

MEDI-CAL
NOVEMBER 2022
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2022-23 *and* 2023-24



The Great Seal

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

**MEDI-CAL
NOVEMBER 2022
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2022-23 and 2023-24**

Fiscal Forecasting Division
State Department of Health Care Services
1501 Capitol Avenue, Suite 2001
Sacramento, CA 95814



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NOVEMBER 2022 MEDI-CAL ESTIMATE

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The November 2022 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.

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18	1% FMAP INCREASE FOR PREVENTIVE SERVICES	Regular PC	47
124	10% PROVIDER PAYMENT REDUCTION	Regular PC	303
103	2020 MCO ENROLLMENT TAX MANAGED CARE PLANS	Regular PC	238
104	2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	Regular PC	241
83	2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	Regular PC	216
253	2024 MCO ENROLLMENT TAX MANAGED CARE PLANS	Regular PC	580
252	2024 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	Regular PC	578
254	2024 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	Regular PC	582
114	AB 1629 ANNUAL RATE ADJUSTMENTS	Regular PC	270
115	AB 97 ELIMINATIONS	Regular PC	273
20	ACA DSH REDUCTION	Regular PC	52
21	ACA OPTIONAL EXPANSION MLR RISK CORRIDOR	Regular PC	55
6	ACCELERATED ENROLLMENT FOR ADULTS	Regular PC	21
18	ACTUARIAL COSTS FOR RATE DEVELOPMENT	Other Admin	75
116	ACUPUNCTURE RATE INCREASE	Regular PC	279
171	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	Regular PC	446
97	AIDS HEALTHCARE CENTERS (OTHER M/C)	Base PC	61
215	ALAMEDA COUNTY SUPPORTIVE HOUSING	Regular PC	516
230	AMERICAN RESCUE PLAN INCREASED FMAP FOR HCBS	Regular PC	545
43	ANNUAL COGNITIVE ASSESSMENTS	Regular PC	114
216	BACKFILL LOST TITLE X FAMILY PLANNING FUNDING	Regular PC	517
240	BASE RECOVERIES	Base PC	96
48	BCCTP DRUG REBATES	Regular PC	128
181	BEHAVIORAL HEALTH BRIDGE HOUSING	Regular PC	454
60	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE	Regular PC	162
22	BEHAVIORAL HEALTH TREATMENT	Regular PC	57
4	BREAST AND CERVICAL CANCER TREATMENT	Regular PC	15
228	CALAIM - BH PAYMENT REFORM	Regular PC	541
63	CALAIM - BH QUALITY IMPROVEMENT PROGRAM	Regular PC	165
221	CALAIM - DENTAL INITIATIVES	Regular PC	525
5	CALAIM - INMATE PRE-RELEASE PROGRAM	Regular PC	18
25	CALAIM - LTC BENEFIT TRANSITION	Regular PC	67
1	CALAIM - MEDI-CAL PATH	Other Admin	23
32	CALAIM - ORGAN TRANSPLANT	Regular PC	88
6	CALAIM - POPULATION HEALTH MANAGEMENT	Other Admin	39
88	CALAIM - TRANSITIONING POPULATIONS	Regular PC	222
251	CALAIM- DESIGNATED STATE HEALTH PROGRAMS	Regular PC	575
73	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES	Regular PC	194
70	CALHEERS DEVELOPMENT	Other Admin	199
83	CALHHS AGENCY HIPAA FUNDING	Other Admin	226
192	CALHOPE	Regular PC	474
243	CALIFORNIA BEHAVIORAL HEALTH CBC DEMONSTRATION	Regular PC	571
89	CALIFORNIA BH CBC DEMONSTRATION ADMIN	Other Admin	236
28	CALIFORNIA COMMUNITY TRANSITIONS COSTS	Regular PC	75
44	CALIFORNIA HEALTH INTERVIEW SURVEY	Other Admin	132
79	CALIFORNIA SMOKERS' HELPLINE	Other Admin	219

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140	CAPITAL PROJECT DEBT REIMBURSEMENT	Regular PC	357
101	CAPITATED RATE ADJUSTMENT FOR FY 2023-24	Regular PC	234
24	CAPMAN	Other Admin	89
193	CARE COURT	Regular PC	477
50	CARE COURT - OTHER ADMIN	Other Admin	144
5	CASE MANAGEMENT FOR OTLICP	County Admin	17
184	CCI IHSS RECONCILIATION	Regular PC	461
31	CCI-ADMINISTRATIVE COSTS	Other Admin	106
79	CCI-MANAGED CARE PAYMENTS	Regular PC	204
96	CCI-QUALITY WITHHOLD REPAYMENTS	Regular PC	232
4	CCS CASE MANAGEMENT	Other Admin	33
34	CCS DEMONSTRATION PROJECT	Regular PC	93
42	CCT FUND TRANSFER TO CDSS	Regular PC	110
49	CCT OUTREACH - ADMINISTRATIVE COSTS	Other Admin	141
71	CDDS ADMINISTRATIVE COSTS	Other Admin	203
87	CDPH I&E PROGRAM AND EVALUATION	Other Admin	232
70	CHART REVIEW	Regular PC	184
16	CHDP COUNTY ALLOCATION	Other Admin	70
232	CIGARETTE AND TOBACCO SURTAX FUNDS	Regular PC	551
195	CLINIC WORKFORCE STABILIZATION RETENTION PROGRAM	Regular PC	482
76	CLPP CASE MANAGEMENT SERVICES	Other Admin	214
224	CLPP FUND	Regular PC	535
237	CMS DEFERRED CLAIMS	Regular PC	563
51	CMS DEFERRED CLAIMS - OTHER ADMIN	Other Admin	146
16	COMMUNITY FIRST CHOICE OPTION	Regular PC	42
31	COMMUNITY HEALTH WORKER	Regular PC	85
165	CONTINUOUS CHIP COVERAGE DURING THE COVID-19 PHE	Regular PC	426
44	CONTINUOUS GLUCOSE MONITORING SYSTEMS BENEFIT	Regular PC	116
105	COORDINATED CARE INITIATIVE RISK MITIGATION	Regular PC	243
8	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	Other Admin	45
1	COUNTY ADMINISTRATION ALLOCATION	County Admin	8
249	COUNTY BH RECOUPMENTS	Regular PC	573
98	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM	Base PC	63
12	COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE	Other Admin	56
77	COUNTY ORGANIZED HEALTH SYSTEMS	Base PC	32
239	COUNTY SHARE OF OTLICP-CCS COSTS	Regular PC	569
3	COUNTY SPECIALTY MENTAL HEALTH ADMIN	Other Admin	29
162	COVID-19 - SICK LEAVE BENEFITS	Regular PC	417
159	COVID-19 BEHAVIORAL HEALTH	Regular PC	409
157	COVID-19 CASELOAD IMPACT	Regular PC	405
168	COVID-19 CASELOAD IMPACT BASE ADJUSTMENT	Regular PC	435
163	COVID-19 ELIGIBILITY	Regular PC	419
167	COVID-19 INCREASED FMAP - DHCS	Regular PC	431
52	COVID-19 INCREASED FMAP - OTHER ADMIN	Other Admin	148
166	COVID-19 LTC REIMBURSEMENT RATES	Regular PC	428

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164	COVID-19 VACCINE ADMINISTRATION	Regular PC	422
141	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	Regular PC	361
15	CS3 PROXY ADJUSTMENT	Regular PC	40
2	CYBHI - BH SERVICES AND SUPPORTS PLATFORM	Other Admin	27
208	CYBHI - CALHOPE STUDENT SUPPORT	Regular PC	503
29	CYBHI - DYADIC SERVICES	Regular PC	80
183	CYBHI - EVIDENCE-BASED BH PRACTICES	Regular PC	459
182	CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY	Regular PC	456
89	CYBHI - STUDENT BH INCENTIVE PROGRAM	Regular PC	224
189	CYBHI - URGENT NEEDS AND EMERGENT ISSUES	Regular PC	470
15	DATA REPORTING AND ANALYTICS SUPPORT SYSTEMS	Other Admin	66
65	DENTAL ASO ADMINISTRATION 2016 CONTRACT	Other Admin	184
66	DENTAL FI ADMINISTRATION 2016 CONTRACT	Other Admin	188
67	DENTAL FI-DBO ADMIN 2022 CONTRACT	Other Admin	191
90	DENTAL MANAGED CARE (OTHER M/C)	Base PC	53
238	DENTAL MANAGED CARE MLR RISK CORRIDOR	Regular PC	566
178	DENTAL SERVICES	Base PC	81
75	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	Other Admin	212
73	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	Other Admin	208
204	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	Base PC	89
39	DIABETES PREVENTION PROGRAM	Regular PC	103
37	DOULA BENEFIT	Regular PC	99
126	DPH INTERIM & FINAL RECONS	Regular PC	308
122	DPH INTERIM RATE	Regular PC	298
112	DPH INTERIM RATE COVID-19 INCREASED FMAP ADJUST	Regular PC	263
111	DPH INTERIM RATE GROWTH	Regular PC	261
138	DPH PHYSICIAN & NON-PHYS. COST	Regular PC	349
58	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	Regular PC	154
13	DRUG MEDI-CAL COUNTY ADMINISTRATION	Other Admin	58
55	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	Base PC	10
35	DRUG MEDI-CAL PARITY RULE ADMINISTRATION	Other Admin	114
59	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	Regular PC	159
57	DRUG MEDI-CAL STATE PLAN SERVICES	Base PC	14
132	DSH PAYMENT	Regular PC	328
121	DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT	Regular PC	295
29	ELECTRONIC ASSET VERIFICATION PROGRAM	Other Admin	101
173	ELECTRONIC VISIT VERIFICATION FED PENALTIES	Regular PC	450
150	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	Regular PC	387
90	EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.	Other Admin	238
7	ENHANCED FEDERAL FUNDING	County Admin	21
187	EQUITY & PRACTICE TRANSFORMATION PAYMENTS	Regular PC	465
202	EVIDENCE-BASED DENTAL PRACTICES	Regular PC	493
38	EXPANSION TO SCREENING FOR ADDITIONAL SUBSTANCES	Regular PC	101
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54	FEDERAL DRUG REBATES	Regular PC	147
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74	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	Other Admin	210
137	FFP FOR LOCAL TRAUMA CENTERS	Regular PC	346
42	FIELD TESTING OF MEDI-CAL MATERIALS	Other Admin	128
223	FOSTER YOUTH SUBSTANCE USE DISORDER GRANT PROGRAM	Regular PC	533
33	FPACT HPV VACCINE COVERAGE	Regular PC	91
110	FQHC/RHC/CBRC RECONCILIATION PROCESS	Regular PC	258
153	FREE CLINICS AUGMENTATION	Regular PC	396
233	FUNDING ADJUST.—ACA OPT. EXPANSION	Regular PC	553
234	FUNDING ADJUST.—OTLICP	Regular PC	555
3	FUNDING FOR COUNTY REDETERMINATIONS	County Admin	13
118	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	Regular PC	285
120	GDSP PRENATAL SCREENING PROGRAM FEE INCREASE	Regular PC	292
143	GEMT SUPPLEMENTAL PAYMENT PROGRAM	Regular PC	367
92	GENDER-AFFIRMING CARE	Other Admin	240
78	GEOGRAPHIC MANAGED CARE	Base PC	38
72	GLOBAL PAYMENT PROGRAM	Regular PC	190
130	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	Regular PC	321
108	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	Regular PC	251
22	HCBA WAIVER ADMINISTRATIVE COST	Other Admin	85
207	HCBS SP - ASSISTED LIVING WAIVER EXPANSION	Regular PC	500
203	HCBS SP - CALBRIDGE BH NAVIGATOR PROGRAM	Regular PC	495
56	HCBS SP - CONTINGENCY MANAGEMENT	Regular PC	151
41	HCBS SP - CONTINGENCY MANAGEMENT ADMIN	Other Admin	126
227	HCBS SP - ETSB FOR LAGUNA HONDA HOSPITAL RESIDENTS	Regular PC	539
86	HCBS SP - HOUSING AND HOMELESSNESS INCENTIVE PROG	Regular PC	218
172	HCBS SP - IHSS HCBS CARE ECONOMY PMTS	Regular PC	448
217	HCBS SP - NON-IHSS CARE ECONOMY PMTS	Regular PC	519
186	HCBS SP CDDS	Regular PC	463
78	HCBS SP CDDS - OTHER ADMIN	Other Admin	217
63	HCO COST REIMBURSEMENT 2017 CONTRACT	Other Admin	180
64	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	Other Admin	182
62	HCO OPERATIONS 2017 CONTRACT	Other Admin	178
20	HEALTH ENROLLMENT NAVIGATORS	Other Admin	80
38	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	Other Admin	120
72	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	Other Admin	205
69	HEALTH-RELATED ACTIVITIES - CDSS	Other Admin	197
41	HEARING AID COVERAGE FOR CHILDREN PROGRAM	Regular PC	108
226	HIPP PREMIUM PAYOUTS (MISC. SVCS.)	Base PC	94
19	HITECH AND PUBLIC HEALTH REGISTRIES SUPPORT	Other Admin	77
188	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER	Regular PC	468
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135	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	Regular PC	340
17	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	Regular PC	45
19	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	Regular PC	50
235	HOSPITAL QAF - CHILDREN'S HEALTH CARE	Regular PC	557
128	HOSPITAL QAF - FFS PAYMENTS	Regular PC	313
154	HOSPITAL QAF - MANAGED CARE PAYMENTS	Regular PC	397
213	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	Regular PC	513
198	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	Regular PC	485
156	IGT ADMIN. & PROCESSING FEE	Regular PC	403
231	IMD ANCILLARY SERVICES	Regular PC	547
196	INDIAN HEALTH SERVICES	Regular PC	483
236	INDIAN HEALTH SERVICES FUNDING SHIFT	Regular PC	561
205	INFANT DEVELOPMENT PROGRAM	Regular PC	497
219	INFRASTRUCTURE PYMT FOR CLINIC ABORTION PROVIDERS	Regular PC	521
71	INTERIM AND FINAL COST SETTLEMENTS - SMHS	Regular PC	186
7	INTERIM AND FINAL COST SETTLEMENTS-SMHS	Other Admin	41
80	KIT FOR NEW PARENTS	Other Admin	221
191	LA COUNTY JUSTICE-INVOLVED POP. SVCS & SUPPORTS	Regular PC	472
28	LA COUNTY PUBLIC HEALTH NURSING PILOT	Other Admin	99
117	LABORATORY RATE METHODOLOGY CHANGE	Regular PC	281
190	LAWSUITS/CLAIMS	Base PC	86
26	LITIGATION RELATED SERVICES	Other Admin	95
47	LITIGATION SETTLEMENTS	Regular PC	126
23	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	Regular PC	61
123	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	Regular PC	300
6	LOS ANGELES COUNTY HOSPITAL INTAKES	County Admin	19
210	LOS ANGELES COUNTY REPRODUCTIVE HEALTH PILOT	Regular PC	508
113	LTC RATE ADJUSTMENT	Regular PC	265
81	MANAGED CARE HEALTH CARE FINANCING PROGRAM	Regular PC	210
127	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	Regular PC	310
82	MANAGED CARE PUBLIC HOSPITAL EPP	Regular PC	213
102	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	Regular PC	236
139	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	Regular PC	352
85	MATERNAL AND CHILD HEALTH	Other Admin	229
36	MEDCOMPASS SOLUTION	Other Admin	116
74	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	Regular PC	197
99	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	Base PC	66
95	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	Base PC	58
13	MEDI-CAL COUNTY INMATE REIMBURSEMENT	Regular PC	36
46	MEDI-CAL DRUG REBATE FUND	Regular PC	122
33	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	Other Admin	110
56	MEDICAL FI BO & IT CHANGE ORDERS	Other Admin	161
53	MEDICAL FI BO & IT COST REIMBURSEMENT	Other Admin	152
60	MEDICAL FI BO HOURLY REIMBURSEMENT	Other Admin	174

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58	MEDICAL FI BO TELEPHONE SERVICE CENTER	Other Admin	169
59	MEDICAL FI BUSINESS OPERATIONS	Other Admin	171
54	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	Other Admin	157
55	MEDICAL FI IT INFRASTRUCTURE SERVICES	Other Admin	159
81	MEDI-CAL INPATIENT SERVICES FOR INMATES	Other Admin	223
35	MEDICAL INTERPRETERS PILOT PROJECT	Regular PC	95
200	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG	Regular PC	489
21	MEDI-CAL RECOVERY CONTRACTS	Other Admin	82
148	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	Regular PC	383
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9	MEDI-CAL RX - ADMINISTRATIVE COSTS	Other Admin	48
53	MEDI-CAL RX- ADDITIONAL SUPPLEMENTAL REBATES	Regular PC	143
1	MEDI-CAL STATE INMATE PROGRAMS	Regular PC	8
52	MEDICAL SUPPLY REBATES	Regular PC	141
211	MEDI-CAL TCM PROGRAM	Base PC	91
36	MEDICALLY TAILORED MEALS PILOT PROGRAM	Regular PC	97
48	MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM	Other Admin	139
14	MEDICARE OPTIONAL EXPANSION ADJUSTMENT	Regular PC	38
177	MEDICARE PAYMENTS - PART D PHASED-DOWN	Base PC	78
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45	MEDICATION THERAPY MANAGEMENT PROGRAM	Regular PC	119
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34	MFP/CCT SUPPLEMENTAL FUNDING	Other Admin	112
80	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	Regular PC	207
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64	MHP COSTS FOR FFPSA	Regular PC	167
65	MHP STRTP GRANTS	Regular PC	172
199	MHSF - PROVIDER ACES TRAININGS	Regular PC	487
8	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	Regular PC	25
209	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	Regular PC	506
25	MITA	Other Admin	92
47	MMA - DSH ANNUAL INDEPENDENT AUDIT	Other Admin	137
27	MULTIPURPOSE SENIOR SERVICES PROGRAM	Regular PC	72
144	NDPH IGT SUPPLEMENTAL PAYMENTS	Regular PC	371
152	NDPH SUPPLEMENTAL PAYMENT	Regular PC	392
30	NEWBORN HEARING SCREENING PROGRAM	Other Admin	104
11	NON-EMERGENCY FUNDING ADJUSTMENT	Regular PC	32
136	NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS	Regular PC	343
10	NON-OTLIPC CHIP	Regular PC	29
106	NURSING FACILITY RATE ADJUSTMENTS	Regular PC	245
14	OTLIPC, MCAP, SPECIAL POPULATIONS ADMIN COSTS	Other Admin	62
67	OUT OF STATE YOUTH - SMHS	Regular PC	177
93	OUTREACH & ENROLLMENT ASSIST. FOR DUAL BENES	Other Admin	242
85	PACE (OTHER M/C)	Base PC	48

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27	PASRR	Other Admin	97
23	PAVE SYSTEM	Other Admin	87
212	PEER SUPPORT SPECIALIST SERVICES	Regular PC	510
68	PERSONAL CARE SERVICES	Other Admin	195
176	PERSONAL CARE SERVICES (MISC. SVCS.)	Base PC	75
50	PHARMACY RETROACTIVE ADJUSTMENTS	Regular PC	134
161	PHARMACY-BASED COVID-19 TESTS	Regular PC	414
2	PHASING IN THE MEDI-CAL ASSET LIMIT REPEAL	Regular PC	11
88	PIA EYEWEAR COURIER SERVICE	Other Admin	234
17	POSTAGE & PRINTING	Other Admin	72
3	POSTPARTUM CARE EXTENSION	Regular PC	13
109	PP-GEMT IGT PROGRAM	Regular PC	255
131	PRIVATE HOSPITAL DSH REPLACEMENT	Regular PC	325
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93	PROP 56 - BEHAVIORAL HEALTH INCENTIVE PROGRAM	Regular PC	230
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129	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	Regular PC	317
220	PROP 56 - PROVIDER ACES TRAININGS	Regular PC	523
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92	RECONCILIATION OF MCO TAX FUND 3156	Regular PC	228
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84	REGIONAL MODEL	Base PC	42
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8	SAVE	County Admin	23
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12	SCHIP FUNDING FOR PRENATAL CARE	Regular PC	34
5	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	Other Admin	37
40	SDMC SYSTEM M&O SUPPORT	Other Admin	124
201	SELF-DETERMINATION PROGRAM - CDDS	Regular PC	491
94	SENIOR CARE ACTION NETWORK (OTHER M/C)	Base PC	56
68	SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS	Regular PC	180
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45	SSA COSTS FOR HEALTH COVERAGE INFO.	Other Admin	134
169	STATE ONLY CLAIMING ADJUSTMENTS	Regular PC	438
170	STATE ONLY CLAIMING ADJUSTMENTS - SMHS AND DMC	Regular PC	443
51	STATE SUPPLEMENTAL DRUG REBATES	Regular PC	138
147	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	Regular PC	380
32	STATEWIDE VERIFICATION HUB	Other Admin	108
185	TARGETED CASE MGMT. SVCS. - CDDS (MISC. SVCS.)	Base PC	84
26	TELEHEALTH	Regular PC	70
39	T-MSIS	Other Admin	122
76	TWO PLAN MODEL	Base PC	26
75	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	Regular PC	202
7	UNDOCUMENTED EXPANSION AGES 26 THROUGH 49	Regular PC	23
229	URBAN INDIAN ORGANIZATIONS FUNDING SHIFT	Regular PC	543
82	VETERANS BENEFITS	Other Admin	225
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206	WATSONVILLE COMMUNITY HOSPITAL ACQUISITION	Regular PC	499
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NOVEMBER 2022 MEDI-CAL ESTIMATE GUIDE TO KEY FEATURES OF REGULAR POLICY CHANGES

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

PROP 56 - DEVELOPMENTAL SCREENINGS

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

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

REGULAR POLICY CHANGE NUMBER:
IMPLEMENTATION DATE:
ANALYST:
FISCAL REFERENCE NUMBER:

154
1/2020
Joel Singh
2171

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

Permanent reference number, does not change each November.

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
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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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.

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NOTE: FOR THE NOVEMBER 2022 ESTIMATE:

- CURRENT YEAR = FY 2022-23
- BUDGET YEAR = FY 2023-24
- APPROPRIATION = MAY 2022 ESTIMATE + BUDGET ACT CHANGES, FY 2022-23

November 2022 Medi-Cal Estimate

Current Year (FY 2022-23) Projected Expenditures Compared to the Appropriation

(Dollars in Millions)

Medical Care Services	FY 2022-23 Appropriation	Nov 2022 Estimate	Change	
			Amount	Percent
Total Funds	\$131,639.3	\$130,802.1	(\$837.2)	-0.6%
Federal Funds	\$83,730.2	\$86,355.3	\$2,625.1	3.1%
General Fund	\$35,012.1	\$30,504.1	(\$4,508.0)	-12.9%
Other Non-Federal Funds	\$12,897.0	\$13,942.7	\$1,045.7	8.1%

County Administration	FY 2022-23 Appropriation	Nov 2022 Estimate	Change	
			Amount	Percent
Total Funds	\$5,941.0	\$6,418.6	\$477.6	8.0%
Federal Funds	\$4,542.2	\$4,685.3	\$143.1	3.2%
General Fund	\$1,379.2	\$1,633.7	\$254.5	18.5%
Other Non-Federal Funds	\$19.6	\$99.6	\$80.0	408.2%

Fiscal Intermediary	FY 2022-23 Appropriation	Nov 2022 Estimate	Change	
			Amount	Percent
Total Funds	\$479.8	\$525.3	\$45.5	9.5%
Federal Funds	\$336.9	\$362.9	\$26.0	7.7%
General Fund	\$142.9	\$162.4	\$19.5	13.6%
Other Non-Federal Funds	\$0.0	\$0.0	\$0.0	n/a

Total Expenditures	FY 2022-23 Appropriation	Nov 2022 Estimate	Change	
			Amount	Percent
Total Funds	\$138,060.0	\$137,746.0	(\$314.0)	-0.2%
Federal Funds	\$88,609.4	\$91,403.5	\$2,794.1	3.2%
General Fund	\$36,534.2	\$32,300.1	(\$4,234.0)	-11.6%
Other Non-Federal Funds	\$12,916.6	\$14,042.2	\$1,125.6	8.7%

Note: Totals may not add due to rounding.

November 2022 Medi-Cal Estimate

Budget Year (FY 2023-24) Projected Expenditures Compared to Current Year (FY 2022-23)

(Dollars in Millions)

Medical Care Services	FY 2022-23 Estimate	FY 2023-24 Estimate	Change	
			Amount	Percent
Total Funds	\$130,802.1	\$132,248.0	\$1,445.9	1.1%
Federal Funds	\$86,355.3	\$80,779.7	(\$5,575.6)	-6.5%
General Fund	\$30,504.1	\$37,138.2	\$6,634.1	21.7%
Other Non-Federal Funds	\$13,942.7	\$14,330.1	\$387.4	2.8%

County Administration	FY 2022-23 Estimate	FY 2023-24 Estimate	Change	
			Amount	Percent
Total Funds	\$6,418.6	\$6,077.3	(\$341.3)	-5.3%
Federal Funds	\$4,685.3	\$4,576.6	(\$108.7)	-2.3%
General Fund	\$1,633.7	\$1,411.6	(\$222.1)	-13.6%
Other Non-Federal Funds	\$99.6	\$89.1	(\$10.5)	-10.5%

Fiscal Intermediary	FY 2022-23 Estimate	FY 2023-24 Estimate	Change	
			Amount	Percent
Total Funds	\$525.3	\$591.80	\$66.5	12.7%
Federal Funds	\$362.9	\$427.9	\$65.0	17.9%
General Fund	\$162.4	\$163.9	\$1.5	0.9%
Other Non-Federal Funds	\$0.0	\$0.0	\$0.0	\$0.0

Total Expenditures	FY 2022-23 Estimate	FY 2023-24 Estimate	Change	
			Amount	Percent
Total Funds	\$137,746.0	\$138,917.2	\$1,171.2	0.9%
Federal Funds	\$91,403.5	\$85,784.3	(\$5,619.3)	-6.1%
General Fund	\$32,300.1	\$38,713.7	\$6,413.6	19.9%
Other Non-Federal Funds	\$14,042.3	\$14,419.2	\$376.9	2.7%

Note: Totals may not add due to rounding.

Medi-Cal Local Assistance Estimate

Management Summary

November 2022 Estimate

This document is intended to provide a high-level overview of the November 2022 Medi-Cal Local Assistance Estimate (Estimate).

The Department of Health Care Services (DHCS) estimates Medi-Cal spending to be \$137.7 billion total funds (\$32.3 billion General Fund) in Fiscal Year (FY) 2022-23 and \$138.9 billion total funds (\$38.7 billion General Fund) in FY 2023-24. 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:

- Overview of Major New Items
- Summary of Estimate Totals
- Major Drivers of Changes in General Fund Spending
- Caseload Projections
- Detail Tables

Overview of Major New Items

This section summarizes major new items in the Governor's Budget that affect spending in Medi-Cal.

- **Managed Care Organization (MCO) Tax Renewal.** DHCS proposes to enact a three-year MCO tax renewal effective January 1, 2024, through December 31, 2026, to provide additional revenue for the Medi-Cal program to support access to health care services and minimize the need for reductions to the program. This tax renewal will maintain the structure from the prior tax authorized in AB 115 (Chapter 348, Statutes of 2019) with minor modifications, including updates to the base enrollment period to reflect calendar year 2021 enrollment data and adjusted for enrollment changes to managed care plans anticipated on January 1, 2024. The proposed MCO provider tax would offset an estimated \$6.5 billion in General Fund costs in Medi-Cal through FY 2026-27 (\$316.5 million in FY 2023-24 and about \$2 billion annually in FY 2024-25 and each of the following two years). The Administration will explore opportunities over the next few months to increase the MCO tax to provide support for the Medi-Cal program.
- **California Behavioral Health Community-Based Continuum Demonstration.** As a part of the CalAIM transformation, DHCS will seek approval of a new proposed Medicaid Section 1115 demonstration, titled California's Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration, to expand access and strengthen the continuum of mental health services for Medi-Cal members living with serious mental illness (SMI) and serious emotional disturbance (SED), through a staged implementation beginning no sooner than January 1, 2024. The fiscal impact for the Department of Health Care Services and Department of Social Services over the five years of the waiver is estimated to be \$6.1 billion total funds (\$314 million General Fund). The DHCS budget includes \$5.7 million total funds (\$0.31 million General Fund) in FY 2023-24.

CalBH-CBC will expand behavioral health services from prevention, wellness, outpatient, and recovery to crisis, inpatient, and residential services statewide, with a focus on children and youth, people experiencing or at risk of homelessness, and justice-involved individuals. The CalBH-CBC Demonstration complements and amplifies the state's current and planned initiatives to build out the behavioral health continuum of care, such as the Community Assistance, Recovery and Empowerment (CARE) Act, Children and Youth Behavioral Health Initiative, Behavioral Health Continuum Infrastructure Program, Bridge Housing, peer and recovery services, and mobile crisis, to name a few. Building off these critical investments, the CalBH-CBC Demonstration will:

- Strengthen the continuum of community-based services that reduce the need for institutional care by expanding coverage for evidence-based therapies and home-based services for children and families, Assertive Community Treatment (ACT), Forensic ACT, Coordinated Specialty Care for First-Episode Psychosis, Supported Employment Services, Rent/Temporary Housing, and Community Health Worker services in the county behavioral health delivery system;
- Improve integrated medical, behavioral health and social services for foster children and youth;

- Build statewide centers of excellence in behavioral health services to support statewide practice transformations;
 - Enhance quality of care and pre-discharge care coordination in psychiatric hospitals and residential settings;
 - Implement strategies to decrease lengths of stay in emergency departments; and
 - Provide coverage for short-term inpatient psychiatric and residential mental health treatment in facilities that meet the federal criteria for an institution for mental disease (IMD).
- **California Advancing and Innovating Medi-Cal (CalAIM) Behavioral Health Payment Reform Cash Flow Funding.** The proposed budget includes \$375 million General Fund one-time in FY 2023-24 to initially fund the non-federal share of behavioral health-related services at the start of the CalAIM Behavioral Health Payment Reform. These funds will mitigate a significant cash flow issue for counties as they transition from cost-based reimbursement to fee-schedule.
 - **Designated State Health Programs (DSHP) Funding and Primary Care and Obstetric Rate Increases.** DHCS has submitted a proposal to continue the DSHP program under the CalAIM 1115 waiver effective January 1, 2023 to December 31, 2026. The DSHP proposal would allow DHCS to claim \$646.4 million in federal funding over four years to support the Providing Access and Transforming Health (PATH) program. As part of its approval of DSHP proposals, the federal Centers for Medicare and Medicaid Services (CMS) require that states provide rate increases for certain services if the Medicaid to Medicare provider rate ratio is below 80 percent. Effective January 1, 2024, primary care will receive a 10 percent increase in fee-for-service (FFS) for all codes under 80 percent of Medicare and obstetric and doula care will receive a 10 percent increase (including for the codes that don't have a Medicare equivalent) in both FFS and managed care. The impact in FY 2022-23 is estimated to be \$40.4 million General Fund savings from DSHP claiming. The net impact from the provider rate increases and DSHP claiming is estimated to be \$22 million total funds (\$152.9 million General Fund savings) in FY 2023-24. The Administration will continue to evaluate the need for additional targeted provider rate increases at May Revision.
 - **CARE Court Funding.** The Estimate includes \$57 million General Fund in FY 2022-23 and \$16.5 million General Fund in FY 2023-24 for CARE Act related county costs. In October 2022, the Department allocated the \$57 million for one-time administrative CARE Act startup costs to cover information technology infrastructure costs and planning and preparation activities. The budget assumes the counties of Glenn, Orange, Riverside, San Diego, Stanislaus, and Tuolumne and the City and County of San Francisco implement the program beginning October 1, 2023. The budget assumes county behavioral health costs for these counties in FY 2023-24 associated with clinical assessments and time spent in court by county reimbursed behavioral health providers. DHCS assumes the remaining counties implement the provisions of this Act no later than December 1, 2024. The Administration will continue to work with counties and stakeholders to refine the ongoing program cost estimate.

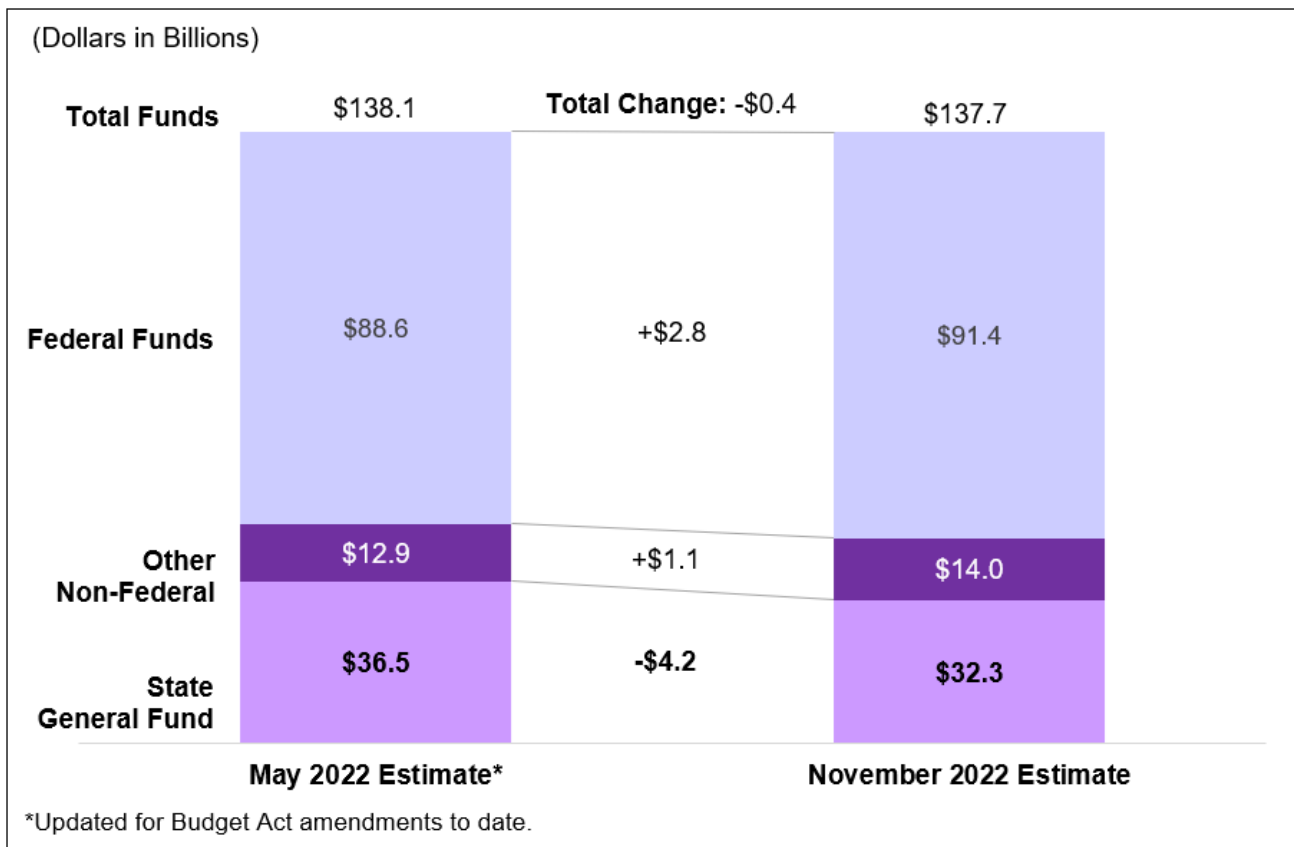
- **Proposed Budget Delays.** Given projected General Fund revenues, the Medi-Cal Estimate features the following changes:
 - The 2022 Budget Act included funding to buy back the current two-week delay of FFS checkwrite payments at the end of each June. This buyback is now proposed to be delayed until FY 2024-25. This action reduces costs by \$1.1 billion total funds (\$378 million General Fund) in FY 2022-23.
 - The Estimate reflects the delay of funding for Round 6 of the Behavioral Health Continuum Infrastructure Program (BHCIP) until FY 2025-26 and FY 2026-27, resulting in General Fund savings of \$480.7 million in FY 2022-23.
 - The 2022 Budget Act assumed the provision of an additional \$500 million from the General Fund for the Behavioral Health Bridge Housing program in FY 2023-24. The Governor's Budget delays \$250 million of this amount to FY 2024-25.

Summary of Estimate Totals

This section provides a summary of bottom-line total spending amounts in the Estimate. Later sections will describe new proposals and other factors that drive changes in projected spending.

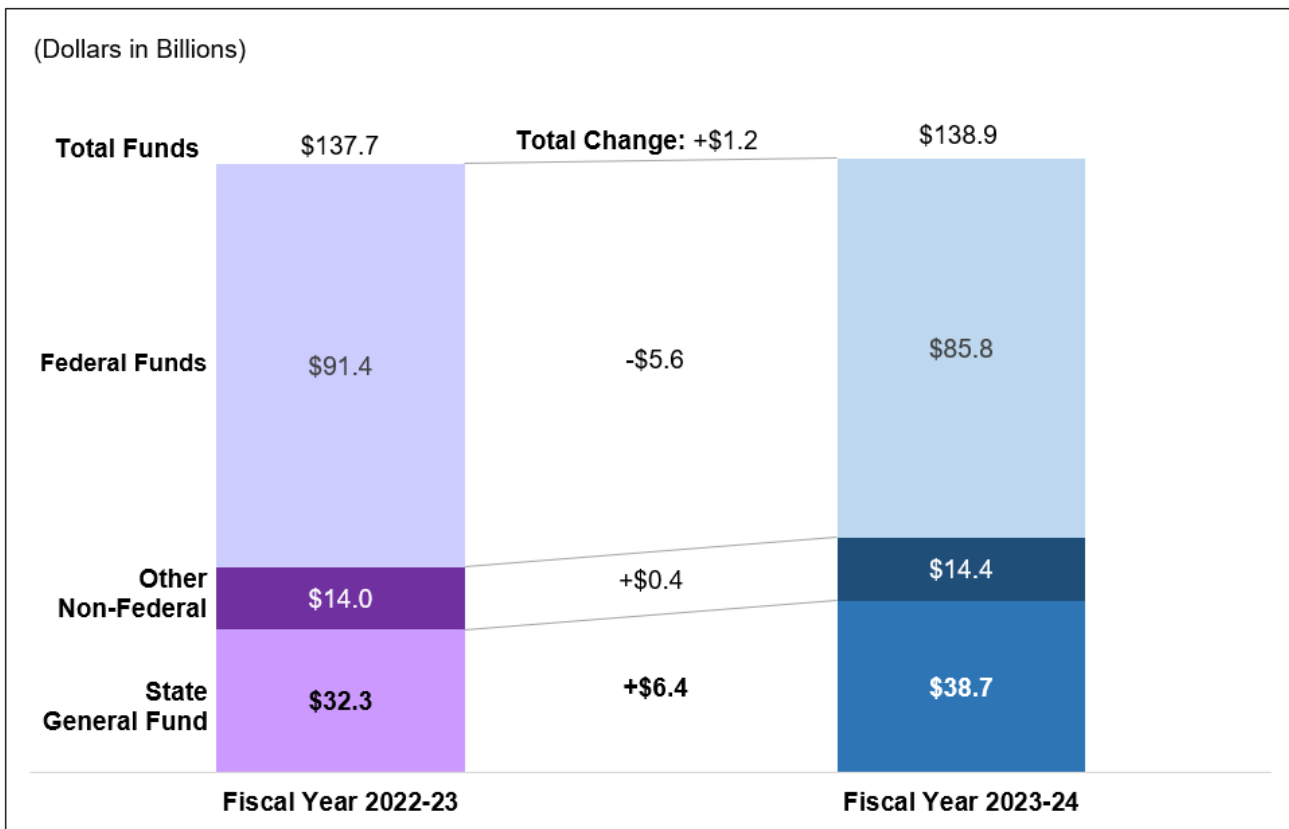
As shown below, the Estimate projects a \$0.4 billion decrease in total spending (a \$4.2 billion decrease in General Fund spending) for FY 2022-23 compared to the revised 2022 Budget Act. This reflects a 0.2 percent increase in estimated total spending and an 11.6 percent decrease in estimated General Fund spending.

FY 2022-23 Comparison



As shown below, the Estimate projects that Medi-Cal spending will increase by \$1.2 billion total funds (\$6.4 billion General Fund) in FY 2023-24 compared to FY 2022-23. This reflects a 0.9 percent increase in total funds and a 19.9 percent increase in General Fund spending.

Year-Over-Year Change from FY 2022-23 to FY 2023-24



Major Drivers of Changes in General Fund Spending

The primary non-federal funding source for Medi-Cal is the state General Fund. A number of factors contribute to changes in projected General Fund spending in Medi-Cal in the Estimate. The table below and the narrative that follows describe the most significant factors.

Summary of Major Drivers of Changes in General Fund Spending

Dollars in Millions

	Current Year FY 2022-23	Budget Year FY 2023-24
	<i>Change from 2022 Budget Act</i>	<i>Change from FY 2022-23</i>
New Items		
CalAIM - Behavioral Health Payment Reform cash flow funding		\$375.0
Care Court county funding		\$16.5
CalAIM - Designated State Health Program implementation	-\$40.4	-\$112.6
Proposed 2024 MCO tax		-\$316.5
Delay buyback of two-week checkwrite hold	-\$309.4	
Delay BHCIP Round 6	-\$480.7	
Subtotals	-\$830.5	-\$37.6
Previously Approved Items and Technical Updates		
State only claiming impacts	-\$2,365.2	\$3,436.3
COVID-19 impacts	-\$773.8	\$2,685.0
End of 2020 MCO tax		\$1,513.7
Year-over-year growth in base managed care costs		\$664.0
Undocumented full-scope expansion ages 26-49		\$634.8
Medi-Cal Drug Rebate Fund transfers to the GF*	-\$43.6	\$363.7
Nursing facility rate increase and quality payments	\$41.0	\$302.4
Year-over-year growth in Medicare costs*		\$260.1
Increase in retroactive managed care payments		\$251.6
Year-over-year growth in FFS base costs		\$223.3
Proposition 56 impacts	-\$295.5	\$88.4
County behavioral health recoupments		-\$63.5
Changes in deferrals impacts	-\$425.3	-\$69.0
ACA disproportionate share hospital reduction		-\$124.3
Medi-Cal Rx additional supplemental drug rebates*	\$124.2	-\$241.3
Changes in Hospital Quality Assurance Fee transfers to the General Fund	-\$139.2	-\$690.9

Summary of Major Drivers of Changes in General Fund Spending

Dollars in Millions

	Current Year FY 2022-23	Budget Year FY 2023-24
	<i>Change from 2022 Budget Act</i>	<i>Change from FY 2022-23</i>
Scheduled end or phasing down of temporary funding items		-\$2,767.9
Shift of BHCIP spending from FY 2021-22	\$160.6	
Medicare eligibility update	\$95.7	
Coordinated Care Initiative IHSS reconciliation	\$86.0	
MCO tax Fund 3156 reconciliation	-\$308.0	
Subtotals	-\$3,843.1	\$6,466.4
Various other changes	\$439.6	-\$15.2
Totals	-\$4,234.0	\$6,413.6

*Adjusted to remove the impact of COVID-19, to avoid double counting.

Major technical factors driving changes in projected General Fund spending are described in greater detail below:

- **State Only Claiming Impacts.** The Estimate includes \$101.5 million in General Fund savings in FY 2022-23 and \$3.3 billion in General Fund costs in FY 2023-24. This reflects a reduction in General Fund spending of \$2.4 billion in FY 2022-23 and an increase in General Fund spending of \$3.4 billion in FY 2023-24 compared to the previous Estimate. The largest drivers of this change include:
 - Based on additional data, the value of repayments to CMS, primarily related to managed care capitation, have increased.
 - Timelines for system changes needed to accurately calculate and process repayments to CMS to correct overclaiming now require that the managed care repayment occur in FY 2023-24 instead of FY 2022-23, resulting in a shift of expenditures between fiscal years.
 - DHCS now anticipates retroactively claiming additional federal funds for individuals that were eligible for federal funding due to having completed the 5-year period of ineligibility, but for which federal funding was not claimed. This results in new General Fund savings of \$587 million in FY 2022-23.

- **COVID-19 Impacts.** The Estimate projects COVID-19 related impacts of \$15.9 billion total funds (\$488 million General Fund) in FY 2022-23 and \$12.3 billion total funds (\$3.2 billion General Fund) in FY 2023-24.

For FY 2022-23, this represents General Fund savings of \$773.8 million compared to the previous estimate. This current year adjustment is primarily related to additional increased federal medical assistance percentage (FMAP) savings from assuming the federal public health emergency (PHE) ends in mid-April 2023 instead of mid-October 2022, offset by increased caseload costs. Additionally, the Estimate no longer separately estimates costs for school-based polymerase chain reaction (PCR) testing, resulting in savings of \$404.6 million total funds (\$102.4 million General Fund) compared to the previous Estimate. Direct FFS claims to Medi-Cal for PCR testing in schools have been very limited to date, and rapid antigen testing is assumed to be the primary tool for school-based testing going forward. The Estimate continues to reflect funding for rapid antigen testing (primarily through managed care capitation payments).

For FY 2023-24, the Estimate projects increased General Fund costs related to COVID-19 impacts of about \$2.7 billion compared to FY 2022-23. This increase primarily reflects the net impact of:

- \$3.6 billion in General Fund costs from the loss of increased FMAP in FY 2023-24 (only a few hundred million dollars of General Fund savings from the period through March 2023 are projected to lag into FY 2023-24).
- \$627 million in General Fund savings as the redeterminations resume and caseload begins to decline.
- Other, relatively smaller, offsetting savings as spending related to various other COVID-19 impacts declines.

These estimates do not reflect the impact of recent congressional action to end the continuous enrollment requirement beginning April 2023 or the gradual phase-down of increased FMAP over calendar year 2023. DHCS continues to evaluate the impact of the recent federal legislation and these impacts will be reflected in the May Revision.

- **End of 2020 MCO Tax.** The current MCO enrollment tax is effective January 1, 2020, through December 31, 2022. In FY 2023-24, there is a decrease to General Fund savings of approximately \$1.5 billion due to the MCO tax ending.
- **Year-Over-Year Growth in Managed Care Costs.** Managed care costs typically grow from year to year through the rate setting process, and due to changes in enrollment. The Estimate assumes that General Fund costs in managed care will grow from FY 2023-24 to FY 2024-25 by approximately \$664 million in base managed care policy changes for reasons related to

changes in rates and changes in enrollment not otherwise accounted for as part of other policies (such as COVID-19 caseload).

- **Adult Expansion Ages 26-49.** The Governor's Budget includes \$844 million total funds (\$634.8 million General Fund) to expand full-scope Medi-Cal coverage to adults aged 26 through 49, regardless of immigration status effective January 1, 2024. This expansion is consistent with the 2022 Budget Act.
- **Medi-Cal Drug Rebate Transfers to the General Fund.** The Estimate projects an increase of \$43.6 million for Medi-Cal Drug Rebate Fund (Fund) transfers in FY 2022-23. This amount is estimated before applying the COVID-19 Increased FMAP impacts and also reflects the assumption that there will not be funds available to keep a reserve in the Fund in FY 2022-23. From FY 2022-23 to FY 2023-24, there is a decrease of Fund transfers estimated due to including an estimated reserve in the Fund in FY 2023-24.
- **Nursing Facility Rate Adjustment.** The freestanding skilled nursing facility financing methodology was extended beginning in January 1, 2023, through December 31, 2026. From the prior estimate, the rate increases and Workforce and Quality Incentive Program (WQIP) impacts in FY 2022-23 are estimated to increase by \$93.4 million total funds (\$41.0 million General Fund) due to updated nursing facility days and estimate of the calendar year (CY) 2023 COVID-19 PHE add-on costs. The FY 2022-23 to FY 2023-24 estimate increases by \$638.1 million total funds (\$302.4 million General Fund) from including 12 months of the CY 2023 rate increase and incentive program, 5 months of the CY 2024 rate increase and incentive program, and the remaining COVID-19 PHE costs in FY 2023-24.
- **Year-Over-Year Growth in Medicare Costs.** Medicare costs typically grow from year to year based on adjustments applied by the federal government. The Estimate assumes that General Fund costs related to Medicare (including premium payments on behalf of Medi-Cal enrollees and Part D clawback costs) will grow by \$260.1 million from FY 2022-23 to FY 2023-24, after adjusting to remove the impact of increased FMAP.
- **Retroactive Managed Care Payments.** There is an increase of approximately \$490.7 million total funds (\$251.6 million General Fund) mainly due to the addition of 10 percent COVID-19 add-ons for long-term care facilities.
- **Year-Over-Year Growth in FFS Base Costs.** The estimate projects growth in General Fund costs for base FFS expenditures of \$223.0 million from FY 2022-23 to FY 2023-24. This increase is mainly attributable to year-over-year growth in estimated pharmacy spending.
- **County Behavioral Health Recoupments.** The Estimate includes \$63.5 million in previously identified recoupments from counties related to psychiatric inpatient hospital claims and state only claiming. These recoupments generate General Fund savings of an equal amount.
- **Proposition 56 Impacts.** The previous Estimate assumed the need for \$295.5 million from the General Fund in FY 2022-23 to cover Proposition 56 payments. Based on revised

Proposition 56 revenue projections, the Estimate now assumes that General Fund support for Proposition 56 payments will not be required in FY 2022-23, creating General Fund savings of \$295.5 million compared to the 2022 Budget Act. The Estimate assumes that \$88.4 million will be needed from the General Fund for Proposition 56 payments in FY 2023-24.

- **Changes in Deferrals Impacts.** Based on recent information on the Centers for Medicare and Medicaid Services (CMS) deferral decisions and updated assumptions for ongoing deferrals, CMS deferrals are estimated to result in \$425.3 million General Fund savings in FY 2022-23 compared to the prior estimate. In particular, \$328 million General Fund of released deferrals transfers were not approved by CMS until late June 2022 and shifted to FY 2022-23. From FY 2022-23 to FY 2023-24, state only claiming deferrals are estimated to be resolved and released, resulting in \$69.0 million General Fund savings.
- **ACA Disproportionate Share Hospital (DSH) Reduction.** The Affordable Care Act (ACA) requires the aggregate, nationwide reduction of DSH allotments in the amount of \$8 billion annually from Federal Fiscal Year (FFY) 2024 through FFY 2027, for a total aggregate reduction of \$32 billion. The FY 2023-24 estimate includes DSH spending reductions of \$844.4 million total funds (\$124.3 million General Fund), starting October 1, 2023.
- **Medi-Cal Rx Additional Supplemental Drug Rebates.** Before considering the impact of COVID-19 increased FMAP, the Estimate projects a decrease of \$124.2 million General Fund savings from additional state supplemental rebates based on a slower assumed ramp up of the Medi-Cal Rx rebate impacts in FY 2022-23. From FY 2022-23 to FY 2023-24, as the ramp up is further along, the Medi-Cal Rx rebate savings are estimated increase by \$233.0 million General Fund.
- **Hospital Quality Assurance Fee (QAF) Transfers to the General Fund.** The FY 2022-23 Hospital QAF children's health care coverage savings increased by \$139.2 million General Fund from the prior estimate based on updated savings estimates from the proposed Hospital QAF VII model. From FY 2022-23 to FY 2023-24, further increased savings of \$690.9 million General Fund will occur in FY 2023-24 from making outstanding payments that were postponed from the Hospital QAF VI program period.
- **Scheduled End or Phasing Down of Temporary Funding Items.** There is a significant number of one-time spending items in FY 2022-23 that are not budgeted to continue into FY 2023-24, resulting in a year-over-year reduction in General Fund spending of about \$2.8 billion. The largest of these include:
 - BCHIP—\$1.1 billion in FY 2022-23 and no funding budgeted in FY 2023-24.
 - Children and Youth Behavioral Health Initiative (CYBHI) – Evidence-Based Behavioral Health Practices—\$429 million in FY 2022-23 and no funding budgeted in FY 2023-24).

- CYBHI – School Behavioral Health Partnerships and Capacity—\$450 million in FY 2022-23 and only \$100 million in FY 2023-24.
 - Behavioral Health Bridge Housing—\$908 million in FY 2022-23 but only \$300 million in FY 2023-24 (including \$50 million appropriated in the 2022 Budget Act and \$250 million in new funding proposed for the 2023 Budget Act).
 - Los Angeles County Justice-Involved Populations Services and Supports, for the misdemeanor incompetent to stand trial population—\$99 million in FY 2022-23 but no funding budgeted in FY 2023-24.
- **Shift of BHCIP Spending from FY 2021-22.** Payments in the amount of \$160.6 million previously estimated in FY 2021-22 are delayed to FY 2022-23. As previously noted, \$480.7 million previously assumed for FY 2022-23 has also shifted to be spent in FY 2025-26 and FY 2026-27. Between these two adjustments, there is a net decrease of \$320.1 million General Fund in FY 2022-23.
 - **Medicare Eligibility Update.** The Department underwent an information system update to correct Buy-In Eligibility codes for dual eligible beneficiaries. This effort was completed in February 2022 and resulted in identifying approximately 95,000 beneficiaries for whom federal financial participation (FFP) is not available, increasing projected General Fund costs. The increase is partially offset by reductions in final Medicare premiums for calendar year 2023 and projected 2024 monthly premium costs (net change of \$95.7 million).
 - **Coordinated Care Initiative (CCI) In-Home Supportive Services (IHSS) Reconciliation.** CCI IHSS Reconciliations have been completed for calendar years 2015, 2016, and 2017 services. The associated reimbursements for overpayments and underpayments will be completed in FY 2022-23. This is inclusive of \$86 million General Fund cost for beneficiaries who were not flagged as receiving IHSS services for managed care plan (MCP) capitation.
 - **Former MCO Tax Reconciliation.** In FY 2022-23, there is an increase of \$308 million General Fund savings resulting from the additional payments to and recoveries from MCPs related to the MCO Tax risk corridor calculations for the remaining MCO Tax Fund (#3156) dollars.
 - **Increased Base Costs as Recent Policies Transition to Base Estimating Methodology.** Several significant policies that implemented in the last 12 months have transitioned into the managed care and FFS base components of the November 2022 Medi-Cal Estimate. These include the transition of certain populations to mandatory managed care in January 2022 pursuant to CalAIM, the expansion of full-scope Medi-Cal to individuals aged 19 through 26 and 50 and older regardless of citizenship or immigration status, the carve-out of the managed care pharmacy benefit to FFS through Medi-Cal Rx, and others. In previous Estimates, spending projections for these items were prepared individually based on prospective assumptions about take-up, average costs, and implementation timing. In contrast, base

spending projections are prepared in aggregate based on recent actual caseload and spending levels.

This shift in methodology, pursuant to standard estimating practice, means that separate policy changes are no longer maintained in the Estimate for these items and costs for these items are included in the base. The shift into the base also results in some increases in projected spending compared to the previous estimate. This is due to differences between what costs were prospectively modeled in previous estimates to be and what recent aggregate actual caseload and spending are. This contributes to increased General Fund base costs in FY 2022-23 in the hundreds of millions of dollars compared to the previous Estimate.

Caseload Projections

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

Estimated Average Monthly Certified Eligibles

November 2022 Estimate

	<u>Eligibles</u>			<u>Year-Over-Year Change</u>	
	<u>FY 2021-22</u>	<u>FY 2022-23</u>	<u>FY 2023-24</u>	<u>FY 2021-22 to</u>	<u>FY 2022-23 to</u>
				<u>FY 2022-23</u>	<u>FY 2023-24</u>
Seniors	1,119,600	1,195,400	1,218,600	6.77%	1.94%
Persons with Disabilities	1,095,200	1,090,300	1,095,500	-0.45%	0.48%
Families and Children	7,492,200	7,846,400	7,458,500	4.73%	-4.94%
Optional Expansion	4,604,200	5,038,700	4,602,800	9.44%	-8.65%
Miscellaneous	57,600	61,800	62,000	7.29%	0.32%
Total	14,368,800	15,232,600	14,437,400	6.01%	-5.22%

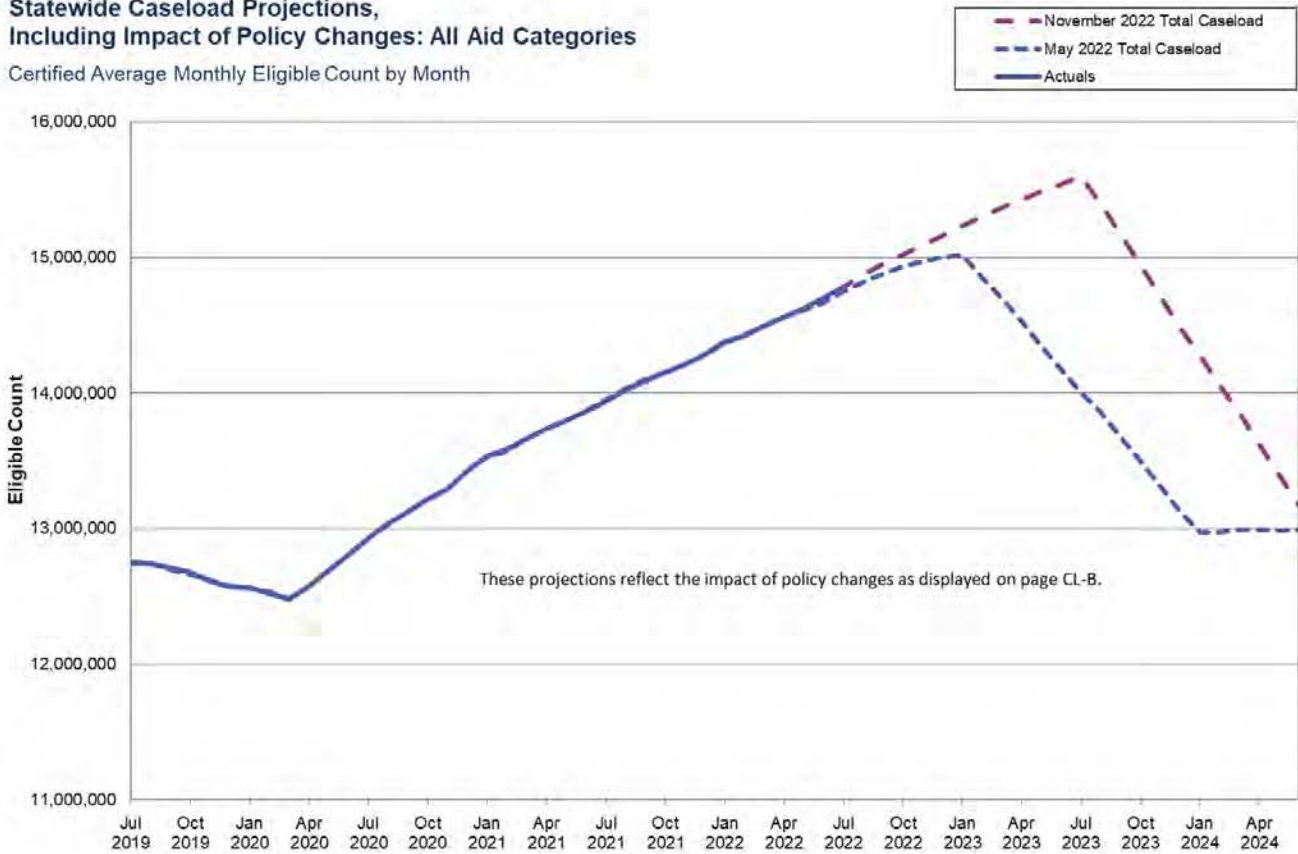
Change from May 2022 Estimate

	<u>Eligibles</u>		<u>Percent</u>	
	<u>FY 2021-22</u>	<u>FY 2022-23</u>	<u>FY 2021-22</u>	<u>FY 2022-23</u>
Seniors	(1,600)	21,200	-0.14%	1.81%
Persons with Disabilities	(1,200)	400	-0.11%	0.04%
Families and Children	1,400	221,300	0.02%	2.90%
Optional Expansion	(1,900)	189,500	-0.04%	3.91%
Miscellaneous	(1,900)	(1,600)	-3.19%	-2.52%
Total	(5,200)	430,800	-0.04%	2.91%

The plot below displays the projected total Medi-Cal caseload over time.

**Statewide Caseload Projections,
Including Impact of Policy Changes: All Aid Categories**

Certified Average Monthly Eligible Count by Month



As summarized in the tables and plot above, the Medi-Cal caseload is projected to continue to grow through July 2023, consistent with the Estimate’s assumption that the federal PHE will continue through mid-April 2023 and the first individuals to leave the Medi-Cal caseload as a result of redeterminations will begin in August 2023. This equates to approximately 2.7 million members leaving Medi-Cal after the PHE ends and eligibility redeterminations are complete.

These projections will be updated for the May Revision to reflect the impact of recent federal changes to the PHE unwinding schedule as well as more recent actual caseload levels.

Reference Information

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

- Major New Items
- COVID-19
- CalAIM
- Home and Community-Based Services Spending Plan
- CYBHI / BCHIP / Behavioral Health Bridge Housing
- Proposition 56

			November 2022 Estimated Amount (In Thousands)				Change from May 2022 Estimate (In Thousands)		November 2022 Estimate Year-over-Year Change (In Thousands)	
			2022-23 (CY)		2023-24 (BY)		2022-23 (CY)		2022-23 to 2023-24	
PC Type	PC #	Policy Change Title	TF	GF	TF	GF	TF	GF	TF	GF
Major New Items										
Reg.	252	2024 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	\$0	\$0	\$1,293,487	\$467,914	\$0	\$0	\$1,293,487	\$467,914
Reg.	253	2024 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	\$0	\$0	\$0	-\$467,914	\$0	\$0	\$0	-\$467,914
	254	2024 MCO ENROLLMENT TAX MANAGED CARE PLANS	\$0	\$0	\$0	-\$316,536	\$0	\$0	\$0	-\$316,536
Reg.	243	CALIFORNIA BEHAVIORAL HEALTH CBC DEMONSTRATION	\$0	\$0	\$4,095	\$137	\$0	\$0	\$4,095	\$137
Other Admin.	89	CALIFORNIA BH CBC DEMONSTRATION ADMIN	\$0	\$0	\$1,556	\$174	\$0	\$0	\$1,556	\$174
Reg.	228	CALAIM - BH PAYMENT REFORM	\$0	\$0	\$375,000	\$375,000	\$0	\$0	\$375,000	\$375,000
Reg.	251	CALAIM- DESIGNATED STATE HEALTH PROGRAMS	\$0	-\$40,402	\$22,710	-\$152,972	\$0	-\$40,402	\$22,710	-\$112,570
Reg.	193	CARE COURT	\$0	\$0	\$16,496	\$16,496	\$0	\$0	\$16,496	\$16,496
Other Admin.	50	CARE COURT - OTHER ADMIN	\$57,000	\$57,000	\$0	\$0	\$57,000	\$57,000	-\$57,000	-\$57,000
Totals			\$57,000	\$16,598	\$1,713,344	-\$77,701	\$57,000	\$16,598	\$1,656,344	-\$94,299
COVID 19										
Reg.	157	COVID-19 CASELOAD IMPACT	\$14,478,464	\$4,127,988	\$12,068,721	\$3,500,248	\$3,376,067	\$1,041,671	-\$2,409,743	-\$627,740
Reg.	166	COVID-19 LTC REIMBURSEMENT RATES	-\$9,056	-\$4,504	-\$38,662	-\$18,858	-\$109,972	-\$53,258	-\$29,606	-\$14,354
Reg.	159	COVID-19 BEHAVIORAL HEALTH	\$190,217	\$14,381	\$63,080	\$4,786	\$82,116	\$5,691	-\$127,137	-\$9,595

			November 2022 Estimated Amount (In Thousands)				Change from May 2022 Estimate (In Thousands)		November 2022 Estimate Year-over-Year Change (In Thousands)	
			2022-23 (CY)		2023-24 (BY)		2022-23 (CY)		2022-23 to 2023-24	
PC Type	PC #	Policy Change Title	TF	GF	TF	GF	TF	GF	TF	GF
Reg.	163	COVID-19 ELIGIBILITY	\$140,049	\$95,277	\$70,505	\$35,253	\$36,286	\$30,886	-\$69,544	-\$60,024
Reg.	162	COVID-19 - SICK LEAVE BENEFITS*	\$6,776	\$65	\$0	\$0	\$4,143	\$21	-\$6,776	-\$65
Reg.	164	COVID-19 VACCINE ADMINISTRATION	\$6,201	\$419	-\$40,800	-\$2,754	-\$170,346	-\$9,006	-\$47,001	-\$3,173
Reg.	N/A	COVID-19 FFS DME RESPIRATORY RATES	\$0	\$0	\$0	\$0	-\$12,778	-\$6,026	\$0	\$0
Reg.	160	COVID-19 VACCINATION INCENTIVE PROGRAM	\$156,822	\$78,411	\$0	\$0	\$23,489	\$11,745	-\$156,822	-\$78,411
Other Admin	10	COVID-19 VACCINATION INCENTIVE PROGRAM ADMIN	\$100,000	\$50,000	\$0	\$0	\$0	\$0	-\$100,000	-\$50,000
Reg.	N/A	COVID-19 TESTING IN SCHOOLS	\$0	\$0	\$0	\$0	-\$404,591	-\$102,449	\$0	\$0
Reg.	161	PHARMACY-BASED COVID-19 TESTS	\$80,384	\$27,136	\$90,884	\$30,681	\$43,932	\$14,375	\$10,500	\$3,544
Reg.	165	CONTINUOUS CHIP COVERAGE DURING THE COVID-19 PHE	\$0	\$86,511	\$0	\$29,101	\$0	\$46,497	\$0	-\$57,410
County Admin.	3	FUNDING FOR COUNTY REDETERMINATIONS	\$109,523	\$54,762	\$0	\$0	\$0	\$0	-\$109,523	-\$54,762
Var.		COVID-19 INCREASED FMAP	\$696,485	-\$4,042,243	\$89,973	-\$405,215	-\$366,502	-\$1,753,953	-\$606,512	\$3,637,028
Totals			\$15,955,865	\$488,202	\$12,303,701	\$3,173,241	\$2,501,844	-\$773,807	-\$3,652,164	\$2,685,039
* Adjusted to remove impact of increased FMAP to avoid double counting.										
CaAIM										
Reg.	73	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES	\$1,175,858	\$431,942	\$1,829,376	\$748,822	-\$243,325	-\$139,778	\$653,518	\$316,880
Reg.	228	CALAIM - BH PAYMENT REFORM	\$0	\$0	\$375,000	\$375,000	\$0	\$0	\$375,000	\$375,000
Other Admin.	1	CALAIM - MEDI-CAL PATH	\$711,900	\$271,215	\$599,900	\$271,950	\$5,280	\$18,115	-\$112,000	\$735
Reg.	221	CALAIM - DENTAL INITIATIVES	\$258,451	\$124,205	\$259,302	\$124,492	\$18,493	\$7,657	\$851	\$287
Reg.	25	CALAIM - LTC BENEFIT TRANSITION	\$201,000	\$96,864	\$48,952	\$23,590	\$96,896	\$47,300	-\$152,048	-\$73,274
Reg.	88	CALAIM - TRANSITIONING POPULATIONS	\$211,712	\$84,672	\$25,981	\$10,394	-\$12,275	-\$1,395	-\$185,731	-\$74,279
Reg.	63	CALAIM - BH QUALITY IMPROVEMENT PROGRAM	\$45,396	\$45,396	\$19,456	\$19,456	\$0	\$0	-\$25,940	-\$25,940
Other Admin	6	CALAIM - POPULATION HEALTH MANAGEMENT	\$49,601	\$4,960	\$52,668	\$5,267	-\$250,399	-\$25,040	\$3,067	\$307
Reg.	5	CALAIM - INMATE PRE-RELEASE PROGRAM	\$6,561	\$3,995	\$109,713	\$39,067	-\$56,427	-\$15,845	\$103,152	\$35,072
Reg.	32	CALAIM - ORGAN TRANSPLANT	\$9,430	\$3,535	\$13,665	\$4,516	-\$1,742	-\$79	\$4,235	\$981
Reg.	251	CALAIM- DESIGNATED STATE HEALTH PROGRAMS	\$0	-\$40,402	\$22,710	-\$152,972	\$0	-\$40,402	\$22,710	-\$112,570
Totals			\$2,669,909	\$1,026,382	\$3,356,723	\$1,469,582	-\$443,499	-\$149,467	\$686,814	\$443,200
Home and Community Based Services Spending Plan										
Reg.	86	HCBS SP - HOUSING AND HOMELESSNESS INCENTIVE PROG	\$644,000	\$0	\$644,000	\$0	-\$236	\$0	\$0	\$0

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			2022-23 (CY)		2023-24 (BY)		2022-23 (CY)		2022-23 to 2023-24	
PC Type	PC #	Policy Change Title	TF	GF	TF	GF	TF	GF	TF	GF
Reg.	227	HCBS SP - ETSB FOR LAGUNA HONDA HOSPITAL RESIDENTS	\$600	\$0	\$0	\$0	\$600	\$0	-\$600	\$0
Reg.	186	HCBS SP CDDS	\$382,513	\$0	\$199,018	\$0	\$151,377	\$0	-\$183,495	\$0
Other Admin.	78	HCBS SP CDDS - OTHER ADMIN	\$2,833	\$0	\$632	\$0	\$377	\$0	-\$2,201	\$0
Reg.	207	HCBS SP - ASSISTED LIVING WAIVER EXPANSION	\$23,297	-\$5,721	\$22,907	-\$12,003	-\$15,270	\$14,771	-\$390	-\$6,282
Reg.	56	HCBS SP - CONTINGENCY MANAGEMENT	\$9,846	\$0	\$27,958	\$0	-\$24,174	\$0	\$18,112	\$0
Other Admin.	41	HCBS SP - CONTINGENCY MANAGEMENT ADMIN	\$2,084	\$0	\$3,750	\$0	-\$9,246	\$0	\$1,666	\$0
Reg.	230	AMERICAN RESCUE PLAN INCREASED FMAP FOR HCBS	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Reg.	217	HCBS SP - NON-IHSS CARE ECONOMY PMTS	\$12,250	\$0	\$0	\$0	\$0	\$0	-\$12,250	\$0
Reg.	172	HCBS SP - IHSS HCBS CARE ECONOMY PMTS	\$165,790	\$0	\$0	\$0	\$165,790	\$0	-\$165,790	\$0
Reg.	203	HCBS SP - CALBRIDGE BH NAVIGATOR PROGRAM	\$29,651	\$0	\$1,296	\$0	-\$151	\$0	-\$28,355	\$0
Totals			\$1,272,864	-\$5,721	\$899,561	-\$12,003	\$269,067	\$14,771	-\$373,303	-\$6,282
CYBHI / BHCIP / BH Bridge Housing										
Reg.	182	CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY	\$450,000	\$450,000	\$100,000	\$100,000	\$0	\$0	-\$350,000	-\$350,000
Reg.	183	CYBHI - EVIDENCE-BASED BH PRACTICES	\$429,000	\$429,000	\$0	\$0	\$0	\$0	-\$429,000	-\$429,000
Other Admin.	2	CYBHI - BH SERVICES AND SUPPORTS PLATFORM	\$230,000	\$230,000	\$124,900	\$124,900	\$0	\$0	-\$105,100	-\$105,100
Reg.	89	CYBHI - STUDENT BH INCENTIVE PROGRAM	\$199,014	\$99,507	\$85,285	\$42,643	\$4,521	\$2,261	-\$113,729	-\$56,865
Reg.	29	CYBHI - DYADIC SERVICES	\$44,156	\$16,727	\$136,192	\$54,574	\$3,909	\$550	\$92,037	\$37,847
Reg.	208	CYBHI - CALHOPE STUDENT SUPPORT	\$21,000	\$21,000	\$24,000	\$24,000	\$1,250	\$1,250	\$3,000	\$3,000
Reg.	189	CYBHI - URGENT NEEDS AND EMERGENT ISSUES	\$120,000	\$120,000	\$26,000	\$26,000	-\$500	-\$500	-\$94,000	-\$94,000
Reg.	60	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE	\$1,339,697	\$1,121,197	\$0	\$0	-\$320,052	-\$320,052	-\$1,339,697	-\$1,121,197
Reg.	181	BEHAVIORAL HEALTH BRIDGE HOUSING	\$907,936	\$907,936	\$300,000	\$300,000	-\$50,000	-\$50,000	-\$607,936	-\$607,936
Totals			\$3,740,803	\$3,395,367	\$796,377	\$672,117	-\$360,872	-\$366,491	-\$2,944,425	-\$2,723,251
Proposition 56										
Reg.	129	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	\$1,348,007	\$475,148	\$1,289,079	\$506,476	\$109,323	-\$21,778	-\$58,928	\$31,328

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			2022-23 (CY)		2023-24 (BY)		2022-23 (CY)		2022-23 to 2023-24	
PC Type	PC #	Policy Change Title	TF	GF	TF	GF	TF	GF	TF	GF
Reg.	142	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	\$578,569	\$199,101	\$580,083	\$225,881	\$26,140	-\$11,897	\$1,514	\$26,780
Reg.	133	PROP 56 - MEDI-CAL FAMILY PLANNING	\$465,341	\$77,409	\$465,341	\$77,409	\$10,073	\$1,249	\$0	\$0
Reg.	93	PROP 56 - BEHAVIORAL HEALTH INCENTIVE PROGRAM	\$90,136	\$39,945	\$0	\$0	\$0	-\$1,397	-\$90,136	-\$39,945
Reg.	151	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	\$69,411	\$21,664	\$74,045	\$22,967	-\$16,217	-\$4,620	\$4,634	\$1,303
Reg.	146	PROP 56 - VALUE-BASED PAYMENT PROGRAM	\$31,005	\$9,348	\$0	\$0	\$0	\$6	-\$31,005	-\$9,348
Reg.	220	PROP 56 - PROVIDER ACES TRAININGS	\$7,100	\$3,550	\$0	\$0	\$0	\$0	-\$7,100	-\$3,550
Reg.	255	PROP 56 - DIRECTED PAYMENT RISK MITIGATION	-\$500,000	-\$175,037	\$0	\$0	-\$500,000	-\$175,037	\$500,000	\$175,037
Reg.	200	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG	\$42,028	\$0	\$52,466	\$0	\$1,248	\$0	\$10,438	\$0
Reg.	155	PROPOSITION 56 FUNDING	\$0	-\$651,127	\$0	-\$744,303	\$0	-\$82,067	\$0	-\$93,176
Totals			\$2,131,597	\$0	\$2,461,014	\$88,430	-\$369,433	-\$295,542	\$329,417	\$88,430

Medi-Cal Funding Summary
November 2022 Estimate Compared to Appropriation
Fiscal Year 2022 - 2023

TOTAL FUNDS

<u>Benefits:</u>	<u>Total Appropriation</u>	<u>Nov 2022 Estimate</u>	<u>Difference Incr./(Decr.)</u>
4260-101-0001/0890 Medi-Cal General and Federal Funds	\$113,600,153,000	\$111,565,562,000	(\$2,034,591,000)
4260-101-0080 CLPP Funds	\$916,000	\$902,000	(\$14,000)
4260-101-0232 Prop 99 Hospital Svc. Acct.	\$77,350,000	\$77,350,000	\$0
4260-101-0233 Prop 99 Physician Svc. Acct	\$22,249,000	\$22,249,000	\$0
4260-101-0236 Prop 99 Unallocated Account	\$31,765,000	\$31,753,000	(\$12,000)
4260-101-3085 Mental Health Services	\$35,627,000	\$31,050,000	(\$4,577,000)
4260-101-3168 Emergency Air Transportation Fund	\$1,120,000	\$4,011,000	\$2,891,000
4260-101-3305 Healthcare Treatment Fund	\$864,603,000	\$651,127,000	(\$213,476,000)
4260-101-3375 Medi-Cal Loan Repayment Program	\$40,780,000	\$42,028,000	\$1,248,000
4260-101-3398 California Emergency Relief Fund	\$0	\$1,077,600,000	\$1,077,600,000
4260-101-8507 Home & Community Based Services (101)*	\$430,259,000	\$338,052,000	(\$92,207,000)
4260-611-0001/0890 Home & Community Based Services(611)*	\$901,418,000	\$1,523,490,000	\$622,072,000
4260-698-0001 Home & Community Based Services (698-0001)*	(\$450,709,000)	(\$761,745,000)	(\$311,036,000)
4260-698-8507 Home & Community Based Services (698-8507)*	(\$450,709,000)	(\$761,745,000)	(\$311,036,000)
4260-102-0001/0890 Capital Debt	\$70,645,000	\$65,962,000	(\$4,683,000)
4260-102-3305 Prop 56 Loan Forgiveness Program	\$0	\$0	\$0
4260-103-3305 Prop 56 Value-Based Payment	\$0	\$0	\$0
4260-601-3375 Medi-Cal Loan Repayment Program 601	\$0	\$0	\$0
4260-104-0001 NDPH Hosp Supp	\$1,900,000	\$1,900,000	\$0
4260-601-3096 NDPH Suppl	\$6,158,000	\$1,723,000	(\$4,435,000)
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	\$311,341,000	\$129,661,000	(\$181,680,000)
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	\$13,280,000	\$38,233,000	\$24,953,000
4260-112-0001 GF Support for Prop 56 Payments*	\$295,543,000	\$0	(\$295,543,000)
4260-695-3305 Health Care Treatment Fund (Less GF)	(\$295,543,000)	\$0	\$295,543,000
4260-113-0001/0890 Children's Health Insurance Program	\$3,777,296,000	\$3,827,281,000	\$49,985,000
4260-119-0001 Behavioral Health Payment Reform	\$0	\$0	\$0
4260-601-3420 Behavioral Health IGT Fund	\$0	\$0	\$0
4260-695-3420 Transfer to Behavioral Health IGT Fund	\$0	\$0	\$0
4260-162-8506 State Fiscal Recovery Fund of 2021	\$218,500,000	\$218,500,000	\$0
4260-601-0942142 Local Trauma Centers	\$71,965,000	\$56,833,000	(\$15,132,000)
4260-601-0942 Health Homes Program Account	\$0	\$0	\$0
4260-601-0995 Reimbursements	\$1,948,290,000	\$2,199,545,000	\$251,255,000
4260-601-3156 MCO Tax Fund	\$0	\$416,000,000	\$416,000,000
4260-601-3213 LTC QA Fund	\$495,668,000	\$517,203,000	\$21,535,000
4260-601-3293 MCO Tax Fund 2016	\$0	\$0	\$0
4260-601-3323 Medi-Cal Emergency Transport Fund	\$65,482,000	\$61,976,000	(\$3,506,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	\$1,841,255,000	\$1,788,007,000	(\$53,248,000)
4260-601-3334 MCO Tax (HCS Special Fund)	\$2,065,534,000	\$2,065,534,000	\$0
4260-601-3428 MCO Tax 2024	\$0	\$0	\$0
4260-601-7502 Demonstration DSH Fund	\$195,365,000	\$220,699,000	\$25,334,000
4260-601-7503 Health Care Support Fund	\$487,000	\$41,051,000	\$40,564,000
4260-601-8108 Global Payment Program Fund	\$1,272,004,000	\$1,235,912,000	(\$36,092,000)
4260-601-8113 DPH GME Special Fund	\$220,470,000	\$282,168,000	\$61,698,000
4260-602-0309 Perinatal Insurance Fund	\$19,214,000	\$10,680,000	(\$8,534,000)
4260-605-0001 SNF Quality & Accountability	\$0	\$0	\$0
4260-605-3167 SNF Quality & Accountability (Non-GF) Only	\$0	\$0	\$0
4260-605-3167 SNF Quality & Accountability	\$20,500,000	\$21,697,000	\$1,197,000
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	\$0	\$0	\$0
4260-606-0834 SB 1100 DSH	\$112,072,000	\$104,399,000	(\$7,673,000)
4260-611-3158/0890 Hospital Quality Assurance	\$3,808,927,000	\$3,657,365,000	(\$151,562,000)
Total Benefits	\$131,639,275,000	\$130,802,113,000	(\$837,162,000)
County Administration:			
4260-101-0001/0890 Medi-Cal General and Federal Funds	\$5,839,280,000	\$6,218,860,000	\$379,580,000
4260-101-8507 Home & Community Base Services	\$5,665,000	\$45,277,000	\$39,612,000
4260-106-0890 Money Follow Person Fed. Grant	\$340,000	\$5,340,000	\$5,000,000
4260-113-0001/0890 Children's Health Insurance Program	\$63,996,000	\$80,635,000	\$16,639,000
4260-117-0001/0890 HIPAA	\$17,867,000	\$14,153,000	(\$3,714,000)
4260-162-8506 State Fiscal Recovery Fund of 2021	\$0	\$0	\$0
4260-601-0942 Health Homes Program Account	\$0	\$0	\$0
4260-601-0995 Reimbursements	\$13,671,000	\$54,171,000	\$40,500,000
4260-601-3420 Behavioral Health IGT Fund	\$0	\$0	\$0
4260-602-3311 Healthcare Svc. Plans Fines and Penalties Fund	\$0	\$0	\$0
4260-605-3167 SNF Quality & Accountability Admin.	\$0	\$0	\$0
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	\$147,000	\$150,000	\$3,000
Total County Administration	\$5,940,966,000	\$6,418,586,000	\$477,620,000
Fiscal Intermediary:			
4260-101-0001/0890 Medi-Cal General and Federal Funds	\$450,750,000	\$496,235,000	\$45,485,000
4260-113-0001/0890 Children's Health Insurance Program	\$25,946,000	\$26,353,000	\$407,000
4260-117-0001/0890 HIPAA	\$3,091,000	\$2,735,000	(\$356,000)
4260-601-0995 Reimbursements	\$0	\$0	\$0
Total Fiscal Intermediary	\$479,787,000	\$525,323,000	\$45,536,000
Grand Total - Total Funds	\$138,060,028,000	\$137,746,022,000	(\$314,006,000)

**Medi-Cal Funding Summary
November 2022 Estimate Compared to Appropriation
Fiscal Year 2022 - 2023**

STATE FUNDS

Benefits:	State Funds Appropriation	Nov 2022 Estimate	Difference Incr./(Decr.)
4260-101-0001 Medi-Cal General Fund* ¹	\$33,515,840,000	\$29,292,558,000	(\$4,223,282,000)
4260-101-0080 CLPP Funds	\$916,000	\$902,000	(\$14,000)
4260-101-0232 Prop 99 Hospital Srv. Acct.	\$77,350,000	\$77,350,000	\$0
4260-101-0233 Prop 99 Physician Srv. Acct	\$22,249,000	\$22,249,000	\$0
4260-101-0236 Prop 99 Unallocated Account	\$31,765,000	\$31,753,000	(\$12,000)
4260-101-3085 Mental Health Services	\$35,627,000	\$31,050,000	(\$4,577,000)
4260-101-3168 Emergency Air Transportation Fund	\$1,120,000	\$4,011,000	\$2,891,000
4260-101-3305 Healthcare Treatment Fund	\$864,603,000	\$651,127,000	(\$213,476,000)
4260-101-3375 Medi-Cal Loan Repayment Program	\$40,780,000	\$42,028,000	\$1,248,000
4260-101-3398 California Emergency Relief Fund	\$0	\$1,077,600,000	\$1,077,600,000
4260-101-8507 Home & Community Based Services (101)	\$430,259,000	\$338,052,000	(\$92,207,000)
4260-611-0001 Home & Community Based Services(611)*	\$450,709,000	\$761,745,000	\$311,036,000
4260-698-0001 Home & Community Based Services (698-0001)*	(\$450,709,000)	(\$761,745,000)	(\$311,036,000)
4260-698-8507 Home & Community Based Services (698-8507)	(\$450,709,000)	(\$761,745,000)	(\$311,036,000)
4260-102-0001 Capital Debt *	\$21,376,000	\$19,018,000	(\$2,358,000)
4260-102-3305 Prop 56 Loan Forgiveness Program	\$0	\$0	\$0
4260-103-3305 Prop 56 Value-Based Payment	\$0	\$0	\$0
4260-601-3375 Medi-Cal Loan Repayment Program 601	\$0	\$0	\$0
4260-104-0001 NDPH Hosp Supp *	\$1,900,000	\$1,900,000	\$0
4260-601-3096 NDPH Suppl	\$6,158,000	\$1,723,000	(\$4,435,000)
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	\$311,341,000	\$129,661,000	(\$181,680,000)
4260-698-3097 Private Hosp Suppl (Less Funded by GF)	(\$118,400,000)	(\$118,400,000)	\$0
4260-112-0001 GF Support for Prop 56 Payments*	\$295,543,000	\$0	(\$295,543,000)
4260-695-3305 Health Care Treatment Fund (Less GF)	(\$295,543,000)	\$0	\$295,543,000
4260-113-0001 Childrens Health Insurance Program *	\$1,059,005,000	\$1,072,184,000	\$13,179,000
4260-119-0001 Behavioral Health Payment Reform	\$0	\$0	\$0
4260-601-3420 Behavioral Health IGT Fund	\$0	\$0	\$0
4260-695-3420 Transfer to Behavioral Health IGT Fund	\$0	\$0	\$0
4260-601-0942142 Local Trauma Centers	\$71,965,000	\$56,833,000	(\$15,132,000)
4260-601-0942 Health Homes Program Account	\$0	\$0	\$0
4260-601-0995 Reimbursements	\$1,948,290,000	\$2,199,545,000	\$251,255,000
4260-601-3156 MCO Tax Fund	\$0	\$416,000,000	\$416,000,000
4260-601-3213 LTC QA Fund	\$495,668,000	\$517,203,000	\$21,535,000
4260-601-3293 MCO Tax Fund 2016	\$0	\$0	\$0
4260-601-3323 Medi-Cal Emergency Transport Fund	\$65,482,000	\$61,976,000	(\$3,506,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	\$1,841,255,000	\$1,788,007,000	(\$53,248,000)
4260-601-3334 MCO Tax (HCS Special Fund)	\$2,065,534,000	\$2,065,534,000	\$0
4260-601-3438 MCO Tax 2024	\$0	\$0	\$0
4260-601-8108 Global Payment Program Fund	\$1,272,004,000	\$1,235,912,000	(\$36,092,000)
4260-601-8113 DPH GME Special Fund	\$220,470,000	\$282,168,000	\$61,698,000
4260-602-0309 Perinatal Insurance Fund	\$19,214,000	\$10,680,000	(\$8,534,000)
4260-605-0001 SNF Quality & Accountability *	\$0	\$0	\$0
4260-605-3167 SNF Quality & Accountability (Non-GF) Only	\$0	\$0	\$0
4260-605-3167 SNF Quality & Accountability	\$20,500,000	\$21,697,000	\$1,197,000
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	\$0	\$0	\$0
4260-606-0834 SB 1100 DSH	\$112,072,000	\$104,399,000	(\$7,673,000)
4260-611-3158 Hospital Quality Assurance Revenue	\$3,808,927,000	\$3,657,365,000	(\$151,562,000)
Total Benefits	\$47,909,061,000	\$44,446,840,000	(\$3,462,221,000)
Total Benefits General Fund *	\$35,012,064,000	\$30,504,060,000	(\$4,508,004,000)
County Administration:			
4260-101-0001 Medi-Cal General Fund *	\$1,361,611,000	\$1,615,513,000	\$253,902,000
4260-101-8507 Home & Community Base Services	\$5,665,000	\$45,277,000	\$39,612,000
4260-113-0001 Childrens Health Insurance Program *	\$13,910,000	\$15,313,000	\$1,403,000
4260-117-0001 HIPAA *	\$3,715,000	\$2,852,000	(\$863,000)
4260-601-0942 Health Homes Program Account	\$0	\$0	\$0
4260-601-0995 Reimbursements	\$13,671,000	\$54,171,000	\$40,500,000
4260-601-3420 Behavioral Health IGT Fund	\$0	\$0	\$0
4260-602-3311 Healthcare Srv. Plans Fines and Penalties Fund	\$0	\$0	\$0
4260-605-3167 SNF Quality & Accountability Admin.	\$0	\$0	\$0
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	\$147,000	\$150,000	\$3,000
Total County Administration	\$1,398,719,000	\$1,733,276,000	\$334,557,000
Total County Administration General Fund *	\$1,379,236,000	\$1,633,678,000	\$254,442,000
Fiscal Intermediary:			
4260-101-0001 Medi-Cal General Fund *	\$134,028,000	\$153,501,000	\$19,473,000
4260-113-0001 Childrens Health Insurance Program *	\$8,110,000	\$8,272,000	\$162,000
4260-117-0001 HIPAA *	\$720,000	\$630,000	(\$90,000)
4260-601-0995 Reimbursements	\$0	\$0	\$0
Total Fiscal Intermediary	\$142,858,000	\$162,403,000	\$19,545,000
Total Fiscal Intermediary General Fund *	\$142,858,000	\$162,403,000	\$19,545,000
Grand Total - State Funds	\$49,450,638,000	\$46,342,519,000	(\$3,108,119,000)
Grand Total - General Fund*	\$36,534,158,000	\$32,300,141,000	(\$4,234,017,000)

Medi-Cal Funding Summary
November 2022 Estimate Compared to Appropriation
Fiscal Year 2022 - 2023

FEDERAL FUNDS

	<u>Federal Funds Appropriation</u>	<u>Nov 2022 Estimate</u>	<u>Difference Incr./(Decr.)</u>
Benefits:			
4260-101-0890 Federal Funds ¹	\$80,084,313,000	\$82,273,004,000	\$2,188,691,000
4260-102-0890 Capital Debt	\$49,269,000	\$46,944,000	(\$2,325,000)
4260-106-0890 Money Follows Person Federal Grant	\$13,280,000	\$38,233,000	\$24,953,000
4260-113-0890 Childrens Health Insurance Fund	\$2,718,291,000	\$2,755,097,000	\$36,806,000
4260-162-8506 State Fiscal Recovery Fund of 2021	\$218,500,000	\$218,500,000	\$0
4260-601-7502 Demonstration DSH Fund	\$195,365,000	\$220,699,000	\$25,334,000
4260-601-7503 Health Care Support Fund	\$487,000	\$41,051,000	\$40,564,000
4260-611-0890 Home & Community Based Services 100% FF	\$450,709,000	\$761,745,000	\$311,036,000
4260-611-0890 Hospital Quality Assurance	\$0	\$0	\$0
Total Benefits	<u>\$83,730,214,000</u>	<u>\$86,355,273,000</u>	<u>\$2,625,059,000</u>
County Administration:			
4260-101-0890 Federal Funds	\$4,477,669,000	\$4,603,347,000	\$125,678,000
4260-106-0890 Money Follows Person Fed. Grant	\$340,000	\$5,340,000	\$5,000,000
4260-113-0890 Childrens Health Insurance Fund	\$50,086,000	\$65,322,000	\$15,236,000
4260-117-0890 HIPAA	\$14,152,000	\$11,301,000	(\$2,851,000)
4260-162-8506 State Fiscal Recovery Fund of 2021	\$0	\$0	\$0
Total County Administration	<u>\$4,542,247,000</u>	<u>\$4,685,310,000</u>	<u>\$143,063,000</u>
Fiscal Intermediary:			
4260-101-0890 Federal Funds	\$316,722,000	\$342,734,000	\$26,012,000
4260-113-0890 Childrens Health Insurance Fund	\$17,836,000	\$18,081,000	\$245,000
4260-117-0890 HIPAA	\$2,371,000	\$2,105,000	(\$266,000)
Total Fiscal Intermediary	<u>\$336,929,000</u>	<u>\$362,920,000</u>	<u>\$25,991,000</u>
Grand Total - Federal Funds	<u>\$88,609,390,000</u>	<u>\$91,403,503,000</u>	<u>\$2,794,113,000</u>

¹ Reflects mid-year adjustments to the Appropriation

Medi-Cal Funding Summary
November 2022 Estimate Comparison of FY 2022-23 to FY 2023-24

TOTAL FUNDS

	FY 2022-23	FY 2023-24	Difference
	Estimate	Estimate	Incr./(Decr.)
Benefits:			
4260-101-0001/0890 Medi-Cal General and Federal Funds	\$111,565,562,000	\$116,924,699,000	\$5,359,137,000
4260-101-0080 CLPP Funds	\$902,000	\$902,000	\$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	\$77,350,000	\$73,748,000	(\$3,602,000)
4260-101-0233 Prop 99 Physician Srvc. Acct	\$22,249,000	\$21,842,000	(\$407,000)
4260-101-0236 Prop 99 Unallocated Account	\$31,753,000	\$30,200,000	(\$1,553,000)
4260-101-3085 Mental Health Services	\$31,050,000	\$27,327,000	(\$3,723,000)
4260-101-3168 Emergency Air Transportation Fund	\$4,011,000	\$1,076,000	(\$2,935,000)
4260-101-3305 Healthcare Treatment Fund	\$651,127,000	\$832,732,000	\$181,605,000
4260-101-3375 Medi-Cal Loan Repayment Program	\$42,028,000	\$0	(\$42,028,000)
4260-101-3398 California Emergency Relief Fund	\$1,077,600,000	\$0	(\$1,077,600,000)
4260-101-8507 Home & Community Based Services (101)	\$338,052,000	\$333,237,000	(\$4,815,000)
4260-611-0001/0890 Home & Community Based Services(611)	\$1,523,490,000	\$0	(\$1,523,490,000)
4260-698-0001 Home & Community Based Services (698-0001)	(\$761,745,000)	\$0	\$761,745,000
4260-698-8507 Home & Community Based Services (698-8507)	(\$761,745,000)	\$0	\$761,745,000
4260-102-0001/0890 Capital Debt	\$65,962,000	\$75,128,000	\$9,166,000
4260-102-3305 Prop 56 Loan Forgiveness Program	\$0	\$0	\$0
4260-103-3305 Prop 56 Value-Based Payment	\$0	\$0	\$0
4260-601-3375 Medi-Cal Loan Repayment Program 601	\$0	\$52,466,000	\$52,466,000
4260-104-0001 NDPH Hosp Supp	\$1,900,000	\$1,900,000	\$0
4260-601-3096 NDPH Suppl	\$1,723,000	\$1,900,000	\$177,000
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	\$129,661,000	\$143,725,000	\$14,064,000
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	\$38,233,000	\$51,857,000	\$13,624,000
4260-112-0001 GF Support for Prop 56 Payments*	\$0	\$88,429,000	\$88,429,000
4260-695-3305 Health Care Treatment Fund (Less GF)	\$0	(\$88,429,000)	(\$88,429,000)
4260-113-0001/0890 Children's Health Insurance Program	\$3,827,281,000	\$0	(\$3,827,281,000)
4260-119-0001 Behavioral Health Payment Reform	\$0	\$375,000,000	\$375,000,000
4260-601-3420 Behavioral Health IGT Fund	\$0	\$1,378,245,000	\$1,378,245,000
4260-695-3420 Transfer to Behavioral Health IGT Fund	\$0	(\$375,000,000)	(\$375,000,000)
4260-162-8506 State Fiscal Recovery Fund of 2021	\$218,500,000	\$0	(\$218,500,000)
4260-601-0942142 Local Trauma Centers	\$56,833,000	\$71,637,000	\$14,804,000
4260-601-0942 Health Homes Program Account	\$0	\$0	\$0
4260-601-0995 Reimbursements	\$2,199,545,000	\$2,007,750,000	(\$191,795,000)
4260-601-3156 MCO Tax Fund	\$416,000,000	\$0	(\$416,000,000)
4260-601-3213 LTC QA Fund	\$517,203,000	\$501,312,000	(\$15,891,000)
4260-601-3293 MCO Tax Fund 2016	\$0	\$0	\$0
4260-601-3323 Medi-Cal Emergency Transport Fund	\$61,976,000	\$62,610,000	\$634,000
4260-601-3331 Medi-Cal Drug Rebates Fund	\$1,788,007,000	\$1,853,824,000	\$65,817,000
4260-601-3334 MCO Tax (HCS Special Fund)	\$2,065,534,000	\$0	(\$2,065,534,000)
4260-601-3428 MCO Tax 2024	\$0	\$784,450,000	\$784,450,000
4260-601-7502 Demonstration DSH Fund	\$220,699,000	\$120,329,000	(\$100,370,000)
4260-601-7503 Health Care Support Fund	\$41,051,000	\$162,219,000	\$121,168,000
4260-601-8108 Global Payment Program Fund	\$1,235,912,000	\$1,145,301,000	(\$90,611,000)
4260-601-8113 DPH GME Special Fund	\$282,168,000	\$268,814,000	(\$13,354,000)
4260-602-0309 Perinatal Insurance Fund	\$10,680,000	\$12,997,000	\$2,317,000
4260-605-0001 SNF Quality & Accountability	\$0	\$0	\$0
4260-605-3167 SNF Quality & Accountability(Non-GF) Only	\$0	\$0	\$0
4260-605-3167 SNF Quality & Accountability	\$21,697,000	\$0	(\$21,697,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	\$0	\$0	\$0
4260-606-0834 SB 1100 DSH	\$104,399,000	\$121,427,000	\$17,028,000
4260-611-3158/0890 Hospital Quality Assurance	\$3,657,365,000	\$5,186,245,000	\$1,528,880,000
Total Benefits	\$130,802,113,000	\$132,247,999,000	\$1,445,886,000
County Administration:			
4260-101-0001/0890 Medi-Cal General and Federal Funds	\$6,218,860,000	\$5,971,021,000	(\$247,839,000)
4260-101-8507 Home & Community Base Services	\$45,277,000	\$1,875,000	(\$43,402,000)
4260-106-0890 Money Follow Person Fed. Grant	\$5,340,000	\$340,000	(\$5,000,000)
4260-113-0001/0890 Children's Health Insurance Program	\$80,635,000	\$0	(\$80,635,000)
4260-117-0001/0890 HIPPA	\$14,153,000	\$16,793,000	\$2,640,000
4260-162-8506 State Fiscal Recovery Fund of 2021	\$0	\$0	\$0
4260-601-0942 Health Homes Program Account	\$0	\$0	\$0
4260-601-0995 Reimbursements	\$54,171,000	\$41,671,000	(\$12,500,000)
4260-601-3420 Behavioral Health IGT Fund	\$0	\$45,472,000	\$45,472,000
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	\$0	\$0	\$0
4260-605-3167 SNF Quality & Accountability Admin.	\$0	\$0	\$0
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	\$150,000	\$150,000	\$0
Total County Administration	\$6,418,586,000	\$6,077,322,000	(\$341,264,000)
Fiscal Intermediary:			
4260-101-0001/0890 Medi-Cal General and Federal Funds	\$496,235,000	\$587,973,000	\$91,738,000
4260-113-0001/0890 Children's Health Insurance Program	\$26,353,000	\$0	(\$26,353,000)
4260-117-0001/0890 HIPAA	\$2,735,000	\$3,901,000	\$1,166,000
4260-601-0995 Reimbursements	\$0	\$0	\$0
Total Fiscal Intermediary	\$525,323,000	\$591,874,000	\$66,551,000
Grand Total - Total Funds	\$137,746,022,000	\$138,917,195,000	\$1,171,173,000

