140	\$29,762,500
REGIONAL MODEL	\$0	\$3,250	\$0	\$22,333,390	\$34,823,430	\$16,103,140
NON-FFS SUBTOTAL	\$13,172,290	\$1,089,460	\$1,658,550	\$669,998,150	\$1,397,342,630	\$675,748,400
TOTAL DOLLARS (1)	\$37,202,130	\$1,983,220	\$5,358,550	\$2,678,450,760	\$2,160,657,190	\$1,004,527,180
ELIGIBLES ***	3,100	500	100	340,200	820,400	408,100
ANNUAL \$/ELIGIBLE	\$12,001	\$3,966	\$53,586	\$7,873	\$2,634	\$2,461
AVG. MO. \$/ELIGIBLE	\$1,000	\$331	\$4,465	\$656	\$219	\$205

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

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

Refer to page following for listing of excluded policy changes.

FISCAL YEAR 2022-23 COST PER ELIGIBLE BASED ON NOVEMBER 2021 ESTIMATE

SERVICE CATEGORY	TOTAL
PHYSICIANS	\$965,073,220
OTHER MEDICAL	\$6,461,835,860
CO. & COMM. OUTPATIENT	\$675,406,310
PHARMACY	\$8,998,189,720
COUNTY INPATIENT	\$1,229,447,360
COMMUNITY INPATIENT	\$5,345,199,940
NURSING FACILITIES	\$1,599,376,850
ICF-DD	\$311,411,110
MEDICAL TRANSPORTATION	\$130,820,080
OTHER SERVICES	\$2,042,498,470
HOME HEALTH	\$271,402,950
FFS SUBTOTAL	\$28,030,661,880
DENTAL	\$1,992,223,460
MENTAL HEALTH	\$2,974,841,460
TWO PLAN MODEL	\$29,517,197,690
COUNTY ORGANIZED HEALTH SYSTEMS	\$11,682,168,090
GEOGRAPHIC MANAGED CARE	\$5,105,960,420
PHP & OTHER MANAG. CARE	\$1,485,844,620
MEDICARE PAYMENTS	\$7,058,399,700
STATE HOSP./DEVELOPMENTAL CNTRS.	\$29,259,490
MISC. SERVICES	\$13,437,924,760
DRUG MEDI-CAL	\$1,103,364,910
REGIONAL MODEL	\$1,568,841,730
NON-FFS SUBTOTAL	\$75,956,026,320
TOTAL DOLLARS (1)	\$103,986,688,200
ELIGIBLES ***	14,263,900
ANNUAL \$/ELIGIBLE	\$7,290
AVG. MO. \$/ELIGIBLE	\$608

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

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

Refer to page following for listing of excluded policy changes.

FISCAL YEAR 2022-23 COST PER ELIGIBLE BASED ON NOVEMBER 2021 ESTIMATE

EXCLUDED POLICY CHANGES: 92

	Base Adj for Late N21 Lawsuits/Claims PC change
2	BREAST AND CERVICAL CANCER TREATMENT
7	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
11	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM
12	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL
13	DISABLED ADULT CHILDREN PROGRAM CLEANUP
16	CS3 PROXY ADJUSTMENT
20	MEDICARE OPTIONAL EXPANSION ADJUSTMENT
21	NON-OTLICP CHIP
29	1% FMAP INCREASE FOR PREVENTIVE SERVICES
34	FAMILY PACT PROGRAM
43	HEARING AID COVERAGE
58	LITIGATION SETTLEMENTS
61	FAMILY PACT DRUG REBATES
71	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
74	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE
81	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT
84	GLOBAL PAYMENT PROGRAM
85	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS
86	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES
88	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG
89	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM
90	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL
91	MH/UCD—SAFETY NET CARE POOL
96	2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.
103	CYBHI - INCREASE ACCESS TO STUDENT BH SERVICES
105	CALAIM – MEDI-CAL PATH
115	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)
117	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND
118	2020 MCO ENROLLMENT TAX MANAGED CARE PLANS
119	2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ
121	PROP 56 - DIRECTED PAYMENT RISK MITIGATION
127	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF
133	EMERGENCY MEDICAL AIR TRANSPORTATION ACT

FISCAL YEAR 2022-23 COST PER ELIGIBLE BASED ON NOVEMBER 2021 ESTIMATE

EXCLUDED POLICY CHANGES: 92

140	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
146	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS
147	HOSPITAL QAF - FFS PAYMENTS
148	HOSPITAL QAF - MANAGED CARE PAYMENTS
150	PRIVATE HOSPITAL DSH REPLACEMENT
151	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS
152	DSH PAYMENT
153	PROP 56 - MEDI-CAL FAMILY PLANNING
154	PROP 56 - VALUE-BASED PAYMENT PROGRAM
155	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
156	DPH PHYSICIAN & NON-PHYS. COST
157	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
158	FFP FOR LOCAL TRAUMA CENTERS
159	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS
160	CAPITAL PROJECT DEBT REIMBURSEMENT
161	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
162	NDPH IGT SUPPLEMENTAL PAYMENTS
163	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS
169	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
170	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
171	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS
172	NDPH SUPPLEMENTAL PAYMENT
173	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
174	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS
175	GEMT SUPPLEMENTAL PAYMENT PROGRAM
176	FREE CLINICS AUGMENTATION
177	PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS
178	PROP 56 - NEMT SUPPLEMENTAL PAYMENTS
179	PROPOSITION 56 FUNDING
180	PROP 56 - AIDS WAIVER RATE INCREASE
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EXCLUDED POLICY CHANGES: 92

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196	STATE ONLY CLAIMING ADJUSTMENTS - SMHS and DMC
207	CALAIM - DENTAL INITIATIVES
208	CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY
210	PROP 56 - PROVIDER ACES TRAININGS
215	LAWSUITS/CLAIMS
216	MEDI-CAL TCM PROGRAM
217	KEDREN COMMUNITY HEALTH & ACUTE PSYCHIATRIC HOSP.
218	PROP 56 PHYSICIANS & DENTISTS LOAN REPAYMENT PROG
221	ALAMEDA WELLNESS CAMPUS
225	CYBHI - CALHOPE STUDENT SUPPORT
228	SECTION 19.56 LEGISLATIVE PRIORITIES
229	MLK JR. HOSPITAL IMPROVEMENT
230	ARRA HITECH - PROVIDER PAYMENTS
232	OUTREACH & ENROLLMENT ASSIST. FOR DUAL BENES
238	CIGARETTE AND TOBACCO SURTAX FUNDS
239	CLPP FUND
240	AUDIT SETTLEMENTS
244	HOSPITAL QAF - CHILDREN'S HEALTH CARE
245	CMS DEFERRED CLAIMS
250	BASE RECOVERIES
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275	BEHAVIORAL HEALTH BRIDGE HOUSING

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**Estimated Average Monthly Certified Eligibles
November 2021 Estimate
Fiscal Years 2020-2021, 2021-2022, & 2022-2023**

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

	2020-2021	2021-2022	2022-2023	20-21 To 21-22 % Change	21-22 To 22-23 % Change
Public Assistance	2,319,300	2,274,400	2,288,800	-1.94%	0.63%
Seniors	413,200	405,800	410,800	-1.79%	1.23%
Persons with Disabilities	894,900	878,500	887,500	-1.83%	1.02%
Families ¹	1,011,200	990,100	990,500	-2.09%	0.04%
Long Term	47,300	43,300	48,200	-8.46%	11.32%
Seniors	37,800	34,400	38,800	-8.99%	12.79%
Persons with Disabilities	9,500	8,900	9,400	-6.32%	5.62%
Medically Needy	4,412,000	4,932,500	4,828,400	11.80%	-2.11%
Seniors	605,400	690,500	718,900	14.06%	4.11%
Persons with Disabilities	204,900	216,000	216,600	5.42%	0.28%
Families ¹	3,601,700	4,026,000	3,892,900	11.78%	-3.31%
Medically Indigent	144,500	145,500	145,300	0.69%	-0.14%
Children	141,400	142,400	142,200	0.71%	-0.14%
Adults	3,100	3,100	3,100	0.00%	0.00%
Other	6,567,900	7,291,700	6,957,200	11.02%	-4.59%
Refugees	500	500	500	0.00%	0.00%
OBRA ²	0	100	100	n/a	n/a
185% Poverty ³	324,800	366,600	340,200	12.87%	-7.20%
133% Poverty	781,900	869,400	820,400	11.19%	-5.64%
100% Poverty	397,300	421,000	408,100	5.97%	-3.06%
Opt. Targeted Low Income Children	879,000	873,900	885,600	-0.58%	1.34%
ACA Optional Expansion	4,131,100	4,703,200	4,445,100	13.85%	-5.49%
Hospital PE	34,700	38,600	38,800	11.24%	0.52%
Medi-Cal Access Program	4,200	4,000	4,000	n/a	n/a
QMB	14,400	14,400	14,400	0.00%	0.00%
GRAND TOTAL ⁴	13,491,000	14,687,400	14,267,900	8.87%	-2.86%
Seniors	1,056,400	1,130,700	1,168,500	7.03%	3.34%
Persons with Disabilities	1,109,300	1,103,400	1,113,500	-0.53%	0.92%
Families and Children ⁵	7,137,300	7,689,400	7,479,900	7.74%	-2.72%
ACA Optional Expansion	4,131,100	4,703,200	4,445,100	13.85%	-5.49%

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

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

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

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

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

	<u>2020-2021</u>	<u>2021-2022</u>	<u>2022-2023</u>
Presumptive Eligibility	28,300	36,800	36,800

⁴ 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.

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

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

<u>Policy Change</u>	<u>Budget Aid Category</u>	Caseload Change		
		Average Monthly Eligibles not in the Base Estimate		
		2020-21	2021-22	2022-23
PC 5 Medi-Cal State Inmates	LT Seniors	10	3	3
	MN Seniors	35	31	31
	MN Persons with Disabilities	7	6	6
	MI Children	4	2	2
	185% Poverty	2	2	2
	ACA Optional Expansion	243	176	176
	Total		302	220
PC 7 Medi-Cal Access Program Mothers 213-322%	MCAP Mothers	2,996	2,661	2,661
	Total	2,996	2,661	2,661
PC 12 Medi-Cal Access Program Infants 266-322%	MCAP Infants	1,155	1,333	1,333
	Total	1,155	1,333	1,333
PC 182 COVID-19 Caseload Impact	PA Seniors	0	(14,296)	(10,404)
	PA Persons with Disabilities	0	(30,248)	(23,444)
	PA Families	0	0	0
	LT Seniors	0	(9,181)	(5,643)
	LT Persons with Disabilities	0	(1,000)	(634)
	MN Seniors	0	72,476	69,235
	MN Persons with Disabilities	0	13,920	12,738
	MN Families	0	810,631	728,914
	185% Poverty	0	92,053	74,508
	133% Poverty	0	207,521	175,968
	100% Poverty	0	51,994	44,005
	OTLIP	0	(26,455)	(17,028)
	ACA Optional Expansion	0	1,132,074	955,063
	Total	0	2,299,490	2,003,277
<i>Estimate impacts reflects the net effect of the base adjustment and total COVID-19 caseload impact that are both described in the COVID-19 Caseload impact policy change.</i>				
PC 6 Undocumented Young Adults Full Scope Expansion	MN Families	0	4,793	9,545
	185% Poverty	0	256	509
	ACA Optional Expansion	0	4,255	8,474
	Total	0	9,304	18,528
PC 4 Undocumented Older Californians Expansion	MN Families	0	10	338
	MN Seniors	0	37	1,254
	ACA Optional Expansion	0	13	434
Total	0	60	2,026	
PC 15 - Phasing in the Medi-Cal Asset Limit Repeal	MN Seniors	0	0	9,417
	MN Persons with Disabilities	0	0	2,599
Total	0	0	12,016	
Total by Aid Category	<u>Budget Aid Category</u>	<u>2020-21</u>	<u>2021-22</u>	<u>2022-23</u>
	PA Seniors	0	(14,296)	(10,404)
	PA Persons with Disabilities	0	(30,248)	(23,444)
	PA Families	0	0	0
	LT Seniors	10	(9,178)	(5,640)
	LT Persons with Disabilities	0	(1,000)	(634)
	MN Seniors	35	72,544	79,937
	MN Persons with Disabilities	7	13,927	15,343
	MN Families	0	815,434	738,797
	MI Children	4	2	2
	MI Adults	0	0	0
	Undocumented Persons	0	0	0
	185% Poverty	2	92,311	75,019
	133% Poverty	0	207,521	175,968
	100% Poverty	0	51,994	44,005
	OTLIP	0	(26,455)	(17,028)
	ACA Optional Expansion	243	1,136,518	964,147
	MCAP Infants	1,155	1,333	1,333
	MCAP Mothers	2,996	2,661	2,661
	Total	4,453	2,313,068	2,040,061

Comparison of Average Monthly Certified Eligibles
November 2021 Estimate
Fiscal Year 2021-22

(With Estimated Impact of Eligibility Policy Changes)

	Appropriation 2021-2022	Nov 2020 2021-2022	Appropriation to Nov % Change
Public Assistance	2,277,500	2,274,400	-0.14%
Seniors	407,700	405,800	-0.47%
Persons with Disabilities	889,400	878,500	-1.23%
Families	980,400	990,100	0.99%
Long Term	42,500	43,300	1.88%
Seniors	33,100	34,400	3.93%
Persons with Disabilities	9,400	8,900	-5.32%
Medically Needy	4,843,700	4,932,500	1.83%
Seniors	673,300	690,500	2.55%
Persons with Disabilities	204,200	216,000	5.78%
Families	3,966,200	4,026,000	1.51%
Medically Indigent	150,500	145,500	-3.32%
Children	147,300	142,400	-3.33%
Adults	3,200	3,100	-3.13%
Other	7,182,300	7,291,700	1.52%
Refugees	600	500	-16.67%
OBRA	100	100	0.00%
185% Poverty	337,800	366,600	8.53%
133% Poverty	849,100	869,400	2.39%
100% Poverty	420,200	421,000	0.19%
Opt. Targeted Low Income Children	905,000	873,900	-3.44%
ACA Optional Expansion	4,612,600	4,703,200	1.96%
Hospital PE	37,800	38,600	2.12%
Medi-Cal Access Program	4,500	4,000	-11.11%
QMB	14,600	14,400	-1.37%
GRAND TOTAL	14,496,500	14,687,400	1.32%
Seniors	1,114,100	1,130,700	1.49%
Persons with Disabilities	1,103,000	1,103,400	0.04%
Families and Children	7,606,000	7,689,400	1.10%
ACA Optional Expansion	4,612,600	4,703,200	1.96%

**Estimated Average Monthly Certified Eligibles
November 2021 Estimate
Fiscal Years 2020-2021, 2021-2022, & 2022-2023**

Managed Care¹					
<i>(With Estimated Impact of Eligibility Policy Changes)</i>***					
	2020-2021	2021-2022	2022-2023	20-21 To 21-22 % Change	21-22 To 22-23 % Change
Public Assistance	2,023,997	1,967,158	1,981,789	-2.81%	0.74%
Seniors	317,619	309,998	316,998	-2.40%	2.26%
Persons with Disabilities	778,072	754,596	762,579	-3.02%	1.06%
Families	928,306	902,564	902,212	-2.77%	-0.04%
Long Term	27,010	20,723	24,929	-23.28%	20.30%
Seniors	21,920	16,490	20,319	-24.77%	23.22%
Persons with Disabilities	5,090	4,232	4,611	-16.86%	8.94%
Medically Needy	3,512,243	4,027,222	3,927,968	14.66%	-2.46%
Seniors	437,855	514,337	537,215	17.47%	4.45%
Persons with Disabilities	147,469	159,528	160,610	8.18%	0.68%
Families	2,926,920	3,353,357	3,230,142	14.57%	-3.67%
Medically Indigent	48,464	49,495	50,011	2.13%	1.04%
Children	48,403	49,428	49,945	2.12%	1.05%
Adults	60	67	66	11.16%	-0.74%
Other	5,651,025	6,404,287	6,099,122	13.33%	-4.77%
Refugees	380	393	420	3.39%	6.77%
OBRA	0	6	7	n/a	9.09%
185% Poverty	198,803	264,035	243,822	32.81%	-7.66%
133% Poverty	744,887	851,637	808,387	14.33%	-5.08%
100% Poverty	384,902	411,925	400,722	7.02%	-2.72%
Opt. Targeted Low Income Children	834,116	822,441	832,777	-1.40%	1.26%
ACA Optional Expansion	3,484,044	4,050,079	3,809,216	16.25%	-5.95%
Medi-Cal Access Program	3,893	3,771	3,771	-3.12%	0.00%
GRAND TOTAL ¹	11,262,739	12,468,884	12,083,819	10.71%	-3.09%
Percent of Statewide	83.48%	84.90%	84.69%		
Seniors	777,394	840,825	874,532	8.16%	4.01%
Persons with Disabilities	930,631	918,357	927,800	-1.32%	1.03%
Families and Children	6,066,337	6,655,386	6,468,007	9.71%	-2.82%
ACA Optional Expansion	3,484,044	4,050,079	3,809,216	16.25%	-5.95%

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

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

**Estimated Average Monthly Certified Eligibles
November 2021 Estimate
Fiscal Years 2020-2021, 2021-2022, & 2022-2023**

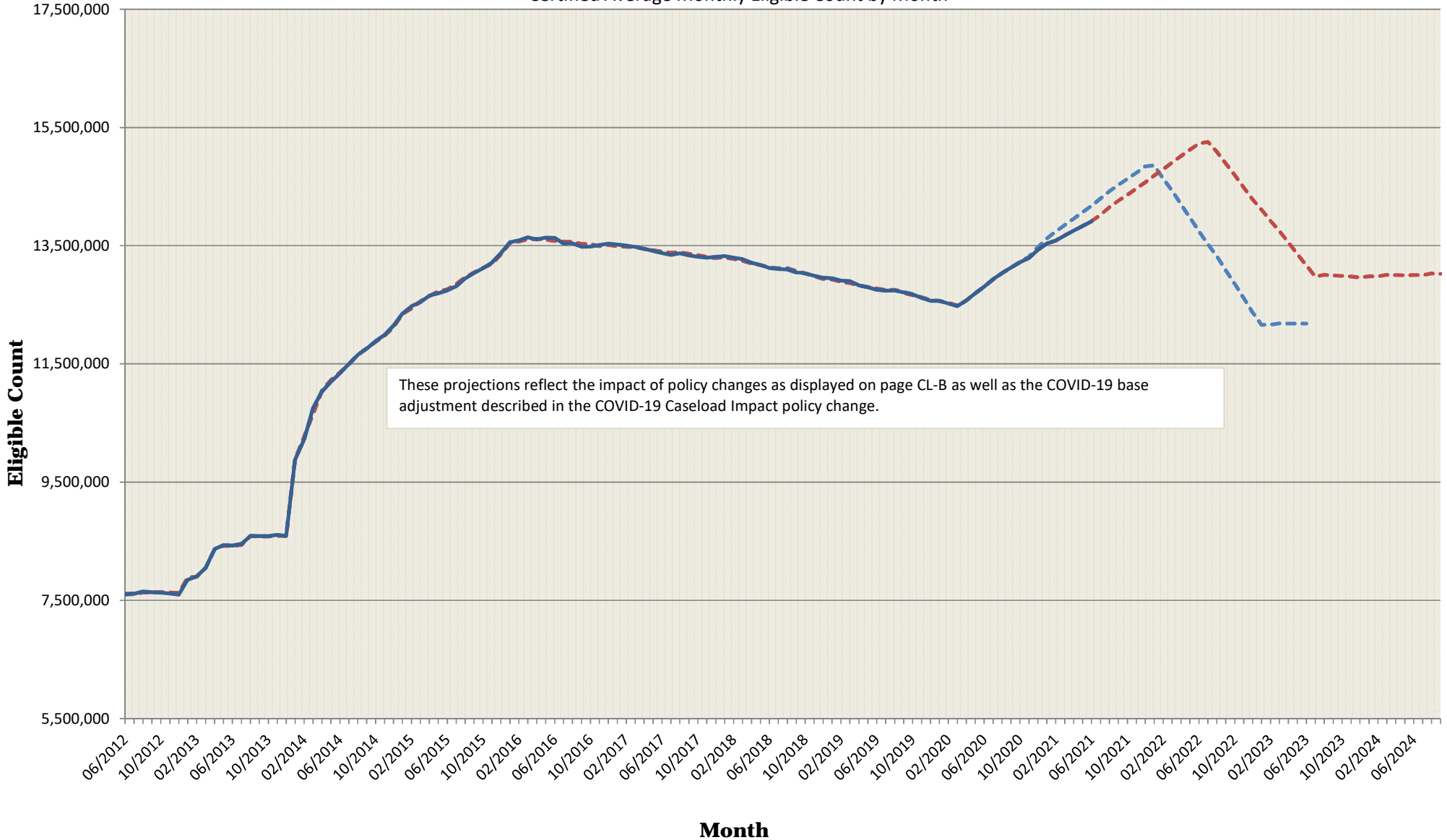
Fee-For-Service <i>(With Estimated Impact of Eligibility Policy Changes)***</i>					
	2020-2021	2021-2022	2022-2023	20-21 To 21-22 % Change	21-22 To 22-23 % Change
Public Assistance	295,303	307,242	307,011	4.04%	-0.08%
Seniors	95,581	95,802	93,802	0.23%	-2.09%
Persons with Disabilities	116,828	123,904	124,921	6.06%	0.82%
Families	82,894	87,536	88,288	5.60%	0.86%
Long Term	20,290	22,577	23,271	11.28%	3.07%
Seniors	15,880	17,910	18,481	12.78%	3.19%
Persons with Disabilities	4,410	4,668	4,789	5.85%	2.61%
Medically Needy	899,757	905,278	900,432	0.61%	-0.54%
Seniors	167,545	176,163	181,685	5.14%	3.13%
Persons with Disabilities	57,432	56,472	55,990	-1.67%	-0.85%
Families	674,780	672,643	662,758	-0.32%	-1.47%
Medically Indigent	96,036	96,005	95,289	-0.03%	-0.75%
Children	92,997	92,972	92,255	-0.03%	-0.77%
Adults	3,040	3,033	3,034	-0.22%	0.02%
Other	916,875	887,413	858,078	-3.21%	-3.31%
Refugees	120	107	80	-10.77%	-24.93%
OBRA	0	94	93	n/a	-0.58%
185% Poverty	125,997	102,565	96,378	-18.60%	-6.03%
133% Poverty	37,013	17,763	12,013	-52.01%	-32.37%
100% Poverty	12,398	9,075	7,378	-26.80%	-18.70%
Opt. Targeted Low Income Children	44,884	51,459	52,823	14.65%	2.65%
ACA Optional Expansion	647,056	653,121	635,884	0.94%	-2.64%
Hospital PE	34,700	38,600	38,800	11.24%	0.52%
Medi-Cal Access Program	307	229	229	-25.51%	0.00%
QMB	14,400	14,400	14,400	0.00%	0.00%
GRAND TOTAL	2,228,261	2,218,516	2,184,081	-0.44%	-1.55%
Percent of Statewide	16.52%	15.10%	15.31%		
Seniors	279,006	289,875	293,968	3.90%	1.41%
Persons with Disabilities	178,669	185,043	185,700	3.57%	0.36%
Families and Children	1,070,963	1,034,014	1,011,893	-3.45%	-2.14%
ACA Optional Expansion	647,056	653,121	635,884	0.94%	-2.64%

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

Statewide Expanded Eligible for Aid Category, Including the Impact of Select Policy Changes: All Aids

M21 Total CL
N21 Total CL
Actuals

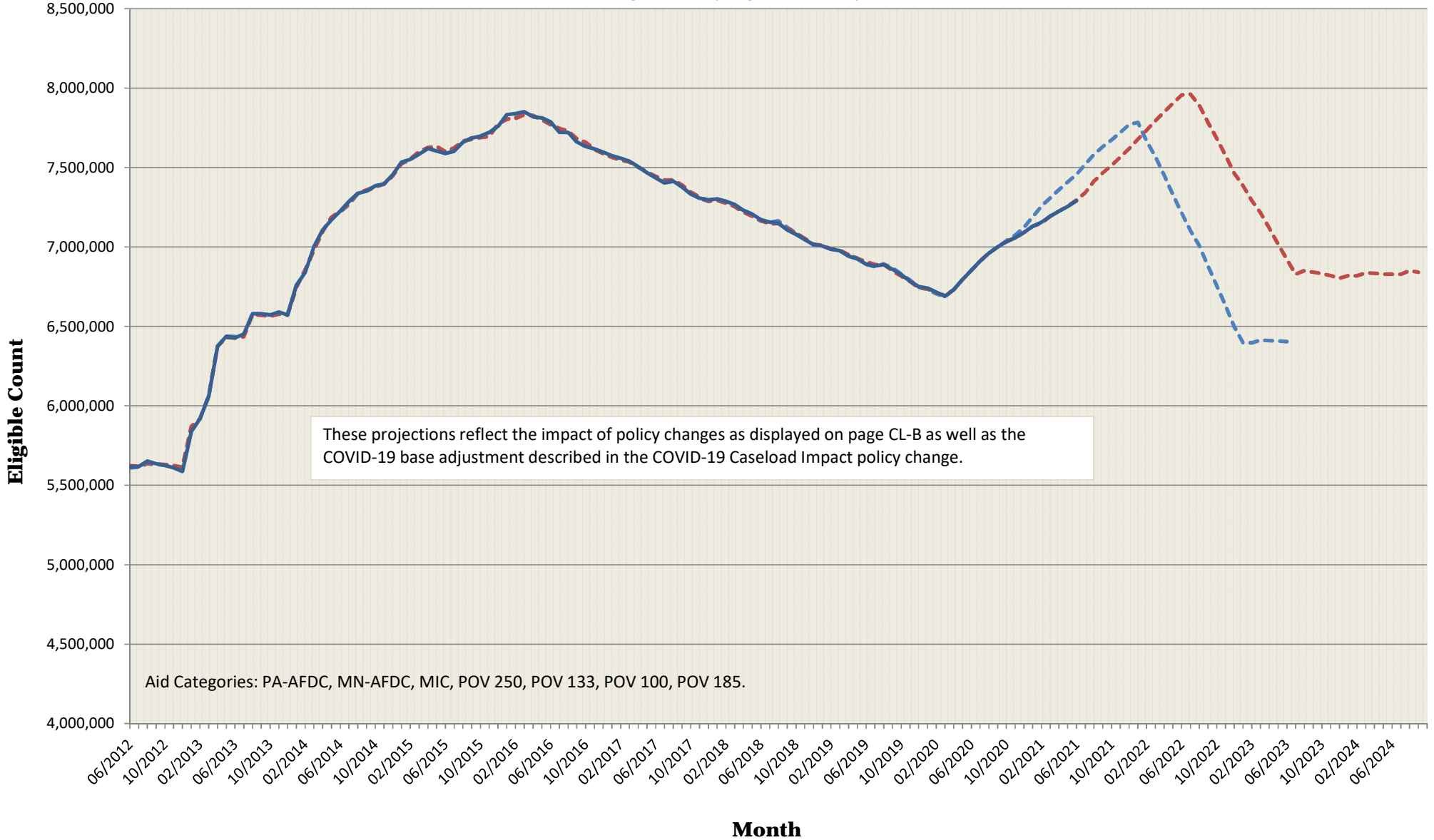
Certified Average Monthly Eligible Count by Month



Statewide Expanded Eligible for Aid Category, Including the Impact of Select Policy Changes: Families and Children (including Pregnant Women)

- M21 Total CL
- N21 Total CL
- Actuals

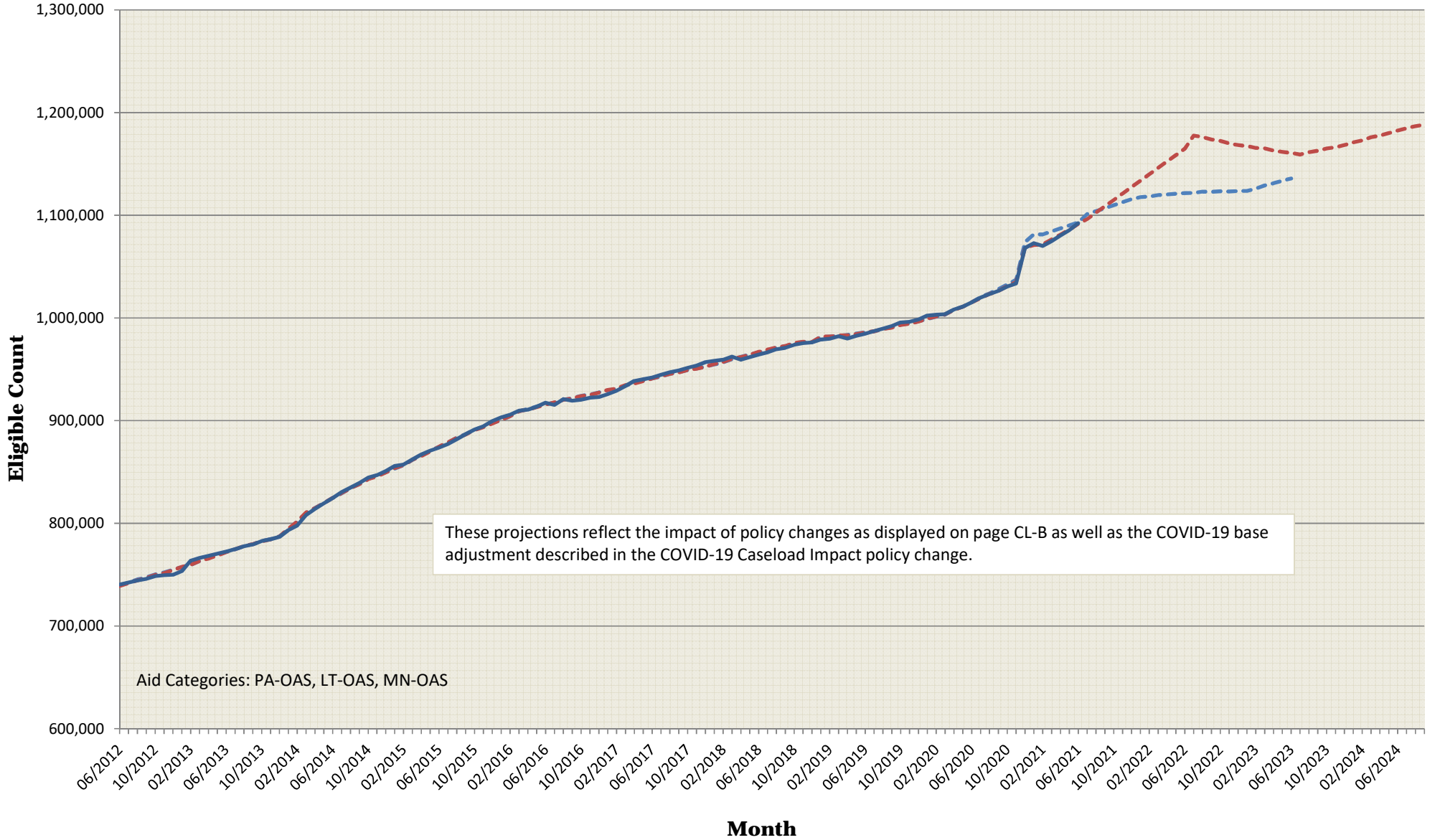
Certified Average Monthly Eligible Count by Month



Statewide Expanded Eligible for Aid Category, Including the Impact of Select Policy Changes: Seniors

- M21 Total CL
- N21 Total CL
- Actuals

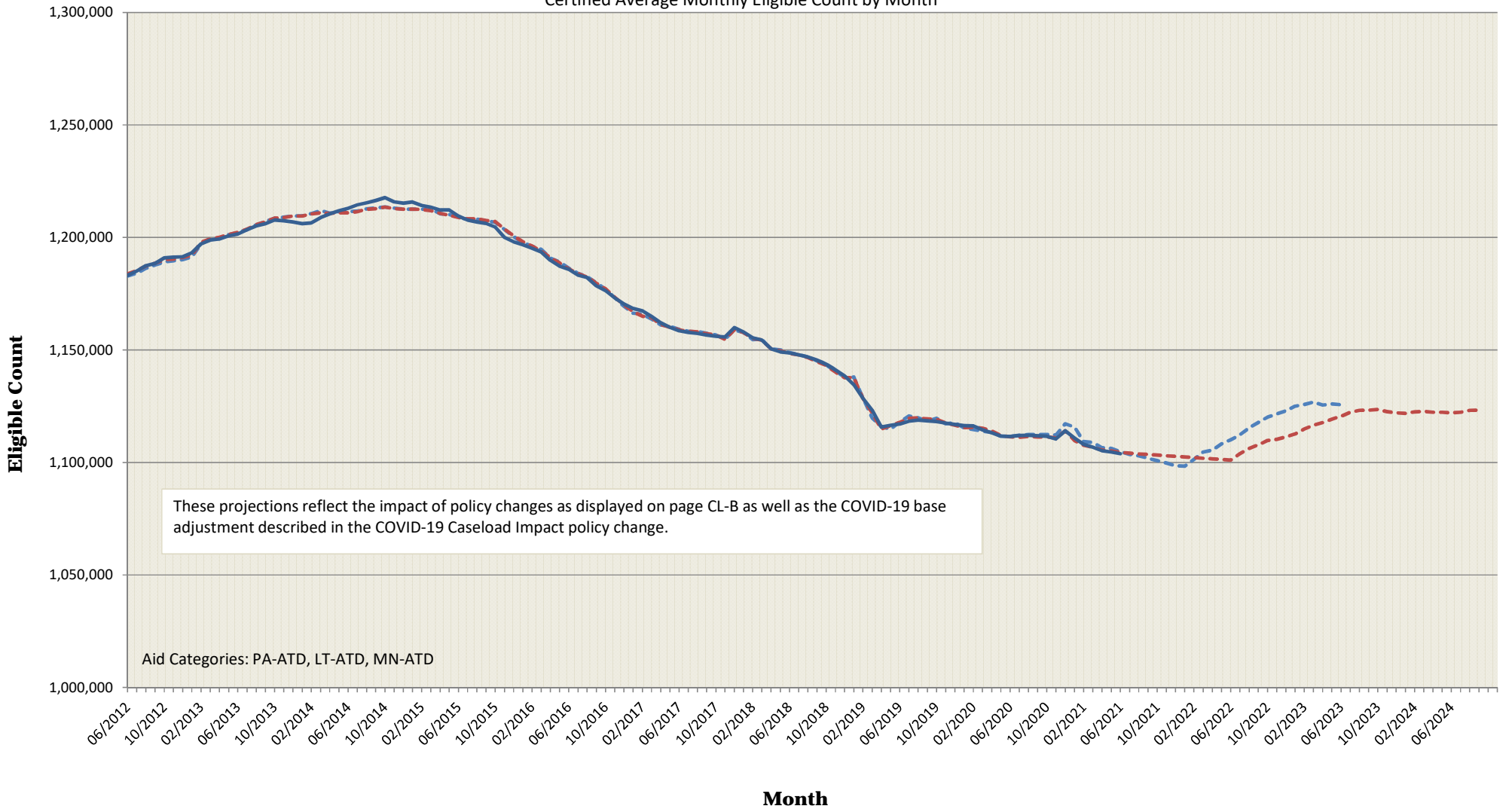
Certified Average Monthly Eligible Count by Month



Statewide Expanded Eligible for Aid Category, Including the Impact of Select Policy Changes: Persons with Disabilities

Certified Average Monthly Eligible Count by Month

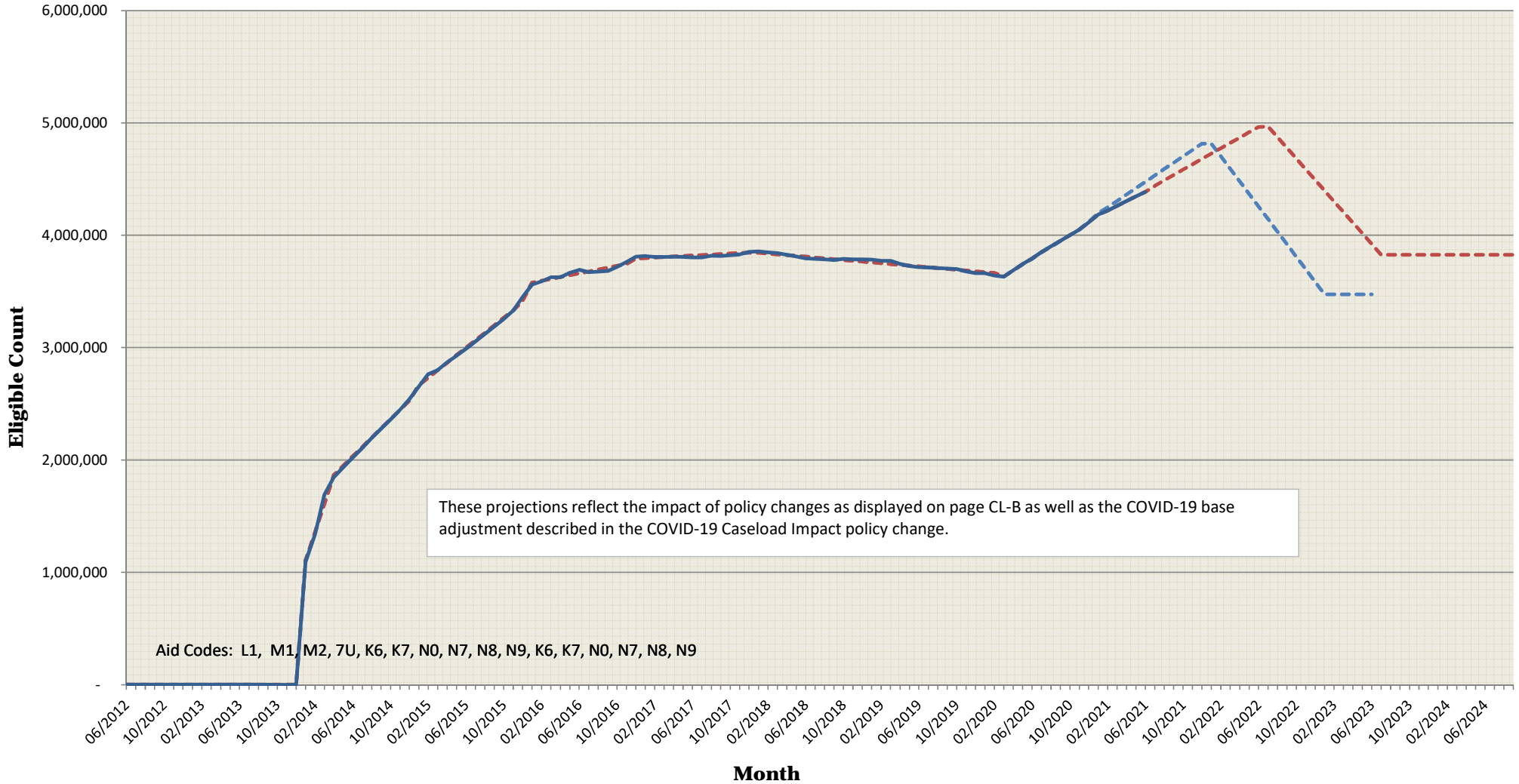
- M21 Total CL
- N21 Total CL
- Actuals



Statewide Expanded Eligible for Aid Category, Including the Impact of Select Policy Changes: ACA Optional Expansion (NEWLY)

- M21 Total CL
- N21 Total CL
- Actuals

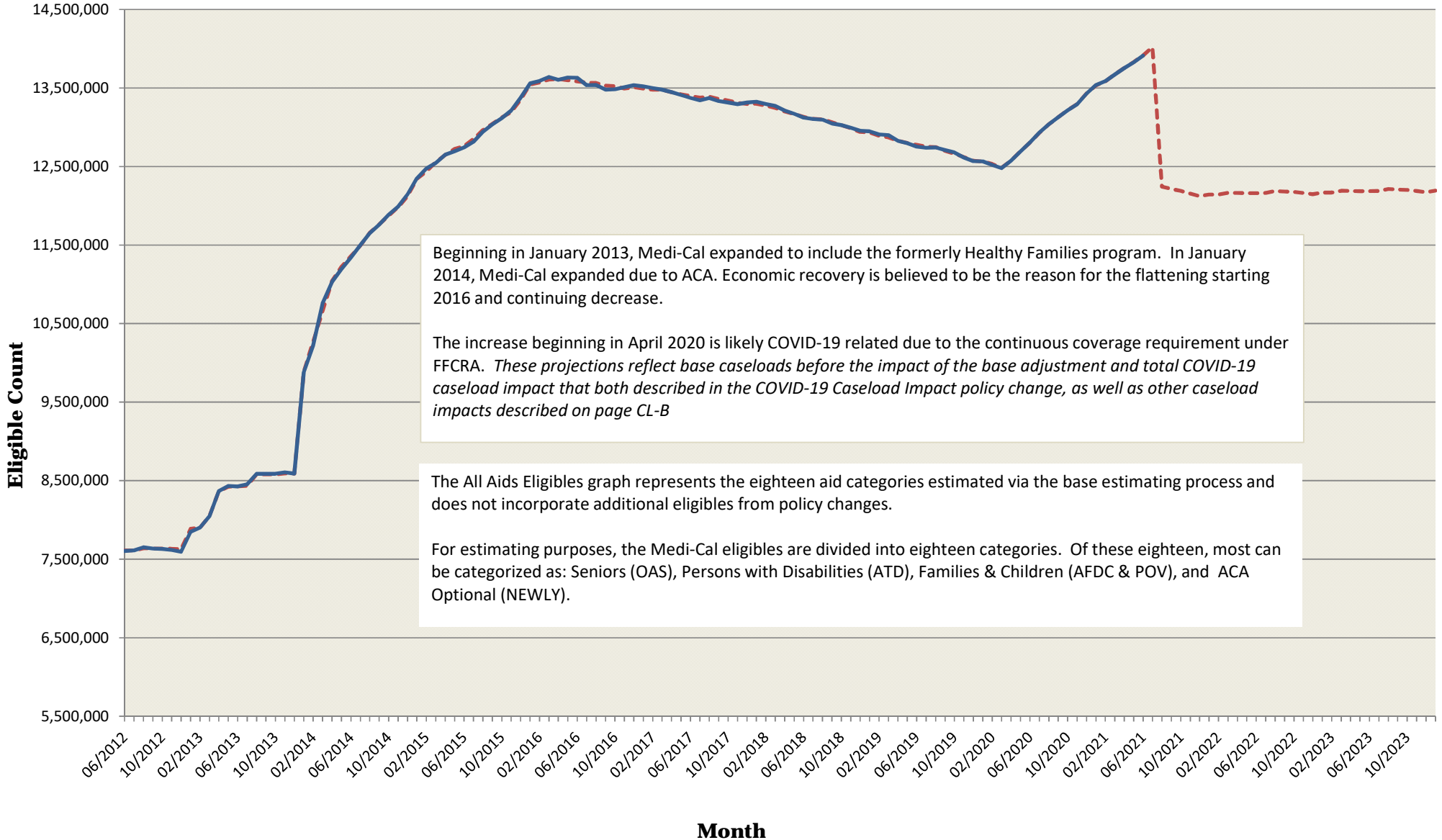
Certified Average Monthly Eligible Count by Month



Statewide Eligible, Base Projection Only for Aid Category: All Aids

--- N21 — Actuals

Certified Average Monthly Eligible Count by Month



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

The increase beginning in April 2020 is likely COVID-19 related due to the continuous coverage requirement under FFCRA. These projections reflect base caseloads before the impact of the base adjustment and total COVID-19 caseload impact that both described in the COVID-19 Caseload Impact policy change, as well as other caseload impacts described on page CL-B

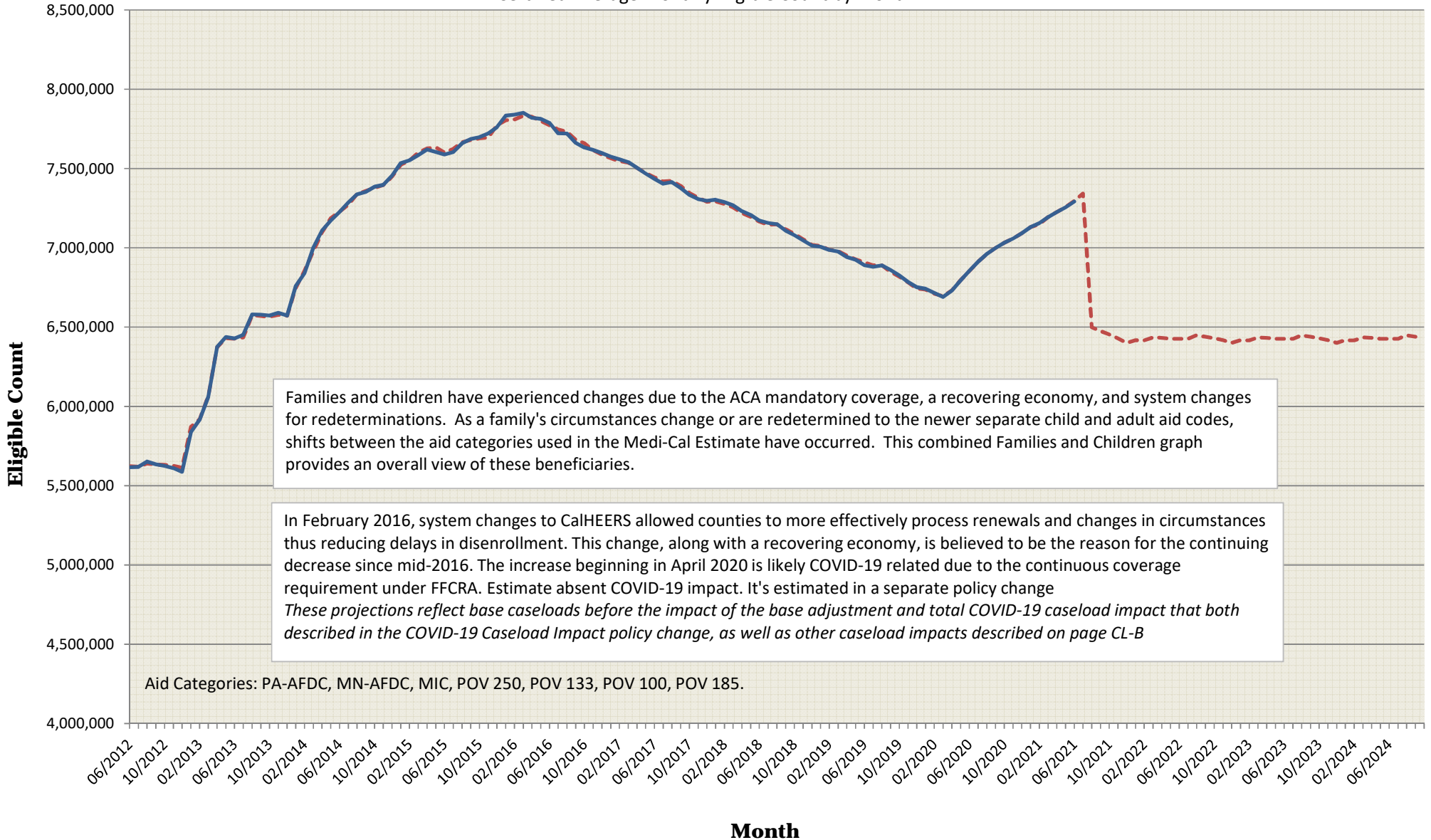
The All Aids Eligibles graph represents the eighteen aid categories estimated via the base estimating process and does not incorporate additional eligibles from policy changes.

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

Statewide Eligible, Base Projection Only for Aid Category: Families and Children (including Pregnant Women)

--- N21 — Actuals

Certified Average Monthly Eligible Count by Month



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

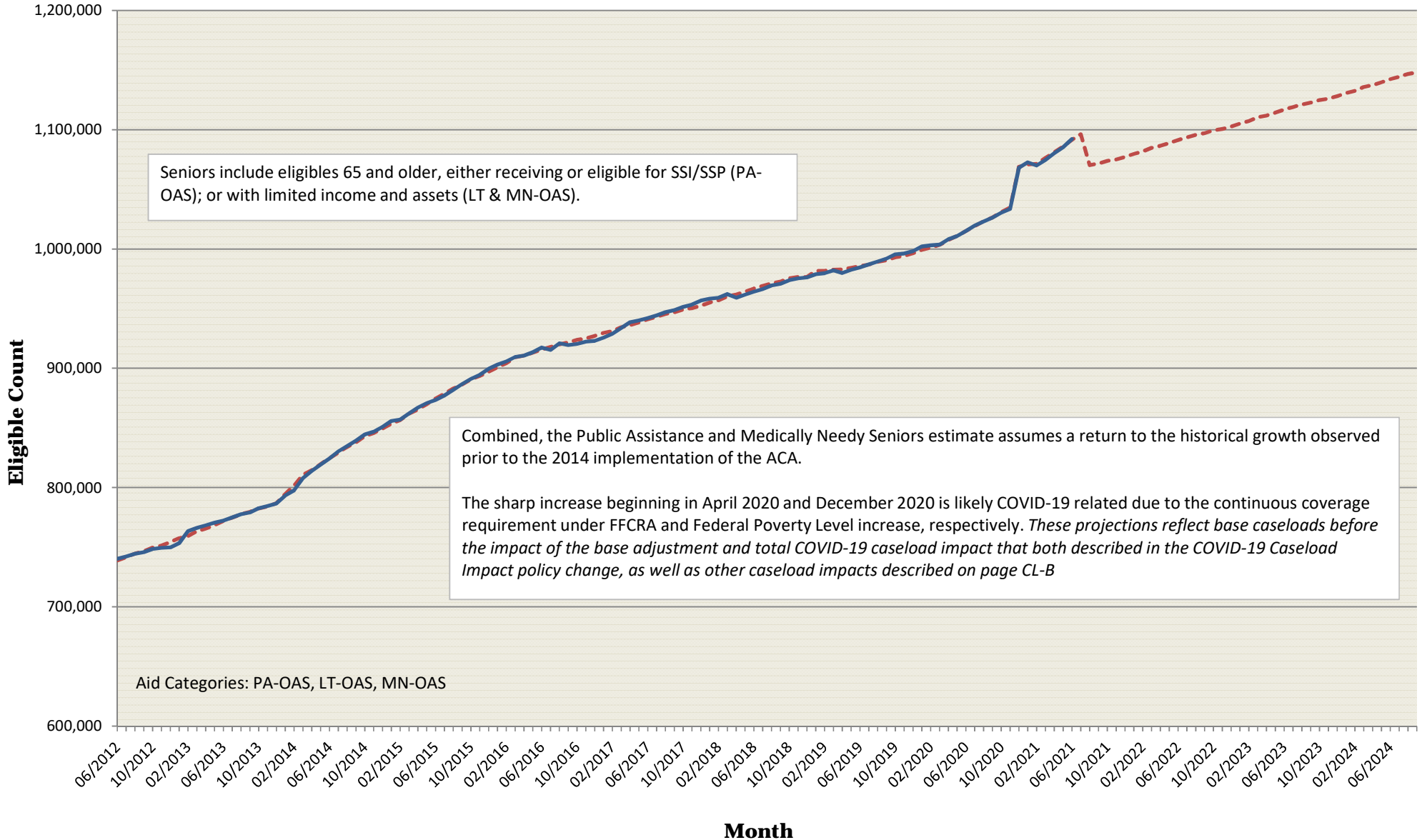
In February 2016, system changes to CalHEERS allowed counties to more effectively process renewals and changes in circumstances thus reducing delays in disenrollment. This change, along with a recovering economy, is believed to be the reason for the continuing decrease since mid-2016. The increase beginning in April 2020 is likely COVID-19 related due to the continuous coverage requirement under FFCRA. Estimate absent COVID-19 impact. It's estimated in a separate policy change *These projections reflect base caseloads before the impact of the base adjustment and total COVID-19 caseload impact that both described in the COVID-19 Caseload Impact policy change, as well as other caseload impacts described on page CL-B*

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

Statewide Eligible, Base Projection Only for Aid Category: Seniors

N21 Actuals

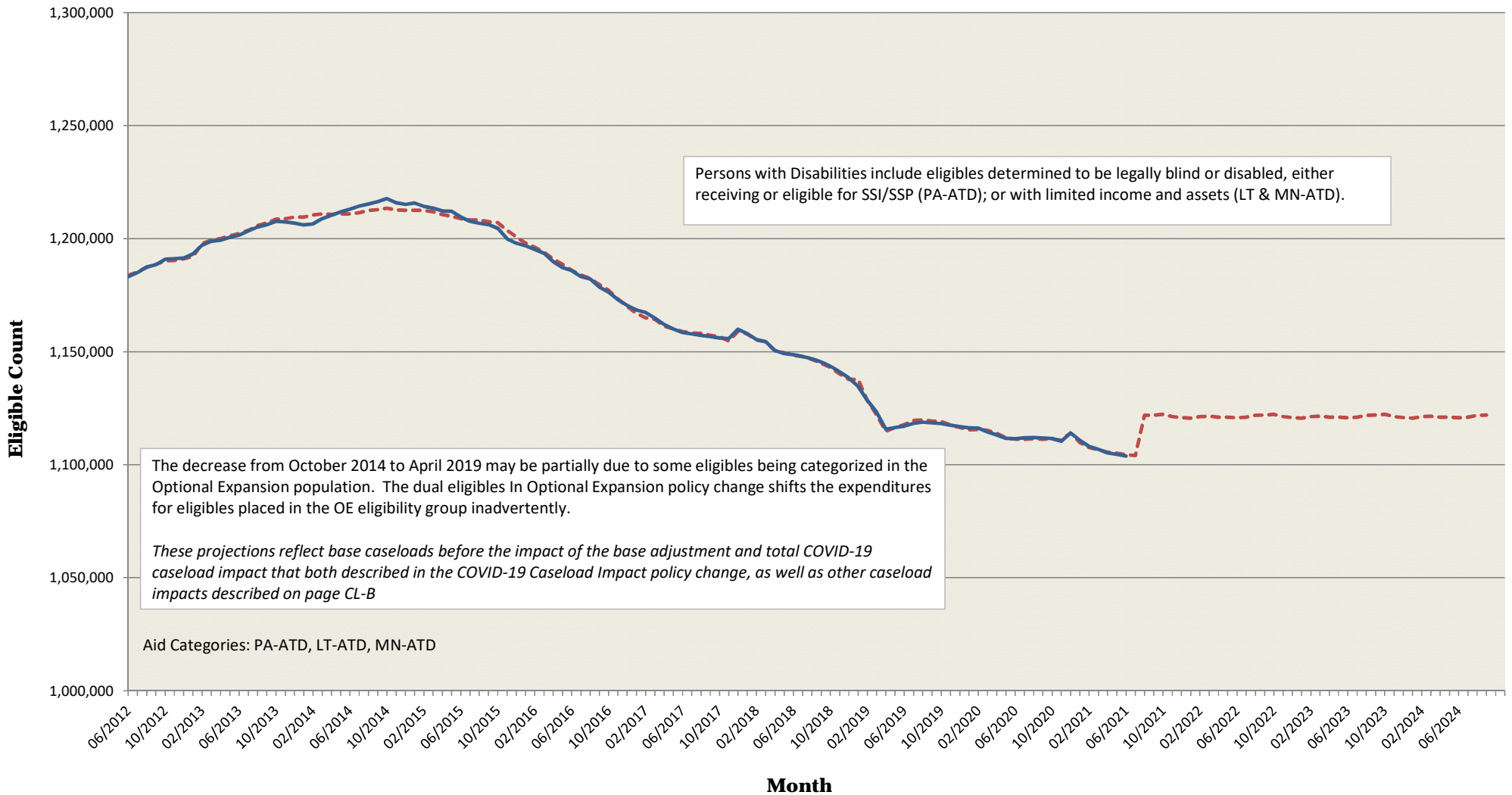
Certified Average Monthly Eligible Count by Month



Statewide Eligible, Base Projection Only for Aid Category: Persons with Disabilities

N21 Actuals

Certified Average Monthly Eligible Count by Month



Statewide Eligible, Base Projection Only for Aid Category: ACA Optional Expansion (NEWLY)

--- N21 — Actuals

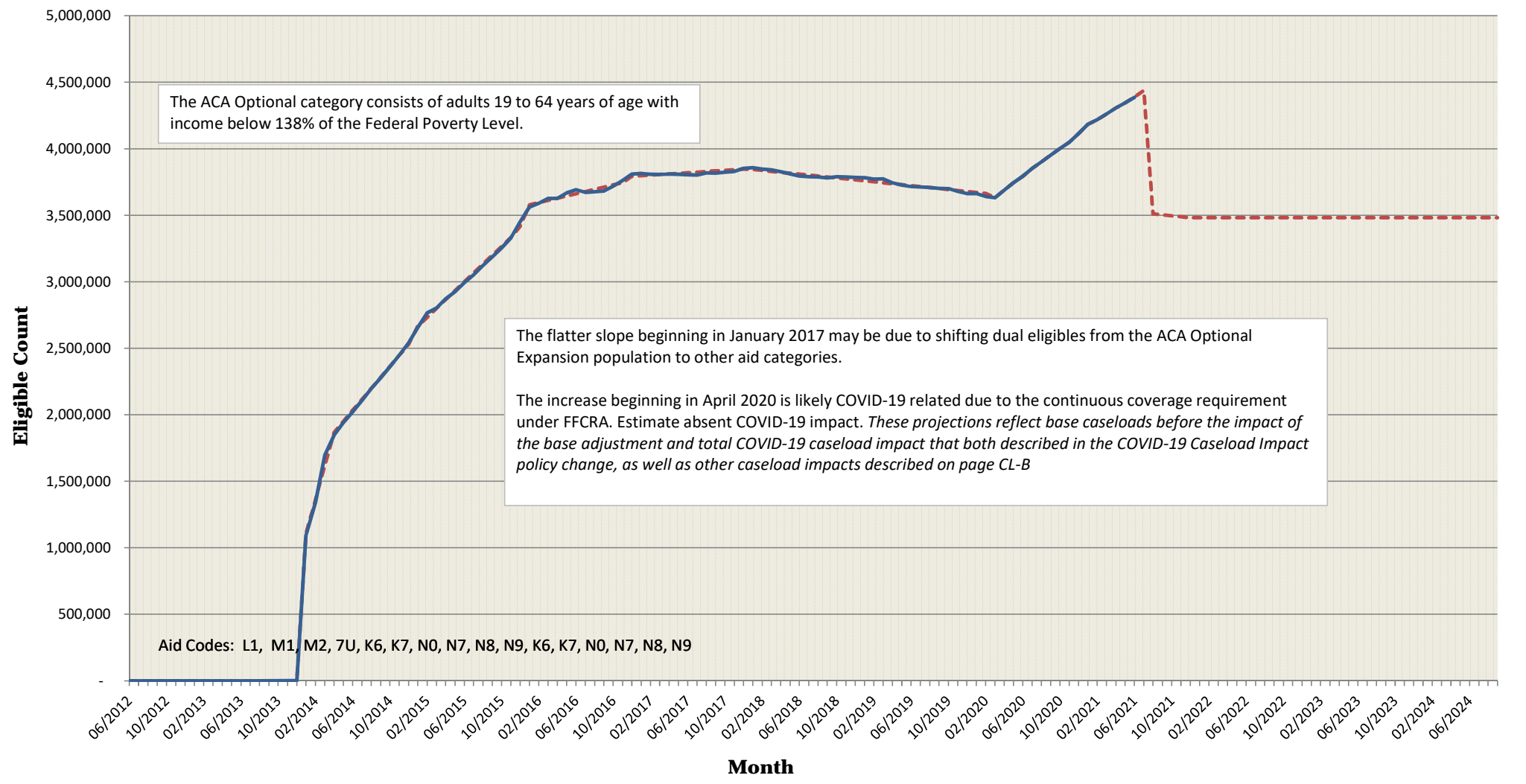
Certified Average Monthly Eligible Count by Month

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 increase beginning in April 2020 is likely COVID-19 related due to the continuous coverage requirement under FFCRA. Estimate absent COVID-19 impact. *These projections reflect base caseloads before the impact of the base adjustment and total COVID-19 caseload impact that both described in the COVID-19 Caseload Impact policy change, as well as other caseload impacts described on page CL-B*

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



MEDI-CAL AID CATEGORY DEFINITIONS

Aid Category	Aid Codes
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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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 (excluding April 2020 – July 2021 due to the COVID-19 pandemic impact) 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 2021 FFS Base Estimate

Fiscal Year		November Estimate Total Expenditure	
PY	FY 2020-21	\$17,914,940,500	
CY	FY 2021-22	\$18,690,158,100	4.33%
BY	FY 2022-23	\$18,369,824,000	-1.71%

Fiscal Year	FFS Base Expenditure		
	May-21	Nov-21	% Change
FY 2020-21	\$17,852,585,600	\$17,914,940,500	0.35%
FY 2021-22	\$18,378,221,900	\$18,690,158,100	1.70%

Overall, the November 2021 FFS Base is estimated at \$18.7 billion for FY 2021-22 and \$18.4 billion for FY 2022-23. The decrease in the budget year is mainly due to the absence of some temporary rate increases, retroactive payments related to Nursing Home Facilities, Inpatients, and FQHC rate reconciliation and a few days of payment.

Items Impacting FFS Base Estimate

Overall Changes: The increase in 2021-22 compared to 2020-2021 is attributable to the temporary rate increase in response to the COVID-19 pandemic, specifically for Nursing Facilities, ICF-DD, and inpatient services which affects July 2021 but is estimated in separate policy changes for later months. Additionally, in FY 2021-22 users return to historical level. The decrease in BY absent temporary rate increases in actual data (July 2021) and a fewer number of payment dates.

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.

HIPPA Code Conversions: The Health Insurance Portability and Accountability Act (HIPAA) mandates the use of standard service/procedure code sets for transactions. The Medi-Cal program implements code conversions to convert its interim (local) codes to national procedure codes in compliance with the HIPAA requirements. Providers are required to discontinue use of Healthcare Common Procedure Coding System (HCPCS) Level III Local codes and utilize HCPCS Level II national HIPAA compliance codes. Several FFS Base Service categories, including Medical Transportation, Home Health, Other Medical, and Other Services have shown unusual patterns in Utilization and/or Rate attributable to the code conversions. While the code conversion is not expected to have an impact on 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 257 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 2021 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	
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	1,824,060	3.31	\$274.06	\$908.48	\$4,971,368,100
2020-21 *	2	1,926,230	3.06	\$267.80	\$819.86	\$4,737,749,300
2020-21 *	3	1,737,830	2.86	\$275.99	\$790.16	\$4,119,505,300
2020-21 *	4	1,990,210	2.66	\$257.11	\$684.40	\$4,086,317,800
2020-21 *	TOTAL	1,869,580	2.97	\$268.79	\$798.53	\$17,914,940,500
2021-22 **	1	2,334,840	3.13	\$257.26	\$805.02	\$5,638,798,300
2021-22 **	2	1,996,530	2.93	\$256.84	\$751.63	\$4,501,965,700
2021-22 **	3	1,970,020	2.87	\$256.70	\$735.49	\$4,346,757,100
2021-22 **	4	1,922,130	2.91	\$250.58	\$728.82	\$4,202,637,100
2021-22 **	TOTAL	2,055,880	2.97	\$255.50	\$757.59	\$18,690,158,100
2022-23 **	1	2,131,450	3.16	\$260.29	\$822.87	\$5,261,720,000
2022-23 **	2	1,983,160	2.94	\$259.97	\$764.96	\$4,551,103,400
2022-23 **	3	2,004,030	2.93	\$259.19	\$759.33	\$4,565,167,200
2022-23 **	4	1,861,000	2.82	\$253.63	\$715.00	\$3,991,833,500
2022-23 **	TOTAL	1,994,910	2.97	\$258.47	\$767.36	\$18,369,824,000

* ACTUAL

** ESTIMATED

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

Physicians Fee-for-Service Base Estimate

Analyst: Kiruthika Kanagasabai

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 Claim)		TOTAL EXPENDITURE	
PY	2020-21	262,980	-	2.58	-	\$84.00	-	\$683,173,500	-
CY	2021-22	295,910	12.5%	2.44	-5.4%	\$85.37	1.6%	\$739,513,800	8.2%
BY	2022-23	286,020	-3.3%	2.43	-0.4%	\$86.56	1.4%	\$721,545,400	-2.4%

Users: Users are estimated to increase by 12.5% for the CY. This assumes a return to the pre-COVID level and higher users in July 2021 related to COVID-10 vaccination services. Users are estimated to decrease by 3.3% in the BY, due to the absence of COVID-19 vaccination services.

Utilization: Claims per user are estimated to decrease by 5.4% in the CY, due to the absence of vaccination services related to COVID-19. Claims are estimated to remain unchanged for the BY.

Rate: The rate is estimated to increase by 1.6% in the CY and assumes a return to the pre-COVID level. BY is estimated to increase by 1.4% and assumes a normal growth rate.

Total Expenditure: The CY is estimated to increase by 8.2%, mainly due to the increase in users and rates, but also offset by a decrease in utilization. The BY is estimated to decrease by 2.4%, mainly due to the decrease in users, perhaps related to fewer payment days.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	M21	N21	% Change
2020-21	\$705,050,300	\$683,173,500	-3.1%
2021-22	\$740,808,900	\$739,513,800	-0.2%

Compared to the May 2021 Estimate, the November 2021 Estimate is decreased by 3.1% for FY 2020-21 due to lower users and rates attributable to the COVID-19 impact. FY 2021-22 estimates remain relatively unchanged.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2021 BASE ESTIMATES)**

PHYSICIANS

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
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	281,820	2.68	\$85.52	\$229.31	\$193,872,000
2020-21 *	2	275,580	2.64	\$83.24	\$219.67	\$181,610,800
2020-21 *	3	242,470	2.54	\$84.69	\$215.42	\$156,699,200
2020-21 *	4	252,040	2.43	\$82.34	\$199.69	\$150,991,500
2020-21 *	TOTAL	262,980	2.58	\$84.00	\$216.48	\$683,173,500
2021-22 **	1	342,570	2.55	\$83.68	\$213.59	\$219,503,900
2021-22 **	2	281,730	2.43	\$87.52	\$212.71	\$179,776,800
2021-22 **	3	291,460	2.36	\$85.52	\$201.98	\$176,609,400
2021-22 **	4	267,890	2.39	\$85.23	\$203.60	\$163,623,700
2021-22 **	TOTAL	295,910	2.44	\$85.37	\$208.26	\$739,513,800
2022-23 **	1	309,180	2.53	\$87.88	\$222.76	\$206,619,000
2022-23 **	2	280,340	2.43	\$87.48	\$212.61	\$178,811,200
2022-23 **	3	298,110	2.39	\$85.47	\$204.43	\$182,825,200
2022-23 **	4	256,450	2.34	\$85.09	\$199.24	\$153,290,000
2022-23 **	TOTAL	286,020	2.43	\$86.56	\$210.23	\$721,545,400

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of claims

Other Medical Fee-for-Service Base Estimate

Analyst: Kiruthika Kanagasabai

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 EXPENDITURE	
PY	2020-21	1,142,270	-	1.62	-	\$178.68	-	\$3,957,520,500	-
CY	2021-22	1,250,930	9.5%	1.59	-1.9%	\$181.42	1.5%	\$4,323,013,600	9.2%
BY	2022-23	1,230,530	-1.6%	1.58	-0.6%	\$181.43	0.0%	\$4,219,935,600	-2.4%

Users: Users are estimated to increase by 9.5% in the CY due to a surge in COVID-19 vaccination services in July 2021 (ongoing increased utilization related to vaccinations is projected separately in a policy change for later months) and users gradually return to pre-COVID levels. Users are estimated to decrease by 1.6% in the BY due to an absence of COVID-19 vaccination services and return to pre-COVID levels.

Utilization: Utilization is estimated to decrease by 1.9% in the CY due to an absence of vaccination services relating to COVID-19. Utilization is estimated to decrease by 0.6%, assuming a return to pre-COVID-19 levels.

Rate: Rate is estimated to increase by 1.5% in the CY due to a one-time FQHC rate adjustment. The BY rate is estimated to remain unchanged.

Total Expenditure: The CY is estimated to increase by 9.2%, primarily due to an increase in users along with a smaller impact from the increase in rates. The BY is estimated to decrease by 2.4% due to the decrease in users of COVID-19 vaccination services, a one-time FQHC rate adjustment, and a return to pre-COVID-19 levels.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	M21	N21	% Change
2020-21	\$4,015,721,500	\$3,957,520,500	-1.4%
2021-22	\$4,268,785,600	\$4,323,013,600	1.3%

Compared to the May 2021 Estimate, the November 2021 Estimate reflects a decrease of 1.4% for FY 2020-21 due to a slight decrease in Users. The BY estimate reflects an increase of 1.3%, mainly assuming users return to pre-COVID levels.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2021 BASE ESTIMATES)**

OTHER MEDICAL

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
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	1,157,560	1.70	\$175.49	\$298.59	\$1,036,911,600
2020-21 *	2	1,240,800	1.65	\$175.20	\$288.38	\$1,073,469,300
2020-21 *	3	1,068,420	1.56	\$176.70	\$275.06	\$881,632,900
2020-21 *	4	1,102,290	1.55	\$188.44	\$291.97	\$965,506,800
2020-21 *	TOTAL	1,142,270	1.62	\$178.68	\$288.72	\$3,957,520,500
2021-22 **	1	1,411,610	1.67	\$180.99	\$302.41	\$1,280,641,300
2021-22 **	2	1,222,520	1.56	\$182.41	\$284.68	\$1,044,065,700
2021-22 **	3	1,179,210	1.56	\$181.80	\$282.87	\$1,000,690,600
2021-22 **	4	1,190,380	1.55	\$180.55	\$279.36	\$997,616,100
2021-22 **	TOTAL	1,250,930	1.59	\$181.42	\$287.99	\$4,323,013,600
2022-23 **	1	1,353,740	1.64	\$181.01	\$296.22	\$1,203,032,700
2022-23 **	2	1,218,430	1.56	\$182.43	\$284.60	\$1,040,303,400
2022-23 **	3	1,210,680	1.57	\$181.74	\$285.98	\$1,038,704,800
2022-23 **	4	1,139,270	1.52	\$180.51	\$274.41	\$937,894,700
2022-23 **	TOTAL	1,230,530	1.58	\$181.43	\$285.78	\$4,219,935,600

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of claims

County & Community Outpatient Fee-for-Service Base Estimate

Analyst: Ernesto Singson

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

FISCAL YEAR		USERS		UTILIZATION (Claims per User)		RATE (Cost per Claim)		TOTAL EXPENDITURE	
PY	2020-21	166,150		1.58		\$174.95		\$551,082,500	
CY	2021-22	190,530	14.7%	1.56	-1.3%	\$162.60	-7.1%	\$578,757,800	5.0%
BY	2022-23	186,260	-2.2%	1.55	-0.6%	\$162.29	-0.2%	\$562,543,200	-2.8%

Users: Users are estimated to increase by 14.7% in the CY, which assumes a return to the pre-COVID level. Users are estimated to decrease by 2.2% in the BY, in part due to a fewer number of payment days.

Utilization: Utilization is estimated to remain relatively unchanged.

Rate: Rate is estimated to decrease by 7.1% from PY to CY. This is perhaps because users were utilizing necessary services at a higher rate during the pandemic. CY and BY estimates assume a return to the pre-COVID level.

Total Expenditure: The CY is estimated to increase by 5.0% due to a higher number of users, but this is also offset by lower rates. The BY is estimated to decrease by 2.8%, mainly due to fewer users.

Reason for Change from Prior Estimate

FISCAL YEAR		TOTAL EXPENDITURE		
		M21	N21	% Change
PY	2020-21	\$544,382,000	\$551,082,500	1.2%
CY	2021-22	\$579,685,600	\$578,757,800	-0.2%

Compared to the May 2021 Estimate, the November 2021 estimate is projected to increase total expenditures by 1.2% in FY 2020-21, mainly due to higher rates. FY 2021-22 is estimated to remain unchanged.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2021 BASE ESTIMATES)**

CO. & COMM. OUTPATIENT

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
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	173,980	1.63	\$183.96	\$299.65	\$156,402,300
2020-21 *	2	175,280	1.63	\$160.04	\$260.91	\$137,199,500
2020-21 *	3	141,830	1.55	\$182.69	\$283.30	\$120,544,700
2020-21 *	4	173,490	1.50	\$174.95	\$263.10	\$136,936,000
2020-21 *	TOTAL	166,150	1.58	\$174.95	\$276.40	\$551,082,500
2021-22 **	1	219,560	1.61	\$169.03	\$272.53	\$179,508,400
2021-22 **	2	186,350	1.55	\$160.37	\$248.74	\$139,054,700
2021-22 **	3	180,870	1.52	\$164.01	\$249.61	\$135,442,500
2021-22 **	4	175,350	1.53	\$155.07	\$237.15	\$124,752,300
2021-22 **	TOTAL	190,530	1.56	\$162.60	\$253.13	\$578,757,800
2022-23 **	1	206,320	1.59	\$168.41	\$268.60	\$166,258,100
2022-23 **	2	185,310	1.55	\$160.37	\$248.99	\$138,420,900
2022-23 **	3	184,480	1.54	\$164.07	\$252.31	\$139,637,300
2022-23 **	4	168,930	1.51	\$154.59	\$233.29	\$118,226,800
2022-23 **	TOTAL	186,260	1.55	\$162.29	\$251.68	\$562,543,200

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of claims

Pharmacy Fee-for-Service Base Estimate

Analyst: Jacob Mills

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

FISCAL YEAR		USERS		UTILIZATION (Claims per User)		RATE (Cost per Claim)		TOTAL EXPENDITURE	
PY	2020-21	483,050	-	2.64	-	\$227.80	-	\$3,490,409,200	-
CY	2021-22	472,230	-2.2%	2.76	4.5%	\$243.18	6.8%	\$3,808,224,700	9.1%
BY	2022-23	440,430	-6.7%	2.81	1.8%	\$262.37	7.9%	\$3,901,044,500	2.4%

Users: Users decreased by 2.2% in the CY and 6.7% in the BY. This is attributable to absence of COVID-19 vaccination services for months following July 2021 (ongoing vaccination costs are separately estimated in a policy change).

Utilization: Utilization is estimated to increase by 4.5% in the CY. This is due to a surge in COVID-19 vaccination services causing average utilization in the PY to be lower than normal. Utilization is estimated to increase by 1.8% assuming utilization returns to pre-COVID-19 pandemic levels.

Rate: The rate is projected to increase by 6.8% for the CY and by 7.9% for the BY, consistent with the historical growth rate and due to additional utilization of relatively low cost COVID-19 vaccines budgeted in a policy change rather than in the FFS base.

Total Expenditure: Total expenditures are estimated to increase by 9.1% in the CY and 2.4% in the BY due to increases in utilization and rate.

Reason for Change from Prior Estimate:

FISCAL YEAR	TOTAL EXPENDITURE		
	M21	N21	% Change
2020-21	\$3,492,897,000	\$3,490,409,200	-0.1%
2021-22	\$3,742,172,300	\$3,808,224,700	1.8%

Compared to the May 2021 Estimate, the November 2021 Estimate for total expenditure for FY 2020-21 decreases by 0.1%. This was caused by increases in Users, but was offset by lower utilization and rates attributable to a surge in COVID-19 vaccination services. Total expenditures for FY 2021-22 are estimated to increase by 1.8%, due to normal growth and an expected return to pre-COVID-19 pandemic levels

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2021 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>
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	444,530	3.06	\$239.76	\$734.63	\$979,684,500
2020-21 *	2	448,460	2.90	\$236.45	\$685.62	\$922,409,700
2020-21 *	3	429,710	2.62	\$229.34	\$601.83	\$775,829,300
2020-21 *	4	609,490	2.16	\$205.56	\$444.35	\$812,485,600
2020-21 *	TOTAL	483,050	2.64	\$227.80	\$602.15	\$3,490,409,200
2021-22 **	1	591,340	2.81	\$228.43	\$641.38	\$1,137,811,300
2021-22 **	2	446,030	2.77	\$247.12	\$683.55	\$914,641,000
2021-22 **	3	435,690	2.73	\$247.83	\$677.69	\$885,778,100
2021-22 **	4	415,880	2.73	\$255.59	\$697.31	\$869,994,300
2021-22 **	TOTAL	472,230	2.76	\$243.18	\$672.02	\$3,808,224,700
2022-23 **	1	470,010	3.01	\$262.11	\$790.10	\$1,114,052,700
2022-23 **	2	444,970	2.77	\$259.39	\$719.36	\$960,282,300
2022-23 **	3	443,600	2.80	\$260.87	\$730.02	\$971,514,200
2022-23 **	4	403,150	2.64	\$267.92	\$707.09	\$855,195,300
2022-23 **	TOTAL	440,430	2.81	\$262.37	\$738.11	\$3,901,044,500

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of prescriptions

County Inpatient Fee-for-Service Base Estimate

Analyst: Atsuko Nonoyama

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 (Claims per User)		RATE (Cost per Claim)		TOTAL EXPENDITURE	
PY	2020-21	4,180	--	5.31	--	\$3,706.12	--	\$988,885,100	--
CY	2021-22	4,090	-2.2%	4.81	-9.4%	\$3,675.64	-0.8%	\$867,545,000	-12.3%
BY	2022-23	3,940	-3.7%	4.80	-0.2%	\$3,631.83	-1.2%	\$825,280,400	-4.9%

Users: Users are estimated to decrease by 2.2% from PY to CY. This is due to the COVID-19 impact and more hospitalization cases and users gradually returning to the pre-COVID level. The change between CY and BY is estimated to be -3.7%, assuming no COVID impact and users fully return to the pre-COVID level.

Utilization: Utilization, or the number of days stayed per user, is expected to decrease by 9.4%. This is due to the COVID-19 impact: more users and longer stays. Estimates between CY and BY are essentially unchanged.

Rate: Rate, or the cost per day, is estimated to decrease by 0.8% from PY to CY and by 1.2% from CY to BY. This is mainly due the absence of a temporary COVID-19 rate increase.

Total Expenditures: Total expenditures are estimated to decrease by 12.3% from PY to CY as all three components are expected to decrease, mainly due to the COVID-19 impact. Total expenditures are estimated to decrease by 4.9% from CY to BY, mainly due to users and utilization gradually returning to the pre-COVID level in the base estimate.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	M21	N21	% Change
2020-21	\$911,901,800	\$988,885,100	8.4%
2021-22	\$818,617,500	\$867,545,000	6.0%

Compared to the May 2021 estimate, the November 2021 estimate is projected to increase by 8.4% in FY 2020-21. This is likely due to high hospitalizations attributable to a surge in COVID-19 cases. For 2021-22, high Users and Rates observed for July 2021 are mainly contributing to the 6.0% increase.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2021 BASE ESTIMATES)**

COUNTY INPATIENT

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
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	4,100	5.46	\$3,487.88	\$19,059.61	\$234,242,600
2020-21 *	2	4,770	5.11	\$3,714.02	\$18,995.90	\$272,059,200
2020-21 *	3	4,430	5.21	\$3,835.87	\$19,987.38	\$265,572,300
2020-21 *	4	3,440	5.54	\$3,795.23	\$21,038.39	\$217,011,000
2020-21 *	TOTAL	4,180	5.31	\$3,706.12	\$19,693.41	\$988,885,100
2021-22 **	1	4,940	4.84	\$3,735.95	\$18,072.70	\$267,996,900
2021-22 **	2	3,880	4.79	\$3,653.73	\$17,511.72	\$203,829,300
2021-22 **	3	4,170	4.81	\$3,690.35	\$17,738.08	\$222,130,700
2021-22 **	4	3,370	4.79	\$3,593.06	\$17,195.10	\$173,588,100
2021-22 **	TOTAL	4,090	4.81	\$3,675.64	\$17,673.82	\$867,545,000
2022-23 **	1	4,370	4.84	\$3,588.42	\$17,372.52	\$227,870,600
2022-23 **	2	3,910	4.79	\$3,647.48	\$17,470.01	\$204,743,200
2022-23 **	3	4,280	4.81	\$3,681.41	\$17,712.73	\$227,601,600
2022-23 **	4	3,200	4.76	\$3,605.90	\$17,175.12	\$165,065,000
2022-23 **	TOTAL	3,940	4.80	\$3,631.83	\$17,449.00	\$825,280,400

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of days stay

Community Inpatient Fee-for-Service Base Estimate

Analyst: Atsuko Nonoyama

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	
PY	2020-21	24,130	--	5.42	--	\$2,621.36	--	\$4,116,658,600	--
CY	2021-22	26,860	11.3%	5.04	-7.0%	\$2,461.86	-6.1%	\$4,002,299,700	-2.8%
BY	2022-23	26,550	-1.2%	5.03	-0.2%	\$2,449.15	-0.5%	\$3,926,837,800	-1.9%

Users: Users are estimated to increase by 11.3% from PY to CY, assuming Users return to the pre-COVID level. Users are estimated to decrease slightly from CY to BY, partly due to a lesser number of payments in the BY.

Utilization: Utilization, or the number of days stayed per user, is expected to decrease by 7.0%. This is due to the COVID-19 impact that is included in PY, but not CY. The change between CY and BY is estimated to be -0.2%.

Rate: Rate, or the cost per day, is estimated to decrease by 6.1% from PY to CY. This is because of the absence of a temporary COVID-19 rate increase and the on-going rate increase which was implemented in July 2020. These rate increases are estimated in a separate policy change. The BY rate is estimated to decrease by 0.5% absent an on-going rate increase.

Total Expenditures: Total expenditures are estimated to decrease by 2.8% from PY to CY as Utilization and Rates are expected to decrease, mainly due to the COVID-19 impact that is included in PY but not in CY. Total expenditures are estimated to decrease by 1.9% from CY to BY, mainly due to all components gradually returning to the pre-COVID level in the base estimate and fewer payment days in the BY.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	M21	N21	% Change
2020-21	\$3,998,836,900	\$4,116,658,600	2.9%
2021-22	\$3,962,049,800	\$4,002,299,700	1.0%

Compared to the May 2021 estimate, the November 2021 estimate shows an increase of 2.9% in FY 2020-21. This is likely due to high hospitalizations attributable to a surge in COVID-19 cases. For 2021-22, an increase of 1.0% is attributable to a higher rate and longer hospitalizations in July 2021.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2021 BASE ESTIMATES)**

COMMUNITY INPATIENT

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
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	26,990	5.41	\$2,534.38	\$13,700.82	\$1,109,205,100
2020-21 *	2	25,950	5.30	\$2,623.68	\$13,896.45	\$1,081,699,700
2020-21 *	3	22,170	5.64	\$2,637.95	\$14,879.80	\$989,477,300
2020-21 *	4	21,410	5.38	\$2,710.78	\$14,578.52	\$936,276,600
2020-21 *	TOTAL	24,130	5.42	\$2,621.36	\$14,218.91	\$4,116,658,600
2021-22 **	1	30,310	5.20	\$2,522.90	\$13,123.34	\$1,193,330,400
2021-22 **	2	26,280	5.08	\$2,427.36	\$12,328.68	\$972,003,600
2021-22 **	3	25,760	5.00	\$2,427.44	\$12,130.79	\$937,291,800
2021-22 **	4	25,100	4.86	\$2,457.03	\$11,949.86	\$899,673,900
2021-22 **	TOTAL	26,860	5.04	\$2,461.86	\$12,416.94	\$4,002,299,700
2022-23 **	1	29,640	5.17	\$2,436.01	\$12,590.31	\$1,119,615,600
2022-23 **	2	26,220	5.08	\$2,447.12	\$12,428.07	\$977,649,300
2022-23 **	3	26,480	5.00	\$2,444.24	\$12,220.82	\$970,746,300
2022-23 **	4	23,860	4.85	\$2,474.50	\$11,999.01	\$858,826,700
2022-23 **	TOTAL	26,550	5.03	\$2,449.15	\$12,325.29	\$3,926,837,800

* 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 (Claims per User)		RATE (Cost per Claim)		TOTAL EXPENDITURE	
PY	2020-21	22,900		32.11		\$285.10		\$2,514,852,000	
CY	2021-22	25,820	12.8%	32.79	2.1%	\$252.05	-11.6%	\$2,561,376,300	1.8%
BY	2022-23	25,930	0.4%	32.05	-2.3%	\$243.74	-3.3%	\$2,430,985,800	-5.1%

Users: Users are estimated to decrease by 12.8% in the CY. This assumes a return to the pre-COVID level. Users are estimated to remain unchanged in the BY.

Utilization: Utilization is estimated to increase by 2.1% in the CY and decrease by 2.3% in the BY, which reflects a normal fluctuation.

Rate: Rate is estimated to decrease by 11.6%. This is due the absence of a temporary COVID-19 rate increase, an on-going rate increase, and a one-time rate adjustment. The rate is estimated to decrease by 3.3% in the BY absent an on-going rate increase and one-time rate adjustment, which are estimated in a separate policy change.

Total Expenditure: The CY is estimated to increase by 1.8%, reflecting the net impact of higher users and slightly higher utilization, offsetting a lower rate. The BY is estimated to decrease by 5.1% due to slightly lower utilization and rates.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	M21	N21	% Change
2020-21	\$2,494,764,300	\$2,514,852,000	0.8%
2021-22	\$2,496,215,300	\$2,561,376,300	2.6%

Compared to May 2021, the November 2021 estimated total expenditures for FY 20-21 remain relatively unchanged. This is because of several offsetting factors: lower users and utilization and a higher rate in the PY. FY 2021-22 is estimate to increase by 2.6% because a one-time rate adjustment was implemented in July 2021.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2021 BASE ESTIMATES)**

NURSING FACILITIES

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
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	25,920	35.42	\$287.47	\$10,181.72	\$791,771,000
2020-21 *	2	23,600	32.42	\$276.16	\$8,951.89	\$633,758,000
2020-21 *	3	21,270	30.05	\$293.49	\$8,819.49	\$562,895,300
2020-21 *	4	20,790	29.73	\$283.97	\$8,441.89	\$526,427,700
2020-21 *	TOTAL	22,900	32.11	\$285.10	\$9,153.47	\$2,514,852,000
2021-22 **	1	26,700	37.91	\$272.27	\$10,322.25	\$826,734,000
2021-22 **	2	26,870	31.69	\$241.12	\$7,641.06	\$616,029,700
2021-22 **	3	25,370	30.28	\$245.04	\$7,421.06	\$564,896,400
2021-22 **	4	24,350	31.01	\$244.42	\$7,579.13	\$553,716,200
2021-22 **	TOTAL	25,820	32.79	\$252.05	\$8,265.38	\$2,561,376,300
2022-23 **	1	27,270	35.66	\$244.50	\$8,718.59	\$713,391,800
2022-23 **	2	26,870	31.69	\$241.12	\$7,641.06	\$616,029,700
2022-23 **	3	25,580	31.48	\$245.09	\$7,716.00	\$592,182,800
2022-23 **	4	24,000	28.95	\$244.34	\$7,073.41	\$509,381,500
2022-23 **	TOTAL	25,930	32.05	\$243.74	\$7,811.50	\$2,430,985,800

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of days stay

ICF/DD Fee-for-Service Base Estimate

Analyst: My-Ai Bui

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 (Claims per User)		RATE (Cost per Claim)		TOTAL EXPENDITURE	
PY	2020-21	4,400	-	31.32	-	\$267.88	-	\$443,225,400	-
CY	2021-22	4,560	3.6%	31.81	1.6%	\$238.26	-11.1%	\$415,087,600	-6.3%
BY	2022-23	4,630	1.5%	31.00	-2.5%	\$234.25	-8.9%	\$403,517,800	-2.8%

Users: Users are estimated to increase by 3.4%, assuming users return to the pre-COVID level. Users are estimated to increase by 1.5% in the BY as base trends return to the pre-COVID level.

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

Rate: Rates are estimated to decrease by 11.1% in the CY due to the absence of regular and temporary COVID-19 rate increases which are estimated in a separate policy change. Rates are estimated to decrease by 8.9% in the BY due to the absence of an on-going rate increase.

Total Expenditure: Total expenditures are estimated to decrease by 6.3% in the CY and 2.3% in the BY due to lower rates.

Reason for Change from Prior Estimate:

FISCAL YEAR	TOTAL EXPENDITURE		
	M21	N21	% Change
2020-21	\$434,873,300	\$443,225,400	1.9%
2021-22	\$404,910,600	\$415,087,600	2.5%

Compared to the May 2021 Estimate, the November 2021 Estimate total expenditures are higher by 1.9% in FY 2020-21 and 2.5% in FY 2021-22, mainly because temporary and on-going rate increases are in the actuals data, which are estimated in a separate policy change.

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OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2021 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>
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	4,560	35.58	\$257.74	\$9,170.37	\$125,551,500
2020-21 *	2	4,510	33.84	\$285.03	\$9,646.76	\$130,482,100
2020-21 *	3	4,390	28.69	\$263.65	\$7,563.26	\$99,714,000
2020-21 *	4	4,140	26.68	\$263.90	\$7,039.90	\$87,477,800
2020-21 *	TOTAL	4,400	31.32	\$267.88	\$8,390.13	\$443,225,400
2021-22 **	1	4,570	38.07	\$247.23	\$9,411.61	\$129,073,500
2021-22 **	2	4,600	31.16	\$233.99	\$7,290.28	\$100,527,300
2021-22 **	3	4,590	29.64	\$234.22	\$6,943.38	\$95,626,600
2021-22 **	4	4,500	28.34	\$235.11	\$6,663.61	\$89,860,100
2021-22 **	TOTAL	4,560	31.81	\$238.26	\$7,579.98	\$415,087,600
2022-23 **	1	4,700	35.60	\$234.31	\$8,341.09	\$117,533,300
2022-23 **	2	4,650	31.15	\$233.83	\$7,284.94	\$101,535,100
2022-23 **	3	4,650	30.99	\$233.93	\$7,250.75	\$101,162,100
2022-23 **	4	4,530	26.09	\$235.04	\$6,132.32	\$83,287,400
2022-23 **	TOTAL	4,630	31.00	\$234.25	\$7,262.45	\$403,517,800

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of days stay

Medical Transportation Fee-for-Service Base Estimate

Analyst: Jacob Mills

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

FISCAL YEAR		USERS		UTILIZATION (Claims per User)		RATE (Cost per Claim)		TOTAL EXPENDITURE	
PY	2020-21	19,980	-	2.67	-	\$146.34	-	\$93,836,400	-
CY	2021-22	23,920	19.7%	2.69	0.7%	\$145.41	-0.6%	\$112,445,700	19.8%
BY	2022-23	23,970	0.2%	2.68	-0.4%	\$144.83	-0.4%	\$111,589,500	-0.8%

Users: Users are estimated to increase by 19.7% in the CY, assuming a return to the pre-COVID-19 pandemic level. Users from CY to BY are expected to remain relatively unchanged.

Utilization: Utilizations are estimated to remain relatively unchanged.

Rate: Rates are estimated to remain relatively unchanged.

Total Expenditure: Total expenditures are estimated to increase by 19.8% in the CY, mainly due to an increase in Users. The BY total expenditures are estimated to remain relatively unchanged.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	M21	N21	% Change
2020-21	\$105,641,100	\$93,836,400	-11.2%
2021-22	\$123,773,300	\$112,445,700	-9.2%

Compared to the May 2021 Estimate, the November 2021 Estimate is lower by -11.2% in 2020-21 due to fewer Users impacted by the COVID-19 pandemic. BY expenditures are estimated to decrease by 9.8% due to lower users in July 2021. These savings are estimated in a separate policy change.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2021 BASE ESTIMATES)**

MEDICAL TRANSPORTATION

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
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	22,130	2.83	\$144.68	\$409.46	\$27,183,500
2020-21 *	2	21,890	2.68	\$153.95	\$412.16	\$27,060,900
2020-21 *	3	18,080	2.56	\$144.58	\$370.43	\$20,097,900
2020-21 *	4	17,830	2.59	\$140.70	\$364.36	\$19,494,100
2020-21 *	TOTAL	19,980	2.67	\$146.34	\$391.31	\$93,836,400
2021-22 **	1	26,240	2.84	\$148.15	\$420.71	\$33,116,500
2021-22 **	2	24,470	2.64	\$148.63	\$391.74	\$28,756,800
2021-22 **	3	22,920	2.64	\$144.63	\$381.32	\$26,214,200
2021-22 **	4	22,050	2.65	\$139.17	\$368.17	\$24,358,200
2021-22 **	TOTAL	23,920	2.69	\$145.41	\$391.76	\$112,445,700
2022-23 **	1	26,800	2.78	\$146.77	\$408.40	\$32,829,900
2022-23 **	2	24,350	2.65	\$148.12	\$391.96	\$28,633,500
2022-23 **	3	23,330	2.68	\$143.75	\$385.17	\$26,953,000
2022-23 **	4	21,400	2.59	\$139.58	\$360.90	\$23,173,100
2022-23 **	TOTAL	23,970	2.68	\$144.83	\$387.97	\$111,589,500

* 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	
PY	2020-21	166,630	-	2.36	-	\$174.68	-	\$824,378,900	-
CY	2021-22	217,810	30.7%	2.54	7.6%	\$152.86	-12.5%	\$1,016,199,300	23.3%
BY	2022-23	217,210	-0.3%	2.53	-0.4%	\$151.98	-0.6%	\$1,002,073,800	-1.4%

Users: Users are estimated to increase in CY primarily due to a projected return to more normal levels after COVID-19 lowered users in the PY. This is particularly true for LEA users due to the COVID-19 impact on schools and the users related to the restoration of adult optical and optical lab services. The BY is essentially unchanged from CY.

Utilization: Utilization is estimated to increase by 7.6% in the CY, primarily due to the increase in LEA users after COVID-19. LEA has about 5 claims per user, so more LEA claims brings up the average number of claims per user. The BY is essentially unchanged from CY.

Rate: The rate is estimated to decrease by 12.5% in the CY, primarily due to the increase in LEA claims that average only about \$25 per claim and optical lab claims that average only about \$20 per claim. The BY is essentially unchanged from CY.

Total Expenditure: Total expenditures are estimated to increase in the CY by 23.3%, mainly related to a return to more normal expenditure levels after reductions due to COVID-19. Also, there are continued increases in Waiver Services renewal and expansion, minimum wage increases for HCBS, and Hospice rate increases. The BY is down only slightly from CY.

Reason for Change from Prior Estimate:

FISCAL YEAR	TOTAL EXPENDITURE		
	M21	N21	% Change
2020-21	\$880,532,800	\$824,378,900	-6.4%
2021-22	\$974,924,200	\$1,016,199,300	4.2%

Compared to the May 2021 Estimate, the Nov 2021 Estimate decreases by 6.4% in FY 2020-21 and increases by 4.2% in FY 2021-22. The decrease in PY is mainly due to the drop in Users and Utilization caused by COVID-19, which is now all actual base data. The increase in the BY is primarily due to ongoing increases in Waiver Services renewal and expansions, minimum wage increases for HCBS Waivers, and Hospice rate increases moving into the base.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
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OTHER SERVICES

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
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	137,650	2.48	\$223.16	\$553.51	\$228,575,400
2020-21 *	2	163,610	2.34	\$186.22	\$435.27	\$213,643,900
2020-21 *	3	168,030	2.22	\$174.93	\$387.54	\$195,351,800
2020-21 *	4	197,230	2.42	\$130.54	\$315.72	\$186,807,800
2020-21 *	TOTAL	166,630	2.36	\$174.68	\$412.28	\$824,378,900
2021-22 **	1	217,120	2.73	\$166.70	\$455.14	\$296,453,000
2021-22 **	2	217,500	2.28	\$159.97	\$364.04	\$237,542,500
2021-22 **	3	211,310	2.46	\$151.80	\$373.95	\$237,055,000
2021-22 **	4	225,310	2.70	\$134.48	\$362.69	\$245,148,800
2021-22 **	TOTAL	217,810	2.54	\$152.86	\$388.80	\$1,016,199,300
2022-23 **	1	216,600	2.68	\$163.90	\$439.35	\$285,495,800
2022-23 **	2	218,300	2.28	\$160.02	\$364.87	\$238,956,600
2022-23 **	3	216,530	2.50	\$151.64	\$379.48	\$246,506,500
2022-23 **	4	217,400	2.66	\$133.38	\$354.36	\$231,115,000
2022-23 **	TOTAL	217,210	2.53	\$151.98	\$384.45	\$1,002,073,800

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of claims

Home Health Fee-for-Service Base Estimate

Analyst: Ernesto Singson

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

FISCAL YEAR		USERS		UTILIZATION (Claims per User)		RATE (Cost per Claim)		TOTAL EXPENDITURE	
PY	2020-21	3,440		5.38		\$1,128.97		\$250,918,400	
CY	2021-22	3,940	14.5%	5.35	-0.6%	\$1,050.02	-7.0%	\$265,694,600	5.9%
BY	2022-23	4,030	2.3%	5.21	-2.6%	\$1,049.96	0.0%	\$264,470,300	-0.5%

Users: Users are estimated to increase by 14.5% assuming Assisted Living Waiver Pilot Program (ALWPP) services will be billed correctly under Home Health. This service was billed under Other Service from March – July 2021 for an unknown reason, resulting in a significant user decrease in the PY. Users are estimated to increase by 2.3% in the BY, assuming users return to a normal trend.

Utilization: Utilization is estimated to remain relatively unchanged.

Rate: The rate is projected to decrease by 7.0% in the CY, assuming it returns to a normal rate. The rate was high in the PY due to the absence of ALWPP services, which generally lowered rate. The rate is estimated to remain unchanged in the BY.

Total Expenditure: CY expenditure estimates are projected to increase by 5.9% in the CY due to higher users, but it is also offset by a lower rate. The BY expenditure estimate decreased by 0.5% due to a slightly higher number of users, but this is offset by a decrease in utilization.

Reason for Change from Prior Estimate

FISCAL YEAR		TOTAL EXPENDITURE		
		M21	N21	% Change
PY	2020-21	\$268,011,700	\$250,918,400	-6.4%
CY	2021-22	\$266,278,800	\$265,694,600	-0.2%

Compared to the May 2021 Estimate, the November 2021 estimate reflects a decrease of 6.4% in FY 2020-21. This is mainly due to ALWPP service having been billed under Other Services from March to July 2021. FY 2021-22 expenditures are estimated to remain unchanged.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2021 BASE ESTIMATES)**

HOME HEALTH

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
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	4,080	5.64	\$1,276.74	\$7,194.63	\$87,968,700
2020-21 *	2	3,910	5.35	\$1,023.93	\$5,480.86	\$64,356,300
2020-21 *	3	3,240	4.87	\$1,089.99	\$5,313.03	\$51,690,500
2020-21 *	4	2,540	5.65	\$1,088.79	\$6,155.23	\$46,902,900
2020-21 *	TOTAL	3,440	5.38	\$1,128.97	\$6,072.86	\$250,918,400
2021-22 **	1	3,860	6.15	\$1,047.71	\$6,444.10	\$74,629,100
2021-22 **	2	4,020	5.24	\$1,040.03	\$5,454.50	\$65,738,300
2021-22 **	3	3,980	5.09	\$1,070.29	\$5,449.10	\$65,021,700
2021-22 **	4	3,900	4.95	\$1,042.52	\$5,158.46	\$60,305,500
2021-22 **	TOTAL	3,940	5.35	\$1,050.02	\$5,622.42	\$265,694,600
2022-23 **	1	4,260	5.60	\$1,048.77	\$5,870.44	\$75,020,500
2022-23 **	2	4,020	5.24	\$1,040.03	\$5,454.50	\$65,738,300
2022-23 **	3	4,020	5.22	\$1,069.89	\$5,589.23	\$67,333,500
2022-23 **	4	3,830	4.71	\$1,039.96	\$4,902.48	\$56,378,000
2022-23 **	TOTAL	4,030	5.21	\$1,049.96	\$5,466.71	\$264,470,300

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of claims

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2021 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>
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	54,750	3.66	\$197.05	\$721.46	\$118,494,100
2020-21 *	2	56,560	3.35	\$186.40	\$624.82	\$106,018,200
2020-21 *	3	50,340	3.14	\$193.29	\$607.66	\$91,761,500
2020-21 *	4	50,160	3.11	\$197.01	\$612.85	\$92,213,900
2020-21 *	TOTAL	52,950	3.33	\$193.33	\$642.89	\$408,487,600
2021-22 **	1	60,920	3.73	\$199.60	\$743.82	\$135,948,700
2021-22 **	2	57,250	3.34	\$187.03	\$624.42	\$107,238,500
2021-22 **	3	58,500	3.26	\$182.34	\$593.60	\$104,170,800
2021-22 **	4	54,820	3.36	\$184.64	\$620.83	\$102,108,000
2021-22 **	TOTAL	57,870	3.43	\$188.95	\$647.21	\$449,465,900
2022-23 **	1	60,600	3.62	\$189.65	\$685.85	\$124,681,600
2022-23 **	2	55,940	3.36	\$188.27	\$633.28	\$106,271,900
2022-23 **	3	57,960	3.35	\$183.29	\$614.78	\$106,901,900
2022-23 **	4	51,900	3.27	\$185.96	\$607.86	\$94,639,000
2022-23 **	TOTAL	56,600	3.41	\$186.90	\$636.79	\$432,494,400

* 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 2021 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>
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	520,010	2.72	\$313.82	\$852.84	\$1,330,467,600
2020-21 *	2	542,400	2.59	\$316.52	\$818.67	\$1,332,137,300
2020-21 *	3	508,750	2.36	\$326.84	\$770.80	\$1,176,442,300
2020-21 *	4	640,430	2.16	\$286.77	\$619.09	\$1,189,454,000
2020-21 *	TOTAL	552,900	2.44	\$310.49	\$757.90	\$5,028,501,200
2021-22 **	1	651,910	2.61	\$298.42	\$778.83	\$1,523,171,800
2021-22 **	2	493,920	2.52	\$308.49	\$776.66	\$1,150,825,700
2021-22 **	3	465,830	2.46	\$319.75	\$785.23	\$1,097,345,900
2021-22 **	4	453,630	2.53	\$310.25	\$783.97	\$1,066,897,700
2021-22 **	TOTAL	516,320	2.53	\$308.07	\$780.88	\$4,838,241,100
2022-23 **	1	530,740	2.69	\$318.67	\$856.79	\$1,364,182,600
2022-23 **	2	480,550	2.55	\$316.76	\$807.97	\$1,164,808,300
2022-23 **	3	470,230	2.52	\$325.55	\$821.11	\$1,158,337,700
2022-23 **	4	437,540	2.45	\$317.97	\$778.79	\$1,022,255,800
2022-23 **	TOTAL	479,760	2.56	\$319.70	\$818.04	\$4,709,584,300

* 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 2021 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>
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	231,520	4.47	\$305.20	\$1,363.71	\$947,181,400
2020-21 *	2	235,240	4.16	\$292.21	\$1,215.21	\$857,611,400
2020-21 *	3	218,130	3.83	\$295.06	\$1,128.91	\$738,747,700
2020-21 *	4	225,000	3.71	\$286.07	\$1,059.97	\$715,467,700
2020-21 *	TOTAL	227,470	4.05	\$295.12	\$1,193.92	\$3,259,008,200
2021-22 **	1	255,760	4.62	\$290.48	\$1,342.03	\$1,029,725,100
2021-22 **	2	248,360	4.00	\$283.55	\$1,133.98	\$844,898,200
2021-22 **	3	250,430	3.90	\$282.39	\$1,100.14	\$826,533,800
2021-22 **	4	245,850	3.96	\$272.90	\$1,079.46	\$796,172,000
2021-22 **	TOTAL	250,100	4.12	\$282.75	\$1,165.30	\$3,497,329,200
2022-23 **	1	264,850	4.39	\$284.06	\$1,246.80	\$990,638,200
2022-23 **	2	250,630	3.98	\$284.93	\$1,133.25	\$852,066,600
2022-23 **	3	254,590	3.99	\$283.36	\$1,130.47	\$863,415,600
2022-23 **	4	239,630	3.80	\$274.96	\$1,043.74	\$750,327,300
2022-23 **	TOTAL	252,420	4.05	\$282.07	\$1,141.09	\$3,456,447,600

* 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 2021 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>
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	118,650	2.25	\$236.23	\$531.18	\$189,066,000
2020-21 *	2	125,430	2.17	\$236.81	\$514.11	\$193,450,700
2020-21 *	3	109,050	2.06	\$238.09	\$491.24	\$160,716,400
2020-21 *	4	116,200	2.04	\$225.26	\$459.52	\$160,189,900
2020-21 *	TOTAL	117,330	2.13	\$234.21	\$499.59	\$703,422,900
2021-22 **	1	152,350	2.16	\$227.92	\$491.62	\$224,699,200
2021-22 **	2	145,210	1.94	\$234.97	\$456.89	\$199,031,400
2021-22 **	3	145,410	1.95	\$228.00	\$445.31	\$194,260,700
2021-22 **	4	143,020	1.97	\$216.73	\$427.73	\$183,519,800
2021-22 **	TOTAL	146,500	2.01	\$226.95	\$455.93	\$801,511,100
2022-23 **	1	154,320	2.09	\$230.36	\$480.93	\$222,652,000
2022-23 **	2	146,660	1.94	\$236.40	\$458.47	\$201,721,200
2022-23 **	3	149,020	1.98	\$229.70	\$455.32	\$203,550,200
2022-23 **	4	137,840	1.93	\$216.67	\$418.25	\$172,946,700
2022-23 **	TOTAL	146,960	1.99	\$228.54	\$454.14	\$800,870,100

* 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 2021 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>
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	17,670	31.89	\$257.72	\$8,217.67	\$435,725,700
2020-21 *	2	16,800	27.95	\$249.94	\$6,987.00	\$352,214,700
2020-21 *	3	14,460	25.71	\$261.65	\$6,727.88	\$291,895,600
2020-21 *	4	13,530	25.66	\$252.72	\$6,485.45	\$263,153,600
2020-21 *	TOTAL	15,620	28.05	\$255.48	\$7,166.63	\$1,342,989,700
2021-22 **	1	15,240	38.79	\$246.98	\$9,579.21	\$437,822,000
2021-22 **	2	16,750	31.70	\$220.62	\$6,994.47	\$351,568,100
2021-22 **	3	16,960	28.56	\$222.27	\$6,348.35	\$322,909,700
2021-22 **	4	16,180	29.16	\$222.81	\$6,497.14	\$315,348,100
2021-22 **	TOTAL	16,280	31.91	\$229.00	\$7,307.38	\$1,427,647,900
2022-23 **	1	17,980	33.39	\$223.78	\$7,471.02	\$402,931,900
2022-23 **	2	17,300	30.83	\$220.87	\$6,808.85	\$353,415,400
2022-23 **	3	17,250	29.65	\$222.61	\$6,599.46	\$341,507,600
2022-23 **	4	16,010	26.97	\$222.68	\$6,005.49	\$288,471,500
2022-23 **	TOTAL	17,140	30.30	\$222.52	\$6,742.16	\$1,386,326,300

* 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 2021 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>
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	42,850	4.26	\$317.98	\$1,355.43	\$174,238,000
2020-21 *	2	44,720	4.14	\$318.39	\$1,317.69	\$176,798,600
2020-21 *	3	39,400	4.12	\$379.14	\$1,563.64	\$184,825,600
2020-21 *	4	36,660	3.83	\$361.07	\$1,382.08	\$152,009,300
2020-21 *	TOTAL	40,910	4.10	\$341.93	\$1,401.22	\$687,871,500
2021-22 **	1	51,510	3.80	\$308.74	\$1,173.47	\$181,352,700
2021-22 **	2	49,440	3.44	\$303.61	\$1,045.28	\$155,029,200
2021-22 **	3	51,240	3.37	\$301.91	\$1,017.72	\$156,446,900
2021-22 **	4	47,560	3.39	\$318.44	\$1,078.77	\$153,913,700
2021-22 **	TOTAL	49,940	3.50	\$308.04	\$1,079.24	\$646,742,600
2022-23 **	1	53,610	3.64	\$307.48	\$1,118.45	\$179,892,900
2022-23 **	2	49,900	3.44	\$307.13	\$1,055.68	\$158,034,100
2022-23 **	3	52,060	3.41	\$304.60	\$1,038.68	\$162,214,600
2022-23 **	4	46,230	3.31	\$319.78	\$1,056.91	\$146,574,900
2022-23 **	TOTAL	50,450	3.45	\$309.36	\$1,068.25	\$646,716,600

* 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 2021 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>
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	32.38	\$265.77	\$8,606.77	\$130,048,300
2020-21 *	2	5,020	29.17	\$267.72	\$7,809.43	\$117,688,100
2020-21 *	3	4,640	26.07	\$264.45	\$6,893.80	\$95,941,100
2020-21 *	4	4,360	24.73	\$260.70	\$6,446.69	\$84,348,400
2020-21 *	TOTAL	4,770	28.25	\$264.99	\$7,485.46	\$428,026,000
2021-22 **	1	4,580	36.80	\$252.46	\$9,291.50	\$127,587,700
2021-22 **	2	4,840	29.22	\$234.57	\$6,854.59	\$99,572,600
2021-22 **	3	4,890	27.30	\$230.97	\$6,306.39	\$92,568,800
2021-22 **	4	4,740	26.46	\$237.96	\$6,296.41	\$89,564,100
2021-22 **	TOTAL	4,760	29.86	\$239.77	\$7,160.32	\$409,293,300
2022-23 **	1	5,060	32.70	\$235.78	\$7,709.61	\$116,928,100
2022-23 **	2	4,940	28.69	\$234.63	\$6,731.17	\$99,714,000
2022-23 **	3	4,950	28.23	\$231.27	\$6,529.46	\$97,040,100
2022-23 **	4	4,700	24.51	\$238.11	\$5,836.91	\$82,338,700
2022-23 **	TOTAL	4,910	28.61	\$234.84	\$6,718.05	\$396,020,900

* 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 2021 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>
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	80,320	2.08	\$266.88	\$555.60	\$133,876,300
2020-21 *	2	85,240	2.03	\$251.33	\$509.14	\$130,190,600
2020-21 *	3	70,350	2.03	\$247.53	\$502.11	\$105,974,900
2020-21 *	4	85,160	2.00	\$219.96	\$439.28	\$112,222,200
2020-21 *	TOTAL	80,270	2.03	\$246.31	\$500.69	\$482,264,000
2021-22 **	1	124,540	1.99	\$211.47	\$421.84	\$157,608,300
2021-22 **	2	110,670	1.89	\$216.08	\$407.71	\$135,363,600
2021-22 **	3	110,840	1.84	\$213.19	\$392.25	\$130,434,500
2021-22 **	4	109,880	2.00	\$199.85	\$399.76	\$131,780,000
2021-22 **	TOTAL	113,980	1.93	\$210.06	\$405.90	\$555,186,300
2022-23 **	1	116,880	2.09	\$219.92	\$459.59	\$161,149,500
2022-23 **	2	110,670	1.93	\$214.70	\$415.37	\$137,905,200
2022-23 **	3	113,270	1.89	\$212.58	\$401.51	\$136,442,800
2022-23 **	4	105,830	1.98	\$198.51	\$393.69	\$124,995,300
2022-23 **	TOTAL	111,660	1.98	\$211.78	\$418.29	\$560,492,800

* 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 2021 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>
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	80,600	3.68	\$214.89	\$791.84	\$191,469,500
2020-21 *	2	86,270	3.40	\$212.02	\$719.81	\$186,285,400
2020-21 *	3	81,520	3.20	\$223.41	\$714.66	\$174,775,800
2020-21 *	4	87,640	3.17	\$213.77	\$677.27	\$178,060,500
2020-21 *	TOTAL	84,010	3.36	\$215.84	\$724.74	\$730,591,200
2021-22 **	1	109,810	3.55	\$211.86	\$751.29	\$247,505,400
2021-22 **	2	97,770	3.01	\$201.23	\$606.28	\$177,820,100
2021-22 **	3	98,110	2.94	\$199.80	\$587.87	\$173,021,600
2021-22 **	4	96,330	3.06	\$198.50	\$606.80	\$175,354,000
2021-22 **	TOTAL	100,500	3.15	\$203.53	\$641.52	\$773,701,200
2022-23 **	1	107,010	3.33	\$203.16	\$677.16	\$217,394,300
2022-23 **	2	100,300	3.01	\$200.09	\$602.88	\$181,405,500
2022-23 **	3	103,010	2.98	\$198.47	\$591.74	\$182,863,600
2022-23 **	4	97,460	2.95	\$197.14	\$582.10	\$170,187,000
2022-23 **	TOTAL	101,940	3.07	\$199.89	\$614.59	\$751,850,400

* 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 2021 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>
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	42,320	4.30	\$229.45	\$987.73	\$125,405,700
2020-21 *	2	44,420	4.04	\$211.27	\$854.54	\$113,864,200
2020-21 *	3	40,300	3.69	\$214.38	\$791.40	\$95,679,800
2020-21 *	4	41,460	3.78	\$198.89	\$751.92	\$93,512,300
2020-21 *	TOTAL	42,120	3.96	\$214.02	\$847.64	\$428,462,000
2021-22 **	1	50,300	4.67	\$213.89	\$998.71	\$150,690,200
2021-22 **	2	45,240	4.09	\$215.42	\$881.45	\$119,634,600
2021-22 **	3	45,590	4.13	\$205.43	\$848.12	\$115,993,700
2021-22 **	4	44,370	4.33	\$200.57	\$869.00	\$115,661,100
2021-22 **	TOTAL	46,370	4.31	\$209.06	\$902.07	\$501,979,600
2022-23 **	1	47,780	4.63	\$213.32	\$988.25	\$141,646,600
2022-23 **	2	44,750	4.10	\$216.55	\$888.69	\$119,318,800
2022-23 **	3	46,030	4.21	\$205.92	\$867.36	\$119,770,000
2022-23 **	4	43,340	4.20	\$201.19	\$844.72	\$109,827,800
2022-23 **	TOTAL	45,470	4.29	\$209.42	\$898.97	\$490,563,300

* 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 2021 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>
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	396,020	2.48	\$233.32	\$577.86	\$686,539,500
2020-21 *	2	433,750	2.34	\$226.02	\$528.49	\$687,705,500
2020-21 *	3	392,340	2.21	\$229.87	\$508.13	\$598,082,200
2020-21 *	4	468,100	2.09	\$213.02	\$446.14	\$626,511,100
2020-21 *	TOTAL	422,560	2.27	\$225.43	\$512.52	\$2,598,838,300
2021-22 **	1	551,820	2.33	\$214.20	\$499.63	\$827,121,400
2021-22 **	2	443,670	2.14	\$223.60	\$478.69	\$637,147,400
2021-22 **	3	431,480	2.12	\$222.48	\$472.05	\$611,053,800
2021-22 **	4	426,420	2.14	\$215.18	\$460.21	\$588,732,000
2021-22 **	TOTAL	463,350	2.19	\$218.48	\$479.13	\$2,664,054,500
2022-23 **	1	469,200	2.31	\$227.72	\$525.65	\$739,902,800
2022-23 **	2	438,380	2.15	\$227.85	\$488.87	\$642,929,500
2022-23 **	3	438,860	2.16	\$226.91	\$489.45	\$644,405,200
2022-23 **	4	411,980	2.08	\$219.11	\$455.87	\$563,428,200
2022-23 **	TOTAL	439,610	2.18	\$225.62	\$491.10	\$2,590,665,700

* 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 2021 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>
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	46,290	2.82	\$225.21	\$633.99	\$88,037,100
2020-21 *	2	47,320	2.75	\$218.73	\$601.03	\$85,324,300
2020-21 *	3	39,350	2.63	\$215.50	\$566.58	\$66,886,100
2020-21 *	4	39,950	2.66	\$226.55	\$602.76	\$72,235,700
2020-21 *	TOTAL	43,230	2.72	\$221.58	\$602.41	\$312,483,200
2021-22 **	1	61,860	2.80	\$206.54	\$578.22	\$107,308,700
2021-22 **	2	60,700	2.55	\$201.69	\$514.72	\$93,726,500
2021-22 **	3	58,140	2.59	\$201.36	\$522.12	\$91,073,800
2021-22 **	4	55,910	2.56	\$203.31	\$520.91	\$87,369,900
2021-22 **	TOTAL	59,150	2.63	\$203.33	\$534.60	\$379,478,900
2022-23 **	1	64,140	2.73	\$209.63	\$572.73	\$110,210,600
2022-23 **	2	60,430	2.56	\$204.72	\$524.09	\$95,010,300
2022-23 **	3	58,990	2.63	\$204.66	\$538.97	\$95,389,800
2022-23 **	4	53,830	2.52	\$206.43	\$520.70	\$84,084,800
2022-23 **	TOTAL	59,350	2.62	\$206.46	\$540.16	\$384,695,500

* 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 2021 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>
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	18.87	\$282.89	\$5,338.29	\$7,756,500
2020-21 *	2	460	16.64	\$284.90	\$4,741.62	\$6,600,300
2020-21 *	3	420	15.53	\$313.61	\$4,870.60	\$6,175,900
2020-21 *	4	410	15.71	\$301.55	\$4,738.25	\$5,761,700
2020-21 *	TOTAL	440	16.77	\$294.17	\$4,934.23	\$26,294,500
2021-22 **	1	480	18.22	\$299.94	\$5,464.61	\$7,859,900
2021-22 **	2	490	13.80	\$319.50	\$4,408.99	\$6,431,500
2021-22 **	3	470	14.76	\$297.12	\$4,386.13	\$6,242,700
2021-22 **	4	420	15.61	\$293.62	\$4,582.92	\$5,746,700
2021-22 **	TOTAL	460	15.59	\$302.36	\$4,714.66	\$26,280,800
2022-23 **	1	500	16.66	\$307.77	\$5,127.43	\$7,642,900
2022-23 **	2	480	13.86	\$319.53	\$4,429.66	\$6,431,000
2022-23 **	3	480	15.39	\$297.18	\$4,572.47	\$6,570,700
2022-23 **	4	410	14.63	\$293.57	\$4,295.58	\$5,255,500
2022-23 **	TOTAL	470	15.17	\$304.81	\$4,622.64	\$25,900,000

* 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 2021 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>
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	170	2.03	\$253.97	\$516.26	\$267,900
2020-21 *	2	130	2.77	\$363.79	\$1,007.13	\$395,800
2020-21 *	3	120	2.35	\$136.61	\$321.24	\$117,900
2020-21 *	4	130	2.42	\$160.50	\$389.19	\$150,200
2020-21 *	TOTAL	140	2.37	\$236.39	\$559.68	\$931,900
2021-22 **	1	210	2.14	\$140.46	\$299.91	\$190,600
2021-22 **	2	210	1.72	\$160.90	\$277.23	\$175,000
2021-22 **	3	200	1.75	\$138.86	\$242.86	\$145,000
2021-22 **	4	200	1.97	\$144.24	\$284.26	\$171,100
2021-22 **	TOTAL	210	1.90	\$145.82	\$276.47	\$681,600
2022-23 **	1	230	2.03	\$143.36	\$290.57	\$201,700
2022-23 **	2	210	1.80	\$168.18	\$302.41	\$190,800
2022-23 **	3	200	1.86	\$147.79	\$275.02	\$165,900
2022-23 **	4	200	2.01	\$148.81	\$299.84	\$177,400
2022-23 **	TOTAL	210	1.93	\$151.52	\$291.99	\$735,900

* 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 2021 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>
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	50	23.46	\$302.54	\$7,098.93	\$1,086,100
2020-21 *	2	150	3.43	\$304.19	\$1,043.23	\$459,000
2020-21 *	3	20	5.40	\$167.33	\$904.23	\$47,000
2020-21 *	4	10	13.83	\$196.45	\$2,717.58	\$65,200
2020-21 *	TOTAL	60	8.54	\$290.16	\$2,477.43	\$1,657,400
2021-22 **	1	50	14.19	\$369.51	\$5,241.83	\$721,600
2021-22 **	2	60	12.68	\$412.81	\$5,233.65	\$1,010,100
2021-22 **	3	60	11.84	\$367.28	\$4,347.96	\$839,200
2021-22 **	4	60	10.51	\$384.52	\$4,039.94	\$779,700
2021-22 **	TOTAL	60	12.16	\$384.58	\$4,675.23	\$3,350,600
2022-23 **	1	60	14.00	\$363.16	\$5,083.28	\$981,100
2022-23 **	2	60	12.68	\$412.81	\$5,233.65	\$1,010,100
2022-23 **	3	60	12.60	\$370.94	\$4,674.38	\$902,200
2022-23 **	4	60	9.21	\$379.33	\$3,492.38	\$674,000
2022-23 **	TOTAL	60	12.12	\$381.23	\$4,620.92	\$3,567,400

* 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 2021 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>
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	84,620	3.15	\$346.89	\$1,091.13	\$276,976,800
2020-21 *	2	89,460	2.80	\$329.07	\$921.85	\$247,416,600
2020-21 *	3	73,750	2.72	\$359.69	\$977.27	\$216,209,400
2020-21 *	4	71,940	2.70	\$367.51	\$992.45	\$214,195,200
2020-21 *	TOTAL	79,940	2.85	\$349.20	\$995.31	\$954,798,100
2021-22 **	1	92,550	3.11	\$351.77	\$1,092.38	\$303,290,400
2021-22 **	2	86,570	2.94	\$358.57	\$1,053.40	\$273,570,200
2021-22 **	3	93,340	2.80	\$347.60	\$972.55	\$272,331,900
2021-22 **	4	85,500	2.72	\$341.45	\$930.17	\$238,588,900
2021-22 **	TOTAL	89,490	2.89	\$350.07	\$1,012.96	\$1,087,781,300
2022-23 **	1	94,360	3.10	\$346.64	\$1,073.91	\$303,991,500
2022-23 **	2	86,570	2.95	\$360.11	\$1,061.46	\$275,665,600
2022-23 **	3	95,270	2.85	\$345.43	\$985.61	\$281,704,100
2022-23 **	4	82,280	2.65	\$347.13	\$920.79	\$227,281,200
2022-23 **	TOTAL	89,620	2.89	\$349.74	\$1,012.29	\$1,088,642,400

* 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 2021 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>
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	68,800	1.77	\$227.42	\$402.95	\$83,170,600
2020-21 *	2	74,230	1.76	\$233.30	\$411.70	\$91,686,900
2020-21 *	3	61,860	1.79	\$217.80	\$389.44	\$72,277,300
2020-21 *	4	68,070	1.85	\$208.46	\$385.30	\$78,687,000
2020-21 *	TOTAL	68,240	1.79	\$221.94	\$397.87	\$325,821,800
2021-22 **	1	93,540	1.89	\$211.68	\$400.88	\$112,496,300
2021-22 **	2	87,240	1.78	\$211.55	\$376.84	\$98,626,500
2021-22 **	3	90,770	1.80	\$209.25	\$376.37	\$102,485,700
2021-22 **	4	89,080	1.83	\$208.04	\$380.85	\$101,773,000
2021-22 **	TOTAL	90,160	1.83	\$210.15	\$383.95	\$415,381,400
2022-23 **	1	92,770	1.88	\$224.49	\$421.72	\$117,370,300
2022-23 **	2	87,240	1.79	\$221.99	\$397.55	\$104,046,900
2022-23 **	3	92,960	1.83	\$220.12	\$403.16	\$112,437,500
2022-23 **	4	85,410	1.81	\$218.31	\$395.35	\$101,303,400
2022-23 **	TOTAL	89,600	1.83	\$221.30	\$404.74	\$435,158,100

* 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 2021 BASE ESTIMATES)**

POV 100

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
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	33,900	1.95	\$260.62	\$506.99	\$51,561,000
2020-21 *	2	38,620	1.89	\$237.03	\$447.98	\$51,901,700
2020-21 *	3	33,010	1.86	\$232.58	\$433.64	\$42,948,800
2020-21 *	4	41,020	1.83	\$212.96	\$390.70	\$48,079,800
2020-21 *	TOTAL	36,640	1.88	\$235.11	\$442.37	\$194,491,200
2021-22 **	1	57,410	1.83	\$202.51	\$369.87	\$63,698,200
2021-22 **	2	48,150	1.64	\$212.41	\$348.22	\$50,296,600
2021-22 **	3	47,750	1.68	\$203.61	\$341.37	\$48,898,700
2021-22 **	4	48,160	1.69	\$201.08	\$340.26	\$49,157,300
2021-22 **	TOTAL	50,360	1.71	\$204.69	\$350.86	\$212,050,800
2022-23 **	1	51,370	1.75	\$219.65	\$384.95	\$59,321,400
2022-23 **	2	48,150	1.64	\$215.53	\$354.19	\$51,158,200
2022-23 **	3	48,820	1.70	\$206.62	\$351.95	\$51,547,800
2022-23 **	4	46,370	1.66	\$203.48	\$338.36	\$47,065,000
2022-23 **	TOTAL	48,680	1.69	\$211.59	\$357.97	\$209,092,400

* 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 14 service categories (Managed Care through Drug Medi-Cal) as displayed in most tables throughout this binder and listed below. The data used for these projections come from a variety of sources, such as other claims processing systems, managed care enrollments, and other payment data. Also, some of the projections in this group come directly from other State departments.

Base Policy Change Service Categories:

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

SUMMARY OF BASE POLICY CHANGES FISCAL YEAR 2021-22

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>ELIGIBILITY</u>					
7	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	\$31,134,000	\$18,328,000	\$0	\$12,806,000
11	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM	\$8,673,000	\$5,857,450	\$2,815,550	\$0
12	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	\$4,766,000	\$3,200,900	\$1,565,100	\$0
ELIGIBILITY SUBTOTAL		\$44,573,000	\$27,386,350	\$4,380,650	\$12,806,000
<u>DRUG MEDI-CAL</u>					
66	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	\$892,440,000	\$759,384,800	\$133,055,200	\$0
67	DRUG MEDI-CAL STATE PLAN SERVICES	\$7,655,000	\$7,140,900	\$514,100	\$0
DRUG MEDI-CAL SUBTOTAL		\$900,095,000	\$766,525,700	\$133,569,300	\$0
<u>MENTAL HEALTH</u>					
72	SMHS FOR ADULTS	\$1,713,905,000	\$1,543,652,700	\$92,280,300	\$77,972,000
73	SMHS FOR CHILDREN	\$1,215,681,000	\$1,123,592,300	\$41,558,700	\$50,530,000
MENTAL HEALTH SUBTOTAL		\$2,929,586,000	\$2,667,245,000	\$133,839,000	\$128,502,000
<u>MANAGED CARE</u>					
92	TWO PLAN MODEL	\$18,813,931,000	\$12,470,514,400	\$6,343,416,600	\$0
93	COUNTY ORGANIZED HEALTH SYSTEMS	\$8,752,755,000	\$5,616,485,150	\$3,136,269,850	\$0
94	GEOGRAPHIC MANAGED CARE	\$3,514,483,000	\$2,309,311,400	\$1,205,171,600	\$0
97	REGIONAL MODEL	\$1,204,630,000	\$814,186,250	\$390,443,750	\$0
100	PACE (Other M/C)	\$976,165,000	\$488,082,500	\$488,082,500	\$0
108	DENTAL MANAGED CARE (Other M/C)	\$115,372,000	\$70,924,550	\$44,447,450	\$0
110	SENIOR CARE ACTION NETWORK (Other M/C)	\$62,378,000	\$31,189,000	\$31,189,000	\$0
112	AIDS HEALTHCARE CENTERS (Other M/C)	\$12,383,000	\$6,191,500	\$6,191,500	\$0
115	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$1,547,000	\$0	\$1,547,000	\$0
MANAGED CARE SUBTOTAL		\$33,453,644,000	\$21,806,884,750	\$11,646,759,250	\$0
<u>OTHER</u>					
198	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$3,872,619,000	\$1,751,174,000	\$2,121,445,000	\$0
199	HOME & COMMUNITY-BASED SVCS.- CDDS (Misc.)	\$2,884,536,000	\$2,884,536,000	\$0	\$0
200	PERSONAL CARE SERVICES (Misc. Svcs.)	\$2,627,091,000	\$2,627,091,000	\$0	\$0
201	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$2,460,939,000	\$0	\$2,460,939,000	\$0
202	DENTAL SERVICES	\$1,634,647,000	\$981,165,550	\$653,481,450	\$0
204	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$274,637,000	\$274,637,000	\$0	\$0
214	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$28,466,000	\$28,466,000	\$0	\$0
215	LAWSUITS/CLAIMS	\$33,860,000	\$16,930,000	\$16,930,000	\$0
216	MEDI-CAL TCM PROGRAM	\$30,211,000	\$30,211,000	\$0	\$0

**SUMMARY OF BASE 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>
	<u>OTHER</u>				
235	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$476,000	\$238,000	\$238,000	\$0
237	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$737,000	\$737,000	\$0	\$0
250	BASE RECOVERIES	(\$399,732,000)	(\$231,426,400)	(\$168,305,600)	\$0
	OTHER SUBTOTAL	\$13,448,487,000	\$8,363,759,150	\$5,084,727,850	\$0
	GRAND TOTAL	\$50,776,385,000	\$33,631,800,950	\$17,003,276,050	\$141,308,000

SUMMARY OF BASE POLICY CHANGES FISCAL YEAR 2022-23

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>ELIGIBILITY</u>					
7	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	\$31,134,000	\$17,572,000	\$0	\$13,562,000
11	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM	\$8,673,000	\$5,637,450	\$3,035,550	\$0
12	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	\$4,766,000	\$3,097,900	\$1,668,100	\$0
ELIGIBILITY SUBTOTAL		\$44,573,000	\$26,307,350	\$4,703,650	\$13,562,000
<u>DRUG MEDI-CAL</u>					
66	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	\$861,224,000	\$727,145,250	\$134,078,750	\$0
67	DRUG MEDI-CAL STATE PLAN SERVICES	\$7,839,000	\$7,310,900	\$528,100	\$0
DRUG MEDI-CAL SUBTOTAL		\$869,063,000	\$734,456,150	\$134,606,850	\$0
<u>MENTAL HEALTH</u>					
72	SMHS FOR ADULTS	\$1,757,825,000	\$1,572,899,200	\$98,371,800	\$86,554,000
73	SMHS FOR CHILDREN	\$1,197,530,000	\$1,096,520,500	\$44,306,500	\$56,703,000
MENTAL HEALTH SUBTOTAL		\$2,955,355,000	\$2,669,419,700	\$142,678,300	\$143,257,000
<u>MANAGED CARE</u>					
92	TWO PLAN MODEL	\$18,324,072,000	\$12,102,999,800	\$6,221,072,200	\$0
93	COUNTY ORGANIZED HEALTH SYSTEMS	\$8,633,716,000	\$5,512,305,350	\$3,121,410,650	\$0
94	GEOGRAPHIC MANAGED CARE	\$3,429,882,000	\$2,243,073,600	\$1,186,808,400	\$0
97	REGIONAL MODEL	\$1,182,102,000	\$796,840,250	\$385,261,750	\$0
100	PACE (Other M/C)	\$1,161,600,000	\$580,800,000	\$580,800,000	\$0
108	DENTAL MANAGED CARE (Other M/C)	\$120,044,000	\$73,796,700	\$46,247,300	\$0
110	SENIOR CARE ACTION NETWORK (Other M/C)	\$67,187,000	\$33,593,500	\$33,593,500	\$0
112	AIDS HEALTHCARE CENTERS (Other M/C)	\$6,816,000	\$3,408,000	\$3,408,000	\$0
115	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$1,624,000	\$0	\$1,624,000	\$0
MANAGED CARE SUBTOTAL		\$32,927,043,000	\$21,346,817,200	\$11,580,225,800	\$0
<u>OTHER</u>					
198	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$4,150,941,000	\$1,874,465,000	\$2,276,476,000	\$0
199	HOME & COMMUNITY-BASED SVCS.- CDDS (Misc.)	\$2,906,112,000	\$2,906,112,000	\$0	\$0
200	PERSONAL CARE SERVICES (Misc. Svcs.)	\$2,762,975,000	\$2,762,975,000	\$0	\$0
201	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$2,726,559,000	\$0	\$2,726,559,000	\$0
202	DENTAL SERVICES	\$1,606,321,000	\$963,962,550	\$642,358,450	\$0
204	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$288,961,000	\$288,961,000	\$0	\$0
214	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$25,070,000	\$25,070,000	\$0	\$0
215	LAWSUITS/CLAIMS	\$10,949,000	\$5,474,500	\$5,474,500	\$0
216	MEDI-CAL TCM PROGRAM	\$27,476,000	\$27,476,000	\$0	\$0

**SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2022-23**

<u>NO.</u>	<u>POLICY CHANGE TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>GENERAL FUNDS</u>	<u>OTHER STATE FUNDS</u>
	<u>OTHER</u>				
235	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$234,000	\$117,000	\$117,000	\$0
237	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,113,000	\$1,113,000	\$0	\$0
250	BASE RECOVERIES	(\$425,862,000)	(\$246,554,150)	(\$179,307,850)	\$0
	OTHER SUBTOTAL	\$14,080,849,000	\$8,609,171,900	\$5,471,677,100	\$0
	GRAND TOTAL	\$50,876,883,000	\$33,386,172,300	\$17,333,891,700	\$156,819,000

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
NOVEMBER 2021 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2021-22**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2021-22 APPROPRIATION		NOV. 2021 EST. FOR 2021-22		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>ELIGIBILITY</u>								
5	7	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	\$35,246,000	\$0	\$31,134,000	\$0	(\$4,112,000)	\$0
7	11	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM	\$7,576,000	\$2,462,600	\$8,673,000	\$2,815,550	\$1,097,000	\$352,950
9	12	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	\$3,624,000	\$1,176,400	\$4,766,000	\$1,565,100	\$1,142,000	\$388,700
ELIGIBILITY SUBTOTAL			\$46,446,000	\$3,639,000	\$44,573,000	\$4,380,650	(\$1,873,000)	\$741,650
<u>DRUG MEDI-CAL</u>								
--	66	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	\$0	\$0	\$892,440,000	\$133,055,200	\$892,440,000	\$133,055,200
--	67	DRUG MEDI-CAL STATE PLAN SERVICES	\$0	\$0	\$7,655,000	\$514,100	\$7,655,000	\$514,100
60	--	NARCOTIC TREATMENT PROGRAM	\$7,557,000	\$451,900	\$0	\$0	(\$7,557,000)	(\$451,900)
61	--	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$835,000	\$56,100	\$0	\$0	(\$835,000)	(\$56,100)
62	--	INTENSIVE OUTPATIENT TREATMENT SERVICES	\$164,000	\$51,500	\$0	\$0	(\$164,000)	(\$51,500)
65	--	RESIDENTIAL TREATMENT SERVICES	\$58,000	\$2,500	\$0	\$0	(\$58,000)	(\$2,500)
DRUG MEDI-CAL SUBTOTAL			\$8,614,000	\$562,000	\$900,095,000	\$133,569,300	\$891,481,000	\$133,007,300
<u>MENTAL HEALTH</u>								
67	72	SMHS FOR ADULTS	\$1,736,536,000	\$91,470,300	\$1,713,905,000	\$92,280,300	(\$22,631,000)	\$810,000
68	73	SMHS FOR CHILDREN	\$1,282,389,000	\$40,673,730	\$1,215,681,000	\$41,558,700	(\$66,708,000)	\$884,970
MENTAL HEALTH SUBTOTAL			\$3,018,925,000	\$132,144,030	\$2,929,586,000	\$133,839,000	(\$89,339,000)	\$1,694,970
<u>MANAGED CARE</u>								
86	92	TWO PLAN MODEL	\$20,560,241,000	\$7,006,984,200	\$18,813,931,000	\$6,343,416,600	(\$1,746,310,000)	(\$663,567,600)
87	93	COUNTY ORGANIZED HEALTH SYSTEMS	\$9,047,490,000	\$3,194,507,900	\$8,752,755,000	\$3,136,269,850	(\$294,735,000)	(\$58,238,050)
88	94	GEOGRAPHIC MANAGED CARE	\$3,676,799,000	\$1,262,738,900	\$3,514,483,000	\$1,205,171,600	(\$162,316,000)	(\$57,567,300)
94	97	REGIONAL MODEL	\$1,266,632,000	\$410,813,700	\$1,204,630,000	\$390,443,750	(\$62,002,000)	(\$20,369,950)

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
NOVEMBER 2021 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2021-22**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2021-22 APPROPRIATION		NOV. 2021 EST. FOR 2021-22		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		MANAGED CARE						
95	100	PACE (Other M/C)	\$956,487,000	\$478,243,500	\$976,165,000	\$488,082,500	\$19,678,000	\$9,839,000
99	108	DENTAL MANAGED CARE (Other M/C)	\$111,031,000	\$43,910,700	\$115,372,000	\$44,447,450	\$4,341,000	\$536,750
100	110	SENIOR CARE ACTION NETWORK (Other M/C)	\$62,378,000	\$31,189,000	\$62,378,000	\$31,189,000	\$0	\$0
103	112	AIDS HEALTHCARE CENTERS (Other M/C)	\$17,906,000	\$8,953,000	\$12,383,000	\$6,191,500	(\$5,523,000)	(\$2,761,500)
104	115	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$1,341,000	\$1,341,000	\$1,547,000	\$1,547,000	\$206,000	\$206,000
		MANAGED CARE SUBTOTAL	\$35,700,305,000	\$12,438,681,900	\$33,453,644,000	\$11,646,759,250	(\$2,246,661,000)	(\$791,922,650)
		OTHER						
181	198	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$3,754,499,000	\$2,009,790,000	\$3,872,619,000	\$2,121,445,000	\$118,120,000	\$111,655,000
182	199	HOME & COMMUNITY-BASED SVCS.- CDDS (Misc.)	\$2,840,726,000	\$0	\$2,884,536,000	\$0	\$43,810,000	\$0
184	200	PERSONAL CARE SERVICES (Misc. Svcs.)	\$2,748,274,000	\$0	\$2,627,091,000	\$0	(\$121,183,000)	\$0
183	201	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$2,504,418,000	\$2,504,418,000	\$2,460,939,000	\$2,460,939,000	(\$43,479,000)	(\$43,479,000)
185	202	DENTAL SERVICES	\$1,580,936,000	\$639,849,300	\$1,634,647,000	\$653,481,450	\$53,711,000	\$13,632,150
186	204	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$257,217,000	\$0	\$274,637,000	\$0	\$17,420,000	\$0
195	214	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$32,904,000	\$0	\$28,466,000	\$0	(\$4,438,000)	\$0
192	215	LAWSUITS/CLAIMS	\$32,350,000	\$16,175,000	\$33,860,000	\$16,930,000	\$1,510,000	\$755,000
191	216	MEDI-CAL TCM PROGRAM	\$34,205,000	\$0	\$30,211,000	\$0	(\$3,994,000)	\$0
208	235	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$821,000	\$410,500	\$476,000	\$238,000	(\$345,000)	(\$172,500)
207	237	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$2,283,000	\$0	\$737,000	\$0	(\$1,546,000)	\$0

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
NOVEMBER 2021 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2021-22**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2021-22 APPROPRIATION		NOV. 2021 EST. FOR 2021-22		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
224	250	BASE RECOVERIES	(\$402,251,000)	(\$169,366,400)	(\$399,732,000)	(\$168,305,600)	\$2,519,000	\$1,060,800
		OTHER SUBTOTAL	\$13,386,382,000	\$5,001,276,400	\$13,448,487,000	\$5,084,727,850	\$62,105,000	\$83,451,450
		GRAND TOTAL	\$52,160,672,000	\$17,576,303,330	\$50,776,385,000	\$17,003,276,050	(\$1,384,287,000)	(\$573,027,280)

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2021-22 AND 2022-23**

NO.	POLICY CHANGE TITLE	NOV. 2021 EST. FOR 2021-22		NOV. 2021 EST. FOR 2022-23		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>ELIGIBILITY</u>							
7	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	\$31,134,000	\$0	\$31,134,000	\$0	\$0	\$0
11	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM	\$8,673,000	\$2,815,550	\$8,673,000	\$3,035,550	\$0	\$220,000
12	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	\$4,766,000	\$1,565,100	\$4,766,000	\$1,668,100	\$0	\$103,000
	ELIGIBILITY SUBTOTAL	\$44,573,000	\$4,380,650	\$44,573,000	\$4,703,650	\$0	\$323,000
<u>DRUG MEDI-CAL</u>							
66	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	\$892,440,000	\$133,055,200	\$861,224,000	\$134,078,750	(\$31,216,000)	\$1,023,550
67	DRUG MEDI-CAL STATE PLAN SERVICES	\$7,655,000	\$514,100	\$7,839,000	\$528,100	\$184,000	\$14,000
	DRUG MEDI-CAL SUBTOTAL	\$900,095,000	\$133,569,300	\$869,063,000	\$134,606,850	(\$31,032,000)	\$1,037,550
<u>MENTAL HEALTH</u>							
72	SMHS FOR ADULTS	\$1,713,905,000	\$92,280,300	\$1,757,825,000	\$98,371,800	\$43,920,000	\$6,091,500
73	SMHS FOR CHILDREN	\$1,215,681,000	\$41,558,700	\$1,197,530,000	\$44,306,500	(\$18,151,000)	\$2,747,800
	MENTAL HEALTH SUBTOTAL	\$2,929,586,000	\$133,839,000	\$2,955,355,000	\$142,678,300	\$25,769,000	\$8,839,300
<u>MANAGED CARE</u>							
92	TWO PLAN MODEL	\$18,813,931,000	\$6,343,416,600	\$18,324,072,000	\$6,221,072,200	(\$489,859,000)	(\$122,344,400)
93	COUNTY ORGANIZED HEALTH SYSTEMS	\$8,752,755,000	\$3,136,269,850	\$8,633,716,000	\$3,121,410,650	(\$119,039,000)	(\$14,859,200)
94	GEOGRAPHIC MANAGED CARE	\$3,514,483,000	\$1,205,171,600	\$3,429,882,000	\$1,186,808,400	(\$84,601,000)	(\$18,363,200)
97	REGIONAL MODEL	\$1,204,630,000	\$390,443,750	\$1,182,102,000	\$385,261,750	(\$22,528,000)	(\$5,182,000)
100	PACE (Other M/C)	\$976,165,000	\$488,082,500	\$1,161,600,000	\$580,800,000	\$185,435,000	\$92,717,500
108	DENTAL MANAGED CARE (Other M/C)	\$115,372,000	\$44,447,450	\$120,044,000	\$46,247,300	\$4,672,000	\$1,799,850
110	SENIOR CARE ACTION NETWORK (Other M/C)	\$62,378,000	\$31,189,000	\$67,187,000	\$33,593,500	\$4,809,000	\$2,404,500
112	AIDS HEALTHCARE CENTERS (Other M/C)	\$12,383,000	\$6,191,500	\$6,816,000	\$3,408,000	(\$5,567,000)	(\$2,783,500)
115	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$1,547,000	\$1,547,000	\$1,624,000	\$1,624,000	\$77,000	\$77,000

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2021-22 AND 2022-23**

NO.	POLICY CHANGE TITLE	NOV. 2021 EST. FOR 2021-22		NOV. 2021 EST. FOR 2022-23		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	MANAGED CARE SUBTOTAL	\$33,453,644,000	\$11,646,759,250	\$32,927,043,000	\$11,580,225,800	(\$526,601,000)	(\$66,533,450)
	OTHER						
198	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$3,872,619,000	\$2,121,445,000	\$4,150,941,000	\$2,276,476,000	\$278,322,000	\$155,031,000
199	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	\$2,884,536,000	\$0	\$2,906,112,000	\$0	\$21,576,000	\$0
200	PERSONAL CARE SERVICES (Misc. Svcs.)	\$2,627,091,000	\$0	\$2,762,975,000	\$0	\$135,884,000	\$0
201	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$2,460,939,000	\$2,460,939,000	\$2,726,559,000	\$2,726,559,000	\$265,620,000	\$265,620,000
202	DENTAL SERVICES	\$1,634,647,000	\$653,481,450	\$1,606,321,000	\$642,358,450	(\$28,326,000)	(\$11,123,000)
204	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$274,637,000	\$0	\$288,961,000	\$0	\$14,324,000	\$0
214	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$28,466,000	\$0	\$25,070,000	\$0	(\$3,396,000)	\$0
215	LAWSUITS/CLAIMS	\$33,860,000	\$16,930,000	\$10,949,000	\$5,474,500	(\$22,911,000)	(\$11,455,500)
216	MEDI-CAL TCM PROGRAM	\$30,211,000	\$0	\$27,476,000	\$0	(\$2,735,000)	\$0
235	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$476,000	\$238,000	\$234,000	\$117,000	(\$242,000)	(\$121,000)
237	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$737,000	\$0	\$1,113,000	\$0	\$376,000	\$0
250	BASE RECOVERIES	(\$399,732,000)	(\$168,305,600)	(\$425,862,000)	(\$179,307,850)	(\$26,130,000)	(\$11,002,250)
	OTHER SUBTOTAL	\$13,448,487,000	\$5,084,727,850	\$14,080,849,000	\$5,471,677,100	\$632,362,000	\$386,949,250
	GRAND TOTAL	\$50,776,385,000	\$17,003,276,050	\$50,876,883,000	\$17,333,891,700	\$100,498,000	\$330,615,650

MEDI-CAL PROGRAM BASE POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	<u>ELIGIBILITY</u>
7	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
11	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM
12	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL
	<u>DRUG MEDI-CAL</u>
66	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER
67	DRUG MEDI-CAL STATE PLAN SERVICES
	<u>MENTAL HEALTH</u>
72	SMHS FOR ADULTS
73	SMHS FOR CHILDREN
	<u>MANAGED CARE</u>
92	TWO PLAN MODEL
93	COUNTY ORGANIZED HEALTH SYSTEMS
94	GEOGRAPHIC MANAGED CARE
97	REGIONAL MODEL
100	PACE (OTHER M/C)
108	DENTAL MANAGED CARE (OTHER M/C)
110	SENIOR CARE ACTION NETWORK (OTHER M/C)
112	AIDS HEALTHCARE CENTERS (OTHER M/C)
115	FAMILY MOSAIC CAPITATED CASE MGMT. (OTH. M/C)
	<u>OTHER</u>
198	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS
199	HOME & COMMUNITY-BASED SVCS.-CDDS (MISC.)
200	PERSONAL CARE SERVICES (MISC. SVCS.)
201	MEDICARE PAYMENTS - PART D PHASED-DOWN
202	DENTAL SERVICES
204	TARGETED CASE MGMT. SVCS. - CDDS (MISC. SVCS.)
214	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC
215	LAWSUITS/CLAIMS
216	MEDI-CAL TCM PROGRAM
235	HIPP PREMIUM PAYOUTS (MISC. SVCS.)
237	CLPP CASE MANAGEMENT SERVICES (MISC. SVCS.)
250	BASE RECOVERIES

MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL

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

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$31,134,000	\$31,134,000
- STATE FUNDS	\$12,806,000	\$13,562,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$31,134,000	\$31,134,000
STATE FUNDS	\$12,806,000	\$13,562,000
FEDERAL FUNDS	\$18,328,000	\$17,572,000

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:

COVID-19 Increased FMAP Extension

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: 7

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.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a decrease primarily due to declining enrollment and a decrease in delivery expenditures. There is no change in total funds from FY 2021-22 to FY 2022-23 in the current estimate. The increase in state fund expenditures is due to the enhanced federal funding budgeted in this policy change for the FFCRA ending on December 31, 2021.

Methodology:

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

Program Forecast	FY 2021-22	FY 2022-23
Average Monthly Caseload	2,661	2,661
Average Expected Deliveries	253	253
Per Member Per Month (PMPM)	\$278.86	\$278.86

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 \$2,008,000 in FY 2021-22 and FY 2022-23. 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 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through December 31, 2021, for this policy change and is shown as a separate line item. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022, on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change. The total estimated costs for MCAP mothers in FY 2021-22 and FY 2022-23 are:

MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
BASE POLICY CHANGE NUMBER: 7

(Dollars in Thousands)

FY 2021-22	TF	SF	FF
65% Title XXI FFP / 35% Perinatal Insurance Fund	\$29,814	\$10,435	\$19,379
FFCRA 4.34% Increased FFP	\$0	(\$756)	\$756
100% Perinatal Insurance Fund	\$3,328	\$3,328	\$0
Premium Payments	(\$2,008)	(\$201)	(\$1,807)
Total	\$31,134	\$12,806	\$18,328

(Dollars in Thousands)

FY 2022-23	TF	SF	FF
65% Title XXI FFP / 35% Perinatal Insurance Fund	\$29,814	\$10,435	\$19,379
100% Perinatal Insurance Fund	\$3,328	\$3,328	\$0
Premium Payments	(\$2,008)	(\$201)	(\$1,807)
Total	\$31,134	\$13,562	\$17,572

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)

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM

BASE POLICY CHANGE NUMBER: 11
IMPLEMENTATION DATE: 7/2014
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 1823

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$8,673,000	\$8,673,000
- STATE FUNDS	\$2,815,550	\$3,035,550
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$8,673,000	\$8,673,000
STATE FUNDS	\$2,815,550	\$3,035,550
FEDERAL FUNDS	\$5,857,450	\$5,637,450

Purpose:

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

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.

COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM

BASE POLICY CHANGE NUMBER: 11

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 CCHIP. 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.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is an increase in total funds due to a lower projected amount of premium collections.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase in General Fund expenditures due to enhanced federal funding being available in FY 2021-22 in this policy change due to the FFCRA.

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 \$1,215,000 in both FY 2021-22 and FY 2022-23. 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 December 31, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022, on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.
7. Assume there will be approximately 8,187 CCHIP beneficiaries in FY 2021-22 and FY 2022-23.

COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM
BASE POLICY CHANGE NUMBER: 11

FY 2021-22	TF	GF	FF
Benefits Title XXI 65/35 GF	\$8,673,000	\$3,036,000	\$5,637,000
FFCRA 4.34% Increased FFP	\$0	(\$220,000)	\$220,000
Total FY 2021-22	\$8,673,000	\$2,816,000	\$5,857,000

FY 2022-23	TF	GF	FF
Benefits Title XXI 65/35 GF	\$8,673,000	\$3,036,000	\$5,637,000
Total FY 2022-23	\$8,673,000	\$3,036,000	\$5,637,000

*Totals may differ due to rounding.

Funding:

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 from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL

BASE POLICY CHANGE NUMBER: 12
IMPLEMENTATION DATE: 11/2013
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 1797

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$4,766,000	\$4,766,000
- STATE FUNDS	\$1,565,100	\$1,668,100
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$4,766,000	\$4,766,000
STATE FUNDS	\$1,565,100	\$1,668,100
FEDERAL FUNDS	\$3,200,900	\$3,097,900

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:

COVID-19 Increased FMAP Extension

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.

MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL

BASE POLICY CHANGE NUMBER: 12

Reason for Change:

The change from the prior estimate, for FY 2021-22, is an increase due to higher eligibles, expenditures, and a change in the weighted average per member, per month (PMPM) costs. There is no change in total funds from FY 2021-22 to FY 2022-23 in the current estimate. The change in general fund expenditures is due to the enhanced federal funding budgeted in this policy change for the FFCRA ending on December 31, 2021.

Methodology:

1. The Department estimates the average monthly FFS enrollment will be 223 in FY 2021-22 and FY 2022-23, and the average monthly Medi-Cal managed care enrollment will be 1,110 in FY 2021-22 and FY 2022-23.
2. The Department estimates the weighted average PMPM cost in FY 2021-22 and FY 2022-23 is \$653.97 for FFS infants and \$241.93 for Medi-Cal Managed Care infants.
3. MCAIP subscribers are subject to monthly premiums. Premiums are estimated to total \$208,000 in FY 2021-22 and FY 2022-23. Premium projections include reductions from waiving premiums due to statewide disasters such as the COVID-19 PHE and California wildfire season.
4. The Federal Financial Participation (FFP) for Title XXI funding decreased to 65% on October 1, 2020.
5. The 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through December 31, 2021, for this policy change and is shown as a separate line item. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022, on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change. The total estimated costs for MCAIP infants in FY 2021-22 and FY 2022-23 are:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
Benefits	\$4,974	\$1,741	\$3,233
Premiums	(\$208)	(\$73)	(\$135)
FFCRA 4.34% Increased FFP	\$0	(\$103)	\$103
Net	\$4,766	\$1,565	\$3,201

FY 2022-23	TF	GF	FF
Benefits	\$4,974	\$1,741	\$3,233
Premiums	(\$208)	(\$73)	(\$135)
Net	\$4,766	\$1,668	\$3,098

*Totals may differ due to rounding.

Funding:

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)

MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL
BASE POLICY CHANGE NUMBER: 12

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

BASE POLICY CHANGE NUMBER: 66
IMPLEMENTATION DATE: 4/2017
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2012

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$892,440,000	\$861,224,000
- STATE FUNDS	\$133,055,200	\$134,078,750
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$892,440,000	\$861,224,000
STATE FUNDS	\$133,055,200	\$134,078,750
FEDERAL FUNDS	\$759,384,800	\$727,145,250

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

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

BASE POLICY CHANGE NUMBER: 66

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.

Reason for Change:

This change from the prior estimate, for FY 2021-22, is an increase due to the following:

- Updated claims data reimbursements for 37 counties were higher compared to the previous projection, and as a result, the overall estimate increased.
- FY 2021-22 including a significant amount of unpaid claims for FY 2018-19, FY 2019-20 and FY 2020-21.

The change in the current estimate, from FY 2021-22 to FY 2022-23, is a net decrease due to the following:

- FY 2021-22 includes more unpaid claims for prior years than FY 2022-23.
- FFCRA Increased FMAP are not assumed for payments in FY 2022-23.

Methodology:

1. DMC-ODS waiver services for opt-in counties began in February 2017 on a phase-in basis.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

BASE POLICY CHANGE NUMBER: 66

2. A total of 37 counties opted-in to begin providing waiver services:
 - 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.
 - For 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.
3. A total of 21 counties have not opted-in to implement DMC-ODS waiver services.
4. 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 2021-22 that will be implemented in July 2021. Costs for rate adjustments are included in this estimate.

Net DMC-ODS Waiver Costs

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

(Dollars in Thousands)

DMC-ODS Waiver Net Cost	FY 2021-22	FY 2022-23
Required Services	\$104,904	\$101,366
Optional Services	\$2,813	\$2,866
Existing Services	\$894,652	\$871,001
Total	\$1,002,369	\$975,233

Claims Payment Error

6. 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 were completed in FY 2018-19 and the funds will be recouped to repay the GF, with completion in FY 2021-22. An estimated \$4,000 in GF is projected to be recouped 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. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER
BASE POLICY CHANGE NUMBER: 66

8. On a cash basis, the total costs for the claims payment error and waiver services costs are estimated to be \$892,440,000 TF and \$861,224,000 TF in FY 2021-22 and FY 2022-23 respectively.

FY 2021-22	TF	GF	FF	FFCRA	CF
Regular					
Current	\$380,962,000	\$78,346,000	\$191,298,000	\$11,759,000	\$99,559,000
ACA Optional	\$610,359,000	\$54,404,000	\$549,323,000	\$0	\$6,632,000
Perinatal					
Current	\$7,962,000	\$0	\$3,981,000	\$247,000	\$3,734,000
ACA Optional	\$3,086,000	\$309,000	\$2,777,000	\$0	\$0
Claims Error					
General Fund	\$0	(\$4,000)	\$0	\$0	\$4,000
Total	\$1,002,369,000	\$133,055,000	\$747,379,000	\$12,006,000	\$109,929,000

FY 2022-23	TF	GF	FF	FFCRA	CF
Regular					
Current	\$370,647,000	\$80,813,000	\$186,118,000	\$0	\$103,716,000
ACA Optional	\$593,832,000	\$52,966,000	\$534,448,000	\$0	\$6,418,000
Perinatal					
Current	\$7,751,000	\$0	\$3,876,000	\$0	\$3,875,000
ACA Optional	\$3,003,000	\$300,000	\$2,703,000	\$0	\$0
Total	\$975,233,000	\$134,079,000	\$727,145,000	\$0	\$114,009,000

Funding:

100% GF (4260-101-0001)
100% Title XIX FF (4260-101-0890)
100% Title XXI FF (4260-113-0890)
100% ACA Title XIX FF (4260-101-0890)
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)

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER
BASE POLICY CHANGE NUMBER: 66

FFCRA 4.34% GF (4260-113-0001)

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

DRUG MEDI-CAL STATE PLAN SERVICES

BASE POLICY CHANGE NUMBER: 67
IMPLEMENTATION DATE: 7/2021
ANALYST: Devon Dyer
FISCAL REFERENCE NUMBER: 2320

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$7,655,000	\$7,839,000
- STATE FUNDS	\$514,100	\$528,100
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$7,655,000	\$7,839,000
STATE FUNDS	\$514,100	\$528,100
FEDERAL FUNDS	\$7,140,900	\$7,310,900

Purpose:

This policy change estimates the Drug Medi-Cal (DMC) expenditures to provide Substance Use Disorder (SUD) services under the State Plan.

Authority:

Title 22, California Code of Regulations 51341.1 and 51516.1

Interdependent Policy Changes:

Drug Medi-Cal Organized Delivery System Waiver
 Drug Medi-Cal Annual Rate Adjustment
 COVID-19 Behavioral Health
 COVID-19 Increased FMAP – DHCS
 COVID-19 Increased FMAP Extension

Background:

The State Plan covers SUD services provided by certified providers under contract with the counties or with the State. State Plan services are defined by treatment modality as described below.

The Narcotic Treatment Program (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.

Outpatient Drug Free (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:

DRUG MEDI-CAL STATE PLAN SERVICES

BASE POLICY CHANGE NUMBER: 67

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

Intensive Outpatient Treatment (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:

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

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

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.

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

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

DRUG MEDI-CAL STATE PLAN SERVICES

BASE POLICY CHANGE NUMBER: 67

individuals with a substance use disorder. DMC-ODS waiver services will include the existing State Plan treatment modalities (NTP, ODF, IOT, and RTS), and additional new and expanded services.

County participation in the DMC-ODS waiver is voluntary. State Plan service expenditures for participating counties has shifted to the Drug Medi-Cal Organized Delivery System Waiver policy change as implementation has progressed.

Reason for Change:

State Plan services for participating counties have shifted to the DMC-ODS waiver resulting in a significant decline in State Plan expenditures. Projections for all State Plan modalities are now included in this consolidated policy change.

Expenditures are projected to be lower in FY 2021-22 and FY 2022-23 as compared to the prior estimate, due to the ongoing shift of Partnership Health Plan (PHP) counties to the DMC-ODS waiver.

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

Methodology:

- Expenditures are estimated using 36 months of cash-basis expenditure data (February 2018-January 2021) and trending the Users, Units/User, and Rate.