Medi-Cal Funding Summary
November 2022 Estimate Comparison of FY 2022-23 to FY 2023-24

STATE FUNDS

Benefits:	FY 2022-23 Estimate	FY 2023-24 Estimate	Difference Incr./(Decr.)
4260-101-0001 Medi-Cal General Fund*	\$29,292,558,000	\$36,530,916,000	\$7,238,358,000
4260-101-0080 CLPP Funds	\$902,000	\$902,000	\$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	\$77,350,000	\$73,748,000	(\$3,602,000)
4260-101-0233 Prop 99 Physician Srvc. Acct	\$22,249,000	\$21,842,000	(\$407,000)
4260-101-0236 Prop 99 Unallocated Account	\$31,753,000	\$30,200,000	(\$1,553,000)
4260-101-3085 Mental Health Services	\$31,050,000	\$27,327,000	(\$3,723,000)
4260-101-3168 Emergency Air Transportation Fund	\$4,011,000	\$1,076,000	(\$2,935,000)
4260-101-3305 Healthcare Treatment Fund	\$651,127,000	\$832,732,000	\$181,605,000
4260-101-3375 Medi-Cal Loan Repayment Program	\$42,028,000	\$0	(\$42,028,000)
4260-101-3398 California Emergency Relief Fund	\$1,077,600,000	\$0	(\$1,077,600,000)
4260-101-8507 Home & Community Based Services (101)	\$338,052,000	\$333,237,000	(\$4,815,000)
4260-611-0001 Home & Community Based Services(611)*	\$761,745,000	\$0	(\$761,745,000)
4260-698-0001 Home & Community Based Services (698-0001)*	(\$761,745,000)	\$0	\$761,745,000
4260-698-8507 Home & Community Based Services (698-8507)	(\$761,745,000)	\$0	\$761,745,000
4260-102-0001 Capital Debt *	\$19,018,000	\$23,602,000	\$4,584,000
4260-102-3305 Prop 56 Loan Forgiveness Program	\$0	\$0	\$0
4260-103-3305 Prop 56 Value-Based Payment	\$0	\$0	\$0
4260-601-3375 Medi-Cal Loan Repayment Program	\$0	\$52,466,000	\$52,466,000
4260-104-0001 NDPH Hosp Supp *	\$1,900,000	\$1,900,000	\$0
4260-601-3096 NDPH Suppl	\$1,723,000	\$1,900,000	\$177,000
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	\$129,661,000	\$143,725,000	\$14,064,000
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	\$88,429,000	\$88,429,000
4260-695-3305 Health Care Treatment Fund (Less GF)	\$0	(\$88,429,000)	(\$88,429,000)
4260-113-0001 Childrens Health Insurance Program *	\$1,072,184,000	\$0	(\$1,072,184,000)
4260-119-0001 Behavioral Health Payment Reform	\$0	\$375,000,000	\$375,000,000
4260-601-3420 Behavioral Health IGT Fund	\$0	\$1,378,245,000	\$1,378,245,000
4260-695-3420 Transfer to Behavioral Health IGT Fund	\$0	(\$375,000,000)	(\$375,000,000)
4260-601-0942142 Local Trauma Centers	\$56,833,000	\$71,637,000	\$14,804,000
4260-601-0942 Health Homes Program Account	\$0	\$0	\$0
4260-601-0995 Reimbursements	\$2,199,545,000	\$2,007,750,000	(\$191,795,000)
4260-601-3156 MCO Tax Fund	\$416,000,000	\$0	(\$416,000,000)
4260-601-3213 LTC QA Fund	\$517,203,000	\$501,312,000	(\$15,891,000)
4260-601-3293 MCO Tax Fund 2016	\$0	\$0	\$0
4260-601-3323 Medi-Cal Emergency Transport Fund	\$61,976,000	\$62,610,000	\$634,000
4260-601-3331 Medi-Cal Drug Rebates Fund	\$1,788,007,000	\$1,853,824,000	\$65,817,000
4260-601-3334 MCO Tax (HCS Special Fund)	\$2,065,534,000	\$0	(\$2,065,534,000)
4260-601-3428 MCO Tax 2024	\$0	\$784,450,000	\$784,450,000
4260-601-8108 Global Payment Program Fund	\$1,235,912,000	\$1,145,301,000	(\$90,611,000)
4260-601-8113 DPH GME Special Fund	\$282,168,000	\$268,814,000	(\$13,354,000)
4260-602-0309 Perinatal Insurance Fund	\$10,680,000	\$12,997,000	\$2,317,000
4260-605-0001 SNF Quality & Accountability *	\$0	\$0	\$0
4260-605-3167 SNF Quality & Accountability (Non-GF) Only	\$0	\$0	\$0
4260-605-3167 SNF Quality & Accountability	\$21,697,000	\$0	(\$21,697,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	\$0	\$0	\$0
4260-606-0834 SB 1100 DSH	\$104,399,000	\$121,427,000	\$17,028,000
4260-611-3158 Hospital Quality Assurance Revenue	\$3,657,365,000	\$5,186,245,000	\$1,528,880,000
Total Benefits	\$44,446,840,000	\$51,468,285,000	\$7,021,445,000
Total Benefits General Fund *	\$30,504,060,000	\$37,138,247,000	\$6,634,187,000
County Administration:			
4260-101-0001 Medi-Cal General Fund *	\$1,615,513,000	\$1,408,001,000	(\$207,512,000)
4260-101-8507 Home & Community Base Services	\$45,277,000	\$1,875,000	(\$43,402,000)
4260-113-0001 Childrens Health Insurance Program *	\$15,313,000	\$0	(\$15,313,000)
4260-117-0001 HIPAA *	\$2,852,000	\$3,564,000	\$712,000
4260-601-0942 Health Homes Program Account	\$0	\$0	\$0
4260-601-0995 Reimbursements	\$54,171,000	\$41,671,000	(\$12,500,000)
4260-601-3420 Behavioral Health IGT Fund	\$0	\$45,472,000	\$45,472,000
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	\$0	\$0	\$0
4260-605-3167 SNF Quality & Accountability Admin.	\$0	\$0	\$0
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	\$150,000	\$150,000	\$0
Total County Administration	\$1,733,276,000	\$1,500,733,000	(\$232,543,000)
Total County Administration General Fund *	\$1,633,678,000	\$1,411,565,000	(\$222,113,000)
Fiscal Intermediary:			
4260-101-0001 Medi-Cal General Fund *	\$153,501,000	\$163,005,000	\$9,504,000
4260-113-0001 Childrens Health Insurance Program *	\$8,272,000	\$0	(\$8,272,000)
4260-117-0001 HIPAA *	\$630,000	\$920,000	\$290,000
4260-601-0995 Reimbursements	\$0	\$0	\$0
Total Fiscal Intermediary	\$162,403,000	\$163,925,000	\$1,522,000
Total Fiscal Intermediary General Fund *	\$162,403,000	\$163,925,000	\$1,522,000
Grand Total - State Funds	\$46,342,519,000	\$53,132,943,000	\$6,790,424,000
Grand Total - General Fund*	\$32,300,141,000	\$38,713,737,000	\$6,413,596,000

Medi-Cal Funding Summary
November 2022 Estimate Comparison of FY 2022-23 to FY 2023-24

FEDERAL FUNDS

	FY 2022-23 Estimate	FY 2023-24 Estimate	Difference Incr./(Decr.)
Benefits:			
4260-101-0890 Federal Funds	\$82,273,004,000	\$80,393,783,000	(\$1,879,221,000)
4260-102-0890 Capital Debt	\$46,944,000	\$51,526,000	\$4,582,000
4260-106-0890 Money Follows Person Federal Grant	\$38,233,000	\$51,857,000	\$13,624,000
4260-113-0890 Childrens Health Insurance Fund	\$2,755,097,000	\$0	(\$2,755,097,000)
4260-162-8506 State Fiscal Recovery Fund of 2021	\$218,500,000	\$0	(\$218,500,000)
4260-601-7502 Demonstration DSH Fund	\$220,699,000	\$120,329,000	(\$100,370,000)
4260-601-7503 Health Care Support Fund	\$41,051,000	\$162,219,000	\$121,168,000
4260-611-0890 Home & Community Based Services 100% FF	\$761,745,000	\$0	(\$761,745,000)
4260-611-0890 Hospital Quality Assurance	\$0	\$0	\$0
Total Benefits	\$86,355,273,000	\$80,779,714,000	(\$5,575,559,000)
County Administration:			
4260-101-0890 Federal Funds	\$4,603,347,000	\$4,563,020,000	(\$40,327,000)
4260-106-0890 Money Follows Person Fed. Grant	\$5,340,000	\$340,000	(\$5,000,000)
4260-113-0890 Childrens Health Insurance Fund	\$65,322,000	\$0	(\$65,322,000)
4260-117-0890 HIPAA	\$11,301,000	\$13,229,000	\$1,928,000
4260-162-8506 State Fiscal Recovery Fund of 2021	\$0	\$0	\$0
Total County Administration	\$4,685,310,000	\$4,576,589,000	(\$108,721,000)
Fiscal Intermediary:			
4260-101-0890 Federal Funds	\$342,734,000	\$424,968,000	\$82,234,000
4260-113-0890 Childrens Health Insurance Fund	\$18,081,000	\$0	(\$18,081,000)
4260-117-0890 HIPAA	\$2,105,000	\$2,981,000	\$876,000
Total Fiscal Intermediary	\$362,920,000	\$427,949,000	\$65,029,000
Grand Total - Federal Funds	\$91,403,503,000	\$85,784,252,000	(\$5,619,251,000)

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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 2022-23

	<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	\$28,594,034,320	\$14,297,017,160	\$14,297,017,160	\$0
B. C/Y BASE POLICY CHANGES	\$59,594,283,010	\$37,966,070,360	\$21,488,170,650	\$140,042,000
C. BASE ADJUSTMENTS	(\$300,856,000)	(\$177,240,450)	(\$123,615,550)	\$0
D. ADJUSTED BASE	\$87,887,461,330	\$52,085,847,070	\$35,661,572,260	\$140,042,000
II. REGULAR POLICY CHANGES				
A. ELIGIBILITY	\$131,035,900	(\$1,159,508,500)	\$1,288,665,400	\$1,879,000
B. AFFORDABLE CARE ACT	\$7,650,511,000	\$7,697,194,200	(\$46,683,200)	\$0
C. BENEFITS	\$2,240,970,930	\$1,550,896,730	\$690,074,190	\$0
D. PHARMACY	(\$3,728,120,870)	(\$3,723,709,840)	(\$1,844,128,040)	\$1,839,717,000
E. DRUG MEDI-CAL	\$8,508,000	\$4,294,500	(\$226,500)	\$4,440,000
F. MENTAL HEALTH	\$1,239,896,000	\$48,035,100	\$1,191,660,900	\$200,000
G. WAIVER--MH/UCD & BTR	\$3,935,932,900	\$2,233,430,200	\$466,590,700	\$1,235,912,000
H. MANAGED CARE	\$10,269,928,470	\$6,583,179,520	(\$736,472,060)	\$4,423,221,000
I. PROVIDER RATES	\$1,274,553,620	\$1,215,075,260	(\$570,314,950)	\$629,793,310
J. SUPPLEMENTAL PMNTS.	\$11,850,965,970	\$7,683,109,020	\$469,803,440	\$3,698,053,500
K. COVID-19	\$2,075,001,000	\$5,111,120,810	(\$2,975,714,810)	(\$60,405,000)
L. STATE ONLY CLAIMING	\$130,720,000	\$232,188,000	(\$101,468,000)	\$0
M. OTHER DEPARTMENTS	\$852,827,000	\$852,204,000	\$623,000	\$0
N. OTHER	\$4,981,921,630	\$5,941,918,120	(\$2,989,923,590)	\$2,029,927,090
O. TOTAL CHANGES	\$42,914,651,540	\$34,269,427,150	(\$5,157,513,500)	\$13,802,737,900
III. TOTAL MEDI-CAL ESTIMATE	\$130,802,112,870	\$86,355,274,210	\$30,504,058,760	\$13,942,779,900

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	MEDI-CAL STATE INMATE PROGRAMS	\$48,278,000	\$48,278,000	\$0	\$0
2	PHASING IN THE MEDI-CAL ASSET LIMIT REPEAL	\$47,240,980	\$23,620,490	\$23,620,490	\$0
4	BREAST AND CERVICAL CANCER TREATMENT	\$24,278,000	\$14,890,800	\$9,387,200	\$0
5	CALAIM - INMATE PRE-RELEASE PROGRAM	\$6,561,000	\$2,566,000	\$3,995,000	\$0
6	ACCELERATED ENROLLMENT FOR ADULTS	\$4,677,920	\$2,338,960	\$2,338,960	\$0
9	REFUGEE MEDICAL ASSISTANCE	\$0	\$0	(\$400,000)	\$400,000
10	NON-OTLIPC CHIP	\$0	\$88,732,500	(\$88,732,500)	\$0
11	NON-EMERGENCY FUNDING ADJUSTMENT	\$0	(\$1,466,740,250)	\$1,466,740,250	\$0
12	SCHIP FUNDING FOR PRENATAL CARE	\$0	\$74,163,400	(\$74,163,400)	\$0
13	MEDI-CAL COUNTY INMATE REIMBURSEMENT	\$0	\$0	(\$1,479,000)	\$1,479,000
14	MEDICARE OPTIONAL EXPANSION ADJUSTMENT	\$0	(\$2,303,600)	\$2,303,600	\$0
15	CS3 PROXY ADJUSTMENT	\$0	\$54,945,200	(\$54,945,200)	\$0
	ELIGIBILITY SUBTOTAL	\$131,035,900	(\$1,159,508,500)	\$1,288,665,400	\$1,879,000
<u>AFFORDABLE CARE ACT</u>					
16	COMMUNITY FIRST CHOICE OPTION	\$7,669,784,000	\$7,669,784,000	\$0	\$0
17	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	\$14,427,000	\$14,427,000	\$0	\$0
18	1% FMAP INCREASE FOR PREVENTIVE SERVICES	\$0	\$8,217,000	(\$8,217,000)	\$0
19	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	\$0	\$36,621,200	(\$36,621,200)	\$0
21	ACA OPTIONAL EXPANSION MLR RISK CORRIDOR	(\$33,700,000)	(\$31,855,000)	(\$1,845,000)	\$0
	AFFORDABLE CARE ACT SUBTOTAL	\$7,650,511,000	\$7,697,194,200	(\$46,683,200)	\$0
<u>BENEFITS</u>					
22	BEHAVIORAL HEALTH TREATMENT	\$890,950,000	\$514,522,300	\$376,427,700	\$0
23	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	\$439,897,000	\$439,897,000	\$0	\$0
24	FAMILY PACT PROGRAM	\$367,441,000	\$279,404,400	\$88,036,600	\$0
25	CALAIM - LTC BENEFIT TRANSITION	\$201,000,000	\$104,136,050	\$96,863,950	\$0
26	TELEHEALTH	\$102,019,980	\$66,053,880	\$35,966,100	\$0
27	MULTIPURPOSE SENIOR SERVICES PROGRAM	\$63,951,000	\$34,949,500	\$29,001,500	\$0
28	CALIFORNIA COMMUNITY TRANSITIONS COSTS	\$47,022,000	\$37,853,000	\$9,169,000	\$0
29	CYBHI - DYADIC SERVICES	\$44,155,960	\$27,428,610	\$16,727,350	\$0
30	REMOTE PATIENT MONITORING	\$29,368,320	\$18,466,460	\$10,901,850	\$0
31	COMMUNITY HEALTH WORKER	\$23,030,970	\$13,951,010	\$9,079,950	\$0
32	CALAIM - ORGAN TRANSPLANT	\$9,430,000	\$5,895,400	\$3,534,600	\$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>BENEFITS</u>					
33	FPACT HPV VACCINE COVERAGE	\$7,002,840	\$3,013,220	\$3,989,620	\$0
34	CCS DEMONSTRATION PROJECT	\$5,473,000	\$2,937,300	\$2,535,700	\$0
35	MEDICAL INTERPRETERS PILOT PROJECT	\$3,347,000	\$0	\$3,347,000	\$0
36	MEDICALLY TAILORED MEALS PILOT PROGRAM	\$2,737,000	\$0	\$2,737,000	\$0
37	DOULA BENEFIT	\$974,400	\$596,680	\$377,720	\$0
38	EXPANSION TO SCREENING FOR ADDITIONAL SUBSTANCES	\$948,780	\$595,760	\$353,020	\$0
39	DIABETES PREVENTION PROGRAM	\$759,910	\$478,600	\$281,300	\$0
40	ROUTINE COSTS FOR CLINICAL TRIALS	\$549,330	\$335,470	\$213,860	\$0
41	HEARING AID COVERAGE FOR CHILDREN PROGRAM	\$459,960	\$0	\$459,960	\$0
42	CCT FUND TRANSFER TO CDSS	\$380,000	\$380,000	\$0	\$0
43	ANNUAL COGNITIVE ASSESSMENTS	\$72,470	\$2,080	\$70,390	\$0
	BENEFITS SUBTOTAL	\$2,240,970,930	\$1,550,896,730	\$690,074,200	\$0
<u>PHARMACY</u>					
44	CONTINUOUS GLUCOSE MONITORING SYSTEMS BENEFIT	\$9,108,800	\$5,717,740	\$3,391,060	\$0
45	MEDICATION THERAPY MANAGEMENT PROGRAM	\$5,044,320	\$3,341,470	\$1,702,860	\$0
46	MEDI-CAL DRUG REBATE FUND	\$0	\$0	(\$1,748,367,000)	\$1,748,367,000
47	LITIGATION SETTLEMENTS	(\$1,741,000)	\$0	(\$1,741,000)	\$0
48	BCCTP DRUG REBATES	(\$4,488,000)	(\$4,488,000)	\$0	\$0
49	FAMILY PACT DRUG REBATES	(\$4,990,000)	(\$4,990,000)	\$0	\$0
50	PHARMACY RETROACTIVE ADJUSTMENTS	(\$69,924,000)	(\$121,494,050)	\$51,570,050	\$0
51	STATE SUPPLEMENTAL DRUG REBATES	(\$60,104,000)	(\$60,104,000)	\$0	\$0
52	MEDICAL SUPPLY REBATES	(\$118,668,000)	(\$59,334,000)	(\$59,334,000)	\$0
53	MEDI-CAL RX- ADDITIONAL SUPPLEMENTAL REBATES	(\$199,228,000)	(\$199,228,000)	(\$91,350,000)	\$91,350,000
54	FEDERAL DRUG REBATES	(\$3,283,131,000)	(\$3,283,131,000)	\$0	\$0
	PHARMACY SUBTOTAL	(\$3,728,120,870)	(\$3,723,709,840)	(\$1,844,128,040)	\$1,839,717,000
<u>DRUG MEDI-CAL</u>					
56	HCBS SP - CONTINGENCY MANAGEMENT	\$9,846,000	\$5,406,000	\$0	\$4,440,000
58	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	\$632,000	\$586,500	\$45,500	\$0
59	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	(\$1,970,000)	(\$1,698,000)	(\$272,000)	\$0
	DRUG MEDI-CAL SUBTOTAL	\$8,508,000	\$4,294,500	(\$226,500)	\$4,440,000
<u>MENTAL HEALTH</u>					
60	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE	\$1,339,697,000	\$218,500,000	\$1,121,197,000	\$0
63	CALAIM - BH QUALITY IMPROVEMENT PROGRAM	\$45,396,000	\$0	\$45,396,000	\$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>MENTAL HEALTH</u>					
64	MHP COSTS FOR FFPSA	\$43,134,000	\$30,636,000	\$12,498,000	\$0
65	MHP STRTP GRANTS	\$7,478,000	\$0	\$7,478,000	\$0
66	MHP COSTS FOR CONTINUUM OF CARE REFORM	\$3,867,000	\$1,159,100	\$2,707,900	\$0
67	OUT OF STATE YOUTH - SMHS	\$2,062,000	\$1,031,000	\$1,031,000	\$0
68	SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS	\$0	(\$1,450,000)	\$1,450,000	\$0
69	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	\$0	\$0	(\$200,000)	\$200,000
70	CHART REVIEW	(\$59,000)	(\$59,000)	\$0	\$0
71	INTERIM AND FINAL COST SETTLEMENTS - SMHS	(\$201,679,000)	(\$201,782,000)	\$103,000	\$0
	MENTAL HEALTH SUBTOTAL	\$1,239,896,000	\$48,035,100	\$1,191,660,900	\$200,000
<u>WAIVER--MH/UCD & BTR</u>					
72	GLOBAL PAYMENT PROGRAM	\$2,625,833,000	\$1,389,921,000	\$0	\$1,235,912,000
73	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES	\$1,175,858,000	\$743,916,200	\$431,941,800	\$0
74	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	\$133,592,900	\$58,542,000	\$75,050,900	\$0
75	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	\$649,000	\$649,000	\$0	\$0
251	CALAIM- DESIGNATED STATE HEALTH PROGRAMS	\$0	\$40,402,000	(\$40,402,000)	\$0
	WAIVER--MH/UCD & BTR SUBTOTAL	\$3,935,932,900	\$2,233,430,200	\$466,590,700	\$1,235,912,000
<u>MANAGED CARE</u>					
79	CCI-MANAGED CARE PAYMENTS	\$2,120,866,470	\$1,060,433,230	\$1,060,433,230	\$0
80	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	\$1,989,171,000	\$1,483,804,950	\$505,366,050	\$0
81	MANAGED CARE HEALTH CARE FINANCING PROGRAM	\$1,864,564,000	\$1,252,922,950	\$611,641,050	\$0
82	MANAGED CARE PUBLIC HOSPITAL EPP	\$1,778,153,000	\$1,373,389,160	\$404,763,840	\$0
83	2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	\$1,525,495,000	\$973,704,000	\$551,791,000	\$0
86	HCBS SP - HOUSING AND HOMELESSNESS INCENTIVE PROG	\$644,000,000	\$361,928,000	\$0	\$282,072,000
87	RETRO MC RATE ADJUSTMENTS	\$213,603,000	\$109,582,400	\$83,519,600	\$20,501,000
88	CALAIM - TRANSITIONING POPULATIONS	\$211,712,000	\$127,039,550	\$84,672,450	\$0
89	CYBHI - STUDENT BH INCENTIVE PROGRAM	\$199,014,000	\$99,507,000	\$99,507,000	\$0
91	WORKFORCE & QUALITY INCENTIVE PROGRAM	\$116,667,000	\$61,366,700	\$55,300,300	\$0
92	RECONCILIATION OF MCO TAX FUND 3156	\$108,000,000	\$0	(\$308,000,000)	\$416,000,000
93	PROP 56 - BEHAVIORAL HEALTH INCENTIVE PROGRAM	\$90,136,000	\$50,191,000	\$39,945,000	\$0
96	CCI-QUALITY WITHHOLD REPAYMENTS	\$19,807,000	\$9,903,500	\$9,903,500	\$0
102	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	\$0	\$0	(\$1,639,114,000)	\$1,639,114,000

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>MANAGED CARE</u>					
103	2020 MCO ENROLLMENT TAX MANAGED CARE PLANS	\$0	\$0	(\$1,576,399,000)	\$1,576,399,000
104	2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	\$0	\$0	(\$489,135,000)	\$489,135,000
105	COORDINATED CARE INITIATIVE RISK MITIGATION	(\$111,260,000)	(\$55,630,000)	(\$55,630,000)	\$0
255	PROP 56 - DIRECTED PAYMENT RISK MITIGATION	(\$500,000,000)	(\$324,962,920)	(\$175,037,080)	\$0
MANAGED CARE SUBTOTAL		\$10,269,928,470	\$6,583,179,520	(\$736,472,060)	\$4,423,221,000
<u>PROVIDER RATES</u>					
106	NURSING FACILITY RATE ADJUSTMENTS	\$316,982,000	\$166,732,600	\$150,249,400	\$0
107	RATE INCREASE FOR FQHCS/RHCS/CBRCS	\$313,053,600	\$197,496,330	\$115,557,270	\$0
108	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	\$192,316,650	\$136,538,150	(\$6,197,710)	\$61,976,210
109	PP-GEMT IGT PROGRAM	\$143,189,590	\$96,553,030	(\$3,977,540)	\$50,614,100
110	FQHC/RHC/CBRC RECONCILIATION PROCESS	\$103,645,660	\$65,387,000	\$38,258,660	\$0
111	DPH INTERIM RATE GROWTH	\$68,037,480	\$43,746,670	\$24,290,810	\$0
112	DPH INTERIM RATE COVID-19 INCREASED FMAP ADJUST	\$87,343,000	\$87,343,000	\$0	\$0
113	LTC RATE ADJUSTMENT	\$50,175,550	\$25,690,370	\$24,485,180	\$0
114	AB 1629 ANNUAL RATE ADJUSTMENTS	\$30,902,980	\$16,344,020	\$14,558,960	\$0
115	AB 97 ELIMINATIONS	\$20,443,000	\$12,381,800	\$8,061,200	\$0
116	ACUPUNCTURE RATE INCREASE	\$10,905,000	\$7,604,500	\$3,300,500	\$0
117	LABORATORY RATE METHODOLOGY CHANGE	\$9,849,000	\$5,660,500	\$4,188,500	\$0
118	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	\$10,349,300	\$6,266,730	\$4,082,570	\$0
119	HOSPICE RATE INCREASES	\$7,257,690	\$3,804,740	\$3,452,940	\$0
120	GDSP PRENATAL SCREENING PROGRAM FEE INCREASE	(\$1,804,410)	(\$1,083,880)	(\$720,530)	\$0
121	DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT	\$230,660	\$122,650	\$108,010	\$0
122	DPH INTERIM RATE	\$0	\$427,546,000	(\$427,546,000)	\$0
123	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	\$0	\$0	(\$517,203,000)	\$517,203,000
124	10% PROVIDER PAYMENT REDUCTION	(\$513,570)	(\$332,130)	(\$181,440)	\$0
125	REDUCTION TO RADIOLOGY RATES	(\$11,549,540)	(\$6,466,810)	(\$5,082,730)	\$0
126	DPH INTERIM & FINAL RECONS	(\$76,260,000)	(\$76,260,000)	\$0	\$0
PROVIDER RATES SUBTOTAL		\$1,274,553,630	\$1,215,075,260	(\$570,314,950)	\$629,793,310
<u>SUPPLEMENTAL PMNTS.</u>					
127	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	\$3,403,178,000	\$2,364,515,000	\$0	\$1,038,663,000
128	HOSPITAL QAF - FFS PAYMENTS	\$3,032,548,000	\$1,549,547,000	\$0	\$1,483,001,000
129	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	\$1,283,976,670	\$831,398,050	\$452,578,610	\$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>					
130	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	\$926,935,000	\$659,141,000	\$0	\$267,794,000
131	PRIVATE HOSPITAL DSH REPLACEMENT	\$733,956,000	\$397,347,000	\$336,609,000	\$0
132	DSH PAYMENT	\$464,328,000	\$356,502,500	\$22,966,500	\$84,859,000
133	PROP 56 - MEDI-CAL FAMILY PLANNING	\$440,957,130	\$367,604,740	\$73,352,390	\$0
134	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	\$304,051,000	\$174,390,000	\$118,400,000	\$11,261,000
135	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	\$275,925,000	\$275,925,000	\$0	\$0
136	NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS	\$157,500,000	\$86,074,000	\$71,426,000	\$0
137	FFP FOR LOCAL TRAUMA CENTERS	\$140,698,000	\$83,865,000	\$0	\$56,833,000
138	DPH PHYSICIAN & NON-PHYS. COST	\$140,447,000	\$140,447,000	\$0	\$0
139	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	\$118,432,000	\$72,796,000	\$565,000	\$45,071,000
140	CAPITAL PROJECT DEBT REIMBURSEMENT	\$84,231,000	\$65,213,500	\$19,017,500	\$0
141	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	\$58,660,000	\$58,660,000	\$0	\$0
142	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	\$57,394,040	\$37,643,250	\$19,750,800	\$0
143	GEMT SUPPLEMENTAL PAYMENT PROGRAM	\$55,446,000	\$55,446,000	\$0	\$0
144	NDPH IGT SUPPLEMENTAL PAYMENTS	\$46,265,000	\$27,875,000	(\$1,150,000)	\$19,540,000
145	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	\$43,393,000	\$21,696,500	\$0	\$21,696,500
146	PROP 56 - VALUE-BASED PAYMENT PROGRAM	\$31,005,000	\$21,657,500	\$9,347,500	\$0
147	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	\$15,705,000	\$15,705,000	\$0	\$0
148	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	\$10,000,000	\$5,465,000	\$4,535,000	\$0
149	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	\$8,000,000	\$4,372,000	\$3,628,000	\$0
150	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	\$6,661,000	\$3,849,000	(\$1,199,000)	\$4,011,000
151	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	\$5,053,120	\$3,475,980	\$1,577,140	\$0
152	NDPH SUPPLEMENTAL PAYMENT	\$4,221,000	\$2,498,000	\$1,900,000	(\$177,000)
153	FREE CLINICS AUGMENTATION	\$2,000,000	\$0	\$2,000,000	\$0
155	PROPOSITION 56 FUNDING	\$0	\$0	(\$651,127,000)	\$651,127,000
156	IGT ADMIN. & PROCESSING FEE	\$0	\$0	(\$14,374,000)	\$14,374,000
	SUPPLEMENTAL PMNTS. SUBTOTAL	\$11,850,965,960	\$7,683,109,020	\$469,803,440	\$3,698,053,500
<u>COVID-19</u>					
157	COVID-19 CASELOAD IMPACT	\$14,478,464,000	\$10,350,476,000	\$4,127,988,000	\$0
159	COVID-19 BEHAVIORAL HEALTH	\$190,217,000	\$175,835,900	\$14,381,100	\$0
160	COVID-19 VACCINATION INCENTIVE PROGRAM	\$156,822,000	\$78,411,000	\$78,411,000	\$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>COVID-19</u>					
161	PHARMACY-BASED COVID-19 TESTS	\$20,731,000	\$13,732,560	\$6,998,440	\$0
162	COVID-19 - SICK LEAVE BENEFITS	\$6,776,000	\$6,700,500	\$75,500	\$0
163	COVID-19 ELIGIBILITY	\$0	\$0	\$0	\$0
164	COVID-19 VACCINE ADMINISTRATION	\$6,201,000	\$5,782,250	\$418,750	\$0
165	CONTINUOUS CHIP COVERAGE DURING THE COVID-19 PHE	\$0	(\$86,511,000)	\$86,511,000	\$0
166	COVID-19 LTC REIMBURSEMENT RATES	(\$9,056,000)	(\$4,551,600)	(\$4,504,400)	\$0
167	COVID-19 INCREASED FMAP - DHCS	(\$254,321,000)	\$3,540,234,000	(\$3,734,150,000)	(\$60,405,000)
168	COVID-19 CASELOAD IMPACT BASE ADJUSTMENT	(\$12,520,833,000)	(\$8,968,988,800)	(\$3,551,844,200)	\$0
	COVID-19 SUBTOTAL	\$2,075,001,000	\$5,111,120,810	(\$2,975,714,810)	(\$60,405,000)
<u>STATE ONLY CLAIMING</u>					
169	STATE ONLY CLAIMING ADJUSTMENTS	\$130,720,000	\$256,065,000	(\$125,345,000)	\$0
170	STATE ONLY CLAIMING ADJUSTMENTS - SMHS and DMC	\$0	(\$23,877,000)	\$23,877,000	\$0
	STATE ONLY CLAIMING SUBTOTAL	\$130,720,000	\$232,188,000	(\$101,468,000)	\$0
<u>OTHER DEPARTMENTS</u>					
171	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	\$714,859,000	\$714,859,000	\$0	\$0
172	HCBS SP - IHSS HCBS CARE ECONOMY PMTS	\$165,790,000	\$165,790,000	\$0	\$0
173	ELECTRONIC VISIT VERIFICATION FED PENALTIES	(\$27,822,000)	(\$28,445,000)	\$623,000	\$0
	OTHER DEPARTMENTS SUBTOTAL	\$852,827,000	\$852,204,000	\$623,000	\$0
<u>OTHER</u>					
179	HOSPITAL & SNF COVID-19 WORKER RETENTION PAYMENTS	\$1,077,600,000	\$0	\$0	\$1,077,600,000
181	BEHAVIORAL HEALTH BRIDGE HOUSING	\$907,936,000	\$0	\$907,936,000	\$0
182	CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY	\$450,000,000	\$0	\$450,000,000	\$0
183	CYBHI - EVIDENCE-BASED BH PRACTICES	\$429,000,000	\$0	\$429,000,000	\$0
184	CCI IHSS RECONCILIATION	\$428,000,000	\$0	\$86,000,000	\$342,000,000
186	HCBS SP CDDS	\$382,513,000	\$382,513,000	\$0	\$0
187	EQUITY & PRACTICE TRANSFORMATION PAYMENTS	\$140,000,000	\$70,000,000	\$70,000,000	\$0
188	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER	\$124,267,320	\$62,133,660	\$62,133,660	\$0
189	CYBHI - URGENT NEEDS AND EMERGENT ISSUES	\$120,000,000	\$0	\$120,000,000	\$0
191	LA COUNTY JUSTICE-INVOLVED POP. SVCS & SUPPORTS	\$99,220,000	\$0	\$99,220,000	\$0
192	CALHOPE	\$105,423,000	\$0	\$96,423,000	\$9,000,000
194	QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES	\$72,322,000	\$61,474,000	\$10,848,000	\$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>OTHER</u>					
195	CLINIC WORKFORCE STABILIZATION RETENTION PROGRAM	\$70,000,000	\$0	\$70,000,000	\$0
196	INDIAN HEALTH SERVICES	\$62,619,630	\$41,746,580	\$20,873,050	\$0
198	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	\$85,442,000	\$85,442,000	\$0	\$0
199	MHSF - PROVIDER ACES TRAININGS	\$44,100,000	\$22,050,000	\$0	\$22,050,000
200	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG	\$42,028,000	\$0	\$0	\$42,028,000
201	SELF-DETERMINATION PROGRAM - CDDS	\$86,758,000	\$86,758,000	\$0	\$0
202	EVIDENCE-BASED DENTAL PRACTICES	\$30,814,000	\$21,114,500	\$9,699,500	\$0
203	HCBS SP - CALBRIDGE BH NAVIGATOR PROGRAM	\$29,651,000	\$0	\$0	\$29,651,000
205	INFANT DEVELOPMENT PROGRAM	\$27,810,000	\$27,810,000	\$0	\$0
206	WATSONVILLE COMMUNITY HOSPITAL ACQUISITION	\$25,000,000	\$0	\$25,000,000	\$0
207	HCBS SP - ASSISTED LIVING WAIVER EXPANSION	\$23,296,900	\$13,093,600	(\$5,720,790)	\$15,924,080
208	CYBHI - CALHOPE STUDENT SUPPORT	\$21,000,000	\$0	\$21,000,000	\$0
209	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	\$20,729,130	\$10,364,570	\$10,364,570	\$0
210	LOS ANGELES COUNTY REPRODUCTIVE HEALTH PILOT	\$20,000,000	\$0	\$20,000,000	\$0
212	PEER SUPPORT SPECIALIST SERVICES	\$12,867,000	\$12,867,000	\$0	\$0
213	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	\$15,281,000	\$8,296,000	\$6,985,000	\$0
214	PACE INFRASTRUCTURE FUNDING	\$10,000,000	\$0	\$10,000,000	\$0
215	ALAMEDA COUNTY SUPPORTIVE HOUSING	\$10,000,000	\$0	\$10,000,000	\$0
216	BACKFILL LOST TITLE X FAMILY PLANNING FUNDING	\$10,000,000	\$0	\$10,000,000	\$0
217	HCBS SP - NON-IHSS CARE ECONOMY PMTS	\$12,250,000	\$6,885,000	\$0	\$5,365,000
219	INFRASTRUCTURE PYMT FOR CLINIC ABORTION PROVIDERS	\$7,425,000	\$0	\$7,425,000	\$0
220	PROP 56 - PROVIDER ACES TRAININGS	\$7,100,000	\$3,550,000	\$3,550,000	\$0
221	CALAIM - DENTAL INITIATIVES	\$6,900,640	\$3,584,370	\$3,316,270	\$0
222	QAF WITHHOLD TRANSFER	\$2,877,000	\$2,059,500	\$817,500	\$0
223	FOSTER YOUTH SUBSTANCE USE DISORDER GRANT PROGRAM	\$1,500,000	\$0	\$1,500,000	\$0
224	CLPP FUND	\$902,000	\$0	\$0	\$902,000
225	WPCS WORKERS' COMPENSATION	\$620,000	\$310,000	\$310,000	\$0
227	HCBS SP - ETSB FOR LAGUNA HONDA HOSPITAL RESIDENTS	\$600,000	\$0	\$0	\$600,000
229	URBAN INDIAN ORGANIZATIONS FUNDING SHIFT	\$0	\$16,539,000	(\$16,539,000)	\$0
230	AMERICAN RESCUE PLAN INCREASED FMAP FOR HCBS	\$0	\$761,745,000	\$0	(\$761,745,000)
231	IMD ANCILLARY SERVICES	\$0	(\$37,244,000)	\$37,244,000	\$0
232	CIGARETTE AND TOBACCO SURTAX FUNDS	\$0	\$0	(\$131,352,000)	\$131,352,000

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>				
233	FUNDING ADJUST.—ACA OPT. EXPANSION	\$0	\$3,974,797,200	(\$3,974,797,200)	\$0
234	FUNDING ADJUST.—OTLICP	\$0	\$109,124,550	(\$109,124,550)	\$0
235	HOSPITAL QAF - CHILDREN'S HEALTH CARE	\$0	\$0	(\$1,115,200,000)	\$1,115,200,000
236	INDIAN HEALTH SERVICES FUNDING SHIFT	\$0	\$14,845,000	(\$14,845,000)	\$0
237	CMS DEFERRED CLAIMS	\$0	\$193,141,000	(\$193,141,000)	\$0
238	DENTAL MANAGED CARE MLR RISK CORRIDOR	(\$18,950,000)	(\$13,081,400)	(\$5,868,600)	\$0
239	COUNTY SHARE OF OTLICP-CCS COSTS	(\$22,981,000)	\$0	(\$22,981,000)	\$0
	OTHER SUBTOTAL	\$4,981,921,620	\$5,941,918,120	(\$2,989,923,590)	\$2,029,927,080
	GRAND TOTAL	\$42,914,651,540	\$34,269,427,150	(\$5,157,513,500)	\$13,802,737,900

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	\$8,392,599,170	\$5,225,425,970	\$2,338,194,840	\$828,978,360
PHYSICIANS	\$926,502,480	\$631,486,720	\$246,235,300	\$48,780,450
OTHER MEDICAL	\$5,495,866,720	\$3,379,909,780	\$2,026,147,720	\$89,809,220
CO. & COMM. OUTPATIENT	\$1,970,229,970	\$1,214,029,470	\$65,811,820	\$690,388,690
PHARMACY	\$12,335,090,280	\$8,314,880,340	\$2,042,056,530	\$1,978,153,410
HOSPITAL INPATIENT	\$11,577,113,550	\$7,701,874,800	\$1,174,995,490	\$2,700,243,250
COUNTY INPATIENT	\$3,729,828,840	\$2,506,981,510	(\$103,315,310)	\$1,326,162,640
COMMUNITY INPATIENT	\$7,847,284,700	\$5,194,893,280	\$1,278,310,800	\$1,374,080,620
LONG TERM CARE	\$2,472,824,210	\$1,504,986,170	\$825,435,670	\$142,402,370
NURSING FACILITIES	\$1,936,484,520	\$1,202,391,090	\$614,883,010	\$119,210,420
ICF-DD	\$536,339,690	\$302,595,080	\$210,552,660	\$23,191,950
OTHER SERVICES	\$2,081,223,190	\$1,444,339,710	\$609,223,820	\$27,659,660
MEDICAL TRANSPORTATION	\$162,129,200	\$127,352,030	\$24,860,920	\$9,916,250
OTHER SERVICES	\$1,685,702,890	\$1,176,985,940	\$488,251,810	\$20,465,130
HOME HEALTH	\$233,391,110	\$140,001,740	\$96,111,080	(\$2,721,710)
TOTAL FEE-FOR-SERVICE	\$36,858,850,390	\$24,191,506,980	\$6,989,906,360	\$5,677,437,060
MANAGED CARE	\$60,167,298,260	\$39,058,484,340	\$14,625,413,690	\$6,483,400,230
TWO PLAN MODEL	\$36,140,118,140	\$23,236,208,740	\$9,036,542,150	\$3,867,367,250
COUNTY ORGANIZED HEALTH SYSTEMS	\$14,184,894,590	\$9,705,602,470	\$2,844,065,800	\$1,635,226,320
GEOGRAPHIC MANAGED CARE	\$6,433,738,360	\$3,881,150,310	\$1,814,672,780	\$737,915,260
PHP & OTHER MANAG. CARE	\$1,497,748,180	\$906,179,890	\$594,810,670	(\$3,242,370)
REGIONAL MODEL	\$1,910,798,990	\$1,329,342,930	\$335,322,290	\$246,133,770
DENTAL	\$1,932,613,150	\$962,124,850	\$912,770,160	\$57,718,140
MENTAL HEALTH	\$3,051,288,710	\$2,932,344,580	(\$74,067,750)	\$193,011,890
AUDITS/ LAWSUITS	\$114,985,000	\$251,504,000	(\$136,519,000)	\$0
EPSDT SCREENS	\$0	\$0	\$0	\$0
MEDICARE PAYMENTS	\$7,156,932,240	\$2,356,379,170	\$4,809,234,530	(\$8,681,450)
STATE HOSP./DEVELOPMENTAL CNTRS.	\$29,282,410	\$31,582,950	(\$2,263,920)	(\$36,630)
MISC. SERVICES	\$21,233,061,940	\$16,159,464,040	\$3,534,422,250	\$1,539,175,650
RECOVERIES	(\$536,727,000)	(\$310,780,950)	(\$225,946,050)	\$0
DRUG MEDI-CAL	\$794,527,770	\$722,664,250	\$71,108,500	\$755,020
GRAND TOTAL MEDI-CAL	\$130,802,112,870	\$86,355,274,210	\$30,504,058,760	\$13,942,779,900

**MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
NOVEMBER 2022 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2022-23**

<u>SERVICE CATEGORY</u>	<u>2022-23 APPROPRIATION</u>	<u>NOV. 2022 EST. FOR 2022-23</u>	<u>DOLLAR DIFFERENCE</u>	<u>% CHANGE</u>
PROFESSIONAL	\$9,874,840,080	\$8,392,599,170	(\$1,482,240,910)	-15.01%
PHYSICIANS	\$1,158,290,060	\$926,502,480	(\$231,787,580)	-20.01%
OTHER MEDICAL	\$6,745,473,480	\$5,495,866,720	(\$1,249,606,760)	-18.53%
CO. & COMM. OUTPATIENT	\$1,971,076,540	\$1,970,229,970	(\$846,570)	-0.04%
PHARMACY	\$9,743,318,800	\$12,335,090,280	\$2,591,771,480	26.60%
HOSPITAL INPATIENT	\$14,502,114,480	\$11,577,113,550	(\$2,925,000,930)	-20.17%
COUNTY INPATIENT	\$4,029,090,170	\$3,729,828,840	(\$299,261,330)	-7.43%
COMMUNITY INPATIENT	\$10,473,024,300	\$7,847,284,700	(\$2,625,739,600)	-25.07%
LONG TERM CARE	\$2,623,233,690	\$2,472,824,210	(\$150,409,480)	-5.73%
NURSING FACILITIES	\$2,009,674,740	\$1,936,484,520	(\$73,190,220)	-3.64%
ICF-DD	\$613,558,950	\$536,339,690	(\$77,219,270)	-12.59%
OTHER SERVICES	\$2,268,088,640	\$2,081,223,190	(\$186,865,450)	-8.24%
MEDICAL TRANSPORTATION	\$183,093,400	\$162,129,200	(\$20,964,200)	-11.45%
OTHER SERVICES	\$1,814,890,240	\$1,685,702,890	(\$129,187,350)	-7.12%
HOME HEALTH	\$270,105,000	\$233,391,110	(\$36,713,900)	-13.59%
TOTAL FEE-FOR-SERVICE	\$39,011,595,690	\$36,858,850,390	(\$2,152,745,300)	-5.52%
MANAGED CARE	\$61,464,211,230	\$60,167,298,260	(\$1,296,912,970)	-2.11%
TWO PLAN MODEL	\$36,663,747,120	\$36,140,118,140	(\$523,628,980)	-1.43%
COUNTY ORGANIZED HEALTH SYSTEMS	\$14,624,577,180	\$14,184,894,590	(\$439,682,590)	-3.01%
GEOGRAPHIC MANAGED CARE	\$6,470,863,540	\$6,433,738,360	(\$37,125,180)	-0.57%
PHP & OTHER MANAG. CARE	\$1,656,519,290	\$1,497,748,180	(\$158,771,110)	-9.58%
REGIONAL MODEL	\$2,048,504,100	\$1,910,798,990	(\$137,705,110)	-6.72%
DENTAL	\$2,378,861,770	\$1,932,613,150	(\$446,248,620)	-18.76%
MENTAL HEALTH	\$2,985,796,880	\$3,051,288,710	\$65,491,830	2.19%
AUDITS/ LAWSUITS	\$74,450,000	\$114,985,000	\$40,535,010	54.45%
MEDICARE PAYMENTS	\$7,098,492,360	\$7,156,932,240	\$58,439,880	0.82%
STATE HOSP./DEVELOPMENTAL CNTRS.	\$25,837,160	\$29,282,410	\$3,445,250	13.33%
MISC. SERVICES	\$18,014,827,600	\$21,233,061,940	\$3,218,234,330	17.86%
RECOVERIES	(\$449,740,000)	(\$536,727,000)	(\$86,987,000)	19.34%
DRUG MEDI-CAL	\$939,941,190	\$794,527,770	(\$145,413,420)	-15.47%
GRAND TOTAL MEDI-CAL	\$131,544,273,880	\$130,802,112,870	(\$742,161,010)	-0.56%
GENERAL FUNDS	\$34,917,062,580	\$30,504,058,760	(\$4,413,003,830)	-12.64%
OTHER STATE FUNDS	\$12,896,996,800	\$13,942,779,900	\$1,045,783,110	8.11%

**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2022 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2022-23**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2022-23 APPROPRIATION		NOV. 2022 EST. FOR 2022-23		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		<u>ELIGIBILITY</u>						
5	1	MEDI-CAL STATE INMATE PROGRAMS	\$51,596,000	\$0	\$48,278,000	\$0	(\$3,318,000)	\$0
15	2	PHASING IN THE MEDI-CAL ASSET LIMIT REPEAL	\$47,398,000	\$23,699,000	\$47,574,000	\$23,787,000	\$176,000	\$88,000
2	4	BREAST AND CERVICAL CANCER TREATMENT	\$58,336,000	\$22,970,700	\$24,278,000	\$9,387,200	(\$34,058,000)	(\$13,583,500)
14	5	CALAIM - INMATE PRE-RELEASE PROGRAM	\$62,988,000	\$19,840,000	\$6,561,000	\$3,995,000	(\$56,427,000)	(\$15,845,000)
9	6	ACCELERATED ENROLLMENT FOR ADULTS	\$16,338,000	\$8,169,000	\$5,103,000	\$2,551,500	(\$11,235,000)	(\$5,617,500)
18	9	REFUGEE MEDICAL ASSISTANCE	\$0	(\$350,000)	\$0	(\$400,000)	\$0	(\$50,000)
21	10	NON-OTLIPC CHIP	\$0	(\$90,726,000)	\$0	(\$88,732,500)	\$0	\$1,993,500
22	11	NON-EMERGENCY FUNDING ADJUSTMENT	\$0	\$1,234,627,850	\$0	\$1,466,740,250	\$0	\$232,112,400
23	12	SCHIP FUNDING FOR PRENATAL CARE	\$0	(\$69,956,900)	\$0	(\$74,163,400)	\$0	(\$4,206,500)
19	13	MEDI-CAL COUNTY INMATE REIMBURSEMENT	\$0	(\$1,531,000)	\$0	(\$1,479,000)	\$0	\$52,000
20	14	MEDICARE OPTIONAL EXPANSION ADJUSTMENT	\$0	\$1,680,000	\$0	\$2,303,600	\$0	\$623,600
16	15	CS3 PROXY ADJUSTMENT	\$0	(\$55,589,500)	\$0	(\$54,945,200)	\$0	\$644,300
1	--	POSTPARTUM CARE EXTENSION	\$182,264,000	\$83,797,000	\$0	\$0	(\$182,264,000)	(\$83,797,000)
4	--	UNDOCUMENTED OLDER CALIFORNIANS EXPANSION	\$745,180,000	\$628,052,500	\$0	\$0	(\$745,180,000)	(\$628,052,500)
6	--	UNDOCUMENTED YOUNG ADULTS FULL SCOPE EXPANSION	\$333,623,000	\$226,026,000	\$0	\$0	(\$333,623,000)	(\$226,026,000)
8	--	MEDI-CAL COUNTY INMATE PROGRAMS	\$36,097,000	\$1,550,500	\$0	\$0	(\$36,097,000)	(\$1,550,500)
24	--	CHIP PREMIUMS	(\$47,785,000)	(\$16,724,750)	\$0	\$0	\$47,785,000	\$16,724,750
274	--	PREMIUMS REDUCTION	\$53,261,000	\$19,510,050	\$0	\$0	(\$53,261,000)	(\$19,510,050)
		ELIGIBILITY SUBTOTAL	\$1,539,296,000	\$2,035,044,450	\$131,794,000	\$1,289,044,450	(\$1,407,502,000)	(\$746,000,000)
		<u>AFFORDABLE CARE ACT</u>						
26	16	COMMUNITY FIRST CHOICE OPTION	\$6,808,506,000	\$0	\$7,669,784,000	\$0	\$861,278,000	\$0

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

**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2022 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2022-23**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2022-23 APPROPRIATION		NOV. 2022 EST. FOR 2022-23		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>AFFORDABLE CARE ACT</u>								
27	17	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	\$16,808,000	\$0	\$14,427,000	\$0	(\$2,381,000)	\$0
29	18	1% FMAP INCREASE FOR PREVENTIVE SERVICES	\$0	(\$4,274,000)	\$0	(\$8,217,000)	\$0	(\$3,943,000)
28	19	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	\$0	(\$39,049,200)	\$0	(\$36,621,200)	\$0	\$2,428,000
--	21	ACA OPTIONAL EXPANSION MLR RISK CORRIDOR	\$0	\$0	(\$33,700,000)	(\$1,845,000)	(\$33,700,000)	(\$1,845,000)
30	--	PAYMENTS TO PRIMARY CARE PHYSICIANS	(\$3,000)	\$0	\$0	\$0	\$3,000	\$0
		AFFORDABLE CARE ACT SUBTOTAL	\$6,825,311,000	(\$43,323,200)	\$7,650,511,000	(\$46,683,200)	\$825,200,000	(\$3,360,000)
<u>BENEFITS</u>								
32	22	BEHAVIORAL HEALTH TREATMENT	\$887,679,000	\$420,970,000	\$890,950,000	\$376,427,700	\$3,271,000	(\$44,542,300)
35	23	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	\$106,472,000	\$0	\$439,897,000	\$0	\$333,425,000	\$0
34	24	FAMILY PACT PROGRAM	\$368,160,000	\$87,780,200	\$367,441,000	\$88,036,600	(\$719,000)	\$256,400
260	25	CALAIM - LTC BENEFIT TRANSITION	\$104,104,000	\$49,564,000	\$201,000,000	\$96,863,950	\$96,896,000	\$47,299,950
37	26	TELEHEALTH	\$132,460,760	\$46,790,890	\$123,451,090	\$43,521,420	(\$9,009,670)	(\$3,269,470)
36	27	MULTIPURPOSE SENIOR SERVICES PROGRAM	\$63,952,000	\$31,480,000	\$63,951,000	\$29,001,500	(\$1,000)	(\$2,478,500)
40	28	CALIFORNIA COMMUNITY TRANSITIONS COSTS	\$12,199,000	\$4,152,000	\$47,022,000	\$9,169,000	\$34,823,000	\$5,017,000
53	29	CYBHI - DYADIC SERVICES	\$40,246,560	\$16,177,300	\$44,155,960	\$16,727,350	\$3,909,400	\$550,050
38	30	REMOTE PATIENT MONITORING	\$32,037,000	\$11,838,100	\$32,037,000	\$11,892,500	\$0	\$54,400
39	31	COMMUNITY HEALTH WORKER	\$19,679,770	\$8,212,850	\$23,331,950	\$9,198,620	\$3,652,180	\$985,770
47	32	CALAIM - ORGAN TRANSPLANT	\$11,172,000	\$3,613,450	\$9,430,000	\$3,534,600	(\$1,742,000)	(\$78,850)
270	33	FPACT HPV VACCINE COVERAGE	\$8,040,000	\$4,581,000	\$7,002,840	\$3,989,620	(\$1,037,160)	(\$591,380)
--	34	CCS DEMONSTRATION PROJECT	\$0	\$0	\$5,473,000	\$2,535,700	\$5,473,000	\$2,535,700
49	35	MEDICAL INTERPRETERS PILOT PROJECT	\$3,169,000	\$3,169,000	\$3,347,000	\$3,347,000	\$178,000	\$178,000

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2022 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2022-23**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2022-23 APPROPRIATION		NOV. 2022 EST. FOR 2022-23		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>BENEFITS</u>								
41	36	MEDICALLY TAILORED MEALS PILOT PROGRAM	\$86,000	\$86,000	\$2,737,000	\$2,737,000	\$2,651,000	\$2,651,000
50	37	DOULA BENEFIT	\$974,400	\$377,110	\$974,400	\$377,720	\$0	\$620
48	38	EXPANSION TO SCREENING FOR ADDITIONAL SUBSTANCES	\$1,534,000	\$567,800	\$1,035,000	\$385,100	(\$499,000)	(\$182,700)
52	39	DIABETES PREVENTION PROGRAM	\$1,144,320	\$421,810	\$759,910	\$281,300	(\$384,410)	(\$140,510)
281	40	ROUTINE COSTS FOR CLINICAL TRIALS	\$4,277,130	\$1,555,810	\$599,250	\$233,300	(\$3,677,880)	(\$1,322,510)
43	41	HEARING AID COVERAGE FOR CHILDREN PROGRAM	\$9,930,000	\$9,930,000	\$461,300	\$461,300	(\$9,468,700)	(\$9,468,700)
51	42	CCT FUND TRANSFER TO CDSS	\$233,000	\$0	\$380,000	\$0	\$147,000	\$0
265	43	ANNUAL COGNITIVE ASSESSMENTS	\$73,660	\$36,160	\$72,470	\$70,390	(\$1,180)	\$34,230
45	--	MFP/CCT SUPPLEMENTAL FUNDING	\$5,000,000	\$0	\$0	\$0	(\$5,000,000)	\$0
BENEFITS SUBTOTAL			\$1,812,623,600	\$701,303,480	\$2,265,509,170	\$698,791,670	\$452,885,580	(\$2,511,810)
<u>PHARMACY</u>								
46	44	CONTINUOUS GLUCOSE MONITORING SYSTEMS BENEFIT	\$9,687,460	\$3,538,910	\$9,936,510	\$3,699,200	\$249,050	\$160,290
55	45	MEDICATION THERAPY MANAGEMENT PROGRAM	\$8,413,780	\$2,945,640	\$5,136,260	\$1,733,890	(\$3,277,520)	(\$1,211,750)
56	46	MEDI-CAL DRUG REBATE FUND	\$0	(\$1,841,255,000)	\$0	(\$1,748,367,000)	\$0	\$92,888,000
--	47	LITIGATION SETTLEMENTS	\$0	\$0	(\$1,741,000)	(\$1,741,000)	(\$1,741,000)	(\$1,741,000)
59	48	BCCTP DRUG REBATES	(\$4,306,000)	\$0	(\$4,488,000)	\$0	(\$182,000)	\$0
61	49	FAMILY PACT DRUG REBATES	(\$11,668,000)	\$0	(\$4,990,000)	\$0	\$6,678,000	\$0
64	50	PHARMACY RETROACTIVE ADJUSTMENTS	(\$48,381,000)	\$52,266,950	(\$69,924,000)	\$51,570,050	(\$21,543,000)	(\$696,900)
63	51	STATE SUPPLEMENTAL DRUG REBATES	(\$81,343,000)	\$0	(\$60,104,000)	\$0	\$21,239,000	\$0
62	52	MEDICAL SUPPLY REBATES	(\$116,268,000)	(\$58,134,000)	(\$118,668,000)	(\$59,334,000)	(\$2,400,000)	(\$1,200,000)
57	53	MEDI-CAL RX- ADDITIONAL SUPPLEMENTAL REBATES	(\$670,311,000)	(\$223,755,600)	(\$199,228,000)	(\$91,350,000)	\$471,083,000	\$132,405,600
65	54	FEDERAL DRUG REBATES	(\$3,098,599,000)	\$0	(\$3,283,131,000)	\$0	(\$184,532,000)	\$0

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2022 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2022-23**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2022-23 APPROPRIATION		NOV. 2022 EST. FOR 2022-23		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>PHARMACY</u>								
54	--	MEDI-CAL RX - MANAGED CARE PHARMACY BENEFIT TO FFS	\$6,794,603,000	\$2,098,162,450	\$0	\$0	(\$6,794,603,000)	(\$2,098,162,450)
60	--	MEDI-CAL RX - ADDITIONAL SAVINGS FROM MAIC IN FFS	(\$14,732,000)	(\$5,165,600)	\$0	\$0	\$14,732,000	\$5,165,600
PHARMACY SUBTOTAL			\$2,767,096,250	\$28,603,750	(\$3,727,201,220)	(\$1,843,788,860)	(\$6,494,297,470)	(\$1,872,392,600)
<u>DRUG MEDI-CAL</u>								
68	56	HCBS SP - CONTINGENCY MANAGEMENT	\$34,020,000	\$0	\$9,846,000	\$0	(\$24,174,000)	\$0
70	58	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	\$527,780	\$35,560	\$632,000	\$45,500	\$104,220	\$9,940
71	59	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	(\$96,000)	(\$232,000)	(\$1,970,000)	(\$272,000)	(\$1,874,000)	(\$40,000)
69	--	DRUG MEDI-CAL MAT BENEFIT	\$432,420	\$88,370	\$0	\$0	(\$432,420)	(\$88,370)
DRUG MEDI-CAL SUBTOTAL			\$34,884,200	(\$108,070)	\$8,508,000	(\$226,500)	(\$26,376,200)	(\$118,430)
<u>MENTAL HEALTH</u>								
74	60	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE	\$1,659,749,000	\$1,441,249,000	\$1,339,697,000	\$1,121,197,000	(\$320,052,000)	(\$320,052,000)
76	63	CALAIM - BH QUALITY IMPROVEMENT PROGRAM	\$45,396,000	\$45,396,000	\$45,396,000	\$45,396,000	\$0	\$0
75	64	MHP COSTS FOR FFPSA	\$45,216,000	\$15,053,000	\$43,134,000	\$12,498,000	(\$2,082,000)	(\$2,555,000)
78	65	MHP STRTP GRANTS	\$7,478,000	\$7,478,000	\$7,478,000	\$7,478,000	\$0	\$0
77	66	MHP COSTS FOR CONTINUUM OF CARE REFORM	\$26,824,000	\$14,304,500	\$3,867,000	\$2,707,900	(\$22,957,000)	(\$11,596,600)
79	67	OUT OF STATE YOUTH - SMHS	\$2,670,000	\$1,335,000	\$2,062,000	\$1,031,000	(\$608,000)	(\$304,000)
80	68	SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS	\$0	\$1,461,000	\$0	\$1,450,000	\$0	(\$11,000)
81	69	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	\$0	(\$200,000)	\$0	(\$200,000)	\$0	\$0
82	70	CHART REVIEW	(\$73,000)	\$0	(\$59,000)	\$0	\$14,000	\$0
83	71	INTERIM AND FINAL COST SETTLEMENTS - SMHS	(\$306,822,000)	\$153,000	(\$201,679,000)	\$103,000	\$105,143,000	(\$50,000)

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2022 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2022-23**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2022-23 APPROPRIATION		NOV. 2022 EST. FOR 2022-23		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		MENTAL HEALTH SUBTOTAL	\$1,480,438,000	\$1,526,229,500	\$1,239,896,000	\$1,191,660,900	(\$240,542,000)	(\$334,568,600)
		<u>WAIVER--MH/UCD & BTR</u>						
84	72	GLOBAL PAYMENT PROGRAM	\$2,558,640,000	\$0	\$2,625,833,000	\$0	\$67,193,000	\$0
86	73	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES	\$1,419,183,000	\$571,720,100	\$1,175,858,000	\$431,941,800	(\$243,325,000)	(\$139,778,300)
87	74	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	\$133,944,000	\$82,093,500	\$137,300,000	\$77,133,500	\$3,356,000	(\$4,960,000)
88	75	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	\$487,000	\$0	\$649,000	\$0	\$162,000	\$0
--	251	CALAIM- DESIGNATED STATE HEALTH PROGRAMS	\$0	\$0	\$0	(\$40,402,000)	\$0	(\$40,402,000)
		WAIVER--MH/UCD & BTR SUBTOTAL	\$4,112,254,000	\$653,813,600	\$3,939,640,000	\$468,673,300	(\$172,614,000)	(\$185,140,300)
		<u>MANAGED CARE</u>						
95	79	CCI-MANAGED CARE PAYMENTS	\$6,824,118,000	\$3,412,059,000	\$4,491,458,000	\$2,245,729,000	(\$2,332,660,000)	(\$1,166,330,000)
101	80	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	\$1,989,172,000	\$505,366,550	\$1,989,171,000	\$505,366,050	(\$1,000)	(\$500)
99	81	MANAGED CARE HEALTH CARE FINANCING PROGRAM	\$1,864,564,000	\$611,641,050	\$1,864,564,000	\$611,641,050	\$0	\$0
98	82	MANAGED CARE PUBLIC HOSPITAL EPP	\$1,778,153,000	\$409,022,320	\$1,778,153,000	\$404,763,840	\$0	(\$4,258,480)
96	83	2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	\$1,525,495,000	\$551,139,400	\$1,525,495,000	\$551,791,000	\$0	\$651,600
104	86	HCBS SP - HOUSING AND HOMELESSNESS INCENTIVE PROG	\$644,236,000	\$0	\$644,000,000	\$0	(\$236,000)	\$0
106	87	RETRO MC RATE ADJUSTMENTS	\$200,531,000	\$94,259,250	\$213,603,000	\$83,519,600	\$13,072,000	(\$10,739,650)
102	88	CALAIM - TRANSITIONING POPULATIONS	\$223,987,000	\$86,067,000	\$211,712,000	\$84,672,450	(\$12,275,000)	(\$1,394,550)
103	89	CYBHI - STUDENT BH INCENTIVE PROGRAM	\$194,493,000	\$97,246,500	\$199,014,000	\$99,507,000	\$4,521,000	\$2,260,500
--	91	WORKFORCE & QUALITY INCENTIVE PROGRAM	\$0	\$0	\$116,667,000	\$55,300,300	\$116,667,000	\$55,300,300
--	92	RECONCILIATION OF MCO TAX FUND 3156	\$0	\$0	\$108,000,000	(\$308,000,000)	\$108,000,000	(\$308,000,000)

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2022 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2022-23**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2022-23 APPROPRIATION		NOV. 2022 EST. FOR 2022-23		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
MANAGED CARE								
109	93	PROP 56 - BEHAVIORAL HEALTH INCENTIVE PROGRAM	\$90,136,000	\$41,342,000	\$90,136,000	\$39,945,000	\$0	(\$1,397,000)
113	96	CCI-QUALITY WITHHOLD REPAYMENTS	\$8,850,000	\$4,425,000	\$19,807,000	\$9,903,500	\$10,957,000	\$5,478,500
117	102	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	\$0	(\$1,644,066,000)	\$0	(\$1,639,114,000)	\$0	\$4,952,000
118	103	2020 MCO ENROLLMENT TAX MANAGED CARE PLANS	\$0	(\$1,541,433,000)	\$0	(\$1,576,399,000)	\$0	(\$34,966,000)
119	104	2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	\$0	(\$524,101,000)	\$0	(\$489,135,000)	\$0	\$34,966,000
120	105	COORDINATED CARE INITIATIVE RISK MITIGATION	(\$111,260,000)	(\$55,630,000)	(\$111,260,000)	(\$55,630,000)	\$0	\$0
--	255	PROP 56 - DIRECTED PAYMENT RISK MITIGATION	\$0	\$0	(\$500,000,000)	(\$175,037,080)	(\$500,000,000)	(\$175,037,080)
105	--	CALAIM – MEDI-CAL PATH	\$706,620,000	\$253,100,000	\$0	\$0	(\$706,620,000)	(\$253,100,000)
116	--	CAPITATED RATE ADJUSTMENT FOR FY 2022-23	(\$1,731,327,000)	(\$596,376,600)	\$0	\$0	\$1,731,327,000	\$596,376,600
MANAGED CARE SUBTOTAL			\$14,207,768,000	\$1,704,061,480	\$12,640,520,000	\$448,823,710	(\$1,567,248,000)	(\$1,255,237,760)
PROVIDER RATES								
263	106	NURSING FACILITY RATE ADJUSTMENTS	\$340,215,000	\$164,565,500	\$316,982,000	\$150,249,400	(\$23,233,000)	(\$14,316,100)
124	107	RATE INCREASE FOR FQHCS/RHCS/CBRCS	\$336,624,830	\$123,022,510	\$314,943,260	\$116,254,800	(\$21,681,570)	(\$6,767,710)
127	108	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	\$215,595,000	(\$7,635,000)	\$221,308,000	(\$7,132,000)	\$5,713,000	\$503,000
131	109	PP-GEMT IGT PROGRAM	\$97,609,010	(\$2,640,730)	\$143,189,590	(\$3,977,540)	\$45,580,580	(\$1,336,820)
130	110	FQHC/RHC/CBRC RECONCILIATION PROCESS	\$138,252,000	\$50,525,400	\$124,335,000	\$45,895,700	(\$13,917,000)	(\$4,629,700)
125	111	DPH INTERIM RATE GROWTH	\$137,495,180	\$43,413,540	\$68,037,480	\$24,290,810	(\$69,457,700)	(\$19,122,730)
129	112	DPH INTERIM RATE COVID-19 INCREASED FMAP ADJUST	\$15,682,000	\$0	\$87,343,000	\$0	\$71,661,000	\$0
128	113	LTC RATE ADJUSTMENT	\$188,228,360	\$91,812,020	\$205,721,820	\$100,390,260	\$17,493,450	\$8,578,240
126	114	AB 1629 ANNUAL RATE ADJUSTMENTS	\$249,396,070	\$118,213,780	\$97,732,380	\$46,043,520	(\$151,663,690)	(\$72,170,270)

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2022 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2022-23**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2022-23 APPROPRIATION		NOV. 2022 EST. FOR 2022-23		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>PROVIDER RATES</u>								
267	115	AB 97 ELIMINATIONS	\$19,637,000	\$9,009,450	\$20,443,000	\$8,061,200	\$806,000	(\$948,250)
286	116	ACUPUNCTURE RATE INCREASE	\$10,905,000	\$3,300,500	\$10,905,000	\$3,300,500	\$0	\$0
144	117	LABORATORY RATE METHODOLOGY CHANGE	(\$1,343,000)	(\$576,150)	\$9,849,000	\$4,188,500	\$11,192,000	\$4,764,650
135	118	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	\$10,012,750	\$3,998,390	\$10,349,300	\$4,082,570	\$336,550	\$84,180
134	119	HOSPICE RATE INCREASES	\$10,264,560	\$4,898,970	\$7,825,000	\$3,722,850	(\$2,439,560)	(\$1,176,120)
136	120	GDSP PRENATAL SCREENING PROGRAM FEE INCREASE	\$5,254,690	\$2,098,580	(\$1,804,410)	(\$720,530)	(\$7,059,100)	(\$2,819,110)
141	121	DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT	\$136,920	\$101,630	\$230,660	\$108,010	\$93,730	\$6,380
137	122	DPH INTERIM RATE	\$0	(\$448,136,600)	\$0	(\$427,546,000)	\$0	\$20,590,600
140	123	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	\$0	(\$495,668,000)	\$0	(\$517,203,000)	\$0	(\$21,535,000)
142	124	10% PROVIDER PAYMENT REDUCTION	(\$102,853,000)	(\$39,684,050)	(\$366,839,000)	(\$129,602,200)	(\$263,986,000)	(\$89,918,150)
143	125	REDUCTION TO RADIOLOGY RATES	(\$12,396,940)	(\$5,354,270)	(\$11,549,540)	(\$5,082,730)	\$847,400	\$271,540
145	126	DPH INTERIM & FINAL RECONS	(\$2,352,000)	\$0	(\$76,260,000)	\$0	(\$73,908,000)	\$0
138	--	PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE	\$6,371,000	\$3,072,600	\$0	\$0	(\$6,371,000)	(\$3,072,600)
139	--	PROP 56 - HOME HEALTH RATE INCREASE	\$123,645,000	\$59,615,050	\$0	\$0	(\$123,645,000)	(\$59,615,050)
PROVIDER RATES SUBTOTAL			\$1,786,379,430	(\$322,046,880)	\$1,182,741,530	(\$584,675,890)	(\$603,637,900)	(\$262,629,010)
<u>SUPPLEMENTAL PMNTS.</u>								
146	127	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	\$3,403,178,000	\$0	\$3,403,178,000	\$0	\$0	\$0
147	128	HOSPITAL QAF - FFS PAYMENTS	\$3,290,656,000	\$0	\$3,032,548,000	\$0	(\$258,108,000)	\$0
149	129	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	\$1,238,684,000	\$496,926,600	\$1,348,007,000	\$475,148,150	\$109,323,000	(\$21,778,450)
151	130	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	\$662,267,000	\$0	\$926,935,000	\$0	\$264,668,000	\$0
150	131	PRIVATE HOSPITAL DSH REPLACEMENT	\$649,538,000	\$324,769,000	\$733,956,000	\$336,609,000	\$84,418,000	\$11,840,000

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2022 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2022-23**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2022-23 APPROPRIATION		NOV. 2022 EST. FOR 2022-23		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		<u>SUPPLEMENTAL PMNTS.</u>						
152	132	DSH PAYMENT	\$438,696,000	\$24,847,500	\$464,328,000	\$22,966,500	\$25,632,000	(\$1,881,000)
153	133	PROP 56 - MEDI-CAL FAMILY PLANNING	\$455,268,000	\$76,159,200	\$465,341,000	\$77,408,600	\$10,073,000	\$1,249,400
155	134	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	\$641,991,000	\$118,400,000	\$304,051,000	\$118,400,000	(\$337,940,000)	\$0
157	135	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	\$216,479,000	\$0	\$275,925,000	\$0	\$59,446,000	\$0
165	136	NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS	\$105,000,000	\$52,500,000	\$157,500,000	\$71,426,000	\$52,500,000	\$18,926,000
158	137	FFP FOR LOCAL TRAUMA CENTERS	\$176,671,000	\$0	\$140,698,000	\$0	(\$35,973,000)	\$0
156	138	DPH PHYSICIAN & NON-PHYS. COST	\$100,637,000	\$0	\$140,447,000	\$0	\$39,810,000	\$0
159	139	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	\$120,092,000	\$849,000	\$118,432,000	\$565,000	(\$1,660,000)	(\$284,000)
160	140	CAPITAL PROJECT DEBT REIMBURSEMENT	\$87,299,000	\$21,375,500	\$84,231,000	\$19,017,500	(\$3,068,000)	(\$2,358,000)
163	141	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	\$66,376,000	\$0	\$58,660,000	\$0	(\$7,716,000)	\$0
167	142	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	\$552,429,000	\$210,998,250	\$578,569,000	\$199,100,800	\$26,140,000	(\$11,897,450)
175	143	GEMT SUPPLEMENTAL PAYMENT PROGRAM	\$27,147,000	\$0	\$55,446,000	\$0	\$28,299,000	\$0
162	144	NDPH IGT SUPPLEMENTAL PAYMENTS	\$38,528,000	(\$1,021,000)	\$46,265,000	(\$1,150,000)	\$7,737,000	(\$129,000)
161	145	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	\$41,000,000	\$0	\$43,393,000	\$0	\$2,393,000	\$0
154	146	PROP 56 - VALUE-BASED PAYMENT PROGRAM	\$31,005,000	\$9,341,450	\$31,005,000	\$9,347,500	\$0	\$6,050
169	147	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	\$14,782,000	\$0	\$15,705,000	\$0	\$923,000	\$0
170	148	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	\$10,000,000	\$5,000,000	\$10,000,000	\$4,535,000	\$0	(\$465,000)
173	149	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	\$8,000,000	\$4,000,000	\$8,000,000	\$3,628,000	\$0	(\$372,000)
133	150	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	\$3,500,000	\$0	\$6,661,000	(\$1,199,000)	\$3,161,000	(\$1,199,000)

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2022 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2022-23**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2022-23 APPROPRIATION		NOV. 2022 EST. FOR 2022-23		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>SUPPLEMENTAL PMNTS.</u>								
174	151	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	\$85,628,000	\$26,284,000	\$69,411,000	\$21,664,000	(\$16,217,000)	(\$4,620,000)
172	152	NDPH SUPPLEMENTAL PAYMENT	\$12,752,000	\$1,900,000	\$4,221,000	\$1,900,000	(\$8,531,000)	\$0
176	153	FREE CLINICS AUGMENTATION	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$0	\$0
179	155	PROPOSITION 56 FUNDING	\$0	(\$569,060,000)	\$0	(\$651,127,000)	\$0	(\$82,067,000)
181	156	IGT ADMIN. & PROCESSING FEE	\$0	(\$13,534,000)	\$0	(\$14,374,000)	\$0	(\$840,000)
148	--	HOSPITAL QAF - MANAGED CARE PAYMENTS	\$1,797,400,000	\$0	\$0	\$0	(\$1,797,400,000)	\$0
164	--	PROP 56 - DEVELOPMENTAL SCREENINGS	\$59,669,000	\$29,081,850	\$0	\$0	(\$59,669,000)	(\$29,081,850)
166	--	PROP 56 - ADVERSE CHILDHOOD EXPERIENCES SCREENINGS	\$47,352,000	\$20,245,100	\$0	\$0	(\$47,352,000)	(\$20,245,100)
168	--	PROP 56 - CBAS SUPPLEMENTAL PAYMENTS	\$29,880,000	\$14,323,000	\$0	\$0	(\$29,880,000)	(\$14,323,000)
171	--	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS	\$25,656,000	\$12,362,000	\$0	\$0	(\$25,656,000)	(\$12,362,000)
177	--	PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS	\$8,240,000	\$3,852,400	\$0	\$0	(\$8,240,000)	(\$3,852,400)
178	--	PROP 56 - NEMT SUPPLEMENTAL PAYMENTS	\$7,158,000	\$3,625,550	\$0	\$0	(\$7,158,000)	(\$3,625,550)
180	--	PROP 56 - AIDS WAIVER RATE INCREASE	\$4,538,000	\$2,199,000	\$0	\$0	(\$4,538,000)	(\$2,199,000)
		SUPPLEMENTAL PMNTS. SUBTOTAL	\$14,459,496,000	\$877,424,400	\$12,524,913,000	\$695,866,050	(\$1,934,583,000)	(\$181,558,350)
<u>COVID-19</u>								
182	157	COVID-19 CASELOAD IMPACT	\$11,102,397,000	\$3,086,317,150	\$14,478,464,000	\$4,127,988,000	\$3,376,067,000	\$1,041,670,850
186	159	COVID-19 BEHAVIORAL HEALTH	\$108,101,000	\$8,690,600	\$190,217,000	\$14,381,100	\$82,116,000	\$5,690,500
256	160	COVID-19 VACCINATION INCENTIVE PROGRAM	\$133,333,000	\$66,666,500	\$156,822,000	\$78,411,000	\$23,489,000	\$11,744,500
279	161	PHARMACY-BASED COVID-19 TESTS	\$36,451,750	\$12,761,410	\$80,383,870	\$27,136,250	\$43,932,130	\$14,374,830
188	162	COVID-19 - SICK LEAVE BENEFITS	\$2,633,000	\$50,500	\$6,776,000	\$75,500	\$4,143,000	\$25,000
189	163	COVID-19 ELIGIBILITY	\$103,763,000	\$64,391,000	\$140,049,000	\$95,277,000	\$36,286,000	\$30,886,000

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2022 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2022-23**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2022-23 APPROPRIATION		NOV. 2022 EST. FOR 2022-23		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>COVID-19</u>								
184	164	COVID-19 VACCINE ADMINISTRATION	\$176,547,000	\$9,424,700	\$6,201,000	\$418,750	(\$170,346,000)	(\$9,005,950)
191	165	CONTINUOUS CHIP COVERAGE DURING THE COVID-19 PHE	\$0	\$40,014,000	\$0	\$86,511,000	\$0	\$46,497,000
185	166	COVID-19 LTC REIMBURSEMENT RATES	\$100,916,000	\$48,753,850	(\$9,056,000)	(\$4,504,400)	(\$109,972,000)	(\$53,258,250)
194	167	COVID-19 INCREASED FMAP - DHCS	\$556,468,000	(\$2,113,112,000)	(\$254,321,000)	(\$3,734,150,000)	(\$810,789,000)	(\$1,621,038,000)
--	168	COVID-19 CASELOAD IMPACT BASE ADJUSTMENT	\$0	\$0	(\$12,520,833,000)	(\$3,551,844,200)	(\$12,520,833,000)	(\$3,551,844,200)
187	--	COVID-19 FFS DME RESPIRATORY RATES	\$12,778,000	\$6,025,550	\$0	\$0	(\$12,778,000)	(\$6,025,550)
190	--	COVID-19 TESTING IN SCHOOLS	\$404,591,000	\$102,449,150	\$0	\$0	(\$404,591,000)	(\$102,449,150)
192	--	COVID-19 BASE RECOVERIES	\$0	\$0	\$0	\$0	\$0	\$0
COVID-19 SUBTOTAL			\$12,737,978,750	\$1,332,432,410	\$2,274,702,870	(\$2,860,300,000)	(\$10,463,275,870)	(\$4,192,732,420)
<u>STATE ONLY CLAIMING</u>								
195	169	STATE ONLY CLAIMING ADJUSTMENTS	\$130,230,000	\$2,249,280,000	\$130,720,000	(\$125,345,000)	\$490,000	(\$2,374,625,000)
196	170	STATE ONLY CLAIMING ADJUSTMENTS - SMHS and DMC	(\$6,020,000)	\$14,476,000	\$0	\$23,877,000	\$6,020,000	\$9,401,000
STATE ONLY CLAIMING SUBTOTAL			\$124,210,000	\$2,263,756,000	\$130,720,000	(\$101,468,000)	\$6,510,000	(\$2,365,224,000)
<u>OTHER DEPARTMENTS</u>								
33	171	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	\$540,376,000	\$0	\$714,859,000	\$0	\$174,483,000	\$0
--	172	HCBS SP - IHSS HCBS CARE ECONOMY PMTS	\$0	\$0	\$165,790,000	\$0	\$165,790,000	\$0
197	173	ELECTRONIC VISIT VERIFICATION FED PENALTIES	(\$27,431,000)	\$623,000	(\$27,822,000)	\$623,000	(\$391,000)	\$0
OTHER DEPARTMENTS SUBTOTAL			\$512,945,000	\$623,000	\$852,827,000	\$623,000	\$339,882,000	\$0
<u>OTHER</u>								
--	179	HOSPITAL & SNF COVID-19 WORKER RETENTION PAYMENTS	\$0	\$0	\$1,077,600,000	\$0	\$1,077,600,000	\$0

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2022 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2022-23**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2022-23 APPROPRIATION		NOV. 2022 EST. FOR 2022-23		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
275	181	BEHAVIORAL HEALTH BRIDGE HOUSING	\$957,936,000	\$957,936,000	\$907,936,000	\$907,936,000	(\$50,000,000)	(\$50,000,000)
208	182	CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY	\$450,000,000	\$450,000,000	\$450,000,000	\$450,000,000	\$0	\$0
236	183	CYBHI - EVIDENCE-BASED BH PRACTICES	\$429,000,000	\$429,000,000	\$429,000,000	\$429,000,000	\$0	\$0
--	184	CCI IHSS RECONCILIATION	\$0	\$0	\$428,000,000	\$86,000,000	\$428,000,000	\$86,000,000
269	186	HCBS SP CDDS	\$231,136,000	\$0	\$382,513,000	\$0	\$151,377,000	\$0
266	187	EQUITY & PRACTICE TRANSFORMATION PAYMENTS	\$140,000,000	\$70,000,000	\$140,000,000	\$70,000,000	\$0	\$0
205	188	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER	\$303,484,000	\$151,742,000	\$285,672,000	\$142,836,000	(\$17,812,000)	(\$8,906,000)
291	189	CYBHI - URGENT NEEDS AND EMERGENT ISSUES	\$120,500,000	\$120,500,000	\$120,000,000	\$120,000,000	(\$500,000)	(\$500,000)
282	191	LA COUNTY JUSTICE-INVOLVED POP. SVCS & SUPPORTS	\$100,000,000	\$100,000,000	\$99,220,000	\$99,220,000	(\$780,000)	(\$780,000)
277	192	CALHOPE	\$110,000,000	\$96,423,000	\$105,423,000	\$96,423,000	(\$4,577,000)	\$0
252	194	QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES	\$108,483,000	\$16,272,000	\$72,322,000	\$10,848,000	(\$36,161,000)	(\$5,424,000)
--	195	CLINIC WORKFORCE STABILIZATION RETENTION PROGRAM	\$0	\$0	\$70,000,000	\$70,000,000	\$70,000,000	\$70,000,000
219	196	INDIAN HEALTH SERVICES	\$64,060,000	\$21,460,000	\$64,061,000	\$21,353,500	\$1,000	(\$106,500)
209	198	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	\$61,690,000	\$0	\$85,442,000	\$0	\$23,752,000	\$0
271	199	MHSF - PROVIDER ACES TRAININGS	\$44,100,000	\$0	\$44,100,000	\$0	\$0	\$0
218	200	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG	\$40,780,000	\$0	\$42,028,000	\$0	\$1,248,000	\$0
220	201	SELF-DETERMINATION PROGRAM - CDDS	\$36,069,000	\$0	\$86,758,000	\$0	\$50,689,000	\$0
257	202	EVIDENCE-BASED DENTAL PRACTICES	\$37,110,000	\$12,915,800	\$30,814,000	\$9,699,500	(\$6,296,000)	(\$3,216,300)
211	203	HCBS SP - CALBRIDGE BH NAVIGATOR PROGRAM	\$29,802,000	\$0	\$29,651,000	\$0	(\$151,000)	\$0
213	205	INFANT DEVELOPMENT PROGRAM	\$25,760,000	\$0	\$27,810,000	\$0	\$2,050,000	\$0

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2022 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2022-23**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2022-23 APPROPRIATION		NOV. 2022 EST. FOR 2022-23		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
--	206	WATSONVILLE COMMUNITY HOSPITAL ACQUISITION	\$0	\$0	\$25,000,000	\$25,000,000	\$25,000,000	\$25,000,000
227	207	HCBS SP - ASSISTED LIVING WAIVER EXPANSION	\$38,567,200	(\$20,492,020)	\$23,296,900	(\$5,720,790)	(\$15,270,300)	\$14,771,240
225	208	CYBHI - CALHOPE STUDENT SUPPORT	\$19,750,000	\$19,750,000	\$21,000,000	\$21,000,000	\$1,250,000	\$1,250,000
226	209	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	\$80,882,240	\$40,441,120	\$45,379,010	\$22,689,510	(\$35,503,230)	(\$17,751,620)
292	210	LOS ANGELES COUNTY REPRODUCTIVE HEALTH PILOT	\$20,000,000	\$20,000,000	\$20,000,000	\$20,000,000	\$0	\$0
222	212	PEER SUPPORT SPECIALIST SERVICES	\$31,508,000	\$0	\$12,867,000	\$0	(\$18,641,000)	\$0
224	213	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	\$10,224,000	\$4,677,000	\$15,281,000	\$6,985,000	\$5,057,000	\$2,308,000
293	214	PACE INFRASTRUCTURE FUNDING	\$10,000,000	\$10,000,000	\$10,000,000	\$10,000,000	\$0	\$0
288	215	ALAMEDA COUNTY SUPPORTIVE HOUSING	\$10,000,000	\$10,000,000	\$10,000,000	\$10,000,000	\$0	\$0
290	216	BACKFILL LOST TITLE X FAMILY PLANNING FUNDING	\$10,000,000	\$10,000,000	\$10,000,000	\$10,000,000	\$0	\$0
223	217	HCBS SP - NON-IHSS CARE ECONOMY PMTS	\$12,250,000	\$0	\$12,250,000	\$0	\$0	\$0
289	219	INFRASTRUCTURE PYMT FOR CLINIC ABORTION PROVIDERS	\$14,849,000	\$14,849,000	\$7,425,000	\$7,425,000	(\$7,424,000)	(\$7,424,000)
210	220	PROP 56 - PROVIDER ACES TRAININGS	\$7,100,000	\$3,550,000	\$7,100,000	\$3,550,000	\$0	\$0
207	221	CALAIM - DENTAL INITIATIVES	\$239,958,000	\$116,547,850	\$258,451,000	\$124,204,950	\$18,493,000	\$7,657,100
212	222	QAF WITHHOLD TRANSFER	(\$445,000)	(\$796,500)	\$2,877,000	\$817,500	\$3,322,000	\$1,614,000
287	223	FOSTER YOUTH SUBSTANCE USE DISORDER GRANT PROGRAM	\$5,000,000	\$5,000,000	\$1,500,000	\$1,500,000	(\$3,500,000)	(\$3,500,000)
239	224	CLPP FUND	\$916,000	\$0	\$902,000	\$0	(\$14,000)	\$0
234	225	WPCS WORKERS' COMPENSATION	\$620,000	\$310,000	\$620,000	\$310,000	\$0	\$0
--	227	HCBS SP - ETSB FOR LAGUNA HONDA HOSPITAL RESIDENTS	\$0	\$0	\$600,000	\$0	\$600,000	\$0
273	229	URBAN INDIAN ORGANIZATIONS FUNDING SHIFT	\$0	(\$25,322,000)	\$0	(\$16,539,000)	\$0	\$8,783,000

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2022 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2022-23**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2022-23 APPROPRIATION		NOV. 2022 EST. FOR 2022-23		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
254	230	AMERICAN RESCUE PLAN INCREASED FMAP FOR HCBS	\$0	\$0	\$0	\$0	\$0	\$0
241	231	IMD ANCILLARY SERVICES	\$0	\$27,827,000	\$0	\$37,244,000	\$0	\$9,417,000
238	232	CIGARETTE AND TOBACCO SURTAX FUNDS	\$0	(\$131,364,000)	\$0	(\$131,352,000)	\$0	\$12,000
242	233	FUNDING ADJUST.—ACA OPT. EXPANSION	\$0	(\$1,903,722,800)	\$0	(\$3,974,797,200)	\$0	(\$2,071,074,400)
243	234	FUNDING ADJUST.—OTLICP	\$0	(\$78,473,250)	\$0	(\$109,124,550)	\$0	(\$30,651,300)
244	235	HOSPITAL QAF - CHILDREN'S HEALTH CARE	\$0	(\$976,000,000)	\$0	(\$1,115,200,000)	\$0	(\$139,200,000)
248	236	INDIAN HEALTH SERVICES FUNDING SHIFT	\$0	(\$15,048,500)	\$0	(\$14,845,000)	\$0	\$203,500
245	237	CMS DEFERRED CLAIMS	\$0	\$226,413,000	\$0	(\$193,141,000)	\$0	(\$419,554,000)
--	238	DENTAL MANAGED CARE MLR RISK CORRIDOR	\$0	\$0	(\$18,950,000)	(\$5,868,600)	(\$18,950,000)	(\$5,868,600)
249	239	COUNTY SHARE OF OTLICP-CCS COSTS	(\$25,337,000)	(\$25,337,000)	(\$22,981,000)	(\$22,981,000)	\$2,356,000	\$2,356,000
231	--	TRIBAL FEDERALLY QUALIFIED HEALTH CENTER	\$28,748,000	\$7,463,800	\$0	\$0	(\$28,748,000)	(\$7,463,800)
232	--	OUTREACH & ENROLLMENT ASSIST. FOR DUAL BENES	\$10,000,000	\$5,000,000	\$0	\$0	(\$10,000,000)	(\$5,000,000)
233	--	HPSM DENTAL INTEGRATION PILOT PROGRAM	\$78,000	\$31,600	\$0	\$0	(\$78,000)	(\$31,600)
258	--	END-OF-FY 2-WEEK CHECKWRITE HOLD BUYBACK	\$795,755,000	\$309,409,650	\$0	\$0	(\$795,755,000)	(\$309,409,650)
283	--	MINIMUM WAGE INFLATION INCREASE	\$16,021,000	\$7,833,400	\$0	\$0	(\$16,021,000)	(\$7,833,400)
		OTHER SUBTOTAL	\$4,626,354,440	\$88,796,150	\$5,420,967,910	(\$2,775,527,170)	\$794,613,470	(\$2,864,323,320)
		GRAND TOTAL	\$67,027,034,660	\$10,846,610,070	\$46,536,049,270	(\$3,419,186,540)	(\$20,490,985,400)	(\$14,265,796,610)

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 2022 ESTIMATE

SERVICE CATEGORY	PA-OAS	NEWLY	PA-ATD	PA-AFDC	LT-OAS	H-PE
PHYSICIANS	\$7,996,360	\$165,422,630	\$68,745,100	\$43,130,900	\$1,551,710	\$57,724,410
OTHER MEDICAL	\$96,622,360	\$1,622,535,440	\$456,723,720	\$375,438,370	\$4,313,800	\$37,319,530
CO. & COMM. OUTPATIENT	\$3,165,610	\$109,180,920	\$90,372,190	\$26,722,110	\$549,990	\$54,499,290
PHARMACY	\$52,955,780	\$6,124,832,600	\$2,555,415,760	\$426,236,190	\$8,705,690	\$24,534,000
COUNTY INPATIENT	\$2,670,390	\$489,720,610	\$20,289,250	\$13,154,240	\$2,879,100	\$83,962,780
COMMUNITY INPATIENT	\$44,604,990	\$1,004,675,280	\$355,303,340	\$186,256,310	\$13,454,490	\$387,016,430
NURSING FACILITIES	\$124,420,090	\$139,015,520	\$350,432,160	\$7,588,250	\$701,047,350	\$2,661,890
ICF-DD	\$3,197,140	\$13,754,080	\$193,973,820	\$1,543,860	\$84,868,470	\$0
MEDICAL TRANSPORTATION	\$4,414,720	\$32,964,500	\$15,119,720	\$3,707,810	\$2,067,510	\$8,341,150
OTHER SERVICES	\$106,839,560	\$18,897,430	\$588,072,510	\$61,856,670	\$60,802,900	\$2,759,140
HOME HEALTH	\$3,861,060	\$1,887,120	\$118,111,360	\$6,667,030	\$51,770	\$209,980
FFS SUBTOTAL	\$450,748,060	\$9,722,886,140	\$4,812,558,930	\$1,152,301,750	\$880,292,790	\$659,028,590
DENTAL	\$56,649,130	\$401,624,770	\$132,785,700	\$220,827,830	\$11,869,650	\$1,762,480
MENTAL HEALTH	\$10,896,640	\$372,232,160	\$1,129,130,450	\$807,480,460	\$823,580	\$8,932,890
TWO PLAN MODEL	\$1,559,810,750	\$13,015,482,690	\$4,947,408,830	\$1,564,363,210	\$0	\$0
COUNTY ORGANIZED HEALTH SYSTEMS	\$443,846,150	\$4,930,523,240	\$1,451,141,410	\$399,509,160	\$803,076,630	\$0
GEOGRAPHIC MANAGED CARE	\$228,456,530	\$2,231,379,770	\$965,573,130	\$250,273,820	\$0	\$0
PHP & OTHER MANAG. CARE	\$333,019,030	\$114,001,760	\$276,862,430	\$4,066,680	\$13,421,670	\$0
MEDICARE PAYMENTS	\$1,998,836,540	\$0	\$1,827,591,840	\$0	\$166,906,680	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$1,492,590	\$0	\$3,224,710	\$3,598,950	\$140,980	\$0
MISC. SERVICES	\$32,510,180	\$2,070	\$310,499,030	\$7,544,420	\$0	\$0
DRUG MEDI-CAL	\$18,038,790	\$350,491,940	\$39,387,000	\$45,611,000	\$1,538,560	\$11,940
REGIONAL MODEL	\$17,758,990	\$687,607,740	\$280,673,040	\$79,871,240	\$0	\$0
NON-FFS SUBTOTAL	\$4,701,315,310	\$22,103,346,130	\$11,364,277,590	\$3,383,146,770	\$997,777,760	\$10,707,310
TOTAL DOLLARS (1)	\$5,152,063,370	\$31,826,232,270	\$16,176,836,520	\$4,535,448,520	\$1,878,070,550	\$669,735,890
ELIGIBLES ***	417,700	5,038,700	872,100	1,103,700	33,000	37,300
ANNUAL \$/ELIGIBLE	\$12,334	\$6,316	\$18,549	\$4,109	\$56,911	\$17,955
AVG. MO. \$/ELIGIBLE	\$1,028	\$526	\$1,546	\$342	\$4,743	\$1,496

(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 2022 ESTIMATE

SERVICE CATEGORY	LT-ATD	POV 250	MN-OAS	MN-ATD	MN-AFDC	MI-C
PHYSICIANS	\$840,760	\$22,166,040	\$26,091,930	\$11,505,600	\$149,487,810	\$28,953,450
OTHER MEDICAL	\$2,684,900	\$198,834,040	\$232,187,580	\$100,551,030	\$1,352,015,370	\$99,407,860
CO. & COMM. OUTPATIENT	\$452,800	\$23,898,530	\$18,297,760	\$12,290,110	\$119,490,550	\$12,566,560
PHARMACY	\$5,035,850	\$330,068,310	\$401,507,010	\$199,305,400	\$2,093,579,690	\$70,167,390
COUNTY INPATIENT	\$1,383,000	\$530,550	\$34,483,530	\$6,580,770	\$96,608,970	\$6,504,930
COMMUNITY INPATIENT	\$5,859,860	\$57,855,300	\$142,620,630	\$38,780,640	\$586,263,190	\$62,151,640
NURSING FACILITIES	\$121,135,820	\$3,533,220	\$235,975,500	\$54,455,460	\$21,448,480	\$10,310,700
ICF-DD	\$196,674,230	\$1,389,870	\$3,554,920	\$14,427,470	\$2,457,340	\$3,406,540
MEDICAL TRANSPORTATION	\$695,220	\$294,740	\$11,178,020	\$7,114,020	\$8,069,380	\$2,943,600
OTHER SERVICES	\$7,263,060	\$32,228,170	\$139,119,010	\$140,175,010	\$86,230,870	\$34,090,980
HOME HEALTH	\$1,410	\$15,692,670	\$2,956,470	\$41,126,610	\$14,121,790	\$16,413,430
FFS SUBTOTAL	\$342,026,940	\$686,491,450	\$1,247,972,360	\$626,312,130	\$4,529,773,450	\$346,917,070
DENTAL	\$3,368,600	\$219,236,050	\$76,427,140	\$26,818,990	\$585,050,270	\$26,209,050
MENTAL HEALTH	\$1,942,810	\$79,049,580	\$15,486,750	\$104,051,960	\$578,041,230	\$78,906,080
TWO PLAN MODEL	\$0	\$757,557,940	\$2,702,522,810	\$828,506,490	\$4,938,974,060	\$38,384,030
COUNTY ORGANIZED HEALTH SYSTEMS	\$193,323,070	\$317,010,880	\$878,067,760	\$407,248,270	\$2,028,079,690	\$30,411,080
GEOGRAPHIC MANAGED CARE	\$0	\$137,346,270	\$379,658,030	\$168,596,490	\$976,750,300	\$5,252,120
PHP & OTHER MANAG. CARE	\$1,050,970	(\$128,650)	\$512,506,930	\$46,723,460	\$1,364,650	(\$23,580)
MEDICARE PAYMENTS	\$0	\$0	\$2,250,706,010	\$773,003,900	\$139,887,270	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$34,150	\$0	\$2,612,040	\$787,010	\$14,144,740	\$516,680
MISC. SERVICES	\$0	\$0	\$58,135,170	\$75,305,020	\$28,578,840	\$1,114,940
DRUG MEDI-CAL	\$370,460	\$51,018,660	\$31,756,070	\$9,752,640	\$172,435,680	\$6,732,500
REGIONAL MODEL	\$0	\$41,821,890	\$66,341,550	\$48,969,010	\$323,932,360	\$1,630,960
NON-FFS SUBTOTAL	\$200,090,080	\$1,602,912,640	\$6,974,220,260	\$2,489,763,240	\$9,787,239,100	\$189,133,860
TOTAL DOLLARS (1)	\$542,117,020	\$2,289,404,090	\$8,222,192,620	\$3,116,075,370	\$14,317,012,550	\$536,050,930
ELIGIBLES ***	7,800	848,900	753,700	216,400	4,079,300	144,800
ANNUAL \$/ELIGIBLE	\$69,502	\$2,697	\$10,909	\$14,400	\$3,510	\$3,702
AVG. MO. \$/ELIGIBLE	\$5,792	\$225	\$909	\$1,200	\$292	\$309