Modality	Regular Type	FY 2021-22				FY 2022-23			
		Average Monthly			Total	Average Monthly			Total
		Users	Units/ User	Rate	Total	Users	Units/ User	Rate	Total
NTP	All Others	328	71.6	\$14.78	\$4,168,100	358	67.0	\$14.78	\$4,253,000
	ACA Optional	361	67.4	\$14.83	\$4,327,000	394	63.3	\$14.83	\$4,433,800
	Regular Total				\$8,495,100				\$8,686,800
ODF	All Others	185	5.6	\$73.77	\$910,300	201	5.2	\$73.82	\$924,400
	ACA Optional	158	5.2	\$72.31	\$711,600	172	4.9	\$72.31	\$729,700
	Regular Total				\$1,621,900				\$1,654,100
IOT	All Others	10	1.8	\$72.36	\$15,000	10	1.8	\$72.36	\$16,400
	ACA Optional	6	3.0	\$76.89	\$15,800	6	3.0	\$76.89	\$17,200
	Regular Total				\$30,800				\$33,600
Overall Regular Total					\$10,147,800				\$10,374,500

DRUG MEDI-CAL STATE PLAN SERVICES

BASE POLICY CHANGE NUMBER: 67

Modality	Perinatal Type	FY 2021-22				FY 2022-23			
		Average Monthly			Total	Average Monthly			Total
		Users	Units/ User	Rate		Users	Units/ User	Rate	
NTP	All Others	2	2.7	\$8.35	\$400	2	2.7	\$8.35	\$500
	ACA Optional	1	2.7	\$7.07	\$0	0	2.7	\$7.07	\$0
	Perinatal Total				\$400				\$500
ODF	All Others	1	3.5	\$65.27	\$2,600	1	3.3	\$65.27	\$2,600
	ACA Optional	1	0.5	\$54.31	\$200	1	0.5	\$54.31	\$200
	Perinatal Total				\$2,800				\$2,800
IOT	All Others	3	3.0	\$89.44	\$5,100	2	3.0	\$89.44	\$5,500
	ACA Optional	1	0.3	\$86.04	\$100	1	0.3	\$86.04	\$100
	Perinatal Total				\$5,200				\$5,600
RTS	All Others	3	12.8	\$99.27	\$43,600	3	13.5	\$99.27	\$50,100
	ACA Optional	1	11.3	\$91.19	\$16,000	1	11.6	\$91.19	\$17,900
	Perinatal Total				\$59,600				\$68,000
Overall Perinatal Total					\$68,000				\$76,900
Overall Total					\$10,215,800				\$10,451,400

2. Annual rate adjustments that are not included in the Drug Medi-Cal base estimate are detailed in the Drug Medi-Cal Annual Rate Adjustment PC.
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. Certain aid codes are eligible for Title XXI federal reimbursement at 76.5% October 2019 through September 2020, and 65% October 2020 and thereafter.

DRUG MEDI-CAL STATE PLAN SERVICES

BASE POLICY CHANGE NUMBER: 67

Total estimated expenditures for DMC State Plan services are:

FY 2021-22	TF	GF	FF	CF*
Title XIX 100%	\$2,551,000	\$0	\$2,551,000	\$2,551,000
50% Title XIX / 50% GF	\$14,000	\$7,000	\$7,000	\$0
ACA 90% FFP/10% GF (2020)	\$5,071,000	\$507,100	\$4,563,900	\$0
Title XXI 100%	\$19,000	\$0	\$19,000	\$10,000
Total	\$7,655,000	\$514,100	\$7,140,900	\$2,561,000

FY 2022-23	TF	GF	FF	CF*
Title XIX 100%	\$2,602,000	\$0	\$2,602,000	\$2,602,000
50% Title XIX / 50% GF	\$16,000	\$8,000	\$8,000	\$0
ACA 90% FFP/10% GF (2020)	\$5,201,000	\$520,100	\$4,680,900	\$0
Title XXI 100%	\$20,000	\$0	\$20,000	\$10,000
Total	\$7,839,000	\$528,100	\$7,310,900	\$2,612,000

Funding:

Title XIX FF (4260-101-0890)

Title XXI FF (4260-113-0890)

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

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

* County Funds are not included in Total Fund

Note: Totals may differ due to rounding

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER: 72
IMPLEMENTATION DATE: 7/2012
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1780

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$1,713,905,000	\$1,757,825,000
- STATE FUNDS	\$170,252,300	\$184,925,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,713,905,000	\$1,757,825,000
STATE FUNDS	\$170,252,300	\$184,925,800
FEDERAL FUNDS	\$1,543,652,700	\$1,572,899,200

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
 California Constitution Article XIII Section 36
 Medi-Cal Specialty Mental Health Services Consolidation (CA-17) Program 1915(b4) Waiver
 Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

COVID-19 Increased FMAP Extension

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 1915(b) 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 who meet criteria for specialty mental health treatment. 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 Medi-Cal program 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: 72

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
- Mental Health Services
- Peer Support Services

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.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a net increase due to updated estimated utilization and costs for Short Doyle/Medi-Cal (SD/MC), based on additional paid claims data through March 30, 2021. The payment lag methodology has been updated to reflect the current payment activity, resulting in estimating more payments for FY 2020-21 than in the prior estimate.

The change between FY 2021-22 and FY 2022-23, in the current estimate, is an increase due to an overall increase of SD/MC and Affordable Care Act (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, 2021, with dates of service from June 2015 through March 2021. The FFS Inpatient data is current as of June 30, 2021, with dates of service from April 2015 through January 2021.
2. Due to the lag in reporting of claims data, the six most recent months of FFS Inpatient data and the nine most recent months of SD/MC data, are weighed (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

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER: 72

create estimates of final monthly claims) is as complete and accurate as possible. Therefore, the most recent months of data are weighted (lag weights) based on observed claiming trends to create projected final claims and client data. The development and application of lag weights is based upon historical reporting trends of the counties.

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 2021-22 Utilization	FY 2022-23 Utilization
SD/MC	206,903	206,914
SD/MC ACA	141,133	143,611
FFS	11,429	11,072
FFS ACA	16,400	17,084
Total	375,865	378,681

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 2020-21	\$2,175,253	\$1,859,669	\$315,584
FY 2021-22	\$2,268,280	\$1,931,781	\$336,499
FY 2022-23	\$2,361,307	\$2,003,893	\$357,414

6. On a cash basis for FY 2021-22, the Department will be paying 1.5% of FY 2020-21 claims, and 98.5% of FY 2021-22 claims for SD/MC claims. For FFS Inpatient claims, the Department will be paying 6.7% of FY 2020-21 claims, and 93.3% of FY 2021-22 claims. The cash amounts (rounded) for Adult's SMHS are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2020-21	\$49,039	\$27,895	\$21,144
FY 2021-22	\$2,216,758	\$1,902,805	\$313,953
Total FY 2021-22	\$2,265,797	\$1,930,700	\$335,097

7. On a cash basis for FY 2022-23, the Department will be paying 1.5% of FY 2021-22 claims, and 98.5% of FY 2022-23 claims for SD/MC claims. For FFS Inpatient claims, the Department will be paying 6.7% of FY 2021-22 claims, and 93.3% of FY 2022-23 claims. The cash amounts (rounded) are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2021-22	\$51,522	\$28,977	\$22,545
FY 2022-23	\$2,307,302	\$1,973,835	\$333,467
Total FY 2022-23	\$2,358,824	\$2,002,812	\$356,012

SMHS FOR ADULTS
BASE POLICY CHANGE NUMBER: 72

8. The chart below shows the FY 2021-22 and FY 2022-23 estimate with the following funding adjustments:

- Medi-Cal claims are eligible for 50% federal reimbursement;
- ACA is funded by 90% FF and 10% GF beginning January 2020;
- GF reimbursement authority is needed to account for the timing of the reimbursement from the county realignment funds to the Department.

(Dollars in Thousands)

Fiscal Year	TF	FF	ACA FF	ACA GF	GF Reimbursement	County
FY 2021-22	\$2,265,797	\$671,497	\$830,522	\$92,280	\$83,126	\$588,371
FY 2022-23	\$2,358,824	\$687,553	\$885,346	\$98,372	\$86,554	\$600,999

9. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.

(Dollars in Thousands)

FFCRA 6.2% XIX Increased FFP	TF	GF Reimbursement	CF	FFCRA
FY 2021-22	\$0	(\$5,154)	(\$36,479)	\$41,633

(Dollars in Thousands)

Fiscal Year	TF	FF	ACA FF	ACA GF	GF Reimbursement	CF	FFCRA
FY 2021-22	\$2,265,797	\$671,497	\$830,522	\$92,280	\$77,972	\$551,892	\$41,633
FY 2022-23	\$2,358,824	\$687,553	\$885,346	\$98,372	\$86,554	\$600,999	\$0

Funding:

100% Title XIX FFP (4260-101-0890)
 100% Reimbursement (4260-601-0995)
 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: 73
IMPLEMENTATION DATE: 7/2012
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1779

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$1,215,681,000	\$1,197,530,000
- STATE FUNDS	\$92,088,700	\$101,009,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,215,681,000	\$1,197,530,000
STATE FUNDS	\$92,088,700	\$101,009,500
FEDERAL FUNDS	\$1,123,592,300	\$1,096,520,500

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
 California Constitution Article XIII Section 36
 Medi-Cal Specialty Mental Health Services Consolidation (CA-17) Program 1915(b4) Waiver
 Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

Not Applicable
 COVID-19 Increased FMAP Extension

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 1915(b) 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 who meet criteria for specialty mental health services. 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

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 73

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

The following Medi-Cal SMHS are available for children:

- Adult Residential Treatment Services*
- Crisis Intervention
- Crisis Stabilization
- Crisis Residential Treatment Services*
- Day Rehabilitation
- Day Treatment Intensive
- Medication Support Services
- Psychiatric Health Facility Services
- Psychiatric Inpatient Hospital Services
- Targeted Case Management
- Therapeutic Behavioral Services
- Mental Health Services
- Therapeutic Foster Care
- Intensive Care Coordination
- Intensive Home Based Services
- Peer Support Services

*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.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a net decrease 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 June 30, 2021 for SD/MC and FFS inpatient claims data, and
- Updated estimated funding for full scope undocumented children at 100% General Fund (GF),
- Updated payment lags, based on historical payment trends, that assume the Department pays more claims in the year services occur; and
- Updating the FFCRA increased funding estimates for FY 2021-22.

The change between FY 2021-22 and FY 2022-23, in the current estimate, is a net increase due to an increase of SD/MC, FFS Inpatient, and ACA utilization for FY 2022-23 based on projections.

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 73

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, 2021, with dates of service from June 2015 through March 2021. The FFS data is current as of June 30, 2021, with dates of service from April 2015 through January 2021.
2. Due to the lag in reporting of claims data, the six most recent months of FFS Inpatient data and the nine most recent months of SD/MC data, are weighed (lag weights) based on observed claiming trends to create projected final claims data.
3. This table displays the forecast of Medi-Cal beneficiaries who will receive SD/MC SMHS and FFS/MC psychiatric inpatient hospital services.

Children	FY 2021-22 Utilization	FY 2022-23 Utilization
SD/MC	258,375	258,467
SD/MC ACA	7,385	7,875
FFS	11,298	11,064
FFS ACA	1,993	2,230
Total	279,051	279,636

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

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2020-21	\$1,975,759	\$1,853,406	\$122,353
FY 2021-22	\$2,029,258	\$1,899,450	\$129,808
FY 2022-23	\$2,082,759	\$1,945,495	\$137,264

5. On a cash basis for FY 2021-22, the Department will be paying 0.8% of FY 2020-21 claims, and 99.2% of FY 2021-22 claims for SD/MC claims. For FFS Inpatient children's claims, the Department will be paying 6.2% of FY 2020-21 claims, and 93.8% of FY 2021-22 claims. The cash amounts (rounded) for Children's SMHS are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2020-21	\$22,413	\$14,827	\$7,586
FY 2021-22	\$2,006,015	\$1,884,255	\$121,760
Total FY 2021-22	\$2,028,428	\$1,899,082	\$129,346

SMHS FOR CHILDREN
BASE POLICY CHANGE NUMBER: 73

6. On a cash basis for FY 2022-23, the Department will be paying 0.8% of FY 2021-22 claims, and 99.2% of FY 2022-23 claims for SD/MC claims. For FFS Inpatient claims, the Department will be paying 6.2% of FY 2021-22 claims, and 93.8% of FY 2022-23. The cash amounts (rounded) for Children's SMHS are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2021-22	\$23,244	\$15,196	\$8,048
FY 2022-23	\$2,058,684	\$1,929,931	\$128,753
Total FY 2022-23	\$2,081,928	\$1,945,127	\$136,801

7. On a cash basis, the Department estimates SD/MC costs of \$36,535,000 in FY 2021-22 and \$38,961,000 in FY 2022-23, for full scope undocumented children funded with 100% GF.
8. The chart below shows the FY 2021-22 and FY 2022-23 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 76.5% federal reimbursement (beginning October 1, 2019), and 65% federal reimbursement (beginning October 1, 2020),
 - ACA is funded by 90% FF / 10% GF beginning January 1, 2020, and
 - GF reimbursement authority is needed to account for the timing of the reimbursement from the county realignment funds to the Department.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF	MCHIP	ACA FF	ACA GF	GF Reimb.	CF
Total FY 2021-22	\$2,028,428	\$36,535	\$802,900	\$218,411	\$45,213	\$5,024	\$53,872	\$866,472
Total FY 2022-23	\$2,081,928	\$38,961	\$815,908	\$232,502	\$48,110	\$5,346	\$56,703	\$884,399

9. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.

(Dollars in Thousands)

FY 2021-22	TF	GF Reimb	CF	FFCRA
FFCRA 6.2% XIX Increased FFP	\$0	(\$2,854)	(\$46,925)	\$49,780
FFCRA 4.34% XXI Increased FFP	\$0	(\$488)	(\$6,800)	\$7,288
Total	\$0	(\$3,342)	(\$53,725)	\$57,068

SMHS FOR CHILDREN
BASE POLICY CHANGE NUMBER: 73

(Dollars in Thousands)

Fiscal Year	TF	GF	FF	MCHIP	ACA FF	ACA GF	GF Reimb	CF	FFCRA
FY 2021-22	\$2,028,428	\$36,535	\$802,900	\$218,411	\$45,213	\$5,024	\$50,530	\$812,747	\$57,068
FY 2022-23	\$2,081,928	\$38,961	\$815,908	\$232,502	\$48,110	\$5,346	\$56,703	\$884,399	\$0

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)
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: 92
IMPLEMENTATION DATE: 7/2000
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 56

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$18,813,931,000	\$18,324,072,000
- STATE FUNDS	\$6,343,416,600	\$6,221,072,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$18,813,931,000	\$18,324,072,000
STATE FUNDS	\$6,343,416,600	\$6,221,072,200
FEDERAL FUNDS	\$12,470,514,400	\$12,102,999,800

Purpose:

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

Authority:

Welfare & Institutions Code 14087.3
 AB 336 (Chapter 95, Statutes of 1991)
 SB 485 (Chapter 722, Statutes of 1992)

Interdependent Policy Changes:

Capitated Rate Adjustment for FY 2022-23
 COVID-19 Increased FMAP – DHCS
 COVID-19 Increased FMAP Extension

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 2021-22, is a decrease due to the removal of the pharmacy benefit costs pursuant to the Medi-Cal Rx policy, effective January 1, 2022. Eligibles and calendar year 2022 rates have been updated.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to: Eligibles are estimated to decrease from FY 2021-22 to FY 2022-23 because eligible through July 2021 include additional enrollment due to COVID-19, while months following July 2021 are assumed to have no COVID-19 impact. The impact of COVID-19 on managed care payments for months following July 2021 are budgeted in the COVID-19 Caseload Impact policy change.

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 92

Methodology:

1. Capitation rates are typically rebased annually on a calendar year (CY) basis. Federal regulations and State law require that the rates be developed according to generally accepted actuarial principles and practices. Rates must be certified by an actuary as actuarially sound in order to ensure federal financial participation (FFP). The rebasing process includes refreshed data and updates to trends, program changes, and other adjustments.
2. On an accrual basis, the last six months of CY 2021 and the first six months of the CY 2022 rates have been budgeted for FY 2021-22.
3. FY 2021-22 weighted rates have been updated from the previous estimate.
4. The estimated rate adjustment anticipated for the CY 2023 rating period to occur in FY 2022-23 is captured in the Capitated Rate Adjustment for FY 2022-23 policy change as a percentage assumption applied to five months of the CY 2023 rates on a cash basis.
5. The eligibles in this PC are reflective of actuals through July 2021 inclusive of COVID-19 caseload impacts, and continues projections at pre-COVID-19 levels thereafter. The COVID-19 Caseload Impact policy change adjusts these base projections to account for the ongoing impact of the COVID-19 pandemic on the Medi-Cal caseload.
6. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of \$252,600,000 for FY 2021-22 and \$282,000,000 for FY 2022-23 were included in the rates.
7. The savings from AB 97 are included in the rates. Savings of \$260,800,000 for FY 2021-22 and \$261,800,000 for FY 2022-23 were included in the rates.
8. Hepatitis C, Indian Health Services, and Maternity supplemental payments are budgeted in this PC.
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 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 benefit implemented on January 1, 2019. The costs associated with these services are reflected in the rates.
12. As of July 1, 2019, the care coordination costs associated with Home and Community-Based Services (HCBS) for non-dual beneficiaries in CCI counties are currently reflected in this PC.
13. 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.

TWO PLAN MODEL
BASE POLICY CHANGE NUMBER: 92

14. 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.
15. As of January 1, 2021, three new Current Procedural Terminology codes related to Psychiatric Collaborative Care (PCC) Management Services were implemented for the treatment of mental health or substance use conditions by the treating physician or other qualified health professional.
16. As of July 1, 2021, Remote Patient Monitoring was included as a covered managed care benefit. The applicable costs associated with these services are reflected in the rates.
17. As of January 1, 2022, a regional rate development model was implemented within certain managed care counties. Managed care plan rates in impacted rating regions will be inclusive of the costs within the multi-county region, producing a larger base for averaging rather than the experience of plans within a single county. The following groupings of counties will be consolidated into single rating regions:
 - a. Fresno, Kings, and Madera
 - b. Riverside and San Bernardino
 - c. San Joaquin and Stanislaus
18. As of January 1, 2022, Doula Services was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.
19. As of January 1, 2022, the costs associated with HCBS High supplemental payments originally in CCI counties are reflected in this PC.
20. The Department receives FFP of 90% for family planning services.
21. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted in the managed care model policy changes. An FMAP split of 65/35 is budgeted for OTLICP.
22. Beginning with this Estimate, the impact of the pharmacy benefit transitioning to FFS effective January 1, 2022, is reflected in the form of reduced rates. Offset costs from the pharmacy benefit transitioning to FFS are reflected in the Medi-Cal Rx – Managed Care Pharmacy Benefit to FFS policy change.

TWO PLAN MODEL
BASE POLICY CHANGE NUMBER: 92

Two-Plan Model costs on an accrual basis are:

(Dollars in Thousands)

FY 2021-22	Eligible Months	Total
Alameda	3,568,383	\$1,027,688
Contra Costa	2,396,237	\$694,822
Kern	3,923,613	\$871,396
Los Angeles	34,735,960	\$7,089,694
Riverside	8,352,070	\$1,950,463
San Bernardino	8,109,759	\$1,971,649
San Francisco	1,703,544	\$557,245
San Joaquin	2,695,419	\$608,251
Santa Clara	3,507,787	\$796,175
Stanislaus	2,231,177	\$550,883
Tulare	2,438,912	\$409,442
Fresno	4,580,677	\$951,410
Kings	581,279	\$111,758
Madera	687,503	\$119,450
Total	79,512,319	\$17,710,326
*Maternity and ACA Maternity	92,233	\$709,383
Hepatitis C Adjustment		\$100,971
Total FY 2021-22		\$18,520,679

*Events

(Dollars in Thousands)

Included in the Above Dollars	FY 2021-22
Mental Health	\$252,600
AB 97	(\$260,800)

TWO PLAN MODEL
BASE POLICY CHANGE NUMBER: 92

(Dollars in Thousands)

FY 2022-23	Eligible Months	Total
Alameda	3,519,507	\$1,020,396
Contra Costa	2,357,614	\$687,948
Kern	3,876,786	\$863,776
Los Angeles	34,373,365	\$7,015,541
Riverside	8,252,537	\$1,928,092
San Bernardino	8,021,364	\$1,953,793
San Francisco	1,684,105	\$552,904
San Joaquin	2,663,956	\$603,659
Santa Clara	3,452,943	\$785,019
Stanislaus	2,206,775	\$545,985
Tulare	2,416,650	\$405,888
Fresno	4,521,778	\$942,491
Kings	575,239	\$110,633
Madera	679,371	\$118,104
Total	78,601,990	\$17,534,227
*Maternity and ACA Maternity	92,233	\$709,383
Hepatitis C Adjustment		\$0
Total FY 2022-23		\$18,243,609

*Events

(Dollars in Thousands)

Included in the Above Dollars	FY 2022-23
Mental Health	\$282,000
AB 97	(\$261,800)

TWO PLAN MODEL
BASE POLICY CHANGE NUMBER: 92

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

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$10,657,967	\$5,328,984	\$5,328,983
100% GF (4260-101-0001)	\$25,336	\$25,336	\$0
90% Family Planning / 10% GF (4260-101-0001/0890)	\$72,459	\$7,246	\$65,213
65% Title XXI / 35% GF (4260-113-0001/0890)	\$707,146	\$247,501	\$459,645
ACA 90% FFP / 10% GF (2020)	\$7,343,501	\$734,350	\$6,609,151
Title XIX 100% FFP	\$7,522	\$0	\$7,522
Total	\$18,813,931	\$6,343,417	\$12,470,514

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$10,474,820	\$5,237,410	\$5,237,410
100% GF (4260-101-0001)	\$25,267	\$25,267	\$0
90% Family Planning / 10% GF (4260-101-0001/0890)	\$49,477	\$4,948	\$44,529
65% Title XXI / 35% GF (4260-113-0001/0890)	\$707,146	\$247,501	\$459,645
ACA 90% FFP / 10% GF (2020)	\$7,059,464	\$705,946	\$6,353,518
Title XIX 100% FFP	\$7,898	\$0	\$7,898
Total	\$18,324,072	\$6,221,072	\$12,103,000

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 93
IMPLEMENTATION DATE: 12/1987
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 57

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$8,752,755,000	\$8,633,716,000
- STATE FUNDS	\$3,136,269,850	\$3,121,410,650
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$8,752,755,000	\$8,633,716,000
STATE FUNDS	\$3,136,269,850	\$3,121,410,650
FEDERAL FUNDS	\$5,616,485,150	\$5,512,305,350

Purpose:

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

Authority:

Welfare & Institutions Code 14087.3

Interdependent Policy Changes:

Capitated Rate Adjustment for FY 2022-23
 COVID-19 Increased FMAP – DHCS
 COVID-19 Increased FMAP Extension

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 2021-22, is a decrease due to the removal of pharmacy benefit costs pursuant to the Medi-Cal Rx policy, effective January 1, 2022. Eligibles and calendar year 2022 rates have been updated.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to: Eligibles are estimated to decrease from FY 2021-22 to FY 2022-23 because eligible through July 2021 include additional enrollment due to COVID-19, while months following July 2021 are assumed to have no COVID-19 impact. The impact of COVID-19 on managed care payments for months following July 2021 are budgeted in the COVID-19 Caseload Impact policy change.

Methodology:

1. Capitation rates are typically rebased annually on a calendar year (CY) basis. Federal regulations and State law require that the rates be developed according to generally accepted actuarial principles and practices. Rates must be certified by an actuary as actuarially sound in order to ensure federal financial participation (FFP). The rebasing

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 93

process includes refreshed data and updates to trends, program changes, and other adjustments.

2. On an accrual basis, the last 6 months of the CY 2021 rates and the first 6 months of the CY 2022 rates have been budgeted for FY 2021-22.
3. FY 2021-22 weighted rates have been updated from the previous estimate.
4. The estimated rate adjustment anticipated for the CY 2023 rating period to occur in FY 2022-23 is captured in the Capitated Rate Adjustment for FY 2022-23 policy change as a percentage assumption applied to five months of the CY 2023 rates on a cash basis.
5. Currently, all COHS plans have assumed risk for long term care services.
6. The eligibles in this PC are reflective of actuals through July 2021 inclusive of COVID-19 caseload impacts, and continues projections at pre-COVID-19 levels thereafter. The COVID-19 Caseload Impact policy change adjusts these base projections to account for the ongoing impact of the COVID-19 pandemic on the Medi-Cal caseload.
7. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of \$148,600,000 for FY 2021-22 and \$157,600,000 for FY 2022-23 were included in the rates.
8. The savings from AB 97 are included in the rates. Savings of \$83,000,000 for FY 2021-22 and \$82,600,000 for FY 2022-23 were included in the rates.
9. Indian Health Services and Hepatitis C supplemental payments are reflected in this PC.
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 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: 93

15. As of July 1, 2019, the care coordination costs associated with Home and Community-Based Services (HCBS) for non-dual beneficiaries in 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, 2021, three new Current Procedural Terminology codes related to Psychiatric Collaborative Care (PCC) Management Services were implemented for the treatment of mental health or substance use conditions by the treating physician or other qualified health professional.
20. 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 now receive maternity supplemental payments for qualified delivery events. These costs continue to be reflected in this PC.
21. As of July 1, 2021, Remote Patient Monitoring was included as a covered managed care benefit. The applicable costs associated with these services are reflected in the rates.
22. As of January 1, 2022, a regional rate development model was implemented within certain managed care counties. MCP rates in impacted rating regions will be inclusive of the costs within the multi-county region, producing a larger base for averaging rather than the experience of plans within a single county. The following groupings of counties will be consolidated into single rating regions:
 - a. San Luis Obispo and Santa Barbara
 - b. Merced, Monterey, Santa Cruz
 - c. Marin, Napa, Solano, Yolo, Sonoma, Mendocino, Lake, Humboldt, Lassen, Modoc, Shasta, Siskiyou, Trinity, and Del Norte
23. As of January 1, 2022, Doula services were included as a covered managed care benefit. The costs associated with these services are reflected in the rates.
24. As of January 1, 2022, the costs associated with HCBS High supplemental payments originally in CCI counties are reflected in this PC.
25. The Department receives 90% FFP for family planning services.
26. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted in the managed care model policy changes. An FMAP split of 65/35 is budgeted for OTLICP.

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 93

27. Beginning with this Estimate, the impact of the pharmacy benefit transitioning to FFS effective January 1, 2022, is reflected in the form of reduced rates. Offset costs from pharmacy benefit transitioning to FFS are reflected in the Medi-Cal Rx – Managed Care Pharmacy Benefit to FFS policy change.

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

(Dollars in Thousands)

FY 2021-22	Eligible Months	Total
501- San Luis Obispo	606,514	\$182,136
502- Santa Barbara	1,500,294	\$419,109
503- San Mateo	1,172,808	\$390,439
504- Solano	1,240,085	\$458,563
505- Santa Cruz	770,946	\$270,788
506-Orange	8,460,139	\$2,465,666
507- Napa	334,178	\$126,923
508-Monterey	1,817,134	\$491,820
509- Yolo	589,327	\$219,498
513- Sonoma	1,198,884	\$431,875
514- Merced	1,437,098	\$396,979
510 - Marin	443,491	\$180,959
512 - Mendocino	415,482	\$143,793
515 - Ventura	2,303,532	\$755,451
523 - Del Norte	135,658	\$51,684
517 - Humboldt	628,566	\$227,586
511 - Lake	356,094	\$133,222
518 - Lassen	88,446	\$33,111
519 - Modoc	40,099	\$17,374
520 - Shasta	699,205	\$282,679
521 - Siskiyou	201,190	\$70,479
522 - Trinity	51,202	\$19,115
Total FY 2021-22	24,490,371	\$7,769,249
Maternity and ACA Maternity*	28,991	\$264,825
Hepatitis C Adjustment		\$31,022
Total with Adjustments		\$8,065,096

*Events

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 93

(Dollars in Thousands)

Included in Above Dollars	FY 2021-22
Mental Health	\$148,600
AB 97	(\$83,000)

(Dollars in Thousands)

FY 2022-23	Eligible Months	Total
501- San Luis Obispo	595,839	\$179,668
502- Santa Barbara	1,483,072	\$415,799
503- San Mateo	1,149,748	\$385,099
504- Solano	1,221,578	\$453,753
505- Santa Cruz	761,682	\$268,414
506-Orange	8,327,047	\$2,433,965
507- Napa	330,971	\$126,272
508-Monterey	1,800,203	\$488,647
509- Yolo	581,958	\$217,657
513- Sonoma	1,180,511	\$426,862
514- Merced	1,418,908	\$393,325
510 - Marin	436,534	\$178,878
512 - Mendocino	411,736	\$142,873
515 - Ventura	2,269,500	\$747,359
523 - Del Norte	134,780	\$51,516
517 - Humboldt	624,115	\$226,250
511 - Lake	353,012	\$132,420
518 - Lassen	87,748	\$32,893
519 - Modoc	39,642	\$17,234
520 - Shasta	691,400	\$281,131
521 - Siskiyou	199,313	\$69,859
522 - Trinity	50,210	\$18,800
Total FY 2022-23	24,149,506	\$7,688,674
Maternity and ACA Maternity*	28,991	\$264,825
Hepatitis C Adjustment		\$0
Total with Adjustments		\$7,953,499

*Events

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 93

(Dollars in Thousands)

Included in Above Dollars	FY 2022-23
Mental Health	\$157,600
AB 97	(\$82,600)

Funding:

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

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$5,467,564	\$2,733,782	\$2,733,782
100% GF (4260-101-0001)	\$5,540	\$5,540	\$0
90% Family Planning / 10% GF (4260-101-0001/0890)	\$22,262	\$2,226	\$20,036
65% Title XXI / 35% GF (4260-113-0001/0890)	\$300,361	\$105,126	\$195,235
ACA 90% FFP / 10% GF (2020)	\$2,895,953	\$289,596	\$2,606,357
Title XIX 100% FFP	\$61,075	\$0	\$61,075
Total	\$8,752,755	\$3,136,270	\$5,616,485

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$5,443,367	\$2,721,683	\$2,721,684
100% GF (4260-101-0001)	\$5,671	\$5,671	\$0
90% Family Planning / 10% GF (4260-101-0001/0890)	\$15,201	\$1,520	\$13,681
65% Title XXI / 35% GF (4260-113-0001/0890)	\$328,005	\$114,802	\$213,203
ACA 90% FFP / 10% GF (2020)	\$2,777,343	\$277,735	\$2,499,608
Title XIX 100% FFP	\$64,129	\$0	\$64,129
Total	\$8,633,716	\$3,121,411	\$5,512,305

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 94
IMPLEMENTATION DATE: 4/1994
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 58

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$3,514,483,000	\$3,429,882,000
- STATE FUNDS	\$1,205,171,600	\$1,186,808,400
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,514,483,000	\$3,429,882,000
STATE FUNDS	\$1,205,171,600	\$1,186,808,400
FEDERAL FUNDS	\$2,309,311,400	\$2,243,073,600

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 336 (Chapter 95, Statutes of 1991)
 SB 485 (Chapter 722, Statutes of 1992)

Interdependent Policy Changes:

Capitated Rate Adjustment for FY 2022-23
 COVID-19 Increased FMAP – DHCS
 COVID-19 Increased FMAP Extension

Background:

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

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a decrease due to the removal of pharmacy benefit costs pursuant to the Medi-Cal Rx policy, effective January 1, 2022. Eligibles and calendar year 2022 rates have been updated.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to: Eligibles are estimated to decrease from FY 2021-22 to FY 2022-23 because eligibles through July 2021 include additional enrollment due to COVID-19, while months following July 2021 are assumed to have no COVID-19 impact. The impact of COVID-19 on managed care payments for months following July 2021 are budgeted in the COVID-19 Caseload Impact policy change.

Methodology:

1. Capitation rates are typically rebased annually on a calendar year (CY) basis. Federal regulations and State law require that the rates be developed according to generally accepted actuarial principles and practices. Rates must be certified by an actuary as

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 94

actuarially sound in order to ensure federal financial participation (FFP). The rebasing process includes refreshed data and updates to trends, program changes, and other adjustments.

2. On an accrual basis, the last six months of CY 2021 and the first six months of the CY 2022 rates have been budgeted for FY 2021-22.
3. FY 2021-22 weighted rates have been updated from the previous estimate.
4. The estimated rate adjustment anticipated for the CY 2023 rating period to occur in FY 2022-23 is captured in the Capitated Rate Adjustment for FY 2022-23 policy change as a percentage assumption applied to five months of the CY 2023 rates on a cash basis.
5. The eligibles in this PC are reflective of actuals through July 2021 inclusive of COVID-19 caseload impacts, and continues projections at pre-COVID-19 levels thereafter. The COVID-19 Caseload Impact policy change adjusts these base projections to account for the ongoing impact of the COVID-19 pandemic on the Medi-Cal caseload.
6. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of \$52,100,000 for FY 2021-22 and \$62,800,000 for FY 2022-23 were included in the rates.
7. The savings from AB 97 are included in the rates. Savings of \$40,500,000 for FY 2021-22 and \$40,200,000 for FY 2022-23 were included in the rates.
8. Hepatitis C, Indian Health Services, and Maternity supplemental payments are budgeted in this PC.
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 benefit implemented on January 1, 2019. The costs associated with these services are reflected in the rates.
12. As of July 1, 2019, the care coordination costs associated with Home and Community Based Services (HCBS) for non-dual beneficiaries in CCI counties are currently reflected in this PC.
13. 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.
14. As of January 1, 2021, three new Current Procedural Terminology codes related to Psychiatric Collaborative Care (PCC) Management Services were implemented for the

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 94

treatment of mental health or substance use conditions by the treating physician or other qualified health professional.

15. As of July 1, 2021, Remote Patient Monitoring as included as a covered managed care benefit. The applicable costs associated with these services are reflected in the rates.
16. As of January 1, 2022, Doula services was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.
17. As of January 1, 2022, the costs associated with HCBS High supplemental payments originally in CCI counties are reflected in this PC.
18. The Department receives 90% federal reimbursement for family planning services.
19. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted in the managed care model policy changes. An FMAP split of 65/35 is budgeted for OTLICP.
20. Beginning with this Estimate, the impact of the pharmacy benefit transitioning to FFS effective January 1, 2022, is reflected in the form of reduced rates. Offset costs from the pharmacy benefit transitioning to FFS are reflected in the Medi-Cal Rx – Managed Care Pharmacy Benefit to FFS policy change.

GMC dollars on an accrual basis are:
(Dollars in Thousands)

FY 2021-22	Eligible Months	Total
Sacramento	5,162,037	\$1,324,955
San Diego	8,034,967	\$1,997,798
Total	13,197,004	\$3,322,753
Maternity and ACA Maternity*	15,808	\$131,425
Hepatitis C Adjustment		\$16,757
Total FY 2021-22		\$3,470,935

*Events

(Dollars in Thousands)

Included in Dollars Above	FY 2021-22
Mental Health	\$52,100
AB 97	(\$40,500)

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 94

(Dollars in Thousands)

FY 2022-23	Eligible Months	Total
Sacramento	5,107,206	\$1,315,325
San Diego	7,890,196	\$1,965,874
Total	12,997,402	\$3,281,199
Maternity and ACA Maternity*	15,808	\$131,425
Hepatitis C Adjustment		\$0
Total FY 2022-23		\$3,412,624

*Events

(Dollars in Thousands)

Included in Dollars Above	FY 2022-23
Mental Health	\$62,800
AB 97	(\$40,200)

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

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$2,046,442	\$1,023,221	\$1,023,221
100% GF (4260-101-0001)	\$4,589	\$4,589	\$0
90% Family Planning / 10% GF (4260-101-0001/0890)	\$12,026	\$1,203	\$10,823
65% Title XXI / 35% GF (4260-113-0001/0890)	\$125,660	\$43,981	\$81,679
ACA 90% FFP / 10% GF (2020)	\$1,321,780	\$132,178	\$1,189,602
Title XIX 100% FFP	\$3,986	\$0	\$3,986
Total	\$3,514,483	\$1,205,172	\$2,309,311

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$2,021,914	\$1,010,957	\$1,010,957
100% GF (4260-101-0001)	\$4,678	\$4,678	\$0
90% Family Planning / 10% GF (4260-101-0001/0890)	\$8,211	\$821	\$7,390
65% Title XXI / 35% GF (4260-113-0001/0890)	\$125,052	\$43,768	\$81,284
ACA 90% FFP / 10% GF (2020)	\$1,265,841	\$126,584	\$1,139,257
Title XIX 100% FFP	\$4,186	\$0	\$4,186
Total	\$3,429,882	\$1,186,808	\$2,243,074

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 97
IMPLEMENTATION DATE: 11/2013
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1842

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$1,204,630,000	\$1,182,102,000
- STATE FUNDS	\$390,443,750	\$385,261,750
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,204,630,000	\$1,182,102,000
STATE FUNDS	\$390,443,750	\$385,261,750
FEDERAL FUNDS	\$814,186,250	\$796,840,250

Purpose:

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

Authority:

AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:

Capitated Rate Adjustment for FY 2022-23
 COVID-19 Increased FMAP – DHCS
 COVID-19 Increased FMAP Extension

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 2021-22, is a decrease due to the removal of pharmacy benefit costs pursuant to the Medi-Cal Rx policy, effective January 1, 2022. Eligibles and calendar year 2022 rates have been updated.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due: Eligibles are estimated to decrease from FY 2021-22 to FY 2022-23 because eligibles through July 2021 include additional enrollment due to COVID-19, while months following July 2021 are assumed to have no COVID-19 impact. The impact of COVID-19 on managed care payments for months following July 2021 are budgeted in the COVID-19 Caseload Impact policy change.

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 97

Methodology:

1. Capitation rates are typically rebased annually on a calendar year (CY) basis. Federal regulations and State law require that the rates be developed according to generally accepted actuarial principles and practices. Rates must be certified by an actuary as actuarially sound in order to ensure federal financial participation (FFP). The rebasing process includes refreshed data and updates to trends, program changes, and other adjustments.
2. On an accrual basis, the last six months of CY 2021 rates and the first six months of the CY 2022 rates have been budgeted for FY 2021-22.
3. FY 2021-22 weighted rates have been updated from the previous estimate.
4. The estimated rate adjustment anticipated for the CY 2023 rating period to occur in FY 2022-23 is captured in the Capitated Rate Adjustment for FY 2022-23 policy change as a percentage assumption applied to five months of the CY 2023 rates on a cash basis.
5. The eligibles in this PC are reflective of actuals through July 2021 inclusive of COVID-19 caseload impacts, and continues projections at pre-COVID-19 levels thereafter. The COVID-19 Caseload Impact policy change adjusts these base projections to account for the ongoing impact of the COVID-19 pandemic on the Medi-Cal caseload.
6. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of \$26,700,000 for FY 2021-22 and \$29,800,000 for FY 2022-23 were included in the rates.
7. The savings from AB 97 are included in the rates. Savings of \$11,000,000 for FY 2021-22 and \$10,600,000 for FY 2022-23 were included in the rates.
8. Hepatitis C, Indian Health Services, and Maternity supplemental payments are reflected in this PC.
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 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, three new Current Procedural Terminology codes related to Psychiatric Collaborative Care (PCC) Management Services were implemented for the

REGIONAL MODEL
BASE POLICY CHANGE NUMBER: 97

treatment of mental health or substance use conditions by the treating physician or other qualified health professional.

14. As of July 1, 2021, Remote Patient Monitoring was included as a covered managed care benefit. The applicable costs associated with these services are reflected in the rates.
15. As of January 1, 2022, a regional rate development model was implemented within certain managed care counties. MCP rates in impacted rating regions will be inclusive of the costs within the multi-county region, producing a larger base for averaging rather than the experience of plans within a single county. The following counties will be consolidated into a single rating region:
 - a. Tehama, Tuolumne, Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, and Yuba.
16. As of January 1, 2022, Doula services was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.
17. The Department receives 90% FFP for family planning services.
18. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted in the managed care model policy changes. An FMAP split of 65/35 is budgeted for OTLICP.

REGIONAL MODEL
BASE POLICY CHANGE NUMBER: 97

19. Regional Model dollars on an accrual basis are:

(Dollars in Thousands)

FY 2021-22	Eligible Months	Total
Alpine	2,452	\$633
Amador	71,345	\$16,936
Butte	719,367	\$202,226
Calaveras	110,963	\$28,515
Colusa	94,047	\$18,597
El Dorado	330,413	\$84,955
Glenn	121,716	\$28,291
Inyo	46,271	\$10,590
Mariposa	48,869	\$12,302
Mono	28,831	\$6,081
Nevada	222,171	\$56,161
Placer	536,822	\$129,774
Plumas	62,237	\$16,461
Sierra	6,711	\$1,770
Sutter	365,360	\$83,145
Tehama	242,855	\$61,894
Tuolumne	118,990	\$32,768
Yuba	299,334	\$73,917
Imperial	904,848	\$188,395
San Benito	93,899	\$14,875
Total FY 2021-22	4,427,499	\$1,068,286
*Maternity and ACA Maternity	5,415	\$56,523
Hepatitis C Adjustment		\$5,608
Total with Adjustments		\$1,130,418

*Events

(Dollars in Thousands)

Included in Dollars Above	FY 2021-22
Mental Health	\$26,700
AB 97	(\$11,000)

REGIONAL MODEL
BASE POLICY CHANGE NUMBER: 97

(Dollars in Thousands)

FY 2022-23	Eligible Months	Total
Alpine	2,437	\$627
Amador	70,029	\$16,626
Butte	711,240	\$200,418
Calaveras	109,151	\$28,143
Colusa	92,881	\$18,351
El Dorado	323,906	\$83,451
Glenn	120,485	\$28,048
Inyo	45,454	\$10,405
Mariposa	48,160	\$12,131
Mono	28,306	\$5,961
Nevada	217,474	\$54,985
Placer	526,622	\$127,911
Plumas	61,639	\$16,327
Sierra	6,677	\$1,765
Sutter	360,213	\$82,182
Tehama	239,128	\$61,096
Tuolumne	117,007	\$32,378
Yuba	295,033	\$72,972
Imperial	900,307	\$189,252
San Benito	92,013	\$14,564
Total FY 2022-23	4,368,161	\$1,057,593
*Maternity and ACA Maternity	5,415	\$56,523
Hepatitis C Adjustment		\$0
Total with Adjustments		\$1,114,116

*Events

(Dollars in Thousands)

Included in Dollars Above	FY 2022-23
Mental Health	\$29,800
AB 97	(\$10,600)

REGIONAL MODEL
BASE POLICY CHANGE NUMBER: 97

Funding:

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

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$663,587	\$331,794	\$331,794
100% GF (4260-101-0001)	\$1,196	\$1,196	\$0
ACA 90% FFP / 10% GF (2020)	\$436,863	\$43,687	\$393,176
90% Family Planning / 10% GF (4260-101-0001/0890)	\$4,025	\$403	\$3,623
65% Title XXI / 35% GF (4260-113-0001/0890)	\$38,187	\$13,365	\$24,822
Title XIX 100% (4260-101-0890)	\$60,772	\$0	\$60,772
Total**	\$1,204,630	\$390,444	\$814,186

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$657,036	\$328,518	\$328,518
100% GF (4260-101-0001)	\$1,215	\$1,215	\$0
ACA 90% FFP / 10% GF (2020)	\$419,193	\$41,920	\$377,273
90% Family Planning / 10% GF (4260-101-0001/0890)	\$2,748	\$275	\$2,473
65% Title XXI / 35% GF (4260-113-0001/0890)	\$38,099	\$13,335	\$24,765
Title XIX 100% (4260-101-0890)	\$63,811	\$0	\$63,811
Total**	\$1,182,102	\$385,262	\$796,840

**Difference due to rounding.

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 100
IMPLEMENTATION DATE: 7/1992
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 62

	FY 2021-22	FY 2022-23
FULL YEAR COST - TOTAL FUNDS	\$976,165,000	\$1,161,600,000
- STATE FUNDS	\$488,082,500	\$580,800,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$976,165,000	\$1,161,600,000
STATE FUNDS	\$488,082,500	\$580,800,000
FEDERAL FUNDS	\$488,082,500	\$580,800,000

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

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 22 contracts with PACE organizations for risk-based capitated 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.

Below is a list of PACE organizations:

PACE (Other M/C)
BASE POLICY CHANGE NUMBER: 100

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	January 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
	Los Angeles	January 1, 2022
Innovative Integrated Health	Fresno	August 1, 2014
	Kern	January 1, 2020
	Tulare	January 1, 2020
	Orange	January 1, 2022
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
InnovAge California PACE (Downey)	Los Angeles	January 1, 2022
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: 100

Asian Heritage Health Care	Los Angeles	January 1, 2022
ConcertoHealth PACE	Los Angeles	July 1, 2022
ConcertoCare PACE	Kern	January 1, 2023
	Tulare	January 1, 2023
Loma Linda University Health	Riverside	January 1, 2023
	San Bernardino	January 1, 2023
Providence PACE	Napa	January 1, 2023
	Solano	January 1, 2023
	Sonoma	January 1, 2023
Clinicas PACE	Ventura	January 1, 2023

Reason for Change:

The change from the prior estimate, for FY 2021-22, is an increase due to higher estimated eligibles and the addition of InnovAge Sacramento and Sequoia Fresno into the estimated cost. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a net increase due to a projected increase in enrollment and higher rates.

Methodology:

1. Assume the calendar year (CY) 2021, CY 2022, and CY 2023 rates will be calculated using plan specific experienced-based data to build actuarially sound prospective rates.
2. FY 2021-22 and FY 2022-23 estimated funding is based on CY 2021 rates and projected CY 2022 and CY 2023 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 2022 rates during the January 2022 capitation cycle.
5. The Department plans to implement the CY 2023 rates during the January 2023 capitation cycle.
6. Health care plans that began January 2021 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 \$33,848,000 TF in FY 2021-22 and \$81,777,000 TF in FY 2022-23.

PACE (Other M/C)
BASE POLICY CHANGE NUMBER: 100

FY 2021-22	TF Cost (Rounded)	Eligible Months	Avg. Mo. Enrollment
Centers for Elders' Independence (Alameda and Contra Costa)	\$72,329,000	10,284	857
Sutter Senior Care	\$35,275,000	5,442	454
AltaMed Senior Care (Los Angeles)	\$207,837,000	41,208	3,434
OnLok (SF, Alameda and Santa Clara)	\$163,450,000	20,142	1,679
St. Paul's PACE	\$59,380,000	12,522	1,044
Los Angeles Jewish Homes	\$14,272,000	2,748	229
CalOptima PACE	\$31,011,000	4,992	416
InnovAge (San Bernardino and Riverside)	\$72,557,000	12,726	1,061
Redwood Coast (Humboldt)	\$13,877,000	2,334	195
Innovative Integrated Health (Fresno, Kern, Tulare)	\$83,277,000	14,729	1,227
San Ysidro San Diego	\$124,620,000	21,426	1,786
Stockton PACE (San Joaquin and Stanislaus)	\$26,138,000	3,690	308
Gary & Mary West (San Diego)	\$11,956,000	1,987	166
Family Health Centers of San Diego	\$11,673,000	1,916	160
Central Valley (Stanislaus)	\$8,618,000	1,135	95
LA Coast (Los Angeles)	\$10,232,000	1,590	133
Pacific PACE (Los Angeles)	\$13,018,000	2,015	168
Sequoia (Fresno)	\$5,173,000	837	70
InnovAge (Sacramento)	\$11,472,000	1,788	149
Total Capitation Payments	\$976,165,000	163,511	13,631
Total FY 2021-22	\$976,165,000		

*Totals may differ due to rounding.

PACE (Other M/C)
BASE POLICY CHANGE NUMBER: 100

FY 2022-23	TF Cost (Rounded)	Eligible Months	Avg. Mo. Enrollment
Centers for Elders' Independence (Alameda and Contra Costa)	\$78,075,000	10,572	881
Sutter Senior Care	\$38,018,000	5,586	466
AltaMed Senior Care (Los Angeles & Orange)	\$237,981,000	43,350	3,613
OnLok (SF, Alameda and Santa Clara)	\$177,259,000	20,862	1,739
St. Paul's PACE	\$65,933,000	13,242	1,104
Los Angeles Jewish Homes	\$14,986,000	2,748	229
CalOptima PACE	\$34,452,000	5,280	440
InnovAge (San Bernardino and Riverside)	\$83,924,000	14,022	1,169
Redwood Coast (Humboldt)	\$15,476,000	2,478	207
Innovative Integrated Health (Fresno, Kern, Tulare)	\$103,268,000	17,297	1,441
San Ysidro San Diego	\$165,098,000	27,042	2,254
Stockton PACE (San Joaquin and Stanislaus)	\$39,130,000	5,261	438
Gary & Mary West (San Diego)	\$17,898,000	2,833	236
Family Health Centers of San Diego	\$17,475,000	2,732	228
Central Valley (Stanislaus)	\$12,902,000	1,619	135
LA Coast (Los Angeles)	\$15,318,000	2,266	189
Pacific PACE (Los Angeles)	\$19,489,000	2,873	239
Sequoia (Fresno)	\$7,744,000	1,194	100
InnovAge (Sacramento)	\$17,174,000	2,550	213
Total Capitation Payments	\$1,161,600,000	183,807	15,321
Total FY 2022-23	\$1,161,600,000		

*Totals may differ due to rounding.

Funding:

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

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 108
IMPLEMENTATION DATE: 7/2004
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1029

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$115,372,000	\$120,044,000
- STATE FUNDS	\$44,447,450	\$46,247,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$115,372,000	\$120,044,000
STATE FUNDS	\$44,447,450	\$46,247,300
FEDERAL FUNDS	\$70,924,550	\$73,796,700

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

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: 108

1, 2014, in addition to the adult dental benefits which include services for pregnant women, emergency services, Federally Required Adult Dental Services (FRADs), services provided at an Intermediate Care Facility/Skilled Nursing Facility, and services for Department of Developmental Services consumers. Effective January 1, 2018, the full restoration of adult dental benefits includes the remaining services which were not restored in 2014, such as restorative services (crowns), prosthodontic services (partial dentures), and endodontic services (root canals). The impact of the restoration of adult dental benefits is included in the capitation rates.

The Medi-Cal DMC plan contracts establish a single-sided risk corridor in the form of a minimum Medical Loss Ratio (MLR) of 85% for the FY 2019-20, July 1, 2020, through December 31, 2020, and CY 2021 rating periods. The Department will require DMC plans to remit necessary funds that do not meet the 85% threshold. The necessary data to perform the calculation is not currently available, thus an estimated net recoupment/payment is unable to be determined at this time. However, the Department expects any recoupments or payments to occur no later than FY 2022-23.

The CalAIM Dental Benefits and Pay-For-Performance initiatives (CalAIM Dental) will begin January 1, 2022. Components for these initiatives involve performance payments for preventive services rendered to adults and children, and statewide coverage for new benefits Caries Risk Assessment Bundle and Silver Diamine Fluoride.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is an increase due to increased eligible counts and rates. The change from FY 2021-22 to FY 2022-23, 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 or CalAIM Dental is captured in their respective policy changes.
3. 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 2021-22	Total Member Months	Average Monthly Eligibles	Total Costs
Adult - GMC	3,170,004	264,167	\$33,238,265
Child - GMC	2,586,648	215,554	\$36,527,447
Adult - PHP	3,245,472	270,456	\$29,243,865
Child - PHP	1,556,664	129,722	\$17,311,407

DENTAL MANAGED CARE (Other M/C)
BASE POLICY CHANGE NUMBER: 108

FY 2022-23	Total Member Months	Average Monthly Eligibles	Total Costs
Adult - GMC	3,170,004	264,167	\$34,335,128
Child - GMC	2,586,648	215,554	\$37,732,852
Adult - PHP	3,245,472	270,456	\$30,208,912
Child - PHP	1,556,664	129,722	\$17,882,684

Funding:

FY 2021-22	TF	GF	FF
Regular FMAP T19	\$78,920,000	\$39,460,000	\$39,460,000
ACA 90% FFP/10% GF (2020)	\$31,083,000	\$3,108,000	\$27,975,000
Title 21 65% FFP/35% GF	\$5,369,000	\$1,879,000	\$3,490,000
Total	\$115,372,000	\$44,447,000	\$70,925,000

FY 2022-23	TF	GF	FF
Regular FMAP T19	\$82,116,000	\$41,058,000	\$41,058,000
ACA 90% FFP/10% GF (2020)	\$32,342,000	\$3,234,000	\$29,108,000
Title 21 65% FFP/35% GF	\$5,586,000	\$1,955,000	\$3,631,000
Total	\$120,044,000	\$46,247,000	\$73,797,000

*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)

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

SENIOR CARE ACTION NETWORK (Other M/C)

BASE POLICY CHANGE NUMBER: 110
IMPLEMENTATION DATE: 2/1985
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 61

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$62,378,000	\$67,187,000
- STATE FUNDS	\$31,189,000	\$33,593,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$62,378,000	\$67,187,000
STATE FUNDS	\$31,189,000	\$33,593,500
FEDERAL FUNDS	\$31,189,000	\$33,593,500

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

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. Expansion to San Diego County is anticipated effective January 1, 2023. 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:

There is no change from the prior estimate for FY 2021-22. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due projected Calendar Year (CY) 2022 and CY 2023 rates, and additional costs related to health plan expansion into San Diego County as of CY 2023.

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 14,048 in FY 2021-22 and 14,473 in FY 2022-23.

SENIOR CARE ACTION NETWORK (Other M/C)

BASE POLICY CHANGE NUMBER: 110

3. The CY 2021 rates are final rates.
4. CY 2022 and CY 2023 rates were projected by trending forward the CY 2021 final rates.
5. Assume one month of FY 2020-21 payments and 11 months of FY 2021-22 are paid in FY 2021-22.
6. Assume one month of FY 2021-22 payments and 11 months of FY 2022-23 are paid in FY 2022-23.
7. Anticipated costs on a cash basis are:

(Dollars in Thousands)

FY 2021-22	Costs	Eligible Months	Avg. Monthly Enrollment
Los Angeles	\$38,825	116,712	9,726
Riverside	\$11,304	30,480	2,540
San Bernardino	\$7,202	21,384	1,782
FY 2021-22*	\$57,330	168,576	14,048
FY 2020-21**	\$5,048		
Total FY 2021-22	\$62,378		

(Dollars in Thousands)

FY 2022-23	Costs	Eligible Months	Avg. Monthly Enrollment
Los Angeles	\$41,352	116,712	9,726
Riverside	\$11,906	30,480	2,540
San Bernardino	\$7,591	21,384	1,782
San Diego	\$930	2,125	425
FY 2022-23*	\$61,778	170,701	14,473
FY 2021-22**	\$5,409		
Total FY 2022-23	\$67,187		

*Assumes 11 months of capitation payments.

**Assumes 1 month of capitation payments.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2021-22	\$62,378	\$31,189	\$31,189
FY 2022-23	\$67,187	\$33,593	\$33,594

SENIOR CARE ACTION NETWORK (Other M/C)
BASE POLICY CHANGE NUMBER: 110

Funding:

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

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change

AIDS HEALTHCARE CENTERS (Other M/C)

BASE POLICY CHANGE NUMBER: 112
IMPLEMENTATION DATE: 5/1985
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 63

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$12,383,000	\$6,816,000
- STATE FUNDS	\$6,191,500	\$3,408,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$12,383,000	\$6,816,000
STATE FUNDS	\$6,191,500	\$3,408,000
FEDERAL FUNDS	\$6,191,500	\$3,408,000

Purpose:

This policy change estimates the cost of capitation rates for Positive Healthcare, which is the Medi-Cal managed care plan operated by AIDS Healthcare Foundation (AHF).

Authority:

Welfare & Institutions Code 14088.85

Interdependent Policy Changes:

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

Background:

The HIV/AIDS capitated case management project in Los Angeles became operational in April 1995.

The Department held a contract with AHF as a Primary Care Case Management (PCCM) plan through June 30, 2019. Effective July 1, 2019, AHF 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 and changed plan pharmacy coverage.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a decrease due to updated CY 2022 rates excluding pharmacy.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to updated CY 2022 rates and projected CY 2023 rates excluding pharmacy.

Methodology:

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

AIDS HEALTHCARE CENTERS (Other M/C)

BASE POLICY CHANGE NUMBER: 112

Member Months	Dual	Medi-Cal Only
CY 2021	3,400	4,305
CY 2022	3,400	4,305
CY 2023	3,400	4,305

2) Assume the following paid rates:

Paid Rates	Dual	Medi-Cal Only
CY 2021	\$93.46	\$3,749.45
CY 2022	\$92.87	\$1,477.51
CY 2023	\$97.52	\$1,551.38

*On a cash basis, assume a one-month lag from service month to payment month.

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

FY 2021-22	Year	Paid Rate	MM	TF
Dual	CY 2021	\$93.46	1,983	\$185,000
Medi-Cal Only	CY 2021	\$3,749.45	2,511	\$9,416,000
Dual	CY 2022	\$92.87	1,417	\$132,000
Medi-Cal Only	CY 2022	\$1,477.51	1,794	\$2,650,000
Total	N/A	N/A	N/A	\$12,383,000

FY 2022-23	Year	Paid Rate	MM	TF
Dual	CY 2022	\$92.87	1,983	\$184,000
Medi-Cal Only	CY 2022	\$1,477.51	2,511	\$3,710,000
Dual	CY 2023	\$97.52	1,417	\$138,000
Medi-Cal Only	CY 2023	\$1,551.38	1,794	\$2,783,000
Total**	N/A	N/A	N/A	\$6,816,000

FY 2021-22	TF	GF	FF
Dual	\$317,000	\$158,000	\$158,000
Medi-Cal Only	\$12,066,000	\$6,033,000	\$6,033,000
Total FY 2021-22**	\$12,383,000	\$6,191,000	\$6,192,000

FY 2022-23	TF	GF	FF
Dual	\$322,000	\$161,000	\$161,000
Medi-Cal Only	\$6,493,000	\$3,247,000	\$3,247,000
Total FY 2022-23**	\$6,816,000	\$3,408,000	\$3,408,000

**Difference due to rounding.

AIDS HEALTHCARE CENTERS (Other M/C)
BASE POLICY CHANGE NUMBER: 112

Funding:

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

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change

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

BASE POLICY CHANGE NUMBER: 115
IMPLEMENTATION DATE: 3/2018
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 66

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$1,547,000	\$1,624,000
- STATE FUNDS	\$1,547,000	\$1,624,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,547,000	\$1,624,000
STATE FUNDS	\$1,547,000	\$1,624,000
FEDERAL FUNDS	\$0	\$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 diagnosed 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 was determined Family Mosaic Project capitation rates for calendar year (CY) 2014 to current were not compliant with actuarial standards, therefore, federal funding was 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 was used to return the previously claimed federal funding back to CY 2014. It is the Department's intention to implement a system fix to ensure going forward 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 2021-22, is an increase due to updated draft CY 2022 rates.

FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)
BASE POLICY CHANGE NUMBER: 115

The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to projected CY 2022 and CY 2023 rate growth.

Methodology:

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

- 413 in FY 2020-21
- 413 in FY 2021-22
- 413 in FY 2022-23

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

- \$3,669.62 for July 1, 2019 through December 31, 2020 (Bridge Period)
- \$3,669.62 in CY 2021
- \$3,853.10 in CY 2022
- \$4,045.76 in CY 2023

3) Anticipated costs on a cash basis are:

Fiscal Year	TF	GF	FF
FY 2021-22	\$1,547,000	\$1,547,000	\$0
FY 2022-23	\$1,624,000	\$1,624,000	\$0

Dollars include a one-month managed care payment lag.

Funding:

100% State GF (4260-101-0001)

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

BASE POLICY CHANGE NUMBER: 198
IMPLEMENTATION DATE: 7/1988
ANALYST: Joulia Dib
FISCAL REFERENCE NUMBER: 76

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$3,872,619,000	\$4,150,941,000
- STATE FUNDS	\$2,121,445,000	\$2,276,476,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,872,619,000	\$4,150,941,000
STATE FUNDS	\$2,121,445,000	\$2,276,476,000
FEDERAL FUNDS	\$1,751,174,000	\$1,874,465,000

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

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 2021-22 were revised up 3.1% because:

- Actual 2022 premiums are used in this estimate and they are \$3.00 higher for Part A and \$12.40 higher for Part B than assumed premiums in the prior estimate; and
- Three months of higher expenditures from the temporary suspension of eligibility redeterminations as required by the Families First Coronavirus Response Act (FFCRA) are included in this estimate.

Expenditures are projected to grow 7.2% between FY 2021-22 and FY 2022-23 due to:

- A projected increase in the Part A premium of \$11.00 and Part B premium of \$5.97 between 2022 and 2023.
- The FY 2022-23 increase is partially offset by three months of actual expenditures in FY 2021-22 that include the caseload increase resulting from the FFCRA temporary

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

BASE POLICY CHANGE NUMBER: 198

suspension of eligibility redeterminations. Projections are based on the historical trend absent this temporary increase in caseload from the FFCRA.

Premiums:

Calendar Year	2021	2022		2023
	Actual	May 2021 Estimate	Nov 2021 Actual	Nov 2021 Estimate
Part A	\$471.00	\$496.00	\$499.00	\$510.00
Part B	\$148.50	\$157.70	\$170.10	\$176.07

Average Monthly Beneficiaries:

FY	2020-21	2021-22		2022-23
	Actual	May 2021 Estimate	Nov 2021 Estimate	Nov 2021 Estimate
Part A	169,600	168,100	166,800	165,300
Part B	1,485,000	1,444,300	1,466,200	1,459,000

Methodology:

- The Centers for Medicare and Medicaid set the following premiums for 2021 and 2022.

Calendar Year	Part A	Part B
2021	\$471.00	\$148.50
2022	\$499.00	\$170.10

- For 2023, the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance is projecting a 2.20% growth in the Medicare Part A premium. Applying this growth to the prior year Part A premium calculates as $\$499.00 \times 1.022 = \510.00 (rounded).
- For 2023, the Medicare Part B premium is projected to grow 3.51% based on the average growth for 2019 to 2021. Applying this growth to the prior year Part B premium calculates as $\$170.10 \times 1.0351 = \176.07 (rounded).

FY 2021-22	Part A	Part B
Average Monthly Beneficiaries	166,800	1,466,200
Rate 07/2021-12/2021	\$471.00	\$148.50
Rate 01/2022-06/2022	\$499.00	\$170.10
FY 2022-23	Part A	Part B
Average Monthly Beneficiaries	165,300	1,459,000
Rate 07/2022-12/2022	\$499.00	\$170.10
Rate 01/2023-06/2023	\$510.00	\$176.07

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

BASE POLICY CHANGE NUMBER: 198

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 that are not already reflected in expenditures 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 are budgeted in the COVID-19 Increased FMAP – DHCS and COVID-19 Increased FMAP Extension policy changes.

5. Effective December 1, 2020, State law requires all countable income over 100% and up to 138% of the Federal Poverty Level (FPL) be disregarded after taking all other disregards, deductions, and exclusions into account for those persons eligible under the program for aged and disabled persons. This resulted in some individuals shifting between aid categories making them eligible for Medicare Part B premiums. The increase in beneficiaries that are not already reflected in actual expenditures are budgeted in the FPL Increase for Aged and Disabled Persons policy change.

Funding:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
Title XIX 50/50	\$3,462,936	\$1,731,468	\$1,731,468
State GF 100%	\$389,977	\$389,977	\$0
Title XIX 100% FFP	\$19,706	\$0	\$19,706
Total	\$3,872,619	\$2,121,445	\$1,751,174

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Title XIX 50/50	\$3,706,138	\$1,853,069	\$1,853,069
State GF 100%	\$423,407	\$423,407	\$0
Title XIX 100% FFP	\$21,396	\$0	\$21,396
Total	\$4,150,941	\$2,276,476	\$1,874,465

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

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

BASE POLICY CHANGE NUMBER: 199
IMPLEMENTATION DATE: 7/1990
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 23

	FY 2021-22	FY 2022-23
FULL YEAR COST - TOTAL FUNDS	\$2,884,536,000	\$2,906,112,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,884,536,000	\$2,906,112,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$2,884,536,000	\$2,906,112,000

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

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: 199

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.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is a net increase due to a decrease in FY 2021-22 expenditures, which is being driven by a slower than expected return to pre-COVID service utilization, and offset by prior year expenditures that were received and invoiced later than had previously been anticipated to be paid in FY 2020-21.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to the assumption that service utilization will return to and exceed pre-COVID levels in FY 2022-23.

Methodology:

1. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension 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 2021-22	\$5,352,700	\$2,468,164	\$2,676,350	\$208,186
FY 2022-23	\$5,730,358	\$2,824,246	\$2,864,907	\$41,205

Funding:

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

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

PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 200
IMPLEMENTATION DATE: 4/1993
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 22

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$2,627,091,000	\$2,762,975,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,627,091,000	\$2,762,975,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$2,627,091,000	\$2,762,975,000

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

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: 200

The Governor's Budget estimates the CCI project will no longer be cost-effective. Therefore, pursuant to the provisions of current law, the program was discontinued in FY 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 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.

Reason for Change:

The change for FY 2021-22, from the previous estimate, is a decrease due to updated expenditure data provided by CDSS and the temporary increased federal funding for COVID-19. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to updated expenditure data provided by CDSS.

Methodology:

1. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through December 31, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022, on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.
2. The following estimates were provided by CDSS on a cash basis.

(Dollars in Thousands)

FY 2021-22	TF	FFP	CDSS GF/ County Share
PCSP/IPO	\$4,945,240	\$2,472,620	\$2,472,620
FFCRA	\$0	\$154,471	(\$154,471)
Total	\$4,945,240	\$2,627,091	\$2,318,149
FY 2022-23	TF	FFP	CDSS GF/ County Share
PCSP/IPO	\$5,525,950	\$2,762,975	\$2,762,975
Total	\$5,525,950	\$2,762,975	\$2,762,975

Funding:

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

FFCRA 6.2% Increased FFP (4260-106-0890)

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER: 201
IMPLEMENTATION DATE: 1/2006
ANALYST: Joulia Dib
FISCAL REFERENCE NUMBER: 1019

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$2,460,939,000	\$2,726,559,000
- STATE FUNDS	\$2,460,939,000	\$2,726,559,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,460,939,000	\$2,726,559,000
STATE FUNDS	\$2,460,939,000	\$2,726,559,000
FEDERAL FUNDS	\$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 Caseload Impact
 COVID-19 Increased FMAP – DHCS
 COVID-19 Increased FMAP Extension

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: 201

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

<u>Calendar Year</u>	<u>PMPM rate</u>
2019	\$127.31
2020	\$133.94
2021	\$137.76
2022	\$147.83
2023	\$154.47 (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
FY 2018-19	\$2,138,142,285	1,417,617
FY 2019-20	\$2,210,196,898	1,422,203
FY 2020-21	\$2,009,620,969	1,479,629

Reason for Change:

Expenditures for FY 2021-22 are 1.7% lower than the prior estimate because actuals include three months of the reduction in PMPM rate resulting from the Families First Coronavirus Response Act (FFCRA). This is partly offset by three months of increases in beneficiaries resulting from the FFCRA temporary suspension of eligibility redeterminations.

The increase in projected expenditures between FY 2021-22 and FY 2022-23 of 10.8% is due to:

- An estimated increase in the PMPM rate of \$6.64 for 2023,
- FY 2021-22 includes three months of increases in beneficiaries resulting from the FFCRA temporary suspension of eligibility redeterminations and an estimated growth in average monthly beneficiaries of 0.96% based on the historical trend; and
- FY 2021 -22 includes three months of the reduction in PMPM rate resulting from the Families First Coronavirus Response Act (FFCRA).

The projected reduction in payments from FFCRA that are not already reflected in expenditures are budgeted in the COVID-19 Increased FMAP – DHCS policy change. The projected increase in caseload from the FFCRA temporary suspension of eligibility redeterminations that are not already reflected in expenditures are budgeted in the COVID-19 Caseload Impact policy change.

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER: 201

Methodology:

1. 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.
2. The 2022 growth increased 7.31% over 2021 amounts per the *Centers for Medicare & Medicaid Services*. Medi-Cal's PMPM rate for 2022 is \$147.83.
3. The 2023 growth is estimated to increase 4.49% over 2022 amounts per the *Centers for Medicare & Medicaid Services*. Medi-Cal's estimated PMPM rate for 2023 is \$154.47.
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 2016 to July 2021.
6. The Phased-down Contribution is funded 100% by State General Fund.
7. 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 that are not already reflected in expenditures are budgeted in the COVID-19 Caseload Impact policy change.

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, for 2021 by \$17.08 below the \$137.76 PMPM, and for 2022 by \$18.33 below the \$147.83 PMPM. FY 2020-21 included a billing adjustment for the retroactive rate change for January to May 2020, and the reduced PMPM rate through end of the FY 2020-21. FY 2021-22 includes three months of savings from the reduced PMPM rate, which are already reflected in expenditures. Savings from the reduced PMPM not already reflected in actuals are budgeted in the COVID-19 Increased FMAP – DHCS policy change.

	Payment Months	Est. Ave. Monthly Beneficiaries	Est. Ave. Monthly Cost	Total Cost
FY 2021-22	12	1,499,829	\$205,078,300	\$2,460,939,000
FY 2022-23	12	1,514,172	\$227,213,300	\$2,726,559,000

Funding:

100% GF (4260-101-0001)

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

DENTAL SERVICES

BASE POLICY CHANGE NUMBER: 202
IMPLEMENTATION DATE: 7/1988
ANALYST: Devon Dyer
FISCAL REFERENCE NUMBER: 135

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$1,634,647,000	\$1,606,321,000
- STATE FUNDS	\$653,481,450	\$642,358,450
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,634,647,000	\$1,606,321,000
STATE FUNDS	\$653,481,450	\$642,358,450
FEDERAL FUNDS	\$981,165,550	\$963,962,550

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

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: 202

Reason for Change:

Expenditures are projected to be higher in FY 2021-22 as compared to the prior estimate due to an increased number of users and utilization. Dental offices have returned to full capacity after California resumed most normal business operations as part of the decline in COVID-19 cases and economic reopening.

Expenditures are projected to decrease between fiscal years in the current estimate due to FY 2021-22 including one month of increased actual expenditures due to dental offices reaching full capacity after California resumed most normal business operations as part of the decline in COVID-19 cases and economic reopening.

Methodology:

1. Dental expenditures are estimated using 36-months of cash-basis expenditure data (August 2018-July 2021) 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 are included in the BCCTP policy change.

Funding:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF	\$1,067,336	\$533,668	\$533,668
ACA 90% FFP/10% GF (2020)	\$315,917	\$31,592	\$284,325
65% Title XXI/35% GF (10/2020)	\$250,945	\$87,831	\$163,114
Title XIX 100% GF	\$391	\$391	\$0
Title XIX 100% FFP	\$58	\$0	\$58
Total	\$1,634,647	\$653,482	\$981,165

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF	\$1,047,962	\$523,981	\$523,981
ACA 90% FFP/10% GF (2020)	\$309,112	\$30,911	\$278,201
65% Title XXI/35% GF (10/2020)	\$248,805	\$87,082	\$161,723
Title XIX 100% GF	\$384	\$384	\$0
Title XIX 100% FFP	\$57	\$0	\$57
Total	\$1,606,321	\$642,359	\$963,962

COVID-19 funding through December 31, 2021 is identified in the COVID 19 Increased FMAP – DHCS policy change
 COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

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

BASE POLICY CHANGE NUMBER: 204
IMPLEMENTATION DATE: 7/1991
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 26

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$274,637,000	\$288,961,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$274,637,000	\$288,961,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$274,637,000	\$288,961,000

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

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.

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.

TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)
BASE POLICY CHANGE NUMBER: 204

Reason for Change:

The change in FY 2021-22, from the prior estimate, is a net increase due to updated rates, and methodology updated to assume 75% of funding in current year rather than 83%.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to increases in paid expenditures from FY 2021-22 to FY 2022-23, offset by prior year expenditures in FY 2021-22.

Methodology:

1. The 6.2% Title XIX FFCRA increased FMAP for expenditures through December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	DHCS FFP	FFCRA	Total FFP
FY 2021-22	\$510,406	\$235,769	\$255,203	\$19,434	\$274,637
FY 2022-23	\$569,782	\$280,821	\$284,891	\$4,070	\$288,961

Funding:

100% Title XIX (4260-101-0890)

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

DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

BASE POLICY CHANGE NUMBER: 214
IMPLEMENTATION DATE: 7/1997
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 77

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$28,466,000	\$25,070,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$28,466,000	\$25,070,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$28,466,000	\$25,070,000

Purpose:

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

Authority:

Interagency Agreement (IA) 03-75282
 IA 03-75283
 Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

COVID-19 Increased FMAP Extension

Background:

The Department entered into an IA with CDDS to reimburse the Federal Financial Participation (FFP) for Medi-Cal clients served at DCs and SOFs. There are two DCs and one SOF 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 SOFs 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.

DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

BASE POLICY CHANGE NUMBER: 214

Reason for Change:

The change in FY 2021-22, from the prior estimate is a decrease due to a lower number of consumers and a lower settlement figure than previously anticipated.

The change from FY 2021-22 to FY 2022-23, in the current estimate is a decrease due to anticipating a further decrease in consumers and lower settlement figures for claims in FY 2022-23.

Methodology:

- The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.

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

(Dollars in Thousands)

Fiscal Year	Total Funds	CDDS GF	FFP Regular	FFCRA
FY 2021-22	\$54,945	\$26,479	\$27,804	\$662
FY 2022-23	\$50,637	\$25,567	\$25,070	\$0

Funding:

100% Title XIX (4260-101-0890)

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

LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER: 215
IMPLEMENTATION DATE: 7/2017
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 2080

	FY 2021-22	FY 2022-23
FULL YEAR COST - TOTAL FUNDS	\$33,860,000	\$10,949,000
- STATE FUNDS	\$16,930,000	\$5,474,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$33,860,000	\$10,949,000
STATE FUNDS	\$16,930,000	\$5,474,500
FEDERAL FUNDS	\$16,930,000	\$5,474,500

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:

The State Legislature appropriates funds 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 for FY 2021-22, from the prior estimate, is an increase due to a shift in timing for lawsuit/settlement payments.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to fewer settlement and lawsuit payments expected to be made.

LAWSUITS/CLAIMS
BASE POLICY CHANGE NUMBER: 215

Methodology:

FY 2021-22	Total Amount
Attorney Fees	
Schwartz v. Nevada County Board of Supervisors, et al.	\$1,000
Total	\$1,000
Provider Settlements	
Vibra Rehabilitation Hospital of San Bernardino (dba Ballard Rehabilitation Hospital) v. DHCS	\$70,000
Total	\$70,000
Other Attorneys Fees	
Independent Living Center, et al. v. Kent, et al. (Friedman)	\$8,194,000
Total	\$8,194,000
<u>Other Provider Settlements</u>	
LA Care	\$24,940,000
AHF	(\$624,000)
Total	\$24,316,000
FY 2021-22 Total (rounded)	\$32,581,000
FY 2022-23	
Other Provider Settlements	
LA Care	\$9,599,000
Total	\$9,599,000
FY 2022-23 Total (rounded)	\$9,599,000

LAWSUITS/CLAIMS
BASE POLICY CHANGE NUMBER: 215

FY 2021-22			
	Committed	Balance	Budgeted
Attorney Fees <\$30,000	\$1,000	\$199,000	\$200,000
Provider Settlements <\$100,000	\$70,000	\$930,000	\$1,000,000
Beneficiary Settlements <\$10,000	\$0	\$150,000	\$150,000
Small Claims Court	\$0	\$0	\$0
Other Attorney Fees	\$8,194,000	\$0	\$8,194,000
Other Provider Settlements	\$24,316,000	\$0	\$24,316,000
Other Beneficiary Settlements	\$0	\$0	\$0
Interest Paid	\$0	\$0	\$0
Totals (Rounded)	\$32,581,000	\$1,279,000	\$33,860,000

FY 2022-23	
	Budget
Attorney Fees<\$30,000;Provider Settlements<\$100,000; Beneficiary Settlements<\$10,000	\$0
Other Attorney Fees	\$1,350,000
Other Provider Settlements	\$9,599,000
Other Beneficiary Settlements	\$0
Interest Paid	\$0
Totals (Rounded)	\$10,949,000

Funding:

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

MEDI-CAL TCM PROGRAM

BASE POLICY CHANGE NUMBER: 216
IMPLEMENTATION DATE: 6/1995
ANALYST: Neejkajsiab Yang
FISCAL REFERENCE NUMBER: 27

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$30,211,000	\$27,476,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$30,211,000	\$27,476,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$30,211,000	\$27,476,000

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

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.

MEDI-CAL TCM PROGRAM

BASE POLICY CHANGE NUMBER: 216

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to:

- The completion of audit reports for several FYs used to update the reconciliation numbers, resulting in the LGAs refunding the Department causing a decrease from the prior estimate.
- Updated SPA impact for regular claims and added SPA impact for Affordable Care Act (ACA) claims.
- The FFCRA increased FMAP claims for FY 2019-20 and FY 2020-21 were delayed to FY 2021-22.
- Identified ineligible encounters which decreased the regular and ACA base averages, due to Unsatisfactory Immigration Status clients.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to the SPA impact increase 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 \$26,554,000 (regular invoices) and \$2,881,000 (ACA invoices) for FY 2021-22 and FY 2022-23, are based on average expenditures from FY 2015-16 through FY 2020-21 for regular and ACA payments. The FY 2020-21 expenditures are excluded from the projected base payments due to an artificially low amount of FFP paid out this year due to system updates.
3. In FY 2021-22 and FY 2022-23, the Department will complete reconciliations for FY 2012-13 through FY 2020-21.
4. In FY 2021-22, the Department anticipates an increase of \$2,054,000 in payments due to the SPA impact of LGAs opting in or out of the TCM program by adding or deleting TCM target populations.
5. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures for dates of service through December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.

MEDI-CAL TCM PROGRAM
BASE POLICY CHANGE NUMBER: 216

6. On a cash basis, the FFCRA increased FMAP for dates of service FY 2019-20 and 2020-21 is expected to be paid in FY 2021-22. The FFCRA increased FMAP for FY 2021-22 is expected to be paid in FY 2022-23.

FY 2021-22	TF	FF	FFCRA
FY 2020-21 Base (Average Expenditures)	\$26,554,000	\$26,554,000	\$0
FY 2020-21 Base (ACA Expenditures)	\$2,881,000	\$2,881,000	\$0
6.2% FMAP Increase (FY 2019-20)	\$379,000	\$0	\$379,000
6.2% FMAP Increase (FY 2020-21)	\$1,646,000		\$1,646,000
SPA Impact			
Regular Claims	\$1,849,000	\$1,849,000	\$0
ACA Claims	\$205,000	\$205,000	\$0
Reconciliation			
Regular Claims	(\$2,558,000)	(\$2,558,000)	\$0
ACA Claims	(\$745,000)	(\$745,000)	\$0
Total FY 2021-22	\$30,211,000	\$28,186,000	\$2,025,000

FY 2022-23	TF	FF	FFCRA
FY 2021-22 Base (Average Expenditures)	\$26,554,000	\$26,554,000	\$0
FY 2021-22 Base (ACA Expenditures)	\$2,881,000	\$2,881,000	\$0
6.2% FMAP Increase (FY 2022-23)	\$823,000	\$0	\$823,000
Reconciliation			
Regular Claims	(\$2,092,000)	(\$2,092,000)	\$0
ACA Claims	(\$690,000)	(\$690,000)	\$0
Total FY 2022-23	\$27,476,000	\$26,653,000	\$823,000

Funding:

100% Title XIX FFP (4260-101-0890)
100% Title XIX ACA (4260-101-0890)
FFCRA 6.2% Increased FFP (4260-101-0890)

HIPP PREMIUM PAYOUTS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 235
IMPLEMENTATION DATE: 1/1993
ANALYST: Neejkajsiab Yang
FISCAL REFERENCE NUMBER: 91

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$476,000	\$234,000
- STATE FUNDS	\$238,000	\$117,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$476,000	\$234,000
STATE FUNDS	\$238,000	\$117,000
FEDERAL FUNDS	\$238,000	\$117,000

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

Interdependent Policy Changes:

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

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 will change managed care enrollment to include members with other health coverage, which may decrease HIPP enrollment members. The CalAIM changes are anticipated with an effective date of January 1, 2022.

Reason for Change:

The change in FY 2021-22 from the prior estimate, and from FY 2021-22 to FY 2022-23 in the current estimate, is a decrease due to a reduction in program enrollment effective January 2022.

HIPP PREMIUM PAYOUTS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 235

Methodology:

1. HIPP premium costs are determined by:
 - Actual premium expenses for July 2020 through June 2021,
 - Projected premium expense for July 2021 through June 2023,
 - The average per member per month (PMPM) premium amount,
 - Current member count,
 - The assumption that premium costs will increase by 5% each fiscal year based on historical trends,
 - The assumption that eight HIPP beneficiaries in foster youth aid code will continue their HIPP program eligibility, and
 - The assumption that approximately 25% of the remaining HIPP beneficiaries (less those 8 beneficiaries in foster youth aid codes) will continue their HIPP program eligibility for a period of 12 months under a Medical Exemption Request.
2. The average PMPM premium cost including ancillary costs is estimated to be \$515 in FY 2021-22 and \$541 in FY 2022-23.
3. The average monthly HIPP enrollment is estimated to be 118 for July 2021 through December 2021, 36 for January 2022 through June 2022, and 36 for FY 2022-23.
4. Costs for FY 2021-22 and FY 2022-23 are estimated to be:

For July 2021 through December 2021, \$515 (average PMPM premium cost) x 118 (current member count) x 6 months = \$365,000 TF (rounded)

For January 2022 through June 2022, \$ 515 (average PMPM premium cost) x 36 (estimated member count) x 6 months = \$111,000 (rounded)

FY 2022-23: \$541 (average PMPM premium cost) x 36 (estimated member count x 12 months = \$234,000 TF (rounded)

Fiscal Year	TF	GF	FF
FY 2021-22	\$476,000	\$238,000	\$238,000
FY 2022-23	\$234,000	\$117,000	\$117,000

Funding:

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

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change

CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 237
IMPLEMENTATION DATE: 7/2021
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 1083

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$737,000	\$1,113,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$737,000	\$1,113,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$737,000	\$1,113,000

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 a decrease due to updated payment timing and estimated payment values.

The change in the current estimate from FY 2021-22 to FY 2022-23 in the current estimate, is an increase due to updated projected payment timing and estimated payment values.

Methodology:

1. Cash basis expenditures vary from year-to-year based on when claims are actually paid.
2. The estimated expenditures on a cash basis for **FY 2021-22** are **\$737,000 Federal Funds** and for **FY 2022-23** they are **\$1,113,000 Federal Funds**.

Funding:

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

BASE RECOVERIES

BASE POLICY CHANGE NUMBER: 250
IMPLEMENTATION DATE: 7/1987
ANALYST: Celine Donaldson
FISCAL REFERENCE NUMBER: 127

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$399,732,000	-\$425,862,000
- STATE FUNDS	-\$168,305,600	-\$179,307,850
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$399,732,000	-\$425,862,000
STATE FUNDS	-\$168,305,600	-\$179,307,850
FEDERAL FUNDS	-\$231,426,400	-\$246,554,150

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

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.

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.

BASE RECOVERIES

BASE POLICY CHANGE NUMBER: 250

FY 2021-22 recoveries continue to experience the ongoing impact of public health emergency which can be seen in additional months of actual recovery data. For prospective months, projections have been returned to normal levels (pre-COVID-19) for this policy change. The projected impact of the public health emergency is estimated in the COVID-19 Base Recoveries policy change.

Overall, FY 2021-22 recovery collections are projected to be slightly lower than the prior estimate due to general collection projections including one month of actual recoveries data reflecting the ongoing impact of the public health emergency.

In the current estimate, recoveries are projected to increase in FY 2022-23 due to:

- Increases in general and personal injury collections based on the historical trend absent the impact of the public health emergency.
- The prior estimate included additional one-time recovery efforts for health insurance recoveries related to dental and Managed Care plans to occur in FY 2020-21. These one-time collections were postponed to FY 2021-22 due operational delays resulting from the public health emergency and are estimated in the COVID-19 Base Recoveries policy change. In this policy change, FY 2022-23 ongoing collections for these additional health insurance recoveries.

(Dollars in Thousands)

Recovery Type	FY 2021-22	FY 2022-23
Personal Injury Collections	(\$121,758)	(\$123,236)
Workers' Comp. Collections	(\$2,089)	(\$2,339)
Health Insurance Collections	(\$75,100)	(\$92,600)
General Collections	(\$200,785)	(\$207,687)
TOTAL	(\$399,732)	(\$425,862)

Methodology:

1. The recoveries estimate uses the trend in monthly recoveries for July 2018 – July 2021.

BASE RECOVERIES
BASE POLICY CHANGE NUMBER: 250

Funding:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	(\$320,818)	(\$160,409)	(\$160,409)
Title XIX 65 FF / 35 GF (4260-101-0890/0001)	(\$4,416)	(\$1,546)	(\$2,870)
Title XIX FFP (4260-101-0890)	(\$10,988)	\$0	(\$10,988)
90% Title XIX ACA FF / 6% GF (4260-101-0890/0001)	(\$63,510)	(\$6,351)	(\$57,159)
TOTAL	(\$399,732)	(\$168,306)	(\$231,426)

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	(\$341,790)	(\$170,895)	(\$170,895)
Title XIX 65 FF / 35 GF (4260-101-0890/0001)	(\$4,705)	(\$1,647)	(\$3,058)
Title XIX FFP (4260-101-0890)	(\$11,706)	\$0	(\$11,706)
90% Title XIX ACA FF / 6% GF (4260-101-0890/0001)	(\$67,661)	(\$6,766)	(\$60,895)
TOTAL	(\$425,862)	(\$179,308)	(\$246,554)

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

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POSTPARTUM CARE EXTENSION

REGULAR POLICY CHANGE NUMBER: 1
IMPLEMENTATION DATE: 7/2022
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2276

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$290,975,000
- STATE FUNDS	\$0	\$143,613,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$290,975,000
STATE FUNDS	\$0	\$143,613,000
FEDERAL FUNDS	\$0	\$147,362,000

Purpose:

This policy change estimates the benefit costs of extending postpartum care to individuals who are currently pregnant and receiving Medi-Cal pregnancy-related services, from the last day of their pregnancy for an additional 12 months.

Authority:

American Rescue Plan (ARP) Act (2021)
SPA 21-032

Interdependent Policy Changes:

COVID-19 Caseload Impact

Background:

Medi-Cal provides coverage for pregnancy and pregnancy-related services, including postpartum care for individuals who are pregnant. Prior to SB 104 (Chapter 67, Statutes of 2019), postpartum care was terminated 60 days after the last day of pregnancy. SB 104 extended postpartum care for up to 12 months after the last day of pregnancy specifically for beneficiaries who receive pregnancy-related services and are diagnosed with a mental health condition.

The passage of ARP allows a Medicaid eligible individual who is receiving pregnancy-related services to remain eligible for Medi-Cal postpartum care for an additional 12 months after the last day of their 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 Coronavirus Disease 2019 (COVID-19) Caseload Impact policy change captures individuals who would have otherwise been disenrolled during the public health emergency (PHE) after their postpartum care coverage ended. The federal PHE is assumed to end on June 30, 2022. These individuals will maintain their current coverage until the implementation of this policy, regardless of the end of the PHE.

POSTPARTUM CARE EXTENSION

REGULAR POLICY CHANGE NUMBER: 1

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a decrease due extending the assumed PHE end date to June 30, 2022. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to implementation costs occurring in FY 2022-23 after the assumed PHE end date.

Methodology:

1. Assume this population would have otherwise not been eligible to receive services after the 60 day postpartum period.
2. Assume an April 1, 2022, effective date for this policy.
3. Assume the COVID-19 PHE period ends June 30, 2022, and costs for this program cannot be captured during the PHE period.

FY 2022-23	TF	GF	SF	FF
50% Title XIX FF / 50% GF	\$268,918,000	\$134,459,000	\$0	\$134,459,000
100% Title XXI	\$12,903,000	\$0	\$0	\$12,903,000
100% Perinatal Insurance Fund	\$9,154,000	\$0	\$9,154,000	\$0
Total	\$290,975,000	\$134,459,000	\$9,154,000	\$147,362,000

Funding:

50% Title XIX FF / 50% GF (4260-101-0890/0001)
 Perinatal Insurance Fund (4260-602-0309)
 Title XXI FFP (4260-113-0890)

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER: 2
IMPLEMENTATION DATE: 1/2002
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 3

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$59,142,000	\$59,789,000
- STATE FUNDS	\$23,296,850	\$23,533,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$59,142,000	\$59,789,000
STATE FUNDS	\$23,296,850	\$23,533,200
FEDERAL FUNDS	\$35,845,150	\$36,255,800

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
 COVID-19 Increased FMAP Extension – Other Admin

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: 2

Reason for Change:

The change from the prior estimate for FY 2021-22, is a decrease due to updating the enrollment and rates data for January 2021 through June 2021. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a slight increase due to higher expenditures anticipated in FY 2022-23.

Methodology:

1. As of June 2021, there were a total of 5,986 beneficiaries, of which 3,837 were in FFS and 2,149 were in managed care. Additionally, 2,197 of the FFS beneficiaries were eligible for State-Only services.
2. As of June 2021, 74 of the FFS beneficiaries were in accelerated enrollment.
3. Assume the State will pay Medicare and other health coverage premiums for an average of 192 beneficiaries monthly in FY 2021-22 and FY 2022-23. Assume an average monthly premium cost per beneficiary of \$150.05.
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 2021-22			FY 2022-23		
	TF	GF	FF	TF	GF	FF
Full Scope Costs	\$55,278	\$19,432	\$35,845	\$55,902	\$19,647	\$36,255
State-Only Services	\$3,353	\$3,353	\$0	\$3,374	\$3,374	\$0
State-Only Premiums	\$512	\$512	\$0	\$512	\$512	\$0
Total	\$59,142	\$23,297	\$35,845	\$59,789	\$23,534	\$36,255

* Totals may differ due to rounding.

BREAST AND CERVICAL CANCER TREATMENT
REGULAR POLICY CHANGE NUMBER: 2

Funding:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
General Fund 4260-101-0001	\$3,865	\$3,865	\$0
50 Title XIX FF / 50 GF (4260-101-0890/0001)	\$566	\$283	\$283
Title XIX 65 FF / 35 GF (4260-101-0890/0001)	\$54,711	\$19,149	\$35,562
FY 2021-22 Total	\$59,142	\$23,297	\$35,845
FY 2022-23	TF	GF	FF
General Fund 4260-101-0001	\$3,886	\$3,886	\$0
50 Title XIX FF / 50 GF (4260-101-0890/0001)	\$541	\$271	\$270
Title XIX 65 FF / 35 GF (4260-101-0890/0001)	\$55,362	\$19,377	\$35,985
FY 2022-23 Total	\$59,789	\$23,534	\$36,255

* Totals may differ due to rounding.

** COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change.

*** COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension and COVID-19 Increased FMAP Extension – Other Admin Policy Changes.

FPL INCREASE FOR AGED AND DISABLED PERSONS

REGULAR POLICY CHANGE NUMBER: 3
IMPLEMENTATION DATE: 1/2021
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2140

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$76,072,000	\$81,374,000
- STATE FUNDS	\$38,036,000	\$40,687,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	24.20 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$57,662,600	\$81,374,000
STATE FUNDS	\$28,831,290	\$40,687,000
FEDERAL FUNDS	\$28,831,290	\$40,687,000

Purpose:

This policy change estimates the 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 20-0045

Interdependent Policy Changes:

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

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.

Due to the impacts of the Coronavirus Disease 2019 (COVID-19) public health emergency, the original implementation date of August 1, 2020, was changed to December 1, 2020. On November 19, 2020, the Department received approval for State Plan Amendment (SPA) 20-0045 from the Centers for Medicare & Medicaid Services for a December 1, 2020, effective date. In November 2020, the Department issued formal county guidance and the Statewide Automated Welfare Systems updates were completed.

FPL INCREASE FOR AGED AND DISABLED PERSONS

REGULAR POLICY CHANGE NUMBER: 3

Reason for Change:

The change for FY 2021-22, in the current estimate, is a decrease due to the benefits portion of this policy change being budgeted in the statewide, fee-for-service, and managed care base. Since the completion of the December 2020 transition, this policy change will only continue to budget the Medicare Part B premiums for dual eligibles. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to an increase in Medicare Part B premiums.

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 the benefits portion of this policy are budgeted in the statewide, fee-for-service, and managed care base. This policy change will only continue to budget the Medicare Part B premiums for dual eligibles.
5. Assume an estimated cost of **\$76,072,000 (\$38,036,000 GF)** in FY 2021-22 and **\$81,374,000 (\$40,687,000 GF)** in FY 2022-23 for premiums.

Funding:

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

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

UNDOCUMENTED OLDER CALIFORNIANS EXPANSION

REGULAR POLICY CHANGE NUMBER: 4
IMPLEMENTATION DATE: 5/2022
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2294

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$52,532,000	\$589,846,000
- STATE FUNDS	\$41,611,000	\$496,061,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$52,532,000	\$589,846,000
STATE FUNDS	\$41,611,000	\$496,061,000
FEDERAL FUNDS	\$10,921,000	\$93,785,000

Purpose:

This policy change estimates the benefit costs to expand full-scope Medi-Cal benefits to adults 50 years of age or older, regardless of immigration status.

Authority:

AB 128 (Chapter 21, Statutes of 2021)

Interdependent Policy Changes:

COVID-19 Increased FMAP Extension

Background:

California provides restricted-scope Medi-Cal coverage (emergency and pregnancy related services only) to low income adults, including undocumented immigrants, who are 19 years of age or older and are not in a satisfactory immigration status, or are unable to verify their citizenship or immigration status, and who are otherwise Medi-Cal eligible. Full-scope coverage expanded to eligible individuals up to age 25, inclusive, regardless of citizenship or immigration status beginning January 1, 2020. Federal financial participation (FFP) is available, regardless of immigration status, for emergency and pregnancy related services.

No sooner than May 1, 2022, individuals who are 50 years of age or older who meet other Medi-Cal eligibility requirements but who do not have satisfactory immigration status or are unable to verify their immigration status or citizenship will be eligible for full-scope Medi-Cal benefits. California will continue to receive FFP for the emergency services provided to this population, 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 2021-22, is a decrease due to a projected increase in offsetting cost savings for current restricted-scope Medi-Cal expenditures. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to a full year of costs in FY 2022-23.

Methodology:

1. Assume this policy is effective no sooner than May 1, 2022.

UNDOCUMENTED OLDER CALIFORNIANS EXPANSION

REGULAR POLICY CHANGE NUMBER: 4

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 \$71,636,000, beginning in FY 2022-23.
3. The Department assumes adults from two populations will transition to full scope benefits in FY 2021-22: (1) current restricted scope adults and (2) a portion of adults that are currently eligible for restricted scope benefits, but have not enrolled into Medi-Cal.
4. Assume offsetting cost savings for current restricted-scope Medi-Cal expenditures.
5. On a cash basis, net expenditures are estimated to be:

(Dollars in Thousands)

Fiscal Years	TF	GF	FF
FY 2021-22	\$52,532	\$41,611	\$10,921
FY 2022-23	\$589,846	\$496,061	\$93,785

*Totals may differ due to rounding.

Funding:

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

100% GF (4260-101-0001)

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change

MEDI-CAL STATE INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 5
IMPLEMENTATION DATE: 12/2016
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 1569

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$52,275,000	\$49,275,000
- STATE FUNDS	\$5,900,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$52,275,000	\$49,275,000
STATE FUNDS	\$5,900,000	\$0
FEDERAL FUNDS	\$46,375,000	\$49,275,000

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 enrolled in 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)
 AB 80 (Chapter 12, Statutes of 2020)

Interdependent Policy Changes:

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

Background:

AB 1628 (Chapter 729, Statutes of 2010) authorizes the Department and the CDCR to:

- Claim FFP for inpatient hospital services to Medi-Cal enrolled 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 this service was funded through the CDCR with 100% GF.

MEDI-CAL STATE INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 5

AB 396 (Chapter 394, Statutes of 2011) authorizes the Department and the CDCR to:

- Claim FFP for inpatient hospital services provided to Medi-Cal enrolled juvenile inmates, in State correctional facilities, when these services are provided off the grounds of the facility. Previously these services were paid for by the CDCR with 100% GF.

AB 80 (Chapter 12, Statutes of 2020) conforms the suspension of benefits for juveniles, as defined under state law, with the existing federal law, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act). The definition of juvenile has changed (both State and County) to include individuals under the age of 21 or individuals enrolled in the former foster youth group under the age of 26. "Eligible Juveniles", as defined by the SUPPORT Act, only impacts Medi-Cal suspension of benefits policies and does not impact eligibility age restrictions or age requirements for general Medi-Cal programs.

For State inmates, with the 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 2021-22, from the prior estimate, is a decrease due to projecting lower amounts for the retroactive payments and for projecting an increase in the general fund (GF) payment to the Centers for Medicare & Medicaid Services (CMS). Additionally, the estimates were updated with actuals based on current invoices from FY 2020-21. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to completing the GF payment to CMS in FY 2021-22.

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 2021-22 and FY 2022-23 are annualized projections primarily based on actual claims data for FY 2020-21 quarters 1 through 4.
3. Assume \$3,000,000 federal funds (FF) in retroactive payments will be paid in FY 2021-22 starting in July 2021.
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.

MEDI-CAL STATE INMATE PROGRAMS
REGULAR POLICY CHANGE NUMBER: 5

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 2021-22 and FY 2022-23.
7. In December 2021, the Department paid CMS \$5,900,000 GF for overpaid FFP that was paid to CDCR. The overpayment was caused by an issue related to the total computable calculations for claims paid between FY 2011-12 through FY 2019-20. This payment is not reflected in the below FY 2021-22 table.

FY 2021-22	TF	FF
Adults - Non ACA	\$14,748,000	\$7,374,000
Adults - ACA	\$45,666,000	\$41,514,000
Medical Parole	\$769,000	\$385,000
Juveniles	\$4,000	\$2,000
Total Retroactive Payments ACA	\$1,250,000	\$1,250,000
Total Retroactive Payments Non-ACA	\$3,500,000	\$1,750,000
Total FY 2021-22	\$65,937,000	\$52,275,000
FY 2022-23	TF	FF
Adults - Non ACA	\$14,748,000	\$7,374,000
Adults - ACA	\$45,666,000	\$41,514,000
Medical Parole	\$769,000	\$385,000
Juveniles	\$4,000	\$2,000
Total FY 2022-23	\$61,187,000	\$49,275,000

*Totals may differ due to rounding.

8. Assume an estimated annual cost of **\$46,375,000 FF and \$5,900,000 GF in FY 2021-22** and **\$49,275,000 FF in FY 2022-23**.

Funding:

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

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

100% GF (4260-101-0001)

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

UNDOCUMENTED YOUNG ADULTS FULL SCOPE EXPANSION

REGULAR POLICY CHANGE NUMBER: 6
IMPLEMENTATION DATE: 1/2020
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2127

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$303,181,000	\$350,731,000
- STATE FUNDS	\$206,811,000	\$236,453,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	86.45 %	75.98 %
APPLIED TO BASE		
TOTAL FUNDS	\$41,081,000	\$84,245,600
STATE FUNDS	\$28,022,890	\$56,796,010
FEDERAL FUNDS	\$13,058,140	\$27,449,580

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

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 2021-22, is a decrease due to a projected decrease in benefit costs. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to a higher year-end population as phase-in continues in FY 2022-23 for the population that is eligible, but has not enrolled into Medi-Cal.

Methodology:

1. Program implementation occurred on January 1, 2020.
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 \$38,084,000 in FY 2021-22 and \$43,420,000 in FY 2022-23.

UNDOCUMENTED YOUNG ADULTS FULL SCOPE EXPANSION

REGULAR POLICY CHANGE NUMBER: 6

3. The Department assumes approximately 100,000 adults from two populations will transition to full scope benefits by FY 2022-23, 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)

Fiscal Years	TF	GF	FF
FY 2021-22	\$303,181	\$206,811	\$96,370
FY 2022-23	\$350,731	\$236,453	\$114,278

Funding:

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

100% GF (4260-101-0001)

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change

MEDI-CAL COUNTY INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 8
IMPLEMENTATION DATE: 4/2017
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 1755

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$50,699,000	\$37,485,000
- STATE FUNDS	\$1,604,500	\$1,684,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	70.41 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$15,001,800	\$0
STATE FUNDS	\$474,770	\$0
FEDERAL FUNDS	\$14,527,060	\$0

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 enrolled in 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)
 AB 80 (Chapter 12, Statutes of 2020)

Interdependent Policy Changes:

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

Background:

AB 1628 (Chapter 729, Statutes of 2010) authorizes the Department and counties to:

- Claim FFP for inpatient hospital services for Medi-Cal enrolled 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 enrolled 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: 8

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.

AB 80 (Chapter 12, Statutes of 2020) conforms the suspension of benefits for juveniles, as defined under state law, with the existing federal law, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act). The definition of juvenile has changed (both State and County) to include individuals under the age of 21 or individuals enrolled in the former foster youth group under the age of 26. "Eligible Juveniles", as defined by the SUPPORT Act, only impacts Medi-Cal suspension of benefits policies and does not impact eligibility age restrictions or age requirements for general Medi-Cal programs.

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 Medi-Cal enrolled 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 enrolled 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 2021-22, from the prior estimate, is a decrease due to updated payment data from FY 2018-19 quarter 4 through FY 2020-21 quarter 3. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease 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.

MEDI-CAL COUNTY INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 8

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 enrolled 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.
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, 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 2021-22 and FY 2022-23 is based on actual claims paid from April 2019 through March 2021. To project for FY 2022-23, 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 2021-22 and FY 2022-23 are:

(Dollars in Thousands)	FY 2021-22			FY 2022-23		
County Adult	TF	GF	FF	TF	GF	FF
Adult County - Non ACA	\$3,184	\$550	\$2,634	\$3,343	\$577	\$2,766
Adult County - ACA	\$32,311	\$985	\$31,326	\$33,927	\$1,035	\$32,892
Compassionate Release	\$12	\$6	\$6	\$14	\$7	\$7
Juvenile	\$192	\$63	\$129	\$201	\$66	\$135
Total Retroactive Payments	\$15,000	\$0	\$15,000	\$0	\$0	\$0
Retro ACA	\$7,102	\$0	\$7,102	\$0	\$0	\$0
Retro Non-ACA	\$7,898	\$0	\$7,898	\$0	\$0	\$0
Grand Total	\$50,699	\$1,604	\$49,095	\$37,485	\$1,685	\$35,800

*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)

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 December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

ACCELERATED ENROLLMENT FOR ADULTS

REGULAR POLICY CHANGE NUMBER: 9
IMPLEMENTATION DATE: 7/2021
ANALYST: Kalandie Coleman
FISCAL REFERENCE NUMBER: 2264

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$14,869,000	\$17,843,000
- STATE FUNDS	\$7,434,500	\$8,921,500
PAYMENT LAG	0.8260	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$12,281,800	\$17,843,000
STATE FUNDS	\$6,140,900	\$8,921,500
FEDERAL FUNDS	\$6,140,900	\$8,921,500

Purpose:

This policy change estimates the costs of providing Accelerated Enrollment into Medi-Cal for adults ages 19 through 64 years of age.

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

The Department expanded Accelerated Enrollment for adults, ages 19 through 64, using the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) at the time of application. Accelerated Enrollment for adults provides immediate and temporary benefits for adults applying through CalHEERS while income verifications are pending. Negotiations for settling the Rivera v. Kent lawsuit are covered by the extension of Accelerated Enrollment to adults. This expanded coverage also provides additional pathways for Medi-Cal with the onset of the Coronavirus Disease 2019 (COVID-19) public health emergency.

Reason for Change:

There is a slight decrease for FY 2021-22, from the prior estimate, due adjusting to a ten month cash estimate based on program expenditures beginning in September 2021. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to a full year of implementation occurring in FY 2022-23.

Methodology:

1. Assume an effective date of July 1, 2021. Program expenditures began in September 2021.
2. Assume Accelerated Enrollment temporary benefits will end after 2 months.
3. Assume 55% of Accelerated Enrollment population will be enrolled in Medi-Cal. This 55% will be captured in the regular Medi-Cal expenditure estimates.
4. Assume estimated costs for FY 2021-22 and FY 2022-23 are:

ACCELERATED ENROLLMENT FOR ADULTS
REGULAR POLICY CHANGE NUMBER: 9

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2021-22	\$14,869	\$7,435	\$7,434
FY 2022-23	\$17,843	\$8,922	\$8,921

*Totals may differ due to rounding.

Funding:

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

DISABLED ADULT CHILDREN PROGRAM CLEANUP

REGULAR POLICY CHANGE NUMBER: 13
IMPLEMENTATION DATE: 7/2021
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2191

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$1,616,000	\$0
- STATE FUNDS	\$2,924,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,616,000	\$0
STATE FUNDS	\$2,924,000	\$0
FEDERAL FUNDS	-\$1,308,000	\$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: 13

Reason for Change:

There is no change from the prior estimate for FY 2021-22. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to the expectation all reimbursements to CMS and refunds to eligibles will occur in FY 2021-22.

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 2021-22:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
Part B Adjustment	\$0	\$1,308	(\$1,308)
Share of Cost Adjustment	\$1,616	\$1,616	\$0
Total	\$1,616	\$2,924	(\$1,308)

Funding:

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

CALAIM INMATE PRE-RELEASE PROGRAM

REGULAR POLICY CHANGE NUMBER: 14
IMPLEMENTATION DATE: 1/2023
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2332

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$50,232,000
- STATE FUNDS	\$0	\$15,534,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$50,232,000
STATE FUNDS	\$0	\$15,534,000
FEDERAL FUNDS	\$0	\$34,698,000

Purpose:

This policy change estimates the cost for the development, implementation, ongoing maintenance, and operation, of certain California Advancing & Innovating Medi-Cal (CalAIM) initiatives involving justice-involved populations.

Authority:

Penal Code Section 4011.11
 Welfare & Institutions Code Sections 14011.10, 14132.275, 14184.800, and 14186
 AB 133 (Chapter 143, Statutes of 2021)

Interdependent Policy Change:

Not Applicable

Background:

California is requesting federal authority necessary to implement CalAIM, a framework that encompasses broad-based delivery system, program and payment reform across the Medi-Cal program. CalAIM recognizes the opportunity to move California's whole-person care approach – first authorized by the Medi-Cal 2020 Section 1115 demonstration – to a statewide level, with a clear focus on improving health and reducing health disparities and inequities. Collectively, the Section 1115 CalAIM demonstration and Section 1915(b) waiver, along with related contractual and Medi-Cal State Plan changes, will enable California to fully execute the CalAIM initiative, providing benefits to certain high needs, hard-to-reach populations, with the objective of improving health outcomes for Medi-Cal beneficiaries and other low-income people in the state.

Inmates leaving correctional facilities are at extremely high risk of poor outcomes due to high rates of mental illness, substance use disorders, complex medical conditions, and unmet social needs such as housing insecurity, unemployment, and inadequate social connections. CalAIM proposes to improve outcomes for this population by mandating county inmate pre-release application processes, allowing Medi-Cal reimbursement for services in the 90 day time period prior to release, and to ensure a facilitated referral and linkage ("warm hand-off") to behavioral health services, both to providers in managed care networks and to county behavioral health departments.

CALAIM INMATE PRE-RELEASE PROGRAM

REGULAR POLICY CHANGE NUMBER: 14

This proposed policy change estimate costs for the following CalAIM initiatives for justice-involved populations:

- **Mandatory County Pre-Release Applications**
 - To mandate all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2023, which would include collaboration with county jails, probation offices, and youth correctional facilities.
 - To ensure the majority of county inmates/juveniles that are eligible for Medi-Cal and are in need of ongoing physical or behavioral health treatment receive timely access to Medi-Cal services upon release from incarceration.
- **“In Reach” Services up-to-90 days prior to release**
 - To provide targeted Medi-Cal services to eligible justice-involved populations up to 90-days pre-release, which include: Enhanced Care Management or other care coordination, as appropriate; community-based physical and behavioral health clinical consultation services provided via telehealth or, optionally, in-person as needed, including behavioral health referrals/linkages; Medically Assisted Treatment; associated laboratory/radiology services; and a 30-day supply of medication, including Durable Medical Equipment, for use post-release into the community. Managed care plans may also offer “in reach” to arrange ‘Community Supports’ as a substitute to State Plan benefits. These offerings include items such as community transitions, housing navigation, housing deposits, and respite care.

Reason for Change:

This is a new policy change.

Methodology:

1. Assume the Mandatory County Pre-Release Applications and the “In Reach” Services up-to-90 days prior to release (including Behavioral Health Referrals/Linkages) policies implement January 1, 2023.
2. Assume funding will support the new costs to counties to implement the above mentioned initiatives, including developing new services tailored to clients with criminal justice involvement, training for staff and providers, developing new programs and processes to meet the mandate requirements.
3. Assume County/Jail probation administrative costs will begin in FY 2024-25.
4. Total estimated costs for FY 2021-22 and FY 2022-23 are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2021-22	\$0	\$0	\$0
FY 2022-23	\$50,232	\$15,534	\$34,698

Funding:

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

100% GF (4260-101-0001)

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

PHASING IN THE MEDI-CAL ASSET LIMIT REPEAL

REGULAR POLICY CHANGE NUMBER: 15
IMPLEMENTATION DATE: 8/2022
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2324

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$45,452,000
- STATE FUNDS	\$0	\$22,726,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$45,452,000
STATE FUNDS	\$0	\$22,726,000
FEDERAL FUNDS	\$0	\$22,726,000

Purpose:

This policy change estimates the benefit and program costs to disregard countable assets up to \$130,000 for an individual and \$65,000 for each additional person when determining eligibility for Non-Modified Adjusted Gross Income (Non-MAGI) Medi-Cal, Medicare Savings Programs, and Long-term Care.

Authority:

AB 133 (Chapter 143, Statutes of 2021)

Interdependent Policy Change:

Not Applicable

Background:

California has asset limits for each Non-MAGI Medi-Cal program, which are outlined in State statute for the various coverage groups subject to such asset limits. The methodologies for asset treatment are set forth in the Medicaid State Plan and the limits are established in both State statute and regulations. To be eligible for Non-MAGI Medi-Cal, including Long-term Care, the countable assets for one person may not exceed \$2,000, or \$3,000 for two people. These amounts have not changed since 1989. The asset limits for the Medicare Savings Programs are \$7,970 for an individual and \$11,960 for two people.

AB 133 requires, upon receipt of federal approval, that the asset limits for Non-MAGI programs, Medicare Savings Programs, and Long-term Care be increased to \$130,000 for one person and \$65,000 for each additional person no sooner than July 1, 2022. In addition, no sooner than January 1, 2024, upon receipt of federal approval, the asset test for Non-MAGI programs, Medicare Savings Programs, and Long-term Care will be eliminated.

Reason for Change:

This is a new policy change.

Methodology:

1. Assume the asset limit implements July 1, 2022.
2. Assume the asset repeal implements no sooner than January 1, 2024.

PHASING IN THE MEDI-CAL ASSET LIMIT REPEAL
REGULAR POLICY CHANGE NUMBER: 15

3. Assume there will be impacts to the Non-MAGI Medi-Cal, Medicare Savings Programs, and Long-term Care populations.
4. Assume the Department will pay Medicare Part B premiums for dual eligibles.
5. Assume the Department will pay Medicare Part A premiums for individuals enrolled into Medicare Savings Programs.
6. Federal Funds for In-Home Supportive Services are budgeted in the Personal Care Services (Misc. Svcs.) policy change and the General Fund share is included in the budget for the California Department of Social Services.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2021-22	\$0	\$0	\$0
FY 2022-23	\$45,452	\$22,726	\$22,726

Funding:

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

CS3 PROXY ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 16
IMPLEMENTATION DATE: 4/2017
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2155

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$53,950,300	-\$54,257,100
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$53,950,300	-\$54,257,100
FEDERAL FUNDS	\$53,950,300	\$54,257,100

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

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 2021-22, from the prior estimate, is a General Fund (GF) savings decrease due to updating the estimate with more current adjustment memos. The change from FY 2021-22 to FY 2022-2023, in the current estimate, is a GF savings increase due to projecting higher adjustment memos in FY 2022-23.

Methodology:

1. Effective FY 2020-21, assume a two quarter adjustment lag.

CS3 PROXY ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 16

2. This adjustment shifts funding from Title XIX federal funds with a 50% GF match to Title XXI federal funds with a 35% GF match for claims after October 1, 2020.
3. Previously, the CS3 Proxy adjustments were budgeted in the Non-OTLICP CHIP policy change.
4. Total estimated costs for FY 2021-22 and FY 2022-23 are:

Funding:

(Dollars in Thousands)

FY 2021-22	Fund Number	TF	GF	FF
50% Title XIX /50 % GF	4260-101-0890/0001	(\$233,482)	(\$116,741)	(\$116,741)
65% Title XXI / 35% GF	4260-113-0890/0001	\$233,482	\$81,719	\$151,763
Title XIX FF	4260-101-0890	(\$63,092)	\$0	(\$63,092)
Title XIX GF	4260-101-0001	\$63,092	\$63,092	\$0
Title XXI FF	4260-113-0890	\$82,020	\$0	\$82,020
Title XXI GF	4260-113-0001	(\$82,020)	(\$82,020)	\$0
Net Impact (rounded)		\$0	(\$53,950)	\$53,950

* Totals may differ due to rounding

(Dollars in Thousands)

FY 2022-23	Fund Number	TF	GF	FF
50% Title XIX /50 % GF	4260-101-0890/0001	(\$237,034)	(\$118,517)	(\$118,517)
65% Title XXI / 35% GF	4260-113-0890/0001	\$237,034	\$82,962	\$154,072
Title XIX FF	4260-101-0890	(\$62,340)	\$0	(\$62,340)
Title XIX GF	4260-101-0001	\$62,340	\$62,340	\$0
Title XXI FF	4260-113-0890	\$81,042	\$0	\$81,042
Title XXI GF	4260-113-0001	(\$81,042)	(\$81,042)	\$0
Net Impact (rounded)		\$0	(\$54,257)	\$54,257

* Totals may differ due to rounding

**COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

*** COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

CDCR RETRO REPAYMENT

REGULAR POLICY CHANGE NUMBER: 17
IMPLEMENTATION DATE: 12/2018
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2109

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$11,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$11,000	\$0
FEDERAL FUNDS	-\$11,000	\$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 were returned to CMS.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is an increase due to a delay in processing the final payments. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease as all remaining payments are expected to be completed in FY 2021-22.

CDCR RETRO REPAYMENT
REGULAR POLICY CHANGE NUMBER: 17**Methodology:**

1. Approximately \$11,000 were returned to the appropriate federal fund sources below.

FY 2021-22	TF	GF	FF
Title XIX ACA Recoupment	\$0	\$10,000	(\$10,000)
Title XIX Recoupment	\$0	\$1,000	(\$1,000)
Total FY 2021-22	\$0	\$11,000	(\$11,000)

Funding:

100% GF (4260-101-0001)

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

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

REFUGEE MEDICAL ASSISTANCE

REGULAR POLICY CHANGE NUMBER: 18
IMPLEMENTATION DATE: 11/2020
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2237

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

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 a \$600,000 annual reimbursement cap under the grant for these services.

Reason for Change:

There is no change from the prior estimate for FY 2021-22. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to fewer months being adjusted for in FY 2022-23.

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 2021-22 are October 1, 2019, through March 31, 2021, for a total estimated reimbursable amount of \$282,000. The current claiming periods for FY 2022-23 are April 1, 2021, through March 31, 2022, for a total estimated reimbursable amount of \$200,000.

REFUGEE MEDICAL ASSISTANCE
REGULAR POLICY CHANGE NUMBER: 18

Fiscal Year	TF	GF	GF Reimbursement
FY 2021-22	\$0	(\$282,000)	\$282,000
FY 2022-23	\$0	(\$200,000)	\$200,000

Funding:

100% GF (4260-101-0001)

Reimbursement GF (4260-601-0995)

MEDI-CAL COUNTY INMATE REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 19
IMPLEMENTATION DATE: 2/2018
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2029

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

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)
 AB 80 (Chapter 12, Statutes of 2020)

Interdependent Policy Changes:

Medi-Cal County Inmate Programs
 COVID-19 Increased FMAP – DHCS
 COVID-19 Increased FMAP Extension

Background:

For county inmates, counties may participate in the MCIP that will allow coverage for specified services to Medi-Cal enrolled 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 enrolled 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, FY 2021-22, is a decrease due to actual payment data from the last two years being used to project payments. Additionally, the FY 2021-22 reimbursement is further reduced by the availability of the COVID-19 Increased FMAP which reduces the GF liability in the Medi-Cal County Inmate Programs. The change from FY 2021-22 to FY 2022-23,

MEDI-CAL COUNTY INMATE REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 19

in the current estimate, is an increase due to projected growth in the program and due to the COVID-19 Increased FMAP expiring in FY 2021-22.

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 GF column represents the amount GF spent and the reimbursement column represents the amount recouped from the counties for the GF amount.
4. The Department makes federal fund payments to all hospital types including Designated Public Hospitals (DPH), Non-Designated Public Hospitals (NDPH), and private hospitals, however GF is only paid out to the NDPH and private hospitals, therefore no GF recoupment takes place for the DPHs as payments to DPHs are only federal funds.
5. The Department estimates payments of \$50,699,000 TF (\$49,095,000 FF) and \$37,485,000 TF (\$35,800,000 FF) will be paid in FY 2021-22 and FY 2022-23, 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.
6. The total estimated GF reimbursement in FY 2021-22 and FY 2022-23 will be:

FY 2021-22	GF	Reimbursement
Non ACA	\$533,000	\$543,000
ACA	\$985,000	\$1,008,000
Juvenile	\$63,000	\$68,000
Compassionate Release	\$6,000	\$6,000
Total	\$1,587,000	\$1,625,000

FY 2022-23	GF	Reimbursement
Non ACA	\$577,000	\$571,000
ACA	\$1,035,000	\$1,022,000
Juvenile	\$66,000	\$66,000
Compassionate Release	\$7,000	\$6,000
Total	\$1,685,000	\$1,665,000

*Totals may differ due to rounding.

MEDI-CAL COUNTY INMATE REIMBURSEMENT
REGULAR POLICY CHANGE NUMBER: 19

Funding:

100% GF (4260-101-0001)

Reimbursement GF (4260-610-0995)

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

MEDICARE OPTIONAL EXPANSION ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 20
IMPLEMENTATION DATE: 7/2021
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2033

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$962,400	\$962,400
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$962,400	\$962,400
FEDERAL FUNDS	-\$962,400	-\$962,400

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 2021-22, is a General Fund (GF) increase due to utilizing more recent actual memos for a full FY 2021-22 projection. There is no change from FY 2021-22 to FY 2022-23 in the current estimate.

MEDICARE OPTIONAL EXPANSION ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 20

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. Manual adjustments will continue for Medicare Part A and/or Part B eligibles remaining in the Optional Expansion aid codes.
3. Those Medi-Cal eligibles with Part A and/or Part B are estimated in the Optional Expansion aid category.
4. The overall adjustment is estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2021-22	\$0	\$962,000	(\$962,000)
FY 2022-23	\$0	\$962,000	(\$962,000)

Funding:

FY 2021-22	TF	GF	FF
90% ACA Title XIX FF /10% GF (4260-101-0890/0001)	(\$2,406,000)	(\$241,000)	(\$2,165,000)
50 % Title XIX FF / 50% GF (4260-101-0890/0001)	\$2,406,000	\$1,203,000	\$1,203,000
Total	\$0	\$962,000	(\$962,000)

FY 2022-23	TF	GF	FF
90% ACA Title XIX FF /10% GF (4260-101-0890/0001)	(\$2,406,000)	(\$241,000)	(\$2,165,000)
50 % Title XIX FF / 50% GF (4260-101-0890/0001)	\$2,406,000	\$1,203,000	\$1,203,000
Total	\$0	\$962,000	(\$962,000)

* Totals may differ due to rounding

NON-OTLICP CHIP

REGULAR POLICY CHANGE NUMBER: 21
IMPLEMENTATION DATE: 12/1998
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 13

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$86,166,900	-\$86,166,900
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$86,166,900	-\$86,166,900
FEDERAL FUNDS	\$86,166,900	\$86,166,900

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

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).

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- 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 2021-22, is a General Fund (GF) savings increase due to an increase in estimated expenditures for the Medicaid Expansion population. There is no change from FY 2021-22 to FY 2022-23 in the current estimate.

Methodology:

1. It is assumed the estimated costs of the HPE, Medicaid Expansion, and Resource Disregard aid codes will be \$574,446,000 TF in FY 2021-22 and FY 2022-23.
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. Beginning October 1, 2020, estimated costs are eligible for Title XXI 65/35 FMAP.
3. Total estimated costs for FY 2021-22 and FY 2022-23 are:

(Dollars in Thousands)

FY 2021-22	TF	GF
Resource Disregard	\$99	(\$15)
HPE	\$7,094	(\$1,064)
Medicaid Expansion	\$567,253	(\$85,088)
Total Cost	\$574,446	(\$86,167)

FY 2022-23	TF	GF
Resource Disregard	\$99	(\$15)
HPE	\$7,094	(\$1,064)
Medicaid Expansion	\$567,253	(\$85,088)
Total Cost	\$574,446	(\$86,167)

Funding:

(Dollars in Thousands)

FY 2021-22	Fund Number	TF	GF	FF
50 % Title XIX / 50 % GF	4260-101-0890/0001	(\$574,446)	(\$287,223)	(\$287,223)
65 % Title XXI / 35 % GF	4260-113-0890/0001	\$574,446	\$201,056	\$373,390
Net Impact (rounded)		\$0	(\$86,167)	\$86,167

NON-OTLICP CHIP
REGULAR POLICY CHANGE NUMBER: 21

FY 2022-23	Fund Number	TF	GF	FF
50 % Title XIX / 50 % GF	4260-101-0890/0001	(\$574,446)	(\$287,223)	(\$287,223)
65 % Title XXI / 35 % GF	4260-113-0890/0001	\$574,446	\$201,056	\$373,390
Net Impact (rounded)		\$0	(\$86,167)	\$86,167

*COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

** COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change

NON-EMERGENCY FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 22
IMPLEMENTATION DATE: 12/1997
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 15

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$1,205,139,600	\$1,205,139,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$1,205,139,600	\$1,205,139,600
FEDERAL FUNDS	-\$1,205,139,600	-\$1,205,139,600

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

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: 22

Reason for Change:

The change from the prior estimate, for FY 2021-22, is an increase due to an increase in Fee-for-Service (FFS) expenditures. There is no change from FY 2021-22 to FY 2022-23 in the current estimate.

Methodology:

1. Based on updated January 2021 through June 2021 FFS expenditure reports of non-emergency services provided to this population, the Department estimates non-emergency FFS costs will be \$469,329,000 TF in FY 2021-22 and FY 2022-23.
2. Based on updated January 2021 through June 2021 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 \$531,218,000 TF in FY 2021-22 and FY 2022-23. The repayment for this group will be 90% FFP.
3. Based on updated January 2021 through June 2021 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 \$817,145,000 TF in FY 2021-22 and FY 2022-23. The repayment for this group is at 50/50 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 2021-22 and FY 2022-23:

(Dollars in Thousands)

FFS and MC costs	FY 2021-22		FY 2022-23	
	TF	FF Repayment	TF	FF Repayment
All Others (50% FF / 50% GF)	\$1,038,238	\$519,119	\$1,038,238	\$519,119
All Others (65% FF / 35% GF)	\$8,096	\$5,262	\$8,096	\$5,262
All Others (Title XXI)	\$53,856	\$35,006	\$53,856	\$35,006
ACA	\$717,502	\$645,752	\$717,502	\$645,752
Total	\$1,817,692	\$1,205,139	\$1,817,692	\$1,205,139

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)

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

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

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER: 23
IMPLEMENTATION DATE: 7/2005
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 1007

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$73,523,700	-\$69,726,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$73,523,700	-\$69,726,800
FEDERAL FUNDS	\$73,523,700	\$69,726,800

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:

Not Applicable

Background:

AB 131 required the Department to submit a State Plan Amendment to claim CHIP federal funding for prenatal care for undocumented women, and legal immigrants who have been in the country for less than five years through the Medi-Cal Program and the Medi-Cal Access Infants Program. Previously, these costs for prenatal care were funded with 100% General Fund for the Medi-Cal Program. California draws down federal CHIP funding through the Title XXI unborn option for both programs.

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.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is an increase in general fund savings due to updated expenditure reports showing increased prenatal costs. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a general fund savings decrease due to the FFCRA increased FMAP funding ending for this policy change December 2021. Additionally, prenatal costs are projected to decrease slightly in FY 2022-23.

Methodology:

1. Assume the FMAP for Title XXI is 65% FF and 35% GF beginning October 1, 2020.

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER: 23

2. The 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through December 31, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022, on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.
3. The total fund cost of prenatal care for undocumented and legal immigrant women is estimated to be:

(Dollars in Thousands)

FY 2021-22	\$109,458
FY 2022-23	\$107,272

Funding:

(Dollars in Thousands)

FY 2021-22	Fund Number	TF	GF	FF
100% State GF	4260-101-0001	(\$109,458)	(\$109,458)	\$0
Title XXI 65% FF / 35% GF	4260-113-0890/0001	\$109,458	\$38,310	\$71,148
FFCRA 4.34% Increased FFP	4260-113-0890/0001	\$0	(\$2,376)	\$2,376
Net Impact		\$0	(\$73,524)	\$73,524

(Dollars in Thousands)

FY 2022-23	Fund Number	TF	GF	FF
100% State GF	4260-101-0001	(\$107,272)	(\$107,272)	\$0
Title XXI 65% FF / 35% GF	4260-113-0890/0001	\$107,272	\$37,545	\$69,727
Net Impact		\$0	(\$69,727)	\$69,727

* COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

CHIP PREMIUMS

REGULAR POLICY CHANGE NUMBER: 24
IMPLEMENTATION DATE: 7/2014
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 1879

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$48,232,000	-\$48,232,000
- STATE FUNDS	-\$16,881,200	-\$16,881,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$48,232,000	-\$48,232,000
STATE FUNDS	-\$16,881,200	-\$16,881,200
FEDERAL FUNDS	-\$31,350,800	-\$31,350,800

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 2021-22, is a decrease in premium revenue due to updated actuals that reflect recent increases in premium waivers due to wildfires and COVID-19. There is no change between FY 2021-22 and FY 2022-23 in the current estimate.

Methodology:

1. Children under 1 year of age and American Indians/Alaskan Natives are exempt from paying monthly premiums.
2. The Department provides discounts to individuals who prepay, establish automatic electronic fund transfers, and those families with multiple children.

CHIP PREMIUMS
REGULAR POLICY CHANGE NUMBER: 24

3. 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 public health emergency and California wildfire season.
4. Beginning October 1, 2020, assume estimated costs are eligible for Title XXI 65/35 FMAP.

The total estimated premium revenue for OTLICP are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2021-22	(\$48,232)	(\$16,881)	(\$31,351)
FY 2022-23	(\$48,232)	(\$16,881)	(\$31,351)

Funding:

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

COMMUNITY FIRST CHOICE OPTION

REGULAR POLICY CHANGE NUMBER: 26
IMPLEMENTATION DATE: 12/2012
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 1595

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$5,995,155,000	\$6,068,888,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$5,995,155,000	\$6,068,888,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$5,995,155,000	\$6,068,888,000

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

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: 26

quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated.

Reason for Change:

The change for FY 2021-22, 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 2021-22 to 2022-23, in the current estimate, is an increase due to updated expenditure data provided by CDSS.

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 December 31, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022, on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension change.
3. The estimated costs are provided by CDSS on a cash basis. In FY 2021-22, the estimated costs are \$5,995,155,000, which includes \$332,580,000 of increased FMAP at 6.2% for COVID-19 through December 31, 2021. In FY 2022-23, the estimated costs are \$6,068,888,000.

Funding:

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

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

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS

REGULAR POLICY CHANGE NUMBER: 27
IMPLEMENTATION DATE: 2/2016
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1967

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$20,385,000	\$19,168,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$20,385,000	\$19,168,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$20,385,000	\$19,168,000

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 2021-22, is an increase due to higher projected payments. The change from FY 2021-22 to 2022-23, in the current estimate, is a decrease due to an actual quarterly payment in FY 2021-22 coming in higher than previously projected.

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

HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS

REGULAR POLICY CHANGE NUMBER: 27

qualified hospital, then successfully complete the Medi-Cal application process, and are enrolled in the ACA Optional Expansion program.

2. The Department processes 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 \$4,792,000 for FY 2021-22 and FY 2022-23 based on the average expenditures of the most recent 8 quarters of data available (FY 2018-19 Q4, FY 2019-20 Q1-4, and FY 2020-21 Q1-3).
3. The Department will also claim the enhanced Title XIX ACA FMAP for beneficiaries receiving services in DPHs and estimates to pay DPHs \$20,385,000 in FY 2021-22 and \$19,168,000 in FY 2022-23. The estimated pass-through costs are included in the chart below.

(Dollars in Thousands)

FY 2021-22	TF	FF
FY 2020-21 Q3	\$6,009	\$6,009
FY 2020-21 Q4	\$4,792	\$4,792
FY 2021-22 Q1	\$4,792	\$4,792
FY 2021-22 Q2	\$4,792	\$4,792
Net Impact	\$20,385	\$20,385

FY 2022-23	TF	FF
FY 2021-22 Q3	\$4,792	\$4,792
FY 2021-22 Q4	\$4,792	\$4,792
FY 2022-23 Q1	\$4,792	\$4,792
FY 2022-23 Q2	\$4,792	\$4,792
Net Impact	\$19,168	\$19,168

Funding:

(Dollars in Thousands)

FY 2021-22	TF	FF
90% Title XIX ACA FF / 10% GF (4260-101-0890/0001)	\$20,385	\$20,385
Net Impact	\$20,385	\$20,385

FY 2022-23	TF	FF
90% Title XIX ACA FF / 10% GF (4260-101-0890/0001)	\$19,168	\$19,168
Net Impact	\$19,168	\$19,168

HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.

REGULAR POLICY CHANGE NUMBER: 28
IMPLEMENTATION DATE: 1/2014
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1821

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$46,552,850	-\$43,640,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$46,552,850	-\$43,640,000
FEDERAL FUNDS	\$46,552,850	\$43,640,000

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:

COVID-19 Increased FMAP – DHCS

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 2021-22, is an increase in GF due to updated estimated projections that utilize the expenditure trends from higher actuals in FY 2019-20.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase in GF 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: 28

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 2019 Q1 through FY 2019 Q4, the estimated average quarterly adjustment for FY 2020-21 is \$27,559,000. Using claims from the four most recent quarterly adjustments, the estimated average quarterly adjustment for FY 2021-22 is \$27,275,000.
4. The Department estimates to adjust \$110,234,000 TF claims from Title XIX 50/50 FMAP to claim the enhanced Title XIX ACA FMAP in FY 2020-21 and \$109,100,000 TF in FY 2021-22. The estimated funding adjustment is included in the chart below.

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
50% Title XIX FF / 50% GF	(\$110,234)	(\$55,117)	(\$55,117)
93% Title XIX FF / 7% GF	\$81,976	\$5,738	\$76,237
90% Title XIX FF / 10% GF	\$28,259	\$2,826	\$25,433
Net Impact	\$0	(\$46,553)	\$46,553

*Totals may not add due to rounding

FY 2022-23	TF	GF	FF
50% Title XIX FF / 50% GF	(\$109,100)	(\$54,550)	(\$54,550)
90% Title XIX FF / 10% GF	\$109,100	\$10,910	\$98,190
Net Impact	\$0	(\$43,640)	\$43,640

Funding:

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)

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

1% FMAP INCREASE FOR PREVENTIVE SERVICES

REGULAR POLICY CHANGE NUMBER: 29
IMPLEMENTATION DATE: 1/2016
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1791

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$4,242,000	-\$4,242,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$4,242,000	-\$4,242,000
FEDERAL FUNDS	\$4,242,000	\$4,242,000

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: 29

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a net increase in savings due to the following:

- Decrease in FFS savings as a result of fewer office visits during the COVID-19 Public Health Emergency (PHE),
- The Families First Coronavirus Response Act (FFCRA) provided increased federal funding by increasing the FMAP by 6.2 percent beginning January 1, 2020, therefore, reducing the General Fund (GF) portion in which the 1% is based on, resulting in lower 1% savings, and
- Managed care projected savings were higher based on an increase in quarterly rates and enrollment data.

There is no change in the current estimate from FY 2021-22 to FY 2022-23.

Methodology:

1. The 1% FMAP savings will include the following periods of savings in FY 2021-22:
 - FFS – July 1, 2020 through June 30, 2021
 - Managed care – January 1, 2021 through December 31, 2021
2. FY 2022-23 will include the following periods of savings:
 - FFS – July 1, 2021 through June 30, 2022
 - Managed care – January 1, 2022 through December 31, 2022
3. Total savings for the 1% FMAP increase for preventive services are as follows:

FY 2021-22	TF	GF	FF
FFS:			
FY 2020-21 Savings	\$0	(\$120,000)	\$120,000
Total FFS	\$0	(\$120,000)	\$120,000
Managed Care:			
FY 2020-21 Savings	\$0	(\$2,061,000)	\$2,061,000
FY 2021-22 Savings	\$0	(\$2,061,000)	\$2,061,000
Total Managed Care	\$0	(\$4,122,000)	\$4,122,000
Total FY 2021-22	\$0	(\$4,242,000)	\$4,242,000

FY 2022-23	TF	GF	FF
FFS:			
FY 2021-22 Savings	\$0	(\$120,000)	\$120,000
Total FFS	\$0	(\$120,000)	\$120,000
Managed Care:			
FY 2021-22 Savings	\$0	(\$2,061,000)	\$2,061,000
FY 2022-23 Savings	\$0	(\$2,061,000)	\$2,061,000
Total Managed Care	\$0	(\$4,122,000)	\$4,122,000
Total FY 2022-23	\$0	(\$4,242,000)	\$4,242,000

1% FMAP INCREASE FOR PREVENTIVE SERVICES
REGULAR POLICY CHANGE NUMBER: 29

Funding:

100% Title XIX (4260-101-0890)

100% GF (4260-101-0001)

PAYMENTS TO PRIMARY CARE PHYSICIANS

REGULAR POLICY CHANGE NUMBER: 30
IMPLEMENTATION DATE: 11/2013
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 1659

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$3,000	-\$3,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$3,000	-\$3,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	-\$3,000	-\$3,000

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: 30

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 2022-23.

Reason for Change:

The change for FY 2021-22 from the prior estimate, is due to lower estimated recoupments based on actual recoupment data from February 2021 to July 2021.

There is no change from FY 2021-22 to FY 2022-23, 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 \$3,000 TF is estimated to be recouped in FY 2021-22 and \$3,000 TF in FY 2022-23.

Recoupments	TF	FF
FY 2021-22	(\$3,000)	(\$3,000)
FY 2022-23	(\$3,000)	(\$3,000)

Funding:

100% Title XIX (4260-101-0890)

ACA OPTIONAL EXPANSION MLR RISK CORRIDOR

REGULAR POLICY CHANGE NUMBER: 31
IMPLEMENTATION DATE: 7/2020
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2064

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$33,000,000	\$0
- STATE FUNDS	-\$1,815,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$33,000,000	\$0
STATE FUNDS	-\$1,815,000	\$0
FEDERAL FUNDS	-\$31,185,000	\$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.

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 2021-22, is an increase in expected net recoupments due to a shift in recoupment from FY 2020-21 to FY 2021-22.

ACA OPTIONAL EXPANSION MLR RISK CORRIDOR

REGULAR POLICY CHANGE NUMBER: 31

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease in anticipated recoupments due to no further MLR risk corridor calculations being required after FY 2021-22.

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 2021-22. At this time, the Department estimates a net \$33,000,000 in recoupments and repayments across all MCPs.
4. The ACA OE MLR risk corridor estimated recoupments are:

Fiscal Year	TF	GF	FF
FY 2021-22	(\$33,000,000)	(\$1,815,000)	(\$31,185,000)
FY 2022-23	\$0	\$0	\$0

Funding:

ACA 95% FFP / 5% GF (2017)

ACA 94% FFP / 6% GF (2018)

BEHAVIORAL HEALTH TREATMENT

REGULAR POLICY CHANGE NUMBER: 32
IMPLEMENTATION DATE: 10/2016
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1855

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$1,058,853,000	\$866,319,000
- STATE FUNDS	\$463,205,550	\$410,841,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,058,853,000	\$866,319,000
STATE FUNDS	\$463,205,550	\$410,841,000
FEDERAL FUNDS	\$595,647,450	\$455,478,000

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

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: 32

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.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a net decrease due to the following:

- For FFS, the increase is due to a portion of FY 2019-20 and FY 2020-21 claims, previously budgeted in FY 2020-21, is now expected to be paid in FY 2021-22.
- For managed care – The decrease is due to the following:
 - The number of FY 2020-21 and FY 2021-22 supplemental capitation payments is expected to decrease due to decreases in BHT utilization.
 - Calendar Year (CY) rate for 2022 increased.

The change in the current estimate, from FY 2021-22 to FY 2022-23, is due to the following:

- FFS - The decrease is due to more prior year payments estimated for FY 2021-22.
- Managed care – Base capitation rates, effective January 1, 2023, are captured in the Cap Rate Adjustment policy change.

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.
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.

BEHAVIORAL HEALTH TREATMENT

REGULAR POLICY CHANGE NUMBER: 32

7. The FFS cost reimbursement estimates were provided by DDS. The estimated annual cost on an accrual basis is \$13,493,000 TF.
8. On a cash basis, FFS reimbursements are estimated to be paid as follows:

Fee-for-Service Claims	Accrual	FY 2021-22	FY 2022-23
FY 2019-20 claims	\$13,806,000	\$527,000	\$0
FY 2020-21 claims	\$13,493,000	\$4,493,000	\$363,000
FY 2021-22 claims	\$13,493,000	\$11,244,000	\$2,249,000
FY 2022-23 claims	\$13,493,000		\$11,243,000
Total		\$16,264,000	\$13,855,000

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. Beginning January 2021, managed care rates are updated on a calendar year basis. Starting January 1, 2023, BHT will transition to the base capitation rates.
11. Due to the supplemental capitation payment methodology, assume 76% of payments will be paid in the same fiscal year and 24% of payments will be paid the following fiscal year.
12. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through December 31, 2021. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.

(Dollars in Thousands)

Rate Year	Accrual	FY 2021-22	FY 2022-23
FY 2019-20 - FFS	\$13,806	\$527	\$0
FY 2020-21 - FFS	\$13,493	\$4,493	\$363
FY 2020-21 - Managed Care	\$864,233	\$219,882	(\$1,174)
FY 2021-22 - FFS	\$13,493	\$11,244	\$2,249
FY 2021-22 - Managed Care	\$1,083,307	\$822,707	\$261,992
FY 2022-23 - FFS	\$13,493	\$0	\$11,243
FY 2022-23 - Managed Care	\$1,192,579	\$0	\$591,646
Total		\$1,058,853	\$866,319

(Dollars in Thousands)

FY 2021-22	TF	GF	FF	FFCRA
Fee-for-Service	\$16,264	\$7,235	\$8,551	\$478
Managed Care	\$1,042,589	\$455,971	\$548,106	\$38,512
Total	\$1,058,853	\$463,206	\$556,657	\$38,990

BEHAVIORAL HEALTH TREATMENT
REGULAR POLICY CHANGE NUMBER: 32

FY 2022-23	TF	GF	FF	FFCRA
Fee-for-Service	\$13,855	\$6,571	\$7,284	\$0
Managed Care	\$852,464	\$404,270	\$448,194	\$0
Total	\$866,319	\$410,841	\$455,478	\$0

Funding:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
100% GF (4260-113-0001)	\$62,721	\$62,721	\$0
100% Title XXI (4260-113-0890)	\$116,345	\$0	\$116,345
65% Title XXI / 35% GF (4260-113-0001/0890)	\$2,793	\$978	\$1,815
50% Title XIX / 50% GF (4260-101-0001/0890)	\$876,994	\$438,497	\$438,497
FFCRA 6.2% Increased FFP (4260-101-0001/0890)	\$0	(\$34,048)	\$34,048
FFCRA 4.34% Increased FFP (4260-113-0001/0890)	\$0	(\$4,942)	\$4,942
Total	\$1,058,853	\$463,206	\$595,647

FY 2022-23	TF	GF	FF
100% GF (4260-113-0001)	\$51,245	\$51,245	\$0
100% Title XXI (4260-113-0890)	\$95,168	\$0	\$95,168
65% Title XXI / 35% GF (4260-113-0001/0890)	\$2,380	\$833	\$1,547
50% Title XIX / 50% GF (4260-101-0001/0890)	\$717,526	\$358,763	\$358,763
Total	\$866,319	\$410,841	\$455,478

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

REGULAR POLICY CHANGE NUMBER: 33
IMPLEMENTATION DATE: 5/2013
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1476

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$532,400,000	\$523,841,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$532,400,000	\$523,841,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$532,400,000	\$523,841,000

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

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. The Department submitted SPA 21-0002 to CMS on March 23, 2021, to renew the 1915(i) state plan option for a new five year term effective October 1, 2021, through September 30, 2026.

ABX3 5 "AB 5" (Chapter 20, Statutes of 2009), eliminated non-emergency medical transportation and various optional services for adults in September 2009. SPA 11-041 authorizes CDDS to claim reimbursement, effective October 1, 2011 for the eliminated services rendered in FY 2011-12 and forward, enabling persons with developmental disabilities access to these benefits.

ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

REGULAR POLICY CHANGE NUMBER: 33

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.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is an increase due to higher prior year expenditures being received than were previously anticipated.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to an increase in current year expenditures, driven by assumed recovery from the current public health emergency occurring in FY 2022-23 and is offset by higher than previously estimated prior year expenditures in FY 2021-22.

Methodology:

- The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	FF	FFCRA
FY 2021-22	\$987,051	\$454,651	\$493,526	\$38,874
FY 2022-23	\$1,032,842	\$509,001	\$516,421	\$7,420

Funding:

100% Title XIX FFP (4260-101-0890)
FFCRA 6.2% Increased FFP (4260-101-0890)

FAMILY PACT PROGRAM

REGULAR POLICY CHANGE NUMBER: 34
IMPLEMENTATION DATE: 1/1997
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$352,260,000	\$369,130,000
- STATE FUNDS	\$83,989,200	\$88,012,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$352,260,000	\$369,130,000
STATE FUNDS	\$83,989,200	\$88,012,000
FEDERAL FUNDS	\$268,270,800	\$281,118,000

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

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 2021-22, is decrease due to a reduction in clients utilizing the Family PACT services during the Coronavirus Disease 2019 (COVID-19) national

FAMILY PACT PROGRAM

REGULAR POLICY CHANGE NUMBER: 34

public health emergency (PHE) and updated actual expenditure data. The change from FY 2021-22 to 2022-23, in the current estimate, is an increase due to a slight increase in projected users of Family PACT services in FY 2022-23.

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 2021-22		FY 2022-23	
	TF	GF	TF	GF
Physicians	\$57,642	\$13,743	\$61,678	\$14,706
Other Medical	\$269,741	\$64,314	\$280,623	\$66,909
Co. & Comm. Outpatient	\$1,212	\$289	\$1,274	\$304
Pharmacy	\$23,665	\$5,642	\$25,555	\$6,093
Total	\$352,260	\$83,989	\$369,130	\$88,012

*Totals may differ due to rounding.

Funding:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890/0001)	\$11,343	\$5,672	\$5,672
100% GF (4260-101-0001)	\$49,140	\$49,140	\$0
90% Family Planning / 10% GF (4260-101-0890/0001)	\$291,777	\$29,178	\$262,599
Total	\$352,260	\$83,989	\$268,271

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890/0001)	\$11,886	\$5,943	\$5,943
100% GF (4260-101-0001)	\$51,494	\$51,494	\$0
90% Family Planning / 10% GF (4260-101-0890/0001)	\$305,750	\$30,575	\$275,175
Total	\$369,130	\$88,012	\$281,118

*Totals may differ due to rounding.

FAMILY PACT PROGRAM
REGULAR POLICY CHANGE NUMBER: 34

** COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change.

***COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER: 35
IMPLEMENTATION DATE: 7/2000
ANALYST: Neejkajsiab Yang
FISCAL REFERENCE NUMBER: 25

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$109,512,000	\$122,305,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$109,512,000	\$122,305,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$109,512,000	\$122,305,000

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
 SPA 15-021
 Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

Not applicable

Background:

LEAs, which consist of school districts, county offices of education, charter schools, community colleges, and university campuses, may enroll as Medi-Cal providers through the LEA 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. 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 (PHE) are effective for 90 days unless extended or terminated.

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER: 35

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to:

- FY 2021-22 interim payments increased due to the inclusion of FY 2020-21 actual payments and the inclusion of the SPA 15-021 impact.
- FY 2021-22 interim payments include a lower reduction in claims due to the PHE.
- FY 2021-22 rate inflation decreased from 2% to 1.6163% based on updated information. The increase includes FY 2020-21 actuals and is applied to the SPA 15-021 impact.
- The estimate for the retro claiming has been removed to a future fiscal year.
- Reduced FFY 2021-22 Quarter 1 and 2 Title XIX FFCRA increased FMAP based on actuals.
- Title XXI FFCRA increased FMAP under LEA BOP are enhanced under Title XXI EPC is no longer included.
- The Title XIX and Title XXI FFCRA increased FMAP recoupments will not be processed through an EPC, but recouped through the cost settlement process in FY 2023-24.
- FY 2021-22 cost reconciliation due to the State does not include EPCs for Title XIX ACA and Title XXI.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to higher estimated total claims in FY 2022-23 and no FFCRA increased FMAP EPCs or increases included in FY 2022-23.

Methodology:

1. The estimate is based on the average of the preceding three state fiscal years of actual paid claims data.
2. The FY 2021-22 and FY 2022-23 interim payments include a rate inflation that is based on the Implicit Deflator for Gross Domestic Products. The rate table includes the rate inflation in the established rates.
3. Assume a 15 percent claim reduction for FY 2021-22 for averaged claims per year and rate inflation due to low claiming during the PHE.
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 recent paid claims data, 78% of the adjudicated LEA payments were from Title XIX Medi-Cal population, and 21% from Title XXI OTLIC population. The LEAs will receive the Title XXI OTLIC payment adjustment for the enhanced FFP through the cost settlement process between FY 2023-24 and FY 2025-26.
5. Title XIX ACA related aid codes allowable under the LEA Program are not included in this estimate. The LEAs will receive the Title XIX ACA payment adjustment for the enhanced FFP through the cost settlement process between FY 2023-24 and FY 2025-26.
6. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through December 31, 2021 for this policy change.
7. Assume adjustments for cost report reconciliations due back to the State will be received in FY 2021-22 and FY 2022-23.

LOCAL EDUCATION AGENCY (LEA) PROVIDERS
REGULAR POLICY CHANGE NUMBER: 35

(Dollars in Thousands)

FY 2021-22	TF	FF	FFCRA
FY 2021-22 Interim Payments	\$91,289	\$91,289	\$0
SPA 15-021 Impact	\$18,258	\$18,258	\$0
Rate Inflation	\$1,771	\$1,771	\$0
COVID-19 6.2% EPC Retro Claims	\$2,840	\$0	\$2,840
COVID-19 6.2% Increase	\$1,132	\$0	\$1,132
FY 2021-22 Reconciliation due to State	(\$5,778)	(\$5,778)	\$0
Total	\$109,512	\$105,540	\$3,972

FY 2022-23	TF	FF	FFCRA
FY 2022-23 Interim Payments	\$105,038	\$105,038	\$0
SPA 15-021 Impact	\$21,008	\$21,008	\$0
Rate Inflation	\$2,037	\$2,037	\$0
FY 2022-23 Reconciliation due to State	(\$5,778)	(\$5,778)	\$0
Total	\$122,305	\$122,305	\$0

Funding:

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

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

MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

REGULAR POLICY CHANGE NUMBER: 36
 IMPLEMENTATION DATE: 7/2019
 ANALYST: Ryan Chin
 FISCAL REFERENCE NUMBER: 28

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$51,506,000	\$63,951,000
- STATE FUNDS	\$24,954,000	\$31,975,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$51,506,000	\$63,951,000
STATE FUNDS	\$24,954,000	\$31,975,500
FEDERAL FUNDS	\$26,552,000	\$31,975,500

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

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. The Coordinated Care Initiative (CCI) was previously scheduled to transition MSSP to a managed care benefit effective January 1, 2023; however, effective January 1, 2022, MSSP will no longer be transitioned to Managed Care and will be carved-out of CCI. MSSP will operate as a waiver benefit in all CCI demonstration counties, as it did prior to the implementation of CCI in 2014.

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.

Effective January 1, 2022, the total MSSP reimbursement (both for fee-for-service and managed care) is budgeted in this policy change, as is an increase in rates and slots as a result of the Home and Community-Based Services spending plan. The reimbursement for CCI activities are

MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

REGULAR POLICY CHANGE NUMBER: 36

budgeted in the CCI-Administrative Costs policy change for July 1, 2021, through December 31, 2021.

Reason for Change:

The change for FY 2021-22, from the prior estimate, is an increase due to an increase in the number of slots and the rate paid per slot and inclusion of the MSSP costs in CCI in this policy change effective January 1, 2022. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to the increased slots and rates, and the MSSP costs in CCI, being captured for a full year in this policy change.

Methodology:

1. Assume an increase and slots and rates effective January 1, 2022.
2. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through December 31, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022, on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.
3. For FY 2021-22, assume the increased FMAP for COVID-19 is 6.2% for Title XXI is estimated at \$799,000 for this policy change.
4. The estimates below were provided by CDA on a cash basis.

Fiscal Years	TF	GF	FF	GF Reimb.	FFCRA Extension (FF)
FY 2021-22	\$51,506,000	(\$1,597,000)	\$27,350,000	\$25,753,000	\$799,000
FY 2022-23	\$63,951,500	\$0	\$31,976,000	\$31,975,500	\$0

*Totals may differ due to rounding.

Funding:

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

GF 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 from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

TELEHEALTH

REGULAR POLICY CHANGE NUMBER: 37
IMPLEMENTATION DATE: 1/2022
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2302

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$54,332,000	\$132,886,000
- STATE FUNDS	\$19,166,500	\$46,941,100
PAYMENT LAG	0.9312	0.9968
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$50,594,000	\$132,460,800
STATE FUNDS	\$17,847,840	\$46,790,890
FEDERAL FUNDS	\$32,746,110	\$85,669,880

Purpose:

This policy change estimates the costs for telephone/audio-only services at parity.

Authority:

Health Omnibus Bill of 2021 (AB 133)
Welfare and Institutions Code Section 14124.12

Interdependent Policy Changes:

Not Applicable

Background:

Currently, the Department is paying at parity for services provided via telephone/audio-only during the COVID-19 public health emergency (PHE) when the service meets all of the requirements of a face to face visit and conditions of the billing code. The Department plans to continue payment parity for telephone/audio-only services, including for clinics, after the PHE. In 2021, the Department convened an advisory group of stakeholders, to provide recommendations to inform the Department in establishing and adopting billing and utilization management protocols for telehealth modalities to increase access and equity and reduce disparities in the Medi-Cal program.

Reason for Change:

There is no change from the prior estimate, for FY 2021-22. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to a full year of costs being captured.

Methodology:

1. Assume implementation will begin in January 1, 2022.
2. The estimated costs for FY 2021-22 and FY 2022-23 are:

Fiscal Years	TF	GF	FF
FY 2021-22	\$54,332,000	\$19,167,000	\$35,165,000
FY 2022-23	\$132,886,000	\$46,942,000	\$85,944,000

TELEHEALTH
REGULAR POLICY CHANGE NUMBER: 37

Funding:

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

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

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

REMOTE PATIENT MONITORING

REGULAR POLICY CHANGE NUMBER: 38
IMPLEMENTATION DATE: 7/2021
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2251

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$32,037,000	\$32,037,000
- STATE FUNDS	\$11,703,700	\$11,703,700
PAYMENT LAG	0.8470	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$27,135,300	\$32,037,000
STATE FUNDS	\$9,913,030	\$11,703,700
FEDERAL FUNDS	\$17,222,300	\$20,333,300

Purpose:

This policy change estimates the costs for expanded remote patient monitoring (RPM) as an allowable telehealth modality.

Authority:

Not Applicable

Interdependent Policy Changes:

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

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.

Managed care costs for RPM 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 in the current estimate, for FY 2021-22, is a decrease due to removing managed care costs because RPM costs are now included in the managed care base capitation rates.

There is no change in the current estimate, from FY 2021-22 to FY 2022-23.

Methodology:

1. RPM was implemented on July 1, 2021 for FFS and managed care beneficiaries with full scope Medi-Cal or pregnancy-only coverage.
2. Beneficiaries must have a primary diagnosis of an acute or chronic disease.

REMOTE PATIENT MONITORING

REGULAR POLICY CHANGE NUMBER: 38

3. Total estimated costs for RPM, on cash basis, is \$32,037,000 TF (\$11,704,000 GF) for FY 2021-22 and FY 2022-23.

Funding:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF XIX
50% Title XIX / 50% GF (4260-101-0001/0890)	\$21,250	\$10,625	\$10,625
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$10,787	\$1,079	\$9,708
Total	\$32,037	\$11,704	\$20,333

(Dollars in Thousands)

FY 2022-23	TF	GF	FF XIX
50% Title XIX / 50% GF (4260-101-0001/0890)	\$21,250	\$10,625	\$10,625
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$10,787	\$1,079	\$9,708
Total	\$32,037	\$11,704	\$20,333

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 funding through January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

COMMUNITY HEALTH WORKER

REGULAR POLICY CHANGE NUMBER: 39
IMPLEMENTATION DATE: 2/2022
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2269

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$7,375,000	\$47,046,000
- STATE FUNDS	\$2,527,400	\$16,946,950
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$7,375,000	\$47,046,000
STATE FUNDS	\$2,527,400	\$16,946,950
FEDERAL FUNDS	\$4,847,600	\$30,099,050

Purpose:

This policy change estimates the cost for adding Community Health Workers (CHWs) to the class of skilled and trained individuals who are able to provide clinically appropriate Medi-Cal covered benefits and services in both Fee-for-Service (FFS) and managed care delivery systems.

Authority:

Not Applicable

Interdependent Policy Changes:

COVID-19 Increased FMAP Extension

Background:

CHWs are skilled and trained health educators who work directly with individuals who may have difficulty understanding and/or interacting with providers due to cultural and/or language barriers. CHWs can assist those individuals by helping them to navigate the relationship with their health care providers, assist them in accessing health care services, and provide key linkages with other similar and related community-based resources. As a result, CHWs help to extend the reach of providers into underserved communities, reduce health disparities, enhance provider communication, and improve health outcomes and overall quality measures. Working in conjunction with health care providers, CHWs can bridge gaps in communication and instill lasting health knowledge to individuals within their communities to reduce health and mental health disparities experienced by vulnerable communities in California.

Effective July 1, 2022, the Department proposes to add CHWs as another class of skilled and trained individuals who are able to provide clinically appropriate Medi-Cal covered benefits and services. CHWs would render Medi-Cal covered benefits and services, and would be under the supervision of a licensed, enrolled Medi-Cal provider. These services would be available under both the FFS and managed care delivery system.

COMMUNITY HEALTH WORKER

REGULAR POLICY CHANGE NUMBER: 39

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a decrease due to the following:

- The effective date shifted from January 1, 2022 to July 1, 2022, resulting in no FFS costs incurring in FY 2021-22.
- Managed care capitation rate costs for Current Year (CY) 2022, on a cash basis, will begin in February 2022.

The change in the current estimate, from FY 2021-22 to FY 2022-23, is an increase due to the following:

- Managed care costs for FY 2022-23 reflecting 7 months of CY 2022 rates compared to FY 2021-22 capturing five months of CY 2022 rates.
- An assumed ramp up of costs for CY 2023 rates.
- FFS costs for FY 2022-23 includes a full years' cost.

Methodology:

1. Assume CHWs will begin providing Medi-Cal benefits and services beginning July 1, 2022 for both FFS and managed care.
2. Managed care capitation rates for CY 2022, on a cash basis, will be realized in FY 2021-22.
3. Total estimated costs for CHWs, on a cash basis, is as follows:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
Managed Care	\$7,375	\$2,527	\$4,848
Total	\$7,375	\$2,527	\$4,848

FY 2022-23	TF	GF	FF
Fee-for-Service (Lagged)	\$7,219	\$3,299	\$3,920
Managed Care	\$39,827	\$13,648	\$26,179
Total	\$47,046	\$16,947	\$30,099

Funding:

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$4,156,000	\$2,078,000	\$2,078,000
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$2,709,000	\$271,000	\$2,438,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$510,000	\$178,000	\$332,000
Total	\$7,375,000	\$2,527,000	\$4,848,000

COMMUNITY HEALTH WORKER
REGULAR POLICY CHANGE NUMBER: 39

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$28,884,000	\$14,442,000	\$14,442,000
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$15,407,000	\$1,541,000	\$13,866,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$2,755,000	\$964,000	\$1,791,000
Total	\$47,046,000	\$16,947,000	\$30,099,000

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 40
IMPLEMENTATION DATE: 12/2008
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1228

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$12,310,000	\$13,052,000
- STATE FUNDS	\$4,451,000	\$4,797,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$12,310,000	\$13,052,000
STATE FUNDS	\$4,451,000	\$4,797,000
FEDERAL FUNDS	\$7,859,000	\$8,255,000

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), (P.L. 116-127), Section 6008
 Coronavirus Aid, Relief, and Economic Security (CARES) Act, 2020 (P.L. 116-136), Section 3811
 California Welfare and Institutions Code, Chapter 300, Section 14196.2
 Consolidated Appropriations Act, 2021 (P.L. 108-361), Section 204

Interdependent Policy Changes:

CCT Fund Transfer to CDSS
 COVID-19 Increased FMAP Extension

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.