(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 2022 ESTIMATE

SERVICE CATEGORY	MI-A	REFUGEE	OBRA	POV 185	POV 133	POV 100
PHYSICIANS	\$331,570	\$89,950	\$230	\$81,360,130	\$17,103,570	\$9,707,490
OTHER MEDICAL	\$645,720	\$1,652,860	\$63,970	\$266,481,350	\$241,346,710	\$113,265,400
CO. & COMM. OUTPATIENT	\$70,780	\$149,430	\$2,830	\$24,346,130	\$13,421,280	\$12,374,990
PHARMACY	\$1,180,750	\$979,710	\$1,010	\$70,189,360	\$142,238,640	\$142,776,380
COUNTY INPATIENT	\$1,626,190	\$8,000	\$7,880	\$42,941,400	\$1,103,230	\$1,202,300
COMMUNITY INPATIENT	\$1,777,350	\$51,880	\$2,440	\$467,889,220	\$72,323,920	\$27,706,250
NURSING FACILITIES	\$12,802,080	\$0	\$192,800	\$3,056,410	\$9,400,700	\$1,058,660
ICF-DD	\$1,306,590	\$0	\$62,640	\$31,090	\$207,110	\$109,950
MEDICAL TRANSPORTATION	\$88,990	\$7,620	\$2,820	\$2,180,720	\$462,290	\$191,040
OTHER SERVICES	\$771,540	\$18,950	\$630	\$7,554,100	\$22,600,680	\$10,661,930
HOME HEALTH	\$120	\$0	\$0	\$3,128,190	\$6,898,820	\$2,476,830
FFS SUBTOTAL	\$20,601,680	\$2,958,390	\$337,250	\$969,158,110	\$527,106,950	\$321,531,230
DENTAL	\$124,410	\$187,510	\$20,830	\$14,804,340	\$248,695,790	\$98,255,290
MENTAL HEALTH	\$0	\$180,050	\$1,800,490	\$1,937,640	\$24,656,060	\$37,477,880
TWO PLAN MODEL	\$14,910	\$1,374,170	\$0	\$337,864,330	\$672,777,620	\$339,555,390
COUNTY ORGANIZED HEALTH SYSTEMS	\$318,490	\$319,240	\$0	\$168,242,210	\$240,130,420	\$127,576,530
GEOGRAPHIC MANAGED CARE	\$1,150	\$799,900	\$0	\$68,764,910	\$115,428,800	\$53,037,410
PHP & OTHER MANAG. CARE	(\$182,160)	\$0	\$0	\$667,080	\$135,310	\$80,090
MEDICARE PAYMENTS	\$0	\$0	\$0	\$0	\$0	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$11,260	\$0	\$360	\$1,236,110	\$0	\$1,482,820
MISC. SERVICES	\$180	\$0	\$0	\$20,990	\$5,910,660	\$3,082,440
DRUG MEDI-CAL	\$130,860	\$117,470	\$0	\$15,925,370	\$35,517,240	\$18,522,490
REGIONAL MODEL	\$0	\$12,750	\$0	\$22,554,260	\$36,407,810	\$17,400,610
NON-FFS SUBTOTAL	\$419,100	\$2,991,090	\$1,821,690	\$632,017,230	\$1,379,659,710	\$696,470,940
TOTAL DOLLARS (1)	\$21,020,780	\$5,949,480	\$2,158,940	\$1,601,175,340	\$1,906,766,660	\$1,018,002,170
ELIGIBLES ***	3,000	2,100	0	392,500	850,800	426,400
ANNUAL \$/ELIGIBLE	\$7,007	\$2,833		\$4,079	\$2,241	\$2,387
AVG. MO. \$/ELIGIBLE	\$584	\$236		\$340	\$187	\$199

(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 2022 ESTIMATE

SERVICE CATEGORY	TOTAL
PHYSICIANS	\$692,209,640
OTHER MEDICAL	\$5,202,090,020
CO. & COMM. OUTPATIENT	\$521,851,850
PHARMACY	\$12,649,709,520
COUNTY INPATIENT	\$805,657,140
COMMUNITY INPATIENT	\$3,454,593,170
NURSING FACILITIES	\$1,798,535,100
ICF-DD	\$520,965,130
MEDICAL TRANSPORTATION	\$99,843,880
OTHER SERVICES	\$1,319,943,150
HOME HEALTH	\$233,604,680
FFS SUBTOTAL	\$27,299,003,270
DENTAL	\$2,124,717,840
MENTAL HEALTH	\$3,253,026,710
TWO PLAN MODEL	\$31,704,597,220
COUNTY ORGANIZED HEALTH SYSTEMS	\$12,418,824,240
GEOGRAPHIC MANAGED CARE	\$5,581,318,640
PHP & OTHER MANAG. CARE	\$1,303,565,670
MEDICARE PAYMENTS	\$7,156,932,240
STATE HOSP./DEVELOPMENTAL CNTRS.	\$29,282,410
MISC. SERVICES	\$522,703,930
DRUG MEDI-CAL	\$797,358,670
REGIONAL MODEL	\$1,624,982,220
NON-FFS SUBTOTAL	\$66,517,309,790
TOTAL DOLLARS (1)	\$93,816,313,070
ELIGIBLES ***	15,228,200
ANNUAL \$/ELIGIBLE	\$6,161
AVG. MO. \$/ELIGIBLE	\$513

(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 2022 ESTIMATE

EXCLUDED POLICY CHANGES: 124

	QAF WITHHOLD TRANSFER ADJUSTMENT
	QAF WITHHOLD ADJUSTMENT
	COVID-19 ELIGIBILITY BASE ADJUSTMENT
3	POSTPARTUM CARE EXTENSION
4	BREAST AND CERVICAL CANCER TREATMENT
8	MINIMUM WAGE INCREASE - CASELOAD SAVINGS
14	MEDICARE OPTIONAL EXPANSION ADJUSTMENT
15	CS3 PROXY ADJUSTMENT
16	COMMUNITY FIRST CHOICE OPTION
18	1% FMAP INCREASE FOR PREVENTIVE SERVICES
19	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.
20	ACA DSH REDUCTION
24	FAMILY PACT PROGRAM
28	CALIFORNIA COMMUNITY TRANSITIONS COSTS
33	FPACT HPV VACCINE COVERAGE
35	MEDICAL INTERPRETERS PILOT PROJECT
36	MEDICALLY TAILORED MEALS PILOT PROGRAM
47	LITIGATION SETTLEMENTS
49	FAMILY PACT DRUG REBATES
50	PHARMACY RETROACTIVE ADJUSTMENTS
59	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
60	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE
63	CALAIM - BH QUALITY IMPROVEMENT PROGRAM
65	MHP STRTP GRANTS
68	SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS
69	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT
70	CHART REVIEW
71	INTERIM AND FINAL COST SETTLEMENTS - SMHS
72	GLOBAL PAYMENT PROGRAM
73	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES
75	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG
83	2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.
89	CYBHI - STUDENT BH INCENTIVE PROGRAM
90	DENTAL MANAGED CARE (Other M/C)

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

EXCLUDED POLICY CHANGES: 124

92	RECONCILIATION OF MCO TAX FUND 3156
95	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
98	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM
99	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL
102	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND
103	2020 MCO ENROLLMENT TAX MANAGED CARE PLANS
104	2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ
108	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF
123	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
127	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS
128	HOSPITAL QAF - FFS PAYMENTS
130	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS
131	PRIVATE HOSPITAL DSH REPLACEMENT
132	DSH PAYMENT
133	PROP 56 - MEDI-CAL FAMILY PLANNING
134	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
135	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
137	FFP FOR LOCAL TRAUMA CENTERS
138	DPH PHYSICIAN & NON-PHYS. COST
139	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS
140	CAPITAL PROJECT DEBT REIMBURSEMENT
141	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS
142	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS
143	GEMT SUPPLEMENTAL PAYMENT PROGRAM
144	NDPH IGT SUPPLEMENTAL PAYMENTS
145	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
146	PROP 56 - VALUE-BASED PAYMENT PROGRAM
147	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
148	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
149	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
150	EMERGENCY MEDICAL AIR TRANSPORTATION ACT
151	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS
152	NDPH SUPPLEMENTAL PAYMENT
153	FREE CLINICS AUGMENTATION

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

EXCLUDED POLICY CHANGES: 124

154	HOSPITAL QAF - MANAGED CARE PAYMENTS
155	PROPOSITION 56 FUNDING
156	IGT ADMIN. & PROCESSING FEE
160	COVID-19 VACCINATION INCENTIVE PROGRAM
163	COVID-19 ELIGIBILITY
169	STATE ONLY CLAIMING ADJUSTMENTS
170	STATE ONLY CLAIMING ADJUSTMENTS - SMHS and DMC
171	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS
172	HCBS SP - IHSS HCBS CARE ECONOMY PMTS
173	ELECTRONIC VISIT VERIFICATION FED PENALTIES
175	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)
176	PERSONAL CARE SERVICES (Misc. Svcs.)
179	HOSPITAL & SNF COVID-19 WORKER RETENTION PAYMENTS
181	BEHAVIORAL HEALTH BRIDGE HOUSING
182	CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY
183	CYBHI - EVIDENCE-BASED BH PRACTICES
184	CCI IHSS RECONCILIATION
185	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)
187	EQUITY & PRACTICE TRANSFORMATION PAYMENTS
188	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER
189	CYBHI - URGENT NEEDS AND EMERGENT ISSUES
190	LAWSUITS/CLAIMS
191	LA COUNTY JUSTICE-INVOLVED POP. SVCS & SUPPORTS
192	CALHOPE
195	CLINIC WORKFORCE STABILIZATION RETENTION PROGRAM
198	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS
199	MHSF - PROVIDER ACES TRAININGS
200	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG
202	EVIDENCE-BASED DENTAL PRACTICES
203	HCBS SP - CALBRIDGE BH NAVIGATOR PROGRAM
206	WATSONVILLE COMMUNITY HOSPITAL ACQUISITION
207	HCBS SP - ASSISTED LIVING WAIVER EXPANSION
208	CYBHI - CALHOPE STUDENT SUPPORT
209	MINIMUM WAGE INCREASE FOR HCBS WAIVERS

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

EXCLUDED POLICY CHANGES: 124

210	LOS ANGELES COUNTY REPRODUCTIVE HEALTH PILOT
211	MEDI-CAL TCM PROGRAM
213	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS
214	PACE INFRASTRUCTURE FUNDING
215	ALAMEDA COUNTY SUPPORTIVE HOUSING
216	BACKFILL LOST TITLE X FAMILY PLANNING FUNDING
217	HCBS SP - NON-IHSS CARE ECONOMY PMTS
219	INFRASTRUCTURE PYMT FOR CLINIC ABORTION PROVIDERS
220	PROP 56 - PROVIDER ACES TRAININGS
221	CALAIM - DENTAL INITIATIVES
222	QAF WITHHOLD TRANSFER
223	FOSTER YOUTH SUBSTANCE USE DISORDER GRANT PROGRAM
224	CLPP FUND
227	HCBS SP - ETSB FOR LAGUNA HONDA HOSPITAL RESIDENTS
229	URBAN INDIAN ORGANIZATIONS FUNDING SHIFT
230	AMERICAN RESCUE PLAN INCREASED FMAP FOR HCBS
232	CIGARETTE AND TOBACCO SURTAX FUNDS
235	HOSPITAL QAF - CHILDREN'S HEALTH CARE
237	CMS DEFERRED CLAIMS
238	DENTAL MANAGED CARE MLR RISK CORRIDOR
239	COUNTY SHARE OF OTLICP-CCS COSTS
240	BASE RECOVERIES
249	COUNTY BH RECOUPMENTS
251	CALAIM- DESIGNATED STATE HEALTH PROGRAMS
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MEDI-CAL PROGRAM ESTIMATE SUMMARY FISCAL YEAR 2023-24

	<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	\$29,040,596,550	\$14,520,298,270	\$14,520,298,270	\$0
B. B/Y BASE POLICY CHANGES	\$61,266,916,000	\$37,824,939,600	\$22,297,228,400	\$1,144,748,000
C. BASE ADJUSTMENTS	(\$459,590,000)	(\$251,678,500)	(\$207,911,500)	\$0
D. ADJUSTED BASE	\$89,847,922,550	\$52,093,559,380	\$36,609,615,170	\$1,144,748,000
II. REGULAR POLICY CHANGES				
A. ELIGIBILITY	\$1,340,316,590	(\$778,097,010)	\$2,114,921,590	\$3,492,000
B. AFFORDABLE CARE ACT	\$6,582,901,000	\$7,002,337,600	(\$164,465,600)	(\$254,971,000)
C. BENEFITS	\$1,561,804,160	\$1,247,955,550	\$313,848,610	\$0
D. PHARMACY	(\$4,096,322,410)	(\$4,054,304,810)	(\$1,895,841,600)	\$1,853,824,000
E. DRUG MEDI-CAL	\$28,149,000	\$21,801,100	(\$175,100)	\$6,523,000
F. MENTAL HEALTH	(\$116,500,000)	(\$166,206,650)	\$39,601,650	\$10,105,000
G. WAIVER--MH/UCD & BTR	\$4,654,743,000	\$2,657,120,750	\$597,350,250	\$1,400,272,000
H. MANAGED CARE	\$13,313,279,000	\$8,838,965,000	\$1,708,853,000	\$2,765,461,000
I. PROVIDER RATES	\$2,223,017,530	\$1,859,309,590	(\$329,651,100)	\$693,359,040
J. SUPPLEMENTAL PMNTS.	\$14,846,181,600	\$9,748,146,410	\$388,537,690	\$4,709,497,500
K. COVID-19	(\$965,245,840)	(\$513,681,570)	(\$405,170,270)	(\$46,394,000)
L. STATE ONLY CLAIMING	\$130,576,000	(\$3,204,253,000)	\$3,334,829,000	\$0
M. OTHER DEPARTMENTS	\$633,783,000	\$633,783,000	\$0	\$0
N. OTHER	\$2,263,394,690	\$5,393,279,810	(\$5,174,006,120)	\$2,044,121,000
O. TOTAL CHANGES	\$42,400,077,310	\$28,686,155,770	\$528,632,000	\$13,185,289,540
III. TOTAL MEDI-CAL ESTIMATE	\$132,247,999,860	\$80,779,715,150	\$37,138,247,180	\$14,330,037,540

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2023-24

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>ELIGIBILITY</u>					
1	MEDI-CAL STATE INMATE PROGRAMS	\$48,278,000	\$48,278,000	\$0	\$0
2	PHASING IN THE MEDI-CAL ASSET LIMIT REPEAL	\$99,099,590	\$49,549,790	\$49,549,790	\$0
3	POSTPARTUM CARE EXTENSION	\$207,820,000	\$104,218,500	\$102,094,500	\$1,507,000
4	BREAST AND CERVICAL CANCER TREATMENT	\$26,079,000	\$15,998,050	\$10,080,950	\$0
5	CALAIM - INMATE PRE-RELEASE PROGRAM	\$109,713,000	\$70,646,000	\$39,067,000	\$0
6	ACCELERATED ENROLLMENT FOR ADULTS	\$5,296,000	\$2,648,000	\$2,648,000	\$0
7	UNDOCUMENTED EXPANSION AGES 26 THROUGH 49	\$844,031,000	\$209,247,000	\$634,784,000	\$0
8	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	\$0	\$0	\$0	\$0
9	REFUGEE MEDICAL ASSISTANCE	\$0	\$0	(\$400,000)	\$400,000
10	NON-OTLICIP CHIP	\$0	\$88,065,900	(\$88,065,900)	\$0
11	NON-EMERGENCY FUNDING ADJUSTMENT	\$0	(\$1,488,216,950)	\$1,488,216,950	\$0
12	SCHIP FUNDING FOR PRENATAL CARE	\$0	\$70,252,000	(\$70,252,000)	\$0
13	MEDI-CAL COUNTY INMATE REIMBURSEMENT	\$0	\$0	(\$1,585,000)	\$1,585,000
15	CS3 PROXY ADJUSTMENT	\$0	\$51,216,700	(\$51,216,700)	\$0
	ELIGIBILITY SUBTOTAL	\$1,340,316,590	(\$778,097,010)	\$2,114,921,590	\$3,492,000
<u>AFFORDABLE CARE ACT</u>					
16	COMMUNITY FIRST CHOICE OPTION	\$7,413,067,000	\$7,413,067,000	\$0	\$0
17	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	\$14,208,000	\$14,208,000	\$0	\$0
18	1% FMAP INCREASE FOR PREVENTIVE SERVICES	\$0	\$4,276,000	(\$4,276,000)	\$0
19	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	\$0	\$35,861,600	(\$35,861,600)	\$0
20	ACA DSH REDUCTION	(\$844,374,000)	(\$465,075,000)	(\$124,328,000)	(\$254,971,000)
	AFFORDABLE CARE ACT SUBTOTAL	\$6,582,901,000	\$7,002,337,600	(\$164,465,600)	(\$254,971,000)
<u>BENEFITS</u>					
22	BEHAVIORAL HEALTH TREATMENT	\$16,347,000	\$8,594,050	\$7,752,950	\$0
23	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	\$615,147,000	\$615,147,000	\$0	\$0
24	FAMILY PACT PROGRAM	\$393,078,000	\$298,898,900	\$94,179,100	\$0
25	CALAIM - LTC BENEFIT TRANSITION	\$48,952,000	\$25,361,650	\$23,590,350	\$0
26	TELEHEALTH	\$96,890,470	\$62,732,730	\$34,157,750	\$0
27	MULTIPURPOSE SENIOR SERVICES PROGRAM	\$63,951,000	\$31,975,500	\$31,975,500	\$0
28	CALIFORNIA COMMUNITY TRANSITIONS COSTS	\$66,077,000	\$51,579,000	\$14,498,000	\$0
29	CYBHI - DYADIC SERVICES	\$136,192,490	\$81,618,250	\$54,574,250	\$0
30	REMOTE PATIENT MONITORING	\$32,037,000	\$20,144,500	\$11,892,500	\$0

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

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2023-24

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>BENEFITS</u>					
31	COMMUNITY HEALTH WORKER	\$59,211,000	\$33,800,350	\$25,410,650	\$0
32	CALAIM - ORGAN TRANSPLANT	\$13,665,000	\$9,149,100	\$4,515,900	\$0
33	FPACT HPV VACCINE COVERAGE	\$8,040,000	\$3,459,500	\$4,580,500	\$0
34	CCS DEMONSTRATION PROJECT	\$2,430,000	\$1,261,950	\$1,168,050	\$0
35	MEDICAL INTERPRETERS PILOT PROJECT	\$1,466,000	\$0	\$1,466,000	\$0
37	DOULA BENEFIT	\$3,630,910	\$2,222,930	\$1,407,980	\$0
38	EXPANSION TO SCREENING FOR ADDITIONAL SUBSTANCES	\$1,035,000	\$649,900	\$385,100	\$0
39	DIABETES PREVENTION PROGRAM	\$999,100	\$629,330	\$369,770	\$0
40	ROUTINE COSTS FOR CLINICAL TRIALS	\$737,000	\$449,600	\$287,400	\$0
41	HEARING AID COVERAGE FOR CHILDREN PROGRAM	\$1,511,730	\$0	\$1,511,730	\$0
42	CCT FUND TRANSFER TO CDSS	\$278,000	\$278,000	\$0	\$0
43	ANNUAL COGNITIVE ASSESSMENTS	\$128,450	\$3,310	\$125,150	\$0
	BENEFITS SUBTOTAL	\$1,561,804,160	\$1,247,955,540	\$313,848,610	\$0
<u>PHARMACY</u>					
44	CONTINUOUS GLUCOSE MONITORING SYSTEMS BENEFIT	\$14,997,000	\$9,413,700	\$5,583,300	\$0
45	MEDICATION THERAPY MANAGEMENT PROGRAM	\$23,204,590	\$15,370,990	\$7,833,600	\$0
46	MEDI-CAL DRUG REBATE FUND	\$0	\$0	(\$1,521,210,000)	\$1,521,210,000
48	BCCTP DRUG REBATES	(\$4,170,000)	(\$4,170,000)	\$0	\$0
49	FAMILY PACT DRUG REBATES	(\$7,543,000)	(\$7,543,000)	\$0	\$0
50	PHARMACY RETROACTIVE ADJUSTMENTS	(\$10,934,000)	\$0	(\$10,934,000)	\$0
51	STATE SUPPLEMENTAL DRUG REBATES	(\$64,440,000)	(\$64,440,000)	\$0	\$0
52	MEDICAL SUPPLY REBATES	(\$89,001,000)	(\$44,500,500)	(\$44,500,500)	\$0
53	MEDI-CAL RX- ADDITIONAL SUPPLEMENTAL REBATES	(\$666,855,000)	(\$666,855,000)	(\$332,614,000)	\$332,614,000
54	FEDERAL DRUG REBATES	(\$3,291,581,000)	(\$3,291,581,000)	\$0	\$0
	PHARMACY SUBTOTAL	(\$4,096,322,410)	(\$4,054,304,810)	(\$1,895,841,600)	\$1,853,824,000
<u>DRUG MEDI-CAL</u>					
56	HCBS SP - CONTINGENCY MANAGEMENT	\$27,958,000	\$21,510,000	\$0	\$6,448,000
58	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	\$1,145,000	\$991,100	\$78,900	\$75,000
59	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	(\$954,000)	(\$700,000)	(\$254,000)	\$0
	DRUG MEDI-CAL SUBTOTAL	\$28,149,000	\$21,801,100	(\$175,100)	\$6,523,000
<u>MENTAL HEALTH</u>					
63	CALAIM - BH QUALITY IMPROVEMENT PROGRAM	\$19,456,000	\$0	\$19,456,000	\$0
64	MHP COSTS FOR FFPSA	\$52,259,000	\$29,712,000	\$13,813,000	\$8,734,000

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

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2023-24

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>MENTAL HEALTH</u>					
66	MHP COSTS FOR CONTINUUM OF CARE REFORM	\$4,311,000	\$1,279,350	\$3,031,650	\$0
67	OUT OF STATE YOUTH - SMHS	\$2,112,000	\$1,056,000	\$1,056,000	\$0
68	SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS	\$0	(\$2,201,000)	\$2,201,000	\$0
69	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	\$0	\$0	(\$200,000)	\$200,000
70	CHART REVIEW	(\$25,000)	(\$25,000)	\$0	\$0
71	INTERIM AND FINAL COST SETTLEMENTS - SMHS	(\$198,708,000)	(\$198,815,000)	\$107,000	\$0
243	CALIFORNIA BEHAVIORAL HEALTH CBC DEMONSTRATION	\$4,095,000	\$2,787,000	\$137,000	\$1,171,000
	MENTAL HEALTH SUBTOTAL	(\$116,500,000)	(\$166,206,650)	\$39,601,650	\$10,105,000
<u>WAIVER--MH/UCD & BTR</u>					
72	GLOBAL PAYMENT PROGRAM	\$2,800,544,000	\$1,400,272,000	\$0	\$1,400,272,000
73	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES	\$1,829,376,000	\$1,080,553,750	\$748,822,250	\$0
74	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	\$1,500,000	\$0	\$1,500,000	\$0
75	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	\$613,000	\$613,000	\$0	\$0
251	CALAIM- DESIGNATED STATE HEALTH PROGRAMS	\$22,710,000	\$175,682,000	(\$152,972,000)	\$0
	WAIVER--MH/UCD & BTR SUBTOTAL	\$4,654,743,000	\$2,657,120,750	\$597,350,250	\$1,400,272,000
<u>MANAGED CARE</u>					
79	CCI-MANAGED CARE PAYMENTS	\$402,758,000	\$201,379,000	\$201,379,000	\$0
80	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	\$2,058,008,000	\$1,535,153,400	\$522,854,600	\$0
81	MANAGED CARE HEALTH CARE FINANCING PROGRAM	\$1,864,564,000	\$1,252,922,950	\$611,641,050	\$0
82	MANAGED CARE PUBLIC HOSPITAL EPP	\$1,853,760,000	\$1,428,899,150	\$424,860,850	\$0
86	HCBS SP - HOUSING AND HOMELESSNESS INCENTIVE PROG	\$644,000,000	\$341,964,000	\$0	\$302,036,000
87	RETRO MC RATE ADJUSTMENTS	\$704,333,000	\$369,240,950	\$335,092,050	\$0
88	CALAIM - TRANSITIONING POPULATIONS	\$25,981,000	\$15,587,250	\$10,393,750	\$0
89	CYBHI - STUDENT BH INCENTIVE PROGRAM	\$85,285,000	\$42,642,500	\$42,642,500	\$0
91	WORKFORCE & QUALITY INCENTIVE PROGRAM	\$287,114,000	\$151,021,800	\$136,092,200	\$0
96	CCI-QUALITY WITHHOLD REPAYMENTS	\$16,091,000	\$8,045,500	\$8,045,500	\$0
101	CAPITATED RATE ADJUSTMENT FOR FY 2023-24	\$4,077,898,000	\$2,666,535,800	\$1,411,362,200	\$0
102	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	\$0	\$0	(\$1,678,975,000)	\$1,678,975,000
252	2024 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	\$0	\$0	(\$467,914,000)	\$467,914,000
253	2024 MCO ENROLLMENT TAX MANAGED CARE PLANS	\$0	\$0	(\$316,536,000)	\$316,536,000

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

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2023-24

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>MANAGED CARE</u>					
254	2024 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	\$1,293,487,000	\$825,572,700	\$467,914,300	\$0
	MANAGED CARE SUBTOTAL	\$13,313,279,000	\$8,838,965,000	\$1,708,853,000	\$2,765,461,000
<u>PROVIDER RATES</u>					
106	NURSING FACILITY RATE ADJUSTMENTS	\$784,603,000	\$412,700,700	\$371,902,300	\$0
107	RATE INCREASE FOR FQHCS/RHCS/CBRCS	\$323,283,230	\$203,949,920	\$119,333,310	\$0
108	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	\$176,662,760	\$120,314,020	(\$6,260,760)	\$62,609,510
109	PP-GEMT IGT PROGRAM	\$338,602,290	\$220,283,170	(\$11,118,410)	\$129,437,530
110	FQHC/RHC/CBRC RECONCILIATION PROCESS	\$115,009,000	\$72,555,850	\$42,453,150	\$0
111	DPH INTERIM RATE GROWTH	\$144,289,600	\$93,306,110	\$50,983,500	\$0
113	LTC RATE ADJUSTMENT	\$119,088,080	\$60,973,980	\$58,114,100	\$0
114	AB 1629 ANNUAL RATE ADJUSTMENTS	\$0	\$0	\$0	\$0
115	AB 97 ELIMINATIONS	\$28,407,000	\$17,384,600	\$11,022,400	\$0
116	ACUPUNCTURE RATE INCREASE	\$26,724,000	\$18,634,800	\$8,089,200	\$0
117	LABORATORY RATE METHODOLOGY CHANGE	(\$11,713,600)	(\$6,732,240)	(\$4,981,350)	\$0
118	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	\$5,687,000	\$3,442,550	\$2,244,450	\$0
119	HOSPICE RATE INCREASES	(\$10,456,780)	(\$5,481,700)	(\$4,975,070)	\$0
120	GDSP PRENATAL SCREENING PROGRAM FEE INCREASE	(\$2,713,280)	(\$1,629,820)	(\$1,083,470)	\$0
121	DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT	(\$1,494,300)	(\$807,930)	(\$686,370)	\$0
122	DPH INTERIM RATE	\$0	\$457,809,700	(\$457,809,700)	\$0
123	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	\$0	\$0	(\$501,312,000)	\$501,312,000
124	10% PROVIDER PAYMENT REDUCTION	(\$513,570)	(\$332,130)	(\$181,440)	\$0
125	REDUCTION TO RADIOLOGY RATES	(\$12,230,900)	(\$6,845,980)	(\$5,384,920)	\$0
126	DPH INTERIM & FINAL RECONS	\$199,784,000	\$199,784,000	\$0	\$0
	PROVIDER RATES SUBTOTAL	\$2,223,017,530	\$1,859,309,590	(\$329,651,100)	\$693,359,040
<u>SUPPLEMENTAL PMNTS.</u>					
127	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	\$3,617,930,000	\$2,510,039,000	\$0	\$1,107,891,000
128	HOSPITAL QAF - FFS PAYMENTS	\$2,938,988,000	\$1,710,581,000	\$0	\$1,228,407,000
129	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	\$1,225,011,770	\$743,707,440	\$481,304,330	\$0
130	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	\$590,330,000	\$333,900,000	\$0	\$256,430,000
131	PRIVATE HOSPITAL DSH REPLACEMENT	\$663,770,000	\$331,885,000	\$331,885,000	\$0
132	DSH PAYMENT	\$463,471,000	\$334,788,000	\$27,000,000	\$101,683,000
133	PROP 56 - MEDI-CAL FAMILY PLANNING	\$440,957,130	\$367,604,740	\$73,352,390	\$0

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SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2023-24

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>SUPPLEMENTAL PMNTS.</u>					
134	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	\$307,494,000	\$163,769,000	\$118,400,000	\$25,325,000
135	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	\$222,736,000	\$222,736,000	\$0	\$0
136	NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS	\$105,000,000	\$52,500,000	\$52,500,000	\$0
137	FFP FOR LOCAL TRAUMA CENTERS	\$173,056,000	\$101,419,000	\$0	\$71,637,000
138	DPH PHYSICIAN & NON-PHYS. COST	\$99,696,000	\$99,696,000	\$0	\$0
139	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	\$119,181,000	\$68,842,000	\$742,000	\$49,597,000
140	CAPITAL PROJECT DEBT REIMBURSEMENT	\$79,338,000	\$55,736,000	\$23,602,000	\$0
141	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	\$52,822,000	\$52,822,000	\$0	\$0
142	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	\$58,878,420	\$35,951,510	\$22,926,920	\$0
143	GEMT SUPPLEMENTAL PAYMENT PROGRAM	\$3,480,000	\$3,480,000	\$0	\$0
144	NDPH IGT SUPPLEMENTAL PAYMENTS	\$41,636,000	\$23,053,500	(\$1,161,000)	\$19,743,500
147	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	\$15,270,000	\$15,270,000	\$0	\$0
148	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	\$10,000,000	\$5,000,000	\$5,000,000	\$0
149	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	\$8,000,000	\$4,000,000	\$4,000,000	\$0
150	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	\$2,380,000	\$1,304,000	\$0	\$1,076,000
151	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	\$5,716,270	\$3,943,220	\$1,773,050	\$0
152	NDPH SUPPLEMENTAL PAYMENT	\$4,240,000	\$2,340,000	\$1,900,000	\$0
153	FREE CLINICS AUGMENTATION	\$2,000,000	\$0	\$2,000,000	\$0
154	HOSPITAL QAF - MANAGED CARE PAYMENTS	\$3,594,800,000	\$2,503,779,000	\$0	\$1,091,021,000
155	PROPOSITION 56 FUNDING	\$0	\$0	(\$744,303,000)	\$744,303,000
156	IGT ADMIN. & PROCESSING FEE	\$0	\$0	(\$12,384,000)	\$12,384,000
	SUPPLEMENTAL PMNTS. SUBTOTAL	\$14,846,181,600	\$9,748,146,410	\$388,537,690	\$4,709,497,500
<u>COVID-19</u>					
157	COVID-19 CASELOAD IMPACT	\$12,068,721,000	\$8,568,473,100	\$3,500,247,900	\$0
159	COVID-19 BEHAVIORAL HEALTH	\$63,080,000	\$58,293,750	\$4,786,250	\$0
161	PHARMACY-BASED COVID-19 TESTS	\$29,328,160	\$19,427,530	\$9,900,630	\$0
163	COVID-19 ELIGIBILITY	\$0	\$0	\$0	\$0
164	COVID-19 VACCINE ADMINISTRATION	(\$40,800,000)	(\$38,045,550)	(\$2,754,450)	\$0
165	CONTINUOUS CHIP COVERAGE DURING THE COVID-19 PHE	\$0	(\$29,101,000)	\$29,101,000	\$0
166	COVID-19 LTC REIMBURSEMENT RATES	(\$38,662,000)	(\$19,804,000)	(\$18,858,000)	\$0
167	COVID-19 INCREASED FMAP - DHCS	(\$35,117,000)	\$243,494,000	(\$232,217,000)	(\$46,394,000)
168	COVID-19 CASELOAD IMPACT BASE ADJUSTMENT	(\$13,011,796,000)	(\$9,316,419,400)	(\$3,695,376,600)	\$0

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

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2023-24

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	COVID-19 SUBTOTAL	(\$965,245,840)	(\$513,681,570)	(\$405,170,270)	(\$46,394,000)
	STATE ONLY CLAIMING				
169	STATE ONLY CLAIMING ADJUSTMENTS	\$130,576,000	(\$3,179,552,000)	\$3,310,128,000	\$0
170	STATE ONLY CLAIMING ADJUSTMENTS - SMHS and DMC	\$0	(\$24,701,000)	\$24,701,000	\$0
	STATE ONLY CLAIMING SUBTOTAL	\$130,576,000	(\$3,204,253,000)	\$3,334,829,000	\$0
	OTHER DEPARTMENTS				
171	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	\$633,783,000	\$633,783,000	\$0	\$0
	OTHER DEPARTMENTS SUBTOTAL	\$633,783,000	\$633,783,000	\$0	\$0
	OTHER				
181	BEHAVIORAL HEALTH BRIDGE HOUSING	\$300,000,000	\$0	\$300,000,000	\$0
182	CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY	\$100,000,000	\$0	\$100,000,000	\$0
186	HCBS SP CDDS	\$199,018,000	\$199,018,000	\$0	\$0
187	EQUITY & PRACTICE TRANSFORMATION PAYMENTS	\$215,000,000	\$107,500,000	\$107,500,000	\$0
188	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER	\$254,314,000	\$127,157,000	\$127,157,000	\$0
189	CYBHI - URGENT NEEDS AND EMERGENT ISSUES	\$26,000,000	\$0	\$26,000,000	\$0
192	CALHOPE	\$44,577,000	\$0	\$40,000,000	\$4,577,000
193	CARE COURT	\$16,496,000	\$0	\$16,496,000	\$0
194	QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES	\$252,590,000	\$214,701,000	\$37,889,000	\$0
196	INDIAN HEALTH SERVICES	\$55,056,000	\$36,704,000	\$18,352,000	\$0
198	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	\$58,033,000	\$58,033,000	\$0	\$0
199	MHSF - PROVIDER ACES TRAININGS	\$45,500,000	\$22,750,000	\$0	\$22,750,000
200	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG	\$52,466,000	\$0	\$0	\$52,466,000
201	SELF-DETERMINATION PROGRAM - CDDS	\$140,689,000	\$140,689,000	\$0	\$0
202	EVIDENCE-BASED DENTAL PRACTICES	\$33,421,000	\$23,072,750	\$10,348,250	\$0
203	HCBS SP - CALBRIDGE BH NAVIGATOR PROGRAM	\$1,296,000	\$0	\$0	\$1,296,000
205	INFANT DEVELOPMENT PROGRAM	\$21,900,000	\$21,900,000	\$0	\$0
207	HCBS SP - ASSISTED LIVING WAIVER EXPANSION	\$22,907,000	\$11,453,000	(\$12,003,000)	\$23,457,000
208	CYBHI - CALHOPE STUDENT SUPPORT	\$24,000,000	\$0	\$24,000,000	\$0
209	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	\$39,401,560	\$19,700,780	\$19,700,780	\$0
212	PEER SUPPORT SPECIALIST SERVICES	\$25,417,000	\$18,630,000	\$0	\$6,787,000
213	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	\$7,786,000	\$4,225,000	\$3,561,000	\$0
219	INFRASTRUCTURE PYMT FOR CLINIC ABORTION PROVIDERS	\$22,282,000	\$0	\$22,282,000	\$0
221	CALAIM - DENTAL INITIATIVES	\$7,753,130	\$4,030,830	\$3,722,300	\$0
222	QAF WITHHOLD TRANSFER	\$2,238,000	\$1,119,000	\$1,119,000	\$0

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

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2023-24

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
OTHER					
223	FOSTER YOUTH SUBSTANCE USE DISORDER GRANT PROGRAM	\$3,500,000	\$0	\$3,500,000	\$0
224	CLPP FUND	\$902,000	\$0	\$0	\$902,000
225	WPCS WORKERS' COMPENSATION	\$620,000	\$310,000	\$310,000	\$0
228	CALAIM - BH PAYMENT REFORM	\$375,000,000	\$0	\$375,000,000	\$0
229	URBAN INDIAN ORGANIZATIONS FUNDING SHIFT	\$0	\$8,064,000	(\$8,064,000)	\$0
231	IMD ANCILLARY SERVICES	\$0	(\$44,564,000)	\$44,564,000	\$0
232	CIGARETTE AND TOBACCO SURTAX FUNDS	\$0	\$0	(\$125,790,000)	\$125,790,000
233	FUNDING ADJUST.—ACA OPT. EXPANSION	\$0	\$4,020,145,200	(\$4,020,145,200)	\$0
234	FUNDING ADJUST.—OTLICP	\$0	\$114,884,250	(\$114,884,250)	\$0
235	HOSPITAL QAF - CHILDREN'S HEALTH CARE	\$0	\$0	(\$1,806,096,000)	\$1,806,096,000
236	INDIAN HEALTH SERVICES FUNDING SHIFT	\$0	\$15,846,000	(\$15,846,000)	\$0
237	CMS DEFERRED CLAIMS	\$0	\$267,911,000	(\$267,911,000)	\$0
239	COUNTY SHARE OF OTLICP-CCS COSTS	(\$21,300,000)	\$0	(\$21,300,000)	\$0
249	COUNTY BH RECOUPMENTS	(\$63,468,000)	\$0	(\$63,468,000)	\$0
OTHER SUBTOTAL		\$2,263,394,690	\$5,393,279,810	(\$5,174,006,120)	\$2,044,121,000
GRAND TOTAL		\$42,400,077,320	\$28,686,155,770	\$528,632,010	\$13,185,289,540

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

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY FISCAL YEAR 2023-24

SERVICE CATEGORY	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
PROFESSIONAL	\$8,341,736,700	\$4,999,709,440	\$2,394,895,880	\$947,131,370
PHYSICIANS	\$925,665,410	\$555,322,490	\$291,329,760	\$79,013,160
OTHER MEDICAL	\$5,432,033,590	\$3,217,531,620	\$1,989,900,390	\$224,601,580
CO. & COMM. OUTPATIENT	\$1,984,037,700	\$1,226,855,320	\$113,665,740	\$643,516,630
PHARMACY	\$12,203,153,630	\$7,450,338,900	\$2,435,749,980	\$2,317,064,750
HOSPITAL INPATIENT	\$11,056,559,690	\$7,105,681,500	\$1,398,377,100	\$2,552,501,100
COUNTY INPATIENT	\$3,840,690,500	\$2,486,584,390	(\$49,175,300)	\$1,403,281,410
COMMUNITY INPATIENT	\$7,215,869,200	\$4,619,097,110	\$1,447,552,400	\$1,149,219,690
LONG TERM CARE	\$969,955,340	\$534,279,550	\$317,081,340	\$118,594,440
NURSING FACILITIES	\$515,386,610	\$304,458,100	\$115,074,050	\$95,854,460
ICF-DD	\$454,568,720	\$229,821,450	\$202,007,290	\$22,739,980
OTHER SERVICES	\$2,262,612,550	\$1,482,448,270	\$710,355,930	\$69,808,350
MEDICAL TRANSPORTATION	\$128,621,850	\$81,589,680	\$30,685,420	\$16,346,750
OTHER SERVICES	\$1,887,295,080	\$1,275,597,720	\$562,486,580	\$49,210,790
HOME HEALTH	\$246,695,620	\$125,260,880	\$117,183,930	\$4,250,810
TOTAL FEE-FOR-SERVICE	\$34,834,017,910	\$21,572,457,660	\$7,256,460,230	\$6,005,100,010
MANAGED CARE	\$67,526,429,000	\$37,593,108,520	\$23,129,681,920	\$6,803,638,560
TWO PLAN MODEL	\$40,486,614,520	\$22,343,910,190	\$14,082,226,360	\$4,060,477,970
COUNTY ORGANIZED HEALTH SYSTEMS	\$15,857,728,440	\$9,288,974,240	\$4,901,769,640	\$1,666,984,570
GEOGRAPHIC MANAGED CARE	\$7,257,462,950	\$3,760,374,880	\$2,721,075,670	\$776,012,400
PHP & OTHER MANAG. CARE	\$1,774,442,740	\$924,170,690	\$817,220,670	\$33,051,390
REGIONAL MODEL	\$2,150,180,340	\$1,275,678,520	\$607,389,590	\$267,112,230
DENTAL	\$2,012,375,350	\$1,176,003,000	\$714,721,820	\$121,650,520
MENTAL HEALTH	\$4,281,975,220	\$2,689,308,550	\$347,925,190	\$1,244,741,470
AUDITS/ LAWSUITS	\$1,350,000	\$268,586,000	(\$267,236,000)	\$0
EPSDT SCREENS	\$0	\$0	\$0	\$0
MEDICARE PAYMENTS	\$7,555,184,130	\$1,904,358,420	\$5,657,502,960	(\$6,677,250)
STATE HOSP./DEVELOPMENTAL CNTRS.	\$27,340,730	\$27,486,960	(\$121,940)	(\$24,290)
MISC. SERVICES	\$15,538,451,380	\$15,119,239,650	\$322,183,380	\$97,028,350
RECOVERIES	(\$480,354,000)	(\$278,137,400)	(\$202,216,600)	\$0
DRUG MEDI-CAL	\$951,230,150	\$707,303,780	\$179,346,210	\$64,580,160
GRAND TOTAL MEDI-CAL	\$132,247,999,860	\$80,779,715,150	\$37,138,247,180	\$14,330,037,540

**MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2022-23 AND 2023-24**

<u>SERVICE CATEGORY</u>	<u>NOV. 2022 EST. FOR 2022-23</u>	<u>NOV. 2022 EST. FOR 2023-24</u>	<u>DOLLAR DIFFERENCE</u>	<u>% CHANGE</u>
PROFESSIONAL	\$8,392,599,170	\$8,341,736,700	(\$50,862,470)	-0.61%
PHYSICIANS	\$926,502,480	\$925,665,410	(\$837,070)	-0.09%
OTHER MEDICAL	\$5,495,866,720	\$5,432,033,590	(\$63,833,130)	-1.16%
CO. & COMM. OUTPATIENT	\$1,970,229,970	\$1,984,037,700	\$13,807,730	0.70%
PHARMACY	\$12,335,090,280	\$12,203,153,630	(\$131,936,650)	-1.07%
HOSPITAL INPATIENT	\$11,577,113,550	\$11,056,559,690	(\$520,553,850)	-4.50%
COUNTY INPATIENT	\$3,729,828,840	\$3,840,690,500	\$110,861,650	2.97%
COMMUNITY INPATIENT	\$7,847,284,700	\$7,215,869,200	(\$631,415,510)	-8.05%
LONG TERM CARE	\$2,472,824,210	\$969,955,340	(\$1,502,868,870)	-60.78%
NURSING FACILITIES	\$1,936,484,520	\$515,386,610	(\$1,421,097,910)	-73.39%
ICF-DD	\$536,339,690	\$454,568,720	(\$81,770,970)	-15.25%
OTHER SERVICES	\$2,081,223,190	\$2,262,612,550	\$181,389,360	8.72%
MEDICAL TRANSPORTATION	\$162,129,200	\$128,621,850	(\$33,507,350)	-20.67%
OTHER SERVICES	\$1,685,702,890	\$1,887,295,080	\$201,592,200	11.96%
HOME HEALTH	\$233,391,110	\$246,695,620	\$13,304,510	5.70%
TOTAL FEE-FOR-SERVICE	\$36,858,850,390	\$34,834,017,910	(\$2,024,832,490)	-5.49%
MANAGED CARE	\$60,167,298,260	\$67,526,429,000	\$7,359,130,740	12.23%
TWO PLAN MODEL	\$36,140,118,140	\$40,486,614,520	\$4,346,496,380	12.03%
COUNTY ORGANIZED HEALTH SYSTEMS	\$14,184,894,590	\$15,857,728,440	\$1,672,833,850	11.79%
GEOGRAPHIC MANAGED CARE	\$6,433,738,360	\$7,257,462,950	\$823,724,600	12.80%
PHP & OTHER MANAG. CARE	\$1,497,748,180	\$1,774,442,740	\$276,694,560	18.47%
REGIONAL MODEL	\$1,910,798,990	\$2,150,180,340	\$239,381,360	12.53%
DENTAL	\$1,932,613,150	\$2,012,375,350	\$79,762,200	4.13%
MENTAL HEALTH	\$3,051,288,710	\$4,281,975,220	\$1,230,686,510	40.33%
AUDITS/ LAWSUITS	\$114,985,000	\$1,350,000	(\$113,635,000)	-98.83%
MEDICARE PAYMENTS	\$7,156,932,240	\$7,555,184,130	\$398,251,890	5.56%
STATE HOSP./DEVELOPMENTAL CNTRS.	\$29,282,410	\$27,340,730	(\$1,941,670)	-6.63%
MISC. SERVICES	\$21,233,061,940	\$15,538,451,380	(\$5,694,610,560)	-26.82%
RECOVERIES	(\$536,727,000)	(\$480,354,000)	\$56,373,000	-10.50%
DRUG MEDI-CAL	\$794,527,770	\$951,230,150	\$156,702,380	19.72%
GRAND TOTAL MEDI-CAL	\$130,802,112,870	\$132,247,999,860	\$1,445,886,990	1.11%
GENERAL FUNDS	\$30,504,058,760	\$37,138,247,180	\$6,634,188,420	21.75%
OTHER STATE FUNDS	\$13,942,779,900	\$14,330,037,540	\$387,257,630	2.78%

**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2022-23 AND 2023-24**

NO.	POLICY CHANGE TITLE	NOV. 2022 EST. FOR 2022-23		NOV. 2022 EST. FOR 2023-24		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>ELIGIBILITY</u>							
1	MEDI-CAL STATE INMATE PROGRAMS	\$48,278,000	\$0	\$48,278,000	\$0	\$0	\$0
2	PHASING IN THE MEDI-CAL ASSET LIMIT REPEAL	\$47,574,000	\$23,787,000	\$99,338,000	\$49,669,000	\$51,764,000	\$25,882,000
3	POSTPARTUM CARE EXTENSION	\$0	\$0	\$207,820,000	\$102,094,500	\$207,820,000	\$102,094,500
4	BREAST AND CERVICAL CANCER TREATMENT	\$24,278,000	\$9,387,200	\$26,079,000	\$10,080,950	\$1,801,000	\$693,750
5	CALAIM - INMATE PRE-RELEASE PROGRAM	\$6,561,000	\$3,995,000	\$109,713,000	\$39,067,000	\$103,152,000	\$35,072,000
6	ACCELERATED ENROLLMENT FOR ADULTS	\$5,103,000	\$2,551,500	\$5,296,000	\$2,648,000	\$193,000	\$96,500
7	UNDOCUMENTED EXPANSION AGES 26 THROUGH 49	\$0	\$0	\$844,031,000	\$634,784,000	\$844,031,000	\$634,784,000
8	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	\$0	\$0	(\$114,694,000)	(\$38,300,700)	(\$114,694,000)	(\$38,300,700)
9	REFUGEE MEDICAL ASSISTANCE	\$0	(\$400,000)	\$0	(\$400,000)	\$0	\$0
10	NON-OTLICP CHIP	\$0	(\$88,732,500)	\$0	(\$88,065,900)	\$0	\$666,600
11	NON-EMERGENCY FUNDING ADJUSTMENT	\$0	\$1,466,740,250	\$0	\$1,488,216,950	\$0	\$21,476,700
12	SCHIP FUNDING FOR PRENATAL CARE	\$0	(\$74,163,400)	\$0	(\$70,252,000)	\$0	\$3,911,400
13	MEDI-CAL COUNTY INMATE REIMBURSEMENT	\$0	(\$1,479,000)	\$0	(\$1,585,000)	\$0	(\$106,000)
14	MEDICARE OPTIONAL EXPANSION ADJUSTMENT	\$0	\$2,303,600	\$0	\$0	\$0	(\$2,303,600)
15	CS3 PROXY ADJUSTMENT	\$0	(\$54,945,200)	\$0	(\$51,216,700)	\$0	\$3,728,500
	ELIGIBILITY SUBTOTAL	\$131,794,000	\$1,289,044,450	\$1,225,861,000	\$2,076,740,100	\$1,094,067,000	\$787,695,650
<u>AFFORDABLE CARE ACT</u>							
16	COMMUNITY FIRST CHOICE OPTION	\$7,669,784,000	\$0	\$7,413,067,000	\$0	(\$256,717,000)	\$0
17	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	\$14,427,000	\$0	\$14,208,000	\$0	(\$219,000)	\$0
18	1% FMAP INCREASE FOR PREVENTIVE SERVICES	\$0	(\$8,217,000)	\$0	(\$4,276,000)	\$0	\$3,941,000
19	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	\$0	(\$36,621,200)	\$0	(\$35,861,600)	\$0	\$759,600
20	ACA DSH REDUCTION	\$0	\$0	(\$844,374,000)	(\$124,328,000)	(\$844,374,000)	(\$124,328,000)

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 2022-23 AND 2023-24**

NO.	POLICY CHANGE TITLE	NOV. 2022 EST. FOR 2022-23		NOV. 2022 EST. FOR 2023-24		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>AFFORDABLE CARE ACT</u>							
21	ACA OPTIONAL EXPANSION MLR RISK CORRIDOR	(\$33,700,000)	(\$1,845,000)	\$0	\$0	\$33,700,000	\$1,845,000
	AFFORDABLE CARE ACT SUBTOTAL	\$7,650,511,000	(\$46,683,200)	\$6,582,901,000	(\$164,465,600)	(\$1,067,610,000)	(\$117,782,400)
<u>BENEFITS</u>							
22	BEHAVIORAL HEALTH TREATMENT	\$890,950,000	\$376,427,700	\$16,347,000	\$7,752,950	(\$874,603,000)	(\$368,674,750)
23	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	\$439,897,000	\$0	\$615,147,000	\$0	\$175,250,000	\$0
24	FAMILY PACT PROGRAM	\$367,441,000	\$88,036,600	\$393,078,000	\$94,179,100	\$25,637,000	\$6,142,500
25	CALAIM - LTC BENEFIT TRANSITION	\$201,000,000	\$96,863,950	\$48,952,000	\$23,590,350	(\$152,048,000)	(\$73,273,600)
26	TELEHEALTH	\$123,451,090	\$43,521,420	\$132,327,880	\$46,650,840	\$8,876,780	\$3,129,420
27	MULTIPURPOSE SENIOR SERVICES PROGRAM	\$63,951,000	\$29,001,500	\$63,951,000	\$31,975,500	\$0	\$2,974,000
28	CALIFORNIA COMMUNITY TRANSITIONS COSTS	\$47,022,000	\$9,169,000	\$66,077,000	\$14,498,000	\$19,055,000	\$5,329,000
29	CYBHI - DYADIC SERVICES	\$44,155,960	\$16,727,350	\$136,192,490	\$54,574,250	\$92,036,530	\$37,846,890
30	REMOTE PATIENT MONITORING	\$32,037,000	\$11,892,500	\$32,037,000	\$11,892,500	\$0	\$0
31	COMMUNITY HEALTH WORKER	\$23,331,950	\$9,198,620	\$59,211,000	\$25,410,650	\$35,879,050	\$16,212,030
32	CALAIM - ORGAN TRANSPLANT	\$9,430,000	\$3,534,600	\$13,665,000	\$4,515,900	\$4,235,000	\$981,300
33	FPACT HPV VACCINE COVERAGE	\$7,002,840	\$3,989,620	\$8,040,000	\$4,580,500	\$1,037,160	\$590,880
34	CCS DEMONSTRATION PROJECT	\$5,473,000	\$2,535,700	\$2,430,000	\$1,168,050	(\$3,043,000)	(\$1,367,650)
35	MEDICAL INTERPRETERS PILOT PROJECT	\$3,347,000	\$3,347,000	\$1,466,000	\$1,466,000	(\$1,881,000)	(\$1,881,000)
36	MEDICALLY TAILORED MEALS PILOT PROGRAM	\$2,737,000	\$2,737,000	\$0	\$0	(\$2,737,000)	(\$2,737,000)
37	DOULA BENEFIT	\$974,400	\$377,720	\$3,630,910	\$1,407,980	\$2,656,510	\$1,030,250
38	EXPANSION TO SCREENING FOR ADDITIONAL SUBSTANCES	\$1,035,000	\$385,100	\$1,035,000	\$385,100	\$0	\$0
39	DIABETES PREVENTION PROGRAM	\$759,910	\$281,300	\$999,100	\$369,770	\$239,190	\$88,460
40	ROUTINE COSTS FOR CLINICAL TRIALS	\$599,250	\$233,300	\$737,000	\$287,400	\$137,750	\$54,100

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 2022-23 AND 2023-24**

NO.	POLICY CHANGE TITLE	NOV. 2022 EST. FOR 2022-23		NOV. 2022 EST. FOR 2023-24		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>BENEFITS</u>							
41	HEARING AID COVERAGE FOR CHILDREN PROGRAM	\$461,300	\$461,300	\$1,511,730	\$1,511,730	\$1,050,430	\$1,050,430
42	CCT FUND TRANSFER TO CDSS	\$380,000	\$0	\$278,000	\$0	(\$102,000)	\$0
43	ANNUAL COGNITIVE ASSESSMENTS	\$72,470	\$70,390	\$128,450	\$125,150	\$55,980	\$54,760
	BENEFITS SUBTOTAL	\$2,265,509,170	\$698,791,670	\$1,597,241,560	\$326,341,710	(\$668,267,610)	(\$372,449,970)
<u>PHARMACY</u>							
44	CONTINUOUS GLUCOSE MONITORING SYSTEMS BENEFIT	\$9,936,510	\$3,699,200	\$14,997,000	\$5,583,300	\$5,060,490	\$1,884,100
45	MEDICATION THERAPY MANAGEMENT PROGRAM	\$5,136,260	\$1,733,890	\$23,204,590	\$7,833,600	\$18,068,320	\$6,099,710
46	MEDI-CAL DRUG REBATE FUND	\$0	(\$1,748,367,000)	\$0	(\$1,521,210,000)	\$0	\$227,157,000
47	LITIGATION SETTLEMENTS	(\$1,741,000)	(\$1,741,000)	\$0	\$0	\$1,741,000	\$1,741,000
48	BCCTP DRUG REBATES	(\$4,488,000)	\$0	(\$4,170,000)	\$0	\$318,000	\$0
49	FAMILY PACT DRUG REBATES	(\$4,990,000)	\$0	(\$7,543,000)	\$0	(\$2,553,000)	\$0
50	PHARMACY RETROACTIVE ADJUSTMENTS	(\$69,924,000)	\$51,570,050	(\$10,934,000)	(\$10,934,000)	\$58,990,000	(\$62,504,050)
51	STATE SUPPLEMENTAL DRUG REBATES	(\$60,104,000)	\$0	(\$64,440,000)	\$0	(\$4,336,000)	\$0
52	MEDICAL SUPPLY REBATES	(\$118,668,000)	(\$59,334,000)	(\$89,001,000)	(\$44,500,500)	\$29,667,000	\$14,833,500
53	MEDI-CAL RX- ADDITIONAL SUPPLEMENTAL REBATES	(\$199,228,000)	(\$91,350,000)	(\$666,855,000)	(\$332,614,000)	(\$467,627,000)	(\$241,264,000)
54	FEDERAL DRUG REBATES	(\$3,283,131,000)	\$0	(\$3,291,581,000)	\$0	(\$8,450,000)	\$0
	PHARMACY SUBTOTAL	(\$3,727,201,220)	(\$1,843,788,860)	(\$4,096,322,410)	(\$1,895,841,600)	(\$369,121,190)	(\$52,052,750)
<u>DRUG MEDI-CAL</u>							
56	HCBS SP - CONTINGENCY MANAGEMENT	\$9,846,000	\$0	\$27,958,000	\$0	\$18,112,000	\$0
58	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	\$632,000	\$45,500	\$1,145,000	\$78,900	\$513,000	\$33,400
59	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	(\$1,970,000)	(\$272,000)	(\$954,000)	(\$254,000)	\$1,016,000	\$18,000
	DRUG MEDI-CAL SUBTOTAL	\$8,508,000	(\$226,500)	\$28,149,000	(\$175,100)	\$19,641,000	\$51,400

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 2022-23 AND 2023-24**

NO.	POLICY CHANGE TITLE	NOV. 2022 EST. FOR 2022-23		NOV. 2022 EST. FOR 2023-24		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
MENTAL HEALTH							
60	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE	\$1,339,697,000	\$1,121,197,000	\$0	\$0	(\$1,339,697,000)	(\$1,121,197,000)
63	CALAIM - BH QUALITY IMPROVEMENT PROGRAM	\$45,396,000	\$45,396,000	\$19,456,000	\$19,456,000	(\$25,940,000)	(\$25,940,000)
64	MHP COSTS FOR FFPSA	\$43,134,000	\$12,498,000	\$52,259,000	\$13,813,000	\$9,125,000	\$1,315,000
65	MHP STRTP GRANTS	\$7,478,000	\$7,478,000	\$0	\$0	(\$7,478,000)	(\$7,478,000)
66	MHP COSTS FOR CONTINUUM OF CARE REFORM	\$3,867,000	\$2,707,900	\$4,311,000	\$3,031,650	\$444,000	\$323,750
67	OUT OF STATE YOUTH - SMHS	\$2,062,000	\$1,031,000	\$2,112,000	\$1,056,000	\$50,000	\$25,000
68	SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS	\$0	\$1,450,000	\$0	\$2,201,000	\$0	\$751,000
69	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	\$0	(\$200,000)	\$0	(\$200,000)	\$0	\$0
70	CHART REVIEW	(\$59,000)	\$0	(\$25,000)	\$0	\$34,000	\$0
71	INTERIM AND FINAL COST SETTLEMENTS - SMHS	(\$201,679,000)	\$103,000	(\$198,708,000)	\$107,000	\$2,971,000	\$4,000
243	CALIFORNIA BEHAVIORAL HEALTH CBC DEMONSTRATION	\$0	\$0	\$4,095,000	\$137,000	\$4,095,000	\$137,000
	MENTAL HEALTH SUBTOTAL	\$1,239,896,000	\$1,191,660,900	(\$116,500,000)	\$39,601,650	(\$1,356,396,000)	(\$1,152,059,250)
WAIVER--MH/UCD & BTR							
72	GLOBAL PAYMENT PROGRAM	\$2,625,833,000	\$0	\$2,800,544,000	\$0	\$174,711,000	\$0
73	CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES	\$1,175,858,000	\$431,941,800	\$1,829,376,000	\$748,822,250	\$653,518,000	\$316,880,450
74	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	\$137,300,000	\$77,133,500	\$1,500,000	\$1,500,000	(\$135,800,000)	(\$75,633,500)
75	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	\$649,000	\$0	\$613,000	\$0	(\$36,000)	\$0
251	CALAIM- DESIGNATED STATE HEALTH PROGRAMS	\$0	(\$40,402,000)	\$22,710,000	(\$152,972,000)	\$22,710,000	(\$112,570,000)
	WAIVER--MH/UCD & BTR SUBTOTAL	\$3,939,640,000	\$468,673,300	\$4,654,743,000	\$597,350,250	\$715,103,000	\$128,676,950

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2022-23 AND 2023-24**

NO.	POLICY CHANGE TITLE	NOV. 2022 EST. FOR 2022-23		NOV. 2022 EST. FOR 2023-24		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	MANAGED CARE						
79	CCI-MANAGED CARE PAYMENTS	\$4,491,458,000	\$2,245,729,000	\$402,758,000	\$201,379,000	(\$4,088,700,000)	(\$2,044,350,000)
80	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	\$1,989,171,000	\$505,366,050	\$2,058,008,000	\$522,854,600	\$68,837,000	\$17,488,550
81	MANAGED CARE HEALTH CARE FINANCING PROGRAM	\$1,864,564,000	\$611,641,050	\$1,864,564,000	\$611,641,050	\$0	\$0
82	MANAGED CARE PUBLIC HOSPITAL EPP	\$1,778,153,000	\$404,763,840	\$1,853,760,000	\$424,860,850	\$75,607,000	\$20,097,000
83	2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	\$1,525,495,000	\$551,791,000	\$0	\$0	(\$1,525,495,000)	(\$551,791,000)
86	HCBS SP - HOUSING AND HOMELESSNESS INCENTIVE PROG	\$644,000,000	\$0	\$644,000,000	\$0	\$0	\$0
87	RETRO MC RATE ADJUSTMENTS	\$213,603,000	\$83,519,600	\$704,333,000	\$335,092,050	\$490,730,000	\$251,572,450
88	CALAIM - TRANSITIONING POPULATIONS	\$211,712,000	\$84,672,450	\$25,981,000	\$10,393,750	(\$185,731,000)	(\$74,278,700)
89	CYBHI - STUDENT BH INCENTIVE PROGRAM	\$199,014,000	\$99,507,000	\$85,285,000	\$42,642,500	(\$113,729,000)	(\$56,864,500)
91	WORKFORCE & QUALITY INCENTIVE PROGRAM	\$116,667,000	\$55,300,300	\$287,114,000	\$136,092,200	\$170,447,000	\$80,791,900
92	RECONCILIATION OF MCO TAX FUND 3156	\$108,000,000	(\$308,000,000)	\$0	\$0	(\$108,000,000)	\$308,000,000
93	PROP 56 - BEHAVIORAL HEALTH INCENTIVE PROGRAM	\$90,136,000	\$39,945,000	\$0	\$0	(\$90,136,000)	(\$39,945,000)
96	CCI-QUALITY WITHHOLD REPAYMENTS	\$19,807,000	\$9,903,500	\$16,091,000	\$8,045,500	(\$3,716,000)	(\$1,858,000)
101	CAPITATED RATE ADJUSTMENT FOR FY 2023-24	\$0	\$0	\$4,077,898,000	\$1,411,362,200	\$4,077,898,000	\$1,411,362,200
102	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	\$0	(\$1,639,114,000)	\$0	(\$1,678,975,000)	\$0	(\$39,861,000)
103	2020 MCO ENROLLMENT TAX MANAGED CARE PLANS	\$0	(\$1,576,399,000)	\$0	\$0	\$0	\$1,576,399,000
104	2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	\$0	(\$489,135,000)	\$0	\$0	\$0	\$489,135,000
105	COORDINATED CARE INITIATIVE RISK MITIGATION	(\$111,260,000)	(\$55,630,000)	\$0	\$0	\$111,260,000	\$55,630,000
252	2024 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	\$0	\$0	\$0	(\$467,914,000)	\$0	(\$467,914,000)
253	2024 MCO ENROLLMENT TAX MANAGED CARE PLANS	\$0	\$0	\$0	(\$316,536,000)	\$0	(\$316,536,000)

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2022-23 AND 2023-24**

NO.	POLICY CHANGE TITLE	NOV. 2022 EST. FOR 2022-23		NOV. 2022 EST. FOR 2023-24		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
MANAGED CARE							
254	2024 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	\$0	\$0	\$1,293,487,000	\$467,914,300	\$1,293,487,000	\$467,914,300
255	PROP 56 - DIRECTED PAYMENT RISK MITIGATION	(\$500,000,000)	(\$175,037,080)	\$0	\$0	\$500,000,000	\$175,037,080
	MANAGED CARE SUBTOTAL	\$12,640,520,000	\$448,823,710	\$13,313,279,000	\$1,708,853,000	\$672,759,000	\$1,260,029,290
PROVIDER RATES							
106	NURSING FACILITY RATE ADJUSTMENTS	\$316,982,000	\$150,249,400	\$784,603,000	\$371,902,300	\$467,621,000	\$221,652,900
107	RATE INCREASE FOR FQHCS/RHCS/CBRCS	\$314,943,260	\$116,254,800	\$325,234,640	\$120,053,630	\$10,291,380	\$3,798,830
108	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	\$221,308,000	(\$7,132,000)	\$189,593,000	(\$6,719,000)	(\$31,715,000)	\$413,000
109	PP-GEMT IGT PROGRAM	\$143,189,590	(\$3,977,540)	\$338,602,290	(\$11,118,410)	\$195,412,700	(\$7,140,870)
110	FQHC/RHC/CBRC RECONCILIATION PROCESS	\$124,335,000	\$45,895,700	\$115,009,000	\$42,453,150	(\$9,326,000)	(\$3,442,550)
111	DPH INTERIM RATE GROWTH	\$68,037,480	\$24,290,810	\$144,289,600	\$50,983,500	\$76,252,120	\$26,692,680
112	DPH INTERIM RATE COVID-19 INCREASED FMAP ADJUST	\$87,343,000	\$0	\$0	\$0	(\$87,343,000)	\$0
113	LTC RATE ADJUSTMENT	\$205,721,820	\$100,390,260	\$119,088,080	\$58,114,100	(\$86,633,740)	(\$42,276,160)
114	AB 1629 ANNUAL RATE ADJUSTMENTS	\$97,732,380	\$46,043,520	\$65,726,000	\$30,965,000	(\$32,006,380)	(\$15,078,520)
115	AB 97 ELIMINATIONS	\$20,443,000	\$8,061,200	\$28,407,000	\$11,022,400	\$7,964,000	\$2,961,200
116	ACUPUNCTURE RATE INCREASE	\$10,905,000	\$3,300,500	\$26,724,000	\$8,089,200	\$15,819,000	\$4,788,700
117	LABORATORY RATE METHODOLOGY CHANGE	\$9,849,000	\$4,188,500	(\$11,713,600)	(\$4,981,350)	(\$21,562,600)	(\$9,169,850)
118	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	\$10,349,300	\$4,082,570	\$5,687,000	\$2,244,450	(\$4,662,300)	(\$1,838,120)
119	HOSPICE RATE INCREASES	\$7,825,000	\$3,722,850	(\$11,112,410)	(\$5,287,010)	(\$18,937,410)	(\$9,009,860)
120	GDSP PRENATAL SCREENING PROGRAM FEE INCREASE	(\$1,804,410)	(\$720,530)	(\$2,713,280)	(\$1,083,470)	(\$908,880)	(\$362,940)
121	DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT	\$230,660	\$108,010	(\$1,494,300)	(\$686,370)	(\$1,724,960)	(\$794,380)
122	DPH INTERIM RATE	\$0	(\$427,546,000)	\$0	(\$457,809,700)	\$0	(\$30,263,700)

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CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2022-23 AND 2023-24**

NO.	POLICY CHANGE TITLE	NOV. 2022 EST. FOR 2022-23		NOV. 2022 EST. FOR 2023-24		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>PROVIDER RATES</u>							
123	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	\$0	(\$517,203,000)	\$0	(\$501,312,000)	\$0	\$15,891,000
124	10% PROVIDER PAYMENT REDUCTION	(\$366,839,000)	(\$129,602,200)	(\$366,839,000)	(\$129,602,200)	\$0	\$0
125	REDUCTION TO RADIOLOGY RATES	(\$11,549,540)	(\$5,082,730)	(\$12,230,900)	(\$5,384,920)	(\$681,360)	(\$302,190)
126	DPH INTERIM & FINAL RECONS	(\$76,260,000)	\$0	\$199,784,000	\$0	\$276,044,000	\$0
	PROVIDER RATES SUBTOTAL	\$1,182,741,530	(\$584,675,890)	\$1,936,644,120	(\$428,156,700)	\$753,902,590	\$156,519,180
<u>SUPPLEMENTAL PMNTS.</u>							
127	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	\$3,403,178,000	\$0	\$3,617,930,000	\$0	\$214,752,000	\$0
128	HOSPITAL QAF - FFS PAYMENTS	\$3,032,548,000	\$0	\$2,938,988,000	\$0	(\$93,560,000)	\$0
129	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	\$1,348,007,000	\$475,148,150	\$1,289,079,000	\$506,476,200	(\$58,928,000)	\$31,328,050
130	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	\$926,935,000	\$0	\$590,330,000	\$0	(\$336,605,000)	\$0
131	PRIVATE HOSPITAL DSH REPLACEMENT	\$733,956,000	\$336,609,000	\$663,770,000	\$331,885,000	(\$70,186,000)	(\$4,724,000)
132	DSH PAYMENT	\$464,328,000	\$22,966,500	\$463,471,000	\$27,000,000	(\$857,000)	\$4,033,500
133	PROP 56 - MEDI-CAL FAMILY PLANNING	\$465,341,000	\$77,408,600	\$465,341,000	\$77,408,600	\$0	\$0
134	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	\$304,051,000	\$118,400,000	\$307,494,000	\$118,400,000	\$3,443,000	\$0
135	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	\$275,925,000	\$0	\$222,736,000	\$0	(\$53,189,000)	\$0
136	NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS	\$157,500,000	\$71,426,000	\$105,000,000	\$52,500,000	(\$52,500,000)	(\$18,926,000)
137	FFP FOR LOCAL TRAUMA CENTERS	\$140,698,000	\$0	\$173,056,000	\$0	\$32,358,000	\$0
138	DPH PHYSICIAN & NON-PHYS. COST	\$140,447,000	\$0	\$99,696,000	\$0	(\$40,751,000)	\$0
139	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	\$118,432,000	\$565,000	\$119,181,000	\$742,000	\$749,000	\$177,000
140	CAPITAL PROJECT DEBT REIMBURSEMENT	\$84,231,000	\$19,017,500	\$79,338,000	\$23,602,000	(\$4,893,000)	\$4,584,500
141	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	\$58,660,000	\$0	\$52,822,000	\$0	(\$5,838,000)	\$0

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CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2022-23 AND 2023-24**

NO.	POLICY CHANGE TITLE	NOV. 2022 EST. FOR 2022-23		NOV. 2022 EST. FOR 2023-24		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>SUPPLEMENTAL PMNTS.</u>							
142	PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	\$578,569,000	\$199,100,800	\$580,083,000	\$225,880,950	\$1,514,000	\$26,780,150
143	GEMT SUPPLEMENTAL PAYMENT PROGRAM	\$55,446,000	\$0	\$3,480,000	\$0	(\$51,966,000)	\$0
144	NDPH IGT SUPPLEMENTAL PAYMENTS	\$46,265,000	(\$1,150,000)	\$41,636,000	(\$1,161,000)	(\$4,629,000)	(\$11,000)
145	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	\$43,393,000	\$0	\$0	\$0	(\$43,393,000)	\$0
146	PROP 56 - VALUE-BASED PAYMENT PROGRAM	\$31,005,000	\$9,347,500	\$0	\$0	(\$31,005,000)	(\$9,347,500)
147	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	\$15,705,000	\$0	\$15,270,000	\$0	(\$435,000)	\$0
148	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	\$10,000,000	\$4,535,000	\$10,000,000	\$5,000,000	\$0	\$465,000
149	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	\$8,000,000	\$3,628,000	\$8,000,000	\$4,000,000	\$0	\$372,000
150	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	\$6,661,000	(\$1,199,000)	\$2,380,000	\$0	(\$4,281,000)	\$1,199,000
151	PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	\$69,411,000	\$21,664,000	\$74,045,000	\$22,967,000	\$4,634,000	\$1,303,000
152	NDPH SUPPLEMENTAL PAYMENT	\$4,221,000	\$1,900,000	\$4,240,000	\$1,900,000	\$19,000	\$0
153	FREE CLINICS AUGMENTATION	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$0	\$0
154	HOSPITAL QAF - MANAGED CARE PAYMENTS	\$0	\$0	\$3,594,800,000	\$0	\$3,594,800,000	\$0
155	PROPOSITION 56 FUNDING	\$0	(\$651,127,000)	\$0	(\$744,303,000)	\$0	(\$93,176,000)
156	IGT ADMIN. & PROCESSING FEE	\$0	(\$14,374,000)	\$0	(\$12,384,000)	\$0	\$1,990,000
	SUPPLEMENTAL PMNTS. SUBTOTAL	\$12,524,913,000	\$695,866,050	\$15,524,166,000	\$641,913,750	\$2,999,253,000	(\$53,952,300)
<u>COVID-19</u>							
157	COVID-19 CASELOAD IMPACT	\$14,478,464,000	\$4,127,988,000	\$12,068,721,000	\$3,500,247,900	(\$2,409,743,000)	(\$627,740,100)
159	COVID-19 BEHAVIORAL HEALTH	\$190,217,000	\$14,381,100	\$63,080,000	\$4,786,250	(\$127,137,000)	(\$9,594,850)
160	COVID-19 VACCINATION INCENTIVE PROGRAM	\$156,822,000	\$78,411,000	\$0	\$0	(\$156,822,000)	(\$78,411,000)
161	PHARMACY-BASED COVID-19 TESTS	\$80,383,870	\$27,136,250	\$90,883,680	\$30,680,600	\$10,499,800	\$3,544,350

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FISCAL YEARS 2022-23 AND 2023-24**

NO.	POLICY CHANGE TITLE	NOV. 2022 EST. FOR 2022-23		NOV. 2022 EST. FOR 2023-24		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>COVID-19</u>							
162	COVID-19 - SICK LEAVE BENEFITS	\$6,776,000	\$75,500	\$0	\$0	(\$6,776,000)	(\$75,500)
163	COVID-19 ELIGIBILITY	\$140,049,000	\$95,277,000	\$70,505,000	\$35,253,000	(\$69,544,000)	(\$60,024,000)
164	COVID-19 VACCINE ADMINISTRATION	\$6,201,000	\$418,750	(\$40,800,000)	(\$2,754,450)	(\$47,001,000)	(\$3,173,200)
165	CONTINUOUS CHIP COVERAGE DURING THE COVID-19 PHE	\$0	\$86,511,000	\$0	\$29,101,000	\$0	(\$57,410,000)
166	COVID-19 LTC REIMBURSEMENT RATES	(\$9,056,000)	(\$4,504,400)	(\$38,662,000)	(\$18,858,000)	(\$29,606,000)	(\$14,353,600)
167	COVID-19 INCREASED FMAP - DHCS	(\$254,321,000)	(\$3,734,150,000)	(\$35,117,000)	(\$232,217,000)	\$219,204,000	\$3,501,933,000
168	COVID-19 CASELOAD IMPACT BASE ADJUSTMENT	(\$12,520,833,000)	(\$3,551,844,200)	(\$13,011,796,000)	(\$3,695,376,600)	(\$490,963,000)	(\$143,532,400)
	COVID-19 SUBTOTAL	\$2,274,702,870	(\$2,860,300,000)	(\$833,185,320)	(\$349,137,300)	(\$3,107,888,200)	\$2,511,162,700
<u>STATE ONLY CLAIMING</u>							
169	STATE ONLY CLAIMING ADJUSTMENTS	\$130,720,000	(\$125,345,000)	\$130,576,000	\$3,310,128,000	(\$144,000)	\$3,435,473,000
170	STATE ONLY CLAIMING ADJUSTMENTS - SMHS and DMC	\$0	\$23,877,000	\$0	\$24,701,000	\$0	\$824,000
	STATE ONLY CLAIMING SUBTOTAL	\$130,720,000	(\$101,468,000)	\$130,576,000	\$3,334,829,000	(\$144,000)	\$3,436,297,000
<u>OTHER DEPARTMENTS</u>							
171	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	\$714,859,000	\$0	\$633,783,000	\$0	(\$81,076,000)	\$0
172	HCBS SP - IHSS HCBS CARE ECONOMY PMTS	\$165,790,000	\$0	\$0	\$0	(\$165,790,000)	\$0
173	ELECTRONIC VISIT VERIFICATION FED PENALTIES	(\$27,822,000)	\$623,000	\$0	\$0	\$27,822,000	(\$623,000)
	OTHER DEPARTMENTS SUBTOTAL	\$852,827,000	\$623,000	\$633,783,000	\$0	(\$219,044,000)	(\$623,000)
<u>OTHER</u>							
179	HOSPITAL & SNF COVID-19 WORKER RETENTION PAYMENTS	\$1,077,600,000	\$0	\$0	\$0	(\$1,077,600,000)	\$0
181	BEHAVIORAL HEALTH BRIDGE HOUSING	\$907,936,000	\$907,936,000	\$300,000,000	\$300,000,000	(\$607,936,000)	(\$607,936,000)
182	CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY	\$450,000,000	\$450,000,000	\$100,000,000	\$100,000,000	(\$350,000,000)	(\$350,000,000)

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NO.	POLICY CHANGE TITLE	NOV. 2022 EST. FOR 2022-23		NOV. 2022 EST. FOR 2023-24		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER						
183	CYBHI - EVIDENCE-BASED BH PRACTICES	\$429,000,000	\$429,000,000	\$0	\$0	(\$429,000,000)	(\$429,000,000)
184	CCI IHSS RECONCILIATION	\$428,000,000	\$86,000,000	\$0	\$0	(\$428,000,000)	(\$86,000,000)
186	HCBS SP CDDS	\$382,513,000	\$0	\$199,018,000	\$0	(\$183,495,000)	\$0
187	EQUITY & PRACTICE TRANSFORMATION PAYMENTS	\$140,000,000	\$70,000,000	\$215,000,000	\$107,500,000	\$75,000,000	\$37,500,000
188	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER	\$285,672,000	\$142,836,000	\$254,314,000	\$127,157,000	(\$31,358,000)	(\$15,679,000)
189	CYBHI - URGENT NEEDS AND EMERGENT ISSUES	\$120,000,000	\$120,000,000	\$26,000,000	\$26,000,000	(\$94,000,000)	(\$94,000,000)
191	LA COUNTY JUSTICE-INVOLVED POP. SVCS & SUPPORTS	\$99,220,000	\$99,220,000	\$0	\$0	(\$99,220,000)	(\$99,220,000)
192	CALHOPE	\$105,423,000	\$96,423,000	\$44,577,000	\$40,000,000	(\$60,846,000)	(\$56,423,000)
193	CARE COURT	\$0	\$0	\$16,496,000	\$16,496,000	\$16,496,000	\$16,496,000
194	QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES	\$72,322,000	\$10,848,000	\$252,590,000	\$37,889,000	\$180,268,000	\$27,041,000
195	CLINIC WORKFORCE STABILIZATION RETENTION PROGRAM	\$70,000,000	\$70,000,000	\$0	\$0	(\$70,000,000)	(\$70,000,000)
196	INDIAN HEALTH SERVICES	\$64,061,000	\$21,353,500	\$55,056,000	\$18,352,000	(\$9,005,000)	(\$3,001,500)
198	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	\$85,442,000	\$0	\$58,033,000	\$0	(\$27,409,000)	\$0
199	MHSF - PROVIDER ACES TRAININGS	\$44,100,000	\$0	\$45,500,000	\$0	\$1,400,000	\$0
200	MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG	\$42,028,000	\$0	\$52,466,000	\$0	\$10,438,000	\$0
201	SELF-DETERMINATION PROGRAM - CDDS	\$86,758,000	\$0	\$140,689,000	\$0	\$53,931,000	\$0
202	EVIDENCE-BASED DENTAL PRACTICES	\$30,814,000	\$9,699,500	\$33,421,000	\$10,348,250	\$2,607,000	\$648,750
203	HCBS SP - CALBRIDGE BH NAVIGATOR PROGRAM	\$29,651,000	\$0	\$1,296,000	\$0	(\$28,355,000)	\$0
205	INFANT DEVELOPMENT PROGRAM	\$27,810,000	\$0	\$21,900,000	\$0	(\$5,910,000)	\$0
206	WATSONVILLE COMMUNITY HOSPITAL ACQUISITION	\$25,000,000	\$25,000,000	\$0	\$0	(\$25,000,000)	(\$25,000,000)
207	HCBS SP - ASSISTED LIVING WAIVER EXPANSION	\$23,296,900	(\$5,720,790)	\$22,907,000	(\$12,003,000)	(\$389,900)	(\$6,282,210)

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 2022-23 AND 2023-24**

NO.	POLICY CHANGE TITLE	NOV. 2022 EST. FOR 2022-23		NOV. 2022 EST. FOR 2023-24		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER						
208	CYBHI - CALHOPE STUDENT SUPPORT	\$21,000,000	\$21,000,000	\$24,000,000	\$24,000,000	\$3,000,000	\$3,000,000
209	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	\$45,379,010	\$22,689,510	\$72,071,630	\$36,035,810	\$26,692,620	\$13,346,310
210	LOS ANGELES COUNTY REPRODUCTIVE HEALTH PILOT	\$20,000,000	\$20,000,000	\$0	\$0	(\$20,000,000)	(\$20,000,000)
212	PEER SUPPORT SPECIALIST SERVICES	\$12,867,000	\$0	\$25,417,000	\$0	\$12,550,000	\$0
213	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	\$15,281,000	\$6,985,000	\$7,786,000	\$3,561,000	(\$7,495,000)	(\$3,424,000)
214	PACE INFRASTRUCTURE FUNDING	\$10,000,000	\$10,000,000	\$0	\$0	(\$10,000,000)	(\$10,000,000)
215	ALAMEDA COUNTY SUPPORTIVE HOUSING	\$10,000,000	\$10,000,000	\$0	\$0	(\$10,000,000)	(\$10,000,000)
216	BACKFILL LOST TITLE X FAMILY PLANNING FUNDING	\$10,000,000	\$10,000,000	\$0	\$0	(\$10,000,000)	(\$10,000,000)
217	HCBS SP - NON-IHSS CARE ECONOMY PMTS	\$12,250,000	\$0	\$0	\$0	(\$12,250,000)	\$0
219	INFRASTRUCTURE PYMT FOR CLINIC ABORTION PROVIDERS	\$7,425,000	\$7,425,000	\$22,282,000	\$22,282,000	\$14,857,000	\$14,857,000
220	PROP 56 - PROVIDER ACES TRAININGS	\$7,100,000	\$3,550,000	\$0	\$0	(\$7,100,000)	(\$3,550,000)
221	CALAIM - DENTAL INITIATIVES	\$258,451,000	\$124,204,950	\$259,302,000	\$124,491,600	\$851,000	\$286,650
222	QAF WITHHOLD TRANSFER	\$2,877,000	\$817,500	\$2,238,000	\$1,119,000	(\$639,000)	\$301,500
223	FOSTER YOUTH SUBSTANCE USE DISORDER GRANT PROGRAM	\$1,500,000	\$1,500,000	\$3,500,000	\$3,500,000	\$2,000,000	\$2,000,000
224	CLPP FUND	\$902,000	\$0	\$902,000	\$0	\$0	\$0
225	WPCS WORKERS' COMPENSATION	\$620,000	\$310,000	\$620,000	\$310,000	\$0	\$0
227	HCBS SP - ETSB FOR LAGUNA HONDA HOSPITAL RESIDENTS	\$600,000	\$0	\$0	\$0	(\$600,000)	\$0
228	CALAIM - BH PAYMENT REFORM	\$0	\$0	\$375,000,000	\$375,000,000	\$375,000,000	\$375,000,000
229	URBAN INDIAN ORGANIZATIONS FUNDING SHIFT	\$0	(\$16,539,000)	\$0	(\$8,064,000)	\$0	\$8,475,000
230	AMERICAN RESCUE PLAN INCREASED FMAP FOR HCBS	\$0	\$0	\$0	\$0	\$0	\$0
231	IMD ANCILLARY SERVICES	\$0	\$37,244,000	\$0	\$44,564,000	\$0	\$7,320,000
232	CIGARETTE AND TOBACCO SURTAX FUNDS	\$0	(\$131,352,000)	\$0	(\$125,790,000)	\$0	\$5,562,000
233	FUNDING ADJUST.—ACA OPT. EXPANSION	\$0	(\$3,974,797,200)	\$0	(\$4,020,145,200)	\$0	(\$45,348,000)

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 2022-23 AND 2023-24**

NO.	POLICY CHANGE TITLE	NOV. 2022 EST. FOR 2022-23		NOV. 2022 EST. FOR 2023-24		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER						
234	FUNDING ADJUST.—OTLICP	\$0	(\$109,124,550)	\$0	(\$114,884,250)	\$0	(\$5,759,700)
235	HOSPITAL QAF - CHILDREN'S HEALTH CARE	\$0	(\$1,115,200,000)	\$0	(\$1,806,096,000)	\$0	(\$690,896,000)
236	INDIAN HEALTH SERVICES FUNDING SHIFT	\$0	(\$14,845,000)	\$0	(\$15,846,000)	\$0	(\$1,001,000)
237	CMS DEFERRED CLAIMS	\$0	(\$193,141,000)	\$0	(\$267,911,000)	\$0	(\$74,770,000)
238	DENTAL MANAGED CARE MLR RISK CORRIDOR	(\$18,950,000)	(\$5,868,600)	\$0	\$0	\$18,950,000	\$5,868,600
239	COUNTY SHARE OF OTLICP-CCS COSTS	(\$22,981,000)	(\$22,981,000)	(\$21,300,000)	(\$21,300,000)	\$1,681,000	\$1,681,000
249	COUNTY BH RECOUPMENTS	\$0	\$0	(\$63,468,000)	(\$63,468,000)	(\$63,468,000)	(\$63,468,000)
	OTHER SUBTOTAL	\$5,420,967,910	(\$2,775,527,170)	\$2,547,613,630	(\$5,036,901,790)	(\$2,873,354,280)	(\$2,261,374,610)
	GRAND TOTAL	\$46,536,049,270	(\$3,419,186,540)	\$43,128,949,580	\$850,951,370	(\$3,407,099,690)	\$4,270,137,900

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

FISCAL YEAR 2023-24 COST PER ELIGIBLE BASED ON NOVEMBER 2022 ESTIMATE

SERVICE CATEGORY	PA-OAS	NEWLY	PA-ATD	PA-AFDC	LT-OAS	H-PE
PHYSICIANS	\$8,171,710	\$173,720,250	\$72,103,810	\$44,711,820	\$1,639,060	\$57,896,890
OTHER MEDICAL	\$95,934,430	\$1,584,453,050	\$460,417,610	\$373,519,990	\$4,432,860	\$37,474,390
CO. & COMM. OUTPATIENT	\$3,339,490	\$121,819,710	\$99,366,600	\$28,603,110	\$584,290	\$55,736,200
PHARMACY	\$52,618,800	\$5,496,029,400	\$2,567,151,520	\$427,080,730	\$9,139,980	\$24,590,790
COUNTY INPATIENT	\$4,556,660	\$586,202,920	\$36,625,950	\$23,298,500	\$4,766,810	\$85,184,180
COMMUNITY INPATIENT	\$50,433,210	\$1,152,956,810	\$392,646,680	\$206,903,120	\$15,574,420	\$391,060,510
NURSING FACILITIES	\$27,993,590	\$21,344,180	\$77,595,680	\$7,216,390	\$175,115,690	\$2,712,890
ICF-DD	\$2,625,090	\$9,780,670	\$160,596,250	\$1,585,660	\$75,637,520	\$0
MEDICAL TRANSPORTATION	\$5,648,760	\$40,771,400	\$19,169,210	\$4,628,750	\$2,657,600	\$8,501,530
OTHER SERVICES	\$104,079,300	\$36,355,860	\$670,517,360	\$76,367,470	\$62,917,870	\$2,841,700
HOME HEALTH	\$4,164,470	\$1,846,850	\$125,761,240	\$6,969,710	\$60,450	\$209,730
FFS SUBTOTAL	\$359,565,520	\$9,225,281,090	\$4,681,951,910	\$1,200,885,250	\$352,526,550	\$666,208,810
DENTAL	\$53,321,240	\$374,111,460	\$125,163,830	\$207,815,240	\$11,627,160	\$1,658,620
MENTAL HEALTH	\$13,932,790	\$489,105,420	\$1,578,756,140	\$1,118,882,650	\$1,042,510	\$11,996,260
TWO PLAN MODEL	\$1,626,406,080	\$14,551,098,130	\$5,116,162,490	\$1,687,485,080	\$0	\$0
COUNTY ORGANIZED HEALTH SYSTEMS	\$487,547,360	\$5,284,322,840	\$1,596,454,140	\$412,934,290	\$941,704,920	\$0
GEOGRAPHIC MANAGED CARE	\$243,756,910	\$2,511,958,700	\$1,018,889,580	\$270,609,720	\$0	\$0
PHP & OTHER MANAG. CARE	\$397,596,280	\$126,789,410	\$332,748,330	\$4,134,520	\$16,856,060	\$0
MEDICARE PAYMENTS	\$2,118,246,300	\$0	\$1,939,708,120	\$0	\$184,382,490	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$1,393,700	\$0	\$3,010,850	\$3,360,280	\$131,630	\$0
MISC. SERVICES	\$16,509,520	\$4,880	\$236,546,480	\$5,883,860	\$0	\$0
DRUG MEDI-CAL	\$24,565,140	\$345,738,430	\$55,120,560	\$63,874,170	\$2,095,260	\$15,000
REGIONAL MODEL	\$20,203,060	\$716,772,320	\$315,512,230	\$79,875,550	\$0	\$0
NON-FFS SUBTOTAL	\$5,003,478,380	\$24,399,901,590	\$12,318,072,740	\$3,854,855,370	\$1,157,840,040	\$13,669,880
TOTAL DOLLARS (1)	\$5,363,043,910	\$33,625,182,680	\$17,000,024,650	\$5,055,740,620	\$1,510,366,580	\$679,878,690
ELIGIBLES ***	420,500	4,602,800	873,900	1,103,700	35,700	37,300
ANNUAL \$/ELIGIBLE	\$12,754	\$7,305	\$19,453	\$4,581	\$42,307	\$18,227
AVG. MO. \$/ELIGIBLE	\$1,063	\$609	\$1,621	\$382	\$3,526	\$1,519

(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 2023-24 COST PER ELIGIBLE BASED ON NOVEMBER 2022 ESTIMATE

SERVICE CATEGORY	LT-ATD	POV 250	MN-OAS	MN-ATD	MN-AFDC	MI-C
PHYSICIANS	\$911,890	\$23,838,450	\$26,444,770	\$11,979,810	\$155,154,180	\$30,127,900
OTHER MEDICAL	\$2,850,360	\$201,663,990	\$224,777,770	\$101,245,810	\$1,326,765,980	\$99,254,630
CO. & COMM. OUTPATIENT	\$280,640	\$26,911,800	\$19,487,580	\$13,431,790	\$126,516,390	\$11,525,130
PHARMACY	\$5,568,500	\$364,934,920	\$402,878,520	\$200,873,040	\$2,248,483,240	\$72,475,500
COUNTY INPATIENT	\$2,465,880	\$3,536,300	\$58,964,110	\$11,670,270	\$165,542,340	\$11,109,440
COMMUNITY INPATIENT	\$7,414,210	\$68,298,760	\$157,557,930	\$43,115,020	\$640,852,650	\$68,835,000
NURSING FACILITIES	\$31,455,180	\$4,447,320	\$51,534,170	\$11,952,470	\$3,820,040	\$10,514,570
ICF-DD	\$171,583,790	\$3,250,230	\$2,881,250	\$11,896,380	\$1,843,120	\$3,674,910
MEDICAL TRANSPORTATION	\$886,050	\$517,620	\$13,887,200	\$8,952,220	\$9,834,300	\$3,644,080
OTHER SERVICES	\$7,144,720	\$45,111,450	\$136,602,690	\$166,080,890	\$105,470,460	\$41,757,700
HOME HEALTH	\$1,750	\$17,575,640	\$3,199,780	\$43,650,040	\$13,715,240	\$17,337,720
FFS SUBTOTAL	\$230,562,980	\$760,086,490	\$1,098,215,780	\$624,847,730	\$4,797,997,940	\$370,256,570
DENTAL	\$3,321,790	\$188,041,730	\$71,379,790	\$25,446,160	\$541,382,490	\$24,664,640
MENTAL HEALTH	\$2,459,260	\$115,548,510	\$19,932,910	\$146,574,950	\$830,539,140	\$117,327,800
TWO PLAN MODEL	\$0	\$757,397,620	\$2,875,078,420	\$860,169,040	\$5,438,572,390	\$42,122,460
COUNTY ORGANIZED HEALTH SYSTEMS	\$228,158,170	\$304,053,230	\$983,513,220	\$449,919,800	\$2,139,822,600	\$31,401,820
GEOGRAPHIC MANAGED CARE	\$0	\$137,479,540	\$414,364,990	\$178,679,020	\$1,076,067,950	\$5,685,030
PHP & OTHER MANAG. CARE	\$1,330,060	\$70,440	\$606,777,420	\$56,832,150	\$1,323,270	\$12,760
MEDICARE PAYMENTS	\$0	\$0	\$2,352,207,340	\$821,867,490	\$138,772,380	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$31,890	\$0	\$2,438,970	\$734,820	\$13,206,700	\$482,420
MISC. SERVICES	\$0	\$0	\$29,515,680	\$57,358,810	\$22,288,520	\$869,540
DRUG MEDI-CAL	\$504,510	\$57,296,170	\$43,471,880	\$13,720,430	\$241,511,300	\$9,428,990
REGIONAL MODEL	\$0	\$39,005,800	\$76,435,290	\$55,349,410	\$332,533,130	\$1,629,100
NON-FFS SUBTOTAL	\$235,805,690	\$1,598,893,040	\$7,475,115,910	\$2,666,652,080	\$10,776,019,870	\$233,624,560
TOTAL DOLLARS (1)	\$466,368,670	\$2,358,979,540	\$8,573,331,700	\$3,291,499,810	\$15,574,017,810	\$603,881,130
ELIGIBLES ***	8,500	862,300	771,400	219,100	3,775,800	144,900
ANNUAL \$/ELIGIBLE	\$54,867	\$2,736	\$11,114	\$15,023	\$4,125	\$4,168
AVG. MO. \$/ELIGIBLE	\$4,572	\$228	\$926	\$1,252	\$344	\$347

(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 2023-24 COST PER ELIGIBLE BASED ON NOVEMBER 2022 ESTIMATE

SERVICE CATEGORY	MI-A	REFUGEE	OBRA	POV 185	POV 133	POV 100
PHYSICIANS	\$345,440	\$91,760	\$180	\$74,457,890	\$17,163,570	\$9,812,690
OTHER MEDICAL	\$668,560	\$1,701,250	\$66,750	\$239,478,390	\$234,542,880	\$109,843,440
CO. & COMM. OUTPATIENT	\$81,030	\$153,810	\$3,130	\$20,535,430	\$13,685,230	\$12,929,170
PHARMACY	\$1,154,830	\$897,090	\$1,050	\$59,099,400	\$139,421,230	\$159,886,520
COUNTY INPATIENT	\$3,468,640	\$4,480	\$12,940	\$65,797,780	\$1,959,860	\$2,080,580
COMMUNITY INPATIENT	\$2,031,900	\$57,690	\$2,920	\$468,822,060	\$80,483,090	\$29,908,900
NURSING FACILITIES	\$2,938,710	\$0	\$197,340	\$2,744,810	\$9,393,800	\$1,013,450
ICF-DD	\$1,093,110	\$0	\$78,200	\$18,820	\$223,310	\$126,340
MEDICAL TRANSPORTATION	\$112,380	\$7,490	\$3,320	\$2,479,430	\$577,000	\$236,450
OTHER SERVICES	\$690,670	\$20,010	\$800	\$6,813,150	\$28,943,720	\$14,353,220
HOME HEALTH	\$130	\$0	\$0	\$2,959,800	\$7,024,830	\$2,436,630
FFS SUBTOTAL	\$12,585,390	\$2,933,590	\$366,640	\$943,206,950	\$533,418,520	\$342,627,390
DENTAL	\$117,080	\$175,740	\$19,530	\$12,355,060	\$226,991,770	\$89,762,640
MENTAL HEALTH	\$0	\$219,570	\$2,195,750	\$2,542,920	\$36,661,830	\$55,726,970
TWO PLAN MODEL	\$17,800	\$1,548,150	\$0	\$350,999,910	\$707,858,180	\$357,737,400
COUNTY ORGANIZED HEALTH SYSTEMS	\$362,460	\$378,720	\$0	\$166,788,760	\$241,562,450	\$128,484,870
GEOGRAPHIC MANAGED CARE	\$1,380	\$924,450	\$0	\$71,595,440	\$121,595,890	\$55,944,410
PHP & OTHER MANAG. CARE	(\$24,140)	\$0	\$0	(\$325,040)	(\$87,910)	(\$132,560)
MEDICARE PAYMENTS	\$0	\$0	\$0	\$0	\$0	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$10,520	\$0	\$340	\$1,154,130	\$0	\$1,384,480
MISC. SERVICES	\$100	\$0	\$0	\$11,320	\$4,609,700	\$2,403,980
DRUG MEDI-CAL	\$178,200	\$128,140	\$0	\$22,310,070	\$49,757,970	\$25,949,130
REGIONAL MODEL	\$0	\$14,510	\$0	\$21,612,470	\$35,440,180	\$17,001,590
NON-FFS SUBTOTAL	\$663,400	\$3,389,280	\$2,215,620	\$649,045,050	\$1,424,390,050	\$734,262,910
TOTAL DOLLARS (1)	\$13,248,790	\$6,322,870	\$2,582,260	\$1,592,252,000	\$1,957,808,580	\$1,076,890,310
ELIGIBLES ***	3,000	2,300	0	341,500	818,000	412,300
ANNUAL \$/ELIGIBLE	\$4,416	\$2,749		\$4,663	\$2,393	\$2,612
AVG. MO. \$/ELIGIBLE	\$368	\$229		\$389	\$199	\$218

(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 2023-24 COST PER ELIGIBLE BASED ON NOVEMBER 2022 ESTIMATE

SERVICE CATEGORY	TOTAL
PHYSICIANS	\$708,572,070
OTHER MEDICAL	\$5,099,092,160
CO. & COMM. OUTPATIENT	\$554,990,540
PHARMACY	\$12,232,285,050
COUNTY INPATIENT	\$1,067,247,630
COMMUNITY INPATIENT	\$3,776,954,900
NURSING FACILITIES	\$441,990,270
ICF-DD	\$446,894,650
MEDICAL TRANSPORTATION	\$122,514,780
OTHER SERVICES	\$1,506,069,030
HOME HEALTH	\$246,914,030
FFS SUBTOTAL	\$26,203,525,120
DENTAL	\$1,957,356,000
MENTAL HEALTH	\$4,543,445,390
TWO PLAN MODEL	\$34,372,653,150
COUNTY ORGANIZED HEALTH SYSTEMS	\$13,397,409,650
GEOGRAPHIC MANAGED CARE	\$6,107,553,010
PHP & OTHER MANAG. CARE	\$1,543,901,050
MEDICARE PAYMENTS	\$7,555,184,130
STATE HOSP./DEVELOPMENTAL CNTRS.	\$27,340,730
MISC. SERVICES	\$376,002,380
DRUG MEDI-CAL	\$955,665,350
REGIONAL MODEL	\$1,711,384,640
NON-FFS SUBTOTAL	\$72,547,895,470
TOTAL DOLLARS (1)	\$98,751,420,580
ELIGIBLES ***	14,433,000
ANNUAL \$/ELIGIBLE	\$6,842
AVG. MO. \$/ELIGIBLE	\$570