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 40

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 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 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 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.

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.

On December 27, 2020, the President signed the Consolidated Appropriations Act, 2021 into law, which includes an extension of the MFP grant through FFY 2023 and appropriates funding through 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.

Beginning January 1, 2021, SB 214 created 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. However, SB 214 was invalidated due to federal legislation that modified criteria for the MFP grant. As a result, the Department proposed amendments to the statute through trailer bill language to align the state-funded CCT population with the new federal requirements. There is also current legislation to align eligibility requirements of the proposed state-funded CCT population with existing federal requirements.

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

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 40

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 2021-22, is a decrease due to a shift in implementation of the state-funded CCT population from July 2021 to September 2021. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to additional enrollments from the non-DD CCT participants.

Methodology:

1. Assume estimated costs of waiver impacted services for persons residing year-round in Nursing Facility (NF)-Bs would be \$89,936 in FY 2021-22 and FY 2022-23. 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 through December 2021. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022, on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension.
3. Assume the newly authorized state-funded CCT population began transitioning to the CCT program in September 2021.
4. 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 authorized state-funded CCT population.
5. Assume 120 pre-transitions that are unsuccessful for non-DD beneficiaries in FY 2021-22 and 140 in FY 2022-23 cost \$1,509 annually; reimbursed at 100% MFP.
6. Of the state-funded CCT population, assume 33 pre-transitions that are unsuccessful for non-DD beneficiaries in FY 2021-22 and 20 in FY 2022-23 cost \$1,509 annually; reimbursed at 100% GF.
7. Assume non-DD CCT participants, upon transitioning into CCT, cost \$18,000 annually in FY 2021-22 and FY 2022-23; 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 through December 2021. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension.
8. Assume 760 individuals will transition from an inpatient facility to the CCT program in Calendar Year (CY) 2022. Of the 760 individuals, assume 360 are from the state-funded CCT population and 400 are from the non-DD CCT participants.

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 40

9. Assume 270 individuals will transition from an inpatient facility to the non-DD CCT participants in CY 2023. No new individuals will transition from the state-funded CCT population in CY 2023.
10. Assume \$23,919,000 has been awarded for CY 2021.
11. Assume \$27,403,000 will be awarded for CY 2022, which will allow CCT transitions to continue through December 31, 2022.
12. Assume the federal government will issue a new grant award in CY 2023 at least equal to the current grant awarded, which will allow CCT transitions to continue through December 31, 2023.
13. Below is the overall impact of the CCT Demonstration project in FY 2021-22 and FY 2022-23.

FY 2021-22	TF	GF	FF
CCT Costs (PC 40):			
Non-DD GF costs and Total FFP	\$8,544,000	\$6,453,000	\$2,091,000
State-Funded CCT Population	\$3,766,000	\$1,238,000	\$2,528,000
FFCRA 3.1% Increased FFP	\$0	\$168,000	(\$168,000)
Total Costs	\$12,310,000	\$7,859,000	\$4,451,000
CCT Savings:			
Total Non-DD GF savings and Total FFP	(\$46,219,000)	(\$23,826,000)	(\$22,393,000)
CCT Fund Transfer to CDSS (PC 51):			
CCT Fund Transfer Costs	\$141,000	\$0	\$141,000
FFCRA 3.1% Increased FFP	\$9,000	\$0	\$9,000
Total Costs	\$150,000	\$0	\$150,000
CCT Outreach - Admin costs (OA 42)	\$340,000	\$0	\$340,000
Total of CCT PCs including pass through	(\$33,419,000)	(\$15,967,000)	(\$17,452,000)

*The savings are included in the total, however, they are fully reflected in the base estimates.

CALIFORNIA COMMUNITY TRANSITIONS COSTS
REGULAR POLICY CHANGE NUMBER: 40

FY 2022-23	TF	GF	FF
CCT Costs (PC 40):			
Non-DD GF costs and Total FFP	\$9,286,000	\$7,017,000	\$2,269,000
State-Funded CCT Population	\$3,766,000	\$1,238,000	\$2,528,000
Total Cost	\$13,052,000	\$8,255,000	\$4,797,000
CCT Savings:			
Total Non-DD GF savings and Total FFP	(\$63,419,000)	(\$31,710,000)	(\$31,709,000)
CCT Fund Transfer to CDSS (PC 51):	\$165,000	\$0	\$165,000
CCT Outreach - Admin costs (OA 42)	\$340,000	\$0	\$340,000
Total of CCT PCs including pass through	(\$49,862,000)	(\$23,455,000)	(\$26,407,000)

*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)

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension 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 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$10,491,000	\$112,000
- STATE FUNDS	\$10,491,000	\$112,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$10,491,000	\$112,000
STATE FUNDS	\$10,491,000	\$112,000
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the cost to the Department to pay contractors 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 April 2023.

In FY 2021-22, the Department received an additional one-time budget allocation to provide the medically tailored meal intervention services available through the Pilot to a broader population. The one-time budget allocation is separate from the funds allocated to the Pilot and will not be included in the Pilot evaluation report. The one-time budget allocation expands the eligible population to include Medi-Cal participants with diabetes, chronic obstructive pulmonary disease, renal disease, chronic kidney disease, cancer, and malnutrition. The one-time budget allocation also adds Fresno, Kings, Madera, Santa Cruz, and Tulare counties to the Pilot program service area.

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

MEDICALLY TAILORED MEALS PILOT PROGRAM

REGULAR POLICY CHANGE NUMBER: 41

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a slight decrease due to revised contract amendment with Mathematica that resulted in a shift of funds that were spent in FY 2020-21. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to a new one-time budget allocation in FY 2021-22. FY 2022-23 only budgets the evaluation services cost.

Methodology:

1. The Pilot began in April 2018.
2. Assume the cost for **FY 2021-22** is **\$10,491,000 TF** and **\$112,000 TF** for **FY 2022-23**.

Funding:

100% GF (4260-101-0001)

CCS DEMONSTRATION PROJECT

REGULAR POLICY CHANGE NUMBER: 42
IMPLEMENTATION DATE: 4/2013
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1775

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$8,591,000	\$0
- STATE FUNDS	\$4,077,360	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$8,591,000	\$0
STATE FUNDS	\$4,077,360	\$0
FEDERAL FUNDS	\$4,513,640	\$0

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

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 two-sided 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. There will be a risk corridor repayment for FY 2018-19. Due to the 1115 Waiver expiring on December 31, 2020, the demonstration project was expected to sunset no sooner than December 31, 2020. However, due to the COVID-19 impact, CMS granted an extension of one year on the 1115 Waiver. The RCHSD demonstration project will sunset December 31, 2021.

CCS DEMONSTRATION PROJECT

REGULAR POLICY CHANGE NUMBER: 42

Reason for Change:

The change from the prior estimate, for FY 2021-22, is an increase due to applying final Calendar Year (CY) 2021 rates and a FY 2018-19 risk corridor payment now expected to occur in FY 2021-22.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to the sunset of the RCHSD demonstration project on December 31, 2021.

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 seven months of the CY 2021 RCHSD rate will pay in FY 2021-22.
3. The final CY 2021 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 2020-21 (Jan-June 2021)	320	\$3,377.87	\$1,080,918	\$6,486,000
FY 2021-22 (July-Dec 2021)	320	\$3,377.87	\$1,080,918	\$6,486,000
FY 2022-23	0	\$0	\$0	\$0

4. Assume the final capitation payment will occur in January 2022.
5. The FY 2018-19 risk corridor data was collected in January 2021. Final risk corridor calculations for FY 2018-19 are expected to result in a payment of \$1,024,349 in FY 2021-22.
6. Bridge Period risk corridor data is estimated to be collected no sooner than 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.
7. Total estimated costs for FY 2021-22 on a cash basis are:

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$7,356,000	\$3,678,000	\$3,678,000
88% Title XXI / 12% GF (4260-113-0001/0890)	\$143,000	\$17,000	\$126,000
65% Title XXI / 35% GF (4260-113-0001/0890)	\$1,092,000	\$382,000	\$710,000
Total	\$8,591,000	\$4,077,000	\$4,514,000

CCS DEMONSTRATION PROJECT

REGULAR POLICY CHANGE NUMBER: 42

Funding:

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

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

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

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change

HEARING AID COVERAGE

REGULAR POLICY CHANGE NUMBER: 43
IMPLEMENTATION DATE: 9/2021
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2189

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$10,000,000	\$10,000,000
- STATE FUNDS	\$10,000,000	\$10,000,000
PAYMENT LAG	0.8560	0.9990
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$8,560,000	\$9,990,000
STATE FUNDS	\$8,560,000	\$9,990,000
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the cost of providing hearing aids and associated services to children ages 17 and under, who are otherwise not eligible for Medi-Cal, do not have health insurance coverage for hearing aids and related services, and are at or below 600% Federal Poverty Level (FPL).

Authority:

Budget Act of 2020

Interdependent Policy Changes:

Not Applicable

Background:

The Department introduced a new California state-only benefit for children, ages 0-17, who are otherwise not eligible for Medi-Cal, and with a household income up to 600 percent of the federal poverty level, effective July 1, 2021. This benefit will be available to children with no health insurance or whose existing health insurance does not cover hearing aids and related services. Referral or valid hearing aid prescription from an audiologist, otolaryngologist, or physician will be required. This program is funded with 100% General Fund (GF).

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.

Reason for Change:

There is no change from the prior estimate for FY 2021-22.

There is no change in the current estimate, from FY 2021-22 to FY 2022-23.

Methodology:

1. The hearing aid coverage began on July 1, 2021. Payments began in September 2021.
2. Annual costs are estimated to be \$10,000,000 TF/GF.

HEARING AID COVERAGE

REGULAR POLICY CHANGE NUMBER: 43

3. FY 2021-22 and FY 2022-23 payments for hearing aids to these non-Medi-Cal children are estimated to be:

Hearing Aid Coverage	TF	GF	FF
FY 2021-22	\$10,000,000	\$10,000,000	\$0
FY 2022-23	\$10,000,000	\$10,000,000	\$0

Funding:

100% GF (4260-101-0001)

MFP/CCT SUPPLEMENTAL FUNDING

REGULAR POLICY CHANGE NUMBER: 45
IMPLEMENTATION DATE: 7/2021
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2275

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$5,000,000	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$5,000,000	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$5,000,000	\$0

Purpose:

This policy change budgets supplemental funding in Money Follows the Person (MFP) that the Centers for Medicare and Medicaid Services (CMS) made available to state MFP grantees to support planning and capacity building activities.

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
 Consolidated Appropriations Act, 2021 (P.L. 108-361) Section 204

Interdependent Policy Changes:

Not Applicable

Background:

On September 23, 2020, CMS notified MFP state grantees of a supplemental funding opportunity for those that operate MFP Demonstration programs. The Department developed 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 home and community-based services capacity. The Department submitted their proposal for supplemental funding to CMS on June 30, 2021.

Reason for Change:

There is no change from the prior estimate for FY 2021-22. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to a one-time cost in the current year.

Methodology:

1. Assume MFP supplemental funding can be spent in the year it was awarded and for four years after, as long as grant funding remains available.

MFP/CCT SUPPLEMENTAL FUNDING
REGULAR POLICY CHANGE NUMBER: 45

2. Assume the Department will receive a one-time MFP supplemental funding up to **\$5,000,000 TF** in **FY 2021-22**.

Funding:

MFP Federal Grant (4260-106-0890)

CONTINUOUS GLUCOSE MONITORING SYSTEMS BENEFIT

REGULAR POLICY CHANGE NUMBER: 46
IMPLEMENTATION DATE: 2/2022
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2174

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$7,859,000	\$5,522,000
- STATE FUNDS	\$2,742,700	\$1,426,600
PAYMENT LAG	0.9217	0.8909
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$7,243,600	\$4,919,600
STATE FUNDS	\$2,527,950	\$1,270,960
FEDERAL FUNDS	\$4,715,690	\$3,648,590

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 enter into rebate agreements with the various manufacturers for the CGM system and supplies.

CONTINUOUS GLUCOSE MONITORING SYSTEMS BENEFIT

REGULAR POLICY CHANGE NUMBER: 46

The rebate savings agreements will also apply to beneficiaries under 21 who are already eligible for CGM under Medi-Cal and Family Health. The rebates will offset the General Fund (GF) costs for CGMs.

Reason for Change:

This change from the prior estimate, for FY 2021-22, is a net increase due to the following:

- The payment start date for FFS shifted from January 2022 to March 2022.
- The projected caseload for CGM utilization decreased.
- The rebate savings for CGM products will begin in FY 2022-23 due to the assumed six months lag time for rebate claims processing.

The change in the current estimate, from FY 2021-22 to FY 2022-23, is due to the following:

- No rebate savings included in FY 2021-22, and
- FY 2022-23 including a full years' CGM benefit cost.

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 CGM system payments will start February 2022 for managed care, and March 2022 for FFS.
3. Assume the Department will negotiate and secure rebates for the CGM systems with various manufacturers to offsets GF costs.
4. Assume in September 2022, the Department will begin invoicing all CGM manufacturers with whom it has executed rebate agreements for reimbursement on CGM devices.
5. Assume utilization controls would specify that poorly controlled diabetes need to be demonstrated to be eligible for CGMs.
6. 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) – The monitor translates the readings from the sensors and transmitters into dynamic data, generating glucose direction and rate of change. Monitors will be a one-time cost every three years.
 - CGM Sensors – Patients will receive monthly supplies (one sensor lasts for approximately 10 days). The CGM sensors are small sensors that would be located just underneath the skin to measure the glucose levels.
 - Transmitters – The transmitter is a small device that fits onto the sensors and sends data to the CGM monitor. Transmitters are replaced on a quarterly basis throughout the year.

CONTINUOUS GLUCOSE MONITORING SYSTEMS BENEFIT

REGULAR POLICY CHANGE NUMBER: 46

7. 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.
8. Total net cost on an accrual basis, for FFS and managed care, is estimated to be:

CGM System - FFS	First Year Cost	Second Year and Ongoing Cost
CGM Office Visits	\$338,000	\$0
CGM - Accessories and Supplies	\$5,295,000	\$4,868,000
SMBG to CGM Transition Savings	(\$1,263,000)	(\$1,263,000)
Rebate Savings	(\$2,517,000)	(\$2,091,000)
Rebate Savings (Ages 21 & Under)	(\$4,036,000)	(\$3,352,000)
Total Fund	(\$2,183,000)	(\$1,838,000)
General Fund	(\$1,341,000)	(\$1,123,000)

CGM System – Managed Care	First Year Cost	Second Year and Ongoing Cost
CGM Office Visits	\$1,189,000	\$0
CGM - Accessories and Supplies	\$18,618,000	\$17,117,000
SMBG to CGM Transition Savings	(\$4,442,000)	(\$4,442,000)
Rebate Savings	(\$8,852,000)	(\$7,351,000)
Rebate Savings (Ages 21 & Under)	\$0	\$0
Total Fund	\$6,513,000	\$5,324,000
General Fund	\$5,305,000	\$4,376,000

9. The total estimated payments in FY 2021-22 and FY 2022-23, on a cash basis are:

FY 2021-22 - CGM System	FFS + Managed Care	FFS	Managed Care
CGM Office Visits	\$609,000	\$113,000	\$496,000
CGM - Accessories and Supplies	\$9,522,000	\$1,765,000	\$7,757,000
SMBG to CGM Transition Savings	(\$2,272,000)	(\$421,000)	(\$1,851,000)
Rebate Savings	\$0	\$0	\$0
Rebate Savings (Ages 21 & Under)	\$0	\$0	\$0
Total Cost of CGM System	\$7,859,000	\$1,457,000	\$6,402,000

CONTINUOUS GLUCOSE MONITORING SYSTEMS BENEFIT
REGULAR POLICY CHANGE NUMBER: 46

FY 2022-23 - CGM System	FFS + Managed Care	FFS	Managed Care
CGM Office Visits	\$920,000	\$226,000	\$694,000
CGM - Accessories and Supplies	\$23,146,000	\$5,153,000	\$17,993,000
SMBG to CGM Transition Savings	(\$5,705,000)	(\$1,263,000)	(\$4,442,000)
Rebate Savings	(\$9,475,000)	(\$2,098,000)	(\$7,377,000)
Rebate Savings (Ages 21 & Under)	(\$3,364,000)	(\$3,364,000)	\$0
Total Cost of CGM System	\$5,522,000	(\$1,346,000)	\$6,868,000

FY 2021-22	TF	GF	FF
Fee-for-Service	\$1,457,000	\$533,000	\$924,000
Managed Care	\$6,402,000	\$2,210,000	\$4,192,000
Rebates Savings	\$0	\$0	\$0
Total	\$7,859,000	\$2,743,000	\$5,116,000

FY 2022-23	TF	GF	FF
Fee-for-Service	\$4,116,000	\$1,504,000	\$2,612,000
Managed Care	\$14,245,000	\$4,919,000	\$9,326,000
Rebates Savings	(\$12,839,000)	(\$4,996,000)	(\$7,843,000)
Total	\$5,522,000	\$1,427,000	\$4,095,000

Funding:

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$4,892,000	\$2,446,000	\$2,446,000
90% Title XIX ACA / 10% GF (4260-101-0001/0890)	\$2,967,000	\$297,000	\$2,670,000
Total	\$7,859,000	\$2,743,000	\$5,116,000

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$2,186,000	\$1,093,000	\$1,093,000
90% Title XIX ACA / 10% GF (4260-101-0001/0890)	\$3,336,000	\$334,000	\$3,002,000
Total	\$5,522,000	\$1,427,000	\$4,095,000

CALAIM - ORGAN TRANSPLANT

REGULAR POLICY CHANGE NUMBER: 47
IMPLEMENTATION DATE: 1/2022
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2199

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$4,789,000	\$1,061,000
- STATE FUNDS	\$1,393,650	\$309,250
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$4,789,000	\$1,061,000
STATE FUNDS	\$1,393,650	\$309,250
FEDERAL FUNDS	\$3,395,350	\$751,750

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:

COVID-19 Increased FMAP Extension

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:

The change from the prior estimate, for FY 2021-22, is an increase due to updated payment lag.

The change in the current estimate, from FY 2021-22 to FY 2022-23, is due FY 2022-23 including a full years costs of the organ transplants carved into managed care, and FY 2021-22 including a bigger payment lag.

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: 47

2. On an ongoing basis, the net annual impact of the shift from FFS to managed care is expected to be budget neutral.

ANNUAL	TF	GF	Title XIX	Title XXI
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
Total	\$0	\$0	\$0	\$0

3. The net fiscal impact for FY 2021-22 and FY 2022-23 is estimate due to the timing of the changes in the FFS and managed care payments.

FY 2021-22 (Lagged)	TF	GF	Title XIX	Title XXI
CalAIM - Organ Transplant Fee-for-Service	(\$32,047,000)	(\$9,326,000)	(\$22,670,000)	(\$51,000)
CalAIM - Organ Transplant Managed Care	\$36,836,000	\$10,720,000	\$26,057,000	\$59,000
Total	\$4,789,000	\$1,394,000	\$3,387,000	\$8,000

FY 2022-23 (Lagged)	TF	GF	Title XIX	Title XXI
CalAIM - Organ Transplant Fee-for-Service	(\$87,345,000)	(\$25,420,000)	(\$61,786,000)	(\$139,000)
CalAIM - Organ Transplant Managed Care	\$88,406,000	\$25,729,000	\$62,537,000	\$140,000
Total	\$1,061,000	\$309,000	\$751,000	\$1,000

Funding:

FY 2021-22 (Lagged)	TF	GF	FFP
50% Title XIX / 50% GF (4260-101-0001/0890)	\$2,280,000	\$1,140,000	\$1,140,000
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)	\$2,498,000	\$250,000	\$2,248,000
Total	\$4,789,000	\$1,394,000	\$3,395,000

FY 2022-23 (Lagged)	TF	GF	FFP
50% Title XIX / 50% GF (4260-101-0001/0890)	\$506,000	\$253,000	\$253,000
65% Title XXI / 35% GF (4260-113-0001/0890)	\$3,000	\$1,000	\$2,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$552,000	\$55,000	\$497,000
Total	\$1,061,000	\$309,000	\$752,000

CALAIM - ORGAN TRANSPLANT
REGULAR POLICY CHANGE NUMBER: 47

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

EXPANSION TO SCREENING FOR ADDITIONAL SUBSTANCES

REGULAR POLICY CHANGE NUMBER: 48
 IMPLEMENTATION DATE: 6/2021
 ANALYST: Joel Singh
 FISCAL REFERENCE NUMBER: 2158

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$3,140,000	\$1,570,000
- STATE FUNDS	\$1,150,000	\$575,400
PAYMENT LAG	0.9610	1.0000
% REFLECTED IN BASE	7.61 %	14.30 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,787,900	\$1,345,500
STATE FUNDS	\$1,021,050	\$493,120
FEDERAL FUNDS	\$1,766,860	\$852,370

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

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:

There is no change from the prior estimate for FY 2021-22.

The change in the current estimate, from FY 2021-22 to FY 2022-23, is due to FY 2021-22 including the EPC payments for dates of service between June 9, 2020 and June 16, 2021.

EXPANSION TO SCREENING FOR ADDITIONAL SUBSTANCES

REGULAR POLICY CHANGE NUMBER: 48

Methodology:

1. Expansion to screening for additional substances, effective June 9, 2020, was implemented on June 16, 2021.
2. The EPC for the period from June 9, 2020 to June 16, 2021 occurred in October 2021. The EPC costs are included in the FY 2021-22 totals.
3. Total estimated payments for the screenings are:

Additional Substances Screening	TF	GF	FF
FY 2021-22	\$3,140,000	\$1,150,000	\$1,990,000
FY 2022-23	\$1,570,000	\$575,000	\$995,000

Funding:

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$2,090,000	\$1,045,000	\$1,045,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$1,050,000	\$105,000	\$945,000
Total	\$3,140,000	\$1,150,000	\$1,990,000

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$1,046,000	\$523,000	\$523,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$524,000	\$52,000	\$472,000
Total	\$1,570,000	\$575,000	\$995,000

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

MEDICAL INTERPRETERS PILOT PROJECT

REGULAR POLICY CHANGE NUMBER: 49
IMPLEMENTATION DATE: 12/2021
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1989

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$1,260,000	\$2,400,000
- STATE FUNDS	\$1,260,000	\$2,400,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,260,000	\$2,400,000
STATE FUNDS	\$1,260,000	\$2,400,000
FEDERAL FUNDS	\$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 2021-22, is a decrease due to a delay in the pilot project start date from July 2021 to October 2021. In addition, a one-time cost of \$60,000 GF is now estimated in FY 2021-22 for the pilot site contractors' start-up costs.

The change in the current estimate, from FY 2021-22 to FY 2022-23, is due to a full year of the estimated costs being included in FY 2022-23.

Methodology:

1. Assume the Medical Interpreters Pilot Project will be effective October 1, 2021.
2. On an accrual basis, assume \$2,400,000 GF annually will be reimbursed for the pilot project; \$2,000,000 GF for pilot site contractors and \$400,000 GF for pilot project evaluators.
3. A one-time \$60,000 GF start-up cost for pilot site contractors is estimated to be paid in December 2021.

MEDICAL INTERPRETERS PILOT PROJECT
REGULAR POLICY CHANGE NUMBER: 49

4. An estimated \$600,000 GF quarterly reimbursement is expected to begin in January 2022.
5. Total estimated reimbursement for FY 2021-22 and FY 2022-23, on a cash basis, are:

FY 2021-22	TF	GF
Pilot Site Contractors – One-Time	\$60,000	\$60,000
Pilot Site Contractors - Quarterly	\$1,000,000	\$1,000,000
Pilot Project Evaluator – Quarterly	\$200,000	\$200,000
Total	\$1,260,000	\$1,260,000

FY 2022-23	TF	GF
Pilot Site Contractors - Quarterly	\$2,000,000	\$2,000,000
Pilot Project Evaluator – Quarterly	\$400,000	\$400,000
Total	\$2,400,000	\$2,400,000

Funding:

100% General Fund (4260-101-0001)

DOULA BENEFIT

REGULAR POLICY CHANGE NUMBER: 50
IMPLEMENTATION DATE: 7/2022
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2279

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$1,106,000
- STATE FUNDS	\$0	\$424,350
PAYMENT LAG	1.0000	0.8510
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$941,200
STATE FUNDS	\$0	\$361,120
FEDERAL FUNDS	\$0	\$580,080

Purpose:

This policy change estimates the cost of adding doula services as a covered Medi-Cal benefit in Fee-for-Service (FFS) and managed care delivery systems.

Authority:

Budget Act of 2021

Interdependent Policy Changes:

Not Applicable

Background:

The Department will be adding doula services to the list of preventive services effective July 1, 2022. Doula services include personal support to women and families throughout a woman's pregnancy, childbirth and postpartum experience. This includes emotional and physical support, provided during pregnancy, labor, birth and the postpartum period. Pursuant to 42 Code of Federal Regulations (CFR) Section 440.130(c), doula services must be recommended by a physician or other licensed practitioner.

Medi-Cal's standard doula benefit will include maternity and labor support visits, which can be at the beneficiary's home, or part of a beneficiary's office visit, and during delivery. Currently, there is no certification requirement to operate as a doula in the state of California. For doulas who chose to go through a certification process, the requirements vary based on the organization.

Positive health outcomes as a result of doula services are expected during the pregnancy through childbirth. Research suggests that the doula benefit also results in offsetting savings, due to situations where higher costs for preterm births and cesarean deliveries may be avoided. More positive health outcomes are also expected during the pregnancy through to childbirth. However, no offsetting savings are assumed in this policy change. Such savings will accrue as reductions in base expenditures as they materialize.

Reason for Change:

This change from the prior estimate, for FY 2021-22, is due to the implementation date shift from January 2022 to July 2022.

DOULA BENEFIT

REGULAR POLICY CHANGE NUMBER: 50

The change in the current estimate, from FY 2021-22 to FY 2022-23, is due to no costs incurring in FY 2021-22.

Methodology:

1. Assume the doula benefit will be implemented effective July 1, 2022 in both Medi-Cal FFS and managed care delivery systems for beneficiaries with full scope Medi-Cal or pregnancy-only coverage.
2. Managed care costs for doula benefit 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.
3. An estimated 98,295 births occur in Medi-Cal FFS. Assume 10% of those births will utilize doula services.
4. The estimated cost for doula per labor is \$450.00. Assume the annual cost for doula benefit is \$4,423,000.
5. Assume the doula benefit utilization will occur on a phase in basis with 25% utilization in the first year, 50% in the second year, and full phase-in occurring in the third year.
6. Total estimated costs for the doula benefit, on a cash basis, is as follows:

Doula Benefit	TF	GF	FF
FY 2022-23	\$1,106,000	\$424,000	\$682,000

Funding:

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$770,000	\$385,000	\$385,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$313,000	\$31,000	\$282,000
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$23,000	\$8,000	\$15,000
Total	\$1,106,000	\$424,000	\$682,000

CCT FUND TRANSFER TO CDSS

REGULAR POLICY CHANGE NUMBER: 51
IMPLEMENTATION DATE: 10/2011
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1562

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$150,000	\$165,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$150,000	\$165,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$150,000	\$165,000

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) (P.L. 116-127), Section 6008
 Coronavirus Aid, Relief, and Economic Security (CARES) Act, 2020 (P.L. 116-136) Section 3811
 Consolidated Appropriations Act, 2021 (P.L. 116-361), Section 204

Interdependent Policy Changes:

COVID-19 Increased FMAP Extension

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.

CCT FUND TRANSFER TO CDSS

REGULAR POLICY CHANGE NUMBER: 51

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 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 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.

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.

On December 27, 2020, the President signed the Consolidated Appropriations Act, 2021 into law, which includes an extension of the MFP grant through FFY 2023 and appropriates funding through 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.

Reason for Change:

The change from the prior estimate, FY 2021-22, is a decrease due to an estimated lower utilization of In-Home Supportive Services (IHSS) under CCT. Estimated utilization decreased from 15% to 13%. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to the increased CCT enrollments.

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 13% of all non-DD enrollees utilize IHSS under CCT. Assume each case costs \$10,877 in FY 2021-22 and FY 2022-23. 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 through December 31, 2021. The impact of a

CCT FUND TRANSFER TO CDSS

REGULAR POLICY CHANGE NUMBER: 51

six month extension of the FFCRA increased FMAP through June 30, 2022, on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension.

5. Assume 400 non-DD beneficiaries will transition in FY 2021-22 and 468 in FY 2022-23.
6. Assume \$23,919,000 TF has been awarded for calendar year (CY) 2021, based on federal projections, which will allow CCT transitions to continue through December 31, 2022.
7. Assume the federal government will issue a new grant award for \$27,403,000 TF in CY 2022, based on federal projections, which will allow CCT transitions to continue through December 31, 2023.
8. Below is the overall impact of the CCT Demonstration project in FY 2021-22 and FY 2022-23.

FY 2021-22	TF	GF	FF
CCT Costs (PC 40):			
Non-DD GF costs and Total FFP	\$8,544,000	\$6,453,000	\$2,091,000
State-Funded CCT Population	\$3,766,000	\$1,238,000	\$2,528,000
FFCRA 3.1% Increased FFP	\$0	\$168,000	(\$168,000)
Total Costs	\$12,310,000	\$7,859,000	\$4,451,000
CCT Savings:			
Total Non-DD GF savings and Total FFP	(\$46,219,000)	(\$23,826,000)	(\$22,393,000)
CCT Fund Transfer to CDSS (PC 51):			
CCT Fund Transfer Costs	\$141,000	\$0	\$141,000
FFCRA 3.1% Increased FFP	\$9,000	\$0	\$9,000
Total Costs	\$150,000	\$0	\$150,000
CCT Outreach - Admin costs (OA 42)	\$340,000	\$0	\$340,000
Total of CCT PCs including pass through	(\$33,419,000)	(\$15,967,000)	(\$17,452,000)

*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: 51

FY 2022-23	TF	GF	FF
CCT Costs (PC 40):			
Non-DD GF costs and Total FFP	\$9,286,000	\$7,017,000	\$2,269,000
State-Funded CCT Population	\$3,766,000	\$1,238,000	\$2,528,000
Total Cost	\$13,052,000	\$8,255,000	\$4,797,000
CCT Savings:			
Total Non-DD GF savings and Total FFP	(\$63,419,000)	(\$31,710,000)	(\$31,709,000)
CCT Fund Transfer to CDSS (PC 51):	\$165,000	\$0	\$165,000
CCT Outreach - Admin costs (OA 42)	\$340,000	\$0	\$340,000
Total of CCT PCs including pass through	(\$49,862,000)	(\$23,455,000)	(\$26,407,000)

*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)

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

DIABETES PREVENTION PROGRAM

REGULAR POLICY CHANGE NUMBER: 52
IMPLEMENTATION DATE: 1/2022
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2056

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$197,000	\$1,230,000
- STATE FUNDS	\$71,700	\$446,700
PAYMENT LAG	0.7090	0.9427
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$139,700	\$1,159,500
STATE FUNDS	\$50,840	\$421,100
FEDERAL FUNDS	\$88,840	\$738,420

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

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: 52

- 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 2021-22, is a decrease due to payments delayed until January 2022 due to provider enrollment delays.

The change in the current estimate, from FY 2021-22 to FY 2022-23, is due to only Core Sessions – Attendance costs will be incurred in FY 2021-22. Costs for Core Sessions – Performance, Core Maintenance, and Ongoing Maintenance will begin in FY 2022-23 due to phased-in beneficiary participation.

Methodology:

1. Assume DPP payments will start January 1, 2022.
2. Total annual cost for the Core Sessions is estimated to be \$966,000 TF.

Core Sessions – Attendance:	\$675,000 TF
Core Sessions – Performance:	\$291,000 TF
3. Assume a six-month phase-in for beneficiary participation in the Core Sessions beginning January 2022. Assume Performance payments will be phased-in over a six-month period and will be paid at the end of Core Sessions, beginning July 1, 2022, on a six-month phase in basis.
4. Total annual cost for the Core Maintenance Sessions is estimated to be \$344,000 TF.
5. Assume Core Maintenance Sessions will start July 1, 2022, and will be phased-in over a six-month period.
6. Total annual cost for the Ongoing Maintenance Sessions is estimated to be \$182,000 TF.
7. Assume Ongoing Maintenance Sessions will start January 1, 2023, and will be phased-in over a six-month period.

DIABETES PREVENTION PROGRAM
REGULAR POLICY CHANGE NUMBER: 52

8. Total estimated payments are:

DPP	Annual Cost	FY 2021-22	FY 2022-23
Core Sessions - Attendance	\$675,000	\$197,000	\$675,000
Core Sessions - Performance	\$291,000	\$0	\$230,000
Core Maintenance	\$344,000	\$0	\$272,000
Ongoing Maintenance	\$182,000	\$0	\$53,000
Total	\$1,492,000	\$197,000	\$1,230,000

Funding:

FY 2021-22	TF	GF	FFP
50% Title XIX / 50% GF (4260-101-0001/0890)	\$130,000	\$65,000	\$65,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$67,000	\$7,000	\$60,000
Total	\$197,000	\$72,000	\$125,000

FY 2022-23	TF	GF	FFP
50% Title XIX / 50% GF (4260-101-0001/0890)	\$808,000	\$404,000	\$404,000
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$2,000	\$1,000	\$1,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$420,000	\$42,000	\$378,000
Total	\$1,230,000	\$447,000	\$783,000

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

CYBHI - DYADIC SERVICES

REGULAR POLICY CHANGE NUMBER: 53
IMPLEMENTATION DATE: 1/2023
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2328

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$89,954,000
- STATE FUNDS	\$0	\$41,961,100
PAYMENT LAG	1.0000	0.9721
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$87,444,300
STATE FUNDS	\$0	\$40,790,380
FEDERAL FUNDS	\$0	\$46,653,900

Purpose:

This policy change estimates the costs of adding dyadic services as a Medi-Cal benefit for children under 21 years old and their parents/guardians.

Authority:

AB 133 (Chapter 143, Statutes of 2021)

Interdependent Policy Changes:

Not Applicable

Background:

The Children and Youth Behavioral Health Initiative (CYBHI) is a multiyear package of investments as part of the FY 2021-22 budget agreement. The CYBHI is intended to transform California's behavioral health system for children and youth aged 0-25 into a world-class, innovative, up-stream focused, ecosystem where all children and young adults are routinely screened, supported, and served for emerging behavioral health needs. Dyadic services are included in the CYBHI package.

The Department proposes to add dyadic services as a covered outpatient benefit in both fee-for-service (FFS) and managed care delivery systems for beneficiaries under 21 years old. Children typically see medical providers over a dozen times during infancy and early childhood, but routine visits do not always surface issues that could lead to behavioral health problems later in the child's life. Dyadic services allow medical and behavioral health providers to work as teams, treating both the child and the parent/caregiver. The behavioral health provider screens the family for trauma and stress, interpersonal safety, tobacco and substance use, mental health symptoms, and social determinants of health (such as food or housing insecurity), and is able to provide timely support, referrals, and coordination. Dyadic services have been proven to improve outcomes for children by addressing issues early, before they lead to serious health problems.

Reason for Change:

This is a new policy change.

CYBHI - DYADIC SERVICES
REGULAR POLICY CHANGE NUMBER: 53

Methodology:

1. Assume the dyadic services benefit will begin January 1, 2023.
2. Total estimated costs for dyadic services, on a cash basis, is as follows.

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Fee-for-Service	\$9,120	\$4,431	\$4,689
Managed Care	\$80,834	\$37,530	\$43,304
Total	\$89,954	\$41,961	\$47,993

Funding:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$69,848	\$34,924	\$34,924
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$20,106	\$7,037	\$13,069
Total	\$89,954	\$41,961	\$47,993

MEDI-CAL RX - MANAGED CARE PHARMACY BENEFIT TO FFS

REGULAR POLICY CHANGE NUMBER: 54
 IMPLEMENTATION DATE: 1/2022
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 2165

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$2,990,390,000	\$6,794,603,000
- STATE FUNDS	\$924,067,550	\$2,098,162,450
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,990,390,000	\$6,794,603,000
STATE FUNDS	\$924,067,550	\$2,098,162,450
FEDERAL FUNDS	\$2,066,322,450	\$4,696,440,550

Purpose:

This policy change estimates the fee-for-service (FFS) costs 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

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 delivery system is referred to as Medi-Cal Rx. In January 2021, Centene Corporation announced plans to acquire Magellan Health, the parent company of the Medi-Cal Rx vendor, Magellan Medicaid Administration, Inc. (MMA). This acquisition required additional time for exploration of acceptable conflict avoidance protocols to protect the Medi-Cal claims data and other proprietary information. The Medi-Cal Rx Assumption of Operations (AOO) is assumed January 1, 2022.

The Department estimates total savings from Medi-Cal Rx will be approximately \$307 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.

MEDI-CAL RX - MANAGED CARE PHARMACY BENEFIT TO FFS

REGULAR POLICY CHANGE NUMBER: 54

- 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 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

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 was 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

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
- Medical Supply Rebates
- Non-Hospital 340B Clinic Supplemental Payments
- Medi-Cal Rx – Additional Supplemental Rebates

Other Admin

- Medi-Cal Rx – Administrative Costs

Reason for Change:

The change from the prior estimate for FY 2021-22 is due to:

- Updating and removing the managed care savings and related managed care administration savings from this policy change as these savings are now captured in the managed care base capitation rates. The managed care savings are now display only in this policy change.
- Increase in FFS costs based on updated estimates trended using a ten year average of Consumer Price Index for drug pricing.
- Updated funding splits based on Calendar Year (CY) 2022 managed care rate and enrollment.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to including a full year of FFS costs and 340B savings in FY 2022-23.

MEDI-CAL RX - MANAGED CARE PHARMACY BENEFIT TO FFS

REGULAR POLICY CHANGE NUMBER: 54

Methodology:

1. Assume the Department will transition MC pharmacy costs beginning January 1, 2022.
2. The Department expects savings related to Medi-Cal Rx will be phased-in gradually, reaching approximately \$307 million in General Fund savings.
3. The estimated annual MC pharmacy savings and the related MC administration savings is \$6,823,151,000 TF. These savings are captured in the managed care base capitation rates and are display only in this policy change.
4. Costs for FFS pharmacy costs are estimated to be \$7,105,505,000 TF.
5. The Department expects saving related to non-hospital 340B clinics to be \$147,000,000 TF annually.
6. The impact of a six month extension of the FFCRA increased FMAP from January 1, 2022 through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.
7. The estimated annual impact is:

(Dollars in Thousands)

Annual	TF	GF	FF
Estimated Fee-For-Service Pharmacy Costs	\$7,105,505	\$2,222,939	\$4,882,566
Estimated 340B Savings	(\$147,000)	(\$73,500)	(\$73,500)
Total MC to FFS (In PC)	\$6,958,505	\$2,149,439	\$4,809,066
Estimated Managed Care Pharmacy Savings	(\$6,543,935)	(\$2,047,253)	(\$4,496,682)
Managed Care Related Administrative Cost Savings	(\$279,216)	(\$87,352)	(\$191,864)
Net Managed Care Savings (Display Only)	(\$6,823,151)	(\$2,134,605)	(\$4,688,546)
Total MC to FFS (Including Managed Care savings)	\$135,354	\$14,834	\$120,520

MEDI-CAL RX - MANAGED CARE PHARMACY BENEFIT TO FFS

REGULAR POLICY CHANGE NUMBER: 54

7. The estimated cost for FY 2021-22 is:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
Estimated Fee-For-Service Pharmacy Costs	\$3,051,667	\$954,706	\$2,096,961
Estimated 340B Savings	(\$61,277)	(\$30,639)	(\$30,638)
Total MC to FFS (In PC)	\$2,990,390	\$924,067	\$2,066,323
Estimated Managed Care Pharmacy Savings	(\$2,588,043)	(\$809,942)	(\$1,778,101)
Managed Care Related Administrative Cost Savings	(\$110,426)	(\$34,558)	(\$75,868)
Net Managed Care Savings (Display Only)	(\$2,698,469)	(\$844,500)	(\$1,853,969)
Total MC to FFS (Including Managed Care savings)	\$291,921	\$79,567	\$212,354

8. The estimated cost for FY 2022-23 is:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Estimated Fee-For-Service Pharmacy Costs	\$6,941,603	\$2,171,662	\$4,769,941
Estimated 340B Savings	(\$147,000)	(\$73,500)	(\$73,500)
Total MC to FFS (In PC)	\$6,794,603	\$2,098,162	\$4,696,441
Estimated Managed Care Pharmacy Savings	(\$6,350,076)	(\$1,986,562)	(\$4,363,514)
Managed Care Related Administrative Cost Savings	(\$270,944)	(\$84,762)	(\$186,182)
Net Managed Care Savings (Display Only)	(\$6,621,020)	(\$2,071,324)	(\$4,549,696)
Total MC to FFS (Including Managed Care savings)	\$173,583	\$26,838	\$146,745

Funding:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	\$1,517,552	\$758,776	\$758,776
90% Title XIX / 10% GF (4260-101-0001 / 0890)	\$1,400,807	\$140,081	\$1,260,726
65% Title XXI / 35% GF (4260-113-0001 / 0890)	\$72,031	\$25,210	\$46,821
Total	\$2,990,390	\$924,067	\$2,066,323

MEDI-CAL RX - MANAGED CARE PHARMACY BENEFIT TO FFS
REGULAR POLICY CHANGE NUMBER: 54

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	\$3,444,351	\$1,722,176	\$1,722,175
90% Title XIX / 10% GF (4260-101-0001 / 0890)	\$3,186,405	\$318,640	\$2,867,765
65% Title XXI / 35% GF (4260-113-0001 / 0890)	\$163,847	\$57,346	\$106,501
Total	\$6,794,603	\$2,098,162	\$4,696,441

MEDICATION THERAPY MANAGEMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 55
IMPLEMENTATION DATE: 12/2021
ANALYST: Elena Susbilla
FISCAL REFERENCE NUMBER: 2263

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$7,875,000	\$21,375,000
- STATE FUNDS	\$2,757,000	\$7,483,200
PAYMENT LAG	0.9140	0.9405
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$7,197,800	\$20,103,200
STATE FUNDS	\$2,519,900	\$7,037,950
FEDERAL FUNDS	\$4,677,850	\$13,065,240

Purpose:

This policy change estimates the costs for providing medication management payments to Medi-Cal enrolled pharmacies who, by means of signed contracts with the Department, provide a list of specialized services to high-risk and medically complex populations with certain disease states by implementing a new Medication Therapy Management (MTM) program.

Authority:

AB 133 (Chapter 143, Statutes of 2021)
SPA 21-0028

Interdependent Policy Change:

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

Background:

In February 2019, following implementation of the new Fee-For-Service (FFS) Actual Acquisition Cost (AAC)-based pharmacy reimbursement methodology, independent pharmacy providers and the California Pharmacists Association (CPhA), notified the Department that the new methodology, and associated reduced reimbursement could cause certain pharmacies to cease providing specialized medication management services. These specialized services are designed to ensure “at risk” populations remain adherent and compliant with their drug treatment regimens. Characteristics of the “at risk” population receiving medication management services may include homelessness, mental illness, and/or history/evidence of non-compliance or non-adherence with medications.

The Department authorized a survey to determine acquisition costs and identify specialized services provided by those pharmacies in the dispensing of specific drugs. The survey confirmed the AAC methodology resulted in a potential for beneficiary access issues with respect to certain drugs, while being an appropriate reimbursement methodology overall. The drug therapy categories surveyed were identified through direct communications from Medi-Cal providers to the Department, including reports from stakeholders and CPhA.

The Department will implement a separate specific reimbursement methodology for FFS pharmacy services provided in conjunction with certain complex chronic medical conditions

MEDICATION THERAPY MANAGEMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 55

including but not limited to Severe Mental Illness (SMI), Human Immunodeficiency Virus (HIV), Hepatitis C Virus (HCV), cancer, cystic fibrosis and other genetic diseases, Multiple Sclerosis (MS), Hemophilia, Cardio-vascular diseases, lung and respiratory diseases, severe/progressive nervous system disorders, chronic Kidney Disease, Alzheimer's disease or other dementia, End Stage Renal Disease, Osteoporosis and Diabetes. Such services are currently not reimbursable in Medi-Cal. To participate in this program, Medi-Cal enrolled pharmacies will be required to enter into a contract with the Department. The contract will outline the specific requirements and guidelines necessary to receive reimbursement under this methodology. The Department will adopt nationally recognized MTM billing codes, as well as the associated rates paid for each. A review of literature, and other state's MTM programs, suggests an aggregated average of six MTM encounter sessions per beneficiary annually is typical (prior authorization requests will be considered for the medical necessity of additional sessions). It is estimated that each provider will be able to accommodate approximately 30 total MTM beneficiaries at any point in time, meeting with an average of half (15) monthly.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to updated lag as a result of costs that are estimated to begin December 2021.

The change from 2021-22 to FY 2022-23, in the current estimate, is due to two-thirds of the annual cost is assumed in FY 2022-23 while only one-third is assumed in FY 2021-22.

Methodology:

1. CMS approved SPA 21-0028 on September 15, 2021 for the MTM program, effective on July 1, 2021.
2. Assume provider payment per encounter is \$75.00 based on the rate paid for the medication therapy management code in the marketplace.
3. Assume that specialty independent community pharmacy providers, along with some specialty chain pharmacy providers, will contract for these services for an estimated total of 3,000 participating providers. Based on trained staff time and resources necessary to provide MTM sessions, an average of 15 beneficiaries will receive MTM sessions each month (assuming an average total caseload of thirty (30) clients per pharmacy at any point in time annually). Each of these beneficiaries is assumed to have an average of six encounters per year.

$$3,000 \text{ providers} \times 15 \text{ clients/month} \times 12 \text{ months} \times \$75.00/\text{session} = \$40,500,000$$

4. FFS annual costs are estimated at \$40 million TF (\$14.2 million GF):

(Dollars in Thousands)	TF	GF	FF
Annual Costs	\$40,500	\$14,178	\$26,321

5. Assume claims will begin December 1, 2021 due to the need for claim system edits and provider contracts to be in place.
6. Assume the uptake of the benefit will be slow based on historical uptake of similar pharmacist provided services as well as provider contracting, provider training in MTM

MEDICATION THERAPY MANAGEMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 55

provision and pharmacy based accommodations for providing private MTM sessions with clients. Estimate one-third of the annual costs for FY 2021-22, two-thirds of the annual cost in FY 2022-23, and full annual costs in FY 2023-24.

7. The FY 2021-22 FFS costs, before payment lags, are estimated to be:

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF	\$4,660,000	\$2,330,000	\$2,330,000
90% Title XIX / 10% GF	\$2,793,000	\$279,000	\$2,514,000
65% Title XXI / 35%	\$422,000	\$148,000	\$275,000
Total	\$7,875,000	\$2,757,000	\$5,119,000

8. The FY 2022-23 FFS costs, before payment lags, are estimated to be:

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF	\$12,648,000	\$6,324,000	\$6,324,000
90% Title XIX / 10% GF	\$7,581,000	\$758,000	\$6,823,000
65% Title XXI / 35%	\$1,146,000	\$401,000	\$746,000
Total	\$21,375,000	\$7,483,000	\$13,893,000

Funding:

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

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

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

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

MEDI-CAL DRUG REBATE FUND

REGULAR POLICY CHANGE NUMBER: 56
IMPLEMENTATION DATE: 11/2019
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 2124

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

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

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.

For information on the federal share of the rebate collections, see the Federal Drug Rebates, State Supplemental Drug Rebates, Family PACT Drug Rebates, and BCCTP Drug Rebates policy changes.

MEDI-CAL DRUG REBATE FUND

REGULAR POLICY CHANGE NUMBER: 56

Reason for Change:

There is no change in the FY 2021-22 GF transfer amount from the prior estimate.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase in the GF transfer due to:

- Estimating the fund balance remaining at the end of FY 2021-22 will be transferred to the GF in FY 2022-23, and
- Estimating FFCRA increased FMAP funding will end in FY 2021-22.

Methodology:

1. In FY 2021-22, it is estimated that \$1.47 billion will be transferred from the Medi-Cal Drug Rebate Fund to the GF and \$1.95 billion will be transferred from the Medi-Cal Drug Rebate Fund to the GF in FY 2022-23.
2. A balance of \$370.26 million was in the Medi-Cal Drug Rebate Fund as of July 2021. The estimated reserve to be kept in the Medi-Cal Drug rebate fund for FY 2021-22 and FY 2022-23 is \$458 million and \$222 million for each respective fiscal year.
3. The 6.2% Title XIX, 4.34% Title XIX, and 4.34% Title XXI FFCRA increased FMAP is assumed for drug rebates through December 31, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.

MEDI-CAL DRUG REBATE FUND
REGULAR POLICY CHANGE NUMBER: 56

4. The summary of the non-federal share and federal share of the estimated FY 2021-22 and FY 2022-23 rebates and the estimated reserve for each respective fiscal year are:

(Dollars in Thousands)

FY 2021-22 Summary of Drug Rebates	TF	Fund 3331	FF
Federal Drug Rebates	(\$4,797,930)	(\$1,530,027)	(\$3,267,903)
State Supplemental Drug Rebates	(\$126,857)	(\$29,951)	(\$96,906)
Family PACT Drug Rebates	(\$8,619)	(\$1,095)	(\$7,524)
BCCTP Drug Rebates	(\$6,119)	(\$1,843)	(\$4,276)
Subtotal Rebates	(\$4,939,525)	(\$1,562,916)	(\$3,376,609)
FY 2020-21 Balance		(\$370,267)	
Estimated FY 2021-22 Reserve		\$458,267	
Medi-Cal Drug Rebate Fund Transfer		(\$1,474,916)	

(Dollars in Thousands)

FY 2022-23 Summary of Drug Rebates	TF	Fund 3331	FF
Federal Drug Rebates	(\$4,917,182)	(\$1,679,384)	(\$3,237,798)
State Supplemental Drug Rebates	(\$130,779)	(\$33,207)	(\$97,572)
Family PACT Drug Rebates	(\$12,164)	(\$1,564)	(\$10,600)
BCCTP Drug Rebates	(\$6,686)	(\$2,134)	(\$4,552)
Subtotal Rebates	(\$5,066,811)	(\$1,716,289)	(\$3,350,522)
Estimated FY 2021-22 Reserve to transfer		(\$458,267)	
Estimated FY 2022-23 Reserve		\$222,000	
Medi-Cal Drug Rebate Fund Transfer		(\$1,952,556)	

MEDI-CAL DRUG REBATE FUND
REGULAR POLICY CHANGE NUMBER: 56

5. The estimated transfers from the Medi-Cal Drug Rebate Fund to GF are:

(Dollars in Thousands)

FY 2021-22	TF	GF	SF
Drug Rebates Transfer	\$0	(\$1,474,916)	\$1,474,916

(Dollars in Thousands)

FY 2022-23	TF	GF	SF
Drug Rebates Transfer	\$0	(\$1,952,556)	\$1,952,556

Funding:

(Dollars in Thousands)

FY 2021-22	TF	GF	SF
Medi-Cal Drug Rebate Fund (4260-601-3331)	\$1,474,916	\$0	\$1,474,916
100% GF (4260-101-0001)	(\$1,559,646)	(\$1,559,646)	\$0
FFCRA 6.2% GF (4260-101-0001)	\$79,981	\$79,981	\$0
FFCRA 4.34% GF (4260-113-0001)	\$4,639	\$4,639	\$0
FFCRA 4.34% GF (4260-101-0001)	\$110	\$110	\$0
Total	\$0	(\$1,474,916)	\$1,474,916

(Dollars in Thousands)

FY 2022-23	TF	GF	SF
Medi-Cal Drug Rebate Fund (4260-601-3331)	\$1,952,556	\$0	\$1,952,556
100% GF (4260-101-0001)	(\$1,952,556)	(\$1,952,556)	\$0
Total	\$0	(\$1,952,556)	\$1,952,556

MEDI-CAL RX- ADDITIONAL SUPPLEMENTAL REBATES

REGULAR POLICY CHANGE NUMBER: 57
IMPLEMENTATION DATE: 7/2022
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2249

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$670,311,000
- STATE FUNDS	\$0	-\$223,755,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$670,311,000
STATE FUNDS	\$0	-\$223,755,600
FEDERAL FUNDS	\$0	-\$446,555,400

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 delivery system is referred to as Medi-Cal Rx. In January 2021, Centene Corporation announced plans to acquire Magellan Health, the parent company of the Medi-Cal Rx vendor, Magellan Medicaid Administration, Inc. (MMA). This acquisition required additional time for exploration of acceptable conflict avoidance protocols to protect the Medi-Cal claims data and other proprietary information. The Medi-Cal Rx Assumption of Operations (AOO) is assumed January 1, 2022.

State supplemental drug rebates for drugs provided through FFS are negotiated by the Department with drug manufactures to provide additional drug rebates beyond the federal rebate levels (see the Federal Drug Rebate policy change) and are budgeted in the State Supplemental Drug Rebates policy change. Additional supplemental rebates are expected as a result of the MC population shift to Medi-Cal Rx. It is also assumed that due to Med-Cal Rx, rebate contracts with drug manufacturers will be renegotiated resulting in an additional increase in supplemental rebates.

MEDI-CAL RX- ADDITIONAL SUPPLEMENTAL REBATES

REGULAR POLICY CHANGE NUMBER: 57

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
- 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 estimates to begin collecting additional supplemental rebates for Medi-Cal Rx on July 1, 2022.
2. Assume additional supplemental rebates for Medi-Cal Rx will gradually increase to 12% of the annual pharmacy expenditures by FY 2024-25.
3. The estimated annual savings is \$1,044,874,000 TF.

(Dollars in Thousands)

Annual	TF	GF	FF
Additional Supplemental Rebates-MC Carve-Out	(\$852,661)	(\$292,271)	(\$560,390)
Additional Supplemental Rebates- Existing FFS	(\$192,213)	(\$50,464)	(\$141,749)
Total	(\$1,044,874)	(\$342,735)	(\$702,139)

4. The estimated FY 2022-23 savings is:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Additional Supplemental Rebates-MC Carve-Out	(\$595,405)	(\$204,090)	(\$391,315)
Additional Supplemental Rebates- Existing FFS	(\$74,906)	(\$19,666)	(\$55,240)
Total	(\$670,311)	(\$223,756)	(\$446,555)

MEDI-CAL RX- ADDITIONAL SUPPLEMENTAL REBATES
REGULAR POLICY CHANGE NUMBER: 57

Funding:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX/ 50% GF (4260-101-0001/0890)	(\$370,080)	(\$185,040)	(\$185,040)
90% Title XIX/ 10% GF (4260-101-0001/0890)	(\$265,461)	(\$26,546)	(\$238,915)
65% Title XIX/ 35% GF (4260-101-0001/0890)	(\$34,770)	(\$12,170)	(\$22,600)
Total	(\$670,311)	(\$223,756)	(\$446,555)

LITIGATION SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 58
IMPLEMENTATION DATE: 8/2009
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 1449

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$105,000	\$0
- STATE FUNDS	-\$105,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$105,000	\$0
STATE FUNDS	-\$105,000	\$0
FEDERAL FUNDS	\$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 2021-22, is a decrease in the amount of settlement payments the Department expects to receive.

The change from FY 2021-22 to FY 2022-23, 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: 58**Methodology:**

The following settlements are expected to be received in FY 2021-22:

Settlement Name	FY 2021-22
Progenity Inc.	(\$14,000)
Merit Medical Systems, Inc.	(\$42,000)
RA Medical Systems, Inc.	(\$7,000)
Medicrea USA Inc./Medicrea International	(\$42,000)
Total GF Savings	(\$105,000)

Funding:

100% GF (4260-101-0001)

BCCTP DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 59
IMPLEMENTATION DATE: 1/2010
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1433

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$4,276,000	-\$4,552,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$4,276,000	-\$4,552,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	-\$4,276,000	-\$4,552,000

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

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.

BCCTP DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 59

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a decrease in rebate savings due to:

- Including two additional quarters of actual rebate collection data through the quarter ending June 2021, and
- A decrease in estimated BCCTP pharmacy expenditures for the applicable expenditure period.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase in rebate savings due to an increase in estimated BCCTP pharmacy expenditures from FY 2021-22 to FY 2022-23.

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 December 31, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.
4. The estimated rebates to collect are \$6,119,000 in FY 2021-22 and \$6,686,000 in FY 2022-23.
5. Assume, of the total BCCTP rebates collected, the ACA offset for BCCTP is \$540,000 TF in FY 2021-22 and \$590,000 TF in FY 2022-23.
6. The Department estimates \$1,843,000 and \$2,134,000 BCCTP drug rebates to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2021-22 and FY 2022-23, respectively.

(Dollars in Thousands)

FY 2021-22	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	(\$3,626)	(\$3,626)	(\$1,953)
FFCRA 4.34% Increased FFP	(\$110)	(\$110)	\$110
ACA Offset	(\$540)	(\$540)	\$0
Total	(\$4,276)	(\$4,276)	(\$1,843)

(Dollars in Thousands)

FY 2022-23	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	(\$3,962)	(\$3,962)	(\$2,134)
ACA Offset	(\$590)	(\$590)	\$0
Total	(\$4,552)	(\$4,552)	(\$2,134)

*The Fund 3331 Transfer column is for informational purposes only. See Methodology #6.

BCCTP DRUG REBATES
REGULAR POLICY CHANGE NUMBER: 59

Funding:

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

FFCRA 4.34% Increased FFP (4260-101-0890)

MEDI-CAL RX - ADDITIONAL SAVINGS FROM MAIC IN FFS

REGULAR POLICY CHANGE NUMBER: 60
 IMPLEMENTATION DATE: 1/2022
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 2166

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$6,629,000	-\$14,732,000
- STATE FUNDS	-\$2,324,300	-\$5,165,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$6,629,000	-\$14,732,000
STATE FUNDS	-\$2,324,300	-\$5,165,600
FEDERAL FUNDS	-\$4,304,700	-\$9,566,400

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

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 delivery system is referred to as Medi-Cal Rx. In January 2021, Centene Corporation announced plans to acquire Magellan Health, the parent company of the Medi-Cal Rx vendor, Magellan Medicaid Administration, Inc. (MMA). This acquisition required additional time for exploration of acceptable conflict avoidance protocols to protect the Medi-Cal claims data and other proprietary information. The Medi-Cal Rx Assumption of Operations (AOO) is assumed January 1, 2022.

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).

MEDI-CAL RX - ADDITIONAL SAVINGS FROM MAIC IN FFS

REGULAR POLICY CHANGE NUMBER: 60

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 vendor, for drugs which have 3 or more generically equivalent options available. Utilizing the MAIC benchmark will result in savings.

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 was 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.

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
- Medical Supply Rebates
- Non-Hospital 340B Clinic Supplemental Payments
- Medi-Cal Rx – Additional Supplemental Rebates

Other Admin

- Medi-Cal Rx – Administrative Costs

Reason for Change:

There is no change from the prior estimate for FY 2021-22.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to including a full year of savings in FY 2022-23.

Methodology:

1. Assume the Department will begin reimbursing FFS pharmacy claims at the MAIC beginning January 1, 2022.
2. The impact of a six month extension of the FFCRA increased FMAP from January 1, 2022 through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.
3. The estimated annual savings is \$14,732,000 TF.

(Dollars in Thousands)

Annual	TF	GF	FF
Additional Savings from MAIC Implementation in FFS	(\$14,732)	(\$5,166)	(\$9,566)
Total	(\$14,732)	(\$5,166)	(\$9,566)

MEDI-CAL RX - ADDITIONAL SAVINGS FROM MAIC IN FFS
REGULAR POLICY CHANGE NUMBER: 60

3. The estimated savings for FY 2021-22 and FY 2022-23 is:

(Dollars in Thousands)

FY 2021-22 (Lagged)	TF	GF	FF
Additional Savings from MAIC Implementation in FFS	(\$6,629)	(\$2,324)	(\$4,305)
Total	(\$6,629)	(\$2,324)	(\$4,305)

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Additional Savings from MAIC Implementation in FFS	(\$14,732)	(\$5,166)	(\$9,566)
Total	(\$14,732)	(\$5,166)	(\$9,566)

Funding:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	(\$3,931)	(\$1,965)	(\$1,966)
90% Title XIX / 10% GF (4260-101-0001/0890)	(\$2,342)	(\$234)	(\$2,108)
65% Title XXI / 35% GF (4260-113-0001/0890)	(\$356)	(\$125)	(\$231)
Total	(\$6,629)	(\$2,324)	(\$4,305)

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF	(\$8,736)	(\$4,368)	(\$4,368)
90% Title XIX / 10% GF	(\$5,204)	(\$521)	(\$4,683)
65% Title XXI / 35% GF	(\$792)	(\$277)	(\$515)
Total	(\$14,732)	(\$5,166)	(\$9,566)

FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 61
IMPLEMENTATION DATE: 12/1999
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 51

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$7,524,000	-\$10,600,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$7,524,000	-\$10,600,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	-\$7,524,000	-\$10,600,000

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

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: 61

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.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a decrease in TF rebate savings due to:

- Including two additional quarters of actual rebate collection data through the quarter ending June 2021,
- Decreased estimated FFACT pharmacy expenditures for the applicable expenditure period, and

The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase in rebate savings due to an increase in estimated FFACT pharmacy expenditures for the applicable expenditure period

Methodology:

1. The regular Federal Medical Assistance Percentage (FMAP) percentage is applied to 7.96% of the FFACT rebates to account for the purchase of non-family planning drugs, and the family planning percentage (90% FFP) is applied to 92.04% of the FFACT rebates.
2. The 6.2% Title XIX FFCRA increased FMAP is assumed for drug rebates through December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.
3. Assume the ACA offset is \$213,000 TF for FY 2021-22 and \$301,000 TF for FY 2022-23.
4. Actual data from July 2013 to June 2021 is used to project rebates.

FAMILY PACT DRUG REBATES
REGULAR POLICY CHANGE NUMBER: 61

5. The Department estimates \$1,095,000 and \$1,564,000 FFACT rebate collections to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2021-22 and FY 2022-23, respectively.

(Dollars in Thousands)

FY 2021-22	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	(\$7,298)	(\$7,298)	(\$1,108)
FFCRA 6.2% Increased FFP	(\$13)	(\$13)	\$13
ACA Offset	(\$213)	(\$213)	\$0
Total	(\$7,524)	(\$7,524)	(\$1,095)

(Dollars in Thousands)

FY 2022-23	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	(\$10,299)	(\$10,299)	(\$1,564)
ACA Offset	(\$301)	(\$301)	\$0
Total	(\$10,600)	(\$10,600)	(\$1,564)

*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)

MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER: 62
IMPLEMENTATION DATE: 10/2006
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1181

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$15,423,000	-\$121,712,000
- STATE FUNDS	-\$7,711,500	-\$60,856,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$15,423,000	-\$121,712,000
STATE FUNDS	-\$7,711,500	-\$60,856,000
FEDERAL FUNDS	-\$7,711,500	-\$60,856,000

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

Background:

The Department contracts with interested medical supply manufacturers for a negotiated Maximum Acquisition Cost (MAC) for specific medical supplies which guarantees the best price available to all providers. The Department establishes the reimbursement rates for the specific medical supplies based on the contracted MAC. In addition, manufacturers may opt to contract for a MAC plus a Rebate. The rebates are a percentage of the MAC per unit of services (quantity) reimbursed.

The current medical supply rebate contract terms for diabetic test strips and lancets ends December 31, 2021, and new contracts are in negotiation for January 1, 2022, to December 31, 2024. The contract terms for pen needles are effective January 1, 2021, through December 31, 2023. In addition, the Department has contracted for self-monitoring blood glucose (SMBG) monitors, control solution for SMBG monitors, lancing devices, and disposable insulin delivery systems (Omnipods and V-Go) starting January 1, 2022.

Due to system limitations in the Rebate Accounting Information System, manually created invoices for the rebate amounts are sent to manufacturers.

On January 1, 2022, 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 begin with claims invoiced for the FY 2021-22 Q3 time period.

MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER: 62

Reason for Change:

The change in FY 2021-22, from the prior estimate, is an increase in savings due to assuming higher quarterly rebate collections for pen needles.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase in savings due to the implementation of Medi-Cal Rx and assuming additional rebates will be collected for SMBG monitors and supplies starting in FY 2022-23 Q1.

Methodology:

1. Assume the average FFS quarterly collections are:

	Pre Medi-Cal Rx	Post Medi-Cal Rx
Test Strips and Lancets	(\$5,006,000)	(\$28,079,000)
Pen Needles	\$135,000	(\$2,246,000)
SMBG Monitors and Supplies	-	(\$103,000)

2. Assume additional rebates for SMBG monitors and supplies begin with claims invoiced January 1, 2022.
3. The transition of pharmacy benefits from MC to the FFS delivery system, or Medi-Cal Rx, will increase the FFS medical supply rebates, beginning with claims invoiced January 1, 2022.
4. There is a one quarter lag for medical supply rebate collections under the current manual process.
5. With Medi-Cal Rx, the new contractor will take over the drug rebate collections and incorporate the medical supply rebates into the automated rebate system, which has a two quarter lag. Due to the switch to the automated rebate system, assume there will be a delay in rebate collections for the January – March 2022 quarter. These rebates will be collected in FY 2022-23 Q1, resulting in three quarters of rebates collected in FY 2021-22. FY 2022-23 will have four quarters of rebates collected.
6. Assume the total rebates collected are \$15,423,000 in FY 2021-22 and \$121,712,000 in FY 2022-23.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2021-22	(\$15,423)	(\$7,711)	(\$7,712)
FY 2022-23	(\$121,712)	(\$60,856)	(\$60,856)

Funding:

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

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 63
IMPLEMENTATION DATE: 1/1991
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 54

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$96,906,000	-\$97,572,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$96,906,000	-\$97,572,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	-\$96,906,000	-\$97,572,000

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

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.

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 63

Reason for Change:

The change from the prior estimate, for FY 2021-22 is an increase in rebate savings due to:

- Including two additional quarters of actual rebate collection data through the quarter ending June 2021, and
- An increase in estimated FFS pharmacy expenditures for the applicable expenditure period.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase in rebate savings due to an estimated increase in FFS pharmacy expenditures from FY 2021-22 to FY 2022-23.

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 December 31, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension 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 \$2,786,000 FF and \$2,763,000 FF in FY 2021-22 and FY 2022-23, respectively.
5. The optional expansion ACA population collections are estimated to be \$78,873,000 TF for FY 2021-22, of which \$70,986,000 FF is budgeted in this policy change. The amount of \$7,887,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund. For FY 2022-23, the ACA collections are estimated to be \$78,761,000 TF, of which \$70,885,000 FF is budgeted in this policy change. The amount of \$7,876,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund.

STATE SUPPLEMENTAL DRUG REBATES
REGULAR POLICY CHANGE NUMBER: 63

6. The Department estimates to transfer \$29,951,000 and \$33,207,000 state supplemental rebates to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2021-22 and FY 2022-23, respectively.

FY 2021-22	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	(\$21,886,000)	(\$21,886,000)	(\$23,312,000)
FFCRA 6.2% Increased FFP	(\$1,169,000)	(\$1,169,000)	\$1,169,000
100% Title XIX ACA	(\$70,986,000)	(\$70,986,000)	(\$7,887,000)
100% Title XXI FF	(\$2,786,000)	(\$2,786,000)	\$0
FFCRA 4.34% Increased FFP	(\$79,000)	(\$79,000)	\$79,000
Total	(\$96,906,000)	(\$96,906,000)	(\$29,951,000)

FY 2022-23	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	(\$23,924,000)	(\$23,924,000)	(\$25,331,000)
100% Title XIX ACA	(\$70,885,000)	(\$70,885,000)	(\$7,876,000)
100% Title XXI FF	(\$2,763,000)	(\$2,763,000)	\$0
Total	(\$97,572,000)	(\$97,572,000)	(\$33,207,000)

*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)

PHARMACY RETROACTIVE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 64
IMPLEMENTATION DATE: 1/2022
ANALYST: Elena Susbilla
FISCAL REFERENCE NUMBER: 2194

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$99,854,000	-\$110,244,000
- STATE FUNDS	-\$37,221,800	-\$49,307,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$99,854,000	-\$110,244,000
STATE FUNDS	-\$37,221,800	-\$49,307,200
FEDERAL FUNDS	-\$62,632,200	-\$60,936,800

Purpose:

This policy change estimates the retroactive adjustments to payments for pharmacy providers related to the April 1, 2017 change in the pharmacy reimbursement methodology. The retroactive adjustments starting in FY 2021-22, budgeted in this policy change, are based on a placeholder implementation date for budgeting purposes only.

Authority:

CMS Final Rule (CMS-2345-FC), 42 CFR Part 447
 State Plan Amendment (SPA) #17-002
 Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

Not Applicable

Background:

The Centers for Medicare and Medicaid Services (CMS), under the provisions of the Affordable Care Act, required each state Medicaid agency to adopt an actual acquisition cost (AAC) based methodology for Covered Outpatient Drugs (CODs), and to adjust their professional dispensing fee. To satisfy this requirement, California, along with many other state Medicaid agencies, adopted CMS's National Average Drug Acquisition Cost (NADAC) as the basis for AAC for drug ingredient reimbursement. 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 COD's be billed at the AAC.

Providers continued to be paid using the 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 were to be implemented. The initial retroactive adjustment was for one month of claims (April 2017) and installed on May 23, 2019.

In June of 2019, the Department paused the retroactive adjustments prior to a lawsuit, *California Pharmacists Association, et al. v. Kent, et al.*, being filed in U.S. District Court on June 5, 2019, seeking to enjoin the Department from implementing the retroactive adjustments. In addition,

PHARMACY RETROACTIVE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 64

The Department developed a process to address the plaintiff's concerns regarding recoupments resulting from the retroactive adjustments. 139 out of 5100 providers requested and were approved by the Department for an Alternative Payment Arrangement (APA). The APA allow recoupments to occur over a period of time not to exceed 48-months. All recoupments for providers who did not request the APA are assumed to occur over a 12-month period.

The Department was scheduled to resume retroactive pharmacy claim adjustments in February 2021. However, due to factors related to ongoing litigation, the Department is continuing the pause until further notice. This pause applies to all pharmacy claims billed through the Medi-Cal fee-for-service fiscal intermediary and includes those claims that were also subject to an alternative payment arrangement. For budgeting purposes only, the retroactive adjustments are assumed to resume January 1, 2022.

Medi-Cal has reprocessed the APA provider's retroactive adjustments and the federal portion of the repayment due to the CMS occurred in FY 2020-21. The non-APA provider's federal portion of any recoupments will be due once their claims have been reprocessed.

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.

Reason for Change:

The change from the prior estimate for FY 2021-22 is due to:

- Delaying the resumption of the retroactive adjustments from an estimated start date of February 2021 to an estimated start date of January 2022,
- Updating the funding assumptions applied to the retroactive adjustments.

The change in the current estimate, from FY 2021-22 to FY 2022-23 is due to:

- Estimating the balance of the net savings in FY 2022-23 due to assuming the resumption of the retroactive adjustments will start January 2022, and
- Completing the return of the entire Federal Funds (FF) for APA providers in FY 2021-22.

Methodology:

1. The total retroactive adjustments from APA providers and Non-APA providers will result in a net savings of \$223.6 million TF (\$72 million GF).

(Dollars in Thousands)

Total Pharmacy Retroactive Savings	TF	GF	FF
Pharmacy Non-APA Retro Savings	(\$192,686)	(\$62,782)	(\$129,904)
Pharmacy APA Retro Savings	(\$30,919)	(\$10,074)	(\$20,845)
Total	(\$223,605)	(\$72,856)	(\$150,749)

2. For budgeting purposes, assume the retroactive adjustments for providers with a Department-approved APA and Non-APA providers will resume January 2022.

PHARMACY RETROACTIVE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 64

3. Assume the retroactive adjustments for Non-APA providers, for the remaining 22-month period, will occur from January 2022 through June 2023.
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 payment to APA providers for retroactive adjustments totaling \$3.4 TF (\$1.1 million GF) will occur in FY 2021-22.
6. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for retroactive adjustments in this policy change.
7. On a cash basis, the net fiscal impact in FY 2021-22 is estimated to be:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
Pharmacy Non-APA Retro Savings	(\$96,343)	(\$31,391)	(\$64,952)
Pharmacy APA Retro Savings	(\$3,511)	(\$5,830)	\$2,319
Total	(\$99,854)	(\$37,221)	(\$62,633)

8. On a cash basis the savings in FY 2022-23 is estimated to be:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Pharmacy Non-APA Retro Savings	(\$96,343)	(\$35,407)	(\$60,937)
Pharmacy APA Retro Savings	(\$13,901)	(\$13,901)	\$0
Total	(\$110,244)	(\$49,308)	(\$60,937)

PHARMACY RETROACTIVE ADJUSTMENTS
REGULAR POLICY CHANGE NUMBER: 64

Funding:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
50% Title XIX/ 50% GF (4260-101-002/0890)	(\$63,877)	(\$34,161)	(\$29,715)
FFCRA 6.2% Increased FMAP (4260-101-0001/0890)	\$0	\$3,684	(\$3,684)
90% Title XIX/ 10% GF (4260-101-0001/0890)	(\$31,334)	(\$5,096)	(\$26,238)
65% Title XXI/ 35% GF (4260-113-0001/0890)	(\$4,643)	(\$1,835)	(\$2,808)
FFCRA 4.34% Increased FMAP (4260-113-0001/0890)	\$0	\$187	(\$187)
Total	(\$99,854)	(\$37,221)	(\$62,632)

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX/ 50% GF (4260-101-002/0890)	(\$70,523)	(\$38,708)	(\$30,815)
90% Title XIX/ 10% GF (4260-101-0001/0890)	(\$34,595)	(\$7,385)	(\$27,209)
65% Title XXI/ 35% GF (4260-113-0001/0890)	(\$5,126)	(\$2,214)	(\$2,912)
Total	(\$110,244)	(\$49,307)	(\$60,937)

FEDERAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 65
IMPLEMENTATION DATE: 7/1990
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 55

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$3,267,903,000	-\$3,237,798,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$3,267,903,000	-\$3,237,798,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	-\$3,267,903,000	-\$3,237,798,000

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

Background:

The Medicaid Drug Rebate Program, created by OBRA 1990, allows the Department to obtain price discounts for drugs. The program helps lower Medicaid spending on outpatient prescription drugs. Drug manufacturers must enter into a national Medicaid drug rebate agreement in order to obtain Medicaid coverage for their prescription drugs. Drug manufacturers are required to pay a rebate for all outpatient drugs that are dispensed and paid for by the State's Medi-Cal program.

The ACA, HR 3590, and the Health Care and Education Reconciliation Act of 2010 (HCERA), extended 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.

Drug rebates previously reported in the Managed Care (MC) Drug Rebates policy change are now included in this policy change. MC drug rebates are authorized as part of the federal Medicaid drug rebate program, and furthermore, on January 1, 2022, Medi-Cal pharmacy services from MC will transition to the Fee-for-Service (FFS) delivery system. This transition, referred to as Medi-Cal Rx, will shift the majority of rebates currently reported as MC drug rebates to the FFS federal rebates. Combining the drug rebates, previously estimated under the

FEDERAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 65

MC delivery system with the FFS federal drug rebates, will remove the impact of estimating for the shift to Medi-Cal Rx.

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.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is an increase in rebate savings due to:

- Including drug rebates previously reported in the MC Drug Rebates policy change,
- Including two additional quarters of actual rebate collection data through the quarter ending June 2021,
- An estimated increase in MC eligibles data used to project the estimated MC rebate collections, and
- A decrease in the estimated percent of rebates collected for FFS pharmacy expenditures.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease in rebate savings due to:

- An estimated decrease in managed care eligibles data used to project the estimated MC rebate collections,
- An increase in the estimated FFS pharmacy expenditures for the applicable expenditure period, and
- An increase in GF savings due to estimating the FFCRA increased FMAP funding will end in FY 2021-22.

Methodology:

1. Rebates are invoiced quarterly and payments occur six months after the conclusion of each quarter.
2. FFS 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.
3. MC rebates are estimated by using the actual trend data for MC eligibles and applying a historical percentage of actual rebates collected to the trend projection.
4. 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.
5. The 6.2% Title XIX FFCRA increased FMAP and 4.34% Title XXI FFCRA increased FMAP is assumed for drug rebates through December 31, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal

FEDERAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 65

spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.

6. 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 \$160,458,000 FF and \$159,123,000 FF in FY 2021-22 and FY 2022-23, respectively.
7. The optional expansion ACA population collections are estimated to be \$1,511,969,000 TF for FY 2021-22, of which \$1,360,772,000 FF is budgeted in this policy change. The amount of \$151,197,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund. For FY 2022-23, a total of \$1,488,809,000 TF is estimated for the optional expansion population, of which \$1,339,928,000 FF is budgeted in this policy change. The amount of \$148,881,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund.
8. The ongoing additional FF claimed by CMS (ACA Offset) is reflected in this policy change. The additional FF is \$282,895,000 TF for FY 2021-22 and \$289,063,000 TF for FY 2022-23.
9. The Department estimates \$1,530,027,000 and \$1,679,384,000 federal drug rebates to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2021-22 and FY 2022-23, respectively.

(Dollars in Thousands)

FY 2021-22	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	(\$1,380,420)	(\$1,380,420)	(\$1,462,189)
FFCRA 6.2% Increased FFP	(\$78,798)	(\$78,798)	\$78,798
100% Title XIX ACA FF	(\$1,360,772)	(\$1,360,772)	(\$151,197)
100% Title XXI FF	(\$160,458)	(\$160,458)	\$0
FFCRA 4.34% Increased FFP	(\$4,560)	(\$4,560)	\$4,560
ACA Offset	(\$282,895)	(\$282,895)	\$0
Total	(\$3,267,903)	(\$3,267,903)	(\$1,530,027)

FY 2022-23	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	(\$1,449,684)	(\$1,449,684)	(\$1,530,503)
100% Title XIX ACA FF	(\$1,339,928)	(\$1,339,928)	(\$148,881)
100% Title XXI FF	(\$159,123)	(\$159,123)	\$0
ACA Offset	(\$289,063)	(\$289,063)	\$0
Total	(\$3,237,798)	(\$3,237,798)	(\$1,679,384)

*The Fund 3331 Transfer column is for informational purposes only. See Methodology #7

FEDERAL DRUG REBATES
REGULAR POLICY CHANGE NUMBER: 65

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)

HCBS SP - CONTINGENCY MANAGEMENT

REGULAR POLICY CHANGE NUMBER: 68
IMPLEMENTATION DATE: 1/2022
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2278

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$3,638,000	\$23,086,000
- STATE FUNDS	\$3,638,000	\$11,543,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,638,000	\$23,086,000
STATE FUNDS	\$3,638,000	\$11,543,000
FEDERAL FUNDS	\$0	\$11,543,000

Purpose:

This policy change estimates the cost of adding Contingency Management as an optional evidence-based service under the Drug Medi-Cal Organized Delivery Systems (DMC-ODS) Waiver Program using enhanced federal funding from the American Rescue Plan Act of 2021 (ARP).

Authority:

American Rescue Plan (ARP) Act (2021)
Section 11.95, 2021 Budget Act

Interdependent Policy Changes:

American Rescue Plan Increased FMAP for HCBS

Background:

The ARP Act of 2021 provides additional Coronavirus Disease 2019 (COVID-19) relief to states. Section 9817 of the ARP provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS). Increased FMAP is available from April 1, 2021, through March 31, 2022. States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. State funds equivalent to the amount of federal funds attributable to the increased FMAP are deposited in the Home and Community-Based Services American Rescue Plan Fund pursuant to Section 11.95 of the 2021 Budget Act. Section 11.95 appropriates this funding to eligible HCBS activities identified in the HCBS Spending Plan.

The DMC-ODS was originally authorized under California's Section 1115 Bridge to Reform Demonstration Waiver and continued in the Medi-Cal 2020 Waiver. The purpose of the program is to provide organized delivery of health care services for Medicaid eligible individuals with a substance use disorder. The Department has submitted the renewal requests under the CalAIM Section 1115 Demonstration and a CalAIM 1915(b) waiver proposals requesting changes to the DMC-ODS authority and including additional services and benefits, effective January 2022.

HCBS SP - CONTINGENCY MANAGEMENT

REGULAR POLICY CHANGE NUMBER: 68

Effective January 1, 2022, the Department will add contingency management as an optional benefit to the DMC-ODS Waiver as part of the 1915(b) Waiver renewal proposal, as a pilot, through March 2024. Contingency management uses small motivational incentives combined with behavioral treatment and has been shown in repeated meta-analyses to be the only effective treatment for stimulant use disorder. The Department proposes to implement the motivational incentives through one or more mobile applications that will be accessible to patients through smart phones, tablets or computers. The mobile application is an essential component to the contingency management benefit and provides for the:

1. Ability to manage the incentives through an electronic tracking system to prevent diversion or misuse of incentives,
2. Ability to manage the incentives independently from the treating provider, to avoid anti-kickback sanctions,
3. Ability to supplement the behavioral health treatment with educational modules, reminders, and app-based cognitive behavioral therapy, to advance treatment goals, and
4. Ability to evaluate the impact of the program, through automated collection of patient-reported outcomes through surveys.

Contingency management was approved in the 2021 Budget Act as part of the HCBS Spending Plan and is pending CMS approval. Funding for the new DMC-ODS waiver contingency management optional benefit is funded with funds from the Home and Community-Based Services American Rescue Plan Fund.

Reason for Change:

This is a new policy change.

Methodology:

1. Assume contingency management will be added as an optional service to the DMC-ODS Waiver effective January 1, 2022, and the services will begin effective July 1, 2022. The 6-month interim will be used to build the program and provide training.
2. Prior to implementation of the benefit, \$3,638,000 in initial start-up funding will be provided to counties in FY 2021-22 distributed through the Behavioral Health Quality Improvement Program (BH-QIP).
3. Once the benefit is implemented in July 2022, along with the costs of the contingency management incentives and mobile application, there are \$500,000 TF administration and provider training costs estimated in FY 2022-23. This includes approximately \$150,000 in start-up costs and approximately \$350,000 in provider trainings.
4. Total estimated costs for contingency management, on a cash basis, is as follows:

FY 2021-22	TF	HCBS ARP Fund	FF
Initial Start-Up Cost via BH QIP	\$3,638,000	\$3,638,000	\$0
Total	\$3,638,000	\$3,638,000	\$0

HCBS SP - CONTINGENCY MANAGEMENT
REGULAR POLICY CHANGE NUMBER: 68

FY 2022-23	TF	HCBS ARP Fund	FF
Contingency Management Incentive Cost	\$11,776,000	\$5,888,000	\$5,888,000
Mobile Application Cost	\$10,810,000	\$5,405,000	\$5,405,000
Administration and Training Cost	\$500,000	\$250,000	\$250,000
Total	\$23,086,000	\$11,543,000	\$11,543,000

Funding:

100% Title XIX (4260-101-0890)

Home and Community-Based Services American Rescue Plan Fund (4260-101-8507)

DRUG MEDI-CAL MAT BENEFIT

REGULAR POLICY CHANGE NUMBER: 69
IMPLEMENTATION DATE: 7/2021
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2169

	FY 2021-22	FY 2022-23
FULL YEAR COST - TOTAL FUNDS	\$604,000	\$353,000
- STATE FUNDS	\$116,100	\$71,600
PAYMENT LAG	0.8571	0.9918
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$517,700	\$350,100
STATE FUNDS	\$99,510	\$71,010
FEDERAL FUNDS	\$418,180	\$279,090

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

Background:

Under the Medicaid State Plan, the Narcotic Treatment Program (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. The Department submitted State Plan Amendment 20-0006 on September 30, 2020 to cover, effective October 1, 2020, all drugs and biological products approved by the FDA for treatment of opioid addiction in NTP and non-NTP settings.

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: 69

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.

Reason for Change:

The change from the prior estimate for FY 2021-22 is a net decrease due to the following:

- The implementation date shifted from April 1, 2021 to July 1, 2021, and as a result, the retroactive claims payments shifted from FY 2020-21 to FY 2021-22.
- The projected caseload decreased for both NTP State Plan and non-NTP certified clinics.
- Decreased developed rates for FY 2021-22.

The change in the current estimate, from FY 2021-22 to FY 2022-23, is due to the following:

- FY 2021-22 includes nine months of retroactive claims payments, and
- Higher estimated rates for FY 2022-23.

Methodology:

1. Rates for the additional MATs were implemented on July 1, 2021. Currently, the FDA-approved MAT drugs already in the State Plan are methadone and naltrexone. This fiscal assumes the addition of buprenorphine, buprenorphine-naloxone (tablets and film), and long-acting injectables for buprenorphine and naltrexone drugs to the State Plan effective October 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 increased FMAP is assumed for expenditures through December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.
4. Total estimated costs are:

FY 2021-22	TF	GF	FF	FFCRA	CF
Regular					
Current	\$352,000	\$82,000	\$176,000	\$11,000	\$83,000
ACA Optional	\$330,000	\$33,000	\$297,000	\$0	\$0
Perinatal					
Current	\$5,000	\$1,000	\$3,000	\$0	\$1,000
ACA Optional	\$1,000	\$0	\$1,000	\$0	\$0
Total	\$688,000	\$116,000	\$477,000	\$11,000	\$84,000

DRUG MEDI-CAL MAT BENEFIT
REGULAR POLICY CHANGE NUMBER: 69

FY 2022-23	TF	GF	FF	FFCRA	CF
Regular					
Current	\$208,000	\$52,000	\$104,000	\$0	\$52,000
ACA Optional	\$194,000	\$19,000	\$175,000	\$0	\$0
Perinatal					
Current	\$4,000	\$1,000	\$2,000	\$0	\$1,000
ACA Optional	\$0	\$0	\$0	\$0	\$0
Total	\$406,000	\$72,000	\$281,000	\$0	\$53,000

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)

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 70
IMPLEMENTATION DATE: 7/2021
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1724

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$306,000	\$604,000
- STATE FUNDS	\$20,500	\$40,700
PAYMENT LAG	0.7500	0.8738
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$229,500	\$527,800
STATE FUNDS	\$15,380	\$35,560
FEDERAL FUNDS	\$214,120	\$492,210

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

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: 70

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.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a decrease due to lower estimated utilization and updated developed rates for FY 2021-22.

The change in the current estimate, from FY 2021-22 to FY 2022-23, is due to FY 2022-23 reflecting changes for FY 2021-22 and FY 2022-23 rates.

Methodology:

1. The FY 2020-21 developed rates, FY 2021-22 developed rates, and FY 2022-23 estimated rates for regular and perinatal services are:

Regular Services	FY 2020-21 Developed Rates	FY 2021-22 Developed Rates	FY 2022-23 Estimated Rates
NTP Methadone	\$14.20	\$14.65	\$15.15
NTP Individual Counseling	\$16.65	\$17.18	\$17.76
NTP Group Counseling	\$3.80	\$4.06	\$4.20
Intensive Outpatient Treatment	\$76.43	\$78.88	\$81.56
Residential Treatment - EPSDT	\$112.55	\$109.77	\$113.50
ODF Individual Counseling	\$83.30	\$85.96	\$88.88
ODF Group Counseling	\$33.90	\$36.52	\$37.76

Perinatal Services	FY 2020-21 Developed Rates	FY 2021-22 Developed Rates	FY 2022-23 Estimated Rates
NTP Methadone	\$15.29	\$15.78	\$16.32
NTP Individual Counseling	\$23.84	\$24.60	\$25.44
NTP Group Counseling	\$6.09	\$8.22	\$8.50
Intensive Outpatient Treatment	\$91.45	\$94.37	\$97.58
Residential Treatment Services	\$112.55	\$109.77	\$113.50
ODF Individual Counseling	\$119.23	\$123.04	\$127.22
ODF Group Counseling	\$54.25	\$73.98	\$76.50

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 70

2. The incremental rate changes for FY 2021-22 and FY 2022-23 are shown below:

Incremental Difference	FY 2021-22 Regular	FY 2021-22 Perinatal	FY 2022-23 Regular	FY 2022-23 Perinatal
NTP Methadone	\$0.45	\$0.49	\$0.50	\$0.54
NTP Individual Counseling	\$0.53	\$0.76	\$0.58	\$0.84
NTP Group Counseling	\$0.26	\$2.13	\$0.14	\$0.28
Intensive Outpatient Treatment	\$2.45	\$2.92	\$2.68	\$3.21
Residential Treatment Services	(\$2.78)	(\$2.78)	\$3.73	\$3.73
ODF Individual Counseling	\$2.66	\$3.81	\$2.92	\$4.18
ODF Group Counseling	\$2.62	\$19.73	\$1.24	\$2.52

3. The cost estimate for FY 2021-22, based on the incremental rate changes for FY 2020-21 and FY 2021-22 are:

FY 2021-22 - Regular	Total Number of Units	Incremental Difference	Total Rate Adj. Cost
NTP Methadone	454,684	\$0.45	\$205,000
NTP Individual Counseling	222,049	\$0.53	\$118,000
NTP Group Counseling	0	\$0.26	\$0
Intensive Outpatient Treatment	1,302	\$2.45	\$3,000
Residential Treatment - EPSDT	0	(\$2.78)	\$0
ODF Individual Counseling	7,575	\$2.66	\$20,000
ODF Group Counseling	21,537	\$2.62	\$56,000
Total for Regular Services			\$402,000

FY 2021-22 - Perinatal	Total Number of Units	Incremental Difference	Total Rate Adj. Cost
NTP Methadone	0	\$0.49	\$0
NTP Individual Counseling	0	\$0.76	\$0
NTP Group Counseling	0	\$2.13	\$0
Intensive Outpatient Treatment	79	\$2.92	\$0
Residential Treatment Services	479	(\$2.78)	(\$1,000)
ODF Individual Counseling	8	\$3.81	\$0
ODF Group Counseling	76	\$19.73	\$1,000
Total for Perinatal Services			\$0

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 70

4. The cost estimate for FY 2022-23, based on the incremental rate changes for FY 2021-22 and FY 2022-23 are:

FY 2022-23 - Regular	Total Number of Units	Incremental Difference	Total Rate Adj. Cost	FY 2022-23 Rate Adj.
NTP Methadone	454,684	\$0.50	\$226,000	\$431,000
NTP Individual Counseling	222,049	\$0.58	\$130,000	\$248,000
NTP Group Counseling	0	\$0.14	\$0	\$0
Intensive Outpatient Treatment	1,302	\$2.68	\$3,000	\$6,000
Residential Treatment - EPSDT	0	\$3.73	\$0	\$0
ODF Individual Counseling	7,575	\$2.92	\$22,000	\$42,000
ODF Group Counseling	21,537	\$1.24	\$27,000	\$83,000
Total for Regular Services			\$408,000	\$810,000

FY 2022-23 - Perinatal	Total Number of Units	Incremental Difference	Total Rate Adj. Cost	FY 2022-23 Rate Adj.
NTP Methadone	0	\$0.54	\$0	\$0
NTP Individual Counseling	0	\$0.84	\$0	\$0
NTP Group Counseling	0	\$0.28	\$0	\$0
Intensive Outpatient Treatment	79	\$3.21	\$0	\$0
Residential Treatment Services	479	\$3.73	\$2,000	\$1,000
ODF Individual Counseling	8	\$4.18	\$0	\$0
ODF Group Counseling	76	\$2.52	\$0	\$1,000
Total for Perinatal Services			\$2,000	\$2,000

5. Total estimated costs for the annual rate adjustments are:

Annual Rate Adj. Cost	FY 2021-22	FY 2022-23
NTP	\$323,000	\$679,000
ODF	\$77,000	\$126,000
IOT	\$3,000	\$6,000
RTS	(\$1,000)	\$1,000
Total	\$402,000	\$812,000

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT
REGULAR POLICY CHANGE NUMBER: 70

FY 2021-22	TF	GF	FF	FFCRA	CF
Regular					
Current	\$207,000	\$1,000	\$104,000	\$6,000	\$96,000
ACA Optional	\$195,000	\$20,000	\$175,000	\$0	\$0
Perinatal					
Current	\$0	\$0	\$0	\$0	\$0
ACA Optional	\$0	\$0	\$0	\$0	\$0
Total	\$402,000	\$21,000	\$279,000	\$6,000	\$96,000

FY 2022-23	TF	GF	FF	FFCRA	CF
Regular					
Current	\$418,000	\$2,000	\$209,000	\$0	\$207,000
ACA Optional	\$392,000	\$39,000	\$353,000	\$0	\$0
Perinatal					
Current	\$2,000	\$0	\$1,000	\$0	\$1,000
ACA Optional	\$0	\$0	\$0	\$0	\$0
Total	\$812,000	\$41,000	\$563,000	\$0	\$208,000

- The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension 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)

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

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

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

DRUG MEDI-CAL PROGRAM COST SETTLEMENT

REGULAR POLICY CHANGE NUMBER: 71
IMPLEMENTATION DATE: 9/2019
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1723

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$402,000	\$0
- STATE FUNDS	-\$55,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$402,000	\$0
STATE FUNDS	-\$55,000	\$0
FEDERAL FUNDS	-\$347,000	\$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-NTP 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: 71

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 2021-22, is due to the following:

- Audit settlements for FY 2013-14 and FY 2014-15, and cost settlements for FY 2015-16 that were scheduled to be processed in FY 2020-21 were delayed and will now be paid in FY 2021-22.
- Additionally, 11 FY 2015-16 audit settlements have been completed since the last estimate and will also be paid in FY 2021-22.

The change in the current estimate, from FY 2021-22 to FY 2022-23, is due to no cost and audit settlement payments or recoupments in FY 2022-23.

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 audit settlements are based on comparing actual expenditures against the audited cost settlements. 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 following cost settlements and audit settlements for the annual cost reports will be recouped in FY 2021-22:

FY 2021-22	TF	GF	Title XIX	Title XXI	CF
FY 2013-14 Audit Settlements	(\$63,000)	\$0	(\$29,000)	(\$3,000)	(\$31,000)
FY 2014-15 Audit Settlements	(\$50,000)	\$0	(\$35,000)	\$0	(\$15,000)
FY 2015-16 Audit Settlements	(\$694,000)	(\$38,000)	(\$248,000)	(\$16,000)	(\$392,000)
FY 2015-16 Cost Settlements	(\$33,000)	(\$17,000)	(\$20,000)	\$4,000	\$0
Total	(\$840,000)	(\$55,000)	(\$332,000)	(\$15,000)	(\$438,000)

DRUG MEDI-CAL PROGRAM COST SETTLEMENT
REGULAR POLICY CHANGE NUMBER: 71

Funding:

100% General Fund

100% Title XIX (4260-101-0890)

100% Title XXI (4260-113-0890)

BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE

REGULAR POLICY CHANGE NUMBER: 74
IMPLEMENTATION DATE: 7/2021
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2262

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$466,000,000	\$1,659,749,000
- STATE FUNDS	\$166,000,000	\$1,441,249,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$466,000,000	\$1,659,749,000
STATE FUNDS	\$166,000,000	\$1,441,249,000
FEDERAL FUNDS	\$300,000,000	\$218,500,000

Purpose:

This policy change estimates the funding available for competitive grants to qualified entities to construct, acquire and rehabilitate real estate assets or to invest in infrastructure, including mobile crisis services, to expand the community continuum of behavioral health treatment resources.

Authority:

SB 129 (Chapter 69, Statutes of 2021)
American Rescue Plan (ARP) Act (2021)

Interdependent Policy Changes:

Not Applicable

Background:

The Department aims to reduce homelessness, incarceration, unnecessary hospitalizations, and inpatient days and improve outcomes for people with behavioral health conditions by expanding access to community-based treatment. The Department also seeks to ensure Medi-Cal beneficiaries have access to sufficient treatment resources across the behavioral health continuum of care, prioritizing community-based, non-institutional treatment options to address needs in crisis and for longer-term residential treatment. To support these efforts, the Behavioral Health Continuum Infrastructure Program (BHCIP) expands the community continuum of behavioral health treatment resources by providing grants to qualified entities to construct, acquire, and rehabilitate real estate assets or to invest in mobile crisis infrastructure. The investment in real estate assets expands the continuum of services by increasing capacity for short-term crisis stabilization, acute and sub-acute care, crisis residential, community-based mental health residential treatment, substance use disorder residential treatment, peer respite, community and outpatient behavioral health services, and other clinically enriched longer-term treatment and rehabilitation opportunities for persons with behavioral health disorders in the least restrictive and least costly setting.

The BHCIP grant funds will be awarded in the rounds focused on the following: mobile crisis infrastructure, county and tribal planning grants, new launch-ready infrastructure projects, infrastructure focused on children and youth 25 years of age and younger (which is part of the

BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE

REGULAR POLICY CHANGE NUMBER: 74

Children and Youth Behavioral Health Initiative [CYBHI]), and infrastructure to address gaps in the state's behavioral health continuum.

Behavioral treatment resources funded pursuant the program may qualify for an exemption from the California Environmental Quality Act and automatic zoning compliance requirements.

The American Rescue Plan Act (ARPA) includes funding to state and local governments. The funds are distributed to states, tribes, and territories based on a formula that considers the state's share of the nation's unemployment. The ARPA funds can be used for specific purposes including addressing public health impacts, negative economic impacts, and water, sewer, and broadband. State and local governments have until December 31, 2024 to encumber the funds and until December 31, 2026 to liquidate the funds. Given that the DHCS Medi-Cal Estimate is budgeted on a cash basis, DHCS has until December 31, 2026 to expend of the State Fiscal Recovery Fund (SFRF) funds.

The CYBHI augments the behavioral health continuum infrastructure funding for FY 2021-22 and FY 2022-23. The CYBHI is a multiyear package of investments as part of the 2021 Budget Act. The CYBHI is intended to transform California's behavioral health system for children and youth aged 0-25 into a world-class, innovative, up-stream focused, ecosystem where all children and young adults are routinely screened, supported, and served for emerging behavioral health needs. BHCIP infrastructure grants targeted to children and youth aged 25 or younger are part of the CYBHI, however, costs are reflected solely in this policy change.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to being more advanced in the project implementation phase and having further developed project timelines and expenditure amounts.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to including the additional available funding in FY 2022-23.

Methodology:

1. The 2021-22 Budget Act amount of \$743,499,000 TF in local assistance funding is included in the Medi-Cal Estimate. The approved local assistance funding included \$300 million from SFRF available for expenditure through December 31, 2026, and \$443,499,000 from the General Fund available for expenditure through June 30, 2026.
2. Of the funds appropriated in the 2021 Budget Act, assume \$466,000,000 TF will be expended for qualified entities to expand resources in FY 2021-22. This includes:
 - \$166,000,000 GF including, \$150,000,000 to support mobile crisis infrastructure and \$16,000,000 for County and Tribal Planning Grants.
 - \$300,000,000 SFRF will be allocated to the Launch Ready RFA (initial payments).
3. Assume \$1,659,749,000 TF will be available for FY 2022-23. This includes \$277,449,000 GF from the amount appropriated for FY 2021-22 in the 2021 Budget Act, as well as an additional \$1,163,750,000 GF (available for expenditure through June 30, 2027) and \$218,500,000 SFRF (available for expenditure through December 31, 2026). Funding would be made available via a competitive application process.
 - Of the \$1,441,249,000 GF, \$480,500,000 is available to support the Children and Youth RFA, \$480,000,000 for the Addressing Gaps #1 RFA, and \$480,749,000 for the Addressing Gaps #2 RFA.

BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE

REGULAR POLICY CHANGE NUMBER: 74

- The \$218,500,000 SFRF will be allocated to the Launch Ready RFA (progress payments).

(Dollars in Thousands)

Behavioral Health Continuum Infrastructure Program Funding	TF	GF	SFRF
FY 2021-22	\$466,000	\$166,000	\$300,000
FY 2022-23	\$1,659,749	\$1,441,249	\$218,500

Funding:

General Fund (4260-101-0001)

State Fiscal Recovery Fund of 2021 (4260-162-8506)

MHP COSTS FOR FFPSA

REGULAR POLICY CHANGE NUMBER: 75
IMPLEMENTATION DATE: 10/2021
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2252

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$34,124,000	\$45,286,000
- STATE FUNDS	\$10,817,000	\$15,090,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$34,124,000	\$45,286,000
STATE FUNDS	\$10,817,000	\$15,090,000
FEDERAL FUNDS	\$23,307,000	\$30,196,000

Purpose:

This policy change estimates the reimbursement to mental health plans (MHPs) for expenditures related to pre and post care of individuals treated in Short-Term Residential Treatment Programs (STRTPs). Beginning October 1, 2021, MHPs implemented a Qualified Individual (QI) to provide specific intensive case management prior to or within 30 days of an admission to a STRTP. Beginning October 1, 2021, began providing six months of intensive aftercare treatment to Medi-Cal beneficiaries for six months after being discharged from a STRTP.

Authority:

Family First Prevention Services Act (Public Law 115-123)
 Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

Not Applicable
 COVID-19 Increased FMAP Extension

Background:

FFPSA – Qualified Individual

The federal Family First Prevention Services Act (FFPSA) was signed into law on February 9, 2018. Prior to enactment of FFPSA, MHPs were only 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. However, historically there had been no specified criteria or process for making the determination. The MHP's only obligation was 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.

FFPSA requires the independently certified QI to perform a detailed assessment, including reviewing past clinical and social service records, meeting the child and family and administering a detailed Child and Adolescent Needs and Strengths (CANS) survey, and conducting a clinical assessment to determine if a treatment plan of home-based services is

MHP COSTS FOR FFPSA

REGULAR POLICY CHANGE NUMBER: 75

more appropriate than residential care and if not, that the placement in a STRTP provides the most effective and appropriate care setting in the least restrictive environment, and the placement is consistent with the short-term and long-term mental and behavioral health goals and permanency plan for the child. 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 was provided prior to FFPSA, and is expected to require at least 10 hours per client.

FFPSA – After Care

FFPSA also 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 SMHS during the 6 months after discharge. The California Department of Social Services (CDSS) and the Department will utilize the High Fidelity Wrap-Around (HFW) model to meet the aftercare requirement of FFPSA, as its substantial research base demonstrates improved outcomes in children and youth in foster care with complex mental health issues.

Funding

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.

The requirements for FFPSA - QI are beyond what is currently required for medical necessity determinations, and therefore would trigger Proposition 30. For FFPSA - After Care, the Department has created a process for HFW services to ensure the enhanced match rate only applies to aftercare services meeting criteria for the HFW model and meeting medical necessity criteria for SMHS. SMHS provided to beneficiaries that are not part of a HFW model are considered existing county obligations and are not expected to prompt additional state funding requests pursuant to Proposition 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. 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 (PHE). National public health emergencies are effective for 90 days unless extended or terminated.

Reason for Change:

The change from the prior estimate for FY 2021-22 is due to:

- Updating the estimate to include the costs for PC MHP Costs for FFPSA - After Care; and
- Updating this estimate to include payment lags.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to including annual estimates for FY 2022-23, and the FFCRA increased FMAP ending December 31, 2021.

MHP COSTS FOR FFPSA

REGULAR POLICY CHANGE NUMBER: 75

Methodology:
**FFPSA Qualified Individual
Standardized Assessments**

1. Assume 5,028 children and youth will be placed in an STRTP in FY 2021-22 and FY 2022-23.
2. Assume Standardized Assessment by a QI begin on October 1, 2021.
3. Assume a total of 3,771 (5,028*.75) receive a standardized assessment by a QI in FY 2021-22 and 5,028 receive a standardized assessment by a QI in FY 2022-23. 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 \$14,417,287 for a QI to complete standardized assessments in FY 2021-22 and \$19,223,049 in FY 2022-23.

Fiscal Year	STRTP Caseload (5,028*.75)	Assessment Hours	Assessments Per Year	Cost Per Hour (QI)	Assessment Cost
FY 2021-22	3,771	10	1.35	\$283.20	\$14,417,287
FY 2022-23	5,028	10	1.35	\$283.20	\$19,223,049

Child and Family Team (CFT)

6. Assume the children and youth placed in an STRTP will receive, on average, 2.24 CFT meetings during placement evaluation for an STRTP.
7. 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 \$4,784,403 for QI participation in CFTs in FY 2021-22 and \$6,379,204 in FY 2022-23.

Fiscal Year	STRTP Caseload (5,028*.75)	CFT Hours	CFTs Per Year	Cost Per Hour (QI)	CFT Cost
FY 2021-22	3,771	2	2.24	\$283.20	\$4,784,403
FY 2022-23	5,028	2	2.24	\$283.20	\$6,379,204

FFPSA – After Care

8. CDSS estimated the total cost of providing services pursuant to the HFW model to be \$47.6 million from October 1, 2021 through June 30, 2022.

MHP COSTS FOR FFPSA

REGULAR POLICY CHANGE NUMBER: 75

9. Analysis of the set of services contained in the HFW model show that, on average, 45% of these services are likely to be billable to child welfare departments and 55% are estimated to meet medical necessity criteria for SMHS.
10. The Department projects the total cost of providing SMH aftercare services will be \$26.2 million in FY 2021-22 and \$34.9 million in FY 2022-23.
11. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through December 31, 2021 for this policy change. The FFCRA funding will be offset equally between the GF and the county funds (CF). The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.

Funding Summary

12. Assume on a cash basis for FY 2021-22, the Department will pay 99% of FY 2021-22 claims. On a cash basis for FY 2022-23, the Department will pay 1% of FY 2021-22 claims and 99% of FY 2022-23 claims. The estimated costs, on a cash basis, is:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF	FFCRA	CF
Standardized Assessments	\$14,273	\$3,435	\$7,137	\$266	\$3,435
CFTs	\$4,736	\$1,140	\$2,368	\$88	\$1,140
Aftercare	\$25,932	\$6,242	\$12,966	\$482	\$6,242
Total FY 2021-22	\$44,941	\$10,817	\$22,471	\$836	\$10,817

(Dollars in Thousands)

	TF	GF	FF	FFCRA	CF
FY 2021-22					
Assessments	\$144	\$34	\$72	\$3	\$35
CFTs	\$48	\$12	\$24	\$1	\$11
After care	\$261	\$63	\$131	\$4	\$63
Total	\$453	\$109	\$227	\$8	\$109
FY 2022-23					
Assessments	\$19,031	\$4,758	\$9,515	\$0	\$4,758
CFTs	\$6,316	\$1,579	\$3,158	\$0	\$1,579
After care	\$34,576	\$8,644	\$17,288	\$0	\$8,644
Total	\$59,923	\$14,981	\$29,961	\$0	\$14,981
Total FY 2022-23	\$60,376	\$15,090	\$30,188	\$8	\$15,090

MHP COSTS FOR FFPSA
REGULAR POLICY CHANGE NUMBER: 75

Funding:

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

Title XIX GF (4260-101-0001)

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

CALAIM - BH QUALITY IMPROVEMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 76
IMPLEMENTATION DATE: 8/2021
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2187

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$21,750,000	\$45,396,000
- STATE FUNDS	\$21,750,000	\$45,396,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$21,750,000	\$45,396,000
STATE FUNDS	\$21,750,000	\$45,396,000
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the payments to counties under the Behavioral Health Quality Improvement Program (BH-QIP).

Authority:

SB 129 (Chapter 69, Statutes of 2021)

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 third-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

CALAIM - BH QUALITY IMPROVEMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 76

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. The Department anticipates incentive payments continuing into FY 2023-24.

Reason for Change:

There is no change from the prior estimate for FY 2021-22.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to including estimated payment for FY 2022-23.

Methodology:

1. Assume all 56 counties apply for this funding (Sutter/Yuba and Placer/Sierra operate jointly).
2. Assume start-up payments in FY 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 initial incentive payments to counties begin in the first quarter of FY 2021-22.
4. Assume quarterly payments will begin in January 2022.
5. The estimated payments in FY 2021-22 are:

(Dollars in Thousands)

FY 2021-22	TF	GF
Start-Up Costs	\$14,000	\$14,000
Incentive Payments	\$7,750	\$7,750
Total	\$21,750	\$21,750

6. The estimated payments in FY 2022-23 are:

(Dollars in Thousands)

FY 2022-23	TF	GF
Incentive Payments	\$45,396	\$45,396
Total	\$45,396	\$45,396

Funding:

100% GF (4260-101-0001)

MHP COSTS FOR CONTINUUM OF CARE REFORM

REGULAR POLICY CHANGE NUMBER: 77
IMPLEMENTATION DATE: 1/2017
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1957

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$20,725,000	\$20,674,000
- STATE FUNDS	\$10,668,000	\$11,229,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$20,725,000	\$20,674,000
STATE FUNDS	\$10,668,000	\$11,229,500
FEDERAL FUNDS	\$10,057,000	\$9,444,500

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)
 California Constitution Article XIII Section 36
 Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

COVID-19 Increased FMAP Extension

Background:

AB 403 is part of an effort to reform congregate care in California. AB 403 established 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.

MHP COSTS FOR CONTINUUM OF CARE REFORM

REGULAR POLICY CHANGE NUMBER: 77

- 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.

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.

Reason for Change:

There is a minor change from the prior estimate for FY 2021-22 due to updating the payment lags.

The change from FY 2021-22 to FY 2022-23 in the current estimate is a decrease due to estimating fewer CFT cases based on CDSS caseload assumptions for FY 2022-23.

Methodology:

Participation in a Child and Family Team (CFT)

1. Assume mental health staff will work with each child with specialty mental health needs for two hours to determine whether or not a child or youth meets criteria to be placed in an STRTP.
2. This estimate assumes 42% of Medi-Cal EPSDT eligible children with an open child welfare case will need SMHS. Of the 42%, 11,736 are assumed to be open child welfare cases and currently receiving a CFT.
3. Based on filed cost reports for mental health services, the average cost for treatment planning for mental health staff to participate in the CFT is \$4.60 per minute or \$276.00 per hour for FY 2019-20, \$3.56 per minute or \$213.60 per hour for FY 2020-21, FY 2021-22, and FY 2022-23.
4. The estimated FY 2021-22 and FY 2022-23 caseload is updated based on CDSS' projections.

MHP COSTS FOR CONTINUUM OF CARE REFORM

REGULAR POLICY CHANGE NUMBER: 77

5. The estimated annual costs (rounded) for participation in a child and family team in FY 2021-22 and FY 2022-23 are estimated as:

FY 2021-22 CFT							
Tier	Child Welfare Cases	SMHS Cases	Current SMHS Cases	New CFT Cases	CFT Hours Per Year Per Case	CFT Case Hours	FY 2021-22 Cost (Case Hours x \$213.60/hr)
A	B	C	D	E	F	G	H
		(B*42%)		(C-D)		(E*F)	(G*H)
Tier 1	3,220	1,352	679	673	12	8,076	\$1,725,000
Tier 2	5,980	2,512	1,261	1,250	10	12,500	\$2,670,000
Tier 3	21,116	8,869	4,454	4,415	8	35,320	\$7,544,000
Tier 4	21,941	9,215	4,627	4,588	4	18,352	\$3,920,000
Tier 5	3,388	1,423	715	708	4	2,832	\$605,000
Total	55,645	23,371	11,736	11,634		77,080	\$16,464,000

FY 2022-23 CFT							
Tier	Child Welfare Cases	SMHS Cases	Current SMHS Cases	New CFT Cases	CFT Hours Per Year Per Case	CFT Case Hours	FY 2022-23 Cost (Case Hours x \$213.60/hr)
A	B	C	D	E	F	G	H
		(B*42%)		(C-D)		(E*F)	(G*H)
Tier 1	5,120	2,151	1,139	1,012	12	12,144	\$2,594,000
Tier 2	9,519	3,998	2,117	1,882	10	18,820	\$4,020,000
Tier 3	17,852	7,498	3,970	3,528	8	28,224	\$6,029,000
Tier 4	16,686	7,008	3,711	3,298	4	13,192	\$2,818,000
Tier 5	3,595	1,510	800	710	4	2,840	\$606,000
Total	52,772	22,165	11,737	10,429	38	75,208	\$16,067,000

Placement Assessments

- Based on CDSS' estimated number of children currently in a rate classification level (RCL) 10 to 12 residential group homes, assume 3,085 children in FY 2019-20, 2,880 children in FY 2020-21, in FY 2021-22, and FY 2022-23.
- 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

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4. Based on based on median county interim rates for STRTP assessments, the average cost for is \$4.60 per minute or \$276.00 per hour for FY 2019-20, and \$4.09 per minute or \$245.40 per hour for FY 2020-21, FY 2021-22 and for FY 2022-23.
5. The assumed Placement Assessment costs are:
- FY 2019-20: 3,085 x \$276.00 x 4 = \$3,405,840
 FY 2020-21: 2,705 x \$245.40 x 4 = \$2,655,228
 FY 2021-22: 2,536 x \$245.40 x 4 = \$2,489,338
 FY 2022-23: 2,874 x \$245.40 x 4 = \$2,821,118

Training

1. 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 54% for FY 2021-22 and FY 2022-23, 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 2021-22 and FY 2022-23: Federal Share: $\$3,000,000 \times 0.75 \times 0.54 = \$1,215,000$ (Rounded)
 FY 2021-22 and FY 2022-23: 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 2021-22, the Department will pay 0.8% of FY 2020-21 claims, and 99.2% of FY 2021-22 claims. For FY 2022-23, the Department will pay 0.8% of FY 2021-22 claims and 99.2% of FY 2022-23 claims. There is no lag in payment for training costs. The estimated costs, on a cash basis, is:

(Dollars in Thousands)

FY 2021-22	TF	CFT	Placement Assessments	Training
FY 2020-21	\$139	\$118	\$21	\$0
FY 2021-22	\$20,586	\$16,332	\$2,469	\$1,785
Total FY 2021-22	\$20,725	\$16,450	\$2,490	\$1,785

(Dollars in Thousands)

FY 2022-23	TF	CFT	Placement Assessments	Training
FY 2021-22	\$152	\$132	\$20	\$0
FY 2022-23	\$20,522	\$15,938	\$2,799	\$1,785
Total FY 2022-23	\$20,674	\$16,070	\$2,819	\$1,785

MHP COSTS FOR CONTINUUM OF CARE REFORM

REGULAR POLICY CHANGE NUMBER: 77

2. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.

COVID-19 - FFCRA	TF	GF	FF
FY 2021-22	\$0	(\$587,000)	\$587,000

3. The FY 2021-22 and FY 2022-23 estimate is:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
CFT	\$16,450	\$8,225	\$8,225
Placement Assessments	\$2,490	\$1,245	\$1,245
Training	\$1,785	\$1,785	\$0
FFCRA 6.2% Increased FFP	\$0	(\$587)	\$587
Total	\$20,725	\$10,668	\$10,057

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
CFT	\$16,070	\$8,035	\$8,035
Placement Assessments	\$2,819	\$1,409	\$1,410
Training	\$1,785	\$1,785	\$0
Total	\$20,674	\$11,229	\$9,445

Funding:

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

100% GF (4260-101-0001)

FFCRA 6.2% Increased FMAP (4260-101-0001/0890)

MHP STRTP GRANTS

REGULAR POLICY CHANGE NUMBER: 78
IMPLEMENTATION DATE: 7/2021
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2331

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$7,478,000	\$7,478,000
- STATE FUNDS	\$7,478,000	\$7,478,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$7,478,000	\$7,478,000
STATE FUNDS	\$7,478,000	\$7,478,000
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the funding available for grants to Mental Health Plans (MHP) if the Department, in consultation with the Department of Finance, determines that a Short-Term Residential Therapeutic Program (STRTP) contracted with an applicable county mental health plan is no longer eligible for federal financial participation under the Medicaid program due to determination that the STRTP is deemed an institution for mental disease.

Authority:

SB 170 (Statutes of 2021)

Interdependent Policy Changes:

Not Applicable

Background:

The Families First Prevention Services Act (FFPSA) was signed into law 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 for children and youth requiring a therapeutic placement when specific criteria are met. In California, STRTP's regulatory requirements are similar to QRTPs and the California Department of Social Services (CDSS) is working to ensure STRTPs current licensing standards meet the requirements of QRTPs. The definition of a QRTP in Title IV-E overlaps with the criteria used by a state to determine if a facility operates as an Institution for Mental Disease (IMD), as defined 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 assess each STRTP to determine whether or not the STRTP meets the criteria to be considered an IMD. As federal regulations prohibit federal reimbursement for covered services provided to beneficiaries who are residents of an IMD,

MHP STRTP GRANTS

REGULAR POLICY CHANGE NUMBER: 78

MHPs will no longer receive federal reimbursement for specialty mental health services provided to children and youth residing in STRTPs that meet IMD criteria.

The Department will provide grant funding to county MHPs beginning January 1, 2022 through December 31, 2022. Grant funding will support county infrastructure to maintain capacity, for a defined period, while facilities transition to come into compliance with the federal definition of an STRTP.

To the extent the Section 1115 Serious Mental Illness/Serious Emotional Disturbance Waiver is federally approved (current timeline estimate is that the waiver would be implemented as of July 1, 2023), all STRTPs deemed IMDs will be eligible for federal reimbursement during the period of the waiver, and would be exempt from length of stay caps for up to two years.

Reason for Change:

This is a new policy change.

Methodology:

1. Assume a total of \$7,478,000 GF will be provided to county MHPs to support STRTP transition planning and maintain capacity for FY 2021-22 and FY 2022-23.

(Dollars in Thousands)

MHP STRTP Grants	TF	GF
FY 2021-22	\$7,478	\$7,478
FY 2022-23	\$7,478	\$7,478

Funding:

100% Title XIX GF (4260-101-0001)

OUT OF STATE YOUTH - SMHS

REGULAR POLICY CHANGE NUMBER: 79
IMPLEMENTATION DATE: 1/2021
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2268

	FY 2021-22	FY 2022-23
FULL YEAR COST - TOTAL FUNDS	\$1,760,000	\$2,678,000
- STATE FUNDS	\$880,000	\$1,339,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,760,000	\$2,678,000
STATE FUNDS	\$880,000	\$1,339,000
FEDERAL FUNDS	\$880,000	\$1,339,000

Purpose:

This policy change estimates the payments to County Mental Health Plans (MHPs) to provide additional resources to address the higher level needs and increase in intensive specialty mental health services (SMHS) for the youth returning to California from out-of-state placements, as well as those youth who would have been placed out-of-state if the California Department of Social Services (CDSS) had not implemented a new policy against out-of-state placements.

Authority:

Welfare and Institutions Code, Division 9, Part 3, Chapter 8.8, Article 5
Welfare and Institutions Code, Division 9, Part 3, Chapter 8.9

Interdependent Policy Changes:

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

Background:

Approximately 130 youth in foster care returned to California from out-of-state placements in January 2021. The CDSS limited certification of all out-of-state facilities due to patterns of failures to meet California standards, including improper and unwarranted use of restraints, poor use of de-escalation interventions, and preventing youth from leaving facilities, among other issues.

The Department assumes that the returning youth will have higher levels of need and will require more intensive specialty mental health services than the typical children and youth in foster care. In addition to the needs of those youth recently returned from out-of-state, the Department assumes there will be an average of 64 youth per month currently residing in California with needs that are so significant that they would have been placed in an out-of-state facility if one were available. The Department estimates ongoing intensive treatment costs for these youth as well, using the following criteria:

The child or youth is assessed by an independent clinical provider (when the Family First Prevention Service Act is implemented on October 1, 2021, this will be the Qualified Individual)

OUT OF STATE YOUTH - SMHS

REGULAR POLICY CHANGE NUMBER: 79

to be at a level of severity that would have required placement in out-of-state facility. The child/youth must meet one of the requirements below:

- a. Unable to be placed with other or children or youth and requires intensive supervision and support (such as requiring an "Short-Term Residential Therapeutic Program/STRTP of one"); or
- b. Multiple 5150s, STRPS, or hospitalizations without improvement.

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.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a decrease due to:

- Updating the estimated cost based on actual claims data for out of state youth beneficiaries from FY 2020-21. The prior estimate was based total approved STRTP claims for beneficiaries with similar levels of SMHS need; and
- Applying a payment lag.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to:

- Applying a 2.93% growth to FY 2022-23, based on the forecasted increase of SMHS children's services approved claims; and
- Applying the payment lag for claims paid in FY 2022-23.

Methodology:

1. Assume there will be an average of 64 youth per month residing in California with needs that are so significant that they would have been placed in an out-of-state facility if one were available. The 130 youth in foster care that returned to California from out-of-state placements in January 2021 are represented in the monthly estimate of beneficiaries.
2. The estimated cost per beneficiary is \$3,420, and is based on total approved claims for FY 2020-21 for claims identified as out of state youth, with the highest average cost per beneficiary. The annual projected costs are \$2,626,560 on an accrual basis.
(60 x \$3,420 x 12 = \$2,626,560)
3. Assume all of FY 2020-21 claims were paid in FY 2020-21. For FY 2021-22, assume 67% of the claims received, are paid in the same year the service is provided, and the remaining 33% are paid in the next fiscal year. For FY 2022-23, the Department will pay for 67% of FY 2022-23 claims and 33% of FY 2021-22 claims.

OUT OF STATE YOUTH - SMHS
REGULAR POLICY CHANGE NUMBER: 79

4. The accrual estimate for FY 2021-22 and FY 2022-23 is:

(Dollars in Thousands)

Fiscal Year	Accrual	FY 2021-22	FY 2022-23
FY 2021-22	\$2,627	\$1,760	\$867
FY 2022-23	\$2,704	\$0	\$1,811
Total		\$1,760	\$2,678

5. The cash estimate for FY 2021-22 and FY 2022-23 is:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2021-22	\$1,760	\$880	\$880
FY 2022-23	\$2,678	\$1,339	\$1,339

Funding:

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

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS

REGULAR POLICY CHANGE NUMBER: 80
IMPLEMENTATION DATE: 2/2022
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2247

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$712,000	\$6,017,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$712,000	\$6,017,000
FEDERAL FUNDS	-\$712,000	-\$6,017,000

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:

The Families First Prevention Services Act (FFPSA) was enacted 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 for children and youth requiring a therapeutic placement when specific criteria are met. In California, STRTPs regulatory requirements are similar to QRTPs and the California Department of Social Services (CDSS) is working to ensure STRTPs current licensing standards meet the requirements of QRTPs. The definition of a QRTP in Title IV-E overlaps with the criteria used by a state to determine if a facility operates as an IMD, as defined 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 assess each STRTP to determine whether or not the STRTP meets the criteria to be considered an IMD. As federal regulations prohibit federal reimbursement for covered services provided to beneficiaries who are residents of an IMD, the Department will no longer receive federal reimbursement for services provided to children and

SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS

REGULAR POLICY CHANGE NUMBER: 80

youth residing in STRTPs that meet IMD criteria and would have been qualified for federal funds prior to the IMD determination, including medically necessary services for physical health, mental health, dental, and substance use disorders. Since the IMD exclusion pre-dates realignment, specialty mental health costs for beneficiaries in STRTP IMDs would be the responsibility of county mental health plans. The Department will establish a process to repay federal funds on an ongoing basis for ancillary services provided to beneficiaries while a resident of an STRTP that is identified to be an IMDs.

Reason for Change:

The change from the prior estimate for FY 2021-22 is due to updating the estimated impact of transitioning STRTPs that are IMD facilities.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to additional assessments in FY 2022-23.

Methodology:

1. The Department plans to implement assessments of each STRTPs to determine which facilities are IMDs.
2. This policy change estimates the 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, 2022 and December 31, 2022.
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
FY 2021-22	\$0	\$712	(\$712)
FY 2022-23	\$0	\$6,017	(\$6,017)

Funding:

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

100% Title XIX GF (4260-101-0001)

SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT

REGULAR POLICY CHANGE NUMBER: 81
IMPLEMENTATION DATE: 1/2012
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1660

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

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 ten payments totaling \$2,000,000.

Reason for Change:

There is no change from the prior estimate for FY 2021-22. There is no change in the current estimate from FY 2021-22 to FY 2022-23.

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 \$2,000,000.

SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT

REGULAR POLICY CHANGE NUMBER: 81

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	(\$2,000,000)	\$0	\$0
Recoupments	(\$381,000)	\$0	\$0
Total	\$9,608,000	\$11,989,000	\$0

4. The estimate for FY 2021-22 and FY 2022-23 is as follows:

Fiscal Year	TF	GF	FF	Reimbursement
FY 2021-22	\$0	(\$200,000)	\$0	\$200,000
FY 2022-23	\$0	(\$200,000)	\$0	\$200,000

Funding:

100% GF (4260-101-0001)

Reimbursement GF (4260-601-0995)

CHART REVIEW

REGULAR POLICY CHANGE NUMBER: 82
IMPLEMENTATION DATE: 7/2012
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1714

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$50,000	-\$174,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$50,000	-\$174,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	-\$50,000	-\$174,000

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 2021-22 is a decreased recoupment estimate due to the recoupment of nineteen reviews moving from FY 2020-21 to FY 2021-22, to be recouped in FY 2022-23 and hospitals' performance improvements resulting in less recoupments.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increased recoupment estimate due to recoupments for FY 2021-22 to occur in FY 2022-23.

Methodology:

1. The FY 2021-22 estimate includes actual and estimated recoupments from inpatient and outpatient chart reviews conducted for FY 2019-20 that were postponed until FY 2020-21 due to the COVID-19 public health emergency (PHE) and FY 2020-21.
2. The FY 2022-23 estimate includes estimated recoupments from inpatient and outpatient chart reviews to be conducted for FY 2020-21.

CHART REVIEW
REGULAR POLICY CHANGE NUMBER: 82

Fiscal Year	TF	FF
FY 2021-22	(\$50,000)	(\$50,000)
FY 2022-23	(\$174,000)	(\$174,000)

Funding:

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

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 83
IMPLEMENTATION DATE: 7/2015
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1713

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$463,023,000	-\$322,314,000
- STATE FUNDS	\$242,000	\$160,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$463,023,000	-\$322,314,000
STATE FUNDS	\$242,000	\$160,000
FEDERAL FUNDS	-\$463,265,000	-\$322,474,000

Purpose:

This policy change estimates interim and final cost settlements as well as any additional supplemental reimbursements for any eligible costs incurred by mental health plans (MHPs) in providing Specialty Mental Health Services (SMHS) which were not previously reimbursed through the interim payment process, interim settlement process or through some other mechanism.

Authority:

Welfare & Institutions (W&I) Code 14705(c)
 Title 9, California Code of Regulations 1840.105
 ABX4 5 (Chapter 5, Statutes of 2009)
 W&I Code 14723
 State Plan Amendment (SPA) 09-004

Interdependent Policy Changes:

Not Applicable

Background:

The Department reconciles interim payments to county cost reports for 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.

In addition to any reimbursements determined through the interim cost settlement process, MHPs or other public agencies, are eligible to receive supplemental reimbursements of up to

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 83

100% of the allowable costs for providing Specialty Mental Health services to Medi-Cal beneficiaries that do not exceed the MHP's non-risk upper payment limit.

To receive the supplemental payments, the public agency or MHP must certify that it has incurred the public expenditures. The amount of payment is then based on the difference between the Statewide Maximum Allowances for Specialty Mental Health inpatient and outpatient services and the MHP's certified public expenditures. The Centers for Medicare and Medicaid Services (CMS) approved on February 16, 2016, SPA 09-004, which governs and defines supplemental payments and the Certified Public Expenditure Protocol.

Reason for Change:

The change from prior estimate, for FY 2021-22 is an increase due to an increase in additional settlement payments.

The change in the current estimate for FY 2021-22 to FY 2022-23 is a decrease due to less recoupments scheduled for FY 2022-23.

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).
5. To estimate expected expenditures for FY 2021-22 and FY 2022-23 for interim and audit settlements not yet received, the following procedures are used:
 - The average expenditure of \$1,605,000 per interim settlement is determined by dividing the actual net inflow of \$121,964, 000 from FY 2020-21 by 76, the number of interim settlements processed in FY 2020-21. The average expenditure of \$419, 000 per audit settlement is determined by dividing the net inflow, \$11,732,000, by 28, the number of audit settlements processed in FY 2020-21. This amount was then reduced by \$406,000 to account for a reduction in recoupable amounts resulting from the narrowing of final audits by Audits and Investigations. The resulting recoupment amount per audit settlement is \$13,000 per settlement.
 - The average expenditure per settlement is increased by 3% for fiscal years not yet received and which were not present in calculating the averages in prior step.

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 83

- The total number of interim and audit settlements expected to be processed for each fiscal year is multiplied by the average amount per settlement per fiscal year to determine the total amount to be processed for each fiscal year per settlement type. For example, for FY 2013-14 interim settlements, the total number to be processed, 4, is multiplied by \$1,605, 000 to a total of \$6,419,000 to be processed for that fiscal year. The total number of FY 2013-14 audit settlements, 14, is multiplied by \$432, 000 to a total of \$6,042, 000 for that fiscal year. The program projects there would be 57 interim and 14 audit settlements per fiscal year for fiscal years not yet received.
 - The percentage of each fund type of settlements processed in FY 2020-21 is determined to arrive to the estimated amounts of Title XIX and Title XXI for the interim and cost settlement types for FY 2021-22 and FY 2022-23. The percentage is determined by dividing the total amount of Title XIX by the total amount of all interim settlement expenditures processed in FY 2020-21. For Title XXI, the total amount of Title XXI processed in FY 2020-21 is divided by the total of all expenditures for interim settlements for FY 2020-21. This same procedure is followed to determine Title XIX and Title XXI for audit settlements. Assuming that FY 2021-22 estimated settlements will follow the same funding trends, the total estimated amount for each settlement type per fiscal year were multiplied by the percentages representing the Title XIX and Title XXI amounts.
6. To determine final amounts per fund type per settlement type, the following were combined:
- The estimated amounts per fund, per settlement type, per fiscal year settled,
 - The amounts by funding type of actual audit and interim settlements that were received in the spring of FY 2020-21 that will be processed in FY 2021-22, and
 - An estimate for San Francisco County's supplemental claim.
7. The net FF to be reimbursed and/or recouped in FY 2021-22 for interim settlements and audit settlements are as shown:

INTERIM AND FINAL COST SETTLEMENTS - SMHS
REGULAR POLICY CHANGE NUMBER: 83

(Dollars in Thousands)

Interim Settlements and Supplemental Claim	TF	GF	Title XIX	Title XXI
FY 2011-12	(\$3,409)	\$0	(\$3,409)	\$0
FY 2012-13	\$3,688	\$0	\$932	\$2,756
FY 2013-14	(\$7,159)	\$2	(\$6,355)	(\$806)
FY 2014-15	(\$56,168)	\$22	(\$49,311)	(\$6,879)
FY 2015-16	(\$94,217)	\$37	(\$82,715)	(\$11,539)
FY 2016-17	(\$97,044)	\$39	(\$85,197)	(\$11,886)
FY 2018-19	(\$102,953)	\$41	(\$90,385)	(\$12,609)
FY 2019-20	(\$106,043)	\$42	(\$93,097)	(\$12,988)
Supplemental Claim	\$4,178	\$0	\$4,178	\$0
Subtotal	(\$459,127)	\$183	(\$405,359)	(\$53,951)

(Dollars in Thousands)

Audit Settlements	TF	GF	Title XIX	Title XXI
FY 2011-12	(\$1,940)	\$25	(\$1,901)	(\$64)
FY 2012-13	(\$1,386)	\$5	(\$1,436)	\$45
FY 2013-14	(\$185)	\$9	(\$184)	(\$10)
FY 2014-15	(\$189)	\$10	(\$189)	(\$10)
FY 2015-16	(\$196)	\$10	(\$195)	(\$11)
Subtotal	(\$3,896)	\$59	(\$3,904)	(\$51)
Total FY 2021-22	(\$463,023)	\$242	(\$409,264)	(\$54,001)

INTERIM AND FINAL COST SETTLEMENTS - SMHS
REGULAR POLICY CHANGE NUMBER: 83

8. The net FF to be reimbursed and/or recouped in FY 2022-23 for interim settlements and audit settlements are as shown:

(Dollars in Thousands)

Interim Settlements	TF	GF	Title XIX	Title XXI
FY 2017-18	(\$99,955)	\$40	(\$87,753)	(\$12,242)
FY 2020-21	(\$109,224)	\$43	(\$95,890)	(\$13,377)
FY 2021-22	(\$112,500)	\$45	(\$98,766)	(\$13,779)
Subtotal	(\$321,680)	\$128	(\$282,409)	(\$39,398)

(Dollars in Thousands)

Audit Settlements	TF	GF	Title XIX	Title XXI
FY 2016-17	(\$201)	\$10	(\$200)	(\$11)
FY 2018-19	(\$214)	\$11	(\$213)	(\$12)
FY 2019-20	(\$220)	\$11	(\$219)	(\$12)
Subtotal	(\$635)	\$32	(\$632)	(\$35)
Total FY 2022-23	(\$322,314)	\$160	(\$283,041)	(\$39,433)

Funding:

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

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

100% GF (4260-101-0001)

GLOBAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 84
IMPLEMENTATION DATE: 12/2015
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1951

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$3,227,712,000	\$2,561,451,000
- STATE FUNDS	\$1,495,981,000	\$1,280,725,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,227,712,000	\$2,561,451,000
STATE FUNDS	\$1,495,981,000	\$1,280,725,000
FEDERAL FUNDS	\$1,731,731,000	\$1,280,726,000

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)
 American Rescue Plan (ARP) Act (2021)

Interdependent Policy Changes:

COVID-19 Increased FMAP Extension

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

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On August 3, 2020, the Centers for Medicare and Medicaid Services (CMS) approved a six-month GPP extension through December 31, 2020. An additional one-year extension of the Medi-Cal 2020 waiver was approved on December 29, 2020, which extended the GPP program from January 1, 2021 through December 31, 2021.

The ACA requires a reduction in the DSH allotments and was previously scheduled to go into effect on October 1, 2013. Most recently, on December 27, 2020, HR 133 (2020) was enacted with eliminated the DSH reductions for Federal Fiscal Year (FFY) 2021 through FFY 2023, lowered the overall aggregate national reduction to \$32 billion, and postponed the implementation until FFY 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.

On March 11, 2021, HR 1319 (2021), ARP, was enacted. ARP requires that for the federal fiscal years in which the FFCRA increased FMAP is applicable, the states' annual DSH allotments be recalculated such that the total computable DSH expenditures for a state is equal to the total computable DSH expenditures that would have resulted in the absence of the FFCRA increased FMAP. The result is an increase in the DSH allotments for the impacted fiscal years. This policy change reflects the draft ARP-adjusted allotments released by CMS on July 15, 2021.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to:

- The PY 3 final reconciliation shifted from FY 2020-21 to FY 2021-22, and
- Updated estimated PY 5 and PY 6B ARP catch-up payments and PY 6B DSH payments based on updated DSH allotment estimates from the draft ARP-adjusted allotments released by CMS on July 15, 2021.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to:

- Varying final reconciliation payments included in FY 2021-22,
- Inclusion of PY 5 and PY 6B ARP catch-up payments in FY 2021-22,
- Inclusion of PY 6A and PY 6B SNCP payments in FY 2021-22, and
- Lower estimated DSH allotments for PY 7 and PY 8 as a result of the assumed 2% annual increase based on the preliminary, non-ARP adjusted FY 2020-21 DSH allotment.

Methodology:

1. The PY for the Global Payment Program is from July 1 to June 30, to align with the state fiscal year for PY 1 through PY 5. PY 6A is a six-month extension for the period from July 1, 2020, to December 31, 2020. Starting with PY 6B on January 1, 2021, the GPP is a calendar year program. The calendar year program format will continue for subsequent GPP program years.
2. On July 14, 2016, CMS approved \$472 million in SNCP funding for PY 2 through

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PY 5. The \$472 million is subject to applicable weighted FMAP. The Department submitted a request to CMS to continue SNCP funding through the end of PY 6B, December 31, 2021. The SNCP funding is assumed to continue through December 31, 2026.

3. The total federal funding for the GPP for PY1 through PY 11 is estimated at:

(Dollars in Thousands)

Program Year	DPH DSH Allotment	SNCP	Total FFP
PY 1 (7/1/15-6/30/16)	\$869,667	\$236,000	\$1,105,667
PY 2 (7/1/16-6/30/17)	\$903,395	\$236,000	\$1,139,395
PY 3 (7/1/17-6/30/18)	\$931,427	\$236,000	\$1,167,427
PY 4 (7/1/18-6/30/19)	\$967,116	\$236,000	\$1,203,116
PY 5 (7/1/19-6/30/20)	\$1,104,736	\$257,948	\$1,362,684
PY 6A (7/1/20-12/31/20)	\$561,224	\$132,632	\$693,856
PY 6B (1/1/21-12/31/21)	\$1,085,828	\$257,948	\$1,343,776
PY 7 (1/1/22-12/31/22)	\$1,043,507	\$236,000	\$1,279,507
PY 8 (1/1/23-12/31/23)	\$1,048,379	\$236,000	\$1,284,379
PY 9 (1/1/24-12/31/24)	\$1,068,664	\$236,000	\$1,304,664
PY 10 (1/1/24-12/31/25)	\$1,090,428	\$236,000	\$1,326,428
PY 11 (1/1/26-12/31/26)	\$1,112,627	\$236,000	\$1,348,627

4. For PY 1 through PY 5, payments are made on a quarterly basis where three quarters are paid in the current state fiscal year and the fourth quarter is paid the following state fiscal year. For PY 6A, two quarterly payments were made in the current state fiscal year. Beginning with PY 6B, payments will be made on a quarterly basis, where one quarter is paid in the current state fiscal year, and the remaining three quarters are paid in the subsequent state fiscal year.
5. The PY 3 round 6 final close out recoupment of \$6.405 million TF will occur in FY 2021-22.
6. PY 6A includes the CMS approved six-month extension period from July 1, 2020 through December 31, 2020. On December 29, 2020, CMS approved a one-year extension for PY 6B from January 1, 2021 through December 31, 2021. PY 6A and PY 6B assume the inclusion of SNCP funding.
7. Assume PYs 7-11, which is pending GPP renewal from CMS, will include SNCP funding.
8. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.
9. The impact of the 6.2% Title XIX FFCRA increased FMAP does not increase the claimable DSH allotment, as the DSH allotment is a capped amount. Instead, the non-federal share is reduced by 6.2%, reducing the overall TF, while keeping FFP the same that would have

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been paid at 50% federal share / 50% non-federal share. The FFP does not change, while the non-federal share is reduced.

10. CMS released the ARP adjusted FFY 2020 and FFY 2021 DSH allotments on July 15, 2021, however, the application methodology is still under consideration and payments related to the allotment are estimated. Once the application methodology is confirmed, payments will be adjusted and ARP catch-up payments will be made. ARP catch-up payments for FY 2019-20 and FY 2020-21 are scheduled to take place in December 2021.
11. Assume PY 5 and PY 6B ARP catch-up payments are scheduled to take place starting December 2021.
12. In June 2021, CMS tentatively approved SNCP funding for PY 6A and PY 6B. However, CMS did not provide the SNCP funding amounts, therefore, funding is estimated and consisted with the amounts approved for prior years. Assume PY 6A and PY 6B SNCP catch-up payments will occur on October 15, 2021.
13. The estimated GPP payments on a cash basis are:

(Dollars in Thousands)

FY 2021-22	TF	IGT	FF	FFCRA
PY 3 (7/1/17-6/30/18)	(\$6,405)	(\$3,202)	(\$3,203)	\$0
PY 5 (7/1/19-6/30/20)	\$223,107	\$97,721	\$125,386	\$0
PY 6A (7/1/20-12/31/20)	\$236,000	\$103,368	\$118,000	\$14,632
PY 6B (1/1/21-12/31/21)	\$2,135,256	\$978,217	\$1,135,091	\$21,948
PY 7 (1/1/22-12/31/22)	\$639,754	\$319,877	\$319,877	\$0
Total	\$3,227,712	\$1,495,981	\$1,695,151	\$36,580

FY 2022-23	TF	IGT	FF	FFCRA
PY 7 (1/1/22-12/31/22)	\$1,919,261	\$959,630	\$959,631	\$0
PY 8 (1/1/23-12/31/23)	\$642,190	\$321,095	\$321,095	\$0
Total	\$2,561,451	\$1,280,725	\$1,280,726	\$0

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)

MEDI-CAL 2020 WHOLE PERSON CARE PILOTS

REGULAR POLICY CHANGE NUMBER: 85
IMPLEMENTATION DATE: 7/2021
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 1953

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$707,330,000	\$0
- STATE FUNDS	\$309,811,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$707,330,000	\$0
STATE FUNDS	\$309,811,000	\$0
FEDERAL FUNDS	\$397,519,000	\$0

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
 Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

COVID-19 Increased FMAP Extension

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 was approved by CMS in December 2020.

The WPC Pilots allow the following to act as Lead Entities (LEs) that serve 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

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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 that:

- 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. For the extension year of January 1, 2021, through December 31, 2021, two of WPC Pilots discontinued operations and to the Department approved the close out of their programs effective December 31, 2020.

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.

Reason for Change:

The change from the prior estimate for FY 2021-22, is an increase due to the PY5 annual invoice payment delays. WPC has four LEs that have pending invoices for the Department's review.

The change from FY 2021-22 to FY 2022-23 is a decrease due to WPC ending in December 31, 2021, and all payments will be disbursed by June 30, 2022.

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. Payments began in FY 2016-17 through FY 2021-22.

MEDI-CAL 2020 WHOLE PERSON CARE PILOTS

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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. Payments for second round entities began in FY 2017-18 through FY 2021-22.
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 6, are aligned with First Round LEs and correspond to calendar years.
 - a. PY3 corresponds to January 1, 2018, to December 31, 2018.
 - b. PY4 corresponds to January 1, 2019, to December 31, 2019.
 - c. PY5 corresponds to January 1, 2020, to December 31, 2020.
 - d. PY6 corresponds to January 1, 2021, to December 31, 2021.
6. PY3 – PY6 invoices from LEs are due approximately 60 days after the first half of the program year and 90 days after the end of the program year. The Department reviews each invoice and processes payments approximately around the fall and summer.
 - a. PY3 payments were made in October 2018, and May 2019.
 - b. PY4 payments were made in October 2019, June 2020, and July 2020.
 - c. PY5 payments were made in November 2020, June 2021, and July 2021
 - d. PY6 payments will be made in October 2021, and May 2022.
7. LEs may roll over unused funds from the prior PY into the following PY. The rollover process affects actual expenditures in the current year and projected expenditures in the budget year. The Department has reviewed the LE's request to roll unspent PY5 funds into the PY6 budget; therefore, FY 2021-22 estimate has increased. The Department approved all of the PY6 budgets in September 2021.
8. 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.
9. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through December 31, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.
10. In December 2020, the Department received a one-year extension for the 2020 Medi-Cal 1115 Demonstration Waiver, to extend the provision of the waiver to December 31, 2021. The extension year is considered PY6. Two LEs have indicated they will not be operating in PY6. The Department reallocated their funding to other LEs based on performance methodology. Therefore, the estimated payment for this program year includes the estimated allocation of \$600 million and the estimated roll over amount of \$84 million.
11. The payment process for four LEs in FY 2020-21 was delayed by a month, causing delayed payment to be processed in FY 2021-22. The remaining 21 LEs were paid on time in FY 2020-21.

MEDI-CAL 2020 WHOLE PERSON CARE PILOTS
REGULAR POLICY CHANGE NUMBER: 85

12. Below is the expected payment for FY 2021-22. No payments are expected for FY 2022-23 since the last payment process will be completed by June 2022:

(Dollars in Thousands)

FY 2021-22	TF	IGT*	FF
Fed Share Only Title XIX	\$ 353,665	\$0	\$ 353,665
WPC Pilot Special Fund	\$ 309,810	\$ 309,810	\$0
FFCRA 6.2% FFP	\$ 43,854	\$0	\$43,854
Total	\$ 707,330	\$ 309,810	\$ 397,519

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)

CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES

REGULAR POLICY CHANGE NUMBER: 86
IMPLEMENTATION DATE: 2/2022
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2245

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$564,241,000	\$1,338,593,000
- STATE FUNDS	\$237,642,300	\$545,562,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$564,241,000	\$1,338,593,000
STATE FUNDS	\$237,642,300	\$545,562,500
FEDERAL FUNDS	\$326,598,700	\$793,030,500

Purpose:

This policy change estimates the costs to implement a statewide Enhanced Care Management (ECM) benefit, Community Supports, and plan incentives to build infrastructure linked to reform within the Medi-Cal managed care delivery system.

Authority:

California Advancing and Innovating Medi-Cal (CalAIM) Initiative

Interdependent Policy Changes:

COVID-19 Increased FMAP Extension

Background:

Effective January 1, 2022, the Department will implement a new ECM benefit and 14 Community Supports in the Medi-Cal managed care delivery system and establish Medi-Cal managed care health plan (MCP) incentives linked to delivery system reform through investments in Community Supports and ECM. Medi-Cal MCPs in counties without Whole Person Care pilots and/or Health Homes Programs will implement the new ECM benefit on July 1, 2022, for certain mandated populations of focus.

The new ECM benefit transitions successful elements from the current Health Homes Program benefit and the Whole Person Care pilot 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.

Community Supports 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. Community Supports provide for flexible wrap-around services that Medi-Cal MCPs would be

CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES

REGULAR POLICY CHANGE NUMBER: 86

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 Community Supports 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 Community Supports and ECM and are intended to incentivize Medi-Cal MCPs to invest in voluntary Community Supports 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 Community Supports 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:

The change from the prior estimate, for FY 2021-22, is an increase due to updated enrollment assumptions, updated CY 2022 rates for ECM and Community Supports, and updated funding splits. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to FY 2021-22 reflecting a partial year impact and FY 2022-23 reflecting a full year impact.

CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES

REGULAR POLICY CHANGE NUMBER: 86

Methodology:

- Costs are estimated to be:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
Community Supports	\$66,453	\$21,554	\$44,900
Plan Incentives	\$300,000	\$150,000	\$150,000
Enhanced Care Management	\$197,788	\$66,089	\$131,699
Total for FY 2021-22	\$564,241	\$237,642	\$326,599

*Totals may differ due to rounding.

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Community Supports	\$162,811	\$52,807	\$110,004
Plan Incentives	\$600,000	\$300,000	\$300,000
Enhanced Care Management	\$575,782	\$192,755	\$383,026
Total for FY 2022-23	\$1,338,593	\$545,562	\$793,030

*Totals may differ due to rounding.

Funding:

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

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

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

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

REGULAR POLICY CHANGE NUMBER: 87
IMPLEMENTATION DATE: 1/2017
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1954

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$196,370,000	\$79,250,000
- STATE FUNDS	\$90,513,000	\$39,625,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	36.45 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$124,793,100	\$79,250,000
STATE FUNDS	\$57,521,010	\$39,625,000
FEDERAL FUNDS	\$67,272,120	\$39,625,000

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

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 took place between years two and three in order to evaluate program effectiveness.

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

REGULAR POLICY CHANGE NUMBER: 87

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. 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 preventive 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. Payments for this domain concluded in FY 2020-21.

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.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is an increase due to updated actuals. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to program ending in December 2021 and only runout costs being budgeted thereafter.

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 2021-22 includes incentive payments for calendar year (CY) 2021 and the remainder of CY 2020 and FY 2022-23 includes incentive payments for the remainder of CY 2021.

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

REGULAR POLICY CHANGE NUMBER: 87

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. 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 2021-22	\$51,215,000	\$25,482,000	\$25,733,000
FY 2022-23	\$4,054,000	\$2,027,000	\$2,027,000

Domain 2: Caries Risk Assessment and Disease Management

4. This four year incentive program was implemented on January 1, 2017. The Department uses the most recent complete CY for Caries Risk Assessment CDT code data to determine the utilization.
5. 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.
6. Payments are made on a monthly basis. Therefore, FY 2021-22 includes incentive payments for the second six months of CY 2021 and run out payments for CY 2021.

Total Domain 2 costs are estimated to be:

Fiscal Year	TF	GF	FF
FY 2021-22	\$71,584,000	\$32,807,000	\$38,777,000
FY 2022-23	\$0	\$0	\$0

Domain 3: Increase the Continuity of Care

7. 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 2021-22 will include incentive payments for CY 2020 and runout for CY 2019, while FY 2022-23 includes incentive payments for CY 2021 and runout for FY 2020.
8. 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.

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

REGULAR POLICY CHANGE NUMBER: 87

9. This 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 county will return to the same provider at the same rates in subsequent years.
10. 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
FY 2021-22	\$73,571,000	\$32,224,000	\$41,347,000
FY 2022-23	\$75,196,000	\$37,598,000	\$37,598,000

Domain 4: Local Dental Pilot Projects

11. The implementation for this domain was April 15, 2017. Payments are invoiced quarterly beginning FY 2017-18.
12. Fifteen LDPPs were approved; however, two LDPPs have been withdrawn.
13. 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).
14. Payments for this domain concluded in FY 2020-21.

Total Domain 4 costs are estimated to be:

Fiscal Year	TF	GF	FF
FY 2021-22	\$0	\$0	\$0
FY 2022-23	\$0	\$0	\$0

15. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through December 31, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022, on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE
REGULAR POLICY CHANGE NUMBER: 87

16. On a cash basis, the FY 2021-22 and FY 2022-23 total demonstration costs are:

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF	\$196,370,000	\$98,185,000	\$98,185,000
FFCRA 6.2% Increased FFP	\$0	(\$7,672,000)	\$7,672,000
Total	\$196,370,000	\$90,513,000	\$105,857,000

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF	\$79,250,000	\$39,625,000	\$39,625,000
Total	\$79,250,000	\$39,625,000	\$39,625,000

*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)

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER: 88
IMPLEMENTATION DATE: 7/2013
ANALYST: Elena Susbilla
FISCAL REFERENCE NUMBER: 1769

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$637,000	\$549,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$637,000	\$549,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$637,000	\$549,000

Purpose:

This policy change estimates the federal fund (FF) 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:

In April 2013, CMS approved an amendment to the BTR to establish an uncompensated care pool to reimburse Tribal health programs for the cost of providing services to American Indian and Alaska Native patients who had been eliminated from Medi-Cal coverage due to previous State budget shortfalls. The amendment was intended to maintain IHS and Tribal facilities' financial viability and provide services to eligible individuals. Tribal uncompensated care payments were subsequently authorized under the Medi-Cal 2020 Demonstration through December 31, 2021. Notably, these services have since been restored in the Medi-Cal program, with the exception of chiropractic services.

On June 30, 2021, DHCS submitted a request to amend and renew California's Section 1115 Demonstration, now entitled the CalAIM Section 1115 Demonstration for five years. Included in the CalAIM proposal is the reinstatement of Tribal uncompensated care payments for chiropractic services provided through December 31, 2026.

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 (CPE) under this demonstration. For services provided to IHS eligible individuals, claims will be reimbursed with 100% FFP. For services provided to non-IHS eligible individuals, claims will be reimbursed at California's Federal Medical Assistance Percentage (FMAP) rate.

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER: 88

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to actual encounters received with encounter rate of \$519.

The change from FY 2021-22 to FY 2022-23, in the current estimate is due to the CalAIM proposal recently amended to reinstate tribal uncompensated care chiropractic benefits beyond December 31, 2021.

Methodology:

1. Assume IHS payments will continue after December 31, 2021.
2. The IHS global encounter rate is updated on the Federal Register for each CY. For CY 2020, the rate is \$479, and \$519 for CY 2021.
3. IHS claims are paid for each encounter. Assume IHS payments will be made as follows on a cash basis:

FY 2021-22	TF	FF
Calendar Year 2020	\$14,000	\$14,000
Calendar Year 2021	\$513,000	\$513,000
Calendar Year 2022	\$110,000	\$110,000
Total	\$637,000	\$637,000

FY 2022-23	TF	FF
Calendar Year 2022	\$439,000	\$439,000
Calendar Year 2023	\$110,000	\$110,000
Total	\$549,000	\$549,000

Funding:

100% Health Care Support Fund (4260-601-7503)

MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM

REGULAR POLICY CHANGE NUMBER: 89
IMPLEMENTATION DATE: 12/2020
ANALYST: Elena Susbilla
FISCAL REFERENCE NUMBER: 1952

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$13,231,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$13,231,000	\$0
FEDERAL FUNDS	\$13,231,000	\$0

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 (GF) savings realized under this program will be used as the state share to fund the Dental Transformation Initiative (DTI).

Authority:

California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)

Interdependent Policy Changes:

Medi-Cal 2020 Dental Transformation Initiative

Background:

The Centers for Medicare & Medicaid Services (CMS) approved the State to claim FFP using the CPEs of approved Designated State Health Programs (DSHP) listed below:

State Only Medical Programs
California Children Services (CCS)
Genetically Handicapped Persons Program (GHPP)
Medically Indigent Adult Long Term Care (MIA-LTC)
Breast & Cervical Cancer Treatment Program (BCCTP)
AIDS Drug Assistance Program (ADAP)
Department of Developmental Services (DDS)
Prostate Cancer Treatment Program (PCTP)
Workforce Development Programs
Office of Statewide Health Planning & Development (OSHPD)
<ul style="list-style-type: none"> • Song-Brown Health Care Workforce Training • Steven M. Thompson Physician Corp Loan Repayment Program (STLRP) • Mental Health Loan Assumption Program (MHLAP)

MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM

REGULAR POLICY CHANGE NUMBER: 89

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.

In December 2020, CMS approved a one-year extension for most components of the Medi-Cal 2020 waiver. However, the overall limit up to which the state may claim for Medi-Cal DSHP was not increased above the five-year total of \$375 million. As described in the Medi-Cal 2020 DTI policy change, the DTI continued through June 2021.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to outstanding claims not completed in FY 2020-21.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to claiming completed in FY 2021-22.

Methodology:

1. Additional claims have been completed in July 2021 that finalized all of the claiming for the program.
2. On a cash basis, the total DSHP claiming is:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2021-22	\$0	(\$13,231)	\$13,231

Funding:

100% GF (4260-101-0001)

100% Health Care Support Fund (4260-601-7503)

PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL

REGULAR POLICY CHANGE NUMBER: 90
IMPLEMENTATION DATE: 8/2016
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1950

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$270,000	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$270,000	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	-\$270,000	\$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)

Interdependent Policy Changes:

Not Applicable

Background:

California will fund public provider system projects that will change care delivery and strengthen those systems' ability to receive payment under risk-based alternative payment models. Projects will be reported on a broad range of metrics to meet quality benchmark goals. Over the course of the demonstration, payments will increasingly move towards pay for performance. To promote greater stability, 50% of all Medi-Cal managed care beneficiaries assigned to designated public hospital systems in the aggregate will receive all of or a portion of their care under a contracted alternative payment model by January 2018; 55% by January 2019; and 60% by the end of the waiver renewal period in 2020.

Funding for this pool will not exceed \$7.464 billion in combined federal and state shares of expenditures over a five-year period for designated public hospital systems (DPH) and district/municipal public hospitals (DMPH) to support reforms to care delivery, provider organization and adoption of alternative payment methodologies. The demonstration will provide up to \$1.4 billion annually for the DPH systems and up to \$200 million annually for the DMPH systems for the first three years of the demonstration. The pool will then phase down by 10% in the fourth year of the demonstration and by an additional 15% in the fifth year of the demonstration.

The PRIME program was replaced by the State's Quality Incentive Pool (QIP) managed care direct payment program as of July 1, 2020.

PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL
REGULAR POLICY CHANGE NUMBER: 90

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to the inclusion of DY 14 recoupments.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due the completion of the remaining recoupments in FY 2021-22.

Methodology:

1. DY 14 (FY 2018-19) recoupments in the amount of \$270,000 TF are expected to occur in FY 2021-22 which will complete the remaining transactions for this program.

FY 2021-22	TF	FF
DY 14 DMPH	(\$270,000)	(\$270,000)
Total FY 2021-22	(\$270,000)	(\$270,000)

Funding:

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

MH/UCD—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 91
IMPLEMENTATION DATE: 9/2005
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 1072

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$2,238,000	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$2,238,000	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	-\$2,238,000	\$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).

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 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.

MH/UCD—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 91

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.

The final reconciliation payments for DY 2 (2006-07), DY 3 (2007-08), DY 4 (2008-09), and DY 5 (2009-10) were completed in FY 2019-20. CMS notified DHCS that the DY 2 (2006-07) payments resulted in excess FFP claimed of \$2.2 million. If these payments are not recouped, CMS may issue a deferral.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to recoupment projected for FY 2021-22.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to the completion of recoupments in FY 2021-22.

Methodology:

1. The final reconciliation payments for DY 2007-08, DY 2008-09, and DY 2009-10 were completed in FY 2019-20.
2. The final reconciliation payments for DY 2 (2006-07) were completed in FY 2019-20, which resulted in excess FFP claimed of \$2.2 million which is projected to be recouped in FY 2021-22.

The outstanding recoupments on a cash basis are:

(Dollars in Thousands)

FY 2021-22	FF
DY 2006-07	(\$2,238)
Total	(\$2,238)

MH/UCD—SAFETY NET CARE POOL
REGULAR POLICY CHANGE NUMBER: 91

Funding:

100% Health Care Support Fund (4260-601-7503)

CCI-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 95
IMPLEMENTATION DATE: 4/2014
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 1766

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$7,202,578,000	\$6,676,610,000
- STATE FUNDS	\$3,601,289,000	\$3,338,305,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	58.92 %	60.78 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,958,819,000	\$2,618,566,400
STATE FUNDS	\$1,479,409,520	\$1,309,283,220
FEDERAL FUNDS	\$1,479,409,520	\$1,309,283,220

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)
 California Advancing and Innovating Medi-Cal (CalAIM) Initiative

Interdependent Policy Changes:

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

Background:

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.

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: 95

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 to January 1, 2022, due to the postponement of CalAIM as a consequence of the COVID-19 public health emergency.

As part of the CalAIM Initiative's standardized mandatory enrollment of dual eligibles and statewide integration of long-term care into managed care, the CCI pilot program will sunset December 31, 2022.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a decrease due to both the MSSP benefit and the HCBS High supplemental payment being discontinued as of January 1, 2022, the removal of the pharmacy benefit from the Non-CMC Full-Dual rates pursuant to the Medi-Cal Rx policy effective January 1, 2022, and overall rate reductions due to member mix assumptions. Additionally, the methodology used for the CCI base rates and percent in base was updated to account for the discontinuation of CCI. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to updated CCI base rates and FY 2021-22 containing six months of costs for MSSP benefits and HCBS High supplemental payments. There are no costs for MSSP benefits and HCBS High supplemental payments in FY 2022-23.