(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 2023-24 COST PER ELIGIBLE BASED ON NOVEMBER 2022 ESTIMATE

EXCLUDED POLICY CHANGES: 124

	QAF WITHHOLD TRANSFER ADJUSTMENT
	QAF WITHHOLD ADJUSTMENT
	COVID-19 ELIGIBILITY BASE ADJUSTMENT
3	POSTPARTUM CARE EXTENSION
4	BREAST AND CERVICAL CANCER TREATMENT
8	MINIMUM WAGE INCREASE - CASELOAD SAVINGS
14	MEDICARE OPTIONAL EXPANSION ADJUSTMENT
15	CS3 PROXY ADJUSTMENT
16	COMMUNITY FIRST CHOICE OPTION
18	1% FMAP INCREASE FOR PREVENTIVE SERVICES
19	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.
20	ACA DSH REDUCTION
24	FAMILY PACT PROGRAM
28	CALIFORNIA COMMUNITY TRANSITIONS COSTS
33	FPACT HPV VACCINE COVERAGE
35	MEDICAL INTERPRETERS PILOT PROJECT
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103	2020 MCO ENROLLMENT TAX MANAGED CARE PLANS
104	2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ
108	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF
123	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
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FISCAL YEAR 2023-24 COST PER ELIGIBLE BASED ON NOVEMBER 2022 ESTIMATE

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**Estimated Average Monthly Certified Eligibles
November 2022 Estimate
Fiscal Years 2021-2022, 2022-2023, & 2023-2024**

<i>(With Estimated Impact of Eligibility Policy Changes)***</i>					
	2021-2022	2022-2023	2023-2024	21-22 To 22-23 % Change	22-23 To 23-24 % Change
Public Assistance	2,315,800	2,393,500	2,398,100	3.36%	0.19%
Seniors	412,500	417,700	420,500	1.26%	0.67%
Persons with Disabilities	878,500	872,100	873,900	-0.73%	0.21%
Families ¹	1,024,800	1,103,700	1,103,700	7.70%	0.00%
Long Term	43,300	40,800	44,200	-5.77%	8.33%
Seniors	34,700	33,000	35,700	-4.90%	8.18%
Persons with Disabilities	8,600	7,800	8,500	-9.30%	8.97%
Medically Needy	4,739,100	5,034,400	4,751,300	6.23%	-5.62%
Seniors	672,400	744,700	762,400	10.75%	2.38%
Persons with Disabilities	208,100	210,400	213,100	1.11%	1.28%
Families ¹	3,858,600	4,079,300	3,775,800	5.72%	-7.44%
Medically Indigent	150,500	147,800	147,900	-1.79%	0.07%
Children	147,400	144,800	144,900	-1.76%	0.07%
Adults	3,100	3,000	3,000	-3.23%	0.00%
Other	7,120,100	7,616,100	7,095,900	6.97%	-6.83%
Refugees	1,400	2,100	2,300	50.00%	9.52%
OBRA ²	0	0	0	n/a	n/a
185% Poverty ³	350,400	392,500	341,500	12.01%	-12.99%
133% Poverty	826,600	850,800	818,000	2.93%	-3.86%
100% Poverty	414,300	426,400	412,300	2.92%	-3.31%
Opt. Targeted Low Income Children	870,100	848,900	862,300	-2.44%	1.58%
ACA Optional Expansion	4,604,200	5,038,700	4,602,800	9.44%	-8.65%
Hospital PE	34,600	37,300	37,300	7.80%	0.00%
Medi-Cal Access Program	3,800	4,400	4,400	15.79%	0.00%
QMB	14,700	15,000	15,000	2.04%	0.00%
GRAND TOTAL ⁴	14,368,800	15,232,600	14,437,400	6.01%	-5.22%
Seniors	1,119,600	1,195,400	1,218,600	6.77%	1.94%
Persons with Disabilities	1,095,200	1,090,300	1,095,500	-0.45%	0.48%
Families and Children ⁵	7,492,200	7,846,400	7,458,500	4.73%	-4.94%
ACA Optional Expansion	4,604,200	5,038,700	4,602,800	9.44%	-8.65%

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>2021-2022</u>	<u>2022-2023</u>	<u>2023-2024</u>
Presumptive Eligibility	26,200	27,200	27,200

⁴ The following Medi-Cal special program eligibles (average monthly during FY 2020-21 shown in parenthesis) are not included above: BCCTP (3,884), Tuberculosis (40), Dialysis (111), TPN (2), TCVAP (663) 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		
		2021-22	2022-23	2023-24
PC 1 Medi-Cal State Inmates	LT Seniors	3	0	0
	MN Seniors	31	20	20
	MN Persons with Disabilities	6	4	4
	MI Children	2	1	1
	185% Poverty	2	1	1
	ACA Optional Expansion	176	156	156
	Total	220	183	183
PC 95 Medi-Cal Access Program Mothers 213-322%	MCAP Mothers	2,449	2,491	2,491
	Total	2,449	2,491	2,491
PC 99 Medi-Cal Access Program Infants 266-322%	MCAP Infants	1,390	1,901	1,901
	Total	1,390	1,901	1,901
PC 157 COVID-19 Caseload Impact	PA Seniors		2,427	5,201
	PA Persons with Disabilities		815	2,764
	PA Families		0	0
	LT Seniors		(1,258)	1,455
	LT Persons with Disabilities		(273)	447
	MN Seniors		18,355	962
	MN Persons with Disabilities		0	0
	MN Families		130,800	(172,504)
	185% Poverty		23,566	(27,472)
	133% Poverty		15,186	(17,746)
	100% Poverty		5,122	(8,937)
	OTLICP		(4,163)	9,448
	ACA Optional Expansion		192,051	(243,848)
Total		382,627	(450,229)	
PC 2 - Phasing in the Medi-Cal Asset Limit Repeal	MN Seniors	0	7,969	17,581
	MN Persons with Disabilities	0	2,199	4,852
	Total	0	10,168	22,432
Total by Aid Category	<u>Budget Aid Category</u>	<u>2021-22</u>	<u>2022-23</u>	<u>2023-24</u>
	PA Seniors	0	2,427	5,201
	PA Persons with Disabilities	0	815	2,764
	PA Families	0	0	0
	LT Seniors	3	(1,258)	1,455
	LT Persons with Disabilities	0	(273)	447
	MN Seniors	31	26,343	18,563
	MN Persons with Disabilities	6	2,203	4,856
	MN Families	0	130,800	(172,504)
	MI Children	2	1	1
	MI Adults	0	0	0
	Undocumented Persons	0	0	0
	185% Poverty	2	23,568	(27,471)
	133% Poverty	0	15,186	(17,746)
	100% Poverty	0	5,122	(8,937)
	OTLICP	0	(4,163)	9,448
	ACA Optional Expansion	176	192,207	(243,692)
	MCAP Infants	1,390	1,901	1,901
	MCAP Mothers	2,449	2,491	2,491
	Total	4,059	397,370	(423,222)

Comparison of Average Monthly Certified Eligibles
November 2022 Estimate
Fiscal Year 2021-22

(With Estimated Impact of Eligibility Policy Changes)

	Appropriation 2022-2023	Nov 2022 2022-2023	Appropriation to Nov % Change
Public Assistance	2,295,100	2,393,500	4.29%
Seniors	412,900	417,700	1.16%
Persons with Disabilities	867,200	872,100	0.57%
Families	1,015,000	1,103,700	8.74%
Long Term	42,200	40,800	-3.32%
Seniors	34,000	33,000	-2.94%
Persons with Disabilities	8,200	7,800	-4.88%
Medically Needy	4,911,900	5,034,400	2.49%
Seniors	727,300	744,700	2.39%
Persons with Disabilities	214,500	210,400	-1.91%
Families	3,970,100	4,079,300	2.75%
Medically Indigent	153,000	147,800	-3.40%
Children	150,000	144,800	-3.47%
Adults	3,000	3,000	0.00%
Other	7,399,600	7,616,100	2.93%
Refugees	2,200	2,100	-4.55%
OBRA	0	0	n/a
185% Poverty	368,800	392,500	6.43%
133% Poverty	822,900	850,800	3.39%
100% Poverty	420,200	426,400	1.48%
Opt. Targeted Low Income Children	878,100	848,900	-3.33%
ACA Optional Expansion	4,849,200	5,038,700	3.91%
Hospital PE	39,900	37,300	-6.52%
Medi-Cal Access Program	3,800	4,400	15.79%
QMB	14,500	15,000	3.45%
GRAND TOTAL	14,801,800	15,232,600	2.91%
Seniors	1,174,200	1,195,400	1.81%
Persons with Disabilities	1,089,900	1,090,300	0.04%
Families and Children	7,625,100	7,846,400	2.90%
ACA Optional Expansion	4,849,200	5,038,700	3.91%

**Estimated Average Monthly Certified Eligibles
November 2022 Estimate
Fiscal Years 2021-2022, 2022-2023, & 2023-2024**

Managed Care¹					
<i>(With Estimated Impact of Eligibility Policy Changes)</i>***					
	2021-2022	2022-2023	2023-2024	21-22 To 22-23 % Change	22-23 To 23-24 % Change
Public Assistance	2,028,388	2,262,671	2,376,008	11.55%	5.01%
Seniors	317,562	361,191	403,352	13.74%	11.67%
Persons with Disabilities	766,512	825,240	871,715	7.66%	5.63%
Families	944,315	1,076,240	1,100,941	13.97%	2.30%
Long Term	24,634	39,194	44,090	59.10%	12.49%
Seniors	20,000	31,923	35,611	59.61%	11.55%
Persons with Disabilities	4,634	7,271	8,479	56.91%	16.62%
Medically Needy	3,838,016	4,370,778	4,626,540	13.88%	5.85%
Seniors	482,883	615,992	698,267	27.57%	13.36%
Persons with Disabilities	150,136	173,092	197,739	15.29%	14.24%
Families	3,204,997	3,581,694	3,730,533	11.75%	4.16%
Medically Indigent	52,459	57,938	59,904	10.45%	3.39%
Children	52,387	57,858	59,821	10.44%	3.39%
Adults	72	80	83	12.41%	3.87%
Other	6,237,674	7,136,075	6,981,611	14.40%	-2.16%
Refugees	746	1,508	1,824	102.11%	20.93%
OBRA	0	(0)	(0)	n/a	n/a
185% Poverty	228,372	343,925	340,646	50.60%	-0.95%
133% Poverty	795,601	848,325	815,955	6.63%	-3.82%
100% Poverty	404,919	423,581	411,269	4.61%	-2.91%
Opt. Targeted Low Income Children	836,692	842,305	860,144	0.67%	2.12%
ACA Optional Expansion	3,967,730	4,672,194	4,547,534	17.75%	-2.67%
Medi-Cal Access Program	3,614	4,238	4,238	17.27%	0.00%
GRAND TOTAL ¹	12,181,171	13,866,657	14,088,153	13.84%	1.60%
Percent of Statewide	84.78%	91.03%	97.58%		
Seniors	820,445	1,009,105	1,137,230	22.99%	12.70%
Persons with Disabilities	921,281	1,005,603	1,077,933	9.15%	7.19%
Families and Children	6,467,283	7,173,928	7,319,309	10.93%	2.03%
ACA Optional Expansion	3,967,730	4,672,194	4,547,534	17.75%	-2.67%

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

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

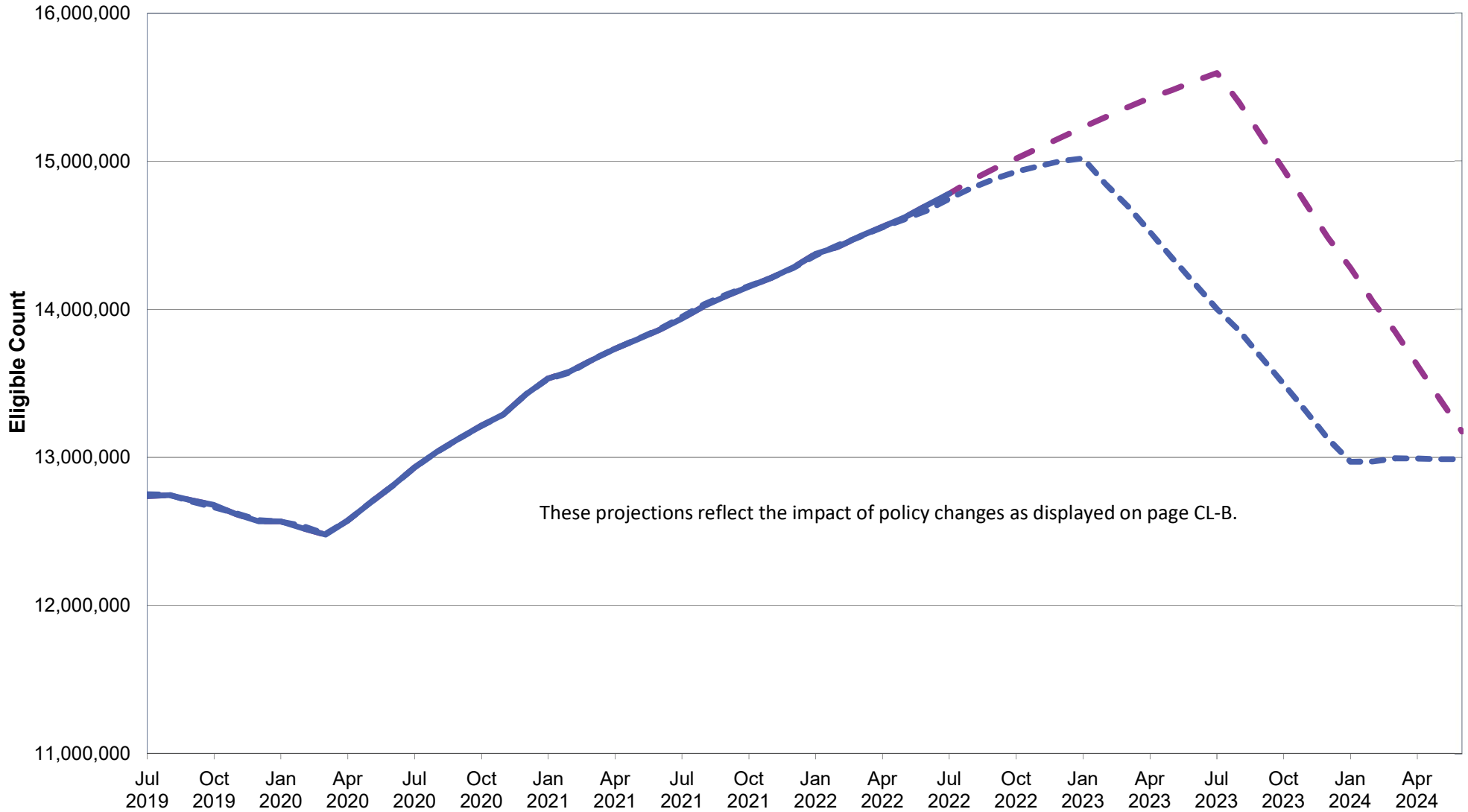
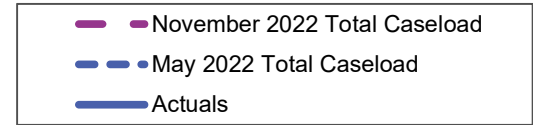
**Estimated Average Monthly Certified Eligibles
November 2022 Estimate
Fiscal Years 2021-2022, 2022-2023, & 2023-2024**

Fee-For-Service (With Estimated Impact of Eligibility Policy Changes)***					
	2021-2022	2022-2023	2023-2024	21-22 To 22-23 % Change	22-23 To 23-24 % Change
Public Assistance	287,412	130,829	22,092	-54.48%	-83.11%
Seniors	94,938	56,509	17,148	-40.48%	-69.65%
Persons with Disabilities	111,989	46,860	2,185	-58.16%	-95.34%
Families	80,485	27,460	2,759	-65.88%	-89.95%
Long Term	18,666	1,606	111	-91.39%	-93.12%
Seniors	14,700	1,077	89	-92.67%	-91.71%
Persons with Disabilities	3,966	529	21	-86.65%	-95.99%
Medically Needy	901,084	663,622	124,760	-26.35%	-81.20%
Seniors	189,517	128,708	64,133	-32.09%	-50.17%
Persons with Disabilities	57,964	37,308	15,361	-35.64%	-58.83%
Families	653,603	497,606	45,267	-23.87%	-90.90%
Medically Indigent	98,042	89,862	87,996	-8.34%	-2.08%
Children	95,013	86,942	85,079	-8.49%	-2.14%
Adults	3,029	2,920	2,917	-3.59%	-0.11%
Other	882,426	480,025	114,289	-45.60%	-76.19%
Refugees	654	592	476	-9.49%	-19.54%
OBRA	0	0	0	n/a	9.09%
185% Poverty	122,028	48,575	854	-60.19%	-98.24%
133% Poverty	30,999	2,475	2,045	-92.02%	-17.37%
100% Poverty	9,381	2,819	1,031	-69.95%	-63.44%
Opt. Targeted Low Income Children	33,409	6,595	2,156	-80.26%	-67.31%
ACA Optional Expansion	636,470	366,506	55,266	-42.42%	-84.92%
Hospital PE	34,600	37,300	37,300	7.80%	0.00%
Medi-Cal Access Program	186	162	162	-13.03%	0.00%
QMB	14,700	15,000	15,000	2.04%	0.00%
GRAND TOTAL	2,187,629	1,365,943	349,247	-37.56%	-74.43%
Percent of Statewide	15.22%	8.97%	2.42%		
Seniors	299,155	186,295	81,370	-37.73%	-56.32%
Persons with Disabilities	173,919	84,697	17,567	-51.30%	-79.26%
Families and Children	1,024,917	672,472	139,191	-34.39%	-79.30%
ACA Optional Expansion	636,470	366,506	55,266	-42.42%	-84.92%

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

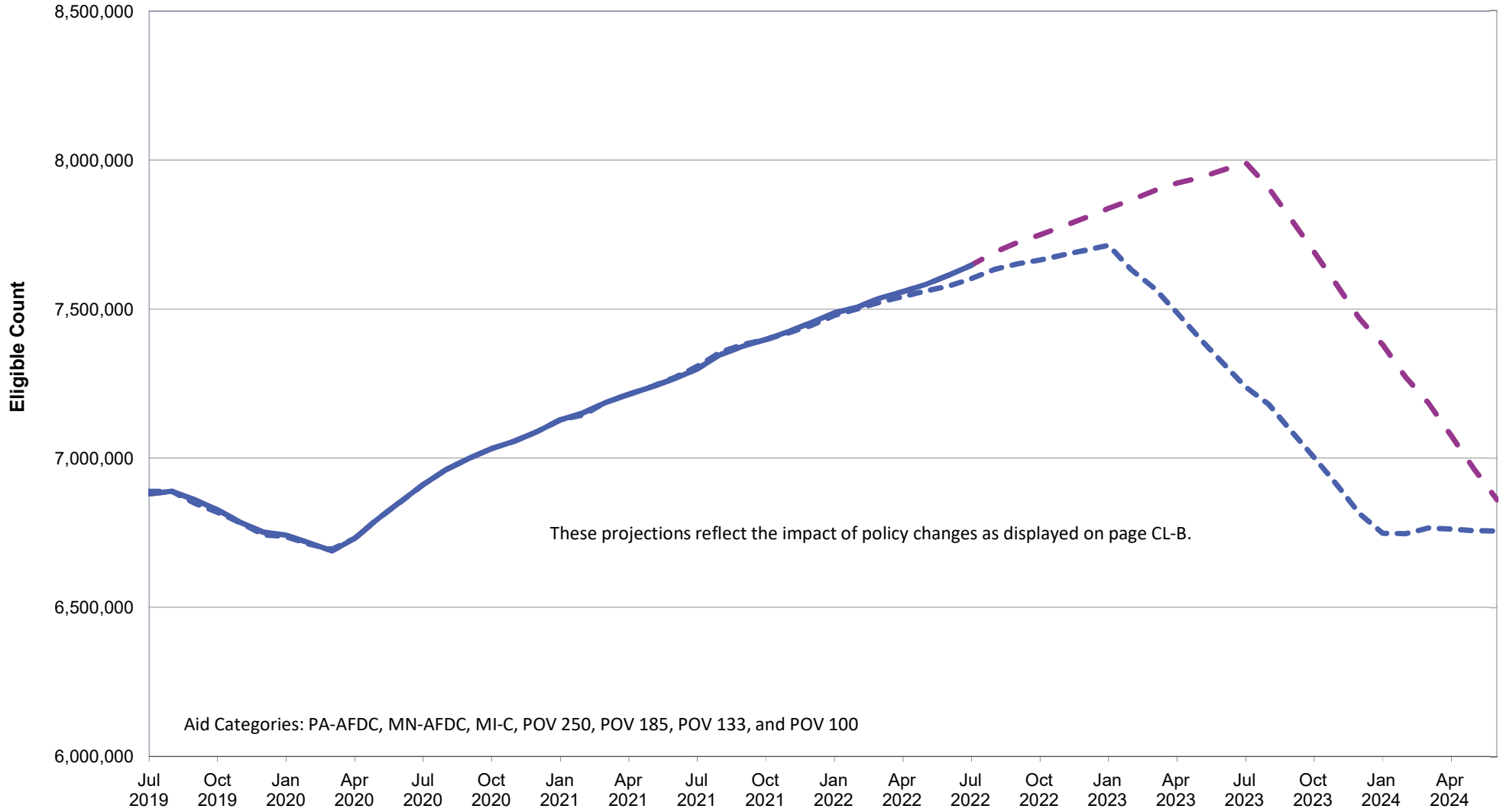
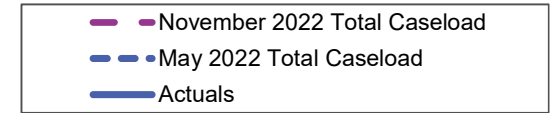
Statewide Caseload Projections, Including Impact of Policy Changes: All Aid Categories

Certified Average Monthly Eligible Count by Month



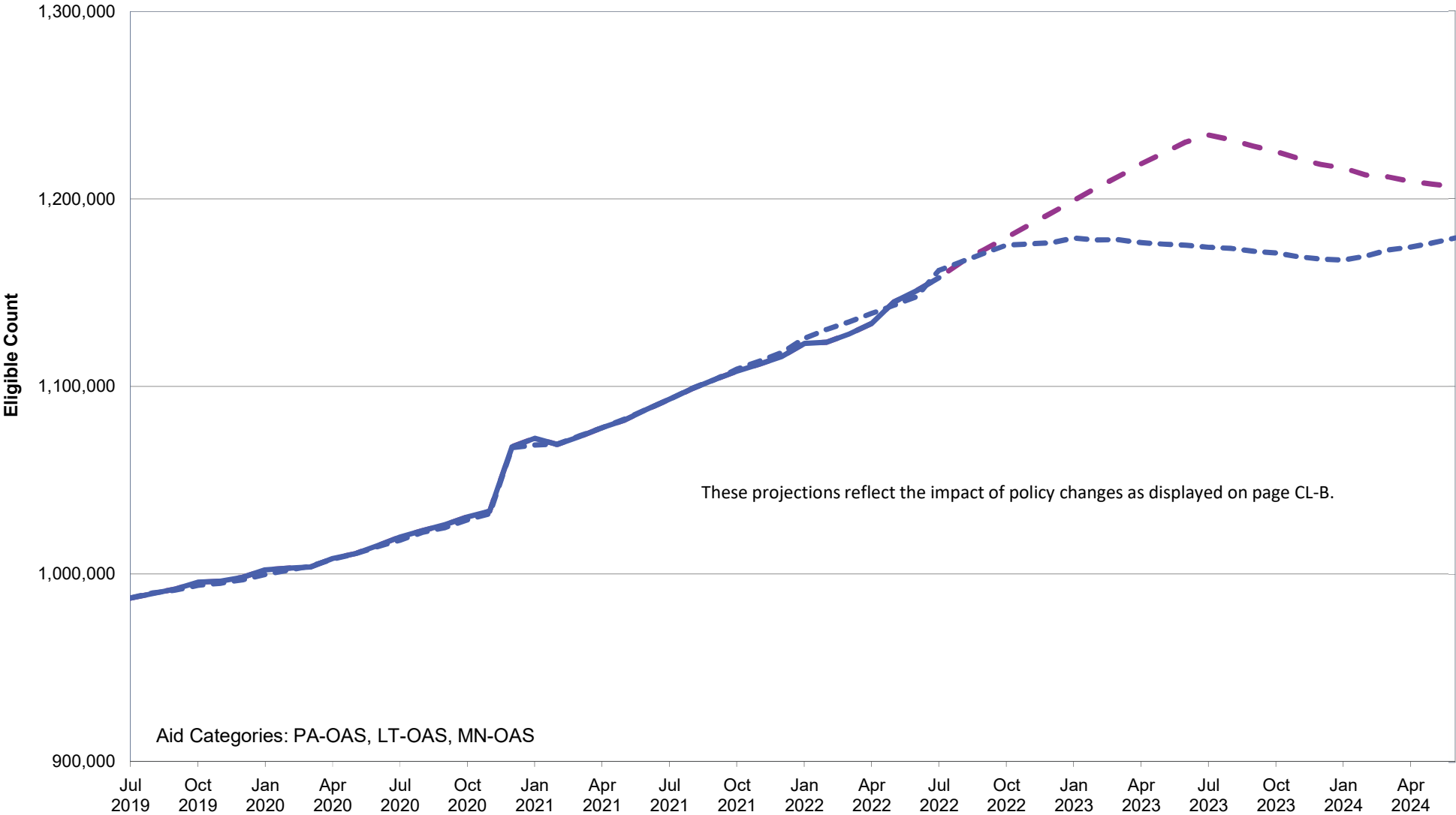
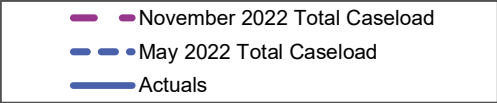
Statewide Caseload Projections, Including Impact of Policy Changes: Families and Children

Certified Average Monthly Eligible Count by Month



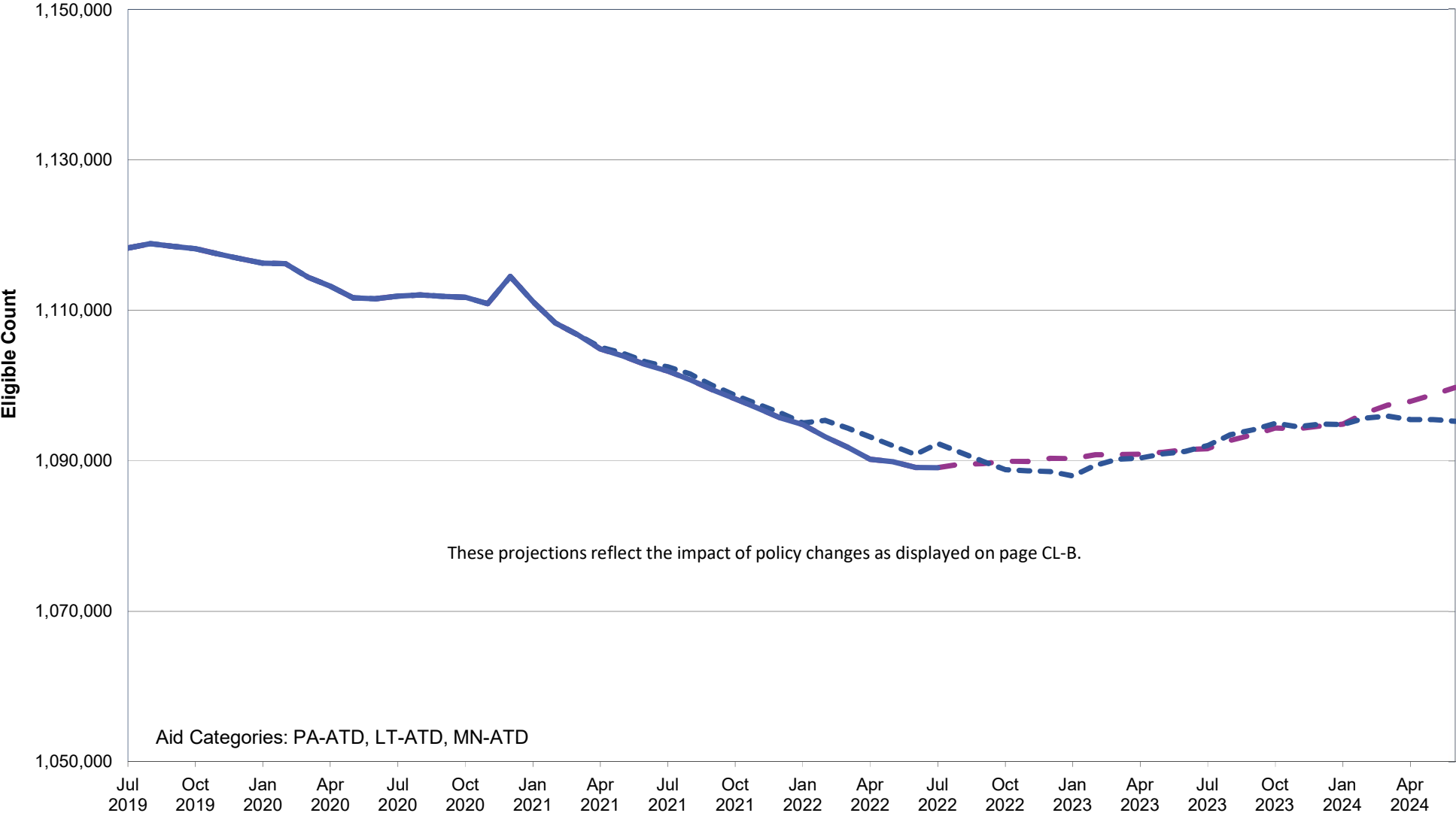
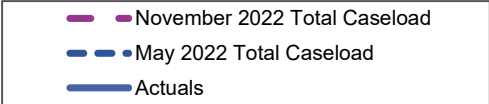
Statewide Caseload Projections, Including the Impact of Policy Changes: Seniors

Certified Average Monthly Eligible Count by Month



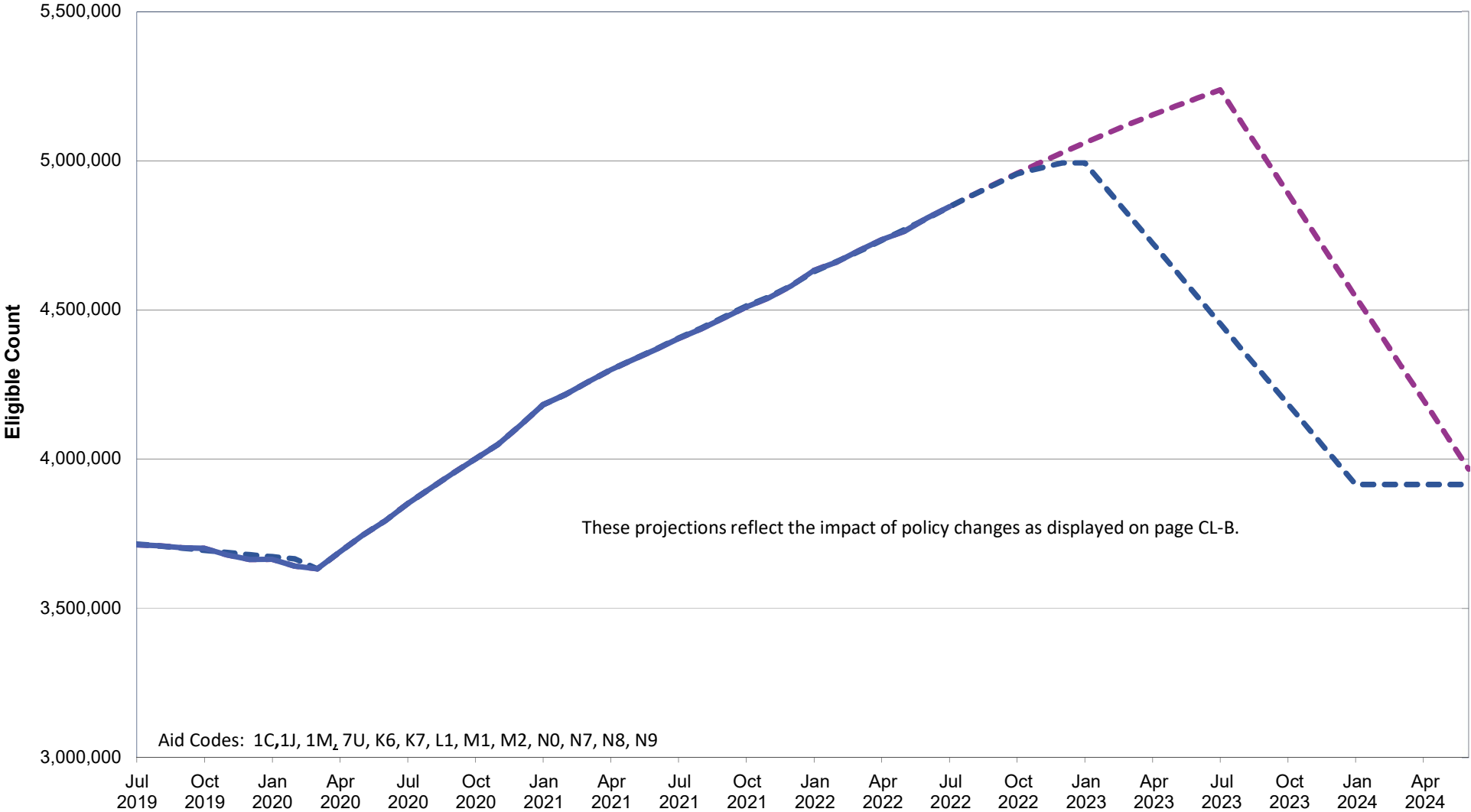
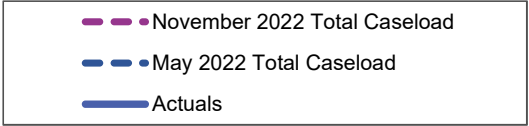
Statewide Caseload Projections, Including Impact of Policy Changes: Persons with Disabilities

Certified Average Monthly Eligible Count by Month



Statewide Caseload Projections, Including Impact of Policy Changes: ACA Optional Expansion (NEWLY)

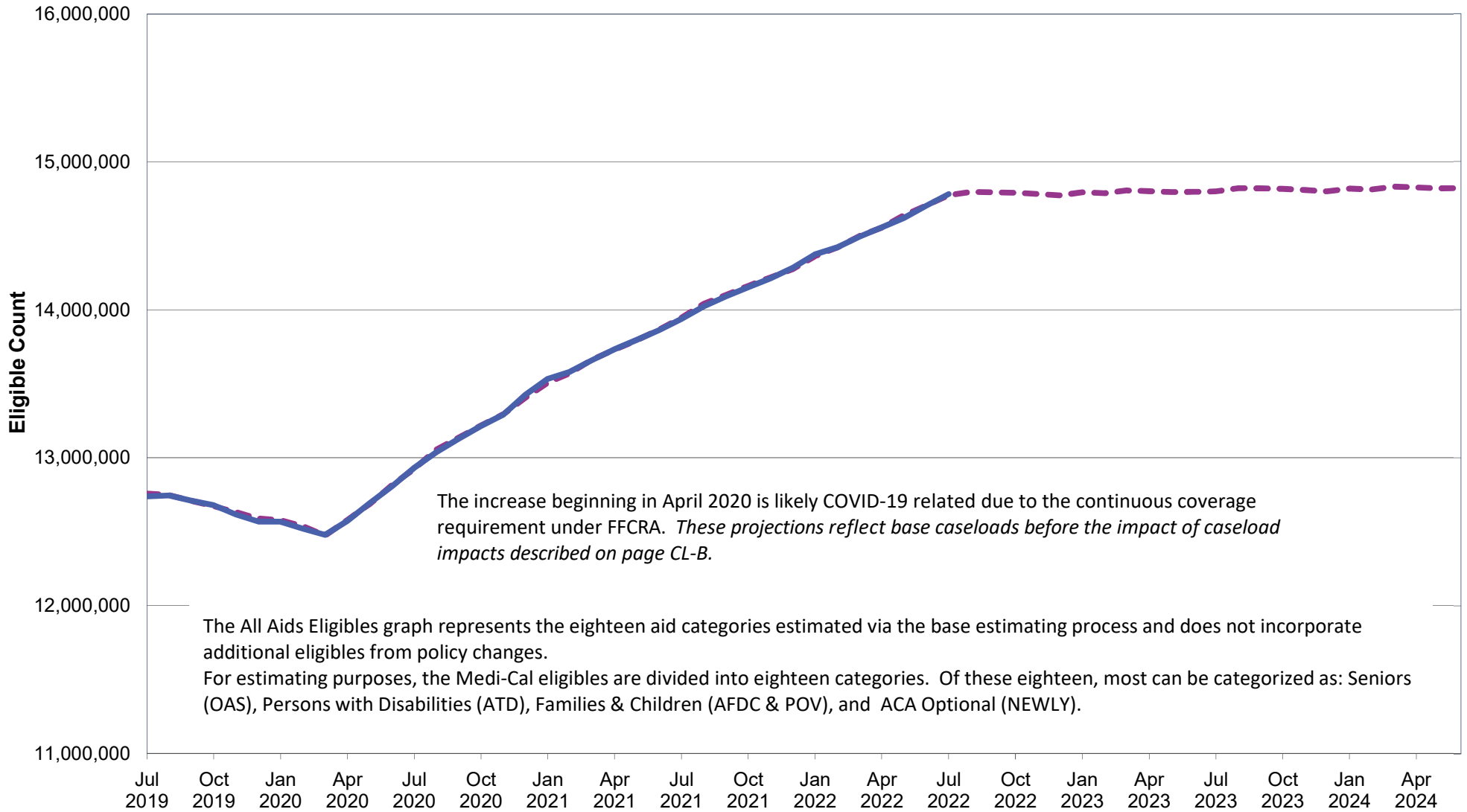
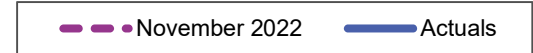
Certified Average Monthly Eligible Count by Month



Aid Codes: 1C,1J, 1M, 7U, K6, K7, L1, M1, M2, N0, N7, N8, N9

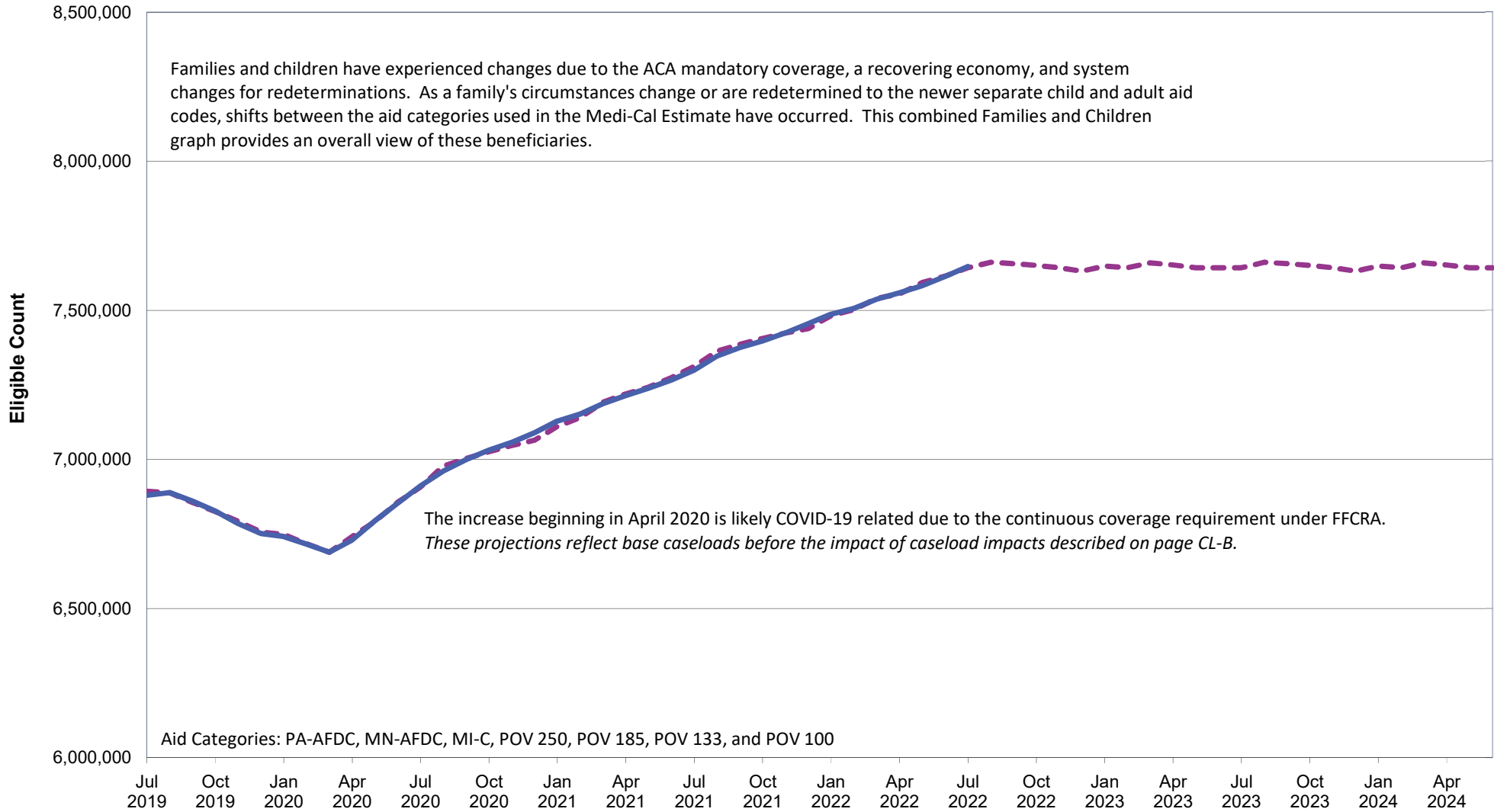
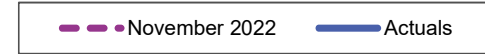
Statewide Caseload Projections, Base Projection Only: All Aid Categories

Certified Average Monthly Eligible Count by Month



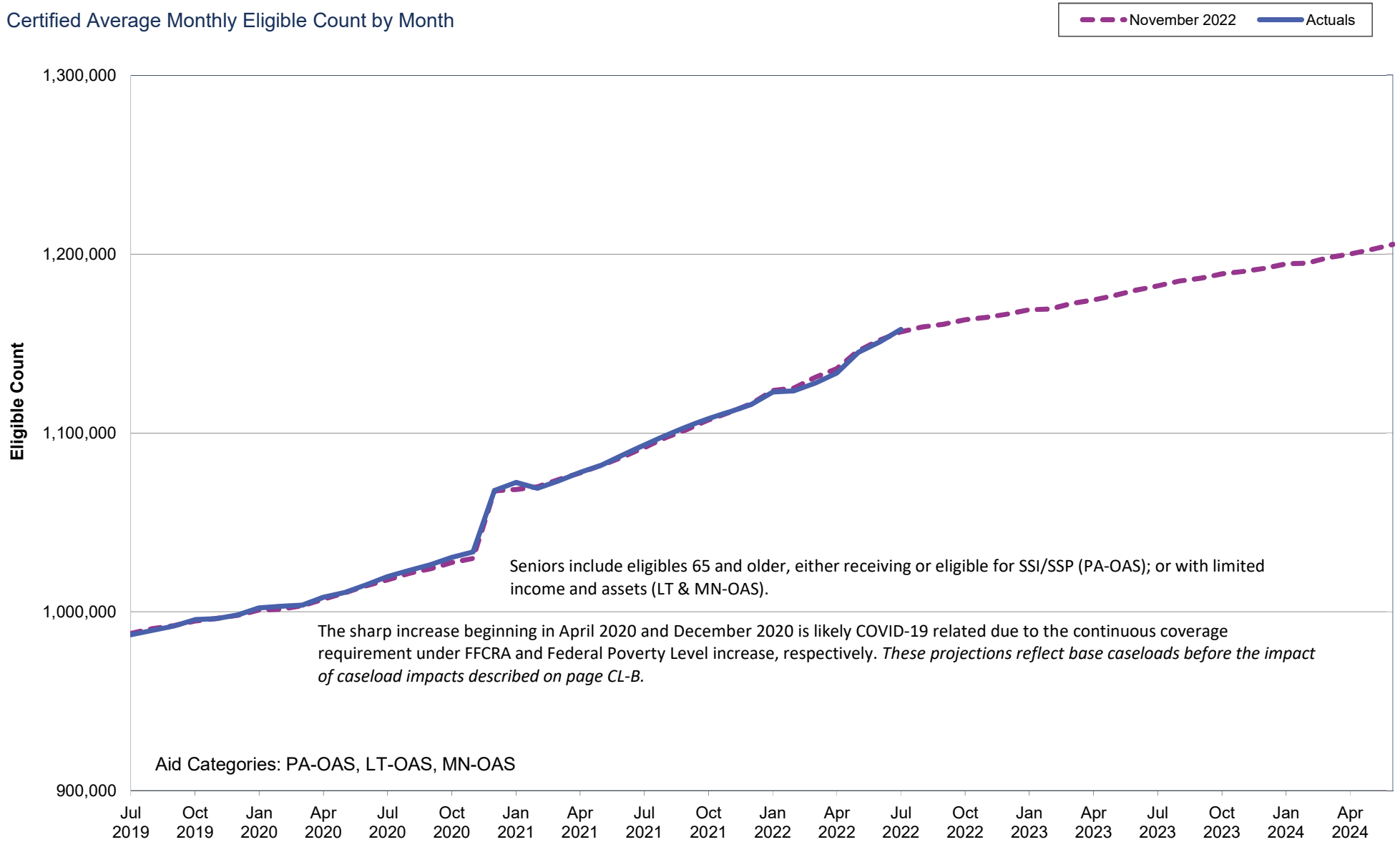
Statewide Caseload Projections, Base Projection Only: Families and Children

Certified Average Monthly Eligible Count by Month



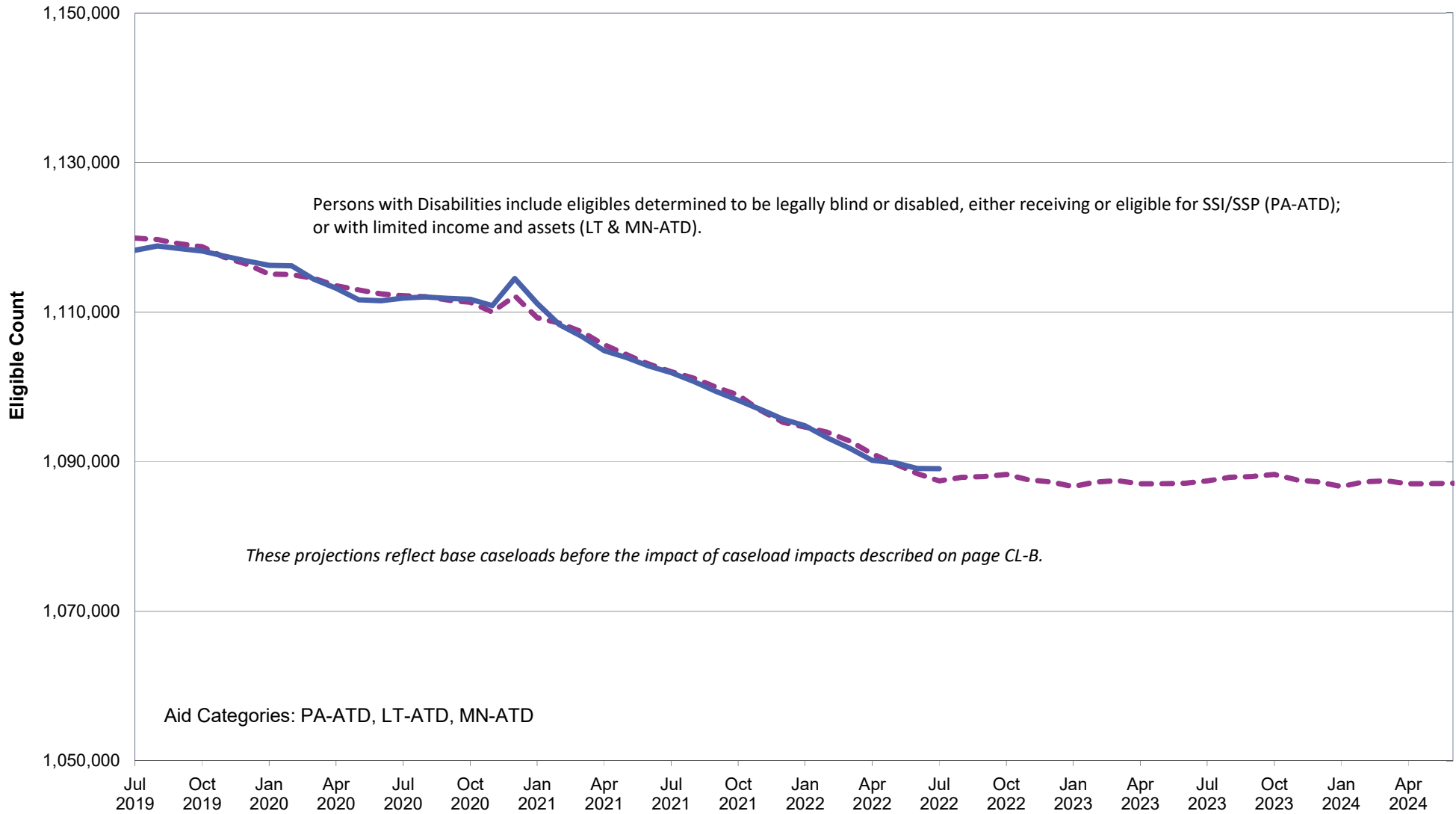
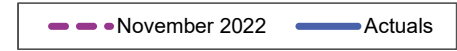
Statewide Caseload Projections, Base Projection Only: Seniors

Certified Average Monthly Eligible Count by Month



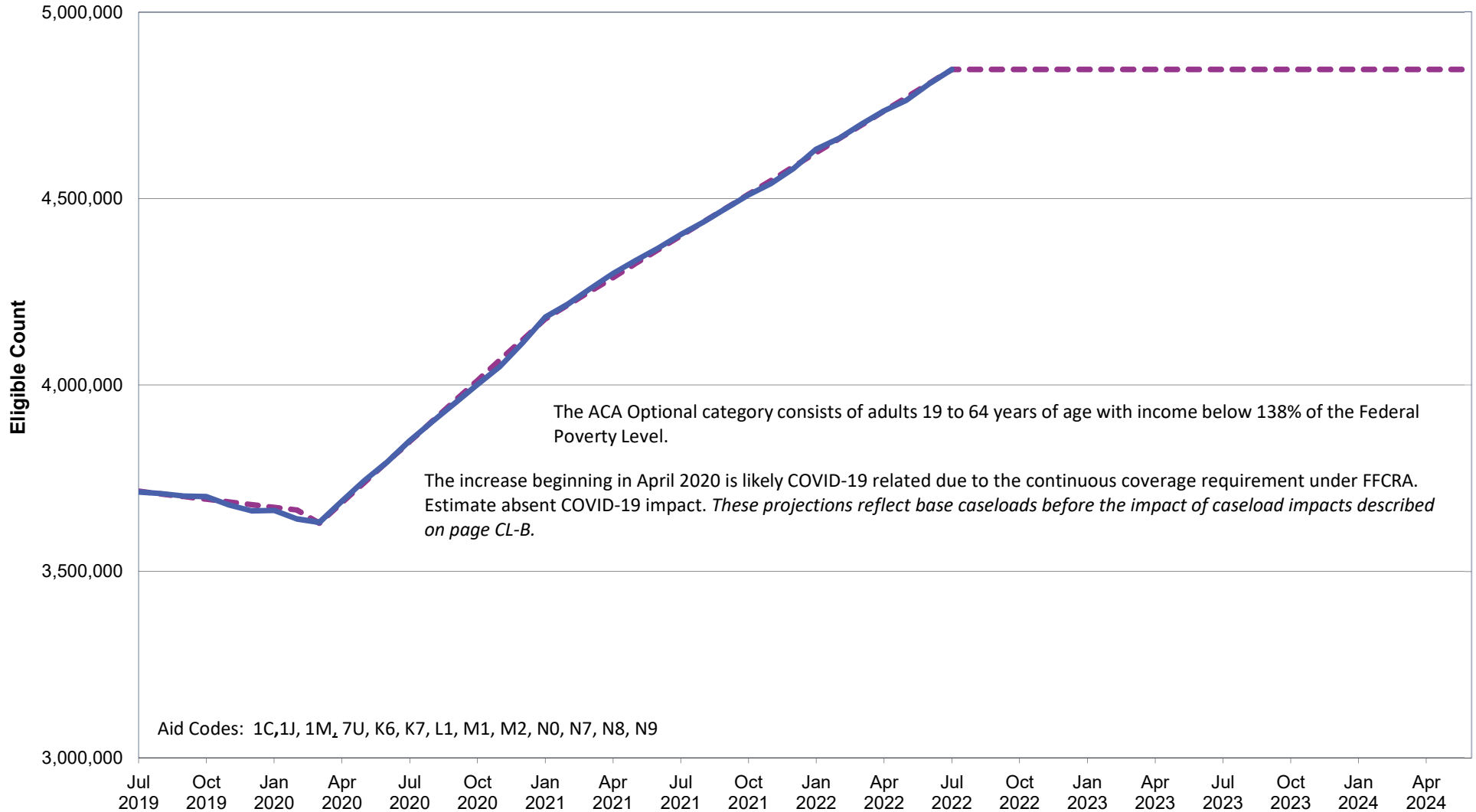
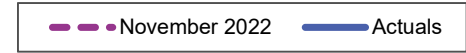
Statewide Caseload Projections, Base Projection Only: Persons with Disabilities

Certified Average Monthly Eligible Count by Month



Statewide Caseload Projections, Base Projection Only: ACA Optional Expansion (NEWLY)

Certified Average Monthly Eligible Count by Month



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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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.

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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 60 months (excluding April 2020 – July 2021 due to the COVID-19 pandemic impact for some aid categories) 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 2022 FFS Base Estimate

Fiscal Year		November Estimate Total Expenditure	
PY	FY 2021-22	\$22,939,428,900	
CY	FY 2022-23	\$28,594,034,300	24.65%
BY	FY 2023-24	\$29,040,596,500	1.56%

Fiscal Year	FFS Base Expenditure		
	May-22	Nov-22	% Change
FY 2021-22	\$19,202,514,400	\$22,939,428,900	19.46%
FY 2022-23	\$18,551,222,100	\$28,594,034,300	54.14%

Overall, the November 2022 FFS Base is estimated at \$28.6 billion for FY 2022-23 and \$29.0 billion for FY 2023-24. The increase in the budget year is mainly from Pharmacy service category, specifically average unit per user and dollar per unit.

Items Impacting FFS Base Estimate

Overall Changes: Compared to the M22 estimate, the N22 estimate includes the impact of the CalAIM FFS beneficiaries' transition to managed care and the transition of the managed care pharmacy benefit to FFS due to the Medi-Cal Rx carve-out implementation. It also includes the cost of extending rate increases provided for skilled nursing facilities during the pandemic. The projections also align with the most recent level of users, which is reduced from before the pandemic. These specific impact will be described in each of the service categories.

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.

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 258 processing days, CY and BY has 252 processing days.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2022 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	
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	2,439,590	3.01	\$257.66	\$776.04	\$5,679,680,300
2021-22 *	2	2,230,560	2.72	\$264.50	\$720.31	\$4,820,081,100
2021-22 *	3	3,676,520	3.73	\$143.45	\$534.56	\$5,895,929,100
2021-22 *	4	3,984,770	4.13	\$132.56	\$547.40	\$6,543,738,400
2021-22 *	TOTAL	3,082,860	3.53	\$175.47	\$620.08	\$22,939,428,900
2022-23 **	1	4,387,770	4.56	\$139.63	\$637.06	\$8,385,875,700
2022-23 **	2	3,943,190	4.08	\$141.01	\$575.63	\$6,809,432,500
2022-23 **	3	4,247,530	4.24	\$135.81	\$576.48	\$7,345,911,200
2022-23 **	4	3,853,460	3.86	\$135.52	\$523.58	\$6,052,814,900
2022-23 **	TOTAL	4,107,990	4.20	\$138.07	\$580.05	\$28,594,034,300
2023-24 **	1	4,373,980	4.56	\$141.44	\$644.77	\$8,460,638,100
2023-24 **	2	3,972,950	4.13	\$141.62	\$584.88	\$6,971,036,700
2023-24 **	3	4,114,760	4.18	\$138.94	\$580.16	\$7,161,680,900
2023-24 **	4	3,994,400	3.98	\$135.13	\$538.02	\$6,447,240,800
2023-24 **	TOTAL	4,114,020	4.22	\$139.42	\$588.24	\$29,040,596,500

* ACTUAL

** ESTIMATED

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

Physicians Fee-for-Service Base Estimate

Analyst: Violet Chan

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

FISCAL YEAR		USERS		UTILIZATION (Claims per User)		RATE (Cost per Claim)		TOTAL EXPENDITURE	
PY	2021-22	296,580	-	2.37	-	\$81.81	-	\$691,162,900	-
CY	2022-23	275,170	-7.2%	2.43	2.5%	\$85.09	4.0%	\$681,570,900	-1.4%
BY	2023-24	274,470	-0.3%	2.45	0.8%	\$85.22	0.2%	\$687,193,000	0.8%

Users: Users are estimated to decrease by 7.2% for the CY, in part due to the CalAIM implementation in January 2022 which transitioned beneficiaries from FFS to Managed Care. Users are estimated to remain relatively unchanged in the BY.

Utilization: Claims per user are estimated to increase by 2.5% in the CY, partly due to the availability of telehealth services. Utilization is estimated to remain relatively unchanged in the BY.

Rate: The rate is estimated to increase by 4.0% in the CY due to rate adjustments that occurred mainly in December 2021. The adjustments lowered the rate in the PY and are not assumed to occur in the CY. The BY rate is estimated to increase by 0.2% and assumes a normal growth rate.

Total Expenditure: The CY is estimated to decrease by 1.4%, mainly due to a decrease in users, but also offset by an increase in utilization and rate. The BY is estimated to increase by 0.8%, mainly due to the increase in utilization.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	M22	N22	% Change
2021-22	\$734,830,600	\$691,162,900	-5.9%
2022-23	\$751,883,900	\$681,570,900	-9.4%

Compared to the May 2022 Estimate, the November 2022 Estimate expenditure decreased by 5.9% for FY 2021-22 due to lower utilization and rates. The FY 2022-23 expenditure estimate decreased by 9.4% due to a decrease in users and rates.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2022 BASE ESTIMATES)**

PHYSICIANS

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
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	340,860	2.54	\$81.09	\$205.78	\$210,433,600
2021-22 *	2	284,930	2.41	\$81.65	\$197.16	\$168,531,100
2021-22 *	3	295,890	2.21	\$81.46	\$179.77	\$159,580,700
2021-22 *	4	264,650	2.30	\$83.40	\$192.23	\$152,617,600
2021-22 *	TOTAL	296,580	2.37	\$81.81	\$194.20	\$691,162,900
2022-23 **	1	296,090	2.50	\$86.43	\$216.34	\$192,170,900
2022-23 **	2	269,820	2.43	\$85.71	\$208.65	\$168,895,100
2022-23 **	3	289,460	2.41	\$84.02	\$202.43	\$175,781,300
2022-23 **	4	245,300	2.34	\$83.95	\$196.66	\$144,723,500
2022-23 **	TOTAL	275,170	2.43	\$85.09	\$206.41	\$681,570,900
2023-24 **	1	295,520	2.54	\$86.57	\$219.95	\$194,994,200
2023-24 **	2	268,840	2.44	\$85.82	\$209.50	\$168,969,600
2023-24 **	3	288,800	2.41	\$84.06	\$202.58	\$175,510,800
2023-24 **	4	244,730	2.39	\$84.19	\$201.20	\$147,718,500
2023-24 **	TOTAL	274,470	2.45	\$85.22	\$208.64	\$687,193,000

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of claims

Other Medical Fee-for-Service Base Estimate

Analyst: Violet Chan

Background: Other Medical includes clinics and specialist service providers. Payments to Federally Qualified Health Care Centers and Rural Health Centers (FQHC/RHC) are approximately 88% 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	2021-22	1,296,210	-	1.57	-	\$183.13	-	\$4,485,514,200	-
CY	2022-23	1,275,730	-1.6%	1.57	0.0%	\$188.55	3.0%	\$4,545,645,200	1.3%
BY	2023-24	1,254,610	-1.7%	1.58	0.6%	\$188.59	0.0%	\$4,482,184,500	-1.4%

Users: Users are estimated to decrease by 1.6% in the CY and by 1.7% in the BY, in part due to CalAIM implementation in January 2022 which transitioned beneficiaries from FFS to Managed Care.

Utilization: Utilization is estimated to remain relatively unchanged for both CY and BY

Rate: Rate is estimated to increase by 3.0% in the CY due to the FQHC/RHC rate adjustment. BY is estimated to remain unchanged. Future rate increases for FQHC and Indian Health are estimated through policy changes.

Total Expenditure: The CY is estimated to increase by 1.3%, primarily due to an increase in rates. The BY is estimated to decrease by 1.4% due to a decrease in users.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	M22	N22	% Change
2021-22	\$4,451,655,700	\$4,485,514,200	0.8%
2022-23	\$4,277,891,100	\$4,545,645,200	6.3%

Compared to the May 2022 Estimate, the November 2022 Estimate for Total Expenditure for FY 2021-22 increased 0.8% due to a slight increase in users and rate. The FY 2022-23 estimated increase of 6.3% is due to an increase in users and rate.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2022 BASE ESTIMATES)**

OTHER MEDICAL

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
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	1,410,910	1.66	\$180.78	\$299.36	\$1,267,100,000
2021-22 *	2	1,286,700	1.56	\$186.65	\$290.52	\$1,121,443,300
2021-22 *	3	1,210,230	1.54	\$181.91	\$279.30	\$1,014,035,200
2021-22 *	4	1,276,990	1.54	\$183.49	\$282.68	\$1,082,935,600
2021-22 *	TOTAL	1,296,210	1.57	\$183.13	\$288.37	\$4,485,514,200
2022-23 **	1	1,446,670	1.64	\$188.31	\$308.25	\$1,337,788,900
2022-23 **	2	1,252,200	1.56	\$188.97	\$294.23	\$1,105,296,400
2022-23 **	3	1,249,760	1.58	\$188.41	\$297.06	\$1,113,759,200
2022-23 **	4	1,154,280	1.51	\$188.55	\$285.55	\$988,800,600
2022-23 **	TOTAL	1,275,730	1.57	\$188.55	\$296.93	\$4,545,645,200
2023-24 **	1	1,369,650	1.63	\$188.39	\$307.04	\$1,261,612,000
2023-24 **	2	1,248,260	1.56	\$188.95	\$294.87	\$1,104,211,800
2023-24 **	3	1,247,600	1.58	\$188.31	\$296.73	\$1,110,615,500
2023-24 **	4	1,152,920	1.54	\$188.78	\$290.78	\$1,005,745,200
2023-24 **	TOTAL	1,254,610	1.58	\$188.59	\$297.71	\$4,482,184,500

* 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	2021-22	185,940		1.55		\$175.29		\$606,870,200	
CY	2022-23	168,240	-9.5%	1.55	0.0%	\$179.64	2.5%	\$562,697,900	-7.3%
BY	2023-24	167,820	-0.2%	1.56	0.6%	\$178.64	-0.6%	\$559,551,800	-0.6%

Users: Users are estimated to decrease by 9.5% in the CY partly due to the CalAIM implementation in January 2022 which transitioned beneficiaries from FFS to Managed Care. The BY is relatively unchanged, assuming users stay with the current trend.

Utilization: Utilization is estimated to remain relatively unchanged.

Rate: Rate is estimated to increase by 2.5% in the CY because July 2022 actual was higher than previously projected. The rate is estimated to remain relatively unchanged in the BY.

Total Expenditure: Total expenditure is estimated to decrease by 7.3% in the CY due to lower users. Total expenditure is estimated to remain relatively unchanged in the BY.

Reason for Change from Prior Estimate

Fiscal Year	TOTAL EXPENDITURE		
	M22	N22	% Change
2021-22	\$603,665,500	\$606,870,200	0.5%
2022-23	\$579,047,000	\$562,697,900	-2.8%

Compared to the May 2022 Estimate, the November 2022 estimated total expenditures for FY 2021-22 is relatively unchanged. Expenditures are estimated to decrease by 2.8% in FY 2022-23 due to lower users.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2022 BASE ESTIMATES)**

CO. & COMM. OUTPATIENT

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
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	219,290	1.61	\$178.41	\$287.43	\$189,092,300
2021-22 *	2	190,640	1.55	\$165.82	\$256.48	\$146,686,000
2021-22 *	3	174,260	1.49	\$186.21	\$277.07	\$144,848,800
2021-22 *	4	159,560	1.55	\$170.64	\$263.74	\$126,243,100
2021-22 *	TOTAL	185,940	1.55	\$175.29	\$271.99	\$606,870,200
2022-23 **	1	186,110	1.60	\$189.46	\$302.66	\$168,979,900
2022-23 **	2	170,270	1.55	\$175.25	\$272.10	\$138,990,500
2022-23 **	3	167,710	1.54	\$179.52	\$276.30	\$139,017,000
2022-23 **	4	148,880	1.51	\$171.94	\$259.07	\$115,710,400
2022-23 **	TOTAL	168,240	1.55	\$179.64	\$278.71	\$562,697,900
2023-24 **	1	186,550	1.59	\$185.05	\$294.97	\$165,077,900
2023-24 **	2	169,030	1.55	\$175.63	\$272.65	\$138,255,400
2023-24 **	3	167,150	1.54	\$179.10	\$275.48	\$138,143,900
2023-24 **	4	148,570	1.53	\$173.22	\$264.91	\$118,074,500
2023-24 **	TOTAL	167,820	1.56	\$178.64	\$277.85	\$559,551,800

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of claims

Pharmacy Fee-for-Service Base Estimate

Analyst: My-Ai Bui

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	2021-22	1,782,400	-	3.48	-	\$104.17	-	\$7,760,232,500	-
CY	2022-23	3,155,220	77.02%	4.02	15.33%	\$91.72	-11.95%	\$13,950,673,100	79.77%
BY	2023-24	3,163,180	0.25%	4.05	0.83%	\$94.01	2.49%	\$14,453,675,700	3.61%

Users: Users increased by 77.02% in the CY and by 0.25% in the BY. The increase in the CY assumes that the managed care pharmacy benefit is fully transitioned into FFS pursuant to the Medi-Cal Rx carve-out, and also reflects additional users due to growth in caseload during the pandemic through July 2022.

Utilization: Utilization is estimated to increase by 15.33% in the CY. This is due to the average managed care beneficiary having a larger number of prescriptions than the average prior year FFS beneficiary.

Rate: The rate is projected to decrease by 11.95%. This is due to the majority of managed care beneficiaries' utilizing a lower cost prescriptions.

Total Expenditure: Total expenditures are estimated to increase by 79.77% in the CY due to the Medi-Cal Rx Managed Care being fully transitioned to the FFS as well as growth in caseload and utilization during the pandemic. The 3.61% increase in the BY is due to normal projected increases in utilization and rates in some aid categories.

Reason for Change from Prior Estimate:

FISCAL YEAR	TOTAL EXPENDITURE		
	M22	N22	% Change
2021-22	\$3,986,097,800	\$7,760,232,500	94.7%
2022-23	\$3,966,883,100	\$13,950,673,100	251.7%

Compared to the May 2022 Estimate, the November 2022 Estimate of total expenditures for both fiscal years increased significantly. This is because the managed care pharmacy benefit has now fully transitioned to FFS and additional caseload growth during the pandemic are reflected in actual data and projections.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2022 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>
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	743,040	2.50	\$208.92	\$522.34	\$1,164,361,200
2021-22 *	2	693,680	2.34	\$213.08	\$497.60	\$1,035,529,800
2021-22 *	3	2,663,400	3.57	\$86.59	\$309.16	\$2,470,228,600
2021-22 *	4	3,029,460	3.91	\$86.96	\$340.01	\$3,090,113,000
2021-22 *	TOTAL	1,782,400	3.48	\$104.17	\$362.82	\$7,760,232,500
2022-23 **	1	3,374,710	4.36	\$92.87	\$404.60	\$4,096,221,700
2022-23 **	2	3,049,800	3.82	\$91.60	\$349.55	\$3,198,155,500
2022-23 **	3	3,262,720	4.14	\$91.68	\$379.87	\$3,718,245,400
2022-23 **	4	2,933,630	3.69	\$90.36	\$333.84	\$2,938,050,500
2022-23 **	TOTAL	3,155,220	4.02	\$91.72	\$368.46	\$13,950,673,100
2023-24 **	1	3,384,550	4.38	\$96.75	\$423.98	\$4,304,963,000
2023-24 **	2	3,071,800	3.89	\$93.35	\$363.30	\$3,347,926,400
2023-24 **	3	3,152,710	4.02	\$92.83	\$373.33	\$3,531,004,200
2023-24 **	4	3,043,640	3.87	\$92.48	\$358.10	\$3,269,782,000
2023-24 **	TOTAL	3,163,180	4.05	\$94.01	\$380.78	\$14,453,675,700

* 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 (Days per User)		RATE (Cost per Day)		TOTAL EXPENDITURE	
PY	2021-22	4,080	--	5.12	--	\$3,747.26	--	\$939,415,800	--
CY	2022-23	4,020	-1.5%	5.01	-2.1%	\$3,748.22	0.0%	\$904,636,100	-3.7%
BY	2023-24	4,020	0.0%	5.01	0.0%	\$3,797.98	1.3%	\$916,693,800	1.3%

Users: Users are estimated to decrease by 1.5% 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. No change is estimated between CY and BY, assuming no further COVID impact and that users fully return to the pre-COVID level.

Utilization: Utilization, or the number of days stayed per user, is expected to decrease by 2.1% from PY to CY. This is due to the COVID-19 impact, which appears to have led to more users and longer stays in PY, and is returning to the pre-COVID level. BY is unchanged from CY, with shorter stays consistent with the pre-COVID level.

Rate: Rate, or the cost per day, is estimated to remain the same from PY to CY as a lower level due to the absence of temporary COVID rate increase is canceled out by on-going rate increase. It increases by 1.3% from CY to BY mainly due to the on-going rate increase implemented on July 2022.

Total Expenditures: Total expenditures are estimated to decrease by 3.7% from PY to CY due to decreased users and utilization. Total expenditures are estimated to increase by 1.3% from CY to BY, due to the regular rate increase.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	M22	N22	% Change
2021-22	\$931,095,100	\$939,415,800	0.9%
2022-23	\$844,410,300	\$904,636,100	7.1%

Compared to the May 2022 estimate, the November 2022 estimate is projected to increase by 0.9% in FY 2021-22. This is likely due to high hospitalizations attributable to COVID-19 cases. For FY 2022-23, higher users and utilization for July 2022 as well as the on-going rate increase are contributing to the 7.1% increase.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2022 BASE ESTIMATES)**

COUNTY INPATIENT

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
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	4,800	5.12	\$3,796.74	\$19,434.64	\$279,800,600
2021-22 *	2	4,030	5.31	\$3,832.80	\$20,333.33	\$245,667,400
2021-22 *	3	3,520	4.67	\$3,648.08	\$17,026.66	\$179,784,500
2021-22 *	4	3,980	5.33	\$3,680.60	\$19,600.19	\$234,163,400
2021-22 *	TOTAL	4,080	5.12	\$3,747.26	\$19,177.62	\$939,415,800
2022-23 **	1	4,380	5.06	\$3,671.66	\$18,562.54	\$243,862,700
2022-23 **	2	4,040	4.97	\$3,758.82	\$18,680.17	\$226,526,500
2022-23 **	3	4,270	4.98	\$3,794.16	\$18,887.96	\$242,005,100
2022-23 **	4	3,380	5.02	\$3,778.01	\$18,978.06	\$192,241,700
2022-23 **	TOTAL	4,020	5.01	\$3,748.22	\$18,765.94	\$904,636,100
2023-24 **	1	4,370	5.05	\$3,764.68	\$19,020.21	\$249,360,200
2023-24 **	2	4,050	4.98	\$3,821.71	\$19,017.27	\$230,971,400
2023-24 **	3	4,270	4.96	\$3,821.83	\$18,952.43	\$242,944,600
2023-24 **	4	3,380	5.05	\$3,783.43	\$19,092.67	\$193,417,700
2023-24 **	TOTAL	4,020	5.01	\$3,797.98	\$19,016.67	\$916,693,800

* 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	2021-22	24,030	--	5.29	--	\$2,622.24	--	\$4,000,243,700	--
CY	2022-23	23,320	-3.0%	5.03	-4.9%	\$2,480.08	-5.4%	\$3,487,440,400	-12.8%
BY	2023-24	23,110	-0.9%	5.05	0.4%	\$2,498.98	0.8%	\$3,501,748,900	0.4%

Users: Users are estimated to decrease by 3.0% from PY to CY and by 0.9% from CY to BY, assuming users return to the pre-COVID level. Processing payment days also decreased by 2.3% from PY to CY, which also contributes to the decrease.

Utilization: Utilization, or the number of days stayed per user, is expected to decrease by 4.9% from PY to CY. This is due to the COVID-19 impact, which appears to have led to more users and longer stays in PY, waning in the CY, with utilization returning to the pre-COVID level. The change between CY and BY is virtually flat at an estimated increase to be 0.4%.

Rate: Rate, or the cost per day, is estimated to decrease by 5.4% from PY to CY. This is due to the absence of a temporary COVID-19 rate increase in the FFS base for months after July 2022 (costs for COVID-19 rate increases for months after July are included, where appropriate, in policy changes) and the on-going rate increase implemented in July 2020. These rate increases are estimated in a separate policy change. The BY rate is estimated to increase by 0.8% due to projected long-term rate growth.

Total Expenditures: Total expenditures are estimated to decrease by 12.8% from PY to CY as all three components are expected to decrease, mainly due to the COVID-19 impact that is included fully in PY but only for July in the CY. Total expenditures are estimated to increase by 0.4% from CY to BY, due to assumed long-term rate growth.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	M22	N22	% Change
2021-22	\$4,094,241,500	\$4,000,243,700	-2.3%
2022-23	\$3,927,656,000	\$3,487,440,400	-11.2%

Compared to the May 2022 estimate, the November 2022 estimate shows a decrease of 2.3% in FY 2021-22. This is likely due to lower-than-expected hospitalizations attributable to COVID-19 cases. For 2022-23, the estimate decreases by 11.2% due to lowered users estimated for CY.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2022 BASE ESTIMATES)**

COMMUNITY INPATIENT

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
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	27,880	5.38	\$2,696.30	\$14,498.41	\$1,212,530,800
2021-22 *	2	24,540	5.29	\$2,634.52	\$13,936.51	\$1,026,075,600
2021-22 *	3	22,040	5.43	\$2,590.42	\$14,066.69	\$930,047,600
2021-22 *	4	21,670	5.03	\$2,540.76	\$12,789.75	\$831,589,800
2021-22 *	TOTAL	24,030	5.29	\$2,622.24	\$13,870.76	\$4,000,243,700
2022-23 **	1	26,710	5.09	\$2,480.27	\$12,631.50	\$1,012,218,200
2022-23 **	2	23,000	5.10	\$2,472.68	\$12,606.89	\$869,835,300
2022-23 **	3	23,260	5.02	\$2,471.97	\$12,419.46	\$866,664,900
2022-23 **	4	20,310	4.85	\$2,498.21	\$12,125.82	\$738,722,100
2022-23 **	TOTAL	23,320	5.03	\$2,480.08	\$12,462.47	\$3,487,440,400
2023-24 **	1	25,920	5.17	\$2,482.26	\$12,834.07	\$997,885,800
2023-24 **	2	22,950	5.11	\$2,497.21	\$12,750.08	\$878,016,900
2023-24 **	3	23,250	5.01	\$2,501.45	\$12,529.49	\$873,871,100
2023-24 **	4	20,300	4.90	\$2,520.71	\$12,345.27	\$751,975,100
2023-24 **	TOTAL	23,110	5.05	\$2,498.98	\$12,629.21	\$3,501,748,900

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of days stay

Nursing Facility Fee-for-Service Base Estimate

Analyst: Yuhao Wu

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	2021-22	23,540	-	32.12	-	\$294.03	-	\$2,667,480,000	-
CY	2022-23	23,500	-0.2%	31.17	-3.0%	\$298.29	1.4%	\$2,621,295,800	-1.7%
BY	2023-24	23,460	-0.2%	31.33	-0.5%	\$295.53	-0.9%	\$2,606,389,500	-0.6%

Users: Users are estimated to remain relatively unchanged (-0.2%) in both CY and BY.

Utilization: Utilization is estimated to decrease by 3.0% in CY and slightly decrease by 0.5% in BY, which reflects a normal fluctuation.

Rate: The rate is estimated to change only by minor amounts year to year, with an increase of 1.5% in CY, and decrease by 0.9% in BY.

Total Expenditure: The CY is estimated to decrease by 1.7% is mainly due to lower utilization. The BY is estimated to remain relatively unchanged.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	M22	N22	% Change
2021-22	\$2,621,048,700	\$2,667,480,000	1.8%
2022-23	\$2,420,222,700	\$2,621,295,800	8.3%

Compared to the May 2022 Estimate, the November 2022 Estimate total expenditures for FY 2021-22 increased by 1.8%, due to lower users but also offset by higher rate. FY 2022-23 is estimated to increase by 8.3% because it includes the cost of extending the skilled nursing rate increases provided in connection with the COVID-19 pandemic.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2022 BASE ESTIMATES)**

NURSING FACILITIES

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
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	24,750	37.96	\$299.70	\$11,375.49	\$844,709,400
2021-22 *	2	23,980	30.94	\$292.55	\$9,052.14	\$651,256,500
2021-22 *	3	22,800	28.29	\$295.41	\$8,356.33	\$571,572,900
2021-22 *	4	22,630	30.83	\$286.68	\$8,837.74	\$599,941,200
2021-22 *	TOTAL	23,540	32.12	\$294.03	\$9,442.88	\$2,667,480,000
2022-23 **	1	24,950	34.64	\$309.22	\$10,710.02	\$801,513,100
2022-23 **	2	24,170	30.63	\$293.40	\$8,988.23	\$651,803,300
2022-23 **	3	23,130	30.70	\$296.13	\$9,090.37	\$630,787,600
2022-23 **	4	21,730	28.28	\$291.33	\$8,238.97	\$537,191,800
2022-23 **	TOTAL	23,500	31.17	\$298.29	\$9,297.12	\$2,621,295,800
2023-24 **	1	24,790	34.50	\$299.36	\$10,329.32	\$768,153,900
2023-24 **	2	24,170	30.72	\$293.33	\$9,010.84	\$653,442,800
2023-24 **	3	23,130	30.68	\$296.17	\$9,085.43	\$630,444,600
2023-24 **	4	21,730	29.10	\$292.22	\$8,502.10	\$554,348,300
2023-24 **	TOTAL	23,460	31.33	\$295.53	\$9,259.73	\$2,606,389,500

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of days stay

ICF/DD Fee-for-Service Base Estimate

Analyst: Yuhao Wu

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	2021-22	4,210	-	32.12	-	\$314.23	-	\$509,413,100	-
CY	2022-23	4,140	-1.7%	31.16	-3.0%	\$326.24	3.8%	\$504,403,100	-1.0%
BY	2023-24	4,160	0.5%	31.10	-0.2%	\$326.35	0.0%	\$506,593,700	0.4%

Users: Users are estimated to decrease by 1.7% in CY, and remain relatively unchanged in the BY.

Utilization: Utilization is estimated to decrease 3% in CY, which reflects normal fluctuation for this service category. Utilization is expected to remain relatively unchanged in the BY.

Rate: The rate is estimated to increase 3% in the CY, reflecting rate increase was implemented in January 2022. Rates are estimated to remain relatively unchanged in the BY for base projections. Regular rate increases for ICF/DDs are budgeted in the LTC Rate Adjustment policy change.

Total Expenditure: Total expenditures are estimated to decrease by 1% in the CY, and increase by 0.4% in the BY.

Reason for Change from Prior Estimate:

FISCAL YEAR	TOTAL EXPENDITURE		
	M22	N22	% Change
2021-22	\$432,862,000	\$509,413,100	17.7%
2022-23	\$399,719,100	\$504,403,100	26.2%

Compared to the May 2022 Estimate, actual total expenditures for FY 2021-22 increase by 17.7%, primarily due to one-time retroactive payment for rate increase was implemented in November 2021. Total expenditures for FY 2022-23 increase 26.2% reflecting rate increase implemented in January 2022 and the cost of assuming the continuation of rate increases provided in connection with the COVID-19 pandemic.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2022 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>
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	4,360	38.39	\$263.83	\$10,127.40	\$132,425,900
2021-22 *	2	4,260	31.24	\$288.25	\$9,004.21	\$115,190,900
2021-22 *	3	4,220	28.80	\$398.65	\$11,481.78	\$145,439,700
2021-22 *	4	3,980	29.73	\$327.97	\$9,749.19	\$116,356,600
2021-22 *	TOTAL	4,210	32.12	\$314.23	\$10,093.18	\$509,413,100
2022-23 **	1	4,200	36.10	\$326.54	\$11,787.32	\$148,351,600
2022-23 **	2	4,170	31.00	\$325.99	\$10,104.82	\$126,527,200
2022-23 **	3	4,170	31.07	\$325.36	\$10,110.25	\$126,590,000
2022-23 **	4	4,000	26.22	\$327.21	\$8,579.26	\$102,934,400
2022-23 **	TOTAL	4,140	31.16	\$326.24	\$10,164.06	\$504,403,100
2023-24 **	1	4,220	35.51	\$327.70	\$11,637.19	\$147,400,800
2023-24 **	2	4,200	31.02	\$325.28	\$10,090.07	\$127,014,200
2023-24 **	3	4,200	31.05	\$325.51	\$10,108.14	\$127,236,500
2023-24 **	4	4,020	26.62	\$326.79	\$8,698.34	\$104,942,200
2023-24 **	TOTAL	4,160	31.10	\$326.35	\$10,150.85	\$506,593,700

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of days stay

Medical Transportation Fee-for-Service Base Estimate

Analyst: Joy Oda

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

FISCAL YEAR		USERS		UTILIZATION		RATE		TOTAL EXPENDITURE	
				(Claims per User)		(Cost per Claim)			
PY	2021-22	19,730	-	2.84	-	\$136.00	-	\$91,554,400	-
CY	2022-23	18,550	-6.0%	2.74	-3.5%	\$140.45	3.3%	\$85,575,200	-6.5%
BY	2023-24	18,590	0.2%	2.76	0.7%	\$140.26	-0.1%	\$86,365,200	0.9%

Users: Users are estimated to decrease 6.0% in the CY, based on recent actual trends. In the BY, users are estimated to remain relatively unchanged.

Utilization: Utilization is estimated to decrease by 3.5% in the CY and remain relatively unchanged in the BY.

Rate: The CY rate is estimated to increase by 3.3% due to recent actuals trended forward. The BY rate remains relatively unchanged.

Total Expenditure: Total expenditures are estimated to decrease by 6.5% in the CY due to lower users and lower utilization. The BY is relatively unchanged.

Reason for Change from Prior Estimate

FISCAL YEAR	TOTAL EXPENDITURE		
	M22	N22	% Change
2021-22	\$101,428,500	\$91,554,400	-9.7%
2022-23	\$108,181,200	\$85,575,200	-20.9%

Compared to the May 2022 Estimate, the November 2022 Estimate is lower by 9.7% in FY 2021-22 and by 20.9% in FY 2022-23 due to lower users based on recent actual trends.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2022 BASE ESTIMATES)**

MEDICAL TRANSPORTATION

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
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	22,880	2.98	\$139.23	\$415.09	\$28,494,400
2021-22 *	2	20,720	2.65	\$139.25	\$368.99	\$22,934,000
2021-22 *	3	17,920	2.84	\$132.80	\$376.86	\$20,263,900
2021-22 *	4	17,410	2.90	\$131.33	\$380.20	\$19,862,000
2021-22 *	TOTAL	19,730	2.84	\$136.00	\$386.61	\$91,554,400
2022-23 **	1	20,840	2.81	\$143.78	\$403.44	\$25,224,500
2022-23 **	2	18,740	2.70	\$142.99	\$385.78	\$21,685,500
2022-23 **	3	18,200	2.77	\$138.24	\$383.54	\$20,943,500
2022-23 **	4	16,420	2.65	\$135.59	\$359.74	\$17,721,700
2022-23 **	TOTAL	18,550	2.74	\$140.45	\$384.43	\$85,575,200
2023-24 **	1	21,060	2.84	\$142.97	\$406.02	\$25,648,300
2023-24 **	2	18,700	2.71	\$142.83	\$386.61	\$21,686,300
2023-24 **	3	18,180	2.77	\$138.33	\$383.46	\$20,917,400
2023-24 **	4	16,410	2.71	\$135.87	\$368.00	\$18,113,200
2023-24 **	TOTAL	18,590	2.76	\$140.26	\$387.23	\$86,365,200

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of claims

Other Services Fee-for-Service Base Estimate

Analyst: My-Ai Bui

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		RATE		TOTAL EXPENDITURE	
				(Claims per User)		(Cost per Claim)			
PY	2021-22	191,510	-	2.83	-	\$153.84	-	\$1,000,327,300	-
CY	2022-23	198,530	3.67%	2.91	2.75%	\$145.33	-5.53%	\$1,006,604,700	0.63%
BY	2023-24	193,800	-2.38%	2.89	-0.70%	\$147.44	1.45%	\$989,866,400	-1.66%

Users: Users are estimated to increase in the CY, primarily due to LEA users returning to a normal level. July 2022 was unusually high, which we assume is temporary. The BY decrease reflects the absence of the one-time increase in July 2022.

Utilization: Utilization is estimated to increase by 2.75% in the CY, primarily due to an increase in LEA users. The LEA category has about 5 claims per user, so having more LEA claims brings up the average number of claims per user. The BY is essentially unchanged from the CY.

Rate: The rate is estimated to decrease by 5.53% in the CY, primarily due to the increase in LEA claims that averaged only about \$28 per claim and optical lab claims that averaged only about \$20 per claim. The BY is essentially unchanged from the CY.

Total Expenditure: Total expenditures are estimated to increase in the CY by 0.63%, primarily due to an increase in users. The BY total expenditures are down only slightly from the CY.

Reason for Change from Prior Estimate:

FISCAL YEAR	TOTAL EXPENDITURE		
	M22	N22	% Change
2021-22	\$1,016,199,300	\$1,000,327,300	-1.6%
2022-23	\$1,002,073,800	\$1,006,604,700	0.5%

Compare to the May 2022 Estimate, the November Estimate expenditure decreased by 1.6% due to lower user. The FY 2022-23 expenditure estimate increase by 0.5% due to higher utilization.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2022 BASE ESTIMATES)**

OTHER SERVICES

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
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	197,040	2.87	\$170.75	\$490.70	\$290,058,800
2021-22 *	2	172,960	2.15	\$215.24	\$462.85	\$240,162,000
2021-22 *	3	165,460	2.74	\$161.83	\$443.65	\$220,225,800
2021-22 *	4	230,560	3.36	\$107.38	\$361.26	\$249,880,700
2021-22 *	TOTAL	191,510	2.83	\$153.84	\$435.29	\$1,000,327,300
2022-23 **	1	210,260	3.12	\$149.55	\$466.77	\$294,433,400
2022-23 **	2	196,170	2.60	\$156.62	\$407.28	\$239,686,700
2022-23 **	3	189,530	2.83	\$154.38	\$436.48	\$248,183,400
2022-23 **	4	198,140	3.06	\$123.28	\$377.34	\$224,301,200
2022-23 **	TOTAL	198,530	2.91	\$145.33	\$422.53	\$1,006,604,700
2023-24 **	1	192,960	3.02	\$157.05	\$474.89	\$274,906,700
2023-24 **	2	194,980	2.60	\$156.94	\$407.45	\$238,329,800
2023-24 **	3	189,200	2.83	\$153.89	\$435.13	\$246,982,600
2023-24 **	4	198,060	3.10	\$124.83	\$386.49	\$229,647,200
2023-24 **	TOTAL	193,800	2.89	\$147.44	\$425.64	\$989,866,400

* 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	2021-22	2,500		6.21		\$1,004.16		\$187,214,700	
CY	2022-23	3,890	55.6%	5.04	-18.8%	\$1,035.17	3.1%	\$243,492,000	30.1%
BY	2023-24	4,020	3.3%	4.98	-1.2%	\$1,041.84	0.6%	\$250,334,100	2.8%

Users: Users are estimated to increase by 55.6% in the CY, assuming that the Assisted Living Waiver Pilot Program (ALWPP) Care Coordinator services, currently appearing under the Other Services, revert back to the Home Health category in actuals. Users are estimated to increase by 3.3% for the BY, assuming users return to the normal growth trend.

Utilization: Utilization is estimated to decrease by 18.8% in the CY. The PY utilization was high because some providers were temporarily billed two separate claims in order to receive full reimbursement related to Assisted Living Waiver (ALW) services at Residential Care Facilities. Utilization is estimated to decrease by 1.2% in the BY, assuming ALW billing will be corrected going forward.

Rate: The rate is estimated to increase by 3.1% in the CY, absent the ALWPP and ALW billing issue. The rate is estimated to remain relatively unchanged in the BY.

Total Expenditure: The expenditure is estimated to increase by 30.1% in the CY due to increased users and an increased rate. Expenditure is estimated to increase by 2.8% in the BY due to increased users.

Reason for Change from Prior Estimate

Fiscal Year	TOTAL EXPENDITURE		
	M22	N22	% Change
2021-22	\$230,397,700	\$187,214,700	-18.7%
2022-23	\$257,551,600	\$243,492,000	-5.5%

Compared to the May 2022 Estimate, the November 2022 Estimate for Total Expenditure decreased by 18.7% in FY 2021-22, mainly because ALWPP services were billed under Other Services. Total Expenditure is estimated to decrease by 5.5% in FY 2022-23 because ALWPP services was billed under Other Services for the month of July 2022.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2022 BASE ESTIMATES)**

HOME HEALTH

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
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	2,690	7.25	\$1,036.32	\$7,512.79	\$60,673,300
2021-22 *	2	2,450	6.36	\$998.11	\$6,346.81	\$46,604,600
2021-22 *	3	2,220	5.97	\$1,001.59	\$5,980.43	\$39,901,400
2021-22 *	4	2,650	5.21	\$967.93	\$5,043.51	\$40,035,400
2021-22 *	TOTAL	2,500	6.21	\$1,004.16	\$6,234.46	\$187,214,700
2022-23 **	1	3,700	5.76	\$1,018.81	\$5,863.32	\$65,110,700
2022-23 **	2	4,010	4.99	\$1,034.14	\$5,162.15	\$62,030,500
2022-23 **	3	4,020	5.01	\$1,059.15	\$5,302.34	\$63,933,600
2022-23 **	4	3,820	4.44	\$1,028.50	\$4,570.08	\$52,417,100
2022-23 **	TOTAL	3,890	5.04	\$1,035.17	\$5,219.73	\$243,492,000
2023-24 **	1	4,240	5.34	\$1,040.91	\$5,557.50	\$70,635,300
2023-24 **	2	4,010	5.00	\$1,035.02	\$5,177.26	\$62,212,000
2023-24 **	3	4,020	5.00	\$1,061.16	\$5,308.65	\$64,009,700
2023-24 **	4	3,820	4.53	\$1,028.54	\$4,662.49	\$53,477,000
2023-24 **	TOTAL	4,020	4.98	\$1,041.84	\$5,187.89	\$250,334,100

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of claims

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2022 BASE ESTIMATES)**

PA-OAS

AVERAGE MONTHLY

YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	58,250	3.72	\$206.55	\$768.07	\$134,210,800
2021-22 *	2	54,680	3.33	\$201.23	\$670.34	\$109,965,400
2021-22 *	3	108,220	2.90	\$119.13	\$345.39	\$112,133,700
2021-22 *	4	125,320	3.02	\$105.79	\$319.20	\$120,008,800
2021-22 *	TOTAL	86,620	3.15	\$145.58	\$458.26	\$476,318,600
2022-23 **	1	138,960	3.29	\$110.31	\$362.84	\$151,255,800
2022-23 **	2	122,730	2.98	\$111.59	\$332.24	\$122,324,600
2022-23 **	3	135,310	3.03	\$103.39	\$312.89	\$127,010,000
2022-23 **	4	119,920	2.85	\$106.86	\$304.06	\$109,384,900
2022-23 **	TOTAL	129,230	3.04	\$108.06	\$328.86	\$509,975,200
2023-24 **	1	139,130	3.24	\$106.29	\$344.72	\$143,881,400
2023-24 **	2	123,680	2.99	\$109.49	\$327.75	\$121,607,000
2023-24 **	3	130,540	2.98	\$106.63	\$318.12	\$124,578,400
2023-24 **	4	124,690	2.90	\$103.30	\$299.27	\$111,948,900
2023-24 **	TOTAL	129,510	3.03	\$106.44	\$323.03	\$502,015,800

* 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 2022 BASE ESTIMATES)**

LT-OAS

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
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	14,930	34.03	\$272.49	\$9,271.91	\$415,224,000
2021-22 *	2	14,330	27.33	\$265.62	\$7,259.70	\$312,123,500
2021-22 *	3	15,690	21.76	\$264.53	\$5,756.45	\$270,932,900
2021-22 *	4	15,990	23.00	\$256.22	\$5,891.94	\$282,607,000
2021-22 *	TOTAL	15,230	26.40	\$265.41	\$7,006.74	\$1,280,887,300
2022-23 **	1	16,900	26.63	\$276.77	\$7,369.92	\$373,638,600
2022-23 **	2	16,220	24.48	\$265.12	\$6,490.97	\$315,775,600
2022-23 **	3	16,810	23.05	\$261.77	\$6,033.48	\$304,249,100
2022-23 **	4	15,530	20.71	\$260.32	\$5,390.92	\$251,142,000
2022-23 **	TOTAL	16,360	23.77	\$266.66	\$6,339.43	\$1,244,805,400
2023-24 **	1	16,770	27.09	\$268.78	\$7,281.62	\$366,422,000
2023-24 **	2	16,270	24.53	\$265.14	\$6,504.67	\$317,442,300
2023-24 **	3	16,550	23.36	\$263.02	\$6,143.48	\$305,074,000
2023-24 **	4	15,780	21.16	\$260.86	\$5,520.37	\$261,415,800
2023-24 **	TOTAL	16,340	24.08	\$264.76	\$6,374.92	\$1,250,354,200

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2022 BASE ESTIMATES)**

MN-OAS

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
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	102,890	3.86	\$219.06	\$846.06	\$261,153,600
2021-22 *	2	101,060	3.42	\$217.88	\$744.90	\$225,835,100
2021-22 *	3	168,200	4.27	\$129.37	\$552.80	\$278,942,200
2021-22 *	4	190,910	4.56	\$125.91	\$574.28	\$328,900,600
2021-22 *	TOTAL	140,760	4.14	\$156.47	\$648.15	\$1,094,831,400
2022-23 **	1	206,070	5.30	\$127.59	\$676.11	\$417,967,700
2022-23 **	2	174,020	4.88	\$125.86	\$614.22	\$320,655,900
2022-23 **	3	187,020	5.06	\$119.80	\$606.09	\$340,060,000
2022-23 **	4	169,010	4.73	\$126.29	\$597.44	\$302,914,000
2022-23 **	TOTAL	184,030	5.01	\$124.91	\$625.63	\$1,381,597,600
2023-24 **	1	199,090	5.41	\$124.06	\$670.79	\$400,646,300
2023-24 **	2	177,970	4.87	\$126.07	\$614.13	\$327,893,000
2023-24 **	3	183,250	4.93	\$123.86	\$611.19	\$336,011,700
2023-24 **	4	180,940	4.71	\$124.98	\$588.45	\$319,428,200
2023-24 **	TOTAL	185,320	4.99	\$124.70	\$622.35	\$1,383,979,200

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2022 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>
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	46,220	4.57	\$217.68	\$994.79	\$137,934,200
2021-22 *	2	42,440	3.92	\$219.80	\$861.00	\$109,632,100
2021-22 *	3	59,960	4.33	\$167.47	\$725.26	\$130,470,700
2021-22 *	4	65,700	4.78	\$148.14	\$708.34	\$139,604,500
2021-22 *	TOTAL	53,580	4.44	\$181.38	\$805.08	\$517,641,500
2022-23 **	1	69,450	5.43	\$164.02	\$890.26	\$185,484,300
2022-23 **	2	61,920	4.79	\$166.74	\$798.45	\$148,316,400
2022-23 **	3	68,060	4.88	\$157.31	\$767.35	\$156,687,000
2022-23 **	4	63,160	4.57	\$157.46	\$718.98	\$136,235,400
2022-23 **	TOTAL	65,650	4.93	\$161.46	\$795.55	\$626,723,200
2023-24 **	1	69,730	5.38	\$163.62	\$879.55	\$183,993,800
2023-24 **	2	62,320	4.83	\$166.74	\$805.90	\$150,661,000
2023-24 **	3	66,080	4.84	\$159.60	\$772.40	\$153,123,000
2023-24 **	4	65,150	4.66	\$156.74	\$731.07	\$142,877,300
2023-24 **	TOTAL	65,820	4.94	\$161.75	\$798.48	\$630,655,100

* 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 2022 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>
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	611,480	2.28	\$205.28	\$468.46	\$859,361,500
2021-22 *	2	544,050	2.10	\$215.39	\$453.18	\$739,648,800
2021-22 *	3	887,020	3.03	\$117.20	\$355.55	\$946,138,500
2021-22 *	4	943,990	3.41	\$110.04	\$375.05	\$1,062,117,900
2021-22 *	TOTAL	746,640	2.83	\$142.32	\$402.61	\$3,607,266,800
2022-23 **	1	1,049,430	3.64	\$115.51	\$420.57	\$1,324,068,300
2022-23 **	2	949,490	3.29	\$118.36	\$389.17	\$1,108,543,300
2022-23 **	3	1,016,630	3.42	\$114.50	\$391.30	\$1,193,408,200
2022-23 **	4	919,820	3.14	\$113.98	\$357.69	\$987,028,300
2022-23 **	TOTAL	983,840	3.38	\$115.58	\$390.73	\$4,613,048,200
2023-24 **	1	1,049,940	3.62	\$121.19	\$439.33	\$1,383,798,700
2023-24 **	2	956,330	3.32	\$123.62	\$410.48	\$1,177,664,200
2023-24 **	3	982,430	3.37	\$121.71	\$410.68	\$1,210,398,100
2023-24 **	4	954,010	3.22	\$118.46	\$381.16	\$1,090,907,500
2023-24 **	TOTAL	985,680	3.39	\$121.27	\$411.12	\$4,862,768,500

* 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 2022 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>
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	53,770	2.87	\$203.72	\$583.81	\$94,167,400
2021-22 *	2	51,090	2.68	\$209.86	\$562.68	\$86,241,400
2021-22 *	3	52,970	2.81	\$182.06	\$510.70	\$81,157,000
2021-22 *	4	54,920	3.20	\$153.21	\$490.40	\$80,804,900
2021-22 *	TOTAL	53,190	2.89	\$185.43	\$536.42	\$342,370,700
2022-23 **	1	62,790	3.22	\$165.34	\$532.33	\$100,278,000
2022-23 **	2	56,530	3.03	\$159.92	\$484.42	\$82,152,700
2022-23 **	3	61,310	3.05	\$156.61	\$477.84	\$87,895,000
2022-23 **	4	51,180	3.01	\$158.96	\$478.79	\$73,519,200
2022-23 **	TOTAL	57,960	3.08	\$160.38	\$494.41	\$343,844,900
2023-24 **	1	63,180	3.18	\$162.79	\$517.80	\$98,149,100
2023-24 **	2	57,080	3.03	\$159.81	\$484.65	\$82,988,500
2023-24 **	3	58,570	3.09	\$159.17	\$492.55	\$86,552,800
2023-24 **	4	53,920	3.00	\$157.20	\$471.62	\$76,294,200
2023-24 **	TOTAL	58,190	3.08	\$159.89	\$492.62	\$343,984,700

* 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 2022 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>
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	490	19.89	\$298.27	\$5,931.54	\$8,671,900
2021-22 *	2	490	16.82	\$285.04	\$4,794.20	\$7,009,100
2021-22 *	3	500	15.34	\$308.40	\$4,731.75	\$7,149,700
2021-22 *	4	490	16.01	\$303.33	\$4,857.02	\$7,091,300
2021-22 *	TOTAL	490	17.00	\$298.55	\$5,075.82	\$29,921,900
2022-23 **	1	540	16.49	\$298.12	\$4,916.78	\$7,954,500
2022-23 **	2	520	13.34	\$311.70	\$4,157.94	\$6,447,300
2022-23 **	3	550	14.27	\$299.76	\$4,277.55	\$7,078,200
2022-23 **	4	420	14.95	\$299.02	\$4,469.21	\$5,674,800
2022-23 **	TOTAL	510	14.76	\$301.86	\$4,456.78	\$27,154,800
2023-24 **	1	550	15.71	\$303.68	\$4,770.39	\$7,928,100
2023-24 **	2	520	13.25	\$312.73	\$4,142.85	\$6,497,700
2023-24 **	3	520	14.84	\$303.03	\$4,498.45	\$7,042,700
2023-24 **	4	450	14.56	\$296.89	\$4,321.19	\$5,872,100
2023-24 **	TOTAL	510	14.61	\$304.11	\$4,442.13	\$27,340,600

* 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 2022 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>
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	160	2.44	\$149.51	\$364.56	\$174,600
2021-22 *	2	200	3.05	\$153.36	\$467.92	\$283,600
2021-22 *	3	520	3.73	\$97.05	\$361.64	\$564,500
2021-22 *	4	720	3.69	\$89.46	\$330.17	\$708,500
2021-22 *	TOTAL	400	3.50	\$103.33	\$361.28	\$1,731,300
2022-23 **	1	760	3.95	\$86.50	\$341.50	\$774,000
2022-23 **	2	690	3.74	\$110.50	\$412.75	\$853,900
2022-23 **	3	750	3.78	\$94.30	\$356.55	\$806,200
2022-23 **	4	660	3.66	\$101.89	\$373.39	\$740,900
2022-23 **	TOTAL	720	3.79	\$97.70	\$370.02	\$3,175,000
2023-24 **	1	770	3.98	\$79.14	\$315.23	\$729,500
2023-24 **	2	700	3.76	\$108.96	\$410.00	\$857,500
2023-24 **	3	720	3.83	\$91.62	\$351.35	\$754,400
2023-24 **	4	700	3.64	\$99.60	\$362.66	\$761,000
2023-24 **	TOTAL	720	3.81	\$94.12	\$358.61	\$3,102,400

* 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 2022 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>
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	30	5.18	\$289.43	\$1,500.52	\$154,600
2021-22 *	2	10	7.24	\$272.38	\$1,972.41	\$57,200
2021-22 *	3	20	16.51	\$154.58	\$2,552.65	\$188,900
2021-22 *	4	10	12.04	\$355.21	\$4,277.96	\$98,400
2021-22 *	TOTAL	20	9.79	\$222.49	\$2,179.22	\$499,000
2022-23 **	1	20	7.39	\$219.74	\$1,624.01	\$94,700
2022-23 **	2	30	5.89	\$226.02	\$1,331.62	\$110,500
2022-23 **	3	30	4.79	\$173.32	\$830.21	\$68,900
2022-23 **	4	30	3.84	\$191.37	\$735.45	\$61,000
2022-23 **	TOTAL	30	5.33	\$204.81	\$1,090.70	\$335,200
2023-24 **	1	30	6.29	\$201.76	\$1,269.76	\$105,400
2023-24 **	2	30	6.15	\$229.47	\$1,411.89	\$117,200
2023-24 **	3	30	4.71	\$173.04	\$815.61	\$67,700
2023-24 **	4	30	3.93	\$180.80	\$711.34	\$59,000
2023-24 **	TOTAL	30	5.27	\$199.52	\$1,052.15	\$349,300

* 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 2022 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>
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	86,980	3.01	\$363.99	\$1,095.86	\$285,945,000
2021-22 *	2	77,190	2.82	\$372.60	\$1,051.13	\$243,423,500
2021-22 *	3	94,640	2.87	\$284.82	\$818.77	\$232,473,000
2021-22 *	4	103,110	3.04	\$233.55	\$709.41	\$219,449,700
2021-22 *	TOTAL	90,480	2.94	\$307.16	\$903.76	\$981,291,300
2022-23 **	1	116,430	3.31	\$225.74	\$746.23	\$260,650,800
2022-23 **	2	100,900	3.10	\$239.49	\$742.66	\$224,796,500
2022-23 **	3	115,320	3.02	\$226.02	\$681.73	\$235,859,300
2022-23 **	4	97,880	2.80	\$217.38	\$608.20	\$178,589,500
2022-23 **	TOTAL	107,630	3.06	\$227.34	\$696.73	\$899,896,100
2023-24 **	1	114,840	3.30	\$223.73	\$737.49	\$254,072,400
2023-24 **	2	101,910	3.10	\$239.30	\$741.45	\$226,686,600
2023-24 **	3	110,250	3.06	\$232.61	\$711.09	\$235,186,300
2023-24 **	4	102,960	2.80	\$211.69	\$592.84	\$183,110,200
2023-24 **	TOTAL	107,490	3.07	\$227.09	\$697.02	\$899,055,500

* 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 2022 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>
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	93,300	1.93	\$208.39	\$401.44	\$112,364,700
2021-22 *	2	87,450	1.76	\$221.71	\$389.57	\$102,200,200
2021-22 *	3	131,660	2.43	\$111.65	\$271.04	\$107,054,200
2021-22 *	4	164,460	2.89	\$84.82	\$245.34	\$121,047,900
2021-22 *	TOTAL	119,220	2.37	\$130.73	\$309.43	\$442,666,900
2022-23 **	1	175,800	2.91	\$94.96	\$276.41	\$145,781,400
2022-23 **	2	150,190	2.79	\$97.86	\$273.43	\$123,197,200
2022-23 **	3	172,170	2.63	\$95.59	\$251.27	\$129,778,300
2022-23 **	4	153,410	2.76	\$93.16	\$257.47	\$118,496,300
2022-23 **	TOTAL	162,890	2.77	\$95.37	\$264.62	\$517,253,200
2023-24 **	1	174,830	2.88	\$96.89	\$279.46	\$146,575,100
2023-24 **	2	151,850	2.79	\$97.78	\$272.65	\$124,204,800
2023-24 **	3	163,850	2.66	\$97.74	\$259.69	\$127,653,200
2023-24 **	4	161,730	2.75	\$91.54	\$252.12	\$122,322,200
2023-24 **	TOTAL	163,060	2.77	\$95.99	\$266.13	\$520,755,400

* 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 2022 BASE ESTIMATES)**

POV 100

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
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	62,750	1.89	\$189.46	\$358.15	\$67,424,300
2021-22 *	2	52,200	1.73	\$225.57	\$391.05	\$61,243,900
2021-22 *	3	81,200	2.31	\$119.27	\$275.22	\$67,039,200
2021-22 *	4	86,000	2.76	\$106.07	\$293.14	\$75,634,500
2021-22 *	TOTAL	70,540	2.25	\$142.62	\$320.56	\$271,342,000
2022-23 **	1	96,090	2.72	\$112.33	\$305.83	\$88,158,300
2022-23 **	2	86,240	2.54	\$128.72	\$327.28	\$84,676,300
2022-23 **	3	93,510	2.63	\$117.83	\$310.05	\$86,980,000
2022-23 **	4	84,210	2.52	\$116.05	\$291.97	\$73,763,300
2022-23 **	TOTAL	90,010	2.61	\$118.44	\$308.82	\$333,577,800
2023-24 **	1	96,220	2.81	\$118.94	\$333.84	\$96,364,200
2023-24 **	2	86,960	2.62	\$132.54	\$347.03	\$90,535,700
2023-24 **	3	89,910	2.69	\$125.27	\$336.88	\$90,868,100
2023-24 **	4	87,810	2.60	\$121.15	\$314.88	\$82,952,500
2023-24 **	TOTAL	90,230	2.68	\$124.24	\$333.16	\$360,720,500

* ACTUAL

** ESTIMATED

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

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BASE POLICY CHANGES

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

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Medi-Cal Base Policy Changes

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

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

The second type of base estimate, which had traditionally been called the Non-Fee-for-Service (Non-FFS) Base Estimate, is displayed in this section. Because some of these base estimates include services paid on a fee-for-service basis, that name is technically not correct. As a result, this second type of base estimate will be called Base Policy Changes because as in the past they are entered into the Medi-Cal Estimate and displayed using the policy change format. These Base Policy Changes form the base estimates for the last 13 service categories (Managed Care through Drug Medi-Cal) as displayed in most tables throughout this binder and listed below. The data used for these projections come from a variety of sources, such as other claims processing systems, managed care enrollments, and other payment data. Also, some of the projections in this group come directly from other State departments.

Base Policy Change Service Categories:

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

SUMMARY OF BASE POLICY CHANGES FISCAL YEAR 2022-23

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>DRUG MEDI-CAL</u>					
55	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	\$754,315,000	\$647,170,350	\$107,144,650	\$0
57	DRUG MEDI-CAL STATE PLAN SERVICES	\$6,421,000	\$5,960,900	\$460,100	\$0
	DRUG MEDI-CAL SUBTOTAL	\$760,736,000	\$653,131,250	\$107,604,750	\$0
<u>MENTAL HEALTH</u>					
61	SMHS FOR ADULTS	\$1,713,414,000	\$1,545,700,300	\$93,975,700	\$73,738,000
62	SMHS FOR CHILDREN	\$1,255,090,000	\$1,157,930,800	\$41,535,200	\$55,624,000
	MENTAL HEALTH SUBTOTAL	\$2,968,504,000	\$2,703,631,100	\$135,510,900	\$129,362,000
<u>MANAGED CARE</u>					
76	TWO PLAN MODEL	\$22,982,139,000	\$13,694,934,300	\$9,287,204,700	\$0
77	COUNTY ORGANIZED HEALTH SYSTEMS	\$10,162,932,000	\$6,703,129,900	\$3,459,802,100	\$0
78	GEOGRAPHIC MANAGED CARE	\$4,399,088,000	\$2,959,404,700	\$1,439,683,300	\$0
84	REGIONAL MODEL	\$1,363,395,000	\$939,679,000	\$423,716,000	\$0
85	PACE (Other M/C)	\$1,208,789,000	\$604,394,500	\$604,394,500	\$0
90	DENTAL MANAGED CARE (Other M/C)	\$130,434,000	\$86,489,900	\$43,944,100	\$0
94	SENIOR CARE ACTION NETWORK (Other M/C)	\$67,867,000	\$33,933,500	\$33,933,500	\$0
95	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	\$27,663,000	\$16,983,000	\$0	\$10,680,000
97	AIDS HEALTHCARE CENTERS (Other M/C)	\$8,608,000	\$4,304,000	\$4,304,000	\$0
98	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM	\$6,278,000	\$4,307,700	\$1,970,300	\$0
99	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	\$4,707,000	\$3,212,550	\$1,494,450	\$0
100	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$1,624,000	\$0	\$1,624,000	\$0
	MANAGED CARE SUBTOTAL	\$40,363,524,000	\$25,050,773,050	\$15,302,070,950	\$10,680,000
<u>OTHER</u>					
174	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$4,283,341,000	\$1,804,136,000	\$2,479,205,000	\$0
175	HOME & COMMUNITY-BASED SVCS.- CDDS (Misc.)	\$3,390,555,000	\$3,390,555,000	\$0	\$0
176	PERSONAL CARE SERVICES (Misc. Svcs.)	\$3,051,548,000	\$3,051,548,000	\$0	\$0
177	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$2,845,777,000	\$0	\$2,845,777,000	\$0
178	DENTAL SERVICES	\$1,951,125,000	\$1,165,539,900	\$785,585,100	\$0
185	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$355,576,000	\$355,576,000	\$0	\$0
190	LAWSUITS/CLAIMS	\$116,726,000	\$58,363,000	\$58,363,000	\$0
204	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$29,436,000	\$29,436,000	\$0	\$0
211	MEDI-CAL TCM PROGRAM	\$14,162,000	\$14,162,000	\$0	\$0
226	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$519,000	\$259,500	\$259,500	\$0

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

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	<u>OTHER</u>				
240	BASE RECOVERIES	(\$537,246,000)	(\$311,040,450)	(\$226,205,550)	\$0
	OTHER SUBTOTAL	\$15,501,519,000	\$9,558,534,950	\$5,942,984,050	\$0
	GRAND TOTAL	\$59,594,283,000	\$37,966,070,350	\$21,488,170,650	\$140,042,000

**SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2023-24**

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>DRUG MEDI-CAL</u>					
55	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	\$802,802,000	\$634,096,300	\$112,283,700	\$56,422,000
57	DRUG MEDI-CAL STATE PLAN SERVICES	\$6,423,000	\$5,962,700	\$460,300	\$0
	DRUG MEDI-CAL SUBTOTAL	\$809,225,000	\$640,059,000	\$112,744,000	\$56,422,000
<u>MENTAL HEALTH</u>					
61	SMHS FOR ADULTS	\$2,083,280,000	\$1,527,402,700	\$98,183,300	\$457,694,000
62	SMHS FOR CHILDREN	\$1,742,599,000	\$1,077,087,600	\$46,369,400	\$619,142,000
	MENTAL HEALTH SUBTOTAL	\$3,825,879,000	\$2,604,490,300	\$144,552,700	\$1,076,836,000
<u>MANAGED CARE</u>					
76	TWO PLAN MODEL	\$23,345,223,000	\$13,763,001,750	\$9,582,221,250	\$0
77	COUNTY ORGANIZED HEALTH SYSTEMS	\$10,264,315,000	\$6,773,175,350	\$3,491,139,650	\$0
78	GEOGRAPHIC MANAGED CARE	\$4,469,084,000	\$3,005,317,550	\$1,463,766,450	\$0
84	REGIONAL MODEL	\$1,380,007,000	\$951,690,350	\$428,316,650	\$0
85	PACE (Other M/C)	\$1,450,581,000	\$725,290,500	\$725,290,500	\$0
90	DENTAL MANAGED CARE (Other M/C)	\$134,796,000	\$89,382,050	\$45,413,950	\$0
94	SENIOR CARE ACTION NETWORK (Other M/C)	\$71,850,000	\$35,925,000	\$35,925,000	\$0
95	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	\$27,663,000	\$16,173,000	\$0	\$11,490,000
97	AIDS HEALTHCARE CENTERS (Other M/C)	\$8,608,000	\$4,304,000	\$4,304,000	\$0
98	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM	\$6,278,000	\$4,080,700	\$2,197,300	\$0
99	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	\$4,707,000	\$3,059,550	\$1,647,450	\$0
100	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$1,706,000	\$0	\$1,706,000	\$0
	MANAGED CARE SUBTOTAL	\$41,164,818,000	\$25,371,399,800	\$15,781,928,200	\$11,490,000
<u>OTHER</u>					
174	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$4,385,285,000	\$1,846,774,000	\$2,538,511,000	\$0
175	HOME & COMMUNITY-BASED SVCS.- CDDS (Misc.)	\$3,185,039,000	\$3,185,039,000	\$0	\$0
176	PERSONAL CARE SERVICES (Misc. Svcs.)	\$2,920,079,000	\$2,920,079,000	\$0	\$0
177	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$3,135,449,000	\$0	\$3,135,449,000	\$0
178	DENTAL SERVICES	\$1,951,125,000	\$1,165,539,900	\$785,585,100	\$0
185	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$327,740,000	\$327,740,000	\$0	\$0
190	LAWSUITS/CLAIMS	\$1,350,000	\$675,000	\$675,000	\$0
204	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$27,360,000	\$27,360,000	\$0	\$0
211	MEDI-CAL TCM PROGRAM	\$13,921,000	\$13,921,000	\$0	\$0
226	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$438,000	\$219,000	\$219,000	\$0

**SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2023-24**

<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>				
240	BASE RECOVERIES	(\$480,792,000)	(\$278,356,400)	(\$202,435,600)	\$0
	OTHER SUBTOTAL	\$15,466,994,000	\$9,208,990,500	\$6,258,003,500	\$0
	GRAND TOTAL	\$61,266,916,000	\$37,824,939,600	\$22,297,228,400	\$1,144,748,000

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
NOVEMBER 2022 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2022-23**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2022-23 APPROPRIATION		NOV. 2022 EST. FOR 2022-23		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>DRUG MEDI-CAL</u>								
66	55	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	\$843,195,000	\$127,290,300	\$754,315,000	\$107,144,650	(\$88,880,000)	(\$20,145,650)
67	57	DRUG MEDI-CAL STATE PLAN SERVICES	\$7,263,000	\$488,800	\$6,421,000	\$460,100	(\$842,000)	(\$28,700)
DRUG MEDI-CAL SUBTOTAL			\$850,458,000	\$127,779,100	\$760,736,000	\$107,604,750	(\$89,722,000)	(\$20,174,350)
<u>MENTAL HEALTH</u>								
72	61	SMHS FOR ADULTS	\$1,769,718,000	\$100,893,800	\$1,713,414,000	\$93,975,700	(\$56,304,000)	(\$6,918,100)
73	62	SMHS FOR CHILDREN	\$1,181,184,000	\$41,285,600	\$1,255,090,000	\$41,535,200	\$73,906,000	\$249,600
MENTAL HEALTH SUBTOTAL			\$2,950,902,000	\$142,179,400	\$2,968,504,000	\$135,510,900	\$17,602,000	(\$6,668,500)
<u>MANAGED CARE</u>								
92	76	TWO PLAN MODEL	\$18,590,329,000	\$6,292,361,950	\$22,982,139,000	\$9,287,204,700	\$4,391,810,000	\$2,994,842,750
93	77	COUNTY ORGANIZED HEALTH SYSTEMS	\$8,734,312,000	\$3,145,031,800	\$10,162,932,000	\$3,459,802,100	\$1,428,620,000	\$314,770,300
94	78	GEOGRAPHIC MANAGED CARE	\$3,478,515,000	\$1,200,822,600	\$4,399,088,000	\$1,439,683,300	\$920,573,000	\$238,860,700
97	84	REGIONAL MODEL	\$1,198,362,000	\$389,617,650	\$1,363,395,000	\$423,716,000	\$165,033,000	\$34,098,350
100	85	PACE (Other M/C)	\$1,240,139,000	\$620,069,500	\$1,208,789,000	\$604,394,500	(\$31,350,000)	(\$15,675,000)
108	90	DENTAL MANAGED CARE (Other M/C)	\$134,546,000	\$51,834,250	\$130,434,000	\$43,944,100	(\$4,112,000)	(\$7,890,150)
110	94	SENIOR CARE ACTION NETWORK (Other M/C)	\$66,630,000	\$33,315,000	\$67,867,000	\$33,933,500	\$1,237,000	\$618,500
7	95	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	\$30,998,000	\$0	\$27,663,000	\$0	(\$3,335,000)	\$0
112	97	AIDS HEALTHCARE CENTERS (Other M/C)	\$8,788,000	\$4,394,000	\$8,608,000	\$4,304,000	(\$180,000)	(\$90,000)
11	98	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM	\$3,277,000	\$1,134,950	\$6,278,000	\$1,970,300	\$3,001,000	\$835,350
12	99	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	\$4,867,000	\$1,703,450	\$4,707,000	\$1,494,450	(\$160,000)	(\$209,000)
115	100	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$1,624,000	\$1,624,000	\$1,624,000	\$1,624,000	\$0	\$0
MANAGED CARE SUBTOTAL			\$33,492,387,000	\$11,741,909,150	\$40,363,524,000	\$15,302,070,950	\$6,871,137,000	\$3,560,161,800

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
NOVEMBER 2022 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2022-23**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2022-23 APPROPRIATION		NOV. 2022 EST. FOR 2022-23		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
198	174	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$4,114,701,000	\$2,260,535,000	\$4,283,341,000	\$2,479,205,000	\$168,640,000	\$218,670,000
199	175	HOME & COMMUNITY-BASED SVCS.- CDDS (Misc.)	\$2,981,866,000	\$0	\$3,390,555,000	\$0	\$408,689,000	\$0
200	176	PERSONAL CARE SERVICES (Misc. Svcs.)	\$2,854,821,000	\$0	\$3,051,548,000	\$0	\$196,727,000	\$0
201	177	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$2,738,115,000	\$2,738,115,000	\$2,845,777,000	\$2,845,777,000	\$107,662,000	\$107,662,000
202	178	DENTAL SERVICES	\$1,620,927,000	\$648,308,200	\$1,951,125,000	\$785,585,100	\$330,198,000	\$137,276,900
204	185	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$308,291,000	\$0	\$355,576,000	\$0	\$47,285,000	\$0
215	190	LAWSUITS/CLAIMS	\$74,450,000	\$37,225,000	\$116,726,000	\$58,363,000	\$42,276,000	\$21,138,000
214	204	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$25,881,000	\$0	\$29,436,000	\$0	\$3,555,000	\$0
216	211	MEDI-CAL TCM PROGRAM	\$16,270,000	\$0	\$14,162,000	\$0	(\$2,108,000)	\$0
235	226	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$673,000	\$336,500	\$519,000	\$259,500	(\$154,000)	(\$77,000)
250	240	BASE RECOVERIES	(\$450,413,000)	(\$189,644,800)	(\$537,246,000)	(\$226,205,550)	(\$86,833,000)	(\$36,560,750)
		OTHER SUBTOTAL	\$14,285,582,000	\$5,494,874,900	\$15,501,519,000	\$5,942,984,050	\$1,215,937,000	\$448,109,150
		GRAND TOTAL	\$51,579,329,000	\$17,506,742,550	\$59,594,283,000	\$21,488,170,650	\$8,014,954,000	\$3,981,428,100

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2022-23 AND 2023-24**

NO.	POLICY CHANGE TITLE	NOV. 2022 EST. FOR 2022-23		NOV. 2022 EST. FOR 2023-24		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>DRUG MEDI-CAL</u>							
55	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	\$754,315,000	\$107,144,650	\$802,802,000	\$112,283,700	\$48,487,000	\$5,139,050
57	DRUG MEDI-CAL STATE PLAN SERVICES	\$6,421,000	\$460,100	\$6,423,000	\$460,300	\$2,000	\$200
	DRUG MEDI-CAL SUBTOTAL	\$760,736,000	\$107,604,750	\$809,225,000	\$112,744,000	\$48,489,000	\$5,139,250
<u>MENTAL HEALTH</u>							
61	SMHS FOR ADULTS	\$1,713,414,000	\$93,975,700	\$2,083,280,000	\$98,183,300	\$369,866,000	\$4,207,600
62	SMHS FOR CHILDREN	\$1,255,090,000	\$41,535,200	\$1,742,599,000	\$46,369,400	\$487,509,000	\$4,834,200
	MENTAL HEALTH SUBTOTAL	\$2,968,504,000	\$135,510,900	\$3,825,879,000	\$144,552,700	\$857,375,000	\$9,041,800
<u>MANAGED CARE</u>							
76	TWO PLAN MODEL	\$22,982,139,000	\$9,287,204,700	\$23,345,223,000	\$9,582,221,250	\$363,084,000	\$295,016,550
77	COUNTY ORGANIZED HEALTH SYSTEMS	\$10,162,932,000	\$3,459,802,100	\$10,264,315,000	\$3,491,139,650	\$101,383,000	\$31,337,550
78	GEOGRAPHIC MANAGED CARE	\$4,399,088,000	\$1,439,683,300	\$4,469,084,000	\$1,463,766,450	\$69,996,000	\$24,083,150
84	REGIONAL MODEL	\$1,363,395,000	\$423,716,000	\$1,380,007,000	\$428,316,650	\$16,612,000	\$4,600,650
85	PACE (Other M/C)	\$1,208,789,000	\$604,394,500	\$1,450,581,000	\$725,290,500	\$241,792,000	\$120,896,000
90	DENTAL MANAGED CARE (Other M/C)	\$130,434,000	\$43,944,100	\$134,796,000	\$45,413,950	\$4,362,000	\$1,469,850
94	SENIOR CARE ACTION NETWORK (Other M/C)	\$67,867,000	\$33,933,500	\$71,850,000	\$35,925,000	\$3,983,000	\$1,991,500
95	MEDI-CAL ACCESS PROGRAM MOTHERS 213 -322% FPL	\$27,663,000	\$0	\$27,663,000	\$0	\$0	\$0
97	AIDS HEALTHCARE CENTERS (Other M/C)	\$8,608,000	\$4,304,000	\$8,608,000	\$4,304,000	\$0	\$0
98	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM	\$6,278,000	\$1,970,300	\$6,278,000	\$2,197,300	\$0	\$227,000
99	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	\$4,707,000	\$1,494,450	\$4,707,000	\$1,647,450	\$0	\$153,000
100	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$1,624,000	\$1,624,000	\$1,706,000	\$1,706,000	\$82,000	\$82,000
	MANAGED CARE SUBTOTAL	\$40,363,524,000	\$15,302,070,950	\$41,164,818,000	\$15,781,928,200	\$801,294,000	\$479,857,250

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2022-23 AND 2023-24**

NO.	POLICY CHANGE TITLE	NOV. 2022 EST. FOR 2022-23		NOV. 2022 EST. FOR 2023-24		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER						
174	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$4,283,341,000	\$2,479,205,000	\$4,385,285,000	\$2,538,511,000	\$101,944,000	\$59,306,000
175	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	\$3,390,555,000	\$0	\$3,185,039,000	\$0	(\$205,516,000)	\$0
176	PERSONAL CARE SERVICES (Misc. Svcs.)	\$3,051,548,000	\$0	\$2,920,079,000	\$0	(\$131,469,000)	\$0
177	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$2,845,777,000	\$2,845,777,000	\$3,135,449,000	\$3,135,449,000	\$289,672,000	\$289,672,000
178	DENTAL SERVICES	\$1,951,125,000	\$785,585,100	\$1,951,125,000	\$785,585,100	\$0	\$0
185	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$355,576,000	\$0	\$327,740,000	\$0	(\$27,836,000)	\$0
190	LAWSUITS/CLAIMS	\$116,726,000	\$58,363,000	\$1,350,000	\$675,000	(\$115,376,000)	(\$57,688,000)
204	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$29,436,000	\$0	\$27,360,000	\$0	(\$2,076,000)	\$0
211	MEDI-CAL TCM PROGRAM	\$14,162,000	\$0	\$13,921,000	\$0	(\$241,000)	\$0
226	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$519,000	\$259,500	\$438,000	\$219,000	(\$81,000)	(\$40,500)
240	BASE RECOVERIES	(\$537,246,000)	(\$226,205,550)	(\$480,792,000)	(\$202,435,600)	\$56,454,000	\$23,769,950
	OTHER SUBTOTAL	\$15,501,519,000	\$5,942,984,050	\$15,466,994,000	\$6,258,003,500	(\$34,525,000)	\$315,019,450
	GRAND TOTAL	\$59,594,283,000	\$21,488,170,650	\$61,266,916,000	\$22,297,228,400	\$1,672,633,000	\$809,057,750

MEDI-CAL PROGRAM BASE POLICY CHANGE INDEX

<u>POLICY CHANGE NUMBER</u>	<u>POLICY CHANGE TITLE</u>
	<u>DRUG MEDI-CAL</u>
55	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER
57	DRUG MEDI-CAL STATE PLAN SERVICES
	<u>MENTAL HEALTH</u>
61	SMHS FOR ADULTS
62	SMHS FOR CHILDREN
	<u>MANAGED CARE</u>
76	TWO PLAN MODEL
77	COUNTY ORGANIZED HEALTH SYSTEMS
78	GEOGRAPHIC MANAGED CARE
84	REGIONAL MODEL
85	PACE (OTHER M/C)
90	DENTAL MANAGED CARE (OTHER M/C)
94	SENIOR CARE ACTION NETWORK (OTHER M/C)
95	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
97	AIDS HEALTHCARE CENTERS (OTHER M/C)
98	COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM
99	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL
100	FAMILY MOSAIC CAPITATED CASE MGMT. (OTH. M/C)
	<u>OTHER</u>
174	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS
175	HOME & COMMUNITY-BASED SVCS.-CDDS (MISC.)
176	PERSONAL CARE SERVICES (MISC. SVCS.)
177	MEDICARE PAYMENTS - PART D PHASED-DOWN
178	DENTAL SERVICES
185	TARGETED CASE MGMT. SVCS. - CDDS (MISC. SVCS.)
190	LAWSUITS/CLAIMS
204	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC
211	MEDI-CAL TCM PROGRAM
226	HIPP PREMIUM PAYOUTS (MISC. SVCS.)
240	BASE RECOVERIES

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

BASE POLICY CHANGE NUMBER: 55
IMPLEMENTATION DATE: 4/2017
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2012

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$754,315,000	\$802,802,000
- STATE FUNDS	\$107,144,650	\$168,705,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$754,315,000	\$802,802,000
STATE FUNDS	\$107,144,650	\$168,705,700
FEDERAL FUNDS	\$647,170,350	\$634,096,300

Purpose:

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

Authority:

Drug Medi-Cal Organized Delivery System Waiver
Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

Not Applicable

Background:

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

On August 13, 2015, the Department received approval from the Centers for Medicare and Medicaid Services (CMS) to implement the DMC-ODS waiver. The DMC-ODS is authorized originally 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 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. The interim rate for the existing modalities, except NTP; however, are now paid at the county-established rate instead of the State rates.

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

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

BASE POLICY CHANGE NUMBER: 55

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) remain the same. New services under the waiver, except for non-perinatal IOT and RTS expanded services, are funded with federal funds (FF) and County Funds (CF). Consistent with prior estimates, expanded IOT and RTS services are 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 2022-23, is a net decrease due to the following:

- Updated claims data reimbursements for 37 counties were lower compared to the previous projection, and as a result, the overall estimate decreased;
- The FFCRA impact is assumed to be extended through March 31, 2023; and,
- The amount of estimated unpaid claims for FY 2019-20, FY 2020-21 and FY 2021-22 decreased based on actual claims data.

The change in the current estimate, from FY 2022-23 to FY 2023-24, is a net increase due to the following:

- FY 2022-23 includes more unpaid claims for prior years than FY 2023-24.
- FFCRA funding is not assumed in FY 2023-24.
- Addition of inter-governmental transfers (IGTs) for claims with dates of service on or before July 1, 2023.

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: 55

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.

Net DMC-ODS Waiver Costs

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

(Dollars in Thousands)

DMC-ODS Waiver Net Cost	FY 2022-23	FY 2023-24
Required Services	\$105,370	\$103,897
Optional Services	\$10,437	\$10,163
Existing Services	\$710,344	\$711,605
Total	\$826,151	\$825,665

5. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through March 31, 2023. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.

6. The Department will implement the CalAIM Behavioral Health Payment Reform and a new Intergovernmental Transfers (IGTs) process. For all claims with dates of service of on or after July 1, 2023, counties will transfer the county portion of the submitted claims before FF can be used for payment.

7. On a cash basis, the total for waiver services costs are estimated to be \$754,315,000 TF and \$802,802,000 TF in FY 2022-23 and FY 2023-24 respectively.

(Dollars in Thousands)

FY 2022-23	TF	GF	IGT*	FF	FFCRA	CF
Regular						
Current	\$269,371	\$59,765	\$0	\$135,482	\$12,452	\$61,672
ACA Optional	\$549,352	\$47,165	\$0	\$494,417	\$0	\$7,770
Perinatal						
Current	\$5,281	\$0	\$0	\$2,641	\$246	\$2,394
ACA Optional	\$2,147	\$215	\$0	\$1,932	\$0	\$0
Total	\$826,151	\$107,145	\$0	\$634,472	\$12,698	\$71,836

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER
BASE POLICY CHANGE NUMBER: 55

(Dollars in Thousands)

FY 2023-24	TF	GF	IGT*	FF	FFCRA	CF
Regular						
Current	\$269,208	\$64,821	\$49,159	\$135,400	\$0	\$19,828
ACA Optional	\$549,016	\$47,248	\$5,391	\$494,115	\$0	\$2,262
Perinatal						
Current	\$5,290	\$0	\$1,872	\$2,645	\$0	\$773
ACA Optional	\$2,151	\$215	\$0	\$1,936	\$0	\$0
Total	\$825,665	\$112,284	\$56,422	\$634,096	\$0	\$22,863

Funding:

100% GF (4260-101-0001)
100% Title XIX FF (4260-101-0890)
100% Title XXI FF (4260-113-0890)
100% Title XXI FF (4260-101-0890)
100% ACA Title XIX FF (4260-101-0890)
Medi-Cal County Behavioral Health Fund (4260-601-3420)*
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)
65% Title XXI FF / 35% GF (4260-113-0001/0890)
65% Title XXI FF / 35% GF (4260-101-0001/0890)
50% Title XIX / 50% GF (4260-101-0001/0890)
FFCRA 6.2% Increased FFP (4260-101-0890)
FFCRA 6.2% GF (4260-101-0001)
FFCRA 4.34% Increased FFP (4260-113-0890)
FFCRA 4.34% GF (4260-113-0001)

DRUG MEDI-CAL STATE PLAN SERVICES

BASE POLICY CHANGE NUMBER: 57
IMPLEMENTATION DATE: 7/2021
ANALYST: Devon Dyer
FISCAL REFERENCE NUMBER: 2320

	FY 2022-23	FY 2023-24
FULL YEAR COST - TOTAL FUNDS	\$6,421,000	\$6,423,000
- STATE FUNDS	\$460,100	\$460,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$6,421,000	\$6,423,000
STATE FUNDS	\$460,100	\$460,300
FEDERAL FUNDS	\$5,960,900	\$5,962,700

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

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:

- Admission physical examinations,
- Intake,
- Medical necessity establishment,

DRUG MEDI-CAL STATE PLAN SERVICES

BASE POLICY CHANGE NUMBER: 57

- 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 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.

DRUG MEDI-CAL STATE PLAN SERVICES

BASE POLICY CHANGE NUMBER: 57

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:

There is no significant change from the prior estimate for FY 2022-23 or between fiscal years in the current estimate as expenditures are projected to remain fairly stable.

Methodology:

- Expenditures are estimated using 36 months of cash-basis expenditure data (July 2019-June 2022) and trending the Users, Units/User, and Rate.

Modality	Type	FY 2022-23				FY 2023-24					
		Average Monthly				Average Monthly					
		Users	Units/ User	Rate	Total	Users	Units/ User	Rate	Total		
NTP	All Others	328	61.9	\$15.47	\$3,773,000	328	61.9	\$15.47	\$3,773,000		
	ACA Optional	267	59.3	\$15.45	\$2,935,600	267	59.3	\$15.45	\$2,936,000		
	NTP Total					\$6,708,600					\$6,709,000
ODF	All Others	228	4.9	\$74.46	\$992,700	228	4.9	\$74.46	\$992,700		
	ACA Optional	203	5.0	\$70.59	\$868,500	203	5.0	\$70.59	\$868,500		
	ODF Total					\$1,861,200					\$1,861,200
IOT	All Others	14	5.8	\$152.31	\$145,300	14	5.8	\$152.31	\$145,300		
	ACA Optional	11	3.8	\$148.03	\$75,200	11	3.8	\$148.03	\$75,200		
	IOT Total					\$220,500					\$220,500
RTS	All Others	1	1.7	\$131.33	\$1,800	1	1.9	\$131.33	\$2,000		
	ACA Optional	1	14.0	\$106.45	\$11,900	1	15.2	\$106.45	\$13,200		
	RTS Total					\$13,700					\$15,200
Overall Total						\$8,804,000					\$8,805,900

- Rates include Final Rate Year (RY) 2021-22 rate increases. RY 2022-23 rate increases are budgeted in the Drug Medi-Cal Annual Rate Adjustment PC.

DRUG MEDI-CAL STATE PLAN SERVICES

BASE POLICY CHANGE NUMBER: 57

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.

Funding:

Total estimated expenditures for DMC State Plan services are:

FY 2022-23	TF	GF	FF	CF*
Title XIX 100%	\$2,377,000	\$0	\$2,377,000	\$2,377,000
50% Title XIX / 50% GF	\$142,000	\$71,000	\$71,000	\$0
ACA 90% FFP/10% GF	\$3,891,000	\$389,100	\$3,501,900	\$0
Title XXI 100%	\$11,000	\$0	\$11,000	\$6,000
Total	\$6,421,000	\$460,100	\$5,960,900	\$2,383,000

FY 2023-24	TF	GF	FF	CF*
Title XIX 100%	\$2,377,000	\$0	\$2,377,000	\$2,377,000
50% Title XIX / 50% GF	\$142,000	\$71,000	\$71,000	\$0
ACA 90% FFP/10% GF	\$3,893,000	\$389,300	\$3,503,700	\$0
Title XXI 100%	\$11,000	\$0	\$11,000	\$6,000
Total	\$6,423,000	\$460,300	\$5,962,700	\$2,383,000

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

* County Funds are not included in Total Fund

Note: Totals may differ due to rounding

SMHS FOR ADULTS

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

	FY 2022-23	FY 2023-24
FULL YEAR COST - TOTAL FUNDS	\$1,713,414,000	\$2,083,280,000
- STATE FUNDS	\$167,713,700	\$555,877,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,713,414,000	\$2,083,280,000
STATE FUNDS	\$167,713,700	\$555,877,300
FEDERAL FUNDS	\$1,545,700,300	\$1,527,402,700

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:

Not Applicable

Background:

The Medi-Cal SMHS program is “carved-out” of the broader Medi-Cal program and is administered by the Department under the authority of a 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: 61

The following Medi-Cal SMHS are available for adults:

- Adult Residential Treatment Services
- Crisis Intervention
- Crisis Stabilization
- Crisis Residential Treatment Services
- Day Rehabilitation
- Day Treatment Intensive
- Medication Support Services
- Psychiatric Health Facility Services
- Psychiatric Inpatient Hospital Services
- Targeted Case Management
- 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.

Beginning in FY 2023-24, the Department will implement the California Advancing and Innovating Medi-Cal (CalAIM) Behavioral Health (BH) payment reform, a new intergovernmental transfers (IGTs) process, whereby counties will transfer the county portion of the fee-for-service claims to the Department, before Federal Financial Participation can be used for payment. The IGT process will replace the current Certified Public Expenditure (CPE) method, that reimbursed counties through the interim rate payment process for Short Doyle/Medi-Cal (SD/MC) claims that include Drug Medi-Cal (DMC) State Plan, Drug Medi-Cal Organized Delivery System (DMC ODS), and SMHS.

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 in FY 2022-23, from the prior estimate, is due to:

- Updated projections based on additional actual SD/MC and FFS Inpatient paid claims data,
- Including three quarters of FFCRA Increased FMAP, through March 31, 2023, in this policy change, and
- The SD/MC and FFS Inpatient payment lags were also updated based on the additional actual paid claims data.

The change between FY 2022-23 and FY 2023-24, in the current estimate, is due to:

- Including FY 2023-24 projections, and
- Budgeting IGT funding for payment of SD/MC SMHS claims for dates of service in FY 2023-24.

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER: 61

Methodology:

- 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, 2022, with dates of service from June 2016 through March 2022. The FFS Inpatient data is current as of June, 30, 2022, with dates of service from April 2016 through January 2022.
- 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.
- Applying more weight to recent data necessitates the need to ensure that lag weight adjusted claims data (a process by which months of partial data reporting is extrapolated to create estimates of final monthly claims) is as complete and accurate as possible. Therefore, the most recent months of data are weighted (lag weights) based on observed claiming trends to create projected final claims and client data. The development and application of lag weights is based upon historical reporting trends of the counties.
- The forecast is based on a service year of costs. This accrual costs are estimated below:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2020-21	\$2,218,873	\$1,903,156	\$315,717
FY 2021-22	\$2,226,376	\$1,906,728	\$319,648
FY 2022-23	\$2,273,300	\$1,938,167	\$335,133
FY 2023-24	\$2,336,224	\$1,985,605	\$350,619

- On a cash basis for FY 2022-23, the Department will be paying 0.3% of FY 2020-21 claims, 37.8% of FY 2021-22 claims, and 61.9% of FY 2022-23 SD/MC claims. For FFS Inpatient claims, the Department will be paying 5.4% of FY 2020-21 claims, 31.1% of FY 2021-22 claims, and 63.5% of FY 2022-23 claims. The cash amounts (rounded) for Adult's SMHS are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2020-21	\$22,758	\$5,709	\$17,049
FY 2021-22	\$820,154	\$720,743	\$99,411
FY 2022-23	\$1,412,535	\$1,199,725	\$212,810
Total FY 2022-23	\$2,255,447	\$1,926,177	\$329,270

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER: 61

6. On a cash basis for FY 2023-24, the Department will be paying 0.3% of FY 2021-22 claims, 37.8% of FY 2022-23 claims, and 61.9% of FY 2023-24 claims for SD/MC claims. For FFS Inpatient claims, the Department will be paying 5.4% of FY 2021-22 claims, and 31.1% of FY 2022-23 claims, and 63.5% of FY 2023-24 claims. The cash amounts (rounded) are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2021-22	\$22,981	\$5,720	\$17,261
FY 2022-23	\$836,853	\$732,627	\$104,226
FY 2023-24	\$1,451,733	\$1,229,090	\$222,643
Total FY 2023-24	\$2,311,567	\$1,967,437	\$344,130

7. The FY 2022-23 and FY 2023-24 estimate includes the following funding adjustments:
- Individuals age 19-25, who do not have satisfactory immigration status or are unable to verify satisfactory immigration status or citizenship, are eligible for full scope Medi-Cal benefits effective January 1, 2020, and these claims are reimbursed with 100% GF.
 - 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.
 - IGTs are budgeted in the Medi-Cal County Behavioral Health Fund beginning July 1, 2023.
8. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through March 31, 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
9. On a cash basis, the estimated costs for FY 2022-23 and FY 2023-24 are as follows:

(Dollars in Thousands)

Fiscal Year	TF	FF	ACA FF	GF	GF Reimb	*IGT	CF	FFCRA
FY 2022-23	\$2,255,447	\$678,909	\$803,652	\$93,976	\$73,738	\$0	\$542,033	\$63,139
FY 2023-24	\$2,311,567	\$685,981	\$841,422	\$98,183	\$81,705	\$375,989	\$228,287	\$0

Funding:

100% GF (4260-101-0001)
 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)
 Medi-Cal County Behavioral Health Fund* (4260-601-3420)

SMHS FOR CHILDREN

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

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$1,255,090,000	\$1,742,599,000
- STATE FUNDS	\$97,159,200	\$665,511,400
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,255,090,000	\$1,742,599,000
STATE FUNDS	\$97,159,200	\$665,511,400
FEDERAL FUNDS	\$1,157,930,800	\$1,077,087,600

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

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

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 62

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

Beginning in FY 2023-24, the Department will implement the California Advancing and Innovating Medi-Cal (CalAIM) Behavioral Health (BH) payment reform, a new intergovernmental transfers (IGTs) process, whereby counties will transfer the county portion of the fee-for-service claims to the Department, before Federal Financial Participation can be used for payment. The IGT process will replace the current Certified Public Expenditure (CPE) method, that reimbursed counties through the interim rate payment process for Short Doyle/Medi-Cal (SD/MC) claims that include Drug Medi-Cal (DMC) State Plan, Drug Medi-Cal Organized Delivery System (DMC ODS), and SMHS.

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 2022-23, from the prior estimate, is due to:

- Updated projections based on additional actual SD/MC and FFS Inpatient paid claims data,
- Including three quarters of FFCRA Increased FMAP, through March 31, 2023, in this policy change, and
- The SD/MC and FFS Inpatient payment lags were also updated based on the additional actual paid claims data.

The change between FY 2022-23 and FY 2023-24, in the current estimate, is due to:

- Including FY 2023-24 projections, and

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 62

- Budgeting IGT funding for payment of SD/MC SMHS claims for dates of service in FY 2023-24.

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, 2022, with dates of service from June 2016 through March 2022. The FFS Inpatient data is current as of June, 30, 2022, with dates of service from April 2016 through January 2022.
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 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. The forecast is based on a service year of costs. This accrual costs are estimated below:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2020-21	\$1,980,419	\$1,855,454	\$124,965
FY 2021-22	\$2,031,547	\$1,893,859	\$137,688
FY 2022-23	\$2,042,469	\$1,895,830	\$146,639
FY 2023-24	\$2,053,392	\$1,897,801	\$155,591

5. On a cash basis for FY 2022-23, the Department will be paying 0.2% of FY 2020-21 claims, 35.4% of FY 2021-22 claims, and 64.4% of FY 2022-23 SD/MC claims. For FFS Inpatient claims, the Department will be paying 1.20% of FY 2020-21 claims, 28.6% of FY 2021-22 claims, and 70.2% of FY 2022-23 claims. The cash amounts (rounded) for Children's SMHS are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2020-21	\$5,210	\$3,711	\$1,499
FY 2021-22	\$709,805	\$670,426	\$39,379
FY 2022-23	\$1,323,856	\$1,220,915	\$102,941
Total FY 2022-23	\$2,038,871	\$1,895,052	\$143,819

6. On a cash basis for FY 2023-24, the Department will be paying 0.2% of FY 2021-22 claims, 35.4% of FY 2022-23 claims, and 64.4% of FY 2023-24 claims for SD/MC claims. For FFS Inpatient claims, the Department will be paying 1.2% of FY 2021-22 claims, and 28.6% of FY 2022-23 claims, and 70.2% of FY 2023-24. The cash amounts (rounded) for Children's SMHS are:

SMHS FOR CHILDREN
BASE POLICY CHANGE NUMBER: 62

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2021-22	\$5,440	\$3,788	\$1,652
FY 2022-23	\$713,063	\$671,124	\$41,939
FY 2023-24	\$1,331,408	\$1,222,184	\$109,224
Total FY 2023-24	\$2,049,911	\$1,897,096	\$152,815

7. The FY 2022-23 and FY 2023-24 estimate includes 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, are eligible for full scope Medi-Cal benefits effective May 1, 2016, and these claims are reimbursed with 100% GF,
 - Individuals age 19-25, who do not have satisfactory immigration status or are unable to verify satisfactory immigration status or citizenship, are eligible for full scope Medi-Cal benefits effective January 1, 2020, and these claims are reimbursed with 100% GF,
 - Medi-Cal claims are eligible for 50% federal reimbursement,
 - MCHIP claims are eligible for 65% federal reimbursement (beginning October 1, 2020),
 - ACA is funded by 90% FF / 10% GF beginning January 1, 2020,
 - GF reimbursement authority is needed to account for the timing of the reimbursement from the county realignment funds to the Department, and
 - IGTs are budgeted in the Medi-Cal County Behavioral Health Fund beginning July 1, 2023.
8. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through March 31, 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
9. On a cash basis, the estimated costs for FY 2022-23 and FY 2023-24 are as follows:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF	MCHIP	ACA FF	GF Reimb	*IGT	County	FFCRA
FY 2022-23	\$2,038,871	\$41,535	\$815,905	\$203,486	\$52,471	\$55,624	\$0	\$783,781	\$86,069
FY 2023-24	\$2,049,911	\$46,369	\$814,581	\$207,765	\$54,742	\$65,075	\$554,067	\$307,312	\$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)
Medi-Cal County Behavioral Health Fund* (4260-601-3420)

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 76
IMPLEMENTATION DATE: 7/2000
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 56

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$22,982,139,000	\$23,345,223,000
- STATE FUNDS	\$9,287,204,700	\$9,582,221,250
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$22,982,139,000	\$23,345,223,000
STATE FUNDS	\$9,287,204,700	\$9,582,221,250
FEDERAL FUNDS	\$13,694,934,300	\$13,763,001,750

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 2023-24
 COVID-19 Increased FMAP – DHCS

Background:

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

Reason for Change:

The change from the prior estimate, for FY 2022-23, is an increase due to:

- The previous Estimate projected pre-COVID-19 enrollment levels for FY 2022-23, with the impact of additional enrollment due to COVID-19 was reflected in the COVID-19 Caseload Impact policy change. The current Estimate assumes that enrollment continues at the levels close to those observed in July 2022 (the most recent actual month), which are much higher, with only the incremental impact of further changes in enrollment due to COVID-19 accounted for in the COVID-19 Caseload Impact and COVID-19 Caseload Impact Base Adjustment policy changes.
- Updated CY 2022 rates.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to a slight increase in eligibles.

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 76

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 2022 and the first six months of the CY 2023 rates have been budgeted for FY 2022-23.
3. FY 2022-23 weighted rates have been updated from the previous estimate.
4. The estimated rate adjustment anticipated for the CY 2024 rating period to occur in FY 2023-24 is captured in the Capitated Rate Adjustment for FY 2023-24 policy change as a percentage assumption applied to five months of the CY 2024 rates on a cash basis.
5. The eligibles in this PC are reflective of actuals through July 2022, inclusive of COVID-19 caseload impacts, followed by roughly the same level of monthly enrollment thereafter. The COVID-19 Caseload Impact and COVID-19 Caseload Impact Base Adjustment policy changes adjust these base projections to account for incremental impacts of the COVID-19 pandemic on the Medi-Cal caseload and managed care enrollment.
6. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of \$282,000,000 for FY 2022-23 and \$282,000,000 for FY 2023-24 were included in the rates.
7. Indian Health Services and Maternity supplemental payments are budgeted in this PC.
8. 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.
9. 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.
10. As of January 1, 2022, a regional average rate development model was implemented within certain managed care counties. Managed care plan rates in impacted counties reflect a weighted average blend of the county-specific rates. The following groupings of counties are consolidated into single rating regions:
 - a. Fresno, Kings, and Madera
 - b. Riverside and San Bernardino
 - c. San Joaquin and Stanislaus
11. As of January 1, 2022, the costs associated with HCBS High supplemental payments originally in CCI counties are reflected in this PC.

TWO PLAN MODEL
BASE POLICY CHANGE NUMBER: 76

12. As of January 1, 2022, Rapid Whole Genome Sequencing was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.
 13. As of January 1, 2022, Annual Cognitive Assessments (SB 48) was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.
 14. As of January 1, 2022, the pharmacy benefit was carved-out of the regular capitated rates. The impact associated with the carve-out of this benefit 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.
 15. As of July 1, 2022, certain programs formerly funded by Proposition 56 are now funded by the General Fund through the managed care base capitation rates. These program are as follows:
 - Proposition 56 Intermediate Care Facilities for the Developmentally Disabled,
 - Proposition 56 Freestanding Pediatric Subacute Facilities,
 - Proposition 56 Community-Based Adult Services,
 - Proposition 56 Adverse Childhood Experiences Screening, and
 - Proposition 56 Developmental Screenings.
- These payments are no longer designated as Proposition 56 programs.
16. As of July 1, 2022, Routine Costs for Clinical Trials was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.
 17. As of July 1, 2022, Cancer Biomarker Testing was included as a covered managed care benefit. The costs associated with these services will be reflected in the rates.
 18. Effective January 1, 2023, Doula Services will be included as a covered managed care benefit. The costs associated with these services are reflected in the rates.
 19. Effective January 1, 2023, Behavioral Health Treatment services will transition from a supplemental rate payment approach to the base capitation rates. The remaining CY 2022 supplemental rate expenditures will continue to be budgeted in the Behavioral Health Treatment policy change.
 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.

TWO PLAN MODEL
BASE POLICY CHANGE NUMBER: 76

Two-Plan Model costs on an accrual basis are:

(Dollars in Thousands)

FY 2022-23	Eligible Months	Total
Alameda	4,687,947	\$1,270,652
Contra Costa	3,234,704	\$910,933
Kern	5,072,017	\$1,071,222
Los Angeles	43,178,454	\$9,473,863
Riverside	10,518,771	\$2,357,091
San Bernardino	10,398,371	\$2,407,586
San Francisco	2,236,379	\$693,135
San Joaquin	3,348,724	\$710,630
Santa Clara	4,585,734	\$1,058,925
Stanislaus	2,706,944	\$642,590
Tulare	2,951,558	\$468,538
Fresno	5,645,664	\$1,074,999
Kings	706,565	\$127,446
Madera	852,971	\$135,683
Total	100,124,804	\$22,403,293
*Maternity and ACA Maternity	95,310	\$773,904
Total FY 2022-23		\$23,177,197

*Events

(Dollars in Thousands)

Included in the Above Dollars	FY 2022-23
Mental Health	\$282,000

TWO PLAN MODEL
BASE POLICY CHANGE NUMBER: 76

(Dollars in Thousands)

FY 2023-24	Eligible Months	Total
Alameda	4,705,686	\$1,279,417
Contra Costa	3,242,752	\$915,581
Kern	5,079,177	\$1,074,393
Los Angeles	43,264,619	\$9,509,269
Riverside	10,532,496	\$2,361,554
San Bernardino	10,405,934	\$2,411,603
San Francisco	2,247,425	\$697,185
San Joaquin	3,355,139	\$713,611
Santa Clara	4,589,784	\$1,060,841
Stanislaus	2,710,606	\$644,484
Tulare	2,954,581	\$469,385
Fresno	5,653,756	\$1,078,415
Kings	707,466	\$127,720
Madera	853,483	\$135,845
Total	100,302,903	\$22,479,303
*Maternity and ACA Maternity	100,075	\$812,599
Total FY 2023-24		\$23,291,902

*Events

(Dollars in Thousands)

Included in the Above Dollars	FY 2023-24
Mental Health	\$282,000

TWO PLAN MODEL
BASE POLICY CHANGE NUMBER: 76

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

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$16,935,919	\$8,467,960	\$8,467,960
100% GF (4260-101-0001)	\$36,111	\$36,111	\$0
90% Family Planning / 10% GF (4260-101-0001/0890)	\$46,118	\$4,612	\$41,506
65% Title XXI / 35% GF (4260-113-0001/0890)	\$732,868	\$256,504	\$476,364
ACA 90% FFP / 10% GF (2020)	\$5,220,181	\$522,018	\$4,698,163
Title XIX 100% FFP	\$10,941	\$0	\$10,941
Total*	\$22,982,139	\$9,287,205	\$13,694,934

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$17,576,465	\$8,788,232	\$8,788,232
100% GF (4260-101-0001)	\$38,506	\$38,506	\$0
90% Family Planning / 10% GF (4260-101-0001/0890)	\$51,283	\$5,128	\$46,155
65% Title XXI / 35% GF (4260-101-0001/0890)	\$734,469	\$257,064	\$477,405
ACA 90% FFP / 10% GF (2020)	\$4,932,903	\$493,290	\$4,439,613
Title XIX 100% FFP	\$11,597	\$0	\$11,597
Total	\$23,345,223	\$9,582,221	\$13,763,002

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 77
IMPLEMENTATION DATE: 12/1987
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 57

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$10,162,932,000	\$10,264,315,000
- STATE FUNDS	\$3,459,802,100	\$3,491,139,650
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$10,162,932,000	\$10,264,315,000
STATE FUNDS	\$3,459,802,100	\$3,491,139,650
FEDERAL FUNDS	\$6,703,129,900	\$6,773,175,350

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 2023-24
 COVID-19 Increased FMAP – DHCS

Background:

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

Reason for Change:

The change from the prior estimate, for FY 2022-23, is an increase due to:

- The previous Estimate projected pre-COVID-19 enrollment levels for FY 2022-23, with the impact of additional enrollment due to COVID-19 was reflected in the COVID-19 Caseload Impact policy change. The current Estimate assumes that enrollment continues at the levels close to those observed in July 2022 (the most recent actual month), which are much higher, with only the incremental impact of further changes in enrollment due to COVID-19 accounted for in the COVID-19 Caseload Impact and COVID-19 Caseload Impact Base Adjustment policy changes.
- Updated CY 2022 rates.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to a slight increase in eligibles.

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 77

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 the CY 2022 rates and the first six months of the CY 2023 rates have been budgeted for FY 2022-23.
3. FY 2022-23 weighted rates have been updated from the previous estimate.
4. The estimated rate adjustment anticipated for the CY 2024 rating period to occur in FY 2023-24 is captured in the Capitated Rate Adjustment for FY 2023-24 policy change as a percentage assumption applied to five months of the CY 2024 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 2022, inclusive of COVID-19 caseload impacts, followed by roughly the same level of monthly enrollment thereafter. The COVID-19 Caseload Impact and COVID-19 Caseload Impact Base Adjustment policy changes adjusts these base projections to account for incremental impacts of the COVID-19 pandemic on the Medi-Cal caseload and managed care enrollment.
7. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of \$157,600,000 for FY 2022-23 and \$157,600,000 for FY 2023-24 were included in the rates.
8. Indian Health Services and Maternity supplemental payments are reflected in this PC.
9. 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.
10. 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.
11. As of January 1, 2022, a regional average rate development model was implemented within certain managed care counties. Managed care plan (MCP) rates in impacted counties reflect a weighted average of county-specific or multi-county rates. The following groupings of counties will be consolidated into single rating regions:
 - a. Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo
 - b. Merced, Monterey, and Santa Cruz
 - c. San Luis Obispo and Santa Barbara
12. As of January 1, 2022, the costs associated with HCBS High supplemental payments originally in CCI counties are reflected in this PC.

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 77

13. As of January 1, 2022, Rapid Whole Genome Sequencing was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.
14. As of January 1, 2022, Annual Cognitive Assessments (SB 48) was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.
15. As of January 1, 2022, the pharmacy benefit was carved-out of the regular capitation rates. The impact associated with the carve-out of this benefit 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.

16. As of July 1, 2022, certain programs formerly funded by Proposition 56 are now funded by the General Fund through the managed care base capitation rates. These program are as follows:

- Proposition 56 Intermediate Care Facilities for the Developmentally Disabled,
- Proposition 56 Freestanding Pediatric Subacute Facilities,
- Proposition 56 Community-Based Adult Services,
- Proposition 56 Adverse Childhood Experiences Screening, and
- Proposition 56 Developmental Screenings.

These payments are no longer designated as Proposition 56 programs.

17. As of July 1, 2022, Routine Costs for Clinical Trials was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.
18. As of July 1, 2022, Cancer Biomarker Testing was included as a covered managed care benefit. The costs associated with these services will be reflected in the rates.
19. Effective January 1, 2023, Doula services will be included as a covered managed care benefit. The costs associated with these services are reflected in the rates.
20. Effective January 1, 2023, Behavioral Health Treatment services will transition from a supplemental rate payment approach to the base capitation rates. The remaining CY 2022 supplemental rate expenditures will continue to be budgeted in the Behavioral Health Treatment policy change.
21. Effective July 1, 2023, the Specialty Mental Health Services (SMHS) benefits currently within the scope of certain MCPs will be carved out from their responsibilities and be provided through the SMHS delivery system.
22. The Department receives 90% FFP for family planning services.
23. 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.
24. COHS dollars on an accrual basis are shown below, which excludes both WCM dollars and eligibles:

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 77

(Dollars in Thousands)

FY 2022-23	Eligible Months	Total
501- San Luis Obispo	787,284	\$217,667
502- Santa Barbara	1,853,033	\$485,673
503- San Mateo	1,586,120	\$516,432
504- Solano	1,598,412	\$556,480
505- Santa Cruz	937,337	\$310,609
506-Orange	10,816,554	\$3,101,807
507- Napa	409,028	\$149,226
508-Monterey	2,184,364	\$571,021
509- Yolo	727,028	\$257,072
513- Sonoma	1,520,850	\$522,660
514- Merced	1,758,525	\$460,154
510 - Marin	580,441	\$222,816
512 - Mendocino	489,291	\$161,449
515 - Ventura	2,874,804	\$861,390
523 - Del Norte	149,634	\$52,984
517 - Humboldt	721,411	\$249,609
511 - Lake	415,067	\$146,286
518 - Lassen	104,469	\$37,174
519 - Modoc	48,175	\$19,456
520 - Shasta	835,929	\$307,399
521 - Siskiyou	231,552	\$77,686
522 - Trinity	66,959	\$23,708
Total FY 2022-23	30,696,267	\$9,308,758
Maternity and ACA Maternity*	26,954	\$264,622
Total with Adjustments		\$9,573,380

*Events

(Dollars in Thousands)

Included in Above Dollars	FY 2022-23
Mental Health	\$157,600

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 77

(Dollars in Thousands)

FY 2023-24	Eligible Months	Total
501- San Luis Obispo	788,512	\$218,071
502- Santa Barbara	1,856,415	\$487,039
503- San Mateo	1,586,287	\$516,496
504- Solano	1,601,304	\$557,920
505- Santa Cruz	939,672	\$311,540
506-Orange	10,831,637	\$3,108,598
507- Napa	410,252	\$149,890
508-Monterey	2,188,551	\$572,696
509- Yolo	728,113	\$257,597
513- Sonoma	1,522,665	\$523,484
514- Merced	1,760,122	\$460,770
510 - Marin	581,186	\$223,229
512 - Mendocino	490,541	\$161,903
515 - Ventura	2,876,636	\$862,082
523 - Del Norte	149,647	\$53,028
517 - Humboldt	722,765	\$250,088
511 - Lake	415,759	\$146,599
518 - Lassen	104,535	\$37,196
519 - Modoc	48,165	\$19,440
520 - Shasta	836,903	\$307,687
521 - Siskiyou	231,933	\$77,834
522 - Trinity	66,966	\$23,731
Total FY 2023-24	30,738,567	\$9,326,918
Maternity and ACA Maternity*	28,302	\$277,853
Total with Adjustments		\$9,604,771

*Events

(Dollars in Thousands)

Included in Above Dollars	FY 2023-24
Mental Health	\$157,600

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 77

Funding:

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

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$5,900,496	\$2,950,248	\$2,950,248
100% GF (4260-101-0001)	\$7,831	\$7,831	\$0
90% Family Planning / 10% GF (4260-101-0001/0890)	\$19,711	\$1,971	\$17,740
65% Title XXI / 35% GF (4260-113-0001/0890)	\$331,142	\$115,900	\$215,242
ACA 90% FFP / 10% GF (2020)	\$3,838,523	\$383,852	\$3,454,670
Title XIX 100% FFP	\$65,229	\$0	\$65,229
Total*	\$10,162,932	\$3,459,802	\$6,703,129

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$5,951,644	\$2,975,822	\$2,975,822
100% GF (4260-101-0001)	\$8,344	\$8,344	\$0
90% Family Planning / 10% GF (4260-101-0001/0890)	\$20,436	\$2,044	\$18,392
65% Title XXI / 35% GF (4260-101-0001/0890)	\$333,821	\$116,837	\$216,984
ACA 90% FFP / 10% GF (2020)	\$3,880,927	\$388,093	\$3,492,834
Title XIX 100% FFP	\$69,143	\$0	\$69,143
Total	\$10,264,315	\$3,491,140	\$6,773,175

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

*Difference due to rounding.

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 78
IMPLEMENTATION DATE: 4/1994
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 58

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$4,399,088,000	\$4,469,084,000
- STATE FUNDS	\$1,439,683,300	\$1,463,766,450
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$4,399,088,000	\$4,469,084,000
STATE FUNDS	\$1,439,683,300	\$1,463,766,450
FEDERAL FUNDS	\$2,959,404,700	\$3,005,317,550

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 2023-24
 COVID-19 Increased FMAP – DHCS

Background:

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

Reason for Change:

The change from the prior estimate, for FY 2022-23, is an increase due to:

- The previous Estimate projected pre-COVID-19 enrollment levels for FY 2022-23, with the impact of additional enrollment due to COVID-19 was reflected in the COVID-19 Caseload Impact policy change. The current Estimate assumes that enrollment continues at the levels close to those observed in July 2022 (the most recent actual month), which are much higher, with only the incremental impact of further changes in enrollment due to COVID-19 accounted for in the COVID-19 Caseload Impact and COVID-19 Caseload Impact Base Adjustment policy changes.
- Updated CY 2022 rates.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to a slight increase in eligibles.

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 78

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 2022 and the first six months of the CY 2023 rates have been budgeted for FY 2022-23.
3. FY 2022-23 weighted rates have been updated from the previous estimate.
4. The estimated rate adjustment anticipated for the CY 2024 rating period to occur in FY 2023-24 is captured in the Capitated Rate Adjustment for FY 2023-24 policy change as a percentage assumption applied to five months of the CY 2024 rates on a cash basis.
5. The eligibles in this PC are reflective of actuals through July 2022, inclusive of COVID-19 caseload impacts, followed by roughly the same level of monthly enrollment thereafter. The COVID-19 Caseload Impact and COVID-19 Caseload Impact Base Adjustment policy changes adjust these base projections to account for incremental impacts of the COVID-19 pandemic on the Medi-Cal caseload and managed care enrollment.
6. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of \$62,800,000 for FY 2022-23 and \$62,800,000 for FY 2023-24 were included in the rates.
7. Indian Health Services and Maternity supplemental payments are budgeted in this PC.
8. 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.
9. As of January 1, 2022, the costs associated with HCBS High supplemental payments originally in CCI counties are reflected in this PC.
10. As of January 1, 2022, Rapid Whole Genome Sequencing was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.
11. As of January 1, 2022, Annual Cognitive Assessments (SB 48) was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.
12. As of January 1, 2022, the pharmacy benefit was carved-out of the regular capitation rates. The impact associated with the carve-out of this benefit 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.
13. As of July 1, 2022, certain programs formerly funded by Proposition 56 are now funded by the General Fund through the managed care base capitation rates. These program are as follows:
 - Proposition 56 Intermediate Care Facilities for the Developmentally Disabled,

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 78

- Proposition 56 Freestanding Pediatric Subacute Facilities,
- Proposition 56 Community-Based Adult Services,
- Proposition 56 Adverse Childhood Experiences Screening, and
- Proposition 56 Developmental Screenings.

These payments are no longer designated as Proposition 56 programs.

14. As of July 1, 2022, Routine Costs for Clinical Trials was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.
15. As of July 1, 2022, Cancer Biomarker Testing was included as a covered managed care benefit. The costs associated with these services will be reflected in the rates.
16. Effective January 1, 2023, Doula services will be included as a covered managed care benefit. The costs associated with these services are reflected in the rates.
17. Effective January 1, 2023, Behavioral Health Treatment services will transition from a supplemental rate payment approach to the base capitation rates. The remaining CY 2022 supplemental rate expenditures will continue to be budgeted in the Behavioral Health Treatment policy change.
18. Effective July 1, 2023, the Specialty Mental Health Services (SMHS) benefits currently within the scope of certain managed care plans will be carved out from their responsibility and be provided through the SMHS delivery system.
19. The Department receives 90% FFP for family planning services.
20. 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.

GMC dollars on an accrual basis are:

(Dollars in Thousands)

FY 2022-23	Eligible Months	Total
Sacramento	6,452,706	\$1,576,197
San Diego	10,749,227	\$2,715,916
Total	17,201,933	\$4,292,113
Maternity and ACA Maternity*	16,705	\$144,359
Total FY 2022-23		\$4,436,472

*Events

(Dollars in Thousands)

Included in Dollars Above	FY 2022-23
Mental Health	\$62,800

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 78

(Dollars in Thousands)

FY 2023-24	Eligible Months	Total
Sacramento	6,465,744	\$1,581,618
San Diego	10,764,451	\$2,723,882
Total	17,230,195	\$4,305,500
Maternity and ACA Maternity*	17,540	\$151,577
Total FY 2023-24		\$4,457,077

*Events

(Dollars in Thousands)

Included in Dollars Above	FY 2023-24
Mental Health	\$62,800

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

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$2,402,011	\$1,201,005	\$1,201,005
100% GF (4260-101-0001)	\$5,965	\$5,965	\$0
90% Family Planning / 10% GF (4260-101-0001/0890)	\$8,856	\$886	\$7,970
65% Title XXI / 35% GF (4260-113-0001/0890)	\$135,862	\$47,552	\$88,311
ACA 90% FFP / 10% GF (2020)	\$1,842,755	\$184,276	\$1,658,479
Title XIX 100% FFP	\$3,639	\$0	\$3,639
Total*	\$4,399,088	\$1,439,684	\$2,959,404

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$2,443,594	\$1,221,797	\$1,221,797
100% GF (4260-101-0001)	\$6,320	\$6,320	\$0
90% Family Planning / 10% GF (4260-101-0001/0890)	\$9,866	\$987	\$8,880
65% Title XXI / 35% GF (4260-101-0001/0890)	\$136,473	\$47,766	\$88,708
ACA 90% FFP / 10% GF (2020)	\$1,868,973	\$186,896	\$1,682,075
Title XIX 100% FFP	\$3,858	\$0	\$3,858
Total*	\$4,469,084	\$1,463,766	\$3,005,318

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

* Difference due to rounding.

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 84
IMPLEMENTATION DATE: 11/2013
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1842

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$1,363,395,000	\$1,380,007,000
- STATE FUNDS	\$423,716,000	\$428,316,650
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,363,395,000	\$1,380,007,000
STATE FUNDS	\$423,716,000	\$428,316,650
FEDERAL FUNDS	\$939,679,000	\$951,690,350

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 2023-24
 COVID-19 Increased FMAP – DHCS

Background:

Managed care was previously in 30 counties. AB 1467 expanded managed care into the remaining 28 counties across the state. Expanding managed care into rural counties ensures that beneficiaries throughout the state receive health care through an organized delivery system that coordinates their care and leads to better health outcomes and lower costs.

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

Reason for Change:

The change from the prior estimate, for FY 2022-23, is an increase due to:

- The previous Estimate projected pre-COVID-19 enrollment levels for FY 2022-23, with the impact of additional enrollment due to COVID-19 was reflected in the COVID-19 Caseload Impact policy change. The current Estimate assumes that enrollment continues at the levels close to those observed in July 2022 (the most recent actual month), which are much higher, with only the incremental impact of further changes in enrollment due to COVID-19 accounted for in the COVID-19 Caseload Impact and COVID-19 Caseload Impact Base Adjustment policy changes.
- Updated CY 2022 rates.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to a slight increase in eligibles.

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 84

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 2022 rates and the first six months of the CY 2023 rates have been budgeted for FY 2022-23.
3. FY 2022-23 weighted rates have been updated from the previous estimate.
4. The estimated rate adjustment anticipated for the CY 2024 rating period to occur in FY 2023-24 is captured in the Capitated Rate Adjustment for FY 2023-24 policy change as a percentage assumption applied to five months of the CY 2024 rates on a cash basis.
5. The eligibles in this PC are reflective of actuals through July 2022, inclusive of COVID-19 caseload impacts, followed by roughly the same level of monthly enrollment thereafter. The COVID-19 Caseload Impact and COVID-19 Caseload Impact Base Adjustment policy changes adjusts these base projections to account for incremental impacts of the COVID-19 pandemic on the Medi-Cal caseload and managed care enrollment.
6. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of \$29,800,000 for FY 2022-23 and \$29,800,000 for FY 2023-24 were included in the rates.
7. Indian Health Services and Maternity supplemental payments are reflected in this PC.
8. 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.
9. As of January 1, 2022, a regional rate development model continued to be implemented within certain managed care counties. Managed care plan (MCP) rates in impacted counties are 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 are consolidated into a single rating region:
 - a. Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba.
10. As of January 1, 2022, Rapid Whole Genome Sequencing was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.
11. As of January 1, 2022, Annual Cognitive Assessments (SB 48) was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.
12. As of January 1, 2022, the pharmacy benefit was carved-out of the regular capitation rates. the impact associated with the carve-out of this benefit is reflected in the form of reduced

REGIONAL MODEL
BASE POLICY CHANGE NUMBER: 84

rates. Offset costs from pharmacy benefit transitioning to FFS are reflected in the Medi-Cal Rx – Managed Care Pharmacy Benefit to FFS policy change.

13. As of July 1, 2022, certain programs formerly funded by Proposition 56 are now funded by the General Fund through the managed care base capitation rates. These program are as follows:
- Proposition 56 Intermediate Care Facilities for the Developmentally Disabled,
 - Proposition 56 Freestanding Pediatric Subacute Facilities,
 - Proposition 56 Community-Based Adult Services,
 - Proposition 56 Adverse Childhood Experiences Screening, and
 - Proposition 56 Developmental Screenings.

These payments are no longer designated as Proposition 56 programs.

14. As of July 1, 2022, Routine Costs for Clinical Trials was included as a covered managed care benefit. The costs associated with these services are reflected in the rates.
15. As of July 1, 2022, Cancer Biomarker Testing was included as a covered managed care benefit. The costs associated with these services will be reflected in the rates.
16. Effective January 1, 2023, Doula services will be included as a covered managed care benefit. The costs associated with these services are reflected in the rates.
17. Effective January 1, 2023, Behavioral Health Treatment services will transition from a supplemental rate payment approach to the base capitation rates. The remaining CY 2022 supplemental rate expenditures will continue to be budgeted in the Behavioral Health Treatment policy change.
18. The Department receives 90% FFP 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.

REGIONAL MODEL
BASE POLICY CHANGE NUMBER: 84

20. Regional Model dollars on an accrual basis are:

(Dollars in Thousands)

FY 2022-23	Eligible Months	Total
Alpine	2,848	\$700
Amador	94,068	\$20,643
Butte	865,130	\$223,028
Calaveras	140,679	\$33,223
Colusa	113,818	\$21,865
El Dorado	433,522	\$104,682
Glenn	145,283	\$31,941
Inyo	60,044	\$12,931
Mariposa	61,176	\$14,280
Mono	36,969	\$7,500
Nevada	288,692	\$67,972
Placer	748,148	\$166,021
Plumas	68,787	\$16,790
Sierra	7,733	\$1,843
Sutter	457,532	\$97,834
Tehama	305,880	\$71,563
Tuolumne	154,708	\$38,052
Yuba	379,577	\$86,154
Imperial	1,074,526	\$198,314
San Benito	130,137	\$20,504
Total FY 2022-23	5,569,258	\$1,235,840
*Maternity and ACA Maternity	6,012	\$65,940
Total with Adjustments		\$1,301,780

*Events

(Dollars in Thousands)

Included in Dollars Above	FY 2022-23
Mental Health	\$29,800

REGIONAL MODEL
BASE POLICY CHANGE NUMBER: 84

(Dollars in Thousands)

FY 2023-24	Eligible Months	Total
Alpine	2,842	\$699
Amador	94,056	\$20,644
Butte	866,083	\$223,474
Calaveras	140,785	\$33,295
Colusa	113,837	\$21,869
El Dorado	434,031	\$104,899
Glenn	145,444	\$32,000
Inyo	60,039	\$12,933
Mariposa	61,178	\$14,279
Mono	36,972	\$7,499
Nevada	288,812	\$68,030
Placer	750,263	\$166,806
Plumas	68,794	\$16,793
Sierra	7,742	\$1,844
Sutter	458,294	\$98,186
Tehama	305,926	\$71,598
Tuolumne	154,808	\$38,127
Yuba	379,657	\$86,182
Imperial	1,079,339	\$200,678
San Benito	130,258	\$20,564
Total FY 2023-24	5,579,160	\$1,240,399
*Maternity and ACA Maternity	6,313	\$69,237
Total with Adjustments		\$1,309,636

*Events

(Dollars in Thousands)

Included in Dollars Above	FY 2023-24
Mental Health	\$29,800

REGIONAL MODEL
BASE POLICY CHANGE NUMBER: 84

Funding:

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

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$706,340	\$353,170	\$353,170
100% GF (4260-101-0001)	\$1,411	\$1,411	\$0
ACA 90% FFP / 10% GF (2020)	\$548,661	\$54,866	\$493,795
90% Family Planning / 10% GF (4260-101-0001/0890)	\$2,738	\$274	\$2,464
65% Title XXI / 35% GF (4260-113-0001/0890)	\$39,986	\$13,995	\$25,991
Title XIX 100% (4260-101-0890)	\$64,259	\$0	\$64,259
Total	\$1,363,395	\$423,716	\$939,679

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$714,387	\$357,194	\$357,194
100% GF (4260-101-0001)	\$1,490	\$1,490	\$0
ACA 90% FFP / 10% GF (2020)	\$552,982	\$55,298	\$497,684
90% Family Planning / 10% GF (4260-101-0001/0890)	\$2,907	\$291	\$2,616
65% Title XXI / 35% GF (4260-101-0001/0890)	\$40,125	\$14,044	\$26,081
Title XIX 100% (4260-101-0890)	\$68,115	\$0	\$68,115
Total*	\$1,380,007	\$428,317	\$951,690

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

*Difference due to rounding.

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 85
IMPLEMENTATION DATE: 7/1992
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 62

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$1,208,789,000	\$1,450,581,000
- STATE FUNDS	\$604,394,500	\$725,290,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,208,789,000	\$1,450,581,000
STATE FUNDS	\$604,394,500	\$725,290,500
FEDERAL FUNDS	\$604,394,500	\$725,290,500

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

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 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: 85

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
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
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
ConcertoCare PACE	Kern	January 1, 2024
	Tulare	January 1, 2024

PACE (Other M/C)
BASE POLICY CHANGE NUMBER: 85

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
High Desert PACE	Los Angeles	January 1, 2023
	San Bernardino	January 1, 2023
360 PACE of Sacramento	Sacramento	July 1, 2023
	Placer	July 1, 2023
360 PACE of Riverside	Riverside	July1, 2023
	San Bernardino	July 1, 2023
WelbeHealth Bay Area	Santa Clara	July 1, 2023
	Alameda	July 1, 2023
AgeWell PACE	Sonoma	July 1, 2023
	Marin	July 1, 2023
WelbeHealth Inland Empire PACE	Riverside	July 1, 2023
	San Bernardino	July 1, 2023
Asian Heritage Healthcare	Los Angeles	July 1, 2023
Valley PACE	Fresno	July1, 2023
	Madera	July1, 2023
WelbeHealth Sierra PACE	Sacramento	January 1, 2024
	Stanislaus	January 1, 2024
	San Joaquin	January 1, 2024
Chinatown Service Center	Los Angeles	January 1, 2024
myPlace Health (formerly Prosper Services PACE)	Los Angeles	January 1, 2024

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a decrease due to lower estimated eligibles. The change from FY 2022-23 to FY 2023-24, 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) 2022, CY 2023, and CY 2024 rates will be calculated using plan specific experienced-based data to build actuarially sound prospective rates.
2. FY 2022-23 and FY 2023-24 estimated funding is based on CY 2022 rates and projected CY 2023 and CY 2024 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. Health care plans that began January 2022 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

PACE (Other M/C)
BASE POLICY CHANGE NUMBER: 85

care plans. The new health care plans estimated costs are \$56,834,000 TF in FY 2022-23 and \$120,277,000 TF in FY 2023-24.

FY 2022-23	TF Cost (Rounded)	Eligible Months	Avg. Mo. Enrollment
Centers for Elders' Independence (Alameda and Contra Costa)	\$84,281,000	11,778	982
Sutter Senior Care	\$37,922,000	5,610	468
AltaMed Senior Care (Los Angeles)	\$242,535,000	48,492	4,041
OnLok (SF, Alameda and Santa Clara)	\$173,458,000	20,382	1,699
St. Paul's PACE	\$62,011,000	13,830	1,153
Los Angeles Jewish Homes	\$16,723,000	3,108	259
CalOptima PACE	\$35,039,000	5,538	462
InnovAge (San Bernardino and Riverside)	\$71,687,000	13,806	1,151
Redwood Coast (Humboldt)	\$17,820,000	2,802	234
Innovative Integrated Health (Fresno, Kern, Tulare)	\$99,788,000	19,644	1,637
San Ysidro San Diego	\$165,092,000	29,382	2,449
Stockton PACE (San Joaquin and Stanislaus)	\$45,711,000	6,594	550
Gary & Mary West (San Diego)	\$15,762,000	2,616	218
Family Health Centers of San Diego	\$18,827,000	3,150	263
Central Valley (Stanislaus)	\$18,805,000	2,562	214
LA Coast (Los Angeles)	\$24,593,000	3,708	309
Pacific PACE (Los Angeles)	\$25,402,000	3,762	314
Sequoia (Fresno)	\$33,763,000	5,256	438
InnovAge (Sacramento)	\$19,570,000	3,066	256
Total FY 2022-23	\$1,208,789,000	205,086	17,097

*Totals may differ due to rounding.

PACE (Other M/C)
BASE POLICY CHANGE NUMBER: 85

FY 2023-24	TF Cost (Rounded)	Eligible Months	Avg. Mo. Enrollment
Centers for Elders' Independence (Alameda and Contra Costa)	\$93,895,000	12,498	1,042
Sutter Senior Care	\$40,837,000	5,754	480
AltaMed Senior Care (Los Angeles & Orange)	\$277,337,000	49,296	4,108
OnLok (SF, Alameda and Santa Clara)	\$185,977,000	20,814	1,735
St. Paul's PACE	\$68,501,000	14,550	1,213
Los Angeles Jewish Homes	\$17,559,000	3,108	259
CalOptima PACE	\$39,654,000	5,970	498
InnovAge (San Bernardino and Riverside)	\$80,771,000	14,814	1,235
Redwood Coast (Humboldt)	\$19,682,000	2,946	246
Innovative Integrated Health (Fresno, Kern, Tulare)	\$126,275,000	23,388	1,949
San Ysidro San Diego	\$214,912,000	36,438	3,037
Stockton PACE (San Joaquin and Stanislaus)	\$61,605,000	8,466	706
Gary & Mary West (San Diego)	\$20,189,000	3,192	266
Family Health Centers of San Diego	\$26,082,000	4,158	347
Central Valley (Stanislaus)	\$27,496,000	3,570	298
LA Coast (Los Angeles)	\$35,827,000	5,148	429
Pacific PACE (Los Angeles)	\$33,808,000	4,770	398
Sequoia (Fresno)	\$52,883,000	7,848	654
InnovAge (Sacramento)	\$27,291,000	4,074	340
Total FY 2023-24	\$1,450,581,000	230,802	19,240

*Totals may differ due to rounding.

Funding:

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

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 90
IMPLEMENTATION DATE: 7/2004
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1029

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$130,434,000	\$134,796,000
- STATE FUNDS	\$43,944,100	\$45,413,950
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$130,434,000	\$134,796,000
STATE FUNDS	\$43,944,100	\$45,413,950
FEDERAL FUNDS	\$86,489,900	\$89,382,050

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

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 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 1, 2014, in addition to the adult dental benefits which include services for pregnant women,

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 90

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% beginning with FY 2019-20 rating period. The Department will require DMC plans to remit necessary funds that do not meet the 85% threshold. These recoupments are budgeted in a separate policy change.

The CalAIM Dental Benefits and Pay-For-Performance initiatives (CalAIM Dental) began 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 2022-23, is a decrease due to lower finalized CY 2022 rates and anticipated CY 2023 rates. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to an anticipated increase in CY 2024 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 DMC plans. The withhold amount is returned no sooner than April of the following fiscal year if performance measures in the contract are met.
4. Effective January 1, 2023, a new 3% performance withhold will be 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 the plans are in compliance with the contract.

FY 2022-23	Total Member Months	Average Monthly Eligibles	Total Costs
Adult - GMC	3,193,080	266,090	\$36,663,157
Child - GMC	2,589,048	215,754	\$41,598,898
Adult - PHP	3,275,880	272,990	\$34,055,757
Child - PHP	1,557,384	129,782	\$18,278,323

DENTAL MANAGED CARE (Other M/C)
BASE POLICY CHANGE NUMBER: 90

FY 2023-24	Total Member Months	Average Monthly Eligibles	Total Costs
Adult - GMC	3,193,080	266,090	\$37,873,041
Child - GMC	2,589,048	215,754	\$42,971,661
Adult - PHP	3,275,880	272,990	\$35,179,597
Child - PHP	1,557,384	129,782	\$18,881,508

Funding:

FY 2022-23	TF	GF	FF
Regular FMAP T19	\$71,618,000	\$35,809,000	\$35,809,000
ACA 90% FFP/10% GF (2020)	\$49,802,000	\$4,980,000	\$44,822,000
Title 21 65% FFP/35% GF	\$9,014,000	\$3,155,000	\$5,859,000
Total	\$130,434,000	\$43,944,000	\$86,490,000

FY 2023-24	TF	GF	FF
Regular FMAP T19	\$74,014,000	\$37,007,000	\$37,007,000
ACA 90% FFP/10% GF (2020)	\$51,467,000	\$5,147,000	\$46,320,000
Title 21 65% FFP/35% GF	\$9,315,000	\$3,260,000	\$6,055,000
Total	\$134,796,000	\$45,414,000	\$89,382,000

*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)

65% Title XXI / 35% GF (4260-101-0890/0001)

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

SENIOR CARE ACTION NETWORK (Other M/C)

BASE POLICY CHANGE NUMBER: 94
IMPLEMENTATION DATE: 2/1985
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 61

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$67,867,000	\$71,850,000
- STATE FUNDS	\$33,933,500	\$35,925,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$67,867,000	\$71,850,000
STATE FUNDS	\$33,933,500	\$35,925,000
FEDERAL FUNDS	\$33,933,500	\$35,925,000

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

Background:

SCAN is a Medicare Advantage Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) 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:

The change in FY 2022-23, from the prior estimate, is an increase due to higher estimated costs for long term care services in the CY 2022 and CY 2023 rates. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to projected CY 2024 rate growth.

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 14,982 in FY 2022-23 and in FY 2023-24.
3. The CY 2022 rates are estimated final rates.

SENIOR CARE ACTION NETWORK (Other M/C)
BASE POLICY CHANGE NUMBER: 94

4. CY 2023 and CY 2024 rates were projected by trending forward the CY 2022 estimated final rates.
5. Assume seven months of CY 2022 rating period payments and five months of CY 2023 rating period payments are paid in FY 2022-23.
6. Assume seven months of CY 2023 rating period payments and five months of CY 2024 rating period payments are paid in FY 2023-24.
7. Anticipated costs on a cash basis are:

(Dollars in Thousands)

FY 2022-23	Costs	Eligible Months	Avg. Monthly Enrollment
Los Angeles	\$46,267	122,560	10,213
Riverside	\$12,624	30,461	2,538
San Bernardino	\$8,152	21,664	1,805
San Diego	\$825	2,125	425
Total FY 2022-23	\$67,867	176,810	14,982

(Dollars in Thousands)

FY 2023-24	Costs	Eligible Months	Avg. Monthly Enrollment
Los Angeles	\$48,187	122,560	10,213
Riverside	\$13,156	30,461	2,538
San Bernardino	\$8,502	21,664	1,805
San Diego	\$2,005	5,100	425
Total FY 2023-24	\$71,850	179,785	14,982

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2022-23	\$67,867	\$33,933	\$33,934
FY 2023-24	\$71,850	\$35,925	\$35,925

Funding:

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

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL

BASE POLICY CHANGE NUMBER: 95
IMPLEMENTATION DATE: 7/2014
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 1837

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$27,663,000	\$27,663,000
- STATE FUNDS	\$10,680,000	\$11,490,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$27,663,000	\$27,663,000
STATE FUNDS	\$10,680,000	\$11,490,000
FEDERAL FUNDS	\$16,983,000	\$16,173,000

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 18-0028
 Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS

Background:

MCAP covers pregnant women in families with incomes between 213-322% of the FPL. Effective July 1, 2022, premium contribution amounts were reduced to \$0.00. 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: 95

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 2022-23, is a decrease due to a reduction in anticipated delivery costs. There is no change in total funds in the current estimate for FY 2022-23 to FY 2023-24. However, there is an increase in General Fund due to assuming the FFCRA increased FMAP ends in FY 2022-23.

Methodology:

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

Program Forecast	FY 2022-23	FY 2023-24
Average Monthly Caseload	2,491	2,491
Average Expected Deliveries	110	110
Per Member Per Month (PMPM)	\$277.49	\$277.49

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. The Department assumes 10% of monthly subscribers have a maternity only deductible exceeding \$500 and are ineligible for FFP.
4. The 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through March 31, 2023, for this policy change and is shown as a separate line item. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change. The total estimated costs for MCAP mothers in FY 2023-23 and FY 2023-24 are:

(Dollars in Thousands)

FY 2022-23	TF	SF	FF
65% Title XXI FFP / 35% Perinatal Insurance Fund	\$24,882	\$8,709	\$16,173
100% Perinatal Insurance Fund	\$2,781	\$2,781	\$0
FFCRA 4.34% Increased FFP	\$0	(\$810)	\$810
Total	\$27,663	\$10,680	\$16,983
FY 2023-24	TF	SF	FF
65% Title XXI FFP / 35% Perinatal Insurance Fund	\$24,882	\$8,709	\$16,173
100% Perinatal Insurance Fund	\$2,781	\$2,781	\$0
COVID-19 4.34% Enhanced FFP	\$0	\$0	\$0
Total	\$27,663	\$11,490	\$16,173

*Totals differ due to rounding.

MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
BASE POLICY CHANGE NUMBER: 95

Funding:

Perinatal Insurance Fund (4260-602-0309)

Title XXI FFP (4260-113-0890)

Title XXI FFP (4260-101-0890)

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

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

AIDS HEALTHCARE CENTERS (Other M/C)

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

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$8,608,000	\$8,608,000
- STATE FUNDS	\$4,304,000	\$4,304,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$8,608,000	\$8,608,000
STATE FUNDS	\$4,304,000	\$4,304,000
FEDERAL FUNDS	\$4,304,000	\$4,304,000

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), as well as other health plan(s) participating in the transition of current AHF members.

Authority:

Welfare & Institutions Code 14088.85

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS

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. Positive Healthcare's contract with the Department as a Medi-Cal managed care plan is expected to expire December 31, 2022. Current enrollees will transition to a different health plan. Until these transitions take place and current Positive Healthcare enrollees appear in a different health plan in actual managed care enrollment data, funding for these enrollees past December 31, 2022 will continue to be budgeted in this policy change.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a decrease due to applying final CY 2022 rates to the CY 2023 rating period. The previous estimate cycle utilized a draft rate for the CY 2023 rating period. There is no change from FY 2022-23 to FY 2023-24 in the current estimate.

Methodology:

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

AIDS HEALTHCARE CENTERS (Other M/C)
BASE POLICY CHANGE NUMBER: 97

Member Months	Dual	Medi-Cal Only
CY 2022	3,528	4,980
CY 2023	3,528	4,980

2) Assume the following paid rates:

Paid Rates	Dual	Medi-Cal Only
CY 2022	\$153.37	\$1,619.92
CY 2023	\$153.37	\$1,619.92

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

FY 2022-23	Paid Rate	MM	TF
Dual	\$153.37	3,528	\$541,000
Medi-Cal Only	\$1,619.92	4,980	\$8,067,000
Total	N/A	N/A	\$8,608,000

FY 2023-24	Paid Rate	MM	TF
Dual	\$153.37	3,528	\$541,000
Medi-Cal Only	\$1,619.92	4,980	\$8,067,000
Total	N/A	N/A	\$8,608,000

4) The following chart shows dollars allocate by plan on a cash basis:

FY 2022-23	TF	GF	FF
Positive Healthcare (July 2022 - Jan 2023)	\$5,021,000	\$2,510,500	\$2,510,500
Other health plans - TBD (Feb - June 2023)	\$3,587,000	\$1,793,500	\$1,793,500
Total FY 2022-23	\$8,608,000	\$4,304,000	\$4,304,000

FY 2023-24	TF	GF	FF
Other health plans - TBD	\$8,608,000	\$4,304,000	\$4,304,000
Total FY 2023-24	\$8,608,000	\$4,304,000	\$4,304,000

Funding:

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

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM

BASE POLICY CHANGE NUMBER: 98
IMPLEMENTATION DATE: 7/2014
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 1823

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$6,278,000	\$6,278,000
- STATE FUNDS	\$1,970,300	\$2,197,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$6,278,000	\$6,278,000
STATE FUNDS	\$1,970,300	\$2,197,300
FEDERAL FUNDS	\$4,307,700	\$4,080,700

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
 SB 184 (Chapter 47, Statutes of 2022)
 Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS

Background:

AB 495 created the CHIM fund, which funds the CCHIP, to provide health insurance coverage to low income children under the age of 19.

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

COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM

BASE POLICY CHANGE NUMBER: 98

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. Effective July 1, 2022, premium contribution amounts were reduced to \$0.00.

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 2022-23, is an increase due to an increase in the estimated population and expenditures. Additionally, premium contribution amounts were reduced to \$0.00 beginning July 1, 2022.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase in General Fund expenditures due to the FFCRA enhanced funding ending in FY 2022-23.

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. Effective July 1, 2022, premium contribution amounts were reduced to \$0.00.
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 March 31, 2023, for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
7. Assume there will be approximately 5,488 CCHIP beneficiaries in FY 2022-23 and FY 2023-24.

COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM
BASE POLICY CHANGE NUMBER: 98

FY 2022-23	TF	GF	FF
Benefits Title XXI 65/35 GF	\$6,278,000	\$2,197,000	\$4,081,000
FFCRA 4.34% Increased FFP	\$0	(\$227,000)	\$227,000
Total FY 2022-23	\$6,278,000	\$1,970,000	\$4,308,000

FY 2023-24	TF	GF	FF
Benefits Title XXI 65/35 GF	\$6,278,000	\$2,197,000	\$4,081,000
Total FY 2023-24	\$6,278,000	\$2,197,000	\$4,081,000

*Totals may differ due to rounding.

Funding:

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

65% Title XXI FF / 35% GF (4260-101-0890/0001)

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

FFCRA 4.34% GF (4260-113-0001)

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL

BASE POLICY CHANGE NUMBER: 99
IMPLEMENTATION DATE: 11/2013
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 1797

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$4,707,000	\$4,707,000
- STATE FUNDS	\$1,494,450	\$1,647,450
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$4,707,000	\$4,707,000
STATE FUNDS	\$1,494,450	\$1,647,450
FEDERAL FUNDS	\$3,212,550	\$3,059,550

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 – DHCS

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. Effective July 1, 2022, premium contribution amounts were reduced to \$0.00.

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: 99

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a decrease due to lower projected Medi-Cal Managed Care per member, per month (PMPM) costs. Additionally, effective July 1, 2022, premium contribution amounts were reduced to \$0.00.

There is no change in total funds in the current estimate for FY 2022-23 to FY 2023-24; however, there is an increase in general funds due to assuming COVID-19 increased FMAP ends in FY 2022-23.

Methodology:

1. The Department estimates the average monthly FFS enrollment will be 154 in FY 2022-23 and FY 2023-24, and the average monthly Medi-Cal Managed Care enrollment will be 1,747 in FY 2022-23 and FY 2023-24.
2. The Department estimates the weighted average PMPM cost will be \$583.96 in FY 2022-23 and FY 2023-24 for FFS infants, and \$172.93 in FY 2022-23 and FY 2023-24 for Medi-Cal Managed Care infants.
3. The 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through March 31, 2023, for this policy change and is shown as a separate line item. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change. The total estimated costs for MCAIP infants in FY 2022-23 and FY 2023-24 are:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Benefits	\$4,707	\$1,647	\$3,060
FFCRA 4.34% Increased FFP	\$0	(\$153)	\$153
Net Total	\$4,707	\$1,494	\$3,213

FY 2023-24	TF	GF	FF
Benefits	\$4,707	\$1,647	\$3,060
Net Total	\$4,707	\$1,647	\$3,060

*Totals may differ due to rounding.

Funding:

65% Title XXI FFP/35% GF (4260-101-0890/0001)
 65% Title XXI FFP/35% GF (4260-113-0890/0001)
 FFCRA 4.34% Increased FFP (4260-113-0890)
 FFCRA 4.34% GF (4260-113-0001)

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

BASE POLICY CHANGE NUMBER: 100
IMPLEMENTATION DATE: 3/2018
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 66

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$1,624,000	\$1,706,000
- STATE FUNDS	\$1,624,000	\$1,706,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,624,000	\$1,706,000
STATE FUNDS	\$1,624,000	\$1,706,000
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.

FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)
BASE POLICY CHANGE NUMBER: 100

Reason for Change:

There is no change from the prior estimate for FY 2022-23. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to a growth in projected capitation rates for the CY 2023 and CY 2024 rating periods.