Methodology:

1. All dual eligibles have phased into 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 2021 and CY 2022 rates will be paid in FY 2021-22, and CY 2022 and CY 2023 rates will be paid in FY 2022-23.
4. Although the CCI program will sunset December 31, 2022, the assumed dollars for full-dual eligible that will shift to base rates following the transitioning of CCI are captured within this policy change. On a cash basis, this would account for dollars associated with February through June 2023.
5. The HCBS High supplemental payment is being discontinued effective January 1, 2022, due to the carve-out of MSSP from managed care. The CBAS costs in the HCBS High supplemental payments are being budgeted in the Two Plan, County Organized Health Systems, Geographic Managed Care, and Regional Model PCs effective January 1, 2022, on an accrual basis.
6. Estimated below is the overall impact of the CCI demonstration in FY 2021-22 and FY 2022-23.

CCI-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 95

(Dollars in Thousands)

FY 2021-22	TF	GF	FFP	Reimb	HTF
CCI-Managed Care Payments:					
Base managed care payments	\$7,204,366	\$3,601,289	\$3,602,183	\$0	\$894
Prop 56 - ICF/DD Supplemental Payments	(\$1,788)		(\$894)		(\$894)
Total Managed Care Payments	\$7,202,578	\$3,601,289	\$3,601,289	\$0	\$0
CCI-Savings and Deferral :					
Total Savings (In the Base)	(\$7,237,702)	(\$3,618,851)	(\$3,618,851)	\$0	
CCI-Admin Costs	\$12,223	\$6,112	\$6,112	\$0	
CCI-Quality Withhold Repayments	\$10,571	\$5,286	\$5,286	\$0	
Total of CCI PCs including pass through	(\$12,330)	(\$6,165)	(\$6,165)	\$0	

*Totals may differ due to rounding.

(Dollars in Thousands)

FY 2022-23	TF	GF	FFP	Reimb	HTF
CCI-Managed Care Payments:					
Base managed care payments	\$6,677,670	\$3,338,305	\$3,338,835	\$0	\$530
Prop 56 - ICF/DD Supplemental Payments	(\$1,060)		(\$530)		(\$530)
Total Managed Care Payments	\$6,676,610	\$3,338,305	\$3,338,305	\$0	\$0
CCI-Savings and Deferral :					
Total Savings (In the Base)	(\$6,716,104)	(\$3,358,052)	(\$3,358,052)	\$0	
CCI-Admin Costs	\$6,463	\$3,232	\$3,232	\$0	
CCI-Quality Withhold Repayments	\$11,242	\$5,621	\$5,621	\$0	
Total of CCI PCs including pass through	(\$21,789)	(\$10,895)	(\$10,895)	\$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 December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change

2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.

REGULAR POLICY CHANGE NUMBER: 96
IMPLEMENTATION DATE: 9/2020
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2178

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$2,565,371,000	\$1,532,243,000
- STATE FUNDS	\$931,847,100	\$556,573,050
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,565,371,000	\$1,532,243,000
STATE FUNDS	\$931,847,100	\$556,573,050
FEDERAL FUNDS	\$1,633,523,900	\$975,669,950

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

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 period of January 1, 2020, through December 31, 2022.

Reason for Change:

There is no total fund change from the prior estimate for FY 2021-22. However, due to updated CY 2022 daft rates, funding splits shifted resulting in a slight decrease in General Funds (GF). The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to the MCO Enrollment Tax ending December 31, 2022.

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.

2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.
REGULAR POLICY CHANGE NUMBER: 96

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 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. Starting FY 2020-21, assume a one-month payment lag for all plans subject to MCO tax.
6. The current MCO Enrollment Tax is expected to end December 31, 2022.
7. FFCRA increased FMAP is assumed for expenditures through December 31, 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 separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change. The total estimated federal funds increase is \$106,043,000 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 2021-22	\$2,565,371	\$931,847	\$1,633,524
FY 2022-23	\$1,532,243	\$556,573	\$975,670

Funding:

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

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

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

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change

MANAGED CARE PUBLIC HOSPITAL EPP

REGULAR POLICY CHANGE NUMBER: 98
IMPLEMENTATION DATE: 9/2019
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2060

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$1,201,593,000	\$1,778,153,000
- STATE FUNDS	\$305,801,510	\$414,333,690
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,201,593,000	\$1,778,153,000
STATE FUNDS	\$305,801,510	\$414,333,690
FEDERAL FUNDS	\$895,791,490	\$1,363,819,310

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)
 Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

Managed Care Reimbursements to the General Fund
 COVID-19 Increased FMAP Extension

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 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 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 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: 98

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 October 9, 2020, the Department received CMS pre-print approval to continue the EPP Directed Payment program for the rating period covering July 1, 2019, through December 31, 2020. On December 31, 2020, the Department submitted a pre-print requesting program continuation and approval for the January 1, 2021, through December 31, 2021, rating period.

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.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a decrease due to decreased utilization for updated pool amounts for the Bridge Period (July 1, 2019, through December 31, 2020). The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to updated pool amounts for the CY 2021 rating period and the final Bridge Period FFS sub-pool payment occurring in FY 2022-23.

Methodology:

1. The value of the entire public hospital EPP pool is \$2,534,490,000 TF for the July 1, 2019, through December 31, 2020, (Bridge Period) rating period on an accrual basis.
2. The value of the entire public hospital EPP pool is \$1,792,530,000 TF for the CY 2021 rating period on an accrual basis.
3. The Bridge Period Capitated sub-pool was split into three separate payment periods and the final payment for July 1, 2020, through December 31, 2020, is anticipated to be made in March 2022.
4. The Bridge Period FFS sub-pool was split into three separate payment periods. The July 1, 2019, through December 31, 2019, period payments were made in September 2021. The January 1, 2020, through June 30, 2020, period payments are anticipated to be made in March 2022. The July 1, 2020, through December 31, 2020, period payments are anticipated to be made in September 2022.
5. The January 1, 2021, through June 30, 2021, FFS sub-pool payments will be made in March 2023.
6. The CY 2021 Capitated sub-pool payments will be made in March 2023.
7. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through December 31, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022, on Medi-Cal spending is

MANAGED CARE PUBLIC HOSPITAL EPP
REGULAR POLICY CHANGE NUMBER: 98

roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.

8. On a cash basis, the estimated payments are:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF	ACA
Title XIX	\$520,778	\$260,389	\$260,389	\$0
Title XXI 88/12	\$5,504	\$661	\$4,844	\$0
Title XXI 76.5/23.5	\$22,728	\$5,341	\$17,387	\$0
Title XXI 65/35	\$6,215	\$2,175	\$4,040	\$0
ACA 2019 93/7	\$145,470	\$10,183	\$0	\$135,287
ACA 2020 90/10	\$500,898	\$50,090	\$0	\$450,808
FFCRA 4.34% Increased FFP	\$0	(\$1,097)	\$1,097	\$0
FFCRA 6.20% Increased FFP	\$0	(\$21,940)	\$21,940	\$0
Total FY 2021-22	\$1,201,593	\$305,802	\$309,697	\$586,095

*Total may differ due to rounding.

(Dollars in Thousands)

FY 2022-23	TF	GF	FF	ACA
Title XIX	\$667,314	\$333,657	\$333,657	\$0
Title XXI 76.5/23.5	\$5,504	\$1,294	\$4,211	\$0
Title XXI 65/35	\$43,703	\$15,296	\$28,407	\$0
ACA 2020 90/10	\$1,061,632	\$106,163	\$0	\$955,469
FFCRA 4.34% Increased FFP	\$0	(\$2,039)	\$2,039	\$0
FFCRA 6.20% Increased FFP	\$0	(\$40,037)	\$40,037	\$0
Total FY 2022-23	\$1,778,153	\$414,334	\$408,351	\$955,469

*Total 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)
 FFCRA 4.34% Increased FFP (4260-113-0001/0890)
 FFCRA 6.20% Increased FFP (4260-101-0001/0890)

MANAGED CARE HEALTH CARE FINANCING PROGRAM

REGULAR POLICY CHANGE NUMBER: 99
IMPLEMENTATION DATE: 5/2020
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2061

	FY 2021-22	FY 2022-23
FULL YEAR COST - TOTAL FUNDS	\$1,007,531,000	\$1,864,564,000
- STATE FUNDS	\$308,616,540	\$617,676,250
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,007,531,000	\$1,864,564,000
STATE FUNDS	\$308,616,540	\$617,676,250
FEDERAL FUNDS	\$698,914,460	\$1,246,887,750

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
Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

Managed Care Reimbursements to the General Fund
COVID-19 Increased FMAP Extension

Background:

Effective July 1, 2018, the Department implemented a new voluntary Managed Care Health Care Financing Program which increases payments to MCPs to provide additional support for counties and/or public entities servicing Medi-Cal beneficiaries. Participation is voluntary and the increased payment levels will be evaluated annually.

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.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a decrease due to updated enrollment. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to only six months of the 18-month Bridge Period (July 2020 through December 2020) paying in FY 2021-22 and twelve months of CY 2021 projected participation levels paying in FY 2022-23.

Methodology:

1. The Managed Care Health Care Financing Program began with the FY 2018-19 rating period.

MANAGED CARE HEALTH CARE FINANCING PROGRAM
REGULAR POLICY CHANGE NUMBER: 99

2. Based on final participation levels for the last six months of the 18-month Bridge Period (July 2020 through December 2020), it is estimated total payments of \$1,007,531,000 TF will occur in FY 2021-22.
3. Based on preliminary participation levels for the twelve months of CY 2021, it is estimated total payments will be \$1,864,564,000 TF, and are anticipated to occur in FY 2022-23.
4. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through December 31, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022, on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.
5. Anticipated costs on a cash basis are:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
Bridge Period Title XIX	\$590,342	\$295,171	\$295,171
Bridge Period Title XXI 76.5/23.5	\$42,724	\$10,040	\$32,684
Bridge Period Title XXI 65/35	\$21,362	\$7,477	\$13,885
Bridge Period ACA 90/10	\$353,102	\$35,310	\$317,792
FFCRA 4.34% Increased FFP	\$0	(\$2,781)	\$2,781
FFCRA 6.20% Increased FFP	\$0	(\$36,601)	\$36,601
Total for FY 2021-22	\$1,007,531	\$308,616	\$698,915

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
CY 2021 Title XIX	\$1,076,580	\$538,290	\$538,290
CY 2021 Title XXI 65/35	\$111,097	\$38,884	\$72,213
CY 2021 ACA 90/10	\$634,198	\$63,420	\$570,778
100% State GF	\$42,688	\$42,688	\$0
FFCRA 4.34% Increased FFP	\$0	(\$4,420)	\$4,420
FFCRA 6.20% Increased FFP	\$0	(\$61,186)	\$61,186
Total for FY 2022-23	\$1,864,564	\$617,677	\$1,246,887

*Totals may differ due to rounding.

MANAGED CARE HEALTH CARE FINANCING PROGRAM
REGULAR POLICY CHANGE NUMBER: 99

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 FF / 23.5% GF (4260-113-0001/0890)
65% Title XXI FF / 35% GF (4260-113-0001/0890)
100% State GF (4260-101-0001)
FFCRA 4.34% Increased FFP (4260-113-0001/0890)
FFCRA 6.20% Increased FFP (4260-101-0001/0890)

MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 101
IMPLEMENTATION DATE: 9/2019
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2062

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$962,082,000	\$1,989,172,000
- STATE FUNDS	\$252,532,040	\$530,520,550
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$962,082,000	\$1,989,172,000
STATE FUNDS	\$252,532,040	\$530,520,550
FEDERAL FUNDS	\$709,549,960	\$1,458,651,450

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), and District and Municipal Public Hospitals (DMPHs) based on their performance on designated performance metrics.

Authority:

SB 171 (Chapter 768, Statutes of 2017)
 AB 205 (Chapter 768, Statutes of 2017)
 Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

Managed Care Reimbursements to the General Fund
 COVID-19 Increased FMAP Extension

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.

Effective July 1, 2020, the Department transitioned the existing Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program for DPHs and DMPHs to the QIP directed payment framework. The goal was to enable hospitals to continue quality improvement efforts that have

MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL

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been underway following the June 30, 2020, expiration of the PRIME program. On September 14, 2020, the Department received CMS pre-print approval to implement the new QIP directed payment programs for the transitional period of July 1, 2020, through December 31, 2020. On December 31, 2020, the Department requested federal approval to amend and continue the programs beyond the initial transitional period; the Department is seeking a three-year approval through December 31, 2023.

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.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a slight decrease due to updated actual utilization and payment data. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to only six months of the 18-month Bridge Period (July 2020, through December 2020) paying in FY 2021-22 and twelve months of CY 2021 projected pool amounts paying in FY 2022-23.

Methodology:

1. The maximum value of the Bridge Period QIP is \$1.664 billion total fund. The first twelve months of the Bridge Period pool (July 1, 2019, through June 30, 2020) paid in FY 2020-21. The final six months of the Bridge Period pool (July 1, 2020, through December 31, 2020), including the PRIME Transition program, will pay in FY 2021-22.
2. The maximum value of the CY 2021 QIP is \$1.989 billion total fund. This amount is anticipated to pay out in FY 2022-23.
3. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through December 31, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022, on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.

MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL
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4. On a cash basis, the estimated QIP payments are:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF	ACA
BP Jul'20-Dec'20 Title XIX	\$163,735	\$81,867	\$81,867	\$0
BP Jul'20-Dec'20 ACA 2020 90/10	\$176,015	\$17,602	\$0	\$158,414
BP Jul'20-Dec'20 Title XXI 65/35	\$5,166	\$1,808	\$3,358	\$0
BP Jul'20-Dec'20 Title XXI 76.5/23.5	\$5,166	\$1,214	\$3,952	\$0
PRIME Accruals FY 20/21 Service Period				
BP Jul'20-Dec'20 Title XIX	\$286,235	\$143,117	\$143,117	\$0
BP Jul'20-Dec'20 ACA 2020 90/10	\$307,703	\$30,770	\$0	\$276,933
BP Jul'20-Dec'20 Title XXI 65/35	\$9,031	\$3,161	\$5,870	\$0
BP Jul'20-Dec'20 Title XXI 76.5/23.5	\$9,031	\$2,122	\$6,909	\$0
FFCRA 4.34% Increased FFP	\$0	(\$1,232)	\$1,232	\$0
FFCRA 6.20% Increased FFP	\$0	(\$27,898)	\$27,898	\$0
Total FY 2021-22	\$962,082	\$252,532	\$274,204	\$435,346

*Difference due to rounding.

(Dollars in Thousands)

FY 2022-23	TF	GF	FF	ACA
CY21 Title XIX	\$930,343	\$465,172	\$465,172	\$0
CY21 ACA 2021 90/10	\$1,000,121	\$100,012	\$0	\$900,109
CY21 Title XXI 65/35	\$58,707	\$20,547	\$38,160	\$0
FFCRA 4.34% Increased FFP	\$0	(\$2,336)	\$2,336	\$0
FFCRA 6.20% Increased FFP	\$0	(\$52,875)	\$52,875	\$0
Total FY 2022-23	\$1,989,172	\$530,521	\$558,541	\$900,109

*Difference due to rounding.

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 FF / 23.5% GF (4260-113-0001/0890)
 65% Title XXI FF / 35% GF (4260-113-0001/0890)
 FFCRA 4.34% Increased FFP (4260-113-0001/0890)
 FFCRA 6.20% Increased FFP (4260-101-0001/0890)

CALAIM - TRANSITIONING POPULATIONS

REGULAR POLICY CHANGE NUMBER: 102
IMPLEMENTATION DATE: 1/2022
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2201

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$11,771,000	\$101,037,000
- STATE FUNDS	\$4,347,900	\$50,268,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$11,771,000	\$101,037,000
STATE FUNDS	\$4,347,900	\$50,268,800
FEDERAL FUNDS	\$7,423,100	\$50,768,200

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 (non-dual and dual)
 - Accelerated Enrollment (non-dual and dual)
 - Breast and Cervical Cancer Treatment Program (non-dual)
 - Beneficiaries with Other Healthcare Coverage (non-dual)
 - Beneficiaries in rural zip codes (non-dual)

CALAIM - TRANSITIONING POPULATIONS

REGULAR POLICY CHANGE NUMBER: 102

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. Dual and Non-Dual individuals in long term care facilities who are also in a mandatory aid code, will also be mandatory in Medi-Cal managed care starting in 2023.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a decrease due to refined policy and methodology assumptions on the populations transitioning January 2022. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to additional populations transitioning in January 2023.

Methodology:

1. Costs are assumed to be equal in both the FFS and managed care delivery systems.
2. The transition effective dates are January 1, 2022 and January 1, 2023. Costs below are representative of payment timing differences between delivery systems.

Funding:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
Title XIX 100% FFP (4260-101-0890)	\$1	\$0	\$1
BCCTP Title XIX 65% FF / 35% GF (4260-101-0890/0001)	\$2,094	\$733	\$1,361
100% General Fund 4260-101-0001	\$44	\$44	\$0
50% Title XIX FF / 50% GF (4260-101-0890/0001)	\$6,277	\$3,138	\$3,139
90% Title XIX ACA / 10% GF (4260-101-0890/0001)	\$2,967	\$297	\$2,670
65% Title XXI FF / 35% GF (4260-113-0890/0001)	\$388	\$136	\$252
Total	\$11,771	\$4,348	\$7,423

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Title XIX 100% FFP (4260-101-0890)	\$1	\$0	\$1
BCCTP Title XIX 65% FF / 35% GF (4260-101-0890/0001)	\$254	\$89	\$165
100% General Fund 4260-101-0001	\$10	\$10	\$0
50% Title XIX FF / 50% GF (4260-101-0890/0001)	\$100,178	\$50,089	\$50,089
90% Title XIX ACA / 10% GF (4260-101-0890/0001)	\$508	\$51	\$457
65% Title XXI FF / 35% GF (4260-113-0890/0001)	\$86	\$30	\$56
Total	\$101,037	\$50,269	\$50,768

CYBHI - INCREASE ACCESS TO STUDENT BH SERVICES

REGULAR POLICY CHANGE NUMBER: 103
IMPLEMENTATION DATE: 1/2022
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2260

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$64,831,000	\$129,662,000
- STATE FUNDS	\$32,415,500	\$64,831,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$64,831,000	\$129,662,000
STATE FUNDS	\$32,415,500	\$64,831,000
FEDERAL FUNDS	\$32,415,500	\$64,831,000

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 access to preventive and early intervention behavioral health services for students.

Authority:

AB 133 (Chapter 143, Statutes of 2021)

Interdependent Policy Changes:

COVID-19 Increased FMAP Extension

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, the Department 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 rating period beginning January 1, 2022. These funds will be available over three calendar years.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a decrease due to the revised payment timing schedule. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to the revised payment timing schedule.

CYBHI - INCREASE ACCESS TO STUDENT BH SERVICES

REGULAR POLICY CHANGE NUMBER: 103

Methodology:

1. Assume expenditures of \$64,831,000 TF (\$32,415,500 GF) in FY 2021-22 and \$129,662,000 TF (\$64,831,000 GF) in FY 2022-23.
2. The \$194,493,000 approved in the Budget Act of 2021 is available for encumbrance or expenditure until June 30, 2024 per the Budget Act of 2021, Item 4260-101-0001, Provision 16(a).

FY 2021-22	TF	GF	FF
50% Title XIX / 50%GF	\$64,831,000	\$32,415,500	\$32,415,500
Total	\$64,831,000	\$32,415,500	\$32,415,500

FY 2022-23	TF	GF	FF
50% Title XIX / 50%GF	\$129,662,000	\$64,831,000	\$64,831,000
Total	\$129,662,000	\$64,831,000	\$64,831,000

*Totals may differ due to rounding

Funding:

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

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

HCBS SP - HOUSING AND HOMELESSNESS INCENTIVE PROG

REGULAR POLICY CHANGE NUMBER: 104
IMPLEMENTATION DATE: 6/2022
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2325

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$161,059,000	\$644,236,000
- STATE FUNDS	\$80,529,000	\$322,118,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$161,059,000	\$644,236,000
STATE FUNDS	\$80,529,000	\$322,118,000
FEDERAL FUNDS	\$80,530,000	\$322,118,000

Purpose:

This policy change estimates payments to Medi-Cal managed care plans (MCP) made through the Housing and Homelessness Incentive Program (HHIP) using enhanced federal funding from the American Rescue Plan Act (ARPA) of 2021. The estimated payments are intended to incentivize investments and progress in addressing homelessness and keeping people housed within the Medi-Cal Managed Care program.

Authority:

American Rescue Plan Act (2021)
Section 11.95, Budget Act of 2021

Interdependent Policy Changes:

American Rescue Plan Increased FMAP for HCBS

Background:

The ARPA of 2021 provides additional COVID-19 relief to states. Section 9817 of the ARPA provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS). Increased FMAP is available from April 1, 2021, through March 31, 2024. States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. State funds equivalent to the amount of federal funds attributable to the increased FMAP are deposited in the Home and Community-Based Services American Rescue Plan Fund pursuant to Section 11.95 of the Budget Act of 2021. Section 11.95 appropriates this funding to eligible HCBS activities identified in the HCBS Spending Plan.

The HHIP allows MCPs to earn incentive funds, up to \$1.3 billion TF over the duration of the program, for making investments and progress in addressing homelessness and keeping people housed. The MCPs are to submit plans to the Department that map the continuum of services with a focus on homelessness prevention, interim housing (particularly for the

HCBS SP - HOUSING AND HOMELESSNESS INCENTIVE PROG

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aging and/or disabled population), rapid re-housing (families and youth), and permanent supportive housing. Funds would be allocated by point in time counts of homeless individuals and other housing related metrics determined by the Department. MCPs must meet specified metrics to earn available funds.

Reason for Change:

This is a new policy change.

Methodology:

1. Phase I of HHIP (Planning phase) will begin effective January 1, 2022.
2. Plans may earn incentive payments for completion of deliverables such as Local Homelessness Plans (LHP) and Letters of Support for their respective counties, subject to review and acceptance by the Department.
3. The Department will review LHPs based on proposed measures to be improved, viability of program implementation, alignment with CalAIM and broader state goals, and overall plan soundness.
4. Incentive payments for assessment, planning, and coordination activities will begin no sooner than June 2022.
5. Phase II of HHIP (Outcome/Performance phase) will begin effective no sooner than July 1, 2022.
6. Plans will submit program result data to the Department for evaluation and may earn incentive payments for process and outcome measures achieved during this phase.
7. The costs for this PC on a cash basis for FY 2021-22 and FY 2022-23 are expected to be:

(Dollars in Thousands)

Fiscal Year	TF	SF	FF
FY 2021-22	\$161,059	\$80,529	\$80,530
FY 2022-23	\$644,236	\$322,118	\$322,118

Funding:

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

Home and Community-Based Services American Rescue Plan Fund (4260-101-8507)

CALAIM – MEDI-CAL PATH

REGULAR POLICY CHANGE NUMBER: 105
IMPLEMENTATION DATE: 1/2022
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2285

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$389,650,000	\$706,650,000
- STATE FUNDS	\$194,825,000	\$353,325,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$389,650,000	\$706,650,000
STATE FUNDS	\$194,825,000	\$353,325,000
FEDERAL FUNDS	\$194,825,000	\$353,325,000

Purpose:

This policy change estimates the funding available for support of justice-involved initiatives, implementation of Enhanced Care Management (ECM) and Community Services, and Homelessness and Home and Community Based Service Provider Investments within the Medi-Cal Providing Access and Transforming Health (PATH) supports.

Authority:

Penal Code Section 4011.11
 Welfare & Institutions Code Sections 14011.10, 14132.275, 14184.800, and 14186
 AB 133 (Chapter 133, Statutes of 2021)

Interdependent Policy Changes:

Not Applicable

Background:

A key element of the CalAIM 1115 waiver and Home and Community-Based Services Spending Plan is the request for expenditure authority for the new PATH initiative, to ensure a smooth transition from current waiver pilots to statewide services and capacity building, including for effective pre-release care and coordination with justice agencies. PATH will focus to maintain and build capacity in support of ECM and Community Services, as well as build justice-involved capacity building. PATH funds will be directed to ECM and Community Services providers, Community-Based Organizations (CBOs), counties, public hospitals, and justice partners statewide.

ECM/Community Services Capacity Building

To avoid the loss of critical infrastructure and capacity developed through the Whole Person Care (WPC) Program, PATH will provide funding to transition, build, expand and maintain infrastructure/capacity to support implementation of ECM/Community Services. PATH will provide funding through programs to enable transition and expansion of county, CBOs, and other provider capacity and infrastructure necessary to support ECM and Community Services, as well as funding for WPC pilot counties to retain and transition existing WPC pilot capacity and infrastructure required for ECM/Community Services. This funding will complement the CalAIM incentive program to support implementation of ECM/Community Services.

CALAIM – MEDI-CAL PATH

REGULAR POLICY CHANGE NUMBER: 105

Justice-Involved Capacity Building

The General Fund (GF) request is specific to supporting the justice-involved package, which will be used for ensuring jails and prisons are ready for mandatory Medi-Cal application, behavioral health referral/linkage/warm hand-off from county jails to Medi-Cal managed care plans or county behavioral health departments, “In Reach” services up-to-90 days prior to release, and the re-entry ECM benefit by January 2023. The Department will provide a set of targeted Medicaid services in the 90-day period immediately prior to release for eligible justice-involved populations. These Medicaid services include ECM, limited community-based clinical consultation services provided via telehealth or e-consultation, and a 30-day supply of medication for pre-release into the community. Authority to cover these services is requested for persons incarcerated in State prisons, county jails, and youth correctional facilities.

Homeless and Home and Community Based Service Provider Investments

California is proposing a significant expansion of the homeless system of care that will create over 2,000 direct service jobs for those providing services to homeless and formerly homeless individuals through investments in California Department of Social Services programs. Additionally, Medi-Cal is planning to expand ECM and Community Services. To successfully implement these new investments, local governments and CBOs will need to recruit, onboard, and train a new workforce. In particular, there is a need for a workforce with experience/expertise in working with the disabled and aging populations. Funding will support outreach efforts to publicize job opportunities, workforce development strategies to train staff in evidenced based practices, implement information technology for data sharing, and support training stipends. Funds will also support ECM and Community Services provider capacity building (e.g., workflow development, operational requirements and oversight) and delivery system infrastructure investments (e.g., certified EHR technology, care management document systems, closed-loop referral, billing systems/services, and onboarding/enhancements to health information exchange capabilities).

Reason for Change:

There is an increase from the prior estimate, for FY 2021-22, due to adding other PATH funding requested in the 1115 Waiver renewal application. The change for FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to a full fiscal year of costs in FY 2022-23.

Methodology:

1. The 2021 Budget Act included \$200 million TF (\$100 million GF) for Justice-Involved Capacity Building.
2. The state’s 1115 Waiver Renewal application includes additional federal funding amounts for PATH, the non-federal share for which would be provided by GF and local governments. Pending federal approval, the GF expenditures will be tied to claiming under the CalAIM – Designated State Health Programs policy change.
3. On a cash basis, costs are estimated to be:

(Dollars in Thousands)

Fiscal Years	TF	GF	SF	FF
FY 2021-22	\$389,650	\$172,700	\$22,125	\$194,825
FY 2022-23	\$706,650	\$331,200	\$22,125	\$353,325

CALAIM – MEDI-CAL PATH
REGULAR POLICY CHANGE NUMBER: 105

Funding:

(Dollars in Thousands)

FY 2021-22	TF	GF	SF	FF
100% Title XIX FF (4260-101-0890)	\$60,425	\$0	\$0	\$60,425
HCBS ARP Fund (4260-101-8507)	\$22,125	\$0	\$22,125	\$0
50% Title XIX / 50% GF (4260-101-0890/0001)	\$268,800	\$134,400	\$0	\$134,400
Reimbursement GF (4260-601-0995)	\$38,300	\$38,300	\$0	\$0
Total	\$389,650	\$172,700	\$22,125	\$194,825

FY 2022-23	TF	GF	SF	FF
100% Title XIX FF (4260-101-0890)	\$100,225	\$0	\$0	\$100,225
HCBS ARP Fund (4260-101-8507)	\$22,125	\$0	\$22,125	\$0
50% Title XIX / 50% GF (4260-101-0890/0001)	\$506,200	\$253,100	\$0	\$253,100
Reimbursement GF (4260-601-0995)	\$78,100	\$78,100	\$0	\$0
Total	\$706,650	\$331,200	\$22,125	\$353,325

RETRO MC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 106
IMPLEMENTATION DATE: 1/2016
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1788

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$178,253,000	\$193,016,000
- STATE FUNDS	\$190,346,900	\$90,501,750
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$178,253,000	\$193,016,000
STATE FUNDS	\$190,346,900	\$90,501,750
FEDERAL FUNDS	-\$12,093,900	\$102,514,250

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
 COVID-19 Increased FMAP Extension

Background:

This policy change accounts for retroactive:

- Managed care pass through payments
- Managed care funding adjustments

Reason for Change:

The change from the prior estimate, for FY 2021-22, is an increase due to updated estimates of the retroactive rate adjustments and pass-through payments attributable to calendar year (CY) 2021. Final CY 2021 rates have been incorporated into the estimate.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to higher estimated retroactive rate adjustments and pass-through payments for CY 2022 as compared to CY 2021. The decrease in general fund dollars is due to no funding adjustments anticipated for FY 2022-23.

Methodology:

1. The Department estimates the following retroactive managed care capitation rate adjustments in FY 2021-22 and FY 2022-23:

RETRO MC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 106

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
Retro MC Rate Adjustment Payments	\$130,151	\$65,075	\$65,075
Retro Pass Through Payments	\$48,102	\$18,846	\$29,256
Funding Adjustments	\$0	\$106,425	(\$106,425)
Total FY 2021-22	\$178,253	\$190,347	(\$12,094)

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Retro MC Rate Adjustment Payments	\$139,000	\$69,500	\$69,500
Retro Pass Through Payments	\$54,016	\$21,002	\$33,014
Total FY 2022-23	\$193,016	\$90,502	\$102,514

Funding:

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

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

ACA 90/10 (2019) (4260-101-0890)

Title XIX FFP (4260-611-0890)

100% GF (4260-101-0001)

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change

HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS

REGULAR POLICY CHANGE NUMBER: 107
IMPLEMENTATION DATE: 10/2018
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1907

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$118,180,000	\$0
- STATE FUNDS	\$30,843,500	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$118,180,000	\$0
STATE FUNDS	\$30,843,500	\$0
FEDERAL FUNDS	\$87,336,500	\$0

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

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 established 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 allowed geographic phasing of HHP services. The Department implemented the HHP in four phases, by counties and conditions:

HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS

REGULAR POLICY CHANGE NUMBER: 107

	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 implemented July 2020.

The HHP concluded as of December 31, 2021, with final payments in February 2022. 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:

There is no change from the prior estimate for FY 2021-22. The change in non-federal share dollars is due to updated payment projections.

The change in the current estimate, from FY 2021-22 to FY 2022-23, is a decrease due to the HHP ending effective December 31, 2021.

HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS

REGULAR POLICY CHANGE NUMBER: 107

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 2021-22 (July 2021 through December 2021) is \$306.03.
3. Assume 289,631 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 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 November 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 2021-22 are expected to be:
 FY 2021-22: 289,631 x \$306.03 = \$88,636,000 TF
9. On a cash basis, the cost for FY 2021-22 is expected to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	HHP Fund	FF
FY 2021-22 (90/10)	*\$70,615	\$3,507	\$3,555	\$63,554
FY 2021-22 (50/50)	\$47,565	\$11,811	\$11,971	\$23,783
Total FY 2021-22	\$118,180	\$15,318	\$15,526	\$87,337

*Difference due to rounding.

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 December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change

PROP 56-BEHAVIORAL HEALTH INCENTIVE PROGRAM

REGULAR POLICY CHANGE NUMBER: 109
IMPLEMENTATION DATE: 1/2021
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 2254

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$75,998,000	\$90,136,000
- STATE FUNDS	\$33,286,000	\$42,739,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$75,998,000	\$90,136,000
STATE FUNDS	\$33,286,000	\$42,739,000
FEDERAL FUNDS	\$42,712,000	\$47,397,000

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:

Families First Coronavirus Response Act (FFCRA)
Budget Act of 2021

Interdependent Policy Changes:

Proposition 56 Funding

Background:

The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), increased the excise tax rate on cigarettes and tobacco products and allocates a portion of the tobacco tax revenue to the Department for use as the non-federal share of health care expenditures, subject to appropriation by the Legislature.

The Budget Act of 2019 allocated limited-term Proposition 56 funding for the BHI program.

The BHI program requires Medi-Cal Managed Care Plan's (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 health outcomes tied to beneficiaries diagnosed with a substance use disorder or serious mental illness, or who are homeless.

The BHI Incentive program implemented January 1, 2021, and 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.

PROP 56-BEHAVIORAL HEALTH INCENTIVE PROGRAM

REGULAR POLICY CHANGE NUMBER: 109

Proposition 56 funding, along with federal funds, are used to make these payments. This policy change identifies the interim use of the General Fund (GF) for these Proposition 56 funded payments. See the Proposition 56 Funding 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.

Reason for Change:

There is no change in FY 2021-22 from the prior estimate.

The change from FY 2021-22 to FY 2022-23, in the current estimate is an increase due to more funds being allocated to Program Year 2, which primarily pay in FY 2022-23.

Methodology:

1. On a cash basis, the total directed payments are estimated to be \$76,000,000 in FY 2021-22 and \$90,136,000 in FY 2022-23.
2. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2022, in this policy change.
3. Below is the payment table for FY 2021-22 and FY 2022-23, by funding type.

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
50% Title XIX FF / 50% GF (4260-101-0890/0001)	\$76,000	\$38,000	\$38,000
FFCRA 6.2% Increased FFP	\$0	(\$4,712)	\$4,712
Total	\$75,998	\$33,286	\$42,712
FY 2022-23	TF	GF	FF
50% Title XIX FF / 50% GF (4260-101-0890/0001)	\$90,136	\$45,068	\$45,068
FFCRA 6.2% Increased FFP	\$0	(\$2,329)	\$2,329
Total	\$90,136	\$42,739	\$47,397

*Differences due to rounding

Funding:

50% Title XIX FF / 50% GF (4260-101-0890/0001)
FFCRA 6.2% Increased FFP

SAN MATEO HEALTH PLAN REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 111
IMPLEMENTATION DATE: 2/2021
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2193

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$10,000,000	\$0
- STATE FUNDS	\$10,000,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$10,000,000	\$0
STATE FUNDS	\$10,000,000	\$0
FEDERAL FUNDS	\$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 entered into a settlement to update the DP-NF rate for rate years 2014-2018 which substantially increased 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 reimbursement.

SAN MATEO HEALTH PLAN REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 111

Reason for Change:

The change from the prior estimate, for FY 2021-22, is an increase due to an additional \$10 million in reimbursement that is needed on top of the \$30 million that occurred in FY 2020-21. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to the final reimbursement being completed in FY 2021-22.

Methodology:

1. A reimbursement of \$30,000,000 TF (\$30,000,000 GF) occurred in FY 2020-21.
2. Assume a final reimbursement of **\$10,000,000 TF (\$10,000,000 GF)** will occur in **FY 2021-22**.

Funding:

100% State GF (4260-101-0001)

CCI-QUALITY WITHHOLD REPAYMENTS

REGULAR POLICY CHANGE NUMBER: 113
IMPLEMENTATION DATE: 5/2017
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2031

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$10,571,000	\$11,242,000
- STATE FUNDS	\$5,285,500	\$5,621,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$10,571,000	\$11,242,000
STATE FUNDS	\$5,285,500	\$5,621,000
FEDERAL FUNDS	\$5,285,500	\$5,621,000

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: 113

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 2021-22, is a decrease due to updated actuals. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to FY 2021-22 being based on the withhold amount for CY 2018 and FY 2022-23 being based on the withhold amount for CY 2019.

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. Assume quality withholds for CY 2018 will be repaid in FY 2021-22.
4. Assume quality withholds for CY 2019 will be repaid in FY 2022-23.

FY 2021-22	TF	GF	FF
Quality Withhold Repayment (CY 2018)	\$10,571,000	\$5,285,500	\$5,285,500

FY 2022-23	TF	GF	FF
Quality Withhold Repayment (CY 2019)	\$11,242,000	\$5,621,000	\$5,621,000

Funding:

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

CALAIM - MSSP CARVE-OUT OF CCI

REGULAR POLICY CHANGE NUMBER: 114
IMPLEMENTATION DATE: 1/2022
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 2248

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$1,600,000	\$0
- STATE FUNDS	\$800,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,600,000	\$0
STATE FUNDS	\$800,000	\$0
FEDERAL FUNDS	\$800,000	\$0

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:

There is no change for FY 2021-22 from the prior estimate. There is a decrease from FY 2021-22 to FY 2022-23, in the current estimate, due to the transition occurring in FY 2021-22.

CALAIM - MSSP CARVE-OUT OF CCI
REGULAR POLICY CHANGE NUMBER: 114**Methodology:**

1. Costs are estimated to be:

FY 2021-22	TF	GF	FF
CCI - Managed Care Payments	(\$7,996,000)	(\$3,998,000)	(\$3,998,000)
MSSP	\$9,596,000	\$4,798,000	\$4,798,000
Total	\$1,600,000	\$800,000	\$800,000

Funding:

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

CAPITATED RATE ADJUSTMENT FOR FY 2022-23

REGULAR POLICY CHANGE NUMBER: 116
IMPLEMENTATION DATE: 7/2022
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1338

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$1,725,597,000
- STATE FUNDS	\$0	-\$585,332,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$1,725,597,000
STATE FUNDS	\$0	-\$585,332,800
FEDERAL FUNDS	\$0	-\$1,140,264,200

Purpose:

The policy change estimates the increase for the Managed Care capitation rates for fiscal year (FY) 2022-23.

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

Managed care capitation rates are typically rebased each rating period. After actuarial analysis, upward/downward adjustments are applied to historical data to develop a reasonable "base" for rate development. Additional adjustments such as trends and program changes are applied to base data in order to inform the final capitated rates. This policy change shows the increase in capitation rates from FY 2021-22 to FY 2022-23.

Reason for Change:

The change in capitation rates from FY 2021-22 to FY 2022-23 is a -5.13% average rate decrease on a cash basis, due to the carve-out of pharmacy services that will be covered through Medi-Cal Rx effective January 1, 2022. FY 2022-23 costs assume Behavioral Health Treatment costs will be carved into the capitation rates beginning in the Calendar Year 2023 rating period.

CAPITATED RATE ADJUSTMENT FOR FY 2022-23

REGULAR POLICY CHANGE NUMBER: 116

Methodology:

1. Assume the following dollars per managed care model:

Managed Care Models	FY 2021-22 Estimated Cost	Rate Adjustment	Dollar Adjustment
Two Plan	\$19,615,095,000	-5.47%	-\$1,072,125,589
GMC	\$3,749,835,000	-3.39%	-\$127,119,545
Regional	\$1,257,856,000	-6.69%	-\$84,175,202
COHS	\$8,998,053,000	-4.91%	-\$442,177,435
Total	\$33,620,839,000	-5.13%	-\$1,725,597,772

2. The average rate adjustment from FY 2021-22 to FY 2022-23 would be a 5.63% average rate increase, if pharmacy services were not carved-out of the capitated rates.

Funding:

FY 2022-23	Two Plan	COHS	GMC	Regional	Total
Title XIX 50/50 FFP (4260-101-0001/0890)	(\$615,337,000)	(\$253,784,000)	(\$72,959,000)	(\$48,312,000)	(\$990,392,000)
State GF (4260-101-0001)	(\$1,135,000)	(\$468,000)	(\$135,000)	(\$89,000)	(\$1,827,000)
Family Planning 90/10 GF (4260-101-0001/0890)	(\$10,037,000)	(\$4,139,000)	(\$1,190,000)	(\$788,000)	(\$16,154,000)
Title XXI 65/35 (4260-101-0001/0890)	(\$37,209,000)	(\$15,346,000)	(\$4,412,000)	(\$2,921,000)	(\$59,888,000)
ACA 90% FFP / 10% GF (2020)	(\$408,407,000)	(\$168,440,000)	(\$48,424,000)	(\$32,065,000)	(\$657,336,000)
TF	(\$1,072,125,000)	(\$442,177,000)	(\$127,120,000)	(\$84,175,000)	(\$1,725,597,000)
GF	(\$363,671,050)	(\$149,989,000)	(\$43,120,100)	(\$28,552,650)	(\$585,332,800)
FF	(\$708,453,950)	(\$292,188,000)	(\$83,999,900)	(\$55,622,350)	(\$1,140,264,200)

MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND

REGULAR POLICY CHANGE NUMBER: 117
IMPLEMENTATION DATE: 2/2019
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2063

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

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
Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

COVID-19 Increased FMAP Extension

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.

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.

Reason for Change:

The change from the prior estimate, for FY 2021-22, 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 2021-22 to FY 2022-23, in the current estimate, is an increase due to FY 2022-23 capturing twelve months of reimbursements and FY 2021-22 capturing only six months of reimbursements.

MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND

REGULAR POLICY CHANGE NUMBER: 117

Methodology:

1. Data from FY 2019-20, CY 2021, and CY 2022 are used to estimate the annual commitment from allowable public entities.
2. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through December 31, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022, on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.
3. On a cash basis, the estimated reimbursements to the General Fund are:

(Dollars in Thousands)

Reimbursement	GF
July 1, 2019-Dec 31, 2020 (Bridge Period)	\$927,770
CY 2021	\$9,339
Total	\$937,109
July 1, 2020-Dec 31, 2020 Support Cost to GF	(\$126)
GF	(\$936,983)
FY 2021-22 Net Impact	\$0

(Dollars in Thousands)

Reimbursement	GF
July 1, 2019-Dec 31, 2020 (Bridge Period)	\$104,927
CY 2021	\$1,564,721
CY 2022	\$11,145
Total	\$1,680,794
CY 2021 Support Cost to GF	(\$251)
GF	(\$1,680,543)
FY 2022-23 Net Impact	\$0

Funding:

Reimbursement (4260-601-0995)

100% State GF (4260-101-0001)

2020 MCO ENROLLMENT TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER: 118
IMPLEMENTATION DATE: 2/2021
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2176

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

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.

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 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 (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.

2020 MCO ENROLLMENT TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER: 118

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a slight decrease in MCO tax funds transferred to the GF due to updated funding splits. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to the MCO Enrollment Tax ending December 31, 2022.

Methodology:

1. The MCO Enrollment Tax for the January 1, 2020, through December 31, 2022, period 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 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

FY 2022-23 Medi-Cal	
Enrollees	Rate
0-675,000	\$0.00
675,001-4,000,000	\$55.00
Over 4,000,000	\$0.00

FY 2022-23 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 2021-22: \$2,584,032,000

FY 2022-23: \$1,419,526,000

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. The current MCO Enrollment Tax is expected to end December 31, 2022.
6. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2022, for this policy change.

2020 MCO ENROLLMENT TAX MANAGED CARE PLANS
REGULAR POLICY CHANGE NUMBER: 118

7. The MCO Enrollment Tax fund transfers to the GF are expected to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	MCO Tax
FY 2021-22	\$0	(\$1,691,653)	\$1,691,653
FY 2022-23	\$0	(\$1,508,961)	\$1,508,961

Funding:

3334 MCO Tax

2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ

REGULAR POLICY CHANGE NUMBER: 119
IMPLEMENTATION DATE: 2/2021
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2177

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

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

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 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 (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.

2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ

REGULAR POLICY CHANGE NUMBER: 119

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a slight increase in MCO tax funds transferred to the GF due to updated funding splits. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to the MCO Enrollment Tax ending December 31, 2022.

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. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2022, for this policy change.
4. The current MCO Enrollment Tax is expected to end December 31, 2022.
5. The MCO Enrollment Tax fund transfers to the GF are expected to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	MCO Tax
FY 2021-22	\$0	(\$825,804)	\$825,804
FY 2022-23	\$0	(\$556,573)	\$556,573

Funding:

3334 MCO Tax

COORDINATED CARE INITIATIVE RISK MITIGATION

REGULAR POLICY CHANGE NUMBER: 120
IMPLEMENTATION DATE: 6/2022
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2135

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$111,260,000	\$0
- STATE FUNDS	-\$55,630,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$111,260,000	\$0
STATE FUNDS	-\$55,630,000	\$0
FEDERAL FUNDS	-\$55,630,000	\$0

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. There is also a risk corridor in place for the period of January 1, 2020, through December 31, 2022, for CMC beneficiaries. 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: 120

Reason for Change:

There is no change from the prior estimate for FY 2021-22. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease in recoupments due to all budgeted recoupments occurring in FY 2021-22. No recoupments are anticipated to occur in FY 2022-23.

Methodology:

1. Assume all payments and recoupments attributable to full-benefit dual eligibles for the 2.5 percent member mix threshold for 2014 through 2017 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 eligibles, partial-benefit dual eligibles, and non-dual-eligibles will occur in FY 2021-22.
4. Assume additional recoupments will not happen until FY 2023-24. There will be no recoupments in FY 2022-23.
5. 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)

PROP 56 - DIRECTED PAYMENT RISK MITIGATION

REGULAR POLICY CHANGE NUMBER: 121
IMPLEMENTATION DATE: 7/2021
ANALYST: Ryan Woolsey
FISCAL REFERENCE NUMBER: 2333

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$235,000,000	\$0
- STATE FUNDS	-\$74,547,120	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$235,000,000	\$0
STATE FUNDS	-\$74,547,120	\$0
FEDERAL FUNDS	-\$160,452,880	\$0

Purpose:

This policy change budgets additional payments owed to managed care plans (MCPs), or recoupment of payments due from managed care plans as determined by the one-sided or two-sided risk corridor calculations on Proposition 56 payments.

Authority:

All Plan Letter (APL) 19-015
 APL 19-016
 APL 19-018
 APL 20-013
 APL 20-014
 Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

Proposition 56 Funding

Background:

The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56, 2016) increased the excise tax rate on cigarettes and tobacco products and allocates a portion of the tobacco tax revenue to the Department for use as the nonfederal share of health care expenditures.

Proposition 56 funds are used to fund various payments to Medi-Cal providers, through both the fee-for-service and managed care delivery systems.

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

PROP 56 - DIRECTED PAYMENT RISK MITIGATION

REGULAR POLICY CHANGE NUMBER: 121

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.

Direct Payment Risk Corridors

For FY 2018-19, the Proposition 56 Physician Services directed payments will be subject to a minimum medical expenditure percentage (MEP). Managed care plans (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. This calculation will be a one-sided risk corridor.

For the Bridge Period rating period (July 1, 2019 through December 31, 2020), there are a subset of Proposition 56 directed payment programs that will be subject to one of three two-sided risk corridors. The first risk corridor will apply to the Proposition 56 Physicians Services, Proposition 56 Developmental Screening Services, and Proposition 56 Adverse Childhood Experiences Screening Services programs. The second risk corridor will apply to the Proposition 56 Family Planning Services program. The third risk corridor will apply to the Proposition 56 Value-Based Payment program.

This policy change identifies the use of the General Fund for these Proposition 56 adjustments. See the Proposition 56 Funding policy change for the Proposition 56 offset to the GF.

Reason for Change:

This is a new policy change.

Methodology:

1. In FY 2021-22, managed care Proposition 56 recoupments totaling \$235 million TF (\$75 million state funds) are expected from the one-sided risk corridor calculation for the Proposition 56 Physician Services program. These estimated recoupments are attributable to the FY 2018-19 rating period.
2. The two-sided risk corridors will be calculated retrospectively by the Department with data to be collected no sooner than January 1, 2022. The risk corridors will be based on the aggregate MEPs achieved by each MCP and will utilize MCP-submitted encounters and/or other utilization data. As the necessary data to perform the calculation is not currently available, an estimated net recoupment/payment is unable to be determined at this time. However, the Department expects any recoupments or payments to/from MCPs to occur in FY 2022-23.

PROP 56 - DIRECTED PAYMENT RISK MITIGATION
REGULAR POLICY CHANGE NUMBER: 121

Funding:

FY 2021-22	TF	GF	FF
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	(\$132,848,000)	(\$66,424,000)	(\$66,424,000)
94% Title XIX FF / 6% GF (4260-101-0001 / 0890)	(\$37,592,000)	(\$2,256,000)	(\$35,336,000)
93% Title XIX FF / 7% GF (4260-101-0001 / 0890)	(\$37,592,000)	(\$2,631,000)	(\$34,961,000)
88% Title XXI FF / 12% GF (4260-113-0001/0890)	(\$26,968,000)	(\$3,236,000)	(\$23,732,000)
Total	(\$235,000,000)	(\$74,547,000)	(\$160,453,000)

MANAGED CARE EFFICIENCIES

REGULAR POLICY CHANGE NUMBER: 122
IMPLEMENTATION DATE: 2/2021
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2224

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$304,653,000	\$0
- STATE FUNDS	-\$100,209,300	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$304,653,000	\$0
STATE FUNDS	-\$100,209,300	\$0
FEDERAL FUNDS	-\$204,443,700	\$0

Purpose:

This policy changes estimates the savings associated with implementing Managed Care rate adjustments and efficiencies as deemed actuarially appropriate.

Authority:

42, Code of Regulations 438
Welfare & Institutions Code 14301.1

Interdependent Policy Changes:

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

Background:

The Department implemented 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 for the CY 2021 rating period.
- General rate adjustments as determined actuarially appropriate.

MANAGED CARE EFFICIENCIES

REGULAR POLICY CHANGE NUMBER: 122

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:

There is no change from the prior estimate for FY 2021-22.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease in savings due to these efficiencies being captured within the managed care base rates as of the CY 2022 rating period and going forward.

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 2021-22 are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2021-22	(\$304,653)	(\$100,209)	(\$204,444)

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 December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change

RATE INCREASE FOR FQHCS/RHCS/CBRCS

REGULAR POLICY CHANGE NUMBER: 124
IMPLEMENTATION DATE: 10/2005
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 88

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$316,117,000	\$356,801,000
- STATE FUNDS	\$117,606,500	\$132,742,100
PAYMENT LAG	0.9306	0.9263
% REFLECTED IN BASE	0.35 %	0.32 %
APPLIED TO BASE		
TOTAL FUNDS	\$293,148,900	\$329,447,200
STATE FUNDS	\$109,061,550	\$122,565,540
FEDERAL FUNDS	\$184,087,300	\$206,881,610

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

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 1st of each year.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is an increase due to additional data of FY 2020-21 actuals displaying an increase in visits and paid claims. For FY 2019-20, actuals displayed a drop in visits which drove the prior estimate's trend downwards. The increase also accounts for a cost of living adjustment of 6% for LA CBRCs. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to the projected increase in rates and the cost of living adjustment of 6% for LA CBRCs.

RATE INCREASE FOR FQHCS/RHCS/CBRCS

REGULAR POLICY CHANGE NUMBER: 124

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 5.09% for calendar year (CY) 2020 and 4.12% for CY 2021 and CY 2022.

Rate Year	Projected Visits	Current Rate	Rate with Increase
2020	19,842,885	\$172.09	$\$172.09 \times (1+5.09\%) = \180.85
2021	20,349,911	\$180.85	$\$180.85 \times (1+4.12\%) = \188.30
2022	20,869,892	\$188.30	$\$188.30 \times (1+4.12\%) = \196.05

- 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
2020	\$3,414,762	\$3,588,586	\$173,824
2021	\$3,680,281	\$3,831,888	\$151,607
2022	\$3,929,801	\$4,091,542	\$161,742

- The FY 2021-22 CBRC rate increase of \$28,588,000 is based on the FY 2018-19 audited rate, including an adjustment factor LA County requested to be incorporated into the rate utilizing a 3 year average of payment data from the Paid Claims Summary Reports for FY 2018-19, FY 2019-20, and FY 2020-21. The estimated payment increase is determined by the difference between the calculated estimated payments and the total 3 year average payments per the Paid Claims Summary Reports for FY 2018-19, FY 2019-20, and FY 2020-21. The audited rate for FY 2018-19 audits were effective July 1, 2021.
- The FY 2022-23 CBRC rate increase of \$55,300,000 is based on the FY 2019-20 reported rates, less an adjustment factor based on historical audit adjustments to reported rates. In addition, a cost of living adjustment of 6% was added, per LA County's request. FY 2019-20 reported rates utilized a 3 year average of payment data from the Paid Claims Summary Reports for FY 2018-19, FY 2019-20, and FY 2020-21. The estimated payment increase is determined by the difference between the calculated estimated payments and the total 3 year average of visits and payments per the Paid Claims Summary reports for FY 2018-19, FY 2019-20, and FY 2020-21. The audited rate for FY 2019-20 audits will be effective July 1, 2022.

RATE INCREASE FOR FQHCS/RHCS/CBRCS
REGULAR POLICY CHANGE NUMBER: 124

6. The estimated expenditures in FY 2021-22 and FY 2022-23 are:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
CY 2021 Increase	\$158,059	\$58,803	\$99,256
CY 2022 Increase	\$158,059	\$58,803	\$99,256
FY 2021-22 Total	\$316,117	\$117,605	\$198,512
FY 2022-23	TF	GF	FF
CY 2022 Increase	\$178,401	\$66,371	\$112,030
CY 2023 Increase	\$178,401	\$66,371	\$112,030
FY 2022-23 Total	\$356,802	\$132,742	\$224,060

*Totals may differ due to rounding.

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF	\$214,987,000	\$107,494,000	\$107,493,000
90% Title XIX ACA / 10% GF	\$101,130,000	\$10,113,000	\$91,017,000
FY 2021-22 Total	\$316,117,000	\$117,607,000	\$198,510,000
FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF	\$242,655,000	\$121,328,000	\$121,327,000
90% Title XIX ACA / 10% GF	\$114,146,000	\$11,415,000	\$102,731,000
FY 2022-23 Total	\$356,801,000	\$132,743,000	\$224,058,000

*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 December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

DPH INTERIM RATE GROWTH

REGULAR POLICY CHANGE NUMBER: 125
IMPLEMENTATION DATE: 7/2020
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1162

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$161,321,000	\$281,166,000
- STATE FUNDS	\$53,030,100	\$90,618,600
PAYMENT LAG	1.0000	0.8754
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$161,321,000	\$246,132,700
STATE FUNDS	\$53,030,100	\$79,327,520
FEDERAL FUNDS	\$108,290,900	\$166,805,190

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

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 2021-22, from the prior estimate, is due to updated DPH actual data through July 2021 and lower COVID-19 rates.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to rate increases expected in FY 2022-23.

Methodology:

1. Assume the FY 2022-23 interim rates will be implemented in July 2022.
2. For FY 2021-22:
 - Assume no interim rate increases for county and community-based DPHs.
 - An additional cost of \$161,321,000 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 \$161,321,000 TF.

DPH INTERIM RATE GROWTH

REGULAR POLICY CHANGE NUMBER: 125

3. For FY 2022-23:
 - Assume a 6.21% interim rate increase for county and 4.29% for community-based DPHs.
 - Assume no COVID-19 rate increase for county and community-based DPHs.
 - An additional cost of \$281,166,000 TF is estimated for the FY 2022-23 interim rates. The lagged cost on a cash basis, not in the base, is estimated to be approximately \$246,124,000 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 (4260-101-0890/0001)

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

AB 1629 ANNUAL RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 126
IMPLEMENTATION DATE: 8/2014
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 1508

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$242,944,000	\$248,186,000
- STATE FUNDS	\$115,155,200	\$117,640,200
PAYMENT LAG	0.9642	0.9981
% REFLECTED IN BASE	16.97 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$194,495,000	\$247,714,400
STATE FUNDS	\$92,190,400	\$117,416,680
FEDERAL FUNDS	\$102,304,550	\$130,297,760

Purpose:

This policy change estimates the cost of the AB 1629 rate increases and add-ons for Freestanding Skilled Nursing Facilities, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facilities, Level-B (FSSA/NF-B).

Authority:

AB 1629 (Chapter 875, Statutes of 2004)
 AB 1467 (Chapter 23, Statutes of 2012)
 ABX1 19 (Chapter 4, Statutes of 2011)
 AB 1489 (Chapter 631, Statutes of 2012)
 SB 853 (Chapter 717, Statutes of 2010)
 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)
 SPA 20-0023

Interdependent Policy Changes:

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

Background:

AB 1629 requires the Department to implement a facility-specific rate methodology and impose a Quality Assurance Fee (QAF) on FS/NF-B, FSSA/NF-B, and Freestanding Pediatric Subacute (FS/PSA) facilities. The QAF is used to offset 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.

AB 1629 ANNUAL RATE ADJUSTMENTS

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To determine the QAF amount assessed to these facilities, the Department uses three-year old data as the base revenue and applies growth and trending adjustments to project an estimate of revenues. The QAF and other fees, including licensing and certification fees, cannot collectively exceed what is known as the federal safe harbor limit, which is 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 three years to be reflected in the regular facility specific reimbursement rates. For the August through December 2020 rate period and CY 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 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 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.

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 and CMS approved SPA 20-0023 related to the extension on September 7, 2021. The extension includes a bridge period that extends the current methodology for five months, from August through December 2020,

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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. The QASP program was also extended for 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 be subject to a rate decrease as a result from the revised methodology from the RY 2019-20 rate methodology for the August – December 2020 rating period.

During the COVID-19 Public Health Emergency (PHE), long-term care facilities will receive additional reimbursements in an amount that is equal to 10% of their regular total RY 2019-20 reimbursements. 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 2021-22, is a net decrease due to:

- Revised FFS days based on updated actual utilization data,
- Costs for RY 2018-29 and RY 2019-20 rate increases are fully in the base and are no longer reflected in this policy change,
- Updated CY 2021 and 2022 rate and add-ons, and
- Updated funding assumptions for this policy change.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a net increase due to including:

- A full year of the CY 2022 rate adjustments.

Methodology:

1. Following the August through December 2020 rate period, the effective date of the rate period is January 1, beginning January 1, 2021 and each year thereafter.
2. The rate increase for August through December 2020 rate period is 3.62%. The rate update was implemented on October 29, 2020. The retroactive payment occurred in February 2021.
3. The rate increase for CY 2021 is 3.5%. This rate update was implemented on April 6, 2021. The retroactive payment is occurred in July 2021.
4. The rate increase for CY 2022 is 2.4%. This rate is estimated to implement in February 2022. The retroactive payment is estimated to occur in June 2022.
5. The temporary 10% COVID-19 increased amount will continue and be provided in addition to the August through December 2020 rates, and continue through the PHE period. Refer to COVID-19 FFS Reimbursement Rates policy change for the impact of the increased funding.

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6. The estimated managed care rate adjustment impact for these rate increases is included in the FY 2021-22 and FY 2022-23 managed care capitation rates, respectively.

7. 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

8. The estimated payments on a cash basis are:

	FY 2021-22	FY 2022-23
FFS (Rate Increase)		
Aug-Dec 2020 rate	\$71,729,000	\$71,729,000
CY 2021 rate	\$113,066,000	\$113,066,000
CY 2022 rate	\$31,809,000	\$76,343,000
Add-Ons		
Aug-Dec 2020 add-ons	\$11,440,000	\$11,440,000
CY 2021 add-ons	(\$7,023,000)	(\$7,023,000)
CY 2022 add-ons	(\$7,237,000)	(\$17,369,000)
Retro		
CY 2021 rate	\$25,976,000	
CY 2021 add-ons	(\$1,731,000)	
CY 2022 rate	\$6,362,000	
CY 2022 add-ons	(\$1,447,000)	
Total	\$242,944,000	\$248,186,000
Managed Care	\$246,968,000	\$325,301,000
Total FFS + MC	\$489,912,000	\$573,487,000

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Funding:

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	\$227,152,000	\$113,576,000	\$113,576,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	\$15,792,000	\$1,579,000	\$14,213,000
Total	\$242,944,000	\$115,155,000	\$127,789,000

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	\$232,054,000	\$116,027,000	\$116,027,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	\$16,132,000	\$1,613,000	\$14,519,000
Total	\$248,186,000	\$117,640,000	\$130,546,000

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change

GROUND EMERGENCY MEDICAL TRANSPORTATION QAF

REGULAR POLICY CHANGE NUMBER: 127
IMPLEMENTATION DATE: 4/2019
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 2081

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$207,650,000	\$179,410,000
- STATE FUNDS	\$62,795,000	\$57,385,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	13.76 %	14.39 %
APPLIED TO BASE		
TOTAL FUNDS	\$179,077,400	\$153,592,900
STATE FUNDS	\$54,154,410	\$49,127,300
FEDERAL FUNDS	\$124,922,950	\$104,465,600

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)
 State Plan Amendment (SPA) 18-004
 SPA 19-0020
 Families First Coronavirus Response Act (FFCRA)
 AB 1705 (Chapter 544, Statutes of 2019)
 SPA 20-0009
 SPA 21-0017 (pending)

Interdependent Policy Changes:

COVID-19 Increased FMAP Extension

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, 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.

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Effective July 1, 2018, the add-on was calculated to be \$220.80 and authorized by SPA 18-004. SPA 19-0020 authorizes for the add-on to be provided for codes A0225 Neonatal Emergency Transport and A0434 Specialty Care Transport, effective July 1, 2019. SPA 20-0009 was approved to continue providing the add-on in FY 2020-21. SPA 21-0017, for the FY 2021-22 add-on, has been submitted to CMS and is pending approval.

AB 1705 requires the Department to implement a public provider GEMT (PP-GEMT) program, utilizing intergovernmental transfers. The public providers currently in the GEMT QAF program will transition into the new AB 1705 PP-GEMT Program. Beginning January 1, 2022, these providers would no longer participate in the GEMT QAF program and funds associated with AB 1705 (public providers) will shift into the new PP-GEMT Program 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.

Reason for Change:

The change for FY 2021-22, from the prior estimate, is due to:

- A decrease in managed care payments due to updated calendar year 2022 rates which were lower than previously projected.
- Revised General Fund offset amounts based on updated QAF collection estimates.
- Revised expenditures due to the impact of the PP-GEMT program and actual payment data.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to:

- Decreased estimated FFS and managed care payments and General Fund offset due to the impact of the PP-GEMT Program for the entire fiscal year.

Methodology:

1. The effective date for the GEMT QAF is July 1, 2018 with the approved add-on amount of \$220.80.
2. Assume the GEMT QAF revenue will be \$75,427,000 in FY 2021-22 and \$68,962,000 in FY 2022-23.
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 \$6,977,000 for FY 2021-22 and \$6,376,000 for FY 2022-23. The FY 2018-19, FY 2019-20, and FY 2020-21 offsets are estimated to be delayed until after FY 2022-23.
5. From the remaining GEMT QAF revenue available, total annual GEMT add-on payments for FY 2021-22 are estimated to be \$207,650,000 TF, of which \$28,574,000 TF is for FFS and \$179,076,000 TF is for Managed Care GEMT transport services.

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6. From the remaining GEMT QAF revenue available, total annual GEMT add-on payments for FY 2022-23 are estimated to be \$179,410,000 TF, of which \$25,810,000 TF is for FFS and \$153,600,000 TF is for Managed Care GEMT transport services.
7. FFS Payments: Add-on payments will continue to be paid in FY 2021-22, upon federal approval. Beginning January 1, 2022, a decrease in FY 2021-22 add-on payments is expected due to the impact of the AB 1705 PP-GEMT Program.
8. Managed Care Payments:
 - a. FY 2021-22 is expected to include 7 months of the CY 2021 rates and 5 months of the CY 2022 rates.
 - b. FY 2022-23 is expected to include 7 months of the CY 2022 rates and 5 months of the CY 2023 rates.
 - c. A decrease in the CY 2022 and CY 2023 rates is expected due to the impact of AB 1705 PP-GEMT Program.
9. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.
10. The cash basis estimate is summarized as follows:

FY 2021-22	TF	GF	MEMTF	FF	FFCRA
FFS Payments	\$28,574,000	\$0	\$8,536,000	\$19,560,000	\$478,000
MC Payments	\$179,076,000	\$0	\$54,259,000	\$121,362,000	\$3,455,000
GF Offset 2021-22	\$0	(\$6,977,000)	\$6,977,000	\$0	\$0
Total	\$207,650,000	(\$6,977,000)	\$69,772,000	\$140,922,000	\$3,933,000

FY 2022-23	TF	GF	MEMTF	FF
FFS Payments	\$25,810,000	\$0	\$8,142,000	\$17,668,000
MC Payments	\$153,600,000	\$0	\$49,243,000	\$104,357,000
GF Offset 2022-23	\$0	(\$6,376,000)	\$6,376,000	\$0
Total	\$179,410,000	(\$6,376,000)	\$63,761,000	\$122,025,000

GROUND EMERGENCY MEDICAL TRANSPORTATION QAF
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Funding:

FY 2021-22	TF	GF	MEMTF	FF	FFCRA
100% General Fund (4260-101-0001)	(\$6,977,000)	(\$6,977,000)	\$0	\$0	\$0
MEMTF (4260-601-3323)	\$69,772,000	\$0	\$69,772,000	\$0	\$0
ACA Title XIX FF (4260-101-0890)	\$81,108,000	\$0	\$0	\$81,108,000	\$0
Title XIX FF (4260-101-0890)	\$55,270,000	\$0	\$0	\$55,270,000	\$0
Title XXI FF (4260-113-0890)	\$4,544,000	\$0	\$0	\$4,544,000	\$0
FFCRA 4.34% FF	\$167,000	\$0	\$0	\$0	\$167,000
FFCRA 6.2% FF	\$3,766,000	\$0	\$0	\$0	\$3,766,000
Total	\$207,650,000	(\$6,977,000)	\$69,772,000	\$140,922,000	\$3,933,000

FY 2022-23	TF	GF	MEMTF	FF
100% General Fund (4260-101-0001)	(\$6,376,000)	(\$6,376,000)	\$0	\$0
MEMTF (4260-601-3323)	\$63,761,000	\$0	\$63,761,000	\$0
ACA Title XIX FF (4260-101-0890)	\$70,621,000	\$0	\$0	\$70,621,000
Title XIX FF (4260-101-0890)	\$47,360,000	\$0	\$0	\$47,360,000
Title XXI FF (4260-113-0890)	\$4,044,000	\$0	\$0	\$4,044,000
FFCRA 4.34% FF	\$0	\$0	\$0	\$0
FFCRA 6.2% FF	\$0	\$0	\$0	\$0
Total	\$179,410,000	(\$6,376,000)	\$63,761,000	\$122,025,000

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 128
IMPLEMENTATION DATE: 8/2007
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 1046

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$173,798,000	\$203,234,000
- STATE FUNDS	\$84,809,650	\$99,173,750
PAYMENT LAG	0.9091	0.9863
% REFLECTED IN BASE	1.55 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$155,550,800	\$200,449,700
STATE FUNDS	\$75,905,400	\$97,815,070
FEDERAL FUNDS	\$79,645,370	\$102,634,620

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)
 AB 133 (Chapter 143, Statutes of 2021)

Interdependent Policy Changes:

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

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.

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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).

AB 119 extends the FS/PSA QAF sunset from July 31, 2015 to July 31, 2020. Pursuant to AB 81, FS/PSA are exempt from the QA fee, effective August 1, 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.

AB 133 removes reductions or limitations for FS/PSA or ICF/DD rate setting effective August 1, 2021, including the rate freeze imposed by AB 97 and related legislation. Beginning with RY 2021-22, ICF/DD facilities shall receive an unfrozen reimbursement rate inclusive of any Proposition 56 supplemental payments. However, for RY 2021-22, the reimbursement rate may not be less than the rate authorized by the California Medicaid State Plan, plus any Proposition 56 supplemental payment, in effect for that facility on July 31, 2021.

For FS/PSAs, as defined in Section 51215.8 of Title 22 of the California Code of Regulations, reimbursement rates shall be determined without applying the rate freeze and limitations imposed by AB 97 and related legislation. Beginning with RY 2021-22, the unfrozen reimbursement rates for these facilities shall be inclusive of any Proposition 56 supplemental payments.

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The Proposition 56 costs to remove reductions or limitations for FS/PSA or ICF/DD rate setting are reflected in the Prop 56 – ICF/DD Supplemental Payments and Prop 56 – FS/PSA Supplemental Payments policy changes.

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 three years to be reflected in the regular facility specific reimbursement 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.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a net increase due to:

- The incorporation of the costs associated with removing reductions or limitations on rate setting for ICF/DDs and FS/PSAs pursuant to AB 133 from the former Unfreeze ICF/DD and FS/PSA Rates policy change to this policy change.
- Revised FFS utilization based on updated actual utilization data;

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a net increase due to:

- A full year of the RY 2021-22 rate adjustments in FY 2022-23;
- Including the RY 2022-23 rate adjustments in FY 2022-23; and
- More retroactive payments in FY 2021-22.

Methodology:

1. The effective date for the rate adjustments is August 1st of each rate year. The expected RY 2020-21 and RY 2021-22 implementation dates are as follows:

Facility	FY 2021-22	FY 2022-23
DP/NF-B	11/1/2021	11/1/2022
Rural Swing Beds (non-exempt)	11/1/2021	11/1/2022
Rural Swing Beds (exempt)	11/1/2021	11/1/2022
DP Adult Subacute	11/1/2021	11/1/2022
NF-A	11/1/2021	11/1/2022
ICF/DDs	11/1/2021	11/1/2022
DP Pediatric Subacute	10/15/2021	10/15/2022
FS Pediatric Subacute	10/15/2021	10/15/2022

2. The estimated managed care rate adjustment impacts for RY 2021-22 and 2022-23 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:

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- 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.
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 PHE period. Refer to the COVID-19 FFS Reimbursement Rates policy change for the impact of the increased funding.

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5. The costs below reflect the incremental rate adjustments and add-ons for each facility type:

Fee-for-Service	FY 2021-22	FY 2022-23
Rate Adjustment (20-21)		
DP/NF-B	\$12,337,000	\$12,337,000
Rural Swing Beds (non-exempt)	\$1,000	\$1,000
Rural Swing Beds (exempt)	\$16,000	\$16,000
DP Adult Subacute	\$7,327,000	\$7,327,000
NF-A	\$5,000	\$5,000
ICF/DDs	\$9,169,000	\$9,169,000
DP Pediatric Subacute	\$895,000	\$895,000
FS Pediatric Subacute	(\$317,000)	(\$317,000)
Rate Adjustment (21-22)		
DP/NF-B	\$8,357,000	\$12,536,000
Rural Swing Beds (non-exempt)	\$1,000	\$1,000
Rural Swing Beds (exempt)	\$37,000	\$56,000
DP Adult Subacute	\$5,173,000	\$7,761,000
NF-A	(\$60,000)	(\$91,000)
ICF/DDs	\$77,983,000	\$116,976,000
DP Pediatric Subacute	\$1,112,000	\$1,667,000
FS Pediatric Subacute	\$12,390,000	\$18,584,000
Rate Adjustment (22-23)		
DP/NF-B		\$8,641,000
Rural Swing Beds (non-exempt)		\$1,000
Rural Swing Beds (exempt)		\$45,000
DP Adult Subacute		\$6,083,000
NF-A		\$7,000
ICF/DDs		(\$4,287,000)
DP Pediatric Subacute		\$648,000
FS Pediatric Subacute		\$724,000
Retro Rate Adjustments		
DP/NF-B	\$3,134,000	\$3,241,000
Rural Swing Beds (non-exempt)	\$1,000	\$1,000
Rural Swing Beds (exempt)	\$14,000	\$17,000
DP Adult Subacute	\$1,940,000	\$2,281,000
NF-A	(\$23,000)	\$3,000
ICF/DDs	\$29,243,000	(\$1,608,000)
DP Pediatric Subacute	\$417,000	\$243,000
FS Pediatric Subacute	\$4,646,000	\$271,000
Total FFS	\$173,798,000	\$203,234,000
Managed care	\$0	\$0
Total Cost	\$173,798,000	\$203,234,000

LTC RATE ADJUSTMENT
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6. The estimated impact of unfreezing rates for ICF/DDs and FS/PSAs pursuant to AB 133 is \$79.1 million TF (\$38.6 million GF) in FY 2021-22 and \$131.2 million TF (\$64.0 million GF) ongoing. Of this amount, \$68.6 million TF (\$33.5 million GF) in FY 2021-22 and \$113.8 million TF (\$55.5 million GF) ongoing are assumed to be FFS costs and are included in this policy change. The remaining estimated cost is included in managed care capitation rates.

Funding:

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	\$164,169,000	\$82,085,000	\$82,085,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	\$2,580,000	\$258,000	\$2,322,000
65% Title XXI / 35% GF (4260-113-0001 / 0890)	\$7,049,000	\$2,467,000	\$4,582,000
Total	\$173,798,000	\$84,810,000	\$88,989,000

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	\$191,974,000	\$95,987,000	\$95,987,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	\$3,017,000	\$302,000	\$2,715,000
65% Title XXI / 35% GF (4260-113-0001 / 0890)	\$8,243,000	\$2,885,000	\$5,358,000
Total	\$203,234,000	\$99,174,000	\$104,060,000

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

DPH INTERIM RATE COVID-19 INCREASED FMAP ADJUST

REGULAR POLICY CHANGE NUMBER: 129
IMPLEMENTATION DATE: 5/2020
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2238

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$59,177,000	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$59,177,000	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$59,177,000	\$0

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

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 (PHE). National public health emergencies are effective for 90 days unless extended or terminated.

Adjustment payments will be issued to the DPHs to account for additional federal funding from FFCRA increased FMAP for service periods from January 1, 2020 to December 31, 2021.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to 6 months total in the current estimate based on the average of 6 months of 2021 actual payments.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to no adjustments expected after FY 2021-22.

DPH INTERIM RATE COVID-19 INCREASED FMAP ADJUST
REGULAR POLICY CHANGE NUMBER: 129

Methodology:

1. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures from January 1, 2020 through December 31, 2021 for this policy change.
2. Adjustment payments of \$76 million were made during FY 2020-21. Of that amount, the average of January-June 2021 amounts were used to project through December 2021.
3. The estimated adjustment payments on a cash basis are:

(Dollars in Thousands)

FY 2021-22	TF	FF
FFCRA	\$59,177	\$59,177
Total	\$59,177	\$59,177

Funding:

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

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER: 130
IMPLEMENTATION DATE: 7/2008
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 1329

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$52,717,000	\$111,000,000
- STATE FUNDS	\$19,265,850	\$40,565,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$52,717,000	\$111,000,000
STATE FUNDS	\$19,265,850	\$40,565,700
FEDERAL FUNDS	\$33,451,150	\$70,434,300

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 2018-19 completed audited levels were used to update the CBRC rates as of July 1, 2021. The Department partially completed CBRC reconciliation audits for FY 2018-19 in FY 2020-21 and is scheduled to complete FY 2019-20 audit levels in FY 2021-22. The remaining FY 2018-19 audit levels are scheduled to be completed in FY 2021-22. Interim rates will be adjusted to the completed FY 2019-20 audit levels beginning in FY 2022-23. The remaining interim rates, to the FY 2018-19 audit levels, will be adjusted in FY 2021-22.

Currently, there are 1,484 active FQHCs, 271 active RHCs, 25 active CBRCs, and 106 active IHS/MOA.

FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER: 130

Reason for Change:

The change from the prior estimate, for FY 2021-22, is an increase due to less recoveries and additional payments from issued reconciliations and tentative settlements. Additionally, FY 2018-19 CBRC audits were not fully completed and are now scheduled to be completed by FY 2021-22. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an overall net increase of \$60 million. Approximately \$30 million is due to a significant increase in the CBRC rates implemented in FY 2021-22. The remaining \$30 million is due to a decrease in recoveries from issued reconciliations and tentative settlements and an increase in Erroneous Payment Corrections (EPCs) implemented and paid.

Methodology:

1. FY 2021-22 FQHC and RHC reconciliations are based on actual settlements from July 2018 through June 2021. FY 2022-23 reconciliations are based on a three-year average of actual and estimated projected settlements from July 2018 through June 2021. FY 2018-19, FY 2019-20, and FY 2020-21 FQHC reconciliations include settlements for IHS.
2. The estimated FQHC retroactive rate adjustment of \$36,658,000 for FY 2021-22 is based on a three-year average of FY 2018-19, FY 2019-20, and FY 2020-21 EPC actuals. For FY 2022-23, the amount of \$43,617,000 is based on a three-year average of FY 2019-20 and FY 2020-21 EPC actuals and estimated EPCs for FY 2021-22. The change from the prior year estimate is attributed to larger EPCs implemented and paid. Currently, the fiscal intermediary processes EPCs quarterly.
3. The LA CBRC reconciliation for FY 2021-22 is based on 95% of the projected FY 2018-19 audited and reported settlements. The FY 2022-23 reconciliation is based on 95% of the projected FY 2019-20 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 an increase in the rates and the FY 2018-19 hospital audits scheduled to be completed in FY 2021-22. The significant increase in the rates resulted in an increase in payments of approximately \$30 million.

Reconciliations and Adjustments	FY 2021-22	FY 2022-23
FQHCs Reconciliation	(\$27,172,000)	(\$15,320,000)
RHCs Reconciliation	\$3,120,000	\$7,918,000
FQHC Retroactive Rate Adjustment	\$36,658,000	\$43,617,000
LA CBRCs Reconciliation	\$40,111,000	\$74,785,000
Total	\$52,717,000	\$111,000,000

FY 2021-22	TF	GF	FF
90% Title XIX ACA / 10% GF	\$16,865,000	\$1,687,000	\$15,178,000
65% Title XXI / 35% GF	\$2,311,000	\$809,000	\$1,502,000
50% Title XIX / 50% GF	\$33,541,000	\$16,771,000	\$16,770,000
Total	\$52,717,000	\$19,267,000	\$33,450,000

*Totals may differ due to rounding.

FQHC/RHC/CBRC RECONCILIATION PROCESS
REGULAR POLICY CHANGE NUMBER: 130

FY 2022-23	TF	GF	FF
90% Title XIX ACA / 10% GF	\$35,511,000	\$3,551,000	\$31,960,000
65% Title XXI / 35% GF	\$4,866,000	\$1,703,000	\$3,163,000
50% Title XIX / 50% GF	\$70,623,000	\$35,311,500	\$35,311,500
Total	\$111,000,000	\$40,566,000	\$70,435,000

*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)

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

PP-GEMT PROGRAM

REGULAR POLICY CHANGE NUMBER: 131
IMPLEMENTATION DATE: 1/2022
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 2267

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$61,472,000	\$145,960,000
- STATE FUNDS	\$20,748,000	\$49,405,000
PAYMENT LAG	0.9535	0.9979
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$58,613,600	\$145,653,500
STATE FUNDS	\$19,783,220	\$49,301,250
FEDERAL FUNDS	\$38,830,330	\$96,352,240

Purpose:

This policy change estimates reimbursements to the General Fund (GF) by Intergovernmental Transfer (IGT) from AB 1705 Intergovernmental Transfer Program revenues, and the supplemental reimbursement payments for Ground Emergency Medical Transportation (GEMT) services provided by public GEMT providers.

Authority:

AB 1705 (Chapter 544, Statutes of 2019)

Interdependent Policy Changes:

Not Applicable

Background:

AB 1705 requires the Department to implement the Public Provider GEMT (PP-GEMT) Program no sooner than July 1, 2021. Currently, the Department administers the GEMT Quality Assurance Fee (QAF) program under Welfare and Institutions Code § 14129 et seq. for private and public providers, which is budgeted in the GEMT QAF policy change. In addition, the GEMT Supplemental Payment Program for public governmental entities will sunset on December 31, 2021. The reimbursements made to public providers currently in the GEMT QAF program will transition into the new PP-GEMT Program. The Department will implement the PP-GEMT program effective January 1, 2022. As of January 1, 2022, these public providers will no longer participate in the GEMT QAF program.

A 10 percent fee will be assessed on the IGTs in order to support health care coverage costs and costs associated with administering the program. Fees assessed in excess of the costs will result in a savings to the GF. Eligible emergency medical transport providers will be required to receive an add-on increase to their Medi-Cal FFS fee-for-service (FFS) payment schedule for certain procedure codes. The Department developed the add-on increase based on specific standards, including eligible providers' average costs directly associated with providing Medi-Cal emergency medical transports under the Medi-Cal program.

PP-GEMT PROGRAM
REGULAR POLICY CHANGE NUMBER: 131

Reason for Change:

The change in FY 2021-22, from the prior estimate, is a net increase due to reduced FFS projections and increased managed care projections tied to CY 2022 rates and enrollment estimates.

The change from FY 2021-22 to FY 2022-23 in the current estimate is an increase, due to FY 2022-23 reflecting a full year of implementation.

Methodology:

1. Assume the GEMT IGT Program will be implemented on January 1, 2022.
2. The total payments in FY 2021-22 on an accrual basis are expected to be \$61,472,000 TF, of which \$8,819,000 TF is for Fee-for-Service (FFS) and \$52,653,000 TF is for managed care.
3. Assume that the transfer to the GF for FY 2021-22, based on the 10 percent assessment of each IGT and costs to administer the program, is \$1,360,000.
4. The total payments in FY 2022-23 on an accrual basis are expected to be \$145,960,000 TF, of which \$17,639,000 TF is FFS and \$128,321,000 is for managed care.
5. Assume that the transfer to the GF for FY 2022-23, based on the 10 percent assessment of each IGT and costs to administer the program, is \$4,226,000.
6. FY 2021-22 and FY 2022-23 are summarized as follows:

FY 2021-22	TF	GF	IGT*	FF
GF Offset	\$0	(\$1,360,000)	\$1,360,000	\$0
FFS Payments	\$8,819,000	\$0	\$2,782,000	\$6,037,000
Managed Care Payments	\$52,653,000	\$0	\$17,966,000	\$34,687,000
Total:	\$61,472,000	(\$1,360,000)	\$22,108,000	\$40,724,000

FY 2022-23	TF	GF	IGT*	FF
GF Offset	\$0	(\$4,226,000)	\$4,226,000	\$0
FFS Payments	\$17,639,000	\$0	\$5,564,000	\$12,075,000
Managed Care Payments	\$128,321,000	\$0	\$43,841,000	\$84,480,000
Total:	\$145,960,000	(\$4,226,000)	\$53,631,000	\$96,555,000

PP-GEMT PROGRAM
REGULAR POLICY CHANGE NUMBER: 131

Funding:

FY 2021-22	TF	GF	IGT*	FF
100% GF (4260-101-0001)	\$0	(\$1,360,000)	\$1,360,000	\$0
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$35,478,000	\$0	\$17,739,000	\$17,739,000
90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$24,356,000	\$0	\$2,436,000	\$21,920,000
65% Title XXI FF / 35% GF (4260-113-0890)	\$1,638,000	\$0	\$573,000	\$1,065,000
Total	\$61,472,000	(\$1,360,000)	\$22,108,000	\$40,724,000

FY 2022-23	TF	GF	IGT*	FF
100% GF (4260-101-0001)	\$0	(\$4,226,000)	\$4,226,000	\$0
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$84,458,000	\$0	\$42,229,000	\$42,229,000
90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$57,398,000	\$0	\$5,740,000	\$51,658,000
65% Title XXI FF / 35% GF (4260-113-0890)	\$4,104,000	\$0	\$1,436,000	\$2,668,000
Total	\$145,960,000	(\$4,226,000)	\$53,631,000	\$96,555,000

*Reimbursement GF (4260-601-0995)

EMERGENCY MEDICAL AIR TRANSPORTATION ACT

REGULAR POLICY CHANGE NUMBER: 133
IMPLEMENTATION DATE: 11/2012
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 1612

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$7,720,000	\$7,689,000
- STATE FUNDS	\$3,026,000	\$2,992,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$7,720,000	\$7,689,000
STATE FUNDS	\$3,026,000	\$2,992,000
FEDERAL FUNDS	\$4,694,000	\$4,697,000

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)
 Families First Coronavirus Response Act (FFCRA)
 SPA 20-0011

Interdependent Policy Changes:

COVID-19 Increased FMAP Extension

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 funds and used to provide augmentation payments for eligible Medi-Cal emergency medical air transportation services.

EMERGENCY MEDICAL AIR TRANSPORTATION ACT

REGULAR POLICY CHANGE NUMBER: 133

The augmentation payment amount is per transport and calculated annually; therefore, a State Plan Amendment (SPA) is required annually. On November 24, 2020, SPA 20-0011 was approved for the FY 2020-21 augmentation payments. The Department will submit SPA 21-0046 for the FY 2020-21 augmentation payments by September 2021.

The augmentation payment amount is per transport and calculated annually; therefore, a State Plan Amendment (SPA) is required annually. On September 28, 2021, SPA 21-0046 was submitted to CMS for federal approval to provide augmentation payments for FY 2021-22.

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.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to:

- Updated FY 2021-22 payments based on revised revenue estimates;
- FY 2021-22 payments shifted to FY 2022-23; and
- Updated FY 2021-22 GF transfers based on revised revenue data.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to:

- Less augmentation payments estimated in FY 2022-23; and
- Less GF transfers estimated in FY 2022-23.

Methodology:

1. Implementation date began November 2012.
2. Assume revenue collections for the penalty assessments that end July 1, 2021, will continue to be collected through June 2022.

EMERGENCY MEDICAL AIR TRANSPORTATION ACT

REGULAR POLICY CHANGE NUMBER: 133

3. 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 2020-21 collections, which is estimated to be \$1,325,000.
4. The FY 2022-23 estimated payments include the:
 - FFS augmentation payments for 50 percent of the second half of FY 2021-22, and reconciliation payments for FY 2020-21 and FY 2021-22, and
 - GF transfer from the FY 2021-22 collections, which is estimated to be \$870,000.
5. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.
6. Based on estimated fee collections, the estimated payments on a cash basis are:

FY 2021-22	TF	GF	EMATCC	FFP	FFCRA
GF Offset	\$0	(\$1,325,000)	\$1,325,000	\$0	\$0
Augment Payment	\$7,720,000	\$0	\$3,026,000	\$4,539,000	\$155,000
Total	\$7,720,000	(\$1,325,000)	\$4,351,000	\$4,539,000	\$155,000

FY 2022-23	TF	GF	EMATCC	FFP	FFCRA
GF Offset	\$0	(\$870,000)	\$870,000	\$0	\$0
Augment Payment	\$7,689,000	\$0	\$2,992,000	\$4,487,000	\$210,000
Total	\$7,689,000	(\$870,000)	\$3,862,000	\$4,487,000	\$210,000

Funding:

100% GF (4260-101-0001)
 Title XIX FFP (4260-101-0890)
 Title XXI FFP (4260-113-0890)
 EMATA / EMATCC Fund (4260-101-3168)
 Title XIX FFCRA Increased FFP (4260-101-0890)
 Title XXI FFCRA Increased FFP (4260-113-0890)

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 134
IMPLEMENTATION DATE: 10/2006
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 96

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$8,993,000	\$10,339,000
- STATE FUNDS	\$4,292,050	\$4,934,500
PAYMENT LAG	0.8245	0.9928
% REFLECTED IN BASE	7.38 %	5.90 %
APPLIED TO BASE		
TOTAL FUNDS	\$6,867,500	\$9,659,000
STATE FUNDS	\$3,277,630	\$4,609,930
FEDERAL FUNDS	\$3,589,890	\$5,049,020

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:

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

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 Developmentally Disabled – Habilitative (ICF/DD-H).

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 134

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%.

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 to December 31, 2021, and will be effective until then 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 impacts across policy areas and beneficiary populations within the Medi-Cal program. The Department has received federal approvals for State Plan Amendment (SPA) 20-0024, which authorizes a temporary additional 10 percent reimbursement for eligible LTC facilities during the PHE.

For rate year (RY) 2021-22, the COVID-19 increased amounts will remain unchanged and will be added to the per diem rates that became effective August 1, 2020 2021. Upon expiration of the PHE or national emergency, whichever occurs first, LTC reimbursements will revert to the RY 2021-22 annual per diem rates. The COVID temporary increase applies to room and board services only.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to updated actual payment data and the RY 2020-21 room and board increase fully entering the base (no longer reflected in this policy change).

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to new rate increases for RY 2022-23, offset by the assumed end of the temporary COVID rate increase.

Methodology:

1. Hospice Services:
 - a. The weighted increase for hospice service rates, excluding RHC and SIA, is 5.01% for RY 2021-22 and 5.04% for RY 2022-23.
 - b. The RY 2020-21 hospice rates were implemented January 25, 2021. The retroactive payment for the period of October 2020 through January 24, 2021 was implemented on April 20, 2021.

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 134

- c. 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.
- d. The RY 2022-23 hospice rates are estimated to be one to two percent increase from RY 2021-22 hospice rates.
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 7.42% for RY 2021-22, with no overall increase RY 2022-23 after accounting for the assumed end of the temporary COVID increase during RY 2021-22.
3. The estimated managed care rate adjustment impacts for RY 2021-22 and RY 2022-23 are included in the FY 2021-22 and FY 2022-23 managed care capitation rates, respectively.
4. The estimated payments on a cash basis are:

Cash Basis	FY 2021-22	FY 2022-23
Hospice Services (20-21)	\$64,000	\$64,000
RHC & SIA Payments (20-21)	\$541,000	\$541,000
Hospice Services (21-22)	\$34,000	\$68,000
RHC & SIA Payments (21-22)	\$274,000	\$549,000
Room & Board (21-22)	\$7,926,000	\$8,646,000
Hospice Services Retro (21-22) retro	\$17,000	
RHC & SIA Payments (21-22) retro	\$137,000	
Hospice Services (22-23)	\$0	\$36,000
RHC & SIA Payments (22-23)	\$0	\$278,000
Room & Board (22-23)	\$0	\$0
Hospice Services Retro (22-23) retro	\$0	\$18,000
RHC & SIA Payments (22-23) retro	\$0	\$139,000
TOTAL	\$8,993,000	\$10,339,000

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 134

Funding:

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	\$8,480,000	\$4,240,000	\$4,240,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	\$510,000	\$51,000	\$459,000
65% Title XXI / 35% GF (4260-113-0001 / 0890)	\$3,000	\$1,000	\$2,000
Total	\$8,993,000	\$4,292,000	\$4,701,000

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	\$9,749,000	\$4,874,000	\$4,874,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	\$586,000	\$59,000	\$528,000
65% Title XXI / 35% GF (4260-113-0001 / 0890)	\$4,000	\$1,000	\$2,000
Total	\$10,339,000	\$4,934,000	\$5,404,000

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change

GDSP NEWBORN SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 135
IMPLEMENTATION DATE: 1/2022
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 2184

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$5,275,000	\$2,637,000
- STATE FUNDS	\$2,106,140	\$1,053,050
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$5,275,000	\$2,637,000
STATE FUNDS	\$2,106,140	\$1,053,050
FEDERAL FUNDS	\$3,168,860	\$1,583,950

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

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.

The Department will submit a State Plan Amendment (SPA) to seek federal approval of the fee increase in August 2021.

GDSP NEWBORN SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 135

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to:

- Delayed rate implementation shifted six months of payments from prospective to retroactive payments in FY 2021-22.
- Revised caseload estimate for FY 2021-22 based on updated GDSP newborn projections and updated FFS Medi-Cal birth data.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to no retroactive payments in FY 2022-23.

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 January 2022. The retroactive correction for the July 1, 2020 to December 31, 2021 period, is expected to be implemented in April 2022.
3. The estimated GDSP caseload in California is 440,910 for FY 2021-22 and FY 2022-23. 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 32% 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 \$2,637,000 TF for FY 2021-21 and FY 2022-23.
7. The estimated Medi-Cal FFS costs for FY 2021-22 and FY 2022-23 are:

FY 2021-22	TF	GF	FF
FFS Prospective Rate Increase	\$1,319,000	\$527,000	\$792,000
FFS Retroactive Payments	\$3,956,000	\$1,579,000	\$2,377,000
Total	\$5,275,000	\$2,106,000	\$3,169,000

FY 2022-23	TF	GF	FF
FFS Prospective Rate Increase	\$2,637,000	\$1,053,000	\$1,584,000
Total	\$2,637,000	\$1,053,000	\$1,584,000

GDSP NEWBORN SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 135

Funding:

FY 2021-22	TF	GF	FFP
50% Title XIX/ 50% GF	\$3,929,000	\$1,964,000	\$1,965,000
90% Title XIX / 10% GF	\$1,316,000	\$132,000	\$1,184,000
76.5% Title XXI / 23.5% GF	\$4,000	\$1,000	\$3,000
65% Title XXI / 35% GF	\$26,000	\$9,000	\$17,000
Total	\$5,275,000	\$2,106,000	\$3,169,000

FY 2022-23	TF	GF	FFP
50% Title XIX/ 50% GF	\$1,964,000	\$982,000	\$982,000
90% Title XIX / 10% GF	\$658,000	\$66,000	\$592,000
65% Title XXI / 35% GF	\$15,000	\$5,000	\$10,000
Total	\$2,637,000	\$1,053,000	\$1,584,000

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change

GDSP PRENATAL SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 136
IMPLEMENTATION DATE: 7/2022
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 2336

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$6,405,000
- STATE FUNDS	\$0	\$2,557,750
PAYMENT LAG	1.0000	0.8260
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$5,290,500
STATE FUNDS	\$0	\$2,112,700
FEDERAL FUNDS	\$0	\$3,177,830

Purpose:

This policy change estimates the costs associated with a fee increase for prenatal 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

Interdependent Policy Changes:

Not applicable

Background:

Pursuant to Health & Safety Code Section 124977, the prenatal screening (PNS) Program fee shall be periodically adjusted to fully support GDSP.

CDPH administers California's GDSP, which includes the Prenatal Screening (PNS) Program and the Newborn Screening (NBS) Program. These programs screen 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.

CDPH plans to replace GDSP's current conventional biochemical screening for chromosome abnormalities with a Cell-free DNA (cfDNA) screening. GDSP's screening for neural tube defects (NTD) will remain part of the overall screening process. CDPH will charge a fee of \$232.00 for cfDNA. CDPH will charge a new \$85 fee for NTD testing in the second trimester.

The Department will submit a State Plan Amendment to seek federal approval for the fee increase.

Reason for Change:

This is a new policy change.

GDSP PRENATAL SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 136

Methodology:

1. The Department of Public Health plans to implement an \$85.00 fee increase for the GDSP PNS program, effective July 1, 2022. The Department implements a corresponding Medi-Cal FFS GDSP PNS 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 July 2022.
3. The estimated GDSP caseload in California is 440,910 for FY 2022-23. GDSP assumes approximately 99% of newborns will be screened by the PNS 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 32% 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 \$6,405,000 TF for FY 2022-23.
7. The estimated Medi-Cal FFS costs for FY 2022-23 are:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
FFS Prospective Rate Increase	\$6,405	\$2,558	\$3,847
Total	\$6,405	\$2,558	\$3,847

Funding:

FY 2022-23	TF	GF	FF
50% Title XIX/ 50%GF (4260-101-0001/0890)	\$4,770,000	\$2,385,000	\$2,385,000
90% Title XIX/ 10% GF (4260-101-0001/0890)	\$1,598,000	\$160,000	\$1,438,000
65% Title XXI / 35% GF (4260-113-0001/0890)	\$37,000	\$13,000	\$24,000
Total	\$6,405,000	\$2,558,000	\$3,847,000

DPH INTERIM RATE

REGULAR POLICY CHANGE NUMBER: 137
IMPLEMENTATION DATE: 7/2005
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1161

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$485,649,800	-\$481,535,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$485,649,800	-\$481,535,000
FEDERAL FUNDS	\$485,649,800	\$481,535,000

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.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to updated DPH actual data through July 2021.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to lower projected expenditures in FY 2022-23.

DPH INTERIM RATE
REGULAR POLICY CHANGE NUMBER: 137

Methodology:

1. The funding adjustment is estimated at:

(Dollars in Thousands)

	Expenditures	GF to FF Shift
FY 2021-22	\$1,595,050	\$485,650
FY 2022-23	\$1,571,782	\$481,535

Funding:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890 / 0001)	(\$815,362)	(\$407,681)	(\$407,681)
100% Title XIX FF (4260-101-0890)	\$1,595,050	\$0	\$1,595,050
90% Title XIX ACA / 10% GF (4260-101-0890 / 0001)	(\$779,688)	(\$77,969)	(\$701,719)
Total Funds	\$0	(\$485,650)	\$485,650

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890 / 0001)	(\$810,892)	(\$405,446)	(\$405,446)
100% Title XIX FF (4260-101-0890)	\$1,571,782	\$0	\$1,571,782
90% Title XIX ACA / 10% GF (4260-101-0890 / 0001)	(\$760,890)	(\$76,089)	(\$684,801)
Total Funds	\$0	(\$481,535)	\$481,535

*Totals may differ due to rounding.

PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE

REGULAR POLICY CHANGE NUMBER: 138
IMPLEMENTATION DATE: 1/2019
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 2098

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$6,371,000	\$6,371,000
- STATE FUNDS	\$2,785,600	\$3,167,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	100.00 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the costs of a rate increase for Fee-for-Service (FFS) Pediatric Day Health Care (PDHC) facilities.

Authority:

SPA 18-0037
 Families First Coronavirus Response Act (FFCRA)
 Budget Act of 2021

Interdependent Policy Changes:

Proposition 56 Funding

Background:

The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), increased the excise tax rate on cigarettes and tobacco products and allocates a portion of the tobacco tax revenue to the Department for use as the non-federal share of health care expenditures, subject to appropriation by the Legislature.

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 individual's medical status and developmental functioning so that he or she can remain within the family.

The Budget Act of 2018 allocated Proposition 56 funds for rate increase to PDHC services. The Legislature has continued this funding in subsequent budget acts.

The Department developed the structure and parameters for a rate increase in 2018-19 for PDHC facilities. The Centers for Medicare and Medicaid Services 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: 138

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.

This policy change identifies the use of the General Fund for these Proposition 56 payments. See the Proposition 56 Funding policy change for the Proposition 56 offset to the GF in FY 2021-22. Beginning FY 2022-23, the Department proposes to transition the nonfederal share of this rate increase to be funded by the General Fund.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to updated FFS funding assumptions based on recent payment data.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to FFCRA increased FMAP funding was not assumed for FY 2022-23.

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. An adjustment for the period of January 2019 through June 2020 was made in FY 2020-21.
5. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2022 in this policy change.
6. The supplemental payments are estimated to be:

FY 2021-22	TF	GF	Title XXI FF	Title XIX FF	ACA FF	FFCRA
FFS Ongoing	\$6,371,000	\$2,785,000	\$177,000	\$2,983,000	\$44,000	\$382,000
Total	\$6,371,000	\$2,785,000	\$177,000	\$2,983,000	\$44,000	\$382,000

FY 2022-23	TF	GF	Title XXI FF	Title XIX FF	ACA FF	FFCRA
FFS Ongoing	\$6,371,000	\$3,167,000	\$177,000	\$2,983,000	\$44,000	\$0
Total	\$6,371,000	\$3,167,000	\$177,000	\$2,983,000	\$44,000	\$0

PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE
REGULAR POLICY CHANGE NUMBER: 138

Funding:

FY 2021-22	TF	GF	FF	FFCRA
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$5,965,000	\$2,982,000	\$2,983,000	\$0
90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$49,000	\$5,000	\$44,000	\$0
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$272,000	\$95,000	\$177,000	\$0
100% GF (4260-101-0001)	\$85,000	\$85,000	\$0	\$0
FFCRA 4.34% GF (4260-113-0001)	(\$12,000)	(\$12,000)	\$0	\$0
FFCRA 4.34% GF (4260-113-0890)	\$12,000	\$0	\$0	\$12,000
FFCRA 6.2% GF (4260-101-0001)	(\$370,000)	(\$370,000)	\$0	\$0
FFCRA 6.2% FF (4260-101-0890)	\$370,000	\$0	\$0	\$370,000
Total	\$6,371,000	\$2,785,000	\$3,204,000	\$382,000

FY 2022-23	TF	GF	FF	FFCRA
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$5,965,000	\$2,982,000	\$2,983,000	\$0
90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$49,000	\$5,000	\$44,000	\$0
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$272,000	\$95,000	\$177,000	\$0
100% GF (4260-101-0001)	\$85,000	\$85,000	\$0	\$0
Total	\$6,371,000	\$3,167,000	\$3,204,000	\$0

PROP 56 - HOME HEALTH RATE INCREASE

REGULAR POLICY CHANGE NUMBER: 139
IMPLEMENTATION DATE: 1/2019
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 2077

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$123,645,000	\$123,645,000
- STATE FUNDS	\$54,060,050	\$61,467,050
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	100.00 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$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.

Authority:

SPA 18-0037
 Families First Coronavirus Response Act (FFCRA)
 Budget Act of 2021

Interdependent Policy Changes:

Proposition 56 Funding

Background:

The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), increased the excise tax rate on cigarettes and tobacco products and allocates a portion of the tobacco tax revenue to the Department for use as the non-federal share of health care expenditures, subject to appropriation by the Legislature.

The Budget Act of 2018 allocated Proposition 56 funds for rate increases to home health and private duty nursing (PDN) services. The Legislature has continued this funding in subsequent budget acts.

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

PROP 56 - HOME HEALTH RATE INCREASE

REGULAR POLICY CHANGE NUMBER: 139

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.

This policy change identifies the use of the General Fund for these Proposition 56 payments. See the Proposition 56 Funding policy change for the Proposition 56 offset to the GF in FY 2021-22. Beginning FY 2022-23, the Department proposes to transition the nonfederal share of this rate increase to be funded by the General Fund.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to updated FFS funding assumptions based on recent payment data.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to FFCRA increased FMAP funding was not assumed for FY 2022-23.

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 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. An adjustment for the period of January 2019 through June 2020 was made in FY 2020-21.
4. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2022 in this policy change.
5. The supplemental payments are estimated to be:

FY 2021-22	TF	GF	Title XXI FF	Title XIX FF	ACA FF	FFCRA
FFS Ongoing	\$123,645,000	\$54,060,000	\$3,433,000	\$57,884,000	\$861,000	\$7,407,000
Total	\$123,645,000	\$54,060,000	\$3,433,000	\$57,884,000	\$861,000	\$7,407,000

FY 2022-23	TF	GF	Title XXI FF	Title XIX FF	ACA FF	FFCRA
FFS Ongoing	\$123,645,000	\$61,467,000	\$3,433,000	\$57,884,000	\$861,000	\$0
Total	\$123,645,000	\$61,467,000	\$3,433,000	\$57,884,000	\$861,000	\$0

PROP 56 - HOME HEALTH RATE INCREASE
REGULAR POLICY CHANGE NUMBER: 139

Funding:

FY 2021-22	TF	GF	FF	FFCRA
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$115,768,000	\$57,884,000	\$57,884,000	\$0
90%Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$957,000	\$96,000	\$861,000	\$0
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$0	\$0	\$0	\$0
100% GF (4260-101-0001)	\$5,281,000	\$1,848,000	\$3,433,000	\$0
FFCRA 4.34% GF (4260-113-0001)	(\$229,000)	(\$229,000)	\$0	\$0
FFCRA 4.34% FF (4260-113-0890)	\$229,000	\$0	\$0	\$229,000
FFCRA 6.2% GF (4260-101-0001)	(\$7,178,000)	(\$7,178,000)	\$0	\$0
FFCRA 6.2% FF (4260-101-0890)	\$7,178,000	\$0	\$0	\$7,178,000
Total	\$123,645,000	\$54,060,000	\$62,178,000	\$7,407,000

FY 2022-23	TF	GF	FF	FFCRA
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$115,768,000	\$57,884,000	\$57,884,000	\$0
90%Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$957,000	\$96,000	\$861,000	\$0
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$5,281,000	\$1,848,000	\$3,433,000	\$0
100% GF (4260-101-0001)	\$1,639,000	\$1,639,000	\$0	\$0
Total	\$123,645,000	\$61,467,000	\$62,178,000	\$0

LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES

REGULAR POLICY CHANGE NUMBER: 140
IMPLEMENTATION DATE: 8/2013
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1784

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

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 1762 (Chapter 230, Statutes of 2003)
 AB 1629 (Chapter 875, Statutes of 2004)
 ABX1 19 (Chapter 4, Statutes of 2011)
 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.)

LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES

REGULAR POLICY CHANGE NUMBER: 140

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.

AB 119 extended 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 FS-PSA facilities from the QAF, effective August 1, 2020.

Reason for Change:

The change for FY 2021-22, from the prior estimate, is an estimated decrease in GF transfers due to:

- Decreased prior year transfers due to transferring one month of transfers earlier in FY 2021-22.
- Decreased estimate of the withhold transfers occurring in FY 2021-22, based on actual FY 2020-21 withholds.
- Decreased projected monthly average collections, based on updated collections data through June 2021.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is an estimated increase in GF transfers due to:

- More months are estimated to be transferred in FY 2022-23.
- Increased estimated QAF withhold transfers expected to occur in FY 2022-23.

Methodology:

1. Based on collections and transfer data through September 2021; assume \$447.165 million will be transferred to the GF in FY 2021-22 and \$592.657 million in FY 2022-23.
2. The estimated withhold transfers for the AB 1629 QAF and QAF assessed on ICF-DDs are expected to occur is \$48.722 million in FY 2021-22 and \$63.881 million in FY 2022-23.

LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES

REGULAR POLICY CHANGE NUMBER: 140

3. The estimated fund adjustment from the LTCQAF to the GF is:

(Dollars in Thousands)

FY 2021-22	TF	GF	LTCQAF
FY 2020-21	\$0	(\$91,096)	\$91,096
FY 2021-22	\$0	(\$307,347)	\$307,347
Subtotal	\$0	(\$398,443)	\$398,443
Withhold Transfers	\$0	(\$48,722)	\$48,722
Total	\$0	(\$447,165)	\$447,165

(Dollars in Thousands)

FY 2022-23	TF	GF	LTCQAF
FY 2021-22	\$0	(\$151,079)	\$151,079
FY 2022-23	\$0	(\$377,697)	\$377,697
Subtotal	\$0	(\$528,776)	\$528,776
Withhold Transfers	\$0	(\$63,881)	\$63,881
Total	\$0	(\$592,657)	\$592,657

Funding:

Long Term Care Quality Assurance Fund (4260-601-3213)
100% GF (4260-101-0001)

DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 141
IMPLEMENTATION DATE: 4/2020
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 2161

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$420,000	-\$932,000
- STATE FUNDS	-\$161,820	-\$401,860
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$420,000	-\$932,000
STATE FUNDS	-\$161,820	-\$401,860
FEDERAL FUNDS	-\$258,180	-\$530,140

Purpose:

This policy change estimates the savings resulting from adjustments made to certain Medi-Cal Fee-for-Service (FFS) Durable Medical Equipment (DME) reimbursement rates.

Authority:

Welfare and Institutions Code 14105.48
 SPA 19-0005
 Families First Coronavirus Response Act (FFCRA)
 AB 97 (Chapter 3, Statutes of 2011)
 AB 133 (Chapter 143, Statutes of 2021)

Interdependent Policy Changes:

Not Applicable

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 approved State Plan Amendment (SPA) 19-0005 to adjust Medi-Cal FFS DME reimbursement rates based on Medicare rural rates, effective January 1, 2019. The January 1, 2020 and January 1, 2021 rate adjustments were not found to be necessary; therefore, the Department is not assuming a savings for these years.

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.

DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 141

Assembly Bill 133 (Chapter 143, Statutes of 2021), the Public Health Omnibus Bill of 2021 eliminates the 10 percent provider payment reduction for DME Complex Rehabilitation Technology (CRT) services, as required by AB 97, effective January 1, 2022. The Department will submit a SPA to seek federal approval for the elimination of the payment reduction in September 2021.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to:

- Updated savings based on recent utilization data,
- Implementation dates for the retroactive recoupment of the 2019 rate adjustments shifted from April 2021 to January 2022, and
- Inclusion of the January 2022 DME CRT prospective loss of savings.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a net savings increase due to more months of rate adjustment and retroactive recoupments and loss of savings occurring in FY 2022-23.

Methodology:

1. The annual rate adjustment policy is effective January 1st of each year.
2. The January 2019 updated rates were implemented on March 24, 2020. The FFS annual savings is \$1.574 million TF. The retroactive recoupment for the period of January 2019 through March 23, 2020 is expected to occur over 12 months beginning in January 2022.
3. Reviews of Medi-Cal Rates for 2020 and 2021 found no rates required an adjustment.
4. The January 1, 2022 DME CRT payment reduction exemption is expected to implement in March 2022. The FFS annual loss of savings is estimated to be \$2 million TF. The retroactive loss of savings for the period of January through February 2022 is expected to occur in the month of June 2022.
5. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through December 31, 2021 for this policy change.
6. The FFS savings/loss of savings are estimated to be:

FY 2021-22	TF	GF	FFP	FFCRA
FFS Rate Adjustment (savings)	(\$991,000)	(\$430,000)	(\$543,000)	(\$18,000)
FFS DME CRT Restoration (savings loss)	\$571,000	\$268,000	\$303,000	\$0
Total	(\$420,000)	(\$162,000)	(\$240,000)	(\$18,000)

FY 2022-23	TF	GF	FFP	FFCRA
FFS Rate Adjustment (savings)	(\$2,405,000)	(\$1,093,000)	(\$1,294,000)	(\$18,000)
FFS DME CRT Restoration (savings loss)	\$1,473,000	\$691,000	\$782,000	\$0
Total	(\$932,000)	(\$402,000)	(\$512,000)	(\$18,000)

DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 141

Funding:

FY 2021-22	TF	GF	FFP	FFCRA
50% Title XIX/ 50% GF	(\$364,000)	(\$182,000)	(\$182,000)	\$0
93% Title XIX / 7% GF	(\$35,000)	(\$3,000)	(\$32,000)	\$0
90% Title XIX / 10% GF	\$16,000	\$2,000	\$15,000	\$0
88% Title XXI / 12% GF	(\$52,000)	(\$6,000)	(\$46,000)	\$0
76.5 Title XXI / 23.5% GF	(\$35,000)	(\$8,000)	(\$27,000)	\$0
65% Title XXI / 35% GF	\$50,000	\$17,000	\$32,000	\$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	\$17,000	\$17,000	\$0	\$0
FFCRA 6.2% FFP	(\$17,000)	\$0	\$0	(\$17,000)
Total	(\$420,000)	(\$162,000)	(\$240,000)	(\$18,000)

FY 2022-23	TF	GF	FFP	FFCRA
50% Title XIX/ 50% GF	(\$808,000)	(\$404,000)	(\$404,000)	\$0
93% Title XIX / 7% GF	(\$35,000)	(\$3,000)	(\$32,000)	\$0
90% Title XIX / 10% GF	(\$7,000)	(\$1,000)	(\$6,000)	\$0
88% Title XXI / 12% GF	(\$52,000)	(\$6,000)	(\$46,000)	\$0
76.5 Title XXI / 23.5% GF	(\$35,000)	(\$8,000)	(\$27,000)	\$0
65% Title XXI / 35% GF	\$5,000	\$2,000	\$3,000	\$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	\$17,000	\$17,000	\$0	\$0
FFCRA 6.2% FFP	(\$17,000)	\$0	\$0	(\$17,000)
Total	(\$932,000)	(\$402,000)	(\$512,000)	(\$18,000)

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 142
IMPLEMENTATION DATE: 12/2011
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1580

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$166,726,000	-\$164,723,000
- STATE FUNDS	-\$64,328,150	-\$63,555,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	94.71 %	95.86 %
APPLIED TO BASE		
TOTAL FUNDS	-\$8,819,800	-\$6,819,500
STATE FUNDS	-\$3,402,960	-\$2,631,200
FEDERAL FUNDS	-\$5,416,850	-\$4,188,330

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:

Not Applicable

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: 142

The actuarial equivalent of FFS payment reductions to specified managed care providers was scheduled to be implemented on July 1, 2011; however, because of the delay in implementation, the rates for retroactive periods cannot be certified as actuarially sound. The impact of AB 97 for managed care will be determined on a prospective basis.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to:

- Revised estimates of the pharmacy and DME retroactive recoupments based on updated actual data.
- Updated funding assumptions for this policy change.

The change from FY 2021-22 to FY 2022-23 in the current estimate is due to estimating the completion of the DME retroactive recoupments in FY 2022-23.

Methodology:

1. **Managed Care:** There are no retroactive savings for managed care payments recouped and the implementation of the managed care reductions began October 1, 2013. The impact of AB 97 for managed care is budgeted in the managed care related policy changes and will take place on a prospective basis. The following services are not subject to a reduction:
 - Pharmacy, and
 - Specialty physician services.
2. **FFS:** The Department implements the FFS payment reductions in three phases.
 - **Phase I:** Phase I includes all subject providers except for the previously enjoined providers and the Child Health and Disability Prevention (CHDP) program.
 - PDHC program was first exempted on October 25, 2012, from the 10% payment reduction, effective April 1, 2012. PDHC providers were refunded in July 2013 for the payment reduction for services provided after April 1, 2012. In October 2014, PDHC providers were exempted further for the period of June 1, 2011 to March 31, 2012 and refunded any payment reductions applied for this period.
 - The Department received CMS approval on August 28, 2013 to exempt audiology services provided by Type C Communication Disorder Center that are located in the California counties of Alameda, San Benito, Santa Clara, Santa Cruz, San Francisco, and Sonoma from the 10% payment reduction, effective October 19, 2012. The Department stopped the 10% payment reduction in November 2013 and refunded the payment reduction for the period October 19, 2012 through October 31, 2013 in September 2014.
 - Residential Care Facilities for the Elderly and Care Coordinator Agencies are not subject to the 10% payment reduction. The Department stopped the 10% payment reduction in August 2013 and refunded the payment reduction for the period June 1, 2011 through August 31, 2013 in May 2014.
 - Genetic disease screening program, administered by California Department of Public Health, is not subject to the 10% payment reduction. The Department stopped the 10% payment reduction in December 2013 and refunded the payment reduction for the period June 1, 2011 through November 30, 2013 in August 2014.

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 142

- **Phase II:** Phase II includes all the previously enjoined providers.
 - DME/Medical Supplies payment reduction recoupment for dates of service from June 1, 2011 to October 24, 2013.
 - Nonprofit dental pediatric surgery centers that provide at least 99% of their services under general anesthesia to children with severe dental disease under age of 21 are exempt from the 10% payment reduction effective August 31, 2013.
 - 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%.
 - Assembly Bill 133 (Chapter 143, Statutes of 2021), the Public Health Omnibus Bill of 2021 eliminates the 10 percent provider payment reduction for DME Complex Rehabilitation Technology (CRT) services, as required by AB 97, effective January 1, 2022. See the Durable Medical Equipment Rate Adjustment policy change for the impact of this change.
 - **Phase III:** Phase III includes the CHDP program providers.
3. The Department forgoes the retroactive recoupments prior to the corresponding implementation date for the following providers: Physicians, medical transportation, dental, clinics, certain high-cost drugs, and CHDP.

Provider Type	Payment Reduction Effective Date	Payment Reduction Implementation Date	Total Months of Retroactive Period	Recoupment Start Date	Total Months to Recoup
Phase I	6/1/2011	12/20/2011	7	6/29/2012	24
Phase II					
Physicians	1/10/2014	1/10/2014	N/A	N/A	N/A
Medical Transportation	9/5/2013	9/5/2013	N/A	N/A	N/A
DME/Medical Supplies	6/1/2011	10/24/2013	29	9/1/2017	N/A
Clinics	1/10/2014	1/10/2014	N/A	N/A	N/A
Pharmacy	6/1/2011	2/7/2014	32	3/1/2016	N/A
Phase III (CHDP)	10/1/2014	10/1/2014	N/A	N/A	N/A

10% PROVIDER PAYMENT REDUCTION
REGULAR POLICY CHANGE NUMBER: 142

4. The estimated savings (TF) from AB 97 payment reduction are:
(Dollars in Thousands)

Provider Type		FY 2021-22	FY 2022-23	Annual
Phase I	FFS	(\$46,823)	(\$46,823)	(\$46,823)
	FFS Retro	\$0	\$0	\$0
	Phase I Total	(\$46,823)	(\$46,823)	(\$46,823)
Phase II				
Physicians	FFS	(\$49,746)	(\$49,746)	(\$49,746)
	FFS Retro	\$0	\$0	\$0
Medical Transportation	FFS	(\$14,461)	(\$14,461)	(\$14,461)
	FFS Retro	\$0	\$0	\$0
DME/Medical Supplies	FFS	(\$17,394)	(\$17,394)	(\$17,394)
	FFS Retro	(\$7,510)	(\$5,507)	(\$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	(\$1,315)	(\$1,315)	(\$1,315)
	FFS	(\$108,664)	(\$108,664)	(\$108,664)
	FFS Retro	(\$8,825)	(\$6,822)	(\$8,825)
	Phase II Total	(\$117,489)	(\$115,486)	(\$117,489)

10% PROVIDER PAYMENT REDUCTION
REGULAR POLICY CHANGE NUMBER: 142

Provider Type		FY 2021-22	FY 2022-23	Annual
Phase III (CHDP)	FFS	(\$2,414)	(\$2,414)	(\$2,414)
	FFS Retro	\$0	\$0	\$0
	Phase III Total	(\$2,414)	(\$2,414)	(\$2,414)
	FFS	(\$157,901)	(\$157,901)	(\$157,901)
	FFS Retro	(\$8,825)	(\$6,822)	(\$8,825)
	Managed Care	\$0	\$0	\$0
Grand Total	Grand Total	(\$166,726)	(\$164,723)	(\$166,726)

Funding:

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

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

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

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER: 143
IMPLEMENTATION DATE: 8/2015
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 1505

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$12,729,000	-\$12,522,000
- STATE FUNDS	-\$5,482,260	-\$5,405,460
PAYMENT LAG	0.9839	0.9994
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$12,524,100	-\$12,514,500
STATE FUNDS	-\$5,394,000	-\$5,402,220
FEDERAL FUNDS	-\$7,130,070	-\$7,112,270

Purpose:

This policy change estimates savings resulting from adjustments made to certain radiology reimbursement rates.

Authority:

SB 853 (Chapter 717, Statutes of 2010)
 SPA 19-0003
 SPA 20-0004
 SPA 20-0009

Interdependent Policy Changes:

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

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. SPA 19-0003 was approved on June 4, 2019, to adjust radiology rates exceeding 80% of Medicare's rates, effective January 1, 2019. SPA 20-0004 was approved on April 20, 2020, for rate adjustments effective January 1, 2020 and SPA 21-0009. The Department expects to submit a SPA in January 2022 for the rate adjustments effective January 1, 2022.

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER: 143

Reason for Change:

The change in FY 2021-22, from the prior estimate, is a net decrease in savings due to:

- Delayed implementation of the January 2019 and January 2020 rate increases by three months, resulting in less prospective savings;
- More retroactive savings due the January 2019 and January 2020 implementation day resulting in more retroactive recoupments;

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a net decrease in savings due to:

- Full year of prospective rate adjustments in FY 2022-23;
- More 2019 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 January 1, 2019, reflect an annual FFS savings of \$3,218,000 TF. These rates are expected to be implemented in August 2021.

The total recoupment of retroactive savings from January 1, 2019, through Jul 31, 2021, is estimated to be \$8,312,000 TF and is expected to be implemented in November 2021 over 12 months.

4. The rate adjustments effective January 1, 2020, reflect an annual FFS savings of \$577,000 TF and are expected to be implemented in August 2021.

The total recoupment of retroactive savings from January 1, 2020, through July 31, 2021, is estimated to be \$914,000 TF and is expected to be implemented in November 2021, over 12 months.

5. The rate adjustments effective January 1, 2021, reflect an annual FFS savings of \$2,188,000 TF. These rates are expected to be implemented in September 2021.

The total recoupment of retroactive savings from January 1, 2021, through August 31, 2021, is estimated to be \$1,459,000 TF and is expected to be implemented in January 2022, over 12 months.

6. The rate adjustments effective January 1, 2022, reflect an annual FFS savings of \$2,188,000 TF. These rates are expected to be implemented in April 2022.

The total recoupment of retroactive savings from January 1, 2022 through March 31, 2022, is estimated to be \$547,000 TF and is expected to be implemented in July 2022 over 12 months.

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER: 143

7. The estimated savings for the reduction to radiology reimbursement rates are:

FY 2021-22	TF	GF	TITLE XIX FF	TITLE XXI FF	ACA FF
Prospective Savings	(\$5,849,000)	(\$2,531,000)	(\$2,390,000)	(\$87,000)	(\$841,000)
Recoupment of Retro Savings	(\$6,880,000)	(\$2,952,000)	(\$2,812,000)	(\$117,000)	(\$999,000)
Total	(\$12,729,000)	(\$5,483,000)	(\$5,202,000)	(\$204,000)	(\$1,840,000)

FY 2022-23	TF	GF	TITLE XIX FF	TITLE XXI FF	ACA FF
Prospective Savings	(\$8,170,000)	(\$3,535,000)	(\$3,339,000)	(\$122,000)	(\$1,174,000)
Recoupment of Retro Savings	(\$4,352,000)	(\$1,870,000)	(\$1,779,000)	(\$72,000)	(\$631,000)
Total	(\$12,522,000)	(\$5,405,000)	(\$5,118,000)	(\$194,000)	(\$1,805,000)

Funding:

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

88% Title XXI FF / 12% GF (4260-113-0890/001)

76.5% Title XXI FF / 23.5% GF (4260-113-0890/001)

65% Title XXI FF / 35% GF (4260-113-0890/001)

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

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

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change

LABORATORY RATE METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER: 144
IMPLEMENTATION DATE: 2/2016
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 1703

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$2,294,000	-\$1,547,000
- STATE FUNDS	\$12,269,000	-\$663,450
PAYMENT LAG	1.0000	0.9880
% REFLECTED IN BASE	62.04 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$870,800	-\$1,528,400
STATE FUNDS	\$4,657,310	-\$655,490
FEDERAL FUNDS	-\$5,528,110	-\$872,950

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 through June 30, 2021, and to more than 100% of corresponding Medicare rates thereafter.

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)
 AB 133 (Chapter 143, Statutes of 2021)
 Welfare and Institutions (W&I) Code 14105.22
 SPA 15-015
 SPA 19-0011
 SPA 20-0003
 SPA 20-0010

Interdependent Policy Changes:

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

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.

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Effective July 1, 2015, the new reimbursement methodology is applicable to certain clinical laboratory or laboratory service codes, which may include FPACT and outpatient hospital services. AB 659 changed the frequency of data collection and rate development from once a year to once every three years, with the new rates being effective July 1, 2020.

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.

As a result of the annual Medi-Cal rate review, no fee for service (FFS) Medi-Cal clinical laboratory rates required a rate adjustment, effective January 1, 2021. Since no rates required an adjustment as a result of the review, DHCS did not submit State Plan Amendment (SPA) 21-0008, as noticed on December 31, 2020.

Assembly Bill 133 (Chapter 143, Statutes of 2021) amended W&I Section 14105.22 and added section 14105.222, which required the Department to update clinical laboratory rates as follows:

- (1) Forgive the retroactive overpayments resulting from the reductions for dates of service January 1, 2020 through June 30, 2021;
- (2) Establish reimbursement rates for clinical laboratory services at the rates in effect as of December 31, 2019 for dates of service from July 1, 2021 through June 30, 2022;
- (3) For dates of service on or after July 1, 2022, establish rates to not exceed 100% of the lowest maximum allowance established by the federal Medicare program for the same or similar service.

The Department is submitting SPA 21-0052 to seek federal approval to establish clinical laboratory rates at the rates in effect as of December 31, 2019 for dates of service July 1, 2021 through June 30, 2022. The Department will forgo the annual rate adjustment to 80% of Medicare in 2022.

Effective July 1, 2022, clinical laboratory rates will be established in accordance with W&I Code Section 14105.22, which provides that reimbursement for clinical laboratory or laboratory services may not exceed 100% of the lowest maximum allowance established by the federal Medicare program for the same or similar services. The Department will submit a SPA to seek federal approval to adjust rates.

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.

On January 12, 2021, the Department received federal approval for SPA 20-0010 to adjust clinical laboratory or laboratory services reimbursement rates based on the triennial reimbursement methodology, effective July 1, 2020.

LABORATORY RATE METHODOLOGY CHANGE

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Reason for Change:

The change for FY 2021-22, from the prior estimate, is a decrease in savings due to:

- Removing the impact of the CY 2021 rate adjustment.
- Impacts of AB 133 are reflected in this policy change instead of being reflected separately in the former Clinical Lab Reimbursement Rates policy change.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to fewer retroactive recoupments occurring in FY 2022-23.

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.
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 was implemented in September 2020. The retroactive recoupment from April 2019 through August 2020 was implemented in January 2021.
 - 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 was implemented in February 2021. The retroactive recoupment from January 2020 through January 2021 is forgiven in accordance with AB 133.
5. **Triennial rate adjustment:** The Centers for Medicare and Medicaid Services (CMS) approved the new laboratory rate methodology in July 2015.
 - a. The savings resulting from the July 2020 rate adjustment is estimated to be \$858,000 TF and was implemented April 2021. The retroactive recoupment from July 2020 through March 2020 is forgiven in accordance with AB 133.
6. **July 2021 Rate Adjustment:** Clinical laboratory rates will be established at the rates in effect as of December 31, 2019. No separate fiscal impact is assumed for this change, other than the forgiveness of previous adjustments as described above.
7. **July 2022 Rate Adjustment:** The annual Medi-Cal rate adjustments will apply to clinical laboratory or laboratory services reimbursement rates exceeding 100% of corresponding Medicare rates. The rates are expected to implement on July 1, 2022. The annual impact of this adjustment is estimated to be savings of \$204,000 TF.
8. **FFP Adjustment:** The adjustment will adjust the FFP claimed for the retroactive recoupment periods in accordance with AB 133, such that the state General Fund will cover

LABORATORY RATE METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER: 144

the cost of forgiven adjustments prior to July 1, 2021. Assume 12 months of impact for the 2020 new rate methodology and 18 months of impact for the 2020 annual rate adjustment.

9. The expected adjustments are as follows:

FY 2021-22	TF	GF	FF
Prospective Savings			
2020 New Rate Methodology	(\$858,000)	(\$368,000)	(\$490,000)
Forgive 2020 New Rate Methodology	\$858,000	\$368,000	\$490,000
2019 Annual Rate Adjustment	(\$1,343,000)	(\$576,000)	(\$767,000)
2020 Annual Rate Adjustment	(\$14,900,000)	(\$6,391,000)	(\$8,509,000)
Forgive 2020 Annual Rate Adjustment	\$14,900,000	\$6,391,000	\$8,509,000
Retroactive Recoupments			
2020 New Rate Methodology (retro)	(\$644,000)	(\$277,000)	(\$367,000)
Forgive 2020 New Rate Methodology (retro)	\$644,000	\$277,000	\$367,000
2019 Annual Rate Adjustment (retro)	(\$951,000)	(\$408,000)	(\$543,000)
2020 Annual Rate Adjustment (retro)	(\$16,142,000)	(\$6,924,000)	(\$9,218,000)
Forgive 2020 Annual Rate Adjustment (retro)	\$16,142,000	\$6,924,000	\$9,218,000
FFP Adjustment			
2020 New Rate Methodology (12 months)	\$0	\$490,000	(\$490,000)
2020 Annual Rate Adjustment (18 months)	\$0	\$12,763,000	(\$12,763,000)
Total savings	(\$2,294,000)	\$12,269,000	(\$14,563,000)

FY 2022-23	TF	GF	FF
Prospective Savings			
2020 New Rate Methodology	(\$858,000)	(\$368,000)	(\$490,000)
Forgive 2020 New Rate Methodology	\$858,000	\$368,000	\$490,000
2019 Annual Rate Adjustment	(\$1,343,000)	(\$576,000)	(\$767,000)
2020 Annual Rate Adjustment	(\$14,900,000)	(\$6,391,000)	(\$8,509,000)
Forgive 2020 Annual Rate Adjustment	\$14,900,000	\$6,391,000	\$8,509,000
Annual 2022 Rate Adjustment	(\$153,000)	(\$66,000)	(\$87,000)
Retroactive Recoupments			
Annual 2022 Rate Adjustment (retro)	(\$51,000)	(\$22,000)	(\$29,000)
Total savings	(\$1,547,000)	(\$664,000)	(\$883,000)

LABORATORY RATE METHODOLOGY CHANGE
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Funding:

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	(\$1,869,000)	(\$934,000)	(\$935,000)
90% Title XIX / 10% GF (4260-101-0001 / 0890)	(\$397,000)	(\$40,000)	(\$357,000)
65% Title XXI / 35% GF (4260-113-0001 / 0890)	(\$28,000)	(\$10,000)	(\$18,000)
100% State General Fund	\$13,253,000	\$13,253,000	\$0
100% FFP	(\$13,253,000)	\$0	(\$13,253,000)
Total	(\$2,294,000)	\$12,269,000	(\$14,563,000)

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	(\$1,260,000)	(\$630,000)	(\$630,000)
90% Title XIX / 10% GF (4260-101-0001 / 0890)	(\$268,000)	(\$27,000)	(\$241,000)
65% Title XXI / 35% GF (4260-113-0001 / 0890)	(\$19,000)	(\$7,000)	(\$12,000)
Total	(\$1,547,000)	(\$664,000)	(\$883,000)

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change

DPH INTERIM & FINAL RECONS

REGULAR POLICY CHANGE NUMBER: 145
IMPLEMENTATION DATE: 10/2007
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 1152

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$73,348,000	\$60,992,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$73,348,000	\$60,992,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	-\$73,348,000	\$60,992,000

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: 145

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to updated amounts for FY 2011-12 and FY 2013-14 that will be settled in FY 2021-22 along with FY 2014-15 and FY 2015-16.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to payments for FY 2016-17, 2017-18, and 2018-19 will be paid in FY 2022-23.

Methodology:

1. DPH's final reconciliation for all years will be the difference between the Federal Medical Assistance Percentage (FMAP) rate of the audited costs and the respective payments.
2. The estimated final reconciliation payments and recoupments on a cash basis are:

(Dollars in Thousands)

FY 2021-22	TF	FF	ACA FF
2011-12 Final Reconciliation	\$34,482	\$34,482	\$0
2013-14 Final Reconciliation	\$8,422	(\$16,265)	\$0
2014-15 Final Reconciliation	(\$52,908)	(\$44,384)	(\$8,524)
2015-16 Final Reconciliation	(\$63,344)	(\$51,684)	(\$11,660)
Total	(\$73,348)	(\$77,851)	\$4,503

(Dollars in Thousands)

FY 2022-23	TF	FF	ACA FF
2016-17 Final Reconciliation	(\$7,061)	\$16,831	(\$23,892)
2017-18 Final Reconciliation	61,165	31,786	29,380
2018-19 Final Reconciliation	6,888	14,950	(8,063)
Total	\$60,992	\$63,567	(\$2,575)

Funding:

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

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

MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS

REGULAR POLICY CHANGE NUMBER: 146
IMPLEMENTATION DATE: 9/2019
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2055

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$3,278,827,000	\$3,403,178,000
- STATE FUNDS	\$1,067,062,000	\$1,074,995,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,278,827,000	\$3,403,178,000
STATE FUNDS	\$1,067,062,000	\$1,074,995,000
FEDERAL FUNDS	\$2,211,765,000	\$2,328,183,000

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

REGULAR POLICY CHANGE NUMBER: 146

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 December 17, 2018, the Department received CMS pre-print approval to continue the PHDP for the FY 2018-19 rating period. On June 12, 2020, the Department received approval from CMS for the July 1, 2019 through December 31, 2020 rating period.

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.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is a slight increase due to actual utilization data and internal calculations used to determine payment amounts.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to growth in the total pool size. In addition, the FFCRA increased FMAP is higher in FY 2022-23.

Methodology:

1. The total value of the funding for the private hospital directed payment pool is \$3.28 billion total fund, and \$3.40 billion total fund for the FY 2019-20 and FY 2020-21 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 2019-20 rating period payment (July through December 2019) occurred in September 2021. The second FY 2019-20 rating period payment (January through June 2020) is expected to occur in March 2022.
7. The FY 2020-21 rating period payments are anticipated to occur in September 2022 and March 2023, respectively.
8. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures for the period from January 2020 through December 2021 in this policy change.

MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS
REGULAR POLICY CHANGE NUMBER: 146

9. On a cash basis, the estimated payments are:

(Dollars in Thousands)

FY 2021-22	TF	SF (HQARF)	FF (Title 19)	FF (Title 21)	ACA FF	FFCRA
FY 2019-20	\$3,278,827	\$1,067,062	\$1,006,761	\$120,957	\$1,018,321	\$65,726
Total FY 2021-22	\$3,278,827	\$1,067,062	\$1,006,761	\$120,957	\$1,018,321	\$65,726

(Dollars in Thousands)

FY 2022-23	TF	SF (HQARF)	FF (Title 19)	FF (Title 21)	ACA FF	FFCRA
Bridge Period (July 2020- December 2020) + CY 2021 P1 (Jan-Jun 2021)	\$3,403,178	\$1,074,995	\$1,044,943	\$107,189	\$1,039,614	\$136,437
Total FY 2022-23	\$3,403,178	\$1,074,995	\$1,044,943	\$107,189	\$1,039,614	\$136,437

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)

HOSPITAL QAF - FFS PAYMENTS

REGULAR POLICY CHANGE NUMBER: 147
IMPLEMENTATION DATE: 7/2017
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1475

	FY 2021-22	FY 2022-23
FULL YEAR COST - TOTAL FUNDS	\$2,859,969,000	\$3,358,212,000
- STATE FUNDS	\$1,201,236,000	\$1,380,410,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,859,969,000	\$3,358,212,000
STATE FUNDS	\$1,201,236,000	\$1,380,410,000
FEDERAL FUNDS	\$1,658,733,000	\$1,977,802,000

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

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.

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.

HOSPITAL QAF - FFS PAYMENTS

REGULAR POLICY CHANGE NUMBER: 147

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 Department is currently developing the next program period (QAF VII) which will include payments for the period beginning January 1, 2022. The Department will seek federal approval for QAF VII in Quarter 2 of 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.

Reason for Change:

The change for FY 2021-22, from the prior estimate, is a net decrease due to:

- HQAF V 2018-19 UPL Overage payments are delayed from FY 2020-21 to FY 2021-22 because fee collections in FY 2020-21 were uncertain due to the anticipated fee collection reductions due to the COVID pandemic;
- FY 2021-22 increased due to a shift of Cycle 7 Grants (SF only) which shifted from FY 2020-21 to FY 2021-22 due to fee collection timing;
- FY 2021-22 was recalculated to include enhanced FMAP attributable to FFCRA of 6.2%, and
- FY 2020-21 ACA and FFCRA adjustments are now reflected in one line.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a net decrease due to:

- The current HQAF VI program period ends December 31, 2021. HQAF VII program period is currently under development. The HQAF VII program period is effective January 1, 2022. Cycles 1 to 4 payments for HQAF VII covering dates of service January 2022 to December 2022 will occur in SFY 2022-23;
- Funding adjustments results vary from FY 2020-21 to FY 2021-22; and
- FY 2018-19 UPL Overage payments were completed in FY 2021-22.

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

HOSPITAL QAF - FFS PAYMENTS

REGULAR POLICY CHANGE NUMBER: 147

V program period covers the 30-month period from January 1, 2017, through June 30, 2019 (QAF V).

2. The Hospital QAF VI program periods covers a 30-month period from July 1, 2019, through December 31, 2021.
3. The ACA claiming methodology for the FFS supplemental payments was approved in FY 2017-18. In FY 2021-22, FFS ACA payments for FY 2020-21 will be claimed. In FY 2022-23, FFS ACA payments for FY 2021-22 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.
4. The QAF V UPL overage payback for FY 2018-19 will take place in FY 2021-22. This was calculated in accordance with State Medicaid Director Letter (SMDL) #13-003.
5. QAF VI payments are based on the QAF VI model that was approved by CMS in February 2020. Exact payment timings are subject to change.
6. Assume the HQAF VII program period covers a 12-month period from January 1, 2022, through December 31, 2022.
7. HQAF VII payments are based on the HQAF VI model that was approved by CMS in February 2020. HQAF VII FFS payments are estimated less 8 percent proxy reduction due to CalAIM transition from FFS to MC. The payment schedule and amounts are still under development, payment timings and amounts are subject to change
8. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.
9. 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 to be expended at a later time.

HOSPITAL QAF - FFS PAYMENTS

REGULAR POLICY CHANGE NUMBER: 147

10. On a cash basis, the estimated QAF V- QAF VII payments are:

(Dollars in Thousands)

FY 2021-22	TF	SF(HQARF)	FF	ACA FF	FFCRA	*Return to Fund 3158
QAF V						
FY 2018-19 UPL Overage	\$0	\$217,158	(\$134,022)	(\$83,136)	\$0	\$0
QAF VI						
FY 2020-21	\$983,480	\$473,111	\$454,065	\$0	\$56,304	\$0
FY 2021-22	\$1,876,489	\$864,249	\$900,570	\$0	\$111,670	\$0
FY 2020-21 ACA Adjustment	\$0	(\$353,282)	(\$522,606)	\$940,691	(\$64,803)	\$353,282
Total FY 2021-22	\$2,859,969	\$1,201,236	\$698,007	\$857,555	\$103,171	\$353,282

(Dollars in Thousands)

FY 2022-23	TF	SF(HQARF)	FF	ACA FF	FFCRA	*Return to Fund 3158
QAF VII						
FY 2021-22	\$1,679,106	\$877,228	\$801,878	\$0	\$0	\$0
FY 2022-23	\$1,679,106	\$877,228	\$801,878	\$0	\$0	\$0
QAF VI & VII						
FY 2021-22 ACA Adjustment	\$0	(\$374,046)	(\$490,845)	\$897,293	(\$32,402)	\$374,046
Total FY 2022-23	\$3,358,212	\$1,380,410	\$1,112,911	\$897,293	(\$32,402)	\$374,046

*The Return to Fund 3158 column is for display purposes only (see QAF V-QAF VII Methodology #3 and #9).

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: 148
IMPLEMENTATION DATE: 3/2015
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1761

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$1,797,400,000	\$1,797,400,000
- STATE FUNDS	\$532,761,000	\$591,572,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,797,400,000	\$1,797,400,000
STATE FUNDS	\$532,761,000	\$591,572,000
FEDERAL FUNDS	\$1,264,639,000	\$1,205,828,000

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)
 Title 42, Code of Federal Regulations (CFR) 438.6(d)(3)

Interdependent Policy Changes:

COVID-19 Increased FMAP Extension

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: 148

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 Department is currently developing the next program period (QAF VII) which will include payments for the period beginning January 1, 2022. The Department will seek federal approval for QAF VII in Quarter 2 of 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.

Reason for Change:

There is no change in FY 2020-21, from the prior estimate, to the total fund amount. However, with more recent enrollment data, the funding splits have been updated.

There is no change in the total fund from FY 2021-22 to FY 2022-23 in the current estimate. The non-federal share, however, has increased in FY 2022-23 because the FFCRA increased FMAP for the January 2022 to June 2022 portion of the Calendar Year (CY) 2022 service period is estimated in a separate policy change.

Methodology:

1. The CY 2021 payments are anticipated to occur in FY 2021-22 while the CY 2022 payments are anticipated to occur in FY 2022-23.
2. The Department will collect intergovernmental transfers (IGTs) from the NDPHs and payments will be made from the HQAF Special Fund 3158.
3. The CY 2021 total amounts are within the approved HQAF VI fee model.
4. The CY 2022 total amount will be submitted to CMS as part of the HQAF VII program prior to the start of the rating period.
5. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.

HOSPITAL QAF - MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 148

6. On a cash basis, the estimated QAF payments are:

(Dollars in Thousands)

FY 2021-22	TF	SF(HQARF)	FF (TITLE 19)	FF (TITLE 21)	ACA FF	FFCRA
Managed Care						
Calendar Year 2021	\$1,700,000	\$503,891	\$468,286	\$38,705	\$633,494	\$55,624
Total MC	\$1,700,000	\$503,891	\$468,286	\$38,705	\$633,494	\$55,624
NDPH IGT						
Calendar Year 2021	\$97,400	\$28,870	\$26,830	\$2,218	\$36,295	\$3,187
Total NDPH IGT	\$97,400	\$28,870	\$26,830	\$2,218	\$36,295	\$3,187
Total FY 2021-22	\$1,797,400	\$532,761	\$495,116	\$40,923	\$669,789	\$58,811

(Dollars in Thousands)

FY 2022-23	TF	SF(HQARF)	FF (TITLE 19)	FF (TITLE 21)	ACA FF	FFCRA
Managed Care						
Calendar Year 2022	\$1,700,000	\$559,515	\$468,286	\$38,705	\$633,494	\$0
Total MC	\$1,700,000	\$559,515	\$468,286	\$38,705	\$633,494	\$0
NDPH IGT						
Calendar Year 2022	\$97,400	\$32,057	\$26,830	\$2,218	\$36,295	\$0
Total NDPH IGT	\$97,400	\$32,057	\$26,830	\$2,218	\$36,295	\$0
Total FY 2022-23	\$1,797,400	\$591,572	\$495,116	\$40,923	\$669,789	\$0

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)

PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 149
IMPLEMENTATION DATE: 1/2018
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 2048

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$1,222,805,000	\$1,215,755,000
- STATE FUNDS	\$440,668,000	\$485,870,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	4.94 %	5.43 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,162,398,400	\$1,149,739,500
STATE FUNDS	\$418,899,000	\$459,488,020
FEDERAL FUNDS	\$743,499,430	\$690,251,490

Purpose:

This policy change estimates the expenditures related to providing supplemental payments for certain physician services.

Authority:

Title 42, Code of Federal Regulations (CFR) 447(f)
 State Plan Amendment (SPA) 17-030
 SPA 18-0033
 SPA 19-0021
 Families First Coronavirus Response Act (FFCRA)
 Budget Act of 2021

Interdependent Policy Changes:

Proposition 56 Funding

Background:

The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), increased the excise tax rate on cigarettes and tobacco products and allocates a portion of the tobacco tax revenue to the Department for use as the non-federal share of health care expenditures, subject to appropriation by the Legislature.

The Budget Act of 2017 allocated Proposition 56 funds for supplemental payments for physician services. The Legislature has continued this funding in subsequent budget acts.

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 the specified physician services 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).

PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 149

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 December 31, 2020, the Department requested approval from CMS for the CY 2021 rating period (January 1 through December 31, 2021).

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.

Beginning July 1, 2019, the directed payments are subject to a two-sided risk corridor. The two-sided risk corridor will be calculated retrospectively by the Department with activities beginning no sooner than January 1, 2022. The risk corridors will be based on the aggregate MEPs achieved by each MCP and will utilize MCP-submitted encounters and/or other utilization data. The necessary data to perform the calculation is not currently available, thus an estimated net recoupment/payment is unable to be determined at this time. However, the Department expects any recoupments or payments to/from MCPs to occur in 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 the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated.

This policy change identifies the use of the General Fund for these Proposition 56 payments. See the Proposition 56 Funding policy change for the Proposition 56 offset to the GF.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is a decrease due to:

- Decreased total fund FFS payments based on recent actual data, likely due to reduced utilization during the COVID-19 pandemic.
- Decreased total fund managed care payments based on revised Calendar Year (CY) 2021 and CY 2022 capitation rates.
- Updating managed care funding assumptions based on actual payment data.

PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS

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The change from FY 2021-22 to FY 2022-23, in the current estimate, is a net decrease due to:

- FFS payments are assumed to return to pre-pandemic levels.
- Decreased managed care payments based on CY 2022 capitation rates.
- FFCRA funding is not assumed in FY 2022-23.

Methodology:

1. This policy is effective July 1, 2017.

FFS Physician Supplemental Payments

2. Payments will be made via supplemental payments.
3. Assume the FFS supplemental payments are approximately \$60,409,000 TF for FY 2021-22 based on recent actual payments.
4. Assume the FFS supplemental payments are approximately \$65,965,000 in FY 2022-23 and ongoing, consistent with levels prior to the COVID-19 pandemic.

Managed Care Physician Directed Payments

5. Risk-based capitation rates paid to MCPs will be enhanced, based on anticipated utilization of the specified services, to fund the required provider payments.
6. Assume that the annual estimated value of enhanced capitation rate increases for MCPs to fund the supplemental rate increase, on an accrual basis, is \$1,160,595,000 TF in FY 2021-22 and \$1,149,790,000 TF in FY 2022-23.
7. The impact of the recoupments related to the MEP for FY 2018-19 are reflected in the Prop 56 – Directed Payment Risk Mitigation policy change.
8. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2022 in this policy change.
9. Funds allocated for the supplemental payments are as follows:

FY 2021-22	TF	GF	Title XXI FF	Title XIX FF	ACA FF	FFCRA
FFS Pmts (ongoing)	\$60,409,000	\$23,706,000	\$7,216,000	\$19,151,000	\$7,480,000	\$2,856,000
Mgd Care Pmts	\$1,162,396,000	\$416,962,000	\$83,098,000	\$328,404,000	\$287,661,000	\$46,271,000
Total	\$1,222,805,000	\$440,668,000	\$90,314,000	\$347,555,000	\$295,141,000	\$49,127,000

FY 2022-23	TF	GF	Title XXI FF	Title XIX FF	ACA FF
FFS Pmts	\$65,965,000	\$29,006,000	\$7,879,000	\$20,912,000	\$8,168,000
Mgd Care Pmts	\$1,149,790,000	\$456,865,000	\$82,060,000	\$323,230,000	\$287,635,000
Total	\$1,215,755,000	\$485,871,000	\$89,939,000	\$344,142,000	\$295,803,000

PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS
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Funding:

FY 2021-22	TF	GF	FF	FFCRA
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$695,109,000	\$347,555,000	\$347,554,000	\$0
90%Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$327,934,000	\$32,793,000	\$295,141,000	\$0
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$138,946,000	\$48,631,000	\$90,315,000	\$0
100% GF (4260-101-0001)	\$60,816,000	\$60,816,000	\$0	\$0
FFCRA 4.34% GF (4260-113-0001)	(\$6,030,000)	(\$6,030,000)	\$0	\$0
FFCRA 4.34% FF (4260-113-0890)	\$6,030,000	\$0	\$0	\$6,030,000
FFCRA 6.2% GF (4260-101-0001)	(\$43,097,000)	(\$43,097,000)	\$0	\$0
FFCRA 6.2% FF (4260-101-0890)	\$43,097,000	\$0	\$0	\$43,097,000
Total	\$1,222,805,000	\$440,668,000	\$733,010,000	\$49,127,000

FY 2022-23	TF	GF	FF
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$688,284,000	\$344,142,000	\$344,142,000
90%Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$328,670,000	\$32,867,000	\$295,803,000
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$138,368,000	\$48,429,000	\$89,939,000
100% GF (4260-101-0001)	\$60,433,000	\$60,433,000	\$0
Total	\$1,215,755,000	\$485,871,000	\$729,884,000

PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 150
IMPLEMENTATION DATE: 7/2005
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1071

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$807,830,000	\$634,392,000
- STATE FUNDS	\$373,713,000	\$317,196,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$807,830,000	\$634,392,000
STATE FUNDS	\$373,713,000	\$317,196,000
FEDERAL FUNDS	\$434,117,000	\$317,196,000

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)
 HR 133 (2020)
 American Rescue Plan (ARP) Act (2021)

Interdependent Policy Changes:

COVID-19 Increased FMAP Extension

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

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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. Subsequent federal action has delayed the reduction. Most recently, on December 27, 2020, HR 133 (2020) was enacted which eliminated the DSH reductions for Federal Fiscal Year (FFY) 2021 through FFY 2023, lowered the overall aggregate national reduction to \$32 billion, and postponed the implementation until FFY 2024.

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.

On March 11, 2021, HR 1319 (2021), ARP, was enacted. ARP requires that for the federal fiscal years in which the FFCRA increased FMAP is applicable, the states' annual DSH allotments be recalculated such that the total computable DSH expenditures for a state is equal to the total computable DSH expenditures that would have resulted in the absence of the FFCRA increased FMAP. The result is an increase in the DSH allotments for the impacted fiscal years. This policy change reflects the draft ARP-adjusted allotments released by CMS on July 15, 2021.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to:

- Updated ARP catch-up payment amounts for FY 2019-20 and FY 2020-21 based on the draft ARP-adjusted FFY 2020 and FFY 2021 DSH allotments released by CMS, and
- Lower FY 2021-22 payments based on a lower estimated FFY 2022 DSH allotment.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to assuming the FY 2022-23 DSH allotment is not subject to ARP adjustments, and therefore resulting in the allotment being lower than the FY 2021-22 DSH allotment.

Methodology:

1. The remaining balance of FY 2019-20 final recoupments will be completed in FY 2021-22.
2. The remaining balance of FY 2020-21 final recoupments will be completed in FY 2021-22.
3. The remaining balance of FY 2021-22 final recoupments will be completed in FY 2022-23.

PRIVATE HOSPITAL DSH REPLACEMENT
REGULAR POLICY CHANGE NUMBER: 150

4. CMS released the ARP-adjusted FFY 2020 and FFY 2021 DSH allotments on July 15, 2021. ARP catch-up payments for FY 2019-20 and FY 2020-21 are scheduled to take place in December 2021.
5. The FY 2022-23 DSH allotment will not be subject to ARP adjustments, and thus assumes a 2% annual increase from the preliminary non-ARP adjusted FY 2020-21 allotment.
6. Assumes 11/12 of the FY 2021-22 DSH replacement payment will occur in FY 2021-22, and the remaining 1/12 will occur in FY 2022-23.
7. Assumes 11/12 of the FY 2022-23 DSH replacement payment will occur in FY 2022-23.
8. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.
9. Assumes \$125 million GF savings beginning in FY 2023-24 when allotment reductions are implemented.

It is assumed that the DSH replacement payments will be made as follows on a cash basis:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF	FFCRA
FY 2019-20	\$83,316	\$36,492	\$41,658	\$5,166
FY 2020-21	\$136,554	\$59,811	\$68,277	\$8,466
FY 2021-22	\$587,960	\$277,410	\$293,980	\$16,570
Total FY 2021-22	\$807,830	\$373,713	\$403,915	\$30,202

FY 2022-23	TF	GF	FF	FFCRA
FY 2021-22	\$53,450	\$26,725	\$26,725	\$0
FY 2022-23	\$580,942	\$290,471	\$290,471	\$0
Total FY 2022-23	\$634,392	\$317,196	\$317,196	\$0

Funding:

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

56.2% Title XIX/ 43.8% GF (4260-101-0001/0890)

GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

REGULAR POLICY CHANGE NUMBER: 151
IMPLEMENTATION DATE: 6/2020
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 2024

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$761,754,000	\$542,183,000
- STATE FUNDS	\$226,459,000	\$208,493,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$761,754,000	\$542,183,000
STATE FUNDS	\$226,459,000	\$208,493,000
FEDERAL FUNDS	\$535,295,000	\$333,690,000

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

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: 151

- 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

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.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to:

- Updated ACA adjustment calculations based on updated encounter data,
- An estimated increase in FY 2019-20 final settlement, FY 2020-21 final settlement, and FY 2021-22 interim payment amounts based on updated data, and
- Updated ACA payment methodology beginning with FY 2020-21, in which Q1 and Q2 ACA adjustments will occur at the same time as final settlements.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to:

- All retroactive ACA adjustment payments will occur in FY 2021-22,
- Final settlements for FY 2019-20 and FY 2020-21 will occur in FY 2021-22, and
- FY 2022-23 payments assumed a 5% Consumer Price Index (CPI) adjustment over the FY 2021-22 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).
2. The indirect medical education (IME) payments include costs incurred by DPHs due to teaching activities. Such indirect costs will be calculated by determining the hospital's adjusted Medi-Cal IME payment per inpatient day and multiplying by the total Medi-Cal managed care days.
3. The GME and IME annual distribution amounts are calculated based on the methodologies outlined in SPA 17-0009.
 - FY 2021-22 payments were calculated based on FY 2019-20 cost report data and are estimated at \$445.5 million TF.

GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

REGULAR POLICY CHANGE NUMBER: 151

- FY 2022-23 payments assumed an increase from FY 2021-22 estimated payments based on the CPI annual adjustment. FY 2022-23 payments are estimated to provide \$479 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 2021-22.
 7. ACA adjustments are anticipated to be processed after the respective FY has closed in order to determine the proportion of the hospital's GME payment attributable to ACA. Beginning with FY 2020-21, ACA adjustments for Q1 and Q2 will be processed concurrently with final settlements for the respective FY. ACA adjustments for Q3 and Q4 will be processed once complete encounter data is available. 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 December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.
 9. Assume FY 2019-20 and FY 2020-21 final settlements will be paid in FY 2021-22.
 10. Assume all four quarters of FY 2021-22 will be paid in FY 2021-22.
 11. Assume ACA adjustments for FY 2016-17, FY 2017-18, FY 2018-19, FY 2019-20, and FY 2021-22 Q1 and Q2 will occur in FY 2021-22.
 12. Assume ACA adjustments for FY 2020-21 Q3 and Q4 will occur in FY 2022-23.
 13. Assume FY 2021-22 final settlements will occur in FY 2022-23.
 14. Assume ACA adjustments for FY 2021-22 Q1 and Q2 will occur in FY 2022-23.
 15. Assume all four quarters of FY 2022-23 will be paid in FY 2022-23.

GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS
REGULAR POLICY CHANGE NUMBER: 151

(Dollars in Thousands)

FY 2021-22	TF	IGT	FF	ACA FF	FFCRA
FY 2016-17 ACA Adjustment	\$29,201	\$0	(\$32,446)	\$61,647	\$0
FY 2017-18 ACA Adjustment	\$61,859	\$0	(\$69,561)	\$131,420	\$0
FY 2018-19 ACA Adjustment	\$59,055	\$0	(\$67,366)	\$126,421	\$0
FY 2019-20 ACA Adjustment	\$67,924	\$0	(\$93,926)	\$161,850	\$0
FY 2019-20 Final Settlement	\$67,415	\$31,618	\$33,707	\$0	\$2,090
FY 2020-21 Final Settlement	(\$50,900)	(\$22,294)	(\$25,450)	\$0	(\$3,156)
FY 2020-21 Q1-Q2 ACA Adjustment	\$81,629	\$8,163	\$0	\$73,466	\$0
FY 2021-22 Payment	\$445,571	\$208,972	\$222,786	\$0	\$13,813
Total	\$761,754	\$226,459	(\$32,256)	\$554,804	\$12,747

(Dollars in Thousands)

FY 2022-23	TF	IGT	FF	ACA FF	FFCRA
FY 2020-21 Q3-Q4 ACA Adjustment	\$27,551	\$0	(\$64,958)	\$92,509	\$0
FY 2021-22 Q1-Q2 ACA Adjustment	\$97,049	\$9,705	\$0	\$87,344	\$0
FY 2021-22 Final Settlement	(\$61,441)	(\$40,724)	(\$30,720)	\$0	\$10,003
FY 2022-23 Payment	\$479,024	\$239,512	\$239,512	\$0	\$0
Total	\$542,183	\$208,493	\$143,834	\$179,853	\$10,003

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)

DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 152
IMPLEMENTATION DATE: 7/2005
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1073

	FY 2021-22	FY 2022-23
FULL YEAR COST - TOTAL FUNDS	\$477,375,000	\$430,468,000
- STATE FUNDS	\$87,293,000	\$113,726,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$477,375,000	\$430,468,000
STATE FUNDS	\$87,293,000	\$113,726,000
FEDERAL FUNDS	\$390,082,000	\$316,742,000

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)
 HR 133 (2020)
 American Rescue Plan (ARP) Act (2021)

Interdependent Policy Changes:

COVID-19 Increased FMAP Extension

Background:

Effective July 1, 2005, based on State Plan Amendment (SPA) 05-022 and as part of the MH/UCD and BTR, the federal DSH allotment is available to provide funding for uncompensated Medi-Cal and uninsured costs incurred by DSHs. Eligible hospitals are to receive funding through the DSH program in the following manner:

- Designated Public Hospitals (DPHs) receive their allocation of federal DSH payments from the Demonstration DSH Fund based on the hospitals' certified public expenditures (CPEs), up to 100% of uncompensated Medi-Cal and uninsured costs. DPHs may also

DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 152

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. Most recently, on December 27, 2020, HR 133 (2020) was enacted which eliminated the DSH reductions for Federal Fiscal Year (FFY) 2021 through FFY 2023, lowered the overall aggregate national reduction to \$32 billion, and postponed the implementation until FFY 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.

On March 11, 2021, HR 1319 (2021), ARP, was enacted. ARP requires that for the federal fiscal years in which the FFCRA increased FMAP is applicable, the states' annual DSH allotments be recalculated such that the total computable DSH expenditures for a state is equal to the total computable DSH expenditures that would have resulted in the absence of the FFCRA increased FMAP. The result is an increase in the DSH allotments for the impacted fiscal years. This policy change reflects the draft ARP-adjusted allotments released by CMS on July 15, 2021.

DSH PAYMENT

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Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to:

- Inclusion of DPH FY 2011-12 final reconciliation payments and recoupments,
- Inclusion of DSH FY 2019-20 DPH UC catch-up payments,
- Revised DSH FY 2020-21 payments based on a technical correction and updated data, and
- Decreased FY 2021-22 estimated DSH payments due to an estimated lower DSH allotment for FFY 2022.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to:

- Final reconciliation net recoupments included in FY 2021-22,
- DSH FY 2019-20 and DSH FY 2020-21 NDPH and DPH UC ARP catch-up payments included in FY 2021-22, and
- FY 2022-23 estimated DSH allotment is not subject to ARP adjustments, and therefore is lower than the DSH allotments for the previous three DSH years.

Methodology:

1. CMS released the ARP-adjusted FFY 2020 and FFY 2021 DSH allotments on July 15, 2021. ARP catch-up payments for FY 2019-20 and FY 2020-21 are scheduled to take place in December 2021.
2. The FY 2022-23 DSH allotment will not be subject to ARP adjustments, and therefore assumes a 2% annual increase from the preliminary non-ARP adjusted FY 2020-21 allotment.
3. 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.
4. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.
5. The impact of the 6.2% Title XIX FFCRA increased FMAP does not increase the claimable DSH allotment, as the DSH allotment is a capped amount. The DSH allocation for NDPHs claims the increased FMAP at 56.2% FF / 43.8% GF. The remaining DSH allotment FFP is then allocated to GPP and UC hospitals. For those remaining hospitals, the non-federal share is reduced by 6.2%, reducing the overall TF, while keeping the FFP the same that would have been paid at 50% federal share / 50% non-federal share. The FFP does not change, while the non-federal share is reduced.