Methodology:

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

- 413 in FY 2021-22
- 413 in FY 2022-23
- 413 in FY 2023-24

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

- \$3,853.10 in CY 2022
- \$4,045.76 in CY 2023
- \$4,248.04 in CY 2024

3) Anticipated costs on a cash basis are:

Fiscal Year	TF	GF	FF
FY 2022-23	\$1,624,000	\$1,624,000	\$0
FY 2023-24	\$1,706,000	\$1,706,000	\$0

Funding:

100% State GF (4260-101-0001)

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

BASE POLICY CHANGE NUMBER: 174
IMPLEMENTATION DATE: 7/1988
ANALYST: Joulia Dib
FISCAL REFERENCE NUMBER: 76

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$4,283,341,000	\$4,385,285,000
- STATE FUNDS	\$2,479,205,000	\$2,538,511,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$4,283,341,000	\$4,385,285,000
STATE FUNDS	\$2,479,205,000	\$2,538,511,000
FEDERAL FUNDS	\$1,804,136,000	\$1,846,774,000

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

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 2022-23 were revised up 4.1% from the prior estimate:

- Due to projections including three months of actual expenditures related to the Families First Coronavirus Response Act (FFCRA) continuous coverage requirement and projections being held at the higher level. In the prior estimate, projections were returned to pre-COVID-19 levels. Ongoing changes related to the FFCRA continuous coverage requirement are included in the COVID-19 Caseload Impact policy change.
- The overall increase is partly offset by actual 2023 premiums that are lower than were assumed in the prior estimate by \$4.00 for Part A and \$11.17 for Part B.

Expenditures are projected to grow 2.38% between FY 2022-23 and FY 2023-24 due to an estimated increase in the Part A premium of \$24.00 and Part B premium of \$10.40 between 2023 and 2024.

An estimated increase in General Fund expenditures as a proportion of Total Funds is due to an information system update by the Department to correct for Buy-In Eligibility codes.

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

BASE POLICY CHANGE NUMBER: 174

Premiums:

Calendar Year	2022	2023		2024
	Actual	May 2022 Estimate	Nov 2022 Actual	Nov 2022 Estimate
Part A	\$499.00	\$510.00	\$506.00	\$530.00
Part B	\$170.10	\$176.07	\$164.90	\$175.30

Average Monthly Beneficiaries:

FY	2021-22	2022-23		2023-24
	Actual	May 2022 Estimate	Nov 2022 Estimate	Nov 2022 Estimate
Part A	164,100	161,500	161,300	159,700
Part B	1,559,400	1,460,000	1,611,400	1,623,600

Methodology:

- The Centers for Medicare and Medicaid set the following premiums for 2022 and 2023.

Calendar Year	Part A	Part B
2022	\$499.00	\$170.10
2023	\$506.00	\$164.90

- For 2024, the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance is projecting 4.74% growth in the Medicare Part A premium. Applying this growth to the prior year Part A premium calculates as $\$506.00 \times 1.0474 = \530.00 (rounded).
- For 2024, the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance is projecting 6.31% growth in the Medicare Part B premium. Applying this growth to the prior year Part B premium calculates as $\$164.90 \times 1.0631 = \175.30 (rounded).

FY 2022-23	Part A	Part B
Average Monthly Beneficiaries	161,300	1,611,400
Rate 07/2022-12/2022	\$499.00	\$170.10
Rate 01/2023-06/2023	\$506.00	\$164.90
FY 2023-24	Part A	Part B
Average Monthly Beneficiaries	159,700	1,623,600
Rate 07/2023-12/2023	\$506.00	\$164.90
Rate 01/2024-06/2024	\$530.00	\$175.30

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

BASE POLICY CHANGE NUMBER: 174

4. The Families First Coronavirus Response Act (FFCRA) requires the department suspend eligibility redeterminations during the national public health emergency. Projections are brought up to the last month of actuals and held at that level. Ongoing changes related to the FFCRA continuous coverage requirement are included in the COVID-19 Caseload Impact policy change.

FFCRA also increased the 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. Expenditures from the increased FMAP are budgeted in the COVID-19 Increased FMAP – DHCS policy change.

Funding:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Title XIX 50/50	\$3,569,622	\$1,784,811	\$1,784,811
State GF 100%	\$694,394	\$694,394	\$0
Title XIX 100% FFP	\$19,325		\$19,325
Total	\$4,283,341	\$2,479,205	\$1,804,136

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Title XIX 50/50	\$3,653,942	\$1,826,971	\$1,826,971
State GF 100%	\$711,540	\$711,540	\$0
Title XIX 100% FFP	\$19,803	\$0	\$19,803
Total	\$4,385,285	\$2,538,511	\$1,846,774

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

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

BASE POLICY CHANGE NUMBER: 175
IMPLEMENTATION DATE: 7/1990
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 23

	FY 2022-23	FY 2023-24
FULL YEAR COST - TOTAL FUNDS	\$3,390,555,000	\$3,185,039,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,390,555,000	\$3,185,039,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$3,390,555,000	\$3,185,039,000

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:

Not Applicable

Background:

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

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

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

BASE POLICY CHANGE NUMBER: 175

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 2022-23, from the prior estimate, is an increase due to a shift in payments for prior year expenditures from FY 2021-22 to FY 2022-23.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to higher prior year expenditures in FY 2022-23 than in FY 2023-24.

Methodology:

1. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2023 for this 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 2022-23	\$6,032,316	\$2,641,761	\$3,016,158	\$374,397
FY 2023-24	\$5,740,681	\$2,555,642	\$3,098,333	\$86,706

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: 176
IMPLEMENTATION DATE: 4/1993
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 22

	FY 2022-23	FY 2023-24
FULL YEAR COST - TOTAL FUNDS	\$3,051,548,000	\$2,920,079,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,051,548,000	\$2,920,079,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$3,051,548,000	\$2,920,079,000

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:

Not Applicable

Background:

Eligible services are authorized under Title XIX of the federal Social Security Act (42 U.S.C., Section 1396, et. seq.). The Department draws down and provides FFP to CDSS 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: 176

The Governor's Budget estimated the CCI project would 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 proposed the extension of the Cal MediConnect program and the mandatory enrollment of dual eligibles and integrating of long-term services and supports, 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 2022-23, from the prior estimate, is an increase due to updated expenditure data provided by CDSS that includes FFCRA increased FMAP through June 30, 2023, for this policy change. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to updated expenditure data provided by CDSS.

Methodology:

1. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2023, for this policy change.
2. The following estimates were provided by CDSS on an accrual basis.

(Dollars in Thousands)

FY 2022-23	TF	FF	CDSS GF/ County Share
Title XIX 100% FFP	\$5,792,104	\$2,896,052	\$2,896,052
FFCRA 6.2% Increased FMAP	\$0	\$314,087	(\$314,087)
Total	\$5,792,104	\$3,210,139	\$2,581,965
FY 2023-24	TF	FF	CDSS GF/ County Share
Title XIX 100% FFP	\$6,178,497	\$3,089,248	\$3,089,249
FFCRA 6.2% Increased FMAP	\$0	\$0	\$0
Total	\$6,178,497	\$3,089,248	\$3,089,249

*Totals may differ due to rounding.

PERSONAL CARE SERVICES (Misc. Svcs.)
BASE POLICY CHANGE NUMBER: 176

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

(Dollars in Thousands)

FY 2022-23	TF	FF	CDSS GF/ County Share
Title XIX 100% FFP	\$5,474,923	\$2,737,461	\$2,737,462
FFCRA 6.2% Increased FMAP	\$0	\$314,087	(\$314,087)
Total	\$5,474,923	\$3,051,548	\$2,423,375
FY 2023-24	TF	FF	CDSS GF/ County Share
Title XIX 100% FFP	\$5,840,157	\$2,920,079	\$2,920,078
FFCRA 6.2% Increased FMAP	\$0	\$0	\$0
Total	\$5,840,157	\$2,920,079	\$2,920,078

*Totals may differ due to rounding.

Funding:

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

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

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER: 177
IMPLEMENTATION DATE: 1/2006
ANALYST: Joulia Dib
FISCAL REFERENCE NUMBER: 1019

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$2,845,777,000	\$3,135,449,000
- STATE FUNDS	\$2,845,777,000	\$3,135,449,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,845,777,000	\$3,135,449,000
STATE FUNDS	\$2,845,777,000	\$3,135,449,000
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

Background:

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

To help pay for this benefit, the federal government requires the states to contribute part of their savings for no longer providing the drug benefit to dual eligible beneficiaries. This is called the Phased-down Contribution or "clawback". In 2006, states were required to contribute 90% of their savings. This percentage decreased by 1 2/3% each year until it reached 75% in 2015. The MMA of 2003 sets forth a formula to determine a state's "savings." The formula uses 2003 as a base year for states' dual eligible population drug expenditures and increases the average dual eligible drug costs by a growth factor to reach an average monthly phased-down contribution cost per dual eligible or the per member per month (PMPM) rate.

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER: 177

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

<u>Calendar Year</u>	<u>PMPM rate</u>
2020	\$133.94
2021	\$137.76
2022	\$147.83
2023	\$155.08
2024	\$162.95 (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 2019-20	\$2,210,196,898	1,422,203
FY 2020-21	\$2,009,620,969	1,479,629
FY 2021-22	\$2,350,153,376	1,584,095

Reason for Change:

Expenditures for FY 2022-23 were revised up 3.93% from the prior estimate:

- Due to projections including three months of higher caseload in actuals related to the Families First Coronavirus Response Act (FFCRA) continuous coverage requirement and projections being held at the higher level. In the prior estimate, projections were returned to pre-COVID-19 levels. Ongoing changes related to the FFCRA continuous coverage requirement are included in the COVID-19 Caseload Impact policy change.
- This increase is partly offset by three months of reduced PMPM rate resulting from the FFCRA increased FMAP in actuals. 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.

Expenditures are projected to increase 10.2% between FY 2022-23 and FY 2023-24 because:

- Of an estimated increase in the PMPM rate of \$7.87 for 2024; and
- FY 2022-23 includes three months of the reduced PMPM rate resulting from the FFCRA increased FMAP.

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER: 177

Methodology:

1. 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.
2. The 2023 growth increased 4.90% over 2022 amounts per *the Centers for Medicare & Medicaid Services*. Medi-Cal's PMPM rate for 2023 is \$155.08.
3. The 2024 growth is estimated to increase 5.08% over 2023 amounts based on the average growth for 2021 to 2023. Medi-Cal's estimated PMPM rate for 2024 is \$162.95.
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 2017 to July 2022.
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. Projections are brought up to the last month of actuals and held at that level. Ongoing changes related to the FFCRA continuous coverage requirement are included 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 last day of the calendar quarter 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 2022-23 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	1,627,548	\$237,148,100	\$2,845,777,000
FY 2022-23	12	1,656,667	\$261,287,400	\$3,135,449,000

Funding:

100% GF (4260-101-0001)

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

DENTAL SERVICES

BASE POLICY CHANGE NUMBER: 178
IMPLEMENTATION DATE: 7/1988
ANALYST: Devon Dyer
FISCAL REFERENCE NUMBER: 135

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$1,951,125,000	\$1,951,125,000
- STATE FUNDS	\$785,585,100	\$785,585,100
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,951,125,000	\$1,951,125,000
STATE FUNDS	\$785,585,100	\$785,585,100
FEDERAL FUNDS	\$1,165,539,900	\$1,165,539,900

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 Caseload Impact

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: 178

Reason for Change:

For the current estimate, projections reflect actual COVID-19 impacts resulting from the continuous coverage requirement and implementation of the CalAIM Dental Initiative resulting in increases in expenditure projections for FY 2022-23 over the prior estimate. Ongoing changes related to the related to the FFCRA continuous coverage requirement are included in the COVID-19 Caseload Impact policy change.

There is no change between fiscal years in the current estimate.

Methodology:

1. Dental expenditures are estimated using 36-months of cash-basis expenditure data (July 2019-June 2022) and trending the Users, Units/User, and Rate.
2. A portion of Proposition 56 Supplemental Payments, Domain 2 of Dental Transformation Initiative, and CalAIM - Dental Initiatives estimates are included in this policy change.
3. Dental services estimates for Breast and Cervical Cancer Treatment Program (BCCTP) are included in the BCCTP policy change.
4. The Families First Coronavirus Response Act (FFCRA) requires the department suspend eligibility redeterminations during the national public health emergency. Projections include increases in user counts and costs related to this continuous coverage requirement. Ongoing changes related to the related to the FFCRA continuous coverage requirement are included in the COVID-19 Caseload Impact policy change.

Funding:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	\$1,292,080	\$646,040	\$646,040
ACA 90% FFP/10% GF (4260-101-0001 / 0890)	\$365,617	\$36,562	\$329,056
65% Title XXI/35% GF (4260-113-0001 / 0890)	\$292,884	\$102,509	\$190,375
Title XIX 100% GF	\$474	\$474	\$0
Title XIX 100% FFP	\$70	\$0	\$70
Total	\$1,951,125	\$785,585	\$1,165,541

DENTAL SERVICES
BASE POLICY CHANGE NUMBER: 178

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	\$1,292,080	\$646,040	\$646,040
ACA 90% FFP/10% GF (4260-101-0001 / 0890)	\$365,617	\$36,562	\$329,056
65% Title XXI/35% GF (4260-101-0001 / 0890)	\$292,884	\$102,509	\$190,375
Title XIX 100% GF	\$474	\$474	\$0
Title XIX 100% FFP	\$70	\$0	\$70
Total	\$1,951,125	\$785,585	\$1,165,541

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

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

BASE POLICY CHANGE NUMBER: 185
IMPLEMENTATION DATE: 7/1991
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 26

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$355,576,000	\$327,740,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$355,576,000	\$327,740,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$355,576,000	\$327,740,000

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:

Not Applicable

Background:

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

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

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: 185

Reason for Change:

The change in FY 2022-23, from the prior estimate, is an increase due to change in rates based on the Targeted Case Management time survey.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to assuming increases in rates.

Methodology:

1. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2023 for this 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 2022-23	\$632,698	\$277,122	\$316,349	\$39,227	\$355,576
FY 2023-24	\$636,458	\$308,718	\$318,229	\$9,511	\$327,740

Funding:

100% Title XIX (4260-101-0890)

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

LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER: 190
IMPLEMENTATION DATE: 7/2017
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2080

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$116,726,000	\$1,350,000
- STATE FUNDS	\$58,363,000	\$675,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$116,726,000	\$1,350,000
STATE FUNDS	\$58,363,000	\$675,000
FEDERAL FUNDS	\$58,363,000	\$675,000

Purpose:

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

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

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 from the prior estimate, for FY 2022-23, is an increase due to additional lawsuit settlement payments expected to be made. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to fewer lawsuit settlement payments expected to be made.

LAWSUITS/CLAIMS
BASE POLICY CHANGE NUMBER: 190

Methodology:

FY 2022-23	Total Amount
Provider Settlements	
Alberta Health Services	\$100,000
Total	\$100,000
<u>Other Provider Settlements</u>	
LA Care	\$10,100,000
AHF	(\$624,000)
Blue Cross of CA dba Anthem Blue Cross (sanction settlement)	(\$850,000)
Blue Cross of CA dba Anthem Blue Cross (rate settlement)	\$33,000,000
Molina Healthcare of CA	\$12,000,000
Brius, LLC	\$63,000,000
Total	\$116,626,000
FY 2022-23 Total (rounded)	\$116,726,000
FY 2023-24	
Total	\$0
FY 2023-24 Total (rounded)	\$0

FY 2022-23			
	Committed	Balance	Budgeted
Attorney Fees <\$30,000	\$0	\$200,000	\$200,000
Provider Settlements <\$100,000	\$100,000	\$900,000	\$1,000,000
Beneficiary Settlements <\$10,000	\$0	\$150,000	\$150,000
Small Claims Court	\$0	\$0	\$0
Other Attorney Fees	\$0	N/A	\$0
Other Provider Settlements	\$116,626,000	N/A	\$116,626,000
Other Beneficiary Settlements	\$0	N/A	\$0
Interest Paid	\$0	\$0	\$0
Totals (Rounded)	\$116,726,000	\$1,250,000	\$117,976,000

LAWSUITS/CLAIMS
BASE POLICY CHANGE NUMBER: 190

FY 2023-24	
	Budgeted
Attorney Fees<\$30,000;Provider Settlements<\$100,000; Beneficiary Settlements<\$10,000	\$0
Other Attorney Fees	\$1,350,000
Other Provider Settlements	\$0
Other Beneficiary Settlements	\$0
Interest Paid	\$0
Totals (Rounded)	\$1,350,000

Funding:

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

DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

BASE POLICY CHANGE NUMBER: 204
IMPLEMENTATION DATE: 7/1997
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 77

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$29,436,000	\$27,360,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$29,436,000	\$27,360,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$29,436,000	\$27,360,000

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:

Not Applicable

Background:

The Department entered into an IA with CDDS to reimburse the Federal Financial Participation (FFP) for Medi-Cal clients served at DCs and 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: 204

Reason for Change:

The change in FY 2022-23, from the prior estimate, is due to increased billing rate and Admin billing for facilities resulting in higher estimated reimbursements.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to anticipated lower number of consumers and settlement based on current monthly trends.

Methodology:

1. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2023, for this 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 2022-23	\$55,393	\$25,957	\$28,404	\$1,032
FY 2023-24	\$55,016	\$27,656	\$26,977	\$383

Funding:

100% Title XIX (4260-101-0890)

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

MEDI-CAL TCM PROGRAM

BASE POLICY CHANGE NUMBER: 211
IMPLEMENTATION DATE: 6/1995
ANALYST: Donna Lee
FISCAL REFERENCE NUMBER: 27

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$14,162,000	\$13,921,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$14,162,000	\$13,921,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$14,162,000	\$13,921,000

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:

Not Applicable

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 that 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: 211

Reason for Change:

The change in FY 2022-23, from the prior estimate, is a net decrease due to:

- Base Payment Averages decreasing based on a decreasing trend of claims received through the COVID-19 Public Health Emergency, and decreased payments made as a result of excluding claims for individuals with an Unsatisfactory Immigration Status (UIS).
- Estimated FFCRA 6.2% FMAP increasing.
- Expected audit report payments from LGAs decreasing.
- Expected audit report payments to LGAs decreasing.

Overall, the decrease in the Base Payments is the key reason the FY 2022-23 estimates decreased from the prior estimate.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a net decrease due to:

- Estimated audit report payments from LGAs increasing.
- Estimated audit report payments to LGAs increasing.

Overall, the change from FY 2022-23 to FY 2023-24 is a decrease.

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 \$14,629,000 (Regular invoices) and \$3,269,000 (ACA invoices) for FY 2022-23 and FY 2023-24, are based on the average base payments for FY 2020-21 and 2021-22 Regular and ACA payments. The FY 2020-21 and 2021-22 base payment amounts are used for the projection to accurately reflect future expenditures due to COVID-19 and UIS impacts.
3. In FY 2022-23 and FY 2023-24, the Department will complete reconciliations for FY 2010-11 through FY 2020-21. For the actual audit reports received and estimated audit reports during FY 2022-23, \$5,356,000 is due to the Department, and \$713,000 is due to the LGAs, resulting in a net amount of \$4,643,000 due to the Department. Additionally, during FY 2023-24, an estimated \$5,834,000 is due the Department, and \$950,000 is due to the LGAs, resulting in a net amount of \$4,884,000 due to the Department. The Department anticipates the recoupment of the amounts due during FY 2022-23 and FY 2023-24 based on LGAs' previous invoice history, reimbursement history, and history of reconciliation payments.
4. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures for dates of service through March 31, 2023 only for this policy change.
5. On a cash basis, the FFCRA increased FMAP of \$907,000 is expected to be paid in FY 2022-23.

MEDI-CAL TCM PROGRAM
BASE POLICY CHANGE NUMBER: 211

FY 2022-23	TF	FF	FFCRA
Base (Average Expenditures)	\$14,629,000	\$14,629,000	\$0
Base (ACA Expenditures)	\$3,269,000	\$3,269,000	\$0
6.2% FMAP Increase	\$907,000	\$0	\$907,000
Reconciliation			
Regular Claims	(\$4,097,000)	(\$4,097,000)	\$0
ACA Claims	(\$546,000)	(\$546,000)	\$0
Total FY 2022-23	\$14,162,000	\$13,255,000	\$907,000

FY 2023-24	TF	FF	FFCRA
Base (Average Expenditures)	\$14,629,000	\$14,629,000	\$0
Base (ACA Expenditures)	\$3,269,000	\$3,269,000	\$0
6.2% FMAP Increase	\$907,000	\$0	\$907,000
Reconciliation			
Regular Claims	(\$5,037,000)	(\$5,037,000)	\$0
ACA Claims	\$153,000	\$153,000	\$0
Total FY 2023-24	\$13,921,000	\$13,014,000	\$907,000

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: 226
IMPLEMENTATION DATE: 1/1993
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 91

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$519,000	\$438,000
- STATE FUNDS	\$259,500	\$219,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$519,000	\$438,000
STATE FUNDS	\$259,500	\$219,000
FEDERAL FUNDS	\$259,500	\$219,000

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 21-0057

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS

Background:

The HIPP program is a voluntary program for full-scope Medi-Cal beneficiaries who have a high cost medical condition. Under the HIPP program, the Department pays for premiums, coinsurance, deductibles, and other cost sharing obligations when it is cost effective. HIPP program costs are budgeted separately from other Medi-Cal benefits since these are paid outside of the regular Medi-Cal claims payment procedures. The California Advancing and Innovating Medi-Cal (CalAIM) initiatives have required some HIPP beneficiaries to enroll into managed care as of January 1, 2022. A portion of the remaining HIPP population is required to transition to managed care enrollment starting January 1, 2023. Those with managed care are restricted from the HIPP program, which in turn is expected to decrease HIPP enrollment members. Beneficiaries may apply for a medical exemption from managed care enrollment. If the exemption is approved, they may remain in the HIPP program if all eligibility criteria are still met.

Reason for Change:

The change in FY 2022-23, from the prior estimate is a decrease due to a decrease in actual program enrollment as of June 2022, and an anticipated reduction in program enrollment effective January 2023.

HIPP PREMIUM PAYOUTS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 226

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease based on the additional anticipated reduction in program enrollment in FY 2023-24, and the assumption that premium costs increase by 5% each FY based on historical trends.

Methodology:

1. HIPP premium costs are determined by:
 - Actual premium expenses for July 2021 through June 2022,
 - Projected premium expense for July 2022 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 four HIPP beneficiaries in foster youth aid code will continue their HIPP program eligibility,
 - The assumption that the HIPP beneficiaries decrease 34% in January 2023, and,
 - The assumption that approximately 65% of the remaining HIPP beneficiaries (less those four beneficiaries in foster youth aid codes) will continue their HIPP program eligibility for a period of 12 months under a Medical Exemption Request or waiver.
2. The average PMPM premium cost including ancillary costs is estimated to be \$551 in FY 2022-23 and \$579 in FY 2023-24.
3. The average monthly HIPP enrollment is estimated to be 94 for July 2022 through December 2022, 63 for January 2023 through June 2023, and 63 for FY 2023-24.
4. Costs for FY 2022-23 and FY 2023-24 are estimated to be:

For July 2022 through December 2022, \$551 (average PMPM premium cost) x 94 (current member count) x 6 months = \$311,000 TF (rounded).

For January 2023 through June 2023, \$551 (average PMPM premium cost) x 63 (estimated member count) x 6 months = \$208,000 TF (rounded).

FY 2023-24: \$579 (average PMPM premium cost) x 63 (estimated member count x 12 months = \$438,000 TF (rounded).

Fiscal Year	TF	GF	FF
FY 2022-23	\$519,000	\$260,000	\$259,000
FY 2023-24	\$438,000	\$219,000	\$219,000

Funding:

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

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

BASE RECOVERIES

BASE POLICY CHANGE NUMBER: 240
IMPLEMENTATION DATE: 7/1987
ANALYST: Allison Tamai
FISCAL REFERENCE NUMBER: 127

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	-\$537,246,000	-\$480,792,000
- STATE FUNDS	-\$226,205,550	-\$202,435,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$537,246,000	-\$480,792,000
STATE FUNDS	-\$226,205,550	-\$202,435,600
FEDERAL FUNDS	-\$311,040,450	-\$278,356,400

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 Increased FMAP – DHCS

Background:

Recoveries are credited to the Health Care Deposit Fund and used to finance current obligations of the Medi-Cal program. These recoveries result from collections from personal injury or workers' compensation settlements, judgements or awards; special needs trusts; estates; provider/beneficiary overpayments; and other health insurance to offset the cost of services to Medi-Cal beneficiaries in specified circumstances.

Reason for Change:

Recovery collections vary greatly from month to month, depending on the number of provider audits completed, the financial circumstance of beneficiaries, and fluctuations in settlements, judgements, and awards.

FY 2022-23 recovery collections are projected to be higher than the prior estimate due to workers compensation overpayments, health insurance collections, and the offsetting decline in provider overpayments.

BASE RECOVERIES

BASE POLICY CHANGE NUMBER: 240

- Workers Compensation recoveries are higher than previously projected base on an overall increase in prior year collections. The flow of recoveries varies based on several factors: the type and number of cases have been referred, when negotiations for payment are finalized, and the timing of when a payment is actually issued.
- Additionally, there is an increase in health insurance collections due to the ongoing success of Managed Care plan recoveries based on recent trends. DHCS also anticipates three additional health insurance settlements to be processed within the fiscal year.

In the current estimate, FY 2023-24 recoveries are expected to be lower than FY 2022-23 due to:

- FY 2022-23 including catch-up provider overpayment collections from the prior year resulting from previously granted public health emergency waivers that deferred repayments.
- More prior year health insurance managed care plan collections expected in FY 2022-23 than in FY 2023-24. There is a decrease due to the stabilization of these recoveries.

(Dollars in Thousands)

Recovery Type	FY 2022-23	FY 2023-24
Personal Injury Collections	(\$119,348)	(\$115,614)
Workers' Comp. Collections	(\$5,470)	(\$5,337)
Health Insurance Collections	(\$210,800)	(\$171,900)
General Collections	(\$201,628)	(\$187,941)
TOTAL	(\$537,246)	(\$480,792)

Methodology:

- The recoveries estimate uses the trend in monthly recoveries for July 2019 – July 2022.

Funding:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	(\$431,185)	(\$215,593)	(\$215,593)
Title XIX 65 FF / 35 GF (4260-101-0890/0001)	(\$5,935)	(\$2,077)	(\$3,858)
Title XIX FFP (4260-101-0890)	(\$14,768)	\$0	(\$14,768)
90% Title XIX ACA FF / 6% GF (4260-101-0890/0001)	(\$85,358)	(\$8,536)	(\$76,822)
TOTAL	(\$537,246)	(\$226,206)	(\$311,040)

FY 2023-24	TF	GF	FF
% Title XIX / 50% GF (4260-101-0001/0890)	(\$385,875)	(\$192,938)	(\$192,938)
Title XIX 65 FF / 35 GF (4260-101-0890/0001)	(\$5,312)	(\$1,859)	(\$3,453)
Title XIX FFP (4260-101-0890)	(\$13,216)	\$0	(\$13,216)
90% Title XIX ACA FF / 6% GF (4260-101-0890/0001)	(\$76,389)	(\$7,639)	(\$68,750)
TOTAL	(\$480,792)	(\$202,436)	(\$278,356)

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

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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.

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

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MEDI-CAL STATE INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 1
IMPLEMENTATION DATE: 12/2016
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 1569

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$48,278,000	\$48,278,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$48,278,000	\$48,278,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$48,278,000	\$48,278,000

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

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: 1

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 2022-23, from the prior estimate, is a decrease due to updated actuals based on current invoices from FY 2021-22. There is no change from FY 2022-23 to FY 2023-24 in the current estimate.

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 2022-23 and FY 2023-24 are annualized projections primarily based on actual claims data for FY 2021-22 quarters 1 through 4.
3. The Department will continue to pay ACA payments based on the Federal Medical Assistance Percentage of 90% for calendar year 2020 and beyond.
4. Assume a six-month lag in ongoing payments.
5. The Non-Federal share for this policy change is budgeted in the CDCR's budget. Included below is the total estimated FFP for the Medi-Cal Inpatient Hospital Costs for all eligible (Non-ACA and ACA) adult and juvenile inmates in FY 2022-23 and FY 2023-24.

MEDI-CAL STATE INMATE PROGRAMS
REGULAR POLICY CHANGE NUMBER: 1

FY 2022-23	TF	FF
Adults - Non ACA	\$18,103,000	\$9,052,000
Adults - ACA	\$42,566,000	\$38,697,000
Juveniles	\$4,000	\$2,000
Medical Parole – Non ACA	\$923,000	\$461,000
Medical Parole – ACA	\$73,000	\$66,000
Total FY 2022-23	\$61,669,000	\$48,278,000
FY 2023-24	TF	FF
Adults - Non ACA	\$18,103,000	\$9,052,000
Adults - ACA	\$42,566,000	\$38,697,000
Juveniles	\$4,000	\$2,000
Medical Parole – Non ACA	\$923,000	\$461,000
Medical Parole – ACA	\$73,000	\$66,000
Total FY 2023-24	\$61,669,000	\$48,278,000

*Totals may differ due to rounding.

Funding:

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

100% Title XIX ACA FF (4260-101-0890)

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

PHASING IN THE MEDI-CAL ASSET LIMIT REPEAL

REGULAR POLICY CHANGE NUMBER: 2
IMPLEMENTATION DATE: 7/2022
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2324

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$47,574,000	\$99,338,000
- STATE FUNDS	\$23,787,000	\$49,669,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.70 %	0.24 %
APPLIED TO BASE		
TOTAL FUNDS	\$47,241,000	\$99,099,600
STATE FUNDS	\$23,620,490	\$49,549,790
FEDERAL FUNDS	\$23,620,490	\$49,549,800

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)
SPA 21-0053

Interdependent Policy Change:

COVID-19 Increased FMAP – DHCS

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. Prior to July 1, 2022, to be eligible for Non-MAGI Medi-Cal, including Long-term Care, the countable assets for one person could not exceed \$2,000, or \$3,000 for two people. These amounts had not been changed since 1989. The asset limits for the Medicare Savings Programs were \$7,970 for an individual and \$11,960 for two people.

AB 133 required, 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. The asset limit increase implemented on July 1, 2022.

In addition, AB 133 requires that 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.

PHASING IN THE MEDI-CAL ASSET LIMIT REPEAL

REGULAR POLICY CHANGE NUMBER: 2

Reason for Change:

The change from the prior estimate, for FY 2022-23, is an increase due to an increase in projected benefit costs. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to an increase in caseload and costs as the asset repeal implements in FY 2023-24.

Methodology:

1. Assume the asset limit increase implemented July 1, 2022.
2. Assume the asset repeal implements no sooner than January 1, 2024.
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 2022-23	\$47,574	\$23,787	\$23,787
FY 2023-24	\$99,338	\$49,669	\$49,669

Funding:

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

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

POSTPARTUM CARE EXTENSION

REGULAR POLICY CHANGE NUMBER: 3
IMPLEMENTATION DATE: 7/2023
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2276

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$207,820,000
- STATE FUNDS	\$0	\$103,601,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$207,820,000
STATE FUNDS	\$0	\$103,601,500
FEDERAL FUNDS	\$0	\$104,218,500

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 April 2023. 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: 3

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a decrease due to the extension of the PHE period. Costs cannot be captured during the extended PHE period. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due costs beginning in FY 2023-24 due to the PHE extension.

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 April 2023 and costs for this program cannot be captured during the PHE period.

FY 2023-24	TF	GF	SF	FF
50% Title XIX FF / 50% GF	\$204,189,000	\$102,094,500	\$0	\$102,094,500
100% Title XXI	\$2,124,000	\$0	\$0	\$2,124,000
100% Perinatal Insurance Fund	\$1,507,000	\$0	\$1,507,000	\$0
Total	\$207,820,000	\$102,094,500	\$1,507,000	\$104,218,500

Funding:

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

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER: 4
IMPLEMENTATION DATE: 1/2002
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 3

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$24,278,000	\$26,079,000
- STATE FUNDS	\$9,387,200	\$10,080,950
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$24,278,000	\$26,079,000
STATE FUNDS	\$9,387,200	\$10,080,950
FEDERAL FUNDS	\$14,890,800	\$15,998,050

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)
 AB 133 (Chapter 143, Statutes of 2021)
 Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS

Background:

AB 430 authorized the BCCTP effective January 1, 2002, for individuals at or below 200% of the federal poverty level. Enhanced Title XIX Medicaid funds (65% FF / 35% GF) may be claimed under the federal Medicaid Breast and Cervical Cancer Treatment Act of 2000 (P.L. 106-354) for cancer treatment and full scope Medi-Cal benefits for individuals under 65 years of age who are citizens or legal immigrants with no other health coverage. Every Woman Counts and Family Planning, Access, Care, and Treatment (Family PACT) providers screen beneficiaries.

A State-Only program covers individuals 65 years of age or older regardless of immigration status, individuals who are underinsured, undocumented women, and males for breast cancer treatment only. In FY 2017-18 the coverage term was 18 months for breast cancer and 24 months for cervical cancer, however, coverage limits were removed through AB 1810 beginning in FY 2018-19. Estimated State-Only costs include undocumented individuals' non-emergency services during cancer treatment. With the implementation of the Affordable Care Act (ACA) in January 2014, some BCCTP beneficiaries now have other coverage options available through Covered California and the Individual Insurance Market.

Effective July 1, 2018, Health Omnibus Trailer Bill AB 1810, Chapter 34, Statutes of 2018, signed June 27, 2018, appropriated funding to the General Fund for the elimination of the 18 and 24-month treatment limitations.

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER: 4

Effective May 1, 2022, AB133 granted full scope Medi-Cal to adults who are 50 years of age and older.

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 2022-23, is a decrease due to eligibles shifting from BCCTP into full-scope Medi-Cal. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to using historical actuals to project expenditures.

Methodology:

1. The 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through March 31, 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
2. Assume a total of 5,000 beneficiaries, of which 2,200 were in FFS and 2,800 were in managed care. Additionally, approximately 2,000 of the FFS beneficiaries were eligible for State-Only services.
3. Assume none of the FFS beneficiaries were in accelerated enrollment.
3. Assume the State will pay Medicare and other health coverage premiums for an average of 177 beneficiaries monthly in FY 2022-23 and FY 2023-24. Assume an average monthly premium cost per beneficiary of \$122.99.
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 2022-23			FY 2023-24		
	TF	GF	FF	TF	GF	FF
Full Scope Costs	\$22,966	\$8,075	\$14,891	\$24,683	\$8,685	\$15,998
State-Only Services	\$1,050	\$1,050	\$0	\$1,135	\$1,135	\$0
State-Only Premiums	\$262	\$262	\$0	\$262	\$262	\$0
Total	\$24,278	\$9,387	\$14,891	\$26,079	\$10,081	\$15,998

* Totals may differ due to rounding.

BREAST AND CERVICAL CANCER TREATMENT
REGULAR POLICY CHANGE NUMBER: 4

Funding:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
100% GF (4260-101-0001)	\$1,312	\$1,312	\$0
50 Title XIX FF / 50 GF (4260-101-0890/0001)	\$314	\$157	\$157
Title XIX 65 FF / 35 GF (4260-101-0890/0001)	\$22,652	\$7,928	\$14,724
COVID-19 FFCRA 4.34% BCCTP	\$0	(\$10)	\$10
FY 2022-23 Total	\$24,278	\$9,387	\$14,891
FY 2023-24	TF	GF	FF
100% GF (4260-101-0001)	\$1,396	\$1,396	\$0
50 Title XIX FF / 50 GF (4260-101-0890/0001)	\$306	\$153	\$153
Title XIX 65 FF / 35 GF (4260-101-0890/0001)	\$24,377	\$8,532	\$15,845
COVID-19 FFCRA 4.34% BCCTP	\$0	\$0	\$0
FY 2023-24 Total	\$26,079	\$10,081	\$15,998

* Totals differ due to rounding.

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

CALAIM - INMATE PRE-RELEASE PROGRAM

REGULAR POLICY CHANGE NUMBER: 5
IMPLEMENTATION DATE: 1/2023
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2332

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$6,561,000	\$109,713,000
- STATE FUNDS	\$3,995,000	\$39,067,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$6,561,000	\$109,713,000
STATE FUNDS	\$3,995,000	\$39,067,000
FEDERAL FUNDS	\$2,566,000	\$70,646,000

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: 5

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 no sooner than July 1, 2023, which includes: care management/care coordination; community-based physical and behavioral health clinical consultation services provided via telehealth or, optionally, in-person as needed, including behavioral health referrals/linkages; medications for addiction treatment (also known as medication-assisted treatment or MAT), medications for mental health diagnoses; and other medications to stabilize chronic and significant conditions, associated laboratory/radiology services; and for use post-release into the community a supply of medication (according to the applicable Medi-Cal policy duration for individual medications) and necessary Durable Medical Equipment.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a decrease due to a shift for the In Reach Services implementation date and State Prison administrative costs. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to In Reach Services implementing in FY 2023-24.

Methodology:

1. Assume the Mandatory County Pre-Release Applications will implement January 1, 2023, and the “In Reach” Services up-to-90 days prior to release (including Behavioral Health Referrals/Linkages) policies implement no sooner than July 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 and State Prison administrative costs will begin in FY 2025-26.
4. Total estimated costs for FY 2022-23 and FY 2023-24 are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2022-23	\$6,561	\$3,995	\$2,566
FY 2023-24	\$109,713	\$39,067	\$70,646

CALAIM - INMATE PRE-RELEASE PROGRAM
REGULAR POLICY CHANGE NUMBER: 5

Funding:

100% GF (4260-101-0001)

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

ACCELERATED ENROLLMENT FOR ADULTS

REGULAR POLICY CHANGE NUMBER: 6
IMPLEMENTATION DATE: 7/2022
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 2264

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$5,103,000	\$5,296,000
- STATE FUNDS	\$2,551,500	\$2,648,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	8.33 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$4,677,900	\$5,296,000
STATE FUNDS	\$2,338,960	\$2,648,000
FEDERAL FUNDS	\$2,338,960	\$2,648,000

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:

The change from the prior estimate, for FY 2022-23, is a decrease due to switching from benefit cost estimates to actual expenditure data. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a slight increase due to projections that utilize the expenditure trends from FY 2021-22.

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 estimated costs for FY 2022-23 and FY 2023-24 are:

ACCELERATED ENROLLMENT FOR ADULTS
REGULAR POLICY CHANGE NUMBER: 6

(Dollars in Thousands)

Fiscal Years	TF	GF	FF
FY 2022-23	\$5,103	\$2,552	\$2,552
FY 2023-24	\$5,296	\$2,648	\$2,648

*Totals may differ due to rounding.

Funding:

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

UNDOCUMENTED EXPANSION AGES 26 THROUGH 49

REGULAR POLICY CHANGE NUMBER: 7
IMPLEMENTATION DATE: 2/2024
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2385

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$844,031,000
- STATE FUNDS	\$0	\$634,784,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$844,031,000
STATE FUNDS	\$0	\$634,784,000
FEDERAL FUNDS	\$0	\$209,247,000

Purpose:

This policy change estimates the benefit costs to expand full scope Medi-Cal benefits to adults 26 through 49 years of age, regardless of immigration status.

Authority:

AB 184, (Chapter 47, Statutes of 2022)

Interdependent Policy Changes:

Not Applicable

Background:

California provides restricted-scope Medi-Cal coverage for emergency and pregnancy related services only to low income adults, including undocumented immigrants who do not have 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, ages 19 through 25, regardless of citizenship or immigration status beginning January 1, 2020. Full-scope coverage expanded to eligible individuals, 50 years of age or older, regardless of citizenship or immigration status on May 1, 2022. Full scope coverage will be expanded to eligible individuals, ages 26 through 49, regardless of citizenship or immigration status no later than January 1, 2024. Federal financial participation is available, regardless of immigration status, for emergency and pregnancy related services.

Reason for Change:

This is a new policy change

Methodology:

1. Assume the transition will occur no sooner than January 1, 2024.
2. In-Home Supportive Services are not budgeted in this policy change as they are included in the budget for the Department of Social Services.
3. Assume offsetting cost savings for current restricted-scope Medi-Cal expenditures.

UNDOCUMENTED EXPANSION AGES 26 THROUGH 49
REGULAR POLICY CHANGE NUMBER: 7

4. On a cash basis, net expenditures are estimated to be:

(Dollars in Thousands)

Fiscal Years	TF	GF	FF
FY 2022-23	\$0	\$0	\$0
FY 2023-24	\$844,031	\$634,784	\$209,247

*Totals may differ due to rounding.

Funding:

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

100% GF (4260-101-0001)

MINIMUM WAGE INCREASE - CASELOAD SAVINGS

REGULAR POLICY CHANGE NUMBER: 8
IMPLEMENTATION DATE: 11/2023
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2384

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$114,694,000
- STATE FUNDS	\$0	-\$38,300,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates savings due to a reduction in caseload resulting from the increase in minimum wage.

Authority:

SB 3 (Chapter 4, Statutes of 2016)

Interdependent Policy Changes:

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

Background:

SB 3 authorized a phased-in increase in the minimum wage from \$15.00 per hour to \$17.00 per hour beginning January 1, 2023, through January 1, 2027. The incremental minimum wage increases may be temporarily suspended by the governor based on certain determinations, such as determination of a General Fund (GF) deficit.

The minimum wage increase for employers with 26 or more employees will phase in as follows:

- From January 1, 2023 to December 31, 2023, inclusive, \$15.50 per hour
- From January 1, 2024 to December 31, 2024, inclusive, \$16.00 per hour
- From January 1, 2025 to December 31, 2025, inclusive, \$16.30 per hour
- From January 1, 2026 to December 31, 2026, inclusive, \$16.60 per hour
- From January 1, 2027, until adjusted, \$17.00 per hour.

Two types of Medi-Cal income methodologies exist to calculate program eligibility for applicants and beneficiaries.

First, Modified Adjusted Gross Income (MAGI) Medi-Cal is available to children, pregnant individuals, and adults ages 19 to 64 years of age. MAGI eligibility is determined by comparing an individual or household's federal taxable income to the MAGI Medi-Cal income threshold for that individual. These thresholds are determined by the Federal Poverty Level (FPLs) calculated annually by the federal government. MAGI eligibility is also determined on an individual basis –

MINIMUM WAGE INCREASE - CASELOAD SAVINGS

REGULAR POLICY CHANGE NUMBER: 8

children have a higher income threshold limits than adults, so children will be likely less impacted by minimum wage increases.

For individuals who do not meet the requirements for MAGI Medi-Cal eligibility, a variety of Non-MAGI programs serve to assist general and specific vulnerable populations, such as families with children, individuals over the age of 65, or disabled individuals that are over the income limit for MAGI Medi-Cal. There is no uniform set of rules for Non-MAGI programs, as each program has their own guidelines for eligibility criteria, income threshold limits leveraging the FPL, and property/asset limits used to determine program eligibility.

The increase to minimum wage may potentially decrease the number of those eligible for the Medi-Cal program as earnings place them above the Medi-Cal income threshold limit. As a result, beneficiaries above the Medi-Cal income threshold limit may be referred to Covered California or Non-MAGI Medi-Cal individuals to have a monthly share-of cost (SOC) that must be met before Medi-Cal will begin paying for services. These SOC amounts are deducted from the countable income in order to establish how much the individual must pay toward their care.

Reason for Change:

This is a new policy change.

Methodology:

1. The implementation date for the increase to \$15.50 is January 1, 2023. The implementation date for the increase to \$16.00 is January 1, 2024.
2. Assume a delay in savings to account for individuals not reporting a change in income immediately. In addition, if individuals are deemed ineligible during redetermination, the individual receives a 90 day period in which they can provide additional information to remain eligible. The combination of these items is assumed to be 6 months.
3. Assume new caseload savings and new caseload reductions related to minimum wage increases from January 2023 and on will resume after the end of the COVID-19 continuous coverage requirement.
4. On a cash basis, savings are estimated to be:

(Dollars in Thousands)

FISCAL YEAR	TF	GF	FF
FY 2022-23	\$0	\$0	\$0
FY 2023-24	(\$114,694)	(\$38,302)	(\$76,392)

Funding:

50% Title XIX FF / 50% GF (4260-101-0890/0001)
 90% Title XIX ACA FF / 10% GF (4260-101-0890/0001)
 65 % Title XXI FF / 35% GF (4260-113-0890/0001)
 65 % Title XXI FF / 35% GF (4260-101-0890/0001)
 100% GF (4260-101-0001)
 100% Title XIX FFP (4260-101-0890)

REFUGEE MEDICAL ASSISTANCE

REGULAR POLICY CHANGE NUMBER: 9
IMPLEMENTATION DATE: 11/2020
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2237

	<u>FY 2022-23</u>	<u>FY 2023-24</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 12 months in the United States. This is an increase from the 8 month limit that was previously in effect. Due to a change in federal rules, the extension of the RMA eligibility period to 12 months is now required for individuals whose period of RMA eligibility began on or after October 1, 2021. The Department will implement this change when the public health emergency (PHE) ends. 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:

The change from the prior estimate, for FY 2022-23, is an increase due to the extension of the RMA eligibility period from 8 to 12 months and the processing of claims for RMA coverage for those who stayed in RMA during the PHE. There is no change from FY 2022-23 to FY 2023-24 in the current estimate.

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.

REFUGEE MEDICAL ASSISTANCE
REGULAR POLICY CHANGE NUMBER: 9

2. The total reimbursable amounts are estimated to be:

Fiscal Year	TF	GF	GF Reimbursement
FY 2022-23	\$0	(\$400,000)	\$400,000
FY 2023-24	\$0	(\$400,000)	\$400,000

Funding:

100% GF (4260-101-0001)

Reimbursement GF (4260-601-0995)

NON-OTLICP CHIP

REGULAR POLICY CHANGE NUMBER: 10
IMPLEMENTATION DATE: 12/1998
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 13

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$88,732,500	-\$88,065,900
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$88,732,500	-\$88,065,900
FEDERAL FUNDS	\$88,732,500	\$88,065,900

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

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).
- **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

NON-OTLICP CHIP

REGULAR POLICY CHANGE NUMBER: 10

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 2022-23, is a General Fund (GF) savings decrease due to a decrease in estimated expenditures for the Medicaid Expansion, HPE and Resource Disregard populations. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a slight GF savings decrease due to a decrease in estimated expenditures.

Methodology:

1. It is assumed the estimated costs of the HPE, Medicaid Expansion, and Resource Disregard aid codes will be \$591,550,000 TF in FY 2022-23 and \$587,106,000 TF in FY 2023-24.
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 2022-23 and FY 2023-24 are:

(Dollars in Thousands)

FY 2022-23	TF	GF
Resource Disregard	\$72	(\$11)
HPE	\$6,006	(\$901)
Medicaid Expansion	\$585,472	(\$87,820)
Total Cost	\$591,550	(\$88,732)

FY 2023-24	TF	GF
Resource Disregard	\$73	(\$11)
HPE	\$5,798	(\$870)
Medicaid Expansion	\$581,235	(\$87,185)
Total Cost	\$587,106	(\$88,066)

Funding:

(Dollars in Thousands)

FY 2022-23	Fund Number	TF	GF	FF
50 % Title XIX / 50 % GF	4260-101-0890/0001	(\$591,550)	(\$295,775)	(\$295,775)
65 % Title XXI / 35 % GF	4260-113-0890/0001	\$591,550	\$207,043	\$384,507
Net Impact (rounded)		\$0	(\$88,732)	\$88,732

NON-OTLCP CHIP
REGULAR POLICY CHANGE NUMBER: 10

FY 2023-24	Fund Number	TF	GF	FF
50 % Title XIX / 50 % GF	4260-101-0890/0001	(\$587,106)	(\$293,553)	(\$293,553)
65 % Title XXI / 35 % GF	4260-101-0890/0001	\$587,106	\$205,487	\$381,619
Net Impact (rounded)		\$0	(\$88,066)	\$88,066

* COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

NON-EMERGENCY FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 11
IMPLEMENTATION DATE: 12/1997
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 15

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$1,466,740,250	\$1,488,216,950
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$1,466,740,250	\$1,488,216,950
FEDERAL FUNDS	-\$1,466,740,250	-\$1,488,216,950

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

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: 11

Reason for Change:

The change from the prior estimate, for FY 2022-23, is an increase due to an increase in managed care expenditures. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to an expected increase in managed care expenditures in FY 2023-24.

Methodology:

1. Based on updated January 2022 through June 2022 FFS expenditure reports of non-emergency services provided to this population, the Department estimates non-emergency FFS costs will be \$539,449,000 TF in FY 2022-23 and FY 2023-24.
2. Based on updated January 2022 through June 2022 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 \$783,187,000 TF in FY 2022-23 and \$801,020,000 in FY 2023-24. The repayment for this group will be 90% FFP.
3. Based on updated January 2022 through June 2022 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 \$798,369,000 TF in FY 2022-23 and \$809,223,000 in FY 2023-24. 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 2022-23 and FY 2023-24:

(Dollars in Thousands)

FFS and MC costs	FY 2022-23		FY 2023-24	
	TF	FF Repayment	TF	FF Repayment
All Others (50% FF / 50% GF)	\$1,071,050	\$535,525	\$1,081,904	\$540,952
All Others (65% FF / 35% GF)	\$4,978	\$3,236	\$4,978	\$3,236
All Others (Title XXI)	\$49,999	\$32,499	\$49,999	\$32,499
ACA	\$994,978	\$895,480	\$1,012,811	\$911,530
Total	\$2,121,005	\$1,466,740	\$2,149,692	\$1,488,217

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 is identified in the COVID-19 Increased FMAP – DHCS policy change

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER: 12
IMPLEMENTATION DATE: 7/2005
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 1007

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$74,163,400	-\$70,252,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$74,163,400	-\$70,252,000
FEDERAL FUNDS	\$74,163,400	\$70,252,000

Purpose:

This policy change estimates the savings from the State Children's Health Insurance Program's (SCHIP) federal funding for prenatal care for women previously ineligible for federal funding.

Authority:

AB 131 (Chapter 80, Statutes of 2005)
Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS

Background:

AB 131 required the Department to submit a State Plan Amendment to claim CHIP federal funding for prenatal care for undocumented women, and legal immigrants who have been in the country for less than five years through the Medi-Cal Program and the Medi-Cal Access Infants Program. Previously, these costs for prenatal care were funded with 100% General Fund for the Medi-Cal Program. California draws down federal CHIP funding through the Title XXI unborn option for both programs.

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

Reason for Change:

The change from the prior estimate, for FY 2022-23, is an increase in general fund savings due to updated expenditure reports showing increased prenatal costs. Additionally, FFCRA funding is now accounted for in this policy through March 2023. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a general fund savings decrease due to the FFCRA increased FMAP funding ending for this policy change March 2023. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER: 12

Methodology:

1. Assume the FMAP for Title XXI is 65% FF and 35% GF beginning October 1, 2020.
2. The 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through March 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
3. The total fund cost of prenatal care for undocumented and legal immigrant women is estimated to be:

(Dollars in Thousands)

FY 2022-23	\$108,656
FY 2023-24	\$108,080

Funding:

(Dollars in Thousands)

FY 2022-23	Fund Number	TF	GF	FF
100% State GF	4260-101-0001	(\$108,656)	(\$108,656)	\$0
Title XXI 65% FF / 35% GF	4260-113-0890/0001	\$108,656	\$38,030	\$70,626
FFCRA 4.34% Increased FFP	4260-113-0890/0001	\$0	(\$3,537)	\$3,537
Net Impact		\$0	(\$74,163)	\$74,163

(Dollars in Thousands)

FY 2023-24	Fund Number	TF	GF	FF
100% State GF	4260-101-0001	(\$108,080)	(\$108,080)	\$0
Title XXI 65% FF / 35% GF	4260-101-0890/0001	\$108,080	\$37,828	\$70,252
Net Impact		\$0	(\$70,252)	\$70,252

MEDI-CAL COUNTY INMATE REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 13
IMPLEMENTATION DATE: 2/2018
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2029

	<u>FY 2022-23</u>	<u>FY 2023-24</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:

Not Applicable

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, for FY 2022-23, is a decrease due to capturing recent paid claims data. Additionally, the FY 2022-23 reimbursement is further reduced by the availability of the Coronavirus Disease 2019 (COVID-19) Increased Federal Medical Assistance Percentage (FMAP) which reduces the GF liability in the Medi-Cal County Inmate Programs.

MEDI-CAL COUNTY INMATE REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 13

The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to utilizing recent claims data and due to the COVID-19 Increased FMAP expiring in FY 2022-23.

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 of 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. Assume there will be reduced reimbursement due to COVID-19 increased FMAP being available.
6. The Department estimates payments \$38,711,000 TF (which includes \$37,183,000 FF) in FY 2022-23 and \$40,645,000 TF (which includes \$39,042,000 FF) in FY 2023-24.
7. The total estimated GF reimbursement in FY 2022-23 and FY 2023-24 will be:

FY 2022-23	GF	Reimbursement
Non ACA	\$583,000	\$561,000
ACA	\$854,000	\$852,000
Juvenile	\$46,000	\$52,000
Compassionate Release – Non ACA	\$9,000	\$8,000
Compassionate Release - ACA	\$8,000	\$6,000
Total	\$1,500,000	\$1,479,000

FY 2023-24	GF	Reimbursement
Non ACA	\$641,000	\$634,000
ACA	\$897,000	\$886,000
Juvenile	\$48,000	\$48,000
Compassionate Release – Non ACA	\$9,000	\$9,000
Compassionate Release - ACA	\$8,000	\$8,000
Total	\$1,603,000	\$1,585,000

*Totals may differ due to rounding.

Funding:

100% GF (4260-101-0001)
Reimbursement GF (4260-610-0995)

MEDICARE OPTIONAL EXPANSION ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 14
IMPLEMENTATION DATE: 7/2022
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2033

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$2,303,600	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$2,303,600	\$0
FEDERAL FUNDS	-\$2,303,600	\$0

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
Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS

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.

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 2022-23, is a General Fund (GF) increase due to utilizing more recent actual memos. Additionally, the FY 2020-21 and FY 2021-22 memos will be adjusted in FY 2022-23. The change from FY 2022-23 to FY 2023-24, in the current

MEDICARE OPTIONAL EXPANSION ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 14

estimate, is a GF decrease due to funding for the Optional Expansion eligibility group being adjusted for in the weekly checkwrite and eliminating the need for any additional adjustments after FY 2022-23.

Methodology:

- The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through March 31, 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
- 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

- Manual adjustments will continue for Medicare Part A and/or Part B eligibles remaining in the Optional Expansion aid codes.
- Those Medi-Cal eligibles with Part A and/or Part B are estimated in the Optional Expansion aid category.
- The overall adjustment is estimated to be:

Fiscal Year	TF	GF	FF
FY 2022-23	\$0	\$2,304,000	(\$2,304,000)

Funding:

FY 2022-23	TF	GF	FF
90% ACA Title XIX FF/10% GF (4260-101-0890/0001)	(\$6,814,000)	(\$681,000)	(\$6,133,000)
50 % Title XIX FF/50% GF (4260-101-0890/0001)	\$6,814,000	\$3,407,000	\$3,407,000
FFCRA 6.2% Increased FFP (4260-101-0890/0001)	\$0	(\$422,000)	\$422,000
Total	\$0	\$2,304,000	(\$2,304,000)

* Totals may differ due to rounding

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

CS3 PROXY ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 15
IMPLEMENTATION DATE: 4/2017
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2155

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$54,945,200	-\$51,216,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$54,945,200	-\$51,216,700
FEDERAL FUNDS	\$54,945,200	\$51,216,700

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

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 2022-23, from the prior estimate, is a General Fund (GF) savings decrease due to memo processing shifts. The change from FY 2022-23 to FY 2023-2024, in the current estimate, is a GF savings decrease due to projecting lower adjustment memos in FY 2022-23.

Methodology:

1. Effective FY 2020-21, assume a two quarter adjustment lag.
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.

CS3 PROXY ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 15

3. Previously, the CS3 Proxy adjustments were budgeted in the Non-OTLICP CHIP policy change.
4. Total estimated costs for FY 2022-23 and FY 2023-24 are:

(Dollars in Thousands)

Fiscal Years	TF	GF	FF
FY 2022-23	\$0	(\$54,945)	\$54,945
FY 2023-24	\$0	(\$51,217)	\$51,217

Funding:

(Dollars in Thousands)

FY 2022-23	Fund Number	TF	GF	FF
50% Title XIX /50 % GF	4260-101-0890/0001	(\$237,208)	(\$118,604)	(\$118,604)
65% Title XXI / 35% GF	4260-113-0890/0001	\$237,208	\$83,023	\$154,185
Title XIX FF	4260-101-0890	(\$64,546)	\$0	(\$64,546)
Title XIX GF	4260-101-0001	\$64,546	\$64,546	\$0
Title XXI FF	4260-113-0890	\$83,910	\$0	\$83,910
Title XXI GF	4260-113-0001	(\$83,910)	(\$83,910)	\$0
Net Impact (rounded)		\$0	(\$54,945)	\$54,945

* Totals may differ due to rounding

(Dollars in Thousands)

FY 2023-24	Fund Number	TF	GF	FF
50% Title XIX /50 % GF	4260-101-0890/0001	(\$240,898)	(\$120,449)	(\$120,449)
65% Title XXI / 35% GF	4260-101-0890/0001	\$240,898	\$84,314	\$156,584
Title XIX FF	4260-101-0890	(\$50,273)	\$0	(\$50,273)
Title XIX GF	4260-101-0001	\$50,273	\$50,273	\$0
Title XXI FF	4260-101-0890	\$65,355	\$0	\$65,355
Title XXI GF	4260-101-0001	(\$65,355)	(\$65,355)	\$0
Net Impact (rounded)		\$0	(\$51,217)	\$51,217

* Totals may differ due to rounding

** COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

COMMUNITY FIRST CHOICE OPTION

REGULAR POLICY CHANGE NUMBER: 16
IMPLEMENTATION DATE: 12/2012
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 1595

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$7,669,784,000	\$7,413,067,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$7,669,784,000	\$7,413,067,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$7,669,784,000	\$7,413,067,000

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:

Not Applicable

Background:

The ACA established a new State Plan option, which became available to states on October 1, 2010, to provide home and community-based attendant services and supports through CFCO. CFCO allows States to receive a 6% increase in federal match for expenditures related to this option. The state submitted a State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) which proposed moving federally eligible Personal Care Services Program (PCSP) and In-Home Supportive Services (IHSS) Plus Option program participants into CFCO. The Department budgets Title XIX Federal Financial Participation (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: 16

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 2022-23, from the previous estimate, is an increase due to updated expenditure data provided by CDSS that includes FFCRA increased FMAP through June 30, 2023, for this policy change. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease 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 56.2% Federal Financial Participation.
2. The 6.2% Title XIX FFCRA increased FFCRA increased FMAP is assumed for expenditures through June 30, 2023, for this policy change.
3. The estimated costs CDSS provided on an accrual basis for FY 2022-23 and FY 2023-24 are in the table below.

(Dollars in Thousands)

FY 2022-23	TF	FF	CDSS GF/ County Share
Title XIX 100% FFP	\$13,251,404	\$6,625,702	\$6,625,702
FFCRA 6.2% Increased FMAP	\$0	\$718,581	(\$718,581)
Total	\$13,251,404	\$7,344,283	\$5,907,121
FY 2023-24	TF	FF	CDSS GF/ County Share
Title XIX 100% FFP	\$14,131,877	\$7,065,939	\$7,065,938
FFCRA 6.2% Increased FMAP	\$0	\$0	\$0
Total	\$14,131,877	\$7,065,939	\$7,065,938

COMMUNITY FIRST CHOICE OPTION
REGULAR POLICY CHANGE NUMBER: 16

4. The estimated costs CDSS provided on a cash basis for FY 2022-23 and FY 2023-24 are in the table below.

(Dollars in Thousands)

FY 2022-23	TF	FF	CDSS GF/ County Share
Title XIX 100% FFP	\$13,902,406	\$6,951,203	\$6,951,203
FFCRA 6.2% Increased FMAP	\$0	\$718,581	(\$718,581)
Total	\$13,902,406	\$7,669,784	\$6,232,622
FY 2023-24	TF	FF	CDSS GF/ County Share
Title XIX 100% FFP	\$14,826,133	\$7,413,067	\$7,413,066
FFCRA 6.2% Increased FMAP	\$0	\$0	\$0
Total	\$14,826,133	\$7,413,067	\$7,413,066

Funding:

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

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

HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS

REGULAR POLICY CHANGE NUMBER: 17
 IMPLEMENTATION DATE: 2/2016
 ANALYST: Sabrina Blank
 FISCAL REFERENCE NUMBER: 1967

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$14,427,000	\$14,208,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$14,427,000	\$14,208,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$14,427,000	\$14,208,000

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 2022-23, is a decrease due to adding a quarter of actuals lower than previously projected.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a slight decrease due to updated estimated projections that utilize the expenditure trends from FY 2020-21 and FY 2021-22.

HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS

REGULAR POLICY CHANGE NUMBER: 17

Methodology:

1. The Department assumes enhanced Title XIX ACA FMAP is available for services provided under the temporary HPE program to those individuals who enroll in temporary HPE at a qualified hospital, then successfully complete the Medi-Cal application process, and are enrolled in the ACA Optional Expansion program.
2. The Department 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 \$3,552,000 for FY 2022-23 and FY 2023-24 based on the average expenditures of the most recent 8 quarters of data available (FY 2020-21 Q1-4, and FY 2021-22 Q1-4).
3. The Department will also claim the enhanced Title XIX ACA FMAP for beneficiaries receiving services in DPHs and estimates to pay DPHs \$14,427,000 in FY 2022-23 and \$14,208,000 in FY 2023-24. The estimated pass-through costs are included in the chart below.

(Dollars in Thousands)

FY 2022-23	TF	FF
FY 2021-22 Q3	\$2,676	\$2,676
FY 2021-22 Q4	\$4,647	\$4,647
FY 2022-23 Q1	\$3,552	\$3,552
FY 2022-23 Q2	\$3,552	\$3,552
Net Impact	\$14,427	\$14,427

FY 2023-24	TF	FF
FY 2022-23 Q3	\$3,552	\$3,552
FY 2022-23 Q4	\$3,552	\$3,552
FY 2023-24 Q1	\$3,552	\$3,552
FY 2023-24 Q2	\$3,552	\$3,552
Net Impact	\$14,208	\$14,208

Funding:

ACA 100% FFP (4260-101-0890)

1% FMAP INCREASE FOR PREVENTIVE SERVICES

REGULAR POLICY CHANGE NUMBER: 18
IMPLEMENTATION DATE: 1/2016
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 1791

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$8,217,000	-\$4,276,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$8,217,000	-\$4,276,000
FEDERAL FUNDS	\$8,217,000	\$4,276,000

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: 18

Reason for Change:

The change in FY 2022-23, from the prior estimate, is an increase in managed care savings due to a shift in CY 2021 savings claiming timing from FY 2021-22 to FY 2022-23 and includes Bridge Period Unsatisfactory Immigration Status payback.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease in savings in managed care due to two years (CY 2021 & CY 2022) of savings being claimed in FY 2022-23 as opposed to only one year (CY 2023) of savings claimed in FY 2023-24. The FFS savings increased slightly due to updated actual data through December 2021.

Methodology:

1. The 1% FMAP savings will include the following periods of savings in FY 2022-23:
 - FFS – July 1, 2021 through June 30, 2022
 - Managed care – January 1, 2021 through December 31, 2021
 - Managed care – January 1, 2022 through December 31, 2022
2. FY 2023-24 will include the following periods of savings:
 - FFS – July 1, 2022 through June 30, 2023
 - Managed care – January 1, 2023 through December 31, 2023
3. Due to a request from the CMS (Centers for Medicare & Medicaid Services), the Department has recalculated its Bridge Period savings and will be paying back a portion of those funds in December 2022.
4. Total savings for the 1% FMAP increase for preventive services are as follows:

FY 2022-23	TF	GF	FF
FFS:			
FY 2021-22 Savings	\$0	(\$154,000)	\$154,000
Total FFS	\$0	(\$154,000)	\$154,000
Managed Care:			
FY 2021-22 Savings	\$0	(\$4,122,000)	\$4,122,000
FY 2022-23 Savings	\$0	(\$4,121,000)	\$4,121,000
Bridge Period UIS Payback	\$0	\$180,000	(\$180,000)
Total Managed Care	\$0	(\$8,063,000)	\$8,063,000
Total FY 2022-23	\$0	(\$8,217,000)	\$8,217,000

FY 2023-24	TF	GF	FF
FFS:			
FY 2022-23 Savings	\$0	(\$154,000)	\$154,000
Total FFS	\$0	(\$154,000)	\$154,000
Managed Care:			
FY 2022-23 Savings	\$0	(\$2,061,000)	\$2,061,000
FY 2023-24 Savings	\$0	(\$2,061,000)	\$2,061,000
Total Managed Care	\$0	(\$4,122,000)	\$4,122,000
Total FY 2023-24	\$0	(\$4,276,000)	\$4,276,000

1% FMAP INCREASE FOR PREVENTIVE SERVICES
REGULAR POLICY CHANGE NUMBER: 18

Funding:

100% Title XIX (4260-101-0890)

100% GF (4260-101-0001)

HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.

REGULAR POLICY CHANGE NUMBER: 19
 IMPLEMENTATION DATE: 1/2014
 ANALYST: Sabrina Blank
 FISCAL REFERENCE NUMBER: 1821

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$36,621,200	-\$35,861,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$36,621,200	-\$35,861,600
FEDERAL FUNDS	\$36,621,200	\$35,861,600

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 2022-23, is a decrease in GF due to adding 2 quarters of actuals lower than previously projected.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease in GF due to FY 2023-24 utilizing 4 quarters of averages while FY 2022-23 utilizes 3 quarters of actuals and 1 quarter of averages.

HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.

REGULAR POLICY CHANGE NUMBER: 19

Methodology:

1. The Department assumes enhanced Title XIX ACA Federal Funding (FF) is available for services provided under the HPE program to those individuals who enroll in HPE at a qualified hospital, then successfully complete the Medi-Cal application process, and are enrolled in the ACA Optional Expansion program.
2. Based on actual claims for individuals identified above, the Department retroactively requests enhanced Title XIX ACA FF.
3. Using claims from FY 2021 Q1 through FY 2021 Q3, and a projected average from claims in FY 2020 Q1 through FY 2021 Q3 for FY 2021 Q4, the estimate average quarterly adjustment for FY 2022-23 is \$22,888,000. Using a projected average from claims in FY 2020 Q1 through FY 2021 Q3 for FY 2022 Q1-4, the estimate average quarterly adjustment for FY 2023-24 is \$22,413,000.
4. The Department estimates to adjust \$91,553,000 TF claims from Title XIX 50/50 FMAP to claim the enhanced Title XIX ACA FMAP in FY 2022-23 and \$89,654,000 TF in FY 2023-24. The estimated funding adjustment is included in the chart below.

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX FF / 50% GF	(\$91,553)	(\$45,777)	(\$45,776)
90% Title XIX FF / 10% GF	\$91,553	\$9,155	\$82,398
Net Impact	\$0	(\$36,622)	\$36,622

FY 2023-24	TF	GF	FF
50% Title XIX FF / 50% GF	(\$89,654)	(\$44,827)	(\$44,827)
90% Title XIX FF / 10% GF	\$89,654	\$8,965	\$80,689
Net Impact	\$0	(\$35,862)	\$35,862

*Totals may not add due to rounding

Funding:

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

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

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

ACA DSH REDUCTION

REGULAR POLICY CHANGE NUMBER: 20
IMPLEMENTATION DATE: 10/2023
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 2105

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$844,374,000
- STATE FUNDS	\$0	-\$379,299,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$844,374,000
STATE FUNDS	\$0	-\$379,299,000
FEDERAL FUNDS	\$0	-\$465,075,000

Purpose:

This policy change estimates the reductions to Disproportionate Share Hospitals (DSHs), as required under the Affordable Care Act (ACA).

Authority:

Affordable Care Act (ACA), HR 3590, Section 2551
 HR 2 (2015)
 HR 1892 (2018)
 HR 4378 (2019)
 HR 3055 (2019)
 HR 1865 (2019)
 HR 748 (2020)
 HR 8337
 HR 133

Interdependent Policy Changes:

Not Applicable

Background:

The federal DSH allotment is available for uncompensated Medi-Cal and uninsured costs incurred by DSHs. The Affordable Care Act (ACA) requires the aggregate, nationwide reduction of DSH allotments in the amount of \$8 billion annually Federal Fiscal Year (FFY) 2024 through FFY 2027, for a total aggregate reduction of \$32 billion. The distribution of the aggregate reductions is determined by the Centers for Medicare & Medicaid Services (CMS).

The original effective date of the reduction was October 1, 2013; however, HR 2 (2015) delayed the start date of the reduction until October 1, 2017. HR 1892 (2018) was enacted on February 9, 2018, which postponed the reduction until October 1, 2019. Subsequently, HR 4378 (2019) and HR 3055 (2019) were enacted, postponing the reduction until November 22, 2019, and December 21, 2019, respectively. On December 20, 2019, HR 1865 further delayed the ACA DSH reduction until May 23, 2020. On March 27, 2020, HR 748 (2020) was enacted which eliminated the FFY 2020 reduction and postponed the start of the FFY 2021 reduction until December 1, 2020. On October 1, 2020, HR 8337 postponed the start of the FFY 2021 reduction until December 12, 2020. On December 27, 2020, HR 133 eliminated DSH reductions

ACA DSH REDUCTION

REGULAR POLICY CHANGE NUMBER: 20

for FFYs 2021-2023, lowered the overall national reduction to \$32 billion, and postponed implementation until FFY 2024.

In October 2017, CMS released a simulated California DSH reduction amount of \$166 million, which represented 8.35% of the total national reduction. In October 2019, CMS released a preliminary California DSH reduction amount of \$389.5 million for FFY 2020, representing 9.74% of that year's total national reduction of \$4 billion. In October 2020, CMS released a preliminary California DSH reduction amount of \$266 million for FFY 2021, representing 6.66% of that year's total national reduction. Based on the FFY 2021 amounts released from CMS and updates to the national aggregate total of \$8 billion per year, for estimation purposes for all DSH years impacted by the reduction (FFY 2024-2027), California's percent share of the national reduction is assumed to be 6.66%.

The non-federal share of the payment is funded via the General Fund, certified public expenditures (CPEs), or intergovernmental transfers (IGTs). However, private hospitals receive Medi-Cal DSH replacement payment adjustments from Title XIX funding, along with \$160.00, with the federal share of the \$160.00 from the annual DSH allotment and the non-federal share from the General Fund. The \$160.00 satisfies the State's payment obligations under the Federal DSH statute. See the Private Hospital DSH Replacement, DSH Payment, and Global Payment Program (GPP) policy changes for more information.

Reason for Change:

This is a new policy change.

Methodology:

1. California's DSH allotment is estimated to be \$1.54 billion for FY 2022-23 and \$1.4 billion for FY 2023-24.
2. California's reduction results in no reduction in FY 2022-23 and a total reduction of \$533 million FF for FY 2023-24, for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs). The DSH allotment reduction will offset DSH payments for NDPHs, University of California (UC) DPHs in the DSH Payment policy change, and the remaining DPHs in the Global Payment Program (GPP) policy change.
3. The DSH allotment amount is applied in the DSH payment methodology to determine the reduction amount for the estimated aggregate Private DSH Replacement funding. The amounts are estimated to be \$251 million FF for FY 2023-24. The Private DSH replacement reduction will offset Private DSH replacement payments in the Private Hospital DSH Replacement policy change.
4. Assume the following DSH reduction on an accrual basis:

(Dollars in Thousands)

FY 2023-24	TF	GF	IGT	FF
Private DSH Replacement	(\$250,675)	(\$125,337)	\$0	(\$125,338)
DSH NDPH	(\$20,587)	(\$10,294)	\$0	(\$10,293)
DSH UC	(\$114,367)	\$0	\$0	(\$114,367)
GPP	(\$815,908)	\$0	(\$407,954)	(\$407,954)
Total Reduction FY 2023-24	(\$1,201,537)	(\$135,631)	(\$407,954)	(\$657,952)

ACA DSH REDUCTION

REGULAR POLICY CHANGE NUMBER: 20

5. For Private Hospital DSH Replacement and DSH NDPH:
 - Assume 11/12 of the FY 2023-24 DSH payment reduction will occur in FY 2023-24 and 1/12 will occur in FY 2024-25.
6. For UC DSH:
 - Assume 3/4 of the FY 2023-24 DSH payment reduction will occur in FY 2023-24 and 1/4 will occur in FY 2024-25.
7. For GPP:
 - Assume 5/8 of the FY 2023-24 GPP payment reduction will occur in FY 2023-24 and 3/8 will occur in FY 2024-25.

The aggregate DSH reduction is as follows on a cash basis:

(Dollars in Thousands)

FY 2023-24	TF	GF***	IGT	FF
FY 2023-24 Private DSH Replacement	(\$229,785)	(\$114,892)	\$0	(\$114,893)
FY 2023-24 DSH NDPH	(\$18,871)	(\$9,436)	\$0	(\$9,435)
FY 2023-24 DSH UC*	(\$85,776)	\$0	\$0	(\$85,776)
FY 2023-24 GPP**	(\$509,942)	\$0	(\$254,971)	(\$254,971)
Total Reduction FY 2023-24	(\$844,374)	(\$124,328)	(\$254,971)	(\$465,075)

Funding:

100% Demonstration DSH Fund (4260-601-7502)*

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

100% Global Payment Program Special Fund (4260-601-8108)**

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

ACA OPTIONAL EXPANSION MLR RISK CORRIDOR

REGULAR POLICY CHANGE NUMBER: 21
IMPLEMENTATION DATE: 7/2020
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2064

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	-\$33,700,000	\$0
- STATE FUNDS	-\$1,845,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$33,700,000	\$0
STATE FUNDS	-\$1,845,000	\$0
FEDERAL FUNDS	-\$31,855,000	\$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:

Medi-Cal Managed Care Health Plan Contracts

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 2022-23, is an increase in recoupments due to FY 2017-18 recoupments shifting from FY 2021-22 to FY 2022-23. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to no further MLR risk corridor recoupments or payments occurring after FY 2022-23.

ACA OPTIONAL EXPANSION MLR RISK CORRIDOR

REGULAR POLICY CHANGE NUMBER: 21

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 payments are expected to occur in FY 2022-23. At this time, the Department estimates an approximate \$33,700,000 in net recoupments across all MCPs.
4. The ACA OE MLR risk corridor estimated net recoupments are:

Fiscal Year	TF	GF	FF
FY 2022-23	(\$33,700,000)	(\$1,845,000)	(\$31,855,000)

Funding:

ACA 95% FFP / 5% GF (2017)

ACA 94% FFP / 6% GF (2018)

BEHAVIORAL HEALTH TREATMENT

REGULAR POLICY CHANGE NUMBER: 22
IMPLEMENTATION DATE: 10/2016
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1855

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$890,950,000	\$16,347,000
- STATE FUNDS	\$376,427,700	\$7,752,950
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$890,950,000	\$16,347,000
STATE FUNDS	\$376,427,700	\$7,752,950
FEDERAL FUNDS	\$514,522,300	\$8,594,050

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:

Not Applicable

Background:

SB 870 added W&I Code, Section 14132.56 to direct the Department to implement BHT services to the extent it is required by the federal government to be covered by Medi-Cal for individuals under 21 years of age. On July 7, 2014, the Centers for Medicare and Medicaid Services (CMS) released guidance for states to cover BHT services for Medicaid beneficiaries with an 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: 22

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 2022-23, is an increase due to a portion of FY 2020-21 and FY 2021-22 claims for FFS, previously budgeted in FY 2021-22, is now expected to be paid in FY 2022-23.

The change in the current estimate, from FY 2022-23 to FY 2023-24, is due to the following:

- FFS - The decrease is due to more prior year payments estimated for FY 2022-23.
- Managed care – Base capitation rates, effective January 1, 2023, are captured in the Capitated 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. The IA contract between the Department and DDS was executed in July 2017, with a retroactive effective date of February 1, 2016.
4. 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.
5. The FFS cost reimbursement estimates were provided by DDS. The estimated annual cost on an accrual basis is \$13,501,000 TF for FY 2022-23 and FY 2023-24 claims.

BEHAVIORAL HEALTH TREATMENT

REGULAR POLICY CHANGE NUMBER: 22

6. On a cash basis, FFS reimbursements are estimated to be paid as follows:

Fee-for-Service Claims	Accrual	FY 2022-23	FY 2023-24
FY 2020-21 claims	\$14,042,000	\$768,000	\$0
FY 2021-22 claims	\$13,501,000	\$6,036,000	\$457,000
FY 2022-23 claims	\$13,501,000	\$11,251,000	\$2,250,000
FY 2023-24 claims	\$13,501,000	\$0	\$11,251,000
Total		\$18,055,000	\$13,958,000

Managed Care

7. Managed care payments began in October 2016 for BHT services based on a supplemental capitation payment methodology, retroactive to the implementation date.
8. 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. The CY 2023 BHT PMPM expenditures will be captured in the managed care base costs whilst any remaining CY 2022 supplemental expenditures will continue to be budgeted in this policy change.
9. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through March 31, 2023, for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.

Rate Year	Accrual	FY 2022-23	FY 2023-24
FY 2020-21 - FFS	\$14,042,000	\$768,000	\$0
FY 2020-21 - MC	\$864,078,000	(\$1,110,000)	\$0
FY 2021-22 - FFS	\$13,501,000	\$6,036,000	\$457,000
FY 2021-22 - MC	\$1,070,270,000	\$265,717,000	\$0
FY 2022-23 - FFS	\$13,501,000	\$11,251,000	\$2,250,000
FY 2022-23 - MC	\$1,252,640,000	\$608,288,000	\$2,389,000
FY 2023-24 - FFS	\$13,501,000	\$0	\$11,251,000
Total		\$890,950,000	\$16,347,000

(Dollars in Thousands)

FY 2022-23	TF	GF	FF	FFCRA
Fee-for-Service	\$18,055	\$7,766	\$9,493	\$796
Managed Care	\$872,895	\$368,662	\$458,936	\$45,297
Total	\$890,950	\$376,428	\$468,429	\$46,093

FY 2023-24	TF	GF	FF	FFCRA
Fee-for-Service	\$13,958	\$6,620	\$7,338	\$0
Managed Care	\$2,389	\$1,133	\$1,256	\$0
Total	\$16,347	\$7,753	\$8,594	\$0

BEHAVIORAL HEALTH TREATMENT

REGULAR POLICY CHANGE NUMBER: 22

Funding:

FY 2022-23	TF	GF	FF
100% GF (4260-113-0001)	\$52,472,000	\$52,472,000	\$0
100% Title XXI (4260-113-0890)	\$97,448,000	\$0	\$97,448,000
65% Title XXI / 35% GF (4260-113-0001/0890)	\$3,102,000	\$1,086,000	\$2,016,000
50% Title XIX / 50% GF (4260-101-0001/0890)	\$737,928,000	\$368,964,000	\$368,964,000
FFCRA 6.2% Increased FFP (4260-101-0001/0890)	\$0	(\$40,251,000)	\$40,251,000
FFCRA 4.34% Increased FFP (4260-113-0001/0890)	\$0	(\$5,843,000)	\$5,843,000
Total	\$890,950,000	\$376,428,000	\$514,522,000

FY 2023-24	TF	GF	FF
100% GF (4260-113-0001)	\$144,000	\$144,000	\$0
100% Title XXI (4260-101-0890)	\$266,000	\$0	\$266,000
65% Title XXI / 35% GF (4260-101-0001/0890)	\$2,397,000	\$839,000	\$1,558,000
50% Title XIX / 50% GF (4260-101-0001/0890)	\$13,540,000	\$6,770,000	\$6,770,000
Total	\$16,347,000	\$7,753,000	\$8,594,000

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER: 23
IMPLEMENTATION DATE: 7/2000
ANALYST: Donna Lee
FISCAL REFERENCE NUMBER: 25

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$439,897,000	\$615,147,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$439,897,000	\$615,147,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$439,897,000	\$615,147,000

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:

Local Educational Agencies (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 reimbursement through claims payments and then calculate their total cost of providing these services to Medi-Cal-enrolled students using a Cost and Reimbursement Comparison Schedule (CRCS) that is submitted to the Department annually for the preceding fiscal year. Final payment settlements based on actual CPEs for a given year are considered completed when the Department has audited the LEAs' CRCS.

- If interim reimbursements exceed the audited CPE settlement, the Department collects the overpayment and returns the excess federal match from the LEA to the federal government by means of withholding funds from future interim claims until the LEA's account is reconciled.
- If interim claims reimbursements are less than the audited CPE settlement, the Department draws additional federal funds to reimburse the LEA. These additional draws have not previously been reported on any estimate.

State Plan Amendment 15-021 (SPA 15-021), approved by the Centers for Medicare and Medicaid Services (CMS) expanded the LEA BOP by increasing the types of covered

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER: 23

practitioners, the types of services covered, and by allowing students without an Individualized Education Program (IEP)/ Individualized Family Service Plan (IFSP) to receive covered services as long as they have a care plan in place. Additionally, SPA 15-021 added the Random Moment Time Survey (RMTS) as a statistically valid method of capturing the time that is spent providing direct services to Medi-Cal-enrolled students. It is anticipated that this new method will demonstrate an increase in CPE for the LEAs. Although the SPA was approved in 2020, the covered services go back to FY 2015-16. To allow the LEAs to claim for the newly approved practitioners, services, and beneficiaries, CMS approved a back-casting methodology, which includes the RMTS percentages for direct services, and final settlements are estimated to start in FY 2022-23.

SPA 15-021 also requires the Department to issue interim settlements when an audit and final settlement has not been completed within one year of when the CRCS was filed by the LEA. FY 2022-23 is the first year that the interim settlements will be implemented for the CRCS forms that were due on March 1, 2022. Additionally, LEA BOP previously has not reported the final settlement amounts because the final settlement amounts are determined over the course of three years after the CRCS is filed. In conjunction with reporting the interim settlements, FY 2022-23 is the first year that LEA BOP will report the final settlements amounts.

Because LEA BOP is a CPE program, the total cost of providing the covered services to Medi-Cal beneficiaries is reflected on the CRCS. The FMAP is then broken down as components of the total reported cost: The interim claims submitted by the LEAs are reimbursed at 50 percentage points FFP. However, some of the services or beneficiaries are eligible for increased or enhanced Title XIX and Title XXI FMAP, which is reflected for the first time on the CRCS for 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 in FY 2022-23, from the prior estimate, is an increase due to:

- Program growth for the interim payments is anticipated to be a 40 percentage point increase in response to the expansions from SPA 15-021.
- Reporting the enhanced COVID-19 increased 6.2% and 4.34% FFP in the estimated final settlements.
- The anticipated one percentage point decrease resulting from exclusion of claims for Medi-Cal beneficiaries with UIS.
- The FY 2022-23 rate inflation percentage increased from 1.6163% to 2.6018% based on updated information.
- The introduction of payments to the LEAs for the interim settlements start in FY 2022-23, inclusive of regular and enhanced FMAPs for Title XIX and Title XXI.
- Inclusion of the final audited settlements begins in FY 2022-23, including regular and enhanced FMAPs for Title XIX and Title XXI.
- The amended final settlements for expansion services from the back-casting for FYs 2015-16, 2016-17, and 2017-18 is an increase to the estimate as a result of SPA 15-021 expanding covered services and practitioners resulting in additional claiming.

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER: 23

The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to:

- An increased estimate for the rate inflation for FY 2023-24.
- Interim reimbursements projections increased based on actual FY 2021-22 paid claims and the projected FY 2022-23 expenditures.
- Interim settlements estimates increased in FY 2023-24.
- Final settlements are estimated to decrease in FY 2023-24.
- The back-casting estimate in FY 2023-24 increased due to the addition of two FYs (2018-19 and 2019-20).

Methodology:

1. For FY 2022-23, the estimated interim reimbursement is based on the average of the preceding three FYs of actual paid claims data.
2. For FY 2023-24, the estimated interim reimbursement is based on the average of the preceding two FYs of paid and estimated claims data.
3. Assume a 40 percent program growth increase based upon analysis of the submitted amended CRCS for FY 2015-16 that includes CPEs for the SPA expansion.
4. The FYs 2022-23 and 2023-24 interim payments include a rate inflation that is based on the Implicit Deflator for Gross Domestic Products. The rate tables include the rate inflation in the established rates.
5. SDN 21051 was implemented on June 2022 to disallow UIS claims for FFP. Assume a one percentage point decrease to LEA reimbursements in FY 2022-23 and ongoing for the exclusion of claims for beneficiaries with a UIS. In addition, a retroactive adjustment for the UIS claims will be processed. See the State Only Claiming Adjustments policy change for the retroactive repayment information.
6. Approximately 40 percent of the FY 2020-21 CRCS will receive an interim settlement, scheduled to begin in January 2023 and end by mid-March 2023. This percentage is based upon historical audits that received a limited review or field visit. Because these reviews and visits may occur more than one year after the CRCS is filed, an interim settlement will be based upon the LEAs reported CPE that will be adjusted based upon the outcome of the review or visit. This amount is calculated using Audits & Investigations (A&I) most recently completed final settlement percentage.
7. Approximately 60 percent of the FY 2020-21 CRCS will receive an amended final settlement beginning in October 2022 and ending by March 2023. Historically, A&I conducts a minimal review of 60 percent of the CRCS cost reports submitted. These reviews accept the LEA's reported CPE. Final settlements anticipated in FY 2023-24 will include FYs 2019-20 and 2021-22. For this estimate, this amount is calculated using A&I's most recently completed final settlement percentage.
8. Back-casting for expansion services is based upon 38 percent of the participating LEAs who filed timely for FY 2015-16. These amended CRCS demonstrate median program growth of 155 percentage points. This was reduced slightly to 40 percentage points assuming that not all LEAs will submit the required forms timely and that those who had the most to gain were those who submitted timely. The first batch of back-casting payments span FYs 2022-23

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER: 23

and 2023-24. Portions of two additional FYs are expected to receive amended final settlement payments across FYs 2023-24 and 2024-25.

9. Assume the enhanced FMAPs proportionately for the total costs reports for final settlements. Enhanced FMAPs are not part of the back-casting settlements or of the interim reimbursements.
10. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for FY 2020-21 final settlements in this policy change.

FY 2022-23	TF	Title XIX FF	Title XXI FF	FFCRA
FY 2022-23 Estimated Interim Reimbursement	\$108,525,000	\$108,525,000	\$0	\$0
SPA 15-021 Impact (estimated 40% growth)	\$43,410,000	\$43,410,000	\$0	\$0
Reduction of 1% of UIS Claims	(\$1,519,000)	(\$1,519,000)	\$0	\$0
Rate Inflation (2.6018%)	\$3,914,000	\$3,914,000	\$0	\$0
Interim Settlements for SFY 2020-21	\$19,558,000	\$15,177,000	\$4,382,000	\$0
Final Settlements for SFY 2020-21	\$32,505,000	\$22,765,000	\$6,572,000	\$3,167,000
Back-casting (50% of SFYs 2015-16, 2016-17, 2017-18)	\$233,504,000	\$233,504,000	\$0	\$0
Total	\$439,897,000	\$425,776,000	\$10,954,000	\$3,167,000

FY 2023-24	TF	Title XIX FF	Title XXI FF	FFCRA
Estimated Interim Reimbursement	\$140,040,000	\$140,040,000	\$0	\$0
Rate Inflation (6.4211%)	\$8,992,000	\$8,992,000	\$0	\$0
Interim Settlements for SFY 2021-22	\$20,814,000	\$16,151,000	\$4,663,000	\$0
Final Settlements for SFYs 2019-20, 2021-22	\$31,221,000	\$24,227,000	\$6,994,000	\$0
Back-casting (50% of SFYs 2015-16, 2016-17, 2017-18, 2018-19; 66% of SFY 2019-20)	\$414,080,000	\$414,080,000	\$0	\$0
Total	\$615,147,000	\$603,490,000	\$11,657,000	\$0

Funding:

- 100% Title XIX FF (4260-101-0890)
- 100% Title XXI FF (4260-113-0890)
- 100% Title XXI FF (4260-101-0890)
- FFCRA 6.2% Increased FFP (4260-101-0890)
- FFCRA 4.34% Increased FFP (4260-113-0890)

FAMILY PACT PROGRAM

REGULAR POLICY CHANGE NUMBER: 24
IMPLEMENTATION DATE: 1/1997
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 1

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$367,441,000	\$393,078,000
- STATE FUNDS	\$88,036,600	\$94,179,100
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$367,441,000	\$393,078,000
STATE FUNDS	\$88,036,600	\$94,179,100
FEDERAL FUNDS	\$279,404,400	\$298,898,900

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

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 2022-23, is decrease due updated actual expenditure data and a reduction in users utilizing the Family PACT services during the Coronavirus Disease 2019 (COVID-19) national public health emergency (PHE). The change

FAMILY PACT PROGRAM

REGULAR POLICY CHANGE NUMBER: 24

from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to higher projected users of Family PACT services in FY 2023-24 after the PHE ends.

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)

Fiscal Years	TF	GF	FF
FY 2022-23	\$367,441	\$88,037	\$279,404
FY 2023-24	\$393,078	\$94,179	\$298,899

*Totals may differ due to rounding.

Funding:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
90% Family Planning / 10% GF (4260-101-0890/0001)	\$303,421	\$30,342	\$273,079
50% Title XIX / 50% GF (4260-101-0890/0001)	\$12,651	\$6,326	\$6,325
100% GF (4260-101-0001)	\$51,369	\$51,369	\$0
Total	\$367,441	\$88,037	\$279,404

FY 2023-24	TF	GF	FF
90% Family Planning / 10% GF (4260-101-0890/0001)	\$324,591	\$32,459	\$292,132
50% Title XIX / 50% GF (4260-101-0890/0001)	\$13,534	\$6,767	\$6,767
100% GF (4260-101-0001)	\$54,953	\$54,953	\$0
Total	\$393,078	\$94,179	\$298,899

*Totals may differ due to rounding.

** COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

CALAIM - LTC BENEFIT TRANSITION

REGULAR POLICY CHANGE NUMBER: 25
IMPLEMENTATION DATE: 1/2023
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2196

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$201,000,000	\$48,952,000
- STATE FUNDS	\$96,863,950	\$23,590,350
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$201,000,000	\$48,952,000
STATE FUNDS	\$96,863,950	\$23,590,350
FEDERAL FUNDS	\$104,136,050	\$25,361,650

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

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS

Background:

Under CalAIM, 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.

Under CalAIM, 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. The LTC benefit transition will standardize and reduce the complexity of the varying models of care delivery in California.

CALAIM - LTC BENEFIT TRANSITION

REGULAR POLICY CHANGE NUMBER: 25

Populations moving between counties will have the same experience when it comes to receiving services through a managed care plan.

In addition, under CalAIM, LTC beneficiaries would be enrolled in mandatory managed care enrollment, allowing 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:

The change in FY 2022-23, from the prior estimate, is a net increase due to updated calendar year (CY) 2023 cost estimates. In addition, managed care costs for ICF/DDs and subacute care facilities start in FY 2022-23 with the payment of CY 2023 rates.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to:

- Including a full year of the CalAIM LTC benefit and enrollment transition for skilled nursing facilities in FY 2023-24;
- Including the managed care transition for ICF/DDs and subacute care facilities in FY 2023-24; and
- Including the FFS impact for intermediate care facilities for the developmentally disabled (ICF/DDs) and subacute care facilities starting in FY 2023-24.

Methodology:

1. Assume the LTC benefit and enrollment transition to managed care for skilled nursing facility services will be effective January 1, 2023; and the managed care transitions for services provided in intermediate care facilities for the developmentally disabled (ICF/DDs) and subacute care facilities will be effective later in FY 2023-24.
2. FY 2022-23 includes:
 - The FFS and managed care impact of the skilled nursing facility transitions. The annual value of benefits estimated to shift from FFS to managed care is \$1.8 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 managed care impact for ICF/DDs and subacute care facility costs shifting into managed care will begin, on a cash basis, in February 2023. The annual value of benefits estimated to shift from FFS to managed care is \$307.6 million.
3. FY 2023-24 includes the full year impact of the skilled nursing transitions that were effective January 1, 2023. In addition, FY 2023-24 adds the FFS (with payment lags) impact of the ICF/DDs and subacute care facilities transition.
4. The impacts of the transition in FFS and managed care are shown below:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
FFS (Lagged)	(\$701,751)	(\$338,182)	(\$363,569)
Managed Care	\$902,751	\$435,046	\$467,705
Total	\$201,000	\$96,864	\$104,136

CALAIM - LTC BENEFIT TRANSITION
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(Dollars in Thousands)

FY 2023-24	TF	GF	FF
FFS (Lagged)	(\$2,117,648)	(\$1,020,518)	(\$1,097,130)
Managed Care	\$2,166,600	\$1,044,108	\$1,122,492
Total	\$48,952	\$23,590	\$25,362

Funding:

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

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

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

65% Title XXI FF / 35% GF (4260-101-0001/0890)

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

TELEHEALTH

REGULAR POLICY CHANGE NUMBER: 26
IMPLEMENTATION DATE: 1/2022
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2302

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$132,886,000	\$132,886,000
- STATE FUNDS	\$46,847,600	\$46,847,600
PAYMENT LAG	0.9290	0.9958
% REFLECTED IN BASE	17.36 %	26.78 %
APPLIED TO BASE		
TOTAL FUNDS	\$102,020,000	\$96,890,500
STATE FUNDS	\$35,966,100	\$34,157,740
FEDERAL FUNDS	\$66,053,880	\$62,732,730

Purpose:

This policy change estimates the costs for telephone/audio-only services at parity.

Authority:

The health omnibus bill of 2021 (AB 133)
Welfare and Institutions Code Section 14124.12

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS

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.

Reason for Change:

There is no change from the prior estimate for FY 2022-23. There is no change from FY 2022-23 to FY 2023-24 in the current estimate. Funding levels have been updated for both FY 2022-23 and FY 2023-24.

Methodology:

1. Implementation was on January 1, 2022.
2. Payment lags have been updated for FY 2022-23 and FY 2023-24.
3. The estimated costs for FY 2022-23 and FY 2023-24 are:

Fiscal Years	TF	GF	FF
FY 2022-23	\$132,886,000	\$46,848,000	\$86,038,000
FY 2023-24	\$132,886,000	\$46,848,000	\$86,038,000

TELEHEALTH
REGULAR POLICY CHANGE NUMBER: 26

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)

65% Title XXI / 35% GF (4260-101-0890/0001)

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

MULTIPURPOSE SENIOR SERVICES PROGRAM

REGULAR POLICY CHANGE NUMBER: 27
 IMPLEMENTATION DATE: 7/2019
 ANALYST: Ryan Chin
 FISCAL REFERENCE NUMBER: 28

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$63,951,000	\$63,951,000
- STATE FUNDS	\$29,001,500	\$31,975,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$63,951,000	\$63,951,000
STATE FUNDS	\$29,001,500	\$31,975,500
FEDERAL FUNDS	\$34,949,500	\$31,975,500

Purpose:

This policy change estimates the cost of the Multipurpose Senior Services Program (MSSP).

Authority:

Welfare & Institutions Code 9560-9568
 Welfare & Institutions Code 14132.275
 Welfare & Institutions Code 14186
 SB 1008 (Chapter 33, Statutes of 2012)
 American Rescue Plan (ARP) Act (2021)
 Families First Coronavirus Response Act (FFCRA)
 AB 128 (Chapter 21, Statutes of 2021)

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS

Background:

The MSSP provides social and health care management and purchases supplemental services to assist persons aged 65 and older who are "at risk" of needing nursing facility placement but who wish to remain in the community. The program provides services under a federal 1915(c) home and community-based services waiver. 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 was carved-out of CCI. MSSP operates as a waiver benefit in all CCI demonstration counties (except San Mateo County), as it did prior to the implementation of CCI in 2014. In October 2015, the Health Plan of San Mateo (HPSM) successfully transitioned to a full managed care benefit. Since then, HPSM has worked to fully integrate MSSP services into health plan operations. Due to the robust work undertaken to complete the transition DHCS and HPSM collaborated allowing MSSP to remain a managed care benefit for HPSM.

Effective January 1, 2022, the total MSSP reimbursement (both for fee-for-service and managed care) is budgeted in this policy change as a result of AB 128.

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

MULTIPURPOSE SENIOR SERVICES PROGRAM

REGULAR POLICY CHANGE NUMBER: 27

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.

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. 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 total funds for FY 2022-23 from the prior estimate and for FY 2022-23 to FY 2023-24 in the current estimate. There is a GF decrease for FY 2022-23 from the prior estimate, due to FFCRA increased FMAP funds being available for three quarters of FY 2022-23. There is a GF increase from FY 2022-23 to FY 2023-24 in the current estimate, due to assuming FFCRA increase FMAP funds not being available in FY 2023-24.

Methodology:

1. Assume the MSSP has 11,940 slots at a rate of \$5,356 per slot.
1. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through March 31, 2023, for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
3. The estimates below were provided on a cash basis.

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX FFP / 50% GF	\$63,951	\$31,975	\$31,976
FFCRA 6.2% Increased FFP	\$0	(\$2,974)	\$2,974
Total	\$63,951	\$29,002	\$34,949

FY 2023-24	TF	GF	FF
50% Title XIX FFP / 50% GF	\$63,951	\$31,975	\$31,976
Total	\$63,951	\$31,975	\$31,976

*Totals may differ due to rounding.

MULTIPURPOSE SENIOR SERVICES PROGRAM
REGULAR POLICY CHANGE NUMBER: 27

Funding:

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

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

FFCRA 6.2% GF (4260-101-0001)

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 28
IMPLEMENTATION DATE: 12/2008
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1228

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$47,022,000	\$66,077,000
- STATE FUNDS	\$9,169,000	\$14,498,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$47,022,000	\$66,077,000
STATE FUNDS	\$9,169,000	\$14,498,000
FEDERAL FUNDS	\$37,853,000	\$51,579,000

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
 Families First Coronavirus Response Act (FFCRA), (P.L. 116-127), Section 6008
 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

Background:

The CCT demonstration is authorized under Section 6071 of the Federal DRA of 2005 and was extended by the ACA.

The Extenders Act provided the Centers for Medicare and Medicaid Services (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.

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

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 28

the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated.

On December 27, 2020, the President signed the Consolidated Appropriations Act, 2021 into law, which includes an extension of the Money Follows the Person (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.