DSH PAYMENT
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6. It is assumed that the DSH payments will be made as follows on a cash basis:

FY 2021-22	TF	GF**	IGT*	FF	FFCRA
DSH 2011-12	(\$13,763,000)	\$0	(\$14,111,000)	\$348,000	\$0
DSH 2019-20	\$39,623,000	\$2,406,000	\$0	\$36,876,000	\$341,000
DSH 2020-21	\$130,153,000	\$2,511,000	\$18,646,000	\$108,641,000	\$355,000
DSH 2021-22	\$321,362,000	\$20,618,000	\$57,223,000	\$242,372,000	\$1,149,000
Total FY 2021-22	\$477,375,000	\$25,535,000	\$61,758,000	\$388,237,000	\$1,845,000

FY 2022-23	TF	GF**	IGT*	FF	FFCRA
DSH 2021-22	\$100,065,000	\$2,083,000	\$22,364,000	\$75,618,000	\$0
DSH 2022-23	\$330,403,000	\$22,917,000	\$66,362,000	\$241,124,000	\$0
Total FY 2022-23	\$430,468,000	\$25,000,000	\$88,726,000	\$316,742,000	\$0

Funding:

100% Demonstration DSH Fund (4260-601-7502)

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)

PROP 56 - MEDI-CAL FAMILY PLANNING

REGULAR POLICY CHANGE NUMBER: 153
IMPLEMENTATION DATE: 1/2020
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2130

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$422,419,000	\$407,214,000
- STATE FUNDS	\$69,691,900	\$67,271,400
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	4.15 %	4.30 %
APPLIED TO BASE		
TOTAL FUNDS	\$404,888,600	\$389,703,800
STATE FUNDS	\$66,799,690	\$64,378,730
FEDERAL FUNDS	\$338,088,930	\$325,325,070

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:

State Plan Amendment (SPA) 19-0027
 Budget Act of 2021

Interdependent Policy Changes:

Proposition 56 Funding

Background:

The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), increased the excise tax rate on cigarettes and tobacco products and allocates a portion of the tobacco tax revenue to the Department for use as the non-federal share of health care expenditures, subject to appropriation by the Legislature.

The Budget Act of 2019 allocated Proposition 56 funds for supplemental payments for family planning services. The Legislature has continued this funding in subsequent budget acts.

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 deployed to retroactively apply supplemental payments to July 1, 2019.

In the Medi-Cal managed care delivery system, the Department has implemented 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 May 5, 2020, the Department received pre-print approval from CMS for the July 2, 2019, through December 31, 2020, rating period. On December 31, 2020, the

PROP 56 - MEDI-CAL FAMILY PLANNING

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Department requested approval from CMS for the CY 2021 rating period January 1, 2021, through December 31, 2021.

Beginning July 1, 2019, the directed payments are subject to a two-sided risk corridor. The two-sided risk corridor will be calculated retrospectively by the Department with activities beginning no sooner than January 1, 2022. The risk corridor will be based on the aggregate medical expenditure percentage achieved by each Managed Care Plan (MCP) and will utilize MCP-submitted encounters and/or other utilization data. The necessary data to perform the calculation is not currently available, thus an estimated net recoupment/payment is unable to be determined at this time. The Department expects any recoupments or payments to/from MCPs to occur in FY 2022-23.

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 Funding policy change for the Proposition 56 offset to the GF.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a slight decrease due to a projected decrease in FFS expenditures using historical actuals and updated MC expenditure data. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to updated enrollment and expenditure projections for MC and FFS in FY 2022-23.

Methodology:

1. Assume an effective date of July 1, 2019.
2. Assume the continuation of the Proposition 56 payments through FY 2022-23, 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)

Fiscal Year	TF	GF	FF
FY 2021-22	\$422,419	\$69,692	\$352,727
FY 2022-23	\$407,214	\$67,271	\$339,943

*Totals may differ due to rounding.

Funding:

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

PROP 56 - VALUE-BASED PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 154
IMPLEMENTATION DATE: 4/2020
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 2128

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$363,684,000	\$30,595,000
- STATE FUNDS	\$117,326,150	\$3,547,850
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$363,684,000	\$30,595,000
STATE FUNDS	\$117,326,150	\$3,547,850
FEDERAL FUNDS	\$246,357,850	\$27,047,150

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:

Families First Coronavirus Response Act (FFCRA)
 Welfare and Institutions Code, Article 5.8 (commencing with Section 14188) of Chapter 7 of Part 3 of Division 9

Interdependent Policy Changes:

Proposition 56 Funding

Background:

The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), increased the excise tax rate on cigarettes and tobacco products and allocates a portion of the tobacco tax revenue to the Department for use as the non-federal share of health care expenditures, subject to appropriation by the Legislature.

The Budget Act of 2019 allocated limited-term Proposition 56 funding for the VBP program.

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 the four specified domains. This program also incentivizes improved data quality and completeness.

PROP 56 - VALUE-BASED PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 154

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 May 5, 2020, the Department received pre-print approval from CMS for the multi-year duration of the VBP program.

Beginning July 1, 2019, the directed payments are subject to a two-sided risk corridor. The two-sided risk corridor will be calculated retrospectively by the Department with activities beginning no sooner than July 1, 2023. The risk corridor will be based on the aggregate medical expenditure percentage achieved by each MCP and will utilize MCP-submitted encounters and/or other utilization data. The necessary data to perform the calculation is not currently available, thus an estimated net recoupment/payment is unable to be determined at this time. However, the Department expects any recoupments or payments to/from MCPs to occur in FY 2023-24.

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.

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 Funding 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.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a decrease due to revised CY 2022 enrollment projections. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to the sunset of the VBP program on June 30, 2022.

Methodology:

1. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2022, in this policy change.
2. On a cash basis, the total directed payments are estimated to be \$363,684,000 in FY 2021-22 and \$30,594,000 in FY 2022-23.
3. Below is the payment table for FY 2021-22 and FY 2022-23, by funding type.

PROP 56 - VALUE-BASED PAYMENT PROGRAM
REGULAR POLICY CHANGE NUMBER: 154

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
50% Title XIX FF / 50% GF (4260-101-0890/0001)	\$197,040	\$98,520	\$98,520
ACA 90% FFP / 10% GF (4260-101-0890/0001)	\$130,185	\$13,019	\$117,167
65% Title XXI / 35% GF (4260-113-0890/0001)	\$36,459	\$12,761	\$23,699
FFCRA 4.34% Increased FFP (4260-113-0890)	\$0	(\$806)	\$806
FFCRA 6.2% Increased FFP (4260-113-0890)	\$0	(\$6,167)	\$6,167
Total	\$363,684	\$117,326	\$246,358

*Totals may differ due to rounding

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX FF / 50% GF (4260-101-0890/0001)	\$16,444	\$8,222	\$8,222
ACA 90% FFP / 10% GF(4260-101-0890/0001)	\$11,148	\$1,115	\$10,033
65% Title XXI / 35% GF (4260-113-0890/0001)	\$3,003	\$1,051	\$1,952
FFCRA 4.34% Increased FFP (4260-113-0890)	\$0	(\$778)	\$778
FFCRA 6.2% Increased FFP (4260-113-0890)	\$0	(\$6,062)	\$6,062
Total	\$30,595	\$3,548	\$27,047

*Totals may differ due to rounding

Funding:

50% Title XIX FF / 50% GF (4260-101-0890/0001)
 ACA 90% FFP / 10% GF (4260-101-0890/0001)
 65% Title XXI / 35% GF (4260-113-0890/0001)
 FFCRA 4.34% Increased FFP (4260-113-0890)
 FFCRA 6.2% Increased FFP (4260-113-0890)

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 155
IMPLEMENTATION DATE: 7/2005
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1085

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$312,253,000	\$310,343,000
- STATE FUNDS	\$141,432,000	\$144,823,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$312,253,000	\$310,343,000
STATE FUNDS	\$141,432,000	\$144,823,000
FEDERAL FUNDS	\$170,821,000	\$165,520,000

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

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

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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, SPA 19-0023 was approved by CMS on July 17, 2019 to continue the Private Hospital Supplemental Program through FY 2019-20, and SPA 20-0020 was approved by CMS on June 29, 2020 to continue the program through June 30, 2021. In FY 2021-22 Q1, the Department will submit SPA 21-0014 to extend the Private Hospital Supplemental Fund Program through June 30, 2022. The Department continues to work towards the development of a formulaic methodology to be included in a future SPA, but in the event that it cannot be completed prior to June 30, 2022, another transition SPA will be submitted to CMS in the fourth quarter of 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.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to:

- Updated FY 2020-21 Affordable Care Act (ACA) data, and
- Decreased FY 2021-22 estimated IGT payments.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to FY 2022-23 payments do not include FFCRA increased FMAP.

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 are returned to the providers.
2. IGT payments will be \$49 million TF in FY 2021-22 and \$53 million TF in FY 2022-23.
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%,

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 155

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 2020-21 ACA supplemental payments will be claimed in FY 2021-22, and FY 2021-22 ACA supplemental payments will be claimed in FY 2022-23.
 - The counties will be reimbursed for the IGTs (non-federal share) and an adjustment will be made for the federal share processed at the FFCRA increased FMAP for FY 2020-21 Q1 through FY 2021-22 Q2 and at the regular 50% FMAP for FY 2021-22 Q3 and Q4.
 - 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 FFCRA increased FMAP for FY 2020-21 Q1 through FY 2021-22 Q2 and at the regular 50% FMAP for FY 2021-22 Q3 and Q4.
5. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.
 - The FY 2021-22 Q1 and Q2 payments will be issued at 50% FF/ 50% Special Fund (GF appropriated); there will be no unused GF. The FFCRA increased FMAP will be issued to providers separately during each of the payment rounds for this program.
6. 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.
7. The estimated Private Hospital Supplemental payments and ending balance for FY 2021-22 are shown below:

(Dollars in Thousands)

FY 2021-22 Private Hospital Supplemental Fund Summary	SF
FY 2020-21 Ending Balance	\$7,411
Appropriation (GF)	\$118,400
2021-22 IGT	\$23,032
FY 2020-21 Interest Earned	\$437
Funds Available	\$149,280
Less: FY 2021-22 Cash Expenditures to Hospitals	(\$141,432)
Est. FY 2021-22 Remaining Balance	\$7,848

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
REGULAR POLICY CHANGE NUMBER: 155

(Dollars in Thousands)

FY 2021-22	TF	SF	FF	ACA FF	FFCRA	Return to Providers*	Return to Counties*
FY 2021-22 Cash Expenditures to Providers**	\$292,729	\$141,432	\$142,955	\$0	\$8,342	\$0	\$0
FY 2020-21 ACA FF Adjustment to Providers***	\$17,139	\$0	(\$25,354)	\$45,637	(\$3,144)	\$17,139	\$0
FY 2020-21 ACA FF Adjustment to Counties***	\$2,385	\$0	(\$3,529)	\$6,352	(\$438)	\$0	\$2,385
Total	\$312,253	\$141,432	\$114,072	\$51,989	\$4,760	\$17,139	\$2,385

8. The estimated Private Hospital Supplemental payments and ending balance for FY 2022-23 are shown below:

(Dollars in Thousands)

FY 2022-23 Private Hospital Supplemental Fund Summary	SF
FY 2021-22 Ending Balance	\$7,848
Appropriation (GF)	\$118,400
2022-23 IGT	\$26,423
Est. FY 2021-22 Interest Earned	\$437
Funds Available	\$153,108
Less: FY 2022-23 Cash Expenditures to Hospitals	(\$144,823)
Est. FY 2022-23 Remaining Balance	\$8,285

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
REGULAR POLICY CHANGE NUMBER: 155

(Dollars in Thousands)

FY 2022-23	TF	SF	FF	ACA FF	FFCRA	Return to Providers*	Return to Counties*
FY 2022-23 Cash Expenditures to Providers**	\$289,646	\$144,823	\$144,823	\$0	\$0	\$0	\$0
FY 2021-22 ACA FF Adjustment to Providers***	\$18,108	\$0	(\$24,536)	\$44,165	(\$1,521)	\$18,108	\$0
FY 2021-22 ACA FF Adjustment to Counties***	\$2,589	\$0	(\$3,509)	\$6,316	(\$218)	\$0	\$2,589
Total	\$310,343	\$144,823	\$116,778	\$50,481	(\$1,739)	\$18,108	\$2,589

*The Return to Providers and Return to Counties columns are for display purposes only (see Methodology #4).

Funding:

100% Private Hospital Supplemental Fund (less funded by GF) (4260-698-3097)

100% Private Hospital Supplemental Fund (non-GF) (4260-601-3097)**

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)

DPH PHYSICIAN & NON-PHYS. COST

REGULAR POLICY CHANGE NUMBER: 156
IMPLEMENTATION DATE: 5/2008
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1078

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$382,101,000	\$98,248,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$382,101,000	\$98,248,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$382,101,000	\$98,248,000

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

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: 156

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.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to:

- FY 2006-07 final reconciliation for non-LA County DPHS are assumed to occur in FY 2021-22,
- FY 2013-14 through FY 2018-19 ACA payments for Los Angeles (LA) County DPHs will be paid as interim payments in FY 2021-22,
- FY 2013-14 through FY 2018-19 ACA payments and final reconciliations for non-LA County DPHS are assumed to occur in FY 2021-22, and
- Revised payment calculations for the FY 2019-20 interim reconciliations and FY 2021-22 interim payment.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to:

- Final reconciliations for LA County DPH are estimated to begin in FY 2022-23,
- Fluctuations in the number of reconciliations and amounts each year, and
- A decrease in FFCRA increased FMAP due to no FFCRA increased FMAP in FY 2022-23 interim payments.

Methodology:

1. One annual interim payment is expected to occur for all DPHs for in quarter 4 of each FY 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 was approved by CMS on August 17, 2021 and first time ACA payments are expected to occur in FY 2021-22 Quarter 2. 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 December 31, 2021 for this policy change. The impact of a six month extension of the

DPH PHYSICIAN & NON-PHYS. COST
REGULAR POLICY CHANGE NUMBER: 156

FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.

FY 2021-22	TF	FF	ACA FF	FFCRA
FY 2006-07 Final Reconciliation	(\$1,860,000)	(\$1,860,000)	\$0	\$0
FY 2013-14 Interim ACA Payment	\$7,778,000	\$0	\$7,778,000	\$0
FY 2014-15 Interim ACA Payment	\$21,787,000	\$0	\$21,787,000	\$0
FY 2015-16 Interim ACA Payment	\$26,668,000	\$0	\$26,668,000	\$0
FY 2016-17 Interim ACA Payment	\$23,287,000	\$0	\$23,287,000	\$0
FY 2017-18 Interim ACA Payment	\$21,197,000	\$0	\$21,197,000	\$0
FY 2018-19 Interim ACA Payment	\$23,874,000	\$0	\$23,874,000	\$0
FY 2013-14 Final Reconciliation	(\$7,494,000)	(\$16,757,000)	\$9,263,000	\$0
FY 2014-15 Final Reconciliation	\$22,003,000	(\$4,121,000)	\$26,124,000	\$0
FY 2015-16 Final Reconciliation	\$7,655,000	(\$19,974,000)	\$27,629,000	\$0
FY 2016-17 Final Reconciliation	\$44,670,000	\$5,366,000	\$39,304,000	\$0
FY 2017-18 Final Reconciliation	\$18,910,000	(\$14,117,000)	\$33,027,000	\$0
FY 2018-19 Final Reconciliation	\$38,278,000	(\$2,287,000)	\$40,565,000	\$0
FY 2019-20 Interim Reconciliation	\$52,884,000	(\$9,155,000)	\$62,607,000	(\$568,000)
FY 2021-22 Interim Payment	\$82,464,000	\$77,650,000	\$0	\$4,814,000
Total	\$382,101,000	\$14,745,000	\$363,110,000	\$4,246,000

FY 2022-23	TF	FF	ACA FF	FFCRA
FY 2005-06 Final Reconciliation	(\$1,479,000)	(\$1,479,000)	\$0	\$0
FY 2007-08 Final Reconciliation	\$3,067,000	\$3,067,000	\$0	\$0
FY 2008-09 Final Reconciliation	\$4,666,000	\$4,666,000	\$0	\$0
FY 2012-13 Final Reconciliation	(\$2,105,000)	(\$2,105,000)	\$0	\$0
FY 2013-14 Final Reconciliation	(\$8,706,000)	(\$4,659,000)	(\$4,047,000)	\$0
FY 2014-15 Final Reconciliation	(\$11,820,000)	(\$6,345,000)	(\$5,475,000)	\$0
FY 2015-16 Final Reconciliation	(\$16,698,000)	(\$12,149,000)	(\$4,549,000)	\$0
FY 2016-17 Final Reconciliation	(\$15,360,000)	(\$12,670,000)	(\$2,690,000)	\$0
2020-21 Interim Reconciliation	\$69,033,000	\$6,630,000	\$61,581,000	\$822,000
2022-23 Interim Payment	\$77,650,000	\$77,650,000	\$0	\$0
Total	\$98,248,000	\$52,606,000	\$44,820,000	\$822,000

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)

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 157
IMPLEMENTATION DATE: 4/2004
ANALYST: Neejkajsiab Yang
FISCAL REFERENCE NUMBER: 78

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$225,884,000	\$198,877,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$225,884,000	\$198,877,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$225,884,000	\$198,877,000

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

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.

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 157

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to:

- FY 2002-03 and FY 2003-04 final reconciliations are no longer included in the estimate,
- FY 2013-14 and FY 2015-16 final reconciliations are expected to begin FY 2021-22, and
- Revised FY 2019-20 and FY 2020-21 estimated payments based on updated data.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to more final reconciliations are scheduled in FY 2022-23.

Methodology:

1. Payments of \$225,884,000 and \$198,877,000 are expected to be made in FY 2021-22 and FY 2022-23 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 2021-22.
 - Final reconciliations for Los Angeles (LA) County hospitals will be on a separate timeline from non-LAC hospitals.
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 2020-21 and FY 2021-22 Traditional and ACA claims are estimated based on FY 2019-20 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 December 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 157

FY 2021-22	TF	FF	ACA	FFCRA
FY 2013-14 Final Reconciliation	(\$15,855,000)	(\$11,758,000)	(\$4,097,000)	\$0
FY 2015-16 Final Reconciliation	(\$3,599,000)	(\$1,569,000)	(\$2,030,000)	\$0
FY 2019-20 Payments	\$1,412,000	\$774,000	\$594,000	\$44,000
FY 2020-21 Payments	\$243,926,000	\$120,541,000	\$115,911,000	\$7,474,000
Total	\$225,884,000	\$107,988,000	\$110,378,000	\$7,518,000

FY 2022-23	TF	FF	ACA	FFCRA
FY 2006-07 Final Reconciliation	(\$2,590,000)	(\$2,590,000)	\$0	\$0
FY 2014-15 Final Reconciliation	(\$3,664,000)	(\$1,564,000)	(\$2,100,000)	\$0
FY 2015-16 Final Reconciliation	(\$17,626,000)	(\$10,297,000)	(\$7,329,000)	\$0
FY 2016-17 Final Reconciliation	(\$20,506,000)	(\$10,598,000)	(\$9,908,000)	\$0
FY 2017-18 Final Reconciliation	(\$4,092,000)	(\$1,556,000)	(\$2,536,000)	\$0
FY 2020-21 Payments	\$1,095,000	\$633,000	\$423,000	\$39,000
FY 2021-22 Payments	\$246,260,000	\$123,609,000	\$118,799,000	\$3,852,000
Total	\$198,877,000	\$97,637,000	\$97,349,000	\$3,891,000

Funding:

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

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

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

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER: 158
IMPLEMENTATION DATE: 2/2006
ANALYST: Neejkajsiab Yang
FISCAL REFERENCE NUMBER: 104

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$132,735,000	\$177,122,000
- STATE FUNDS	\$53,616,000	\$75,914,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$132,735,000	\$177,122,000
STATE FUNDS	\$53,616,000	\$75,914,500
FEDERAL FUNDS	\$79,119,000	\$101,207,500

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

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.

Reason for Change:

The decrease in FY 2021-22, from the prior estimate, is due to the revised FY 2020-21 ACA adjustment estimate and payment amounts based on updated data.

The change from FY 2021-22, to FY 2022-23 in the current estimate, is an increase due to higher payments and ACA adjustments budgeted in FY 2022-23 compared to FY 2021-22.

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER: 158

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 2020-21, the ACA supplemental payments will be claimed in FY 2021-22. ACA payments for FY 2021-22 will be claimed in FY 2022-23. The County will be reimbursed for the nonfederal share, and an adjustment will be made for the federal share processed at the FFCRA 56.2% FMAP for FY 2020-21 Q1 through Q4 and FY 2021-22 Q1 and Q2, and at the regular 50% FMAP for FY 2021-22 Q3 and Q4.
4. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.

(Dollars in Thousands)

FY 2021-22	TF	Special Deposit Fund	FF	ACA FF	FFCRA	*Return to Counties
FY 2020-21 ACA Adjustment to Counties	\$10,325	\$0	(\$15,274)	\$27,493	(\$1,894)	\$10,325
FY 2020-21	\$122,410	\$53,616	\$61,205	\$0	\$7,589	\$0
Total FY 2021-22	\$132,735	\$53,616	\$45,931	\$27,493	\$5,695	\$10,325

(Dollars in Thousands)

FY 2022-23	TF	Special Deposit Fund	FF	ACA FF	FFCRA	*Return to Counties
FY 2021-22 ACA Adjustment to Counties	\$15,257	\$0	(\$20,673)	\$37,212	(\$1,282)	\$15,257
FY 2021-22	\$161,865	\$75,915	\$80,932	\$0	\$5,018	\$0
Total FY 2022-23	\$177,122	\$75,915	\$60,259	\$37,212	\$3,736	\$15,257

*The Return to Counties column is for display purposes only (see Methodology #3).

FFP FOR LOCAL TRAUMA CENTERS
REGULAR POLICY CHANGE NUMBER: 158

Funding:

100% Local Trauma Centers Fund (4260-601-0942142)

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: 159
 IMPLEMENTATION DATE: 11/2015
 ANALYST: Autumn Recce
 FISCAL REFERENCE NUMBER: 1899

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$115,613,000	\$118,535,000
- STATE FUNDS	\$44,761,000	\$49,647,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$115,613,000	\$118,535,000
STATE FUNDS	\$44,761,000	\$49,647,000
FEDERAL FUNDS	\$70,852,000	\$68,888,000

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
 SPA 21-0012
 Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

COVID-19 Increased FMAP Extension

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.

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.

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 159

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) 18-0021 capped payments at \$115.2 million effective July 1, 2018. SPA 21-0012, which was approved by CMS on July 16, 2021, increased the payment cap from \$115.2 million to \$123.1 million, effective July 1, 2021. The \$123.1 million total payment represents \$100 million in supplemental payments and \$23.1 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.
- Reconciliations estimated in current year and budget year are subject to revisions based on updated data and audit reports, when applicable.

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.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to:

- Inclusion of FY 2018-19 final reconciliations,
- Inclusion of FY 2020-21 interim reconciliations, and
- Updated FY 2020-21 Affordable Care Act (ACA) optional population payment data.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to higher ACA, interim reconciliations, and final reconciliation payments estimated in FY 2022-23.

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.

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

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4. Assume DRG payments and DRG add-on payments, if necessary, will be sufficient to reach the 72% minimum payment level for FY 2021-22 and FY 2022-23.
5. Expenditures for FY 2021-22 and FY 2022-23 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 2021-22 and FY 2022-23, the supplemental payments and DRG add-on payments are limited by the payment cap of \$123.1 million. FY 2021-22 and FY 2022-23 supplemental payments are estimated to be \$100 million TF.
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 2020-21 ACA supplemental payments will be claimed in FY 2021-22. For FY 2021-22, the ACA payment will be claimed in FY 2022-23. 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, including FFCRA increased FMAP of 6.2% when applicable. 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 December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS
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11. On a cash basis, costs in FY 2021-22 and FY 2022-23 are expected to be:

(Dollars in Thousands)

FY 2021-22	TF	GF	IGT*	FF	ACA FF	FFCRA	Return to County**
Supplemental 2021-22	\$100,000	\$0	\$46,900	\$50,000	\$0	\$3,100	\$0
Supplemental ACA 2020-21	\$15,344	\$0	\$0	(\$22,697)	\$40,855	(\$2,814)	\$15,344
Interim Reconciliation FY 2020-21	(\$1,874)	\$2,233	(\$4,806)	(\$3,530)	\$4,666	(\$437)	\$0
Final Reconciliation 2018-19	\$2,143	\$639	(\$205)	\$337	\$1,372	\$0	\$0
Total	\$115,613	\$2,872	\$41,889	\$24,110	\$46,893	(\$151)	\$15,344

(Dollars in Thousands)

FY 2022-23	TF	GF	IGT*	FF	ACA FF	FFCRA	Return to County**
Supplemental 2022-23	\$100,000	\$0	\$50,000	\$50,000	\$0	\$0	\$0
Supplemental ACA 2021-22	\$18,096	\$0	\$0	(\$24,520)	\$44,136	(\$1,520)	\$18,096
Interim Reconciliation FY 2021-22	\$421	\$472	(\$791)	(\$488)	\$1,258	(\$30)	\$0
Final Reconciliation 2019-20	\$18	\$247	(\$281)	(\$45)	\$100	(\$3)	\$0
Total	\$118,535	\$719	\$48,928	\$24,947	\$45,494	(\$1,553)	\$18,096

**The Return to County column is for display purposes only (see methodology #8)

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 159

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)

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

100% GF (4260-101-0001)

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 160
IMPLEMENTATION DATE: 7/1991
ANALYST: Neejkajsiab Yang
FISCAL REFERENCE NUMBER: 82

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$84,670,000	\$95,602,000
- STATE FUNDS	\$19,106,500	\$28,028,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$84,670,000	\$95,602,000
STATE FUNDS	\$19,106,500	\$28,028,000
FEDERAL FUNDS	\$65,563,500	\$67,574,000

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

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: 160

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.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to:

For hospitals (SB 1732):

- Updated interim payment amounts for FY 2019-20, FY 2020-21, and FY 2021-22 based on recent data;
- Updated FY 2019-20 ACA adjustment amounts based on actuals;
- FY 2015-2016 and FY 2016-17 interim reconciliations shifted from FY 2020-21 to FY 2021-22;
- Updated FY 2016-17, FY 2017-18, and FY 2018-19 interim reconciliation amounts based on recent data;
- FY 1995-96 to FY 2015-16 and FY 1994-95 to FY 2014-15 final reconciliation adjustments shifted from FY 2020-21 to FY 2021-22; and
- FY 1989-90 to FY 2018-19 final reconciliations shifted to a future fiscal year outside of this estimate.

For DP-NFs (SB 1128)

- Updated FY 2019-20 and FY 2020-21 interim payment amounts based on more recent data.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to:

For hospitals (SB 1732):

- Retroactive interim reconciliations and final reconciliation adjustments that occurred in FY 2021-22.

For DP-NFs (SB 1128):

- Increased interim payments in FY 2022-23.

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 2019-20 and FY 2020-21 ACA supplemental payments will be claimed in FY 2021-22 and FY 2022-23 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 for FY 2019-20 Q1 and Q2, and at the FFCRA 56.2% FMAP for FY 2019-20 Q3 and Q4, and FY 2020-21 Q1 through Q4.

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 160

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 December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 160

6. The estimated payments on a cash basis are:

FY 2021-22	TF	GF	FF	FFCRA	ARRA	ACA
Hospitals (SB 1732)						
Interim Payment						
FY 2019-20	\$820,000	\$360,000	\$410,000	\$50,000	\$0	\$0
FY 2020-21	\$45,775,000	\$20,048,000	\$22,888,000	\$2,839,000	\$0	\$0
FY 2021-22	\$34,316,000	\$15,297,000	\$17,158,000	\$1,861,000	\$0	\$0
ACA Adjustment to GF						
FY 2019-20	\$0	(\$12,865,000)	(\$17,066,000)	(\$1,221,000)	\$0	\$31,152,000
Interim Reconciliation						
FY 2015-16	\$7,091,000	\$2,170,000	\$2,170,000	\$0	\$0	\$2,751,000
FY 2016-17	(\$10,382,000)	(\$3,239,000)	(\$3,136,000)	\$0	\$0	(\$4,007,000)
FY 2017-18	(\$11,338,000)	(\$2,994,000)	(\$2,595,000)	\$0	\$0	(\$5,749,000)
FY 2018-19	(\$220,000)	(\$269,000)	(\$260,000)	\$0	\$0	\$309,000
Final Reconciliation						
FY 1994-95 to FY 2014-15	\$0	\$8,000	(\$8,000)	\$0	\$0	\$0
FY 1995-96 to FY 2015-16	\$0	(\$43,000)	\$43,000	\$0	\$0	\$0
FY 1992-93 to FY 2019-20	\$1,383,000	\$633,000	\$602,000	\$0	(\$74,000)	\$222,000
DP-NFs (SB 1128)						
Interim Payment						
FY 2019-20	\$280,000	\$0	\$249,000	\$31,000	\$0	\$0
FY 2020-21	\$16,945,000	\$0	\$15,076,000	\$1,869,000	\$0	\$0
Total FY 2021-22	\$84,670,000	\$19,106,000	\$35,531,000	\$5,429,000	(\$74,000)	\$24,678,000

CAPITAL PROJECT DEBT REIMBURSEMENT
REGULAR POLICY CHANGE NUMBER: 160

FY 2022-23	TF	GF	FF	FFCRA	ARRA	ACA
Hospitals (SB 1732)						
Interim Payment						
FY 2020-21	\$44,096,000	\$21,838,000	\$22,048,000	\$210,000	\$0	\$0
FY 2021-22	\$31,042,000	\$15,521,000	\$15,521,000	\$0	\$0	\$0
ACA Adjustment to GF						
FY 2020-21	\$0	(\$10,794,000)	(\$15,968,000)	(\$1,980,000)	\$0	\$28,742,000
Interim Reconciliation						
FY 2019-20	\$877,000	\$197,000	\$195,000	(\$39,000)	\$0	\$524,000
Final Reconciliation						
FY 1989-90 to FY 2020-21	\$1,383,000	\$633,000	\$602,000	\$0	(\$74,000)	\$222,000
FY 1996-97 to FY 2019-20	\$1,383,000	\$633,000	\$602,000	\$0	(\$74,000)	\$222,000
DP-NFs (SB 1128)						
Interim Payment						
FY 2020-21	\$386,000	\$0	\$343,000	\$43,000	\$0	\$0
FY 2021-22	\$16,435,000	\$0	\$15,458,000	\$977,000	\$0	\$0
Total FY 2022-23	\$95,602,000	\$28,028,000	\$38,801,000	(\$789,000)	(\$148,000)	\$29,710,000

Funding:

100% Title XIX (4260-101-0890)

50% Title XIX Capital Debt FFP / 50% GF (4260-102-0001/0890)

100% GF Capital Debt (4260-102-0001)

100% Title XIX Capital Debt FFP (4260-102-0890)

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

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

QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 161
IMPLEMENTATION DATE: 4/2014
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1563

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$84,000,000	\$29,500,000
- STATE FUNDS	\$42,000,000	\$14,750,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$84,000,000	\$29,500,000
STATE FUNDS	\$42,000,000	\$14,750,000
FEDERAL FUNDS	\$42,000,000	\$14,750,000

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)
 SPA 17-024
 SPA 18-0034
 SPA 19-0043
 AB 81 (Chapter 13, Statutes of 2020)
 SPA 20-0021

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: 161

AB 1489 implemented a 3% increase to the AB 1629 facilities weighted average Medi-Cal reimbursement rate for RY 2013-14 and RY 2014-15, and also extended the quality assurance fee (QAF) and the QASP at 1% of the overall rate level until July 31, 2015.

AB 119 extended 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 GF 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 hours requirement from 3.2 to 3.5, with a minimum of 2.4 certified nursing assistant hours, as an eligibility requirement for the QASP program, beginning in RY 2019-20. 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.

The Department received federal approval of State Plan Amendment (SPA) 20-0021 on September 13, 2021 for the April 2021 awards provided for the 17-month service period of August 1, 2020 through December 31, 2021. QASP award payments are required to be made by April 30, 2021, but in order to obtain federal approval, it was necessary to avoid prepayment of the July through December 2021 portion of the service period. The 17-month service period will be separated into three periods:

- August 1, 2020 through June 30, 2021,
- July 1, 2021 through September 30, 2021, and
- October 1, 2021 through December 31, 2021.

The total pool of funds, \$78 million, available for the awards will be prorated accordingly for each of the three service periods; \$50.5 million for the April 2021 award payment and \$13.75 million for each of the remaining two service periods. However, in an effort to avoid financial issues for facilities eligible for an award payment, the Department issued the remaining two \$13.75 million payments for the July and October service periods in July 2021. The July 2021 payments were paid as usual with 50 percent State Fund and 50 percent federal funds. 50 percent General Fund (GF) and 50 percent Special Fund monies was used for the October payment. The additional GF for the October payment is to cover the federal portion of \$6.875 million for the latter period. The Department will then claim federal funds for the October 2021 service period, which will be used to offset the additional GF share used to pay the additional \$13.5 million award provided in July 2021.

QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 161

Reason for Change:

The change in FY 2021-22, from the prior estimate, is an increase due to:

- The July 2021 to September 2021 quarter payments were delayed to FY 2021-22 and no longer require the use of General Fund,
- The October 2021 to December 2021 quarter payments were delayed to FY 2021-22. The General Fund payment and repayment now occurs in FY 2021-22, resulting in no General Fund impact in FY 2021-22.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to assuming payments end December 2022.

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 2021-22	FY 2022-23
Penalties on Nursing Facilities	\$500,000	\$500,000
QASP GF Appropriation	\$43,236,000	\$0
PLI savings	\$4,287,000	\$0

3. The penalties on nursing facilities will be deposited into the CDPH Skilled Nursing Facility Minimum Staffing Penalty Account and then transferred to the Special Fund. The total amount of supplemental payments may be adjusted in accordance with the amount of administrative penalties deposited into the Special Fund.
4. See the FFP for Department of Public Health Support Costs policy change for the estimated CDPH administrative costs.
5. The GF appropriated QASP funding will continue at RY 2014-15 levels, instead of setting aside a portion of the annual increase.
6. FY 2021-22 includes payments for the July 1, 2021 through September 30, 2021 and October 1, 2021 through December 31, 2021, which were made in July 2021, and payments for the period from January 1, 2022 through June 30, 2022, plus delayed payments. The payments for the October 1, 2021 through December 31, 2021 period were made with 50 percent GF and 50 percent Special Fund. Federal funds will be claimed for the period from October 1, 2021 through December 31, 2021, which will be used to offset the additional GF share used to pay the October 1, 2021 through December 31, 2021 award payments provided in July 2021.

QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 161

7. FY 2022-23 includes payments for:

- The July 1, 2022 to September 30, 2022 and October 1, 2022 to December 31, 2022 periods.

8. Supplemental payments are estimated to be:

(Dollars in Thousands)

FY 2021-22	TF	GF	SF	FF
Supplemental Payments***	\$84,000	\$0	\$42,000	\$42,000
Transfer from GF* to Special Fund**	\$0	\$47,523	(\$47,523)	\$0
Total	\$84,000	\$47,523	(\$5,523)	\$42,000

(Dollars in Thousands)

FY 2022-23	TF	GF	SF	FF
Supplemental Payments***	\$29,500	\$0	\$14,750	\$14,750
Total	\$29,500	\$0	\$14,750	\$14,750

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)***

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 162
IMPLEMENTATION DATE: 10/2013
ANALYST: Neejkajsiab Yang
FISCAL REFERENCE NUMBER: 1600

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$67,330,000	\$43,948,000
- STATE FUNDS	\$21,263,000	\$19,570,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$67,330,000	\$43,948,000
STATE FUNDS	\$21,263,000	\$19,570,000
FEDERAL FUNDS	\$46,067,000	\$24,378,000

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

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.

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 162

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to FY 2019-20 and FY 2020-21 payment finalization amounts, Children's Services adjustments, and FY 2021-22 interim payments were revised based on updated data.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to:

- The addition of FY 2021-22 ACA adjustments; and
- All payment finalizations for prior years are expected to occur in FY 2021-22.

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 2019-20 and FY 2020-21 UPLs were approved by CMS on July 19, 2021, and FY 2021-22 UPL 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. FY 2019-20 and FY 2020-21 interim supplemental payments were processed using 80% of the approved UPL room from FY 2018-19 which was the last approved UPL at the date of payment. Payment finalizations for FY 2019-20 and FY 2020-21 will occur in FY 2021-22. FY 2021-22 and FY 2022-23 interim payment estimates assume that the respective FY's UPLs will be approved prior to interim supplemental payments being processed. For the purpose of this estimate, interim payments were estimated, utilizing the approved UPL room from FY 2020-21.
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 2019-20 and FY 2020-21 ACA supplemental payments will be claimed in FY 2021-22, and FY 2021-22 ACA supplemental payments will be claimed in FY 2022-23. An adjustment will be made for the federal share processed at the regular 50% FMAP for FY 2019-20 Q1 and Q2, at the FFCRA 56.2% FMAP for FY 2019-20 Q3 and Q4, FY 2020-21 Q1 through Q4, and FY 2021-22 Q1 and Q2, and at the regular 50% FMAP for FY 2021-22 Q3 and Q4.
6. FY 2019-20 and FY 2020-21 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 in FY 2021-22. FY 2021-22 Children's Services payments will be reconciled to the FY 2021-22 UPLs in FY 2022-23.
7. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.

NDPH IGT SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 162

8. The estimated NDPH IGT supplemental payments are:

(Dollars in Thousands)

FY 2021-22	TF	GF*	IGT**	FF	ACA	FFCRA	***Return to NDPHs
FY 2019-20 Payment Finalization	\$14,853	\$0	\$1,648	\$501	\$12,673	\$31	\$0
FY 2019-20 Children's Services (Est.)	(\$163)	(\$1,281)	\$1,118	\$0	\$0	\$0	(\$163)
FY 2020-21 Payment Finalization	\$13,656	\$0	\$1,577	\$313	\$11,727	\$39	\$0
FY 2020-21 Children's Services (Est.)	(\$156)	(\$1,196)	\$1,040	\$0	\$0	\$0	(\$156)
FY 2021-22 Interim Payment	\$39,140	\$0	\$18,357	\$19,570	\$0	\$1,213	\$0
Total FY 2021-22	\$67,330	(\$2,477)	\$23,740	\$20,384	\$24,400	\$1,283	(\$319)

(Dollars in Thousands)

FY 2022-23	TF	GF*	IGT**	FF	ACA	FFCRA	***Return to NDPHs
FY 2021-22 ACA Adjustment	\$4,808	\$0	\$0	(\$6,515)	\$11,727	(\$404)	\$4,808
FY 2021-22 Children's Services (Est.)	\$0	(\$1,356)	\$1,356	\$0	\$0	\$0	\$0
FY 2022-23 Interim Payment	\$39,140	\$0	\$19,570	\$19,570	\$0	\$0	\$0
Total FY 2022-23	\$43,948	(\$1,356)	\$20,926	\$13,055	\$11,727	(\$404)	\$4,808

***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)

CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER: 163
IMPLEMENTATION DATE: 6/2002
ANALYST: Neejkajsiab Yang
FISCAL REFERENCE NUMBER: 86

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$61,392,000	\$84,205,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$61,392,000	\$84,205,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$61,392,000	\$84,205,000

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

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).

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

CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER: 163

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.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to:

- RY 2012-13 final reconciliation payments shifted from FY 2020-21 to FY 2021-22;
- RY 2015-2016 final reconciliations shifted from FY 2021-22 to FY 2022-23;
- Inclusion of RY 2019-20 interim payments; and
- Revised interim payment amounts for RY 2020-21 and RY 2021-22 based on updated data.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to higher net final reconciliation payments in FY 2022-23 than in FY 2021-22.

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 a portion of the interim ACA payments for the three most recent RYs will occur in each fiscal year.

4. Assume a portion of the interim payments for the three most recent RYs will occur each fiscal year.

CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS
REGULAR POLICY CHANGE NUMBER: 163

5. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.

FY 2021-22	TF	FF	ACA FF	FFCRA
RY 2012-13 Final Reconciliation	(\$13,471,000)	(\$13,471,000)	\$0	\$0
RY 2013-14 Final Reconciliation	\$2,835,000	\$2,388,000	\$447,000	\$0
RY 2014-15 Final Reconciliation	\$9,283,000	\$7,586,000	\$1,697,000	\$0
RY 2019-20 Interim Reconciliation	\$10,474,000	\$8,352,000	\$1,530,000	\$592,000
RY 2019-20 Interim Payments	\$11,901,000	\$7,740,000	\$3,672,000	\$489,000
RY 2020-21 Interim Payments	\$19,180,000	\$14,460,000	\$2,926,000	\$1,794,000
RY 2021-22 Interim Payments	\$21,190,000	\$15,646,000	\$3,604,000	\$1,940,000
Total	\$61,392,000	\$42,701,000	\$13,876,000	\$4,815,000

FY 2022-23	TF	FF	ACA FF	FFCRA
RY 2015-16 Final Reconciliation	\$6,992,000	\$5,809,000	\$1,183,000	\$0
RY 2016-17 Final Reconciliation	\$7,644,000	\$6,454,000	\$1,190,000	\$0
RY 2017-18 Final Reconciliation	\$7,481,000	\$5,034,000	\$2,447,000	\$0
RY 2020-21 Interim Reconciliation	\$10,157,000	\$7,391,000	\$1,849,000	\$917,000
RY 2020-21 Interim Payments	\$11,129,000	\$6,977,000	\$3,287,000	\$865,000
RY 2021-22 Interim Payments	\$21,552,000	\$17,783,000	\$3,637,000	\$132,000
RY 2022-23 Interim Payments	\$19,250,000	\$15,646,000	\$3,604,000	\$0
Total	\$84,205,000	\$65,094,000	\$17,197,000	\$1,914,000

Funding:

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

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

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

PROP 56 - DEVELOPMENTAL SCREENINGS

REGULAR POLICY CHANGE NUMBER: 164
IMPLEMENTATION DATE: 1/2020
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2171

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$60,811,000	\$60,079,000
- STATE FUNDS	\$24,287,200	\$27,366,250
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	2.38 %	2.41 %
APPLIED TO BASE		
TOTAL FUNDS	\$59,363,700	\$58,631,100
STATE FUNDS	\$23,709,160	\$26,706,720
FEDERAL FUNDS	\$35,654,530	\$31,924,370

Purpose:

This policy change estimates the cost for providing supplemental payments for developmental screenings.

Authority:

Families First Coronavirus Response Act (FFCRA)
Budget Act of 2021

Interdependent Policy Changes:

Proposition 56 Funding

Background:

The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), increased the excise tax rate on cigarettes and tobacco products and allocates a portion of the tobacco tax revenue to the Department for use as the non-federal share of health care expenditures, subject to appropriation by the Legislature.

The Budget Act of 2019 allocated Proposition 56 funds for supplemental payments for developmental screenings. The Legislature has continued this funding in subsequent budget acts.

The Department began providing supplemental payments for clinically appropriate developmental screening services for children, starting January 1, 2020. In the Medi-Cal managed care delivery system, the Department has implemented 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.

Beginning January 1, 2020, the directed payments are subject to a two-sided risk corridor. The two-sided risk corridor will be calculated retrospectively by the Department with activities beginning no sooner than January 1, 2022. The risk corridor will be based on the aggregate medical expenditure percentage achieved by each managed care plans (MCPs) and will utilize MCP-submitted encounters and/or other utilization data. The necessary data to perform the calculation is not currently available, thus an estimated net recoupment/payment is unable to be

PROP 56 - DEVELOPMENTAL SCREENINGS

REGULAR POLICY CHANGE NUMBER: 164

determined at this time. However, the Department expects any recoupments or payments to/from MCPs to occur in FY 2022-23.

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 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.

This policy change identifies the use of the General Fund for these Proposition 56 payments. See the Proposition 56 Funding policy change for the Proposition 56 offset to the GF in FY 2021-22.

Beginning FY 2022-23, the Department proposes to transition this supplemental payment to an ongoing rate increase, the nonfederal share of which will be funded by the General Fund.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a net decrease due to the following:

- Lower estimated cost projections for Fee-for-Service (FFS), and
- Decreased CY 2022 projected enrollment for managed care.

The change in the current estimate, from FY 2021-22 to FY 2022-23, is due to decreased CY 2022 and CY 2023 projected enrollment for FY 2022-23.

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 MCPs will be enhanced, based on anticipated utilization of Developmental Screening services, to fund the required provider payments.
5. 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.

PROP 56 - DEVELOPMENTAL SCREENINGS
REGULAR POLICY CHANGE NUMBER: 164

6. Seven (7) months of the CY 2022 capitation rate increases and five (5) months of the CY 2023 capitation rate increases are expected to pay in FY 2022-23.
7. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2022 in this policy change.
8. Total estimated payments in FY 2021-22 and FY 2022-23 are:

FY 2021-22	TF	GF	FF	FFCRA
Fee-for-Service	\$4,914,000	\$1,987,000	\$2,651,000	\$276,000
Managed Care	\$55,897,000	\$22,300,000	\$30,452,000	\$3,145,000
Total	\$60,811,000	\$24,287,000	\$33,103,000	\$3,421,000

FY 2022-23	TF	GF	FF	FFCRA
Fee-for-Service	\$4,914,000	\$2,263,000	\$2,651,000	\$0
Managed Care	\$55,165,000	\$25,103,000	\$30,062,000	\$0
Total	\$60,079,000	\$27,366,000	\$32,713,000	\$0

Funding:

FY 2021-22	TF	GF	FF	FFCRA
50% Title XIX FF / 50% GF (4260-101-0001 / 0890)	\$44,108,000	\$22,054,000	\$22,054,000	\$0
90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$861,000	\$86,000	\$775,000	\$0
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$15,806,000	\$5,532,000	\$10,274,000	\$0
100% GF (4260-101-0001)	\$36,000	\$36,000	\$0	\$0
FFCRA 4.34% GF (4260-113-0001)	(\$686,000)	(\$686,000)	\$0	\$0
FFCRA 4.34% FF (4260-113-0890)	\$686,000	\$0	\$0	\$686,000
FFCRA 6.2% GF (4260-101-0001)	(\$2,735,000)	(\$2,735,000)	\$0	\$0
FFCRA 6.2% FF (4260-101-0890)	\$2,735,000	\$0	\$0	\$2,735,000
Total	\$60,811,000	\$24,287,000	\$33,103,000	\$3,421,000

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REGULAR POLICY CHANGE NUMBER: 164

FY 2022-23	TF	GF	FF	FFCRA
50% Title XIX FF / 50% GF (4260-101-0001 / 0890)	\$43,558,000	\$21,779,000	\$21,779,000	\$0
90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$874,000	\$87,000	\$787,000	\$0
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$15,611,000	\$5,464,000	\$10,147,000	\$0
100% GF (4260-101-0001)	\$36,000	\$36,000	\$0	\$0
Total	\$60,079,000	\$27,366,000	\$32,713,000	\$0

NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 165
IMPLEMENTATION DATE: 1/2022
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2185

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$52,500,000	\$105,000,000
- STATE FUNDS	\$26,250,000	\$52,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$52,500,000	\$105,000,000
STATE FUNDS	\$26,250,000	\$52,500,000
FEDERAL FUNDS	\$26,250,000	\$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

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 delivery system is referred to as Medi-Cal Rx. In January 2021, Centene Corporation announced plans to acquire Magellan Health, the parent company of the Medi-Cal Rx vendor, Magellan Medicaid Administration, Inc. (MMA). This acquisition required additional time for exploration of acceptable conflict avoidance protocols to protect the Medi-Cal claims data and other proprietary information. The Medi-Cal Rx Assumption of Operations (AOO) is assumed January 1, 2022.

Non-hospital 340B clinics that currently receive reimbursement from MC 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.

NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 165

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.

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 was 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.

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
- Medical Supply Rebates
- Non-Hospital 340B Clinic Supplemental Payments
- Medi-Cal Rx – Additional Supplemental Rebates

Other Admin

- Medi-Cal Rx – Administrative Costs

Reason for Change:

There is no change from the prior estimate for FY 2021-22.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to including a full year of supplemental payments in FY 2022-23.

Methodology:

1. The estimated Non-hospital 340B Clinic Supplemental Payment Pool annual cost is \$105,000,000 TF.
2. The impact of a six month extension of the FFCRA increased FMAP from January 1, 2022 through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.

NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 165

(Dollars in Thousands)

Annual	TF	GF	FF
Non-hospital 340B Clinic Supplemental Payments	\$105,000	\$52,500	\$52,500
Total	\$105,000	\$52,500	\$52,500

3. The estimated cost in FY 2021-22 is \$52,500,000 TF and \$105,000,000 TF in FY 2022-23.

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
Non-hospital 340B Clinic Supplemental Payments	\$52,500	\$26,250	\$26,250
Total	\$52,500	\$26,250	\$26,250

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Non-hospital 340B Clinic Supplemental Payments	\$105,000	\$52,500	\$52,500
Total	\$105,000	\$52,500	\$52,500

Funding:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF	\$52,500	\$26,250	\$26,250
Total	\$52,500	\$26,250	\$26,250

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF	\$105,000	\$52,500	\$52,500
Total	\$105,000	\$52,500	\$52,500

PROP 56 - ADVERSE CHILDHOOD EXPERIENCES SCREENINGS

REGULAR POLICY CHANGE NUMBER: 166
 IMPLEMENTATION DATE: 1/2020
 ANALYST: Joel Singh
 FISCAL REFERENCE NUMBER: 2129

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$47,900,000	\$48,035,000
- STATE FUNDS	\$17,591,150	\$20,008,900
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	2.54 %	2.53 %
APPLIED TO BASE		
TOTAL FUNDS	\$46,683,300	\$46,819,700
STATE FUNDS	\$17,144,340	\$19,502,680
FEDERAL FUNDS	\$29,539,000	\$27,317,040

Purpose:

This policy change estimates the cost for providing Adverse Childhood Experiences (ACEs) screenings.

Authority:

Families First Coronavirus Response Act (FFCRA)
 Budget Act of 2021

Interdependent Policy Changes:

Proposition 56 Funding

Background:

The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), increased the excise tax rate on cigarettes and tobacco products and allocates a portion of the tobacco tax revenue to the Department for use as the non-federal share of health care expenditures, subject to appropriation by the Legislature.

The 2019 Budget Act allocated Proposition 56 funds for rate increase supplemental payments for ACES screenings. The Legislature has continued this funding in subsequent budget acts.

The Department began providing supplemental 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.

Beginning January 1, 2020, the directed payments are subject to a two-sided risk corridor. The two-sided risk corridor will be calculated retrospectively by the Department with activities beginning no sooner than January 1, 2022. The risk corridor will be based on the aggregate medical expenditure percentage achieved by each managed care plans (MCPs) and will utilize MCP-submitted encounters and/or other utilization data. The necessary data to perform the calculation is not currently available, thus an estimated net recoupment/payment is unable to be

PROP 56 - ADVERSE CHILDHOOD EXPERIENCES SCREENINGS

REGULAR POLICY CHANGE NUMBER: 166

determined at this time. However, the Department expects any recoupments or payments to/from MCPs to occur in FY 2022-23.

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:

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.

This policy change identifies the use of the General Fund for these Proposition 56 payments. See the Proposition 56 Funding policy change for the Proposition 56 offset to the GF in FY 2021-22.

Beginning FY 2022-23, the Department proposes to transition this supplemental payment to an ongoing rate increase, the nonfederal share of which will be funded by the General Fund.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a net decrease due to the following:

- Lower estimated cost projections for Fee-for-Service (FFS), and
- Increased managed care capitation and funding assumptions based on updated managed care enrollment projections.

The change in the current estimate, from FY 2021-22 to FY 2022-23, is due to FY 2022-23 managed care costs including increased CY 2022 and projected CY 2023 rates.

Methodology:

1. Fee-for-Service (FFS) and managed care implementation for ACEs began January 1, 2020.

PROP 56 - ADVERSE CHILDHOOD EXPERIENCES SCREENINGS

REGULAR POLICY CHANGE NUMBER: 166

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.

Managed Care Directed Payments

5. Risk-based capitation rates paid to MCPs will be enhanced, based on anticipated utilization of ACEs screening services, to fund the required provider payments.
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. Seven (7) months of the CY 2022 capitation rate increases and five (5) months of the CY 2023 capitation rate increases are expected to pay in FY 2022-23.
8. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2022 in this policy change.
9. Total estimated payments in FY 2021-22 and FY 2022-23 are:

FY 2021-22	TF	GF	FF	FFCRA
Fee-for-Service	\$7,575,000	\$2,892,000	\$4,298,000	\$385,000
Managed Care	\$40,325,000	\$14,699,000	\$23,624,000	\$2,002,000
Total	\$47,900,000	\$17,591,000	\$27,922,000	\$2,387,000

FY 2022-23	TF	GF	FF	FFCRA
Fee-for-Service	\$7,574,000	\$3,276,000	\$4,298,000	\$0
Managed Care	\$40,461,000	\$16,733,000	\$23,728,000	\$0
Total	\$48,035,000	\$20,009,000	\$28,026,000	\$0

PROP 56 - ADVERSE CHILDHOOD EXPERIENCES SCREENINGS
REGULAR POLICY CHANGE NUMBER: 166

Funding:

FY 2021-22	TF	GF	FF	FFCRA
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$30,632,000	\$15,316,000	\$15,316,000	\$0
90%Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$5,888,000	\$589,000	\$5,299,000	\$0
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$11,241,000	\$3,934,000	\$7,307,000	\$0
100% GF (4260-101-0001)	\$139,000	\$139,000	\$0	\$0
FFCRA 4.34% GF (4260-113-0001)	(\$488,000)	(\$488,000)	\$0	\$0
FFCRA 4.34% FF (4260-113-0890)	\$488,000	\$0	\$0	\$488,000
FFCRA 6.2% GF (4260-101-0001)	(\$1,899,000)	(\$1,899,000)	\$0	\$0
FFCRA 6.2% FF (4260-101-0890)	\$1,899,000	\$0	\$0	\$1,899,000
Total	\$47,900,000	\$17,591,000	\$27,922,000	\$2,387,000

FY 2022-23	TF	GF	FF	FFCRA
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$30,668,000	\$15,334,000	\$15,334,000	\$0
90%Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$5,973,000	\$597,000	\$5,376,000	\$0
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$11,256,000	\$3,940,000	\$7,316,000	\$0
100% GF (4260-101-0001)	\$138,000	\$138,000	\$0	\$0
Total	\$48,035,000	\$20,009,000	\$28,026,000	\$0

PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 167
IMPLEMENTATION DATE: 1/2018
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2049

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$493,663,000	\$507,946,000
- STATE FUNDS	\$170,373,950	\$199,843,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	90.80 %	88.25 %
APPLIED TO BASE		
TOTAL FUNDS	\$45,417,000	\$59,683,700
STATE FUNDS	\$15,674,400	\$23,481,590
FEDERAL FUNDS	\$29,742,590	\$36,202,070

Purpose:

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

Authority:

Families First Coronavirus Response Act (FFCRA)
Budget Act of 2021

Interdependent Policy Changes:

Proposition 56 Funding

Background:

The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), increased the excise tax rate on cigarettes and tobacco products and allocates a portion of the tobacco tax revenue to the Department for use as the non-federal share of health care expenditures, subject to appropriation by the Legislature.

The Budget Act of 2017 allocated Proposition 56 funds for supplemental payments for dental services. The Legislature has continued this funding in subsequent budget acts.

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 Schedule of Maximum Allowances (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 Funding 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

PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 167

the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is an increase due to higher check write projections. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due the increase in the Prop 56 portion of the Dental Managed Care rate and addition of incentive payments related to Evidence-Based Dental Practices.

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 changed 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 June 30, 2022, in this policy change.
5. Funds allocated for the supplemental payments are as follows:

FY 2021-22	TF	SF	FF
50% Title XIX / 50% GF	\$319,996,000	\$159,998,000	\$159,998,000
ACA 90% FFP/10% GF	\$111,474,000	\$11,147,000	\$100,327,000
Title 21 65% FFP/35% GF	\$62,193,000	\$21,768,000	\$40,425,000
FFCRA 6.2% Increased FFP	\$0	(\$19,840,000)	\$19,840,000
FFCRA 4.34% Increased FFP	\$0	(\$2,699,000)	\$2,699,000
Total	\$493,663,000	\$170,374,000	\$323,289,000

FY 2022-23	TF	SF	FF
50% Title XIX / 50% GF	\$333,698,000	\$166,849,000	\$166,849,000
ACA 90% FFP/10% GF	\$111,970,000	\$11,197,000	\$100,773,000
Title 21 65% FFP/35% GF	\$62,278,000	\$21,797,000	\$40,481,000
Total	\$507,946,000	\$199,843,000	\$308,103,000

PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 167

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)
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 - CBAS SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 168
IMPLEMENTATION DATE: 3/2020
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2145

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$26,552,000	\$23,702,000
- STATE FUNDS	\$11,630,000	\$11,851,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.02 %	0.02 %
APPLIED TO BASE		
TOTAL FUNDS	\$26,546,700	\$23,697,300
STATE FUNDS	\$11,627,670	\$11,848,630
FEDERAL FUNDS	\$14,919,020	\$11,848,630

Purpose:

This policy change estimates the expenditures related to providing supplemental payments for Community-Based Adult Services (CBAS).

Authority:

Families First Coronavirus Response Act (FFCRA)
Budget Act of 2021

Interdependent Policy Changes:

Proposition 56 Funding

Background:

The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), increased the excise tax rate on cigarettes and tobacco products and allocates a portion of the tobacco tax revenue to the Department for use as the non-federal share of health care expenditures, subject to appropriation by the Legislature.

The Budget Act of 2019 allocated Proposition 56 funds for supplemental payments for CBAS. The Legislature has continued this funding in subsequent budget acts.

This policy change identifies the use of the General Fund (GF) for these Proposition 56 payments. See the Proposition 56 Funding policy change for the Proposition 56 offset to the GF in FY 2021-22. Beginning FY 2022-23, the Department proposes to transition this supplemental payment to an ongoing rate increase, the nonfederal share of which will be funded by 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.

PROP 56 - CBAS SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 168

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a decrease due to updated CY 2022 CCI rates. The change from FY 2021-22 to FY 2022-23 in the current estimate is a decrease due to updated CY 2022 and CY 2023 CCI rates.

Methodology:

1. The Budget Act of 2019 provides for supplemental payments for CBAS in FY 2021-22. Assume supplemental payments will continue through FY 2022-23.
2. Assume Proposition 56 CBAS supplemental payments have a one-month lag.
3. The Managed Care expenditures reflect actuarially appropriate, prospective rate adjustments that recognize pricing pressures due to the fee-for-service supplemental payments.
4. Assume the 6.2% Title XIX FFCRA increased FMAP is for expenditures through June 30, 2022, for this policy change.
5. Estimated supplemental payments are as follows:

FY 2021-22	TF	GF	FF
Managed Care	\$26,546,000	\$13,273,000	\$13,273,000
Fee-For-Service	\$6,000	\$3,000	\$3,000
FFCRA 6.2%	\$0	(\$1,646,000)	\$1,646,000
Total FY 2021-22	\$26,552,000	\$11,630,000	\$14,922,000

FY 2022-23	TF	GF	FF
Managed Care	\$23,697,000	\$11,848,000	\$11,849,000
Fee-For-Service	\$5,000	\$3,000	\$2,000
Total FY 2022-23	\$23,702,000	\$11,851,000	\$11,851,000

*Totals may differ due to rounding.

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)

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 169
IMPLEMENTATION DATE: 12/2010
ANALYST: Neejkajsiab Yang
FISCAL REFERENCE NUMBER: 1616

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$14,013,000	\$14,682,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$14,013,000	\$14,682,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$14,013,000	\$14,682,000

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

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.

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 169

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to:

- Revised FY 2021-22 interim payments based on updated data;
- FY 2019-20 initial reconciliations for a newly eligible facility was delayed from FY 2020-21 to FY 2021-22; and
- Revised FY 2021-22 initial reconciliations based on updated data.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to the delayed FY 2019-20 initial reconciliation for a newly eligible facility which will be processed in FY 2021-22, and higher estimated interim payments in FY 2022-23.

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 December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.

Program payment amounts are estimated to be:

FY 2021-22	TF	Regular FF	ACA FF	FFCRA
Interim Payments				
FY 2021-22	\$10,741,000	\$10,200,000	\$0	\$541,000
Initial Reconciliation				
FY 2019-20	\$592,000	\$441,000	\$104,000	\$47,000
FY 2020-21	\$3,374,000	\$2,558,000	\$499,000	\$317,000
Final Reconciliation				
FY 2017-18	(\$694,000)	(\$717,000)	\$23,000	\$0
FY 2021-22 Total	\$14,013,000	\$12,482,000	\$626,000	\$905,000

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 169

FY 2022-23	TF	Regular FF	ACA FF	FFCRA
Interim Payments				
FY 2022-23	\$11,856,000	\$11,856,000	\$0	\$0
Initial Reconciliation				
FY 2021-22	\$3,514,000	\$2,686,000	\$549,000	\$279,000
Final Reconciliation				
FY 2018-19	(\$688,000)	(\$717,000)	\$29,000	\$0
FY 2022-23 Total	\$14,682,000	\$13,825,000	\$578,000	\$279,000

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: 170
IMPLEMENTATION DATE: 1/2005
ANALYST: Elena Susbilla
FISCAL REFERENCE NUMBER: 1038

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$10,000,000	\$10,000,000
- STATE FUNDS	\$4,690,000	\$5,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$10,000,000	\$10,000,000
STATE FUNDS	\$4,690,000	\$5,000,000
FEDERAL FUNDS	\$5,310,000	\$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

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.

Reason for Change:

There is no change for FY 2021-22 from the prior estimate.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to no FFCRA increased FMAP estimated in FY 2022-23. There is no change to the total funds from FY 2021-22 to FY 2022-23.

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH

REGULAR POLICY CHANGE NUMBER: 170

Methodology:

1. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.
2. Assume annual reimbursements for disproportionate share of outpatient services are \$10,000,000 TF.

FY 2021-22	TF	GF	FF	FFCRA
CY 2021	\$7,500,000	\$3,440,000	\$3,750,000	\$310,000
CY 2022	\$2,500,000	\$1,250,000	\$1,250,000	\$0
Total	\$10,000,000	\$4,690,000	\$5,000,000	\$310,000

FY 2022-23	TF	GF	FF
CY 2022	\$7,500,000	\$3,750,000	\$3,750,000
CY 2023	\$2,500,000	\$1,250,000	\$1,250,000
Total	\$10,000,000	\$5,000,000	\$5,000,000

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: 171
IMPLEMENTATION DATE: 4/2018
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 2045

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$26,264,000	\$27,361,000
- STATE FUNDS	\$11,203,800	\$13,238,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	69.24 %	66.46 %
APPLIED TO BASE		
TOTAL FUNDS	\$8,078,800	\$9,176,900
STATE FUNDS	\$3,446,290	\$4,440,130
FEDERAL FUNDS	\$4,632,520	\$4,736,750

Purpose:

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

Authority:

SPA 17-028
 SPA 18-0029
 SPA 19-022
 CA-0139.R05.01 HCBA Waiver Amendment
 Families First Coronavirus Response Act (FFCRA)
 Budget Act of 2021

Interdependent Policy Changes:

Proposition 56 Funding

Background:

The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), increased the excise tax rate on cigarettes and tobacco products and allocates a portion of the tobacco tax revenue to the Department for use as the non-federal share of health care expenditures, subject to appropriation by the Legislature.

The Budget Act of 2017 allocated Proposition 56 funds for supplemental payments for ICF/DDs, ICF/DD-H facilities, ICF/DD-N facilities. The Budget Act 2018 extended the program to ICF/DD-Continuous Nursing waiver services.

The Legislature has continued this funding in subsequent budget acts. 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 retroactive to July 1, 2018.

CMS approved SPA 18-0029 for the extension of the supplemental payments for the period of August 1, 2018, through July 31, 2019. CMS approved SPA 19-0022 for the extension of the supplemental payments through December 31, 2021.

PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 171

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.

This policy change identifies the use of the General Fund for these Proposition 56 payments. See the Proposition 56 Funding policy change for the Proposition 56 offset to the GF in FY 2021-22.

Beginning FY 2022-23, the Department proposes to transition this supplemental payment to an ongoing rate increase, the nonfederal share of which will be funded by the General Fund.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is a net decrease due to:

- Decreased FFS costs estimate based on updated Medi-Cal FFS days and expenditures.
- Increased managed care payments and funding assumptions based on updated managed care enrollment projections and rates.
- Updating FFS funding assumptions based on actual payment data.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a net increase due to:

- Increased managed care payments based on revised 2021-22 enrollment projections being higher than FY 2020-21;
- No FFCRA funding assumed in FY 2022-23.

Methodology:

1. Payments will be made via FFS supplemental payments and increased managed care capitation payments.
2. This policy is effective August 1, 2017.

Fee-for-Service Supplemental Payments

3. The FFS supplemental payments were implemented June 25, 2018.

PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 171

4. The FFS supplemental payments for ICF/DD, ICF/DD-H, and ICF/DD-N facilities are expected to be \$17.7 million TF annually. The FFS supplemental payments for ICF/DD CNC facilities are expected to be \$451,000 annually.

Managed Care Supplemental Payments

5. The managed care supplemental payments, including CCI, are estimated to be \$5.6 million TF in CY 2021, \$7.2 million TF in CY 2022, and \$9.4 million TF in CY 2023.
6. For managed care payments:
- Assume seven months of the CY 2021 capitation rate increases and 5 months of the CY 2022 capitation rate increases are expected to occur in FY 2021-22.
 - Assume seven months of the CY 2022 capitation rate increases and 5 months of CY 2023 capitation rate increases are occur in FY 2022-23.
7. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2022 in this policy change.
8. Funds allocated for the supplemental payments are as follows:

FY 2021-22	TF	GF	Title XXI FF	Title XIX FF	ACA FF	FFCRA
FFS Payments (ICF/DD, ICF/DD-H, ICF/DD-N)	\$17,733,000	\$7,662,000	\$92,000	\$8,617,000	\$287,000	\$1,075,000
FFS Payments (ICF/DD-CNC)	\$451,000	\$197,000	\$0	\$217,000	\$10,000	\$27,000
CCI Payments	\$1,790,000	\$784,000	\$0	\$895,000	\$0	\$111,000
Managed Care Pmts	\$6,290,000	\$2,561,000	\$158,000	\$2,777,000	\$443,000	\$351,000
Total	\$26,264,000	\$11,204,000	\$250,000	\$12,506,000	\$740,000	\$1,564,000

FY 2022-23	TF	GF	Title XXI FF	Title XIX FF	ACA FF	FFCRA
FFS Payments (ICF/DD, ICF/DD-H, ICF/DD-N)	\$17,734,000	\$8,737,000	\$93,000	\$8,617,000	\$287,000	\$0
FFS Payments (ICF/DD-CNC)	\$451,000	\$224,000	\$0	\$217,000	\$10,000	\$0
CCI Payments	\$1,060,000	\$530,000	\$0	\$530,000	\$0	\$0
Managed Care Pmts	\$8,116,000	\$3,747,000	\$272,000	\$3,538,000	\$559,000	\$0
Total	\$27,361,000	\$13,238,000	\$365,000	\$12,902,000	\$856,000	\$0

PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 171

Funding:

FY 2021-22	TF	GF	FF	FFCRA
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$25,011,000	\$12,506,000	\$12,505,000	\$0
90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$822,000	\$82,000	\$740,000	\$0
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$386,000	\$135,000	\$251,000	\$0
100% GF (4260-101-0001)	\$45,000	\$45,000	\$0	\$0
FFCRA 4.34% GF (4260-113-0001)	(\$13,000)	(\$13,000)	\$0	\$0
FFCRA 4.34% FF (4260-113-0890)	\$13,000	\$0	\$0	\$13,000
FFCRA 6.2% GF (4260-101-0001)	(\$1,551,000)	(\$1,551,000)	\$0	\$0
FFCRA 6.2% FF (4260-101-0890)	\$1,551,000	\$0	\$0	\$1,551,000
Total	\$26,264,000	\$11,204,000	\$13,496,000	\$1,564,000

FY 2022-23	TF	GF	FF	FFCRA
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$25,804,000	\$12,902,000	\$12,902,000	\$0
90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$951,000	\$95,000	\$856,000	\$0
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$561,000	\$196,000	\$365,000	\$0
100% GF (4260-101-0001)	\$45,000	\$45,000	\$0	\$0
FFCRA 4.34% GF (4260-113-0001)	\$0	\$0	\$0	\$0
FFCRA 4.34% FF (4260-113-0890)	\$0	\$0	\$0	\$0
FFCRA 6.2% GF (4260-101-0001)	\$0	\$0	\$0	\$0
FFCRA 6.2% FF (4260-101-0890)	\$0	\$0	\$0	\$0
Total	\$27,361,000	\$13,238,000	\$14,123,000	\$0

NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 172
IMPLEMENTATION DATE: 7/2005
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1076

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$8,007,000	\$4,219,000
- STATE FUNDS	\$5,558,000	\$1,900,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$8,007,000	\$4,219,000
STATE FUNDS	\$5,558,000	\$1,900,000
FEDERAL FUNDS	\$2,449,000	\$2,319,000

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
 SPA 21-0013
 Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

COVID-19 Increased FMAP Extension

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: 172

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. In June 2021, CMS approved SPA 21-0013 to continue the NDPH Supplemental Program through June 30, 2022. Another SPA will be submitted to CMS for approval to continue the NDPH Supplemental Program for 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 the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated.

Reason for Change:

The change in FY 2021-22, from the prior estimate, and from FY 2021-22 to FY 2022-23, in the current estimate, is due to:

- FY 2019-20 and FY 2020-21 FFCRA increased FMAP returned to providers, and
- FY 2013-14 through FY 2019-20 ACA FFP returned to providers.

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. In FY 2021-22, the retroactive ACA adjustments from FY 2013-14 to FY 2019-20 in the SF will be expended to the providers.
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 2020-21 ACA adjustment will be claimed in FY 2021-22, and the FY 2021-22 ACA adjustment will be claimed in FY 2022-23. 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 FFCRA increased FMAP for FY 2020-21 Q1 through FY 2021-22 Q2 and at the regular 50% FMAP for FY 2021-22 Q3 and Q4.
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 December 31, 2021 for this policy change. The impact of a six month extension of the

NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 172

FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.

- FY 2019-20 and FY 2020-21 payments were issued at the FFCRA increased FMAP. The unused GF in the special fund as a result of the FFCRA for FY 2019-20 and FY 2020-21 will be expended to providers in FY 2021-22.
 - The FY 2021-22 payments will be issued at 50% FF/ 50% Special Fund (GF appropriated); there will be no unused GF. For FY 2021-22 Q1 and Q2, the FFCRA increased FMAP will be issued to providers separately.
7. The estimated NDPH Supplemental payments and ending balance for FY 2021-22 are shown below:

FY 2021-22 NDPH Supplemental Fund Summary	SF
FY 2020-21 Ending Balance	\$4,322,000
Appropriation (GF)	\$1,900,000
FY 2020-21 Interest Earned	\$23,000
Funds Available	\$6,245,000
Less: FY 2021-22 Cash Expenditures to Hospitals	(\$5,558,000)
Est. FY 2021-22 Remaining Balance	\$687,000

NDPH SUPPLEMENTAL PAYMENT
REGULAR POLICY CHANGE NUMBER: 172

FY 2021-22	TF	SF**	FF	ACA FF	FFCRA****	Return to Providers*
FY 2021-22 Cash Expenditures to Hospitals**	\$3,918,000	\$1,900,000	\$1,900,000	\$0	\$118,000	\$0
FY 2019-20 FFCRA Return to Providers	\$118,000	\$118,000	\$0	\$0	\$0	\$118,000
FY 2020-21 FFCRA Return to Providers	\$236,000	\$236,000	\$0	\$0	\$0	\$236,000
FY 2013-14 ACA FF Return to Providers***	\$354,000	\$354,000	\$0	\$0	\$0	\$354,000
FY 2014-15 ACA FF Return to Providers***	\$526,000	\$526,000	\$0	\$0	\$0	\$526,000
FY 2015-16 ACA FF Return to Providers***	\$573,000	\$573,000	\$0	\$0	\$0	\$573,000
FY 2016-17 ACA FF Return to Providers***	\$506,000	\$506,000	\$0	\$0	\$0	\$506,000
FY 2017-18 ACA FF Return to Providers***	\$510,000	\$510,000	\$0	\$0	\$0	\$510,000
FY 2018-19 ACA FF Return to Providers***	\$374,000	\$374,000	\$0	\$0	\$0	\$374,000
FY 2019-20 ACA FF Return to Providers***	\$461,000	\$461,000	\$0	\$0	\$0	\$461,000
FY 2020-21 ACA FF Adjustment to Providers***	\$431,000	\$0	(\$638,000)	\$1,148,000	(\$79,000)	\$431,000
Total	\$8,007,000	\$5,558,000	\$1,262,000	\$1,148,000	\$39,000	\$4,089,000

8. The estimated NDPH Supplemental payments and ending balance for FY 2022-23 are shown below:

FY 2022-23 NDPH Supplemental Fund Summary	SF
FY 2021-22 Ending Balance	\$687,000
Appropriation (GF)	\$1,900,000
Est. FY 2021-22 Interest Earned	\$23,000
Funds Available	\$2,610,000
Less: FY 2022-23 Cash Expenditures to Hospitals	(\$1,900,000)
Est. FY 2022-23 Remaining Balance	\$710,000

NDPH SUPPLEMENTAL PAYMENT
REGULAR POLICY CHANGE NUMBER: 172

FY 2022-23	TF	SF**	FF	ACA FF	FFCRA****	Return to Providers*
FY 2022-23 Cash Expenditures to Hospitals**	\$3,800,000	\$1,900,000	\$1,900,000	\$0	\$0	\$0
FY 2021-22 ACA FF Adjustment to Providers***	\$419,000	\$0	(\$619,000)	\$1,115,000	(\$77,000)	\$419,000
Total	\$4,219,000	\$1,900,000	\$1,281,000	\$1,115,000	(\$77,000)	\$419,000

*The Return to Providers column is for display purposes only (see Methodology #4).

Funding:

100% GF (4260-104-0001)

100% NDPH Supplemental Fund (less funded by GF) (4260-698-3096)

100% NDPH Supplemental Fund (non-GF) (4260-601-3096)**

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

100% Title XIX (4260-101-0890)**,**

6.2% Title XIX FFCRA Increased FFP (4260-101-0890)****

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH

REGULAR POLICY CHANGE NUMBER: 173
IMPLEMENTATION DATE: 1/2005
ANALYST: Elena Susbilla
FISCAL REFERENCE NUMBER: 1039

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$8,000,000	\$8,000,000
- STATE FUNDS	\$3,752,000	\$4,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$8,000,000	\$8,000,000
STATE FUNDS	\$3,752,000	\$4,000,000
FEDERAL FUNDS	\$4,248,000	\$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

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.

Reason for Change:

There is no change for FY 2021-22 from the prior estimate.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to no FFCRA estimated in FY 2022-23. There is no change in total funds from FY 2021-22 to FY 2022-23.

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH

REGULAR POLICY CHANGE NUMBER: 173

Methodology:

1. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.
2. Assume annual reimbursements to SRHs providing outpatient services are \$8,000,000 TF.

FY 2021-22	TF	GF	FF	FFCRA
CY 2021	\$6,000,000	\$2,752,000	\$3,000,000	\$248,000
CY 2022	\$2,000,000	\$1,000,000	\$1,000,000	\$0
Total	\$8,000,000	\$3,752,000	\$4,000,000	\$248,000

FY 2022-23	TF	GF	FF
CY 2022	\$6,000,000	\$3,000,000	\$3,000,000
CY 2023	\$2,000,000	\$1,000,000	\$1,000,000
Total	\$8,000,000	\$4,000,000	\$4,000,000

Funding:

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

56.2% Title XIX / 43.8% GF (4260-101-0001/0890)

PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 174
IMPLEMENTATION DATE: 12/2017
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2044

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$67,144,000	\$70,366,000
- STATE FUNDS	\$12,298,000	\$12,842,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	93.12 %	93.19 %
APPLIED TO BASE		
TOTAL FUNDS	\$4,619,500	\$4,791,900
STATE FUNDS	\$846,100	\$874,540
FEDERAL FUNDS	\$3,773,400	\$3,917,380

Purpose:

This policy estimates the expenditures related to 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:

Proposition 56 (2016)
Budget Act of 2021

Interdependent Policy Changes:

Proposition 56 Funding

Background:

The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), increased the excise tax rate on cigarettes and tobacco products and allocates a portion of the tobacco tax revenue to the Department for use as the non-federal share of health care expenditures, subject to appropriation by the Legislature.

The Budget Act of 2017 allocated Proposition 56 funds for supplemental payments for supplemental reimbursements under the Family PACT program. The Legislature has continued this funding in subsequent budget acts.

The Centers for Medicare & Medicaid Services (CMS) approved State Plan Amendment (SPA) 17-029 on November 30, 2017. The SPA authorized 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.

This policy change identifies the use of the General Fund (GF) for these Proposition 56 payments. See the Proposition 56 Funding policy change for the Proposition 56 offset to the GF.

PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 174

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a decrease due to less clients utilizing these services during the Coronavirus Disease 2019 (COVID-19) national public health emergency (PHE) and updated actuals for fee-for-service and managed care expenditures. The change from FY 2021-22 to 2022-23, in the current estimate, is an increase due to projecting more clients using these services in FY 2022-23 following the COVID-19 PHE.

Methodology:

1. Payments will be made via fee-for-service supplemental payments and increased managed capitation 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. Estimated expenditures on a cash basis are as follows:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
E&M Office Visits	\$60,940	\$6,094	\$54,846
Medical Pregnancy Termination	\$6,203	\$6,203	\$0
FY 2021-22 Total	\$67,144	\$12,298	\$54,846
FY 2022-23	TF	GF	FF
E&M Office Visits	\$63,916	\$6,392	\$57,524
Medical Pregnancy Termination	\$6,450	\$6,450	\$0
FY 2022-23 Total	\$70,366	\$12,842	\$57,524

*Totals may differ due to rounding.

Funding:

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

100% GF (4260-101-0001)

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 175
IMPLEMENTATION DATE: 4/2014
ANALYST: Neejkajsiab Yang
FISCAL REFERENCE NUMBER: 1661

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$4,034,000	\$20,196,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$4,034,000	\$20,196,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$4,034,000	\$20,196,000

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

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.

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.

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 175

However, as the Department continues to work on SPA 18-0007 approvals, supplemental reimbursements will resume based on the payment methodologies set forth in the current approved SPA 09-024, which excludes shared direct 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.

Assembly Bill (AB) 1705, effective January 1, 2022, requires the Department to implement a public provider GEMT intergovernmental transfer (IGT) program. The public providers that participate in the GEMT Supplemental Payment Program will transition into the new GEMT IGT program, so the GEMT Supplemental Payment Program will sunset on December 31, 2021. However, close-out activities for the GEMT Supplemental Payment Program, such as interim and final reconciliations, will continue after the effective date of AB 1705.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to:

- FY 2010-11, FY 2011-12, and FY 2017-18 final reconciliations revised based on updated data.
- FY 2012-13, FY 2015-16, and FY 2016-17 final reconciliation remaining recoupments shifted from FY 2020-21 to FY 2021-22.
- Revised FY 2018-19 and FY 2019-20 interim payments decreased to align with the payment methodologies under SPA 09-024, which exclude amounts for shared direct costs.
- FY 2020-21 interim payments shifted to FY 2022-23.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to the net final reconciliations in FY 2021-22 and more interim payment years included in FY 2022-23.

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.

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 175

4. The GEMT CPE reimbursements will sunset on December 31, 2021. Interim payment are estimated for FY 2021-22 Quarter 1 and Quarter 2 only.
5. Interim reconciliations are performed within two years of receipt of the as-filed cost report. Final reconciliations are based on audited cost reports, and the audit and settlement process is completed within three years of the postmark date of the approved cost report. Due to delays in receipt of cost reports, retroactive years are being reconciled in FY 2021-22.
6. 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. However, as the Department continues to work on approvals for SPA 18-0007, payments will resume under the current approved SPA 09-024.
7. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through December 31, 2021 for this policy change. The policy change currently only includes expenditures through December 31, 2021. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.

The estimated payments on a cash basis are:

FY 2021-22	Total FFP	Regular FFP	ARRA	ACA	FFCRA
FY 2010-11 Final Recon.	(\$2,215,000)	(\$1,869,000)	(\$346,000)	\$0	\$0
FY 2011-12 Final Recon.	(\$523,000)	(\$523,000)	\$0	\$0	\$0
FY 2012-13 Final Recon.	(\$132,000)	(\$132,000)	\$0	\$0	\$0
FY 2013-14 Final Recon.	(\$91,000)	(\$61,000)	\$0	(\$30,000)	\$0
FY 2014-15 Final Recon.	(\$210,000)	(\$26,000)	\$0	(\$184,000)	\$0
FY 2015-16 Final Recon.	(\$1,925,000)	(\$803,000)	\$0	(\$1,122,000)	\$0
FY 2016-17 Final Recon.	(\$694,000)	(\$286,000)	\$0	(\$408,000)	\$0
FY 2017-18 Final Recon.	(\$3,115,000)	(\$581,000)	\$0	(\$2,534,000)	\$0
FY 2018-19 Interim Payment	\$6,351,000	\$2,265,000	\$0	\$4,086,000	\$0
FY 2019-20 Interim Payment	\$6,588,000	\$2,400,000	\$0	\$4,047,000	\$141,000
Total FY 2021-22	\$4,034,000	\$384,000	(\$346,000)	\$3,855,000	\$141,000

FY 2022-23	Total FFP	Regular FFP	ARRA	ACA	FFCRA
FY 2018-19 Interim Payment	\$6,351,000	\$2,265,000	\$0	\$4,086,000	\$0
FY 2019-20 Interim Payment	\$6,588,000	\$2,400,000	\$0	\$4,047,000	\$141,000
FY 2020-21 Interim Payment	\$4,395,000	\$1,614,000	\$0	\$2,580,000	\$201,000
FY 2021-22 Interim Payment	\$2,862,000	\$1,053,000	\$0	\$1,677,000	\$132,000
Total FY 2022-23	\$20,196,000	\$7,332,000	\$0	\$12,390,000	\$474,000

GEMT SUPPLEMENTAL PAYMENT PROGRAM
REGULAR POLICY CHANGE NUMBER: 175

Funding:

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

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

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

FREE CLINICS AUGMENTATION

REGULAR POLICY CHANGE NUMBER: 176
IMPLEMENTATION DATE: 5/2022
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2303

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$2,000,000	\$2,000,000
- STATE FUNDS	\$2,000,000	\$2,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,000,000	\$2,000,000
STATE FUNDS	\$2,000,000	\$2,000,000
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the cost of providing funding to support to the California Association of Free and Charitable Clinics (CAFCC).

Authority:

Budget Act of FY 2021-22

Interdependent Policy Changes:

Not Applicable

Background:

AB 128 Budget Act of FY 2021-22 provides funding to support free and charitable clinics that are 501(c)(3) tax-exempt organizations, or operate as a program component or affiliate of a 501(c)(3) organization and do not qualify as Medi-Cal providers. The funds shall be distributed to the CAFCC and the amount allocated to each Free Clinic shall be determined through an allocation methodology developed by the CAFCC.

Reason for Change:

There is no change from the prior estimate for FY 2021-22. There is no change from FY 2021-22 to FY 2022-23 in the current estimate.

Methodology:

1. Assume an ongoing payment of \$2 million GF annually to the CAFCC beginning in FY 2021-22.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2021-22	\$2,000	\$2,000	\$0
FY 2022-23	\$2,000	\$2,000	\$0

Funding:

100% GF (4260-101-0001)

PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 177
IMPLEMENTATION DATE: 3/2019
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 2103

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$8,173,000	\$8,206,000
- STATE FUNDS	\$3,454,400	\$3,958,150
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	79.93 %	79.61 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,640,300	\$1,673,200
STATE FUNDS	\$693,300	\$807,070
FEDERAL FUNDS	\$947,020	\$866,140

Purpose:

This policy change estimates the expenditures related to supplemental payments provided to Freestanding Pediatric Subacute (FS/PSA) Facilities.

Authority:

SPA 18-0042
 SPA 19-0042
 Families First Coronavirus Response Act (FFCRA)
 Budget Act of 2021

Interdependent Policy Changes:

Proposition 56 Funding

Background:

The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), increased the excise tax rate on cigarettes and tobacco products and allocates a portion of the tobacco tax revenue to the Department for use as the non-federal share of health care expenditures subject to appropriation by the Legislature.

The Budget Act of 2018 allocated Proposition 56 funds for supplemental payments to FS/PSA facilities. The Legislature has continued this funding in subsequent budget acts.

On September 18, 2018, the Centers for Medicare and Medicaid Services (CMS) 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 emergencies are effective for 90 days unless extended or terminated.

PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 177

This policy change identifies the use of the General Fund for these Proposition 56 payments. See the Proposition 56 Funding policy change for the Proposition 56 offset to the GF in FY 2021-22.

Beginning FY 2022-23, the Department proposes to transition this supplemental payment to an ongoing rate increase, the nonfederal share of which will be funded by the General Fund.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is a net decrease due to:

- Decreased FFS costs estimate based on updated Medi-Cal FFS days.
- Decreased managed care payments and funding assumptions based on updated managed care rate and enrollment projections.
- Updating FFS funding assumptions based on actual payment data.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a slight increase due to:

- Changes slight differences in managed care payments due to the introduction of an additional rate year.
- No FFCRA funding estimated in FY 2022-23.

Methodology:

1. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2022 for this policy change.
2. The following payments are estimated for FY 2021-22 and FY 2022-23:

FY 2021-22	TF	GF	Title XXI FF	Title XIX FF	ACA FF	FFCRA
FFS Pmts	\$6,532,000	\$2,793,000	\$196,000	\$3,073,000	\$76,000	\$394,000
Mgd Care Pmts	\$1,641,000	\$662,000	\$281,000	\$604,000	\$0	\$94,000
Total	\$8,173,000	\$3,455,000	\$477,000	\$3,677,000	\$76,000	\$488,000

FY 2022-23	TF	GF	Title XXI FF	Title XIX FF	ACA FF	FFCRA
FFS Pmts	\$6,533,000	\$3,187,000	\$196,000	\$3,074,000	\$76,000	\$0
Mgd Care Pmts	\$1,673,000	\$771,000	\$285,000	\$617,000	\$0	\$0
Total	\$8,206,000	\$3,958,000	\$481,000	\$3,691,000	\$76,000	\$0

PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 177

Funding:

FY 2021-22	TF	GF	FF	FFCRA
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$7,354,000	\$3,677,000	\$3,677,000	\$0
90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$85,000	\$9,000	\$76,000	\$0
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$734,000	\$257,000	\$477,000	\$0
100% GF (4260-101-0001)	\$0	\$0	\$0	\$0
FFCRA 4.34% GF (4260-113-0001)	(\$32,000)	(\$32,000)	\$0	\$0
FFCRA 4.34% FF (4260-113-0890)	\$32,000	\$0	\$0	\$32,000
FFCRA 6.2% GF (4260-101-0001)	(\$456,000)	(\$456,000)	\$0	\$0
FFCRA 6.2% FF (4260-101-0890)	\$456,000	\$0	\$0	\$456,000
Total	\$8,173,000	\$3,455,000	\$4,230,000	\$488,000

FY 2022-23	TF	GF	FF	FFCRA
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$7,382,000	\$3,691,000	\$3,691,000	\$0
90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$85,000	\$8,000	\$77,000	\$0
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$739,000	\$259,000	\$480,000	\$0
100% GF (4260-101-0001)	\$0	\$0	\$0	\$0
FFCRA 4.34% GF (4260-113-0001)	\$0	\$0	\$0	\$0
FFCRA 4.34% FF (4260-113-0890)	\$0	\$0	\$0	\$0
FFCRA 6.2% GF (4260-101-0001)	\$0	\$0	\$0	\$0
FFCRA 6.2% FF (4260-101-0890)	\$0	\$0	\$0	\$0
Total	\$8,206,000	\$3,958,000	\$4,248,000	\$0

PROP 56 - NEMT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 178
IMPLEMENTATION DATE: 3/2020
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 2139

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$7,158,000	\$7,158,000
- STATE FUNDS	\$3,318,550	\$3,728,550
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	100.00 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the expenditures related to providing supplemental payments for non-emergency medical transportation (NEMT) services.

Authority:

SPA 19-0044
 SPA 20-0007
 Families First Coronavirus Response Act (FFCRA)
 Budget Act of 2021

Interdependent Policy Changes:

Proposition 56 Funding

Background:

The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), increased the excise tax rate on cigarettes and tobacco products and allocates a portion of the tobacco tax revenue to the Department for use as the non-federal share of health care expenditures, subject to appropriation by the Legislature.

The Budget Act of 2019 allocated Proposition 56 funds for supplemental payments for NEMT services. The Legislature has continued this funding in subsequent budget acts.

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 federal 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 are 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 Transportation and Air Medical Transportation providers will be eligible for the supplemental payments.

PROP 56 - NEMT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 178

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.

This policy change identifies the use of the General Fund for these Proposition 56 payments. See the Proposition 56 Funding policy change for the Proposition 56 offset to the GF in FY 2021-22.

Beginning FY 2022-23, the Department proposes to transition this supplemental payment to an ongoing rate increase, the nonfederal share of which will be funded by the General Fund.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to updated FY 2021-22 estimates based on actual payment data.

There is no change in the total funds from FY 2021-22 to FY 2022-23, in the current estimate. The change in the state share is due to no longer including FFCRA funding in FY 2022-23.

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 annual cost of the FFS supplemental payments is \$7,158,000 TF.
3. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2022 in this policy change.
4. Funds allocated for the supplemental payments are as follows:

Fiscal Year	TF	GF	FFP	FFCRA
FY 2021-22	\$7,158,000	\$3,319,000	\$3,429,000	\$410,000
FY 2022-23	\$7,158,000	\$3,729,000	\$3,429,000	\$0

PROP 56 - NEMT SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 178

Funding:

FY 2021-22	TF	GF	FFP	FFCRA
50% Title XIX/ 50% GF	\$6,606,000	\$3,303,000	\$3,303,000	\$0
90% Title XIX / 10% GF	\$134,000	\$14,000	\$120,000	\$0
65% Title XXI / 35% GF	\$9,000	\$3,000	\$6,000	\$0
FFCRA 6.2% GF	(\$410,000)	(\$410,000)	\$0	\$0
FFCRA 6.2% FFP	\$410,000	\$0	\$0	\$410,000
100% GF	\$409,000	\$409,000	\$0	\$0
Total	\$7,158,000	\$3,319,000	\$3,429,000	\$410,000

FY 2022-23	TF	GF	FFP	FFCRA
50% Title XIX/ 50% GF	\$6,606,000	\$3,303,000	\$3,303,000	\$0
90% Title XIX / 10% GF	\$134,000	\$14,000	\$120,000	\$0
65% Title XXI / 35% GF	\$9,000	\$3,000	\$6,000	\$0
100% GF	\$409,000	\$409,000	\$0	\$0
Total	\$7,158,000	\$3,729,000	\$3,429,000	\$0

PROPOSITION 56 FUNDING

REGULAR POLICY CHANGE NUMBER: 179
IMPLEMENTATION DATE: 7/2018
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 2102

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change replaces General Fund expenditures for specified supplemental payments and rate increases with Proposition 56 funds, and budgets additional General Fund necessary to continue Proposition 56 payments as program expenditures exceed available revenues.

Authority:

California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56)
Budget Act of 2021

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.

Beginning in FY 2022-23, the following items are proposed to transition to General Fund support as ongoing rate increases:

- PROP 56 – Adverse Childhood Experiences Screenings
- PROP 56 – AIDS Waiver Supplemental Payments
- PROP 56 – CBAS Supplemental Payments
- PROP 56 – Developmental Screenings
- PROP 56 – FS-PSA Supplemental Payments
- PROP 56 – Home Health Rate Increase
- PROP 56 – ICF/DD Supplemental Payments
- PROP 56 – NEMT Supplemental Payments
- PROP 56 – Pediatric Day Health Care Rate Increase

Reason for Change:

The change from the prior estimate, for FY 2021-22, is based on updated expenditure data for various policy changes. The change from FY 2021-22 to FY 2022-23, in the current estimate, is based on updated expenditure data for various policy changes.

PROPOSITION 56 FUNDING
REGULAR POLICY CHANGE NUMBER: 179

Methodology:

1. The nonfederal share of Proposition 56 payment items is initially budgeted as General Fund costs in the respective policy changes for these payments. Subsequently, this policy change replaces the General Fund with Healthcare Treatment Fund for those payments budgeted to be supported by Proposition 56.
2. Based on the projected amount of Proposition 56 revenues available, and after accounting for the shift of a number of payments to ongoing General Fund support, an estimated \$28,970,000 is needed from the General Fund to support those payments assumed to continue as Proposition 56 payments in FY 2022-23.

(Dollars in Thousands)

FY 2021-22	Total GF to Prop 56
PROP 56 – Adverse Childhood Experiences Screenings	(\$17,591)
PROP 56 – AIDS Waiver Supplemental Payments	(\$1,872)
PROP 56 – CBAS Supplemental Payments	(\$11,630)
PROP 56 – Developmental Screenings	(\$24,287)
PROP 56 – Directed Payment Risk Mitigation	\$74,547
PROP 56 – FS-PSA Supplemental Payments	(\$3,455)
PROP 56 – Home Health Rate Increase	(\$54,060)
PROP 56 – ICF/DD Supplemental Payments	(\$11,204)
PROP 56 – Medi-Cal Family Planning	(\$69,691)
PROP 56 – NEMT Supplemental Payments	(\$3,318)
PROP 56 – Pediatric Day Health Care Rate Increase	(\$2,785)
PROP 56 – Physician Services Supplemental Payments	(\$440,668)
PROP 56 – Provider ACES Trainings	(\$28,296)
PROP 56 – Dental Services Supplemental Payments	(\$170,374)
PROP 56 – Women’s Health Supplemental Payments	(\$12,298)
PROP 56 – Behavioral Health Incentive Program	(\$33,286)
PROP 56 – Value-Based Payment Program	(\$117,327)
Total of GF dollars in Prop 56 PCs	(\$927,595)
Prop 56 Funding	\$927,595
Grand Total	\$0

*Totals may differ due to rounding

PROPOSITION 56 FUNDING
REGULAR POLICY CHANGE NUMBER: 179

(Dollars in Thousands)

FY 2022-23	Total GF to Prop 56
PROP 56 - Medi-Cal Family Planning	(\$67,271)
PROP 56 - Physician Services Supplemental Payments	(\$485,871)
PROP 56 - Provider ACES Trainings	(\$734)
PROP 56 - Dental Services Supplemental Payments	(\$199,843)
PROP 56 - Women's Health Supplemental Payments	(\$12,842)
PROP 56 - Behavioral Health Incentive Program	(\$42,739)
PROP 56 - Value-Based Payment Program	(\$3,548)
Total of GF dollars in Prop 56 PCs	(\$812,848)
Prop 56 Funding	\$783,878
Additional GF Support for Prop 56 Payments	\$28,970
Grand Total	\$0

*Totals may differ due to rounding

Funding:

Healthcare Treatment Fund (4260-101-3305)

100% Title XIX GF (4260-101-0001)

100% Title XXI GF (4260-113-0001)

Healthcare Treatment Fund (Less Funded by GF) (4260-695-3305)

GF Support for Prop 56 Payments (4260-112-0001)

PROP 56 - AIDS WAIVER RATE INCREASE

REGULAR POLICY CHANGE NUMBER: 180
IMPLEMENTATION DATE: 11/2017
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2050

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$4,274,000	\$4,274,000
- STATE FUNDS	\$1,872,000	\$2,137,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	100.00 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the expenditures related to providing rate increases for specific Acquired Immune Deficiency Syndrome (AIDS) Waiver services.

Authority:

Proposition 56 (2016)
 Families First Coronavirus Response Act (FFCRA)
 Budget Act of 2021

Interdependent Policy Changes:

Proposition 56 Funding

Background:

The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), increased the excise tax rate on cigarettes and tobacco products and allocates a portion of the tobacco tax revenue to the Department for use as the non-federal share of health care expenditures, subject to appropriation by the Legislature.

The Budget Act of 2017 allocated Proposition 56 funds for rate increases for AIDS Waiver services. The Legislature has continued this funding in subsequent budget acts.

The Department developed the structure of the supplemental payments and posted those parameters on its Internet Web site on July 31, 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. These payments were effective retroactively 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 Funding policy change for the Proposition 56 offset to the GF in FY 2021-22. Beginning FY 2022-23, the Department proposes to transition this supplemental payment to an ongoing rate increase, the nonfederal share of which will be funded by the GF.

PROP 56 - AIDS WAIVER RATE INCREASE

REGULAR POLICY CHANGE NUMBER: 180

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.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a decrease to reflect actual expenditures. FY 2021-22 is based on the average of two prior fiscal years of actuals data. There is no change in total funds from FY 2021-22 to FY 2022-23 in the current estimate. The General Fund increase from FY 2021-22 to FY 2022-23 is due to the increase FMAP ending on December 31, 2021.

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 the averages of FY 2019-20 and FY 2020-21 actual expenditure data.
4. Assume approximately \$4,274,000 TF annually in supplemental payments were claimed in previous fiscal years.
5. Assume rates will increase by 90%, excluding administration and care management services.
6. Assume administration rates will increase by 45% and 59% for care management services.
7. Assume the 6.2% Title XIX FFCRA increased FMAP is for expenditures through June 30, 2022.
8. Funds allocated for the supplemental payments are as follows:

FY 2021-22	TF	GF	FF
Healthcare Treatment Fund Prop. 56	\$2,137,000	\$2,137,000	\$0
100% Title XIX	\$2,137,000	\$0	\$2,137,000
6.2% Increased FMAP	\$0	(\$265,000)	\$265,000
Total	\$4,274,000	\$1,872,000	\$2,402,000

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF	\$4,274,000	\$2,137,000	\$2,137,000
Total	\$4,274,000	\$2,137,000	\$2,137,000

PROP 56 - AIDS WAIVER RATE INCREASE
REGULAR POLICY CHANGE NUMBER: 180

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)

IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER: 181
IMPLEMENTATION DATE: 6/2020
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1601

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

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 in FY 2021-22, from the prior estimate, is an increase in administrative fees due to updated FY 2019-20 final settlement amounts based on actuals.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase in administrative fees due to assuming FY 2022-23 interim payments will increase from the prior year.

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.

IGT ADMIN. & PROCESSING FEE
REGULAR POLICY CHANGE NUMBER: 181

2. Beginning SFY 2018-19, GME support costs may be calculated and reimbursed through GME administrative fees.
3. The reimbursement to the GF will be the 5% administrative fee amount less any support costs.
4. Support costs will not be reduced from administrative fees collected as a result of final settlements because the support costs were reimbursed in full from administrative fees collected during interim payments.
5. Administrative costs will be collected each quarter during interim payments. Support costs are not available for reporting until at least one month after the close of the payment period; therefore, support costs for the entire state fiscal year will be calculated one quarter after the close of the respective state fiscal year. Funds transferred to the GF will not occur until support costs are calculated.

FY 2021-22	IGT Subject to the Fee	5% Admin Fee	Support Costs	Reimbursement to GF
FY 2019-20 Final Settlement	\$33,708,000	\$1,685,000	\$0	\$1,685,000
FY 2020-21 Interim Payment	\$187,741,000	\$9,387,000	\$151,000	\$9,236,000
Total	\$221,449,000	\$11,072,000	\$151,000	\$10,921,000

FY 2022-23	IGT Subject to the Fee	5% Admin Fee	Support Costs	Reimbursement to GF
FY 2021-22 Interim Payment	\$222,786,000	\$11,139,000	\$159,000	\$10,981,000
FY 2021-22 Final Settlement	\$17,804,000	\$890,000	\$0	\$890,000
Total	\$240,590,000	\$12,029,000	\$159,000	\$11,871,000

Fiscal Year	TF	GF	GME Special Fund Transfer
FY 2021-22	\$0	(\$10,921,000)	\$10,921,000
FY 2022-23	\$0	(\$11,871,000)	\$11,871,000

Funding:

100% State GF (4260-101-0001)

DPH Graduate Medical Education Special Fund (4260-601-8113)

COVID-19 CASELOAD IMPACT

REGULAR POLICY CHANGE NUMBER: 182
IMPLEMENTATION DATE: 4/2020
ANALYST: Ryan Woolsey
FISCAL REFERENCE NUMBER: 2218

	FY 2021-22	FY 2022-23
FULL YEAR COST - TOTAL FUNDS	\$10,464,267,000	\$9,981,882,000
- STATE FUNDS	\$2,942,531,840	\$2,815,274,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$10,464,267,000	\$9,981,882,000
STATE FUNDS	\$2,942,531,840	\$2,815,274,000
FEDERAL FUNDS	\$7,521,735,160	\$7,166,608,000

Purpose:

This policy change estimates the expenditure changes 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

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 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. The pandemic 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.

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

COVID-19 CASELOAD IMPACT

REGULAR POLICY CHANGE NUMBER: 182

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.

There is considerable uncertainty surrounding the magnitude and duration of COVID-19 caseload impacts.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is an increase in costs due to the assumed extension of the PHE and associated continuous coverage requirement through June 2022. These increased costs are partially offset due to somewhat slower projected growth in cases due to the continuous coverage requirement based on more recent data. Updated estimates of the average monthly cost of each eligible and the mix of eligibles also slightly increase the share of costs paid from the General Fund.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to the assumed decline in the COVID-19 caseload through June 2023.

Methodology:

1. Continuous Coverage Requirement

- a. Based on updated administrative data on the average number of monthly Medi-Cal terminations, assume that, on net, the impact of the continuous coverage requirement on the overall Medi-Cal caseload is about 116,700 each month, beginning in April 2020.
- b. Based on recent growth trends, assume that the monthly 116,700 net increase in cases consists of, on average, 57,900 from the newly eligible aid category, 57,500 from families and children aid categories, 2,200 from seniors aid categories, with an offsetting reduction of 900 per month from persons with disabilities aid categories. This offsetting reduction is assumed to be caused by a decrease in transitions among aid categories under the continuous coverage requirement.
- c. Based on the assumed mix of cases described above, the estimated average monthly cost (excluding Medicare costs) of each eligible that remains in the program due to the continuous coverage requirement is \$349 in FY 2021-22 and FY 2022-23.
- d. Assume the continuous coverage impact begins in April 2020, and continues through June 2022.
- e. Assume that, following the end of the continuous coverage requirement, counties gradually redetermine eligibility over a period of 12 months, through June 2023, for individuals not discontinued under the continuous coverage requirement. Assume that the Medi-Cal caseload returns approximately to levels observed in the second quarter of 2021. This is equivalent to costs for roughly 845,000 individuals being budgeted in this policy change (on top of the base projections). The ongoing level of the Medi-Cal caseload following the 12 month redetermination period is highly uncertain, and will depend on a number of factors including the condition of the labor market, the impact of minimum wage increases, and applicant and beneficiary

COVID-19 CASELOAD IMPACT

REGULAR POLICY CHANGE NUMBER: 182

behavior. This estimate will be updated as additional information on actual trends is available.

2. Continuous Coverage Requirement - Medicare Impact

- a. Based on observed changes in eligible beneficiaries, assume that the number of Medi-Cal beneficiaries for whom the state pays Medicare Part B premiums (see the Medicare Pmnts.-Buy-In Part A & B Premiums policy change) increases by 9,360 each month, beginning July 2020 and continuing through June 2022, due to the continuous coverage requirement.
- b. Assume monthly Part B premiums of \$148.50 in calendar year 2021, \$170.10 in calendar year 2022, and \$176.07 in calendar year 2023.
- c. Based on observed changes in eligible beneficiaries, assume that the number of Medi-Cal beneficiaries for whom the state makes payments under the Medicare Part D clawback (see the Medicare Payments – Part D Phased-Down policy change) increases by 5,940 each month, beginning August 2020 and continuing through June 2022, due to the continuous coverage requirement.
- d. Assume the state's monthly payment per eligible under the Medicare Part D clawback is \$137.76 in calendar year 2021, \$147.83 in calendar year 2022, and \$154.47 in calendar year 2023.
- e. Assume that the number of additional individuals for whom Medicare Part B premiums are paid and for whom the state makes payments under the Medicare Part D clawback decreases over 12 months beginning July 2022.

3. State Only Costs

- a. To account for estimated state-only costs of services provided to individuals without satisfactory immigration status, \$266 million in FY 2021-22 and \$254 million in FY 2022-23 are shifted from federal funds to state General Fund.

After accounting for payment timing, total estimated costs related to the impact of COVID-19 on the Medi-Cal caseload on a cash basis are:

(Dollars in Thousands)

Fiscal Year	TF	GF	Title XIX FF	Title XXI FF	ACA FF
FY 2021-22	\$10,464,267	\$2,942,532	\$1,794,270	-\$43,003	\$5,770,468
FY 2022-23	\$9,981,882	\$2,815,274	\$1,698,065	-\$40,991	\$5,509,534

COVID-19 CASELOAD IMPACT
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4. COVID-19 Impacts in the Base

- a. The FFS base and various other base policy changes reflect actual COVID-19 caseload impacts through July 2021. Specifically, the estimated caseload impact reflected in base projections for this period is roughly 1,865,000 cases.
- b. Net COVID-19 caseload costs estimated to be in the base in FY 2021-22 for months through July 2021 are approximately \$1.3 billion.
- c. In order to more accurately reflect the impacts of COVID-19 on caseload, minor adjustments are required to base caseload projections related to the COVID-19 impact for periods following July 2021.
- d. The following amounts are applied to the base as an adjustment to allow the full COVID-19 caseload impact to be reflected in this policy change.

(Dollars in Thousands)

Fiscal Year	TF	GF	Title XIX FF	Title XXI FF	ACA FF
FY 2021-22	-\$1,442,525	-\$367,904	-\$222,685	\$8,676	-\$860,612
FY 2022-23	-\$198,302	\$72,827	\$121,934	\$13,215	-\$406,279

Funding:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	\$3,665,051	\$1,832,526	\$1,832,526
90% Title XIX / 10% GF (4260-101-0001 / 0890)	\$6,663,358	\$666,336	\$5,997,022
65% Title XXI / 35% GF (4260-113-0001 / 0890)	-\$68,257	-\$23,890	-\$44,368
100% State General Fund	\$467,560	\$467,560	\$0
100% FFP	-\$263,445	\$0	-\$263,445
Total	\$10,464,267	\$2,942,532	\$7,521,735

COVID-19 CASELOAD IMPACT
REGULAR POLICY CHANGE NUMBER: 182

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	\$3,469,817	\$1,734,908	\$1,734,908
90% Title XIX / 10% GF (4260-101-0001 / 0890)	\$6,362,049	\$636,205	\$5,725,844
65% Title XXI / 35% GF (4260-113-0001 / 0890)	-\$65,064	-\$22,773	-\$42,292
100% State General Fund	\$466,933	\$466,933	\$0
100% FFP	-\$251,852	\$0	-\$251,852
Total	\$9,981,882	\$2,815,274	\$7,166,608

COVID-19 funding through December 31, 2021 identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

DESIGNATED PUBLIC HOSPITAL DIRECT GRANTS

REGULAR POLICY CHANGE NUMBER: 183
IMPLEMENTATION DATE: 5/2022
ANALYST: Elena Susbilla
FISCAL REFERENCE NUMBER: 2290

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$300,000,000	\$0
- STATE FUNDS	\$300,000,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$300,000,000	\$0
STATE FUNDS	\$300,000,000	\$0
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the General Fund (GF) available to Designated Public Hospitals (DPH).

Authority:

SB 129 (Chapter 69, Statutes of 2021)

Interdependent Policy Changes:

Not Applicable

Background:

During the COVID-19 pandemic, DPHs have been integral to the public health response effort, including their efforts to increase surge capacity, rapidly expand and deploy testing, assist in the development and distribution of vaccines, and serve vulnerable populations and communities of color.

DPHs play an essential role in the Medi-Cal program, providing care to a disproportionate share of the number of the state's most vulnerable patients, including nearly 40% of the state's uninsured and 35% of Medi-Cal patients in their communities. The strength of these essential health care systems and hospitals is of critical importance to the health and welfare of the people of California.

The Department estimates to pay direct grants to DPHs in support of their health care expenditures.

Reason for Change:

There is no change in FY 2021-22, from the prior estimate.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to no payments in FY 2022-23. Grant funding is available on a one-time basis only in FY 2021-22.

DESIGNATED PUBLIC HOSPITAL DIRECT GRANTS
REGULAR POLICY CHANGE NUMBER: 183**Methodology:**

1. Assume \$300,000,000 GF will be provided to DPHs in FY 2021-22.

(Dollars in Thousands)

Fiscal Year	TF	GF
FY 2021-22	\$300,000	\$300,000

Funding:

100% Title XIX GF (4260-101-0001)

COVID-19 VACCINE ADMINISTRATION

REGULAR POLICY CHANGE NUMBER: 184
IMPLEMENTATION DATE: 1/2021
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2259

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$348,435,000	\$155,348,000
- STATE FUNDS	\$33,746,150	\$1,450,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$348,435,000	\$155,348,000
STATE FUNDS	\$33,746,150	\$1,450,800
FEDERAL FUNDS	\$314,688,850	\$153,897,200

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)
American Rescue Plan Act (ARPA)

Interdependent Policy Changes:

COVID-19 Increased FMAP Extension

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.

On March 11, 2021, the President signed into law H.R. 1319, the American Rescue Plan Act of 2021 (ARPA). The ARPA makes coverage of COVID-19 vaccines and their administration mandatory benefits under Medicaid for the period beginning on the date of the enactment through the last day of the first calendar quarter that begins at least one year after the last day of the emergency period declared by the Secretary of Health and Human Services (HHS). In addition, as of April 1, 2021, the Federal Medicaid Assistance Percentage (FMAP) for vaccines and administration of vaccines is increased to 100 percent.

Effective March 15, 2021, CMS increased the provider reimbursement rate from \$28.39 to \$40.00 for the administration of each single dose COVID-19 vaccine and from \$45.33 to \$80.00 for the administration of COVID-19 vaccines requiring two doses.

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

COVID-19 VACCINE ADMINISTRATION

REGULAR POLICY CHANGE NUMBER: 184

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.

Reason for Change:

The change from the prior estimate for FY 2021-22 is due to:

- Estimating a decrease in the amount of vaccines administered to adults and children in FY 2021-22 based on actual data and projected remaining doses.
- A payment correction for vaccines administered by Federally Qualified Health Centers (FQHCs) is estimated in FY 2021-22.
- Booster doses for beneficiaries age 65 years and older are estimated in FY 2021-22.
- The funding adjustments to claim 100% FFP was previously assumed to be completed monthly starting May 2021. Actual funding adjustments are completed quarterly and the April to June 2021 quarter adjustment was completed in August 2021.

The change from FY 2021-22 to FY 2022-23, in the current estimate is a decrease due to:

- Fewer vaccines are estimated to be administered in FY 2022-23,
- Estimating the completion of the FQHC payment correction in FY 2021-22, and
- Fewer booster doses are expected in FY 2022-23.

Methodology:

1. Payments for COVID-19 vaccine administrations began in January 2021.
2. Assume the reimbursement rate for the COVID-19 vaccine administration is \$45.33 for each set of double-dose vaccines administered from January 1, 2021, to March 14, 2021; and \$40.00 for a single dose vaccine and \$80.00 for a set of double-dose vaccines administered on or after March 15, 2021, based on Medicare rates.
3. Assume rates paid to Federally Qualified Health Centers are based on an Alternative Payment methodology at \$67.00 per dose.
 - Assume the retroactive payment correction to FQHCs will occur by March 2022.
4. Assume vaccines administered to adults are 2.2% single doses and 97.2% double doses. Assume vaccines administered to children are 100% double doses.
5. Assume an additional booster dose will be provided to Medi-Cal beneficiaries age 65 and older starting in October 2021.
6. Assume 100% FMAP for certain expenditures from April 1, 2021, through December 31, 2022, due to the enactment of the ARPA.
7. On a cash basis, funding adjustments will occur quarterly. The April 2021 to June 2021 funding adjustment was completed in August 2021. Three quarters of the current year are adjusted in the same year, and one quarter will be adjusted in the subsequent fiscal year.

COVID-19 VACCINE ADMINISTRATION

REGULAR POLICY CHANGE NUMBER: 184

8. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through December 31, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.
9. Expenditures are reflected on a cash basis after payment lags.
10. The estimated cost for the COVID-19 vaccine administration for FY 2021-22 and FY 2022-23 on an accrual basis before payment lags is:

FY 2021-22	TF	GF	FF
COVID-19 Vaccine Administration	\$303,220,000	\$22,865,000	\$280,355,000
Total	\$303,220,000	\$22,865,000	\$280,355,000

FY 2022-23	TF	GF	FF
COVID-19 Vaccine Administration	\$131,358,000	\$12,072,000	\$119,286,000
Total	\$131,358,000	\$12,072,000	\$119,286,000

11. The estimated costs for COVID-19 vaccine administration for FY 2021-22 and FY 2022-23 on a cash basis after lags is:

FY 2021-22 (Lagged)	TF	GF	FF
COVID-19 Vaccine Administration	\$348,435,000	\$33,746,000	\$314,689,000
Total	\$348,435,000	\$33,746,000	\$314,689,000

FY 2022-23 (Lagged)	TF	GF	FF
COVID-19 Vaccine Administration	\$155,348,000	\$1,451,000	\$153,897,000
Total	\$155,348,000	\$1,451,000	\$153,897,000

COVID-19 VACCINE ADMINISTRATION

REGULAR POLICY CHANGE NUMBER: 184

Funding:

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$73,237,000	\$36,619,000	\$36,618,000
ACA 90/10 FFP (4260-101-0890)	\$25,434,000	\$2,543,000	\$22,891,000
65% Title XXI FF / 35% GF (4260-101-0890)	\$9,635,000	\$3,372,000	\$6,263,000
6.2% FFCRA Increased FMAP (4260-101-0001/0890)	\$0	(\$3,587,000)	\$3,587,000
4.34% FFCRA Increased FMAP (4260-113-0001/0890)	\$0	(\$370,000)	\$370,000
100% Title XIX FFP (4260-101- 0890)	\$246,265,000	\$0	\$246,265,000
100% Title XIX GF (4260-101- 0001)	(\$4,254,000)	(\$4,254,000)	\$0
100% Title XXI FFP (4260-113- 0890)	(\$1,305,000)	\$0	(\$1,305,000)
100% Title XXI GF (4260-113- 0001)	(\$577,000)	(\$577,000)	\$0
Total	\$348,435,000	\$33,746,000	\$314,689,000

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$1,306,000	\$653,000	\$653,000
ACA 90/10 FFP (4260-101-0890)	(\$23,508,000)	(\$2,351,000)	(\$21,157,000)
65% Title XXI FF / 35% GF (4260-101-0890)	\$8,996,000	\$3,149,000	\$5,847,000
100% Title XIX FFP (4260-101- 0890)	\$168,554,000	\$0	\$168,554,000
Total	\$155,348,000	\$1,451,000	\$153,897,000

COVID-19 FFS REIMBURSEMENT RATES

REGULAR POLICY CHANGE NUMBER: 185
IMPLEMENTATION DATE: 7/2020
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 2246

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$379,932,000	\$0
- STATE FUNDS	\$181,218,200	\$0
PAYMENT LAG	0.9963	1.0000
% REFLECTED IN BASE	8.33 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$346,995,000	\$0
STATE FUNDS	\$165,508,070	\$0
FEDERAL FUNDS	\$181,486,940	\$0

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
 State Plan Amendment (SPA) 20-0024

Interdependent Policy Changes:

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

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 (PHE) on January 31, 2020, and a national emergency on March 13, 2020. 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 and economic perspective. This will have fiscal impact across policy areas and beneficiary populations within the Medi-Cal program. The Department received federal approvals for the following programs through the State Plan Amendment (SPA) 20-0024.

- **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 AB 97 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.

COVID-19 FFS REIMBURSEMENT RATES

REGULAR POLICY CHANGE NUMBER: 185

- Long Term Care (LTC) COVID-19 Reimbursement Rate: To provide a 10% increase to facilities' total reimbursements, including add-ons and any Proposition 56 supplemental payments, effective for March 1, 2020, dates of service and through the duration of the PHE, 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 Skilled Nursing Facilities or ICFs, including Developmental Centers and Veterans Homes and any other supplemental payments or ancillary charges.

Reason for Change:

The change for FY 2021-22, from the prior estimate, is a decrease due to the assumed extension of increased rates through June 30, 2022.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to no costs budgeted consistent with the assumption that the PHE ends June 30, 2022.

Methodology:

1. Assume the PHE period ends June 30, 2022.
2. The estimated FY 2021-22 costs for the clinical lab and LTC reimbursement rate increases are as follows:

COVID-19 FFS REIMBURSEMENT RATES

REGULAR POLICY CHANGE NUMBER: 185

FY 2021-22	TF
LTC COVID Reimbursement	
DP/NF-B	\$21,590,000
Rural Swing Bed	\$111,000
NF-A	\$228,000
DP/SA	\$12,726,000
ICF/DDs	\$43,293,000
AB 1629	\$191,683,000
FS/PSA	\$4,510,000
DP/PSA	\$4,690,000
LTC COVID Reimbursement Total	\$278,831,000
Clinical Lab COVID Reimbursement	
Diagnostic Testing Cost	\$52,541,000
Antibody Testing Cost	\$37,189,000
Specimen Collection Cost	\$11,371,000
Clinical Lab COVID Reimbursement Total	\$101,101,000
TOTAL	\$379,932,000

Funding:

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	\$357,710,000	\$178,855,000	\$178,855,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	\$21,658,000	\$2,166,000	\$19,492,000
65% Title XXI / 35% GF (4260-113-0001 / 0890)	\$564,000	\$197,000	\$367,000
Total	\$379,932,000	\$181,218,000	\$198,714,000

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

COVID-19 BEHAVIORAL HEALTH

REGULAR POLICY CHANGE NUMBER: 186
IMPLEMENTATION DATE: 7/2020
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2215

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$274,809,000	\$10,351,000
- STATE FUNDS	\$17,656,750	\$1,534,350
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$274,809,000	\$10,351,000
STATE FUNDS	\$17,656,750	\$1,534,350
FEDERAL FUNDS	\$257,152,250	\$8,816,650

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:

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

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 (PHE) on January 31, 2020, and a national emergency on March 13, 2020. The PHE was last extended to June 30, 2022 and will be effective until then 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, which provides increased federal funding in Medicaid and creates new options for states to address the COVID-19 pandemic.

Due to COVID-19, there has been a significant decrease in utilization with certain Specialty Mental Health Services (SMHS) and Drug Medi-Cal (DMC) (non-Narcotic Treatment Program (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 PHE ends, the Department implemented the following changes to the reimbursement rates.

COVID-19 BEHAVIORAL HEALTH

REGULAR POLICY CHANGE NUMBER: 186

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, 2020 until the end of the COVID-19 public health emergency, the Department provides interim reimbursement equal to the lower of the county's CPE or the county interim rate increased by 100%.

Drug Medi-Cal:

For non-NTP outpatient services in 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 provides 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 provides 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.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is an increase due to the following:

- Six months extension of the PHE through June 30, 2022, and
- Higher utilization of the increased interim rates by counties for SMHS, DMC State Plan and DMC-ODS Waiver.

The change in the current estimate, from FY 2021-22 to FY 2022-23, is due to the PHE ending on June 30, 2022, and FY 2022-23 including only payment lag costs.

Methodology:

1. Interim rate increases 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.

COVID-19 BEHAVIORAL HEALTH

REGULAR POLICY CHANGE NUMBER: 186

3. For SMHS, assume 99% of claims will be paid in the first year, and 1% 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.
4. Total cost for SMHS, DMC State Plan, and DMC ODS are as follows:

FY 2021-22	TF	GF	FF	CF
SMHS Interim Rate – Adult	\$225,809,000	\$8,818,000	\$148,177,000	\$68,814,000
SMHS Interim Rate - Children	\$164,342,000	\$3,469,000	\$85,885,000	\$74,988,000
Non-NTP DMC State Plan Interim Rate	\$439,000	\$22,000	\$307,000	\$110,000
Non-NTP DMC-ODS Interim Rate	\$30,553,000	\$5,348,000	\$22,783,000	\$2,422,000
Total	\$421,143,000	\$17,657,000	\$257,152,000	\$146,334,000

FY 2022-23	TF	GF	FF	CF
SMHS Interim Rate – Adult	\$3,387,000	\$135,000	\$2,235,000	\$1,017,000
SMHS Interim Rate - Children	\$1,315,000	\$29,000	\$688,000	\$598,000
Non-NTP DMC State Plan Interim Rate	\$109,000	\$5,000	\$77,000	\$27,000
Non-NTP DMC-ODS Interim Rate	\$7,801,000	\$1,365,000	\$5,817,000	\$619,000
Total	\$12,612,000	\$1,534,000	\$8,817,000	\$2,261,000

Funding:

100% GF (4260-101-0001)

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

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

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

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

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

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

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

COVID-19 FFS DME RESPIRATORY RATES

REGULAR POLICY CHANGE NUMBER: 187
IMPLEMENTATION DATE: 6/2020
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 2265

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$35,203,000	\$0
- STATE FUNDS	\$16,453,250	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.67 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$34,967,100	\$0
STATE FUNDS	\$16,343,010	\$0
FEDERAL FUNDS	\$18,624,130	\$0

Purpose:

This policy change estimates the payments to increase reimbursement rates for DME oxygen and respiratory equipment to 100 percent of the corresponding Medicare rate and exempt these codes from the ten percent payment reduction authorized by Assembly Bill (AB 97) (Chapter 3, Statutes of 2011) for the duration of the public health emergency (PHE).

Authority:

Welfare & Institutions Code 14105.48
SPA 21-0016

Interdependent Policy Changes:

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

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. 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.

Reimbursement rates for DME oxygen and respiratory equipment are currently limited to 80 percent of the Medicare rate and subject to a ten percent payment reduction, as required by AB 97.

During the PHE, the Department was informed by multiple entities that limitations on supplies of oxygen and respiratory equipment have caused significant challenges in providing necessary access to care for Medi-Cal beneficiaries and result in the inability of patients to be discharged from hospitals or long term care facilities to their homes.

COVID-19 FFS DME RESPIRATORY RATES

REGULAR POLICY CHANGE NUMBER: 187

On March 26, 2021, the Centers for Medicare and Medicaid Services approved SPA 21-0016 to retroactively increase reimbursement rates for oxygen and respiratory equipment to 100 percent of the Medicare rate, in an effort to increase access to these services for Medi-Cal beneficiaries, effective March 1, 2020.

Reason for Change:

The change from the prior estimate for FY 2021-22 is an increase due to additional codes that were identified as well as the assumed extension of impacts through June 30, 2022.

The change in the current estimate from FY 2021-22 to FY 2022-23 is a decrease as no additional payments are expected to be made in FY 2022-23, consistent with the assumption that the PHE ends June 30, 2022.

Methodology:

1. This policy is effective March 1, 2020.
2. Upon SPA approval, certain oxygen and respiratory equipment were identified as eligible for the temporary increased rate. The rate update based on codes initially identified is estimated to be \$2,830,000 TF annually and was implemented June 21, 2021. The Erroneous Payment Correction (EPC) for the period of March 2020 through June 21, 2021 occurred in September 2021.
3. Following the initial rate update an additional 16 codes were identified as being eligible. The rate update based on additional codes is estimated to be \$12,257,000 TF annually and was implemented in September 2021. The EPC for the period of March 2020 through August 2021 is estimated to occur in December 2021.
3. The FFS costs are estimated to be:

FY 2021-22	TF
Initially Identified Codes	\$2,830,000
Additional Codes	\$10,214,000
Initially Identified Codes EPC	\$3,774,000
Additional Codes EPC	\$18,385,000
Total	\$35,203,000

COVID-19 FFS DME RESPIRATORY RATES

REGULAR POLICY CHANGE NUMBER: 187

Funding:

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	\$30,253,000	\$15,127,000	\$15,126,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	\$1,623,000	\$162,000	\$1,461,000
65% Title XXI / 35% GF (4260-113-0001 / 0890)	\$3,327,000	\$1,164,000	\$2,163,000
Total	\$35,203,000	\$16,453,000	\$18,750,000

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

COVID-19 - SICK LEAVE BENEFITS

REGULAR POLICY CHANGE NUMBER: 188
IMPLEMENTATION DATE: 7/2021
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2233

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$7,249,000	\$0
- STATE FUNDS	\$50,500	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$7,249,000	\$0
STATE FUNDS	\$50,500	\$0
FEDERAL FUNDS	\$7,198,500	\$0

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:

Senate Bill (SB) 95
 American Rescue Plan Act of 2021 (ARP)
 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 (PHE) on January 31, 2020, and a national emergency on March 13, 2020. The PHE is still ongoing, as of January 2021, but mandatory COVID-19 paid sick leave benefits ended on December 31, 2020. Discretionary COVID-19 paid sick leave is allowed until September 30, 2021, and the California Department of Social Services (CDSS) requested that this benefit be extended until that date. 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 PHE 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

COVID-19 - SICK LEAVE BENEFITS

REGULAR POLICY CHANGE NUMBER: 188

emergency sick leave, in certain situations, when it is specifically related to the COVID-19 PHE. As a result of SB 95 and the ARP, these emergency sick leave benefits have been extended through September 30, 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 PHE. National public health emergencies are effective for 90 days unless extended or terminated.

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:

The change from the prior estimate, for FY 2021-22, is a decrease due to updated CDSS actuals. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to the PHE benefits ending in September 2021.

Methodology:

1. Assume the COVID-19 sick leave benefits continue through September 30, 2021, or the end of the PHE, whichever is sooner.
2. Assume the 6.2% Title XIX FFCRA increased FMAP is for expenditures through September 30, 2021, or the end of the PHE, whichever is sooner.
3. CDSS 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 through September 30, 2021:

FY 2021-22	TF	GF	FF
WPCS Sick Leave Benefits	\$115,000	\$58,000	\$57,000
IHSS Sick Leave Benefits	\$7,134,000	\$0	\$7,134,000
FFCRA 6.2% Increased FFP	\$0	(\$7,000)	\$7,000
Total	\$7,249,000	\$51,000	\$7,198,000

*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 ELIGIBILITY

REGULAR POLICY CHANGE NUMBER: 189
IMPLEMENTATION DATE: 7/2020
ANALYST: Kalandie Coleman
FISCAL REFERENCE NUMBER: 2211

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$187,018,000	\$0
- STATE FUNDS	\$46,126,000	\$0
PAYMENT LAG	0.8543	1.0000
% REFLECTED IN BASE	98.02 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,163,400	\$0
STATE FUNDS	\$780,230	\$0
FEDERAL FUNDS	\$2,383,210	\$0

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
 American Rescue Plan (ARP) Act (2021)

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 (PHE) on January 31, 2020, and a national emergency on March 13, 2020. The federal COVID-19 PHE was last extended to December 31, 2021, and will be effective until then 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 PHE and economic perspective. This will have fiscal impact across policy areas and beneficiary populations within the Medi-Cal program.

The Department 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

COVID-19 ELIGIBILITY

REGULAR POLICY CHANGE NUMBER: 189

necessary care such as the associated office, clinic, or emergency room visits related to COVID-19 at no cost to the individuals:

- 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. The ARP dated March 11, 2021, required COVID-19 vaccine to be an included benefit under the COVID-19 Uninsured Eligibility Group. Claiming for the administration of the COVID-19 vaccine is now available for the COVID-19 Uninsured Group at 100% FF. California must submit a State Plan Amendment to add vaccine administration reimbursement as a covered benefit under this coverage group.
- 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.

Reason for Change:

The change for FY 2021-22, from the prior estimate, is an increase due to updated actual expenditures, an increase in users in the uninsured and HPE expansion groups, and a PHE end date extension to June 30, 2022. The change for FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due the PHE ending in FY 2021-22.

Methodology:

1. Assume the PHE period will continue through June 30, 2022.
2. Assume 100% GF Funding for Treatment Services and 100% FF Funding for Testing and Testing-Related Services:

(Dollar in Thousands)

FY 2021-22 Service Type	TF	GF	FF
Treatment Services	\$46,126	\$46,126	\$0
Testing and Testing-Related Services	\$140,892	\$0	\$140,892
Total	\$187,018	\$46,126	\$140,892

3. The Department estimates the following Medi-Cal program costs as a result of the COVID-19:

COVID-19 ELIGIBILITY
REGULAR POLICY CHANGE NUMBER: 189

(Dollar in Thousands)

FY 2021-22	TF	GF	FF
COVID-19 Uninsured Eligibility	\$116,859	\$11,046	\$105,813
COVID-19 HPE Expansion	\$70,159	\$35,080	\$35,079
Total	\$187,018	\$46,126	\$140,892

*Totals may differ due to rounding.

Funding:

100% GF (4260-101-0001)

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

COVID-19 TESTING IN SCHOOLS

REGULAR POLICY CHANGE NUMBER: 190
IMPLEMENTATION DATE: 7/2022
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 2272

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$404,591,000
- STATE FUNDS	\$0	\$102,449,150
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$404,591,000
STATE FUNDS	\$0	\$102,449,150
FEDERAL FUNDS	\$0	\$302,141,850

Purpose:

This policy change estimates the cost to provide COVID-19 testing in a school setting through the fee-for-service (FFS) delivery system and Local Educational Agency Billing Option Program.

Authority:

Coronavirus Aid, Relief, and Economic Security (CARES) Act
 California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)

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. 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.

Given the unprecedented nature of the ongoing COVID-19 public health emergency, California requested through the section 1115 federal demonstration authority to carve-out COVID-19 tests for children specifically in a school setting and allow a provider in that setting to directly bill Medi-Cal through the Fee-for-Service delivery system. This request, through the federal Centers for Medicare and Medicaid Services (CMS), has been approved retroactively to February 1, 2021 and will last 60 days past the federal public health emergency.

Following CMS approval of the carve-out, on August 30, 2021, CMS issued State Health Official letter 21-003 which clarified that schools rendering school-based services covered by Medicaid and reimbursed via a certified public expenditure methodology can use the cost report process to obtain reimbursement for COVID-19 testing. This guidance applies to California's Local Educational Agency Billing Option Program and provides an additional path for local educational agencies to seek federal reimbursement for testing.

COVID-19 TESTING IN SCHOOLS

REGULAR POLICY CHANGE NUMBER: 190

Reason for Change:

Since the enactment of the FY 2021-22 Budget Act, schools have utilized direct federal funding to cover the costs of COVID-19 testing, resulting in insignificant claiming to Medi-Cal. The change in FY 2021-22, from the prior estimate, is based on the assumption that schools will continue to use direct federal funding to support testing through June 2022. Medi-Cal payments are expected to start in FY 2022-23 after direct federal funding to schools is assumed to be exhausted.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to payments starting in FY 2022-23. The FY 2022-23 estimate is based on updated utilization assumptions and also assumes that a portion of tests will be reimbursed through the Local Educational Agency Billing Option Program.

Methodology:

1. Assume schools will utilize direct federal funding to pay for tests through June 2022. Medi-Cal costs are expected to start July 2022.
2. Assume 1,780,173 monthly tests. Of the total monthly tests, assume 684,000 are through the state contracted Valencia Branch Laboratory. The remaining tests are estimated to be processed through the Local Educational Agency Billing Option Program or non-Valencia Branch Laboratories.
3. Assume tests performed by the state contracted Valencia Branch Laboratory cost \$21.00 per test.
4. Assume the cost per test for non-Valencia Branch Laboratory tests is \$72.14.
5. Assume testing phases down quarterly and continues through June 2023.
6. The costs on an accrual basis for FY 2022-23 are estimated to be:

(Dollars in Thousands)

ANNUAL	TF	GF	FF
COVID-19 Testing in Schools	\$473,589	\$116,565	\$357,024
FY 2022-23	\$473,589	\$116,565	\$357,024

7. The cash basis estimates for FY 2022-23 in this policy change are:

(Dollars in Thousands)

Cash Basis (Lagged)	TF	GF	FF
COVID-19 Testing in Schools	\$404,591	\$102,449	\$302,142
FY 2022-23	\$404,591	\$102,449	\$302,142

COVID-19 TESTING IN SCHOOLS
REGULAR POLICY CHANGE NUMBER: 190

Funding:

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

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

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

CONTINUOUS CHIP COVERAGE DURING THE COVID-19 PHE

REGULAR POLICY CHANGE NUMBER: 191
IMPLEMENTATION DATE: 7/2021
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2301

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$39,794,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$39,794,000	\$0
FEDERAL FUNDS	-\$39,794,000	\$0

Purpose:

The purpose of this policy change is to estimate the State General Fund impact to provide continuous coverage to individuals enrolled in the state's Title XXI children's health insurance programs during the full duration of the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE).

Authority:

SB 129 (Chapter 69, Statutes of 2021)
SPA 21-032

Interdependent Policy Changes:

Not Applicable

Background:

The Centers for Medicare and Medicaid Services issued guidance which allowed individuals enrolled in Medicaid to remain in coverage for the duration of the COVID-19 PHE, excluding CHIP populations. To prevent coverage disparities from federal policies as it relates to Medicaid and CHIP populations, the Department issued guidance to maintain continuous coverage for individuals enrolled in the Medi-Cal Access Program (MCAP), Medi-Cal Access for Infants Program (MCAIP), and the County Children Health Initiative Program (CCHIP) during the COVID-19 PHE.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is an increase due to incorporating a retroactive component for periods prior to July 2021 during the PHE and due to extending the assumed PHE end date to June 30, 2022. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease as payments are expected to be complete by the end of FY 2021-22.

Methodology:

1. Assume continuous coverage through the PHE for the MCAP, MCAIP, and CCHIP populations.
2. Assume the PHE ends on June 30, 2022.

CONTINUOUS CHIP COVERAGE DURING THE COVID-19 PHE
REGULAR POLICY CHANGE NUMBER: 191

3. Assume the retroactive payment will occur in FY 2021-22 after the PHE ends.

(Dollars in Thousands)

Fiscal Years	TF	GF	FF
FY 2021-22	\$0	\$39,794	(\$39,794)

Funding:

100% Title XXI GF (4260-113-0001)

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

COVID-19 BASE RECOVERIES

REGULAR POLICY CHANGE NUMBER: 192
IMPLEMENTATION DATE: 7/2020
ANALYST: Celine Donaldson
FISCAL REFERENCE NUMBER: 2243

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$14,026,000	\$0
- STATE FUNDS	-\$5,905,550	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$14,026,000	\$0
STATE FUNDS	-\$5,905,550	\$0
FEDERAL FUNDS	-\$8,120,450	\$0

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

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 December 31, 2021 and will be effective until then 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 Personal Injury and Medi-Cal Provider recoveries resulting from the economic impact of the public health emergency. The Department has experienced decreases in new personal injury case filings 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: 192

In the May 2021 estimate, the Base Recoveries policy change reflected increased savings in FY 2020-21 for planned additional other health insurance recovery efforts related to 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 backed out the FY 2020-21 increase in recoveries due to operational delays in implementation resulting from the stay-at-home order and the public health emergency. These recoveries have shifted into FY 2021-22 increasing recoveries beyond what would have happened without the public health emergency. The resumption of additional dental and Managed Care plans other health insurance recovery efforts are expected in FY 2021-22.

Reason for Change:

Additional other health insurance recovery efforts are projected to increase in FY 2021-22 due to the inclusion additional prior year collections for Managed Care plans.

The impact of COVID-19 on recoveries is not expected to continue into FY 2022-23.

Methodology:

- Actual COVID-19 recovery impacts that are captured in the Base Recoveries data are approximately \$23.8 million total fund in FY 2021-22.
- The Department estimates the impacts on the following recovery efforts as a result of the COVID-19:

(Dollars in Thousands)

Recovery Type	FY 2021-22
Medi-Cal Provider Collections	\$29,357
Personal Injury Collections	\$27,815
Health Insurance Recoveries	(\$47,400)
Recoveries Subtotal	\$9,772
Actual COVID-19 recovery impacts in the Base Recoveries policy change	\$(23,798)
TOTAL	(\$14,026)

Funding:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	(\$11,257)	(\$5,629)	(\$5,629)
Title XIX 65 FF / 35 GF (4260-101-0890/0001)	(\$155)	(\$54)	(\$101)
Title XIX FFP (4260-101-0890)	(\$386)	\$0	(\$386)
90% Title XIX ACA FF / 6% GF (4260-101-0890/0001)	(\$2,228)	(\$223)	(\$2,005)
TOTAL	(\$14,026)	(\$5,906)	(\$8,120)

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 INCREASED FMAP - DHCS

REGULAR POLICY CHANGE NUMBER: 194
IMPLEMENTATION DATE: 7/2021
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2217

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$120,408,000	\$0
- STATE FUNDS	-\$2,144,056,000	\$6,764,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$120,408,000	\$0
STATE FUNDS	-\$2,144,056,000	\$6,764,000
FEDERAL FUNDS	\$2,023,648,000	-\$6,764,000

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 December 2021. For the estimated impact of assuming increased FMAP from January 2020 through December 2021 on administrative expenditures, see the COVID-19 Increased FMAP – Other Admin policy change.

Authority:

Families First Coronavirus Response Act (FFCRA)
 Coronavirus Aid, Relief, and Economic Security (CARES) Act

Interdependent Policy Changes:

COVID-19 Increased FMAP Extension
 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. 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: 194

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:

For dollars budgeted in this policy change, there is a decrease in general fund savings from the prior estimate for FY 2021-22 due to policy change updates. There is a decrease in general fund savings from FY 2021-22 to FY 2022-23 due to policy change updates 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 December 31, 2021, in this policy change.
6. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022, on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension 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: 194

(Dollars in Thousands)

FY 2021-22	TF	GF	SF	FF
COVID-19 Increased FMAP - DHCS:				
FFCRA 6.20% Increased FFP	\$0	(\$1,922,148)	\$0	\$1,922,148
FFCRA 4.34% Increased FFP	\$0	(\$95,062)	\$0	\$95,062
BCCTP 4.34% Increased FFP	\$0	(\$15)	\$0	\$15
Medicare Part D FFCRA 6.20% Incr. FFP	(\$126,670)	(\$126,670)	\$0	\$0
Behavioral Health FFCRA 6.20% Incr. FFP	\$5,840	(\$160)	\$0	\$6,001
Behavioral Health FFCRA 4.34% Incr. FFP	\$422	(\$1)	\$0	\$423
Total COVID-19 Incr. FMAP - Regular:	(\$120,408)	(\$2,144,056)	\$0	\$2,023,649
COVID-19 Increased FMAP - Other Admin:				
FFCRA 4.34% Increased FFP	\$0	(\$1,625)	\$0	\$1,625
Total COVID-19 Incr. FMAP - Other Admin:	\$0	(\$1,625)	\$0	\$1,625
COVID-19 Increased FMAP In other PCs:				
FFCRA 6.20% Increased FFP	\$755,301	(\$136,373)	(\$284,904)	\$1,176,577
FFCRA 4.34% Increased FFP	\$10,167	(\$13,813)	(\$6,789)	\$30,769
FFCRA 4.34% Incr. FFP - Other Admin	\$0	\$0	\$0	\$0
Medicare Part D FFCRA 6.20% Incr. FFP	(\$78,639)	(\$78,639)	\$0	\$0
Total COVID-19 Incr. FMAP In other PCs:	\$686,829	(\$228,825)	(\$291,693)	\$1,207,346
COVID-19 Increased FMAP Extension PC:				
FFCRA 6.20% Increased FFP	(\$25,309)	(\$1,197,394)	\$0	\$1,172,085
FFCRA 4.34% Increased FFP	(\$5,030)	(\$49,757)	\$0	\$44,727
BCCTP 4.34% Increased FFP	\$0	(\$12)	\$0	\$12
Medicare Part D FFCRA 6.20% Incr. FFP	(\$109,571)	(\$109,571)	\$0	\$0
FFCRA Special Funds Increased FMAP	\$98,339	(\$435)	(\$63,493)	\$162,267
Other Departments 6.20% Increased FFP	\$640,140	(\$1,597)	\$0	\$641,737
Prop 56 FFCRA 6.20% Increased FFP	\$0	\$0	(\$33,998)	\$33,998
Prop 56 FFCRA 4.34% Increased FFP	\$0	\$0	(\$4,767)	\$4,767
Total COVID-19 Increased FMAP Extension PC:	\$598,569	(\$1,358,766)	(\$102,258)	\$2,059,593
Total COVID-19 Increased FMAP Extension - Other Admin PC:	\$0	(\$737)	\$0	\$737
Total of PCs including COVID-19 Increased FMAP	\$1,164,990	(\$3,734,009)	(\$393,951)	\$5,292,950

*Totals may differ due to rounding.

COVID-19 INCREASED FMAP - DHCS
REGULAR POLICY CHANGE NUMBER: 194

(Dollars in Thousands)

FY 2022-23	TF	GF	SF	FF
COVID-19 Increased FMAP - DHCS:				
FFCRA 6.20% Increased FFP	\$0	\$6,764	\$0	(\$6,764)
FFCRA 4.34% Increased FFP	\$0	\$0	\$0	\$0
BCCTP 4.34% Increased FFP	\$0	\$0	\$0	\$0
Medicare Part D FFCRA 6.20% Increased FFP	\$0	\$0	\$0	\$0
Behavioral Health FFCRA 6.20% Incr. FFP	\$0	\$0	\$0	\$0
Behavioral Health FFCRA 4.34% Incr. FFP	\$0	\$0	\$0	\$0
Total COVID-19 Incr. FMAP - Regular:	\$0	\$6,764	\$0	(\$6,764)
COVID-19 Increased FMAP - Other Admin:				
FFCRA 4.34% Increased FFP	\$0	\$0	\$0	\$0
Total COVID-19 Incr. FMAP - Other Admin:	\$0	\$0	\$0	\$0
COVID-19 Increased FMAP In other PCs:				
FFCRA 6.20% Increased FFP	\$483,933	(\$154,115)	(\$110,732)	\$748,780
FFCRA 4.34% Increased FFP	\$0	(\$8,794)	(\$6,864)	\$15,658
FFCRA 4.34% Incr. FFP - Other Admin	\$0	\$0	\$0	\$0
Medicare Part D FFCRA 6.20% Incr. FFP	\$0	\$0	\$0	\$0
Total COVID-19 Incr. FMAP In other PCs:	\$483,933	(\$162,909)	(\$117,596)	\$764,438
COVID-19 Increased FMAP Extension PC:				
FFCRA 6.20% Increased FFP	\$18,423	(\$496,438)	\$0	\$514,861
FFCRA 4.34% Increased FFP	\$0	(\$29,711)	\$0	\$29,711
BCCTP 4.34% Increased FFP	\$0	\$0	\$0	\$0
Medicare Part D FFCRA 6.20% Incr. FFP	(\$55,058)	(\$55,058)	\$0	\$0
FFCRA Special Funds Increased FMAP	(\$1,201)	\$97,136	(\$296,362)	\$198,025
Other Departments 6.20% Increased FFP	\$54,180	\$0	\$0	\$54,180
Prop 56 FFCRA 6.20% Increased FFP	\$0	\$0	(\$8,391)	\$8,391
Prop 56 FFCRA 4.34% Increased FFP	\$0	\$0	(\$778)	\$778
Total COVID-19 Increased FMAP Extension PC:	\$16,344	(\$484,071)	(\$305,531)	\$805,946
Total COVID-19 Increased FMAP Extension - Other Admin PC:	\$0	(\$369)	\$0	\$369
Total of PCs including COVID-19 Increased FMAP	\$500,277	(\$640,585)	(\$423,127)	\$1,563,989

*Totals may differ due to rounding.

COVID-19 INCREASED FMAP - DHCS
REGULAR POLICY CHANGE NUMBER: 194

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)

STATE ONLY CLAIMING ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 195
IMPLEMENTATION DATE: 1/2021
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2210

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$13,371,000	\$128,643,000
- STATE FUNDS	\$713,765,000	\$1,526,481,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$13,371,000	\$128,643,000
STATE FUNDS	\$713,765,000	\$1,526,481,000
FEDERAL FUNDS	-\$727,136,000	-\$1,397,838,000

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, Medi-Cal Administrative Activities (MAA), Local Education Agency (LEA) services, 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.

Authority:

Not Applicable

Interdependent Policy Changes:

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

REGULAR POLICY CHANGE NUMBER: 195

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

CMS has issued a deferral for the state only claiming issue, for the Federal Fiscal Year (FFY) 2020 Quarter 1 through Quarter 4; and FFY 2021 Quarter 1 through 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 2021-22, from the prior estimate, is due to:

- Managed Care (MC) and Immigration Status Change (ISC) - is an increase due to higher prospective MC costs and lower prospective ISC savings. The changes are due to updated CMS direction applicable beginning July 2019.
- Dental retroactive repayments were delayed and shifted to be paid in FY 2021-22. Dental prospective impacts were updated.
- Prospective impacts for MAA and LEA services have been added to this policy change.
- Targeted Case Management services are now reflected the TCM base payments and no longer in this policy change.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to:

- Managed Care (MC) – an increase due to new retroactive MC costs being included in FY 2022-23 and reduced managed care expenditures overall following the implementation of Medi-Cal Rx as of January 1, 2022.
- Immigration Status Change (ISC) - Lower estimate for the underclaiming related to immigration status change.
- Pharmacy rebate retroactive repayments are estimated to be completed in FY 2022-23 and are lower than FY 2021-22. Prospective rebate impacts are included in FY 2022-23.
- Prospective impacts for pharmacy claims increased due to including a full year impact in FY 2022-23.
- Dental retroactive payments are estimated to be completed in FY 2021-22 and only prospective impacts are now in FY 2022-23.

Methodology:

Retroactive FFP Adjustments

1. Federal repayments are estimated for Managed Care, Pharmacy Rebates, Dental Fee-for-Service (FFS), and Dental Managed Care.
2. Estimates of FFP repayments for Pharmacy Rebates cover claims from May 2016 to September 2021.
3. Estimates of FFP repayments for Dental FFS and Dental Managed Care cover claims from January 2010 through December 2020.

STATE ONLY CLAIMING ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 195

4. The estimated repayments are:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF	CF*
SMHS	\$0	\$0	\$0	\$0
Drug Medi-Cal	\$0	\$0	\$0	\$0
Subtotal (In PC 196)	\$0	\$0	\$0	\$0
Managed Care	\$0	\$0	\$0	\$0
Pharmacy	\$0	\$71,284	(\$71,284)	\$0
Dental FFS and Managed Care	\$0	\$190,258	(\$190,258)	\$0
Immigration Status Change	\$0	\$0	\$0	\$0
MAA	\$0	\$0	\$0	\$0
LEA	\$0	\$0	\$0	\$0
Subtotal (In PC 195)	\$0	\$261,542	(\$261,542)	\$0
Grand Total	\$0	\$261,542	(\$261,542)	\$0

*County Funds are not included in Total Funds

(Dollars in Thousands)

FY 2022-23	TF	GF	FF	CF*
SMHS	\$0	\$0	\$0	\$0
Drug Medi-Cal	\$0	\$0	\$0	\$0
Subtotal (In PC 196)	\$0	\$0	\$0	\$0
Managed Care	\$0	\$1,019,096	(\$1,019,096)	\$0
Pharmacy	\$0	\$84	(\$84)	\$0
Dental FFS and Managed Care	\$0	\$0	\$0	\$0
Immigration Status Change	\$0	\$0	\$0	\$0
Subtotal (In PC 195)	\$0	\$1,019,180	(\$1,019,180)	\$0
Grand Total	\$0	\$1,019,180	(\$1,019,180)	\$0

*County Funds are not included in Total Funds

Prospective Adjustments

5. Prospective adjustments are estimated for Managed Care, Pharmacy Rebates, Pharmacy Claims, Dental FFS, Dental Managed Care, Immigration Status Change, MAA, and LEA services.

STATE ONLY CLAIMING ADJUSTMENTS
REGULAR POLICY CHANGE NUMBER: 195

(Dollars in Thousands)

FY 2021-22	TF	GF	FF	CF*
SMHS	(\$5,745)	\$13,022	(\$18,767)	\$5,745
Drug Medi-Cal	(\$275)	\$1,454	(\$1,729)	\$275
Subtotal (In PC 196)	(\$6,020)	\$14,476	(\$20,496)	\$6,020
Managed Care	\$0	\$485,491	(\$485,491)	\$0
Pharmacy Rebates	\$0	\$0	\$0	\$0
Pharmacy Claims	\$0	\$72,497	(\$72,497)	\$0
Dental FFS and Managed Care	\$0	\$46,577	(\$46,577)	\$0
Immigration Status Change	\$0	(\$152,942)	\$152,942	\$0
MAA	(\$13,371)	\$0	(\$13,371)	\$0
LEA	\$0	\$600	(\$600)	\$0
Subtotal (In PC 195)	(\$13,371)	\$452,223	(\$465,594)	\$0
Grand Total	(\$19,391)	\$466,699	(\$486,090)	\$6,020

*County Funds are not included in Total Funds

(Dollars in Thousands)

FY 2022-23	TF	GF	FF	CF*
SMHS	(\$5,745)	\$13,022	(\$18,767)	\$5,745
Drug Medi-Cal	(\$275)	\$1,454	(\$1,729)	\$275
Subtotal (In PC 196)	(\$6,020)	\$14,476	(\$20,496)	\$6,020
Managed Care	\$0	\$441,677	(\$441,677)	\$0
Pharmacy Rebates	\$142,014	\$44,732	\$97,282	\$0
Pharmacy Claims	\$0	\$112,198	(\$112,198)	\$0
Dental FFS and Managed Care	\$0	\$46,761	(\$46,761)	\$0
Immigration Status Change	\$0	(\$138,667)	\$138,667	\$0
MAA	(\$13,371)	\$0	(\$13,371)	\$0
LEA	\$0	\$600	(\$600)	\$0
Subtotal (In PC 195)	\$128,643	\$507,301	(\$378,658)	\$0
Grand Total	\$122,623	\$521,777	(\$399,154)	\$6,020

*County Funds are not included in Total Funds

STATE ONLY CLAIMING ADJUSTMENTS
REGULAR POLICY CHANGE NUMBER: 195

6. Total federal repayments and prospective adjustments are estimated to be:

(Dollars In Thousands)	TF	GF	FF	CF*
SMHS and DMC (PC 196)	(\$6,020)	\$14,476	(\$20,496)	\$6,020
MC, Pharmacy, Dental, Immigration, MAA, LEA (PC 195)	(\$13,371)	\$713,765	(\$727,136)	\$0
FY 2021-22	(\$19,391)	\$728,241	(\$747,632)	\$6,020

*County Funds are not included in Total Funds

(Dollars In Thousands)	TF	GF	FF	CF*
SMHS and DMC (PC 196)	(\$6,020)	\$14,476	(\$20,496)	\$6,020
MC, Pharmacy, Dental, Immigration, MAA, LEA (PC 195)	\$128,643	\$1,526,481	(\$1,397,838)	\$0
FY 2022-23	\$122,623	\$1,540,957	(\$1,418,334)	\$6,020

*County Funds are not included in Total Funds

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 - SMHS and DMC

REGULAR POLICY CHANGE NUMBER: 196
IMPLEMENTATION DATE: 9/2020
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2198

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$6,020,000	-\$6,020,000
- STATE FUNDS	\$14,476,000	\$14,476,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$6,020,000	-\$6,020,000
STATE FUNDS	\$14,476,000	\$14,476,000
FEDERAL FUNDS	-\$20,496,000	-\$20,496,000

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, Medi-Cal Administrative Activities (MAA), Local Education Agency (LEA) services, and Immigration Status Change, see the State Only Claiming Adjustments policy change.

Authority:

Not Applicable

Interdependent Policy Changes:

State Only Claiming Adjustments

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 has estimated the FFP amounts subject to repayment that must be retroactively returned and updates to associated claiming methodologies for prospective use.

STATE ONLY CLAIMING ADJUSTMENTS - SMHS and DMC

REGULAR POLICY CHANGE NUMBER: 196

CMS Deferral

CMS has issued deferrals for the state only claiming issue, for the Federal Fiscal Year (FFY) 2020 Quarter 1 through Quarter 4; and FFY 2021 Quarter 1 through 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 2021-22, from the prior estimate, is due to updated prospective estimates for SMHS and Drug Medi-Cal.

There is no change from FY 2021-22 to FY 2022-23 in the current estimate.

Methodology:

Retroactive FFP Repayments

1. Federal repayments for amounts in this policy change began in September 2020.
2. Federal repayments of \$123.2 million for Specialty Mental Health Services (SMHS) and Drug Medi-Cal (DMC) programs were completed in FY 2020-21. Of the \$123.2 million, \$61 million is General Fund and \$62.2 million is assumed to be recouped from counties.

(Dollars in Thousands)

FY 2021-22	TF	GF	FF	CF*
SMHS	\$0	\$0	\$0	\$0
Drug Medi-Cal	\$0	\$0	\$0	\$0
Subtotal (In PC 196)	\$0	\$0	\$0	\$0
Managed Care	\$0	\$0	\$0	\$0
Pharmacy	\$0	\$71,284	(\$71,284)	\$0
Dental FFS and Managed Care	\$0	\$190,258	(\$190,258)	\$0
Immigration Status Change	\$0	\$0	\$0	\$0
MAA	\$0	\$0	\$0	\$0
LEA	\$0	\$0	\$0	\$0
Subtotal (In PC 195)	\$0	\$261,542	(\$261,542)	\$0
Grand Total	\$0	\$261,542	(\$261,542)	\$0

*County Funds are not included in Total Funds

STATE ONLY CLAIMING ADJUSTMENTS - SMHS and DMC
REGULAR POLICY CHANGE NUMBER: 196

(Dollars in Thousands)

FY 2022-23	TF	GF	FF	CF*
SMHS	\$0	\$0	\$0	\$0
Drug Medi-Cal	\$0	\$0	\$0	\$0
Subtotal (In PC 196)	\$0	\$0	\$0	\$0
Managed Care	\$0	\$1,019,096	(\$1,019,096)	\$0
Pharmacy	\$0	\$84	(\$84)	\$0
Dental FFS and Managed Care	\$0	\$0	\$0	\$0
Immigration Status Change	\$0	\$0	\$0	\$0
Subtotal (In PC 195)	\$0	\$1,019,180	(\$1,019,180)	\$0
Grand Total	\$0	\$1,019,180	(\$1,019,180)	\$0

*County Funds are not included in Total Funds

Prospective Adjustments

3. Prospective impacts are estimated for SMHS and Drug Medi-Cal in FY 2021-22 and FY 2022-23.

(Dollars in Thousands)

FY 2021-22	TF	GF	FF	CF*
SMHS	(\$5,745)	\$13,022	(\$18,767)	\$5,745
Drug Medi-Cal	(\$275)	\$1,454	(\$1,729)	\$275
Subtotal (In PC 196)	(\$6,020)	\$14,476	(\$20,496)	\$6,020
Managed Care	\$0	\$485,491	(\$485,491)	\$0
Pharmacy Rebates	\$0	\$0	\$0	\$0
Pharmacy Claims	\$0	\$72,497	(\$72,497)	\$0
Dental FFS and Managed Care	\$0	\$46,577	(\$46,577)	\$0
Immigration Status Change	\$0	(\$152,942)	\$152,942	\$0
MAA	(\$13,371)	\$0	(\$13,371)	\$0
LEA	\$0	\$600	(\$600)	\$0
Subtotal (In PC 195)	(\$13,371)	\$452,223	(\$465,594)	\$0
Grand Total	(\$19,391)	\$466,699	(\$486,090)	\$6,020

*County Funds are not included in Total Funds

STATE ONLY CLAIMING ADJUSTMENTS - SMHS and DMC
REGULAR POLICY CHANGE NUMBER: 196

(Dollars in Thousands)

FY 2022-23	TF	GF	FF	CF*
SMHS	(\$5,745)	\$13,022	(\$18,767)	\$5,745
Drug Medi-Cal	(\$275)	\$1,454	(\$1,729)	\$275
Subtotal (In PC 196)	(\$6,020)	\$14,476	(\$20,496)	\$6,020
Managed Care	\$0	\$441,677	(\$441,677)	\$0
Pharmacy Rebates	\$142,014	\$44,732	\$97,282	\$0
Pharmacy Claims	\$0	\$112,198	(\$112,198)	\$0
Dental FFS and Managed Care	\$0	\$46,761	(\$46,761)	\$0
Immigration Status Change	\$0	(\$138,667)	\$138,667	\$0
MAA	(\$13,371)	\$0	(\$13,371)	\$0
LEA	\$0	\$600	(\$600)	\$0
Subtotal (In PC 195)	\$128,643	\$507,301	(\$378,658)	\$0
Grand Total	\$122,623	\$521,777	(\$399,154)	\$6,020

*County Funds are not included in Total Funds

4. Total federal repayments and prospective adjustments are estimated to be:

(Dollars In Thousands)	TF	GF	FF	CF*
SMHS and DMC (PC 196)	(\$6,020)	\$14,476	(\$20,496)	\$6,020
MC, Pharmacy, Dental, Immigration, MAA, LEA (PC 195)	(\$13,371)	\$713,765	(\$727,136)	\$0
FY 2021-22	(\$19,391)	\$728,241	(\$747,632)	\$6,020

*County Funds are not included in Total Funds

(Dollars In Thousands)	TF	GF	FF	CF*
SMHS and DMC (PC 196)	(\$6,020)	\$14,476	(\$20,496)	\$6,020
MC, Pharmacy, Dental, Immigration, MAA, LEA (PC 195)	\$128,643	\$1,526,481	(\$1,397,838)	\$0
FY 2022-23	\$122,623	\$1,540,957	(\$1,418,334)	\$6,020

*County Funds are not included in Total Funds

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)

ELECTRONIC VISIT VERIFICATION FED PENALTIES

REGULAR POLICY CHANGE NUMBER: 197
IMPLEMENTATION DATE: 1/2021
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2163

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$52,868,000	\$0
- STATE FUNDS	\$761,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$52,868,000	\$0
STATE FUNDS	\$761,000	\$0
FEDERAL FUNDS	-\$53,629,000	\$0

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 2021-22, is a net increase due to updated federal penalties from the California Department of Social Services (CDSS) and the California Department of Developmental Services. The change from FY 2021-22 to FY 2022-23 is a decrease due to the assumption that EVV Phase I and Phase II will be implemented by FY 2021-22 and no further penalties will be incurred for all departments.

Methodology:

1. Assume the Department will receive reduced federal funding from January 1, 2021, through March 31, 2022, excluding the CDSS' penalties.
2. Assume CDSS will receive reduced federal funding from January 1, 2021, through June 30, 2022.

ELECTRONIC VISIT VERIFICATION FED PENALTIES
REGULAR POLICY CHANGE NUMBER: 197

FY 2021-22	TF	GF	FF
Dept. of Social Services	(\$42,649,000)	\$0	(\$42,649,000)
Dept. of Developmental Services	(\$10,144,000)	\$0	(\$10,144,000)
Dept. of Health Care Services	\$0	\$761,000	(\$761,000)
Dept. of Aging	(\$55,000)	\$0	(\$55,000)
Dept. of Public Health	(\$20,000)	\$0	(\$20,000)
Total	(\$52,868,000)	\$761,000	(\$53,629,000)

*Totals may differ due to rounding.

Funding:

100% GF (4260-101-0001)

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

HCBS SP - COMM BASED RESIDENTIAL CONTINUUM PILOT

REGULAR POLICY CHANGE NUMBER: 203
IMPLEMENTATION DATE: 7/2022
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2312

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$287,197,000
- STATE FUNDS	\$0	\$106,117,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$287,197,000
STATE FUNDS	\$0	\$106,117,000
FEDERAL FUNDS	\$0	\$181,080,000

Purpose:

This change estimates the payments related to Community-Based Residential Continuum Pilots for Vulnerable, Aging, and Disabled Populations.

Authority:

American Rescue Plan (ARP) Act of 2021 Section 9817
Budget Act of 2021

Interdependent Policy Changes:

American Rescue Plan Increased FMAP for HCBS

Background:

The ARP provides additional Coronavirus Disease 2019 relief to states. Section 9817 of the ARP provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS). Increased FMAP is available from April 1, 2021, through March 31, 2022. States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. State funds equivalent to the amount of federal funds attributable to the increased FMAP are deposited in the Home and Community-Based Services American Rescue Plan Fund pursuant to the Budget Act of 2021. Section 11.95 appropriates this funding to eligible HCBS activities identified in the HCBS Spending Plan.

Of the new activities, HCBS Transition Initiatives expands and enhances community transition programs to additional populations or settings and facilitates individuals transitioning from an institutional or another provider-operated congregate livings arrangement, to a variety of community-based, independent, living arrangements.

The Department intends to implement the Community-Based Residential Continuum Pilots for Vulnerable, Aging, and Disabled Populations in Medi-Cal with available increased FMAP, as

HCBS SP - COMM BASED RESIDENTIAL CONTINUUM PILOT

REGULAR POLICY CHANGE NUMBER: 203

proposed to the Centers for Medicare and Medicaid Services with the submission of the HCBS Spending Plan on July 12, 2021.

The Community-Based Residential Continuum Pilots for Vulnerable, Aging, and Disabled Populations will provide medical and supportive services in the home, independent living setting including permanent supportive housing, and community care settings (home, adult residential facilities, residential care facilities for the elderly, affordable housing) in order to avoid unnecessary healthcare costs, including emergency services and future long-term care placement in a nursing home. Additionally, the Prison, Jail, and Juvenile Justice Re-entry and Diversion Populations, the Community-Based Residential Continuum Pilots for Vulnerable, Aging, and Disabled Populations will establish interim housing or board and care setting where medical, behavioral and social services are available or on-site, as re-entry hubs for this population.

Reason for Change:

This is a new policy change.

Methodology:

1. Assume implementation of the one-time cost will begin on July 1, 2022.

(Dollars in Thousands)

Fiscal Year	TF	HCBS ARP Fund	FF
FY 2022-23	\$287,197	\$106,117	\$181,080

Funding:

Home and Community-Based Services American Rescue Plan Fund (4260-101-8507)
Title XIX 100% FFP (4260-101-0890)

HOME & COMMUNITY-BASED ALTERNATIVES WAIVER

REGULAR POLICY CHANGE NUMBER: 205
IMPLEMENTATION DATE: 10/2017
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2010

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$263,774,000	\$304,000,000
- STATE FUNDS	\$131,887,000	\$152,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	15.37 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$223,231,900	\$304,000,000
STATE FUNDS	\$111,615,970	\$152,000,000
FEDERAL FUNDS	\$111,615,970	\$152,000,000

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

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 Centers for Medicare and Medicaid Services authorized the current Waiver on May 16, 2017, retroactive to January 1, 2017, and expires on December 31, 2021.

No later than October 1, 2021, the Department submitted a waiver renewal application for the HCBA Waiver for a new five-year term, January 1, 2022, through December 31, 2026.

Under the new waiver term, the waiver will:

- Increase the number of slots available under the Waiver,
- Expand the Community Transition Service making it available to participants living in the community who require essential goods and/or services to make their community-based residence safe and to keep them out of an institution,
- Add Assistive Technology as a new waiver service, and

HOME & COMMUNITY-BASED ALTERNATIVES WAIVER

REGULAR POLICY CHANGE NUMBER: 205

- Increase the rate paid to Personal Care Agencies that provide Waiver Personal Care Services, in compliance with increases to the statewide minimum wage.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a decrease based on 18 months of prior year data of actuals showing a slight drop in enrollment and a lower cost per user. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to projecting additional enrollments into the HCBA Waiver.

Methodology:

1. Assume there are 6,024 participants in the HCBA Waiver in FY 2020-21.
2. Assume the annual cost per user is \$50,673.
3. Assume 1,600 new participants will transition in FY 2021-22 and 1,800 in FY 2022-23.
4. Assume Community Transition Services and Assistive Technology Services will begin on July 1, 2022.
5. Assume the PCA rate increase will begin on January 1, 2022.
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.

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
Waiver Costs	\$387,453	\$193,727	\$193,727
Savings from SNF	(\$123,679)	(\$61,840)	(\$61,839)
Net Cost	\$263,774	\$131,887	\$131,887
FY 2022-23	TF	GF	FF
Waiver Costs	\$558,817	\$283,409	\$283,409
Savings from SNF	(\$262,817)	(\$131,408)	(\$131,409)
Net Cost	\$304,000	\$152,000	\$152,000

*Totals may differ due to rounding.

Funding:

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

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

CCI IHSS RECONCILIATION

REGULAR POLICY CHANGE NUMBER: 206
IMPLEMENTATION DATE: 4/2022
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 1942

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$135,495,000	\$0
- STATE FUNDS	\$135,495,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$135,495,000	\$0
STATE FUNDS	\$135,495,000	\$0
FEDERAL FUNDS	\$0	\$0

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 (MCPs) during the reconciliation process.

The 2017 Budget extended the Cal MediConnect program and the mandatory enrollment of dual eligibles and integration of LTSS, except IHSS, into managed care. IHSS was removed from capitation rate payments as of January 1, 2018.

CCI IHSS RECONCILIATION

REGULAR POLICY CHANGE NUMBER: 206

Reason for Change:

The change from the prior estimate, for FY 2021-22, is an increase due to reimbursement for CY 2015 and CY 2016 shifting from FY 2020-21. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to the IHSS reconciliation process being completed in FY 2021-22.

Methodology:

1. Assume the 2015, 2016, and 2017 reconciliation for CY 2015, CY 2016, and CY 2017 service months and reimbursement for overpayments and underpayments will be completed in FY 2021-22.
2. Based on CY 2015, CY 2016, and CY 2017 data, it is estimated that CDSS will owe the MCPs \$135,495,000 TF for IHSS managed care in the seven CCI counties.

Funding:

100% Reimbursement GF (4260-610-0995)

CALAIM - DENTAL INITIATIVES

REGULAR POLICY CHANGE NUMBER: 207
IMPLEMENTATION DATE: 1/2022
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2188

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$120,700,000	\$243,216,000
- STATE FUNDS	\$58,489,100	\$117,674,350
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$120,700,000	\$243,216,000
STATE FUNDS	\$58,489,100	\$117,674,350
FEDERAL FUNDS	\$62,210,900	\$125,541,650

Purpose:

This policy change estimates the cost of the dental benefits and incentive payments covered under the California Advancing and Innovating Medi-Cal (CalAIM) policy. These costs include the estimated incentive payments for the provision of preventive services, caries risk assessment, continuity of care, and adding coverage of Silver Diamine Fluoride (SDF) as a dental benefit for specific populations.

Authority:

Interdependent Policy Changes:

COVID-19 Increased FMAP Extension

Background:

Starting January 1, 2022, the 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, the Department 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.

The four dental initiatives of the CalAIM program are as follows:

- (1) Preventive Services
- (2) Caries Risk Assessment
- (3) Continuity of Care, and
- (4) Adding coverage of Silver Diamine Fluoride (SDF) as a dental benefit for specific populations

CALAIM - DENTAL INITIATIVES

REGULAR POLICY CHANGE NUMBER: 207

Reason for Change:

The four dental CalAIM initiatives were combined for the November 2021 estimate. The change from the prior estimate, for FY 2021-22, is an increase due to updated data in estimating costs. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to the policy implementing in FY 2021-22.

Methodology:

- For Preventive Services, a flat rate performance payment equivalent to 75% of the SMA will be paid for specific preventive services rendered.

FY 2021-22	TF	GF	FF
Fee-for-service	\$59,422,000	\$29,711,000	\$29,711,000
Dental Managed Care	\$1,423,000	\$545,000	\$877,000
Total	\$60,845,000	\$30,256,000	\$30,588,000

FY 2022-23	TF	GF	FF
Fee-for-service	\$118,843,000	\$59,422,000	\$59,422,000
Dental Managed Care	\$3,460,000	\$1,327,000	\$2,134,000
Total	\$122,303,000	\$60,749,000	\$61,556,000

- For Caries Risk Assessment, 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.

FY 2021-22	TF	GF	FF
Fee-for-service	\$15,908,000	\$6,602,000	\$9,306,000
Dental Managed Care	\$1,829,000	\$701,000	\$1,128,000
Total	\$17,737,000	\$7,303,000	\$10,434,000

FY 2022-23	TF	GF	FF
Fee-for-service	\$31,816,000	\$13,204,000	\$18,613,000
Dental Managed Care	\$4,449,000	\$1,706,000	\$2,744,000
Total	\$36,265,000	\$14,910,000	\$21,357,000

- For 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.

FY 2021-22	TF	GF	FF
Fee-for-service	\$40,464,000	\$20,232,000	\$20,232,000
Dental Managed Care	\$0	\$0	\$0
Total	\$40,464,000	\$20,232,000	\$20,232,000

CALAIM - DENTAL INITIATIVES

REGULAR POLICY CHANGE NUMBER: 207

FY 2022-23	TF	GF	FF
Fee-for-service	\$80,929,000	\$40,464,000	\$40,464,000
Dental Managed Care	\$0	\$0	\$0
Total	\$80,929,000	\$40,464,000	\$40,464,000

4. 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.

FY 2021-22	TF	GF	FF
Fee-for-service	\$706,000	\$334,000	\$372,000
Dental Managed Care	\$948,000	\$364,000	\$585,000
Total	\$1,654,000	\$698,000	\$957,000

FY 2022-23	TF	GF	FF
Fee-for-service	\$1,412,000	\$669,000	\$743,000
Dental Managed Care	\$2,307,000	\$884,000	\$1,423,000
Total	\$3,719,000	\$1,553,000	\$2,166,000

5. On a cash basis, the FY 2021-22 and FY 2022-23 total costs are:

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF	\$110,199,000	\$55,099,000	\$55,099,000
ACA 90% FF / 10% GF	\$1,143,000	\$114,000	\$1,028,000
Title XXI 65% FF/35% GF	\$9,358,000	\$3,275,000	\$6,083,000
Total	\$120,700,000	\$58,488,000	\$62,210,000

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF	\$221,625,000	\$110,813,000	\$110,813,000
ACA 90% FF / 10% GF	\$2,780,000	\$278,000	\$2,502,000
Title XXI 65% FF/35% GF	\$18,811,000	\$6,584,000	\$12,227,000
Total	\$243,216,000	\$117,675,000	\$125,542,000

*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)

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY

REGULAR POLICY CHANGE NUMBER: 208
IMPLEMENTATION DATE: 4/2022
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2292

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$100,000,000	\$450,000,000
- STATE FUNDS	\$100,000,000	\$450,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$100,000,000	\$450,000,000
STATE FUNDS	\$100,000,000	\$450,000,000
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates funding for direct grants to local educational agencies (LEAs), institutions of higher education, publicly funded childcare and preschools, health care service plans, community-based organizations (CBOs), tribal entities, behavioral health providers, city mental health authorities, and/or counties to build infrastructure, partnerships, and capacity statewide to increase the number of children and youth 25 years of age and younger receiving preventive and early intervention behavioral health services from schools, providers in school, school affiliated CBOs, or school-based health centers.

Authority:

SB 129 (Chapter 69, Statutes of 2021)

Interdependent Policy Changes:

Not Applicable

Background:

Young people spend many hours in school settings and behavioral health (BH) services should be easily accessible and provided on or near school campuses, through partnerships between schools, commercial health insurance, counties, behavioral health providers and CBOs. This policy change estimates cost to provide direct grants available to various entities to build infrastructure, partnerships, and capacity statewide to increase access to preventive and early intervention behavioral health services for students.

This program, part of the Children and Youth Behavioral Health Initiative (CYBHI), helps expand access to BH school counselors, peer supports, and BH coaches. In addition, the program builds a statewide CBO network by connecting plans, counties, CBOs and schools via data-sharing systems. The proposed resources build services that are sustainable over time, meeting the long-term needs of children and youth.

The CYBHI is a multiyear package of investments. The CYBHI is intended to transform California's behavioral health system for children and youth aged 0-25 into a world-class, innovative, up-stream focused, ecosystem where all children and young adults are routinely screened, supported, and served for emerging behavioral health needs.

CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY

REGULAR POLICY CHANGE NUMBER: 208

Reason for Change:

There is no change from the prior estimate for FY 2021-22.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to the \$450 million appropriation for FY 2022-23.

Methodology:

1. Assume \$100,000,000 GF for grants to LEAs, institutions of higher education, publicly funded childcare and preschools, health care service plans, CBOs, BH providers, schools, tribal entities, city mental health authorities, and/or counties in FY 2021-22. This funding is available for encumbrance or expenditure until June 30, 2024 per 2021 Budget Act, Item 4260-101-0001, Provision 16(b).
2. Assume \$450,000,000 GF is available for grants to LEAs, institutions of higher education, publicly funded childcare and preschools, health care services plans, CBOs, BH providers, schools, tribal entities, city mental health authorities, and/or counties in FY 2022-23. The Department is requesting these funds be available for encumbrance or expenditure until June 30, 2025.
3. Of the \$550 million, \$400 million is targeted to pre-school through 12th grade and \$150 million is targeted to higher education.

(Dollars in Thousands)

School BH Partnership and Capacity Grants	TF	GF
FY 2021-22	\$100,000	\$100,000
FY 2022-23	\$450,000	\$450,000

Funding:

100% Title XIX GF (4260-101-0001)

ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

REGULAR POLICY CHANGE NUMBER: 209
IMPLEMENTATION DATE: 6/2011
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1232

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$106,523,000	\$60,914,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$106,523,000	\$60,914,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$106,523,000	\$60,914,000

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

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 bills the CDDS for reimbursement with 100% General Fund (GF) 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.

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

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.

ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

REGULAR POLICY CHANGE NUMBER: 209

Reason for Change:

The change in FY 2021-22, from prior estimate, is due to:

- Two large prior year (PY) invoices that were previously projected to be paid in FY 2020-21 were not paid until FY 2021-22, and
- A decrease in the utilization of transportation.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to less PY expenditures included in FY 2022-23 compared to FY 2021-22 as a result of PY expenditures that were previously anticipated to be incurred in FY 2020-21 is incurred in FY 2021-22.

Methodology:

1. FY 2021-22 includes a portion of payments for FY 2019-20, FY 2020-21, and FY 2021-22 expenditures. FY 2022-23 includes a portion of payments for FY 2020-21, FY 2021-22, and FY 2022-23 expenditures.
2. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension 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
FY 2021-22	\$196,177	\$89,654	\$98,089	\$8,434	\$106,523
FY 2022-23	\$119,644	\$58,730	\$59,822	\$1,092	\$60,914

Funding:

100% Title XIX (4260-101-0890)

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

PROP 56 - PROVIDER ACES TRAININGS

REGULAR POLICY CHANGE NUMBER: 210
IMPLEMENTATION DATE: 12/2019
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2138

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$56,592,000	\$1,468,000
- STATE FUNDS	\$28,296,000	\$734,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$56,592,000	\$1,468,000
STATE FUNDS	\$28,296,000	\$734,000
FEDERAL FUNDS	\$28,296,000	\$734,000

Purpose:

This policy change estimates the cost to train providers on delivering Adverse Childhood Experiences (ACEs) screenings.

Authority:

Budget Act of 2021

Interdependent Policy Changes:

Proposition 56 Funding

Background:

The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), increased the excise tax rate on cigarettes and tobacco products and allocates a portion of the tobacco tax revenue to the Department for use as the non-federal share of health care expenditures, subject to appropriation by the Legislature.

The Budget Act of 2019 provided \$120 million total funds (\$60 million Proposition 56 funds, \$60 million Federal Funds), available until FY 2021-22 to provide training to Medi-Cal providers on administering ACEs screenings.

This policy change identifies the use of the General Fund (GF) for these Proposition 56 payments. See the Proposition 56 Funding policy change for the Proposition 56 offset to the GF.

See the MHSF Provider ACES Training policy change for training costs funded with the Mental Health Services Fund.

Reason for Change:

There is no change from the prior estimate for FY 2021-22.

The change in the current estimate, from FY 2021-22 to FY 2022-23, reflects a cash lag of \$1,468,000 TF for training claims no later than June 30, 2022.

PROP 56 - PROVIDER ACES TRAININGS
REGULAR POLICY CHANGE NUMBER: 210

Methodology:

1. Payments for ACEs provider trainings began in December 2019.
2. The provider trainings costs are estimated to be \$56,592,000 TF (\$28,296,000 GF) in FY 2021-22 and \$1,468,000 TF (\$734,000 GF) in FY 2022-23.

FY 2021-22	TF	GF	FF
FY 2020-21	\$6,849,000	\$3,424,000	\$3,425,000
FY 2021-22	\$49,743,000	\$24,872,000	\$24,871,000
Total	\$56,592,000	\$28,296,000	\$28,296,000

FY 2022-23	TF	GF	FF
FY 2021-22	\$1,468,000	\$734,000	\$734,000
Total	\$1,468,000	\$734,000	\$734,000

Funding:

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

HCBS SP - CALBRIDGE BH PILOT PROGRAM

REGULAR POLICY CHANGE NUMBER: 211
IMPLEMENTATION DATE: 4/2022
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2318

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$40,000,000	\$0
- STATE FUNDS	\$40,000,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$40,000,000	\$0
STATE FUNDS	\$40,000,000	\$0
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the costs for the CalBridge Behavioral Health Pilot Program using enhanced federal funding from the American Rescue Plan Act of 2021 (ARP).

Authority:

American Recue Plan (ARP) Act (2021)
Section 11.95, 2021 Budget Act

Interdependent Policy Changes:

American Rescue Plan Increased FMAP for HCBS

Background:

The American Rescue Plan Act of 2021 (ARP) provides additional Coronavirus Disease 2019 (COVID-19) relief to states. Section 9817 of the ARP provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS). Increased FMAP is available from April 1, 2021, through March 31, 2022. States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. State funds equivalent to the amount of federal funds attributable to the increased FMAP are deposited in the Home and Community-Based Services American Rescue Plan Fund pursuant to Section 11.95 of the 2021 Budget Act. Section 11.95 appropriates this funding to eligible HCBS activities identified in the HCBS Spending Plan.

The CalBridge Behavioral Health Pilot Program provides grants to acute care hospitals to support hiring trained behavioral health navigators in emergency departments to screen patients and, if appropriate, offer intervention and referral to mental health or substance use disorder programs. Applicants will include general acute care hospitals or health systems, hospital foundations, or physician groups. The one-time funding would also support technical assistance and training for participating emergency departments and support for the Department to administer the funding.

HCBS SP - CALBRIDGE BH PILOT PROGRAM

REGULAR POLICY CHANGE NUMBER: 211

Reason for Change:

This is a new policy change.

Methodology:

1. Assume the Department will enter into a contract with Public Health Institute (PHI), current administrator of the California Bridge Program, in FY 2021-22, and PHI will serve as an administrative and technical assistance (TA) entity for the CalBridge Behavioral Health Pilot Program.
2. Assume the total contract amount will be \$40,000,000, with PHI receiving up to 10 percent (\$4,000,000) to provide administrative and TA services to grantees, consistent with the current administrative percentage for the current contract with PHI. The remaining \$36,000,000 will be distributed to grantees for direct services beginning FY 2021-22.
3. Total estimated costs for the CalBridge Behavioral Health Pilot Program, on a cash basis, is as follows:

(Dollars in Thousands)

FY 2021-22	TF	HCBS ARP Fund
PHI Contractor	\$4,000	\$4,000
Direct Services	\$36,000	\$36,000
Total	\$40,000	\$40,000

Funding:

100% Home and Community-Based Services American Rescue Plan Fund (4260-101-8507)

QAF WITHHOLD TRANSFER

REGULAR POLICY CHANGE NUMBER: 212
IMPLEMENTATION DATE: 7/2017
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2092

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$37,846,000	-\$2,028,000
- STATE FUNDS	\$15,884,000	-\$1,014,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$37,846,000	-\$2,028,000
STATE FUNDS	\$15,884,000	-\$1,014,000
FEDERAL FUNDS	\$21,962,000	-\$1,014,000

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

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.

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REGULAR POLICY CHANGE NUMBER: 212

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.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is due to:

- For HQAF, the prior year withhold transfers decreased from the prior estimate due to an unexpected increase in direct payments received for HQAF VI, Cycle 7.
- For LTC QAF, the new withholds pending transfer decreased from the prior estimate due to actual withholds coming in lower for FY 2020-21, as a result of withhold deferrals and monthly repayment arrangement requests related to COVID-19.
- For GEMT QAF, the estimated FY 2021-22 withholds pending transfer in FY 2022-23 has decreased.

The change from FY 2021-22 to FY 2022-23, in the current estimate is due to:

- For HQAF, the prior year withhold transfers decreased in FY 2022-23 as no HQAF Cycle payouts are scheduled to occur after the last withhold transfer for FY 2022-23.
- For LTC QAF, the estimate increased due to the expectation that withholds will return to pre-pandemic levels, resulting in estimated savings in FY 2022-23.
- For GEMT QAF, the prior year withhold decreased based on the withholds estimated in FY 2021-22.
- No FFCRA increased FMAP estimated in FY 2022-23 in this policy change.

Methodology:

HQAF

1. Prior year FY 2020-21 HQAF withheld payments totaling \$40.87 million TF will be transferred in FY 2021-22.
2. An estimated \$2.44 million TF in HQAF withholds will occur in FY 2021-22. These withholds are pending transfer in the next FY and offsets a portion of the \$40.87 million HQAF withhold transfer.
3. An estimated \$2.44 million of FY 2021-22 HQAF withheld payments will be paid in FY 2022-23. This prior year withhold transfer is offset by \$2.44 million withholds that are estimated to occur in FY 2022-23, but are pending transfer in FY 2023-24.

LTC QAF

4. Prior year FY 2020-21 LTC QAF withheld payments totaling \$8.06 million TF will be transferred in FY 2021-22.
5. An estimated \$8.68 million in LTC QAF withholds will occur in FY 2021-22. These withholds are pending transfer in the next FY and offsets a portion of the \$8.06 million LTC QAF withhold transfer.
6. An estimated \$8.68 million of FY 2021-22 LTC QAF withheld payments will be paid in FY 2022-23. This prior year withhold transfer is offset by \$10.71 million withholds that are estimated to occur in FY 2022-23, but are pending transfer in FY 2023-24.

QAF WITHHOLD TRANSFER
REGULAR POLICY CHANGE NUMBER: 212

GEMT QAF

7. Prior year FY 2020-21 GEMT withheld payments totaling \$0.08 million TF will be transferred in FY 2021-22.
8. An estimated \$0.04 million in GEMT QAF withholds will occur in FY 2021-22. These withholds are pending transfer in the next FY and offsets a portion of the \$0.08 million GEMT QAF withhold transfer.
9. An estimated \$0.04 million of FY 2021-22 GEMT QAF withholds will be paid in FY 2022-23. This prior year withhold transfer is offset by \$0.04 million withholds that are estimated to occur in FY 2022-23, but are pending transfer in FY 2023-24.

FFCRA

10. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through December 31, 2021 for this policy change.

(Dollars in Thousands)

FY 2021-22	TF	GF	FF	FFCRA
HQAF				
HQAF Prior Year Withhold Transfers	\$40,868	\$17,900	\$20,434	\$2,534
HQAF FY 2021-22 New Withholds Pending Transfer	(\$2,442)	(\$1,221)	(\$1,221)	\$0
Subtotal HQAF for FY 2021-22	\$38,426	\$16,679	\$19,213	\$2,534
LTC QAF				
LTC QAF Prior Year Withhold Transfers	\$8,060	\$3,530	\$4,030	\$500
LTC QAF FY 2021-22 New Withholds Pending Transfer	(\$8,683)	(\$4,341)	(\$4,342)	\$0
Subtotal LTC QAF for FY 2021-22	(\$623)	(\$811)	(\$312)	\$500
GEMT QAF				
GEMT QAF Prior Year Withhold Transfers	\$83	\$36	\$42	\$5
GEMT QAF FY 2021-22 New Withholds Pending Transfer	(\$40)	(\$20)	(\$20)	\$0
Subtotal GEMT QAF for FY 2021-22	\$43	\$16	\$22	\$5
Total FY 2021-22	\$37,846	\$15,884	\$18,923	\$3,039

QAF WITHHOLD TRANSFER
REGULAR POLICY CHANGE NUMBER: 212

(Dollars in Thousands)

FY 2022-23	TF	GF	FF	FFCRA
HQAF				
HQAF Prior Year Withhold Transfers	\$2,442	\$1,221	\$1,221	\$0
HQAF FY 2022-23 New Withholds Pending Transfer	(\$2,442)	(\$1,221)	(\$1,221)	\$0
Subtotal HQAF for FY 2022-23	\$0	\$0	\$0	\$0
LTC QAF				
LTC QAF Prior Year Withhold Transfers	\$8,682	\$4,341	\$4,341	\$0
LTC QAF FY 2022-23 New Withholds Pending Transfer	(\$10,710)	(\$5,355)	(\$5,355)	\$0
Subtotal LTC QAF for FY 2022-23	(\$2,028)	(\$1,014)	(\$1,014)	\$0
GEMT QAF				
GEMT QAF Prior Year Withhold Transfers	\$40	\$20	\$20	\$0
GEMT QAF FY 2022-23 New Withholds Pending Transfer	(\$40)	(\$20)	(\$20)	\$0
Subtotal GEMT QAF for FY 2022-23	\$0	\$0	\$0	\$0
Total FY 2022-23	(\$2,028)	(\$1,014)	(\$1,014)	\$0

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)

INFANT DEVELOPMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 213
IMPLEMENTATION DATE: 7/2016
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2009

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$38,319,000	\$28,784,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$38,319,000	\$28,784,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$38,319,000	\$28,784,000

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

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.

INFANT DEVELOPMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 213

Reason for Change:

The change in FY 2021-22, from the prior estimate, is a net increase due to:

- An increase in prior year (PY) expenditures that was previously expected to be paid in FY 2020-21 shifting to FY 2021-22, and
- A decrease in current year (CY) in FY 2021-22 expenditures resulting from delayed recovery from COVID.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to less prior year expenditures included in FY 2022-23 compared to FY 2021-22.

Methodology:

1. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through December 31, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022 on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	FF	FFCRA	Total FFP
FY 2021-22	\$70,513	\$32,194	\$35,257	\$3,062	\$38,320
FY 2022-23	\$56,782	\$27,998	\$28,391	\$393	\$28,784

Funding:

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

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

KEDREN COMMUNITY HEALTH & ACUTE PSYCHIATRIC HOSP.

REGULAR POLICY CHANGE NUMBER: 217
IMPLEMENTATION DATE: 10/2021
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 2297

	FY 2021-22	FY 2022-23
FULL YEAR COST - TOTAL FUNDS	\$30,000,000	\$0
- STATE FUNDS	\$30,000,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$30,000,000	\$0
STATE FUNDS	\$30,000,000	\$0
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the cost of providing a one-time payment to Kedren Community and Acute Psychiatric Hospital.

Authority:

SB 129 (Chapter 69, Statutes of 2021)

Interdependent Policy Changes:

Not Applicable

Background:

SB 129 provides for a one-time payment to Kedren Community and Acute Psychiatric Hospital.

Reason for Change:

There is no change in FY 2021-22, from the prior estimate.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to the one-time payment occurring in FY 2021-22.

Methodology:

1. Assume a one-time payment to Kedren Community and Acute Psychiatric Hospital is expected to occur in FY 2021-22 for \$30 million GF.

(Dollars in Thousands)

FY 2021-22	TF	GF
Kedren Community and Acute Psychiatric Hospital Payment	\$30,000	\$30,000
Total	\$30,000	\$30,000

Funding:

100% GF (4260-101-0001)

PROP 56 PHYSICIANS & DENTISTS LOAN REPAYMENT PROG

REGULAR POLICY CHANGE NUMBER: 218
IMPLEMENTATION DATE: 7/2019
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2097

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$28,477,000	\$41,400,000
- STATE FUNDS	\$28,477,000	\$41,400,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$28,477,000	\$41,400,000
STATE FUNDS	\$28,477,000	\$41,400,000
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the cost of the Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Program.

Authority:

Budget Act of 2021
 Welfare & Institutions Code Section 14114
 Revenue & Taxation Code Section 31005

Interdependent Policy Changes:

Not Applicable

Background:

The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), increased the excise tax rate on cigarettes and tobacco products and allocates a portion of the tobacco tax revenue to the Department for use as the non-federal share of health care expenditures, subject to appropriation by the Legislature.

The Budget Act of 2018 appropriated \$220 million in Proposition 56 funding to the Medi-Cal Physicians and Dentists Loan Repayment Program and enacted Welfare & Institutions Code 14114. The program provides loan assistance payments to qualifying, recent graduate physicians and dentists that serve beneficiaries of Medi-Cal and other specified health care programs.

Each cohort will receive the payments over five years.

The Budget Act of 2019 appropriated an additional \$120 million in Proposition 56 funding and made the combined \$340 million available until June 30, 2029. The Budget Act of 2021 transferred the balance of these appropriations to the Loan Repayment Program Account, Healthcare Treatment Fund.

PROP 56 PHYSICIANS & DENTISTS LOAN REPAYMENT PROG

REGULAR POLICY CHANGE NUMBER: 218

SB 395 (Chapter 489, Statutes of 2021) increased the excise tax on electronic cigarettes. Revenue & Taxation Code Section 31005 allocates a portion of the increased revenue to the Physicians and Dentists Loan Repayment Program.

The Department has contracted with Physicians for a Healthy California (PHC) to implement and administer the Proposition 56 funded Physicians and Dentists Loan Repayment Program pursuant to Welfare and Institutions Code section 14114(g).

Reason for Change:

There is no change from the previous estimate for FY 2021-22. The difference from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to the additional cohort of awarded loan repayments beginning payments in FY 2022-23.

Methodology:

- Cohort 1 is expected to receive \$13.2 million each year for 5 years, with payments beginning in FY 2020-21. Cohort 2 is expected to receive \$13.3 million each year for 5 years, with payment beginning in FY 2021-22. Cohort 3 is expected to receive \$13.1 million each year for 5 years, with payment beginning in FY 2022-23. 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.
- The contract for the administrative costs is \$1.7 million in FY 2021-22 and FY 2022-23, with the payments being retrospective and invoices processed the month after services have been provided.

Fiscal Years	TF	GF
FY 2021-22	\$28,477,000	\$28,477,000
FY 2022-23	\$41,400,000	\$41,400,000

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: 219
IMPLEMENTATION DATE: 4/1998
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 111

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$23,020,000	\$26,428,000
- STATE FUNDS	\$7,711,500	\$8,853,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	12.81 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$20,071,100	\$26,428,000
STATE FUNDS	\$6,723,660	\$8,853,500
FEDERAL FUNDS	\$13,347,480	\$17,574,500

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

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: 219

Reason for Change:

There is no change from the prior estimate for FY 2021-22. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to the rate increase and additional claims from current year to budget year.

Methodology:

1. Currently, there are 102 Indian health clinics participating in Medi-Cal and 6 YRTCs. The YRTC costs were previously budgeted in a separate policy change.
2. Effective CY 2021, the updated per visit rate payable to the Indian health clinics increased by \$40, from \$479 to \$519. The annual rate increase for the additional \$40 is estimated at \$11,113,000 TF.
3. Effective CY 2022, the updated per visit rate payable to the Indian health clinics increased by \$35, from \$519 to \$554. The annual rate increase for the additional \$35 is estimated at \$10,210,000 TF.
4. It is estimated, effective CY 2023, the updated per visit rate payable to the Indian health clinics will increase by \$38, from \$554 to \$592. The annual rate increase for the additional \$38 is estimated at \$11,640,000 TF.
5. On a cash basis, the FY 2021-22 and FY 2022-23 estimates are:

Rate Increase	FY 2021-22	FY 2022-23
CY 2020 rate increase	\$6,350,000	\$0
CY 2021 rate increase	\$11,113,000	\$11,113,000
CY 2022 rate increase	\$0	\$10,210,000
Retro Jan – June 2021 Increase	\$5,557,000	\$0
Retro Jan – June 2022 Increase	\$0	\$5,105,000
Total Rate Increase	\$23,020,000	\$26,428,000

Fiscal Year	TF	GF	FF
FY 2021-22	\$23,020,000	\$7,712,000	\$15,308,000
FY 2022-23	\$26,428,000	\$8,853,000	\$17,575,000

*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 December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

SELF-DETERMINATION PROGRAM - CDDS

REGULAR POLICY CHANGE NUMBER: 220
IMPLEMENTATION DATE: 7/2020
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2208

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$22,085,000	\$36,377,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$22,085,000	\$36,377,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$22,085,000	\$36,377,000

Purpose:

This policy change estimates the federal match for the Self Determination Program (SDP) Waiver of the California Department of Developmental Services (CDDS).

Authority:

Welfare and Institutions (W&I) Code Section 4585.8
 Interagency Agreement (IA) 19-96260

Interdependent Policy Changes:

Not Applicable

Background:

CDDS, under a federal HCBS 1915(c) 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 2021-22, from the prior estimate, is a slight increase in estimates and claims shifting to be paid in FY 2021-22 due to delayed submission of claim files to the Department.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a net increase due to estimated increases in self-determination program enrollments and fewer prior year expenditures in FY 2022-23.

SELF-DETERMINATION PROGRAM - CDDS
REGULAR POLICY CHANGE NUMBER: 220**Methodology:**

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	DHCS FFP
FY 2021-22	\$44,170	\$22,085	\$22,085
FY 2022-23	\$72,753	\$36,376	\$36,377

Funding:

100% Title XIX (4260-101-0890)

ALAMEDA WELLNESS CAMPUS

REGULAR POLICY CHANGE NUMBER: 221
IMPLEMENTATION DATE: 5/2022
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2304

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$15,000,000	\$0
- STATE FUNDS	\$15,000,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$15,000,000	\$0
STATE FUNDS	\$15,000,000	\$0
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the cost of construction of a medical respite and health clinic building.

Authority:

SB 129 (Chapter 69, Statutes of 2021)

Interdependent Policy Changes:

Not Applicable

Background:

The Department will appropriate direct payments to Alameda Point Collaborative for the construction of a medical respite and health clinic building at the Alameda Wellness Campus to serve unhoused adults and seniors with complex health conditions.

The medical respite will serve homeless adults who are:

- Discharged from local hospitals but are too sick to recover on the streets or a shelter,
- Undergoing intensive outpatient medical treatment such as chemotherapy,
- Identified through street medicine, or
- Seeking hospice care.

Reason for Change:

There is no change from the prior estimate for FY 2021-22. The change from FY 2021-22 to FY 2022-23 is a decrease due to the cost being a one-time payment in FY 2021-22.

Methodology:

1. Assume a one-time payment to Alameda Point Collaborative will occur in FY 2021-22.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2021-22	\$15,000	\$15,000	\$0

ALAMEDA WELLNESS CAMPUS
REGULAR POLICY CHANGE NUMBER: 221

Funding:

100% GF (4260-101-0001)

PEER SUPPORT SPECIALIST SERVICES

REGULAR POLICY CHANGE NUMBER: 222
IMPLEMENTATION DATE: 7/2022
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2337

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$31,305,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$31,305,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$31,305,000

Purpose:

This policy change estimates the costs for adding peer support specialist services as a covered benefit in the Specialty Mental Health Services (SMHS) Delivery System, the State Plan, and the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver programs.

Authority:

SB 802 (Chapter 150, Statutes of 2020)

Interdependent Policy Changes:

Not Applicable

Background:

The SMHS program is currently authorized under California's SMHS Section 1915(b) waiver through December 31, 2021. Through the renewal of the Section 1915(b) waiver, California is seeking to renew that authority and consolidate other Medi-Cal managed care authorities with SMHS.

California Counties have the option to provide DMC services either under the Medi-Cal State Plan or the DMC-ODS Waiver program under the Medi-Cal 2020 Section 1115 demonstration to provide Medi-Cal beneficiaries who reside in their county with a range of evidence-based substance use disorder (SUD) treatment services.

The DMC-ODS program was originally authorized under California's Medi-Cal 2020 Section 1115 demonstration, and extended through December 31, 2021. Under CalAIM, the Department is continuing and strengthening the SUD treatment system, building on the existing DMC-ODS program. The Department has submitted the renewal requests under the CalAIM Section 1115 Demonstration and a CalAIM 1915(b) waiver proposals requesting changes to the DMC-ODS authority and including additional services and benefits, effective January 2022.

Prior to SB 803, counties could bill for specified peer support services under the Medi-Cal program, as "other mental health services." SB 803 allows counties to develop peer support specialist certification programs through the SMHS, DMC State Plan, and DMC ODS delivery systems, to establish a new peer support services provider type, and to add peer support services as a Medi-Cal benefit. The bill also allows counties to establish certification fee

PEER SUPPORT SPECIALIST SERVICES

REGULAR POLICY CHANGE NUMBER: 222

schedules to support ongoing program administration activities upon approval from the Department. Additionally, SB 803 requires the Department, subject to federal approval, to establish statewide requirements for counties that opt to certify peer support specialists by July 1, 2022.

The ongoing provision of peer support services is supported by federal funds and by county funds given that SB 803 requires a county that opts to establish a peer specialist certification program for the provision of peer support services to agree to fund the non-federal share of any applicable expenditures and prohibits General Fund moneys for such expenditures.

Peer support specialist services are culturally competent services, provided by certified peer support specialists that promote recovery, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths. Peer support specialists will support California's effort to promote health equity by providing culturally competent services to promote recovery and enhanced access to care across a diverse population, including race/ethnicity, gender identity, sexual orientation, generation, and geographic regions. Certified Peer Support Specialists are unique providers that will be certified by a county or an entity representing a county.

Reason for Change:

This is a new policy change.

Methodology:

1. Assume peer support specialist services will be implemented in July 2022.
2. Total cost for both SMHS and DMC are as follows:

FY 2022-23	TF	GF	FF	CF
SMHS Interim Rate – Adult	\$17,664,000	\$0	\$12,837,000	\$4,827,000
SMHS Interim Rate - Children	\$17,970,000	\$0	\$9,585,000	\$8,385,000
Non-NTP DMC State Plan Interim Rate	\$764,000	\$0	\$543,000	\$221,000
Non-NTP DMC-ODS Interim Rate	\$11,163,000	\$0	\$8,340,000	\$2,823,000
Total	\$47,561,000	\$0	\$31,305,000	\$16,256,000

Funding:

- 100% Title XIX FF (4260-101-0890)
- 100% Title XXI FF (4260-113-0890)
- 100% ACA Title XIX FF (4260-101-0890)

HCBS SP - NON-IHSS CARE ECONOMY PMTS

REGULAR POLICY CHANGE NUMBER: 223
IMPLEMENTATION DATE: 1/2022
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2314

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$12,250,000	\$0
- STATE FUNDS	\$6,125,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$12,250,000	\$0
STATE FUNDS	\$6,125,000	\$0
FEDERAL FUNDS	\$6,125,000	\$0

Purpose:

This policy change estimates the cost to provide a one-time incentive payment to each current direct care, non-In-Home Supportive Services (IHSS) provider of Medi-Cal home and community-based services (HCBS).

Authority:

American Rescue Plan (ARP) Act of 2021
Budget Act of 2021

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS
COVID-19 Increased FMAP Extension
American Rescue Plan Increased FMAP for HCBS

Background:

The ARP provides additional Coronavirus Disease 2019 (COVID-19) relief to states. Section 9817 of the ARP provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for HCBS. Increased FMAP is available from April 1, 2021, through March 31, 2022. States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. State funds equivalent to the amount of federal funds attributable to the increased FMAP are deposited in the Home and Community-Based Services American Rescue Plan Fund pursuant to Section 11.95 of the Budget Act of 2021. Section 11.95 appropriates this funding to eligible HCBS activities identified in the HCBS Spending Plan.

On July 12, 2021, the Department submitted the Medicaid HCBS Spending Plan to the Centers for Medicare & Medicaid Services for approval. The multi-departmental HCBS spending plan includes HCBS initiatives and services that will be led by the Department and/or various other State Departments.

HCBS SP - NON-IHSS CARE ECONOMY PMTS

REGULAR POLICY CHANGE NUMBER: 223

This policy change provides additional support for direct care non-IHSS HCBS providers servicing clients during the COVID-19 emergency, to provide a one-time incentive payment of \$500 to each current direct care, non-IHSS provider of Medi-Cal home and community-based services. This funding focuses on payment for retention, recognition, and workforce development.

Reason for Change:

This is a new policy change.

Methodology:

1. Assume implementation began on January 1, 2022.

(Dollars in Thousands)

Fiscal Year	TF	HCBS ARP Fund	FF
FY 2021-22	\$12,250	\$6,125	\$6,125

Funding:

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

Home and Community-Based Services American Rescue Plan Fund (4260-101-8507)

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

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

REGULAR POLICY CHANGE NUMBER: 224
IMPLEMENTATION DATE: 7/2010
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1526

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$17,085,000	\$10,471,000
- STATE FUNDS	\$7,814,000	\$4,790,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$17,085,000	\$10,471,000
STATE FUNDS	\$7,814,000	\$4,790,000
FEDERAL FUNDS	\$9,271,000	\$5,681,000

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 (QAF).

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-DDs are subject to a QAF based upon their Medi-Cal revenues, with the revenue used to increase rates for the ICF-DDs.

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS
REGULAR POLICY CHANGE NUMBER: 224

Reason for Change:

The change in FY 2021-22, from the prior estimate, is a net decrease due to:

- Two prior year invoices that were previously projected to be paid in FY 2020-21 were not paid until FY 2021-22 and
- Decreased utilization of transportation.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to less prior year expenditures in FY 2022-23.

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
FY 2021-22	\$1,456	\$7,815	\$18,541	\$1,456	\$7,814	\$9,271
FY 2022-23	\$890	\$4,791	\$11,361	\$890	\$4,790	\$5,681

Funding:

100% GF (4260-101-0001)

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

CYBHI - CALHOPE STUDENT SUPPORT

REGULAR POLICY CHANGE NUMBER: 225
IMPLEMENTATION DATE: 9/2021
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2291

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$11,000,000	\$17,000,000
- STATE FUNDS	\$11,000,000	\$17,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$11,000,000	\$17,000,000
STATE FUNDS	\$11,000,000	\$17,000,000
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the funding available to provide training, technical assistance, technology and tools to build and enhance positive social-emotional learning environments in California schools through administration of the CalHOPE Student Support Program.

Authority:

SB 129 (Chapter 69, Statutes of 2021)

Interdependent Policy Changes:

Not Applicable

Background:

The CalHOPE Student Support program launched as part of the Federal Emergency Management Agency (FEMA)/Substance Abuse and Mental Health Services Administration (SAMHSA) Crisis Counseling Program (CCP), in recognition of the challenges and stressors children, youth and families are experiencing: social isolation, lack of school structure, and need to adapt to distance learning. The Department previously partnered with the California Mental Health Services Authority to subcontract with the Sacramento County of Education (SCOE) and provided \$12.6 million to SCOE to establish the CalHOPE Student Support program, available between November 2020 and February 9, 2022. There are \$45 million included in the Children and Youth Behavioral Health Initiative (CYBHI) to extend this program and expand this effort over a three year period. In addition, a student engagement element will be added.

The CYBHI is a multiyear package of investments. The CYBHI is intended to transform California's behavioral health system for children and youth aged 0-25 into a world-class, innovative, up-stream focused ecosystem where all children and young adults are routinely screened, supported, and served for emerging behavioral health needs.

The CalHOPE Student Support Program was designed to give teachers and staff the skills to prepare a healthy learning environment for children, to be able to easily identify signs of stress and poor functioning, provide support for children and youth, and refer to more intensive

CYBHI - CALHOPE STUDENT SUPPORT

REGULAR POLICY CHANGE NUMBER: 225

services where needed. The training and technical assistance aims to create positive social-emotional learning environments in schools to support children, young people, parents, and school staff, addressing the behavioral health challenges created by social isolation and the stress of the public health emergency.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a decrease due to:

- Updating the timing of the contract for the training and technical assistance provider; and
- Updating the FY 2021-22 estimate to reflect the full appropriation across the fiscal years of availability, as expenditures are anticipated to occur.

The change from FY 2021-22 to FY 2022-23, in the current estimate is due to reflecting the appropriation across the fiscal years of availability, as expenditures are anticipated to occur.

Methodology:

1. Assume a total of \$45,000,000 GF will be provided to a training and technical assistance provider and learning communities. The 2021 Budget Act, Item 4260-101-0001, Provision 16(c) authorizes the funds for encumbrance or expenditure until June 30, 2024.
2. On a cash basis for FY 2021-22, the Department will be paying \$11,000,000 GF, and \$17,000,000 GF in FY 2022-23, for the CalHOPE Student Support program.

(Dollars in Thousands)

CalHOPE Student Support Program	TF	GF
FY 2021-22	\$11,000	\$11,000
FY 2022-23	\$17,000	\$17,000

Funding:

100% Title XIX GF (4260-101-0001)

MINIMUM WAGE INCREASE FOR HCBS WAIVERS

REGULAR POLICY CHANGE NUMBER: 226
IMPLEMENTATION DATE: 1/2017
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1975

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$87,925,000	\$96,386,000
- STATE FUNDS	\$43,962,500	\$48,193,000
PAYMENT LAG	0.8345	0.8345
% REFLECTED IN BASE	85.22 %	49.30 %
APPLIED TO BASE		
TOTAL FUNDS	\$10,844,600	\$40,780,100
STATE FUNDS	\$5,422,300	\$20,390,050
FEDERAL FUNDS	\$5,422,300	\$20,390,050

Purpose:

This policy change estimates the costs of increasing the minimum wage for the Assisted Living Waiver (ALW).

Authority:

SB 3 (Chapter 4, Statutes of 2016)

Interdependent Policy Changes:

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

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 ALW.

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.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is an overall increase due to an increase in minimum wage and the AIDS attendant care user costs are assumed to be fully budgeted in the PROP 56 – AIDS Waiver Supplemental Payments policy change. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to the increase in the minimum wage.

MINIMUM WAGE INCREASE FOR HCBS WAIVERS

REGULAR POLICY CHANGE NUMBER: 226

Methodology:

1. Beginning January 1, 2021, the minimum wage increased \$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. Beginning January 1, 2023, the minimum wage will increase \$1.00 from \$14.00 to \$15.00 per hour.
2. Assume a 10% cost increase for employers due to required payroll taxes and other costs.
3. Assume the total amount of users is 5,744 in calendar year (CY) 2021, CY 2022, and CY 2023.
4. For FY 2021-22, assume the total care coordination and assisted living cost minimum wage increase is \$87,925,000 TF. For FY 2022-23, assume the total care coordination and assisted living cost minimum wage increase is \$96,386,000 TF.

Fiscal Year	TF	GF	FF
FY 2021-22	\$87,925,000	\$43,963,000	\$43,962,000
FY 2022-23	\$96,386,000	\$48,193,000	\$48,193,000

Funding:

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

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

HCBS SP - ASSISTED LIVING WAIVER EXPANSION

REGULAR POLICY CHANGE NUMBER: 227
IMPLEMENTATION DATE: 10/2021
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2054

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$13,978,000	\$32,538,000
- STATE FUNDS	\$3,829,000	\$8,896,000
PAYMENT LAG	0.7740	0.9950
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$10,819,000	\$32,375,300
STATE FUNDS	\$2,963,650	\$8,851,520
FEDERAL FUNDS	\$7,855,330	\$23,523,790

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)
 American Rescue Plan (ARP) Act (2021)
 Budget Act of 2021

Interdependent Policy Changes:

American Rescue Plan Increased FMAP for HCBS
 COVID-19 Increased FMAP – DHCS
 COVID-19 Increased FMAP Extension

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. The 2,000 additional slots have been filled and incorporated into the base estimates.

The ARP provides additional Coronavirus Disease 2019 (COVID-19) relief to states. Section 9817 of the ARP provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS). Increased FMAP is available from through March 31, 2024, for this program. States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable

HCBS SP - ASSISTED LIVING WAIVER EXPANSION

REGULAR POLICY CHANGE NUMBER: 227

to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. State funds equivalent to the amount of federal funds attributable to the increased FMAP are deposited in the Home and Community-Based Services American Rescue Plan Fund pursuant to the Budget Act of 2021. Section 11.95 appropriates this funding to eligible HCBS activities identified in the HCBS Spending Plan.

On July 12, 2021, the Department submitted the Medicaid HCBS Spending Plan to CMS for approval. The multi-departmental HCBS spending plan includes HCBS initiatives and services that will be led by the Department and/or various other State Departments.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a net increase in costs due to the waiver being renewed at add an additional 7,000 slots and more enrollees are from the community versus a SNF when savings would usually be captured. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase in net costs due to additional participants transitioning into the ALW, majorly from the community.

Methodology:

1. Assume 7,000 new participants will be phased in by FY 2024-25.
2. Of the new 7,000 participants, assume 5,000 will be from the community only and 2,000 will be from the community and skilled nursing facilities (SNFs).
3. Of the 2,000 participants, assume 60% will be from long-term SNFs and 40% will be from the community; 1,200 participants are from SNFs and 800 participants are from the community.
4. Assume an average of 148 participants will enroll per month.
5. Assume the average annual cost for waiver services is \$23,722.
6. Assume the average annual cost in an SNF is \$77,280.
7. Assume a 10% enhanced FMAP through March 31, 2024.

(Dollars in Thousands)

FY 2021-22	TF	HCBS ARP Fund	GF	FF
Total Cost from Waiver Services	\$31,598	\$12,639	\$0	\$18,959
Total Savings from SNF Transitions	(\$17,620)	\$0	(\$8,810)	(\$8,810)
Net Impact	\$13,978	\$12,639	(\$8,810)	\$10,149
FY 2022-23	TF	HCBS ARP Fund	GF	FF
Total Cost from Waiver Services	\$73,728	\$29,491	\$0	\$44,237
Total Savings from SNF Transitions	(\$41,190)	\$0	(\$20,595)	(\$20,595)
Net Impact	\$32,538	\$29,491	(\$20,595)	\$23,642

HCBS SP - ASSISTED LIVING WAIVER EXPANSION

REGULAR POLICY CHANGE NUMBER: 227

Funding:

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

Home and Community-Based Services American Rescue Plan Fund (4260-101-8507)

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

SECTION 19.56 LEGISLATIVE PRIORITIES

REGULAR POLICY CHANGE NUMBER: 228
IMPLEMENTATION DATE: 12/2021
ANALYST: Ryan Woolsey
FISCAL REFERENCE NUMBER: 2316

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$10,330,000	\$0
- STATE FUNDS	\$10,330,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$10,330,000	\$0
STATE FUNDS	\$10,330,000	\$0
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change allocates funding approved through the Control Section 19.56 of the 2021 Budget Act, to the Department of Health Care Services as the designated state entity for the distribution of funds to the identified recipients.

Authority:

SB 129 (Chapter 69, Statutes of 2021)
 SB 170 (Chapter 240, Statutes of 2021)
 Executive Order No. E 21/22 - 93

Interdependent Policy Changes:

Not Applicable

Background:

SB 129 adds Section 19.56 to the FY 2021-22 Budget Act. Section 19.56 appropriates from the state General Fund (GF) for a variety of legislative priorities. SB 170 amends Section 19.56 to add additional priorities. The Department of Health Care services is the distributing entity for some of these funds. Executive Order No. E 21/22 - 93 allocates funding appropriated in Section 19.56 to the Department of Health Care Services.

Reason for Change:

This is a new policy change.

SECTION 19.56 LEGISLATIVE PRIORITIES

REGULAR POLICY CHANGE NUMBER: 228

Methodology:

1. The Executive Order identifies the following items totaling \$10,330,000 GF:

- \$5,000,000 GF for the County of Orange for the Be Well OC Campus in Irvine.
- \$1,000,000 GF for The Children's Clinic (TCC) for capital support for the new TCC Family Health and Wellness site in Cambodia Town in Long Beach.
- \$2,000,000 GF for the County of Humboldt for upstream investments for the North Coast Healthcare System: creation of a Crisis Residential Care (CRT) center.
- \$330,000 GF to the Camarillo Health Care District for COVID-19 Economic Impact.
- \$2,000,000 GF to the City of National City for the Las Palmas and Wellness Center.

Funding:

100% GF (4260-101-0001)

MLK JR. HOSPITAL IMPROVEMENT

REGULAR POLICY CHANGE NUMBER: 229
IMPLEMENTATION DATE: 11/2021
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 2295

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$10,000,000	\$0
- STATE FUNDS	\$10,000,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$10,000,000	\$0
STATE FUNDS	\$10,000,000	\$0
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the cost of providing additional funding to the private nonprofit hospital, Martin Luther King, Jr. – Los Angeles (MLK-LA) Healthcare Corporation.

Authority:

SB 129 (Chapter 69, Statutes of 2021)

Interdependent Policy Changes:

Not Applicable

Background:

SB 129 provides for a one-time payment to support infrastructure and workforce improvements at MLK-LA.

Reason for Change:

There is no change in FY 2021-22, from the prior estimate.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to the one-time payment occurring in FY 2021-22.

Methodology:

1. Assume a one-time payment to MLK Jr. Hospital is expected to occur in FY 2021-22 for \$10 million GF.

(Dollars in Thousands)

FY 2021-22	TF	GF
MLK Jr. Payment	\$10,000	\$10,000
Total	\$10,000	\$10,000

Funding:

100% GF (4260-101-0001)

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER: 230
IMPLEMENTATION DATE: 12/2011
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1488

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$8,806,000	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$8,806,000	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$8,806,000	\$0

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)
 AB 80 (Chapter 12, Sec 52, Statutes of 2020)

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 closeout continuing through December 2022 and auditing until September 30, 2023. 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 Promoting Interoperability Program. The Medi-Cal Fiscal Intermediary (FI)

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER: 230

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. Contractor costs related to the State's Health Information Technology program are budgeted separately in the ARRA HITECH Incentive Program policy change.

Historically, 60% of applications had received technical assistance through California Provider Technical Assistance Program (CTAP). Since the CTAP has ended, the Department anticipated a 60% reduction in applications. However, larger groups that have participated in CTAP, including Los Angeles County, have advised the Department they will apply on their own and without technical assistance. Additionally, recent stakeholder engagement has identified a "last year" effect, as providers realize this is their last opportunity to get a payment before the program ends, resulting in a 5% increase in applications as a result of this factor.

Reason for Change:

There is no change, from the prior estimate, for FY 2021-22. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due incentive payments concluding December 31, 2021.

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 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.
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.
5. The estimated payments for FY 2021-22 are on a cash-basis.

ARRA HITECH - PROVIDER PAYMENTS
REGULAR POLICY CHANGE NUMBER: 230

FY 2021-22 Professional Incentive Payments			
Eligibility Year	Professionals	Incentive Payments	FF
2	126	\$8,500	\$1,071,000
3	136	\$8,500	\$1,156,000
4	155	\$8,500	\$1,317,500
5	277	\$8,500	\$2,354,500
6	342	\$8,500	\$2,907,000
Total FY 2021-22 Professional Payments			\$8,806,000

FY 2021-22 Hospital Incentive Payments			
Eligibility Year	Hospitals	Incentive Payments	FF
1	0	\$0	\$0
2	0	\$0	\$0
3	0	\$0	\$0
4	0	\$0	\$0
Potential OIG Overpayments			\$0
Total FY 2021-22 Hospital Payments			\$0

Fiscal Year	Professional Payments	Hospital Payments	FF
FY 2021-22	\$8,806,000	\$0	\$8,806,000

Funding:

100% Title XIX (4260-101-0890)

TRIBAL FEDERALLY QUALIFIED HEALTH CENTER

REGULAR POLICY CHANGE NUMBER: 231
IMPLEMENTATION DATE: 1/2021
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2195

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$9,401,000	\$23,732,000
- STATE FUNDS	\$2,440,750	\$6,161,250
PAYMENT LAG	0.9650	1.0000
% REFLECTED IN BASE	20.58 %	18.54 %
APPLIED TO BASE		
TOTAL FUNDS	\$7,205,000	\$19,332,100
STATE FUNDS	\$1,870,600	\$5,018,950
FEDERAL FUNDS	\$5,334,360	\$14,313,130

Purpose:

This policy change estimates the cost to create a Tribal Federally Qualified Health Center (FQHC) provider type in Medi-Cal.

Authority:

State Plan Amendment 20-0044

Interdependent Policy Changes:

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

Background:

The Department established the Tribal FQHC provider type in Medi-Cal effective May 1, 2021. The Tribal FQHC provider type option allows Tribal health clinics to provide services outside the four walls of the facility to Medi-Cal patients other than homeless individuals. Additionally, it allows Tribal health clinics to bill for optional benefits similar to the existing FQHC provider type.

Reason for Change:

The change from the prior estimate, FY 2021-22, is a decrease due to a shift in the implementation date from January 1, 2021, to May 1, 2021. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to a ramp up in expenditures in FY 2022-23.

Methodology:

1. Beginning May 1, 2021, assume the Department can reimburse Tribal FQHCs for providing benefits.
2. Assume the cost to reimburse Tribal FQHC providers is \$9,401,000 TF in FY 2021-22 and \$23,732,000 TF in FY 2022-23.

TRIBAL FEDERALLY QUALIFIED HEALTH CENTER
REGULAR POLICY CHANGE NUMBER: 231

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF	\$4,409,000	\$2,204,000	\$2,205,000
100% Title XIX FFP	\$3,102,000	\$0	\$3,102,000
65% Title XXI / 35% GF	\$189,000	\$66,000	\$123,000
90% Title XIX ACA / 10% GF	\$1,701,000	\$170,000	\$1,531,000
FY 2021-22 Total	\$9,401,000	\$2,440,000	\$6,961,000

*Totals may differ due to rounding

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF	\$11,130,000	\$5,565,000	\$5,565,000
100% Title XIX FFP	\$7,832,000	\$0	\$7,832,000
65% Title XXI / 35% GF	\$477,000	\$167,000	\$310,000
90% Title XIX ACA / 10% GF	\$4,293,000	\$429,000	\$3,864,000
FY 2022-23 Total	\$23,732,000	\$6,161,000	\$17,571,000

*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 December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

OUTREACH & ENROLLMENT ASSIST. FOR DUAL BENES

REGULAR POLICY CHANGE NUMBER: 232
IMPLEMENTATION DATE: 2/2022
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2305

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$2,000,000	\$5,000,000
- STATE FUNDS	\$2,000,000	\$5,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,000,000	\$5,000,000
STATE FUNDS	\$2,000,000	\$5,000,000
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the costs for eligibility outreach and enrollment for beneficiaries dually eligible for Medicare and Medi-Cal.

Authority:

SB 129 (Chapter 69, Statute of 2021)

Interdependent Policy Changes:

Not Applicable

Background:

Per SB 129 (Chapter 69, Statutes of 2021), the Department will contract with a nonprofit agency for Medicare and Medi-Cal eligibility outreach and enrollment efforts, for a total of \$12 million in funding to be available for encumbrance or expenditure until June 30, 2024. The population of focus for this contract is low-income individuals potentially eligible for both Medicare and Medi-Cal. Since the outreach and enrollment efforts will primarily be for Medicare, federal Medicaid funds are not available. The outreach and enrollment would be conducted in coordination with the California Department of Aging and the Health Insurance Counseling and Advocacy Program (HICAP).

Reason for Change:

The change in FY 2021-22, from the prior estimate, is a decrease due to the updated timing of the contract start-up. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to five months of payments budgeted in FY 2021-22 and 12 months of payments budgeted in FY 2022-23.

Methodology:

1. This policy change budgets for a Department contract for Medicare outreach and enrollment assistance for dually eligible individuals.

OUTREACH & ENROLLMENT ASSIST. FOR DUAL BENES
REGULAR POLICY CHANGE NUMBER: 232

Fiscal Year	TF	GF	FF
FY 2021-22	\$2,000,000	\$2,000,000	\$0
FY 2022-23	\$5,000,000	\$5,000,000	\$0

Funding:

100% State General Fund

HPSM DENTAL INTEGRATION PILOT PROGRAM

REGULAR POLICY CHANGE NUMBER: 233
IMPLEMENTATION DATE: 1/2022
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2266

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$606,000	\$78,000
- STATE FUNDS	\$244,350	\$31,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$606,000	\$78,000
STATE FUNDS	\$244,350	\$31,600
FEDERAL FUNDS	\$361,650	\$46,400

Purpose:

The policy change estimates the cost to implement a dental integration pilot program in San Mateo County as a component of the Medi-Cal demonstration project.

Authority:

SB 849 (Chapter 47, Statutes of 2018)

Interdependent Policy Changes:

CalAIM - Dental Initiatives
 COVID-19 Increased FMAP Extension

Background:

SB 849 permits the Department to authorize a dental integration pilot program in San Mateo County as a component of the Medi-Cal demonstration project, subject to appropriation by the Legislature and federal approval. On January 1, 2022, the Department will transition dental benefits for enrollees in Health Plan of San Mateo (HPSM) from the fee-for-service (FFS) delivery system to the HPSM.

The Department will also contract for an evaluation of the pilot program, using funding provided by the HPSM, to be completed and published no later than December 31 of the 6th fiscal year the pilot program is in operation.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a decrease due to updated FFS payment lag factors. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to decrease and completion of lagged FFS payments.

Methodology:

1. Implementation effective January 1, 2022.
2. Any portion of the rate attributable to CalAIM Dental Initiatives is captured in its respective policy change.

HPSM DENTAL INTEGRATION PILOT PROGRAM

REGULAR POLICY CHANGE NUMBER: 233

3. Costs are calculated based on previous FFS payment data for HPSM enrollees, with the assumption that benefit costs in managed care will be the same as in FFS. Additional costs captured in this policy change are the remaining FFS costs, with appropriate payment lags.

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF	\$400,000	\$200,000	\$200,000
ACA 90% FFP/10% GF (2020)	\$111,000	\$11,000	\$100,000
Title 21 65% FFP/35% GF	\$95,000	\$33,000	\$62,000
Total	\$606,000	\$244,000	\$362,000

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF	\$52,000	\$26,000	\$26,000
ACA 90% FFP/10% GF (2020)	\$14,000	\$1,000	\$13,000
Title 21 65% FFP/35% GF	\$12,000	\$4,000	\$8,000
Total	\$78,000	\$31,000	\$47,000

*Totals may differ due to rounding.

Funding:

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

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

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

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

WPCS WORKERS' COMPENSATION

REGULAR POLICY CHANGE NUMBER: 234
IMPLEMENTATION DATE: 11/2016
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1866

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$682,000	\$682,000
- STATE FUNDS	\$341,000	\$341,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$682,000	\$682,000
STATE FUNDS	\$341,000	\$341,000
FEDERAL FUNDS	\$341,000	\$341,000

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) 19-96325

Interdependent Policy Changes:

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

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 contract, IA 19-96325, was implemented effective July 1, 2019, and will remain in effect until June 30, 2022.

Reason for Change:

The change in the current estimate, for FY 2021-22, is a decrease due to updated contract costs from CDSS in the IA which reflects actual costs providing WPCS workers' compensation. There is no change from FY 2021-22 to FY 2022-23, in the current estimate.

Methodology:

1. The current Workers' Compensation contract, IA 19-96325, went into effect July 1, 2019, and will be in effect until June 30, 2022. The estimated costs are based on the assumption that a new or amended contract will be implemented effective July 1, 2022.

WPCS WORKERS' COMPENSATION

REGULAR POLICY CHANGE NUMBER: 234

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 2021-22 and FY 2022-23 is \$682,000 TF.

Fiscal Year	TF	GF	FF
FY 2021-22	\$682,000	\$341,000	\$341,000
FY 2022-23	\$682,000	\$341,000	\$341,000

Funding:

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

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

CYBHI - EVIDENCE-BASED BH PRACTICES

REGULAR POLICY CHANGE NUMBER: 236
IMPLEMENTATION DATE: 7/2022
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2323

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$429,000,000
- STATE FUNDS	\$0	\$429,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$429,000,000
STATE FUNDS	\$0	\$429,000,000
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the cost of supporting scaling and spreading of evidence-based interventions statewide to improve outcomes for children and youth with, or at high risk for, mental health conditions, including a focus on youths experiencing their first break or first episode of psychosis, and/or developing substance use disorders (SUDs).

Authority:

AB 133 (Chapter 143, Statutes of 2021)

Interdependent Policy Changes:

Not Applicable

Background:

The Department, with assistance from a stakeholder workgroup, will select a limited number of evidence-based practices to scale throughout the state based on robust evidence for effectiveness, positive impact on equity, and sustainability. Funding will be issued through grants to counties, tribal entities, commercial plans, managed care plans, community-based organizations, and behavioral health providers to support implementation of these evidence-based practices and programs for children and youth. Grants for county behavioral health departments would be administered through the Department. Grants and incentives for commercial health care and for-profit delivery systems would be administered through a third-party grant administrator, obtained through a Request for Proposal (RFP). Grantees would be required to share standardized data in a statewide behavioral health dashboard.

This proposal would issue grants to ensure that a select group of evidence-based Behavioral Health (BH) practices, such as multi-disciplinary team care for the first episode of psychosis, are available throughout the state.

The Children and Youth Behavioral Health Initiative (CYBHI) is a multiyear package of investments. The CYBHI is intended to transform California's behavioral health system for children and youth aged 0-25 into a world-class, innovative, up-stream focused, ecosystem where all children and young adults are routinely screened, supported, and served for emerging behavioral health needs.

CYBHI - EVIDENCE-BASED BH PRACTICES

REGULAR POLICY CHANGE NUMBER: 236

Reason for Change:

This is a new policy change.

Methodology:

1. This proposal would develop a stakeholder workgroup to identify a small number of evidence-based practices that would then be deployed across the state, through grant-making. The \$429,000,000 is proposed to be available for encumbrance or expenditure until June 30, 2025.
2. The estimate for FY 2022-23 is:

(Dollars in Thousands)

Evidence-Based Behavioral Health Practices	TF	GF
FY 2022-23	\$429,000	\$429,000

Funding:

100% Title XIX GF (4260-101-0001)

CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER: 238
IMPLEMENTATION DATE: 1/2006
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1087

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

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: 238

Methodology:

FY 2021-22	
Hospital Services Account	\$97,987,000
Physicians' Services Account	\$27,831,000
Unallocated Account	\$49,196,000
Total CTPS/Prop. 99	\$175,014,000
GF	(\$175,014,000)
Net Impact	\$0

FY 2022-23	
Hospital Services Account	\$89,639,000
Physicians' Services Account	\$25,769,000
Unallocated Account	\$39,512,000
Total CTPS/Prop. 99	\$154,920,000
GF	(\$154,920,000)
Net Impact	\$0

Funding:

Proposition 99 Hospital Services Account (4260-101-0232)
 Proposition 99 Physician Services Account (4260-101-0233)
 Proposition 99 Unallocated Account (4260-101-0236)
 Title XIX GF (4260-101-0001)

CLPP FUND

REGULAR POLICY CHANGE NUMBER: 239
IMPLEMENTATION DATE: 7/2005
ANALYST: Sasha Jetton
FISCAL REFERENCE NUMBER: 1633

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$916,000	\$916,000
- STATE FUNDS	\$916,000	\$916,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$916,000	\$916,000
STATE FUNDS	\$916,000	\$916,000
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the Childhood Lead Poisoning Prevention (CLPP) Fund allocation to counties for monitoring and oversight of blood lead testing activities.

Authority:

Health & Safety Code, Sections 105285,105286,105295,105305 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: 239

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:

As compared to the prior estimate, the general fund offset is no longer assumed. There is no change between fiscal years.

Methodology:

The CLPP Funding for FY 2021-22 and FY 2022-23 is assumed to be \$916,000.

Funding:

100% CLPP Fund (4260-111-0080)

AUDIT SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 240
IMPLEMENTATION DATE: 7/2016
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 110

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$9,427,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$9,427,000	\$0
FEDERAL FUNDS	-\$9,427,000	\$0

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:

There is no change from the prior estimate for FY 2021-22. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to the settlements being one-time payments.

AUDIT SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 240

Methodology:

List of audit settlements anticipated to be repaid in FY 2021-22:

No	Audit Number	Audit Title & Status	Program Responsible	Original Audit Amount	Adjusted Amount
1	A-09-15-02020	California Improperly Claimed Federal Medicaid Reimbursement for Nonemergency Services Provided to Some Qualified Aliens	Medi-Cal Eligibility Division	\$9,872,618	\$3,775,832
2	A-09-16-02004	California Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals	Enterprise Data and Information Management	\$10,273,335	\$5,650,820
				Total	\$9,426,652

Fiscal Year	TF	GF	FF
FY 2021-22	\$0	\$9,427,000	(\$9,427,000)

Funding:

100% GF (4260-101-0001)

Title XIX FFP (4260-101-0890)

IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER: 241
IMPLEMENTATION DATE: 4/2017
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 35

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$70,954,000	\$37,080,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$70,954,000	\$37,080,000
FEDERAL FUNDS	-\$70,954,000	-\$37,080,000

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: 241

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 2021-22, is an increase due to:

- Adding repayments for FY 2018-19 Q1 through Q4, and FY 2019-20 Q1 through Q4, that were previously assumed to be paid in FY 2020-21;
- Adjusting the repayments to be projected based on actual IMD amounts from the last eight quarters of FY 2018-19 and FY 2020-21 and applying average estimated quarterly repayments;
- Adjusting for a FFS repayment for FY 2020-21 Q1, previously expected to be repaid in FY 2020-21, shifted and will be paid in FY 2021-22; and
- Removing a MC repayment for FY 2020-21 Q1 and Q2, expected to be repaid in FY 2021-22, which was actually repaid in FY 2020-21.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to the estimated repayments that will occur in FY 2021-22.

Methodology:

1. The costs for ancillary services provided to beneficiaries in IMDs are in the Medi-Cal base estimate.
2. The FFS estimated amounts for FY 2021-22 and FY 2022-23 are based on actual deferral repayment amounts for the last eight quarters, using an average estimated repayments to future quarters.
3. For FY 2021-22, the Department estimates to repay FFS deferrals from July 2018 through September 2021 and managed care deferrals from January 2021 through December 2021.
4. For FY 2022-23, the Department estimates to repay FFS deferrals from October 2021 through September 2022 and managed care deferrals from July 2022 through December 2022.

IMD ANCILLARY SERVICES
REGULAR POLICY CHANGE NUMBER: 241

5. The estimated IMD repayments are:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
Fee-For-Service (FFS)			
FY 2018-19 Q1 (July-Sept 2018)	\$0	\$2,086	(\$2,086)
FY 2018-19 Q2 (Oct-Dec 2018)	\$0	\$1,133	(\$1,133)
FY 2018-19 Q3 (Jan-Mar 2019)	\$0	\$4,098	(\$4,098)
FY 2018-19 Q4 (Apr-Jun 2019)	\$0	\$4,692	(\$4,692)
Subtotal FY 2018-19	\$0	\$12,009	(\$12,009)
FY 2019-20 Q1 (July-Sept 2019)	\$0	\$2,924	(\$2,924)
FY 2019-20 Q2 (Oct-Dec 2019)	\$0	\$4,419	(\$4,419)
FY 2019-20 Q3 (Jan-Mar 2019)	\$0	\$5,242	(\$5,242)
FY 2019-20 Q4 (Apr-Jun 2019)	\$0	\$7,069	(\$7,069)
Subtotal FY 2019-20	\$0	\$19,654	(\$19,654)
FY 2020-21 Q1 (July-Sept 2020)	\$0	\$2,211	(\$2,211)
FY 2020-21 Q2 (Oct-Dec 2020)	\$0	\$6,958	(\$6,958)
FY 2020-21 Q3 (Jan-Mar 2021)	\$0	\$6,958	(\$6,958)
FY 2020-21 Q4 (Apr-Jun 2021)	\$0	\$6,958	(\$6,958)
Subtotal FY 2020-21	\$0	\$23,085	(\$23,085)
FY 2021-22 Q1 (July-Sept 2021)	\$0	\$6,958	(\$6,958)
Subtotal FFS	\$0	\$61,706	(\$61,706)
Managed Care			
FY 2020-21 Q3 and Q4 (Jan-Jun 2021)	\$0	\$4,612	(\$4,612)
FY 2021-22 Q1 and Q2 (Jul-Dec 2021)	\$0	\$4,636	(\$4,636)
Subtotal Managed Care		\$9,248	(\$9,248)
Total FY 2021-22	\$0	\$70,954	(\$70,954)

IMD ANCILLARY SERVICES
REGULAR POLICY CHANGE NUMBER: 241

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Fee-For-Service (FFS)			
FY 2021-22 Q2 (Oct-Dec 2021)	\$0	\$6,958	(\$6,958)
FY 2021-22 Q3 (Jan-Mar 2022)	\$0	\$6,958	(\$6,958)
FY 2021-22 Q4 (Apr-Jun 2022)	\$0	\$6,958	(\$6,958)
FY 2022-23 Q1 (July-Sept 2022)	\$0	\$6,958	(\$6,958)
Subtotal FFS	\$0	\$27,832	(\$27,832)
Managed Care			
FY 2021-22 Q3 and Q4 (Jan-Jun 2022)	\$0	\$4,624	(\$4,624)
FY 2021-22 Q1 and Q2 (Jul- Dec 2022)	\$0	\$4,624	(\$4,624)
Subtotal Managed Care	\$0	\$9,248	(\$9,248)
Total FY 2022-23	\$0	\$37,080	(\$37,080)

Funding:

100% General Fund (4260-101-0001)

Title XIX FFP (4260-101-0890)

FUNDING ADJUST.—ACA OPT. EXPANSION

REGULAR POLICY CHANGE NUMBER: 242
IMPLEMENTATION DATE: 7/2015
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1915

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$1,935,296,400	-\$1,883,833,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$1,935,296,400	-\$1,883,833,600
FEDERAL FUNDS	\$1,935,296,400	\$1,883,833,600

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:

Not applicable

Background:

Effective January 1, 2014, the ACA expanded 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 provided an enhanced federal match for optional expansion adults of 100% through calendar year (CY) 2016, and then decreased the match in yearly phases to 90% by 2020.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is an increase in general fund savings due to updated policy changes. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease in general fund savings due to updated policy changes.

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 2021-22 and FY 2022-23 is 90%.
- 3) The total amount of unadjusted ACA optional expansion funding for all policy changes in FY 2021-22 is estimated as \$4,838,241,057 and \$4,709,584,334 in FY 2022-23. These amounts are credited to the Title XIX fund.

FUNDING ADJUST.—ACA OPT. EXPANSION
REGULAR POLICY CHANGE NUMBER: 242

4) The amounts adjusted by this policy change are as follows:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
50% Title XIX / 50%GF	(\$4,838,241)	(\$2,419,121)	(\$2,419,121)
90% Title XIX ACA FF / 10% GF	\$4,838,241	\$483,824	\$4,354,417
Total	\$0	(\$1,935,296)	\$1,935,296

*Totals may differ due to rounding

FY 2022-23	TF	GF	FF
50% Title XIX / 50%GF	(\$4,709,584)	(\$2,354,792)	(\$2,354,792)
90% Title XIX ACA FF / 10% GF	\$4,709,584	\$470,958	\$4,238,626
Total	\$0	(\$1,883,834)	\$1,883,834

*Totals may differ due to rounding.

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 December 31, 2021, is identified in the COVID-19 Increased FMAP
– DHCS policy change

FUNDING ADJUST.—OTLICP

REGULAR POLICY CHANGE NUMBER: 243
IMPLEMENTATION DATE: 7/2015
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1926

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$83,277,900	-\$84,073,950
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$83,277,900	-\$84,073,950
FEDERAL FUNDS	\$83,277,900	\$84,073,950

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:

Not applicable

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.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a general fund savings decrease due to updated policy changes. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a general fund savings increase due to updated 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.

FUNDING ADJUST.—OTLICP
REGULAR POLICY CHANGE NUMBER: 243

- 2) The total amount of unadjusted CHIP funding for all policy changes in FY 2021-22 is estimated as \$555,186,335 and \$560,492,783 in FY 2022-23. 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.
- In FY 2021-22, the Department estimates the additional CHIP funding will offset general fund spending by \$83.3M.
 - In FY 2022-23, the Department estimates the additional CHIP funding will offset general fund spending by \$84.1M.
- 4) The amounts adjusted by policy change are as follows:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
50% Title XIX / 50%GF	(\$555,186)	(\$277,593)	(\$277,593)
65% Title XXI FF / 35% GF	\$555,186	\$194,315	\$360,871
Total	\$0	(\$83,278)	\$83,278

*Totals may differ due to rounding

FY 2022-23	TF	GF	FF
50% Title XIX / 50%GF	(\$560,493)	(\$280,246)	(\$280,246)
65% Title XXI FF / 35% GF	\$560,493	\$196,172	\$364,320
Total	\$0	(\$84,074)	\$84,074

*Totals may differ due to rounding.

Funding:

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

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

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 244
IMPLEMENTATION DATE: 4/2015
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1760

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

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: 244

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 HQAF VI program period (July 1, 2019 through December 31, 2021) in February 2020. This QAF program period is referred to as HQAF VI.

The Department is currently developing the next program period (HQAF VII) which will include payments for the period beginning January 1, 2022. The Department will seek federal approval for QAF VII in Quarter 2 of FY 2021-22.

Reason for Change:

The change from the prior estimate is an increase in children's health care payments in FY 2021-22. HQAF VI cycle 7 payments, totaling \$189.225 million GF savings, were delayed and shifted from FY 2020-21 to FY 2021-22.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase because FY 2022-23 includes full quarterly payments while there was one quarter of partial payments included in FY 2021-22.

Methodology:

1. Payments for children's health care are estimated through the period ending June 30, 2023 in this policy change.
2. The HQAF VI program period covers a 30-month period from July 1, 2019, through December 31, 2021.
3. 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.
4. HQAF VI payments are based on the HQAF VI model that was approved by CMS on In February 2020. The payment schedule is still under development, so timings are subject to change.
5. HQAF VI children's coverage payments for FY 2019-20 and FY 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.
6. Assume the HQAF VII program period covers at least a 12-month period from January 1, 2022, through December 31, 2022.
7. HQAF VII estimated payments are based on the HQAF VI model that was approved by CMS in February 2020. HQAF VII payments are estimated with reductions anticipated due to CalAIM transition from FFS to MC. The payment schedule and amounts for HQAF VII are still under development. Payment timing and amounts are subject to change.

HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 244

8. On an accrual basis, annual funds for children's health care coverage are estimated to be:

(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

(Dollars in Thousands)

Fiscal Year	Authority	HQAF VII Period (Pending)	Amount
FY 2021-22	Proposition 52	1/1/22 to 6/30/22	\$488,000
FY 2022-23	Proposition 52	7/1/22 to 12/31/22	\$488,000

9. Four quarters of HQAF VI children's health care payments will be paid in FY 2021-22. The HQAF VI Cycle 7 payment has been reduced in response to the COVID-19 emergency and will be reconciled at a later date.
10. Four quarters of HQAF VII Children's Health Care payments will be paid in FY 2022-23.
11. On a cash basis, the payments to health care coverage for children and the funding adjustment are:

(Dollars in Thousands)

FY 2021-22	TF	GF	Hosp. QA Rev Fund
FY 2020-21	\$0	(\$441,525)	\$441,525
FY 2021-22	\$0	(\$509,250)	\$509,250
Total FY 2021-22	\$0	(\$950,775)	\$950,775

(Dollars in Thousands)

FY 2022-23	TF	GF	Hosp. QA Rev Fund
FY 2021-22	\$0	(\$488,000)	\$488,000
FY 2022-23	\$0	(\$488,000)	\$488,000
Total FY 2022-23	\$0	(\$976,000)	\$976,000

Funding:

100% GF (4260-101-0001)

100% Hospital Quality Assurance Revenue Fund (4260-611-3158)

CMS DEFERRED CLAIMS

REGULAR POLICY CHANGE NUMBER: 245
IMPLEMENTATION DATE: 4/2017
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 2034

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$177,234,000	-\$233,240,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$177,234,000	-\$233,240,000
FEDERAL FUNDS	-\$177,234,000	\$233,240,000

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 administrative deferral repayments are budgeted in a separate policy change. See the CMS Deferred Claims – Other Admin policy change for more information.

CMS DEFERRED CLAIMS

REGULAR POLICY CHANGE NUMBER: 245

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to:

- Including the actual FFY 2021 Quarter 1 and FFY 2021 Quarter 2 deferral repayments,
- Including estimated FFY 2021 Q3 and FFY 2021 Q4 deferrals for state only claims related to the managed care proxy,
- Shifting the estimated FFY 2022 Quarter 1 deferral from FY 2021-22 to FY 2022-23,
- Including actual resolved deferrals returned to the GF in FY 2021-22, and
- Updating the estimated resolved deferrals for other state only costs based on actual deferrals received for FFY 2020 Quarter 4 through FFY Quarter 2 2021.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to:

- Actual CMS deferral repayment amounts in FY 2021-22,
- Actual resolved deferrals returned to the GF in FY 2021-22,
- The expected end of state only claims deferrals, and
- Estimating all deferrals related to state only claims will be resolved and returned to the GF in FY 2022-23.

Methodology:

1. The Department received CMS deferrals for FFY 2015 Quarter 1 through FFY 2021 Quarter 2.
2. In FY 2021-22, the Department estimates to repay a total of \$335.55 million FF, which includes \$137.9 million of actual CMS deferrals issued for FFY 2021 Quarter 1 and FFY 2021 Quarter 2.
3. Repayment actuals for state only costs deferrals totaling \$113.2 million FF for FFY 2021 Quarter 1 and FFY 2021 Quarter 2, are included in FY 2021-22.
4. Repayments for state only costs deferrals are estimated to be \$210.83 million in FY 2021-22 consisting of \$42.7 million per quarter from FFY 2021 Quarter 1 through FFY 2021 Quarter 4 related to the managed care proxy, \$12 million per quarter from FFY 2021 Quarter 1 through FFY 2021 Quarter 3 related to pharmacy claims, and \$3.7 million in FFY 2021 Quarter 1 related to other state only claims. Additional deferrals for pharmacy claims are not assumed for FFY 2021 Quarter 4 and later quarters and additional deferrals for other state only claims are not assumed for FFY 2021 Quarter 2 and later quarters, consistent with the expected implementation of correct claiming for these items.
5. Repayments for state only cost deferrals are estimated to be \$42.7 million in FY 2022-23 for FFY 2022 Quarter 1 claims related to the managed care proxy. Additional deferrals for the managed care proxy are not assumed for FFY 2022 Quarter 2 and later quarters.
6. An additional placeholder amount of \$50 million per quarter is estimated for all quarters from FFY 2021 Quarter 3 through FFY 2022 Quarter 4.
7. The Department estimates recovering \$158.3 million in resolved deferrals during FY 2021-22. This includes \$53 million in actual resolved deferrals; \$56.7 million in recovered deferred funds related to state only costs, specifically those related to issues other than managed care and pharmacy; and \$48.5 million in resolved deferrals related to the Community First Choice Program (CFCO).

CMS DEFERRED CLAIMS
REGULAR POLICY CHANGE NUMBER: 245

8. The Department estimates all remaining previously deferred funds related to state only costs, including managed care proxy, pharmacy claims, and other state only claims totaling \$437.7 million will be resolved during FY 2022-23.
9. In FY 2022-23, the Department estimates \$38.3 million will be resolved related to the CFCO deferrals.
10. The Department will repay the following estimated deferred claims:

(Dollars in Thousands)

FY 2021-22	Total Estimated Repayment
FFY 2021 Quarter 1 (Oct-Dec 2020)	\$69,910
FFY 2021 Quarter 2 (Jan-Mar 2021)	\$68,084
FFY 2021 Quarter 3 (Apr-Jun 2021)	\$104,779
FFY 2021 Quarter 4 (Jul-Sep 2021)	\$92,779
Subtotal Estimated Repayments	\$372,247
Resolved Deferrals	(\$158,318)
Total FY 2021-22	\$177,234

FY 2022-23	Total Estimated Repayment
FFY 2022 Quarter 1 (Oct-Dec 2021)	\$92,779
FFY 2022 Quarter 2 (Jan-Mar 2022)	\$50,000
FFY 2022 Quarter 3 (Apr-Jun 2022)	\$50,000
FFY 2022 Quarter 4 (Jul-Sep 2022)	\$50,000
Subtotal Estimated Repayments	\$242,779
Estimated Resolved Deferrals	(\$476,019)
Total FY 2021-22	(\$233,240)

Funding:

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

100% Title XIX GF (4260-101-0001)

INDIAN HEALTH SERVICES FUNDING SHIFT

REGULAR POLICY CHANGE NUMBER: 248
IMPLEMENTATION DATE: 7/2019
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2156

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$12,103,000	-\$13,391,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$12,103,000	-\$13,391,000
FEDERAL FUNDS	\$12,103,000	\$13,391,000

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:

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

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: 248

Reason for Change:

The change from the prior estimate, for FY 2021-22, is an increase based on two additional quarters of actuals trending in more visits. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to growth in the estimated rate for CY 2023.

Methodology:

1. Currently, there are 102 Indian health clinics participating in Medi-Cal and 6 YRTC's.
2. Assume a one quarter lag when the claims from 50% GF / 50% FF to 100% FFP is adjusted.
3. In FY 2021-22, it is estimated the Department will spend \$24,206,000 TF (\$12,103,000 GF).
4. In FY 2022-23, it is estimated the Department will spend \$26,782,000 TF (\$13,391,000 GF).

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
IHS FY 2021-22 Base exp. (50% GF / 50% FF)	(\$24,206)	(\$12,103)	(\$12,103)
IHS total expenditures (100% FF)	\$24,206	\$0	\$24,206
FY 2021-22 Total	\$0	(\$12,103)	\$12,103

FY 2022-23	TF	GF	FF
IHS FY 2022-23 Base exp. (50% GF / 50% FF)	(\$26,782)	(\$13,391)	(\$13,391)
IHS total expenditures (100% FF)	\$26,782	\$0	\$26,782
FY 2022-23 Total	\$0	(\$13,391)	\$13,391

*Totals may differ due to rounding.

Funding:

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

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

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

COUNTY SHARE OF OTLICP-CCS COSTS

REGULAR POLICY CHANGE NUMBER: 249
IMPLEMENTATION DATE: 7/2014
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 1906

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	-\$25,466,000	-\$25,337,000
- STATE FUNDS	-\$25,466,000	-\$25,337,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$25,466,000	-\$25,337,000
STATE FUNDS	-\$25,466,000	-\$25,337,000
FEDERAL FUNDS	\$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

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 was funded with 88% FFP, 6% GF, and 6% county funds. From October 1, 2019, to September 30, 2020, CCS-HFP was funded with 76.5% FFP, 11.75% GF, and 11.75% county funds. Effective October 1, 2020 CCS-HFP is funded with 65% FFP, 17.5% GF, and 17.5% county funds. It is assumed that the county share will continue under OTLICP.

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.

COUNTY SHARE OF OTLICP-CCS COSTS

REGULAR POLICY CHANGE NUMBER: 249

Reason for Change:

There is no change from the prior estimate for FY 2021-22. The change from FY 2021-22 to 2022-23, in the current estimate, is a slight decrease due to updated monthly expenditures.

Methodology:

1. The county share reimbursement for OTLICP-CCS in FY 2021-22, at 17.5% for quarter 1 through 4, is estimated to be \$25,748,000.
2. The county share reimbursement for OTLICP-CCS in FY 2022-23, at 17.5% for quarter 1 through 4, is estimated to be \$25,337,000.
3. 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 OTLICP-CCS costs by \$282,000.
4. The 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through December 31, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022, on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension policy change.
5. The county share of OTLICP-CCS costs is estimated in the table below:

Fiscal Year	TF	GF	CF*
FY 2021-22	(\$25,466,000)	(\$25,466,000)	\$25,466,000
FY 2022-23	(\$25,337,000)	(\$25,337,000)	\$25,337,000

* 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)

QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES

REGULAR POLICY CHANGE NUMBER: 252
IMPLEMENTATION DATE: 1/2023
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2329

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$108,483,000
- STATE FUNDS	\$0	\$16,272,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$108,483,000
STATE FUNDS	\$0	\$16,272,000
FEDERAL FUNDS	\$0	\$92,211,000

Purpose:

This proposal estimates the cost for counties to provide qualifying community-based mobile crisis intervention services to Medi-Cal beneficiaries in need of behavioral health services.

Authority:

Welfare & Institutions Code 14680-14685.1
 California Constitution Article XIII Section 36
 Specialty Mental Health Services (SMHS) Program 1915(b) Waiver
 Drug Medi-Cal Organized Delivery System (DMC-ODS) 1115 Waiver
 22 CCR § 51341.1
 American Rescue Plan (ARP) Act of 2021

Interdependent Policy Changes:

Not Applicable

Background:

Under existing law, all specialty mental health plans are required to provide crisis intervention, which may be provided anywhere in the community. However, these are not currently required to be "mobile" services and do not meet all of the requirements in the new federal definition for qualifying community-based mobile crisis intervention services.

The Department proposes to add qualifying community-based mobile crisis intervention services, as soon as January 1, 2023, for a five year period, as a mandatory Medi-Cal benefit available to eligible Medi-Cal beneficiaries, statewide, 24 hours a day, 7 days a week, implemented through county behavioral health delivery systems by multidisciplinary mobile crisis teams in the community. The services would cover both mental health crises, using the specialty mental health benefit, such as crisis intervention services, and Substance Use Disorder (SUD) crises - adding crisis intervention as a component of outpatient services, also known as Outpatient Drug-Free services, in the Drug Medi-Cal State Plan. The Department will develop statewide standards for the new service, such as a requirement for the outreach team to include both a licensed provider, such as a social worker, and a peer support specialist. The benefit would be provided outside a hospital or other facility setting and include screening and assessment, stabilization and de-escalation, and coordination with and referrals to health, social, and other services and supports, as appropriate.

QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES

REGULAR POLICY CHANGE NUMBER: 252

Section 9813 of the ARP provides states with the option of providing qualifying community-based mobile crisis intervention services during a five-year period, starting April 1, 2022, with an opportunity for three years of 85 percent federal medical assistance percentage for qualifying services. The ARP requires the additional federal medical assistance percentage to supplement, not supplant, the level of state spending for these services in the fiscal year before the first quarter the state elects to implement this service. No current Medi-Cal services meet the federal definition of a qualifying community-based mobile crisis intervention service.

Reason for Change:

This is a new policy change.

Methodology:

- To estimate the cost of qualifying community-based mobile crisis intervention services related to SMHS, use the total of FY 2018-19 approved claims for Crisis Stabilization (CS) as the basis. Assume the annual cost for qualifying community-based mobile crisis intervention services will be three times the total of FY 2018-19 CS approved claims.
- For qualifying community-based mobile crisis intervention related to SUD, assume the annual cost is one-third of the total of FY 2018-19 CS approved claims. Assume the split between DMC ODS and DMC State Plan counties is 80% and 20%, respectively.
- Beginning January 1, 2023, under the ARP Act, initial funding splits for qualifying community-based mobile crisis intervention services will be covered with 85% federal funds and 15% State General fund through 2025. The accrual estimate for FY 2022-23 is:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Mobile crisis intervention – SMHS	\$147,196	\$22,079	\$125,117
Mobile crisis intervention – DMC-ODS	\$11,776	\$1,766	\$10,010
Mobile crisis intervention – DMC State Plan	\$2,944	\$442	\$2,502
Total	\$161,916	\$24,287	\$137,629

- Assume 67% of claims for mobile crisis intervention will be paid in the year services are provided and 33% paid in the subsequent year. The cash estimate for FY 2022-23 is:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Mobile crisis intervention – SMHS	\$98,621	\$14,793	\$83,828
Mobile crisis intervention – DMC-ODS	\$7,890	\$1,184	\$6,706
Mobile crisis intervention – DMC State Plan	\$1,972	\$295	\$1,677
Total	\$108,483	\$16,272	\$92,211

Funding:

85% Title XIX FF / 15% GF (4260-101-0001/0890)

AMERICAN RESCUE PLAN INCREASED FMAP FOR HCBS

REGULAR POLICY CHANGE NUMBER: 254
IMPLEMENTATION DATE: 1/2022
ANALYST: Ryan Woolsey
FISCAL REFERENCE NUMBER: 2338

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$2,542,701,000	-\$484,094,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$2,542,701,000	-\$484,094,000
FEDERAL FUNDS	\$2,542,701,000	\$484,094,000

Purpose:

This policy change budgets the receipt of 10 percent increased federal medical assistance percentage (FMAP) for certain home- and community-based services (HCBS).

Authority:

American Rescue Plan (ARP) Act of 2021

Interdependent Policy Changes:

Not Applicable

Background:

The ARP provides additional Coronavirus Disease 2019 relief to states. Section 9817 of ARP includes a provision that temporarily increases the state's FMAP for HCBS by 10%. This provision is effective for eligible HCBS expenditures made during the period of April 1, 2021 through March 31, 2022. As a condition of accepting the increased FMAP, the state is required to expend the additional funds on HCBS program improvement. The ARP defines program improvement as implementing or supplementing implementation of one or more activities to enhance, expand, or strengthen HCBS in the state's Medicaid program. Program improvement expenditures equal to the amount of increased FMAP claimed are required to be made by the end of March 2024.

This policy change accounts for the receipt of increased FMAP for HCBS and the deposit of these funds into the Home & Community-Based Services American Rescue Plan Fund. Various state departments, including the Department of Health Care Services, will make program improvement expenditures from the Home & Community-Based Services American Rescue Plan Fund. Local assistance expenditures by the Department of Health Care Services from the Home & Community-Based Services American Rescue Plan Fund are budgeted in other policy changes.

Reason for Change:

This is a new policy change.

AMERICAN RESCUE PLAN INCREASED FMAP FOR HCBS

REGULAR POLICY CHANGE NUMBER: 254

Methodology:

1. An estimated \$2.5 billion will be claimed during FY 2021-22 and \$484 million will be claimed in FY 2022-23.
2. Increased FMAP, once claimed, will be deposited first into the state General Fund. A transfer of an equal amount will then be made from the General Fund into the Home & Community Based Services American Rescue Plan Fund (Fund 8507).

Funding:

(Dollars in Thousands)

FY 2021-22	TF	FF	GF	SF
100% HCBS 601-100% FF (4260-601-0890)	\$2,542,701	\$2,542,701	\$0	\$0
100% HCBS 698-0001 (4260-698-0001)	-\$2,542,701	\$0	-\$2,542,701	\$0
100% HCBS 601-0001 (4260-601-0001)	\$2,542,701	\$0	\$2,542,701	\$0
100% HCBS 698-8507 (4260-698-8507)	-\$2,542,701	\$0	\$0	-\$2,542,701
Total	\$0	\$2,542,701	\$0	-\$2,542,701

(Dollars in Thousands)

FY 2022-23	TF	FF	GF	SF
100% HCBS 601-100% FF (4260-601-0890)	\$484,094	\$484,094	\$0	\$0
100% HCBS 698-0001 (4260-698-0001)	-\$484,094	\$0	-\$484,094	\$0
100% HCBS 601-0001 (4260-601-0001)	\$484,094	\$0	\$484,094	\$0
100% HCBS 698-8507 (4260-698-8507)	-\$484,094	\$0	\$0	-\$484,094
Total	\$0	\$484,094	\$0	-\$484,094

MEDI-CAL COVID-19 VACCINATION INCENTIVE PROGRAM

REGULAR POLICY CHANGE NUMBER: 256
IMPLEMENTATION DATE: 9/2021
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2281

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$250,000,000	\$0
- STATE FUNDS	\$125,000,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$250,000,000	\$0
STATE FUNDS	\$125,000,000	\$0
FEDERAL FUNDS	\$125,000,000	\$0

Purpose:

This policy change estimates the incentive payments to Medi-Cal managed care plans (MCPs) through the Medi-Cal COVID-19 Vaccination Incentive Program.

Authority:

Title 42, Code of Federal Regulations, Part 438.6(b)
 Medi-Cal Public Assistance Cost Allocation Plan

Interdependent Policy Changes:

Not applicable

Background:

On March 13, 2020, a national public health emergency (PHE) was declared regarding the Novel Coronavirus Disease (COVID-19) outbreak. The Department identified certain target populations that have been disproportionately challenged in the initial phases of vaccine distribution including; homebound and those unable to travel, elderly populations with multiple chronic diseases, members who self-identify as persons of color, and youth 12-25 years old. In an effort to improve vaccine access and boost vaccination rates across these populations and more broadly, the Department implemented the Medi-Cal COVID-19 Vaccination Incentive Program effective September 1, 2021, through February 28, 2022.

The Department has adopted vaccination performance measures for MCPs that include both process and outcome measures. Participating MCPs will develop and submit a Vaccination Response Plan that outlines their strategies for improving vaccination rates including for the target populations. The maximum amount of MCP incentive payments that may be earned by all MCPs for these measures is \$250 million.

Reason for Change:

This is a new policy change.

Methodology:

1. The estimated costs for process and outcome measures for the COVID-19 Vaccination Incentive Program on a cash basis are:

MEDI-CAL COVID-19 VACCINATION INCENTIVE PROGRAM
REGULAR POLICY CHANGE NUMBER: 256

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF	\$250,000	\$125,000	\$125,000
Total	\$250,000	\$125,000	\$125,000

Funding:

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

EVIDENCE-BASED DENTAL PRACTICES

REGULAR POLICY CHANGE NUMBER: 257
IMPLEMENTATION DATE: 7/2022
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2322

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$37,110,000
- STATE FUNDS	\$0	\$12,915,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$37,110,000
STATE FUNDS	\$0	\$12,915,800
FEDERAL FUNDS	\$0	\$24,194,200

Purpose:

This policy change estimates the cost of implementing evidence-based dental practices. Updates include laboratory-processed crowns on posterior teeth for adult Medi-Cal beneficiaries.

Authority:

Proposed amendment to Welfare & Institutions (W&I) Code Section 14132.88(c)

Interdependent Policy Changes:

Not Applicable

Background:

W&I Code Section 14132.88(c) will be amended to reflect coverage of evidence-based dental practices consistent with the American Association of Pediatric Dentists (AAPD) and American Dental Association (ADA) guidelines for Medi-Cal dental benefits located in the Medi-Cal Dental Manual of Criteria (MOC), including the restoration of a posterior tooth back to normal function. According to the AAPD and ADA guidelines, a laboratory-processed crown is recommended for custom fit and long lasting treatment to restore a tooth back to normal function if it is badly broken down regardless if it is an abutment for a partial denture. By limiting laboratory-processed crowns only as an abutment for a cast metal partial denture, Medi-Cal beneficiaries are denied the most current dental standard of care. If the tooth does not meet the criteria of an abutment for a cast partial denture, the only other treatment available to Medi-Cal beneficiaries is a pre-fabricated stainless steel crown. The use of stainless steel crowns can lead to decay and possible damage to gum tissue around the tooth because the margins of the stainless steel crowns are not custom fitted to the tooth the way laboratory-processed crowns are. In standard practice, the stainless steel crown is a temporary solution until a laboratory-processed crown can be produced.

Reason for Change:

This is a new policy change.

Methodology:

1. Cost estimates for this benefit were developed using claims data from FY 2018-19.

EVIDENCE-BASED DENTAL PRACTICES
REGULAR POLICY CHANGE NUMBER: 257

2. 90% of procedures denied for adult laboratory processed crowns for posterior teeth (except as abutments for any fixed prosthesis or removable prosthesis with cast clasps or rests) would be approved for lab processed crowns at the Schedule of Maximum Allowances (SMA) of \$340 each. 10% of the procedures would be processed and determined to not meet the medical necessity for lab processed crowns.
3. 98% of paid claims for a pre-fabricated crown or a temporary fix would be replaced by lab processed crowns at the SMA of \$340 each minus the actual costs already paid for the claims. 2% of these paid claims would still receive a pre-fabricated crown or a temporary fix.
4. 90% of paid claims for alternatives to crowns would be replaced by lab processed crowns at the SMA of \$340 each minus the actual costs already paid for the claims. 10% of these paid claims to still receive an alternative procedure for a temporary fix.
5. Any portion of the costs attributable to Proposition 56 Supplemental Payments is captured in its respective policy change.

FY 2022-23	TF	GF	FF
Fee-for-service	\$31,110,000	\$9,916,000	\$21,194,000
Dental Managed Care	\$6,000,000	\$3,000,000	\$3,000,000
Total	\$37,110,000	\$12,916,000	\$24,194,000

Funding:

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

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

END-OF-FY 2-WEEK CHECKWRITE HOLD BUYBACK

REGULAR POLICY CHANGE NUMBER: 258
IMPLEMENTATION DATE: 6/2023
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2330

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$795,755,000
- STATE FUNDS	\$0	\$309,409,650
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$795,755,000
STATE FUNDS	\$0	\$309,409,650
FEDERAL FUNDS	\$0	\$486,345,350

Purpose:

This policy change estimates the costs of eliminating the practice of withholding provider checkwrites during the last two weeks of the fiscal year.

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

As a cost savings measure for FY 2006-07, the Department enacted a two-week hold on provider checkwrites to occur during the last two weeks of the fiscal year. Catch-up payments were made to providers during the first checkwrite week of the following fiscal year.

Deferring the checkwrite payments for two weeks places a hardship on the estimated 20,000 providers who would have been paid on time. This proposal eliminates this practice for FY 2022-23 by paying the last two checkwrites of the year at the regular calendar year checkwrite dates rather than deferring the payments to FY 2023-24. This also prevents further delay in payments beyond the first checkwrite of the following year if the budget is not signed timely in the future. Paying providers timely mitigates provider cash flow impacts and reduces any potential beneficiary access to care issues. This is especially sensitive for smaller providers, rural locations and intermediate care facilities for the developmentally disabled who may not have access to lines of credit or cash reserves to offset the delayed payments.

Reason for Change:

This is a new policy change.

END-OF-FY 2-WEEK CHECKWRITE HOLD BUYBACK
REGULAR POLICY CHANGE NUMBER: 258

Methodology:

1. The cost of the two-week checkwrite is estimated to be \$795,755,000 TF.

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Checkwrite Hold BuyBack	\$795,755	\$309,410	\$486,345

Funding:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX /50% GF (4260-101-0890)	\$559,741	\$279,870	\$279,871
90% Title XIX / 10% GF (4260-101-0890)	\$15,076	\$1,508	\$13,568
ACA 90% Title XIX / 10% GF (4260-101-0890)	\$197,187	\$19,719	\$177,468
65% Title XXI / 35% GF (4260-113-0890)	\$23,751	\$8,313	\$15,438
Total	\$795,755	\$309,410	\$486,345

CALAIM - LTC BENEFIT TRANSITION

REGULAR POLICY CHANGE NUMBER: 260
IMPLEMENTATION DATE: 1/2023
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2196

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$115,809,000
- STATE FUNDS	\$0	\$55,467,950
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$115,809,000
STATE FUNDS	\$0	\$55,467,950
FEDERAL FUNDS	\$0	\$60,341,050

Purpose:

This policy change estimates the impact of the long term care (LTC) managed care benefit change resulting from the California Advancing and Innovating Medi-Cal (CalAIM) Initiative.

Authority:

California Advancing and Innovating Medi-Cal (CalAIM) 1915(b) Waiver Amendment and Renewal (Pending CMS approval)

Interdependent Policy Changes:

Not Applicable

Background:

Effective January 1, 2023, all Managed Care Plans (MCP) will be required to authorize and cover institutional LTC services as required by state and federal law in an appropriate LTC facility. LTC means care that is provided in a skilled nursing facility (SNF), intermediate care facility (ICF), or sub-acute facility. Those facilities include: Freestanding Skilled Nursing Facilities Level-B (FS/NF-B) (SNFs), Adult Freestanding Subacute Facilities Level-B (FSSA/NF-B), Distinct Part Subacute Facilities Level-B (DP/NF-B), Adult Distinct Part Subacute Facilities Level-B (DPSA/NF-B), NF-Bs designated as Institutions for Mental Diseases (IMD), Distinct Part Pediatric Subacute (DP/PSA), Freestanding Pediatric Subacute Facilities (FS/PSA), Intermediate Care Facility for Developmentally Disabled (ICF/DD), Intermediate Care Facility for Developmentally Disabled with Habilitative (ICF/DD-H), and Intermediate Care Facility for Developmentally Disabled with Nursing (ICF/DD-N).

Currently, LTC services are a full managed care benefit in County Organized Health Systems (COHS) and/or Coordinated Care Initiative (CCI) plans. In non-COHS managed care counties, Medi-Cal Managed Care plans are responsible for the month of admission and the month following.

Effective January 1, 2023, all MCPs will be required to cover LTC facility services. This means that members who are admitted into a LTC facility in non-COHS counties and would otherwise have been disenrolled from the MCP will remain enrolled in managed care beginning January 1, 2023.

CALAIM - LTC BENEFIT TRANSITION

REGULAR POLICY CHANGE NUMBER: 260

This transition will standardize and reduce the complexity of the varying models of care delivery in California. Populations moving between counties will have the same experience when it comes to receiving services through a managed care plan.

Transitioning current populations of beneficiaries to mandatory managed care enrollment will also allow for Medi-Cal managed care plans to provide more coordinated and integrated care and provide beneficiaries with a network of primary care providers and specialists.

Reason for Change:

This is a new policy change.

Methodology:

1. Assume long term care services will be carved in as a managed care benefit statewide, effective January 1, 2023.
2. The annual value of benefits estimated to shift from FFS to managed care is \$2.9 billion. The costs of these services is assumed to be equal in each delivery system. However, due to payment lags, some FFS claims will continue following January 1, 2023. Additionally, the impact of the benefits shifting into managed care will begin, on a cash basis, in February 2023. The lagged impacts of the transition in FFS and managed care are listed below.

(Dollars in Thousands)

FY 2022-23 (Lagged)	TF	GF	FF
FFS	(\$1,092,803)	(\$523,406)	(\$569,397)
Managed Care	\$1,208,612	\$578,874	\$629,738
Total	\$115,809	\$55,468	\$60,341

Funding:

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

65% Title XIX / 35% GF (4260-101-0001/0890)

100% Title XIX (4260-101-0890)

100% GF (4260-101-0001)

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

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

COUNTY BH RECOUPMENTS

REGULAR POLICY CHANGE NUMBER: 262
IMPLEMENTATION DATE: 7/2022
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2343

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$60,840,000
- STATE FUNDS	\$0	-\$60,840,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$60,840,000
STATE FUNDS	\$0	-\$60,840,000
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the recoupments due to the Department from psychiatric inpatient hospital claims approved and paid through the Fiscal Intermediary, and overpayments of Federal Financial Participation (FFP) related to beneficiaries with unsatisfactory immigration status (UIS).

Authority:

AB 757 (Chapter 633, Statutes of 1994)

Interdependent Policy Changes:

Not Applicable

Background:

Psychiatric Inpatient Hospital Claims

The Department consolidated the responsibility to provide inpatient and outpatient specialty mental health services under county mental health plans (MHP) of outpatient Specialty Mental Health Services (SMHS) in 1994 and inpatient services in 1997. The majority of hospitals providing inpatient specialty mental health services receive payment via Medi-Cal's Fee-for-Service claims adjudication system. Medi-Cal pays the federal and non-federal share for psychiatric inpatient hospital services. The non-federal share is initially funded by General Fund and later reimbursed by subtracting the expenditure amount from each county's Mental Health Subaccount in the Sales Tax Account of the Local Revenue Fund.

The Department routinely adds aid codes to the Medi-Cal program. The Department and the former Department of Mental Health did not add new aid codes to the reporting structure used to identify the expenditure amounts for the Mental Health Subaccount. As a result, the Department did not identify and was not fully reimbursed for all of the psychiatric inpatient hospital service expenditures between CY 2011 and 2020.

Beneficiaries with UIS

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 nonemergency and non-pregnancy related services are paid using state only funds. Affected

COUNTY BH RECOUPMENTS

REGULAR POLICY CHANGE NUMBER: 262

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). In FY 2020-21, the Department repaid the FFP amounts subject to repayment totaling \$123.2 million, of which \$61 million is General Fund and \$62.2 million is assumed to be recouped from counties. The Department is recouping the amounts that were the responsibility of the county; specifically amounts associated with qualified non-citizens subject to the five-year bar and individuals who are Permanent Residents or Permanently Residing Under Color of Law.

Reason for Change:

This is a new policy change.

Methodology:

1. Assume recoupments for both psychiatric inpatient claims and beneficiaries with UIS will occur over four state fiscal years beginning 2022-23.
2. The psychiatric inpatient claim recoupments total \$181,136,000.
3. The recoupment for claims related to beneficiaries with UIS is \$62,224,000.
4. The Department will recoup funds over a four year period via weekly checkwrites to counties.

(Dollars in Thousands)

Recoupment Year	Total	Psychiatric Inpatient	Specialty Mental Health UIS	Drug Medi-Cal UIS
FY 2022-23	\$60,840	\$45,284	\$15,157	\$399

(Dollars in Thousands)

BH Recoupments	TF	GF
FY 2022-23	(\$60,840)	(\$60,840)

Funding:

100% Title XIX GF (4260-101-0001)

NURSING FACILITY FINANCING REFORM

REGULAR POLICY CHANGE NUMBER: 263
IMPLEMENTATION DATE: 1/2023
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2181

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$96,480,000
- STATE FUNDS	\$0	\$45,731,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$96,480,000
STATE FUNDS	\$0	\$45,731,600
FEDERAL FUNDS	\$0	\$50,748,400

Purpose:

This policy change estimates the cost of extending the skilled nursing facility rate methodology and Quality Assurance Fee (QAF).

Authority:

Proposed Trailer Bill Language

Interdependent Policy Changes:

Not Applicable

Background:

AB 1629 (Chapter 875, Statutes of 2004), extended by AB 81 (Chapter 13, Statutes of 2020) through 2022, requires the Department to implement a facility-specific rate methodology on Freestanding Skilled Nursing Facilities, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facilities, Level-B (FSSA/NF-B).

Currently, the annual weighted increase across these facilities, not including add-ons, is capped at 2.4%. The methodology also imposes a Quality Assurance Fee (QAF) equivalent to 6% of all facility revenue, which is used to increase rates and offset a portion of the General Fund cost for the rate increases. SB 853 (Chapter 717, Statutes of 2010), extended by AB 81, further implemented a quality and accountability supplemental payment (QASP) program to incentivize quality of care improvements by providing supplemental payments for facilities that achieve various quality metrics.

The Department proposes to extend and reform this framework by tying a growing portion of future rate increases to quality measures replacing the separate QASP program.

Receipts from the extended Quality Assurance Fee are budgeted in the Long Term Care Quality Assurance Fund Expenditures policy change.

Reason for Change:

This is a new policy change.

NURSING FACILITY FINANCING REFORM

REGULAR POLICY CHANGE NUMBER: 263

Methodology:

1. Assume a 5% rate increase for Labor costs and 2% rate increase for Non-Labor costs. The rate increase is expected to be implemented in January 2023.
2. The cash basis managed care rate adjustment impact for Calendar Year 2023 is estimated in FY 2022-23.

(Dollars in Thousands)

FY 2022-23	TF	GF	FFP
Calendar Year 2023	\$96,480	\$45,732	\$50,748
Total	\$96,480	\$45,732	\$50,748

Funding:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-001/ 0890)	\$90,209	\$45,105	\$45,104
90% Title XIX / 10% GF (4260-101-001/ 0890)	\$6,271	\$627	\$5,644
Total	\$96,480	\$45,732	\$50,748

ANNUAL COGNITIVE ASSESSMENTS

REGULAR POLICY CHANGE NUMBER: 265
IMPLEMENTATION DATE: 8/2022
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2345

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$341,000
- STATE FUNDS	\$0	\$170,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$341,000
STATE FUNDS	\$0	\$170,500
FEDERAL FUNDS	\$0	\$170,500

Purpose:

This policy change estimates the costs for the annual cognitive health assessment benefit for Medi-Cal-only beneficiaries, who are 65 years of age or older.

Authority:

SB 48 (Chapter 484, Statutes of 2021)

Interdependent Policy Changes:

Not Applicable

Background:

Pursuant to SB 48, upon appropriation by the Legislature, an annual cognitive health assessment is a covered benefit to Medi-Cal beneficiaries who are 65 years of age and older, if they are otherwise ineligible for a similar assessment as part of an annual wellness visit under the Medicare Program.

Reason for Change:

This is a new policy change.

Methodology:

1. Assume the benefit would be implemented effective July 1, 2022.
2. Payments are estimated to begin August 2022.

FY 2022-23	TF	GF	FF
Annual Cognitive Health Assessments	\$341,000	\$171,000	\$170,000
Total	\$341,000	\$171,000	\$170,000

Funding:

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

EQUITY & PRACTICE TRANSFORMATION PAYMENTS

REGULAR POLICY CHANGE NUMBER: 266
IMPLEMENTATION DATE: 7/2022
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2346

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$400,000,000
- STATE FUNDS	\$0	\$200,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$400,000,000
STATE FUNDS	\$0	\$200,000,000
FEDERAL FUNDS	\$0	\$200,000,000

Purpose:

This policy change estimates the costs of the Equity & Practice Transformation Payments.

Authority:

Budget Act of 2022

Interdependent Policy Changes:

Not Applicable

Background:

The Department proposes to make equity and practice transformation payments to qualifying Medi-Cal managed care plans, or through Medi-Cal managed care plans to their qualified contracted providers, to close critical health equity gaps; address gaps in preventive, maternity, and behavioral health care measures; and address gaps in care arising out of the COVID-19 Public Health Emergency. Such payments are intended to promote patient-centered models of care in pediatric, primary care, obstetrics and gynecology, and behavioral health settings and to align with the goals of the Medi-Cal Comprehensive Quality and Equity Strategy, which has bold equity gap closure goals of "50 by 2025":

- Ensure all health plans exceed 50th percentile for all children's preventive care measures
- Close racial/ethnic disparities in well child visits and immunizations by 50% (state level)
- Close maternity care disparity for black and American Indian/Alaskan Native/Native Hawaiian/Other Pacific Islander (AI/AN/NH/OPI) individuals by 50% (state level)
 - Pre & Postpartum care
 - C-sections
- Improve maternal and adolescent screening and referral for depression by 50% (state level)
- Improve follow-up after an Emergency Department visit for mental health (MH)/substance use disorder (SUD) by 50% (state level)

EQUITY & PRACTICE TRANSFORMATION PAYMENTS

REGULAR POLICY CHANGE NUMBER: 266

These models are intended to promote early identification and treatment of beneficiaries with health-related needs across settings. The models integrate care coordination and case management across physical health, behavioral health, and other local service providers to provide patient-centered care.

The Department proposes provisional language to make this funding available until June 30, 2024.

Reason for Change:

This is a new policy change.

Methodology:

1. The estimated costs are:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Equity & Practice Transformation Recovery Payments	\$400,000	\$200,000	\$200,000
Total	\$400,000	\$200,000	\$200,000

Funding:

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

AB 97 ELIMINATIONS

REGULAR POLICY CHANGE NUMBER: 267
IMPLEMENTATION DATE: 7/2022
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2347

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$20,191,000
- STATE FUNDS	\$0	\$8,986,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$20,191,000
STATE FUNDS	\$0	\$8,986,300
FEDERAL FUNDS	\$0	\$11,204,700

Purpose:

This policy change estimates the costs of eliminating the AB 97 (Chapter 3, Statutes of 2011) provider payment reductions for certain providers.

Authority:

Proposed Trailer Bill Language

Interdependent Policy Changes:

Not Applicable

Background:

AB 97 required the Department to implement up to a 10% provider payment reduction to various Medi-Cal providers. To ensure needs of the COVID-19 public health emergency and aggressive quality and equity goals are met, the Department proposes to eliminate the AB 97 payment reductions for certain providers.

Reason for Change:

This is a new policy change.

AB 97 ELIMINATIONS

REGULAR POLICY CHANGE NUMBER: 267

Methodology:

1. The estimated fee-for-service costs of the AB 97 elimination for the following providers, effective July 1, 2022, are estimated to be \$20.191 million TF (\$8.986 million GF) in FY 2022-23.
2. No managed care impact is assumed for the elimination of the AB 97 payment reductions for these providers.

FY 2022-23 (Lagged)	TF	GF	FF
Nurses	\$223,000	\$104,000	\$119,000
Alternative Birthing Centers	\$5,000	\$2,000	\$3,000
Audiologists/Hearing Aid Dispensers	\$593,000	\$288,000	\$305,000
Respiratory Care Providers	\$0	\$0	\$0
DME Oxygen and Respiratory Services	\$12,462,000	\$5,876,000	\$6,586,000
Chronic Dialysis Clinics	\$6,163,000	\$2,424,000	\$3,739,000
Emergency Medical Air Transportation	\$745,000	\$292,000	\$453,000
Total	\$20,191,000	\$8,986,000	\$11,205,000

3. Proposition 56 supplemental payments for non-emergency medical transportation (NEMT) providers are also proposed to be converted to an ongoing rate increase, beginning in FY 2022-23, thereby eliminating AB 97 reductions for these providers. The estimated value of this rate increase in FY 2022-23 is \$7,158,000 TF (\$3,729,000 GF) and is identified in the Prop 56 – NEMT Supplemental Payments policy change. The GF impact of converting the Proposition 56 supplemental payment to an ongoing rate increase beginning in FY 2022-23 is reflected through a reduction of \$3,729,000 in the amount of Proposition 56 funds used to offset General Fund costs in the Proposition 56 Funding policy change.

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
 90% Title XIX / 10% GF (4260-101-0001/0890)
 65% Title XXI / 35% GF (4260-113-0001/0890)

CALAIM- DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER: 268
IMPLEMENTATION DATE: 5/2022
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 2317

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$30,800,000	-\$123,200,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$30,800,000	-\$123,200,000
FEDERAL FUNDS	\$30,800,000	\$123,200,000

Purpose:

This proposal estimates the additional federal financial participation (FFP) received for Certified Public Expenditures (CPEs) from certain DSHPs (Designated State Health Programs), and the savings to the GF from the reduction in state spending on the DSHPs.

Authority:

CalAIM 1115 Waiver Renewal (Pending CMS approval)

Interdependent Policy Changes:

CalAIM Medi-Cal PATH

Background:

Pursuant to the CalAIM Section 1115 Demonstration renewal request submitted to the Centers for Medicare and Medicaid Services (CMS) on June 30, 2021, the Department proposes to reinstate DSHP, effective January 1, 2022 to December 31, 2026. The Department would utilize additional FFP received through DSHP to support the Providing Access and Transforming Health (PATH) Supports program. This program will support services and capacity building, including payments for supports, infrastructure, interventions, and services to complement the array of care authorized in the consolidated waiver request.

The CalAIM Section 1115 Demonstration renewal, pending CMS approval, would allow the Department to claim up to \$123.2 million FFP annually, for a total of \$616 million FFP over the five-year demonstration period using the CPEs of the approved DSHPs listed below:

CALAIM- DESIGNATED STATE HEALTH PROGRAMS
REGULAR POLICY CHANGE NUMBER: 268

State Only Medical Programs
California Children Services (CCS)
Genetically Handicapped Persons Program (GHPP)
Medically Indigent Adult Long Term Care (MIA-LTC)
Breast & Cervical Cancer Treatment Program (BCCTP)
AIDS Drug Assistance Program (ADAP)
Department of Developmental Services (DDS)
Prostate Cancer Treatment Program (PCTP)
Workforce Development Programs
Office of Statewide Health Planning & Development (OSHPD) <ul style="list-style-type: none"> • Song-Brown Health Care Workforce Training • Steven M. Thompson Physician Corp Loan Repayment Program (STLRP) • Mental Health Loan Assumption Program (MHLAP)

Reason for Change:

This is a new policy change.

Methodology:

1. Assume CMS approval will occur in FY 2021-22, and the first quarter of claiming will begin in May 2022.
2. The estimated total DSHP claiming, on a cash basis is:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2021-22	\$0	(\$30,800)	\$30,800
FY 2022-23	\$0	(\$123,200)	\$123,200

Funding:

100% GF (4260-101-0001)

100% Health Care Support Fund (4260-601-7503)

HCBS SP CDDS

REGULAR POLICY CHANGE NUMBER: 269
IMPLEMENTATION DATE: 1/2022
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2348

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$43,593,000	\$231,796,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$43,593,000	\$231,796,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$43,593,000	\$231,796,000

Purpose:

This policy change estimates the federal reimbursements for the California Department of Developmental Services (CDDS) home and community-based services (HCBS) spending plan items.

Authority:

American Rescue Plan (ARP) Act (2021)
Section 11.95, 2021 Budget Act

Interdependent Policy Changes:

American Rescue Plan Increased FMAP for HCBS

Background:

The American Rescue Plan Act of 2021 (ARP) provides additional Coronavirus Disease 2019 (COVID-19) relief to states. Section 9817 of the ARP provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS). Increased FMAP is available from April 1, 2021 through March 31, 2022. States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. State funds equivalent to the amount of federal funds attributable to the increased FMAP are deposited in the Home and Community-Based Services American Rescue Plan Fund pursuant to Section 11.95 of the 2021 Budget Act. Section 11.95 appropriates this funding to eligible HCBS activities identified in the HCBS Spending Plan.

Reason for Change:

This is a new policy change.

HCBS SP CDDS
REGULAR POLICY CHANGE NUMBER: 269

Methodology:

1. The cash basis estimate for the HCBS spending plan items for CDDS are:

(Dollars in Thousands)

FY 2021-22	TF	HCBS ARP Fund-CDDS	FF
Coordinated Family Support Service	\$31,250	\$18,750	\$12,500
Developmental Services Rate Model Implementation	\$46,576	\$28,283	\$18,293
Social Recreation and Camp Services for Individuals with Developmental Disabilities	\$22,050	\$14,250	\$7,800
Language Access and Cultural Competency Orientations and Translations	\$12,500	\$7,500	\$5,000
Total	\$112,376	\$68,783	\$43,593

(Dollars in Thousands)

FY 2022-23	TF	HCBS ARP Fund-CDDS	FF
Coordinated Family Support Service	\$10,417	\$6,250	\$4,167
Developmental Services Rate Model Implementation	\$518,264	\$312,954	\$205,310
Social Recreation and Camp Services for Individuals with Developmental Disabilities	\$44,100	\$28,450	\$15,650
Language Access and Cultural Competency Orientations and Translations	\$16,667	\$9,998	\$6,669
Total	\$589,448	\$357,652	\$231,796

Funding:

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

FPACT HPV VACCINE COVERAGE

REGULAR POLICY CHANGE NUMBER: 270
IMPLEMENTATION DATE: 7/2022
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2311

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$8,040,000
- STATE FUNDS	\$0	\$4,581,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$8,040,000
STATE FUNDS	\$0	\$4,581,000
FEDERAL FUNDS	\$0	\$3,459,000

Purpose:

This change estimates the costs of providing the human papillomavirus (HPV) vaccination as a covered benefit under the Family Planning, Access, Care and Treatment (Family PACT) Program.

Authority:

State Plan Amendment 10-014

Interdependent Policy Changes:

Not Applicable.

Background:

HPV is a common virus that can cause deadly cancers. The Department proposes to expand the Family PACT program to include the HPV vaccine as a covered benefit for females and males, ages 19 through 45. This policy would increase access to the HPV vaccine, which prevents genital tract, oropharyngeal cancers, and pre-cancers.

Reason for Change:

This is a new policy change.

Methodology:

1. Assume implementation will begin on July 1, 2022.
2. Assume 10,830 Family PACT clients will get a 3 dose HPV vaccine at the medical reimbursement rate of \$742.38.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2022-23	\$8,040	\$4,581	\$3,459

FPACT HPV VACCINE COVERAGE
REGULAR POLICY CHANGE NUMBER: 270**Funding:**

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890/0001)	\$6,918	\$3,459	\$3,459
100% GF (4260-101-0001)	\$1,122	\$1,122	\$0
Total	\$8,040	\$4,581	\$3,459

MHSF - PROVIDER ACES TRAININGS

REGULAR POLICY CHANGE NUMBER: 271
IMPLEMENTATION DATE: 7/2022
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2350

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$44,100,000
- STATE FUNDS	\$0	\$22,050,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$44,100,000
STATE FUNDS	\$0	\$22,050,000
FEDERAL FUNDS	\$0	\$22,050,000

Purpose:

This policy change estimates the cost to train providers on delivering Adverse Childhood Experiences (ACEs) screenings funded with Mental Health Services Funds.

Authority:

Budget Act of 2022

Interdependent Policy Changes:

Not Applicable

Background:

Effective, July 1, 2022, the Department proposes to extend funding for provider trainings for ACEs screenings using available Mental Health Services Funds (MHSF).

See the Prop 56 – Provider ACEs Trainings policy change for the training costs funded with Proposition 56 funds.

Reason for Change:

This is a new policy change.

Methodology:

- The provider trainings costs, funded with Mental Health Services Funds, are estimated to be \$44,100,000 TF (\$22,050,000 SF) in FY 2022-23.

FY 2022-23	TF	MHSF	FF
Provider ACEs Trainings	\$44,100,000	\$22,050,000	\$22,050,000
Total	\$44,100,000	\$22,050,000	\$22,050,000

Funding:

Mental Health Services Fund (4260-101-3085)
 100% Title XIX (4260-101-0890)

COVID-19 INCREASED FMAP EXTENSION

REGULAR POLICY CHANGE NUMBER: 272
IMPLEMENTATION DATE: 1/2022
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2257

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$598,569,000	\$16,344,000
- STATE FUNDS	-\$1,422,259,000	-\$780,433,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$598,569,000	\$16,344,000
STATE FUNDS	-\$1,422,259,000	-\$780,433,000
FEDERAL FUNDS	\$2,020,828,000	\$796,777,000

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 January 2022 through June 2022. For the estimated impact of assuming an extension of the availability of increased FMAP from January 2022 through June 2022 on administrative expenditures, see the COVID-19 Increased FMAP Extension - Other Admin policy change. For the estimated impact of increased FMAP from July 2021 through December 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. 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 EXTENSION

REGULAR POLICY CHANGE NUMBER: 272

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.

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 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 June 30, 2022.
5. Assume a two-month cash lag.
6. The following estimates reflect a cash basis:

(Dollars in Thousands)

FY 2021-22	TF	GF	SF	FF
COVID-19 Increased FMAP:				
FFCRA 6.20% Increased FFP	(\$25,309)	(\$1,197,394)	\$0	\$1,172,085
FFCRA 4.34% Increased FFP	(\$5,030)	(\$49,757)	\$0	\$44,727
BCCTP 4.34% Increased FFP	\$0	(\$12)	\$0	\$12
Medicare Part D FFCRA 6.20% Incr. FFP	(\$109,571)	(\$109,571)	\$0	\$0
FFCRA Special Funds Increased FMAP	\$98,339	(\$435)	(\$63,493)	\$162,267
Other Departments 6.20% Increased FFP	\$640,140	(\$1,597)	\$0	\$641,737
Total COVID-19 Incr. FMAP - Regular:	\$598,569	(\$1,358,766)	(\$63,493)	\$2,020,828
COVID-19 Increased FMAP In Prop 56 PCs:				
FFCRA 6.20% Increased FFP	\$0	\$0	(\$33,998)	\$33,998
FFCRA 4.34% Increased FFP	\$0	\$0	(\$4,767)	\$4,767
Total COVID-19 Incr. FMAP In Prop 56 PCs:	\$0	\$0	(\$38,765)	\$38,765
Total of PCs including COVID-19 Increased FMAP	\$598,569	(\$1,358,766)	(\$102,258)	\$2,059,593

COVID-19 INCREASED FMAP EXTENSION
REGULAR POLICY CHANGE NUMBER: 272

(Dollars in Thousands)

FY 2022-23	TF	GF	SF	FF
COVID-19 Increased FMAP:				
FFCRA 6.20% Increased FFP	\$18,423	(\$496,438)	\$0	\$514,861
FFCRA 4.34% Increased FFP	\$0	(\$29,711)	\$0	\$29,711
BCCTP 4.34% Increased FFP	\$0	\$0	\$0	\$0
Medicare Part D FFCRA 6.20% Incr. FFP	(\$55,058)	(\$55,058)	\$0	\$0
FFCRA Special Funds Increased FMAP	(\$1,201)	\$97,136	(\$296,362)	\$198,025
Other Departments 6.20% Increased FFP	\$54,180	\$0	\$0	\$54,180
Total COVID-19 Incr. FMAP - Regular:	\$16,344	(\$484,071)	(\$296,362)	\$796,777
COVID-19 Increased FMAP In Prop 56 PCs:				
FFCRA 6.20% Increased FFP	\$0	\$0	(\$8,391)	\$8,391
FFCRA 4.34% Increased FFP	\$0	\$0	(\$778)	\$778
Total COVID-19 Incr. FMAP In Prop 56 PCs:	\$0	\$0	(\$9,169)	\$9,169
Total of PCs including COVID-19 Increased FMAP	\$16,344	(\$484,071)	(\$305,531)	\$805,946

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)
Hospital Quality Assurance Revenue Fund (4260-611-3158)
100% Reimbursement (4260-601-0995)
Medi-Cal Drug Rebate Fund (4260-601-3331)
COVID-19 FF T-21 HQAF 4.34% (4260-611-0890)
COVID-19 FF T-19 HQAF 6.2% (4260-611-0890)
SB1100 Priv Hosp Supplemental (Non-GF) 100% (4260-601-3097)
Capital Debt 100% GF (4262-102-0001)
3158 Fed T19 OE HQAF (4260-611-0890)
3158 Fed T19 HQAF (4260-611-0890)
DPH Graduate Medical Education Special Fund (4260-601-8113)
Global Payment Program Special Fund (4260-601-8108)
Emergency Medical Air Transportation Act Fund (4260-101-3168)
MIPA Only Fund (4260-606-0834)
Medi-Cal Emergency Transport Fund (4260-601-3323)
Reimbursement GF (4260-601-0995)
Home and Community Based Services -101
Perinatal Insurance Fund (AIM-Mom)

URBAN INDIAN ORGANIZATIONS FUNDING SHIFT

REGULAR POLICY CHANGE NUMBER: 273
IMPLEMENTATION DATE: 1/2022
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2351

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$11,510,000	-\$25,322,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$11,510,000	-\$25,322,000
FEDERAL FUNDS	\$11,510,000	\$25,322,000

Purpose:

This policy change estimates the technical adjustment in funding from Title XIX 50% federal financial participation (FFP) and Title XXI 65% FFP to 100% FFP temporarily for fee-for-service and managed care expenditures provided in Urban Indian Organizations (UIOs).

Authority:

American Rescue Plan (ARP) Act of 2021
25 U.S.C. 1603(29)

Interdependent Policy Changes:

Not applicable

Background:

The ARP provides 100% Federal Medical Assistance Percentage (FMAP) to states for their medical assistance expenditures for services received by all Medicaid beneficiaries received through an UIO for the eight fiscal quarters beginning April 1, 2021, and ending March 31, 2023. States will be able to claim 100% FMAP for services received through these entities retroactively to April 1, 2021. UIOs that have a grant or contract with the Indian Health Service under Title V of the Indian Health Care Improvement Act are included.

Reason for Change:

This is a new policy change.

Methodology:

1. Assume the Department will begin claiming 100% FFP for UIOs on January 1, 2022, including a retroactive adjustment for claims from April 2021 through December 2021.
2. Assume a one quarter lag for claims that are adjusted to 100% FFP.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2021-22	\$0	(\$11,510)	\$11,510
FY 2022-23	\$0	(\$25,322)	\$25,322

URBAN INDIAN ORGANIZATIONS FUNDING SHIFT
REGULAR POLICY CHANGE NUMBER: 273

Funding:

Title XIX 100% GF (4260-101-0001)
Title XIX 100% FFP (4260-101-0890)
Title XXI 100% GF (4260-113-0001)
Title XXI 100% FFP (4260-113-0890)

PREMIUMS REDUCTION

REGULAR POLICY CHANGE NUMBER: 274
IMPLEMENTATION DATE: 7/2022
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2352

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$53,163,000
- STATE FUNDS	\$0	\$19,080,250
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$53,163,000
STATE FUNDS	\$0	\$19,080,250
FEDERAL FUNDS	\$0	\$34,082,750

Purpose:

This policy change estimates the cost of reducing premiums to zero for the Optional Targeted Low Income Children Program (OTLICP), all State Children's Health Insurance Programs (SCHIP), and the 250 Percent Working Disabled Program (250 Percent WDP).

Authority:

AB 1494 (Chapter 28, Statutes of 2012)
 AB1269 (Chapter 282, Statutes of 2009)
 AB 97 (Chapter 3, Statutes of 2011)
 SPA 17-043
 SPA 17-044
 Trailer Bill Language

Interdependent Policy Changes:

County Children's Health Initiative Program
 Medi-Cal Access Program Mothers 213-322% FPL
 Medi-Cal Access Infant Program 266-322% FPL
 CHIP Premiums

Background:

Effective June 27, 2012, W&I Code Section 14005.26(d)(1)(A) imposed premiums for individuals whose family income is determined to be above 150 percent and up to and including 200 percent of the federal poverty level. Effective January 1, 2014, 14005.26(d)(1)(B) imposed premiums for individuals whose family income is determined to be above 160 percent and up to and including 261 percent of the federal poverty level. The monthly maximum premium for this group with three (3) or more children is \$13 per child or \$39 total.

Effective July 1, 2014, W&I Code Section 15849 was amended to establish subscriber contributions and premiums to individuals enrolled in the Medi-Cal Access Program (MCAP), formerly known as AIM. Subscriber contributions consisting of 1.5 percent of an applicant's adjusted gross income were established as the cost to participate in MCAP.

Access-linked infants born to individuals enrolled in MCAP are eligible for the Medi-Cal Access Infants Program (MCAIP). For infants enrolled in MCAIP, a subscriber contribution was

PREMIUMS REDUCTION

REGULAR POLICY CHANGE NUMBER: 274

established as a monthly premium of thirteen dollars (\$13) per child with a maximum contribution of thirty-nine dollars (\$39) per family.

Further, on July 1, 2014, W&I Code Sections 15850-15864 established premiums on children enrolled in the County Children's Health Initiative Program (CCHIP). The monthly maximum premium for this group with three (3) or more children (\$21 per child or \$63 total).

Finally, effective July 28, 2009, W&I Code Section 14007.9(d) imposed premiums for individuals who are enrolled in the 250 Percent WDP and whose income is determined to be up to and including 250 percent of the federal poverty level. Premiums for this program are based on an individual or couple's net countable income ranging from a minimum of \$20 or \$30 and a maximum \$250 or \$375 per month for an individual and couple respectively.

The Department proposes to reduce premiums for these populations to zero.

Reason for Change:

This is a new policy change.

Methodology:

1. Assume a July 1, 2022, effective and implementation date.
2. Current reductions due to premium waivers are reflected in their respective policy changes.
3. Total ongoing costs associated with the premium reductions are estimated to be \$89,049,000 TF (\$31,012,000 GF/\$323,000 SF). Additionally, \$35,886,000 TF (\$12,133,000 GF/\$122,000 SF) in premium reductions are due to temporary waivers related to wildfires and the COVID-19 pandemic and are already reflected in the CHIP Premiums, Medi-Cal Access Program Mothers 213-322% FPL, and County Children's Health Initiative Program policy changes.
4. Remaining costs associated with the loss of premiums from the CCHIP, MCAP 213-322% FPL, MCAIP 266-322% FPL, OTLICP, and 250 Percent WDP, budgeted in this policy change, are represented below.

FY 2022-23	TF	GF	SF	FF
MCAP Mothers	\$2,008,000	\$0	\$201,000	\$1,807,000
MCAP Infants	\$208,000	\$73,000	\$0	\$135,000
CCHIP	\$1,215,000	\$425,000	\$0	\$790,000
OTLICP	\$48,232,000	\$16,881,000	\$0	\$31,351,000
250% WDP	\$1,500,000	\$1,500,000	\$0	\$0
Total	\$53,163,000	\$18,879,000	\$201,000	\$34,083,000

Funding:

65% Title XXI / 35% GF (4260-113-0890/0001)
 Perinatal Insurance Fund (4260-602-0309)
 100% Title XXI FFP (4260-113-0890)
 100% GF (4260-101-0001)

BEHAVIORAL HEALTH BRIDGE HOUSING

REGULAR POLICY CHANGE NUMBER: 275
IMPLEMENTATION DATE: 7/2022
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2354

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$1,000,000,000
- STATE FUNDS	\$0	\$1,000,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$1,000,000,000
STATE FUNDS	\$0	\$1,000,000,000
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the costs for behavioral health bridge housing.

Authority:

Budget Act of 2022

Interdependent Policy Changes:

Not Applicable

Background:

Funding for behavioral health bridge housing, totaling \$1.5 billion General Fund, is proposed to address the immediate housing and treatment needs of people experiencing unsheltered homelessness with serious behavioral health conditions by providing time-limited operational supports in various bridge housing settings, including existing assisted living settings.

Reason for Change:

This is a new policy change.

Methodology:

1. Assume \$1,000,000,000 General Fund for behavioral health bridge housing in FY 2022-23.

(Dollars in Thousands)

FY 2022-23	TF	GF
Behavioral Health Bridge Housing	\$1,000,000	\$1,000,000
Total	\$1,000,000	\$1,000,000

Funding:

100% GF (4260-101-0001)

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**SUMMARY OF COUNTY ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2021-22**

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
1	COUNTY ADMINISTRATION ALLOCATION	\$2,200,889,000	\$1,100,444,500	\$1,100,444,500	\$0
2	SAWS	\$102,174,000	\$92,390,500	\$9,783,500	\$0
3	FUNDING FOR COUNTY REDETERMINATIONS	\$73,015,000	\$36,507,500	\$36,507,500	\$0
4	CalWORKS APPLICATIONS	\$69,620,000	\$34,810,000	\$34,810,000	\$0
5	CASE MANAGEMENT FOR OTLICP	\$43,442,000	\$21,721,000	\$21,721,000	\$0
6	LOS ANGELES COUNTY HOSPITAL INTAKES	\$38,919,000	\$34,094,500	\$4,824,500	\$0
7	ENHANCED FEDERAL FUNDING	\$0	\$525,000,000	(\$525,000,000)	\$0
8	SAVE	\$0	\$4,000,000	(\$4,000,000)	\$0
	OTHER SUBTOTAL	\$2,528,059,000	\$1,848,968,000	\$679,091,000	\$0
	GRAND TOTAL	\$2,528,059,000	\$1,848,968,000	\$679,091,000	\$0

**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		
	<u>OTHER</u>						
1	COUNTY ADMINISTRATION ALLOCATION	\$0	\$0	\$2,200,889,000	\$0	\$2,200,889,000	\$1,100,444,500
2	SAWS	\$102,174,000	\$0	\$0	\$0	\$102,174,000	\$9,783,500
3	FUNDING FOR COUNTY REDETERMINATIONS	\$73,015,000	\$0	\$0	\$0	\$73,015,000	\$36,507,500
4	CalWORKS APPLICATIONS	\$0	\$0	\$69,620,000	\$0	\$69,620,000	\$34,810,000
5	CASE MANAGEMENT FOR OTLICP	\$0	\$0	\$0	\$43,442,000	\$43,442,000	\$21,721,000
6	LOS ANGELES COUNTY HOSPITAL INTAKES	\$0	\$0	\$0	\$38,919,000	\$38,919,000	\$4,824,500
7	ENHANCED FEDERAL FUNDING	\$0	\$0	\$0	\$0	\$0	(\$525,000,000)
8	SAVE	\$0	\$0	\$0	\$0	\$0	(\$4,000,000)
	OTHER SUBTOTAL	\$175,189,000	\$0	\$2,270,509,000	\$82,361,000	\$2,528,059,000	\$679,091,000
	GRAND TOTAL	\$175,189,000	\$0	\$2,270,509,000	\$82,361,000	\$2,528,059,000	\$679,091,000

**SUMMARY OF COUNTY ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2022-23**

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
1	COUNTY ADMINISTRATION ALLOCATION	\$2,251,069,000	\$1,125,534,500	\$1,125,534,500	\$0
2	SAWS	\$64,145,000	\$58,579,000	\$5,566,000	\$0
3	FUNDING FOR COUNTY REDETERMINATIONS	\$73,015,000	\$36,507,500	\$36,507,500	\$0
4	CalWORKS APPLICATIONS	\$69,620,000	\$34,810,000	\$34,810,000	\$0
5	CASE MANAGEMENT FOR OTLICP	\$43,324,000	\$21,662,000	\$21,662,000	\$0
6	LOS ANGELES COUNTY HOSPITAL INTAKES	\$38,919,000	\$34,094,500	\$4,824,500	\$0
7	ENHANCED FEDERAL FUNDING	\$0	\$531,750,000	(\$531,750,000)	\$0
8	SAVE	\$0	\$4,000,000	(\$4,000,000)	\$0
	OTHER SUBTOTAL	\$2,540,092,000	\$1,846,937,500	\$693,154,500	\$0
	GRAND TOTAL	\$2,540,092,000	\$1,846,937,500	\$693,154,500	\$0

**MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE COST BREAKDOWN
FISCAL YEAR 2022-23**

NO.	POLICY CHANGE TITLE	ONE-TIME CHANGES		ON-GOING CHANGES		TOTAL POLICY CHANGES	GENERAL FUNDS
		PROCEDURAL	CASELOAD	PROCEDURAL	CASELOAD		
	<u>OTHER</u>						
1	COUNTY ADMINISTRATION ALLOCATION	\$0	\$0	\$2,251,069,000	\$0	\$2,251,069,000	\$1,125,534,500
2	SAWS	\$64,145,000	\$0	\$0	\$0	\$64,145,000	\$5,566,000
3	FUNDING FOR COUNTY REDETERMINATIONS	\$73,015,000	\$0	\$0	\$0	\$73,015,000	\$36,507,500
4	CalWORKS APPLICATIONS	\$0	\$0	\$69,620,000	\$0	\$69,620,000	\$34,810,000
5	CASE MANAGEMENT FOR OTLICP	\$0	\$0	\$0	\$43,324,000	\$43,324,000	\$21,662,000
6	LOS ANGELES COUNTY HOSPITAL INTAKES	\$0	\$0	\$0	\$38,919,000	\$38,919,000	\$4,824,500
7	ENHANCED FEDERAL FUNDING	\$0	\$0	\$0	\$0	\$0	(\$531,750,000)
8	SAVE	\$0	\$0	\$0	\$0	\$0	(\$4,000,000)
	OTHER SUBTOTAL	\$137,160,000	\$0	\$2,320,689,000	\$82,243,000	\$2,540,092,000	\$693,154,500
	GRAND TOTAL	\$137,160,000	\$0	\$2,320,689,000	\$82,243,000	\$2,540,092,000	\$693,154,500

**COMPARISON OF FISCAL IMPACTS OF COUNTY ADMINISTRATION POLICY CHANGES
NOVEMBER 2021 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2021-22**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2021-22 APPROPRIATION		NOV. 2021 EST. FOR 2021-22		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
1	1	COUNTY ADMINISTRATION ALLOCATION	\$2,200,889,000	\$1,100,444,500	\$2,200,889,000	\$1,100,444,500	\$0	\$0
2	2	SAWS	\$94,322,000	\$8,727,500	\$102,174,000	\$9,783,500	\$7,852,000	\$1,056,000
8	3	FUNDING FOR COUNTY REDETERMINATIONS	\$73,015,000	\$36,507,500	\$73,015,000	\$36,507,500	\$0	\$0
3	4	CaIWORKS APPLICATIONS	\$67,498,000	\$33,749,000	\$69,620,000	\$34,810,000	\$2,122,000	\$1,061,000
4	5	CASE MANAGEMENT FOR OTLICP	\$43,442,000	\$21,721,000	\$43,442,000	\$21,721,000	\$0	\$0
5	6	LOS ANGELES COUNTY HOSPITAL INTAKES	\$40,547,000	\$4,855,500	\$38,919,000	\$4,824,500	(\$1,628,000)	(\$31,000)
6	7	ENHANCED FEDERAL FUNDING	\$0	(\$542,853,750)	\$0	(\$525,000,000)	\$0	\$17,853,750
7	8	SAVE	\$0	(\$4,000,000)	\$0	(\$4,000,000)	\$0	\$0
		OTHER SUBTOTAL	\$2,519,713,000	\$659,151,250	\$2,528,059,000	\$679,091,000	\$8,346,000	\$19,939,750
		COUNTY ADMINISTRATION GRAND TOTAL	\$2,519,713,000	\$659,151,250	\$2,528,059,000	\$679,091,000	\$8,346,000	\$19,939,750

**COMPARISON OF FISCAL IMPACTS OF COUNTY ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2021-22 AND 2022-23**

NO.	POLICY CHANGE TITLE	NOV. 2021 EST. FOR 2021-22		NOV. 2021 EST. FOR 2022-23		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER						
1	COUNTY ADMINISTRATION ALLOCATION	\$2,200,889,000	\$1,100,444,500	\$2,251,069,000	\$1,125,534,500	\$50,180,000	\$25,090,000
2	SAWS	\$102,174,000	\$9,783,500	\$64,145,000	\$5,566,000	(\$38,029,000)	(\$4,217,500)
3	FUNDING FOR COUNTY REDETERMINATIONS	\$73,015,000	\$36,507,500	\$73,015,000	\$36,507,500	\$0	\$0
4	CalWORKS APPLICATIONS	\$69,620,000	\$34,810,000	\$69,620,000	\$34,810,000	\$0	\$0
5	CASE MANAGEMENT FOR OTLICP	\$43,442,000	\$21,721,000	\$43,324,000	\$21,662,000	(\$118,000)	(\$59,000)
6	LOS ANGELES COUNTY HOSPITAL INTAKES	\$38,919,000	\$4,824,500	\$38,919,000	\$4,824,500	\$0	\$0
7	ENHANCED FEDERAL FUNDING	\$0	(\$525,000,000)	\$0	(\$531,750,000)	\$0	(\$6,750,000)
8	SAVE	\$0	(\$4,000,000)	\$0	(\$4,000,000)	\$0	\$0
	OTHER SUBTOTAL	\$2,528,059,000	\$679,091,000	\$2,540,092,000	\$693,154,500	\$12,033,000	\$14,063,500
	COUNTY ADMINISTRATION GRAND TOTAL	\$2,528,059,000	\$679,091,000	\$2,540,092,000	\$693,154,500	\$12,033,000	\$14,063,500

**MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE INDEX**

<u>POLICY CHANGE NUMBER</u>	<u>POLICY CHANGE TITLE</u>
	<u>OTHER</u>
1	COUNTY ADMINISTRATION ALLOCATION
2	SAWS
3	FUNDING FOR COUNTY REDETERMINATIONS
4	CALWORKS APPLICATIONS
5	CASE MANAGEMENT FOR OTLICP
6	LOS ANGELES COUNTY HOSPITAL INTAKES
7	ENHANCED FEDERAL FUNDING
8	SAVE

COUNTY ADMINISTRATION ALLOCATION

COUNTY ADMIN. POLICY CHANGE NUMBER: 1
IMPLEMENTATION DATE: 7/2012
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 1704

	FY 2021-22		FY 2022-23	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$2,200,889,000	\$0	\$2,251,069,000
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$2,200,889,000	\$0	\$2,251,069,000
STATE FUNDS	\$0	\$1,100,444,500	\$0	\$1,125,534,500
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$2,200,889,000	\$0	\$2,251,069,000
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$2,200,889,000	\$0	\$2,251,069,000
STATE FUNDS	\$0	\$1,100,444,500	\$0	\$1,125,534,500

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 2021-22. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to the Department increasing the total allocation by 2.28% for the projected California CPI, resulting in a \$50M increase.

Methodology:

- The total rounded estimated FY 2021-22 and FY 2022-23 county administration costs are:

(Dollars in Thousands)

Total Allocation	TF	GF	FF
FY 2021-22	\$2,200,889	\$1,100,445	\$1,100,445
FY 2022-23	\$2,251,069	\$1,125,535	\$1,125,535

* 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: Kalandie Coleman
FISCAL REFERENCE NUMBER: 214

	FY 2021-22		FY 2022-23	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$102,174,000	\$0	\$64,145,000	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$102,174,000	\$0	\$64,145,000	\$0
STATE FUNDS	\$9,783,500	\$0	\$5,566,000	\$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$102,174,000	\$0	\$64,145,000	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$102,174,000	\$0	\$64,145,000	\$0
STATE FUNDS	\$9,783,500	\$0	\$5,566,000	\$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)
 SIFRA 1099

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.

With the passage of Affordable Care Act, federal and state statutes require California to first conduct an ex parte review at annual determination. If the ex parte review does not result in continued eligibility, a prepopulated annual redetermination form must be sent to the beneficiary at least 60 days before the annual redetermination date with populated information that the county has available to determine eligibility for both modified adjusted gross income (MAGI) and Non-MAGI programs.

To meet these requirements, the Department created the Non-MAGI prepopulated renewal form and has updated the MAGI prepopulated renewal form to meet Americans with Disabilities Act requirements. DHCS is also developing a prepopulated renewal form for mixed MAGI and Non-MAGI Medi-Cal households.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is an increase due to updated expenditure data provided by CDSS and new one-time costs related to the full-scope expansion for older Californians. The change from FY 2021-22 to 2022-23, in the current estimate, is a decrease due to updated expenditure data provided by CDSS and some one-time costs ending in FY 2021-22.

Methodology:

1. The following estimate was provided by CDSS on a cash basis:

SAWS
COUNTY ADMIN. POLICY CHANGE NUMBER: 2

(Dollars in Thousands)

Line Item	FY 2021-22	FY 2022-23
Statewide Project Management	\$2,850	\$2,791
SB 1341 Medi-Cal/SAWS	\$6,616	\$1,424
WCDS-CalWIN	\$46,586	\$42,664
CalACES	\$24,811	\$5,341
Shared Application Forms Revisions	\$2,800	\$603
Cost of Annual Redetermination Forms	\$12,955	\$10,942
DHCS Legislative Action (Medi-Cal)	\$4,500	\$0
Older Californians Full Scope Expansion 50+	\$1,056	\$0
M/C Redeterminations	\$0	\$380
Total	\$102,174	\$64,145

*Totals may differ due to rounding.

2. In FY 2021-22, there is a \$1,056,000 GF expenditure for the undocumented older Californians full-scope expansion.
3. Assume an estimated annual cost of **\$102,174,000 TF (\$9,784,000 GF)** in FY 2021-22 and **\$64,145,000 TF (\$5,566,000 GF)** in FY 2022-23.

Funding:

50% Title XIX FF / 50% GF (4260-101-0890/0001)
 100% Title XIX FF (4260-101-0890)
 100% State GF (4260-101-0001)
 Enhanced CA 75/25 (4260-101-0890/0001)

FUNDING FOR COUNTY REDETERMINATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER: 3
IMPLEMENTATION DATE: 7/2021
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 2282

	FY 2021-22		FY 2022-23	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$73,015,000	\$0	\$73,015,000	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$73,015,000	\$0	\$73,015,000	\$0
STATE FUNDS	\$36,507,500	\$0	\$36,507,500	\$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$73,015,000	\$0	\$73,015,000	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$73,015,000	\$0	\$73,015,000	\$0
STATE FUNDS	\$36,507,500	\$0	\$36,507,500	\$0

Purpose:

This policy change estimates the one-time costs for counties resuming annual Medi-Cal redeterminations within 12 months at the end of the Coronavirus Disease 2019 public health emergency (PHE).

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 PHE was renewed on April 21, 2021, by the federal government, and will be effective until any further extension(s) occur. 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 FFCRA includes a "continuous coverage requirement." Under the continuous coverage requirement, states must halt most disenrollment of Medicaid eligibles. Those enrolled at the beginning of the enrollment period or those who would have enrolled during the emergency

FUNDING FOR COUNTY REDETERMINATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER: 3

period cannot be disenrolled until the end of the month the public health emergency ends if the Department is to receive a temporary increase in the federal medical assistance percentage (FMAP). 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.

Counties will resume redetermination activities after the PHE ends. There is additional workload associated with the redeterminations resulting from a PHE deferral. This additional workload includes the following elements: reviewing cases to update/correct entries made to comply with the PHE directives, reviewing case comments/journal entries and tasks to identify changes that were previously reported and not acted upon due to the PHE directives, contacting beneficiaries to obtain verifications and/or current status of information that was reported but not acted upon, and documenting these actions in case comments/journal entries for future case reviews. Due to this additional workload, a caseload has been created for deferred determinations, which will process redeterminations for the deferred cases over a 12-month period. Under federal guidance, this workload would require completion in the last 6 months of FY 2021-22 and the first 6 months of FY 2022-23.

Reason for Change:

There is no change from the prior estimate for FY 2021-22 or in the current estimate from FY 2021-22 to FY 2022-23.

Methodology:

1. Assume the PHE ends on June 30, 2022.
2. Assume all Medi-Cal redeterminations that were paused since the onset of the COVID-19 PHE will be resumed and processed per DHCS policies.
3. Assume the average time for processing a redetermination is 60 minutes and the average time for redeterminations cleanup is 45 minutes.
4. Assume an impacted redeterminations caseload is approximately 2,196,000.
5. Assume one-time costs of **\$73,015,000 TF (\$36,507,000 GF)** in **FY 2021-22** and **FY 2022-23** related to county administration costs associated with the processing of the redeterminations caseload.

Funding:

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

CalWORKS APPLICATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER: 4
IMPLEMENTATION DATE: 7/1998
ANALYST: Kalandie Coleman
FISCAL REFERENCE NUMBER: 217

	FY 2021-22		FY 2022-23	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$69,620,000	\$0	\$69,620,000
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$69,620,000	\$0	\$69,620,000
STATE FUNDS	\$0	\$34,810,000	\$0	\$34,810,000
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$69,620,000	\$0	\$69,620,000
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$69,620,000	\$0	\$69,620,000
STATE FUNDS	\$0	\$34,810,000	\$0	\$34,810,000

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:

There is a slight increase from the prior estimate, for FY 2021-22, due to an updated cash estimate provided by CDSS. There is no change from FY 2021-22 to FY 2022-23 in the current estimate.

CaIWORKS APPLICATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER: 4

Methodology:

1. The estimated costs for FY 2021-22 and FY 2022-23 are provided on a cash basis by CDSS:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2021-22	\$69,620	\$34,810	\$34,810
FY 2022-23	\$69,620	\$34,810	\$34,810

*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: 5
IMPLEMENTATION DATE: 12/2012
ANALYST: Kalandie Coleman
FISCAL REFERENCE NUMBER: 1598

	FY 2021-22		FY 2022-23	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$43,442,000	\$0	\$43,324,000
TOTAL FUNDS	\$0	\$43,442,000	\$0	\$43,324,000
STATE FUNDS	\$0	\$21,721,000	\$0	\$21,662,000
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$43,442,000	\$0	\$43,324,000
TOTAL FUNDS	\$0	\$43,442,000	\$0	\$43,324,000
STATE FUNDS	\$0	\$21,721,000	\$0	\$21,662,000

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 for FY 2021-22 from the prior estimate. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a slight decrease due to lower 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 2021-22 is 905,041 and 902,581 for FY 2022-23.

CASE MANAGEMENT FOR OTLICP
COUNTY ADMIN. POLICY CHANGE NUMBER: 5

3. The estimated costs are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2021-22	\$43,442	\$21,721	\$21,721
FY 2022-23	\$43,324	\$21,662	\$21,662

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: 6
IMPLEMENTATION DATE: 7/1994
ANALYST: Kalandie Coleman
FISCAL REFERENCE NUMBER: 213

	FY 2021-22		FY 2022-23	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$38,919,000	\$0	\$38,919,000
TOTAL FUNDS	\$0	\$38,919,000	\$0	\$38,919,000
STATE FUNDS	\$0	\$4,824,500	\$0	\$4,824,500
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$38,919,000	\$0	\$38,919,000
TOTAL FUNDS	\$0	\$38,919,000	\$0	\$38,919,000
STATE FUNDS	\$0	\$4,824,500	\$0	\$4,824,500

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 for FY 2021-22, from the prior estimate, is a decrease due to a decrease in expenditures used to estimate these costs. There is no change from FY 2021-22 to FY 2022-23 in the current estimate.

LOS ANGELES COUNTY HOSPITAL INTAKES

COUNTY ADMIN. POLICY CHANGE NUMBER: 6

Methodology:

1. The reimbursement rate is \$268 for both current year and budget year. Assume in FY 2021-22 and FY 2022-23, PFSWs will continue processing a base caseload of 2,215 per month.

FY 2021-22: $2,215 \times \$268 \times 12 = \$7,123,000$ TF (\$3,561,500 GF)

FY 2022-23: $2,215 \times \$268 \times 12 = \$7,123,000$ TF (\$3,561,500 GF)

2. The Department completed the FY 2019-20 reconciliation in FY 2020-21. The FY 2022-23 reconciliation amounts are placeholders.