On July 27, 2021, AB 133 was approved and resulted in necessary changes to state law to align with federal MFP requirements, which removed barriers to the Department's implementation of the state-only CCT program. AB 133 aligns state statute with the amended federal statute, by reducing the required period of residence in an inpatient facility from 90 days to 60 days. The state-funded, CCT-like program allows CCT Lead Organizations to provide transition services to Medi-Cal beneficiaries who have not yet met the federal, MFP residency eligibility criteria, as a way to help reduce the amount of time beneficiaries are required to remain in an institution during the COVID-19 public health emergency.

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.

Currently, CCT Medi-Cal estimates are based on the average cost of services provided to the projected number of CCT enrollees and participants each fiscal year. However, the 2-year claiming period and the process to draw enhanced matching funds from CMS, which is based on the date of payment, has created an ongoing misalignment between the amounts included in the Medi-Cal estimate and actual payments every quarter. As a result, California must pay for service costs generated in previous years and draw down enhanced federal financial participation (FFP) for those costs.

On March 31, 2022, CMS issued a Memorandum to MFP grantees informing it is increasing the reimbursement rate for MFP supplemental services. These services are now 100% federally funded with no state share. Effective January 1, 2022, supplemental services are fully covered by MFP grant funds at a federal reimbursement rate of 100%. The projected implementation date of CCT supplemental services is in the spring of 2023. Effective January 1, 2022, the definition of supplemental services is modified from one-time services to short-term services to support an MFP participant's transition. Further, the definition is expanded to address critical barriers to transition for MFP participants, including the lack of affordable and accessible housing, food insecurity, and financial and administrative barriers to transitions.

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 28

Reason for Change:

The change from the prior estimate, for FY 2022-23, is an increase primarily due to the policy change now budgeting for Assisted Living Waiver (ALW) institutional transitions, which were not accounted for in the prior estimate. Additionally, there is a projected increase in estimated caseload and cost per participant for the CCT population based on historical actuals.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to additional enrollments from the CCT participants and the additional FY 2021-22 retroactive invoice for ALW transitions being paid in FY 2023-24.

Methodology:

1. Assume estimated costs of waiver impacted services for persons residing year-round in Nursing Facility (NF)-Bs would be \$89,629 in FY 2022-23 and FY 2023-24. The savings from moving participants from NF-Bs to the waiver are 50% FFP and 50% GF.
2. Assume 100% of CCT participants will receive pre-transition demonstration services for up to six months; 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 March 31, 2023, for this policy change.
3. The newly authorized state-funded CCT population began transitioning to the CCT program in October 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 480 individuals will transition from an inpatient facility to the CCT program in FY 2022-23 and 558 in FY 2023-24.
6. Assume 729 ALW institutional transitions qualify to draw down CCT enhanced match funding at \$1,600 per successful transition.
7. Assume 754 ALW participants who transitioned from an institution to a community setting qualify to draw down \$28,500 per year in post-transition Qualified Home and Community-Based Services.
8. Assume a retroactive payment of \$5,679,000 TF will be paid in FY 2022-23 and \$15,324,000 TF in FY 2023-24 for ALW transitions rendered in FY 2021-22.
9. Assume \$27,403,000 will be awarded for CY 2022, which will allow CCT transitions to continue through December 31, 2022.
10. 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.
11. Below is the overall impact of the CCT Demonstration project in FY 2022-23 and FY 2023-24.

CALIFORNIA COMMUNITY TRANSITIONS COSTS
REGULAR POLICY CHANGE NUMBER: 28

FY 2022-23	TF	GF	FF
CCT Costs (PC 28):			
GF costs and Total FFP	\$18,613,000	\$4,514,000	\$14,099,000
State-Funded CCT Population	\$13,000	\$10,000	\$3,000
ALW Transition Costs	\$28,397,000	\$5,739,000	\$22,657,000
FFCRA 3.1% Increased FFP	\$0	(\$1,093,000)	\$1,093,000
Total Costs	\$47,022,000	\$9,169,000	\$37,853,000
CCT Savings:			
Total GF savings and Total FFP	(\$22,497,000)	(\$11,248,000)	(\$11,248,000)
CCT Fund Transfer to CDSS (PC 42):			
CCT Fund Transfer Costs	\$239,000	\$0	\$239,000
FFCRA 3.1% Increased FFP	\$141,000	\$0	\$141,000
Total Costs	\$380,000	\$0	\$380,000
CCT Outreach - Admin costs (OA 49)	\$340,000	\$0	\$340,000
Total of CCT PCs including pass through	\$25,245,000	(\$2,079,000)	\$27,325,000

*The savings are included in the total, however, they are fully reflected in the base estimates.

FY 2023-24	TF	GF	FF
CCT Costs (PC 28):			
GF costs and Total FFP	\$28,014,000	\$6,794,000	\$21,220,000
State-Funded CCT Population	\$21,000	\$16,000	\$5,000
ALW Transition Costs	\$38,041,000	\$7,688,000	\$30,353,000
Total Cost	\$66,077,000	\$14,498,000	\$51,579,000
CCT Savings:			
Total GF savings and Total FFP	(\$26,149,000)	(\$13,075,000)	(\$13,075,000)
CCT Fund Transfer to CDSS (PC 42):	\$278,000	\$0	\$278,000
CCT Outreach - Admin costs (OA 49)	\$340,000	\$0	\$340,000
Total of CCT PCs including pass through	\$40,546,000	\$1,423,000	\$39,122,000

*The savings are included in the total, however, they are fully reflected in the base estimates.

CALIFORNIA COMMUNITY TRANSITIONS COSTS
REGULAR POLICY CHANGE NUMBER: 28

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)

CYBHI - DYADIC SERVICES

REGULAR POLICY CHANGE NUMBER: 29
IMPLEMENTATION DATE: 1/2023
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2328

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$45,531,000	\$138,576,000
- STATE FUNDS	\$17,248,250	\$55,529,350
PAYMENT LAG	0.9698	0.9828
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$44,156,000	\$136,192,500
STATE FUNDS	\$16,727,350	\$54,574,240
FEDERAL FUNDS	\$27,428,610	\$81,618,250

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)
Families First Coronavirus Response Act (FFCRA)

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.

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).

CYBHI - DYADIC SERVICES

REGULAR POLICY CHANGE NUMBER: 29

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 2022-23, is an increase due to revised actuarial cost estimates for Calendar Year (CY) 2023 rates.

The change in the current estimate, from FY 2022-23 to FY 2023-24, is an increase due to FY 2023-24 including a full years of expenditures and ramp up of benefits.

Methodology:

1. Assume the dyadic services benefit will begin January 1, 2023.
2. The 6.2% Title XIX and/or 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through March 31, 2023, for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
3. Total estimated costs for dyadic services, on a cash basis, is as follows.

FY 2022-23	TF	GF	FF	FFCRA
Fee-for-Service	\$5,730,000	\$2,637,000	\$2,929,000	\$164,000
Managed Care	\$39,801,000	\$14,611,000	\$24,474,000	\$716,000
Total	\$45,531,000	\$17,248,000	\$27,403,000	\$880,000

FY 2023-24	TF	GF	FF	FFCRA
Fee-for-Service	\$15,439,000	\$7,548,000	\$7,891,000	\$0
Managed Care	\$123,137,000	\$47,982,000	\$75,155,000	\$0
Total	\$138,576,000	\$55,530,000	\$83,046,000	\$0

CYBHI - DYADIC SERVICES
REGULAR POLICY CHANGE NUMBER: 29

Funding:

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$29,616,000	\$14,808,000	\$14,808,000
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$6,915,000	\$2,420,000	\$4,495,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$9,000,000	\$900,000	\$8,100,000
FFCRA 4.34% GF (4260-113-0001)	(\$767,000)	(\$767,000)	\$0
FFCRA 4.34% FF (4260-113-0890)	\$767,000	\$0	\$767,000
FFCRA 6.2% GF (4260-101-0001)	(\$113,000)	(\$113,000)	\$0
FFCRA 6.2% FF (4260-101-0890)	\$113,000	\$0	\$113,000
Total	\$45,531,000	\$17,248,000	\$28,283,000

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$90,630,000	\$45,315,000	\$45,315,000
65% Title XXI FF / 35% GF (4260-101-0001/0890)	\$21,679,000	\$7,588,000	\$14,091,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$26,267,000	\$2,627,000	\$23,640,000
Total	\$138,576,000	\$55,530,000	\$83,046,000

REMOTE PATIENT MONITORING

REGULAR POLICY CHANGE NUMBER: 30
IMPLEMENTATION DATE: 7/2021
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2251

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$32,037,000	\$32,037,000
- STATE FUNDS	\$11,892,500	\$11,892,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	8.33 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$29,368,300	\$32,037,000
STATE FUNDS	\$10,901,860	\$11,892,500
FEDERAL FUNDS	\$18,466,460	\$20,144,500

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

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:

There is no change from the prior estimate for FY 2022-23.

There is no change in the current estimate, from FY 2022-23 to FY 2023-24.

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.
3. Total estimated costs for RPM, on cash basis, is \$32,037,000 TF (\$11,892,000 GF) for FY 2021-22 and FY 2022-23.

REMOTE PATIENT MONITORING
REGULAR POLICY CHANGE NUMBER: 30

Funding:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF XIX
50% Title XIX / 50% GF (4260-101-0001/0890)	\$21,722	\$10,861	\$10,861
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$10,315	\$1,031	\$9,284
Total	\$32,037	\$11,892	\$20,145

(Dollars in Thousands)

FY 2023-24	TF	GF	FF XIX
50% Title XIX / 50% GF (4260-101-0001/0890)	\$21,722	\$10,861	\$10,861
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$10,315	\$1,031	\$9,284
Total	\$32,037	\$11,892	\$20,145

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

COMMUNITY HEALTH WORKER

REGULAR POLICY CHANGE NUMBER: 31
IMPLEMENTATION DATE: 2/2022
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2269

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$23,869,000	\$59,211,000
- STATE FUNDS	\$9,410,350	\$25,410,650
PAYMENT LAG	0.9775	1.0000
% REFLECTED IN BASE	1.29 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$23,031,000	\$59,211,000
STATE FUNDS	\$9,079,960	\$25,410,650
FEDERAL FUNDS	\$13,951,010	\$33,800,350

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:

Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

Not Applicable

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. The Department also proposed to add violence prevention services (VPS) as part of the CHW state plan amendment (SPA). These services would be available under both the FFS and managed care delivery system.

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).

COMMUNITY HEALTH WORKER

REGULAR POLICY CHANGE NUMBER: 31

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 2022-23, is a net increase due to the following:

- Decreased caseload projections for FFS, and
- Increased updated annual cost estimates for managed care.

The change in the current estimate, from FY 2022-23 to FY 2023-24, is due to increased ramp up projections for FY 2023-24, for both FFS and managed care.

Methodology:

1. CHWs began providing Medi-Cal benefits and services beginning July 1, 2022 for both FFS and managed care.
2. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through March 31, 2023 in this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
3. Total estimated costs for CHWs, on a cash basis, is as follows:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF	FFCRA
Fee-for-Service	\$3,710,000	\$1,548,000	\$2,007,000	\$155,000
Managed Care	\$20,159,000	\$7,862,000	\$11,757,000	\$540,000
Total	\$23,869,000	\$9,410,000	\$13,764,000	\$695,000

FY 2023-24	TF	GF	FF	FFCRA
Fee-for-Service	\$8,519,000	\$3,909,000	\$4,610,000	\$0
Managed Care	\$50,692,000	\$21,502,000	\$29,190,000	\$0
Total	\$59,211,000	\$25,411,000	\$33,800,000	\$0

COMMUNITY HEALTH WORKER
REGULAR POLICY CHANGE NUMBER: 31

Funding:

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$18,638,000	\$9,319,000	\$9,319,000
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$4,182,000	\$418,000	\$3,764,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$1,049,000	\$367,000	\$682,000
FFCRA 4.34% GF (4260-113-0001)	(\$668,000)	(\$668,000)	\$0
FFCRA 4.34% FF (4260-113-0890)	\$668,000	\$0	\$668,000
FFCRA 6.2% GF (4260-101-0001)	(\$26,000)	(\$26,000)	\$0
FFCRA 6.2% FF (4260-101-0890)	\$26,000	\$0	\$26,000
Total	\$23,869,000	\$9,410,000	\$14,459,000

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$47,162,000	\$23,581,000	\$23,581,000
65% Title XXI FF / 35% GF (4260-101-0001/0890)	\$9,550,000	\$955,000	\$8,595,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$2,499,000	\$875,000	\$1,624,000
Total	\$59,211,000	\$25,411,000	\$33,800,000

CALAIM - ORGAN TRANSPLANT

REGULAR POLICY CHANGE NUMBER: 32
IMPLEMENTATION DATE: 1/2022
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2199

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$9,430,000	\$13,665,000
- STATE FUNDS	\$3,534,600	\$4,515,900
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$9,430,000	\$13,665,000
STATE FUNDS	\$3,534,600	\$4,515,900
FEDERAL FUNDS	\$5,895,400	\$9,149,100

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
Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

Not Applicable

Background:

Currently in the Medi-Cal managed care program, organ transplants are a full benefit in County Operated Health Systems (COHS) counties. Non-COHS counties currently only cover kidney and corneal transplants.

Effective January 1, 2022, all organ transplant benefits were standardized and carved into MCP covered benefits statewide for all Medi-Cal managed care members. This will continue to reduce complexity and ensure continuity of care without burdening beneficiaries transitioning from one delivery system to another.

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 2022-23, is a decrease due to updated payment lag for FFS.

CALAIM - ORGAN TRANSPLANT

REGULAR POLICY CHANGE NUMBER: 32

The change in the current estimate, from FY 2022-23 to FY 2023-24, is due to FY 2023-24 including a bigger payment lag and higher cost projections for organ transplants.

Methodology:

1. Effective January 1, 2022, all organ transplants for managed care beneficiaries in non-COHS, were carved into MCPs.
2. On an ongoing basis, the net annual impact of the shift from FFS to managed care is expected to be budget neutral. Net accrual impacts for FY 2022-23 and FY 2023-23 are:

ACCRUAL – FY 2022-23	TF	GF	Title XIX	Title XXI
CalAIM - Organ Transplant Fee-for-Service	(\$292,098,000)	(\$92,429,000)	(\$197,995,000)	(\$1,674,000)
CalAIM - Organ Transplant Managed Care	\$292,098,000	\$92,429,000	\$197,995,000	\$1,674,000
Total	\$0	\$0	\$0	\$0

ACCRUAL – FY 2023-24	TF	GF	Title XIX	Title XXI
CalAIM - Organ Transplant Fee-for-Service	(\$321,308,000)	(\$103,839,000)	(\$215,288,000)	(\$2,181,000)
CalAIM - Organ Transplant Managed Care	\$321,308,000	\$103,839,000	\$215,288,000	\$2,181,000
Total	\$0	\$0	\$0	\$0

3. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through March 31, 2023. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
4. The net fiscal impact for FY 2022-23 and FY 2023-24 is estimated due to the timing of the changes in the FFS and managed care payments.

FY 2022-23 (Lagged)	TF	GF	Title XIX	Title XXI
CalAIM - Organ Transplant Fee-for-Service	(\$239,070,000)	(\$72,594,000)	(\$164,801,000)	(\$1,675,000)
CalAIM - Organ Transplant Managed Care	\$248,500,000	\$76,128,000	\$170,634,000	\$1,738,000
Total	\$9,430,000	\$3,534,000	\$5,833,000	\$63,000

FY 2023-24 (Lagged)	TF	GF	Title XIX	Title XXI
CalAIM - Organ Transplant Fee-for-Service	(\$290,604,000)	(\$96,039,000)	(\$192,626,000)	(\$1,939,000)
CalAIM - Organ Transplant Managed Care	\$304,269,000	\$100,555,000	\$201,683,000	\$2,031,000
Total	\$13,665,000	\$4,516,000	\$9,057,000	\$92,000

CALAIM - ORGAN TRANSPLANT
REGULAR POLICY CHANGE NUMBER: 32

Funding:

FY 2022-23 (Lagged)	TF	GF	FFP
50% Title XIX / 50% GF (4260-101-0001/0890)	\$5,374,000	\$2,687,000	\$2,687,000
65% Title XXI / 35% GF (4260-113-0001/0890)	\$96,000	\$33,000	\$63,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$3,960,000	\$396,000	\$3,564,000
FFCRA 6.2% Increased FFP (4260-101-0001/0890)	\$0	\$418,000	(\$418,000)
Total	\$9,430,000	\$3,534,000	\$5,896,000

FY 2023-24 (Lagged)	TF	GF	FFP
50% Title XIX / 50% GF (4260-101-0001/0890)	\$7,786,000	\$3,893,000	\$3,893,000
65% Title XXI / 35% GF (4260-101-0001/0890)	\$140,000	\$49,000	\$91,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$5,739,000	\$574,000	\$5,165,000
Total	\$13,665,000	\$4,516,000	\$9,149,000

FPACT HPV VACCINE COVERAGE

REGULAR POLICY CHANGE NUMBER: 33
IMPLEMENTATION DATE: 7/2022
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 2311

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$8,040,000	\$8,040,000
- STATE FUNDS	\$4,580,500	\$4,580,500
PAYMENT LAG	0.8710	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$7,002,800	\$8,040,000
STATE FUNDS	\$3,989,620	\$4,580,500
FEDERAL FUNDS	\$3,013,220	\$3,459,500

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. Effective July 1, 2022, the Department expanded the Family PACT program to include the HPV vaccine as a covered benefit for females and males, ages 19 through 45. This policy increases access to the HPV vaccine, which prevents genital tract, oropharyngeal cancers, and pre-cancers.

Reason for Change:

There is no change from the prior estimate for FY 2022-23, or in the current estimate for FY 2022-23 to FY 2023-24.

Methodology:

- Implementation began on July 1, 2022.
- 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 Years	TF	GF	FF
FY 2022-23	\$8,040	\$4,581	\$3,459
FY 2023-24	\$8,040	\$4,581	\$3,459

FPACT HPV VACCINE COVERAGE
REGULAR POLICY CHANGE NUMBER: 33

Funding:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890/0001)	\$6,919	\$3,459	\$3,460
100% GF (4260-101-0001)	\$1,122	\$1,122	\$0
Total	\$8,040	\$4,581	\$3,459

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890/0001)	\$6,919	\$3,459	\$3,460
100% GF (4260-101-0001)	\$1,122	\$1,122	\$0
Total	\$8,040	\$4,581	\$3,459

CCS DEMONSTRATION PROJECT

REGULAR POLICY CHANGE NUMBER: 34
IMPLEMENTATION DATE: 4/2013
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1775

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$5,473,000	\$2,430,000
- STATE FUNDS	\$2,535,700	\$1,168,050
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$5,473,000	\$2,430,000
STATE FUNDS	\$2,535,700	\$1,168,050
FEDERAL FUNDS	\$2,937,300	\$1,261,950

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

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. 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 ended on December 31, 2021.

CCS DEMONSTRATION PROJECT

REGULAR POLICY CHANGE NUMBER: 34

Reason for Change:

The change for FY 2022-23, from the prior estimate, is an increase due to a shift in payment timing for both the FY 2018-19 risk corridor and the final capitation payment for December 2021. An additional payment was added resulting from the Bridge Period risk corridor.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to the sunset of the RCHSD demonstration project and completion of the FY 2018-19 and Bridge Period risk corridors, whereas FY 2023-24 is only budgeting the estimated impact of the CY 2021 risk corridor. Funding levels have been updated with more recent payment data.

Methodology:

1. The RCHSD demonstration project implemented in July 2018.
2. Assume the final month (December 2021) capitation payment will occur in FY 2022-23.
3. 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 \$1,024,000 in FY 2022-23.
4. The Bridge Period (July 2019 – December 2020) risk corridor data was collected in April 2022. Final risk corridor calculations for Bridge Period are expected to result in a payment of \$3,368,000 in FY 2022-23.
5. CY 2021 risk corridor calculations for CY 2021 are estimated to result in a payment of \$2,430,000 in FY 2023-24.
6. Total estimated costs for FY 2022-22 and FY 2023-24 on a cash basis are:

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$4,717,000	\$2,358,500	\$2,358,500
88% Title XXI / 12%GF (4260-113-0001/0890)	\$222,000	\$27,000	\$195,000
76.5% Title XXI / 23.5%GF (4260-113-0001/0890)	\$316,000	\$74,000	\$242,000
65% Title XXI / 35%GF (4260-113-0001/0890)	\$218,000	\$76,000	\$142,000
Total	\$5,473,000	\$2,535,500	\$2,937,500

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$2,117,000	\$1,058,500	\$1,058,500
65% Title XXI / 35%GF (4260-101-0001/0890)	\$313,000	\$110,000	\$203,000
Total	\$2,430,000	\$1,168,500	\$1,261,500

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
 88% Title XXI / 12% GF (4260-113-0001/0890)
 76.5% Title XXI / 23.5%GF (4260-113-0001/0890)
 65% Title XXI / 35% GF (4260-113-0001/0890)
 65% Title XXI / 35% GF (4260-101-0001/0890)
 COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

MEDICAL INTERPRETERS PILOT PROJECT

REGULAR POLICY CHANGE NUMBER: 35
IMPLEMENTATION DATE: 2/2022
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 1989

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$3,347,000	\$1,466,000
- STATE FUNDS	\$3,347,000	\$1,466,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,347,000	\$1,466,000
STATE FUNDS	\$3,347,000	\$1,466,000
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. 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 in FY 2022-23, from the prior estimate, is an increase due to the delay in the pilot project launch and the slower than anticipated usage of interpretation services in FY 2021-22.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to less contractor payments in FY 2023-24 due to the program fund ending June 30, 2024.

Methodology:

1. Assume the Medical Interpreters Pilot Project will be effective October 1, 2021.
2. Assume a delay in the pilot project launch in FY 2021-22, resulting in a rollover of funds to FY 2022-23. The remaining dollars of the \$5,000,000 budget will be used in FY 2023-24.
3. A one-time \$60,000 GF start-up cost for pilot site contractors was paid in February 2022.

MEDICAL INTERPRETERS PILOT PROJECT
REGULAR POLICY CHANGE NUMBER: 35

4. The Budget Act for FY 2019-20 provided \$5 million GF, available for expenditure through June 30, 2024. The table below displays the estimated spending and remaining funds by Appropriation Year:

	TF	GF
Appropriation Year 2019-20		
Prior Years	\$187,000	\$187,000
Estimated in FY 2022-23	\$3,347,000	\$3,347,000
Estimated in FY 2023-24	\$1,466,000	\$1,466,000
Total Estimated Remaining	\$0	\$0

5. Total estimated reimbursement for FY 2022-23 and FY 2023-24 are as follows:

FY 2022-23	TF	GF
Appropriation Year 2019-20	\$3,347,000	\$3,347,000
Total FY 2022-23	\$3,347,000	\$3,347,000

FY 2023-24	TF	GF
Appropriation Year 2019-20	\$1,466,000	\$1,466,000
Total FY 2023-24	\$1,466,000	\$1,466,000

6. Total estimated reimbursement for FY 2022-23 and FY 2023-24, on a cash basis, are:

FY 2022-23	TF	GF
Pilot Site Contractors	\$2,890,000	\$2,890,000
Pilot Project Evaluator	\$406,000	\$406,000
Pilot Site Contractor Compensation	\$51,000	\$51,000
Total	\$3,347,000	\$3,347,000

FY 2023-24	TF	GF
Pilot Site Contractors	\$897,000	\$897,000
Pilot Project Evaluator	\$492,000	\$492,000
Pilot Site Contractor Compensation	\$77,000	\$77,000
Total	\$1,466,000	\$1,466,000

Funding:

100% General Fund (4260-101-0001)

MEDICALLY TAILORED MEALS PILOT PROGRAM

REGULAR POLICY CHANGE NUMBER: 36
IMPLEMENTATION DATE: 7/2022
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2046

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$2,737,000	\$0
- STATE FUNDS	\$2,737,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,737,000	\$0
STATE FUNDS	\$2,737,000	\$0
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), its evaluation, and the Short Term Medically Tailored Meals Intervention Services Program.

Authority:

Welfare & Institutions Code 14042.1
 AB 80 (Chapter 12, Statutes of 2020)
 AB 133 (Chapter 143, Statutes of 2021)
 AB 178 (Chapter 45, Statutes of 2022)

Interdependent Policy Changes:

Not Applicable

Background:

The Department will identify eligible Medi-Cal participants and providers to participate in a four-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 of \$9,300,000 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.

MEDICALLY TAILORED MEALS PILOT PROGRAM

REGULAR POLICY CHANGE NUMBER: 36

The one-time budget allocation also adds Fresno, Kings, Madera, Santa Cruz, and Tulare counties to the Pilot program service area.

AB 178 included a no-cost extension of the expenditure period of the Medically Tailored Meals Short-term Intervention program. The Department projects that the remainder of the FY 2021-22 budget allocation will be fully expended in FY 2022-23.

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

Reason for Change:

The change from the prior estimate, for FY 2022-23, is an increase due to expenditures shifting from FY 2021-22 to FY 2022-23. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to the Pilot ending in FY 2022-23.

Methodology:

1. The Pilot began in April 2018.
2. Assume the cost for **FY 2022-23** is **\$2,737,000 TF**.

Funding:

100% GF (4260-101-0001)

DOULA BENEFIT

REGULAR POLICY CHANGE NUMBER: 37
IMPLEMENTATION DATE: 1/2023
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2279

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$1,344,000	\$4,033,000
- STATE FUNDS	\$521,000	\$1,563,900
PAYMENT LAG	0.7250	0.9003
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$974,400	\$3,630,900
STATE FUNDS	\$377,720	\$1,407,980
FEDERAL FUNDS	\$596,680	\$2,222,930

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:

COVID-19 Increased FMAP – DHCS

Background:

The Department will be adding doula services to the list of preventive services effective January 1, 2023. 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:

There is no change from the prior estimate for FY 2022-23.

DOULA BENEFIT

REGULAR POLICY CHANGE NUMBER: 37

The change in the current estimate, from FY 2022-23 to FY 2023-24, is an increase due to FY 2023-24 including a full year's cost and an increased phased-in utilization.

Methodology:

1. Assume the doula benefit will be implemented effective January 1, 2023 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 \$1,094.00. Assume the annual cost for doula benefit is \$10,753,000.
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	\$1,344,000	\$521,000	\$823,000
FY 2023-24	\$4,033,000	\$1,564,000	\$2,469,000

Funding:

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$954,000	\$477,000	\$477,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$370,000	\$37,000	\$333,000
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$20,000	\$7,000	\$13,000
Total	\$1,344,000	\$521,000	\$823,000

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$2,864,000	\$1,432,000	\$1,432,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$1,109,000	\$111,000	\$998,000
65% Title XXI FF / 35% GF (4260-101-0001/0890)	\$60,000	\$21,000	\$39,000
Total	\$4,033,000	\$1,564,000	\$2,469,000

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

EXPANSION TO SCREENING FOR ADDITIONAL SUBSTANCES

REGULAR POLICY CHANGE NUMBER: 38
 IMPLEMENTATION DATE: 6/2021
 ANALYST: Joel Singh
 FISCAL REFERENCE NUMBER: 2158

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$1,035,000	\$1,035,000
- STATE FUNDS	\$385,100	\$385,100
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	8.33 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$948,800	\$1,035,000
STATE FUNDS	\$353,020	\$385,100
FEDERAL FUNDS	\$595,760	\$649,900

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

Background:

The Department currently screens Medi-Cal beneficiaries for alcohol misuse per the United States Preventive Services Task Force (USPSTF) recommendation. The Department is adding screening for additional substances (i.e., drug use and abuse) as a Medi-Cal benefit for beneficiaries over age 21. Medi-Cal children, ages 0-21 years old, are screened for alcohol and drug use under the American Academy of Pediatrics (AAP) Bright Futures Health tobacco, alcohol, and drug use assessments.

Effective June 9, 2020, the USPSTF assigned a “B” rating to “Unhealthy Drug Use Screening” for adults ages 18 and older, making it a mandatory benefit under the Preventive Services component (Item 13(c)) of the Department’s approved Medicaid State Plan. Adding this benefit will identify, reduce, and prevent problematic use, abuse, and dependence on drugs.

Managed care costs for the screenings are included in base capitation rates, and currently budgeted in the following policy changes: County Organized Health Systems, Two Plan Model, Regional Model, and Geographic Managed Care.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a decrease due to a lower than projected Fee-for-Service (FFS) caseload.

There is no change in the current estimate from FY 2022-23 to FY 2023-24.

EXPANSION TO SCREENING FOR ADDITIONAL SUBSTANCES

REGULAR POLICY CHANGE NUMBER: 38

Methodology:

1. Expansion to screening for additional substances, effective June 9, 2020, was implemented on June 16, 2021.
2. Total estimated payments for the screenings are:

Additional Substances Screening	TF	GF	FF
FY 2022-23	\$1,035,000	\$385,000	\$650,000
FY 2023-24	\$1,035,000	\$385,000	\$650,000

Funding:

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$704,000	\$352,000	\$352,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$331,000	\$33,000	\$298,000
Total	\$1,035,000	\$385,000	\$650,000

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$704,000	\$352,000	\$352,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$331,000	\$33,000	\$298,000
Total	\$1,035,000	\$385,000	\$650,000

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

DIABETES PREVENTION PROGRAM

REGULAR POLICY CHANGE NUMBER: 39
IMPLEMENTATION DATE: 1/2022
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2056

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$825,000	\$1,000,000
- STATE FUNDS	\$305,400	\$370,100
PAYMENT LAG	0.9211	0.9991
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$759,900	\$999,100
STATE FUNDS	\$281,300	\$369,770
FEDERAL FUNDS	\$478,600	\$629,330

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

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: 39

- 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 2022-23, is a decrease due to a lower estimated FFS caseload.

The change in the current estimate, from FY 2022-23 to FY 2023-24, is due to FY 2023-24 including fully phased-in beneficiary participation for Core Sessions, Core Maintenance Sessions, and Ongoing Maintenance Sessions.

Methodology:

1. DPP payments began on January 1, 2022.
2. Total annual cost for the Core Sessions is estimated to be \$648,000 TF.

Core Sessions – Attendance:	\$453,000 TF
Core Sessions – Performance:	\$195,000 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 \$230,000 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 \$122,000 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: 39

8. Total estimated payments are:

DPP	Annual Cost	FY 2022-23	FY 2023-24
Core Sessions - Attendance	\$453,000	\$453,000	\$453,000
Core Sessions - Performance	\$195,000	\$154,000	\$195,000
Core Maintenance	\$230,000	\$182,000	\$230,000
Ongoing Maintenance	\$122,000	\$36,000	\$122,000
Total	\$1,000,000	\$825,000	\$1,000,000

Funding:

FY 2022-23	TF	GF	FFP
50% Title XIX / 50% GF (4260-101-0001/0890)	\$556,000	\$278,000	\$278,000
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)	\$267,000	\$26,000	\$241,000
Total	\$825,000	\$305,000	\$520,000

FY 2023-24	TF	GF	FFP
50% Title XIX / 50% GF (4260-101-0001/0890)	\$674,000	\$337,000	\$337,000
65% Title XXI FF / 35% GF (4260-101-0001/0890)	\$2,000	\$1,000	\$1,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$324,000	\$32,000	\$292,000
Total	\$1,000,000	\$370,000	\$630,000

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

ROUTINE COSTS FOR CLINICAL TRIALS

REGULAR POLICY CHANGE NUMBER: 40
IMPLEMENTATION DATE: 7/2022
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2361

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$688,000	\$737,000
- STATE FUNDS	\$267,850	\$287,400
PAYMENT LAG	0.8710	1.0000
% REFLECTED IN BASE	8.33 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$549,300	\$737,000
STATE FUNDS	\$213,860	\$287,400
FEDERAL FUNDS	\$335,470	\$449,600

Purpose:

This policy change estimates the costs for routine patient care costs associated with participation in all qualifying clinical trials.

Authority:

The Consolidated Appropriations Act of 2021, Public Law 116-260
 Social Security Act, Section 1905(a)(30)
 Welfare and Institutions Code (WIC) 14132.98

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS

Background:

Pursuant to WIC section 14132.98, Medi-Cal currently covers routine patient care costs for beneficiaries participating in clinical trials for cancer treatment only.

In December 2020, Congress passed The Consolidated Appropriations Act of 2021 and amended section 1905(a)(30) of the Social Security Act to require state Medicaid programs to cover routine patient care costs, including travel, as authorized by the state plan and waivers, associated with all qualifying clinical trials.

Medi-Cal currently covers costs related to cancer-only clinical trials. Based on new federal requirements, Medi-Cal coverage will be expanded to cover the costs related to all qualifying clinical trials. The Centers for Medicare and Medicaid Services issued a State Medicaid Directors letter on December 7, 2021, requiring states to cover routine patient costs starting January 1, 2022. A state could qualify for an exception to the effective date if the state needed to enact legislation to implement this requirement. The Department requested an exception on December 30, 2021, based upon the need to amend WIC section 14132.98 to align coverage with the requirements of SSA section 1905(a)(30) to cover routine patient care costs, including travel, for a wider range of clinical trials.

Expanded coverage for routine patient care costs associated with participation in all qualifying clinical trials began July 1, 2022. Managed care costs are included in base capitation rates, and

ROUTINE COSTS FOR CLINICAL TRIALS

REGULAR POLICY CHANGE NUMBER: 40

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 2022-23, is a decrease due to removing managed care costs because routine costs for clinical trials are now included in the managed care base capitation rates.

The change in the current estimate, from FY 2022-23 to FY 2023-24, is an increase due to a higher projected caseload for FY 2023-24.

Methodology:

- Coverage for patient care associated with participation in all qualifying clinical trials began July 1, 2022.
- Total estimated costs, on a cash basis, is \$688,000 TF (\$268,000 GF) for FY 2022-23, and \$737,000 TF (\$287,000 GF) for FY 2023-24.

Funding:

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$492,000	\$246,000	\$246,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$187,000	\$19,000	\$168,000
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$9,000	\$3,000	\$6,000
Total	\$688,000	\$268,000	\$420,000

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$528,000	\$264,000	\$264,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$199,000	\$20,000	\$179,000
65% Title XXI FF / 35% GF (4260-101-0001/0890)	\$10,000	\$3,000	\$7,000
Total	\$737,000	\$287,000	\$450,000

COVID-19 funding is identified in the COVID-19 Increased FMAP - DCHS policy change

HEARING AID COVERAGE FOR CHILDREN PROGRAM

REGULAR POLICY CHANGE NUMBER: 41
IMPLEMENTATION DATE: 12/2021
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2189

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$526,000	\$1,650,000
- STATE FUNDS	\$526,000	\$1,650,000
PAYMENT LAG	0.8770	0.9162
% REFLECTED IN BASE	0.29 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$460,000	\$1,511,700
STATE FUNDS	\$459,960	\$1,511,730
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the cost of providing hearing aids and associated services to children ages 20 and under, who are otherwise not eligible for Medi-Cal, do not have health insurance coverage for hearing aids and related services or have qualifying partial other health coverage for hearing aids, and are at or below 600% Federal Poverty Level (FPL).

Authority:

Budget Act of 2020
AB 179 (Chapter 249, Statutes of 2022)

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% of the federal poverty level, effective July 1, 2021. This benefit is available to children with no health insurance or whose existing health insurance does not cover hearing aids and related services. Valid hearing aid prescription from an otolaryngologist or physician, or referral from an audiologist, otolaryngologist, or physician will be required for program enrollment. This program is funded with 100% General Fund (GF).

Without this benefit, eligible children are at a 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.

HEARING AID COVERAGE FOR CHILDREN PROGRAM

REGULAR POLICY CHANGE NUMBER: 41

Effective January 1, 2023, the eligibility criteria of Hearing Aid Coverage for Children Program (HACCP) has been revised and updated to:

- Expanding the age range of eligible children through 20 years of age, and
- Expanding coverage to children with qualifying partial other health coverage for hearing aids.

Reason for Change:

The change in FY 2022-23, from the prior estimate, is due to amended ramp-up projections to incorporate ages 18-20.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to the continuation of enrollment ramp-up in FY 2023-24.

Methodology:

1. The hearing aid coverage began on July 1, 2021. Payments began in December 2021.
2. Annual costs are estimated to be \$526,000 in FY 2022-23 and \$1,650,000 in FY 2023-24.
3. FY 2022-23 and FY 2023-24 payments for hearing aids to the non-Medi-Cal children are estimated to be:

Hearing Aid Coverage for Children Program	TF	GF
FY 2022-23	\$526,000	\$526,000
FY 2023-24	\$1,650,000	\$1,650,000

Funding:

100% GF (4260-101-0001)

CCT FUND TRANSFER TO CDSS

REGULAR POLICY CHANGE NUMBER: 42
IMPLEMENTATION DATE: 10/2011
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1562

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$380,000	\$278,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$380,000	\$278,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$380,000	\$278,000

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
 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. 108-361), Section 204

Interdependent Policy Changes:

Families First Coronavirus Response Act (FFCRA)

Background:

The CCT demonstration is authorized under Section 6071 of the Federal DRA of 2005 and was extended by the ACA.

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.

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

CCT FUND TRANSFER TO CDSS

REGULAR POLICY CHANGE NUMBER: 42

the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated.

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 2022-23, is an increase due to an estimated higher transitions into CCT and the additional nine months of FFCRA captured in FY 2022-23. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a total decrease due to FFCRA enhanced funding ending March 2023.

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 18.3% of all enrollees utilize IHSS under CCT. Assume each case costs \$10,877 in FY 2022-23 and FY 2023-24. 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 March 31, 2023, for this policy change.
5. Assume 480 beneficiaries will transition in FY 2022-23 and 558 in FY 2023-24.
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 \$32,884,000 TF, minus unobligated funding from 2021 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 2022-23 and FY 2023-24.

CCT FUND TRANSFER TO CDSS
REGULAR POLICY CHANGE NUMBER: 42

FY 2022-23	TF	GF	FF
CCT Costs (PC 28):			
GF costs and Total FFP	\$18,613,000	\$4,514,000	\$14,099,000
State-Funded CCT Population	\$13,000	\$10,000	\$3,000
ALW Transition Costs	\$28,397,000	\$5,739,000	\$22,657,000
FFCRA 3.1% Increased FFP	\$0	(\$1,093,000)	\$1,093,000
Total Costs	\$47,022,000	\$9,169,000	\$37,853,000
CCT Savings:			
Total GF savings and Total FFP	(\$22,497,000)	(\$11,248,000)	(\$11,248,000)
CCT Fund Transfer to CDSS (PC 42):			
CCT Fund Transfer Costs	\$239,000	\$0	\$239,000
FFCRA 3.1% Increased FFP	\$141,000	\$0	\$141,000
Total Costs	\$380,000	\$0	\$380,000
CCT Outreach - Admin costs (OA 49)	\$340,000	\$0	\$340,000
Total of CCT PCs including pass through	\$25,245,000	(\$2,079,000)	\$27,325,000

*The savings are included in the total, however, they are fully reflected in the base estimates.

FY 2023-24	TF	GF	FF
CCT Costs (PC 28):			
GF costs and Total FFP	\$28,014,000	\$6,794,000	\$21,220,000
State-Funded CCT Population	\$21,000	\$16,000	\$5,000
ALW Transition Costs	\$38,041,000	\$7,688,000	\$30,353,000
Total Cost	\$66,077,000	\$14,498,000	\$51,579,000
CCT Savings:			
Total GF savings and Total FFP	(\$26,149,000)	(\$13,075,000)	(\$13,075,000)
CCT Fund Transfer to CDSS (PC 42):	\$278,000	\$0	\$278,000
CCT Outreach - Admin costs (OA 49)	\$340,000	\$0	\$340,000
Total of CCT PCs including pass through	\$40,546,000	\$1,423,000	\$39,122,000

*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: 42

Funding:

MFP Federal Grant (4260-106-0890)

FFCRA 3.1% Increased FFP (4260-106-0890)

ANNUAL COGNITIVE ASSESSMENTS

REGULAR POLICY CHANGE NUMBER: 43
IMPLEMENTATION DATE: 8/2022
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2345

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$87,000	\$136,000
- STATE FUNDS	\$84,500	\$132,500
PAYMENT LAG	0.8330	0.9445
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$72,500	\$128,500
STATE FUNDS	\$70,390	\$125,150
FEDERAL FUNDS	\$2,080	\$3,310

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:

COVID-19 Increased FMAP – DHCS

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:

The change from the prior estimate, for FY 2022-23, is due to updated funding assumptions to account for the beneficiaries with unsatisfactory immigration status (UIS).

The change in the current estimate, from FY 2022-23 to FY 2023-24, is due to a ramp up from the first year of implementation.

Methodology:

1. The benefit was implemented effective July 1, 2022.
2. Payments will begin August 2022.
3. Total estimated costs for the annual cognitive health assessments, on cash basis, is \$87,000 TF (\$85,000 GF) for FY 2022-23 and \$136,000 TF (\$133,000 GF) for FY 2023-24.
4. Assume 95% of those eligible for annual cognitive health assessment under Medi-Cal are not eligible for federal funding and the assessment would be funded by State General Fund. Individuals without Medicare would most likely have state-only coverage.

ANNUAL COGNITIVE ASSESSMENTS

REGULAR POLICY CHANGE NUMBER: 43

Funding:

FY 2022-23	TF	GF	FF
100% General Fund (4260-101-0001)	\$82,000	\$82,000	\$0
50% Title XIX / 50% GF (4260-101-0001/0890)	\$5,000	\$3,000	\$2,000
Total	\$87,000	\$85,000	\$2,000

FY 2023-24	TF	GF	FF
100% General Fund (4260-101-0001)	\$129,000	\$129,000	\$0
50% Title XIX / 50% GF (4260-101-0001/0890)	\$7,000	\$4,000	\$3,000
Total	\$136,000	\$133,000	\$3,000

COVID-19 funding is identified in the COVID-19 Increased FMAP - DCHS policy change

CONTINUOUS GLUCOSE MONITORING SYSTEMS BENEFIT

REGULAR POLICY CHANGE NUMBER: 44
IMPLEMENTATION DATE: 1/2022
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2174

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$10,207,000	\$14,997,000
- STATE FUNDS	\$3,799,900	\$5,583,300
PAYMENT LAG	0.9735	1.0000
% REFLECTED IN BASE	8.33 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$9,108,800	\$14,997,000
STATE FUNDS	\$3,391,060	\$5,583,300
FEDERAL FUNDS	\$5,717,740	\$9,413,700

Purpose:

This policy change estimates the cost of adding continuous glucose monitors (CGMs) as a Medi-Cal benefit for beneficiaries with Type 1 diabetes meeting specific criteria.

Authority:

SB 184 (Chapter 47, Statutes of 2022)

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS

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. Using a CGM replaces the use of standard blood glucose meter (SBGM) and can help to improve surveillance of glucose levels by giving feedback throughout the day. 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 better glucose control and fewer complications and hospitalizations occur when the patient uses a CGM.

CONTINUOUS GLUCOSE MONITORING SYSTEMS BENEFIT

REGULAR POLICY CHANGE NUMBER: 44

Effective January 1, 2022, the Department added CGMs as a covered Medi-Cal benefit for beneficiaries ages 21 and older with Type I diabetes, meeting specific criteria, and with authorization controls in place to demonstrate medical necessity. This is a pharmacy benefit through Medi-Cal Rx for ease of program administration for both providers and the Department. The Department has entered into rebate agreements with various manufacturers for the CGM components. The rebate savings agreements also apply to beneficiaries under 21 who are already eligible for CGM under Medi-Cal and the CCS State-Only programs.

The Department is proposing Trailer Bill Language to amend the definition of medical supplies reimbursement methodology to be inclusive of diabetic supplies, thus allowing the Department to implement a revised reimbursement methodology for CGMs from the current estimated acquisition cost, plus the pharmacy professional dispensing fee, to a Maximum Acquisition Cost (MAC) plus 23%, effective July 1, 2022. Diabetic supplies, with the exception of CGMs, remain subject to the 10 percent AB 97 payment reduction.

Reason for Change:

There is no change in FY 2022-23, from the prior estimate.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase in FY 2023-24 as a result of a quarter lag in rebate collection.

Methodology:

1. CGM became a Medi-Cal benefit for ages 21 and over beginning January 1, 2022.
2. The first rebates were for claims paid in the January through March 2022 quarter and received in the April through June 2022 quarter.
3. Medi-Cal beneficiaries receiving a CGM benefit will have two additional physician visits every year.
4. 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 \$300 per beneficiary will be realized when beneficiaries transition from SMBG, to CGMs for their disease management.
5. Effective July 1, 2022, the reimbursement will change to MAC plus a 23% markup.
6. There is a one-quarter lag for medical supply rebate collections under the current manual process. Rebates for claims paid during April – June 2023 will have a two-quarter lag with the shift to the Medi-Cal Rx rebate system.
7. Total net cost on an accrual basis, for CGM benefit is estimated to be \$10,207,000 TF for FY 2022-23 and \$14,997,000 TF for FY 2023-24.

CONTINUOUS GLUCOSE MONITORING SYSTEMS BENEFIT
REGULAR POLICY CHANGE NUMBER: 44

8. The total estimated payments in FY 2022-23 and FY 2023-24, on a cash basis are:

CGM System	FY 2022-23	FY 2023-24
Office Visits, Accessories and Supplies	\$26,347,000	\$26,347,000
SMBG to CGM Transition Savings	(\$2,180,000)	(\$2,180,000)
Rebate Savings	(\$19,160,000)	(\$14,370,000)
MAC plus 23% Markup	\$5,200,000	\$5,200,000
Total Fund	\$10,207,000	\$14,997,000

Funding:

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$6,948,000	\$3,474,000	\$3,474,000
90% Title XIX ACA / 10% GF (4260-101-0001/0890)	\$3,259,000	\$326,000	\$2,933,000
Total	\$10,207,000	\$3,800,000	\$6,407,000

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$10,209,000	\$5,104,000	\$5,105,000
90% Title XIX ACA / 10% GF (4260-101-0001/0890)	\$4,788,000	\$479,000	\$4,309,000
Total	\$14,997,000	\$5,583,000	\$9,414,000

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

MEDICATION THERAPY MANAGEMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 45
IMPLEMENTATION DATE: 7/2022
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2263

	FY 2022-23	FY 2023-24
FULL YEAR COST - TOTAL FUNDS	\$5,418,000	\$24,179,000
- STATE FUNDS	\$1,829,000	\$8,162,550
PAYMENT LAG	0.9480	0.9597
% REFLECTED IN BASE	1.79 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$5,044,300	\$23,204,600
STATE FUNDS	\$1,702,860	\$7,833,600
FEDERAL FUNDS	\$3,341,470	\$15,370,990

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

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.

MEDICATION THERAPY MANAGEMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 45

The Department has implemented a separate specific reimbursement methodology for FFS pharmacy services provided in conjunction with certain complex chronic medical conditions 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 were formerly not reimbursable in Medi-Cal. To participate in this program, Medi-Cal enrolled pharmacies are 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 has adopted 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 2022-23, from the prior estimate, is due to slower uptake than previously estimated.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to anticipated growth in the program.

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, the Department estimates 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 \$40.5 million TF (\$14.2 million GF):

	TF	GF	FF
Annual Costs	\$40,500,000	\$13,672,000	\$26,828,000

5. Assume claims will begin July 1, 2022 due to the need for claim system edits, provider contracts to be in place, and the pharmacies to build their program.

MEDICATION THERAPY MANAGEMENT PROGRAM
REGULAR POLICY CHANGE NUMBER: 45

6. Assume the uptake of the benefit will be slow based on historical uptake of similar pharmacist provided services, provider contracting, provider training in MTM provision, and pharmacy based accommodations for providing private MTM sessions with clients. Estimate three years to achieve the full estimated pharmacy participation.
7. The FY 2022-23 FFS costs, before payment lags, are estimated to be:

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF	\$3,043,000	\$1,522,000	\$1,521,000
90% Title XIX / 10% GF	\$2,095,000	\$209,000	\$1,886,000
65% Title XXI / 35%	\$280,000	\$98,000	\$182,000
Total	\$5,418,000	\$1,829,000	\$3,589,000

8. The FY 2023-24 FFS costs, before payment lags, are estimated to be:

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF	\$13,581,000	\$6,790,000	\$6,791,000
90% Title XIX / 10% GF	\$9,349,000	\$935,000	\$8,414,000
65% Title XXI / 35%	\$1,249,000	\$437,000	\$812,000
Total	\$24,179,000	\$8,162,000	\$16,017,000

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)

65% Title XXI / 35% GF (4260-101-0001/0890)

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

MEDI-CAL DRUG REBATE FUND

REGULAR POLICY CHANGE NUMBER: 46
IMPLEMENTATION DATE: 11/2019
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 2124

	<u>FY 2022-23</u>	<u>FY 2023-24</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:

Not Applicable

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. For information on the Medi-Cal Drug Rebate Fund impacts from Medi-Cal Rx, see the Medi-Cal Rx – Additional Supplemental Rebates policy change.

MEDI-CAL DRUG REBATE FUND

REGULAR POLICY CHANGE NUMBER: 46

Reason for Change:

The change in FY 2022-23, from the prior estimate, is a decrease in the GF transfer due to:

- The actual fund balance remaining at the end of FY 2021-22 was lower than estimated, and
- FFCRA increased FMAP funding is estimated to continue for an additional three quarters.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease in the GF transfer due to:

- Estimating there will be no fund balance remaining at the end of FY 2022-23 to be transferred to the GF in FY 2023-24, and
- Estimating a reserve of \$222 million be kept in the fund at the end of FY 2023-24.

Methodology:

1. In FY 2022-23, it is estimated that \$1.75 billion will be transferred from the Medi-Cal Drug Rebate Fund to the GF and \$1.52 billion will be transferred from the Medi-Cal Drug Rebate Fund to the GF in FY 2023-24.
2. A balance of \$235.98 million was in the Medi-Cal Drug Rebate Fund as of July 2022. The estimated reserve to be kept in the Medi-Cal Drug Rebate Fund for FY 2022-23 and FY 2023-24 is \$0 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 March 31, 2023, for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.

MEDI-CAL DRUG REBATE FUND
REGULAR POLICY CHANGE NUMBER: 46

4. The summary of the non-federal share and federal share of the estimated FY 2022-23 and FY 2023-24 rebates and the estimated reserve for each respective fiscal year are:

(Dollars in Thousands)

FY 2022-23 Summary of Drug Rebates	TF	Fund 3331	FF
Federal Drug Rebates	(\$4,772,621)	(\$1,489,490)	(\$3,283,131)
State Supplemental Drug Rebates	(\$80,478)	(\$20,374)	(\$60,104)
Family PACT Drug Rebates	(\$5,696)	(\$706)	(\$4,990)
BCCTP Drug Rebates	(\$6,303)	(\$1,815)	(\$4,488)
Subtotal Rebates	(\$4,865,098)	(\$1,512,385)	(\$3,352,713)
FY 2021-22 Fund Balance		(\$235,982)	
Medi-Cal Drug Rebate Fund Transfer		(\$1,748,367)	

(Dollars in Thousands)

FY 2023-24 Summary of Drug Rebates	TF	Fund 3331	FF
Federal Drug Rebates	(\$5,007,491)	(\$1,715,910)	(\$3,291,581)
State Supplemental Drug Rebates	(\$88,700)	(\$24,260)	(\$64,440)
Family PACT Drug Rebates	(\$8,641)	(\$1,098)	(\$7,543)
BCCTP Drug Rebates	(\$6,112)	(\$1,942)	(\$4,170)
Subtotal Rebates	(\$5,110,944)	(\$1,743,210)	(\$3,367,734)
Estimated FY 2023-24 Reserve		\$222,000	
Medi-Cal Drug Rebate Fund Transfer		(\$1,521,210)	

5. The estimated transfers from the Medi-Cal Drug Rebate Fund to GF are:

(Dollars in Thousands)

FY 2022-23	TF	GF	SF
Drug Rebates Transfer	\$0	(\$1,748,367)	\$1,748,367

(Dollars in Thousands)

FY 2023-24	TF	GF	SF
Drug Rebates Transfer	\$0	(\$1,521,210)	\$1,521,210

MEDI-CAL DRUG REBATE FUND
REGULAR POLICY CHANGE NUMBER: 46

Funding:

(Dollars in Thousands)

FY 2022-23	TF	GF	SF
Medi-Cal Drug Rebate Fund (4260-601-3331)	\$1,748,367	\$0	\$1,748,367
100% GF (4260-101-0001)	(\$1,884,892)	(\$1,884,892.09)	\$0
FFCRA 6.2% GF (4260-101-0001)	\$127,515	\$127,515	\$0
FFCRA 4.34% GF (4260-113-0001)	\$8,822	\$8,822	\$0
FFCRA 4.34% GF (4260-101-0001)	\$188	\$188	\$0
Total	(\$0)	(\$1,748,367)	\$1,748,367

(Dollars in Thousands)

FY 2023-24	TF	GF	SF
Medi-Cal Drug Rebate Fund (4260-601-3331)	\$1,521,210	\$0	\$1,521,210
100% GF (4260-101-0001)	(\$1,521,210)	(\$1,521,210)	\$0
Total	\$0	(\$1,521,210)	\$1,521,210

LITIGATION SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 47
IMPLEMENTATION DATE: 8/2009
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 1449

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	-\$1,741,000	\$0
- STATE FUNDS	-\$1,741,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$1,741,000	\$0
STATE FUNDS	-\$1,741,000	\$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 2022-23, is an increase due to additional settlement payments the Department expects to receive. The change from FY 2022-23 to FY 2023-24, 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: 47**Methodology:**

The following settlements are expected to be received in FY 2022-23:

Settlement Name	FY 2022-23
Progenity Inc.	(\$8,000)
Merit Medical Systems, Inc.	(\$42,000)
Cardinal Health	(\$62,000)
Prism Enterprises Inc. (d/b/a Prism Behavioral Solutions)	(\$183,000)
Mallinckrodt Pharmaceuticals (first installment)	(\$392,000)
Clinicas del Camino Real	(\$538,000)
Dignity Health	(\$516,000)
Total GF Savings	(\$1,741,000)

Funding:

100% GF (4260-101-0001)

BCCTP DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 48
IMPLEMENTATION DATE: 1/2010
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1433

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	-\$4,488,000	-\$4,170,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$4,488,000	-\$4,170,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	-\$4,488,000	-\$4,170,000

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

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: 48

Reason for Change:

The change from the prior estimate, for FY 2022-23, is an increase in rebate savings due to:

- Including two additional quarters of actual rebate collection data through the quarter ending June 2022, and
- An increase in estimated BCCTP pharmacy expenditures for the applicable expenditure period.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease in rebate savings due to a decrease in estimated BCCTP pharmacy expenditures from FY 2022-23 to FY 2023-24.

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 March 31, 2023, for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
4. The estimated rebates to collect are \$6,303,000 in FY 2022-23 and \$6,112,000 in FY 2023-24.
5. Assume, of the total BCCTP rebates collected, the ACA offset for BCCTP is \$581,000 TF in FY 2022-23 and \$563,000 TF in FY 2023-24.
6. The Department estimates \$1,815,000 and \$1,942,000 BCCTP drug rebates to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2022-23 and FY 2023-24, respectively.

(Dollars in Thousands)

FY 2022-23	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	(\$3,719)	(\$3,719)	(\$2,003)
ACA Offset	(\$581)	(\$581)	\$0
FFCRA 4.34% Increased FFP	(\$188)	(\$188)	\$188
Total	(\$4,488)	(\$4,488)	(\$1,815)

(Dollars in Thousands)

FY 2023-24	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	(\$3,607)	(\$3,607)	(\$1,942)
ACA Offset	(\$563)	(\$563)	\$0
Total	(\$4,170)	(\$4,170)	(\$1,942)

*The Fund 3331 Transfer column is for informational purposes only. See Methodology #6.

BCCTP DRUG REBATES
REGULAR POLICY CHANGE NUMBER: 48

Funding:

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

FFCRA 4.34% Increased FFP (4260-101-0890)

FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 49
IMPLEMENTATION DATE: 12/1999
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 51

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	-\$4,990,000	-\$7,543,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$4,990,000	-\$7,543,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	-\$4,990,000	-\$7,543,000

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

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 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

FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 49

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 2022-23, is a decrease in rebate savings due to:

- Including two additional quarters of actual rebate collection data through the quarter ending June 2022 and,
- Decreased estimated FPACT pharmacy expenditures for the applicable expenditure period.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase in rebate savings due to an estimated increase in FPACT pharmacy expenditures from FY 2022-23 to FY 2023-24.

Methodology:

1. The regular Federal Medical Assistance Percentage (FMAP) percentage is applied to 7.96% of the FPACT 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 FPACT rebates.
2. The 6.2% Title XIX FFCRA increased FMAP is assumed for drug rebates through March 31, 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
3. Assume the ACA offset is \$206,000 TF for FY 2022-23 and \$312,000 TF for FY 2023-24.
4. Actual data from July 2013 to June 2022 is used to project rebates.
5. The Department estimates \$706,000 and \$1,098,000 FPACT rebate collections to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2022-23 and FY 2023-24, respectively.

(Dollars in Thousands)

FY 2022-23	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	(\$4,767)	(\$4,767)	(\$723)
FFCRA 6.2% Increased FFP	(\$206)	(\$206)	\$0
ACA Offset	(\$17)	(\$17)	\$17
Total	(\$4,990)	(\$4,990)	(\$706)

(Dollars in Thousands)

FY 2023-24	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	(\$7,231)	(\$7,231)	(\$1,098)
ACA Offset	(\$312)	(\$312)	\$0
Total	(\$7,543)	(\$7,543)	(\$1,098)

*The Fund 3331 Transfer column is for informational purposes only. See Methodology #5.

FAMILY PACT DRUG REBATES
REGULAR POLICY CHANGE NUMBER: 49

Funding:

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

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

PHARMACY RETROACTIVE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 50
IMPLEMENTATION DATE: 1/2023
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2194

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	-\$69,924,000	-\$10,934,000
- STATE FUNDS	\$51,570,050	-\$10,934,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$69,924,000	-\$10,934,000
STATE FUNDS	\$51,570,050	-\$10,934,000
FEDERAL FUNDS	-\$121,494,050	\$0

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 will resume in FY 2022-23.

Authority:

CMS Final Rule (CMS-2345-FC), 42 CFR Part 447
 State Plan Amendment (SPA) #17-002
 Budget Act of 2022

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' 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. This 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.

PHARMACY RETROACTIVE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 50

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, 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). All 139 providers are independent pharmacy providers. 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 an 8-month period.

The Department was scheduled to resume retroactive pharmacy claim adjustments in February 2021. However, due to factors related to ongoing litigation at the time, the Department continued the pause. 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 APA. The recoupments for the retroactive adjustments are assumed to resume in January 2023.

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 providers' federal portion of any recoupments will be due once their claims have been reprocessed.

The Budget Act of 2022 cancels the retroactive recoupments for independent pharmacy providers.

Reason for Change:

The change in FY 2022-23, from the prior estimate, is due to a change in implementation date for the chain pharmacy retroactive adjustments from September 1, 2022 to January 2023.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to FY 2023-24 containing the balance of the recoupments.

Methodology:

1. Assume the retroactive recoupments for independent pharmacy providers will not be collected, and the General Fund will be used to repay CMS the federal funds amount of the cancelled pharmacy recoupments.
2. For budgeting purposes, assume the retroactive adjustments for chain pharmacy providers and the federal repayment for independent pharmacies will resume January 2023 and will be completed over 8 months.
3. Assume the remaining payments to independent and chain pharmacies will occur in FY 2022-23.

PHARMACY RETROACTIVE ADJUSTMENTS
REGULAR POLICY CHANGE NUMBER: 50

4. On a cash basis, the net impact in FY 2022-23 is estimated to be:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Federal repayment	\$0	\$69,582	(\$69,582)
Remaining payments	\$49,010	\$17,547	\$31,463
Pharmacy recoupments	(\$118,934)	(\$35,559)	(\$83,375)
Total	(\$69,924)	\$51,570	(\$121,494)

5. On a cash basis, the net impact in FY 2023-24 is estimated to be:

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Pharmacy recoupments	(\$10,934)	(\$10,934)	\$0
Total	(\$10,934)	(\$10,934)	\$0

PHARMACY RETROACTIVE ADJUSTMENTS
REGULAR POLICY CHANGE NUMBER: 50

Funding:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-002/0890)	\$30,068	\$15,034	\$15,034
90% Title XIX/ 10% GF (4260-101-0001/0890)	\$16,468	\$1,647	\$14,821
65% Title XXI / 35% GF (4260-113-0001/0890)	\$2,475	\$866	\$1,609
100% Title XXI GF (4260-113-001)	\$1,718	\$1,718	\$0
100% Title XXI FFP (4260-113-0890)	(\$7,724)	\$0	(\$7,724)
100% Title XIX GF (4260-101-0001)	\$32,305	\$32,305	\$0
100% Title XIX FFP (4260-101-0890)	(\$145,234)	\$0	(\$145,234)
Total	(\$69,924)	\$51,570	(\$121,494)

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
100% Title XXI GF (4260-101-001)	(\$552)	(\$552)	\$0
100% Title XIX GF (4260-101-0001)	(\$10,382)	(\$10,382)	\$0
Total	(\$10,934)	(\$10,934)	\$0

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 51
IMPLEMENTATION DATE: 1/1991
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 54

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	-\$60,104,000	-\$64,440,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$60,104,000	-\$64,440,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	-\$60,104,000	-\$64,440,000

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

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: 51

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a decrease in rebate savings due to:

- Including two additional quarters of actual rebate collection data through the quarter ending June 2022, and
- Estimating a decrease in pharmacy expenditures for the applicable expenditure period.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase in rebate savings due to an estimated increase in pharmacy expenditures from FY 2022-23 to FY 2023-24.

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 March 31, 2023, for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
4. CHIP rebates are funded at 88% FF/ 12% GF through September 30, 2019, 76.5% FF/ 23.5% GF beginning October 1, 2019, and 65% FF / 35% GF beginning October 1, 2020. Assume CHIP drug rebates collections are \$3,603,000 FF and \$3,737,000 FF in FY 2022-23 and FY 2023-24, respectively.
5. The optional expansion ACA population collections are estimated to be \$43,545,000 TF for FY 2022-23, of which \$39,191,000 FF is budgeted in this policy change. The amount of \$4,354,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund. For FY 2023-24, the ACA collections are estimated to be \$47,994,000 TF, of which \$43,195,000 FF is budgeted in this policy change. The amount of \$4,799,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund.

STATE SUPPLEMENTAL DRUG REBATES
REGULAR POLICY CHANGE NUMBER: 51

6. The Department estimates to transfer \$20,374,000 and \$24,260,000 state supplemental rebates to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2022-23 and FY 2023-24, respectively.

FY 2022-23	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	(\$15,721,000)	(\$15,721,000)	(\$17,609,000)
FFCRA 6.2% Increased FFP	(\$1,408,000)	(\$1,408,000)	\$1,408,000
100% Title XIX ACA	(\$39,191,000)	(\$39,191,000)	(\$4,354,000)
100% Title XXI FF	(\$3,603,000)	(\$3,603,000)	\$0
FFCRA 4.34% Increased FFP	(\$181,000)	(\$181,000)	\$181,000
Total	(\$60,104,000)	(\$60,104,000)	(\$20,374,000)

FY 2023-24	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	(\$17,508,000)	(\$17,508,000)	(\$19,461,000)
100% Title XIX ACA	(\$43,195,000)	(\$43,195,000)	(\$4,799,000)
100% Title XXI FF	(\$3,737,000)	(\$3,737,000)	\$0
Total	(\$64,440,000)	(\$64,440,000)	(\$24,260,000)

*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)

FFCRA 4.34% Increased FFP (4260-101-0890)

MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER: 52
IMPLEMENTATION DATE: 10/2006
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1181

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	-\$118,668,000	-\$89,001,000
- STATE FUNDS	-\$59,334,000	-\$44,500,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$118,668,000	-\$89,001,000
STATE FUNDS	-\$59,334,000	-\$44,500,500
FEDERAL FUNDS	-\$59,334,000	-\$44,500,500

Purpose:

This policy change estimates the revenues from the medical supply rebates collected by the Department through contracts with medical supply manufacturers.

Authority:

Welfare & Institutions Code 14100.95(a) and 14105.47(c)(1)

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS

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 medical supply rebate contract time periods are:

- Diabetic test strips, lancets, self-monitoring blood glucose (SMBG) monitors, control solution for SMBG monitors, and lancing devices: Contracts ended December 31, 2021, and new contracts are effective for January 1, 2022, to December 31, 2024.
- Pen needles: Contracts are effective January 1, 2021, through December 31, 2023.
- Disposable insulin delivery systems (DiDD) (Omnipods and V-Go): Contracts are effective January 1, 2022 to December 31, 2024.

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) transitioned 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

MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER: 52

operations. It is estimated that the takeover for rebate operations will begin with claims invoiced for the FY 2022-23 Q4 time period.

Reason for Change:

The change in FY 2022-23, from the prior estimate, is an increase in savings due to the addition of rebate collections for DiDD.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease in savings due to a one-time shift in the timing of rebate collections as a result of switching from a manual system to an automated system causing only three quarters of rebates to be collected in FY 2023-24.

Methodology:

1. Assume the average FFS quarterly collections are for medical supply rebates are \$29,667,000.
2. Assume additional rebates for DiDD begin with claims paid on or after 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 paid on or after 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 April – June 2023 quarter. These rebates will be collected in FY 2023-24 Q2, resulting in three quarters of rebates collected in FY 2023-24.
6. Assume the total rebates collected are \$118,668,000 in FY 2022-23 and \$89,001,000 in FY 2023-24.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2022-23	(\$118,668)	(\$59,334)	(\$59,334)
FY 2023-24	(\$89,001)	(\$44,500)	(\$44,501)

Funding:

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

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

MEDI-CAL RX- ADDITIONAL SUPPLEMENTAL REBATES

REGULAR POLICY CHANGE NUMBER: 53
IMPLEMENTATION DATE: 7/2022
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2249

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	-\$199,228,000	-\$666,855,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$199,228,000	-\$666,855,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	-\$199,228,000	-\$666,855,000

Purpose:

This policy change (PC) 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
Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

Not Applicable

Background:

On January 7, 2019, the Governor issued Executive Order N-01-19, which required the Department to transition Medi-Cal pharmacy services from MC to FFS. With this change, Medi-Cal pharmacy benefits will be provided and managed through Medi-Cal Rx. On 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 to develop conflict avoidance protocols to protect the Medi-Cal claims data and other proprietary information. The Medi-Cal Rx Assumption of Operations (AOO) began 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.

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 General Fund (GF).

MEDI-CAL RX- ADDITIONAL SUPPLEMENTAL REBATES

REGULAR POLICY CHANGE NUMBER: 53

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

This 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- Additional Supplemental Rebates
- Medical Supply Rebates
- Non-Hospital 340B Clinic Supplemental Payments

Other Admin

- Medi-Cal Rx – Administrative Costs

Reason for Change:

The change in FY 2022-23, from the prior estimate, is due to:

- Decreased estimated savings based on updated rebate collection assumptions,
- Update to the funding to reflect transfers from the Medi-Cal Drug Rebate Fund to the GF, and
- Including increased FMAP through March 31, 2023 in this policy change.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to increased estimated savings based on rebate collection assumptions in FY 2023-24 and no FFCRA increased FMAP is assumed in FY 2023-24.

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 impact of the 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through March 31, 2023, for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.

MEDI-CAL RX- ADDITIONAL SUPPLEMENTAL REBATES
REGULAR POLICY CHANGE NUMBER: 53

4. The estimated savings is \$290,579,000 TF in FY 2022-23 and \$999,469,000 TF in FY 2023-24.

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Additional Supplemental Rebates-MC Carve-Out	(\$290,579)	(\$91,350)	(\$199,228)
Additional Supplemental Rebates- Existing FFS	\$0	\$0	\$0
Total	(\$290,579)	(\$91,350)	(\$199,228)

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Additional Supplemental Rebates-MC Carve-Out	(\$875,096)	(\$299,961)	(\$575,135)
Additional Supplemental Rebates- Existing FFS	(\$124,373)	(\$32,653)	(\$91,720)
Total	(\$999,469)	(\$332,614)	(\$666,855)

5. The estimated transfers from the Medi-Cal Drug Rebate Fund to GF are:

(Dollars in Thousands)

FY 2022-23	TF	GF	Medi-Cal Drug Rebate Fund	FF
Drug Rebates Transfer	\$0	(\$91,350)	\$91,350	\$0
Rebate Federal Funds	(\$199,228)	\$0	\$0	(\$199,228)
Total	(\$199,228)	(\$91,350)	\$91,350	(\$199,228)

(Dollars in Thousands)

FY 2023-24	TF	GF	Medi-Cal Drug Rebate Fund	FF
Drug Rebates Transfer	\$0	(\$332,614)	\$332,614	\$0
Rebate Federal Funds	(\$666,855)	\$0	\$0	(\$666,855)
Total	(\$666,855)	(\$332,614)	\$332,614	(\$666,855)

MEDI-CAL RX- ADDITIONAL SUPPLEMENTAL REBATES
REGULAR POLICY CHANGE NUMBER: 53

Funding:

(Dollars in Thousands)

FY 2022-23	TF	GF	SF	FF
Medi-Cal Drug Rebate Fund (4260-601-3331)	\$91,350	\$0	\$91,350	\$0
100% GF (4260-101-0001)	(\$99,603)	(\$99,603)	\$0	\$0
100% Title XIX FFP (4260-101-0890)	(\$181,324)	\$0	\$0	(\$181,324)
100% Title XXI FFP (4260-113-0890)	(\$9,652)	\$0	\$0	(\$9,652)
FFCRA 6.2% Increase FMAP	\$0	\$7,769	\$0	(\$7,769)
FFCRA 4.34% Increase FMAP	\$1	\$484	\$0	(\$483)
Total	(\$199,228)	(\$91,350)	\$91,350	(\$199,228)

(Dollars in Thousands)

FY 2023-24	TF	GF	SF	FF
Medi-Cal Drug Rebate Fund (4260-601-3331)	\$332,614	\$0	\$332,614	\$0
100% GF (4260-101-0001)	(\$332,614)	(\$332,614)	\$0	\$0
100% Title XIX FFP (4260-101-0890)	(\$633,100)	\$0	\$0	(\$633,100)
100% Title XXI FFP (4260-101-0890)	(\$33,755)	\$0	\$0	(\$33,755)
Total	(\$666,855)	(\$332,614)	\$332,614	(\$666,855)

FEDERAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 54
IMPLEMENTATION DATE: 7/1990
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 55

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	-\$3,283,131,000	-\$3,291,581,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$3,283,131,000	-\$3,291,581,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	-\$3,283,131,000	-\$3,291,581,000

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

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 transitioned 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: 54

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 2022-23, is an increase in rebate savings due to:

- Including two additional quarters of actual rebate collection data through the quarter ending June 30, 2022,
- An increase in estimated MC eligibles data used to project the estimated MC rebate collections,
- A decrease in estimated pharmacy expenditures for the applicable expenditure period, and,
- Estimating three additional quarters of FFCRA increased FMAP in this policy change.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase in rebate savings due to:

- Estimating an increase in pharmacy expenditures from FY 2022-23 to FY 2023-24, and
- Estimating an increase in MC eligibles data from FY 2022-23 to FY 2023-24.

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 March 31, 2023. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS 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.

FEDERAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 54

Assume CHIP drug rebate collections are \$171,789,000 FF and \$178,175,000 FF in FY 2022-23 and FY 2023-24, respectively.

7. The optional expansion ACA population collections are estimated to be \$1,476,220,000 TF for FY 2022-23, of which \$1,328,598,000 FF is budgeted in this policy change. The amount of \$147,622,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund. For FY 2023-24, a total of \$1,521,754,000 TF is estimated for the optional expansion population, of which \$1,369,579,000 FF is budgeted in this policy change. The amount of \$152,175,000 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 \$259,256,000 TF for FY 2022-23 and \$271,094,000 TF for FY 2023-24.
9. The Department estimates \$1,489,490,000 and \$1,715,910,000 federal drug rebates to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2022-23 and FY 2023-24, respectively.

(Dollars in Thousands)

FY 2022-23	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	(\$1,388,757)	(\$1,388,757)	(\$1,476,599)
FFCRA 6.2% Increased FFP	(\$126,090)	(\$126,090)	\$126,090
100% Title XIX ACA FF	(\$1,328,598)	(\$1,328,598)	(\$147,622)
100% Title XXI FF	(\$171,789)	(\$171,789)	\$0
FFCRA 4.34% Increased FFP	(\$8,641)	(\$8,641)	\$8,641
ACA Offset	(\$259,256)	(\$259,256)	\$0
Total	(\$3,283,131)	(\$3,283,131)	(\$1,489,490)

FY 2023-24	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	(\$1,472,733)	(\$1,472,733)	(\$1,563,735)
100% Title XIX ACA FF	(\$1,369,579)	(\$1,369,579)	(\$152,175)
100% Title XXI FF	(\$178,175)	(\$178,175)	\$0
ACA Offset	(\$271,094)	(\$271,094)	\$0
Total	(\$3,291,581)	(\$3,291,581)	(\$1,715,910)

*The Fund 3331 Transfer column is for informational purposes only. See Methodology #7.

FEDERAL DRUG REBATES
REGULAR POLICY CHANGE NUMBER: 54

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)

FFCRA 4.34% Increased FFP (4260-101-0890)

HCBS SP - CONTINGENCY MANAGEMENT

REGULAR POLICY CHANGE NUMBER: 56
IMPLEMENTATION DATE: 5/2022
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2278

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$9,846,000	\$27,958,000
- STATE FUNDS	\$4,440,000	\$6,448,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$9,846,000	\$27,958,000
STATE FUNDS	\$4,440,000	\$6,448,000
FEDERAL FUNDS	\$5,406,000	\$21,510,000

Purpose:

This policy change estimates the cost of adding Contingency Management as an optional evidence-based Medi-Cal benefit under the Drug Medi-Cal Organized Delivery System (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
 Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

Not Applicable

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 (HCBS ARP) 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 Centers for Medicare and Medicaid Services (CMS) approved the addition of contingency management as an optional benefit in DMC-ODS counties as part of the 1115 Demonstration Waiver renewal, as a pilot, beginning July 1, 2022 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

HCBS SP - CONTINGENCY MANAGEMENT

REGULAR POLICY CHANGE NUMBER: 56

disorder. Contingency management was approved in the 2021 Budget Act, funded from the HCBS ARP Fund.

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 2022-23, is a net decrease due to the following:

- Services start date was delayed from July 2022 to November 2022 with phased-in county implementation.
- Addition of the FFCRA funding through June 30, 2023.

The change in the current estimate, from FY 2022-23 to FY 2023-24, is due to the following:

- Start-up funding is assumed for FY 2022-23, and
- FY 2023-24 including fully phased-in services for counties through March 2024.

Methodology:

1. Contingency management was added as an optional service to the DMC-ODS Waiver effective January 1, 2022, and the services will begin effective November 1, 2022. The 9-month interim will be used to build the program and provide training.
2. Prior to implementation of the benefit, \$3,535,000 in initial start-up funding was provided to counties in FY 2021-22 and distributed through the Behavioral Health Quality Improvement Program (BH-QIP). An additional \$3 million in start-up funding will be distributed in FY 2022-23.
3. Once the benefit is implemented, FY 2022-23 will include the following costs:
 - Incentive costs for patients averaging \$300 per year (up to a maximum of \$599)
 - Contingency management coordinator services costs
4. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2023 for this policy change.
5. Total estimated costs for contingency management, on a cash basis, is as follows:

FY 2022-23	TF	HCBS ARP Fund	FF	FFCRA
Initial Start-up Cost via BH-QIP	\$3,000,000	\$3,000,000	\$0	\$0
CM Incentive Costs	\$2,455,000	\$516,000	\$1,889,000	\$50,000
CM Services Costs	\$4,391,000	\$924,000	\$3,378,000	\$89,000
Total	\$9,846,000	\$4,440,000	\$5,267,000	\$139,000

HCBS SP - CONTINGENCY MANAGEMENT
REGULAR POLICY CHANGE NUMBER: 56

FY 2023-24	TF	HCBS ARP Fund	FF	FFCRA
CM Incentive Costs	\$9,322,000	\$2,150,000	\$7,172,000	\$0
CM Services Costs	\$18,636,000	\$4,298,000	\$14,338,000	\$0
Total	\$27,958,000	\$6,448,000	\$21,510,000	\$0

Funding:

100% Title XIX (4260-101-0890)

100% Title XXI (4260-113-0890)

100% Title XXI (4260-101-0890)

100% ACA Title XIX FF (4260-101-0890)

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

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

Home and Community-Based Services American Rescue Plan Fund (4260-101-8507)

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 58
IMPLEMENTATION DATE: 7/2021
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1724

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$632,000	\$1,145,000
- STATE FUNDS	\$45,500	\$153,900
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$632,000	\$1,145,000
STATE FUNDS	\$45,500	\$153,900
FEDERAL FUNDS	\$586,500	\$991,100

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:

Not Applicable

Background:

The DMC program currently covers the following Substance Use Disorder (SUD) services under the State Plan: Outpatient Drug-Free Treatment Services (ODF), Intensive Outpatient Treatment Services (IOT), Residential Treatment Services (RTS) for pregnant and postpartum women, and the Narcotic Treatment Program (NTP).

Annually, the Department adjusts the DMC rates based on the cumulative growth in the Implicit Price (CIP) Deflator for the Costs of Goods and Services to Governmental Agencies reported by the Department of Finance. The proposed DMC rates are based either on the developed rates using annual cost report settlement data, or the FY 2009-10 Budget Act rates adjusted for the CIP deflator, whichever is lower.

The following DMC rates are adjusted each year:

- NTP Dosing – Regular and Perinatal
- NTP Individual Counseling – Regular and Perinatal
- NTP Group Counseling – Regular and Perinatal
- IOT – Regular and Perinatal
- 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: 58

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 2022-23, is due to an increase in the incremental rates from FY 2021-22 to FY 2022-23.

The change in the current estimate, from FY 2022-23 to FY 2023-24, is due to FY 2023-24 reflecting changes for FY 2022-23 and FY 2023-24 rates.

Methodology:

1. The FY 2021-22 developed rates, FY 2022-23 developed rates, and FY 2023-24 estimated rates for regular and perinatal services are:

Regular Services	FY 2021-22 Developed Rates	FY 2022-23 Developed Rates	FY 2023-24 Estimated Rates
NTP Methadone	\$14.65	\$16.20	\$16.83
NTP Individual Counseling	\$17.18	\$19.01	\$19.75
NTP Group Counseling	\$4.06	\$4.49	\$4.67
Intensive Outpatient Treatment	\$78.88	\$87.24	\$90.64
Residential Treatment - EPSDT	\$109.77	\$128.47	\$150.31
ODF Individual Counseling	\$85.96	\$95.07	\$98.78
ODF Group Counseling	\$36.52	\$40.40	\$41.98

Perinatal Services	FY 2021-22 Developed Rates	FY 2022-23 Developed Rates	FY 2023-24 Estimated Rates
NTP Methadone	\$15.78	\$17.45	\$18.13
NTP Individual Counseling	\$24.60	\$27.21	\$28.27
NTP Group Counseling	\$8.22	\$9.09	\$9.44
Intensive Outpatient Treatment	\$94.37	\$104.37	\$108.44
Residential Treatment Services	\$109.77	\$128.47	\$150.31
ODF Individual Counseling	\$123.04	\$136.08	\$141.39
ODF Group Counseling	\$73.98	\$81.82	\$85.01

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 58

2. The incremental rate changes for FY 2022-23 and FY 2023-24 are shown below:

Incremental Difference	FY 2022-23 Regular	FY 2022-23 Perinatal	FY 2023-24 Regular	FY 2023-24 Perinatal
NTP Methadone	\$1.55	\$1.67	\$0.63	\$0.68
NTP Individual Counseling	\$1.83	\$2.61	\$0.74	\$1.06
NTP Group Counseling	\$0.43	\$0.87	\$0.18	\$0.35
Intensive Outpatient Treatment	\$8.36	\$10.00	\$3.40	\$4.07
Residential Treatment Services	\$18.70	\$18.70	\$21.84	\$21.84
ODF Individual Counseling	\$9.11	\$13.04	\$3.71	\$5.31
ODF Group Counseling	\$3.88	\$7.84	\$1.58	\$3.19

3. 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
NTP Methadone	375,344	\$1.55	\$582,000
NTP Individual Counseling	167,038	\$1.83	\$306,000
NTP Group Counseling	0	\$0.43	\$0
Intensive Outpatient Treatment	1,946	\$8.36	\$16,000
Residential Treatment - EPSDT	61	\$18.70	\$1,000
ODF Individual Counseling	8,250	\$9.11	\$75,000
ODF Group Counseling	21,775	\$3.88	\$84,000
Total for Regular Services			\$1,064,000

FY 2022-23 - Perinatal	Total Number of Units	Incremental Difference	Total Rate Adj. Cost
NTP Methadone	0	\$1.67	\$0
NTP Individual Counseling	2	\$2.61	\$0
NTP Group Counseling	0	\$0.87	\$0
Intensive Outpatient Treatment	140	\$10.00	\$1,000
Residential Treatment Services	0	\$18.70	\$0
ODF Individual Counseling	14	\$13.04	\$0
ODF Group Counseling	31	\$7.84	\$0
Total for Perinatal Services			\$1,000

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 58

4. The cost estimate for FY 2023-24, based on the incremental rate changes for FY 2022-23 and FY 2023-24 are:

FY 2023-24 - Regular	Total Number of Units	Incremental Difference	Total Rate Adj. Cost	FY 2023-24 Rate Adj.
NTP Methadone	375,344	\$0.63	\$236,000	\$818,000
NTP Individual Counseling	167,038	\$0.74	\$124,000	\$430,000
NTP Group Counseling	0	\$0.18	\$0	\$0
Intensive Outpatient Treatment	1,946	\$3.40	\$7,000	\$23,000
Residential Treatment - EPSDT	61	\$21.84	\$1,000	\$2,000
ODF Individual Counseling	8,250	\$3.71	\$31,000	\$106,000
ODF Group Counseling	21,775	\$1.58	\$34,000	\$118,000
Total for Regular Services			\$433,000	\$1,497,000

FY 2023-24 - Perinatal	Total Number of Units	Incremental Difference	Total Rate Adj. Cost	FY 2023-24 Rate Adj.
NTP Methadone	0	\$0.68	\$0	\$0
NTP Individual Counseling	2	\$1.06	\$0	\$0
NTP Group Counseling	0	\$0.35	\$0	\$0
Intensive Outpatient Treatment	140	\$4.07	\$1,000	\$2,000
Residential Treatment Services	0	\$21.84	\$0	\$0
ODF Individual Counseling	14	\$5.31	\$0	\$0
ODF Group Counseling	31	\$3.19	\$0	\$0
Total for Perinatal Services			\$1,000	\$2,000

5. Total estimated costs for the annual rate adjustments are:

Annual Rate Adj. Cost	FY 2022-23 Rates	FY 2023-24 Rates	FY 2022-23 (Lagged)	FY 2023-24 (Lagged)
NTP	\$888,000	\$1,248,000	\$666,000	\$1,158,000
ODF	\$159,000	\$224,000	\$119,000	\$208,000
IOT	\$17,000	\$25,000	\$13,000	\$23,000
RTS	\$1,000	\$2,000	\$1,000	\$2,000
Total	\$1,065,000	\$1,499,000	\$799,000	\$1,391,000

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 58

FY 2022-23	TF	GF	IGT*	FF	FFCRA	CF
Regular						
Current	\$374,000	\$3,000	\$0	\$187,000	\$17,000	\$167,000
ACA Optional	\$424,000	\$43,000	\$0	\$381,000	\$0	\$0
Perinatal						
Current	\$1,000	\$0	\$0	\$1,000	\$0	\$0
ACA Optional	\$0	\$0	\$0	\$0	\$0	\$0
Total	\$799,000	\$46,000	\$0	\$569,000	\$17,000	\$167,000

FY 2023-24	TF	GF	IGT*	FF	FFCRA	CF
Regular						
Current	\$651,000	\$5,000	\$75,000	\$326,000	\$0	\$245,000
ACA Optional	\$738,000	\$74,000	\$0	\$664,000	\$0	\$0
Perinatal						
Current	\$2,000	\$0	\$0	\$1,000	\$0	\$1,000
ACA Optional	\$0	\$0	\$0	\$0	\$0	\$0
Total	\$1,391,000	\$79,000	\$75,000	\$991,000	\$0	\$246,000

6. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through March 31, 2023, for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
7. Effective July 1, 2023, non-federal share of costs that was initially funded with county funds (CF), will be funded through an inter-governmental transfer (IGT).
8. 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)
 100% Title XXI FF (4260-101-0890)
 Medi-Cal County Behavioral Health Fund (4260-601-3420)*
 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)

DRUG MEDI-CAL PROGRAM COST SETTLEMENT

REGULAR POLICY CHANGE NUMBER: 59
IMPLEMENTATION DATE: 7/2021
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1723

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	-\$1,970,000	-\$954,000
- STATE FUNDS	-\$272,000	-\$254,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$1,970,000	-\$954,000
STATE FUNDS	-\$272,000	-\$254,000
FEDERAL FUNDS	-\$1,698,000	-\$700,000

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: 59

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 2022-23, is due to the following:

- Additional audit settlements for FY 2015-16 and FY 2016-17, and cost settlements for FY 2015-16, FY 2016-17 and FY 2017-18 are expected to be paid in FY 2022-23.
- A change in the timing for the processing of the cost and audit settlements have shifted and some prior year settlements are still to be paid in FY 2022-23.

The change in the current estimate, from FY 2022-23 to FY 2023-24, is a decrease due to less audit settlements and cost settlement recoupments occurring in FY 2023-24.

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.

DRUG MEDI-CAL PROGRAM COST SETTLEMENT

REGULAR POLICY CHANGE NUMBER: 59

3. The following estimated cost settlements and audit settlements for the annual cost reports will be recouped in FY 2022-23 and FY 2023-24:

FY 2022-23	TF	GF	Title XIX	Title XXI	CF
FY 2015-16 Audit Settlements	(\$860,000)	\$0	(\$385,000)	\$17,000	(\$492,000)
FY 2016-17 Audit Settlements	(\$372,000)	(\$10,000)	(\$194,000)	\$9,000	(\$177,000)
FY 2017-18 Audit Settlements	(\$935,000)	(\$10,000)	(\$473,000)	\$21,000	(\$473,000)
FY 2018-19 Audit Settlements	(\$492,000)	(\$5,000)	(\$249,000)	\$11,000	(\$249,000)
FY 2015-16 Cost Settlements	\$9,000	\$35,000	(\$27,000)	\$1,000	\$0
FY 2016-17 Cost Settlements	(\$33,000)	(\$39,000)	\$6,000	\$0	\$0
FY 2017-18 Cost Settlements	(\$499,000)	(\$174,000)	(\$341,000)	\$16,000	\$0
FY 2018-19 Cost Settlements	(\$179,000)	(\$69,000)	(\$116,000)	\$6,000	\$0
Total	(\$3,361,000)	(\$272,000)	(\$1,779,000)	\$81,000	(\$1,391,000)

FY 2023-24	TF	GF	Title XIX	Title XXI	CF
FY 2018-19 Audit Settlements	(\$443,000)	(\$5,000)	(\$224,000)	\$10,000	(\$224,000)
FY 2019-20 Audit Settlements	(\$198,000)	(\$2,000)	(\$100,000)	\$4,000	(\$100,000)
FY 2018-19 Cost Settlements	(\$229,000)	(\$89,000)	(\$148,000)	\$8,000	\$0
FY 2019-20 Cost Settlements	(\$408,000)	(\$158,000)	(\$264,000)	\$14,000	\$0
Total	(\$1,278,000)	(\$254,000)	(\$736,000)	\$36,000	(\$324,000)

Funding:

100% General Fund

100% Title XIX (4260-101-0890)

100% Title XXI (4260-113-0890)

100% Title XXI (4260-101-0890)

BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE

REGULAR POLICY CHANGE NUMBER: 60
IMPLEMENTATION DATE: 7/2022
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2262

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$1,339,697,000	\$0
- STATE FUNDS	\$1,121,197,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,339,697,000	\$0
STATE FUNDS	\$1,121,197,000	\$0
FEDERAL FUNDS	\$218,500,000	\$0

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)
 AB 179 (Chapter 249, Statutes of 2022)
 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: 60

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 BHCIP 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 for FY 2022-23 from the prior estimate is a net decrease due to including payments that were previously estimated for FY 2021-22 in FY 2022-23, and shifting FY 2022-23 amounts to be spent in later years.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to no estimated payments in FY 2023-24.

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. 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 \$1,339,697,000 TF will be paid in FY 2022-23. This includes \$438,147,000 GF from the amount appropriated for FY 2021-22 in the 2021 Budget Act, as well as an additional \$683,050,000 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 \$1,121,197,000 GF, \$480,500,000 is available to support the Children and Youth RFA, and \$480,000,000 for the Crisis and Behavioral Health Continuum RFA.

BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE

REGULAR POLICY CHANGE NUMBER: 60

- 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 2022-23	\$1,339,697	\$1,121,197	\$218,500

4. The table below displays the estimated spending and remaining funds by Appropriation Years:

(Dollars in Thousands)

	TF	GF	SFRF
Appropriation Year 2021-22			
Prior Years	\$305,352	\$5,352	\$300,000
Estimated in FY 2022-23	\$438,147	\$438,147	\$0
Total Estimated Remaining	\$0	\$0	\$0
Appropriation Year 2022-23			
Estimated in FY 2022-23	\$901,550	\$683,050	\$218,500
Estimated in FY 2023-24	\$0	\$0	\$0
Total Estimated Remaining	\$480,700	\$480,700	\$0

5. The estimated costs in FY 2022-23 is as follows:

(Dollars in Thousands)

FY 2022-23	TF	GF	SFRF
Appropriation Year 2021-22	\$438,147	\$438,147	\$0
Appropriation Year 2022-23	\$901,550	\$683,050	\$218,500
Total FY 2022-23	\$1,339,697	\$1,121,197	\$218,500

Funding:

General Fund (4260-101-0001)

State Fiscal Recovery Fund of 2021 (4260-162-8506)

CALAIM - BH QUALITY IMPROVEMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 63
IMPLEMENTATION DATE: 8/2021
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2187

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$45,396,000	\$19,456,000
- STATE FUNDS	\$45,396,000	\$19,456,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$45,396,000	\$19,456,000
STATE FUNDS	\$45,396,000	\$19,456,000
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 California Advancing and Innovating Medi-Cal (CalAIM) BH-QIP is an incentive payment program to support Mental Health Plans (MHP), Drug Medi-Cal State Plans (DMC) and Drug Medi-Cal Organized Delivery Systems (DMC-ODS) as they prepare for changes in the CalAIM initiative and other approved administration priorities. The three CalAIM BH-QIP goals are:

1. Payment Reform

- Implement new Current Procedural Technology/ Healthcare Common Procedure Coding System (CPT/HCPCS) procedure codes, modifiers, place of service codes, and taxonomy codes.
- Update county claiming systems to successfully submit 837 transactions to the Short-Doyle Medi-Cal (SD/MC) claiming system.
- Implement new Intergovernmental Transfer (IGT) agreement protocol.

2. Implementation of CalAIM Behavioral Health Policy Changes

- Implement standardized screening tools in compliance with DHCS guidance.
- Implement standardized transition of care tools in compliance with DHCS guidance.
- For DMC Only: Assist providers to implement American Society of Addiction Medicine (ASAM) criteria to determine level of care in compliance with DHCS guidance.
- Implement revised documentation standards, including but not limited to, assessment domains, problem lists, progress notes, and applicable timeliness standards.

CALAIM - BH QUALITY IMPROVEMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 63

- Provide guidance and training to county-operated and county-contracted providers on all new behavioral health policies, as outlined by DHCS in Behavioral Health Information Notices.

3. Data Exchange

- Promote bi-directional data exchange between MHP, DMC, DMC-ODS and Managed Care Plans (MCPs) in order to improve health outcomes and health equity through enhanced coordination of care.

Each participating county earns incentive payments in the CalAIM BHQIP by achieving certain milestones as outlined in the program's implementation plan and instructions. The Department anticipates incentive payments continuing into FY 2023-24.

Reason for Change:

There is no change for FY 2022-23 from the prior estimate.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to including estimated payment for FY 2023-24.

Methodology:

1. Assume all 57 counties apply for this funding (Sutter/Yuba operate jointly).
2. Start-up payments were made 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. Initial incentive payments to counties began in the third quarter of FY 2021-22.
4. Assume additional payments will be made based on counties achieving deliverable milestones in FY 2022-23 and FY 2023-24.
5. The estimated payments in FY 2022-23 and FY 2023-24 are:

(Dollars in Thousands)

Incentive Payments	TF	GF
FY 2022-23	\$45,396	\$45,396
FY 2023-24	19,456	19,456

Funding:

100% GF (4260-101-0001)

MHP COSTS FOR FFPSA

REGULAR POLICY CHANGE NUMBER: 64
IMPLEMENTATION DATE: 10/2021
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2252

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$43,134,000	\$52,259,000
- STATE FUNDS	\$12,498,000	\$22,547,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$43,134,000	\$52,259,000
STATE FUNDS	\$12,498,000	\$22,547,000
FEDERAL FUNDS	\$30,636,000	\$29,712,000

Purpose:

This policy change estimates the reimbursement to mental health plans (MHPs) for expenditures related to pre and post care of children and youth in Foster Care treated in Short-Term Residential Therapeutic 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, MHPs began providing six months of intensive aftercare treatment to children and youth in Foster Care for six months after being discharged from a STRTP to a family-based setting.

Authority:

Family First Prevention Services Act (Public Law 115-123)
 Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

Not Applicable

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 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 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 of the strengths and needs of the child, including reviewing past clinical and social service records, meeting with the child, youth and family completing a detailed Child and Adolescent Needs and Strengths (CANS) tool, and conducting a clinical assessment to determine if home-based placement and services are more appropriate than residential care and if not, that the placement in a STRTP provides the most effective and appropriate level of care setting in the

MHP COSTS FOR FFPSA

REGULAR POLICY CHANGE NUMBER: 64

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 engage 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) to provide recommendations for more appropriate services. 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 foster 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 Wraparound (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 needs.

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 2022-23 is due to updating the payment lag assumed to spread payments over 3 years.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to including annual estimates for FY 2023-24, including estimated IGTs.

MHP COSTS FOR FFPSA

REGULAR POLICY CHANGE NUMBER: 64

Methodology:

FFPSA Qualified Individual Standardized Assessments

1. Assume 4,436 (5,914*.75) children and youth will be placed in an STRTP in FY 2021-22, 5,914 in FY 2022-23, and 4,303 in FY 2023-24.
2. Assume Standardized Assessment by a QI began on October 1, 2021.
3. Assume a total of 4,436 receive a standardized assessment by a QI in FY 2021-22 and 5,914 receive a standardized assessment by a QI in FY 2022-23 and FY 2023-24. Each standardized assessment will take 10 total hours to complete.
4. Assume children and youth placed in an STRTP will receive, on average, 1.37 assessments per year in FY 2021-22 and FY 2022-23. Assume children and youth placed in an STRTP will receive, on average, 1.42 assessments per year for FY 2023-24.
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 \$17,210,970 for a QI to complete standardized assessments in FY 2021-22, \$22,945,374 in FY 2022-23 and \$17,304,256 in FY 2023-24.

Fiscal Year	STRTP Caseload	Assessment Hours	Assessments Per Year	Cost Per Hour (QI)	Assessment Cost
FY 2021-22	4,436	10	1.37	\$283.20	\$17,210,970
FY 2022-23	5,914	10	1.37	\$283.20	\$22,945,374
FY 2023-24	4,303	10	1.42	\$283.20	\$17,304,256

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 in FY 2021-22, and 3.03 in FY 2022 and FY 2023-24.
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 \$5,628,113 for QI participation in CFTs in FY 2021-22 and \$10,149,559 in FY 2022-23, and \$7,384,774 in FY 2023-24.

Fiscal Year	STRTP Caseload	CFT Hours	CFTs Per Year	Cost Per Hour (QI)	CFT Cost
FY 2021-22	4,436	2	2.24	\$283.20	\$5,628,113
FY 2022-23	5,914	2	3.03	\$283.20	\$10,149,559
FY 2023-24	4,303	2	3.00	\$283.20	\$7,503,305

MHP COSTS FOR FFPSA

REGULAR POLICY CHANGE NUMBER: 64

FFPSA – After Care

8. CDSS estimates the total cost of providing services pursuant to the HFW model to be \$47,600,000 from October 1, 2021 through June 30, 2022 and \$54,450,000 in FY 2022-23, and \$53,742,000 in FY 2023-24.
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 \$19,635,000 million in FY 2021-22, \$29,947,500 in FY 2022-23, and \$29,558,000 in FY 2023-24.
11. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through March 31, 2023 for this policy change. The FFCRA funding will be offset equally between the GF and the county funds (CF). The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
12. The Department will implement the CalAIM Behavioral Health Payment Reform and a new Intergovernmental Transfers (IGTs) process. For all claims with dates of service on or after July 1, 2023, counties will transfer the county portion of the submitted claims to the Department before Federal Financial Participation can be used for payment. IGTs are budgeted in the Medi-Cal County Behavioral Health Fund beginning July 1, 2023.