(Dollars in Thousands)

Line Item	FY 2021-22			FY 2022-23		
	TF	GF	FF	TF	GF	FF
PFSW Base	\$7,123	\$3,561	\$3,562	\$7,123	\$3,561	\$3,562
FY 2019-20 Recon.	\$17,162	\$1,263	\$15,899			
FY 2019-20 Pass.	\$14,634	\$0	\$14,634			
FY 2020-21 Recon.				\$17,162	\$1,263	\$15,899
FY 2020-21 Pass.				\$14,634	\$0	\$14,634
Total	\$38,919	\$4,824	\$34,095	\$38,919	\$4,824	\$34,095

Funding:

(Dollars in Thousands)

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	\$30,533	\$0	\$30,533
100% GF	4260-101-0001	\$1,263	\$1,263	\$0
Total		\$38,919	\$4,824	\$34,095

FY 2022-23	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	\$30,533	\$0	\$30,533
100% GF	4260-101-0001	\$1,263	\$1,263	\$0
Total		\$38,919	\$4,824	\$34,095

ENHANCED FEDERAL FUNDING

COUNTY ADMIN. POLICY CHANGE NUMBER: 7
IMPLEMENTATION DATE: 1/2015
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 1835

	FY 2021-22		FY 2022-23	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$0	\$0	\$0
STATE FUNDS	-\$525,000,000	\$0	-\$531,750,000	\$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$0	\$0	\$0
STATE FUNDS	-\$525,000,000	\$0	-\$531,750,000	\$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: 7

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 2021-22, is a decrease 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 2021-22 to 2022-23, in the current estimate, is an increase in GF savings due to updated estimated claim funding projections that utilize the expenditure trends from 3 quarters of prior claim actuals for FY 2020-21 and 1 quarter of current claim actuals for FY 2021-22.

Methodology:

1. The effective date for the Department's APD was August 6, 2020.
2. The Department receives reports from CDSS identifying actual expenditure costs eligible for enhanced funding.
3. 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.
4. 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. In FY 2022-23, the Department will claim payments for FY 2021-22 quarters 3 and 4 and FY 2022-23 1 and 2.
5. The savings are estimated to be:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
Title XIX at 50% FFP	(\$2,100,000)	(\$1,050,000)	(\$1,050,000)
Title XIX at 75% FFP	\$2,100,000	\$525,000	\$1,575,000
Total Difference	\$0	(\$525,000)	\$525,000

FY 2022-23	TF	GF	FF
Title XIX at 50% FFP	(\$2,127,000)	(\$1,064,000)	(\$1,064,000)
Title XIX at 75% FFP	\$2,127,000	\$532,000	\$1,596,000
Total Difference	\$0	(\$532,000)	\$532,000

*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: 8
IMPLEMENTATION DATE: 10/1988
ANALYST: Kalandie Coleman
FISCAL REFERENCE NUMBER: 215

	FY 2021-22		FY 2022-23	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$0	\$0	\$0
STATE FUNDS	-\$4,000,000	\$0	-\$4,000,000	\$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$0	\$0	\$0
STATE FUNDS	-\$4,000,000	\$0	-\$4,000,000	\$0

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 prior estimate for FY 2021-22, or in the current estimate for FY 2021-22 to FY 2022-23.

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: 8

2. The Medi-Cal accrual costs for SAVE reported over the last three years by the counties were:

Fiscal Year	Actual	Fiscal Year	Estimated
FY 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	\$8,115,482	FY 2021-22	\$8,000,000

3. Based on claims through June 2020, federal funds will be:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
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
Net Impact	\$0	(\$4,000)	\$4,000

FY 2022-23	TF	GF	FF
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
Net Impact	\$0	(\$4,000)	\$4,000

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 2021 Medi-Cal Estimate

**OTHER ADMINISTRATION
FUNDING SUMMARY**

Other Administration Tab contains funding for items under both the County Administration and the Fiscal Intermediary components of the Medi-Cal Estimate (located in the Management Summary Tab). The Fiscal Intermediary Tab of the Medi-Cal Estimate has been moved to the Other Administration Tab. These items continue to be budgeted in the Medi-Cal's Fiscal Intermediary component. The policy changes related to the Fiscal Intermediary can be found under the following subsections: DHCS-MEDICAL FI, DHCS-HEALTH CARE OPTIONS, AND DHCS-DENTAL FI.

<u>FY 2021-2022 Estimate:</u>	<u>Total Funds</u>	<u>Federal Funds</u>	<u>General Funds</u>	<u>Other State Funds</u>
OTHER ADMINISTRATION				
County Administration	\$3,004,222,000	\$2,674,230,000	\$311,883,000	\$18,109,000
Fiscal Intermediary	\$443,328,000	\$285,680,000	\$157,648,000	\$0
Total Other Administration Tab	\$3,447,550,000	\$2,959,910,000	\$469,531,000	\$18,109,000

Management Summary:

COUNTY ADMINISTRATION	\$5,532,283,000	\$4,523,199,000	\$990,974,000	\$18,109,000
Shown in Other Administration Tab	\$3,004,222,000	\$2,674,230,000	\$311,883,000	\$18,109,000
Shown in County Administration Tab	\$2,528,061,000	\$1,848,969,000	\$679,091,000	\$0
FISCAL INTERMEDIARY	\$443,328,000	\$285,680,000	\$157,648,000	\$0
Shown in Other Administration Tab	\$443,328,000	\$285,680,000	\$157,648,000	\$0

<u>FY 2022-2023 Estimate:</u>	<u>Total Funds</u>	<u>Federal Funds</u>	<u>General Funds</u>	<u>Other State Funds</u>
OTHER ADMINISTRATION				
County Administration	\$2,951,187,000	\$2,453,232,000	\$484,012,000	\$13,943,000
Fiscal Intermediary	\$448,934,000	\$310,467,000	\$138,467,000	\$0
Total Other Administration Tab	\$3,400,121,000	\$2,763,699,000	\$622,479,000	\$13,943,000

Management Summary:

COUNTY ADMINISTRATION	\$5,491,281,000	\$4,300,171,000	\$1,177,167,000	\$13,943,000
Shown in Other Administration Tab	\$2,951,187,000	\$2,453,232,000	\$484,012,000	\$13,943,000
Shown in County Administration Tab	\$2,540,094,000	\$1,846,939,000	\$693,155,000	\$0
FISCAL INTERMEDIARY	\$448,934,000	\$310,467,000	\$138,467,000	\$0
Shown in Other Administration Tab	\$448,934,000	\$310,467,000	\$138,467,000	\$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>
	<u>DHCS-OTHER</u>				
1	INTERIM AND FINAL COST SETTLEMENTS-SMHS	\$297,944,000	\$297,944,000	\$0	\$0
2	COUNTY SPECIALTY MENTAL HEALTH ADMIN	\$248,436,000	\$240,381,000	\$8,055,000	\$0
3	CCS CASE MANAGEMENT	\$170,431,000	\$110,669,000	\$59,762,000	\$0
4	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$156,882,000	\$156,244,000	\$638,000	\$0
5	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$149,725,000	\$149,725,000	\$0	\$0
6	MEDI-CAL RX - ADMINISTRATIVE COSTS	\$97,648,000	\$52,203,450	\$45,444,550	\$0
7	CALAIM - POPULATION HEALTH MANAGEMENT	\$75,000,000	\$67,500,000	\$7,500,000	\$0
8	DRUG MEDI-CAL COUNTY ADMINISTRATION	\$48,243,000	\$47,878,000	\$365,000	\$0
9	HEALTH ENROLLMENT NAVIGATORS	\$47,844,000	\$23,922,000	\$23,922,000	\$0
10	SMH MAA	\$45,914,000	\$45,914,000	\$0	\$0
11	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	\$43,679,000	\$39,239,000	\$4,440,000	\$0
12	MIS/DSS SYSTEM AND SURS & MARS SUBSYSTEM	\$42,850,000	\$32,091,850	\$10,758,150	\$0
13	ARRA HITECH INCENTIVE PROGRAM	\$40,975,000	\$40,975,000	\$0	\$0
14	CHDP COUNTY ALLOCATION	\$33,962,000	\$22,005,000	\$11,957,000	\$0
15	POSTAGE & PRINTING	\$31,277,000	\$15,510,000	\$15,767,000	\$0
16	OTLCP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	\$29,643,000	\$12,938,500	\$16,704,500	\$0
17	ACTUARIAL COSTS FOR RATE DEVELOPMENT	\$21,988,000	\$10,994,000	\$10,685,000	\$309,000
18	HCBA WAIVER ADMINISTRATIVE COST	\$16,727,000	\$8,363,500	\$8,363,500	\$0
19	LA COUNTY PUBLIC HEALTH NURSING PILOT	\$16,500,000	\$16,500,000	\$0	\$0
20	PAVE SYSTEM	\$12,713,000	\$14,107,900	(\$1,394,900)	\$0
21	CAPMAN	\$11,672,000	\$8,672,300	\$2,999,700	\$0
22	CCI-ADMINISTRATIVE COSTS	\$11,213,000	\$5,606,500	\$5,606,500	\$0
23	MEDI-CAL RECOVERY CONTRACTS	\$10,443,000	\$7,832,250	\$2,610,750	\$0
24	MITA	\$10,424,000	\$9,100,200	\$1,323,800	\$0
25	CYBHI - BH SERVICES AND SUPPORTS PLATFORM	\$10,000,000	\$0	\$10,000,000	\$0
26	LITIGATION RELATED SERVICES	\$9,980,000	\$4,990,000	\$4,990,000	\$0
27	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	\$7,404,000	\$4,992,000	\$2,412,000	\$0
28	NEWBORN HEARING SCREENING PROGRAM	\$6,131,000	\$3,065,500	\$3,065,500	\$0
29	PASRR	\$6,056,000	\$4,542,000	\$1,514,000	\$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>
<u>DHCS-OTHER</u>					
30	ELECTRONIC ASSET VERIFICATION PROGRAM	\$5,621,000	\$2,810,500	\$2,810,500	\$0
31	DRUG MEDI-CAL PARITY RULE ADMINISTRATION	\$4,407,000	\$2,938,000	\$1,469,000	\$0
32	MEDCOMPASS SOLUTION	\$3,770,000	\$3,380,350	\$389,650	\$0
33	PACES	\$2,799,000	\$2,375,000	\$424,000	\$0
34	MEDI-CAL NONMEDICAL TRANSPORTATION	\$2,704,000	\$1,977,000	\$727,000	\$0
35	T-MSIS	\$1,855,000	\$1,571,100	\$283,900	\$0
36	SDMC SYSTEM M&O SUPPORT	\$2,325,000	\$1,162,500	\$1,162,500	\$0
37	SSA COSTS FOR HEALTH COVERAGE INFO.	\$1,718,000	\$859,000	\$859,000	\$0
38	CALIFORNIA HEALTH INTERVIEW SURVEY	\$1,400,000	\$1,400,000	\$0	\$0
39	ENCRYPTION OF PHI DATA	\$1,208,000	\$604,000	\$604,000	\$0
40	FAMILY PACT PROGRAM ADMIN.	\$1,207,000	\$1,086,300	\$120,700	\$0
41	MMA - DSH ANNUAL INDEPENDENT AUDIT	\$773,000	\$386,500	\$386,500	\$0
42	CCT OUTREACH - ADMINISTRATIVE COSTS	\$340,000	\$340,000	\$0	\$0
43	LTSS ACTUARIAL STUDY	\$100,000	\$0	\$100,000	\$0
46	COVID-19 INCREASED FMAP - OTHER ADMIN	\$0	\$1,625,000	(\$1,625,000)	\$0
47	CMS DEFERRED CLAIMS - OTHER ADMIN	\$0	(\$4,804,000)	\$4,804,000	\$0
87	COVID-19 INCREASED FMAP EXTENSION - OTHER ADMIN	\$0	\$737,000	(\$737,000)	\$0
	DHCS-OTHER SUBTOTAL	\$1,741,931,000	\$1,472,354,200	\$269,267,800	\$309,000
<u>DHCS-MEDICAL FI</u>					
48	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	\$48,420,000	\$35,693,400	\$12,726,600	\$0
49	MEDICAL FI BO & IT COST REIMBURSEMENT	\$46,251,000	\$33,119,050	\$13,131,950	\$0
50	MEDICAL FI IT INFRASTRUCTURE SERVICES	\$30,681,000	\$22,616,200	\$8,064,800	\$0
51	MEDICAL FI BO & IT CHANGE ORDERS	\$28,734,000	\$21,183,550	\$7,550,450	\$0
52	MEDICAL FI BO OTHER ESTIMATED COSTS	\$19,590,000	\$13,708,300	\$5,881,700	\$0
53	MEDICAL FI BO TELEPHONE SERVICE CENTER	\$13,643,000	\$9,560,400	\$4,082,600	\$0
54	MEDICAL FI BUSINESS OPERATIONS	\$13,072,000	\$9,636,250	\$3,435,750	\$0
55	MEDICAL FI BO HOURLY REIMBURSEMENT	\$10,437,000	\$7,692,400	\$2,744,600	\$0
56	MEDICAL FI BO MISCELLANEOUS EXPENSES	\$2,371,000	\$1,619,150	\$751,850	\$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>
	DHCS-MEDICAL FI SUBTOTAL	\$213,199,000	\$154,828,700	\$58,370,300	\$0
	<u>DHCS-HEALTH CARE OPT</u>				
57	HCO OPERATIONS 2017 CONTRACT	\$34,800,000	\$17,661,150	\$17,138,850	\$0
58	HCO COST REIMBURSEMENT 2017 CONTRACT	\$20,520,000	\$10,413,900	\$10,106,100	\$0
59	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	\$15,600,000	\$7,917,000	\$7,683,000	\$0
	DHCS-HEALTH CARE OPT SUBTOTAL	\$70,920,000	\$35,992,050	\$34,927,950	\$0
	<u>DHCS-DENTAL FI</u>				
60	DENTAL ASO ADMINISTRATION 2016 CONTRACT	\$48,181,000	\$30,793,500	\$17,387,500	\$0
61	DENTAL FI ADMINISTRATION 2016 CONTRACT	\$20,830,000	\$15,144,250	\$5,685,750	\$0
83	COVID-19 VACCINATION INCENTIVE PROGRAM ADMIN	\$100,000,000	\$50,000,000	\$50,000,000	\$0
	DHCS-DENTAL FI SUBTOTAL	\$169,011,000	\$95,937,750	\$73,073,250	\$0
	<u>OTHER DEPARTMENTS</u>				
62	PERSONAL CARE SERVICES	\$384,224,000	\$384,224,000	\$0	\$0
63	HEALTH-RELATED ACTIVITIES - CDSS	\$337,606,000	\$337,606,000	\$0	\$0
64	HCBS SP - IHSS HCBS CARE ECONOMY PMTS	\$137,275,000	\$137,275,000	\$0	\$0
65	CALHEERS DEVELOPMENT	\$123,320,000	\$89,914,500	\$33,405,500	\$0
66	CDDS ADMINISTRATIVE COSTS	\$93,799,000	\$93,799,000	\$0	\$0
67	MATERNAL AND CHILD HEALTH	\$48,738,000	\$48,738,000	\$0	\$0
68	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	\$55,172,000	\$41,379,000	\$0	\$13,793,000
69	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	\$33,047,000	\$33,047,000	\$0	\$0
70	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	\$16,908,000	\$12,901,000	\$0	\$4,007,000
71	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	\$5,250,000	\$5,250,000	\$0	\$0
72	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG	\$5,009,000	\$5,009,000	\$0	\$0
73	CLPP CASE MANAGEMENT SERVICES	\$2,722,000	\$2,722,000	\$0	\$0
74	CALIFORNIA SMOKERS' HELPLINE	\$2,671,000	\$2,671,000	\$0	\$0
75	KIT FOR NEW PARENTS	\$449,000	\$449,000	\$0	\$0
76	VETERANS BENEFITS	\$1,100,000	\$1,100,000	\$0	\$0
77	MEDI-CAL INPATIENT SERVICES FOR INMATES	\$1,077,000	\$1,077,000	\$0	\$0
78	CHHS AGENCY HIPAA FUNDING	\$1,022,000	\$1,022,000	\$0	\$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>
<u>OTHER DEPARTMENTS</u>					
79	VITAL RECORDS	\$891,000	\$883,000	\$8,000	\$0
80	MERIT SYSTEM SERVICES FOR COUNTIES	\$190,000	\$95,000	\$95,000	\$0
81	CDPH I&E PROGRAM AND EVALUATION	\$86,000	\$86,000	\$0	\$0
82	PIA EYEWEAR COURIER SERVICE	\$766,000	\$383,000	\$383,000	\$0
86	HCBS SP CDDS - OTHER ADMIN	\$1,167,000	\$1,167,000	\$0	\$0
	OTHER DEPARTMENTS SUBTOTAL	\$1,252,489,000	\$1,200,797,500	\$33,891,500	\$17,800,000
	GRAND TOTAL	\$3,447,550,000	\$2,959,910,200	\$469,530,800	\$18,109,000

**SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2022-23**

<u>NO.</u>	<u>POLICY CHANGE TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>GENERAL FUNDS</u>	<u>OTHER STATE FUNDS</u>
	<u>DHCS-OTHER</u>				
1	INTERIM AND FINAL COST SETTLEMENTS-SMHS	\$208,974,000	\$208,974,000	\$0	\$0
2	COUNTY SPECIALTY MENTAL HEALTH ADMIN	\$248,285,000	\$241,099,000	\$7,186,000	\$0
3	CCS CASE MANAGEMENT	\$157,505,000	\$102,534,800	\$54,970,200	\$0
4	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$159,780,000	\$159,780,000	\$0	\$0
5	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$129,875,000	\$129,875,000	\$0	\$0
6	MEDI-CAL RX - ADMINISTRATIVE COSTS	\$93,705,000	\$71,732,750	\$21,972,250	\$0
7	CALAIM - POPULATION HEALTH MANAGEMENT	\$225,000,000	\$202,500,000	\$22,500,000	\$0
8	DRUG MEDI-CAL COUNTY ADMINISTRATION	\$55,749,000	\$55,337,000	\$412,000	\$0
10	SMH MAA	\$51,586,000	\$51,586,000	\$0	\$0
11	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	\$438,000	\$357,000	\$81,000	\$0
12	MIS/DSS SYSTEM AND SURS & MARS SUBSYSTEM	\$29,420,000	\$22,015,350	\$7,404,650	\$0
14	CHDP COUNTY ALLOCATION	\$33,962,000	\$22,005,000	\$11,957,000	\$0
15	POSTAGE & PRINTING	\$31,277,000	\$15,510,000	\$15,767,000	\$0
16	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	\$26,309,000	\$12,189,750	\$14,119,250	\$0
17	ACTUARIAL COSTS FOR RATE DEVELOPMENT	\$22,913,000	\$11,456,500	\$11,307,000	\$149,500
18	HCBA WAIVER ADMINISTRATIVE COST	\$24,186,000	\$12,093,000	\$12,093,000	\$0
19	LA COUNTY PUBLIC HEALTH NURSING PILOT	\$8,250,000	\$8,250,000	\$0	\$0
20	PAVE SYSTEM	\$19,326,000	\$14,027,800	\$5,298,200	\$0
21	CAPMAN	\$17,470,000	\$12,975,000	\$4,495,000	\$0
22	CCI-ADMINISTRATIVE COSTS	\$5,958,000	\$2,979,000	\$2,979,000	\$0
23	MEDI-CAL RECOVERY CONTRACTS	\$7,882,000	\$5,911,500	\$1,970,500	\$0
24	MITA	\$10,997,000	\$9,600,700	\$1,396,300	\$0
25	CYBHI - BH SERVICES AND SUPPORTS PLATFORM	\$230,000,000	\$0	\$230,000,000	\$0
26	LITIGATION RELATED SERVICES	\$9,980,000	\$4,990,000	\$4,990,000	\$0
27	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	\$7,404,000	\$4,992,000	\$2,412,000	\$0
28	NEWBORN HEARING SCREENING PROGRAM	\$6,273,000	\$3,136,500	\$3,136,500	\$0
29	PASRR	\$6,056,000	\$4,542,000	\$1,514,000	\$0
30	ELECTRONIC ASSET VERIFICATION PROGRAM	\$5,621,000	\$2,810,500	\$2,810,500	\$0
31	DRUG MEDI-CAL PARITY RULE ADMINISTRATION	\$5,862,000	\$3,908,000	\$1,954,000	\$0

**SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2022-23**

<u>NO.</u>	<u>POLICY CHANGE TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>GENERAL FUNDS</u>	<u>OTHER STATE FUNDS</u>
<u>DHCS-OTHER</u>					
32	MEDCOMPASS SOLUTION	\$3,984,000	\$2,936,200	\$1,047,800	\$0
33	PACES	\$3,361,000	\$2,611,400	\$749,600	\$0
34	MEDI-CAL NONMEDICAL TRANSPORTATION	\$2,724,000	\$1,987,000	\$737,000	\$0
35	T-MSIS	\$2,747,000	\$2,347,500	\$399,500	\$0
36	SDMC SYSTEM M&O SUPPORT	\$2,325,000	\$1,162,500	\$1,162,500	\$0
37	SSA COSTS FOR HEALTH COVERAGE INFO.	\$1,476,000	\$738,000	\$738,000	\$0
38	CALIFORNIA HEALTH INTERVIEW SURVEY	\$1,400,000	\$1,400,000	\$0	\$0
39	ENCRYPTION OF PHI DATA	\$1,500,000	\$750,000	\$750,000	\$0
40	FAMILY PACT PROGRAM ADMIN.	\$1,207,000	\$1,086,300	\$120,700	\$0
41	MMA - DSH ANNUAL INDEPENDENT AUDIT	\$800,000	\$400,000	\$400,000	\$0
42	CCT OUTREACH - ADMINISTRATIVE COSTS	\$340,000	\$340,000	\$0	\$0
44	COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE	\$48,143,000	\$28,942,000	\$19,201,000	\$0
45	MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM	\$1,000,000	\$500,000	\$500,000	\$0
87	COVID-19 INCREASED FMAP EXTENSION - OTHER ADMIN	\$0	\$369,000	(\$369,000)	\$0
	DHCS-OTHER SUBTOTAL	\$1,911,050,000	\$1,442,738,050	\$468,162,450	\$149,500
<u>DHCS-MEDICAL FI</u>					
48	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	\$49,197,000	\$36,266,250	\$12,930,750	\$0
49	MEDICAL FI BO & IT COST REIMBURSEMENT	\$44,812,000	\$32,058,350	\$12,753,650	\$0
50	MEDICAL FI IT INFRASTRUCTURE SERVICES	\$30,450,000	\$22,445,800	\$8,004,200	\$0
51	MEDICAL FI BO & IT CHANGE ORDERS	\$27,009,000	\$19,911,300	\$7,097,700	\$0
52	MEDICAL FI BO OTHER ESTIMATED COSTS	\$20,276,000	\$14,185,700	\$6,090,300	\$0
53	MEDICAL FI BO TELEPHONE SERVICE CENTER	\$14,121,000	\$9,894,950	\$4,226,050	\$0
54	MEDICAL FI BUSINESS OPERATIONS	\$13,529,000	\$9,972,750	\$3,556,250	\$0
55	MEDICAL FI BO HOURLY REIMBURSEMENT	\$10,663,000	\$7,859,900	\$2,803,100	\$0
56	MEDICAL FI BO MISCELLANEOUS EXPENSES	\$2,318,000	\$1,580,550	\$737,450	\$0
	DHCS-MEDICAL FI SUBTOTAL	\$212,375,000	\$154,175,550	\$58,199,450	\$0

**SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2022-23**

<u>NO.</u>	<u>POLICY CHANGE TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>GENERAL FUNDS</u>	<u>OTHER STATE FUNDS</u>
<u>DHCS-HEALTH CARE OPT</u>					
57	HCO OPERATIONS 2017 CONTRACT	\$34,800,000	\$17,661,150	\$17,138,850	\$0
58	HCO COST REIMBURSEMENT 2017 CONTRACT	\$20,520,000	\$10,413,900	\$10,106,100	\$0
59	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	\$15,600,000	\$7,917,000	\$7,683,000	\$0
	DHCS-HEALTH CARE OPT SUBTOTAL	\$70,920,000	\$35,992,050	\$34,927,950	\$0
<u>DHCS-DENTAL FI</u>					
60	DENTAL ASO ADMINISTRATION 2016 CONTRACT	\$48,319,000	\$30,874,000	\$17,445,000	\$0
61	DENTAL FI ADMINISTRATION 2016 CONTRACT	\$21,108,000	\$15,378,750	\$5,729,250	\$0
	DHCS-DENTAL FI SUBTOTAL	\$69,427,000	\$46,252,750	\$23,174,250	\$0
<u>OTHER DEPARTMENTS</u>					
62	PERSONAL CARE SERVICES	\$384,520,000	\$384,520,000	\$0	\$0
63	HEALTH-RELATED ACTIVITIES - CDSS	\$368,394,000	\$368,394,000	\$0	\$0
65	CALHEERS DEVELOPMENT	\$138,413,000	\$100,971,600	\$37,441,400	\$0
66	CDDS ADMINISTRATIVE COSTS	\$65,500,000	\$65,500,000	\$0	\$0
67	MATERNAL AND CHILD HEALTH	\$47,668,000	\$47,668,000	\$0	\$0
68	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	\$55,172,000	\$41,379,000	\$0	\$13,793,000
69	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	\$33,047,000	\$33,047,000	\$0	\$0
70	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	\$12,901,000	\$12,901,000	\$0	\$0
71	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	\$6,235,000	\$6,235,000	\$0	\$0
72	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG	\$5,316,000	\$5,316,000	\$0	\$0
73	CLPP CASE MANAGEMENT SERVICES	\$8,166,000	\$8,166,000	\$0	\$0
74	CALIFORNIA SMOKERS' HELPLINE	\$2,400,000	\$2,400,000	\$0	\$0
75	KIT FOR NEW PARENTS	\$816,000	\$816,000	\$0	\$0
76	VETERANS BENEFITS	\$1,100,000	\$1,100,000	\$0	\$0
77	MEDI-CAL INPATIENT SERVICES FOR INMATES	\$1,121,000	\$1,121,000	\$0	\$0
78	CHHS AGENCY HIPAA FUNDING	\$1,037,000	\$1,037,000	\$0	\$0
79	VITAL RECORDS	\$891,000	\$883,000	\$8,000	\$0
80	MERIT SYSTEM SERVICES FOR COUNTIES	\$190,000	\$95,000	\$95,000	\$0
82	PIA EYEWEAR COURIER SERVICE	\$941,000	\$470,500	\$470,500	\$0

**SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2022-23**

<u>NO.</u>	<u>POLICY CHANGE TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>GENERAL FUNDS</u>	<u>OTHER STATE FUNDS</u>
	<u>OTHER DEPARTMENTS</u>				
86	HCBS SP CDDS - OTHER ADMIN	\$2,521,000	\$2,521,000	\$0	\$0
	OTHER DEPARTMENTS SUBTOTAL	\$1,136,349,000	\$1,084,541,100	\$38,014,900	\$13,793,000
	GRAND TOTAL	<u>\$3,400,121,000</u>	<u>\$2,763,699,500</u>	<u>\$622,479,000</u>	<u>\$13,942,500</u>

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2021 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2021-22**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2021-22 APPROPRIATION		NOV. 2021 EST. FOR 2021-22		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		<u>DHCS-OTHER</u>						
--	1	INTERIM AND FINAL COST SETTLEMENTS-SMHS	\$0	\$0	\$297,944,000	\$0	\$297,944,000	\$0
2	2	COUNTY SPECIALTY MENTAL HEALTH ADMIN	\$204,027,000	\$0	\$248,436,000	\$8,055,000	\$44,409,000	\$8,055,000
1	3	CCS CASE MANAGEMENT	\$170,612,000	\$59,843,550	\$170,431,000	\$59,762,000	(\$181,000)	(\$81,550)
3	4	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$150,159,000	\$0	\$156,882,000	\$638,000	\$6,723,000	\$638,000
4	5	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$119,211,000	\$0	\$149,725,000	\$0	\$30,514,000	\$0
8	6	MEDI-CAL RX - ADMINISTRATIVE COSTS	\$76,825,000	\$37,759,900	\$97,648,000	\$45,444,550	\$20,823,000	\$7,684,650
88	7	CALAIM - POPULATION HEALTH MANAGEMENT	\$300,000,000	\$30,000,000	\$75,000,000	\$7,500,000	(\$225,000,000)	(\$22,500,000)
17	8	DRUG MEDI-CAL COUNTY ADMINISTRATION	\$39,698,000	\$771,000	\$48,243,000	\$365,000	\$8,545,000	(\$406,000)
14	9	HEALTH ENROLLMENT NAVIGATORS	\$44,970,000	\$22,485,000	\$47,844,000	\$23,922,000	\$2,874,000	\$1,437,000
5	10	SMH MAA	\$48,129,000	\$0	\$45,914,000	\$0	(\$2,215,000)	\$0
6	11	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	\$46,847,000	\$4,756,000	\$43,679,000	\$4,440,000	(\$3,168,000)	(\$316,000)
7	12	MIS/DSS SYSTEM AND SURS & MARS SUBSYSTEM	\$27,411,000	\$7,227,000	\$42,850,000	\$10,758,150	\$15,439,000	\$3,531,150
9	13	ARRA HITECH INCENTIVE PROGRAM	\$33,560,000	\$0	\$40,975,000	\$0	\$7,415,000	\$0
12	14	CHDP COUNTY ALLOCATION	\$33,962,000	\$11,957,000	\$33,962,000	\$11,957,000	\$0	\$0
15	15	POSTAGE & PRINTING	\$27,044,000	\$13,650,500	\$31,277,000	\$15,767,000	\$4,233,000	\$2,116,500
11	16	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	\$37,994,000	\$19,589,650	\$29,643,000	\$16,704,500	(\$8,351,000)	(\$2,885,150)
18	17	ACTUARIAL COSTS FOR RATE DEVELOPMENT	\$21,104,000	\$10,167,000	\$21,988,000	\$10,685,000	\$884,000	\$518,000
20	18	HCBA WAIVER ADMINISTRATIVE COST	\$21,566,000	\$10,783,000	\$16,727,000	\$8,363,500	(\$4,839,000)	(\$2,419,500)
87	19	LA COUNTY PUBLIC HEALTH NURSING PILOT	\$16,500,000	\$0	\$16,500,000	\$0	\$0	\$0
23	20	PAVE SYSTEM	\$12,711,000	\$3,342,100	\$12,713,000	(\$1,394,900)	\$2,000	(\$4,737,000)
25	21	CAPMAN	\$8,904,000	\$2,194,200	\$11,672,000	\$2,999,700	\$2,768,000	\$805,500

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2021 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2021-22**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2021-22 APPROPRIATION		NOV. 2021 EST. FOR 2021-22		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		<u>DHCS-OTHER</u>						
21	22	CCI-ADMINISTRATIVE COSTS	\$11,213,000	\$5,606,500	\$11,213,000	\$5,606,500	\$0	\$0
26	23	MEDI-CAL RECOVERY CONTRACTS	\$8,305,000	\$2,076,250	\$10,443,000	\$2,610,750	\$2,138,000	\$534,500
22	24	MITA	\$10,624,000	\$1,393,450	\$10,424,000	\$1,323,800	(\$200,000)	(\$69,650)
89	25	CYBHI - BH SERVICES AND SUPPORTS PLATFORM	\$10,000,000	\$10,000,000	\$10,000,000	\$10,000,000	\$0	\$0
24	26	LITIGATION RELATED SERVICES	\$9,980,000	\$4,990,000	\$9,980,000	\$4,990,000	\$0	\$0
28	27	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	\$7,405,000	\$2,412,500	\$7,404,000	\$2,412,000	(\$1,000)	(\$500)
29	28	NEWBORN HEARING SCREENING PROGRAM	\$6,131,000	\$3,065,500	\$6,131,000	\$3,065,500	\$0	\$0
27	29	PASRR	\$6,056,000	\$1,514,000	\$6,056,000	\$1,514,000	\$0	\$0
31	30	ELECTRONIC ASSET VERIFICATION PROGRAM	\$5,621,000	\$2,810,500	\$5,621,000	\$2,810,500	\$0	\$0
44	31	DRUG MEDI-CAL PARITY RULE ADMINISTRATION	\$4,407,000	\$1,469,000	\$4,407,000	\$1,469,000	\$0	\$0
33	32	MEDCOMPASS SOLUTION	\$3,081,000	\$808,300	\$3,770,000	\$389,650	\$689,000	(\$418,650)
32	33	PACES	\$2,798,000	\$423,250	\$2,799,000	\$424,000	\$1,000	\$750
84	34	MEDI-CAL NONMEDICAL TRANSPORTATION	\$2,704,000	\$727,000	\$2,704,000	\$727,000	\$0	\$0
36	35	T-MSIS	\$3,101,000	\$441,700	\$1,855,000	\$283,900	(\$1,246,000)	(\$157,800)
34	36	SDMC SYSTEM M&O SUPPORT	\$2,325,000	\$1,162,500	\$2,325,000	\$1,162,500	\$0	\$0
35	37	SSA COSTS FOR HEALTH COVERAGE INFO.	\$1,589,000	\$794,500	\$1,718,000	\$859,000	\$129,000	\$64,500
39	38	CALIFORNIA HEALTH INTERVIEW SURVEY	\$1,142,000	\$0	\$1,400,000	\$0	\$258,000	\$0
40	39	ENCRYPTION OF PHI DATA	\$750,000	\$375,000	\$1,208,000	\$604,000	\$458,000	\$229,000
37	40	FAMILY PACT PROGRAM ADMIN.	\$1,207,000	\$120,700	\$1,207,000	\$120,700	\$0	\$0
41	41	MMA - DSH ANNUAL INDEPENDENT AUDIT	\$800,000	\$400,000	\$773,000	\$386,500	(\$27,000)	(\$13,500)
43	42	CCT OUTREACH - ADMINISTRATIVE COSTS	\$340,000	\$0	\$340,000	\$0	\$0	\$0
--	43	LTSS ACTUARIAL STUDY	\$0	\$0	\$100,000	\$100,000	\$100,000	\$100,000

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2021 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2021-22**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2021-22 APPROPRIATION		NOV. 2021 EST. FOR 2021-22		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>DHCS-OTHER</u>								
45	46	COVID-19 INCREASED FMAP - OTHER ADMIN	\$0	(\$1,904,000)	\$0	(\$1,625,000)	\$0	\$279,000
46	47	CMS DEFERRED CLAIMS - OTHER ADMIN	\$0	(\$30,003,000)	\$0	\$4,804,000	\$0	\$34,807,000
--	87	COVID-19 INCREASED FMAP EXTENSION - OTHER ADMIN	\$0	\$0	\$0	(\$737,000)	\$0	(\$737,000)
13	--	SMHS COUNTY UR & QA ADMIN	\$34,079,000	\$963,000	\$0	\$0	(\$34,079,000)	(\$963,000)
16	--	DRUG MEDI-CAL COUNTY UR & QA ADMIN	\$9,871,000	\$0	\$0	\$0	(\$9,871,000)	\$0
19	--	MANAGED CARE REGULATIONS - MH PARITY	\$19,144,000	\$2,735,000	\$0	\$0	(\$19,144,000)	(\$2,735,000)
30	--	PERFORMANCE OUTCOMES SYSTEM	\$4,091,000	\$1,892,000	\$0	\$0	(\$4,091,000)	(\$1,892,000)
38	--	MANAGED CARE REGULATIONS - MENTAL HEALTH	\$5,453,000	\$1,721,000	\$0	\$0	(\$5,453,000)	(\$1,721,000)
91	--	RECONCILIATION	\$0	\$0	\$0	\$0	\$0	\$0
DHCS-OTHER SUBTOTAL			\$1,613,451,000	\$250,520,550	\$1,741,931,000	\$269,267,800	\$128,480,000	\$18,747,250
<u>DHCS-MEDICAL FI</u>								
48	48	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	\$48,420,000	\$12,726,600	\$48,420,000	\$12,726,600	\$0	\$0
49	49	MEDICAL FI BO & IT COST REIMBURSEMENT	\$44,717,000	\$12,813,950	\$46,251,000	\$13,131,950	\$1,534,000	\$318,000
51	50	MEDICAL FI IT INFRASTRUCTURE SERVICES	\$30,681,000	\$8,064,800	\$30,681,000	\$8,064,800	\$0	\$0
50	51	MEDICAL FI BO & IT CHANGE ORDERS	\$28,753,000	\$7,558,400	\$28,734,000	\$7,550,450	(\$19,000)	(\$7,950)
52	52	MEDICAL FI BO OTHER ESTIMATED COSTS	\$19,590,000	\$5,880,950	\$19,590,000	\$5,881,700	\$0	\$750
53	53	MEDICAL FI BO TELEPHONE SERVICE CENTER	\$13,643,000	\$4,082,600	\$13,643,000	\$4,082,600	\$0	\$0
54	54	MEDICAL FI BUSINESS OPERATIONS	\$13,072,000	\$3,435,000	\$13,072,000	\$3,435,750	\$0	\$750
55	55	MEDICAL FI BO HOURLY REIMBURSEMENT	\$10,498,000	\$2,758,950	\$10,437,000	\$2,744,600	(\$61,000)	(\$14,350)
56	56	MEDICAL FI BO MISCELLANEOUS EXPENSES	\$2,468,000	\$786,050	\$2,371,000	\$751,850	(\$97,000)	(\$34,200)

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2021 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2021-22**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2021-22 APPROPRIATION		NOV. 2021 EST. FOR 2021-22		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DHCS-MEDICAL FI SUBTOTAL	\$211,842,000	\$58,107,300	\$213,199,000	\$58,370,300	\$1,357,000	\$263,000
		<u>DHCS-HEALTH CARE OPT</u>						
58	57	HCO OPERATIONS 2017 CONTRACT	\$38,280,000	\$18,852,750	\$34,800,000	\$17,138,850	(\$3,480,000)	(\$1,713,900)
59	58	HCO COST REIMBURSEMENT 2017 CONTRACT	\$17,820,000	\$8,776,350	\$20,520,000	\$10,106,100	\$2,700,000	\$1,329,750
60	59	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	\$17,160,000	\$8,451,300	\$15,600,000	\$7,683,000	(\$1,560,000)	(\$768,300)
		DHCS-HEALTH CARE OPT SUBTOTAL	\$73,260,000	\$36,080,400	\$70,920,000	\$34,927,950	(\$2,340,000)	(\$1,152,450)
		<u>DHCS-DENTAL FI</u>						
61	60	DENTAL ASO ADMINISTRATION 2016 CONTRACT	\$42,084,000	\$15,178,750	\$48,181,000	\$17,387,500	\$6,097,000	\$2,208,750
62	61	DENTAL FI ADMINISTRATION 2016 CONTRACT	\$20,738,000	\$5,711,750	\$20,830,000	\$5,685,750	\$92,000	(\$26,000)
--	83	COVID-19 VACCINATION INCENTIVE PROGRAM ADMIN	\$0	\$0	\$100,000,000	\$50,000,000	\$100,000,000	\$50,000,000
		DHCS-DENTAL FI SUBTOTAL	\$62,822,000	\$20,890,500	\$169,011,000	\$73,073,250	\$106,189,000	\$52,182,750
		<u>OTHER DEPARTMENTS</u>						
64	62	PERSONAL CARE SERVICES	\$406,386,000	\$0	\$384,224,000	\$0	(\$22,162,000)	\$0
65	63	HEALTH-RELATED ACTIVITIES - CDSS	\$319,690,000	\$0	\$337,606,000	\$0	\$17,916,000	\$0
--	64	HCBS SP - IHSS HCBS CARE ECONOMY PMTS	\$0	\$0	\$137,275,000	\$0	\$137,275,000	\$0
66	65	CALHEERS DEVELOPMENT	\$116,948,000	\$31,139,800	\$123,320,000	\$33,405,500	\$6,372,000	\$2,265,700
67	66	CDDS ADMINISTRATIVE COSTS	\$63,525,000	\$0	\$93,799,000	\$0	\$30,274,000	\$0
68	67	MATERNAL AND CHILD HEALTH	\$47,668,000	\$0	\$48,738,000	\$0	\$1,070,000	\$0
69	68	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	\$41,379,000	(\$13,793,000)	\$55,172,000	\$0	\$13,793,000	\$13,793,000
70	69	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	\$33,047,000	\$0	\$33,047,000	\$0	\$0	\$0
71	70	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	\$16,908,000	\$0	\$16,908,000	\$0	\$0	\$0

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2021 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2021-22**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2021-22 APPROPRIATION		NOV. 2021 EST. FOR 2021-22		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER DEPARTMENTS						
72	71	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	\$4,890,000	\$0	\$5,250,000	\$0	\$360,000	\$0
80	72	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG	\$5,009,000	\$0	\$5,009,000	\$0	\$0	\$0
73	73	CLPP CASE MANAGEMENT SERVICES	\$8,964,000	\$0	\$2,722,000	\$0	(\$6,242,000)	\$0
74	74	CALIFORNIA SMOKERS' HELPLINE	\$2,400,000	\$0	\$2,671,000	\$0	\$271,000	\$0
77	75	KIT FOR NEW PARENTS	\$1,702,000	\$0	\$449,000	\$0	(\$1,253,000)	\$0
76	76	VETERANS BENEFITS	\$1,100,000	\$0	\$1,100,000	\$0	\$0	\$0
78	77	MEDI-CAL INPATIENT SERVICES FOR INMATES	\$1,036,000	\$0	\$1,077,000	\$0	\$41,000	\$0
79	78	CHHS AGENCY HIPAA FUNDING	\$1,022,000	\$0	\$1,022,000	\$0	\$0	\$0
75	79	VITAL RECORDS	\$891,000	\$8,000	\$891,000	\$8,000	\$0	\$0
81	80	MERIT SYSTEM SERVICES FOR COUNTIES	\$190,000	\$95,000	\$190,000	\$95,000	\$0	\$0
82	81	CDPH I&E PROGRAM AND EVALUATION	\$187,000	\$0	\$86,000	\$0	(\$101,000)	\$0
83	82	PIA EYEWEAR COURIER SERVICE	\$941,000	\$470,500	\$766,000	\$383,000	(\$175,000)	(\$87,500)
--	86	HCBS SP CDDS - OTHER ADMIN	\$0	\$0	\$1,167,000	\$0	\$1,167,000	\$0
		OTHER DEPARTMENTS SUBTOTAL	\$1,073,883,000	\$17,920,300	\$1,252,489,000	\$33,891,500	\$178,606,000	\$15,971,200
		OTHER ADMINISTRATION TOTAL	\$3,035,258,000	\$383,519,050	\$3,447,550,000	\$469,530,800	\$412,292,000	\$86,011,750
		GRAND TOTAL COUNTY AND OTHER ADMINISTRATION	\$5,554,971,000	\$1,042,670,300	\$5,975,609,000	\$1,148,621,800	\$420,638,000	\$105,951,500

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2021-22 AND 2022-23**

NO.	POLICY CHANGE TITLE	NOV. 2021 EST. FOR 2021-22		NOV. 2021 EST. FOR 2022-23		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	<u>DHCS-OTHER</u>						
1	INTERIM AND FINAL COST SETTLEMENTS-SMHS	\$297,944,000	\$0	\$208,974,000	\$0	(\$88,970,000)	\$0
2	COUNTY SPECIALTY MENTAL HEALTH ADMIN	\$248,436,000	\$8,055,000	\$248,285,000	\$7,186,000	(\$151,000)	(\$869,000)
3	CCS CASE MANAGEMENT	\$170,431,000	\$59,762,000	\$157,505,000	\$54,970,200	(\$12,926,000)	(\$4,791,800)
4	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$156,882,000	\$638,000	\$159,780,000	\$0	\$2,898,000	(\$638,000)
5	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$149,725,000	\$0	\$129,875,000	\$0	(\$19,850,000)	\$0
6	MEDI-CAL RX - ADMINISTRATIVE COSTS	\$97,648,000	\$45,444,550	\$93,705,000	\$21,972,250	(\$3,943,000)	(\$23,472,300)
7	CALAIM - POPULATION HEALTH MANAGEMENT	\$75,000,000	\$7,500,000	\$225,000,000	\$22,500,000	\$150,000,000	\$15,000,000
8	DRUG MEDI-CAL COUNTY ADMINISTRATION	\$48,243,000	\$365,000	\$55,749,000	\$412,000	\$7,506,000	\$47,000
9	HEALTH ENROLLMENT NAVIGATORS	\$47,844,000	\$23,922,000	\$0	\$0	(\$47,844,000)	(\$23,922,000)
10	SMH MAA	\$45,914,000	\$0	\$51,586,000	\$0	\$5,672,000	\$0
11	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	\$43,679,000	\$4,440,000	\$438,000	\$81,000	(\$43,241,000)	(\$4,359,000)
12	MIS/DSS SYSTEM AND SURS & MARS SUBSYSTEM	\$42,850,000	\$10,758,150	\$29,420,000	\$7,404,650	(\$13,430,000)	(\$3,353,500)
13	ARRA HITECH INCENTIVE PROGRAM	\$40,975,000	\$0	\$0	\$0	(\$40,975,000)	\$0
14	CHDP COUNTY ALLOCATION	\$33,962,000	\$11,957,000	\$33,962,000	\$11,957,000	\$0	\$0
15	POSTAGE & PRINTING	\$31,277,000	\$15,767,000	\$31,277,000	\$15,767,000	\$0	\$0
16	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	\$29,643,000	\$16,704,500	\$26,309,000	\$14,119,250	(\$3,334,000)	(\$2,585,250)
17	ACTUARIAL COSTS FOR RATE DEVELOPMENT	\$21,988,000	\$10,685,000	\$22,913,000	\$11,307,000	\$925,000	\$622,000
18	HCBA WAIVER ADMINISTRATIVE COST	\$16,727,000	\$8,363,500	\$24,186,000	\$12,093,000	\$7,459,000	\$3,729,500
19	LA COUNTY PUBLIC HEALTH NURSING PILOT	\$16,500,000	\$0	\$8,250,000	\$0	(\$8,250,000)	\$0
20	PAVE SYSTEM	\$12,713,000	(\$1,394,900)	\$19,326,000	\$5,298,200	\$6,613,000	\$6,693,100
21	CAPMAN	\$11,672,000	\$2,999,700	\$17,470,000	\$4,495,000	\$5,798,000	\$1,495,300
22	CCI-ADMINISTRATIVE COSTS	\$11,213,000	\$5,606,500	\$5,958,000	\$2,979,000	(\$5,255,000)	(\$2,627,500)
23	MEDI-CAL RECOVERY CONTRACTS	\$10,443,000	\$2,610,750	\$7,882,000	\$1,970,500	(\$2,561,000)	(\$640,250)

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2021-22 AND 2022-23**

NO.	POLICY CHANGE TITLE	NOV. 2021 EST. FOR 2021-22		NOV. 2021 EST. FOR 2022-23		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	<u>DHCS-OTHER</u>						
24	MITA	\$10,424,000	\$1,323,800	\$10,997,000	\$1,396,300	\$573,000	\$72,500
25	CYBHI - BH SERVICES AND SUPPORTS PLATFORM	\$10,000,000	\$10,000,000	\$230,000,000	\$230,000,000	\$220,000,000	\$220,000,000
26	LITIGATION RELATED SERVICES	\$9,980,000	\$4,990,000	\$9,980,000	\$4,990,000	\$0	\$0
27	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	\$7,404,000	\$2,412,000	\$7,404,000	\$2,412,000	\$0	\$0
28	NEWBORN HEARING SCREENING PROGRAM	\$6,131,000	\$3,065,500	\$6,273,000	\$3,136,500	\$142,000	\$71,000
29	PASRR	\$6,056,000	\$1,514,000	\$6,056,000	\$1,514,000	\$0	\$0
30	ELECTRONIC ASSET VERIFICATION PROGRAM	\$5,621,000	\$2,810,500	\$5,621,000	\$2,810,500	\$0	\$0
31	DRUG MEDI-CAL PARITY RULE ADMINISTRATION	\$4,407,000	\$1,469,000	\$5,862,000	\$1,954,000	\$1,455,000	\$485,000
32	MEDCOMPASS SOLUTION	\$3,770,000	\$389,650	\$3,984,000	\$1,047,800	\$214,000	\$658,150
33	PACES	\$2,799,000	\$424,000	\$3,361,000	\$749,600	\$562,000	\$325,600
34	MEDI-CAL NONMEDICAL TRANSPORTATION	\$2,704,000	\$727,000	\$2,724,000	\$737,000	\$20,000	\$10,000
35	T-MSIS	\$1,855,000	\$283,900	\$2,747,000	\$399,500	\$892,000	\$115,600
36	SDMC SYSTEM M&O SUPPORT	\$2,325,000	\$1,162,500	\$2,325,000	\$1,162,500	\$0	\$0
37	SSA COSTS FOR HEALTH COVERAGE INFO.	\$1,718,000	\$859,000	\$1,476,000	\$738,000	(\$242,000)	(\$121,000)
38	CALIFORNIA HEALTH INTERVIEW SURVEY	\$1,400,000	\$0	\$1,400,000	\$0	\$0	\$0
39	ENCRYPTION OF PHI DATA	\$1,208,000	\$604,000	\$1,500,000	\$750,000	\$292,000	\$146,000
40	FAMILY PACT PROGRAM ADMIN.	\$1,207,000	\$120,700	\$1,207,000	\$120,700	\$0	\$0
41	MMA - DSH ANNUAL INDEPENDENT AUDIT	\$773,000	\$386,500	\$800,000	\$400,000	\$27,000	\$13,500
42	CCT OUTREACH - ADMINISTRATIVE COSTS	\$340,000	\$0	\$340,000	\$0	\$0	\$0
43	LTSS ACTUARIAL STUDY	\$100,000	\$100,000	\$0	\$0	(\$100,000)	(\$100,000)
44	COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE	\$0	\$0	\$48,143,000	\$19,201,000	\$48,143,000	\$19,201,000
45	MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM	\$0	\$0	\$1,000,000	\$500,000	\$1,000,000	\$500,000
46	COVID-19 INCREASED FMAP - OTHER ADMIN	\$0	(\$1,625,000)	\$0	\$0	\$0	\$1,625,000
47	CMS DEFERRED CLAIMS - OTHER ADMIN	\$0	\$4,804,000	\$0	\$0	\$0	(\$4,804,000)

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2021-22 AND 2022-23**

NO.	POLICY CHANGE TITLE	NOV. 2021 EST. FOR 2021-22		NOV. 2021 EST. FOR 2022-23		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>DHCS-OTHER</u>							
87	COVID-19 INCREASED FMAP EXTENSION - OTHER ADMIN	\$0	(\$737,000)	\$0	(\$369,000)	\$0	\$368,000
	DHCS-OTHER SUBTOTAL	\$1,741,931,000	\$269,267,800	\$1,911,050,000	\$468,162,450	\$169,119,000	\$198,894,650
<u>DHCS-MEDICAL FI</u>							
48	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	\$48,420,000	\$12,726,600	\$49,197,000	\$12,930,750	\$777,000	\$204,150
49	MEDICAL FI BO & IT COST REIMBURSEMENT	\$46,251,000	\$13,131,950	\$44,812,000	\$12,753,650	(\$1,439,000)	(\$378,300)
50	MEDICAL FI IT INFRASTRUCTURE SERVICES	\$30,681,000	\$8,064,800	\$30,450,000	\$8,004,200	(\$231,000)	(\$60,600)
51	MEDICAL FI BO & IT CHANGE ORDERS	\$28,734,000	\$7,550,450	\$27,009,000	\$7,097,700	(\$1,725,000)	(\$452,750)
52	MEDICAL FI BO OTHER ESTIMATED COSTS	\$19,590,000	\$5,881,700	\$20,276,000	\$6,090,300	\$686,000	\$208,600
53	MEDICAL FI BO TELEPHONE SERVICE CENTER	\$13,643,000	\$4,082,600	\$14,121,000	\$4,226,050	\$478,000	\$143,450
54	MEDICAL FI BUSINESS OPERATIONS	\$13,072,000	\$3,435,750	\$13,529,000	\$3,556,250	\$457,000	\$120,500
55	MEDICAL FI BO HOURLY REIMBURSEMENT	\$10,437,000	\$2,744,600	\$10,663,000	\$2,803,100	\$226,000	\$58,500
56	MEDICAL FI BO MISCELLANEOUS EXPENSES	\$2,371,000	\$751,850	\$2,318,000	\$737,450	(\$53,000)	(\$14,400)
	DHCS-MEDICAL FI SUBTOTAL	\$213,199,000	\$58,370,300	\$212,375,000	\$58,199,450	(\$824,000)	(\$170,850)
<u>DHCS-HEALTH CARE OPT</u>							
57	HCO OPERATIONS 2017 CONTRACT	\$34,800,000	\$17,138,850	\$34,800,000	\$17,138,850	\$0	\$0
58	HCO COST REIMBURSEMENT 2017 CONTRACT	\$20,520,000	\$10,106,100	\$20,520,000	\$10,106,100	\$0	\$0
59	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	\$15,600,000	\$7,683,000	\$15,600,000	\$7,683,000	\$0	\$0
	DHCS-HEALTH CARE OPT SUBTOTAL	\$70,920,000	\$34,927,950	\$70,920,000	\$34,927,950	\$0	\$0
<u>DHCS-DENTAL FI</u>							
60	DENTAL ASO ADMINISTRATION 2016 CONTRACT	\$48,181,000	\$17,387,500	\$48,319,000	\$17,445,000	\$138,000	\$57,500
61	DENTAL FI ADMINISTRATION 2016 CONTRACT	\$20,830,000	\$5,685,750	\$21,108,000	\$5,729,250	\$278,000	\$43,500

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2021-22 AND 2022-23**

NO.	POLICY CHANGE TITLE	NOV. 2021 EST. FOR 2021-22		NOV. 2021 EST. FOR 2022-23		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>DHCS-DENTAL FI</u>							
83	COVID-19 VACCINATION INCENTIVE PROGRAM ADMIN	\$100,000,000	\$50,000,000	\$0	\$0	(\$100,000,000)	(\$50,000,000)
	DHCS-DENTAL FI SUBTOTAL	\$169,011,000	\$73,073,250	\$69,427,000	\$23,174,250	(\$99,584,000)	(\$49,899,000)
<u>OTHER DEPARTMENTS</u>							
62	PERSONAL CARE SERVICES	\$384,224,000	\$0	\$384,520,000	\$0	\$296,000	\$0
63	HEALTH-RELATED ACTIVITIES - CDSS	\$337,606,000	\$0	\$368,394,000	\$0	\$30,788,000	\$0
64	HCBS SP - IHSS HCBS CARE ECONOMY PMTS	\$137,275,000	\$0	\$0	\$0	(\$137,275,000)	\$0
65	CALHEERS DEVELOPMENT	\$123,320,000	\$33,405,500	\$138,413,000	\$37,441,400	\$15,093,000	\$4,035,900
66	CDDS ADMINISTRATIVE COSTS	\$93,799,000	\$0	\$65,500,000	\$0	(\$28,299,000)	\$0
67	MATERNAL AND CHILD HEALTH	\$48,738,000	\$0	\$47,668,000	\$0	(\$1,070,000)	\$0
68	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	\$55,172,000	\$0	\$55,172,000	\$0	\$0	\$0
69	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	\$33,047,000	\$0	\$33,047,000	\$0	\$0	\$0
70	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	\$16,908,000	\$0	\$12,901,000	\$0	(\$4,007,000)	\$0
71	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	\$5,250,000	\$0	\$6,235,000	\$0	\$985,000	\$0
72	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG	\$5,009,000	\$0	\$5,316,000	\$0	\$307,000	\$0
73	CLPP CASE MANAGEMENT SERVICES	\$2,722,000	\$0	\$8,166,000	\$0	\$5,444,000	\$0
74	CALIFORNIA SMOKERS' HELPLINE	\$2,671,000	\$0	\$2,400,000	\$0	(\$271,000)	\$0
75	KIT FOR NEW PARENTS	\$449,000	\$0	\$816,000	\$0	\$367,000	\$0
76	VETERANS BENEFITS	\$1,100,000	\$0	\$1,100,000	\$0	\$0	\$0
77	MEDI-CAL INPATIENT SERVICES FOR INMATES	\$1,077,000	\$0	\$1,121,000	\$0	\$44,000	\$0
78	CHHS AGENCY HIPAA FUNDING	\$1,022,000	\$0	\$1,037,000	\$0	\$15,000	\$0
79	VITAL RECORDS	\$891,000	\$8,000	\$891,000	\$8,000	\$0	\$0

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2021-22 AND 2022-23**

NO.	POLICY CHANGE TITLE	NOV. 2021 EST. FOR 2021-22		NOV. 2021 EST. FOR 2022-23		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>OTHER DEPARTMENTS</u>							
80	MERIT SYSTEM SERVICES FOR COUNTIES	\$190,000	\$95,000	\$190,000	\$95,000	\$0	\$0
81	CDPH I&E PROGRAM AND EVALUATION	\$86,000	\$0	\$0	\$0	(\$86,000)	\$0
82	PIA EYEWEAR COURIER SERVICE	\$766,000	\$383,000	\$941,000	\$470,500	\$175,000	\$87,500
86	HCBS SP CDDS - OTHER ADMIN	\$1,167,000	\$0	\$2,521,000	\$0	\$1,354,000	\$0
	OTHER DEPARTMENTS SUBTOTAL	\$1,252,489,000	\$33,891,500	\$1,136,349,000	\$38,014,900	(\$116,140,000)	\$4,123,400
	OTHER ADMINISTRATION TOTAL	\$3,447,550,000	\$469,530,800	\$3,400,121,000	\$622,479,000	(\$47,429,000)	\$152,948,200
	GRAND TOTAL COUNTY AND OTHER ADMINISTRATION	\$5,975,609,000	\$1,148,621,800	\$5,940,213,000	\$1,315,633,500	(\$35,396,000)	\$167,011,700

MEDI-CAL OTHER ADMINISTRATION POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	<u>DHCS-OTHER</u>
1	INTERIM AND FINAL COST SETTLEMENTS-SMHS
2	COUNTY SPECIALTY MENTAL HEALTH ADMIN
3	CCS CASE MANAGEMENT
4	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES
5	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES
6	MEDI-CAL RX - ADMINISTRATIVE COSTS
7	CALAIM - POPULATION HEALTH MANAGEMENT
8	DRUG MEDI-CAL COUNTY ADMINISTRATION
9	HEALTH ENROLLMENT NAVIGATORS
10	SMH MAA
11	HEALTH INFORMATION EXCHANGE INTEROPERABILITY
12	MIS/DSS SYSTEM AND SURS & MARS SUBSYSTEM
13	ARRA HITECH INCENTIVE PROGRAM
14	CHDP COUNTY ALLOCATION
15	POSTAGE & PRINTING
16	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS
17	ACTUARIAL COSTS FOR RATE DEVELOPMENT
18	HCBA WAIVER ADMINISTRATIVE COST
19	LA COUNTY PUBLIC HEALTH NURSING PILOT
20	PAVE SYSTEM
21	CAPMAN
22	CCI-ADMINISTRATIVE COSTS
23	MEDI-CAL RECOVERY CONTRACTS
24	MITA
25	CYBHI - BH SERVICES AND SUPPORTS PLATFORM
26	LITIGATION RELATED SERVICES
27	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)
28	NEWBORN HEARING SCREENING PROGRAM
29	PASRR
30	ELECTRONIC ASSET VERIFICATION PROGRAM
31	DRUG MEDI-CAL PARITY RULE ADMINISTRATION
32	MEDCOMPASS SOLUTION
33	PACES
34	MEDI-CAL NONMEDICAL TRANSPORTATION
35	T-MSIS
36	SDMC SYSTEM M&O SUPPORT
37	SSA COSTS FOR HEALTH COVERAGE INFO.
38	CALIFORNIA HEALTH INTERVIEW SURVEY

MEDI-CAL OTHER ADMINISTRATION POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	<u>DHCS-OTHER</u>
39	ENCRYPTION OF PHI DATA
40	FAMILY PACT PROGRAM ADMIN.
41	MMA - DSH ANNUAL INDEPENDENT AUDIT
42	CCT OUTREACH - ADMINISTRATIVE COSTS
43	LTSS ACTUARIAL STUDY
44	COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE
45	MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM
46	COVID-19 INCREASED FMAP - OTHER ADMIN
47	CMS DEFERRED CLAIMS - OTHER ADMIN
87	COVID-19 INCREASED FMAP EXTENSION - OTHER ADMIN
	<u>DHCS-MEDICAL FI</u>
48	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES
49	MEDICAL FI BO & IT COST REIMBURSEMENT
50	MEDICAL FI IT INFRASTRUCTURE SERVICES
51	MEDICAL FI BO & IT CHANGE ORDERS
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
	<u>DHCS-HEALTH CARE OPT</u>
57	HCO OPERATIONS 2017 CONTRACT
58	HCO COST REIMBURSEMENT 2017 CONTRACT
59	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT
	<u>DHCS-DENTAL FI</u>
60	DENTAL ASO ADMINISTRATION 2016 CONTRACT
61	DENTAL FI ADMINISTRATION 2016 CONTRACT
83	COVID-19 VACCINATION INCENTIVE PROGRAM ADMIN
	<u>OTHER DEPARTMENTS</u>
62	PERSONAL CARE SERVICES
63	HEALTH-RELATED ACTIVITIES - CDSS
64	HCBS SP - IHSS HCBS CARE ECONOMY PMTS
65	CALHEERS DEVELOPMENT
66	CDDS ADMINISTRATIVE COSTS

**MEDI-CAL OTHER ADMINISTRATION
POLICY CHANGE INDEX**

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	<u>OTHER DEPARTMENTS</u>
67	MATERNAL AND CHILD HEALTH
68	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN
69	DEPARTMENT OF SOCIAL SERVICES ADMIN COST
70	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS
71	DEPARTMENT OF AGING ADMINISTRATIVE COSTS
72	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG
73	CLPP CASE MANAGEMENT SERVICES
74	CALIFORNIA SMOKERS' HELPLINE
75	KIT FOR NEW PARENTS
76	VETERANS BENEFITS
77	MEDI-CAL INPATIENT SERVICES FOR INMATES
78	CHHS AGENCY HIPAA FUNDING
79	VITAL RECORDS
80	MERIT SYSTEM SERVICES FOR COUNTIES
81	CDPH I&E PROGRAM AND EVALUATION
82	PIA EYEWEAR COURIER SERVICE
86	HCBS SP CDDS - OTHER ADMIN

INTERIM AND FINAL COST SETTLEMENTS-SMHS

OTHER ADMIN. POLICY CHANGE NUMBER: 1
IMPLEMENTATION DATE: 7/2015
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1757

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$297,944,000	\$208,974,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$297,944,000	\$208,974,000

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 & Institutions (W&I) 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 2021-22, is an increase due to:

- A new methodology to accurately reflect all FY 2021-22 cost estimates and
- An increase in the number of fiscal years of interim and audit settlements for FY 2021-22.

The change in the current estimate for FY 2021-22 to FY 2022-23 is an increase due a methodology change used in FY 2021-22 for FY 2022-23.

INTERIM AND FINAL COST SETTLEMENTS-SMHS

OTHER ADMIN. POLICY CHANGE NUMBER: 1

Methodology:

1. Interim cost settlements are based on the difference between each county MHP's filed cost report and the payments they received from the Department.
2. Final cost settlements are based on the difference between each county MHP's final audited cost report and the payments they received from the Department.
3. Cost settlements for administration, UR/QA, and MH MAA are each determined separately.
4. To estimate the expected expenditures for FY 2021-22 and FY 2022-23 for interim and audit settlements not yet received, the following procedures is used:
 - The average expenditure of \$1,043,000 per interim settlement is determined by dividing the actual net outflow of \$84,537,000 from FY 2020-21 by 81, the number of interim settlements processed in FY 2020-21. The average expenditure of \$155,000 per audit settlement is determined by dividing the net inflow, \$5,564,000, by 36, the number of audit settlements processed in FY 2020-21. This average expenditure was reduced by \$150,000 to account for a reduction in recoupable amounts resulting from the narrowing of final audits by Audits and Investigations (A&I). The resulting recoupment amount per audit settlement is estimated to be \$5,000 per settlement.
 - The average expenditure per settlement is increased by 3% for fiscal years not yet received and is not present in calculating the averages in prior step.
 - The total number of interim and audit settlements expected to be processed for each fiscal year is multiplied by the average amount per settlement per fiscal year to determine the total amount to be processed for each fiscal year per settlement type. For example, for FY 2013-14 interim settlements, the total number to be processed, 4, is multiplied by \$1,043,000 to a total of \$4,174,000 to be processed for that fiscal year. The total number of FY 2013-14 audit settlements, 14, is multiplied by \$5,000 to a total of \$66,000 for that fiscal year. For audits and settlements for FY 2012-13 and prior, LGFD figured a total of 45 outstanding payments based on information provided by A&I. LGFD projects that there would be 57 interim and 14 audit settlements per fiscal year for fiscal years not yet received.
 - The percentage of each fund type of settlements processed in FY 2020-21 is determined to arrive to the estimated amounts of Title XIX and Title XXI for the interim and cost settlement types for FY 2021-22 and FY 2022-23. The percentage is determined by dividing the total amount of Title XIX by the total amount of all interim settlement expenditures processed in FY 2020-21. For Title XXI, the total amount of Title XXI processed in FY 2020-21 is divided by the total of all expenditures for interim settlements for FY 2020-21. Assuming that FY 2021-22 estimated settlements will follow the same funding trends, the total estimated amount for each settlement type per fiscal year is multiplied by the percentages representing the Title XIX and Title XXI amounts.

INTERIM AND FINAL COST SETTLEMENTS-SMHS
OTHER ADMIN. POLICY CHANGE NUMBER: 1

5. To determine final amounts for interim and cost settlements for each fiscal year, the following amounts were totaled:
- The estimated amounts per fund, per settlement type, per fiscal year settled and
 - The amounts by funding type of actual audit and interim settlements that were received in the spring of FY 2020-21 that will be processed in FY 2021-22.
6. The net FF to be reimbursed and/or recouped in FY 2020-21 for interim settlements and audit settlements is shown below:

(Dollars in Thousands)

Interim Settlements	Total FF	Title XIX FF	Title XXI FF
FY 2011-12	(\$1,418)	(\$1,301)	(\$117)
FY 2012-13	\$42	(\$5)	\$47
FY 2013-14	\$4,916	\$4,925	(\$9)
FY 2014-15	\$36,529	\$36,604	(\$75)
FY 2015-16	\$61,274	\$61,400	(\$126)
FY 2016-17	\$63,112	\$63,242	(\$130)
FY 2018-19	\$66,955	\$67,093	(\$138)
FY 2019-20	\$68,964	\$69,106	(\$142)
Subtotal	\$300,374	\$301,064	(\$690)

(Dollars in Thousands)

Audit Settlements	Total FF	Title XIX FF	Title XXI FF
FY 2011-12	(\$1,383)	(\$1,380)	(\$3)
FY 2012-13	(\$843)	(\$840)	(\$3)
FY 2013-14	(\$66)	(\$67)	\$1
FY 2014-15	(\$68)	(\$69)	\$1
FY 2015-16	(\$70)	(\$71)	\$1
Subtotal	(\$2,430)	(\$2,427)	(\$3)
Total FY 2021-22	\$297,944	\$298,637	(\$693)

INTERIM AND FINAL COST SETTLEMENTS-SMHS
OTHER ADMIN. POLICY CHANGE NUMBER: 1

7. The net FF to be reimbursed and/or recouped in FY 2022-23 for interim settlements and audit settlements is shown below:

(Dollars in Thousands)

Interim Settlements	Total FF	Title XIX FF	Title XXI FF
FY 2017-18	\$65,005	\$65,139	(\$134)
FY 2020-21	\$71,032	\$71,179	(\$147)
FY 2021-22	\$73,164	\$73,315	(\$151)
Subtotal	\$209,201	\$209,633	(\$432)

(Dollars in Thousands)

Audit Settlements	Total FF	Title XIX FF	Title XXI FF
FY 2016-17	(\$73)	(\$74)	\$1
FY 2018-19	(\$76)	(\$78)	\$2
FY 2019-20	(\$78)	(\$80)	\$2
Subtotal	(\$227)	(\$232)	\$5
Total FY 2022-23	\$208,974	\$209,401	(\$427)

Funding:

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

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

COUNTY SPECIALTY MENTAL HEALTH ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 2
IMPLEMENTATION DATE: 7/2012
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1721

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$248,436,000	\$248,285,000
STATE FUNDS	\$8,055,000	\$7,186,000
FEDERAL FUNDS	\$240,381,000	\$241,099,000

Purpose:

This policy change estimates the reimbursement for 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 14707.5
 Welfare & Institutions Code 14711(c)
 California Constitution Article XIII Section 36
 CMS Final Rule (CMS-2333-F) (Parity Final Rule)
 Title 42, Code of Federal Regulations Part 438

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. Along with administration costs, counties can claim reimbursement costs for county Utilization Review and Quality Assurance (QAUR), Performance Outcomes System (POS), Managed Care Regulations – Mental Health, and MH Parity Final Rule.

The QAUR and POS 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 funding for the cost increase.

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. And on March 30, 2017, CMS issued the Parity Final Rule, to strengthen access to mental health and substance use disorder services for Medicaid beneficiaries.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is an increase due to:

- Updated base year expenditures, resulting in higher estimated accrual amounts;
- Including the cost estimated for QAUR, POS, Managed Care Regulations – Mental Health, and MH Parity Final Rule, and updated growth factor of 5.10% from 7.45%.

COUNTY SPECIALTY MENTAL HEALTH ADMIN
OTHER ADMIN. POLICY CHANGE NUMBER: 2

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to applying a 5.1% growth factor, based on the compounded annual growth rate from FY 2015-16 through FY 2018-19.

Methodology:

1. Mental Health administration costs are based on historical claims payment data. Assume 21.19% of each fiscal year claims will be paid in the year the services occur, 67.02% is paid in the following year, and 11.79% in the third year. The estimate costs are:

(Dollars in Thousands)

Fiscal Year	Type	Accrual	FY 2021-22	FY 2022-23
FY 2019-20	Other Admin	\$303,794	\$35,817	\$0
	MCHIP	\$23,648	\$2,788	\$0
	QAUR	\$44,548	\$5,252	\$0
	POS	\$3,139	\$370	\$0
	Parity	\$23,526	\$2,774	\$0
	Managed Care	\$28,216	\$3,327	\$0
FY 2020-21	Other Admin	\$319,281	\$213,982	\$37,643
	MCHIP	\$24,854	\$16,657	\$2,930
	QAUR	\$46,820	\$31,379	\$5,520
	POS	\$3,299	\$2,211	\$389
	Parity	\$23,526	\$15,767	\$2,774
	Managed Care	\$10,811	\$7,246	\$1,275
FY 2021-22	Other Admin	\$335,558	\$71,105	\$224,897
	MCHIP	\$26,121	\$5,535	\$17,507
	QAUR	\$49,208	\$19,927	\$32,980
	POS	\$3,467	\$735	\$2,324
	Parity	\$23,526	\$4,985	\$15,768
	Managed Care	\$7,173	\$1,534	\$4,807
FY 2022-23	Other Admin	\$352,665	\$0	\$74,730
	MCHIP	\$27,452	\$0	\$5,817
	QAUR	\$51,717	\$0	\$10,959
	POS	\$3,644	\$0	\$772
	Parity	\$24,726	\$0	\$5,239
	Managed Care	\$7,539	\$0	\$1,597
Total		\$1,768,259	\$441,391	\$447,928

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

COUNTY SPECIALTY MENTAL HEALTH ADMIN
OTHER ADMIN. POLICY CHANGE NUMBER: 2

federal enhanced reimbursement. Beginning October 1, 2020, enhanced CHIP funding will decrease from 76.5% to 65%.

3. QAUR expenditures are shared between FF and CF. Pursuant to Proposition 30, GF funding is provided for levels of service that are provided above those levels mandated by the 2011 Realignment. Skilled professional medical personnel (SPMP) are eligible for enhanced federal reimbursement of 75%. All other personnel are eligible for 50% federal reimbursement.
4. POS expenditures are eligible for reimbursement at 50%, and costs for clinical staffing is eligible for enhanced FF at 75%.
5. Managed Care Parity related to pre-authorizations of outpatient services and concurrent reviews of 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% CF and 50% General Funds (GF) pursuant to the California Constitution, Article 13, Section 36(c)(5)(A).
6. For the Managed Care Regulations Final Rule claims, the non-federal share is funded with CF and GF, consistent with the California Constitution, Article 13, Section 36 (c)(5)(A).

(Dollars in Thousands)

Claim Type	FY 2021-22				FY 2022-23			
	TF	FF	GF	CF	TF	FF	GF	CF
Other Admin	\$320,904	\$160,452	\$0	\$160,452	\$337,270	\$168,635	\$0	\$168,635
MCHIP	\$24,980	\$17,321	\$0	\$7,659	\$26,254	\$17,065	\$0	\$9,189
QAUR	\$56,558	\$37,215	\$963	\$18,380	\$49,459	\$32,148	\$1,008	\$16,303
POS	\$3,316	\$2,687	\$629	\$0	\$3,485	\$2,824	\$661	\$0
Parity	\$23,526	\$16,410	\$3,558	\$3,558	\$23,781	\$16,587	\$3,597	\$3,597
Managed Care Regulations	\$12,107	\$6,295	\$2,906	\$2,906	\$7,680	\$3,840	\$1,921	\$1,920
Total	\$441,391	\$240,381	\$8,055	\$192,954	\$447,928	\$241,099	\$7,186	\$199,643

Funding:

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

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

100% Title XIX GF (4260-101-0001)

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 3
IMPLEMENTATION DATE: 7/1999
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 230

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$170,431,000	\$157,505,000
STATE FUNDS	\$59,762,000	\$54,970,200
FEDERAL FUNDS	\$110,669,000	\$102,534,800

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, for FY 2021-22, is a decrease due to lower updated CMS Net costs and updated Rady Children's Hospital costs.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease primarily due to lower expected CCS case management costs in FY 2022-23. The lower costs are due to a shift of the CCS population into the Medi-Cal program as a result of the public health emergency.

Methodology:

1. The county administrative estimate for the budget year is updated every May based on additional data collected.
2. For FY 2021-22, the CCS case management costs are based on budgeted county expenditures of \$162,986,000.

CCS CASE MANAGEMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 3

For FY 2022-23, caseload is expected to decrease by 8.64% from FY 2021-22.

$$\$162,986,000 \times (1 - 8.64\%) = \$148,905,000$$

3. Assume administrative costs of \$1,057,000 in both FY 2021-22 and FY 2022-23 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 \$2,613,000 in FY 2021-22 and \$2,606,000 in FY 2022-23.
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 2021-22	FY 2022-23
County Administration:	\$31,587,000	\$31,261,000
County share of cost:	(\$2,970,000)	(\$2,939,000)
Total Medi-Cal OTLICP:	\$28,617,000	\$28,322,000

6. County data processing costs associated with CMS Net for OTLICP are estimated to be \$343,000 in FY 2021-22 and \$366,000 FY 2022-23.
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 \$24,595,000 in FY 2021-22 and \$23,384,000 in FY 2022-23.
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 \$248,000 in FY 2021-22. The Rady Pilot program will expire on December 31, 2021.
9. Enhanced, Title XIX (75% FFP), funding is available for Skilled Professional Medical Personnel (SPMP) for the Medi-Cal and OTLICP populations in FY 2021-22 and FY 2022-23.

CCS CASE MANAGEMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 3

FY 2021-22				
CCS Medi-Cal/OTLICP	TF*	GF	FF	CF**
CCS Case Management	\$28,617,000	\$6,624,000	\$21,993,000	\$2,970,000
CMS Net	\$343,000	\$120,000	\$223,000	\$0
Subtotal	\$28,960,000	\$6,744,000	\$22,216,000	\$2,970,000
CCS Medi-Cal				
CCS Case Management	\$162,986,000	\$62,730,000	\$100,256,000	\$0
Medi-Cal Expansion	\$1,057,000	\$1,057,000	\$0	\$0
CMS Net	\$2,270,000	\$1,135,000	\$1,135,000	\$0
Subtotal	\$166,313,000	\$64,922,000	\$101,391,000	\$0
Rady Children's Hospital	(\$248,000)	(\$124,000)	(\$124,000)	\$0
WCM Implementation	(\$24,595,000)	(\$11,781,000)	(\$12,814,000)	\$0
Total	\$170,431,000	\$59,762,000	\$110,669,000	\$2,970,000

FY 2022-23				
CCS Medi-Cal/OTLICP	TF*	GF	FF	CF**
CCS Case Management	\$28,322,000	\$6,556,000	\$21,766,000	\$2,939,000
CMS Net	\$366,000	\$128,000	\$238,000	\$0
Subtotal	\$28,688,000	\$6,684,000	\$22,004,000	\$2,939,000
CCS Medi-Cal				
CCS Case Management	\$148,905,000	\$57,311,000	\$91,594,000	\$0
Medi-Cal Expansion	\$1,057,000	\$1,057,000	\$0	\$0
CMS Net	\$2,240,000	\$1,120,000	\$1,120,000	\$0
Subtotal	\$152,202,000	\$59,488,000	\$92,714,000	\$0
Rady Children's Hospital	\$0	\$0	\$0	\$0
WCM Implementation	(\$23,384,000)	(\$11,201,000)	(\$12,183,000)	\$0
Total*	\$157,505,000	\$54,970,000	\$102,535,000	\$2,939,000

* Totals may differ due to rounding

** County Funds are not included in the Total Fund

CCS CASE MANAGEMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 3

Funding:

FY 2021-22	TF	GF	FF	CF**
50% Title XIX / 50% GF (4260-101-0890/0001)	\$68,806,000	\$34,403,000	\$34,403,000	\$0
75% Title XIX / 25% GF (4260-101-0890/0001)	\$89,668,000	\$22,417,000	\$67,251,000	\$0
65% Title XXI / 35% GF (4260-113-0890/0001)	(\$3,100,000)	(\$1,085,000)	(\$2,015,000)	\$0
65% Title XXI / 17.5% GF / 17.5% CF (4260-113-0890/0001)	\$14,000,000	\$2,970,000	\$11,030,000	\$2,970,000
100% GF (4260-101-0001)	\$1,057,000	\$1,057,000	\$0	\$0
Total	\$170,431,000	\$59,762,000	\$110,669,000	\$2,970,000

FY 2022-23	TF	GF	FF	CF**
50% Title XIX / 50% GF (4260-101-0890/0001)	\$62,468,000	\$31,234,000	\$31,234,000	\$0
75% Title XIX / 25% GF (4260-101-0890/0001)	\$83,033,000	\$20,758,000	\$62,275,000	\$0
65% Title XXI / 35% GF (4260-113-0890/0001)	(\$2,908,000)	(\$1,018,000)	(\$1,890,000)	\$0
65% Title XXI / 17.5% GF / 17.5% CF (4260-113-0890/0001)	\$13,855,000	\$2,939,000	\$10,916,000	\$2,939,000
100% GF (4260-101-0001)	\$1,057,000	\$1,057,000	\$0	\$0
Total*	\$157,505,000	\$54,970,000	\$102,535,000	\$2,939,000

* Totals may differ due to rounding

** County Funds are not included in the Total Fund

*** COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – Other Admin policy change

*** COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – Other Admin policy change.

SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 4
IMPLEMENTATION DATE: 7/1992
ANALYST: Neejkajsiab Yang
FISCAL REFERENCE NUMBER: 235

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$156,882,000	\$159,780,000
STATE FUNDS	\$638,000	\$0
FEDERAL FUNDS	\$156,244,000	\$159,780,000

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.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is an increase due to:

- Inclusion of the FY 2015-16 Q1 through FY 2017-18 Q4 one-time GF payment for Los Angeles Unified School District (LAUSD) revised claims.
- FY 2019-20 Q1 invoices for Glenn LEC were received later than expected which shifted payments from FY 2020-21 to FY 2021-22.
- Updated FY 2020-21 Q1 estimate based on the average of FY 2019-20 Q2 through Q4 amounts which now includes one quarter of actual invoice claims.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to applying the Employment Cost Index (ECI) growth factor for FY 2020-21 Q1 through FY 2020-21 Q4 in FY 2022-23.

SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 4

Methodology:

The FY 2021-22 estimate includes:

1. The FY 2019-20 Q1 amount is based on actual invoice claims by Glenn LEC for FY 2019-20 Q1.
2. The FY 2019-20 Q2 amount is based on actual invoice claims for FY 2019-20 Q2.
3. The FY 2019-20 Q3 and Q4 estimates are based on actual invoice claims for FY 2018-19 Q3 to Q4, plus an ECI growth adjustment factor of 2.60% per year.
4. The FY 2020-21 Q1 estimate is based on the average of the actual invoices received for FY 2019-20 Q2 and estimates for FY 2019-20 Q3 and Q4 (per the SMAA Manual).
5. The GF request for LAUSD is a one-time payment due to missing the two-year claiming limit for revised claims submitted to the Department for FY 2015-16 Q1 through FY 2017-18 Q4.

The FY 2022-23 estimate includes:

1. The FY 2020-21 Q2 amount is based on the actual invoice claims for FY 2019-20 Q2 plus a 2.60% ECI adjustment factor.
2. The FY 2020-21 Q3 and Q4 estimates are based on the estimated amount for FY 2019-20 Q3 and Q4, plus a 2.60% ECI adjustment factor.
3. The FY 2021-22 Q1 estimate is based on an average of the FY 2020-21 Q2 through Q4 estimates (per the SMAA Manual).

FY 2021-22	TF	GF	FF
FY 2019-20 Q1-Q4	\$117,310,000	\$0	\$117,310,000
FY 2020-21 Q1	\$38,934,000	\$0	\$38,934,000
FY 2015-16 Q1 through FY 2017-18 Q4 (LAUSD)	\$638,000	\$638,000	\$0
Total	\$156,882,000	\$638,000	\$156,244,000

FY 2022-23	TF	GF	FF
FY 2020-21 Q2-Q4	\$119,835,000	\$0	\$119,835,000
FY 2021-22 Q1	\$39,945,000	\$0	\$39,945,000
Total	\$159,780,000	\$0	\$159,780,000

Funding:

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

100% GF (4260-101-0001)

COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 5
IMPLEMENTATION DATE: 7/1992
ANALYST: Neejkajsiab Yang
FISCAL REFERENCE NUMBER: 1963

	FY 2021-22	FY 2022-23
TOTAL FUNDS	\$149,725,000	\$129,875,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$149,725,000	\$129,875,000

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 2021-22, from the prior estimate, is due to:

For CMAA:

- Increased FY 2019-20 and FY 2021-21 estimated payments based on FY 2018-19 actuals which is the basis for the projections and an annual 8% growth factor included.
- Inclusion of FY 2019-20 Q1 remaining claims.

For TMAA:

- Increased FY 2019-20 and FY 2020-21 estimated payments based on FY 2018-19 actuals which is the basis for the projections and an annual 8% growth factor.
- Fewer quarters estimated for FY 2020-21.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a net decrease due to:

- Fewer quarters of CMAA payments are expected in FY 2021-23 than in FY 2021-22. The CMAA FY 2021-22 payments include five quarters, while CMAA FY 2022-23 only includes payments for four quarters.

COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 5

- For TMAA, there are more quarters estimated at the higher quarterly estimate in FY 2021-22 than in FY 2022-23.
- An increase in CMAA and TMAA quarterly payments estimated in FY 2021-22 based on an 8% growth factor.

Methodology:

County Medi-Cal Administrative Activities

1. The CMAA FY 2021-22 estimate includes the remaining FY 2019-20 Q1 to Q4 claims and FY 2020-21 Q1 claims.
 - The estimated base payments for FY 2019-20 and FY 2020-21 claims assumes an 8% growth factor from FY 2018-19 and FY 2019-20, based on growth in CMAA claims from FY 2014-15 through FY 2018-19.

CMAA FY 2021-22 Estimated Payments	
FY 2019-20 Q1 - Q4	\$117,238,000
FY 2020-21 Q1	\$31,654,000
Total	\$148,892,000

2. The CMAA FY 2022-23 estimate includes FY 2020-21 Q2 to Q4 claims and FY 2021-22 Q1 claims. The estimated base payments for FY 2020-21 and FY 2021-22 claims assume an 8% growth factor, based on CMAA growth in claims from FY 2014-15 through FY 2018-19.

CMAA FY 2022-23 Estimated Payments	
FY 2020-21 Q2 to Q4	\$94,963,000
FY 2021-22 Q1	\$34,187,000
Total	\$129,150,000

Tribal Medi-Cal Administrative Activities

1. The TMAA FY 2021-22 estimate includes the remaining FY 2019-20 Q2 to Q4 claims and FY 2020-21 Q1 to Q2 claims.
 - The estimated base payments for FY 2019-20 and 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 Q2 to Q4	\$484,000
FY 2020-21 Q1 to Q2	\$349,000
Total	\$833,000

COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 5

2. The TMAA FY 2022-23 estimate includes FY 2020-21 Q3 to Q4 and FY 2021-22 Q1 to Q2 claims. The estimated base payments for FY 2020-21 and FY 2021-22 claims assume an 8% growth factor based on growth in TMAA claims from FY 2014-15 through FY 2018-19.

TMAA FY 2022-23 Estimated Payments	
FY 2020-21 Q3 to Q4	\$349,000
FY 2021-22 Q1 to Q2	\$376,000
Total	\$725,000

3. Total CMAA and TMAA reimbursements for FY 2021-22 and FY 2022-23 on a cash basis are:

FY 2021-22	TF	FF
County MAA	\$148,892,000	\$148,892,000
Tribal MAA	\$833,000	\$833,000
Total	\$149,725,000	\$149,725,000

FY 2022-23	TF	FF
County MAA	\$129,150,000	\$129,150,000
Tribal MAA	\$725,000	\$725,000
Total	\$129,875,000	\$129,875,000

Funding:

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

MEDI-CAL RX - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 6
IMPLEMENTATION DATE: 7/2020
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2167

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$97,648,000	\$93,705,000
STATE FUNDS	\$45,444,550	\$21,972,250
FEDERAL FUNDS	\$52,203,450	\$71,732,750

Purpose:

This policy change estimates the net impact from the cost of the new administrative services vendor contract for Medi-Cal Rx and impact on the current Fee-for-Service (FFS) pharmacy claims administrator.

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. With this change, Medi-Cal pharmacy benefits will be provided and managed through Medi-Cal Rx. To facilitate and support the carve-out and ongoing management of the Medi-Cal pharmacy benefit, the Department procured a vendor, Magellan Medicaid Administration, Inc., to provide administrative services for Medi-Cal Rx.

The Medi-Cal Rx vendor will provide modern pharmacy support systems, including:

- claims administration and utilization management services,
- pharmacy drug rebate administration, and
- provider and beneficiary support.

In January 2021, Centene Corporation announced plans to acquire Magellan Health, the parent company of the Medi-Cal Rx vendor, Magellan Medicaid Administration, Inc. (MMA). This acquisition required additional time for exploration of acceptable conflict avoidance protocols between Centene and MMA to protect the Medi-Cal claims data and other proprietary information. The Medi-Cal Rx Assumption of Operations (AOO) is assumed January 1, 2022. Since January 1, 2021, Medi-Cal Rx has provided transitional services and supports (TSS) which include Customer Service Center, Clinical Staff Support, Pharmacy Service Portal, as well as Outreach and Education and other services. These transitional services support a smooth transition for AOO.

The Department estimates a cost savings for the administrative services compared to the existing FFS pharmacy claims administration vendor contract. Effective July 1, 2020, a consulting and project management contractor has been in place is support of takeover of

MEDI-CAL RX - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 6

operations from the current Medi-Cal Fiscal Intermediary and managed care plans related to Medi-Cal Rx. The consultant contractor work efforts will be extended through FY 2021-22.

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 2021-22 and FY 2022-23:

- Vendor costs funded at 50% FF / 50% GF, 100% GF, 75% FF / 25% GF, and Title XXI 65% FF / 35% GF.

Consulting

- FY 2020-21 and FY 2021-22 costs funded at 90% FF / 10% GF.

This policy change (PC) is part of the carve-out effort transitioning managed care 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
- Medical Supply Rebates
- Non-Hospital 340B Clinic Supplemental Payments
- Medi-Cal Rx – Additional Supplemental Rebates

Other Admin

- Medi-Cal Rx – Administrative Costs

Reason for Change:

The change from the prior estimate for FY 2021-22 is due to:

- The carryover of expected FY 2020-21 payments due to negotiations,
- Incorporating change request and rebate service expenditures, and
- Including a funding adjustment for contractor costs previously claimed at 50%/50% FMAP to 90%/10% FMAP.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to:

- Increased estimate for change requests,
- Including the funding adjustments for vendor costs previously claimed at 50%/50% FMAP to 75%/25% FMAP.

Methodology:

1. Assume the FFS related administrative cost is an annual savings of \$4,968,000 TF.
2. Assume the new pharmacy-related administrative cost are \$98,501,000 TF annually.

MEDI-CAL RX - ADMINISTRATIVE COSTS
OTHER ADMIN. POLICY CHANGE NUMBER: 6

(Dollars in Thousands)

Annual	TF	GF	FF
FFS Related Administrative Cost Savings	(\$4,968)	(\$1,242)	(\$3,726)
New Pharmacy Related Administrative Costs	\$98,501	\$25,054	\$73,447
Net Administrative Costs	\$93,533	\$23,812	\$69,721

3. Contractor costs are included in FY 2021-22 and FY 2022-23.
4. The estimated cost for FY 2021-22 and FY 2022-23 is:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
FFS Related Administrative Cost Savings	(\$1,222)	(\$306)	(\$916)
New Pharmacy Related Administrative Costs	\$98,870	\$45,750	\$53,120
Total	\$97,648	\$45,444	\$52,204

FY 2022-23	TF	GF	FF
FFS Related Administrative Cost Savings	(\$4,968)	(\$1,242)	(\$3,726)
New Pharmacy Related Administrative Costs	\$98,673	\$23,214	\$75,459
Total	\$93,705	\$21,972	\$71,733

MEDI-CAL RX - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 6

Funding:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
FI 75% Title XIX / 25% GF	(\$1,222)	(\$306)	(\$916)
90% Title XIX / 10% GF	\$9,864	\$986	\$8,878
FI 50% Title XIX / 50% GF	\$95,541	\$47,771	\$47,770
50% Title XIX / 50% GF	(\$7,068)	(\$3,534)	(\$3,534)
FI 65% Title XXI / 35% GF	\$9	\$3	\$6
65% Title XXI / 35% GF	\$0	\$0	\$0
FI 100% GF	\$509	\$509	\$0
100% GF	\$15	\$15	\$0
FI 4.34% Title XXI FFCRA	\$0	\$0	\$0
4.34% Title XXI FFCRA	\$0	\$0	\$0
Total	\$97,648	\$45,444	\$52,204

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
FI 75% Title XIX / 25% GF	(\$4,968)	(\$1,242)	(\$3,726)
FI 75% Title XIX / 25% GF	\$49,050	\$12,262	\$36,788
FI 50% Title XIX / 50% GF	\$48,870	\$24,435	\$24,435
90% Title XIX / 10% GF	\$220	\$22	\$198
Certification -FI 50/50	(\$56,127)	(\$28,064)	(\$28,063)
Certification +FI 75/25	\$56,127	\$14,032	\$42,095
FI T21 65/35	\$10	\$4	\$6
65% Title XXI / 35% GF	\$0	\$0	\$0
FI 100% GF	\$522	\$522	\$0
100% GF	\$1	\$1	\$0
Total	\$93,705	\$21,972	\$71,733

CALAIM - POPULATION HEALTH MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 7
IMPLEMENTATION DATE: 7/2021
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2288

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$75,000,000	\$225,000,000
STATE FUNDS	\$7,500,000	\$22,500,000
FEDERAL FUNDS	\$67,500,000	\$202,500,000

Purpose:

This policy change estimates the cost for creating the Population Health Management service under the California Advancing and Innovating Medi-Cal (CalAIM) policy.

Authority:

Not applicable

Interdependent Policy Changes:

Not applicable

Background:

In alignment with the CalAIM Population Health Management strategy, the Department will implement a Medi-Cal Population Health Management service that would utilize Medi-Cal administrative and clinical data and information for the Department, Managed Care Plans, counties, providers, beneficiaries, and other Department partners to use in support of the delivery of care for all of Medi-Cal beneficiaries. Information will be available from many Medi-Cal delivery systems and programs, including but not limited to managed care, fee-for-service, specialty mental health, substance use disorder, dental services, long term services & supports, developmental disability services, in-home supportive services (IHSS), 1915c Waivers, Supplemental Nutrition Assistance Program (SNAP), Women, Infants, and Children (WIC), In Lieu of Services (ILOS), and Lab links. This service will also provide the Department and others with access to identifications of potential gaps in care, provider/care manager information, information on social determinates of health, allow for population health analytics, health education and tips for beneficiaries. Additionally, the service would provide Medi-Cal beneficiaries with access to their administrative and clinical information, as appropriate. Clinical data will be phased in over time.

Throughout the Medi-Cal program many of the services provided are provided and maintained through individual administrative functions and there is not currently a single process to bring these services together and provide a holistic approach to delivering Medi-Cal to Californians.

This proposal seeks to provide a service that provides access to necessary information for many different parties, utilizing standard policies. The service will limit the burden on Medi-Cal beneficiaries when receiving services and support the many programs in Medi-Cal through a standardized approach. Additionally, this service will allow the Department to have an elevated view of the care provided to Medi-Cal beneficiaries.

CALAIM - POPULATION HEALTH MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 7

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a decrease due to transitioning from budgeting a multi-year appropriation to budgeting on a cash basis for the procurement and implementation of the contracted services. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to a full year of expenditures for the contract.

Methodology:

1. On a cash basis, costs for the procurement of this service and initial implementation cost assumed for the vendor are estimated to be:

Fiscal Year	TF	GF	FF
FY 2021-22	\$75,000,000	\$7,500,000	\$67,500,000
FY 2022-23	\$225,000,000	\$22,500,000	\$202,500,000

Funding:

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

DRUG MEDI-CAL COUNTY ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 8
IMPLEMENTATION DATE: 7/2014
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1813

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$48,243,000	\$55,749,000
STATE FUNDS	\$365,000	\$412,000
FEDERAL FUNDS	\$47,878,000	\$55,337,000

Purpose:

This policy change estimates the administrative costs reimbursements for counties who provide Drug Medi-Cal (DMC) services, and 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)
 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.

On August 13, 2015, the Department received approval from the Centers for Medicare and Medicaid Services (CMS) to implement the DMC-ODS waiver.

DMC County Administrative Costs

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. Costs are limited to a maximum of 15% of services provided. 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.

DRUG MEDI-CAL COUNTY ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 8

- Audit Settlement – The Department has the authority to audit the cost reports within three years of the cost settlement.

DMC County UR and QA Administrative Costs

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 2021-22 is a net increase due to the following:

- DMC UR and QA admin costs, previously budgeted in a separate policy change titled Drug Medi-Cal County UR & QA Admin, have been updated and are now included in this policy change.
- FY 2015-16 annual settlement costs, and a portion of FY 2019-20 admin claims, previously budgeted in FY 2020-21, has shifted to be paid in FY 2021-22.
- County Admin claims projections for FY 2019-20 and FY 2020-21 decreased based on actual claims received.
- UR and QA Admin has an increased projection based on the actual claims received.

The change in the current estimate, from FY 2021-22 to FY 2022-23, is due to the following:

- Higher estimated annual settlement claims in FY 2022-23.
- An ongoing increase in the number of counties submitting quarterly claims for both County Admin and UR and QA Admin.

Methodology:

1. DMC county administration and UR and QA administration expenditures are split between Federal, State and County Funds (CF).
2. Based on past claims payment lag, assume 40.37% of the claims will be paid in the first year, 35.85% in the second year and the remaining 23.78% will be paid in the third year.
3. Estimates for quarterly claims are based on actual claims processed and estimated for future periods, either based on lag rates calculated for years 2 and 3, or on historical growth in claim dollars processed for future years.
4. For counties that submit claims annually, assume claims will be submitted and paid during interim cost settlement.
5. Annual settlements for county administration claims will be paid as follows:
 - FY 2015-16 and FY 2016-17 annual settlement claims payments will be processed in FY 2021-22.
 - FY 2017-18 and FY 2018-19 annual settlement claims payments are expected to be paid in FY 2022-23.

DRUG MEDI-CAL COUNTY ADMINISTRATION

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6. ODS waiver county administrative claims are included in the current estimate for counties that submit quarterly interim claims.
7. Effective January 1, 2020 through June 30, 2021, during the COVID-19 PHE, the administrative costs cap on DMC administration was increased from 15% to 30%. Assume some counties' claims have increased beyond the 15% cap.
8. UR and QA costs for SPMP will receive enhanced federal reimbursement of 75%. All other personnel will receive 50% federal reimbursement.
9. The estimated DMC county administration, annual settlement, and UR and QA administration costs for FY 2021-22 and FY 2022-23 are:

(Dollars in Thousands)

DMC County Admin.	Accrual	FY 2021-22	FY 2022-23
FY 2019-20 Claims	\$16,041	\$3,815	\$0
FY 2020-21 Claims	\$22,991	\$8,242	\$5,468
FY 2021-22 Claims	\$27,937	\$11,278	\$10,016
FY 2022-23 Claims	\$33,948	\$0	\$13,704
Total		\$23,335	\$29,188

(Dollars in Thousands)

Annual Settlements	Accrual	FY 2021-22	FY 2022-23
FY 2015-16 Claims	\$25,111	\$25,111	\$0
FY 2016-17 Claims	\$26,366	\$26,366	\$0
FY 2017-18 Claims	\$27,157	\$0	\$27,157
FY 2018-19 Claims	\$27,972	\$0	\$27,972
Total		\$51,477	\$55,129

(Dollars in Thousands)

DMC UR and QA Admin.	Accrual	FY 2021-22	FY 2022-23
FY 2019-20 Claims	\$12,998	\$3,091	\$0
FY 2020-21 Claims	\$14,088	\$5,051	\$3,350
FY 2021-22 Claims	\$18,339	\$7,403	\$6,575
FY 2022-23 Claims	\$23,873	\$0	\$9,637
Total		\$15,545	\$19,562

DRUG MEDI-CAL COUNTY ADMINISTRATION
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FY 2021-22	TF	GF	Title XIX	CF
County Administration	\$23,335,000	\$117,000	\$11,667,000	\$11,551,000
UR and QA Administration	\$15,545,000	\$0	\$10,473,000	\$5,072,000
Annual Settlements	\$51,477,000	\$248,000	\$25,738,000	\$25,491,000
Total	\$90,357,000	\$365,000	\$47,878,000	\$42,114,000

FY 2022-23	TF	GF	Title XIX	CF
County Administration	\$29,188,000	\$146,000	\$14,594,000	\$14,448,000
UR and QA Administration	\$19,562,000	\$0	\$13,179,000	\$6,383,000
Annual Settlements	\$55,129,000	\$266,000	\$27,564,000	\$27,299,000
Total	\$103,879,000	\$412,000	\$55,337,000	\$48,130,000

Funding:

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

100% GF (4260-101-0001)

HEALTH ENROLLMENT NAVIGATORS

OTHER ADMIN. POLICY CHANGE NUMBER: 9
IMPLEMENTATION DATE: 6/2020
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2144

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$47,844,000	\$0
STATE FUNDS	\$23,922,000	\$0
FEDERAL FUNDS	\$23,922,000	\$0

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 in FY 2021-22, from the prior estimate, is an increase due to program funding shifting from FY 2020-21 to FY 2021-22 as a result of delayed outreach and enrollment activities due to COVID-19 impact. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to program activities concluding June 30, 2022.

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 **\$47,844,000 TF (\$23,922,000 GF)** will be paid in FY 2021-22. Based on claims submission, dollars may shift to be paid in FY 2022-23.

Funding:

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

SMH MAA

OTHER ADMIN. POLICY CHANGE NUMBER: 10
IMPLEMENTATION DATE: 7/2012
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1722

	FY 2021-22	FY 2022-23
TOTAL FUNDS	\$45,914,000	\$51,586,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$45,914,000	\$51,586,000

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 (W&I) Code 14132.47
 Assembly Bill (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:

There is no change from the prior estimate in FY 2021-22.

The change from FY 2021 to FY 2022-23, in the current estimate is an increase due to applying a 12.35% growth rate to FY 2021-22 cost estimate.

Methodology:

1. County MHPs 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 2020-21.
3. For FY 2020-21, the Department projects to receive \$86,601,000 TF in SMH MAA claims on an accrual basis.

(Dollars in Thousands)

Fiscal Years	Expenditures	Growth	Increase
2020-21	\$86,602	12.35%	\$10,695
2021-22	\$97,297	12.35%	\$12,020
2022-23	\$109,317	12.35%	\$13,501

SMH MAA
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4. Based on historical claims received, assume 10.69% of FY 2020-21 claims will be paid in the year services occur and 89.31% are paid in the following year. Assume 10.96% of FY 2021-22 and FY 2022-23 claims will be paid in the year services occur and 89.31% are paid in the following year.

(Dollars in Thousands)

Fiscal Years	Accrual	FY 2021-22	FY 2022-23
2020-21	\$86,602	\$77,340	\$0
2021-22	\$95,354	\$10,406	\$86,894
2022-23	\$104,947	\$0	\$11,691
Total	\$286,904	\$87,746	\$98,586

*Totals may differ due to rounding.

5. Skilled professional medical personnel (SPMP) are eligible for enhanced federal reimbursement of 75%. All other personnel are eligible for 50% federal reimbursement. Based on actual claims submitted for costs incurred in FY 2019-20, assume 9.3% of costs are eligible for 75% reimbursement and the remaining 90.30% are eligible for 50% reimbursement. SMH MAA total expenditures are shared between federal funds (FF) and county funds (CF).

(Dollars in Thousands)

Expenditures	FY 2021-22			FY 2022-23		
	TF	FF	CF	TF	FF	CF
SPMP (75/25)	\$8,165	\$6,123	\$2,041	\$9,173	\$6,880	\$2,293
Other (50/50)	\$79,581	\$39,791	\$39,791	\$89,413	\$44,706	\$44,706
Total	\$87,746	\$45,914	\$41,832	\$98,586	\$51,586	\$47,000

*Totals may differ due to rounding.

Funding:

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

HEALTH INFORMATION EXCHANGE INTEROPERABILITY

OTHER ADMIN. POLICY CHANGE NUMBER: 11
IMPLEMENTATION DATE: 6/2020
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2159

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$43,679,000	\$438,000
STATE FUNDS	\$4,440,000	\$81,000
FEDERAL FUNDS	\$39,239,000	\$357,000

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 Department's 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 45 of the Code of Federal Regulations, Section 170.213
 Title 22 of the California Code of Regulations, Section 51476

Interdependent Policy Changes:

Not Applicable

Background:

On February 29, 2016, the Centers for Medicare and Medicaid Services (CMS) notified states of opportunities 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, approved by CMS in February 2020, was constructed based on the CMS guidance and supports Health Information Organizations (HIO) onboarding and technical assistance as well as establish interfaces between HIOs and Controlled Substance Utilization Review and Evaluation System (CURES). The Department of Justice (DOJ) CURES project seeks to support the connectivity of HIEs and providers to the state Prescription Drug Monitoring Program. DOJ will be responsible for establishing application programming interfaces and web components necessary to optimize the CURES system and comply with legislative mandates.

While the Cal-HOP program and associated federal approval ended in September 2021, the Department has requested federal approval for enhanced federal funds to use with unspent general funds to support other interoperability and data exchange efforts for Medi-Cal beneficiaries during FY 2021-22.

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 Department's HIE solution also

HEALTH INFORMATION EXCHANGE INTEROPERABILITY

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supports compliance with recently published and emerging federal requirements for health information interoperability.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is an overall decrease for this policy change. Due to delays in the completion of Cal-HOP milestones, a reduced estimate of expenses will occur in FY 2021-22. The CDE budget for FY 2021-22 is minimally increased for this period due to a deferral of expenditures related to the Health Data Hub Training contract from FY 2020-21 to FY 2021-22.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is an overall decrease for the policy change. The Cal-HOP expenses are expected to be completed in FY 2021-22. The costs remaining are related to the CDE Project, which are a slight change from the FY 2021-22 amounts.

Methodology:

1. Estimated expenditures for the Cal-HOP program are \$42,827,992 TF (\$4,282,799 GF) in FY 2021-22.
2. Estimated expenditures for the CDE project are \$851,000 TF (\$157,095 GF) in FY 2021-22 and \$438,200 TF (\$80,892 GF) in FY 2022-23.

CDE Cost Estimates - Source of Cost	FY 2021-22	FY 2022-23	Total
NextGen Health Data Hub Software-as-a-Service	\$132,600	\$66,300	\$198,900
HIE Subject-Matter Expert (SME)	\$243,000	\$121,500	\$364,500
Change Management SME	\$220,000	\$20,000	\$240,000
NextGen Health Data Hub System Administration	\$230,400	\$230,400	\$460,800
NextGen Health Data Hub Training	\$25,000	\$0	\$25,000
Total	\$851,000	\$438,200	\$1,289,200

FY 2021-22	TF	GF	FF
Cal-HOP	\$42,828,000	\$4,283,000	\$38,545,000
Clinical Data Exchange	\$851,000	\$157,000	\$694,000
Total*	\$43,679,000	\$4,440,000	\$39,239,000

FY 2022-23	TF	GF	FF
Clinical Data Exchange	\$438,000	\$81,000	\$357,000
Total	\$438,000	\$81,000	\$357,000

*Note: some slight variations due to rounding

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: 12
IMPLEMENTATION DATE: 7/2002
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 252

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$42,850,000	\$29,420,000
STATE FUNDS	\$10,758,150	\$7,404,650
FEDERAL FUNDS	\$32,091,850	\$22,015,350

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 – 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

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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, and the MARS system was implemented in February 2019. 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. The systems are now eligible to receive enhanced funding of 75% / 25%.

The existing MIS/DSS, SURS, and MARS contract with Optum will expire June 2023. Amendment #4 to the current contract addresses 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 Operational Annual Planning Document Update (OAPDU) to seek enhanced funding from CMS for contract Amendment #4 was approved by CMS in November 2020. Although the enhanced funding was approved by CMS and no changes to cost were incurred, the business model for hardware storage services requested in Amendment #4 changed. DGS is currently reviewing the changes.

Reason for Change:

The changes from the prior estimate, for FY 2021-22, is an increase due to the shifting of FY 2020-21 dollars to FY 2021-22 as a result of the execution of Amendment #4 delay.

The change from FY 2021-22 to FY 2022-23 in the current estimate, is a decrease due to the delay of the execution of Amendment #4. The costs associated with this decrease are Oracle refreshes, Software refreshes, Hardware refreshes, and MISDSS/Cognos licenses costs.

Methodology:

1. MIS/DSS total contract Amendment #4 costs began in December 2021, 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 (\$8,551,000 for FY 2021-22, and \$3,689,000 for FY 2022-23).
2. SURS and MARS contract Amendment #4 began in December 2021, 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). DD&I 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.

MIS/DSS SYSTEM AND SURS & MARS SUBSYSTEM
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3. The estimated breakdown of the SURS costs are:

SURS	FY 2021-22	FY 2022-23
DD&I Costs (90%/10%)	\$0	\$0
Operational Costs (75%/25%)	\$13,191,000	\$8,737,000
Total	\$13,191,000	\$8,737,000

Totals may differ due to rounding

The estimated breakdown of the MARS costs are:

MARS	FY 2021-22	FY 2022-23
DD&I Costs (90%/10%)	\$0	\$0
Operational Costs (75%/25%)	\$3,428,000	\$3,114,000
Total	\$3,428,000	\$3,114,000

Totals may differ due to rounding

4. The estimated breakdown of MIS/DSS costs are:

MIS/DSS	FY 2021-22	FY 2022-23
DD&I Costs (90%/10%)	\$894,000	\$894,000
Operational Costs (75%/25%)	\$24,618,000	\$15,940,000
Operational Costs (50%/50%)	\$719,000	\$735,000
Total	\$26,231,000	\$17,569,000

Totals may differ due to rounding

5. The estimated total costs for SURS, MARS and MIS/DSS are:

SURS, MARS and MIS/DSS	TF	GF	FF
DD&I Costs (90%/10%)	\$894,000	\$89,000	\$805,000
Operational Costs (75%/25%)	\$41,237,000	\$10,309,000	\$30,928,000
Operational Costs (50%/50%)	\$719,000	\$360,000	\$359,000
Total FY 2021-22	\$42,850,000	\$10,758,000	\$32,092,000

Totals may differ due to rounding

SURS, MARS and MIS/DSS	TF	GF	FF
DD&I Costs (90%/10%)	\$894,000	\$89,000	\$805,000
Operational Costs (75%/25%)	\$27,791,000	\$6,948,000	\$20,843,000
Operational Costs (50%/50%)	\$735,000	\$184,000	\$551,000
Total FY 2022-23	\$29,420,000	\$7,221,000	\$22,199,000

Totals may differ due to rounding

MIS/DSS SYSTEM AND SURS & MARS SUBSYSTEM
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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)

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS Admin policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – Other Admin policy change.

ARRA HITECH INCENTIVE PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 13
IMPLEMENTATION DATE: 7/2010
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1370

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$40,975,000	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$40,975,000	\$0

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)
 AB 80 (Chapter 12, Sec 52, Statutes of 2020)
 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 until January 1, 2024.

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. AB 80 authorizes an extension of program activities related to auditing and program closeout until January 1, 2024.

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. This IAPD-U was originally set to expire on September 30, 2020. An IAPD-U for FFY 2021 was approved by CMS on October 28, 2020, and is considered retroactive to September 22, 2020. This IAPD-U for FFY 2021 expired on September 30, 2021. The Department submitted the FFY 2022 IAPD-U for CMS' review in May 2021. This IAPD-U would be retroactive to the date of submission and expire on September 30, 2022.

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

ARRA HITECH INCENTIVE PROGRAM

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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 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. Activities related to the CTAP program have concluded as of September 30, 2020.
- 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. Beginning in July 2021, the Department began work on a final landscape assessment as part of the essential Promoting Interoperability Program closeout operations required by CMS.
- 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 (Cal-OHII) to expand the SHIG to address additional use cases in order to facilitate the exchange of health and behavioral health information.

Reasons for Change:

The change from the prior estimate, for FY 2021-22, is an increase due to delays in invoicing for services in FY 2020-21, deferred expenses from FY 2020-21 shifting into FY 2021-22, and the additional funding for the HIT Landscape Assessment.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to all of the costs for HITECH contracts being paid out in FY 2021-22.

Methodology:

1. The ARRA HITECH Incentive Program is eligible for Title XIX 90% FF.

ARRA HITECH INCENTIVE PROGRAM
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2. For the CAIR Onboarding, and CalREDIE eCR projects, the 10% non-federal share is budgeted by California Department of Public Health (CDPH). This policy change budgets the Title XIX 90% FF that will be provided to CDPH per the contracts through an interagency agreement.
3. The HITEMS project costs are eligible for Title XIX 90% FF. The 10% non-federal share is budgeted by EMSA.
4. For the California HIT/HIE Stakeholder Summit, the 10% non-federal share will be provided by outside entities.
5. SHIG/Cal-OHII project costs are eligible for Title XIX 90% FF.
6. The HIT Landscape Assessment costs are eligible for Title XIX 90% FF. The 10% non-federal share is provided by outside entities.
7. The medical Fiscal Intermediary (FI) projects are eligible for ARRA HITECH funding under the IBM FI contract. The FI processes all Medi-Cal payments on the behalf of the Department which includes implementation and maintenance of the State Level Registry, the online application portal providers use to apply for incentive payments.

FY 2021-22	TF	Reimburs.	SF	FF
CAIR Onboarding (90% FF/10% GF)	\$2,993,000	\$0	\$0	\$2,993,000
CalREDIE eCR (90% FF/10% GF)	\$1,253,000	\$0	\$0	\$1,253,000
HITEMS (90% FF/10% GF)	\$34,667,000	\$0	\$0	\$34,667,000
California HIT/HIE Summit (90% FF/10% GF)	\$64,000	\$0	\$0	\$64,000
SHIG / Cal-OHII (90% FF/10% GF)	\$1,518,000	\$0	\$0	\$1,518,000
HIT Landscape Assessment (90% FF/10% GF)	\$480,000	\$0	\$0	\$480,000
Total FY 2021-22	\$40,975,000	\$0	\$0	\$40,975,000

Funding:

100% Title XIX (4260-101-0890)

CHDP COUNTY ALLOCATION

OTHER ADMIN. POLICY CHANGE NUMBER: 14
IMPLEMENTATION DATE: 7/1996
ANALYST: Sasha Jetton
FISCAL REFERENCE NUMBER: 229

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$33,962,000	\$33,962,000
STATE FUNDS	\$11,957,000	\$11,957,000
FEDERAL FUNDS	\$22,005,000	\$22,005,000

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; however, children can receive case management either through a Medi-Cal managed care plan or Fee-for-Service CHDP providers. In addition, eligible children receive case management services through county California Children's Services (CCS) programs, county Health Care Program for Children in Foster Care programs, home and community based service waiver providers and county behavioral health programs.

Reason for Change:

There is no change from the prior estimate for FY 2021-22 or between fiscal years.

Methodology:

The allocation amount for both FY 2021-22 and FY 2022-23 is \$33,962,000 (\$11,957,000 GF)

CHDP COUNTY ALLOCATION
OTHER ADMIN. POLICY CHANGE NUMBER: 14

Funding:

FY 2021-22	TF	GF	FF
Title XIX (50% FF / 50% GF)	\$15,081,000	\$7,540,500	\$7,540,500
Title XIX (75% FF / 25% GF)	\$17,666,000	\$4,416,500	\$13,249,000
Title XIX (100% FF)	\$1,215,000	\$0	\$1,215,000
Total	\$33,962,000	\$11,957,000	\$22,005,000
FY 2022-23	TF	GF	FF
Title XIX (50% FF / 50% GF)	\$15,081,000	\$7,540,500	\$7,540,500
Title XIX (75% FF / 25% GF)	\$17,666,000	\$4,416,500	\$13,249,000
Title XIX (100% FF)	\$1,215,000	\$0	\$1,215,000
Total	\$33,962,000	\$11,957,000	\$22,005,000

POSTAGE & PRINTING

OTHER ADMIN. POLICY CHANGE NUMBER: 15
IMPLEMENTATION DATE: 7/1993
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 231

	FY 2021-22	FY 2022-23
TOTAL FUNDS	\$31,277,000	\$31,277,000
STATE FUNDS	\$15,767,000	\$15,767,000
FEDERAL FUNDS	\$15,510,000	\$15,510,000

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
 California Revenue and Tax Code § 61005

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, Third Party Liability (TPL) 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 2021-22, is an increase due to an increase in estimated 1095-B and Base Mass Mailings as well as an increase in general mailing costs due to a change in vendor for these services from MAXIMUS to the Office of State Publishing (OSP). Costs for the general printing and mailing services had previously been budgeted in the OTLICP, MCAP, Special Populations Admin Costs policy change.

There is no change from FY 2021-22 to FY 2022-23 in the current estimate.

Methodology:

1. Based on FY 2020-21 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 \$0.71.

$$14,500,000 \text{ mailings} \times \$0.71 \text{ per mailing} = \$10,296,000 \text{ (rounded)}$$

3. Based on FY 2020-21 actuals, assume that 3% 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 \$0.71 per unit.

$$3\% \times 14,500,000 \text{ mailings} = 435,000 \text{ returned mailings}$$

$$435,000 \text{ returned mailings} \times \$0.71 \text{ per unit} = \$309,000 \text{ (rounded)}$$

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 \$0.71 per unit and based on FY 2020-21 actuals, assume 130,000 mailers will be sent out to beneficiaries.

$$130,000 \text{ mailings} \times \$0.71 \text{ per mailing} = \$92,000 \text{ (rounded)}$$

5. TAR postage costs for Medi-Cal are assumed to be \$80,000 for FY 2021-22 and FY 2022-23.
6. OSP costs for printing Family Planning, Access, Care, and Treatment program brochures are assumed to be \$150,000 in FY 2021-22 and \$150,000 FY 2022-23.
7. The Department estimates the printing and postage costs for FY 2021-22 and FY 2022-23 are:

POSTAGE & PRINTING
OTHER ADMIN. POLICY CHANGE NUMBER: 15

FY 2021-22	TF	GF	FF
Base Mass Mailing	\$17,900,000	\$9,078,000	\$8,822,000
1095B			
1095 Mailings	\$10,296,000	\$5,148,000	\$5,148,000
Reprinted/Corrected Form 1095-B	\$309,000	\$155,000	\$154,000
Notice for Requested Action	\$92,000	\$46,000	\$46,000
1095 B Subtotal	\$10,697,000	\$5,349,000	\$5,348,000
Emergency Mailings	\$2,600,000	\$1,300,000	\$1,300,000
TAR Postage	\$80,000	\$40,000	\$40,000
Total	\$31,277,000	\$15,767,000	\$15,510,000
FY 2022-23	TF	GF	FF
Base Mass Mailing	\$17,900,000	\$9,078,000	\$8,822,000
1095B			
1095 Mailings	\$10,296,000	\$5,148,000	\$5,148,000
Reprinted/Corrected Form 1095-B	\$309,000	\$155,000	\$154,000
Notice for Requested Action	\$92,000	\$46,000	\$46,000
1095 B Subtotal	\$10,697,000	\$5,349,000	\$5,348,000
Emergency Mailings	\$2,600,000	\$1,300,000	\$1,300,000
TAR Postage	\$80,000	\$40,000	\$40,000
Total	\$31,277,000	\$15,767,000	\$15,510,000

*Totals may differ due to rounding.

Funding:

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

100% GF (4260-101-0001)

OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 16
IMPLEMENTATION DATE: 1/2013
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 1748

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$29,643,000	\$26,309,000
STATE FUNDS	\$16,704,500	\$14,119,250
FEDERAL FUNDS	\$12,938,500	\$12,189,750

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 20-10359
 Maximus Contract 12-89315 A12

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: 16

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. DHCS will look to include contract support to conduct field testing of Medi-Cal materials into other threshold languages for cultural accuracy and appropriateness. Per the Governor's Proposed Budget (2021-2022), the Department will look to include contract support to conduct field testing of Medi-Cal materials into other threshold languages for cultural accuracy and appropriateness.

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. Effective July 1, 2021, the Department awarded a Non-Competitive Bid to the existing vendor to administer this program.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is a decrease primarily due to a decrease in overall contract costs. Additionally, the Special Populations Publications line item costs have transitioned into the Postage & Printing policy change. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to a decrease in expected contract costs.

Methodology:

1. This estimate is based on an average of actual usage and processing of the applications, postage, and vendor contract rates and services.
2. Contract costs are eligible for Title XXI 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:

OTLIPC, MCAP, SPECIAL POPULATIONS ADMIN COSTS
OTHER ADMIN. POLICY CHANGE NUMBER: 16

(Dollars in Thousands)

Program	FY 2021-22	FY 2022-23
OTLIPC	\$14,282	\$13,241
MCAP	\$3,409	\$3,149
CCHIP	\$4,241	\$4,241
Hearing Aids	\$6,711	\$5,628
Field Testing Contract Support	\$1,000	\$50

5. Contract costs and administrative vendor service costs by cost category are as follows:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
Contract Costs	\$13,880	\$4,967	\$8,913
Applications Processing, Printing and Courier Services, Letters and Notices, Transaction Forwarding Fee	\$3,206	\$1,603	\$1,603
Call Minute Rate per Minute	\$4,846	\$2,423	\$2,423
Hearing Aids	\$6,711	\$6,711	\$0
Field Testing Contract Support	\$1,000	\$1,000	\$0
Total	\$29,643	\$16,704	\$12,939

FY 2022-23	TF	GF	FF
Contract Costs	\$13,225	\$4,738	\$8,487
Applications Processing, Printing and Courier Services, Letters and Notices, Transaction Forwarding Fee, Pregnancy Materials	\$2,932	\$1,466	\$1,466
Call Minute Rate per Minute	\$4,474	\$2,237	\$2,237
Hearing Aids	\$5,628	\$5,628	\$0
Field Testing Contract Support	\$50	\$50	\$0
Total	\$26,309	\$14,119	\$12,190

*Totals may differ due to rounding.

OTLIPC, MCAP, SPECIAL POPULATIONS ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 16

Funding:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890/0001)	\$8,782	\$5,391	\$4,391
65% Title XXI / 35% GF (4260-113-0890/0001)	\$13,150	\$4,602	\$8,548
100% GF (4260-101-0001)	\$7,711	\$6,711	\$0
Total	\$29,643	\$16,704	\$12,939

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890/0001)	\$8,136	\$4,118	\$4,068
65% Title XXI / 35% GF (4260-113-0890/0001)	\$12,495	\$4,373	\$8,122
100% GF (4260-101-0001)	\$5,678	\$5,628	\$0
Total	\$26,309	\$14,119	\$12,190

*Totals may differ due to rounding.

** COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP - Other Admin policy change

*** COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension –Other Admin policy change.

ACTUARIAL COSTS FOR RATE DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 17
IMPLEMENTATION DATE: 8/2015
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1937

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$21,988,000	\$22,913,000
STATE FUNDS	\$10,994,000	\$11,456,500
FEDERAL FUNDS	\$10,994,000	\$11,456,500

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 in FY 2021-22, from the prior estimate, is an increase due to updated actuarial contractor cost projections. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase primarily by higher ongoing actuarial service costs in budget year.

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: 17

4. Specific costs are identified for existing workloads (Coordinated Care Initiative (CCI), Health Homes Program, and Hospital Quality Assurance Fee (HQAF) program; however, ongoing actuarial services are needed as these, and other new programs are integrated into the overall managed care delivery system rate setting process.

The FY 2021-22 and FY 2022-23 amounts on an accrual basis are estimated to be:

Policy	FY 2021-22	FY 2022-23
CCI - Administrative Costs	\$1,010,000	\$505,000
Health Homes Program - Contractor Costs	\$325,000	\$0
Ongoing Actuarial Services	\$20,615,000	\$22,195,000
HQAF Program	\$300,000	\$300,000
Total	\$22,250,000	\$23,000,000

The FY 2021-22 and FY 2022-23 amounts on a cash basis are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	HHP Fund	HQAF	FF
FY 2021-22	\$21,988	\$10,685	\$161	\$148	\$10,994
FY 2022-23	\$22,913	\$11,307	\$0	\$149	\$11,457

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)

HCBA WAIVER ADMINISTRATIVE COST

OTHER ADMIN. POLICY CHANGE NUMBER: 18
IMPLEMENTATION DATE: 7/2019
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2152

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$16,727,000	\$24,186,000
STATE FUNDS	\$8,363,500	\$12,093,000
FEDERAL FUNDS	\$8,363,500	\$12,093,000

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 current Waiver was authorized by the Center for Medicare and Medicaid Services on May 16, 2017, retroactive to January 1, 2017, and expires on December 31, 2021.

No later than October 1, 2021, the Department submitted a waiver renewal application for the HCBA Waiver for a new five-year term, effective January 1, 2022, through December 31, 2026.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a decrease based on 18 months of prior year data of actuals showing a slight drop in enrollment. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase in costs due to projecting additional enrollments of beneficiaries into the HCBA Waiver.

Methodology:

1. The per-member per-month payment to HCBA Waiver Agencies is \$186.56.
2. Assume there are 6,024 participants in the HCBA Waiver in FY 2020-21.
3. Assume 1,600 new participants will be enrolled in FY 2021-22 and 1,800 participants in FY 2022-23.
4. Assume 98% of all current and new waiver participants will enroll with a Waiver Agency and receive administrative services.

HCBA WAIVER ADMINISTRATIVE COST
OTHER ADMIN. POLICY CHANGE NUMBER: 18

Fiscal Year	TF	GF	FF
FY 2021-22	\$16,727,000	\$8,364,000	\$8,363,000
FY 2022-23	\$24,186,000	\$12,093,000	\$12,093,000

*Totals may differ due to rounding.

Funding:

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

LA COUNTY PUBLIC HEALTH NURSING PILOT

OTHER ADMIN. POLICY CHANGE NUMBER: 19
IMPLEMENTATION DATE: 3/2022
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2271

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$16,500,000	\$8,250,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$16,500,000	\$8,250,000

Purpose:

This policy change estimates the Federal Financial Participation (FFP) for administrative costs related to the Los Angeles County Child Welfare Public Health Nursing (PHN) Early Intervention Pilot Program.

Authority:

Welfare and Institutions (W&I) Code, Section 16521.8

Interdependent Policy Changes:

Not Applicable

Background:

In FY 2021-22, the Department expects to start FFP reimbursements for the Child Welfare PHN Early Intervention Pilot Program conducted in the County of Los Angeles to improve outcomes for the expanded population of youth at risk of entering the foster care system by maximizing access to health care and health education, and connecting youth and families to safety net services. It is the intent of the Legislature for the program to maximize the use of county public health nurses (PHNs) in the field in order to provide families with children who are at risk of being placed in the child welfare system with preventative services to meet their medical, mental, and behavioral health needs.

Los Angeles County has begun administrative work on the pilot program. The Department plans to secure Centers for Medicare and Medicaid Services (CMS) approval to cover any cost that falls outside the scope of Medicaid administrative activities directly related to the implementation of California's State Plan.

The Department plans to enter into an Interagency Agreement (IA) contract with Los Angeles County to enable the Department to receive FFP for administrative costs for the pilot program.

Reason for Change:

There is no change from the prior estimate for FY 2021-22.

The change in the current estimate, from FY 2021-22 to FY 2022-23, is due to more prior year costs included in FY 2021-22.

Methodology:

1. Assume payments for administrative costs, for program years FY 2019-20 and FY 2020-21, will begin in March 2022.
2. Assume administrative costs payments for FY 2021-22 will be paid in FY 2022-23.

LA COUNTY PUBLIC HEALTH NURSING PILOT
OTHER ADMIN. POLICY CHANGE NUMBER: 19

3. The estimated administrative cost reimbursements for FY, for FY 2021-22 and FY 2022-23, on a cash basis are:

(Dollars in Thousands)

FY 2021-22	TF	FF
FY 2019-20 Claims	\$8,250	\$8,250
FY 2020-21 Claims	\$8,250	\$8,250
Total	\$16,500	\$16,500

(Dollars in Thousands)

FY 2022-23	TF	FF
FY 2021-22 Claims	\$8,250	\$8,250
Total	\$8,250	\$8,250

Funding:

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

PAVE SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 20
IMPLEMENTATION DATE: 4/2016
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 1932

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$12,713,000	\$19,326,000
STATE FUNDS	-\$1,394,900	\$5,298,200
FEDERAL FUNDS	\$14,107,900	\$14,027,800

Purpose:

This policy change estimates the costs for the 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 requested funding to cover ongoing PAVE M&O costs.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is an increase due to the ongoing PAVE M&O activities which include an anticipated increase in the number of providers in PAVE.

The change from FY 2021-22 to FY 2022-23 in the current estimate, is an increase due to the ongoing PAVE M&O activities, which include anticipated increase in the number of providers in PAVE. It is anticipated that the Dental Providers will be added to PAVE in July 2022.

Methodology:

1. The Department is continuing to add programs and benefits to PAVE on a phase-in basis with costs having begun 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: 20

2. The Department received Centers for Medicare and Medicaid Services (CMS) certification in April 2021, which will allow the M&O Federal Financial Participation (FFP) to be claimed at 75% FF / 25% GF on the Provider cost. The CMS State Medicaid Letter does not indicate that Help Desk cost for Provider Management are allowable at 75% FF / 25% GF; therefore, Help Desk cost will continue to be claimed at 50% FF / 50% GF. CMS approved the two-year retroactive claiming period from April 2019 to March 2021 and the department is preparing the "Good Cause Waiver Letter" to request CMS to approve the claiming period beyond the two-year filing limit, which is October 2018 to March 2019. The total FFP recoupment of \$4,939,000 was processed after the Department received approval on the "Good Cause Waiver Letter" from CMS.
3. The total cost for FY 2021-22 is \$12,713,000. The total cost for FY 2022-23 is \$19,326,000. 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 apply and are enrolled, the monthly rates continuously increase.
4. The FY 2021-22 and FY 2022-23 costs are as follows:

FY 2021-22	TF	GF	FF
Help Desk Cost	\$890,000	\$436,000	\$454,000
Provider Cost	\$11,823,000	\$8,715,000	\$3,108,000
M&O Recoupment of Funds Post Certification	\$0	(\$4,939,000)	\$4,939,000
Total	\$12,713,000	\$4,212,000	\$8,501,000

*Totals may differ due to rounding.

FY 2022-23	TF	GF	FF
Help Desk Cost	\$960,000	\$470,000	\$490,000
Provider Cost	\$18,366,000	\$4,829,000	\$13,537,000
Total	\$19,326,000	\$5,299,000	\$14,027,000

*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)

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

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – Other Admin policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – Other Admin policy change.

CAPMAN

OTHER ADMIN. POLICY CHANGE NUMBER: 21
IMPLEMENTATION DATE: 10/2012
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 1318

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$11,672,000	\$17,470,000
STATE FUNDS	\$2,999,700	\$4,495,000
FEDERAL FUNDS	\$8,672,300	\$12,975,000

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 Health Insurance Portability and Accountability Act (HIPAA) impose 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 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 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 CAPMAN include the following contract and other related costs:

CAPMAN Maintenance and Operations (M&O)

The CAPMAN 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 current contract will be out of funds in October 2022 although the contract effective period is April 1, 2018, through March 31, 2023. The Department will procure a new vendor with the contract beginning in July 2022 with a 3-month turnover/takeover period ending in October 2022.

CAPMAN

OTHER ADMIN. POLICY CHANGE NUMBER: 21

CAPMAN Certified Product Owner (CPO)

The CAPMAN 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 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. An amendment was executed to extend the contract through March 31, 2022.

CAPMAN Support Services:

The Department plans to consolidate the current CPO and other services resulting in a new contract, CAPMAN Support Services. The contract will be effective from February 2022 through January 2026. The contract will provide services in the area of product management, infrastructure performance monitoring, infrastructure and support the Department in managing the prime vendor transition and new operational processes including Service Level Agreements and Work Order Authorizations.

CAPMAN Web Services Engineer (WSE)

The CAPMAN WSE contract ensures performance system monitoring, addresses unresolved issues, and provides infrastructure support. The WSE contract is effective for the period December 3, 2019, through December 2, 2021, and includes three one-year optional extensions. An amendment is in process to extend the contract through December 2, 2022.

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/Software

In FY 2021-22 and FY 2022-23 costs associated with licensed software used by the CAPMAN system and cloud infrastructure costs.

Discovery & Planning

The CAPMAN system requires planning for continuously increasing healthcare policies and populations to be able to support complex growth.

Reason for Change:

The change from prior estimate for FY 2021-22, is due to an increase to CAPMAN M&O costs to develop, deliver, and support requests for current and historical detailed payment data at the beneficiary level volume, complexity, and rate of change to Managed Care Plan contracts with retroactive implications.

The change from FY 2021-22 to FY 2022-23 in the current estimate, is due to an increase in contractor resource costs to maintain, the system and an expected 3-month overlap between the current operations vendor and the newly procured vendors.

CAPMAN
OTHER ADMIN. POLICY CHANGE NUMBER: 21

Methodology:

1. CAPMAN M&O is estimated to cost \$8,752,000 TF in FY 2021-22, and \$13,147,000 TF in FY 2022-23.
2. Support Service and CPO are estimated to cost \$695,000 TF in FY 2021-22 and \$2,000,000 TF in FY 2022-23.
3. CAPMAN WSE is estimated to cost \$300,000 TF in FY 2021-22 and \$50,000 TF in FY 2022-23.
4. The SCO IAA contract is estimated to be \$20,000 TF in FY 2021-22 and \$10,000 in FY 2022-23.
5. Hardware/Software costs are estimated to be \$1,544,000 TF in FY 2021-22 and \$1,544,000 TF in FY 2022-23.
6. Discovery and planning for future Capitated Management System costs are estimated to be \$360,000 TF in FY 2021-22 and \$720,000 in FY 2022-23.

FY 2021-22	TF	GF	FF
CAPMAN M&O	\$8,752,000	\$2,188,000	\$6,564,000
Support Services/CPO Contract	\$695,000	\$174,000	\$521,000
CAPMAN WSE	\$300,000	\$75,000	\$225,000
SCO IAA	\$20,000	\$5,000	\$15,000
Hardware/Software	\$1,544,000	\$386,000	\$1,158,000
Discovery & Planning	\$360,000	\$36,000	\$324,000
Total	\$11,671,000	\$2,864,000	\$8,807,000

*Totals differ due to rounding

FY 2022-23	TF	GF	FF
CAPMAN M&O	\$13,147,000	\$3,287,000	\$9,860,000
Support Services/CPO Contract	\$2,000,000	\$500,000	\$1,500,000
CAPMAN WSE	\$50,000	\$13,000	\$37,000
SCO IAA	\$10,000	\$3,000	\$7,000
Hardware/Software	\$1,544,000	\$386,000	\$1,158,000
Discovery & Planning	\$720,000	\$72,000	\$648,000
Total	\$17,471,000	\$4,261,000	\$13,210,000

*Totals differ due to rounding

CAPMAN
OTHER ADMIN. POLICY CHANGE NUMBER: 21

Funding:

90% HIPAA FF / 10% HIPAA Fund (4260-117-0001/0890)

75% HIPAA FF / 25% HIPAA Fund (4260-117-0001/0890)

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

100% State GF (4260-101-0001)

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – Other Admin policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension policy change.

CCI-ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 22
IMPLEMENTATION DATE: 7/2012
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 1677

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$11,213,000	\$5,958,000
STATE FUNDS	\$5,606,500	\$2,979,000
FEDERAL FUNDS	\$5,606,500	\$2,979,000

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. The CCI aims to improve service delivery for people with dual eligibility and Medi-Cal only beneficiaries who rely on long-term services and supports (LTSS) to maintain residence in their communities. LTSS includes both home and community-based services and institutional long-term care services. Services are provided through the managed care delivery system for all Medi-Cal beneficiaries who rely on such services. The Department hired contractors to do the following:

- Stakeholder and Advocate Outreach,
- Quality assurance and monitoring by an External Quality Review Organization (EQRO),
- Evaluation,
- Project Management,
- Multipurpose Senior Services Program (MSSP) Transition,
- IT Project Management, and
- Data Outcomes and Evaluation Development (Encounter Data Quality and Performance Measures).

The 2017 Budget 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 was delayed to January 1, 2022, due to the postponement of CalAIM as a consequence of the COVID-19 public health

CCI-ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 22

emergency. With the delay of CalAIM, the Department submitted a 12-month extension request to CMS for the Medi-Cal 2020 waiver, extending its effective date to December 31, 2021.

As part of the CalAIM Initiative's standardized mandatory enrollment of dual eligibles and statewide integration of long-term care into managed care, the CCI pilot program will sunset December 31, 2022.

Reason for Change:

There is no change from the prior estimate for FY 2021-22. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to MSSP being carved out as of January 1, 2022, and the CCI pilot program ending December 31, 2022.

Methodology:

1. The CCI development, implementation, and operation costs began July 2012 and will continue through December 2022.
2. All costs for FY 2021-22 and FY 2022-23 will be funded at 50/50 FMAP.

FY 2021-22	TF	GF	FF
Stakeholder and Advocate Outreach	\$3,248,000	\$1,624,000	\$1,624,000
Encounter Data Quality & Perform. Measures	\$2,322,000	\$1,161,000	\$1,161,000
Evaluation	\$2,125,000	\$1,062,500	\$1,062,500
Technical Project Manager (IT)	\$1,034,000	\$517,000	\$517,000
Project Management	\$484,000	\$242,000	\$242,000
EQRO Monitoring	\$1,000,000	\$500,000	\$500,000
MSSP Transition	\$1,000,000	\$500,000	\$500,000
Total	\$11,213,000	\$5,606,500	\$5,606,500

FY 2022-23	TF	GF	FF
Stakeholder and Advocate Outreach	\$1,895,000	\$947,000	\$947,000
Encounter Data Quality & Perform. Measures	\$1,355,000	\$677,000	\$677,000
Evaluation	\$1,240,000	\$620,000	\$620,000
Technical Project Manager (IT)	\$603,000	\$302,000	\$302,000
Project Management	\$282,000	\$141,000	\$141,000
EQRO Monitoring	\$583,000	\$292,000	\$292,000
Total	\$5,958,000	\$2,979,000	\$2,979,000

Funding:

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

MEDI-CAL RECOVERY CONTRACTS

OTHER ADMIN. POLICY CHANGE NUMBER: 23
IMPLEMENTATION DATE: 2/2008
ANALYST: Neejkajsiab Yang
FISCAL REFERENCE NUMBER: 1551

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$10,443,000	\$7,882,000
STATE FUNDS	\$2,610,750	\$1,970,500
FEDERAL FUNDS	\$7,832,250	\$5,911,500

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	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.

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.

MEDI-CAL RECOVERY CONTRACTS

OTHER ADMIN. POLICY CHANGE NUMBER: 23

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to:

- For the HMS – Health Insurance contract, there is an increase from the prior FY 2021-22 estimate due to increased recovery projections from managed care recoveries, which includes a three-year look-back period.
- For Online Database Contracts, there is a decrease from the prior FY 2021-22 estimate, due to the current RELX contract expiring on December 31, 2021. This contract will be renewed as an IT requisition, and will no longer be included in this policy change.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to:

- For the HMS – Health Insurance contract, there is a decrease due to lower recovery projections from managed care recoveries, which is expected to normalize in FY 2022-23.
- For the Online Database Contracts, there is a decrease from the prior FY 2021-22 estimate, due to the current RELX contract expiring on December 31, 2021. This contract will be renewed as an IT requisition, and will no longer be included in this policy change.

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 2021-22 Recoveries	FY 2022-23 Recoveries	Contingency Fee %	FY 2021-22 Contingency Fee	FY 2022-23 Contingency Fee
HMS 18	\$122,500,000	\$92,600,000	8.50%	\$10,413,000	\$7,871,000

MEDI-CAL RECOVERY CONTRACTS

OTHER ADMIN. POLICY CHANGE NUMBER: 23

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 2021-22	FY 2022-23
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.	\$19,000	\$0
Total	\$30,000	\$11,000

3. The payments shown below include recent recovery activity.

FY 2021-22	TF	GF	FF
Health Insurance	\$10,413,000	\$2,603,000	\$7,810,000
Online Database Contracts	\$30,000	\$8,000	\$22,000
Total	\$10,443,000	\$2,611,000	\$7,832,000

FY 2022-23	TF	GF	FF
Health Insurance	\$7,871,000	\$1,968,000	\$5,903,000
Online Database Contracts	\$11,000	\$3,000	\$8,000
Total	\$7,882,000	\$1,971,000	\$5,911,000

Funding:

75% Title XIX / 25% GF (4260-101-0001/0890)

MITA

OTHER ADMIN. POLICY CHANGE NUMBER: 24
IMPLEMENTATION DATE: 1/2011
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 1137

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$10,424,000	\$10,997,000
STATE FUNDS	\$1,323,800	\$1,396,300
FEDERAL FUNDS	\$9,100,200	\$9,600,700

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 required by CMS, which includes a State MITA roadmap. Additionally, CMS requires Medi-Cal Enterprise Systems Certification in order to approve ongoing enhanced funding.

MITA
OTHER ADMIN. POLICY CHANGE NUMBER: 24

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 for the prior estimate for FY 2021-22 is a decrease due to the expiration of the Technical Consultant contract effective January 2021.

The change from FY 2021-22 to FY 2022-23 in the current estimate, is an increase due to the amount estimated for the MITA Support services upon re-procurement.

Methodology:

1. The FY 2021-22 and FY 2022-23 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. The projected FY 2021-22 and FY 2022-23 costs are:

FY 2021-22	APD	TF	GF	FF
MITA Contract	MITA	\$4,887,000	\$621,000	\$4,266,000
UCSD IA	MITA	\$487,000	\$62,000	\$425,000
Provider Management	PROV.	\$250,000	\$32,000	\$218,000
Enterprise Certification Support Services	MITA	\$4,800,000	\$609,000	\$4,191,000
Total		\$10,424,000	\$1,324,000	\$9,100,000

*Totals may differ due to rounding.

MITA
OTHER ADMIN. POLICY CHANGE NUMBER: 24

FY 2022-23	APD	TF	GF	FF
MITA Contract	MITA	\$5,460,000	\$693,000	\$4,767,000
UCSD IA	MITA	\$487,000	\$62,000	\$425,000
Provider Management	PROV.	\$250,000	\$32,000	\$218,000
Enterprise Certification Support Services	MITA	\$4,800,000	\$609,000	\$4,191,000
Total		\$10,997,000	\$1,396,000	\$9,601,000

*Totals may differ due to rounding.

Funding:

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

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

100% State GF (4260-101-0001)

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – Other Admin policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – Other Admin policy change.

CYBHI - BH SERVICES AND SUPPORTS PLATFORM

OTHER ADMIN. POLICY CHANGE NUMBER: 25
IMPLEMENTATION DATE: 1/2022
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2289

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$10,000,000	\$230,000,000
STATE FUNDS	\$10,000,000	\$230,000,000
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the cost for procuring a business services vendor to implement a statewide, all-payer behavioral health (BH) direct services and supports platform to be integrated with screening, clinic-based care, and app-based support services for children and youth 25 and younger, integrating an e-consult service into the platform, and providing related provider training.

Authority:

AB 133 (Chapter 143, Statutes of 2021)

Interdependent Policy Changes:

Not applicable

Background:

The Children and Youth Behavioral Health Initiative (CYBHI) is a multiyear package of investments. The CYBHI is intended to transform California's behavioral health system for children and youth aged 0-25 into a world-class, innovative, up-stream focused, ecosystem where all children and young adults are routinely screened, supported, and served for emerging behavioral health needs.

The Department aims to procure a business services vendor to deliver and monitor BH wellness services and treatments so the most effective, least resource-intensive services and treatments are available to children and youth 25 years of age and younger who may not need individual counseling, but need help managing stress and building resilience, through a direct service, virtual platform.

This direct services and supports platform would support regular automated age appropriate assessments/screenings and self-monitoring tools, and would develop tools to help families navigate how to access help, regardless of payer source. The direct services and supports platform will provide age appropriate and culturally competent support and resources, such as interactive education, self-monitoring tools, app-based games, videos, book suggestions, automated cognitive behavioral therapy and mindfulness exercises, all designed to build skills and enhance well-being. Children and youth 25 years of age and younger with more significant needs would be guided to peers or coaches. Those whose interactions with the platform show they may need clinical services for mental health conditions and/or substance use disorders will be guided to their health plan to set up assessment visits, allowing ongoing, continuous relationships with licensed clinicians through telehealth or in-person. The direct service platform also builds in coverage by licensed clinical social workers, so assessments can be performed to determine which children and youth need ongoing clinical services, and which have needs that can be met by peers or coaches. The direct services and supports platform will also include e-

CYBHI - BH SERVICES AND SUPPORTS PLATFORM

OTHER ADMIN. POLICY CHANGE NUMBER: 25

consult and e-referrals, to ensure primary care providers can coordinate care with mental health and substance use disorder specialists (e.g., psychiatrists) and clients may have seamless referrals, when needed. The direct services and supports platform will also be accessible by telephone. In addition, training for pediatric and other primary care providers will be offered, to support use of the platform in care of their patients.

Reason for Change:

There is no change from the prior estimate for FY 2021-22. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to a full year of costs, additional activities related to implementation of the platform, and the inclusion of e-consult and provider training.

Methodology:

1. The \$10 million in costs for FY 2021-22 are for planning and development of the BH services and supports platform. Per the Budget Act of 2021, Item 4260-101-0001, Provision 16(d), the \$10 million is available for encumbrance or expenditure until June 30, 2024.
2. The \$230 million in costs for FY 2022-23 are for activities related to stakeholder engagement, project implementation planning, building out service components with an expert panel, e-consult (\$60 million), and provider training (\$50 million). The Department requests authority to expend FY 2022-23 resources in this policy change through June 30, 2025.
3. Total costs are estimated to be:

Fiscal Year	TF	GF	FF
FY 2021-22	\$10,000,000	\$10,000,000	\$0
FY 2022-23	\$230,000,000	\$230,000,000	\$0

Funding:

100% General Fund (4260-101-0001)

LITIGATION RELATED SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 26
IMPLEMENTATION DATE: 7/2009
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 1381

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$9,980,000	\$9,980,000
STATE FUNDS	\$4,990,000	\$4,990,000
FEDERAL FUNDS	\$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 in FY 2021-22 from the prior estimate and in the current estimate from FY 2021-22 to FY 2022-23.

Methodology:

1. Based on prior Department of Justice litigation costs and projected workload, costs are projected to be \$7,880,000 for both FY 2021-22 and FY 2022-23.
2. Based on prior actuary costs and the Department's projected workload, costs will be \$2,100,000 in both FY 2021-22 and FY 2022-23.

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
Litigation Representation	\$7,880	\$3,940	\$3,940
Consulting Actuaries	\$2,100	\$1,050	\$1,050
Total	\$9,980	\$4,990	\$4,990

LITIGATION RELATED SERVICES
OTHER ADMIN. POLICY CHANGE NUMBER: 26

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Litigation Representation	\$7,880	\$3,940	\$3,940
Consulting Actuaries	\$2,100	\$1,050	\$1,050
Total	\$9,980	\$4,990	\$4,990

Funding:

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

MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)

OTHER ADMIN. POLICY CHANGE NUMBER: 27
IMPLEMENTATION DATE: 7/2009
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 1441

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$7,404,000	\$7,404,000
STATE FUNDS	\$2,412,000	\$2,412,000
FEDERAL FUNDS	\$4,992,000	\$4,992,000

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: 27

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 2021-22, or in the current estimate, from FY 2021-22 to FY 2022-23.

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. The projected costs for FY 2021-22 and FY 2022-23 are:

FY 2021-22	TF	GF	FF
Reporting and Tracking (50% FF / 50% GF)	\$2,244,000	\$1,122,000	\$1,122,000
Maintenance & Operations (75% FF / 25% GF)	\$5,160,000	\$1,290,000	\$3,870,000
Total	\$7,404,000	\$2,412,000	\$4,992,000

Totals differ due to rounding.

FY 2022-23	TF	GF	FF
Reporting and Tracking (50% FF / 50% GF)	\$2,244,000	\$1,122,000	\$1,122,000
Maintenance & Operations (75% FF / 25% GF)	\$5,160,000	\$1,290,000	\$3,870,000
Total	\$7,404,000	\$2,412,000	\$4,992,000

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: 28
IMPLEMENTATION DATE: 7/2014
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1824

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$6,131,000	\$6,273,000
STATE FUNDS	\$3,065,500	\$3,136,500
FEDERAL FUNDS	\$3,065,500	\$3,136,500

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. Effective July 1, 2021, Amendment A02 extended the contract for two years with a new end date of June 30, 2023. Amendment A02 added \$1,080,000 for FY 2021-22 and FY 2022-23.
- HCC contract #19-96295 began June 1, 2020, and expires June 30, 2024.

NEWBORN HEARING SCREENING PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 28

Reason for Change:

There is no change from the prior estimate for FY 2021-22. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to an update in the HCC contract.

Methodology:

1. The HCC contract for tracking and monitoring services costs for FY 2021-22 is \$5,051,000 and \$5,193,000 for FY 2022-23.
2. The Data Management Contract for the use of a vendor's data management system cost for FY 2021-22 and FY 2022-23 is \$1,080,000.
3. The estimated costs for FY 2021-22 and FY 2022-23 are as follows:

FY 2021-22	TF	GF	FF
HCC Contract	\$5,051,000	\$2,526,000	\$2,525,000
Data Management Contract	\$1,080,000	\$540,000	\$540,000
Total	\$6,131,000	\$3,066,000	\$3,065,000

FY 2022-23	TF	GF	FF
HCC Contract	\$5,193,000	\$2,597,000	\$2,596,000
Data Management Contract	\$1,080,000	\$540,000	\$540,000
Total	\$6,273,000	\$3,137,000	\$3,136,000

*Totals may differ due to rounding.

Funding:

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

PASRR

OTHER ADMIN. POLICY CHANGE NUMBER: 29
IMPLEMENTATION DATE: 7/2013
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1720

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$6,056,000	\$6,056,000
STATE FUNDS	\$1,514,000	\$1,514,000
FEDERAL FUNDS	\$4,542,000	\$4,542,000

Purpose:

This policy change estimates the contractor costs for the Preadmission Screening and Resident Review (PASRR) Level II evaluations.

Authority:

Title 42, Code of Federal Regulations 483.100-483.136, 483.200-483.206

Interdependent Policy Changes:

Not Applicable

Background:

As mandated by federal regulations, the Department contracts with an independent contractor to complete all Level II PASRR evaluations. Per this service contract, Evaluators 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 system.

Reason for Change:

There is no change in FY 2021-22 from the prior estimate.

There is no change from FY 2021-22 to FY 2022-23 in the current estimate.

Methodology:

- Expenditures for the service contract started in August 2020 and is effective until June 30, 2023. The service contract has a yearly maximum amount of \$6,056,000.
- The PASRR payments on a cash basis are estimated at:

FY 2021-22	TF	GF	FF
Evaluations	\$6,056,000	\$1,514,000	\$4,542,000

FY 2022-23	TF	GF	FF
Evaluations	\$6,056,000	\$1,514,000	\$4,542,000

PASRR
OTHER ADMIN. POLICY CHANGE NUMBER: 29

Funding:

75% Title XIX / 25% GF (4260-101-0001/0890)

ELECTRONIC ASSET VERIFICATION PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 30
IMPLEMENTATION DATE: 12/2017
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2002

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$5,621,000	\$5,621,000
STATE FUNDS	\$2,810,500	\$2,810,500
FEDERAL FUNDS	\$2,810,500	\$2,810,500

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: 30

Due to changes in federal law, and unforeseen delays in internal and external work efforts due to the ongoing COVID-19 public health emergency (PHE), the Department's objective is full electronic implementation by the end of 2021.

Reason for Change:

There is no change from the prior estimate for FY 2021-22. There is no change from FY 2021-22 to FY 2022-23.

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 1,380,000 in FY 2021-22 and FY 2022-23.
4. The reimbursement rate, based on estimated query volume, is estimated to be \$468,400 per month for FY 2021-22 and FY 2022-23.
5. The estimated vendor cost are:

FY 2021-22: \$468,400 x 12 months = **\$5,621,000 TF (\$2,811,000 GF)**

FY 2022-23: \$468,400 x 12 months = **\$5,621,000 TF (\$2,811,000 GF)**

Funding:

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

DRUG MEDI-CAL PARITY RULE ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 31
IMPLEMENTATION DATE: 11/2021
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2206

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$4,407,000	\$5,862,000
STATE FUNDS	\$1,469,000	\$1,954,000
FEDERAL FUNDS	\$2,938,000	\$3,908,000

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 (SUD) 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 SUD 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 SUD 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:

There is no change from the prior estimate for FY 2021-22.

The change in the current estimate, from FY 2021-22 to FY 2022-23, is due to an addition quarters cost included in FY 2022-23.

Methodology:

1. Payments for the Parity Rule activities began in November 2021.
2. Assume claims for the first three quarters (Q1 – Q3) will be paid in the same fiscal year, and claims for the last quarter (Q4) will be paid the following fiscal year.
3. Non-federal share of the costs will be funded through 50% General Fund (GF) and 50% County Fund (CF).

DRUG MEDI-CAL PARITY RULE ADMINISTRATION
OTHER ADMIN. POLICY CHANGE NUMBER: 31

4. The estimated Parity Rule administrative costs for FY 2021-22 and FY 2022-23 are:

FY 2021-22	TF	GF	FF	CF
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
Total	\$5,876,000	\$1,469,000	\$2,938,000	\$1,469,000

FY 2022-23	TF	GF	FF	CF
DMC Administration - Regular	\$7,522,000	\$1,881,000	\$3,760,000	\$1,881,000
DMC Administration - UR & QA	\$294,000	\$73,000	\$148,000	\$73,000
Total	\$7,816,000	\$1,954,000	\$3,908,000	\$1,954,000

Funding:

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

100% General Fund (4260-101-0001)

MEDCOMPASS SOLUTION

OTHER ADMIN. POLICY CHANGE NUMBER: 32
IMPLEMENTATION DATE: 7/2017
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 1982

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$3,770,000	\$3,984,000
STATE FUNDS	\$389,650	\$1,047,800
FEDERAL FUNDS	\$3,380,350	\$2,936,200

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

Interdependent Policy Changes:

Not Applicable

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. The Department obtained Centers for Medicare and Medicaid Services (CMS) certification approval of the MedCompass system on May 14, 2021. The Department submitted a cost recoupment change in MedCompass M&O federal financial participation (FFP), from 50% FF / 50% GF to 75% FF / 25% GF. The Department recouped 25% of the funds previously paid at 50% FF / 50% GF that are deemed eligible to be paid at 75% FF / 25% GF, for the timeframe of May 15, 2019, to May 14, 2021. The maximum recoupment amount during this time period is estimated to be \$601,257.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is an overall increase due to:

- The licensing costs for the month of June and July of 2021 were paid in July due to year-end accounting processes delaying when this invoice can be paid;
- The 10% withhold payment for completion of CMS certifying the MedCompass solution was originally anticipated to be paid in June of 2021. However, the invoice arrived after the accounting deadline; it was paid in July 2021;
- FY 2021-22 costs has also been updated to show the anticipated M&O recoupment of funds post CMS certification;
- The change request (CR) costs increased for eleven months;
- M&O costs were revised to reflect the correct Children's Health Insurance Program cost allocation percentage.

MEDCOMPASS SOLUTION
OTHER ADMIN. POLICY CHANGE NUMBER: 32

The change in costs from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to an increase in CR costs and an increase of 88 new licenses.

Methodology:

1. The estimated costs are based upon the contract provisions.
2. All costs, from October 1, 2020, to May 14, 2021, are currently paid at 50% FF/ 50% GF. Now that the system is certified, these cost, will be claimed at 75% FF/ 25% GF.
3. The current contract with MedCompass vendor, AssureCare, expired on July 31, 2021. The Department will exercise the contract extension option for three years to prevent any lapse in services for FY 2021-22.

FY 2021-22	TF	GF	FF
M&O	\$3,640,000	\$957,000	\$2,683,000
10% Payment to vendor (Post Certification)	\$130,000	\$34,000	\$96,000
M&O Recoupment of Funds Post Certification	\$0	(\$601,000)	\$601,000
Total FY 2021-22	\$3,770,000	\$390,000	\$3,380,000

*Totals may differ due to rounding

FY 2022-23	TF	GF	FF
M&O	\$3,984,000	\$1,048,000	\$2,936,000
Total FY 2022-23	\$3,984,000	\$1,048,000	\$2,936,000

*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)
 100% Title XIX FFP (4260-101-0890)
 100% GF (4260-101-0001)
 65% Title XXI / 35% GF (4260-113-0890/0001)

PACES

OTHER ADMIN. POLICY CHANGE NUMBER: 33
IMPLEMENTATION DATE: 9/2016
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 1972

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$2,799,000	\$3,361,000
STATE FUNDS	\$424,000	\$749,600
FEDERAL FUNDS	\$2,375,000	\$2,611,400

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
 Contract # 17-94060
 Contract # 22-20002
 Contract # 20-10301
 Contract # 20-10347
 Contract # 20-10349
 Contract # 20-10348

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 or a contracted managed care arrangement. PACES play a vital role in the collection of encounter and provider network data from Medi-Cal's numerous managed care plans. PACES accept 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

PACES
OTHER ADMIN. POLICY CHANGE NUMBER: 33

Delivery System counties. Extending the 274 process to behavioral health and dental will allow the Department to monitor the networks within those models.

Reason for Change:

There is no change from the prior estimate, for FY 2021-2022.

The change in the current estimate, from FY 2021-22 to FY 2022-23, is an increase due to the replacement of all the existing maintenance and operations (M&O) and design, development, and implementation (DD&I) services contracts excluding the Project Manager contract that will expire in October 2021.

Methodology:

1. Includes ongoing cloud platform and services costs of \$350,000 annually.
2. A Project Manager contractor in support of new efforts to extend PACES interfaces and process new data sources started providing services at the beginning of October 2020 through October 2021 for a total contract value of \$250,000.
3. A new 5-year contract for a vendor to provide M&O and DD&I services is estimated to start providing services at the beginning of October 2022 through September 2027 for an estimated total contract value of \$16,250,000.
4. Total costs are estimated to be:

FY 2021-22	TF	GF	FF
DD&I	\$1,948,000	\$249,000	\$1,700,000
M&O	\$500,000	\$131,000	\$369,000
Cloud Hosting Services	\$350,000	\$45,000	\$305,000
Total	\$2,798,000	\$425,000	\$2,374,000

Totals may differ due to rounding.

FY 2022-23	TF	GF	FF
DD&I	\$636,000	\$81,000	\$555,000
M&O	\$2,375,000	\$624,000	\$1,751,000
Cloud Hosting Services	\$350,000	\$45,000	\$305,000
Total	\$3,361,000	\$750,000	\$2,611,000

Totals may differ due to rounding.

Funding:

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

75% Title XIX / 25% GF (4260-101-0001/0890)

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

100% State GF (4260-101-0001)

PACES**OTHER ADMIN. POLICY CHANGE NUMBER: 33**

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – Other Admin policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – Other Admin policy change.

MEDI-CAL NONMEDICAL TRANSPORTATION

OTHER ADMIN. POLICY CHANGE NUMBER: 34
IMPLEMENTATION DATE: 3/2021
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2073

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$2,704,000	\$2,724,000
STATE FUNDS	\$727,000	\$737,000
FEDERAL FUNDS	\$1,977,000	\$1,987,000

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 FI optional contractual services to cover the cost of NMT technology costs. By March 2022, the Department anticipates that the Medical FI will have technology in place to process

MEDI-CAL NONMEDICAL TRANSPORTATION

OTHER ADMIN. POLICY CHANGE NUMBER: 34

the beneficiary reimbursements. A State Plan Amendment will be necessary to implement mileage reimbursement.

Reason for Change:

There is no change from the prior estimate for FY 2021-22.

The change in the current estimate, from FY 2021-22 to FY 2022-23, is due to higher mileage reimbursement costs as a result of an increase in the number of round trips estimated in FY 2022-23.

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. Phase II activities for NMT began in July 2021 using the current manual process for intake, transport scheduling and reporting. By March 2022, the Medical FI will have technology in place to process the beneficiary reimbursements.
3. Assume the Department will expand its Medical FI optional contractual services by \$2,500,000 TF in both FY 2021-22 and FY 2022-23 to cover the cost of NMT technology costs.
4. Activities for the Medical FI contract started in March 2021.
5. Assume that eligible FFS beneficiaries requesting mileage reimbursement will make approximately 43,500 round trips in FY 2021-22, and 47,850 round trips in FY 2022-23.
6. Assume that 90% of the trips will average 25 miles per round trip and 10% will average 50 miles per round trip.
7. 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.
8. Assume the total mileage reimbursements for round trips costs for FFS beneficiaries would total \$204,000 TF in FY 2020-21, and \$224,000 in FY 2022-23.
9. Total costs for NMT services is estimated to be:

FY 2021-22	TF	GF	FF
Medical FI Contract*	\$2,500,000	\$625,000	\$1,875,000
Mileage Reimbursement	\$204,000	\$102,000	\$102,000
Total	\$2,704,000	\$727,000	\$1,977,000

MEDI-CAL NONMEDICAL TRANSPORTATION
OTHER ADMIN. POLICY CHANGE NUMBER: 34

FY 2022-23	TF	GF	FF
Medical FI Contract*	\$2,500,000	\$625,000	\$1,875,000
Mileage Reimbursement	\$224,000	\$112,000	\$112,000
Total	\$2,724,000	\$737,000	\$1,987,000

Funding:

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

*FI 75% Title XIX / 25% GF (4260-101-0001/0890)

T-MSIS

OTHER ADMIN. POLICY CHANGE NUMBER: 35
IMPLEMENTATION DATE: 9/2013
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 1768

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$1,855,000	\$2,747,000
STATE FUNDS	\$283,900	\$399,500
FEDERAL FUNDS	\$1,571,100	\$2,347,500

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 433.120
 CMS Informational Bulletin: T-MSIS State Compliance

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS Admin
 COVID-19 Increased FMAP Extension – Other 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. On August 10, 2018, CMS issued a State Health Official (SHO) letter (#18-008) 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 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

OTHER ADMIN. POLICY CHANGE NUMBER: 35

- 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 submitted an IAPD in July 2020 to request enhanced funding to procure contractor services to manage the additional workload in order to meet the T-MSIS requirements. In October 2020, the Department received a CMS Request for Additional Information (RAI) letter. A response to the RAI was submitted in November of 2020. In December of 2020, CMS granted approval for the IAPDU for FFY 2021.

To date, the contractors have not been procured due to internal delays in completing the RFO. The contracts timeline has been revised to December 2021 – November 2022, with payments expected to begin in January 2022. There will be no change in the total cost of the contracts. The FFY 2022 IAPD was submitted to CMS in September 2021. The IAPD will include a request for revised funding for the contractor costs in FFY 2022, as the allocated amount was not utilized in the FFY 2021.

Beginning FY 2021-22, 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:

The change from the prior estimate for FY 2021-22, is a decrease due to contract and Request for Offer (RFO) delays. The revised timeline is December 2021 – November 2022, with payments expected to begin in January 2022.

The change in the current estimate, from FY 2021-22 to FY 2022-23 is an increase due to contract and RFO delays.

Methodology:

1. Support and maintenance for Data Quality was procured in February 2020 and the re-procurement was executed in December 2020. Data Quality is a module within the Informatica tool, which validates system data.
2. The software maintenance renewal for PowerCenter was executed December 2020. PowerCenter is a separate module within the Informatica tool, which extracts, transforms, and loads system data.

T-MSIS
OTHER ADMIN. POLICY CHANGE NUMBER: 35

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.
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 payments will begin in January 2022.

FY 2021-22	TF	GF	FF
M&O	\$354,000	\$93,000	\$261,000
Design, Development, and Implementation (DD&I)	\$1,501,000	\$192,000	\$1,309,000
Total	\$1,855,000	\$285,000	\$1,570,000

Totals may differ due to rounding.

FY 2022-23	TF	GF	FF
M&O	\$372,000	\$98,000	\$274,000
DD&I	\$2,375,000	\$302,000	\$2,073,000
Total	\$2,747,000	\$400,000	\$2,347,000

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)

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

100% State GF (4260-101-0001)

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – DHCS Admin policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – Other Admin policy change.

SDMC SYSTEM M&O SUPPORT

OTHER ADMIN. POLICY CHANGE NUMBER: 36
IMPLEMENTATION DATE: 7/2013
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 1732

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$2,325,000	\$2,325,000
STATE FUNDS	\$1,162,500	\$1,162,500
FEDERAL FUNDS	\$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 two-year contract with two one-year optional year extensions in June of 2018. The executed contract executed the initial two-years without optional years, from July 1, 2018, to June 30, 2020. In April 2020, the Department executed the first optional year extension, extending the contract through June 30, 2021. In April of 2021, the Department executed the second optional year extension, extending the contract through June 30, 2022. The Department is now in the process of securing a new six-year contract with two one-year optional extensions. The new contract is planned to begin July 1, 2022, and end June 30, 2030, assuming options years are executed.

Reason for Change:

There is no change from the prior estimate, for FY 2021-22, or in the current estimate, from FY 2021-22 to FY 2022-23.

Methodology:

1. The contractor cost for the current 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: 36

FY 2021-22	TF	GF	FF
M&O	\$1,992,000	\$996,000	\$996,000
Software	\$333,000	\$167,000	\$166,000
Total	\$2,325,000	\$1,163,000	\$1,162,000

Totals may differ due to rounding.

FY 2022-23	TF	GF	FF
M&O	\$1,992,000	\$996,000	\$996,000
Software	\$333,000	\$167,000	\$166,000
Total	\$2,325,000	\$1,163,000	\$1,162,000

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: 37
IMPLEMENTATION DATE: 1/1989
ANALYST: Neejkajsiab Yang
FISCAL REFERENCE NUMBER: 237

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$1,718,000	\$1,476,000
STATE FUNDS	\$859,000	\$738,000
FEDERAL FUNDS	\$859,000	\$738,000

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 2021-22, from the prior estimate, is an increase due to updated actual billings were higher than estimated, and an increase in the projected average quarterly estimate.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease based on lower quarterly estimates used to project FY 2022-23. The FY 2022-23 estimate is based on the current actual billings from SSA for FY 2019-20, FY 2020-21, and the projection for FY 2021-22.

Methodology:

- The following projections are averaged based upon the most current actual billings from SSA.

Fiscal Year	TF	GF	FF
FY 2021-22	\$1,718,000	\$859,000	\$859,000
FY 2022-23	\$1,476,000	\$738,000	\$738,000

Funding:

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

CALIFORNIA HEALTH INTERVIEW SURVEY

OTHER ADMIN. POLICY CHANGE NUMBER: 38
IMPLEMENTATION DATE: 7/2015
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1902

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$1,400,000	\$1,400,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,400,000	\$1,400,000

Purpose:

This policy change estimates the California Health Interview Survey (CHIS) contract services costs.

Authority:

Interagency Agreement (IA) 21-10053

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, 2021, through June 30, 2027, at which point a new seven-year contract will be executed.

Reason for Change:

The change from the previous estimate, for FY 2021-22, is an increase due to higher associated contract costs. There is no change from FY 2021-22 to FY 2022-23 in the current estimate.

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 FY 2021-22, the CHIS contract was renewed and the annual reimbursement amount was increased.
3. On an accrual basis, beginning FY 2021-22, the maximum reimbursable amount for California Health Interview Survey is \$1,400,000 FF annually.

CALIFORNIA HEALTH INTERVIEW SURVEY
OTHER ADMIN. POLICY CHANGE NUMBER: 38

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 2021-22 and FY 2022-23, on a cash basis, are:

(Dollars in Thousands)

FY 2021-22	TF	FF
FY 2020-21 Claims	\$700	\$700
FY 2021-22 Claims	\$700	\$700
Total	\$1,400	\$1,400

FY 2022-23	TF	FF
FY 2021-22 Claims	\$700	\$700
FY 2022-23 Claims	\$700	\$700
Total	\$1,400	\$1,400

*Totals may differ due to rounding.

Funding:

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

ENCRYPTION OF PHI DATA

OTHER ADMIN. POLICY CHANGE NUMBER: 39
IMPLEMENTATION DATE: 5/2010
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 1452

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$1,208,000	\$1,500,000
STATE FUNDS	\$604,000	\$750,000
FEDERAL FUNDS	\$604,000	\$750,000

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 implemented 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 current 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 protecting PHI data. The next phase is for the Department to adopt the approach of the principle of least privilege to restrict access to PHI data by managing elevated privilege accounts. Administrators have the enormous responsibility of managing access rights, sharing and storage of sensitive PHI/Personally Identifiable Information data, which should be protected from abuse at all, times.

To ensure accountability of Department's administrators and employees with access to PHI data, the Department is focusing on implementing Privilege Access Management (PAM). The Department is continuing to implement the Principles of Confidentiality, Integrity and Availability in the most secure manner available. The implementation of managed Privilege Access will greatly reduce the Departments inherent risk pertaining to account compromise, privilege escalation and lateral movement. This will have the residual effect of deterring breaches and cutting off the spread of ransomware before it is allowed to propagate across the organization.

ENCRYPTION OF PHI DATA

OTHER ADMIN. POLICY CHANGE NUMBER: 39

Reason for Change:

The change from the prior estimate, for FY 2021-22, is an increase due to the implementation of PAM.

The change in the current estimate, from FY 2021-22 to FY 2022-23, is an increase due to the expansion of PHI protection through PAM and licensing, support, and maintenance costs associated with the PAM solution.

Methodology:

1. 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)

2. Initial and annual costs include licensing, software maintenance, implementation and contracted personnel to perform the administrative functions of the solution.
 - a. PAM – a solution that requires privilege users to “check-out” their individual privileged account that logs all actions performed by that user in the privileged session. (\$250,000)
 - b. Two contractors to plan, design, and implement the PAM solution as well as performing on-going administration, maintenance, and department adoption into different areas of operation. (\$500,000)

3. The following amounts are based upon the latest projections of cost:

Fiscal Year	TF	GF	FF
FY 2021-22	\$1,208,000	\$604,000	\$604,000
FY 2022-23	\$1,500,000	\$750,000	\$750,000

Funding:

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

FAMILY PACT PROGRAM ADMIN.

OTHER ADMIN. POLICY CHANGE NUMBER: 40
IMPLEMENTATION DATE: 7/2012
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1675

	FY 2021-22	FY 2022-23
TOTAL FUNDS	\$1,207,000	\$1,207,000
STATE FUNDS	\$120,700	\$120,700
FEDERAL FUNDS	\$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 2021-22. There is no change from FY 2021-22 to FY 2022-23 in the current estimate.

FAMILY PACT PROGRAM ADMIN.
OTHER ADMIN. POLICY CHANGE NUMBER: 40**Methodology:**

1. The administrative costs for the Family PACT program are estimated in the table below:

Fiscal Year	TF	GF	FF
FY 2021-22	\$1,207,000	\$120,700	\$1,086,300
FY 2022-23	\$1,207,000	\$120,700	\$1,086,300

Funding:

90% Family Planning / 10% GF (4260-101-0890/0001)

MMA - DSH ANNUAL INDEPENDENT AUDIT

OTHER ADMIN. POLICY CHANGE NUMBER: 41
IMPLEMENTATION DATE: 7/2009
ANALYST: Elena Susbilla
FISCAL REFERENCE NUMBER: 266

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$773,000	\$800,000
STATE FUNDS	\$386,500	\$400,000
FEDERAL FUNDS	\$386,500	\$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 2021-22, from the prior estimate, is due to lower actual invoice amounts for May 2021 and June 2021 than originally estimated.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to higher estimated payments in 2022-23 based on an estimated monthly average of the total contract amount.

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 2021-22, the Department will make payments for the FY 2017-18 and FY 2018-19 audit invoices.
3. In FY 2022-23, the Department will make payments for the FY 2018-19 and FY 2019-20 audit invoices.

Fiscal Year	TF	GF	FF
FY 2021-22	\$773,000	\$386,000	\$387,000
FY 2022-23	\$800,000	\$400,000	\$400,000

Funding:

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

CCT OUTREACH - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 42
IMPLEMENTATION DATE: 4/2011
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1556

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$340,000	\$340,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$340,000	\$340,000

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
 Consolidated Appropriations Act, 2021 (P.L. 108-361) Section 204

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: 42

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.

On December 27, 2020, the President signed the Consolidated Appropriations Act, 2021 into law, which includes an extension of the MFP grant through FFY 2023 and appropriates funding through 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.

Reason for Change:

There is no change from the prior estimate, for FY 2021-22. There is no change, in the current estimate, from FY 2021-22 to FY 2022-23.

Methodology:

1. Assume \$340,000 from the MFP grant administrative funding is expected to be paid in FY 2021-22 and FY 2022-23.
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
 - ARDC Workgroup.

CCT OUTREACH - ADMINISTRATIVE COSTS
OTHER ADMIN. POLICY CHANGE NUMBER: 42

FY 2021-22	TF	GF	FF
CCT Costs (PC 40):			
Non-DD GF costs and Total FFP	\$8,544,000	\$6,453,000	\$2,091,000
State-Funded CCT Population	\$3,766,000	\$1,238,000	\$2,528,000
FFCRA 3.1% Increased FFP	\$0	\$168,000	(\$168,000)
Total Costs	\$12,310,000	\$7,859,000	\$4,451,000
CCT Savings:			
Total Non-DD GF savings and Total FFP	(\$46,219,000)	(\$23,826,000)	(\$22,393,000)
CCT Fund Transfer to CDSS (PC 51):			
CCT Fund Transfer Costs	\$141,000	\$0	\$141,000
FFCRA 3.1% Increased FFP	\$9,000	\$0	\$9,000
Total Costs	\$150,000	\$0	\$150,000
CCT Outreach - Admin costs (OA 42)	\$340,000	\$0	\$340,000
Total of CCT PCs including pass through	(\$33,419,000)	(\$15,967,000)	(\$17,452,000)

*The savings are included in the total, however, they are fully reflected in the base estimates.

CCT OUTREACH - ADMINISTRATIVE COSTS
OTHER ADMIN. POLICY CHANGE NUMBER: 42

FY 2022-23	TF	GF	FF
CCT Costs (PC 40):			
Non-DD GF costs and Total FFP	\$9,286,000	\$7,017,000	\$2,269,000
State-Funded CCT Population	\$3,766,000	\$1,238,000	\$2,528,000
Total Cost	\$13,052,000	\$8,255,000	\$4,797,000
CCT Savings:			
Total Non-DD GF savings and Total FFP	(\$63,419,000)	(\$31,710,000)	(\$31,709,000)
CCT Fund Transfer to CDSS (PC 51):	\$165,000	\$0	\$165,000
CCT Outreach - Admin costs (OA 42)	\$340,000	\$0	\$340,000
Total of CCT PCs including pass through	(\$49,862,000)	(\$23,455,000)	(\$26,407,000)

*The savings are included in the total, however, they are fully reflected in the base estimates.

Funding:

MFP Federal Grant (4260-106-0890)

LTSS ACTUARIAL STUDY

OTHER ADMIN. POLICY CHANGE NUMBER: 43
IMPLEMENTATION DATE: 7/2020
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2143

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$100,000	\$0
STATE FUNDS	\$100,000	\$0
FEDERAL FUNDS	\$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 analyzed the potential costs of various LTSS benefits designs for older adults and individuals living with disabilities. The study was 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 for FY 2021-22, from the prior estimate, is an increase due to timing for receipt of the final invoice. The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to the expectation that all remaining payments for this PC will be made in FY 2021-22.

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 2021-22	\$100,000	\$100,000

Funding:

100% GF (4260-101-0001)

COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE

OTHER ADMIN. POLICY CHANGE NUMBER: 44
IMPLEMENTATION DATE: 11/2022
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2334

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$0	\$48,143,000
STATE FUNDS	\$0	\$19,201,000
FEDERAL FUNDS	\$0	\$28,942,000

Purpose:

This policy change estimates the costs for funding counties to implement changes to stay in compliance with the federal data exchange standards and regulations of the Interoperability Final Rule.

Authority:

Interoperability Final Rule (CMS-9115-F)

Interdependent Policy Changes:

Not Applicable

Background:

On May 1, 2020, the Centers for Medicare and Medicaid Services (CMS) published the "CMS Interoperability and Patient Access final rule" to further advance interoperability for Medicaid and Children's Health Insurance Program (CHIP) providers and improve beneficiaries' access to their data. The final rule requirements include county support of payer to payer data exchange as requested by patients and patient access to their health information. Given the federal mandate, this proposal results in a Proposition 30 impact where the non-federal share of costs for counties to come into compliance is split between counties and the state. Federal law already requires Medi-Cal managed care plans to comply with the data exchange standards and regulations.

Reason for Change:

This is a new policy change.

Methodology:

1. Assume incentive payments to counties will begin in November 2022.
2. Total estimated costs to implement interoperability final rule over two years is estimated to be \$96,285,000 TF (\$38,402,000 GF).
3. The estimated payments in FY 2022-23 are:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF	CF
Interoperability Final Rule	\$67,344	\$19,201	\$28,942	\$19,201
Total	\$67,344	\$19,201	\$28,942	\$19,201

COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE
OTHER ADMIN. POLICY CHANGE NUMBER: 44

Funding:

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

100% General Fund (4260-101-0001)

MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 45
IMPLEMENTATION DATE: 1/2023
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2321

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$0	\$1,000,000
STATE FUNDS	\$0	\$500,000
FEDERAL FUNDS	\$0	\$500,000

Purpose:

This policy change estimates the cost of the Department's contract with public or private entities for the purpose of assisting dual eligible beneficiaries with enrollment, benefit, and access questions for Medicare and Medi-Cal managed care plans.

Authority:

AB 133 (Budget Act of FY 2021-22)

Interdependent Policy Changes:

Not Applicable

Background:

The Health Omnibus within the 2021 Budget Act requires that the Department contract with public or private entities to assist dual eligible beneficiaries understand their health care coverage options, overcome barriers in their access to care, and address eligibility and enrollment barriers. This contract is intended to enable the continuation and expansion of the existing CalMediConnect (CMC) Independent Ombudsman, which offers ombudsman services to CMC beneficiaries. The ombudsman service is performed by an independent, third party firm, allowing for more objective analysis and observation, and was designed to:

- Assist potential enrollees
- Assist enrollees filing appeals and complaints when needed
- Investigate, negotiate, and resolve enrollee problems/complaints with CMC plans

The Budget Act of FY 2021-22 requires the Department to oversee a contract that will continue this independent ombudsman program to provide these services to dual eligible beneficiaries after the transition of CMC to a Dual Eligible Special Needs Plan (D-SNP) aligned enrollment model.

Reason for Change:

This is a new policy change.

Methodology:

1. Annual contract costs are expected to be \$2,000,000.
2. Implementation of this contract is expected to be January 2023.
3. The anticipated FY 2022-23 costs of this contract are:

MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM
OTHER ADMIN. POLICY CHANGE NUMBER: 45

Fiscal Year	TF	GF	FF
FY 2022-23	\$1,000,000	\$500,000	\$500,000

Funding:

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

COVID-19 INCREASED FMAP - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 46
IMPLEMENTATION DATE: 7/2021
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2216

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$1,625,000	\$0
FEDERAL FUNDS	\$1,625,000	\$0

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 December 2021. For the estimated impact of assuming increased FMAP from January 2020 through December 2021 on benefits expenditures, see the COVID-19 Increased FMAP – DHCS policy change.

Authority:

Families First Coronavirus Response Act (FFCRA)
 Coronavirus Aid, Relief, and Economic Security (CARES) Act

Interdependent Policy Changes:

COVID-19 Increased FMAP Extension
 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. 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:

For dollars budgeted in this policy change, there is a decrease in general fund savings from the prior estimate for FY 2021-22 due to policy change updates. There is a decrease in general fund savings from FY 2021-22 to FY 2022-23 due to the end of the public health emergency.

COVID-19 INCREASED FMAP - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 46

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 December 31, 2021, in this policy change.
3. The impact of a six month extension of the FFCRA increased FMAP through June 30, 2022, 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)

FY 2021-22	TF	GF	SF	FF
COVID-19 Increased FMAP - DHCS:				
FFCRA 6.20% Increased FFP	\$0	(\$1,922,148)	\$0	\$1,922,148
FFCRA 4.34% Increased FFP	\$0	(\$95,062)	\$0	\$95,062
BCCTP 4.34% Increased FFP	\$0	(\$15)	\$0	\$15
Medicare Part D FFCRA 6.20% Incr. FFP	(\$126,670)	(\$126,670)	\$0	\$0
Behavioral Health FFCRA 6.20% Incr. FFP	\$5,840	(\$160)	\$0	\$6,001
Behavioral Health FFCRA 4.34% Incr. FFP	\$422	(\$1)	\$0	\$423
Total COVID-19 Incr. FMAP - Regular:	(\$120,408)	(\$2,144,056)	\$0	\$2,023,649
COVID-19 Increased FMAP - Other Admin:				
FFCRA 4.34% Increased FFP	\$0	(\$1,625)	\$0	\$1,625
Total COVID-19 Incr. FMAP - Other Admin:	\$0	(\$1,625)	\$0	\$1,625
COVID-19 Increased FMAP In other PCs:				
FFCRA 6.20% Increased FFP	\$755,301	(\$136,373)	(\$284,904)	\$1,176,577
FFCRA 4.34% Increased FFP	\$10,167	(\$13,813)	(\$6,789)	\$30,769
FFCRA 4.34% Incr. FFP - Other Admin	\$0	\$0	\$0	\$0
Medicare Part D FFCRA 6.20% Incr. FFP	(\$78,639)	(\$78,639)	\$0	\$0
Total COVID-19 Incr. FMAP In other PCs:	\$686,829	(\$228,825)	(\$291,693)	\$1,207,346
COVID-19 Increased FMAP Extension PC:				
FFCRA 6.20% Increased FFP	(\$25,309)	(\$1,197,394)	\$0	\$1,172,085
FFCRA 4.34% Increased FFP	(\$5,030)	(\$49,757)	\$0	\$44,727

COVID-19 INCREASED FMAP - OTHER ADMIN
OTHER ADMIN. POLICY CHANGE NUMBER: 46

BCCTP 4.34% Increased FFP	\$0	(\$12)	\$0	\$12
Medicare Part D FFCRA 6.20% Incr. FFP	(\$109,571)	(\$109,571)	\$0	\$0
FFCRA Special Funds Increased FMAP	\$98,339	(\$435)	(\$63,493)	\$162,267
Other Departments 6.20% Increased FFP	\$640,140	(\$1,597)	\$0	\$641,737
Prop 56 FFCRA 6.20% Increased FFP	\$0	\$0	(\$33,998)	\$33,998
Prop 56 FFCRA 4.34% Increased FFP	\$0	\$0	(\$4,767)	\$4,767
Total COVID-19 Increased FMAP Extension PC:	\$598,569	(\$1,358,766)	(\$102,258)	\$2,059,593
Total COVID-19 Increased FMAP Extension - Other Admin PC:	\$0	(\$737)	\$0	\$737
Total of PCs including COVID-19 Increased FMAP	\$1,164,990	(\$3,734,009)	(\$393,951)	\$5,292,950

*Totals may differ due to rounding.

(Dollars in Thousands)

FY 2022-23	TF	GF	SF	FF
COVID-19 Increased FMAP - DHCS:				
FFCRA 6.20% Increased FFP	\$0	\$6,764	\$0	(\$6,764)
FFCRA 4.34% Increased FFP	\$0	\$0	\$0	\$0
BCCTP 4.34% Increased FFP	\$0	\$0	\$0	\$0
Medicare Part D FFCRA 6.20% Increased FFP	\$0	\$0	\$0	\$0
Behavioral Health FFCRA 6.20% Incr. FFP	\$0	\$0	\$0	\$0
Behavioral Health FFCRA 4.34% Incr. FFP	\$0	\$0	\$0	\$0
Total COVID-19 Incr. FMAP - Regular:	\$0	\$6,764	\$0	(\$6,764)
COVID-19 Increased FMAP - Other Admin:				
FFCRA 4.34% Increased FFP	\$0	\$0	\$0	\$0
Total COVID-19 Incr. FMAP - Other Admin:	\$0	\$0	\$0	\$0
COVID-19 Increased FMAP In other PCs:				
FFCRA 6.20% Increased FFP	\$483,933	(\$154,115)	(\$110,732)	\$748,780
FFCRA 4.34% Increased FFP	\$0	(\$8,794)	(\$6,864)	\$15,658
FFCRA 4.34% Incr. FFP - Other Admin	\$0	\$0	\$0	\$0
Medicare Part D FFCRA 6.20% Incr. FFP	\$0	\$0	\$0	\$0
Total COVID-19 Incr. FMAP In other PCs:	\$483,933	(\$162,909)	(\$117,596)	\$764,438
COVID-19 Increased FMAP Extension PC:				

COVID-19 INCREASED FMAP - OTHER ADMIN
OTHER ADMIN. POLICY CHANGE NUMBER: 46

FFCRA 6.20% Increased FFP	\$18,423	(\$496,438)	\$0	\$514,861
FFCRA 4.34% Increased FFP	\$0	(\$29,711)	\$0	\$29,711
BCCTP 4.34% Increased FFP	\$0	\$0	\$0	\$0
Medicare Part D FFCRA 6.20% Incr. FFP	(\$55,058)	(\$55,058)	\$0	\$0
FFCRA Special Funds Increased FMAP	(\$1,201)	\$97,136	(\$296,362)	\$198,025
Other Departments 6.20% Increased FFP	\$54,180	\$0	\$0	\$54,180
Prop 56 FFCRA 6.20% Increased FFP	\$0	\$0	(\$8,391)	\$8,391
Prop 56 FFCRA 4.34% Increased FFP	\$0	\$0	(\$778)	\$778
Total COVID-19 Increased FMAP Extension PC:	\$16,344	(\$484,071)	(\$305,531)	\$805,946
Total COVID-19 Increased FMAP Extension - Other Admin PC:	\$0	(\$369)	\$0	\$369
Total of PCs including COVID-19 Increased FMAP	\$500,277	(\$640,585)	(\$423,127)	\$1,563,989

*Totals may differ due to rounding.

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: 47
IMPLEMENTATION DATE: 7/2021
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 2123

	FY 2021-22	FY 2022-23
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$4,804,000	\$0
FEDERAL FUNDS	-\$4,804,000	\$0

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 policy change. See the CMS Deferred Claims policy change for more information.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is due to the repayment of actual deferrals for FFY 2020 Q1 and FFY 2020 Q2, and estimating the resolution of the Low Income Health Program (LIHP) deferrals in a future FY.

CMS DEFERRED CLAIMS - OTHER ADMIN
OTHER ADMIN. POLICY CHANGE NUMBER: 47**Methodology:**

1. In FY 2021-22, the Department has repaid a total of \$4.8 million FF for CMS deferrals issued for FFY 2021 Q1 and FFY 2021 Q2.

FY 2021-22	Total Estimated Repayment
FFY 2021 Quarter 1 (Oct - Dec 2020)	\$4,552,000
FFY 2021 Quarter 2 (Jan - Mar 2021)	\$252,000
Total FY 2021-22	\$4,804,000

Funding:

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

MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 48
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2119

	FY 2021-22	FY 2022-23
TOTAL FUNDS	\$48,420,000	\$49,197,000
STATE FUNDS	\$12,726,600	\$12,930,750
FEDERAL FUNDS	\$35,693,400	\$36,266,250

Purpose:

This policy change estimates the cost of the IBM Medical Fiscal Intermediary (FI) contract IT Operations and Development Services.

Authority:

IBM Contract # 18-95302

Interdependent Policy Changes:

COVID-19 Increased FMAP – Other Admin
 COVID-19 Increased FMAP Extension – Other Admin

Background:

The IBM 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 M&O 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 M&O Services
- Project Management Office

Reason for Change:

There is no change from the prior estimate for FY 2021-22.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to the Consumer Price Index (CPI) being applied in FY 2022-23.

MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 48

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. Beginning contract year 3 and each year thereafter through the end of the IBM contract, CPI adjustments are applied annually to the contract cost.

FY 2021-22	TF	GF	FF
Application Development Services	\$33,235,000	\$8,736,000	\$24,499,000
Application M&O Services	\$9,167,000	\$2,409,000	\$6,758,000
Project Management Office	\$6,018,000	\$1,582,000	\$4,436,000
Total	\$48,420,000	\$12,727,000	\$35,693,000

FY 2022-23	TF	GF	FF
Application Development Services	\$34,012,000	\$8,940,000	\$25,072,000
Application M&O Services	\$9,167,000	\$2,409,000	\$6,758,000
Project Management Office	\$6,018,000	\$1,582,000	\$4,436,000
Total	\$49,197,000	\$12,931,000	\$36,266,000

Funding:

FI 75% Title XIX FF / 25% GF (4260-101-0001/0890)

FI 100% GF (4260-101-0001)

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

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP – Other Admin DHCS policy change

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – Other Admin policy change

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 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$46,251,000	\$44,812,000
STATE FUNDS	\$13,131,950	\$12,753,650
FEDERAL FUNDS	\$33,119,050	\$32,058,350

Purpose:

This policy change estimates the total cost reimbursement of the Gainwell Medical Fiscal Intermediary (FI) contracts.

Authority:

Gainwell Contract # 18-95357
IBM Contract # 18-95302

Interdependent Policy Changes:

COVID-19 Increased FMAP – Other Admin
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
 - Postal rates utilized to mail documents to providers, beneficiaries, the State, the federal government, or any other Medi-Cal or State program-related business. Return envelope postage is also reimbursable.
- Parcel Services and Common Carriers
 - The actual charges paid for parcel services and common carriers for the delivery of: Medi-Cal and other health program claim and Treatment Authorization Request (TAR) forms to providers; and documents, materials, and equipment to providers, beneficiaries, and State or federal offices.

MEDICAL FI BO & IT COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 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.

MEDICAL FI BO & IT COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 49

- Sales Tax
 - The Department will reimburse the contractor only for the actual sales and/or use tax paid by the Contractor to the California Board of Equalization for the operations of this contract.
- Audits and Research
 - Annual audits for the Electronic Data Processing Application System shall be cost reimbursed for the direct cost of the audit as paid to the independent auditor by the contractor, excluding procurement costs or effort expended by the contractor.
- Change Order and/or Amendments
 - Certain costs associated with Contract Change Orders/Amendments can be paid through Cost Reimbursement.

Costs under these categories consist of direct costs, or subsets thereof, which can be specifically identified with the particular cost objective.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is due to marginal increases in Equipment & Services and Consultant Contracts.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to reductions in Consultant Contracts.

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. Beginning contract year 3 and each year thereafter through the end of the Gainwell and IBM contracts, CPI adjustments are applied annually to the contract cost.

MEDICAL FI BO & IT COST REIMBURSEMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 49

FY 2021-22	TF	GF	FF
Postage (50% FF / 50% GF)	\$1,668,000	\$816,000	\$852,000
Parcel Services & Common Carriers (50% FF / 50% GF)	\$261,000	\$128,000	\$133,000
Equipment & Services (75% FF / 25% GF)	\$7,365,000	\$1,935,000	\$5,430,000
Facilities Improvement & Modification (75% FF / 25% GF)	\$9,268,000	\$2,436,000	\$6,832,000
Consultant Contracts (50% FF / 50% GF, 75% FF / 25% GF, 90% FF / 10% GF)	\$23,076,000	\$6,013,000	\$17,063,000
Telecommunications & Data Center (75% FF / 25% GF)	\$1,460,000	\$407,000	\$1,053,000
Other Cost Reimbursable Items (50% FF / 50% GF, 75% FF / 25% GF)	\$3,153,000	\$1,397,000	\$1,756,000
Total	\$46,251,000	\$13,132,000	\$33,119,000

FY 2022-23	TF	GF	FF
Postage (50% FF / 50% GF)	\$1,668,000	\$817,000	\$851,000
Parcel Services & Common Carriers (50% FF / 50% GF)	\$261,000	\$128,000	\$133,000
Equipment & Services (75% FF / 25% GF)	\$7,547,000	\$1,984,000	\$5,563,000
Facilities Improvement & Modification (75% FF / 25% GF)	\$9,526,000	\$2,504,000	\$7,022,000
Consultant Contracts (50% FF / 50% GF, 75% FF / 25% GF, 90% FF / 10% GF)	\$21,197,000	\$5,518,000	\$15,679,000
Telecommunications & Data Center (75% FF / 25% GF)	\$1,460,000	\$406,000	\$1,054,000
Other Cost Reimbursable Items (50% FF / 50% GF, 75% FF / 25% GF)	\$3,153,000	\$1,397,000	\$1,756,000
Total	\$44,812,000	\$12,754,000	\$32,058,000

MEDICAL FI BO & IT COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 49

Funding:

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

FI 100% GF (4260-101-0001)

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

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)

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP – Other Admin DHCS policy change

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension –Other Admin policy change

MEDICAL FI IT INFRASTRUCTURE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 50
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2118

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$30,681,000	\$30,450,000
STATE FUNDS	\$8,064,800	\$8,004,200
FEDERAL FUNDS	\$22,616,200	\$22,445,800

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

Interdependent Policy Changes:

COVID-19 Increased FMAP – Other Admin
 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

Reason for Change:

There is no change from the prior estimate for FY 2021-22.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to minimal reductions to estimated infrastructure costs.

MEDICAL FI IT INFRASTRUCTURE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 50

Methodology:

1. Costs are paid under an hourly rate or via a fixed price negotiated during the procurement phase of the contract.
2. Contract costs are shared between Federal Funds (FF) and General Funds (GF).
3. Beginning contract year 3 and each year thereafter through the end of the IBM contract, CPI adjustments are applied annually to the contract cost.

FY 2021-22	TF	GF	FF
Mainframe Data Center Operations Services	\$5,410,000	\$1,422,000	\$3,988,000
Midrange Data Center Operations Services	\$2,916,000	\$767,000	\$2,149,000
Midrange Storage Operations Services	\$255,000	\$67,000	\$188,000
Managed Network Services	\$3,896,000	\$1,024,000	\$2,872,000
Disaster Recovery	\$1,884,000	\$495,000	\$1,389,000
Service Delivery Mgmt, Asset Mgmt, and Facilities	\$6,749,000	\$1,774,000	\$4,975,000
Fixed Security Services	\$2,564,000	\$674,000	\$1,890,000
Hardware and Refresh	\$586,000	\$154,000	\$432,000
Software	\$6,421,000	\$1,688,000	\$4,733,000
Total	\$30,681,000	\$8,065,000	\$22,616,000

FY 2022-23	TF	GF	FF
Mainframe Data Center Operations Services	\$5,518,000	\$1,450,000	\$4,068,000
Midrange Data Center Operations Services	\$2,801,000	\$737,000	\$2,064,000
Midrange Storage Operations Services	\$255,000	\$67,000	\$188,000
Managed Network Services	\$3,929,000	\$1,032,000	\$2,897,000
Disaster Recovery	\$1,790,000	\$471,000	\$1,319,000
Service Delivery Mgmt, Asset Mgmt, and Facilities	\$6,749,000	\$1,774,000	\$4,975,000
Fixed Security Services	\$2,564,000	\$674,000	\$1,890,000
Hardware and Refresh	\$557,000	\$147,000	\$410,000
Software	\$6,287,000	\$1,652,000	\$4,635,000
Total	\$30,450,000	\$8,004,000	\$22,446,000

Funding:

FI 75% Title XIX / 25% GF (4260-101-0001/0890)

FI 100% GF (4260-101-0001)

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

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP – Other Admin DHCS policy change

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension –Other Admin policy change

MEDICAL FI BO & IT CHANGE ORDERS

OTHER ADMIN. POLICY CHANGE NUMBER: 51
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2117

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$28,734,000	\$27,009,000
STATE FUNDS	\$7,550,450	\$7,097,700
FEDERAL FUNDS	\$21,183,550	\$19,911,300

Purpose:

This policy change estimates the cost of the Gainwell Medical Fiscal Intermediary (FI) contract Change Orders (i.e. Change Requests).

Authority:

Gainwell Contract # 18-95357
 IBM Contract # 18-95302
 Senate Bill (SB) 853 (Chapter 717, Statutes of 2010)
 Welfare & Institutions (W&I) Code Section 14105.05

Interdependent Policy Changes:

COVID-19 Increased FMAP – Other Admin
 COVID-19 Increased FMAP Extension – Other Admin

Background:

The Gainwell 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 Gainwell 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.

MEDICAL FI BO & IT CHANGE ORDERS

OTHER ADMIN. POLICY CHANGE NUMBER: 51

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 BO 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.

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 the Department of General Services when they approved the contract.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is a net decrease due to:

- A reduction of COVID-19 Change Orders due to majority of invoices paid out of FY 2020-21 and
- A reallocation of Change Order costs due to new Change Orders and existing Change Orders under negotiations.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a net decrease due to:

- Reductions in various Change Order estimates and
- The removal of Change Order costs as a result of Change Order terms ending in FY 2021-22.

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. Contract costs are shared between Federal Funds (FF) and General Funds (GF).
4. Beginning contract year 3 and each year thereafter through the end of the contract, CPI adjustments are applied annually to the contract cost.

MEDICAL FI BO & IT CHANGE ORDERS
OTHER ADMIN. POLICY CHANGE NUMBER: 51

FY 2021-22	TF	GF	FF
COVID-19	\$260,000	\$68,000	\$192,000
Contract Innovations	\$220,000	\$58,000	\$162,000
Level 1 Help Desk	\$1,000,000	\$262,000	\$738,000
COGNOS	\$265,000	\$70,000	\$195,000
File Maintenance	\$4,849,000	\$1,274,000	\$3,575,000
State Level Registry Services	\$1,550,000	\$408,000	\$1,142,000
CMS 64 SIT UAT and PROD Infrastructure Support	\$103,000	\$27,000	\$76,000
Infrastructure Software License Assessment	\$791,000	\$208,000	\$583,000
Security Services	\$4,356,000	\$1,145,000	\$3,211,000
Testing Services	\$6,605,000	\$1,736,000	\$4,869,000
Formulary Liaison Services	\$1,260,000	\$331,000	\$929,000
FOAG	\$2,100,000	\$552,000	\$1,548,000
McWeb	\$15,000	\$4,000	\$11,000
Production Environment Hardware Refresh	\$500,000	\$131,000	\$369,000
Software License – Part II	\$69,000	\$18,000	\$51,000
TPL Liaison	\$262,000	\$69,000	\$193,000
App Dynamics	\$28,000	\$7,000	\$21,000
Sharepoint File Servers	\$20,000	\$5,000	\$15,000
MC Web/RAIS and other App support	\$300,000	\$79,000	\$221,000
API Connect	\$358,000	\$94,000	\$264,000
UDS Forte SW Support	\$36,000	\$10,000	\$26,000
SPE Dev & SIT Server Refresh	\$123,000	\$32,000	\$91,000
Perimeter Firewall -Advanced Threat Protection	\$81,000	\$21,000	\$60,000
Solaris to RHEL Migration	\$117,000	\$30,000	\$87,000
Provider Portal T&M	\$1,774,000	\$467,000	\$1,307,000
SAP BO Licenses	\$1,692,000	\$444,000	\$1,248,000
Total	\$28,734,000	\$7,550,000	\$21,184,000

MEDICAL FI BO & IT CHANGE ORDERS
OTHER ADMIN. POLICY CHANGE NUMBER: 51

FY 2022-23	TF	GF	FF
Contract Innovations	\$111,000	\$30,000	\$81,000
Level 1 Help Desk	\$1,019,000	\$268,000	\$751,000
COGNOS	\$250,000	\$66,000	\$184,000
File Maintenance	\$5,078,000	\$1,334,000	\$3,744,000
State Level Registry Services	\$583,000	\$153,000	\$430,000
CMS 64 SIT UAT and PROD Infrastructure Support	\$103,000	\$27,000	\$76,000
Infrastructure Software License Assessment	\$791,000	\$208,000	\$583,000
Security Services	\$4,360,000	\$1,146,000	\$3,214,000
Testing Services	\$6,700,000	\$1,761,000	\$4,939,000
Formulary Liaison Services	\$1,260,000	\$331,000	\$929,000
FOAG	\$2,200,000	\$578,000	\$1,622,000
Production Environment Hardware Refresh	\$500,000	\$131,000	\$369,000
Software License – Part II	\$61,000	\$16,000	\$45,000
TPL Liaison	\$263,000	\$69,000	\$194,000
Sharepoint File Servers	\$20,000	\$5,000	\$15,000
MC Web/RAIS and other App support	\$2,970,000	\$781,000	\$2,189,000
API Connect	\$359,000	\$94,000	\$265,000
Perimeter Firewall -Advanced Threat Protection	\$81,000	\$21,000	\$60,000
Provider Portal T&M	\$300,000	\$79,000	\$221,000
Total	\$27,009,000	\$7,098,000	\$19,911,000

Funding:

FI 75% Title XIX / 25% GF (4260-101-0001/0890)

FI 100% GF (4260-101-0001)

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

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP – Other Admin DHCS policy change

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension –Other Admin policy change

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 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$19,590,000	\$20,276,000
STATE FUNDS	\$5,881,700	\$6,090,300
FEDERAL FUNDS	\$13,708,300	\$14,185,700

Purpose:

This policy change estimates the other estimated costs of the Gainwell Medical Fiscal Intermediary (FI) contract.

Authority:

Gainwell Contract # 18-95357

Interdependent Policy Changes:

COVID-19 Increased FMAP – Other Admin
 COVID-19 Increased FMAP Extension – Other Admin

Background:

The Gainwell 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 Gainwell 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.

Reason for Change:

There is no change from the prior estimate for FY 2021-22.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to a Consumer Price Index (CPI) adjustment to the cost estimate.

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).

MEDICAL FI BO OTHER ESTIMATED COSTS
OTHER ADMIN. POLICY CHANGE NUMBER: 52

3. Beginning contract year 3 and each year thereafter through the end of the Gainwell contract, CPI adjustments are applied annually to the contract cost.

FY 2021-22	TF	GF	FF
Process Appeals (75% FF/25% GF, 100% GF)	\$693,000	\$182,000	\$511,000
Support Audits (75% FF/25% GF)	\$148,000	\$38,000	\$110,000
Process Drug Rebates (75% FF/25% GF)	\$1,050,000	\$276,000	\$774,000
Provide Litigation Support (75% FF/25% GF)	\$151,000	\$39,000	\$112,000
Service Delivery Support (75% FF/25% GF)	\$8,702,000	\$2,287,000	\$6,415,000
Publish Provider Communication Materials (75% FF/25% GF, 50% FF/50% GF)	\$2,822,000	\$1,189,000	\$1,633,000
Conduct Provider Outreach and Education (75% FF/25% GF)	\$4,053,000	\$1,065,000	\$2,988,000
Print and Mail Medi-Cal Information (75% FF/25% GF, 50% FF/50% GF)	\$1,814,000	\$764,000	\$1,050,000
Perform Proactive Provider Research (75% FF/25% GF)	\$157,000	\$41,000	\$116,000
Total	\$19,590,000	\$5,881,000	\$13,709,000

FY 2022-23	TF	GF	FF
Process Appeals (75% FF/25% GF, 100% GF)	\$717,000	\$189,000	\$528,000
Support Audits (75% FF/25% GF)	\$153,000	\$41,000	\$112,000
Process Drug Rebates (75% FF/25% GF)	\$1,087,000	\$285,000	\$802,000
Provide Litigation Support (75% FF/25% GF)	\$157,000	\$42,000	\$115,000
Service Delivery Support (75% FF/25% GF)	\$9,007,000	\$2,368,000	\$6,639,000
Publish Provider Communication Materials (75% FF/25% GF, 50% FF/50% GF)	\$2,921,000	\$1,230,000	\$1,691,000
Conduct Provider Outreach and Education (75% FF/25% GF)	\$4,194,000	\$1,102,000	\$3,092,000
Print and Mail Medi-Cal Information (75% FF/25% GF, 50% FF/50% GF)	\$1,877,000	\$791,000	\$1,086,000
Perform Proactive Provider Research (75% FF/25% GF)	\$163,000	\$43,000	\$120,000
Total	\$20,276,000	\$6,091,000	\$14,185,000

MEDICAL FI BO OTHER ESTIMATED COSTS
OTHER ADMIN. POLICY CHANGE NUMBER: 52**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 65% Title XXI / 35% GF (4260-113-0001/0890)

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP –
Other Admin DHCS policy changeCOVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately
identified in the COVID-19 Increased FMAP Extension – Other Admin policy change

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 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$13,643,000	\$14,121,000
STATE FUNDS	\$4,082,600	\$4,226,050
FEDERAL FUNDS	\$9,560,400	\$9,894,950

Purpose:

This policy change estimates the Telephone Service Center (TSC) costs of the Gainwell Medical Fiscal Intermediary (FI) contract.

Authority:

Gainwell Contract # 18-95357

Interdependent Policy Changes:

COVID-19 Increased FMAP – Other Admin
 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 Gainwell 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

Reason for Change:

There is no change from the prior estimate for FY 2021-22.

The change in FY 2021-22 and FY 2022-23, in the current estimate, is an increase due to a Consumer Price Index (CPI) adjustment to the estimate.

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. Beginning contract year 3 and each year thereafter through the end of the Gainwell contract, CPI adjustments are applied annually to the cost.

FY 2021-22	TF	GF	FF
TSC – Conduct Provider Customer Services (75% FF/25% GF, 50% FF/50% GF)	\$7,774,000	\$2,327,000	\$5,447,000
TSC – Conduct Member Customer Services (75% FF/25% GF, 50% FF/50% GF)	\$4,402,000	\$1,317,000	\$3,085,000
TSC – Provide Financial Services (75% FF/25% GF, 50% FF/50% GF)	\$1,467,000	\$439,000	\$1,028,000
Total	\$13,643,000	\$4,083,000	\$9,560,000

FY 2022-23	TF	GF	FF
TSC – Conduct Provider Customer Services (75% FF/25% GF, 50% FF/50% GF)	\$8,046,000	\$2,408,000	\$5,638,000
TSC – Conduct Member Customer Services (75% FF/25% GF, 50% FF/50% GF)	\$4,556,000	\$1,364,000	\$3,192,000
TSC – Provide Financial Services (75% FF/25% GF, 50% FF/50% GF)	\$1,519,000	\$454,000	\$1,065,000
Total	\$14,121,000	\$4,226,000	\$9,895,000

Funding:

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

FI 75% Title XIX / 25% GF (4260-101-0001/0890)

FI 100% GF (4260-101-0001)

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

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP – Other Admin DHCS policy change

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – Other Admin policy change

MEDICAL FI BUSINESS OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 54
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2111

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$13,072,000	\$13,529,000
STATE FUNDS	\$3,435,750	\$3,556,250
FEDERAL FUNDS	\$9,636,250	\$9,972,750

Purpose:

This policy change estimates the operational costs of the Gainwell Medical Fiscal Intermediary (FI) contract.

Authority:

Gainwell Contract # 18-95357

Interdependent Policy Changes:

COVID-19 Increased FMAP – Other Admin
 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 Gainwell Business Operations FI contract started in October 2019. The Gainwell Business Operations FI contract term is five years with five one-year optional extensions.

The Operations functions and services of the Gainwell 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.

Reason for Change:

There is no change from the prior estimate for FY 2021-22.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to a Consumer Price Index (CPI) adjustment to the estimate.

Methodology:

1. Operation costs are paid using Fixed Plus pricing methodology with a rate for an annual volume threshold and a rate for each transaction which exceeds that threshold.
2. Projected volumes are established by the Department using trends and counts from previous years and the FI rate established by the contract is applied to the respective volume.
3. Takeover costs are not paid with Local Assistance funds.
4. Costs are shared between Federal Funds (FF) and General Funds (GF).
5. Beginning contract year 3 and each year thereafter through the end of the Gainwell contract, CPI adjustments are applied annually to the cost.

MEDICAL FI BUSINESS OPERATIONS
OTHER ADMIN. POLICY CHANGE NUMBER: 54

FY 2021-22	TF	GF	FF
Process Paper Claims	\$7,211,000	\$1,895,000	\$5,316,000
Process Suspended Claims	\$2,860,000	\$752,000	\$2,108,000
Manage Records	\$1,124,000	\$295,000	\$829,000
Process Member Card Requests	\$1,551,000	\$408,000	\$1,143,000
Process Paper TAR	\$326,000	\$86,000	\$240,000
Total	\$13,072,000	\$3,436,000	\$9,636,000

FY 2022-23	TF	GF	FF
Process Paper Claims	\$7,463,000	\$1,962,000	\$5,501,000
Process Suspended Claims	\$2,960,000	\$778,000	\$2,182,000
Manage Records	\$1,164,000	\$306,000	\$858,000
Process Member Card Requests	\$1,605,000	\$421,000	\$1,184,000
Process Paper TAR	\$337,000	\$89,000	\$248,000
Total	\$13,529,000	\$3,556,000	\$9,973,000

Funding:

FI 75% Title XIX / 25% GF (4260-101-0001/0890)

FI 100% GF (4260-101-0001/0890)

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

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP – Other Admin DHCS policy change

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension –Other Admin policy change

MEDICAL FI BO HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 55
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2113

	FY 2021-22	FY 2022-23
TOTAL FUNDS	\$10,437,000	\$10,663,000
STATE FUNDS	\$2,744,600	\$2,803,100
FEDERAL FUNDS	\$7,692,400	\$7,859,900

Purpose:

This policy change estimates the hourly reimbursement costs of the Gainwell Medical Fiscal Intermediary (FI) contract.

Authority:

Gainwell Contract # 18-95357

Interdependent Policy Changes:

COVID-19 Increased FMAP – Other Admin
 COVID-19 Increased FMAP Extension – Other Admin

Background:

The Gainwell 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 Gainwell 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

Reason for Change:

The change from the prior estimate, for FY 2021-22, is due to a decrease in the Consumer Price Index (CPI) adjustment.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to an increase in the CPI adjustment.

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. Beginning contract year 3 and each year thereafter through the end of the Gainwell, contract CPI adjustments are applied annually to the contract cost.

FY 2021-22	TF	GF	FF
Perform Medical Review Services	\$5,958,000	\$1,566,000	\$4,392,000
Service Changes (formerly Systems Group)	\$4,479,000	\$1,179,000	\$3,300,000
Total	\$10,437,000	\$2,745,000	\$7,692,000

FY 2022-23	TF	GF	FF
Perform Medical Review Services	\$6,167,000	\$1,621,000	\$4,546,000
Service Changes (formerly Systems Group)	\$4,496,000	\$1,182,000	\$3,314,000
Total	\$10,663,000	\$2,803,000	\$7,860,000

Funding:

FI 75% Title XIX / 25% GF (4260-101-0001/0890)

FI 100% GF (4260-101-0001)

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

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP – Other Admin DHCS policy change

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension –Other Admin policy change

MEDICAL FI BO MISCELLANEOUS EXPENSES

OTHER ADMIN. POLICY CHANGE NUMBER: 56
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2114

	FY 2021-22	FY 2022-23
TOTAL FUNDS	\$2,371,000	\$2,318,000
STATE FUNDS	\$751,850	\$737,450
FEDERAL FUNDS	\$1,619,150	\$1,580,550

Purpose:

This policy change estimates the cost of miscellaneous expenses of the Gainwell Medical Fiscal Intermediary (FI) contract.

Authority:

Gainwell Contract # 18-95357
 Interagency Agreement (IA) # 18-95321, 18-85091, 16-93264, & 18-95090

Interdependent Policy Changes:

COVID-19 Increased FMAP – Other Admin
 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 Gainwell 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.

Reason for Change:

The change from the prior estimate for FY 2021-22 is a decrease due to a minor decrease in reimbursement volumes for various Interagency Agreements.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to a minor decrease in reimbursement volumes for various Interagency Agreements.

Methodology:

1. Miscellaneous 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).

FY 2021-22	TF	GF	FF
Interagency Agreements (75% FF/25% GF, 50% FF/50% GF)	\$2,371,000	\$752,000	\$1,619,000
Total	\$2,371,000	\$752,000	\$1,619,000

FY 2022-23	TF	GF	FF
Interagency Agreements (75% FF/25% GF, 50% FF/50% GF)	\$2,318,000	\$737,000	\$1,581,000
Total	\$2,318,000	\$737,000	\$1,581,000

Funding:

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

FI 75% Title XIX / 25% GF (4260-101-0001/0890)

FI 100% GF (4260-101-0001)

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

COVID-19 funding through December 31, 2021 is identified in the COVID-19 Increased FMAP – Other Admin DHCS policy change

COVID-19 funding from January 1, 2022 to June 30, 2022 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – Other Admin policy change

HCO OPERATIONS 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 57
IMPLEMENTATION DATE: 11/2018
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 2051

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$34,800,000	\$34,800,000
STATE FUNDS	\$17,138,850	\$17,138,850
FEDERAL FUNDS	\$17,661,150	\$17,661,150

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 – Other 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:

The change from the prior estimate for FY 2021-22, is a decrease due to updated projections.

There is no change from FY 2021-22 to FY 2022-23 in the current estimate.

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: 57

(Dollars in Thousands)

FY 2021-22	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced Title XXI	Enhanced Title XXI
Transactions	\$6,612	\$3,141	\$3,140	\$116	\$215
Packet Mailings	\$6,612	\$3,141	\$3,140	\$116	\$215
BDA/Call Center	\$21,576	\$10,249	\$10,248	\$378	\$701
Total	\$34,800	\$16,531	\$16,528	\$610	\$1,131

(Dollars in Thousands)

FY 2022-23	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced Title XXI	Enhanced Title XXI
Transactions	\$6,612	\$3,141	\$3,140	\$116	\$215
Packet Mailings	\$6,612	\$3,141	\$3,140	\$116	\$215
BDA/Call Center	\$21,576	\$10,249	\$10,248	\$378	\$701
Total	\$34,800	\$16,531	\$16,528	\$610	\$1,131

Funding:

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

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

COVID-19 funding is identified through December 31, 2021, in the COVID-19 Increased FMAP – DHCS Admin policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – Other Admin policy change.

HCO COST REIMBURSEMENT 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 58
IMPLEMENTATION DATE: 11/2018
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 2052

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$20,520,000	\$20,520,000
STATE FUNDS	\$10,106,100	\$10,106,100
FEDERAL FUNDS	\$10,413,900	\$10,413,900

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 – Other 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:

The change from the prior estimate for FY 2021-22, is an increase due to actual and projection adjustments. These adjustments include necessary costs related to the material and system changes needed to include PACE plans as a Plans Choice in all counties where PACE operates. There is no change from FY 2021-22 to FY 2022-23 in the current estimate.

Methodology:

1. Contract costs are shared between GF and FF.

HCO COST REIMBURSEMENT 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 58

(Dollars in Thousands)

FY 2021-22	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced Title XXI	Enhanced Title XXI
Postage	\$10,421	\$4,950	\$4,950	\$182	\$339
Printing	\$3,068	\$1,457	\$1,457	\$54	\$100
Materials Maintenance and Development	\$2,548	\$1,210	\$1,210	\$45	\$83
Mass Mailings	\$806	\$383	\$383	\$14	\$26
Other Cost. Reimb.	\$1,019	\$484	\$484	\$18	\$33
Additional Systems Group Staff	\$2,193	\$1,042	\$1,042	\$38	\$71
Miscellaneous	\$465	\$221	\$221	\$8	\$15
Total*	\$20,520	\$9,747	\$9,747	\$359	\$667

*Totals may differ due to rounding.

(Dollars in Thousands)

FY 2022-23	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced Title XXI	Enhanced Title XXI
Postage	\$10,421	\$4,950	\$4,950	\$182	\$339
Printing	\$3,068	\$1,457	\$1,457	\$54	\$100
Materials Maintenance and Development	\$2,548	\$1,210	\$1,210	\$45	\$83
Mass Mailings	\$806	\$383	\$383	\$14	\$26
Other Cost. Reimb.	\$1,019	\$484	\$484	\$18	\$33
Additional Systems Group Staff	\$2,193	\$1,042	\$1,042	\$38	\$71
Miscellaneous	\$465	\$221	\$221	\$8	\$15
Total*	\$20,520	\$9,747	\$9,747	\$359	\$667

*Totals may differ due to rounding.

Funding:

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

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

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – Other Admin policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – Other Admin policy change.

HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 59
IMPLEMENTATION DATE: 11/2018
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 2053

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$15,600,000	\$15,600,000
STATE FUNDS	\$7,683,000	\$7,683,000
FEDERAL FUNDS	\$7,917,000	\$7,917,000

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 – Other 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:

The change from the prior estimate for FY 2021-22, is a decrease due to actual and projection adjustments.

There is no change from FY 2021-22 to FY 2022-23, in the current estimate.

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 2021-22 and FY 2022-23 are based on 217.5 ESRs per year.

HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 59

(Dollars in thousands)

FY 2021-22	TF	GF	FF
Title XIX (50% FF / 50% GF)	\$14,820	\$7,410	\$7,410
Title XXI (65% FF / 35% GF)	\$780	\$273	\$507
Total	\$15,600	\$7,683	\$7,917

*Totals may differ due to rounding.

(Dollars in thousands)

FY 2022-23	TF	GF	FF
Title XIX (50% FF / 50% GF)	\$14,820	\$7,410	\$7,410
Title XXI (65% FF / 35% GF)	\$780	\$273	\$507
Total	\$15,600	\$7,683	\$7,917

*Totals may differ due to rounding.

Funding:

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

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

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – Other Admin policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – Other Admin policy change.

DENTAL ASO ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 60
IMPLEMENTATION DATE: 3/2018
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2007

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$48,181,000	\$48,319,000
STATE FUNDS	\$17,387,500	\$17,445,000
FEDERAL FUNDS	\$30,793,500	\$30,874,000

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 of California (Delta) was awarded a multi-year ASO 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; and
- 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: 60

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. 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 the 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 2021-22, is an increase due to invoice payments returning to a regular monthly schedule. Previously, June payments were budgeted in July of the following fiscal year. The change from FY 2021-22 to FY 2022-23, 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 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. 58% of costs are funded at 50% FF and 50% GF
 - ii. 42% 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 are met for calendar year 2021, the funds will be released in May 2022.
4. TSC minutes are based on actual invoices funded at 50% FF and 50% GF.

DENTAL ASO ADMINISTRATION 2016 CONTRACT
OTHER ADMIN. POLICY CHANGE NUMBER: 60

FY 2021-22	TF	GF	FF
Administration/Operations (75% FF / 25% GF)	\$23,840,000	\$5,960,000	\$17,880,000
Provider Enrollment (50% FF / 50% GF & 75% FF / 25% GF)	\$4,206,000	\$1,493,000	\$2,713,000
2% Withhold (net of prior year withhold release)	(\$29,000)	(\$8,000)	(\$21,000)
Total ACSL/TAR	\$28,017,000	\$7,445,000	\$20,572,000
TSC – Provider (50% FF / 50% GF)	\$6,796,000	\$3,398,000	\$3,398,000
TSC – Beneficiary (50% FF / 50% GF)	\$10,730,000	\$5,365,000	\$5,365,000
Total TSC	\$17,526,000	\$8,763,000	\$8,763,000
Total Operations Costs	\$45,543,000	\$16,208,000	\$29,335,000

FY 2022-23	TF	GF	FF
Administration/Operations (75% FF / 25% GF)	\$23,872,000	\$5,968,000	\$17,904,000
Provider Enrollment (50% FF / 50% GF & 75% FF / 25% GF)	\$4,213,000	\$1,496,000	\$2,717,000
2% Withhold (net of prior year withhold release)	(\$18,000)	(\$5,000)	(\$13,000)
Total ACSL/TAR	\$28,067,000	\$7,459,000	\$20,608,000
TSC – Provider (50% FF / 50% GF)	\$7,296,000	\$3,648,000	\$3,648,000
TSC – Beneficiary (50% FF / 50% GF)	\$10,274,000	\$5,137,000	\$5,137,000
Total TSC	\$17,570,000	\$8,785,000	\$8,785,000
Total Operations Costs	\$45,637,000	\$16,244,000	\$29,393,000

5. Cost reimbursements are based on actual invoices with a caseload growth factor.

FY 2021-22	TF	GF	FF
Total Cost Reimbursable	\$2,638,000	\$1,180,000	\$1,458,000

FY 2022-23	TF	GF	FF
Total Cost Reimbursable	\$2,682,000	\$1,201,000	\$1,481,000

6. Total Administration Cost

Fiscal Year	TF	GF	FF
FY 2021-22	\$48,181,000	\$17,388,000	\$30,793,000
FY 2022-23	\$48,319,000	\$17,445,000	\$30,874,000

Funding:

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

FI 75% Title XIX / 25% GF (4260-101-0001/0890)

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

DENTAL FI ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 61
IMPLEMENTATION DATE: 11/2017
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2006

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$20,830,000	\$21,108,000
STATE FUNDS	\$5,685,750	\$5,729,250
FEDERAL FUNDS	\$15,144,250	\$15,378,750

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:

A contract amendment was executed to change the FI contractor's name from DXC Technology Services (DXC) to Gainwell Technologies LLC (Gainwell). Gainwell assumes all contractual responsibilities and obligations under the multi-year FI contract from 2016 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: 61

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 2021-22, is an increase due to higher TAR volumes and change order costs. The change from FY 2021-22 to FY 2022-23, 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 2020-21 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.

FY 2021-22	TF	GF	FF
Scanned Claims/TAR	\$11,659,000	\$2,915,000	\$8,744,000
Check Write	\$257,000	\$64,000	\$193,000
Change Orders	\$228,000	\$114,000	\$114,000
Total	\$12,144,000	\$3,093,000	\$9,051,000

FY 2022-23	TF	GF	FF
Scanned Claims/TAR	\$11,743,000	\$2,936,000	\$8,807,000
Check Write	\$261,000	\$65,000	\$196,000
Change Orders	\$230,000	\$115,000	\$115,000
Total	\$12,234,000	\$3,116,000	\$9,118,000

4. Cost reimbursements are based on actual invoices.

Fiscal Year	TF	GF	FF
FY 2021-22	\$1,709,000	\$849,000	\$860,000
FY 2022-23	\$1,605,000	\$796,000	\$809,000

DENTAL FI ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 61

5. Hourly Reimbursables:

System Group	TF	GF	FF
FY 2021-22	\$6,977,000	\$1,744,000	\$5,233,000
FY 2022-23	\$7,269,000	\$1,817,000	\$5,452,000

6. Total Administration Cost:

Fiscal Year	TF	GF	FF
FY 2021-22	\$20,830,000	\$5,686,000	\$15,144,000
FY 2022-23	\$21,108,000	\$5,729,000	\$15,379,000

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: 62
IMPLEMENTATION DATE: 4/1993
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 236

	FY 2021-22	FY 2022-23
TOTAL FUNDS	\$384,224,000	\$384,520,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$384,224,000	\$384,520,000

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 2021-22, from the prior estimate, is a decrease due to updated expenditure data provided by CDSS. The change from FY 2021-22 to FY 2022-23, in the current estimate, is a slight increase due to updated expenditure data provided by CDSS.

PERSONAL CARE SERVICES
OTHER ADMIN. POLICY CHANGE NUMBER: 62

Methodology:

1. On an accrual basis, CDSS estimated FY 2021-22 expenditures at \$441,939,000 FF and at \$441,977,000 FF in FY 2022-23.
2. On a cash basis, the estimates below were provided by CDSS.

(Dollars in Thousands)

FY 2021-22	TF	DHCS FFP	CDSS GF/ County Match
EW Time & Health Related	\$603,745	\$301,873	\$301,873
CMIPS II	\$137,627	\$68,813	\$68,813
CMIPS II EVV	\$27,077	\$13,538	\$13,538
Total	\$768,449	\$384,224	\$384,224
FY 2022-23	TF	DHCS FFP	CDSS GF/ County Match
EW Time & Health Related	\$604,210	\$302,105	\$302,105
CMIPS II	\$137,732	\$68,866	\$68,866
CMIPS II EVV	\$27,098	\$13,549	\$13,549
Total	\$769,040	\$384,520	\$384,520

*Totals may differ due to rounding.

Funding:

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

HEALTH-RELATED ACTIVITIES - CDSS

OTHER ADMIN. POLICY CHANGE NUMBER: 63
IMPLEMENTATION DATE: 7/1992
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 233

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$337,606,000	\$368,394,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$337,606,000	\$368,394,000

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 an increase for FY 2021-22, from the prior estimate, due to updated expenditure data provided by CDSS. The change from FY 2021-22 to FY 2022-23 in the current estimate is an increase due to updated expenditure data provided by CDSS on a cash basis.

Methodology:

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

HEALTH-RELATED ACTIVITIES - CDSS

OTHER ADMIN. POLICY CHANGE NUMBER: 63

(Dollars in Thousands)

FY 2021-22	TF	DHCS FFP	CDSS GF/ County Match
CWS	\$342,765	\$171,383	\$171,383
CWS/CMS	\$6,823	\$3,411	\$3,411
CSBG/APS	\$325,624	\$162,812	\$162,812
TOTAL	\$675,212	\$337,606	\$337,606
FY 2022-23	TF	DHCS FFP	CDSS GF/ County Match
CWS	\$392,912	\$196,456	\$196,456
CWS/CMS	\$7,177	\$3,588	\$3,588
CSBG/APS	\$336,698	\$168,349	\$168,349
TOTAL	\$736,787	\$368,394	\$368,394

*Totals may differ due to rounding.

Funding:

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

HCBS SP - IHSS HCBS CARE ECONOMY PMTS

OTHER ADMIN. POLICY CHANGE NUMBER: 64
IMPLEMENTATION DATE: 1/2022
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2313

	FY 2021-22	FY 2022-23
TOTAL FUNDS	\$137,275,000	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$137,275,000	\$0

Purpose:

This policy change budgets the Title XIX federal financial participation (FFP) for the California Department of Social Services (CDSS) providing Coronavirus Disease 2019 (COVID-19) Incentive Payments to In-Home Supportive Services (IHSS) providers.

Authority:

American Rescue Plan (ARP) Act (2021)
Budget Act of 2021

Interdependent Policy Changes:

American Rescue Plan Increased FMAP for HCBS

Background:

The ARP provides additional COVID-19 relief to states. Section 9817 of the ARP provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS). Increased FMAP is available from April 1, 2021, through March 31, 2022. States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. State funds equivalent to the amount of federal funds attributable to the increased FMAP are deposited in the Home and Community-Based Services American Rescue Plan Fund pursuant to Section 11.95 of the Budget Act of 2021. Section 11.95 appropriates this funding to eligible HCBS activities identified in the HCBS Spending Plan.

On July 12, 2021, the Department submitted the Medicaid HCBS Spending Plan to the Centers for Medicare & Medicaid Services for approval. The multi-departmental HCBS spending plan includes HCBS initiatives and services that will be led by the Department and/or various other State Departments.

This policy change allows CDSS to provide a one-time incentive payment to each current IHSS provider that provided IHSS to program recipients during a minimum of two months between March 2020 and March 2021 of the pandemic, for retention, recognition, and workforce development, through the IHSS Case Management Information and Payrolling System.

Reason for Change:

This is a new policy change.

HCBS SP - IHSS HCBS CARE ECONOMY PMTS

OTHER ADMIN. POLICY CHANGE NUMBER: 64

Methodology:

1. Assume implementation began on January 1, 2022.
2. The non-federal share is budgeted by CDSS.
3. FY 2021-22 costs are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	HCBS ARP Fund - CDSS	FF
FY 2021-22	\$274,550	\$137,275	\$137,275

Funding:

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

CALHEERS DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 65
IMPLEMENTATION DATE: 6/2012
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 1679

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$123,320,000	\$138,413,000
STATE FUNDS	\$33,405,500	\$37,441,400
FEDERAL FUNDS	\$89,914,500	\$100,971,600

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 #19-96234

Interdependent Policy Changes:

COVID-19 Increased FMAP – Other Admin
 COVID-19 Increased FMAP Extension – Other 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: 65

The ACA offers additional enhanced federal funding for developing/upgrading Medicaid eligibility systems and for interactions of such systems with the ACA-required health benefit exchanges. The Department also receives enhanced federal funding for the requirements validation, design, development, testing, and implementation of MEDS related system changes needed to interface with the CalHEERS. The majority of CalHEERS' costs are shared between Covered California and Medi-Cal. For any D&I or M&O activities that are not eligible for federal reimbursement, costs are funded 100% by either the Department or Covered California, as applicable.

The Department requested its own enhanced federal funding from the Centers for Medicare and Medicaid Services (CMS) for the HEMI. In October 2020, CMS approved funding through federal fiscal year (FFY) 2022. The Department will submit an Operational Advanced Planning Document in July 2021 to seek approval for HEMI funding. For CalHEERS, in September 2020 CMS approved funding through FFY 2022. The Department will submit an As Needed Advanced Planning Document in August of 2021 to seek approval for funding through subsequent fiscal years and approval of a new proposed cost share effective October 1, 2021, between the Department (86.970%) and Covered California (13.030%).

Reason for Change:

For the CalHEERS portion, the change from the prior estimate for FY 2021-22, there is an increase due to technical enhancements that are necessary for the CalHEERS cloud environments to perform at an optimal level for the changing and complex requirements of the Department and Covered California.

There is an increase from FY 2021-22 to FY 2022-23 in the current estimate due to revised projections

For the HEMI portion, there is no change from the prior estimate for FY 2021-22 and in the current estimate from FY 2021-22 to FY 2022-23.

The overall change from the prior estimate is an increase due to CalHEERS technical enhancements that are necessary for the CalHEERS technology refreshes and cloud environments.

The overall change from FY 2021-22 to FY 2022-23 in the current estimate, is an increase due to revised projections.

Methodology:

1. CalHEERS' costs are shared between Covered California and Medi-Cal based on the approved Cost Allocation Plan.
 - Effective October 1, 2019, the cost share was 12.590% from Covered California and 87.410% from the Department. This cost share was approved by CMS in September 2020 to continue through September 30, 2021;
 - Effective October 1, 2021, the proposed cost share is 13.030% from Covered California and 86.970% from the Department;
 - Effective FY 2021-22, costs for all Medi-Cal activities that are not eligible for federal reimbursement are identified separately from Title XIX and Title XXI;

CALHEERS DEVELOPMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 65

- All costs directly attributable to the Department are the responsibility of the Department.
2. Costs incurred are for CalHEERS' D&I and M&O activities, which have different FFP reimbursement percentages.
- The D&I portion of costs is eligible for:
 - i. Title XIX at 90% federal reimbursement;
 - ii. Title XXI at 65% federal reimbursement.
 - The M&O portion of costs is eligible for:
 - i. Title XIX at 75% federal reimbursement;
 - ii. Title XXI at 65% federal reimbursement.
3. The estimates for FY 2021-22 and FY 2022-23 are as follows:

FY 2021-22	TF	GF	FF
Title XIX (90% FF / 10% GF)	\$17,630,000	\$1,763,000	\$15,867,000
Title XIX (75% FF / 25% GF)	\$81,537,000	\$20,384,000	\$61,153,000
Title XXI (65% FF / 35% GF)	\$15,783,000	\$5,524,000	\$10,259,000
DHCS – 100% State GF	\$4,790,000	\$4,790,000	\$0
CalHEERS Subtotal	\$119,740,000	\$32,461,000	\$87,278,000
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	\$2,635,000
Total	\$123,320,000	\$33,405,000	\$89,914,000

Totals may differ due to rounding.

FY 2022-23	TF	GF	FF
Title XIX (90% FF / 10% GF)	\$20,220,000	\$2,022,000	\$18,198,000
Title XIX (75% FF / 25% GF)	\$91,488,000	\$22,862,000	\$68,586,000
Title XXI (65% FF / 35% GF)	\$17,772,000	\$6,220,000	\$11,552,000
DHCS – 100% State GF	\$5,393,000	\$5,393,000	\$0
CalHEERS Subtotal	\$134,833,000	\$36,497,000	\$98,336,000
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	\$2,635,000
Total	\$138,413,000	\$37,441,000	\$100,971,000

Totals may differ due to rounding.

CALHEERS DEVELOPMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 65

Funding:

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

75% Title XIX / 25% GF (4260-101-0001/0890)

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

100% GF (4260-101-0001)

COVID-19 funding through December 31, 2021, is identified in the COVID-19 Increased FMAP – Other Admin policy change

COVID-19 funding from January 1, 2022, to June 30, 2022, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – Other Admin policy change.

CDDS ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 66
IMPLEMENTATION DATE: 7/1997
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 243

	FY 2021-22	FY 2022-23
TOTAL FUNDS	\$93,799,000	\$65,500,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$93,799,000	\$65,500,000

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 Facility (SOF) Medi-Cal Administration, DC/SOF Medi-Cal Eligibility, 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 in FY 2021-22, from the prior estimate, is a net increase due to having more recent expenditure trends that informs the updated accrual estimate. Paid expenditures are updated through October 2021.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to updated paid expenditure data that informs changes to assumptions on timing of future paid expenditures.

CDDS ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 66

Methodology:

CDDS provides the following cash estimates of its administrative cost components:

FY 2021-22		DHCS FFP	CDDS GF	IA #
1	DC/SOCF Medi-Cal Admin.	\$1,150,000	\$1,150,000	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.	\$40,870,000	\$40,870,000	01-15834
4	RC Medicaid Admin.	\$36,854,000	\$12,285,000	03-75734
5	NHR Admin.	\$246,000	\$246,000	03-75285
6	TCM Headquarters Admin.	\$13,336,000	\$13,336,000	03-75284
	TCM HIPAA*	\$638,000	\$0	03-75284
	Total	\$93,799,000	\$68,412,000	

FY 2022-23		DHCS FFP	CDDS GF	IA #
1	DC/SOCF Medi-Cal Admin.	\$1,150,000	\$1,150,000	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.	\$35,226,000	\$35,226,000	01-15834
4	RC Medicaid Admin.	\$19,048,000	\$6,349,333	03-75734
5	NHR Admin.	\$197,000	\$197,000	03-75285
6	TCM Headquarters Admin.	\$8,536,000	\$8,536,000	03-75284
	TCM HIPAA*	\$638,000	\$0	03-75284
	Total	\$65,500,000	\$51,983,333	

Funding:

100% Title XIX (4260-101-0890)

100% HIPAA FFP (4260-117-0890)*

MATERNAL AND CHILD HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER: 67
IMPLEMENTATION DATE: 7/1992
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 234

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$48,738,000	\$47,668,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$48,738,000	\$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: 67

- 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 in from the prior estimate, for FY 2021-22 is due to a decrease in timely FI\$Cal reports which allows for invoicing. MCAH estimates that the remainder of FY 2020-21 and the majority of FY 2021-22 will be reimbursed in FY 2021-22.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is a decrease due to a decrease in the amount of FY 2021-22 invoices expected to be reimbursed in FY 2021-22.

Methodology:

1. The Department claims Title XIX federal funds with Certified Public Expenditures from local agencies.
2. The following estimates have been provided on a cash basis by CDPH.

(Dollars in Thousands)

FY 2021-22	DHCS FFP	CDPH GF	County Match
BIH	\$4,082	\$1,908	\$1,629
CPSP & PCG	\$43,559	\$0	\$31,508
AFLP	\$1,097	\$0	\$946
Total for FY 2021-22	\$48,738	\$1,908	\$34,083

(Dollars in Thousands)

FY 2021-22	DHCS FFP	CDPH GF	County Match
BIH	\$3,701	\$1,545	\$1,715
CPSP & PCG	\$42,590	\$0	\$30,197
AFLP	\$1,377	\$0	\$1,196
Total for FY 2022-23	\$47,668	\$1,545	\$33,108

Funding:

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

HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN

OTHER ADMIN. POLICY CHANGE NUMBER: 68
IMPLEMENTATION DATE: 7/1999
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 246

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$55,172,000	\$55,172,000
STATE FUNDS	\$13,793,000	\$13,793,000
FEDERAL FUNDS	\$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) 21-10019

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: 68

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:

The change from the prior estimate, for FY 2021-22, is an increase due to a revision in reimbursement methodology. There is no change from FY 2021-22 to FY 2022-23 in the current estimate.

Methodology:

1. CDSS provides the annual Local Revenue Fund of \$13,793,000 for FY 2021-22 and FY 2022-23.
2. Assume CDSS reimburses the GF to the Department 60 days after the end of each fiscal quarter.

(Dollars in Thousands)

Fiscal Year	TF	FF	GF Reimb.	CDSS GF
FY 2021-22	\$55,172	\$41,379	\$13,793	\$13,793
FY 2022-23	\$55,172	\$41,379	\$13,793	\$13,793

Funding:

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

DEPARTMENT OF SOCIAL SERVICES ADMIN COST

OTHER ADMIN. POLICY CHANGE NUMBER: 69
IMPLEMENTATION DATE: 7/2002
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 256

	FY 2021-22	FY 2022-23
TOTAL FUNDS	\$33,047,000	\$33,047,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$33,047,000	\$33,047,000

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:

There is no change from the prior estimate, for FY 2021-22. There is no change from FY 2021-22 to FY 2022-23 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: 69

(Dollars in Thousands)

FY 2021-22	TF	DHCS FFP	CDSS GF
IHSS PCSP	\$26,706	\$13,353	\$13,353
IHSS Health Related	\$128	\$64	\$64
CWS/CMS for Medi-Cal	\$2,000	\$1,000	\$1,000
IHSS Plus Option Sec. 1915(j)	\$5,928	\$2,964	\$2,964
SAWS	\$1,103	\$552	\$552
Medi-Cal State Hearings	\$18,827	\$9,413	\$9,413
Public Inquiry and Response	\$500	\$250	\$250
Medicaid Disability Evaluation Services	\$6,329	\$3,164	\$3,164
Estate Recovery Claims	\$8	\$4	\$4
CECRIS	\$165	\$82	\$82
Electronic Visit Verification	\$4,400	\$2,200	\$2,200
TOTAL	\$66,094	\$33,047	\$33,047
FY 2022-23	TF	DHCS FFP	CDSS GF
IHSS PCSP	\$26,706	\$13,353	\$13,353
IHSS Health Related	\$128	\$64	\$64
CWS/CMS for Medi-Cal	\$2,000	\$1,000	\$1,000
IHSS Plus Option Sec. 1915(j)	\$5,928	\$2,964	\$2,964
SAWS	\$1,103	\$552	\$552
Medi-Cal State Hearings	\$18,827	\$9,413	\$9,413
Public Inquiry and Response	\$500	\$250	\$250
Medicaid Disability Evaluation Services	\$6,329	\$3,164	\$3,164
Estate Recovery Claims	\$8	\$4	\$4
CECRIS	\$165	\$82.30	\$82
Electronic Visit Verification	\$4,400	\$2,200	\$2,200
TOTAL	\$66,094	\$33,047	\$33,047

* 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: 70
IMPLEMENTATION DATE: 7/2007
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 1192

	FY 2021-22	FY 2022-23
TOTAL FUNDS	\$16,908,000	\$12,901,000
STATE FUNDS	\$4,007,000	\$0
FEDERAL FUNDS	\$12,901,000	\$12,901,000

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 Acquired Immunodeficiency Syndrome (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.

The Office of AIDS operates and administers the Human Immunodeficiency Virus (HIV)/AIDS waiver. The HIV/AIDS waiver program provides services designed to allow people with HIV or

FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 70

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 the Centers for Medi-Care and Medicaid Services.

The CHCQ program has the responsibility for regulatory oversight of health facilities, certified nurse assistants, home health aides, certified hemodialysis technicians, 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,
- Centralized Application Unit, and
- Intermediate Care Facility for the Developmentally Disabled Continuous Nursing Pilot Project Waiver.

The SNF implemented a quality and accountability supplemental payment program for nursing facilities through the approval of Senate Bill 853. The Department will reimburse CDPH's Skilled Nursing Facilities administrative costs from this Special Fund.

Reason for Change:

There is no change from the prior estimate for FY 2021-22. The change from FY 2021-22 to FY 2022-23 is due to the state fund portion for the Skilled Nursing facilities being funded by CDPH GF instead of DHCS SF beginning FY 2022-23.

Methodology:

1. CDPH provides the General Fund match.
2. For MCAH, the estimate includes an enhanced FMAP of 75% for Skilled Professional Medical Personnel costs for eligible activities. The estimate also includes funding for the Black Infant Health Program.

FY 2021-22	DHCS FFP*	DHCS SF**	CDPH GF	Other Match
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	\$2,999,000	\$0	\$0	\$2,999,000
Skilled Nursing Facilities	\$4,007,000	\$4,007,000	\$0	\$0
Total	\$12,901,000	\$4,007,000	\$3,463,000	\$5,431,000

FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS
OTHER ADMIN. POLICY CHANGE NUMBER: 70

FY 2022-23	DHCS FFP*	DHCS SF**	CDPH GF	Other Match
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	\$2,999,000	\$0	\$0	\$2,999,000
Skilled Nursing Facilities	\$4,007,000	\$0	\$4,007,000	\$0
Total	\$12,901,000	\$0	\$7,470,000	\$5,431,000

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: 71
IMPLEMENTATION DATE: 7/1984
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 253

	FY 2021-22	FY 2022-23
TOTAL FUNDS	\$5,250,000	\$6,235,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$5,250,000	\$6,235,000

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).

Authority:

Interagency Agreements:
 CBAS 03-76137
 MSSP 01-15976

Interdependent Policy Changes:

Not Applicable

Background:

The CDA coordinates with the Department to obtain FFP for the administrative costs for services related to Medi-Cal beneficiaries. CDA budgets the matching General Fund (GF).

Reason for Change:

The change from FY 2021-22, from the prior estimate, is an increase due to updated cash estimates provided by CDA. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase 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: 71

(Dollars in Thousands)

Program Support	FY 2021-22		FY 2022-23	
CBAS Support	CDA GF	FFP	CDA GF	FFP
FY 2020-21 DOS	\$399	\$513	\$0	\$0
FY 2021-22 DOS	\$2,538	\$3,170	\$846	\$1,057
FY 2022-23 DOS	\$0	\$0	\$2,668	\$3,433
Total CBAS	\$2,937	\$3,683	\$3,514	\$4,490
MSSP Support				
FY 2020-21 DOS	\$223	\$258	\$0	\$0
FY 2021-22 DOS	\$1,129	\$1,309	\$376	\$436
FY 2022-23 DOS	\$0	\$0	\$1,129	\$1,309
Total MSSP	\$1,352	\$1,567	\$1,505	\$1,1745
Grand Total	\$4,289	\$5,250	\$5,019	\$6,235

Totals may differ due to rounding.

Funding:

100% Title XIX (4260-101-0890)

100% MFP Federal Grant (4260-106-0890)*

FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG

OTHER ADMIN. POLICY CHANGE NUMBER: 72
IMPLEMENTATION DATE: 7/2020
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2244

	FY 2021-22	FY 2022-23
TOTAL FUNDS	\$5,009,000	\$5,316,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$5,009,000	\$5,316,000

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. Please note that OSHPD has begun a year-long process of transitioning from OSHPD to the Department of Health Care Access and Information (HCAI).

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/HCAI 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 the Department the appropriate mechanism to transfer the federal portion of the Health Care Data Payments system costs to OSHPD/HCAI. OSHPD/HCAI is providing the state share.

Reason for Change:

There is no change from the prior estimate for FY 2021-22. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to higher costs in the third year of the IA.

Methodology:

- Costs are estimated at \$5,009,007 for FY 2021-22 and \$5,316,348 for FY 2022-23.

Fiscal Years	TF	GF	FF
FY 2021-22	\$5,009,000	\$0	\$5,009,000
FY 2022-23	\$5,316,000	\$0	\$5,316,000

FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG
OTHER ADMIN. POLICY CHANGE NUMBER: 72

Funding:

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

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

CLPP CASE MANAGEMENT SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 73
IMPLEMENTATION DATE: 7/1997
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 239

	FY 2021-22	FY 2022-23
TOTAL FUNDS	\$2,722,000	\$8,166,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$2,722,000	\$8,166,000

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 2021-22 is a decrease due to delays in local jurisdictions invoicing to the State.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to delay in local jurisdictions invoicing to the State.

Methodology:

1. 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)

FY 2021-22	DHCS FFP	CDPH CLPP Fee Funds
FY 2019-20 Claims	\$2,722	\$2,722
Total for FY 2020-21	\$2,722	\$2,722

(Dollars in Thousands)

FY 2022-23	DHCS FFP	CDPH CLPP Fee Funds
FY 2020-21 Claims	\$2,722	\$2,722
FY 2021-22 Claims	\$2,722	\$2,722
FY 2022-23 Claims	\$2,722	\$2,722
Total for FY 2021-22	\$8,166	\$8,166

Funding:

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

CALIFORNIA SMOKERS' HELPLINE

OTHER ADMIN. POLICY CHANGE NUMBER: 74
IMPLEMENTATION DATE: 1/2014
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 1680

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$2,671,000	\$2,400,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$2,671,000	\$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 guidelines and the Department policies for providing services to Medi-Cal beneficiaries. CDPH ensures the Helpline services includes specially trained counselors to provide free telephone-based counseling, education, and support to Medi-Cal beneficiaries who currently smoke or have recently quit smoking.

The Department has an existing IA with CDPH to enable the State to receive 50% FFP for Helpline services administrative costs beginning July 1, 2013.

Reason for Change:

The change from the current year estimate for FY 2021-22 is a decrease due to prior year invoices paid in FY 2021-22.

The change in the budget year estimate, from FY 2021-22 to FY 2022-23, is a decrease due to fewer current 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 expenditures on an accrual basis for both FY 2021-22 and FY 2022-23 are \$2,400,000/FY. 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 2021-22 and FY2022-23, on a cash basis are:

FY 2021-22	TF	FF
FY 2020-21 Claims	\$671,000	\$671,000
FY 2021-22 Claims	\$2, 000,000	\$2,000,000
Total for FY 2021-22	\$2,671,000	\$2,671,000

FY 2022-23	TF	FF
FY 2021-22 Claims	\$400,000	\$400,000
FY 2022-23 Claims	\$2,000,000	\$2,000,000
Total for FY 2022-23	\$2,400,000	\$2,400,000

Funding:

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

KIT FOR NEW PARENTS

OTHER ADMIN. POLICY CHANGE NUMBER: 75
IMPLEMENTATION DATE: 7/2001
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 249

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$449,000	\$816,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$449,000	\$816,000

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 2021-22 is a decrease due to:

- FY 2018-19 invoices that were estimated to be paid in FY 2020-21, will be paid in FY 2021-22; and
- FY 2019-20 and FY 2020-21 invoices that were estimated to be paid in FY 2021-22, will be paid in FY 2022-23.

The change in the current estimate, from FY 2021-22 to FY 2022-23 is an increase due to claims for FY 2019-20 and FY 2020-21 were not received by CCFC as estimated. These invoices are expected to be paid in FY 2022-23.

Methodology:

1. CCFC distributed 96,000 kits in FY 2020-21 and an estimated 175,000 kits in FY 2021-22 and FY 2022-23. Of these kits, 43.38% are expected to be distributed to Medi-Cal eligible newborns.
2. Each kit, basic or custom, costs \$15.63.
3. The Department will pay for the estimated cost of kits distributed to parents of Medi-Cal eligible newborns, shown in the table below.

KIT FOR NEW PARENTS
OTHER ADMIN. POLICY CHANGE NUMBER: 75

	Annual Number of Kits	Medi-Cal	Total Medi-Cal Kits	Cost per kit	Total Cost (Accrual)
FY 2018-19	132,328	43.38%	57,404	\$15.63	\$897,223
FY 2019-20	145,597	43.38%	63,160	\$15.63	\$987,190
FY 2020-21	96,000	43.38%	41,645	\$15.63	\$650,908
FY 2021-22	175,000	43.38%	75,915	\$15.63	\$1,186,551
FY 2022-23	175,000	43.38%	75,915	\$15.63	\$1,186,551

4. Assume the Department will pay \$449,000 in FY 2021-22 and \$816,000 in FY 2022-23 for kits to new parents of Medi-Cal eligible newborns.

Fiscal Year	FY 2021-22	FY 2022-23
Total	\$897,000	\$1,633,000
Total FF (50%)	\$449,000	\$816,000

Funding:

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

VETERANS BENEFITS

OTHER ADMIN. POLICY CHANGE NUMBER: 76
IMPLEMENTATION DATE: 12/1988
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 232

	FY 2021-22	FY 2022-23
TOTAL FUNDS	\$1,100,000	\$1,100,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$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) # 20-10053

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, 2020, and was renewed effective July 1, 2020.

Reason for Change:

There is no change from the prior estimate for FY 2021-22. There is no change from FY 2021-22 to FY 2022-23 in the current estimate.

Methodology:

- The contract amount is estimated to be \$1,100,000 for FY 2021-22 and FY 2022-23. The non-federal match is budgeted by CDVA.

FY	FY 2021-22			FY 2022-23		
	TF	CDVA GF	DHCS FF	TF	CDVA GF	DHCS FF
Administrative	\$724,000	\$362,000	\$362,000	\$724,000	\$362,000	\$362,000
Workload Units	\$1,476,000	\$738,000	\$738,000	\$1,476,000	\$738,000	\$738,000
Total	\$2,200,000	\$1,100,000	\$1,100,000	\$2,200,000	\$1,100,000	\$1,100,000

Funding:

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

MEDI-CAL INPATIENT SERVICES FOR INMATES

OTHER ADMIN. POLICY CHANGE NUMBER: 77
IMPLEMENTATION DATE: 3/2011
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 1665

	FY 2021-22	FY 2022-23
TOTAL FUNDS	\$1,077,000	\$1,121,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,077,000	\$1,121,000

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)
 AB 80 (Chapter 12, Statutes of 2020)
 Interagency Agreement #20-10027 (CDCR Agreement #19-00211)

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.

MEDI-CAL INPATIENT SERVICES FOR INMATES

OTHER ADMIN. POLICY CHANGE NUMBER: 77

AB 80 (Chapter 12, Statutes of 2020) conforms the suspension of benefits for juveniles, as defined under state law, with the existing federal law, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act). The definition of juvenile has changed (both State and County) to include individuals under the age of 21 or individuals enrolled in the former foster youth group under the age of 26. "Eligible Juveniles," as defined by the SUPPORT Act, only impacts Medi-Cal suspension of benefits policies and does not impact eligibility age restrictions or age requirements for general Medi-Cal programs.

Reason for Change:

The change from the prior estimate, for FY 2021-22, is an increase due to an increase in personnel costs. The change from FY 2021-22 to FY 2022-23, in the current estimate, is an increase due to projecting an increase in personnel costs.

Methodology:

1. Implementation of the Inmate Eligibility Program began April 1, 2011.
2. Administrative costs are in accordance with Interagency Agreement #20-10027.
3. Reimbursements for administrative costs began in March 2011.
4. The federal share of ongoing administrative costs is **\$1,077,000** in **FY 2021-22** and **\$1,121,000** in **FY 2022-23**.

Funding:

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

CHHS AGENCY HIPAA FUNDING

OTHER ADMIN. POLICY CHANGE NUMBER: 78
IMPLEMENTATION DATE: 7/2001
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 257

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$1,022,000	\$1,037,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,022,000	\$1,037,000

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) 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.

A three-year IA beginning July 1, 2020, has been executed and payments started in August 2020.

Reason for Change:

There is no change from the prior estimate for FY 2021-22. The change from FY 2021-22 to FY 2022-23 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
FY 2021-22	\$1,022,000	\$1,022,000
FY 2022-23	\$1,037,000	\$1,037,000

Funding:

100% HIPAA (4260-117-0890)

VITAL RECORDS

OTHER ADMIN. POLICY CHANGE NUMBER: 79
IMPLEMENTATION DATE: 5/2016
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1774

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$891,000	\$891,000
STATE FUNDS	\$8,000	\$8,000
FEDERAL FUNDS	\$883,000	\$883,000

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:

There is no change in FY 2021-22 from the prior estimate. There is no change from FY 2021-22 to FY 2022-23 in the current estimate.

VITAL RECORDS

OTHER ADMIN. POLICY CHANGE NUMBER: 79

Methodology:

1. The annual state cost to deliver vital records data is \$1,166,000 TF. The Department receives 75% FFP for ongoing costs to obtain vital records data, with the 25% state share provided by the CDPH 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 2021-22 and FY 2022-23 on a cash basis are:

(Totals Rounded to Thousands)

FY 2021-22	TF	HSSF	GF	FF
FY 2020-21 Records Data	\$292,000	\$73,000	\$0	\$219,000
FY 2020-21 Certified Copies	\$4,000	\$0	\$2,000	\$2,000
FY 2021-22 Records Data	\$875,000	\$219,000	\$0	\$656,000
FY 2021-22 Certified Copies	\$12,000	\$0	\$6,000	\$6,000
Total	\$1,183,000	\$292,000	\$8,000	\$883,000

FY 2022-23	TF	HSSF	GF	FF
FY 2021-22 Records Data	\$292,000	\$73,000	\$0	\$219,000
FY 2021-22 Certified Copies	\$4,000	\$0	\$2,000	\$2,000
FY 2022-23 Records Data	\$875,000	\$219,000	\$0	\$656,000
FY 2022-23 Certified Copies	\$12,000	\$0	\$6,000	\$6,000
Total	\$1,183,000	\$292,000	\$8,000	\$883,000

*Totals may differ due to rounding.

Funding:

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

MERIT SYSTEM SERVICES FOR COUNTIES

OTHER ADMIN. POLICY CHANGE NUMBER: 80
IMPLEMENTATION DATE: 7/2003
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 263

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$190,000	\$190,000
STATE FUNDS	\$95,000	\$95,000
FEDERAL FUNDS	\$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 2021-22 or in the current estimate from FY 2021-22 to FY 2022-23.

Methodology:

1. CalHR provided the estimates on a cash basis.
2. The estimated reimbursement is \$190,000 TF (\$95,000 GF) in FY 2021-22 and \$190,000 TF (\$95,000 GF) in FY 2022-23.

Funding:

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

CDPH I&E PROGRAM AND EVALUATION

OTHER ADMIN. POLICY CHANGE NUMBER: 81
IMPLEMENTATION DATE: 7/2021
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 261

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$86,000	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$86,000	\$0

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 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:

There is a decrease from the prior estimate for FY 2021-22 due to updated payment timing and estimated expenditures. There is a decrease in the current estimate from FY 2021-22 to FY 2022-23 due to no payments anticipated to be made in FY 2022-23.

CDPH I&E PROGRAM AND EVALUATION

OTHER ADMIN. POLICY CHANGE NUMBER: 81

Methodology:

1. CDPH budgets the non-federal matching funds.
2. The estimates are budgeted on a cash basis based on anticipated payment timing of invoices.
3. The estimated costs for **FY 2021-22** are estimated to be **\$86,000 Federal Funds**.

Funding:

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

PIA EYEWEAR COURIER SERVICE

OTHER ADMIN. POLICY CHANGE NUMBER: 82
IMPLEMENTATION DATE: 7/2003
ANALYST: Elena Susbilla
FISCAL REFERENCE NUMBER: 1114

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$766,000	\$941,000
STATE FUNDS	\$383,000	\$470,500
FEDERAL FUNDS	\$383,000	\$470,500

Purpose:

This policy change estimates courier services costs for Prison Industry Authority (PIA) eyewear.

Authority:

Interagency Agreement (IA) #18-95000/A01

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.

Reason for Change:

The change in FY 2021-22, from the prior estimate, is a decrease due to the effect of COVID-19 and the delay in invoicing for Quarter 3 FY 2020-21 services.

The change from FY 2021-22 to FY 2022-23, in the current estimate, is due to an increase in courier costs resulting from the restoration of adult optician and optical lab services and return of demand to pre-COVID levels.

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. There is a one-quarter lag between services provided and payment of the invoice.
2. The cost of shipping 132,200 packages was paid in FY 2020-21 which includes actuals for service quarter FY 2019-20 Q4 and FY 2020-21 Q1 and Q2. Reduction was due to the effects of COVID-19.

PIA EYEWEAR COURIER SERVICE
OTHER ADMIN. POLICY CHANGE NUMBER: 82

Service Quarter	Packages (rounded)
FY 2019-20 Q4	30,700
FY 2020-21 Q1	53,500
FY 2020-21 Q2	48,000
Total	132,200

$$\$2.13 * 132,200 = \$282,000 \text{ (rounded)}$$

3. Assume 359,800 packages will be paid in FY 2021-22 and 441,600 will be paid in FY 2022-23 based upon an assumed return to pre-COVID-19 estimated costs.

Service Quarter	Packages (rounded)
FY 2020-21 Q3	62,000
FY 2020-21 Q4	77,000
FY 2021-22 Q1	110,400
FY 2021-22 Q2	110,400
Total FY 2021-22	359,800

$$\$2.13 \times 359,800 = \$766,000 \text{ TF (rounded)}$$

Service Quarter	Packages (rounded)
FY 2021-22 Q3	110,400
FY 2021-22 Q4	110,400
FY 2022-23 Q1	110,400
FY 2022-23 Q2	110,400
Total FY 2022-23	441,600

$$\$2.13 \times 441,600 = \$941,000 \text{ TF (rounded)}$$

Fiscal Year	TF	GF	FF
FY 2021-22	\$766,000	\$383,000	\$383,000
FY 2022-23	\$941,000	\$470,000	\$471,000

Funding:

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

COVID-19 VACCINATION INCENTIVE PROGRAM ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 83
IMPLEMENTATION DATE: 9/2021
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2339

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$100,000,000	\$0
STATE FUNDS	\$50,000,000	\$0
FEDERAL FUNDS	\$50,000,000	\$0

Purpose:

This policy change estimates the cost of administering the Medi-Cal COVID-19 Vaccination Incentive Program.

Authority:

Title 42, Code of Federal Regulations, Part 438.6(b)
 Medi-Cal Public Assistance Cost Allocation Plan

Interdependent Policy Changes:

Not Applicable

Background:

On March 13, 2020, a national public health emergency (PHE) was declared regarding the COVID-19 outbreak. The Department identified certain target populations that have been disproportionately challenged in the initial phases of vaccine distribution including; homebound and those unable to travel, elderly populations with multiple chronic diseases, members who self-identify as persons of color, and youth 12-25 years old. In an effort to improve vaccine access and boost vaccination rates across these populations and more broadly, the Department will implement the Medi-Cal COVID-19 Vaccination Incentive Program effective September 1, 2021, through February 28, 2022.

The Department has adopted vaccination performance measures for MCPs that include both process and outcome measures. Participating MCPs will develop and submit a Vaccination Response Plan that outlines their strategies for improving vaccination rates including for the target populations. A \$100 million pool of funds available for MCPs to utilize for direct member incentives (e.g. \$50 gift card to grocery store) as part of the MCP's Vaccination Response Plan.

Reason for Change:

This is a new policy change.

Methodology:

- The estimated costs for direct member incentives for the COVID-19 Vaccination Incentive Program on a cash basis are:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF	\$100,000	\$50,000	\$50,000
Total	\$100,000	\$50,000	\$50,000

COVID-19 VACCINATION INCENTIVE PROGRAM ADMIN
OTHER ADMIN. POLICY CHANGE NUMBER: 83

Funding:

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

HCBS SP CDDS - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 86
IMPLEMENTATION DATE: 3/2022
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2349

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$1,167,000	\$2,521,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,167,000	\$2,521,000

Purpose:

This policy change estimates the federal reimbursements as a one-time payment or ongoing payments for the California Department of Developmental Services (CDDS) home and community-based services (HCBS) spending plan other administrative items.

Authority:

American Rescue Plan (ARP) Act (2021)
Section 11.95, 2021 Budget Act

Interdependent Policy Changes:

American Rescue Plan Increased FMAP for HCBS

Background:

The American Rescue Plan Act of 2021 (ARP) provides additional Coronavirus Disease 2019 (COVID-19) relief to states. Section 9817 of the ARP provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS). Increased FMAP is available from April 1, 2021 through March 31, 2022. States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. State funds equivalent to the amount of federal funds attributable to the increased FMAP are deposited in the Home and Community-Based Services American Rescue Plan Fund pursuant to Section 11.95 of the 2021 Budget Act. Section 11.95 appropriates this funding to eligible HCBS activities identified in the HCBS Spending Plan.

Reason for Change:

This is a new policy change.

HCBS SP CDDS - OTHER ADMIN
OTHER ADMIN. POLICY CHANGE NUMBER: 86

Methodology:

1. The cash basis estimate for the HCBS spending plan administrative items for CDDS are:

(Dollars in Thousands)

FY 2021-22	TF	HCBS ARP Fund-CDDS	FF
Developmental Services Rate Model Implementation (Other Admin)	\$2,084	\$1,667	\$417
Modernize Regional Center Information Technology Systems	\$3,750	\$3,000	\$750
Enhanced Community Integration for Children and Adolescents	\$12,500	\$12,500	\$0
Total	\$18,334	\$17,167	\$1,167

(Dollars in Thousands)

FY 2022-23	TF	HCBS ARP Fund-CDDS	FF
Developmental Services Rate Model Implementation (Other Admin)	\$8,854	\$7,083	\$1,771
Modernize Regional Center Information Technology Systems	\$3,750	\$3,000	\$750
Total	\$12,604	\$10,083	\$2,521

Funding:

100% Title XIX (4260-101-0890)

COVID-19 INCREASED FMAP EXTENSION - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 87
IMPLEMENTATION DATE: 1/2022
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2258

	<u>FY 2021-22</u>	<u>FY 2022-23</u>
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$737,000	-\$369,000
FEDERAL FUNDS	\$737,000	\$369,000

Purpose:

This policy change estimates the CHIP administrative expenditures of an assumed extension of the availability of increased federal medical assistance percentage (FMAP) from January 2022 through June 2022. For the estimated impact of assuming an extension of the availability of increased FMAP from January 2022 through June 2022 on benefits expenditures, see the COVID-19 Increased FMAP Extension - DHCS policy change. For the estimated impact of increased FMAP from July 2021 through December 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. 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: 87

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 June 30, 2022.
3. Assume a two-month cash lag.
4. The following estimates are on a cash basis:

(Dollars in Thousands)

FY 2021-22	TF	GF	SF	FF
COVID-19 Increased FMAP - Other Admin:				
FFCRA 4.34% Increased FFP	\$0	(\$737)	\$0	\$737
Total COVID-19 Incr. FMAP - Other Admin:	\$0	(\$737)	\$0	\$737

(Dollars in Thousands)

FY 2022-23	TF	GF	SF	FF
COVID-19 Increased FMAP - Other Admin:				
FFCRA 4.34% Increased FFP	\$0	(\$369)	\$0	\$369
Total COVID-19 Incr. FMAP - Other Admin:	\$0	(\$369)	\$0	\$369

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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MEDI-CAL INFORMATION ONLY
November 2021
FISCAL YEARS 2021-22 & 2022-23

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).

Community Inpatient

- Community Hospital Inpatient
- Consists of Non-Designated Public Hospitals, Private Hospitals, and some Designated Public Hospitals. The Non-Designated Public Hospitals and Private Hospitals are paid using a Diagnosis Related Group payment methodology. The Designated Public Hospitals are paid based on an interim per diem rate utilizing Certified Public Expenditures. DPH payments are 100% federal funds and the DPH pays the State's match. More information is available at the Department's website (www.dhcs.ca.gov).

Nursing Facilities

- | | |
|--|--|
| <ul style="list-style-type: none">• Long Term Care Nursing Facility• Long Term Care Intermediate Care Facility (NF-A)• Pediatric Subacute Care – Long Term Care• These three provider types include Nursing Facility - Level A (NF-A), Nursing Facility – Level B (NF-B), Distinct Part Skilled Nursing | Facilities of General Acute Care Hospitals (DP/NF-Bs), Distinct Part Adult Subacute Units for General Acute Care Hospitals (DP/SA), Rural Swing Beds, Institution for Mental Diseases, Acute and Transitional Inpatient Care Administrative Days (Administrative Days Level 1) |
|--|--|

ICF-DD

- Long Term Care Intermediate Care Facility/Developmentally Disabled

Medical Transportation

- Ground Medical Transportation
- Air Ambulance Transportation

Other Services

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

Home Health

- Home Health Agency (except Home & Community Based Services)

Effective January 1, 2014, the Affordable Care Act (ACA) ~~establishes~~ **established** 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~~ **simplified** the enrollment process and ~~eliminates~~ **eliminated** the asset test for MAGI eligible. Existing income eligibility rules for aged, blind, and disabled persons did not change.

The ~~new standard~~ **ACA** allows current recipients of Medi-Cal to continue to enroll in the program and ~~grants~~ **granted** 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~~ **imposed** 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~~ **ceased to be effective**, January 1, 2019. **Effective January 1, 2020, California established an equivalent penalty on individuals without health coverage.**

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.

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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)

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Targeted Case Management (TCM)

The TCM Program provides specialized case management services to Medi-Cal eligible individuals who are developmentally disabled. These clients can gain access to needed medical, social, educational, and other services. TCM services include:

- Needs assessment
- Development of an individualized service plan
- Linkage and consultation
- Assistance with accessing services
- Crisis assistance planning
- Periodic review

1915(i) HCBS State Plan Services

The 1915(i) State Plan Services program provides home and community-based services (HCBS) to persons with developmental disabilities (DD) who are Regional Center consumers but do not meet nursing facility level of care criteria required for enrollment in the HCBS Waiver of Persons with DD. As of February 1, 2016, Behavioral Health Treatment (BHT) services for 1915(i) participants under the age of 21 is a state plan benefit and paid through the managed care delivery system or fee-for-service for members not eligible to enroll into managed care. The 1915(i) State Plan Amendment (SPA) 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 **The Department submitted a SPA to renew the 1915(i) Waiver, effective on October 1, 2016, through September 30, 2021. The Centers for Medicare and Medicaid Services (CMS) approved the 1915(i) State Plan for a new 5-year term, effective October 1, 2021, through September 30, 2026.**

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.

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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 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.~~

~~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 effective date of the SPA will be the date of approval, or a prospective date thereafter.~~

~~The Department submitted a SPA to add Intensive Transition Services and Speech-Language Pathology Assistants as a new provider type. The effective date of the SPA is to be determined, subject to CMS approval.~~

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. Per CMS' direction, the Department withdrew the SPA and resubmitted it as Disaster Relief SPA (DR SPA) 21-0049 with a retroactive effective date of May 1, 2020. CMS approved the DR SPA 21-0049 on December 15, 2021.

The Department submitted three SPAs to CMS but withdrew them per CMS directive and resubmitted as consolidated DR SPA 21-0050. The consolidated DR SPA included reimbursement rates for specified providers from January 1, 2020, to December 31, 2021, as authorized under W&I Code section 4691.12, effective March 1, 2020. Additionally, the DR SPA added Intensive Transition Services and Speech-Language Pathology Assistants as a new provider type, effective July 1, 2020, as well as increased payment rates through the end of the Public Health Emergency, effective January 16, 2021. CMS approved the consolidated DR SPA 21-0050 on December 22, 2021.

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

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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. 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.

Through California's Home and Community-Based Services (HCBS) Spending Plan, the Department proposed adding 7,000 slots to the ALW in the effort to eliminate the current ALW waitlist. The addition of these slots will enable the Department to provide sufficient capacity to enroll all waitlisted beneficiaries and to clear pending enrollments while still providing a cushion for continued growth.

On October 27, 2021, the Department submitted an ALW technical amendment to increase the maximum number of waiver slots to CMS for approval with a retroactive implementation date of July 1, 2021. Once approved, CMS informed the Department that agencies could immediately start enrolling clients on the waitlist. The Department intends to submit an ALW amendment to remove the 60%/40% enrollment ratio by the end of SFY 2021-22.

The Department is assessing the ALW for integration in the HCBA Waiver. **The Department will continue activities for the integration of ALW into the HCBA Waiver. The high-level purpose of integrating the ALW and HCBA Waiver is to expand ALW services statewide, while reducing the internal burden of administering two 1915(c) waivers. To ensure the highest-quality outcome when integrating the ALW and HCBA Waivers, the Department will be implementing a phased-in integration of the ALW and HCBA Waiver by the end of the current ALW term, February 28, 2024.**

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Community-Based Adult Services (CBAS)

AB 97 (Chapter 3, Statutes of 2011) eliminated Adult Day Health Care (ADHC) a Medi-Cal optional benefit. A lawsuit was filed challenging elimination of ADHC (*Darling et al. v. Douglas et al.*), resulting in a settlement agreement between DHCS and the plaintiffs. The settlement agreement eliminated the ADHC program effective March 31, 2012, and replaced it with a new program called CBAS. CBAS is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to approved program participants. CBAS provides necessary medical and social services to individuals with intensive health care needs. CBAS became a managed care benefit effective April 1, 2012, through an amendment to the “Bridge to Reform” 1115 Medicaid waiver. Under the Bridge to Reform Waiver, CBAS was authorized for a temporary extension through December 31, 2015. The Department submitted a new 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 received CMS approval of its proposal to apply a one-year extension of this waiver to December 31, 2021 due to the COVID-19 public health emergency. **CMS approved the Department’s 1115 Waiver renewal application on December 29, 2021, for a new five year term, effective January 1, 2022, through December 31, 2027.**

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~~ **March 31, 2022.**

The renewed 1115 Waiver includes an ongoing remote services option for CBAS. Under certain unique circumstances, CBAS Emergency Remote Services (ERS) may be provided in response to the individual’s person-centered needs. This is for CBAS members who have unique circumstances and are time limited to facilitate availability for services when beneficiaries are not able to access in person services.

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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 implemented the structure of provider supplemental payments for qualified CBAS services **funding the state share with revenues from the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56)**. The supplemental payments structure is **was** subject to suspension on June 30, 2021. The Governor's Budget proposes to extend the supplemental payments until December 31, 2022. **The Budget Act of 2021 removed this suspension. The 2022 Governor's Budget proposes to shift the state funding source of these supplemental payments to the General Fund.**

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.

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 submitted a waiver renewal application for the HCBA Waiver for a new five-year term, January 1, 2022, through December 31, 2026. The Department received a 90-day temporary extension of the current waiver that was set to expire December 31, 2021. The temporary extension expires March 31, 2022.**

The following changes included in the waiver renewal application will have an impact on the Medi-Cal budget: the addition of new waiver services, a rate increase for Personal Care Agencies in response to the statewide minimum wage increase, and additional waiver slots beginning on January 1, 2024, based on projected enrollment and attrition trends. 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

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slots may only be used by specific groups of individuals, as identified in the HCBA Waiver. CMS approved the amendment, effective January 1, 2020.

The current HCBA Waiver term ends December 31, 2021, and the Department is currently engaged in a stakeholder and technical workgroup process to obtain stakeholder input on recommended changes to include in the waiver renewal application that will be submitted to CMS. As part of this process, the Department is assessing integration of the ALW into the HCBA Waiver through the renewal. The waiver renewal application will request a new five-year waiver term effective January 1, 2022, through December 31, 2026, and will be posted for a 30-day public comment period in July 2021 prior to submission to CMS in September 2021.

Acquired Immune Deficiency Syndrome (AIDS) Medi-Cal Waiver

Local agencies, under contract with the California Department of Public Health (**CDPH**), 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

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. The California Department of Public Health is currently engaged in a stakeholder process to obtain stakeholder input regarding recommended changes to include in the waiver renewal application that will be submitted to CMS no later than September 2021.

The Department, on behalf of CDPH, submitted a waiver renewal application for the AIDS Waiver for a new five-year term, effective January 1, 2022, through December 31, 2026. The Department received a 90-day temporary extension of the current waiver that was set to expire December 31, 2021. The temporary extension expires March 31, 2022.

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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 **funding the state share with revenues from the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56)**. 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. **The 2022 Governor's Budget proposes to shift the state funding source of this rate increase to the General Fund.**

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 center, household and personal care assistance, protective supervision, care management, respite, transportation, meal services, social services, minor home repair/maintenance and communication services.

The program provides services under a federal 1915(c) home and community-based services waiver. The Department submitted a waiver renewal application on March 28, 2019. The 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 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.

The MSSP benefit was scheduled to be carved out from the ~~GGI~~ **Coordinated Care Initiative (CCI)**, subject to CMS approval, effective January 1, 2021. This proposed carve out was delayed to January 1, 2022, due to the postponement of the California Advancing and Innovating Medi-Cal (CalAIM) initiative and the COVID-19 public health emergency. With the delay of CalAIM, the Department submitted a 12-month extension request to CMS for the Medi-Cal 2020 waiver extending its current term through December 31, 2021.

The Department is carving out the MSSP benefit through the MSSP waiver within CCI counties, effective January 1, 2022.

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. **The Budget Act of 2021 extended this supplemental funding and increased the number of program slots, effective January 1, 2022.**

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Home and Community-Based Waiver for Persons with Developmental Disabilities

The HCBS DD Waiver provides home and community-based services to persons with developmental disabilities who are Regional Center consumers as an alternative to care provided in a facility that meets the Federal requirement of an intermediate care facility for the 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 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 amendment was approved with an effective date 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

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adds services to transition consumers placed at Institutions for Mental Diseases into alternative community settings. The amendment was approved with an effective date of January 19, 2021.

The Department submitted a Waiver Amendment for a time-limited rate increase for Independent Living Program (ILP) providers, pursuant to AB 79, with an effective term of January 1, 2021 through December 31, 2021. The amendment was approved with an effective date of January 1, 2021.

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.

The California Department of Developmental Disabilities engaged in a stakeholder process to obtain stakeholder input regarding recommended changes to include in the waiver renewal application that was submitted to CMS in March 2021. **CMS approved the waiver renewal for a new five-year term, effective July 1, 2021, through June 30, 2026.**

Managed Care Programs

Program of All Inclusive Care for the Elderly (PACE)

PACE is a federally defined, comprehensive, and capitated managed care model program that delivers fully integrated services. PACE covered services include all medical long-term services and supports, dental, vision and other specialty services, allowing enrolled beneficiaries who would otherwise be in an intermediate care facility or in a skilled nursing facility to maintain independence in their homes and communities. Participants must be 55 years or older and determined by the Department to meet the Medi-Cal regulatory criteria for nursing facility placement. PACE participants receive their services from a nearby PACE Center where clinical services, therapies, and social interaction take place.

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

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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.

The population that is eligible for the state-funded program are residents of inpatient facilities who meet the eligibility criteria to enroll in the federally-funded Money Follows the Person (MFP) Rebalancing Demonstration, with one exception (MFP is known as California Community Transitions (CCT) in our state). To be eligible for the federally-funded program, a beneficiary is required to have been a resident of an inpatient facility for at least 60 days – the state-funded program removes the 60-day eligibility criteria to provide transition coordination services to beneficiaries residing in SNF who meet all other MFP/CCT enrollment criteria; including:

- **At least one day of their stay in the facility must be funded by Medicaid; and**
- **The beneficiary would continue to require skilled nursing care in a facility if not for the transition coordination and home and community-based long-term services and supports provided/secured for them through the CCT program.**

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

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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 September 23, 2020, 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 **developed** 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 Department submitted its application to CMS on June 30, 2021. On July 27, 2021, CMS approved the Department's MFP Supplemental Funding application. CMS approved the Department's request for \$5 million in supplemental funding to conduct a statewide Gap Analysis and Multiyear Roadmap of its Home and Community-Based Services (HCBS) and Managed Medi-Cal Long-Term Supports and Services (MLTSS) programs and networks. The Department's project narrative identified how the funding will be utilized for planning and capacity building activities to accelerate long-term care system transformation design and implementation, and to expand HCBS capacity.**

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, 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.

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. Under the Consolidated Appropriations Act of 2021, the 90 day minimum stay requirement will be reduced to 60 days, effective January 26, 2021.

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 CMS has approved 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~~ **ended** June 30, 2020 (PY 5). On ~~June 30, 2019~~ **October 9, 2020**, the Department ~~requested~~ **received** 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~~ **are** separate and distinct from the existing ~~previous~~ 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~~ **expired** on June 30, 2020. This transition will promote value-based purchasing and ties funding to quality outcomes. Additionally, the Department ~~proposes to align~~ **aligned** 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.

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- Global Payment Program (GPP) – A new program aimed at improving the way care is delivered to California’s remaining uninsured. GPP transforms traditional hospital funding for DPHs from a system that focuses on hospital-based services and cost-based reimbursement into a value-based payment structure. Under the GPP, DPHs are incentivized to provide ambulatory primary and preventive care to the remaining uninsured through a value-based payment structure that rewards the provision of care in more appropriate settings. This new and innovative approach to restructuring these traditional hospital-focused funds allows California to better target funding for the remaining uninsured and incentivize delivery system change – focusing on the provision of primary and preventive care, and shifting away from avoidable emergency room and hospital utilization. The federal funding for GPP will be a combination of the DSH funding for participating DPHs and \$236 million in federal funding for the first year from the prior 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~~ **allows** 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. However, as described in the Medi-Cal 2020 Designated State Health Programs policy change, CMS did not grant the state ability to claim for DHSP above the existing five-year limit of \$375 million.

MANAGED CARE

Medi-Cal Managed Care Rates

Base rates are developed utilizing primarily plan reported cost and utilization data by category of service (i.e. Inpatient Hospital, Emergency Room, Physician Primary Care, 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 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 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 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. As of rating periods beginning on or after July 2018, each plan's final rate is a blend consisting of 75% of the county-specific rate and 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 State has implemented supplemental payments for the costs of maternity services related to labor/delivery 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 with CY 2021, rates are developed annually on a calendar year basis thereafter.

MANAGED CARE

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. This Managed Care Organization (MCO) Enrollment Tax 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.

Coordinated Care Initiative (CCI) Program

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. MSSP will be removed from capitation rate payments effective January 1, 2022.

As part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative's standardized mandatory enrollment of dual eligibles and statewide integration of long-term care into managed care, the CCI pilot program will sunset December 31, 2022.

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, July 1, 2020, through December 31, 2020, and CY 2021 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 Medi-Cal FFS program. The services rendered in the above scenario are commonly referred to as

MANAGED CARE

“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 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.

Effective January 1, 2023, long term care (LTC) services that were previously “carved-out” of managed care in non-COHS, non-CCI counties, will be integrated into managed care. Under the current policy, managed care beneficiaries in non-COHS, non-CCI counties are disenrolled from managed care plans one month after the month of admission to an LTC facility, at which point the FFS delivery system would be responsible for providing all State Plan services. Until a beneficiary is disenrolled, the managed care plan is responsible for medically necessary LTC services within this timeframe. With the January 1, 2023, managed care LTC “carve-in,” both the beneficiary and related ongoing LTC expenditures will remain in the managed care delivery system.

LTC services are not currently “carved-out” of managed care in COHS and CCI counties. Therefore, there will be no change to their responsibility regarding LTC services within these counties.

Managed Care Procurement

The objective of the managed care procurement process is to procure commercial plans to provide high quality, accessible, and cost-effective health care through established networks of organized systems of care, which emphasize primary and preventive care. The draft Request for Proposal (RFP) 20-10029 was released on June 1, 2021. The RFP will provide procurement information and a draft of the new MCP Contract awarded through the RFP process. The RFP process will be used to procure commercial health plans in the following Plan Model types: Two-Plan, Geographic Managed Care (GMC), and Regional. Based on current approvals for County Plan Model changes that will be effective January 1, 2024, San Benito County will join Central California Alliance for Health (CAAH) as part of the COHS plan model and Imperial County will become a new Single Plan Model. All final County Plans Model changes are contingent on passing all Plan operational readiness activities in FY 2022-23. The RFP will not be used to procure the COHS Plans, or Local Initiative Plans in the Non-COHS plan model types. The Department intends to release the final RFP on February 2, 2022. Contract awards are anticipated mid-2022 with a target operational start date of January 1, 2024, once MCPs have successfully demonstrated operational readiness.

PROVIDER RATES

Reimbursement Methodology and the Quality Assurance Fee for Freestanding Nursing Facility Level Bs & Freestanding Subacute Level B Facilities

AB 1629 (Chapter 875, Statutes of 2004) required the Department to develop a cost-based, facility-specific reimbursement rate methodology for Freestanding Nursing Facility Level-Bs (FS/NF-Bs), 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.

PROVIDER RATES

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.

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.

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 90th percentile to the 95th 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)

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.

PROVIDER RATES

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 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%.

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 Department expects the suspension of this supplemental payment program to be delayed until January 1, 2023.~~ **Subsequent Budget Acts have continued this funding. The 2022 Governor's Budget proposes to shift the state share funding source of these supplemental payments to General Fund. The Budget Act of 2021 additionally eliminated reductions, limitations or increases to ICF/DD facilities and unfroze the rate.**

PROVIDER RATES

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.

CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM)

CalAIM is a comprehensive set of proposals that collectively 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. DMC-ODS Program Renewal and Policy Improvements

This assumption has been deleted; see updated information under “CalAIM Drug Medi-Cal Organized System Renewal”.

2. Behavioral Health Payment Reform

The Department is planning to implement the first phase of behavioral health (BH) payment reform in FY ~~2023-24~~ 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.

3. BH Medical Necessity Updated Criteria for Specialty Mental Health Services

~~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~~ **modifying the criteria for specialty mental health services** to align with state/federal requirements and more clearly delineate and standardize the benefit statewide, **effective January 1, 2022**. As part of this effort, the Department is also seeking to identify and implement screening and transition of care tool that may **tools that shall** be used to determine the appropriate level of care for mental health services, **effective January 1, 2023**. ~~It is anticipated that the new medical necessity criteria would be implemented no sooner than January 1, 2022.~~

CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM)

4. 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 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.

5. 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.

CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM)

6. Enhancing CCS and CHDP Oversight and Monitoring

The California Children's Services (**CCS**) program provides case management services, diagnostic, and treatment services, and physical and occupational therapy services to children and youth with eligible medical conditions **special health care needs**. The Child Health and Disability Prevention (**CHDP**) 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 **CCS and CHDP** beneficiaries are best served when their care is delivered in a standardized and consistent manner **across the State**. In alignment with the State's responsibility to **Through the CalAIM initiative, the State shall** ensure that the same **consistent** high quality standard of care, is compliant with federal and State guidelines for all, **is provided to all qualified** beneficiaries, as a part of its California Advancing and Innovating Medi-Cal (CalAIM) initiative, DHCS. **As part of this initiative, the Department** will implement new processes **and procedures** to provide enhanced monitoring and oversight of all 58 counties **and 3 cities (Berkeley, Long Beach, and Pasadena)** to ensure continuous, and unwavering optimal care **is provided** for children **this medically fragile population**. To implement the **this** enhanced monitoring and oversight, of California Children's Services and Child Health and Disability Prevention in all counties, DHCS **the Department** 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 **and implementation** of auditing tools to assess county operations and compliance; **evaluating and analyzing analysis and evaluation of** the findings gathered during audits **(desk, on-site and/or virtual)** to identify gaps and vulnerabilities across counties within the **these** programs; **implementation of corrective action plans as necessary**; 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 **conducting** provider oversight and the **providing the necessary** medical and dental care for beneficiaries. DHCS **The Department** will also enter into a Memorandum of Understanding with each County/City **county/city** that will detail how the **outline the** State will monitor county activities, policies and procedures, conduct audits, and implement corrective action plans **and county/city responsibilities to hold both entities accountable for action/in-action**.

After initial deployment of the enhanced monitoring and oversight, DHCS **the Department** will continue to conduct ongoing audits, **stay be** proactive with emerging developments, and monitor trends to ensure high-quality consistent care. DHCS **The Department** will allow sufficient time for counties/**cities** to implement and adjust to this new structure prior to engaging in any sort of progressive action. DHCS **The Department** 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 **and** no additional funds **will be** added to the county/city budgets.

CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM)

7. Enhancing Eligibility Oversight & Monitoring

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.

9. CalAIM DMC-ODS Renewal

The Department received CMS approval to renew the DMC-ODS program and incorporate additional services and benefits, effective January 2022. Through the new CalAIM 1115 Demonstration, the Department will continue the:

- **Waiver of the IMD exclusion to secure federal Medicaid matching funds for DMC-ODS services that are provided in an IMD to individuals over 21 and under 65, and**
- **Continuation of the DMC-ODS Certified Public Expenditure (CPE) Protocols. CPE protocols would continue until Behavioral Health Payment Reform begins.**

CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM)

Effective January 1, 2022, the rest of the DMC-ODS transitions from the 1115 Waiver Demonstration to the 1915(b) waiver authority, and corresponding State Plan Amendments (SPA) including the Medi-Cal managed care plans, county mental health plans and DMC-ODS plans, incorporating improvements to improve quality and access, based on the experience of the first five pilot years. The Department has conducted outreach efforts to encourage counties to participate in the DMC-ODS waiver and new counties have expressed interest in participating. The fiscal impact from the expected increased county participation is still to be determined.

AMERICAN RESCUE PLAN ACT

On March 11, 2021, the President signed the American Rescue Plan Act (ARPA) of 2021. ARPA includes several major provisions related to Medicaid. Most notably, ARPA: (1) provides 100 percent federal funding for COVID-19 vaccine administration, as described in the COVID-19 Vaccine Administration policy change; (2) adjusts the allocation of federal Disproportionate Share Hospital payments to account for an unintended interaction with increased FMAP previously provided under the Families First Coronavirus Response Act; (3) provides an additional temporary increase in the FMAP for certain home and community-based services, including behavioral health services; and (4) provides various funding streams related to behavioral health, described in greater detail below.

- Behavioral Health Funding in ARPA

The ARPA provides various funding streams related to behavioral health. Some of these funding streams, such as that provided through Section 9813 (described immediately below) would come through the Medicaid program. Others would come in the form of additional grant funding outside of Medicaid.

Section 9813 provides 85 percent Medicaid match for **qualifying community-based mobile crisis response intervention services** for twelve quarters during the five-year period starting April 1, 2022. Crisis response is a key gap in the state's system of behavioral health (BH) care. While the state is in the process of implementing the Family Urgent Response System services (FURS), Section 9813 funds cannot supplant existing services, so the Department does not expect the funding could be used for FURS. The administration has the opportunity to consider adding mobile crisis response as a Medi-Cal benefit as part of the FY 2022-23 budget process, with implementation no sooner than July 1, 2022. **The Estimate includes a proposal to use the 85 percent Medicaid match in the Mobile Crisis Services policy change.**

Sections 2701 and 2702 provide additional funding that would be made available to California counties using existing processes with additional workload to amend allocations and contracts. The funding ~~would be~~ **is** administered by Substance Abuse and Mental Health Services Administration and must be spent by September 23, 2025.

Section 2703 provides grant funding to support mental and behavioral health training for health care professionals, para-professions, and public safety offers. ~~Grant funding would require a new program to be established for policy development and administration. The amount allocated to California is not specified as guidance is pending.~~ **In order to spend the additional unanticipated funding made available through ARPA, the Department will need to develop policy and administration protocols. At this time, additional amounts allocated to California is still unknown.**

Sections 2706 and 2707 provide funding to award grants to support states, local, tribal, and territorial governments; tribal organizations, nonprofit community-based organizations; and primary behavioral health organizations. Section 2706 grant awards will go toward supporting community-based overdose prevention programs, syringe services programs, and other harm reduction services, with a focus on drug misuse. Section 2707 grant awards will go towards addressing increased community behavioral health needs exacerbated by the COVID-19

AMERICAN RESCUE PLAN ACT

pandemic (e.g., training the mental and behavioral health workforce using telehealth to deliver services). ~~Grant funding would require a new program to be established for policy development and administration. The amount allocated to California is not specified as guidance is pending.~~

In addition to the funding above, the American Rescue Plan Act also included funding to state and local governments. The funds are distributed to states, tribes, and territories based on a formula that considers the state's share of the nation's unemployment. The ARPA funds can be used for specific purposes including addressing public health impacts, negative economic impacts, and water, sewer, and broadband. State and local governments have until December 31, 2024 to expend the ARPA funds. Specified ARPA funds to California are deposited into the Coronavirus Fiscal Recovery Fund of 2021.

INFORMATION ONLY
REVENUES1. Revenues

The State is expected to receive the following revenues from quality assurance fees and other collections (accrual basis):

FY 2021-22:	\$32,850,000 <u>\$31,714,000</u>	ICF-DD Quality Assurance Fee
	\$486,302,000	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	\$9,612,000 <u>\$9,115,000</u>	ICF-DD Transportation/Day Care Quality Assurance Fee
	\$2,584,032,000	MCO Enrollment Tax (Item 4260-601-3334)
	\$2,305,935,000	Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
	\$3,248,000 <u>\$3,575,000</u>	Emergency Medical Air Transportation (EMATA) Fund (Item 4260-101-3168)
	\$66,604,000 <u>\$75,427,000</u>	Medi-Cal Emergency Medical Transport (MEMTF) (Item 4260-601-3323)
	\$1,474,916,000 <u>\$1,562,916,000</u>	Medi-Cal Drug Rebates Fund (Item 4260-601-3331)
	\$6,963,499,000 <u>\$7,059,016,000</u>	Total
FY 2022-23:	<u>\$27,737,000</u>	ICF-DD Quality Assurance Fee
	<u>\$486,302,000</u>	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	<u>\$9,115,000</u>	ICF-DD Transportation/Day Care Quality Assurance Fee
	<u>\$1,419,526,000</u>	MCO Enrollment Tax (Item 4260-601-3334)
	<u>\$2,618,509,000</u>	Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
	<u>\$2,398,000</u>	Emergency Medical Air Transportation (EMATA) Fund (Item 4260-101-3168)
	<u>\$68,962,000</u>	Medi-Cal Emergency Medical Transport (MEMTF) (Item 4260-601-3323)
	<u>\$1,708,339,000</u>	Medi-Cal Drug Rebates Fund (Item 4260-601-3331)
	<u>\$6,340,888,000</u>	Total

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.

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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.

Proposition 52, approved by California voters on November 8, 2016, permanently extends the Hospital QAF program.

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The California Department of Public Health (CDPH) lowered Licensing and Certification (L&C) fees for long-term care providers for FY 2010-11. The aggregate amount of the reductions allowed the QA fee amounts collected from the freestanding NF-Bs and ICF/DDs (including Habilitative and Nursing) to increase by an equal amount. Currently, the QA fee amounts are calculated to be net of the L&C fees in order to be within the federally designated cap, which provides for the maximum amount of QA fees that can be collected. For FY 2011-12, CDPH increased L&C fees which resulted in a reduction in the collection of the QA fee by an equal amount to the L&C fee increase for free-standing NF-Bs, Freestanding Pediatric Subacute Facilities and ICF/DDs (including Habilitative and Nursing).

Effective January 1, 2011, AB 2173 (Chapter 547, Statutes of 2010) imposes an additional penalty of \$4 for convictions involving vehicle violations.

AB 119 (Chapter 17, Statutes of 2015) extends the AB 1629 facility-specific rate methodology, QAF, and QASP program through July 31, 2020. Further, beginning rate year 2015-16, the annual weighted average rate increase is 3.62%, and the QASP will continue at FY 2014-15 levels, rather than setting aside a portion of the annual rate increase. Additionally, beginning FY 2015-16, the legislation requires the Department to incorporate direct care staff retention as a performance measure into the QASP Program.

SB 523 (Chapter 773, Statutes of 2017) implements a Ground Emergency Medical Transportation (GEMT) Quality Assurance Fee (QAF) on all ground emergency medical transports, effective July 1, 2018. The QAF will be assessed on each GEMT transport for base ground emergency medical services. The revenue generated by the QAF collections will be deposited directly into the Medi-Cal Emergency Medical Transportation Fund (MEMTF).

ELIGIBILITY

1. Impact of SB 708 on Long-Term Care for Aliens **Individuals with Unsatisfactory Immigration Status**

Section 4 of SB 708 (Chapter 148, Statutes of 1999) reauthorizes state-only funded long-term care for ~~eligible aliens~~ **individuals with unsatisfactory immigration status** 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~~ **individuals with unsatisfactory immigration status** who are not entitled to full-scope benefits and who are not legally present. This limit is at 110% of the FY 1999-00 estimate of eligibles, unless the legislature authorizes additional funds. SB 708 does not eliminate the uncodified language that the *Crespin* decision relied upon to make the current program available to eligible new applicants. Because the number of undocumented immigrants receiving State-only long-term care has not increased above the number in the 1999-00 base year, no fiscal impact is expected due to the spending limit.

INFORMATION ONLY**2. Refugee Resettlement Program**

The federal Refugee Resettlement Program provides medical services to refugees during their first eight months in the United States. In California, these medical services are provided through the Medi-Cal delivery system and funded with 100% federal funds through a federal grant. The California Department of Public Health administers the Refugee Resettlement Program federal grant. With the Affordable Care Act, a majority of refugees are expected to be eligible for Medi-Cal and will no longer receive their medical services through the Refugee Resettlement Program. The Department expects the number of eligibles receiving their medical services under the Refugee Resettlement Program to be negligible. All medical costs associated with the Refugee Resettlement Program will be funded 100% through the federal grant.

3. FFP Claiming Methodology Update for Lawfully Present Pregnant Women and Children

Under an approved State Plan Amendment, the Department may claim Federal Financial Participation (FFP) for full scope Medi-Cal services provided to eligible documented immigrants who are lawfully present in the United States if they are under 21 years of age or pregnant. This includes New Qualified Immigrants and other lawfully present immigrants as defined by the federal government. The Department has determined that some of these immigrants who are currently claimed at a 50/50 federal/state matching rate are eligible for a higher FFP matching rate (currently 65/35). 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) **originally required** 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 system implementation of the SB 260 auto enrollment was moved to July 1, 2022, due to the pandemic and other initiatives. Covered California is considering a pilot phase between January and June 2022, to coincide with the anticipated end of the federal COVID-19 Public Health Emergency.** 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 ~~Conform~~ 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~~

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policy, including system modifications, is anticipated to occur after **This policy was implemented, effective** October 1, 2020.

6. **Postpartum Care Extension**

Medi-Cal provides coverage for pregnancy and pregnancy-related services, including postpartum care for individuals who are pregnant. Prior to SB 104 (Chapter 67, Statutes of 2019), postpartum care was terminated 60 days after the last day of pregnancy. SB 104 extended postpartum care for up to 12 months after the last day of pregnancy specifically for beneficiaries who receive pregnancy-related services and are diagnosed with a mental health condition. The passage of ARP allows a Medicaid eligible individual who is receiving pregnancy-related services to remain eligible for Medi-Cal postpartum care for an additional 12 months after the last day of their pregnancy. Implementation of this new policy was effective April 1, 2022. However, costs for this policy are captured after the assumed PHE end period of June 30, 2022.

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.

8. **Medi-Cal Eligibility for New Afghan Arrivals**

As a result of the U.S. withdrawal from Afghanistan, there is a significant influx of Afghan arrivals who will need full Medi-Cal coverage. These individuals and future arrivals may have a variety of different immigration statuses upon entry to the United States. Many of these arrivals will be eligible for federally funded full scope Medi-Cal to the same extent as refugees, and may be eligible for other federal and state benefits and services if they qualify. For example, individuals with “Special Immigrant” (SI) parole, or SI Visa status, are eligible for the same federal benefits as refugees if they meet all eligibility requirements. Some of the new Afghan arrivals will enter the United States with other immigration statuses, or circumstances under which they may qualify for state-funded full scope Medi-Cal if otherwise eligible. The influx of new Afghan arrivals will potentially increase costs across state-funded and federally-funded full scope Medi-Cal programs, and Refugee Medical Assistance. Because these immigrants will be eligible in existing programs and aid codes, the Department will have to develop a plan to track the costs associated with these beneficiaries.

INFORMATION ONLY**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.

2. The Affordable Care Act (ACA) DSH Reduction

The ACA originally required that reductions be applied to states' Disproportionate Share Hospital (DSH) allotments starting in Federal Fiscal Year (FFY) 2014, with an effective start date of October 1, 2013. State-specific reduction amounts are determined by the Centers for Medicare & Medicaid Services (CMS). Multiple instances of legislative action at the federal level have delayed the implementation of the DSH reduction. Most recently, on December 27, 2020, HR 133 (2020) was enacted which eliminated the DSH reductions for FFYs 2021-2023, lowered the overall aggregate national reduction to \$32 billion, and postponed the implementation until FFY 2024.

The most recent California DSH reduction figure released by CMS is for FFY 2021, in the amount of \$266.3 million, which represents 6.66% of that year's total national reduction of \$4 billion, which has since been eliminated by HR 133 (2020).

For the next year in which DSH reductions are applicable (FFY 2024), the national reduction will be \$8 billion. State-specific reductions have not yet been released by CMS.

BENEFITS1. ~~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,~~

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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. Universal screening of all newborns for Pompe Disease and MPS I began 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. Child Health and Disability Prevention (CHDP)

The CHDP program administered by the state and **implemented by the** counties provides 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 the former 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 **income eligible** children, including the former CHDP non-Medi-Cal population. All persons under 19 years of age who were eligible for state-only CHDP service (the former CHDP non-Medi-Cal population) were shifted to full-scope Medi-Cal **and budgeted in the EPSDT Screens policy change. EPSDT costs now are captured in the Fee-For-Service base expenditures and the policy change was retired in the May 2020 Medi-Cal Local Assistance Estimate.** For FY 2019-20, the few remaining CHDP screens are included in the CHDP policy change.

The Department is proposing to sunset CHDP by July 1, 2023. The Department's proposal preserves presumptive eligibility enrollment activities currently offered through the CHDP Gateway, as well as activities performed by CHDP counties under the Childhood Lead Poisoning Prevention Program (CLPP). Further, this proposal ensures the continuation of the Health Care Program for Children in Foster Care (HCPCFC). On July 1, 2023, the Department will launch the Children's Presumptive Eligibility Program to replace the CHDP Gateway. The Children's Presumptive Eligibility Program will expand provider access to include all applicable Medi-Cal providers. The majority of children and youth under the age of 21 will be enrolled into a MCP, through which they will receive all medically necessary services. This aligns with the Department's goal under CalAIM to reduce administrative complexities. The proposal will also enhance coordination of care and increase standardization of care across Medi-Cal by consolidating care responsibilities for children/youth under the Medi-Cal managed care plans.

3. Palliative Care Services Implementation

SB 1004 (**Chapter 574, Statutes of 2014**) requires the Department to:

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- Establish standards and provide technical assistance for Medi-Cal managed care plans to ensure delivery of palliative care services;
- Establish guidance on the medical conditions and prognoses that render a beneficiary eligible for the palliative care services;
- Develop a palliative care policy that, to the extent practicable, is cost neutral to the General Fund on an ongoing basis;
- Define palliative care services; and
- Provide access to curative care for beneficiaries eligible for palliative care.

Services are available concurrently with curative care and care is provided through a coordinated interdisciplinary team.

HOME & COMMUNITY BASED-SERVICES

1. No additional information.

BREAST AND CERVICAL CANCER TREATMENT

1. No additional information.

PHARMACY

1. Pharmacy Rebate Timeliness

This assumption has been deleted as it no longer has a fiscal impact.

2. New High Cost Treatments for Specific Conditions

Three high-cost treatments are now available for spinal muscular atrophy (SMA), which is detected earlier due to implementation of newborn screening. The treatments are:

- Onasemnogene abeparvovec (Zolgensma), a gene therapy, approved by the Federal Drug Administration (FDA) on May 24, 2019, at a cost of \$2,100,000 per beneficiary;
- ~~Evrysdi~~ **Risdaplam (Evrysdi)**, an oral medication taken daily, (cost per person per year), and
- Nusinersen, an infusion every four months.

There are three high cost medications that together cover beneficiaries with Duchene muscular dystrophy:

- Golodirsen and ~~Vitolarsen~~ **Vitolarsen** which treats individuals with dystrophin mutations amenable to exon 53 skipping, and
- Exondys 51, which treats individuals with dystrophin mutations amenable to exon 51 skipping.

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There are four high-cost medications for treatment of cystic fibrosis, specifically cystic fibrosis transmembrane modulators, which treat individuals with amenable mutations in the CFTR protein:

- Trikafta,
- Symdeko,
- Orkambi, and
- Kalydeco.

3. 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.

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.

4. 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 (W&I), 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,

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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. Effective January 1, 2021 the **limitation of "within the United States" within this section of** W&I Code was removed, thus allowing the Department to negotiate Medi-Cal drug rebate contracts based on global **(foreign)** drug prices.

5. Proposed California Children's Services (CCS) Eligible Medical Condition

Multisystem Inflammatory Syndrome in Children (MIS-C) is a rare, but serious sequela of the COVID-19 infection in children. Care for affected children requires coordination of many different pediatric sub-specialties. The Department is not advocating for MIS-C to be added to the list of CCS eligible conditions, but individuals under 21 years of age suspected of having MIS-C with significant cardiac dysfunction, vasculitis, coagulopathy, or evidence of other major organ involvement should be opened to CCS for treatment services.

DRUG MEDI-CAL

1. Substance Use Disorder Managed Care Program Renewal and Policy Improvements

This assumption has been deleted; see updated information under "CalAIM Drug Medi-Cal Organized System Renewal".

2. Residential Treatment Services (RTS) EPSDT Rates

Effective July 1, 2018, the Department added RTS rate for EPSDT clients under the Drug Medi-Cal State Plan services. RTS provides rehabilitation services to beneficiaries with substance use disorder diagnosis in a non-medical residential setting. Due to the limited number of licensed residential facilities that are certified to provide services to EPSDT beneficiaries, it is unknown if there will be utilization for these services.

3. Early Intervention for Beneficiaries Under 21 Years Old

The Department ~~proposes~~ **plans** to add early intervention screenings and referral for treatment services for beneficiaries under age 21 as a mandatory benefit to the DMC-ODS Waiver as part of the ~~4415 Waiver extension proposal~~ **DMC-ODS program**, effective January 1, 2022. Most substance use disorders start in adolescence, yet the DMC-ODS Waiver ~~does~~ **did** not include any services for adolescents at high risk of developing substance use disorders. Adding this mandatory benefit to the DMC-ODS Waiver ~~would help~~ **helps** prevent the progression from risky substance use to substance use disorders. Early intervention services are currently covered under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit and because the EPSDT benefit existed prior to 2011 Realignment, the Department is not required to use State General Funds to cover the non-federal share of the costs.

INFORMATION ONLY**MENTAL HEALTH****1. Short-Term Residential Therapeutic Program/Qualified Residential Treatment Programs**

Congress enacted the ~~Families~~ **Family** First Prevention Services Act (FFPSA) on February 9, 2018. ~~The intent~~ **One of the intents** 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~~ **equivalent** 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~~ **QRTPs may be determined to meet criteria as** an Institution for Mental Disease (IMD) in Title XIX. ~~Title XIX,~~ **which** 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 **implement** ~~complete~~ these assessments **in three phases between December 2021 and December 2022. Pending approval and implementation of the SMI/SED Demonstration Waiver noted below, the state anticipates receiving federal reimbursement for services provided to beneficiaries in those STRTP facilities that are assessed to be IMDs, exempting STRTPs from the standard length of stay limitations for a two-year period.**

2. Family Urgent Response System

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~~ **required** the counties to have mobile services in place no later than six months after January 1, 2021, as long as an extension is **was** 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. Counties are required to have~~ **All counties complied with the law and had** mobile units in place by **as of** June 30, 2021.

3. SMI SED Demonstration Waiver

CMS developed an opportunity for states to receive federal funds for mental services provided to populations with a Serious Mental Illness or Serious Emotional Disturbance (SMI/SED), similar to the DMC-ODS Waiver pilots. This waiver, upon CMS approval would allow FPP to be drawn down for IMD services that fall within the

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approved diagnosis. The Department proposes to submit a proposal for the SMI/SED Demonstration Waiver, in the Fall of 2022.

4. 9-8-8 Crisis Line

The National Suicide Hotline Designation Act of 2020 launches a national 9-8-8 suicide prevention and mental health crisis line on July 1, 2022, and gives authority for states to issue a fee to support state operations. Vibrant Health funded California to do implementation planning in this fiscal year, and the Department will fund crisis call centers with \$20 million to support building capacity during the current fiscal year. In addition, the American Rescue Plan Act allows states to implement a new Medicaid benefit, Mobile Crisis Response Services, with an 85% federal match for the first three years of services for 12 quarters during the five year period starting April 2022. The interplay between this mobile crisis benefit and the 9-8-8 implementation is still to be determined.

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~~ **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, 2021). 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, 2021) or in three years from CMS' approval of California's repayment schedule, whichever is longer. Interest begins on the date of CMS' demand letter.

Repayment of deferred claims: Claims for which California has drawn down federal funding but CMS has deferred on or before June 30, 2017, CMS will issue a disallowance, triggering the appeal process. However, if the appeal is unsuccessful, California will be required to

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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.

INFORMATION ONLY**MANAGED CARE**

1. Proposition 56 Risk Corridors

This item has been deleted as this item is now a new policy change.

2. CalAIM – Managed Care SMHS Carve-Out

Specialty Mental Health Services (SMHS) benefits are currently within the scope of certain Medi-Cal managed care plans in two counties (Partnership in Solano, for certain enrollees, and Kaiser in Sacramento). Effective no sooner than July 1, 2023, the SMHS benefits will be carved out from these managed care plans' responsibility and be provided through the Behavioral Health delivery system.

PROVIDER RATES

1. Prenatal Screening Program Fee Increase

This item has been deleted as this item is now a new policy change.

2. 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.

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

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

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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. **SPA-19-0009 is currently under Department review.**

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.

OTHER: AUDITS AND LAWSUITS

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 scheduled to occur as follows, subject to applicable run-out and reconciliation periods provided in the settlement terms, **and contractual risk corridor calculations**: *Molina* (January 1, 2018); *Blue Cross* (January 1, 2019); *Health Net* (January 1, 2020).

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~~

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applicants in the backlog that they have a right to hearing on the delay, and (2) grant all pending applicants that appear eligible conditional eligibility for Medi-Cal benefits.

~~Petitioners' Motion for Preliminary Injunction (PI) Motion was granted on January 20, 2015. The Preliminary Injunction prohibited the Department from failing to comply with its duty to make eligibility determinations within 45 days unless certain specified legal exceptions apply. It further ordered that when an application has not been determined within 45 days, the Department may comply with the injunction by (1) for applicants who appear likely 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. Review was granted on October 9, 2019, and on July 8, 2020 the Supreme Court ruled in favor of Petitioners in ordering the Court of Appeal opinion to be depublished. The Supreme Court also directed the Court of Appeal to award costs to Petitioners associated with the Supreme Court's review and to consider awarding attorney fees. In April 2021, the parties reached a settlement agreement including payment of approximately \$856,000 in attorneys' fees and costs, which is now displayed in the Lawsuits/Claims policy change in this Estimate. This matter is now closed and will no longer be reported in these Informational Assumptions.~~

INFORMATION ONLY**3. MALDEF, et al. Title VI Administrative Complaints; Analina Jimenez Perea, et al., v. et al., *Deuschel v. CHHS 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 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

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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 had commenced, but was later stayed under multiple stipulations due to the COVID-19 public health emergency. ~~Currently, the matter is stayed through February 8, 2021.~~ **The stay was lifted on April 9, 2021, and discovery is continuing.** ~~¶The court has set a deadline of July 2, 2021~~ **August 31, 2021,** for the Plaintiff's class certification motion.

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~~ is stayed until January 24, 2021. **The court has set the hearing** with a demurrer and trial setting conference for **September 14, 2021** ~~scheduled for April 1, 2021.~~

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 Blue Shield, and Health Net actions have all been formally stayed after being designated related cases to Myers.

5. 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

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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 July 12, 2021.~~ **The case was settled and the lawsuit was dismissed with prejudice on June 14, 2021. This matter is now closed and will no longer be reported in these Informational Assumptions.**

6. 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. 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. Briefing was completed in December 2020. On February 4, 2021, the Department announced it will pause retroactive recoupments for past pharmacy claims until further notice. On March 10, 2021, the court ordered the parties to participate in mediation, staying all deadlines until that process is complete.

7. 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 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

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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. The \$4.3 million payment to intervenors HLB was displayed in the Lawsuits/Claims policy change in the 2020 May Revise Local Assistance Medi-Cal Estimate. On February 21, 2020, attorney Friedman filed a notice of appeal with the Ninth Circuit. On April 5, 2021, the Ninth Circuit increased the award to attorney Friedman to approximately \$8.2 million, which is now displayed in the Lawsuits/Claims policy change in this Estimate. **On April 19, 2021, attorney Friedman filed a request for attorneys' fees and costs related to the fee appeal, totaling approximately \$3.2 million. On April 27, 2021, the Ninth Circuit issued a clerk's mandate, awarding \$1,217 in costs to attorney Friedman, and assigned an appellate commissioner to determine the appropriate fee amount.**

8. 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 and mediation are ongoing.

9. 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. **The Department has filed a Motion for Summary Judgement with the**

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hearing for this motion scheduled for September 1, 2021. No trial date has been set, and discovery is ongoing.

10. Community Health Center Alliance, et al. v. Will Lightbourne, et al.

On October 29, 2020, the Community Health Center Alliance for Patient Access (CHCAPA) and its constituent Federally Qualified Health Center (FQHC) members sued the Department and Director Lightbourne in the Eastern District Court of California. Plaintiffs' Complaint alleges that the Department's transition of the pharmacy benefit from Medi-Cal managed care to the Medi-Cal Rx fee-for-service delivery system will prevent FQHCs from receiving the full extent of the cost-based Prospective Payment System (PPS) reimbursement for pharmacy services mandated under federal law. Plaintiffs seek to enjoin the implementation of the Medi-Cal Rx transition, along with the State's extension of the Medi-Cal 2020 demonstration project (which authorizes managed care generally) on procedural grounds.

Plaintiffs contend that the primary impact of the transition of the pharmacy benefit from Medi-Cal managed care to Medi-Cal Rx on FQHCs will be to deprive California FQHCs of the opportunity to profit on their drug sales to Medi-Cal managed care plans, which FQHCs purchase at discounted 340B rates. Furthermore, Plaintiffs claim that other aspects of the State's PPS reimbursement to FQHCs violate federal law, particularly for FQHCs who decide to "carve-in" the costs of pharmacy services to their PPS rate. In this regard, Plaintiffs allege that the inflation-based growth rate for PPS rates will prevent FQHCs from receiving adjustments to their PPS rate to account for increases in pharmaceutical costs that exceed inflation, and that California's process for adjusting PPS rates violates federal law by limiting those adjustments to 80 percent of the per visit increase in costs.

On November 9, 2020, Plaintiffs filed a Motion for Temporary Restraining Order (TRO), seeking to enjoin the implementation of Medi-Cal Rx on January 1, 2021. Then, on November 16, 2020, the Department announced that it was deferring implementation of Medi-Cal Rx transition until April 1, 2021. On November 24, 2020, the Court denied Plaintiffs' TRO Motion without a hearing. Thereafter, on December 15, 2020, the Court ordered the Department to file its Motion to Dismiss and Plaintiffs to file its Motion for Preliminary Injunction on December 24, 2020.

On February 17, 2021, the Department announced it was postponing the prior April 1, 2021, effective date for the Medi-Cal Rx transition (to a later effective date to be subsequently determined).

On March 9, 2021, the court held a hearing on the Department's Motion to Dismiss and Plaintiffs' Motion for Preliminary Injunction. In a ruling from the bench, the court granted the Department's Motion to Dismiss, without prejudice, in light of the postponed effective date and the still pending federal administrative process associated with the transition- **, and denied the Plaintiffs' motion on mootness grounds.**

INFORMATION ONLY**11. Audit of California 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 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;
- \$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.

INFORMATION ONLY**12. 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 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 projected amounts instead of actual incurred expenses and payments;
- \$26,533,060 for not limiting total operating expenses to amounts that would be allowable under Medicare cost principles;
- \$670,658 for including bad debts as an additional operating expense;
- \$2,925,693 for 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.

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.

13. 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

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payments made to hospitals after closure, 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.

14. Conflict of Record Retention

Welfare and Institutions (W&I) Code section 14170.8's three year record retention requirement for pharmacies is inconsistent with federal and state law, which requires ten years of record retention. The Department anticipates many 340B audits in the near future that may create a legal conflict. The Department of Office of Legal Services recommends amending the statute to resolve the conflict in law.

The inconsistencies of the current conflicting record retention laws has a direct fiscal impact to the Department. Appeal issues caused by the inconsistencies within the laws requires additional resources of attorneys and auditors. Additionally, the Department risks losing potential savings from audits appealed by the providers. Estimated savings will be determined in the future based upon appealed cases due to the inconsistencies of pharmaceutical providers record retention requirements.

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.

INFORMATION ONLY**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 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.

OTHER: RECOVERIES**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

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on the date of death and against ABLE account funds that enter a beneficiary's probate estate.

2. Recovery Audit Contractor (RAC)

Title 42 Code of Federal Regulations Section 455.500 through 455.518 requires that States enter into contract with one or more RACs for the purpose of identifying underpayments and overpayments and recouping overpayments. The RAC Program's mission is to reduce improper Medi-Cal payments through the efficient detection and collection of overpayments, the identification of underpayments, the reporting of fraudulent and/or criminal activities, and the implementation of actions that will prevent future improper payments.

State Plan Amendment (SPA) 20 – 0017 provides the Department exemption from contracting with a RAC through February 1, 2022. A request for proposal for the Department to enter into contract with a RAC was awarded in June 2021. The RAC will be paid on a contingency basis determined by the amounts recovered from overpayments identified, and the refunded amounts of identified underpayments. The Department does not anticipate any contract costs in FY 2021-22 or FY 2022-23.

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 Medi-Cal Eligibility Division~~ **two contracts with CDPH to obtain vital records data. One contract allows the Department to obtain electronic data files of birth, death, and fetal death records from CDPH. The second contract allows the Third Party Liability Recovery Division, the Audits & Investigations Division, and the Medi-Cal Eligibility Division to request certified copies of birth, death, marriage, divorce, and fetal death records of Medi-Cal beneficiaries from CDPH.** The Department may amend the ~~new~~ **new contract for certified copies** to include other divisions as appropriate.

2. Electronic Visit Verification

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

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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 CURES Act will require extensive multi-agency planning, collaboration, and coordination. The Department is collaborating with CDSS, DDS, CDPH, and CDA to develop a cross-department EVV solution that meets federal requirements.

FISCAL INTERMEDIARY: MEDICAL

1. No additional information.

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

1. No additional information.

FISCAL INTERMEDIARY: DENTAL

1. 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

PC 10 Medicare Part B Disregard

AFFORDABLE CARE ACT

Not applicable.

BENEFITS

PC 44 Rapid Whole Genome Sequencing

HOME & COMMUNITY-BASED SERVICES

Not applicable.

BREAST AND CERVICAL CANCER

Not applicable.

PHARMACY

PC 52 OTC Adult Acetaminophen & Cough/Cold Products

PC 53 Blood Factor Reimbursement Methodology

DRUG MEDI-CAL

Not applicable.

MENTAL HEALTH

PC 71 Pathways to Well-Being

1115 WAIVER—MH/UCD & BTR

Not applicable.

MANAGED CARE

Not applicable.

PROVIDER RATES

Not applicable.

SUPPLEMENTAL PAYMENTS

Not applicable.

COVID-19

Not applicable.

OTHER: AUDITS AND LAWSUITS

Not applicable.

OTHER: REIMBURSEMENTS

Not applicable.

DISCONTINUED POLICY CHANGES

Fully Incorporated into Base Data/Ongoing

OTHER: RECOVERIES

Not applicable.

OTHER: MISCELLANEOUS

OA 16 Drug Medi-Cal County UR & QA Admin

FISCAL INTERMEDIARY: MEDICAL

Not applicable.

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

Not applicable.

FISCAL INTERMEDIARY: DENTAL

Not applicable.

DISCONTINUED POLICY CHANGES

Time Limited/No Longer Available

ELIGIBILITY

PC 257 Long Term Care Share of Cost Adjustment
PC 25 Minimum Wage Increase – Caseload Savings
PC 10 Provisional Postpartum Care Extension

AFFORDABLE CARE ACT

Not applicable.

BENEFITS

PC 34 LEA Expansion

HOME & COMMUNITY-BASED SERVICES

Not applicable.

BREAST AND CERVICAL CANCER

Not applicable.

PHARMACY

Not applicable.

DRUG MEDI-CAL

Not applicable.

MENTAL HEALTH

Not applicable.

1115 WAIVER—MH/UCD & BTR

PC 84 BTR LIHP MCE

MANAGED CARE

PC 24 Health Insurer Fee
PC 113 Adjust MC Cap Payments for July 2019-Dec 2020
PC 97 Extended File Correction
PC 111 Recoupment of Unallowed Capitation Payments

PROVIDER RATES

PC 164 Prop 56 – Hosp-Based Pediatric Phys Suppl Pymts

SUPPLEMENTAL PAYMENTS

PC 168 IGT Payments for Hospital Services

COVID-19

COVID-19 Utilization Changes

DISCONTINUED POLICY CHANGES

Time Limited/No Longer Available

STATE ONLY CLAIMING

PC 245 State Only Claiming Adjustments - TCM

OTHER: AUDITS AND LAWSUITS

Not applicable.

OTHER: REIMBURSEMENTS

PC 203 CCS SAR EPC

OTHER: RECOVERIES

PC 217 Repayment to CMS for Contingency Fee Offsets

OTHER: MISCELLANEOUS

OA 91 Reconciliation

PC 219 Fund 3156 Transfer to the General Fund

PC 247 Fund 3311 Transfer to the General Fund

PC 286 Reconciliation

FISCAL INTERMEDIARY: MEDICAL

OA 57 CMS Deferred Claims - FI

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

Not applicable.

FISCAL INTERMEDIARY: DENTAL

Not applicable.

DISCONTINUED POLICY CHANGES

Withdrawn

ELIGIBILITY

Not applicable.

AFFORDABLE CARE ACT

Not applicable.

BENEFITS

PC 39 MSSP Supplemental Payments

HOME & COMMUNITY-BASED SERVICES

Not applicable.

BREAST AND CERVICAL CANCER

Not applicable.

PHARMACY

PC 123 Managed Care Drug Rebates

DRUG MEDI-CAL

PC 60 Narcotic Treatment Program
PC 61 Outpatient Drug Free Treatment Services
PC 62 Intensive Outpatient Treatment Services
PC 65 Residential Treatment Services

MENTAL HEALTH

OA 13 SMHS County UR & QA Admin
OA 19 Managed Care Regulations – MH Parity
OA 30 Performance Outcomes System
OA 38 Managed Care Regulations – Mental Health
PC 70 Specialty Mental Health Svcs Supp Reimbursement
PC 72 Late Claims for SMHS
PC 241 MHP Costs for FFPSA – Aftercare Services

1115 WAIVER—MH/UCD & BTR

Not applicable.

MANAGED CARE

Not applicable.

PROVIDER RATES

PC 270 Unfreeze ICF/DD and FS-PSA Rates
PC 280 Complex Rehab Technology Reimbursement Rates
PC 132 Clinical Lab Reimbursement Rates

DISCONTINUED POLICY CHANGES

Withdrawn

SUPPLEMENTAL PAYMENTS

Not applicable.

COVID-19

Not applicable.

OTHER: AUDITS AND LAWSUITS

Not applicable.

OTHER: REIMBURSEMENTS

Not applicable.

OTHER: RECOVERIES

Not applicable.

OTHER: MISCELLANEOUS

Not applicable.

FISCAL INTERMEDIARY: MEDICAL

Not applicable.

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

Not applicable.

FISCAL INTERMEDIARY: DENTAL

PC 227 CalAIM Dental Caries Risk Assessment

PC 229 CalAIM Dental Silver Diamine Fluoride

PC 230 CalAIM Dental Continuity of Care