Funding Summary

13. Assume on a cash basis for FY 2022-23, the Department will pay 35.4% of FY 2021-22 claims and 64.4% of FY 2022-23 claims. On a cash basis for FY 2023-24, the Department will pay 0.2% of FY 2021-22 claims, 35.4% of FY 2022-23 claims, and 64.4% of FY 2023-24 claims. The estimated costs, on a cash basis, are:

(Dollars in Thousands)

	TF	GF	FF	FFCRA	CF
FY 2021-22					
Assessments	\$6,092	\$1,334	\$3,046	\$378	\$1,334
CFTs	\$1,992	\$436	\$996	\$124	\$436
After care	\$6,949	\$1,522	\$3,475	\$430	\$1,522
Total	\$15,033	\$3,292	\$7,517	\$932	\$3,292
FY 2022-23					
Assessments	\$14,777	\$3,351	\$7,388	\$687	\$3,351
CFTs	\$6,536	\$1,482	\$3,268	\$304	\$1,482
After care	\$19,286	\$4,373	\$9,643	\$897	\$4,373
Total	\$40,599	\$9,206	\$20,299	\$1,888	\$9,206
Total FY 2022-23	\$55,632	\$12,498	\$27,816	\$2,820	\$12,498

MHP COSTS FOR FFPSA
REGULAR POLICY CHANGE NUMBER: 64

(Dollars in Thousands)

	TF	GF	FF	FFCRA	IGT*	CF
FY21-22						
Assessments	\$34	\$7	\$17	\$2	\$0	\$8
CFTs	\$11	\$2	\$6	\$1	\$0	\$2
After care	\$40	\$9	\$20	\$2	\$0	\$9
Total	\$85	\$18	\$43	\$5	\$0	\$19
FY22-23						
Assessments	\$8,123	\$1,842	\$4,061	\$378	\$0	\$1,842
CFTs	\$3,593	\$815	\$1,796	\$167	\$0	\$815
After care	\$10,602	\$2,404	\$5,301	\$493	\$0	\$2,404
Total	\$22,318	\$5,061	\$11,158	\$1,038	\$0	\$5,061
FY23-24						
Assessments	\$11,144	\$2,786	\$5,572	\$0	\$2,786	\$0
CFTs	\$4,756	\$1,189	\$2,378	\$0	\$1,189	\$0
After care	\$19,036	\$4,759	\$9,518	\$0	\$4,759	\$0
Total	\$34,936	\$8,734	\$17,468	\$0	\$8,734	\$0
TOTAL FY 2023-24	\$57,339	\$13,813	\$28,669	\$1,043	\$8,734	\$5,080

Funding:

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

100% Title XIX GF (4260-101-0001)

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

Medi-Cal County Behavioral Health Fund* (4260-601-3420)

MHP STRTP GRANTS

REGULAR POLICY CHANGE NUMBER: 65
IMPLEMENTATION DATE: 7/2022
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2331

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$7,478,000	\$0
- STATE FUNDS	\$7,478,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$7,478,000	\$0
STATE FUNDS	\$7,478,000	\$0
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the funding available for Behavioral Health Quality Improvement Program (BHQIP) grants to Mental Health Plans (MHPs) if the Department, in consultation with the Department of Finance, determines that a Short-Term Residential Therapeutic Program (STRTP) contracted with an applicable county MHP is no longer eligible for federal financial participation under the Medicaid program due to determination that the STRTP is deemed to be an institution for mental diseases (IMD).

Authority:

Welfare & Institutions Code 14184.405

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 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 the Centers for Medicare and Medicaid Services (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, MHPs will no longer receive federal reimbursement

MHP STRTP GRANTS

REGULAR POLICY CHANGE NUMBER: 65

for specialty mental health services provided to children and youth residing in STRTPs that meet IMD criteria. The Department will issue determinations between December 2021 and December 2022.

The Department will provide BHQIP grant funding to county MHPs beginning January 1, 2022 through June 30, 2023. Grant funding will support county infrastructure to maintain capacity, for a defined period, while facilities come into compliance with the federal definition of QRTP.

To the extent the Section 1115 California Behavioral Health Community-Based Continuum Waiver is federally approved, 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:

There is no change for FY 2022-23 from the prior estimate.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to no estimated grant funds for FY 2023-24.

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 2022-23.

(Dollars in Thousands)

MHP STRTP Grants	TF	GF
FY 2022-23	\$7,478	\$7,478

Funding:

100% GF (4260-101-0001)

MHP COSTS FOR CONTINUUM OF CARE REFORM

REGULAR POLICY CHANGE NUMBER: 66
IMPLEMENTATION DATE: 1/2017
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1957

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$3,867,000	\$4,311,000
- STATE FUNDS	\$2,707,900	\$3,031,650
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,867,000	\$4,311,000
STATE FUNDS	\$2,707,900	\$3,031,650
FEDERAL FUNDS	\$1,159,100	\$1,279,350

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:

Not Applicable

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) must have a mental health approval and that process is overseen 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, Diagnostic, and Treatment (EPSDT)). Either a CFT or an interagency placement committee (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: 66

- 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 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 2022-23 is a decrease due to updating the methodology to use actual paid claims from FY 2017-18 through FY 2019-20 to project Continuum of Care Reform costs for FY 2022-23 and FY 2023-24. The 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP) expenditures are included for FY 2022-23.

The change from FY 2022-23 to FY 2023-24 in the current estimate is an increase due to including FY 2023-24 projections, increased General Fund estimate for training costs, and the end of FFCRA increased funding in FY 2022-23.

Methodology:

1. The FY 2022-23 and FY 2023-24 estimated costs are forecasted based on actual claims data.
2. The CFT costs are estimated by using actual claims data from FY 2017-18 through FY 2019-20.
3. The Placement Assessments costs are estimated by using actual claims data from FY 2018-19 through FY 2019-20.
4. Training costs are based on CDSS 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 2022-23 and 53% for FY 2023-24, 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 2022-23: Federal Share: $\$3,000,000 \times 0.75 \times 0.54 = \$1,215,000$ (Rounded)

FY 2023-24: Federal Share: $\$3,000,000 \times 0.75 \times 0.53 = \$1,192,000$ (Rounded)

FY 2022-23: General Fund Match: $\$3,000,000 \times (1 - (0.75 \times 0.54)) = \$1,785,000$ (Rounded)

FY 2023-24: General Fund Match: $\$3,000,000 \times (1 - (0.75 \times 0.53)) = \$1,808,000$ (Rounded)

MHP COSTS FOR CONTINUUM OF CARE REFORM

REGULAR POLICY CHANGE NUMBER: 66

Funding Summary

5. The estimate and lag are based on Short Doyle/Medi-Cal Children paid claims data. On a cash basis for FY 2022-23, the Department will pay 0.20% of FY 2020-21 claims data, 35.40% of FY 2021-22 claims and 64.40% of FY 2022-23 claims. For FY 2023-24, the Department will pay 0.20% of FY 2021-22 claims, 35.40% of FY 2022-23 claims, and 64.40% of FY 2023-24 claims. There is no lag in payment for training costs.
6. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through March 31, 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
7. The FY 2022-23 and FY 2023-24 estimate, on a cash basis, is:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF	FFCRA
CFT	\$586	\$261	\$298	\$27
Placement Assessments	\$1,496	\$662	\$766	\$68
Training	\$1,785	\$1,785	\$0	\$0
Total	\$3,867	\$2,708	\$1,064	\$95

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
CFT	\$708	\$348	\$360
Placement Assessments	\$1,795	\$876	\$919
Training	\$1,808	\$1,808	\$0
Total	\$4,311	\$3,032	\$1,279

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)
 100% GF (4260-101-0001)
 FFCRA 6.2% Increased FMAP (4260-101-0001/0890)
 FFCRA 4.34% Increased FMAP (4260-113-0001/0890)

OUT OF STATE YOUTH - SMHS

REGULAR POLICY CHANGE NUMBER: 67
IMPLEMENTATION DATE: 1/2021
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2268

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$2,062,000	\$2,112,000
- STATE FUNDS	\$1,031,000	\$1,056,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,062,000	\$2,112,000
STATE FUNDS	\$1,031,000	\$1,056,000
FEDERAL FUNDS	\$1,031,000	\$1,056,000

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 & Institutions Code, Division 9, Part 3, Chapter 8.8, Article 5
 Welfare & Institutions Code, Division 9, Part 3, Chapter 8.9

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS

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.

These returning youth have higher levels of need and will require more intensive SMHS 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 (qualified individual, per the Family First Prevention Service Act) 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:

OUT OF STATE YOUTH - SMHS

REGULAR POLICY CHANGE NUMBER: 67

- a. Unable to be placed with other children or youth and requires intensive supervision and support (such as requiring a “Short-Term Residential Therapeutic Program (STRTP) of one”); or
- b. Multiple 5150s, STRTP placement, 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 2022-23, is a decrease due to lower actual claiming from FY 2021-22 that was paid on a cash basis in FY 2022-23.

The change from FY 2022-23 to FY 2023-24 in the current estimate is a slight increase due to adding estimated claims to be paid in FY 2023-24.

Methodology:

1. 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. Based on actual claims incurred in FY 2021-22 and the adjustment for payment lag, the FY 2021-22 accrual is estimated to be \$2,030,000 for the 130 youth returned to California.
3. Assume the Department will pay for 65% of claims received, in the same year the service is provided, and the remaining 35% is paid in the next fiscal year.
4. The estimated growth of costs from FY 2021-22 to FY 2022-23 and FY 2023-24 is 2.42%, based on the forecasted increase of SMHS children's services approved claims.
5. The accrual estimates for FY 2021-22, FY 2022-23, and FY 2023-24 are:

(Dollars in Thousands)

Fiscal Year	Accrual	FY 2022-23	FY 2023-24
FY 2021-22	\$2,030	\$710	\$0
FY 2022-23	\$2,079	\$1,351	\$728
FY 2023-24	\$2,129	\$0	\$1,384
Total		\$2,062	\$2,112

OUT OF STATE YOUTH - SMHS
REGULAR POLICY CHANGE NUMBER: 67

6. The cash estimates for FY 2022-23 and FY 2023-24 are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2022-23	\$2,062	\$1,031	\$1,031
FY 2023-24	\$2,112	\$1,056	\$1,056

Funding:

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

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS

REGULAR POLICY CHANGE NUMBER: 68
IMPLEMENTATION DATE: 2/2022
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2247

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$1,450,000	\$2,201,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$1,450,000	\$2,201,000
FEDERAL FUNDS	-\$1,450,000	-\$2,201,000

Purpose:

This proposal estimates the ongoing costs resulting from ancillary Medi-Cal services (that is, services other than specialty mental health services) provided to Medi-Cal beneficiaries while in Short-Term Residential Therapeutic Programs (STRTPs) that are classified as Institutions for Mental Diseases (IMDs). 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: 68

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.

Ancillary services are the state's responsibility. 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 2022-23 is a slight decrease, due to revised estimated amount of claims for facilities that may be determined to be IMDs.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to a portion of FY 2022-23 claims estimated to be returned in FY 2023-24.

Methodology:

1. The Department plans to implement assessments of each STRTP 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 ancillary 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. The accrual estimates for FY 2022-23 and FY 2023-24 are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2022-23	\$0	\$2,230	(\$2,230)
FY 2023-24	\$0	\$2,186	(\$2,186)

5. The impact of determinations is estimated to phase in gradually, beginning in February 2022. The estimated impact of determinations on a cash basis is displayed below.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2022-23	\$0	\$1,450	(\$1,450)
FY 2023-24	\$0	\$2,201	(\$2,201)

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: 69
IMPLEMENTATION DATE: 1/2012
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1660

	<u>FY 2022-23</u>	<u>FY 2023-24</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 2022-23.

There is no change in the current estimate from FY 2022-23 to FY 2023-24.

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: 69

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 2022-23 and FY 2023-24 is as follows:

Fiscal Year	TF	GF	FF	Reimbursement
FY 2022-23	\$0	(\$200,000)	\$0	\$200,000
FY 2023-24	\$0	(\$200,000)	\$0	\$200,000

Funding:

100% GF (4260-101-0001)

Reimbursement GF (4260-601-0995)

CHART REVIEW

REGULAR POLICY CHANGE NUMBER: 70
IMPLEMENTATION DATE: 7/2012
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1714

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	-\$59,000	-\$25,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$59,000	-\$25,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	-\$59,000	-\$25,000

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 (MHPs).

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 MHPs by comparing claims to the corresponding patient chart entries. The Department recoups the disallowed claims.

Reason for Change:

The change in FY 2022-23, from the prior estimate, is due to updated estimated recoupment amounts based on actuals. Additionally, hospitals and MHPs are performing at a higher compliance level, resulting in lower recoupment amounts.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to the assumption that the FY 2023-24 estimate is based solely on recoupments for Inpatient Reviews. The Department has decided that the FY 2023-24 estimate will exclude Outpatient Review recoupments for the FY 2022-23 reviews.

Methodology:

1. The FY 2022-23 estimate includes estimated recoupments from inpatient and outpatient chart reviews to be conducted for FY 2021-22.

CHART REVIEW
REGULAR POLICY CHANGE NUMBER: 70

2. The FY 2023-24 estimate includes estimated recoupments from Inpatient Chart Reviews to be conducted for FY 2022-23 only. The Department has decided that they will perform solely technical assistance reviews on Inpatient recoupments without imposing Outpatient Review recoupments for FY 2022-23.

Fiscal Year	TF	FF
FY 2022-23	(\$59,000)	(\$59,000)
FY 2023-24	(\$25,000)	(\$25,000)

Funding:

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

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 71
IMPLEMENTATION DATE: 7/2015
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1713

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	-\$201,679,000	-\$198,708,000
- STATE FUNDS	\$103,000	\$107,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$201,679,000	-\$198,708,000
STATE FUNDS	\$103,000	\$107,000
FEDERAL FUNDS	-\$201,782,000	-\$198,815,000

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 Code 14705(c)
 Title 9, California Code of Regulations 1840.105
 ABX4 5 (Chapter 5, Statutes of 2009)
 Welfare & Institutions 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.

INTERIM AND FINAL COST SETTLEMENTS - SMHS

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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 100% of the allowable costs for providing SMHS 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 in FY 2022-23, from the prior estimate, is due to the lower than expected number of cost and audit settlements that have been received and forecasting that average number of settlements forward into the upcoming fiscal year.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to the projected cost estimates are based on the overall number of settlements.

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 2022-23 and FY 2023-24 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: 71

- 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.
 - The percentage of each fund type of settlements processed in FY 2020-21 was used to determine the estimated amounts of Title XIX and Title XXI for the interim and audit settlement types for FY 2022-23 and FY 2023-24. Assuming that FY 2022-23 and FY 2023-24 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 funding splits.
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 2021-22 that will be processed in FY 2022-23, and
7. 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 2014-15	(\$28,887)	\$11	(\$25,360)	(\$3,538)
FY 2015-16	(\$64,464)	\$26	(\$56,595)	(\$7,895)
FY 2016-17	(\$97,044)	\$39	(\$85,197)	(\$11,886)
FY 2018-19	(\$10,837)	\$4	(\$9,514)	(\$1,327)
Subtotal	(\$201,232)	\$80	(\$176,666)	(\$24,646)

(Dollars in Thousands)

Audit Settlements	TF	GF	Title XIX	Title XXI
FY 2015-16	(\$126)	\$6	(\$125)	(\$7)
FY 2018-19	(\$290)	\$15	(\$289)	(\$16)
FY 2019-20	(\$31)	\$2	(\$31)	(\$2)
Subtotal	(\$447)	\$23	(\$445)	(\$25)
Total FY 2022-23	(\$201,679)	\$103	(\$177,111)	(\$24,671)

INTERIM AND FINAL COST SETTLEMENTS - SMHS
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8. The net FF to be reimbursed and/or recouped in FY 2023-24 for interim settlements and audit settlements are as shown:

(Dollars in Thousands)

Interim Settlements	TF	GF	Title XIX	Title XXI
FY 2018-19	(\$92,117)	\$36	(\$80,871)	(\$11,282)
FY 2019-20	(\$106,043)	\$42	(\$93,097)	(\$12,988)
Subtotal	(\$198,160)	\$78	(\$173,968)	(\$24,270)

(Dollars in Thousands)

Audit Settlements	TF	GF	Title XIX	Title XXI
FY 2017-18	(\$281)	\$15	(\$280)	(\$16)
FY 2019-20	(\$267)	\$14	(\$266)	(\$15)
Subtotal	(\$548)	\$29	(\$546)	(\$31)
Total FY 2023-24	(\$198,708)	\$107	(\$174,514)	(\$24,301)

Funding:

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

GLOBAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 72
IMPLEMENTATION DATE: 12/2015
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1951

	FY 2022-23	FY 2023-24
FULL YEAR COST - TOTAL FUNDS	\$2,625,833,000	\$2,800,544,000
- STATE FUNDS	\$1,235,912,000	\$1,400,272,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,625,833,000	\$2,800,544,000
STATE FUNDS	\$1,235,912,000	\$1,400,272,000
FEDERAL FUNDS	\$1,389,921,000	\$1,400,272,000

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)
 California Advancing and Innovating Medi-Cal (CalAIM) Section 1115(a) Medicaid Demonstration

Interdependent Policy Changes:

ACA DSH Reduction

Background:

Since 2005, the Designated Public Hospital and Clinic systems (DPH systems) have received partial support for health expenditures made on behalf of the uninsured through a combination of California's 1115 Waivers' Safety Net Care Pool (SNCP), now known as Uncompensated Care Pool (UC Pool), 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 UC Pool 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 UC Pool 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 prior UC Pool and DSH system that provides funding based on the volume of hospitalizations, the GPP promotes the right care, at the right time, in the right setting for uninsured Californians served by the DPH systems.

GLOBAL PAYMENT PROGRAM

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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.

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. See the ACA DSH Reduction policy change for more information.

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

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 FFY 2020 and FFY 2021 allotments released by CMS on July 15, 2021, as well as the preliminary ARP-adjusted FFY 2022 allotment released on October 13, 2021.

On December 29, 2021, CMS approved CalAIM, a multi-year initiative focused on system, program, and payment reform that will allow California to take a population health, person-centered approach to provided services, with the goal of improving health outcomes for Medi-Cal and other low-income populations. CalAIM is effective from January 1, 2022, through December 31, 2026. A key change to the GPP is the incorporation of equity-enhancing services.

Reason for Change:

The change in FY 2022-23, from the prior estimate, is due to:

- Inclusion of the PY 7 final reconciliation payments,
- Updated estimated GPP DSH allotment allocation for PY 8, and
- Updated estimated PY 9 payments based on using the FFY 2022 preliminary ARP-adjusted DSH allotment with a 2% increase to determine the FFY 2023 DSH allotment.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to:

- Final reconciliation payments included in FY 2022-23,
- Higher PY 9 payments as a result of the estimating the FFY 2023 DSH allotment using the FFY 2022 preliminary ARP-adjusted DSH allotment with a 2% annual increase, and

GLOBAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 72

- Lower PY 10 payments as a result of estimating the FFY 2024 DSH allotment using the preliminary non-ARP adjusted FFY 2022 DSH allotment with a 2% annual increase.

Methodology:

1. The PY for the GPP was originally established as July 1 to June 30, to align with the state fiscal year for PY 1 through PY 5. PY 6 (formerly 6A) is a six-month extension aligning with the fiscal period of July 1, 2020, to December 31, 2020. Starting with PY 7 (formerly 6B) on January 1, 2021, the GPP will align with the calendar year period of January 1 to December 31. The calendar year program format will continue for subsequent GPP program years.
2. On July 14, 2016, CMS approved \$472 million in UC Pool funding for PY 2 through PY 5. The \$472 million is subject to applicable weighted FMAP. On December 29, 2021, CMS approved the continuation of the UC Pool funding in the amount of \$472 million annually through December 31, 2026.
3. The total federal funding for the GPP for PY 1 through PY 12 is estimated at:

(Dollars in Thousands)

Program Year	DPH DSH FFP Allotment	UC Pool FFP	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)	\$1,072,741	\$257,948	\$1,330,689
PY 6 (Formerly 6A) (7/1/20-12/31/20)	\$561,224	\$132,632	\$693,856
PY 7 (Formerly 6B) (1/1/21-12/31/21)	\$1,140,494	\$265,264	\$1,405,758
PY 8 (Formerly 7) (1/1/22-12/31/22)	\$1,103,611	\$257,948	\$1,361,559
PY 9 (Formerly 8) (1/1/23-12/31/23)	\$1,192,033	\$236,000	\$1,428,033
PY 10(1/1/24-12/31/24)	\$1,080,990	\$236,000	\$1,316,990
PY 11 (1/1/25-12/31/25)	\$1,103,032	\$236,000	\$1,339,032
PY 12 (1/1/26-12/31/26)	\$1,125,514	\$236,000	\$1,361,514

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 6 (formerly 6A), two quarterly payments were made in the current state fiscal year. Beginning with PY 7 (formerly 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 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through March 31, 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.

GLOBAL PAYMENT PROGRAM

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6. 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 been paid at 50% federal share / 50% non-federal share. The FFP does not change, while the non-federal share is reduced.
7. PY 7 final reconciliation payments will take place in FY 2022-23.
8. The FFY 2024 DSH allotment is not expected to be subject to ARP adjustments, and therefore assumes a 2% annual increase over the preliminary non-ARP adjusted FFY 2022 allotment.
9. The estimated GPP payments on a cash basis are:

(Dollars in Thousands)

FY 2022-23	TF	IGT	FF	FFCRA
PY 7 (formerly 6B) (1/1/21-12/31/21)	\$70,187	\$30,742	\$39,445	\$0
PY 8 (Formerly 7) (1/1/22- 12/31/22)	\$1,841,630	\$848,162	\$978,836	\$14,632
PY 9 (Formerly 8) (1/1/23- 12/31/23)	\$714,016	\$357,008	\$357,008	\$0
Total	\$2,625,833	\$1,235,912	\$1,375,289	\$14,632

FY 2023-24	TF	IGT	FF	FFCRA
PY 9 (Formerly 8) (1/1/23- 12/31/23)	\$2,142,049	\$1,071,025	\$1,071,024	\$0
PY 10 (1/1/24-12/31/24)	\$658,495	\$329,247	\$329,248	\$0
Total	\$2,800,544	\$1,400,272	\$1,400,272	\$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)

CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES

REGULAR POLICY CHANGE NUMBER: 73
IMPLEMENTATION DATE: 2/2022
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2245

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$1,175,858,000	\$1,829,376,000
- STATE FUNDS	\$431,941,800	\$748,822,250
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,175,858,000	\$1,829,376,000
STATE FUNDS	\$431,941,800	\$748,822,250
FEDERAL FUNDS	\$743,916,200	\$1,080,553,750

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
Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

Not Applicable

Background:

Effective January 1, 2022, the Department implemented a new ECM benefit and 14 Community Supports in the Medi-Cal managed care delivery system and established 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 implemented 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 is 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 are statewide within the managed care delivery system effective January 1, 2022. Community

CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES

REGULAR POLICY CHANGE NUMBER: 73

Supports provide for flexible wrap-around services that Medi-Cal MCPs would be able to offer as a part of their overall population health management strategy as viable substitutes to more costly services such as hospital inpatient and long-term institutional care. Medium to high-risk and/or high-cost Medi-Cal beneficiaries who experience, or are at risk of experiencing, poor health outcomes may benefit from accessing non-traditional alternatives to State Plan benefits.

The proposed 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, program period) 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.

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 2022-23, is a decrease due to updated Community Supports estimates and adjusting the incentive payment timing from accrual to cash. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to the incentive payment timing, continued program ramp-up including growth in existing populations of focus, and the addition of new populations of focus in the CY 2023 rates.

CALAIM ECM-COMMUNITY SUPPORTS-PLAN INCENTIVES

REGULAR POLICY CHANGE NUMBER: 73

Methodology:

- The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through March 31, 2023, for this policy change. The estimated FY 2022-23 FFCRA increased FMAP amount is \$21,161,000 FF for 6.2% Title XIX and \$495,000 FF for 4.34% Title XXI. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
- Costs are estimated to be:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Community Supports	\$198,272	\$57,599	\$140,674
Plan Incentives	\$300,000	\$150,000	\$150,000
Enhanced Care Management	\$677,586	\$224,343	\$453,243
Total for FY 2022-23	\$1,175,858	\$431,942	\$743,916

*Totals may differ due to rounding.

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Community Supports	\$236,960	\$74,408	\$162,552
Plan Incentives	\$600,000	\$300,000	\$300,000
Enhanced Care Management	\$992,416	\$374,415	\$618,001
Total for FY 2023-24	\$1,829,376	\$748,822	\$1,080,554

*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)
 65% Title XXI / 35% GF (4260-101-0001/0890)
 FFCRA 4.34% Increased FFP (4260-113-0890)
 FFCRA 6.20% Increased FFP (4260-101-0890)

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

REGULAR POLICY CHANGE NUMBER: 74
IMPLEMENTATION DATE: 1/2017
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1954

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$137,300,000	\$1,500,000
- STATE FUNDS	\$77,133,500	\$1,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	2.70 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$133,592,900	\$1,500,000
STATE FUNDS	\$75,050,900	\$1,500,000
FEDERAL FUNDS	\$58,542,000	\$0

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 – DHCS

Background:

Through the Medi-Cal 2020 Waiver, the Department implemented and oversaw four dental efforts (domains), which were collectively referred to as the Dental Transformation Initiative (DTI) program.

The four domains of the DTI program were 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 aimed 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 offered incentive payments to dental provider service office locations that provided 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: 74

The Caries Risk Assessment and Disease Management domain enabled 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 were 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 was 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 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 aimed to encourage the continuity of care among Medi-Cal beneficiaries age 20 and under. This domain was 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 expanded to include 19 counties and a rate increase of \$60. The Department hoped to increase utilization and participation with the expansion efforts.

The Department required the selected LDPPs to have broad-based provider and community support and collaboration, including Tribes and Indian health programs, with incentives related to goals and metrics that contribute to the overall goals of any one of the three abovementioned programs. The Department issued payments to pilot providers (i.e. the entity or entities providing the pilot proposal application) only on the basis of an approved application. Fifteen LDPPs were approved; however, two LDPP were unable to execute their contracts.

The 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.

Under the Special Terms and Conditions (STCs) of the Medi-Cal 2020 Waiver, the DTI Program was allocated \$148 million annually for each of the five program years (calendar years (CY) 2016-2020), equating to a total pool of \$740 million for the entirety of the program. During the demonstration of the DTI, the Department met performance goals, and was authorized an additional \$5 million. With the COVID-19 pandemic, an additional \$148 million was allocated to DTI during the extension of the Medi-Cal 2020 Waiver for CY 2021. The DTI Program projected to surpass its total allotment of \$893 million in FY 2022-23 and the remainder will be backfilled from the general fund.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is an increase due to updated actuals and projections as the program closes out. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to program ending in December 2021 and only runout costs being budgeted thereafter.

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

REGULAR POLICY CHANGE NUMBER: 74

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, counted towards the domains performance metrics and incentive payments. Incentive payments were paid on a semi-annual basis. The timing of the payments assumed the incentives were completed by the first payment of the following fiscal year. Therefore, FY 2022-23 includes incentive payments for calendar year (CY) 2021.
2. Service Office Locations were reimbursed for services in accordance with the Schedule of Maximum Allowances (SMA). In addition, qualified service office locations may have received 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 2022-23	\$57,676,000	\$25,262,000	\$32,414,000
FY 2023-24	\$0	\$0	\$0

Domain 2: Caries Risk Assessment and Disease Management

4. This four year incentive program was implemented on January 1, 2017. The Department used the most recent complete CY for Caries Risk Assessment CDT code data to determine the utilization.
5. Domain 2 had three levels of risk assessment; Low, Moderate and High Risk. Low Risk children were 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 had the option of receiving an interim caries arresting medication twice per year.
6. Payments were made on a monthly basis. Therefore, FY 2022-23 includes run out payments for CY 2021.

Total Domain 2 costs are estimated to be:

Fiscal Year	TF	GF	FF
FY 2022-23	\$3,708,000	\$2,796,000	\$912,000
FY 2023-24	\$0	\$0	\$0

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

REGULAR POLICY CHANGE NUMBER: 74

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 2022-23 includes incentive payments for CY 2021 and runout for CY 2020, while FY 2023-24 includes runout incentive payments for FY 2021.
8. This incentive program was available to service office locations that provided examinations to an enrolled Medi-Cal beneficiary for two, three, four, five, and six year continuous periods.
9. This incentive program was only available for services performed on child beneficiary participants age 20 and under. The Department assumed that the beneficiaries from the baseline year for the county would return to the same provider at the same rates in subsequent years.
10. Incentive payment amounts were 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 was increased.

Total Domain 3 costs are estimated to be:

Fiscal Year	TF	GF	FF
FY 2022-23	\$75,916,000	\$49,076,000	\$26,840,000
FY 2023-24	\$1,500,000	\$1,500,000	\$0

Domain 4: Local Dental Pilot Projects

11. This domain has ended and does not have expenditures projected in FY 2022-23 and FY 2023-24.

For all domains:

12. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through December 31, 2022, for this policy change. The impact of FFCRA increased FMAP extension, is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
13. The DTI program is projected to surpass the amount originally authorized under the Medi-Cal 2020 waiver's STCs. The DTI program is projected to end with an approximate deficit of \$31.7 million and will be backfilled from the GF. \$30.2 million will be paid in FY 2022-23 and \$1.5 million will be paid in FY 2023-24.
14. On a cash basis, the FY 2022-23 and FY 2023-24 total demonstration costs are:

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF	\$107,057,000	\$53,528,500	\$53,528,500
FFCRA 6.2% Increased FFP	\$0	(\$6,638,000)	\$6,638,000
100% GF	\$30,243,000	\$30,243,000	\$0
Total	\$137,300,000	\$77,133,000	\$60,167,000

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE
REGULAR POLICY CHANGE NUMBER: 74

FY 2023-24	TF	GF	FF
100% GF	\$1,500,000	\$1,500,000	\$0
Total	\$1,500,000	\$1,500,000	\$0

*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)

100% GF (4260-101-0001)

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER: 75
IMPLEMENTATION DATE: 7/2013
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1769

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$649,000	\$613,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$649,000	\$613,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$649,000	\$613,000

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)
 California Advancing and Innovating Medi-Cal Section 1115(a) Medicaid Demonstration (CalAIM)

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 December 29, 2021, CMS approved California's Section 1115 Demonstration, named CalAIM. With this approval, Tribal uncompensated care payments for chiropractic services will be 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.

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER: 75

Reason for Change:

The change in FY 2022-23, from the prior estimate, is due to an increased actual encounter rate in calendar year (CY) 2022.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to a decrease in payments based on a revised encounter rate projection based on actuals in CY 2022.

Methodology:

1. Assume IHS payments will continue until December 31, 2026.
2. The IHS global encounter rate is updated on the Federal Register for each CY. For CY 2022 the rate is \$640, for CY 2023 the rate is \$699, and the projected CY 2024 rate is \$763.
3. IHS claims are paid for each encounter. Assume IHS payments will be made as follows on a cash basis:

FY 2022-23	TF	FF
Calendar Year 2022	\$507,000	\$507,000
Calendar Year 2023	\$142,000	\$142,000
Total	\$649,000	\$649,000

FY 2023-24	TF	FF
Calendar Year 2023	\$458,000	\$458,000
Calendar Year 2024	\$155,000	\$155,000
Total	\$613,000	\$613,000

Funding:

100% Health Care Support Fund (4260-601-7503)

CCI-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 79
IMPLEMENTATION DATE: 4/2014
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 1766

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$4,491,458,000	\$402,758,000
- STATE FUNDS	\$2,245,729,000	\$201,379,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	52.78 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,120,866,500	\$402,758,000
STATE FUNDS	\$1,060,433,230	\$201,379,000
FEDERAL FUNDS	\$1,060,433,230	\$201,379,000

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

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 (CMC) 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: 79

The MSSP benefit was carved out from managed care effective January 1, 2022, and re-implemented as a fee-for-service Home and Community-Based Services MSSP Waiver program in the CCI counties.

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 2022-23, is a decrease due to the CCI pilot program ending December 31, 2022. Starting January 1, 2023, only the historic full-dual CMC population is captured in this policy change. The change from FY 2022-23 to FY 2023-24, in the current estimate, is decrease due to the CCI pilot program ending December 31, 2022. Only the historic full-dual CMC population is captured in FY 2023-24.

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. Although the CCI program will sunset December 31, 2022, the assumed dollars for the historic full-dual CMC population will shift to mainstream base rates via affiliated Dual Eligible Special Needs Plans (D-SNP) and are captured within this policy change. On a cash basis, this would account for all dollars associated with February 2023 through June 2024.
4. The assumed dollars for the historic non-CMC population are being budgeted in the Two Plan, County Organized Health Systems (COHS), Geographic Managed Care (GMC), and Regional Model PCs effective January 1, 2023, on an accrual basis.
5. The HCBS High supplemental payment was discontinued effective January 1, 2022, due to the carve-out of MSSP from managed care. The CBAS costs, historically in the HCBS High supplemental payment, are being budgeted in the Two Plan, COHS, GMC, and Regional Model PCs effective January 1, 2022, on an accrual basis.
6. With the carve-in of LTC services into mainstream managed care, effective January 1, 2023, the estimated costs for LTC institutional services for the non-CMC segment of the historic CCI population are being budgeted in the Two Plan, COHS, GMC, and Regional Model PCs effective January 1, 2023, on an accrual basis.
7. Paid rates vary throughout the fiscal year depending on the most recently available approved rates. CY 2022 CCI rates and CY 2023 mainstream rates for the historic CMC population will be paid in FY 2022-23, and CY 2023 and CY 2024 mainstream rates for the historic CMC population will be paid in FY 2023-24.
8. Estimated below is the overall impact for FY 2022-23 and FY 2023-24.

CCI-MANAGED CARE PAYMENTS
REGULAR POLICY CHANGE NUMBER: 79

(Dollars in Thousands)

FY 2022-23	TF	GF	FFP
CCI-Managed Care Payments:			
Base managed care payments	\$4,491,458	\$2,245,729	\$2,245,729
Total Managed Care Payments	\$4,491,458	\$2,245,729	\$2,245,729
CCI-Savings and Deferral :			
Total Savings (In the Base)	(\$4,530,598)	(\$2,265,299)	(\$2,265,299)
CCI-Admin Costs	\$5,958	\$2,979	\$2,979
CCI-Quality Withhold Repayments	\$19,807	\$9,904	\$9,904
Total of CCI PCs including pass through	(\$13,375)	(\$6,687)	(\$6,687)

*Totals may differ due to rounding.

(Dollars in Thousands)

FY 2023-24	TF	GF	FFP
CCI-Managed Care Payments:			
Base managed care payments	\$402,758	\$201,379	\$201,379
Total Managed Care Payments	\$402,758	\$201,379	\$201,379
CCI-Admin Costs	\$0	\$0	\$0
CCI-Quality Withhold Repayments	\$16,091	\$8,046	\$8,046
Total of CCI PCs including pass through	\$418,849	\$209,425	\$209,425

*Totals may differ due to rounding.

Funding:

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

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 80
IMPLEMENTATION DATE: 9/2019
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2062

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$1,989,171,000	\$2,058,008,000
- STATE FUNDS	\$505,366,050	\$522,854,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,989,171,000	\$2,058,008,000
STATE FUNDS	\$505,366,050	\$522,854,600
FEDERAL FUNDS	\$1,483,804,950	\$1,535,153,400

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

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 been underway following the June 30, 2020, expiration of the PRIME program. On September

MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 80

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 January 20 and February 2 of 2022, the Department received approval from CMS for QIP payments for DPHs and DMPHs, respectively, for the rating periods covering January 1, 2021, 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:

There is no change from the prior estimate for FY 2022-23. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to the growth in the total pool amount for CY 2022.

Methodology:

1. 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.
2. The maximum value of the CY 2022 QIP is \$2.058 billion total fund. This amount is anticipated to pay out in FY 2023-24.
3. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through March 31, 2023, for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
4. On a cash basis, the estimated QIP payments are:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF	ACA FF
CY21 Title XIX	\$873,493	\$436,747	\$436,747	\$0
CY21 ACA 2021 90/10	\$1,061,427	\$106,143	\$0	\$955,284
CY21 Title XXI 65/35	\$54,251	\$18,988	\$35,263	\$0
FFCRA 6.2% Increased FFP	\$0	(\$54,157)	\$54,157	\$0
FFCRA 4.34% Increased FFP	\$0	(\$2,354)	\$2,354	\$0
Total FY 2022-23	\$1,989,171	\$505,366	\$528,521	\$955,284

*Difference due to rounding.

MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL
REGULAR POLICY CHANGE NUMBER: 80

(Dollars in Thousands)

FY 2023-24	TF	GF	FF	ACA FF
CY22 Title XIX	\$903,721	\$451,860	\$451,860	\$0
CY22 ACA 2021 90/10	\$1,098,158	\$109,816	\$0	\$988,343
CY22 Title XXI 65/35	\$56,128	\$19,645	\$36,483	\$0
FFCRA 6.2% Increased FFP	\$0	(\$56,031)	\$56,031	\$0
FFCRA 4.34% Increased FFP	\$0	(\$2,436)	\$2,436	\$0
Total FY 2023-24	\$2,058,008	\$522,854	\$546,810	\$988,343

*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)
65% Title XXI FF / 35% GF (4260-113-0001/0890)
65% Title XXI FF / 35% GF (4260-101-0001/0890)
FFCRA 6.20% Increased FFP (4260-101-0890)
FFCRA 4.34% Increased FFP (4260-113-0890)
FFCRA 4.34% Increased FFP (4260-101-0890)

MANAGED CARE HEALTH CARE FINANCING PROGRAM

REGULAR POLICY CHANGE NUMBER: 81
IMPLEMENTATION DATE: 5/2020
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2061

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$1,864,564,000	\$1,864,564,000
- STATE FUNDS	\$611,641,050	\$611,641,050
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,864,564,000	\$1,864,564,000
STATE FUNDS	\$611,641,050	\$611,641,050
FEDERAL FUNDS	\$1,252,922,950	\$1,252,922,950

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

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:

There is no change from the prior estimate for FY 2022-23. There is no change from FY 2022-23 to FY 2023-24 in the current estimate.

Methodology:

1. The Managed Care Health Care Financing Program began with the FY 2018-19 rating period.
2. 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.

MANAGED CARE HEALTH CARE FINANCING PROGRAM
REGULAR POLICY CHANGE NUMBER: 81

3. Payments for the CY 2022 rating period are anticipated to occur in FY 2023-24. However, participation levels for the CY 2022 rating period are not known at this time, pending anticipated updates to the CY 2022 rates. Therefore, the estimated total payments for the CY 2022 rating period are assumed to be \$1,864,564,000 TF, consistent with the CY 2021 rating period.
4. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through March 31, 2023, for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
5. Anticipated costs on a cash basis are:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
CY 2021 Title XIX	\$1,076,032	\$538,016	\$538,016
CY 2021 Title XXI 65/35	\$111,645	\$39,076	\$72,570
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	(\$4,845)	\$4,845
FFCRA 6.20% Increased FFP	\$0	(\$66,714)	\$66,714
Total for FY 2022-23	\$1,864,564	\$611,641	\$1,252,923

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
CY 2022 Title XIX	\$1,076,032	\$538,016	\$538,016
CY 2022 Title XXI 65/35	\$111,645	\$39,076	\$72,570
CY 2022 ACA 90/10	\$634,198	\$63,420	\$570,778
100% State GF	\$42,688	\$42,688	\$0
FFCRA 4.34% Increased FFP	\$0	(\$4,845)	\$4,845
FFCRA 6.20% Increased FFP	\$0	(\$66,714)	\$66,714
Total for FY 2023-24	\$1,864,564	\$611,641	\$1,252,923

*Totals may differ due to rounding.

MANAGED CARE HEALTH CARE FINANCING PROGRAM

REGULAR POLICY CHANGE NUMBER: 81

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)
65% Title XXI FF / 35% GF (4260-101-0001/0890)
100% State GF (4260-101-0001)
FFCRA 4.34% Increased FFP (4260-113-0890)
FFCRA 4.34% GF (4260-113-0001)
FFCRA 4.34% Increased FFP (4260-101-0890)
FFCRA 4.34% GF (4260-101-0001)
FFCRA 6.20% Increased FFP (4260-101-0890)
FFCRA 6.2% GF (4260-101-0001)

MANAGED CARE PUBLIC HOSPITAL EPP

REGULAR POLICY CHANGE NUMBER: 82
IMPLEMENTATION DATE: 9/2019
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2060

	FY 2022-23	FY 2023-24
FULL YEAR COST - TOTAL FUNDS	\$1,778,153,000	\$1,853,760,000
- STATE FUNDS	\$404,763,840	\$424,860,850
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,778,153,000	\$1,853,760,000
STATE FUNDS	\$404,763,840	\$424,860,850
FEDERAL FUNDS	\$1,373,389,160	\$1,428,899,150

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

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: 82

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 January 20 and February 2, 2022, the Department received CMS pre-print approval to continue the EPP Directed Payment program for the rating period covering January 1, 2021, through December 31, 2021. On July 14, 2022, the Department received CMS pre-print approval to continue the EPP Directed Payment program for the rating period covering January 1, 2022, through December 31, 2022.

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

Reason for Change:

There is no total fund change from the prior estimate for FY 2022-23. However, due to updated funding splits, there was a decrease in General Funds. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to the growth in the total pool amount for CY 2022.

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 value of the entire public hospital EPP pool is \$1,878,640,000 TF for the CY 2022 rating period on an accrual basis.
4. The Bridge Period Capitated sub-pool was split into three separate payment periods and the final payments for July 1, 2020, through December 31, 2020, were made in March 2022.
5. The Bridge Period FFS sub-pool was split into three separate payment periods and the final payments for July 1, 2020, through December 31, 2020, were made in September 2022.
6. The January 1, 2021, through June 30, 2021, FFS sub-pool payments are anticipated to be made in March 2023. The July 1, 2021, through December 31, 2021, FFS sub-pool payments are anticipated to be made in September 2023. The January 1, 2022, through June 30, 2022, FFS sub-pool payments are anticipated to be made in March 2024.
7. The January 1, 2021, through June 30, 2021, Capitated sub-pool payments were made in September 2022. The July 1, 2021, through December 31, 2021, Capitated sub-pool

MANAGED CARE PUBLIC HOSPITAL EPP
REGULAR POLICY CHANGE NUMBER: 82

payments are anticipated to be made in March 2023. The January 1, 2022, through June 30, 2022, Capitated sub-pool payments are anticipated to be made in September 2023. The July 1, 2022, through December 31, 2022, Capitated sub-pool payments are anticipated to be made in March 2024.

8. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through March 31, 2023, for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
9. On a cash basis, the estimated payments are:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF	ACA FF
Title XIX	\$647,026	\$323,513	\$323,513	\$0
Title XXI 76.5/23.5	\$4,977	\$1,170	\$3,807	\$0
Title XXI 65/35	\$37,745	\$13,211	\$24,534	\$0
ACA 2020 90/10	\$1,088,405	\$108,840	\$0	\$979,564
FFCRA 4.34% Increased FFP	\$0	(\$1,854)	\$1,854	\$0
FFCRA 6.20% Increased FFP	\$0	(\$40,116)	\$40,116	\$0
Total FY 2022-23	\$1,778,153	\$404,764	\$393,825	\$979,564

*Totals may differ due to rounding.

(Dollars in Thousands)

FY 2023-24	TF	GF	FF	ACA FF
Title XIX	\$677,004	\$338,502	\$338,502	\$0
Title XXI 65/35	\$44,593	\$15,608	\$28,986	\$0
ACA 2020 90/10	\$1,132,163	\$113,216	\$0	\$1,018,947
FFCRA 4.34% Increased FFP	\$0	(\$1,851)	\$1,851	\$0
FFCRA 6.20% Increased FFP	\$0	(\$40,614)	\$40,614	\$0
Total FY 2023-24	\$1,853,760	\$424,861	\$409,953	\$1,018,947

*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)
 76.5% Title XXI FF / 23.5% GF (4260-113-0001/0890)
 65% Title XXI FF / 35% GF (4260-113-0001/0890)
 65% Title XXI FF / 35% GF (4260-101-0001/0890)
 FFCRA 4.34% Increased FFP (4260-113-0890)
 FFCRA 4.34% Increased FFP (4260-101-0890)
 FFCRA 6.20% Increased FFP (4260-101-0890)

2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.

REGULAR POLICY CHANGE NUMBER: 83
IMPLEMENTATION DATE: 9/2020
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2178

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$1,525,495,000	\$0
- STATE FUNDS	\$551,791,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,525,495,000	\$0
STATE FUNDS	\$551,791,000	\$0
FEDERAL FUNDS	\$973,704,000	\$0

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

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 2022-23. However, due to updated funding splits there is a slight increase in General Funds (GF). The change from FY 2022-23 to FY 2023-24, 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: 83

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 and is budgeted for in the COVID-19 Increased FMAP – DHCS policy change.
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 2022-23	\$1,525,495	\$551,791	\$973,704

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 is identified in the COVID-19 Increased FMAP – DHCS policy change

HCBS SP - HOUSING AND HOMELESSNESS INCENTIVE PROG

REGULAR POLICY CHANGE NUMBER: 86
IMPLEMENTATION DATE: 10/2022
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2325

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$644,000,000	\$644,000,000
- STATE FUNDS	\$282,072,000	\$302,036,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$644,000,000	\$644,000,000
STATE FUNDS	\$282,072,000	\$302,036,000
FEDERAL FUNDS	\$361,928,000	\$341,964,000

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 under Section 9817 of 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
Families First Coronavirus Response Act (FFCRA)

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, 2025. 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 \$1.288 billion TF over the duration of the program, for achieving progress in addressing homelessness and keeping people housed and developing the necessary capacity and partnerships to connect their members to needed

HCBS SP - HOUSING AND HOMELESSNESS INCENTIVE PROG

REGULAR POLICY CHANGE NUMBER: 86

housing service. 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 aging and/or disabled population), rapid re-housing (families and youth), and permanent supportive housing. Funds are made available based on point in time counts of homeless individuals and other factors determined by the Department. MCPs must meet specified metrics to earn available 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. 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 2022-23, is a decrease to align costs with the HCBS Spending Plan. There is no change from FY 2022-23 to FY 2023-24 in the current estimate. FFCRA-related dollars previously budgeted in the COVID-19 Increased FMAP – DHCS PC is now being budgeted in this PC.

Methodology:

1. Phase I of HHIP (Planning phase) began effective January 1, 2022. Plans may earn incentive payments for completion of Local Homelessness Plans (LHP) and Investment Plans for their respective counties, subject to review and acceptance by the Department.
2. In Phase II of HHIP (Outcome/Performance phase), plans may earn incentive payments based on achievement of specified metrics and measures.
3. Incentive payments will begin no sooner than October 2022.
4. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2023, for this policy change.
5. The costs for this PC on a cash basis for FY 2022-23 and FY 2023-24 are expected to be:

(Dollars in Thousands)

FY 2022-23	TF	SF	FF	FFCRA
Title XIX	\$644,000	\$322,000	\$322,000	\$0
FFCRA 6.20% Increased FFP	\$0	(\$39,928)	\$0	\$39,928
Total FY 2022-23	\$644,000	\$282,072	\$322,000	\$39,928

FY 2023-24	TF	SF	FF	FFCRA
Title XIX	\$644,000	\$322,000	\$322,000	\$0
FFCRA 6.20% Increased FFP	\$0	(\$19,964)	\$0	\$19,964
Total FY 2023-24	\$644,000	\$302,036	\$322,000	\$19,964

Funding:

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

Home and Community-Based Services American Rescue Plan Fund (4260-101-8507)

FFCRA 6.20% Increased FFP (4260-101-0890)

RETRO MC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 87
IMPLEMENTATION DATE: 1/2016
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1788

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$213,603,000	\$704,333,000
- STATE FUNDS	\$104,020,600	\$335,092,050
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$213,603,000	\$704,333,000
STATE FUNDS	\$104,020,600	\$335,092,050
FEDERAL FUNDS	\$109,582,400	\$369,240,950

Purpose:

This policy change estimates retroactive managed care capitation rate adjustments.

Authority:

Welfare & Institutions Code, section 14087.3

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS

Background:

This policy change accounts for retroactive:

- Retro Managed Care Rate Adjustments,
- Managed care pass through payments, and
- Managed care funding adjustments.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is an increase due to higher estimated retroactive adjustments. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to higher retroactive adjustments mainly related to anticipated CY 2022 rate updates and pass-through payments for FY 2023-24.

Methodology:

1. The Department estimates the following retroactive managed care capitation rate adjustments in FY 2022-23 and FY 2023-24:

(Dollars in Thousands)

FY 2022-23	TF	GF	HQARF	FF
Retro MC Rate Adjustment Payments	\$159,586	\$70,518	\$20,501	\$68,567
Retro Pass Through Payments	\$54,017	\$21,002	\$0	\$33,014
Funding Adjustments	\$0	(\$8,001)	\$0	\$8,001
Total FY 2022-23	\$213,603	\$83,520	\$20,501	\$109,582

RETRO MC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 87

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Retro MC Rate Adjustment Payments	\$641,261	\$310,896	\$330,366
Retro Pass Through Payments	\$63,071	\$24,196	\$38,875
Total FY 2023-24	\$704,333	\$335,092	\$369,241

Funding:

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

65% Title XXI FF / 35% GF (4260-101-0001/0890)

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

ACA 90/10 (2019) (4260-101-0890)

ACA 100% (2014-2016) (4260-101-0890)

Title XIX FFP (4260-101-0890)

Title XXI FFP (4260-113-0890)

100% GF (4260-101-0001)

Hospital Quality Assurance Revenue Fund (4260-611-3158)

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

CALAIM - TRANSITIONING POPULATIONS

REGULAR POLICY CHANGE NUMBER: 88
IMPLEMENTATION DATE: 12/2021
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2201

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$211,712,000	\$25,981,000
- STATE FUNDS	\$84,672,450	\$10,393,750
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$211,712,000	\$25,981,000
STATE FUNDS	\$84,672,450	\$10,393,750
FEDERAL FUNDS	\$127,039,550	\$15,587,250

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: 88

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. Additionally, the Department identified individuals who were subject to transition as part of Phase I and did not transition for various reasons, but will transition as part of Phase 2 on January 1, 2023. This population includes dual and non-dual beneficiaries.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a decrease due to updated payment data and payment timing. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to the remaining populations transitioning in January 2023. Dollars in FY 2023-24 represent the remaining costs from the January 2023 transition.

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 2022-23	TF	GF	FF
Title XIX 100% FFP (4260-101-0890)	\$25	\$0	\$25
BCCTP Title XIX 65% FF / 35% GF (4260-101-0890/0001)	\$1,607	\$562	\$1,045
100% General Fund 4260-101-0001	\$37	\$37	\$0
50% Title XIX FF / 50% GF (4260-101-0890/0001)	\$156,473	\$78,237	\$78,236
90% Title XIX ACA / 10% GF (4260-101-0890/0001)	\$51,652	\$5,165	\$46,487
65% Title XXI FF / 35% GF (4260-113-0890/0001)	\$1,918	\$671	\$1,247
Total	\$211,712	\$84,672	\$127,040

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Title XIX 100% FFP (4260-101-0890)	\$3	\$0	\$3
BCCTP Title XIX 65% FF / 35% GF (4260-101-0890/0001)	\$176	\$62	\$114
100% General Fund 4260-101-0001	\$4	\$4	\$0
50% Title XIX FF / 50% GF (4260-101-0890/0001)	\$19,224	\$9,612	\$9,612
90% Title XIX ACA / 10% GF (4260-101-0890/0001)	\$6,339	\$634	\$5,705
65% Title XXI FF / 35% GF (4260-101-0890/0001)	\$235	\$82	\$153
Total	\$25,981	\$10,394	\$15,587

CYBHI - STUDENT BH INCENTIVE PROGRAM

REGULAR POLICY CHANGE NUMBER: 89
IMPLEMENTATION DATE: 1/2022
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2260

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$199,014,000	\$85,285,000
- STATE FUNDS	\$99,507,000	\$42,642,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$199,014,000	\$85,285,000
STATE FUNDS	\$99,507,000	\$42,642,500
FEDERAL FUNDS	\$99,507,000	\$42,642,500

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)
 SB 154 (Chapter 43, Statutes of 2022)

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS

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.

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 implemented 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. The initial Student Behavioral Health Incentive assessment funds

CYBHI - STUDENT BH INCENTIVE PROGRAM

REGULAR POLICY CHANGE NUMBER: 89

will be paid out to plans within Program Year 1 (Calendar Year 2022). For Program Years 2 (CY 2023) and 3 (CY 2024), Medi-Cal managed care plans will receive incentive payments from the Department based on achieving outlined milestones and performance metrics.

This policy change was previously titled CYBHI – Increase Access to Student Behavioral Health Services.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is an increase due to updated payment projection amounts for Needs Assessment and Target Intervention incentive funds. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to issuance of frontloaded Target Intervention Allocation Pool interim payments in FY 2022-23.

Methodology:

1. Assume expenditures of \$199,014,000 TF (\$99,507,000 GF) in FY 2022-23 and \$85,285,000 TF (\$42,642,000 GF) in FY 2023-24.
2. A total of \$398,986,000 TF (\$194,493,000 GF) is available for the local assistance portion of this program, available for expenditure through June 30, 2025. The table below displays the estimated spending and remaining funds by Appropriation Year:

	TF	GF	FF
Appropriation Year 2021-22			
Prior Years	\$19,403,000	\$9,701,500	\$9,701,500
Estimated in FY 2022-23	\$199,014,000	\$99,507,000	\$99,507,000
Estimated in FY 2023-24	\$85,285,000	\$42,642,500	\$42,642,500
Total Estimated Remaining	\$85,284,000	\$42,642,000	\$42,642,000

3. The estimated costs in FY 2022-23 and FY 2023-24 are as follows:

FY 2022-23	TF	GF	FF
50% Title XIX / 50%GF	\$199,014,000	\$99,507,000	\$99,507,000
Total	\$199,014,000	\$99,507,000	\$99,507,000

FY 2023-24	TF	GF	FF
50% Title XIX / 50%GF	\$85,285,000	\$42,642,000	\$42,642,000
Total	\$85,285,000	\$42,642,000	\$42,642,000

*Totals may differ due to rounding

Funding:

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

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

WORKFORCE & QUALITY INCENTIVE PROGRAM

REGULAR POLICY CHANGE NUMBER: 91
IMPLEMENTATION DATE: 2/2023
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2388

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$116,667,000	\$287,114,000
- STATE FUNDS	\$55,300,300	\$136,092,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$116,667,000	\$287,114,000
STATE FUNDS	\$55,300,300	\$136,092,200
FEDERAL FUNDS	\$61,366,700	\$151,021,800

Purpose:

This policy change estimates the cost providing Workforce & Quality Incentive Program (WQIP) directed payments to Freestanding Skilled Nursing Facilities, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facilities, Level-B (FSSA/NF-B).

Authority:

AB 186 (Chapter 46, Statutes of 2022)

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS

Background:

AB 186 established the WQIP for calendar years 2023 through 2026 to provide nursing facilities which meet workforce and quality benchmarks directed payments through the Medi-Cal managed care delivery system. The WQIP succeeds the former Quality & Accountability Supplemental Payment program. AB 186 requires the Department to develop the methodology, parameters and eligibility criteria for receipt of WQIP directed payments in consultation with stakeholders.

Statute requires the Department to set the amount of performance-based directed payments to target an aggregate amount of \$280 million for the 2023 calendar year and to increase the targeted amount in subsequent years by an amount equal to one percent of facilities' non-labor costs.

Reason for Change:

There is no change from the prior estimate for FY 2022-23. The WQIP costs were previously included in the Nursing Facility Financing Reform policy change in the May 2022 Estimate. The Nursing Facility Financing Reform policy change was renamed to Nursing Facility Rate Adjustments in the November 2022 Estimate.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to a 12-month impact is included in FY 2023-24. In addition, a portion of the annual non-labor impact is added to the calendar year 2024 WQIP estimate.

WORKFORCE & QUALITY INCENTIVE PROGRAM

REGULAR POLICY CHANGE NUMBER: 91

Methodology:

1. Assume that WQIP directed payments will be \$280 million for calendar year 2023 and that on a cash basis, 5 months will be included in managed care capitated rates in FY 2022-23 and 12 months will be included in managed care capitated rates in FY 2023-24.
2. Assume that one percent of facilities' non-labor costs in calendar year 2023 equals \$17.074 million. Assume that WQIP directed payments will be \$17.074 million in calendar year 2024 and that on a cash basis 5 months will be included in managed care capitated rates in FY 2023-24 and 12 months will be included in managed care capitated rates in FY 2024-25.

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
WQIP Directed Payments	\$116,667	\$55,300	\$61,367
Total	\$116,667	\$55,300	\$61,367

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
WQIP Directed Payments	\$287,114	\$136,092	\$151,022
Total	\$287,114	\$136,092	\$151,022

Funding:

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

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

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

RECONCILIATION OF MCO TAX FUND 3156

REGULAR POLICY CHANGE NUMBER: 92
IMPLEMENTATION DATE: 12/2022
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2395

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$108,000,000	\$0
- STATE FUNDS	\$108,000,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$108,000,000	\$0
STATE FUNDS	\$108,000,000	\$0
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the additional payments to and recoveries from Managed Care Plans (MCPs) related to the managed care organization (MCO) Tax risk corridor calculations for the remaining MCO Tax Fund 3156 dollars within the General Fund (GF).

Authority:

SB 78 (Chapter 33, Statutes of 2013)

Interdependent Policy Changes:

Not Applicable

Background:

SB 78 was signed by the Governor on June 27, 2013, and authorized a sales tax rate of 3.9375% on the total operating revenue of MCPs for the period July 1, 2013, through June 30, 2016. Total operating revenue is exclusive of amounts received by a MCP pursuant to a subcontract with another MCP to provide health care services to Medi-Cal beneficiaries.

The calculations necessary to complete the reconciliation of MCO Tax Fund 3156 were not available at the time of the previous estimate. The initial calculations have subsequently been performed, and the Department now has an estimate of net amounts owed to MCPs and the residual dollars that will be swept into the GF from the MCO Tax Fund 3156.

Reason for Change:

This is a new policy change.

Methodology:

1. Approximately \$416 million remains in the MCO Tax Fund 3156.
2. Estimated Total Fund (TF) amount to be paid to MCPs in FY 2022-23 is \$108 million. Assume \$308 million will be swept into the GF from the MCO Tax Fund 3156.

RECONCILIATION OF MCO TAX FUND 3156
REGULAR POLICY CHANGE NUMBER: 92

(Dollars in Thousands)

Fiscal Year	TF	GF	SF (3156)
FY 2022-23	\$108,000	(\$308,000)	\$416,000

Funding:

100% GF

100% MCO Tax Fund (3156)

PROP 56 - BEHAVIORAL HEALTH INCENTIVE PROGRAM

REGULAR POLICY CHANGE NUMBER: 93
IMPLEMENTATION DATE: 7/2022
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 2254

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$90,136,000	\$0
- STATE FUNDS	\$39,945,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$90,136,000	\$0
STATE FUNDS	\$39,945,000	\$0
FEDERAL FUNDS	\$50,191,000	\$0

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 Incentive program implemented on January 1, 2021, is intended to incentivize physical and behavioral health outcomes within the Medi-Cal Managed Care program and improve evidence-based medical and behavioral health integration practices.

Proposition 56 funding, along with federal funds, are used to make these payments. This policy change identifies the 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

PROP 56 - BEHAVIORAL HEALTH INCENTIVE PROGRAM

REGULAR POLICY CHANGE NUMBER: 93

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 to the Total Fund from the prior estimate for FY 2022-23; however, there is a decrease in the General Fund due to the increased amount of federal funding from FFCRA from the extension of the national public health emergency. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to the sunset of the Behavioral Health Incentive program on December 31, 2022, with the final payment completed in June 2023.

Methodology:

1. On a cash basis, the total directed payments are estimated to be \$90,136,000 in FY 2022-23.
2. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2023, for this policy change.
3. Below is the payment table for FY 2022-23, by funding type.

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX FF / 50% GF	\$90,136	\$45,068	\$45,068
FFCRA 6.2% Increased FFP	\$0	(\$5,123)	\$5,123
Total	\$90,136	\$39,945	\$50,191

*Differences due to rounding

Funding:

50% Title XIX FF / 50% GF (4260-101-0890/0001)
 FFCRA 6.2% Increased FFP (4260-101-0890)
 FFCRA 6.2% GF (4260-101-0001)

CCI-QUALITY WITHHOLD REPAYMENTS

REGULAR POLICY CHANGE NUMBER: 96
IMPLEMENTATION DATE: 5/2017
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2031

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$19,807,000	\$16,091,000
- STATE FUNDS	\$9,903,500	\$8,045,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$19,807,000	\$16,091,000
STATE FUNDS	\$9,903,500	\$8,045,500
FEDERAL FUNDS	\$9,903,500	\$8,045,500

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, Multi-Purpose Senior Services Program, and other Home and Community-Based Services. 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, increased to 2% in CY 2016, increased to 3% in CY 2017 through CY 2019, and increased to 4% in CY 2020 through CY 2022. Repayments of withholds are based on performance measures.

CCI-QUALITY WITHHOLD REPAYMENTS

REGULAR POLICY CHANGE NUMBER: 96

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 2022-23, is an increase due to the repayment of CY 2018 withholds shifting from FY 2021-22 to FY 2022-23. Both CY 2018 and CY 2019 withholds will now be repaid in FY 2022-23. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to FY 2023-24 being based on the withholds amounts for only CY 2020.

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 CMS and the State will evaluate plan performance according to the specified metrics in order to determine how much of the withheld amount a plan will be repaid for a given year.
3. Assume quality withholds for CY 2018 and CY 2019 will be repaid in FY 2022-23.
4. Assume quality withholds for CY 2020 will be repaid in FY 2023-24.

FY 2022-23	TF	GF	FF
Quality Withhold Repayment (CY 2018 & CY 2019)	\$19,807,000	\$9,903,500	\$9,903,500

FY 2023-24	TF	GF	FF
Quality Withhold Repayment (CY 2020)	\$16,091,000	\$8,045,500	\$8,045,500

Funding:

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

CAPITATED RATE ADJUSTMENT FOR FY 2023-24

REGULAR POLICY CHANGE NUMBER: 101
IMPLEMENTATION DATE: 7/2023
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1338

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$4,077,898,000
- STATE FUNDS	\$0	\$1,411,362,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$4,077,898,000
STATE FUNDS	\$0	\$1,411,362,200
FEDERAL FUNDS	\$0	\$2,666,535,800

Purpose:

The policy change estimates the increase for the Managed Care capitation rates for fiscal year (FY) 2023-24.

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 the base data in order to inform the final capitated rates. This policy change shows the increase in capitation rates from FY 2022-23 to FY 2023-24.

Reason for Change:

The change in capitation rates from FY 2022-23 to FY 2023-24 is a 10.24% average rate increase on a cash basis, primarily due to:

- Draft Calendar Year (CY) 2023 and CY 2024 rate growth projections in the range of 3.5% to 4.0% annually, depending on Managed Care model and year,
- Behavioral Health Treatment (BHT) supplemental payments carving into Managed Care base rates effective January 1, 2023, and
- The transition of the non-Cal MediConnect (CMC) Coordinated Care Initiative (CCI) population into the base rates.

The carve-in costs for BHT and the transition of the non-CMC CCI population into the base rates represent a shift in where these costs are represented in the Estimate. These costs do not represent cost growth.

CAPITATED RATE ADJUSTMENT FOR FY 2023-24

REGULAR POLICY CHANGE NUMBER: 101

Methodology:

1. Assume the following dollars per managed care model:

Managed Care Models	FY 2022-23 Estimated Cost	Rate Adjustment	Dollar Adjustment
Two Plan	\$23,805,907,614	11.89%	\$2,830,790,184
GMC	\$4,621,060,960	10.90%	\$503,613,026
Regional	\$1,456,672,817	3.67%	\$53,495,616
COHS	\$9,924,735,917	6.95%	\$689,999,237
Total	\$39,808,377,308	10.24%	\$4,077,898,063

Funding:

FY 2023-24	Two Plan	COHS	GMC	Regional	Total
Title XIX 50/50 FFP (4260-101-0001/0890)	\$1,667,149,000	\$406,364,000	\$296,595,000	\$31,505,000	\$2,401,613,000
State GF (4260-101-0001)	\$3,414,000	\$832,000	\$607,000	\$65,000	\$4,918,000
Family Planning 90/10 GF (4260-101-0001- 0890)	\$6,550,000	\$1,597,000	\$1,165,000	\$124,000	\$9,436,000
Title XXI 65/35 (4260-101-0001/0890)	\$106,907,000	\$26,058,000	\$19,019,000	\$2,020,000	\$154,004,000
ACA 90% FFP / 10% GF (2020)	\$1,046,771,000	\$255,148,000	\$186,226,000	\$19,782,000	\$1,507,927,000
TF	\$2,830,791,000	\$689,999,000	\$503,612,000	\$53,496,000	\$4,077,898,000
GF	\$979,738,050	\$238,808,800	\$174,300,250	\$18,515,100	\$1,411,362,200
FF	\$1,851,052,950	\$451,190,200	\$329,311,750	\$34,980,900	\$2,666,535,800

MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND

REGULAR POLICY CHANGE NUMBER: 102
IMPLEMENTATION DATE: 2/2019
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2063

	<u>FY 2022-23</u>	<u>FY 2023-24</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:

Not Applicable

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 2022-23, is a decrease due to the GF reimbursement collection in this policy change being updated to align with the most recent corresponding GF expenditure payments and expected GF reimbursement levels. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to growth in the size of programs that are supported by voluntary IGT reimbursements.

MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND

REGULAR POLICY CHANGE NUMBER: 102

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 March 31, 2023, for this policy change and has already been adjusted for in the corresponding GF expenditure payments and expected GF reimbursement levels. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS 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)	\$102,184
CY 2021	\$1,526,640
CY 2022	\$10,541
Total	\$1,639,365
CY 2021 Support Cost to GF	(\$251)
GF	(\$1,639,114)
FY 2022-23 Net Impact	\$0

(Dollars in Thousands)

Reimbursement	GF
CY 2021	\$106,897
CY 2022	\$1,559,511
CY 2023	\$12,818
Total	\$1,679,226
CY 2022 Support Cost to GF	(\$251)
GF	(\$1,678,975)
FY 2023-24 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: 103
IMPLEMENTATION DATE: 2/2021
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2176

	<u>FY 2022-23</u>	<u>FY 2023-24</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: 103

Reason for Change:

The change from the prior estimate, for FY 2022-23, is an increase in MCO tax funds transferred to the GF due to updated funding splits associated with the extension of the public health emergency. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to the MCO Enrollment Tax ending December 31, 2022.

Methodology:

- The 2020 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.
- Different rates are assessed to Medi-Cal and non-Medi-Cal health plans.
- 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 2022-23: \$1,419,526,000

- 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.
- The current MCO Enrollment Tax is expected to end December 31, 2022.
- The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through March 31, 2023, for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.

2020 MCO ENROLLMENT TAX MANAGED CARE PLANS
REGULAR POLICY CHANGE NUMBER: 103

7. The MCO Enrollment Tax fund transfers to the GF are expected to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	MCO Tax
FY 2022-23	\$0	(\$1,576,399)	\$1,576,399

Funding:

3334 MCO Tax

2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ

REGULAR POLICY CHANGE NUMBER: 104
IMPLEMENTATION DATE: 2/2021
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2177

	<u>FY 2022-23</u>	<u>FY 2023-24</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: 104

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a decrease in MCO tax funds transferred to the GF due to updated funding splits associated with the extension of the public health emergency. The change from FY 2022-23 to FY 2023-24, 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 March 31, 2023, for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS 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 2022-23	\$0	(\$489,135)	\$489,135

Funding:

3334 MCO Tax

COORDINATED CARE INITIATIVE RISK MITIGATION

REGULAR POLICY CHANGE NUMBER: 105
IMPLEMENTATION DATE: 6/2023
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2135

	<u>FY 2022-23</u>	<u>FY 2023-24</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. This two-sided risk corridor allows for additional recoveries from MCPs in the event of profit (up-side) above a specific threshold, and additional payments to MCPs in the event of loss (down-side) greater than a specified threshold.

There is also a one-sided (up-side) risk corridor in place for the period of January 1, 2020, through December 31, 2022, for CMC beneficiaries. The necessary data to perform the calculation for this risk corridor is not currently available, thus an estimated net recoupment is unable to be determined at this time. The Department expects any recoupments from MCPs to occur no sooner than FY 2023-24.

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.

COORDINATED CARE INITIATIVE RISK MITIGATION

REGULAR POLICY CHANGE NUMBER: 105

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).

Reason for Change:

There is no change from the prior estimate for FY 2022-23. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to the budgeted recoupments occurring in FY 2022-23. Estimated payments or recoupments for FY 2023-24 are not available at this time.

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 2022-23.
2. Assume all CMC payments and recoupments for DY one (1) through three (3) will occur in FY 2022-23.
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 2022-23.
4. Estimated payments or recoupments for other rating periods that are anticipated to occur in FY 2023-24 are not available at this time.
5. Total recoupments are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2022-23	(\$111,260)	(\$55,630)	(\$55,630)
FY 2023-24	\$0	\$0	\$0

*Totals may differ due to rounding.

Funding:

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

NURSING FACILITY RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 106
IMPLEMENTATION DATE: 1/2023
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2181

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$316,982,000	\$784,603,000
- STATE FUNDS	\$150,249,400	\$371,902,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$316,982,000	\$784,603,000
STATE FUNDS	\$150,249,400	\$371,902,300
FEDERAL FUNDS	\$166,732,600	\$412,700,700

Purpose:

This policy change estimates the cost of extending the skilled nursing facility rate methodology and Quality Assurance Fee (QAF).

Authority:

AB 186 (Chapter 46, Statutes of 2022)

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS

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.

AB 186 extended the nursing facility financing methodology, beginning in January 2023 through December 31, 2026, and made modifications and updates that better balance distribution of the annual rate increase, with a focus on workforce, and creating a glide path to a system that further incentivizes quality and can operate under the Medi-Cal managed care environment

There are four core components: 1) An annual rate increase, 2) A transition from the QASP to a new Workforce and Quality Incentive Program (WQIP) directed payment under Managed Care, 3) a bridge rate in Calendar Year 2023 equivalent to the COVID PHE add-on, and 4) A base rate augmentation starting in Calendar Year (CY) 2024 if a facility meets specified workforce standards such as a collective bargaining

NURSING FACILITY RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 106

agreement or participation in a Labor Management Committee.

Annual Rate Framework

- Annual rate increase would be based on updated annual percentage increase. The ongoing annual percentage increase would have separate budgetary growth limits for labor costs vs other cost categories:
 - 5% for Labor Costs
 - 2% for Non-Labor Costs
- This would establish two rate components going forward with the subsequent years' increase.
- Beginning in calendar year 2024, half of the annual increase for non-labor costs will be allocated to base rates and half to increasing WQIP directed payments.

Transition QASP to a Workforce & Quality Incentive Program Directed Payment under Managed Care

Through consultation with stakeholders, the Department proposes to establish the methodology, parameters and eligibility criteria for receipt of WQIP directed payments. The Department proposes to modify the qualifying criteria for a quality increase from a percentile method to a benchmark and threshold method. This would ensure that all facilities are eligible to receive a quality increase if they meet an established threshold of quality in each measure and facilities that meet the higher quality benchmark receive a greater per diem award.

Calendar 2023 Bridge Rate Equivalent to COVID-19 PHE rate add-on

For CY 2023 only, facilities would receive a bridge rate add-on equivalent to the current COVID-19 PHE rate add-on. This add-on would not be considered part of the base rate for future rate increases. The funds will continue to be restricted to allowable costs set forth in AB 81 and subject to audit. Additionally, at least 85% of the funds from the add-on must be used for labor costs (increased wages or benefits, shift incentive payments, staff retention bonuses, pay differential for workers employed by more than one facility, or overtime payments to nonmanagerial workers). Spent funds determined not to meet these requirements will be recouped and redistributed to the Workforce & Quality Incentive Program.

Workforce Standards and Base Rate Augmentation

For CY 2024 through CY 2026, DHCS would establish workforce standards such as a collective bargaining agreement or similar agreement, prevailing wage, average salary above minimum wage, participation in a Labor Management Committee of skilled nursing facility employers and workers, or other determined factors. These criteria could vary based on facility demographics or other factors, such as facility size or rural versus urban location. Facilities that meet the workforce standards would receive a base rate augmentation. A facility could receive the base rate augmentation for the first time in CY 2024, CY 2025, or CY 2026 depending on when the facility meets the workforce standards. Subsequent annual rate increases for a facility that has met and continues to meet the workforce standards would be calculated off of the augmented base rate subject to the annual growth limits described in the May Revision proposal. Annual rate increases for a facility which has not yet met or fails to continue to meet the workforce standards would be calculated off of the unaugmented base rate subject to the annual growth limits described in the May Revision proposal.

Receipts from the extended QAF are budgeted in the Long-Term Care Quality Assurance Fund Expenditures policy change.

The WQIP directed payments are budgeted in the Workforce & Quality Incentive Program policy change.

NURSING FACILITY RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 106

Reason for Change:

The change in FY 2022-23, from the prior estimate, is due to:

- Updated nursing facility days,
- Updated estimate of the CY 2023 COVID-19 PHE rate add-on, and
- Removing the WQIP estimated costs from this policy change. These costs are now budgeted in the separate Workforce & Quality Incentive Program policy change.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to:

- Including 12 months of the CY 2023 rate increase and 5 months of the CY 2024 rate increase in FY 2023-24, and
- Including the remaining CY 2023 COVID-19 PHE rate add-on in FY 2023-24.

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. Assume that a rate add-on equivalent to the COVID-19 PHE rate add-on is continued for Calendar Year 2023.
3. Assume a base rate augmentation starting in Calendar Year (CY) 2024 if a facility meets specified workforce standards.
4. The cash basis managed care rate adjustment impact for FY 2022-23 and FY 2023-24 is estimated to be:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Rate Increase	\$94,160	\$44,632	\$49,528
COVID-19 Add-on	\$222,822	\$105,617	\$117,205
Total	\$316,982	\$150,249	\$166,733

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Rate Increase	\$472,653	\$224,038	\$248,615
COVID-19 Add-on	\$311,950	\$147,864	\$164,086
Total	\$784,603	\$371,902	\$412,701

Funding:

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

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

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

RATE INCREASE FOR FQHCS/RHCS/CBRCS

REGULAR POLICY CHANGE NUMBER: 107
IMPLEMENTATION DATE: 10/2005
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 88

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$341,180,000	\$347,028,000
- STATE FUNDS	\$125,939,550	\$128,098,200
PAYMENT LAG	0.9231	0.9372
% REFLECTED IN BASE	0.60 %	0.60 %
APPLIED TO BASE		
TOTAL FUNDS	\$313,053,600	\$323,283,200
STATE FUNDS	\$115,557,270	\$119,333,310
FEDERAL FUNDS	\$197,496,330	\$203,949,920

Purpose:

This policy change estimates the rate increase for all Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) under the prospective payment system (PPS) reimbursement methodology and the rate increase for Cost-Based Reimbursement Clinics (CBRCs).

Authority:

Section 1833 of the Social Security Act
Welfare & Institutions Code, section 14170 and 14132.100

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS

Background:

The Benefits Improvement and Protection Act of 2000 required the Department to reimburse FQHCs and RHCs based on the PPS reimbursement methodology. Clinics chose a PPS rate based on either 1) the average of the clinic's 1999 and 2000 cost-based rate or, 2) the clinic's 2000 cost-based rate. The clinic receives an annual rate adjustment based on the percentage increase in the Medicare Economic Index and is effective October 1st of each year.

The Department reimburses the CBRCs, owned or operated by Los Angeles County, at 100% of reasonable and allowable costs. The Department pays an interim rate to the clinics, which is adjusted once the audit reports are finalized. The interim rate is adjusted July 1 of each year.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a decrease due to a lower estimated CBRC rate increase based on the FY 2020-2021 reported rates and a three year average of visits. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to the projected increase in rates and visits.

Methodology:

1. The projected visits are based on the average percent increase of the last three years of actual visit counts.

RATE INCREASE FOR FQHCS/RHCS/CBRCS
REGULAR POLICY CHANGE NUMBER: 107

2. The rate increase will be used as a trend factor to calculate the estimated cost per visit rate. The rate increase percent was 4.36% for calendar year (CY) 2021 and 4.06% for CY 2022 and CY 2023.

Rate Year	Projected Visits	Current Rate	Rate with Increase
2021	21,489,314	\$180.85	\$180.85 x (1+4.36%) = \$188.74
2022	22,103,722	\$188.74	\$188.74 x (1+4.06%) = \$196.40
2023	22,735,697	\$196.40	\$196.40 x (1+4.06%) = \$204.37

3. The estimated expenditures are the increased rate multiplied by the number of projected visits. The projected annual expenditures due to the rate increase are:

(Dollars in Thousands)

Federal Rate Year	Expenditures	Exp. with Increase	Rate Increase
2021	\$3,886,342	\$4,055,893	\$169,551
2022	\$4,171,856	\$4,341,171	\$169,315
2023	\$4,465,291	\$4,646,494	\$181,204

4. The FY 2022-23 CBRC rate increase of \$44,643,000 is based on the FY 2020-2021 reported rates and a three year average of visits. The estimated payment increase is determined by the difference between the calculated estimated payments and the total three year average payments per the Paid Claims Summary Reports for FY 2019-20, FY 2020-21, and FY 2021-22.
5. The FY 2023-24 CBRC rate decrease of \$2,832,000 is based on the FY 2020-21 reported rates. FY 2020-21 reported rates utilized a three year average of payment data from the Paid Claims Summary Reports for FY 2020-21 and FY 2021-22 and the FY 2022-23 estimates. The estimated payment decrease is determined by the difference between the calculated estimated payments and the total three year average of visits and payments.
6. The estimated expenditures in FY 2022-23 and FY 2023-24 are:

(Dollars in Thousands)

FY 2022-23	TF
CY 2022 Increase	\$170,590
CY 2023 Increase	\$170,590
FY 2022-23 Total	\$341,180

FY 2023-24	TF
CY 2023 Increase	\$173,514
CY 2024 Increase	\$173,514
FY 2023-24 Total	\$347,028

RATE INCREASE FOR FQHCS/RHCS/CBRCS
REGULAR POLICY CHANGE NUMBER: 107

Funding:

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF	\$220,177,000	\$110,089,000	\$110,088,000
90% Title XIX ACA / 10% GF	\$106,000,000	\$10,600,000	\$95,400,000
65% Title XXI / 35% GF	\$15,003,000	\$5,251,000	\$9,752,000
FY 2022-23 Total	\$341,180,000	\$125,940,000	\$215,240,000

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF	\$223,951,000	\$111,976,000	\$111,975,000
90% Title XIX ACA / 10% GF	\$107,817,000	\$10,782,000	\$97,035,000
65% Title XXI / 35% GF	\$15,260,000	\$5,341,000	\$9,919,000
FY 2023-24 Total	\$347,028,000	\$128,099,000	\$218,929,000

*Totals may differ due to rounding.

**COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

GROUND EMERGENCY MEDICAL TRANSPORTATION QAF

REGULAR POLICY CHANGE NUMBER: 108
IMPLEMENTATION DATE: 4/2019
ANALYST: Thomas Soteros-McNamara
FISCAL REFERENCE NUMBER: 2081

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$221,308,000	\$189,593,000
- STATE FUNDS	\$64,187,000	\$60,473,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	13.10 %	6.82 %
APPLIED TO BASE		
TOTAL FUNDS	\$192,316,700	\$176,662,800
STATE FUNDS	\$55,778,500	\$56,348,740
FEDERAL FUNDS	\$136,538,150	\$120,314,020

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)
 Families First Coronavirus Response Act (FFCRA)
 AB 1705 (Chapter 544, Statutes of 2019)
 SPA 20-0009
 SPA 21-0017

Interdependent Policy Changes:

PP-GEMT IGT Program

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 fiscal year (FY) in the amount of 10 percent of the annual QAF collection amount, and 3) to be used, along with a federal match, to provide an add-on to the reimbursement rates for base ground emergency transport services.

The Department collects gross transport and revenue data from GEMT providers in order to calculate an annual QAF amount. The QAF is assessed on each GEMT transport for base ground emergency medical services, effective July 1, 2018. The revenue generated by the QAF collections is deposited directly into the Medi-Cal Emergency Medical Transportation Fund (MEMTF).

For fiscal year 2018-19, the Department was required to provide an add-on to the Medi-Cal FFS reimbursements for codes A0427 Advanced Life Support (ALS) Emergency, A0429 Basic Life Support (BLS) Emergency, and A0433 ALS2 using available QAF revenue, effective July 1, 2018.

GROUND EMERGENCY MEDICAL TRANSPORTATION QAF

REGULAR POLICY CHANGE NUMBER: 108

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, was approved on August 20, 2021. SPA 22-0040, for the FY 2022-23 add-on, was submitted to CMS in July 2022.

AB 1705 requires the Department to implement a public provider GEMT intergovernmental transfer (PP-GEMT IGT) program, utilizing intergovernmental transfers. The public providers currently in the GEMT QAF program will transition into the new AB 1705 PP-GEMT IGT Program. Beginning January 1, 2023, these providers would no longer participate in the GEMT QAF program and funds associated with AB 1705 (public providers) will shift into the PP-GEMT IGT 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 2022-23, from the prior estimate, is a small net increase due to updated spending projections, primarily in managed care.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to public providers having shifted to the PP-GEMT IGT Program for a full year during FY 2023-24.

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 \$77,089,000 in FY 2022-23 and \$72,652,000 in FY 2023-24.
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 \$7,132,000 for FY 2022-23 and \$6,719,000 for FY 2023-24. The FY 2018-19, FY 2019-20, and FY 2020-21 offsets are estimated to be delayed until after FY 2023-24.
5. From the remaining GEMT QAF revenue available, total annual GEMT add-on payments for FY 2022-23 are estimated to be \$221,308,000 TF, of which \$28,999,000 TF is for FFS and \$192,309,000 TF is for Managed Care GEMT transport services.
6. From the remaining GEMT QAF revenue available, total annual GEMT add-on payments for FY 2023-24 are estimated to be \$189,593,000 TF, of which \$12,927,000 TF is for FFS and \$176,666,000 TF is for Managed Care GEMT transport services.

GROUND EMERGENCY MEDICAL TRANSPORTATION QAF
REGULAR POLICY CHANGE NUMBER: 108

7. FFS Payments: Beginning January 1, 2023, a decrease in FY 2022-23 add-on payments is expected due to the impact of the AB 1705 PP-GEMT IGT Program.
8. Managed Care Payments:
 - a. FY 2022-23 is expected to include 7 months of the CY 2022 rates and 5 months of the CY 2023 rates.
 - b. FY 2023-24 is expected to include 7 months of the CY 2023 rates and 5 months of the CY 2024 rates.
 - c. A decrease in the CY 2023 rates is expected due to the impact of AB 1705 PP-GEMT IGT Program.
9. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through March 31, 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
10. The cash basis estimate is summarized as follows:

FY 2022-23	TF	GF	MEMTF	FF	FFCRA
FFS Payments	\$28,999,000	\$0	\$8,480,000	\$19,784,000	\$735,000
MC Payments	\$192,309,000	\$0	\$55,707,000	\$131,564,000	\$5,038,000
GF Offset 2021-22	\$0	(\$7,132,000)	\$7,132,000	\$0	\$0
Total	\$221,308,000	(\$7,132,000)	\$71,319,000	\$151,348,000	\$5,773,000

FY 2023-24	TF	GF	MEMTF	FF
FFS Payments	\$12,927,000	\$0	\$4,108,000	\$8,819,000
MC Payments	\$176,666,000	\$0	\$56,365,000	\$120,301,000
GF Offset 2022-23	\$0	(\$6,719,000)	\$6,719,000	\$0
Total	\$189,593,000	(\$6,719,000)	\$67,192,000	\$129,120,000

Funding:

FY 2022-23	TF	GF	MEMTF	FF	FFCRA
100% General Fund (4260-101-0001)	(\$7,132,000)	(\$7,132,000)	\$0	\$0	\$0
MEMTF (4260-601-3323)	\$71,319,000	\$0	\$71,319,000	\$0	\$0
ACA Title XIX FF (4260-101-0890)	\$88,961,000	\$0	\$0	\$88,961,000	\$0
Title XIX FF (4260-101-0890)	\$57,380,000	\$0	\$0	\$57,380,000	\$0
Title XXI FF (4260-101-0890)	\$5,007,000	\$0	\$0	\$5,007,000	\$0
FFCRA 4.34% FF	\$267,000	\$0	\$0	\$0	\$267,000
FFCRA 6.2% FF	\$5,506,000	\$0	\$0	\$0	\$5,506,000
Total	\$221,308,000	(\$7,132,000)	\$71,319,000	\$151,348,000	\$5,773,000

GROUND EMERGENCY MEDICAL TRANSPORTATION QAF
REGULAR POLICY CHANGE NUMBER: 108

FY 2023-24	TF	GF	MEMTF	FF
100% General Fund (4260-101-0001)	(\$6,719,000)	(\$6,719,000)	\$0	\$0
MEMTF (4260-601-3323)	\$67,192,000	\$0	\$67,192,000	\$0
ACA Title XIX FF (4260-101-0890)	\$75,096,000	\$0	\$0	\$75,096,000
Title XIX FF (4260-101-0890)	\$49,918,000	\$0	\$0	\$49,918,000
Title XXI FF (4260-101-0890)	\$4,106,000	\$0	\$0	\$4,106,000
Total	\$189,593,000	(\$6,719,000)	\$67,192,000	\$129,120,000

PP-GEMT IGT PROGRAM

REGULAR POLICY CHANGE NUMBER: 109
IMPLEMENTATION DATE: 1/2023
ANALYST: Thomas Soteros-McNamara
FISCAL REFERENCE NUMBER: 2267

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$149,218,000	\$339,077,000
- STATE FUNDS	\$48,600,000	\$118,485,000
PAYMENT LAG	0.9596	0.9986
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$143,189,600	\$338,602,300
STATE FUNDS	\$46,636,560	\$118,319,120
FEDERAL FUNDS	\$96,553,030	\$220,283,170

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)
 Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

Ground Emergency Transportation QAF

Background:

AB 1705 requires the Department to implement the Public Provider GEMT Intergovernmental Transfer (PP-GEMT IGT) 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. Pursuant to AB 1705, the GEMT Supplemental Payment Program for public governmental entities is assumed to sunset on December 31, 2022. The reimbursements made to public providers currently in the GEMT QAF program will transition into the new PP-GEMT IGT Program. The Department will implement the PP-GEMT IGT program effective January 1, 2023. As of January 1, 2023, public providers will no longer be eligible to 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 IGT PROGRAM

REGULAR POLICY CHANGE NUMBER: 109

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 2022-23, from the prior estimate, is an increase due to higher calendar year 2023 supplemental reimbursement rates in managed care and higher projected enrollment.

The change from FY 2022-23 to FY 2023-24 in the current estimate is an increase, due to FY 2023-24 capturing a full twelve months of program expenditures.

Methodology:

1. Assume the PP-GEMT IGT program will be implemented on January 1, 2023.
2. The total payments in FY 2022-23 on an accrual basis are expected to be \$149,218,000 TF, of which \$18,426,000 TF is FFS and \$130,792,000 is for managed care.
3. 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 \$4,145,000.
4. The total payments in FY 2023-24 on an accrual basis are expected to be \$339,077,000 TF, of which \$36,851,000 is FFS and \$302,226,000 is for managed care.
5. Assume that the transfer to the GF for FY 2023-24, based on the 10 percent assessment of each IGT and costs to administer the program, is \$11,134,000.
6. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through March 31, 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
7. FY 2022-23 and FY 2023-24 are summarized as follows:

FY 2022-23	TF	GF	IGT*	FF	FFCRA
GF Offset	\$0	(\$4,145,000)	\$4,145,000	\$0	\$0
FFS Payments	\$18,426,000	\$0	\$5,544,000	\$12,571,000	\$311,000
Managed Care Payments	\$130,792,000	\$0	\$43,056,000	\$85,209,000	\$2,527,000
Total:	\$149,218,000	(\$4,145,000)	\$52,745,000	\$97,780,000	\$2,838,000

PP-GEMT IGT PROGRAM
REGULAR POLICY CHANGE NUMBER: 109

FY 2023-24	TF	GF	IGT*	FF
GF Offset	\$0	(\$11,134,000)	\$11,134,000	\$0
FFS Payments	\$36,851,000	\$0	\$11,710,000	\$25,141,000
Managed Care Payments	\$302,226,000	\$0	\$106,775,000	\$195,451,000
Total:	\$339,077,000	(\$11,134,000)	\$129,619,000	\$220,592,000

Funding:

FY 2022-23	TF	GF	IGT*	FF
100% GF (4260-101-0001)	\$0	(\$4,145,000)	\$4,145,000	\$0
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$89,245,000	\$0	\$44,623,000	\$44,622,000
90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$56,702,000	\$0	\$5,670,000	\$51,032,000
65% Title XXI FF / 35% GF (4260-113-0890)	\$3,271,000	\$0	\$1,145,000	\$2,126,000
FFCRA 4.34% GF	(\$71,000)	\$0	(\$71,000)	\$0
FFCRA 4.34% FF	\$71,000	\$0	\$0	\$71,000
FFCRA 6.2% GF	(\$2,767,000)	\$0	(\$2,767,000)	\$0
FFCRA 6.2% FF	\$2,767,000	\$0	\$0	\$2,767,000
Total	\$149,218,000	(\$4,145,000)	\$52,745,000	\$100,618,000

FY 2023-24	TF	GF	IGT*	FF
100% GF (4260-101-0001)	\$0	(\$11,134,000)	\$11,134,000	\$0
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$103,350,000	\$0	\$103,350,000	\$103,351,000
90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$12,479,000	\$0	\$12,479,000	\$112,308,000
65% Title XXI FF / 35% GF (4260-101-0001 / 0890)	\$223,248,000	\$0	\$2,656,000	\$4,933,000
Total	\$339,077,000	(\$11,134,000)	\$129,619,000	\$220,592,000

*Reimbursement GF (4260-601-0995)

FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER: 110
IMPLEMENTATION DATE: 7/2008
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 1329

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$124,335,000	\$115,009,000
- STATE FUNDS	\$45,895,700	\$42,453,150
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	16.64 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$103,645,700	\$115,009,000
STATE FUNDS	\$38,258,660	\$42,453,150
FEDERAL FUNDS	\$65,387,000	\$72,555,850

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.

Currently, there are 1,556 active FQHCs, 274 active RHCs, 27 active CBRCs, 62 active IHS/MOAs, and 48 active Tribal FQHCs that transitioned from IHS/MOAs.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is an overall net decrease due to a decrease in CBRC visits and provider reported rates. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an overall net decrease due to FY 2023-24 being based on a three-year average of EPCs and actual settlement recoveries from July 2020 through June 2022 and the FY 2022-23 estimated amounts.

FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER: 110

Methodology:

1. FY 2022-23 FQHC and RHC reconciliations are based on a three-year average of actual settlements from July 2019 through June 2022. The FY 2023-24 reconciliations are based on a three-year average of actual settlements from July 2020 through June 2022 and the FY 2022-23 estimated amounts. The FQHC reconciliation amount includes settlements for IHS.
2. The estimated FQHC retroactive rate adjustment of \$78,153,000 for FY 2022-23 is based on pending EPCs and an average of paid EPCs from July 2019 through June 2022. For FY 2023-24, the amount of \$71,053,000 is based on a three-year average of EPCs from July 2020 through June 2022 and the FY 2022-23 estimated amount. 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 2022-23 is based on a three-year average of actual settlements from July 2019 through June 2022. The FY 2023-24 reconciliation is based on a three-year average of actual settlements from July 2020 through June 2022 and the FY 2022-23 estimated amount. The change from the prior estimate is due to a decrease in both visits and provider reported rates.

Reconciliations and Adjustments	FY 2022-23	FY 2023-24
FQHCs Reconciliation	\$24,576,000	\$19,615,000
RHCs Reconciliation	\$9,606,000	\$8,542,000
FQHC Retroactive Rate Adjustment	\$78,153,000	\$71,053,000
LA CBRCs Reconciliation	\$12,000,000	\$15,799,000
Total	\$124,335,000	\$115,009,000

FY 2022-23	TF	GF	FF
90% Title XIX ACA / 10% GF	\$38,629,000	\$3,863,000	\$34,766,000
65% Title XXI / 35% GF	\$5,468,000	\$1,914,000	\$3,554,000
50% Title XIX / 50% GF	\$80,238,000	\$40,119,000	\$40,119,000
Total	\$124,335,000	\$45,896,000	\$78,439,000

*Totals may differ due to rounding.

FY 2023-24	TF	GF	FF
90% Title XIX ACA / 10% GF	\$35,732,000	\$3,573,000	\$32,159,000
65% Title XXI / 35% GF	\$5,057,000	\$1,770,000	\$3,287,000
50% Title XIX / 50% GF	\$74,220,000	\$37,110,000	\$37,110,000
Total	\$115,009,000	\$42,453,000	\$72,556,000

*Totals may differ due to rounding.

FQHC/RHC/CBRC RECONCILIATION PROCESS
REGULAR POLICY CHANGE NUMBER: 110

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)

65% Title XXI / 35% GF (4260-101-0001/0890)

DPH INTERIM RATE GROWTH

REGULAR POLICY CHANGE NUMBER: 111
IMPLEMENTATION DATE: 7/2020
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1162

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$77,175,000	\$169,553,000
- STATE FUNDS	\$27,553,100	\$59,910,100
PAYMENT LAG	0.8816	0.8510
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$68,037,500	\$144,289,600
STATE FUNDS	\$24,290,810	\$50,983,500
FEDERAL FUNDS	\$43,746,670	\$93,306,110

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 2022-23, from the prior estimate, is due to:

- Updated DPH actual data through July 2022,
- The DPH county growth rate for FY 2022-23 is included in the Fee-for-Service (FFS) base and no longer reflected in the policy change, and
- A decrease in estimated DPH expenditures.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to an increase in estimated DPH expenditures in FY 2023-24.

Methodology:

1. The FY 2022-23 interim rates were implemented in July 2022.
2. Assume the FY 2023-24 interim rates will be implemented July 2023.
3. For FY 2022-23:
 - Assume a 9.20% interim rate increase for community-based DPHs.

DPH INTERIM RATE GROWTH

REGULAR POLICY CHANGE NUMBER: 111

- The county-based DPH interim rate growth is considered in the base and is not included in this policy change.
 - Assume no COVID-19 rate increase for county and community-based DPHs.
 - An additional cost of \$77,175,000 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 \$68,041,000 TF.
4. For FY 2023-24:
- Assume a 4.47% interim rate increase for county and 8.82% for community-based DPHs.
 - Assume no COVID-19 rate increase for county and community-based DPHs.
 - An additional cost of \$169,553,000 TF is estimated for the FY 2023-24 interim rates. The lagged cost on a cash basis, not in the base, is estimated to be approximately \$144,292,000 TF.
5. 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)

DPH INTERIM RATE COVID-19 INCREASED FMAP ADJUST

REGULAR POLICY CHANGE NUMBER: 112
IMPLEMENTATION DATE: 7/2022
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 2238

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$87,343,000	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$87,343,000	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$87,343,000	\$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:

Not Applicable

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 March 31, 2023.

Reason for Change:

The change in FY 2022-23, from the prior estimate, is an increase in expenditures due to:

- Shifting the April 2022 payment from FY 2021-22 to FY 2022-23,
- Assuming FFCRA increased FMAP through March 31, 2023, resulting in an additional nine months of payments and,

DPH INTERIM RATE COVID-19 INCREASED FMAP ADJUST

REGULAR POLICY CHANGE NUMBER: 112

- Updating the projected monthly payments based on an average of actual expenditures.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to assuming the FFCRA increased FMAP will end on March 31, 2023, and no payments will occur in FY 2023-24.

Methodology:

1. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through March 31, 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
2. Actual payments for April 2022 and May 2022 service months were made in August 2022 and September 2022.
3. April 2021-March 2022 actual amounts were used to project from June 2022 through March 2023.
4. The estimated adjustment payments on a cash basis are:

(Dollars in Thousands)

Fiscal Year	TF	FF
FY 2022-23	\$87,343	\$87,343

Funding:

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

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 113
IMPLEMENTATION DATE: 8/2007
ANALYST: Thomas Soteros-McNamara
FISCAL REFERENCE NUMBER: 1046

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$210,285,000	\$124,348,000
- STATE FUNDS	\$102,617,050	\$60,680,900
PAYMENT LAG	0.9783	0.9577
% REFLECTED IN BASE	75.61 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$50,175,600	\$119,088,100
STATE FUNDS	\$24,485,180	\$58,114,100
FEDERAL FUNDS	\$25,690,370	\$60,973,980

Purpose:

This policy change estimates the annual long-term care (LTC) rate adjustment for Nursing Facility-A (NF-A), Distinct Part (DP) Nursing Facility-B (DP/NF-B), Rural Swing Bed, 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). Finally, it 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

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.

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.

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 113

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%.

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.

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%.

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.

The 2022 Budget Act transitioned Proposition 56 supplemental payments for ICF/DDs and FS-PSAs to ongoing rate increase funded from the General Fund. SPA 22-0061 will incorporate amounts equivalent to the former Proposition 56 supplemental payment amounts into the facility's base rates. For RY 2022-23, Proposition 56 supplemental payment amounts are included in the annual base rate build up.

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.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a modest net increase due to:

- Retroactive rate adjustments for certain facilities previously scheduled to be paid in FY 2021-22 were delayed until July 2022.

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 113

- Higher projected costs for ICF-DD facility rate increases in FY 2022-23.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a net decrease due to fewer retroactive adjustments projected to be paid in FY 2023-24 compared to FY 2022-23.

Methodology:

- The effective date for the rate adjustments is August 1st of each rate year. The expected RY 2022-23 and RY 2023-24 implementation dates are as follows:

Facility	FY 2022-23	FY 2023-24
DP/NF-B	11/1/2022	11/1/2023
Rural Swing Beds (non-exempt)	11/1/2022	11/1/2023
Rural Swing Beds (exempt)	11/1/2022	11/1/2023
DP Adult Subacute	11/1/2022	11/1/2023
NF-A	11/1/2022	11/1/2023
ICF/DDs	11/1/2022	11/1/2023
DP Pediatric Subacute	10/15/2022	10/15/2023
FS Pediatric Subacute	10/15/2022	10/15/2023

- The estimated managed care rate adjustment impacts for RY 2022-23 and 2023-24 are not reflected in this policy change, but are included in the managed care capitation rates.
- Assume add-ons remain in place for ongoing costs for providers' rates impacted by a rate freeze. The add-on descriptions are listed below:
 - SB 3 (Chapter 4, Statutes of 2016) Minimum Wage Increases: For employers who employ 26 or more employees.
 - \$10.50 per hour, effective January 2017.
 - \$11.00 per hour, effective January 2018.
 - \$12.00 per hour, effective January 2019.
 - \$13.00 per hour, effective January 2020.
 - \$14.00 per hour, effective January 2021.
 - \$15.00 per hour, effective January 2022.
 - \$15.50 per hour, effective January 2023.
 - \$16.00 per hour, effective January 2024 (estimated)
 - Payroll-Based Journal: Effective July 1, 2016, CMS requires facilities to submit direct care staffing information based on payroll data.

LTC RATE ADJUSTMENT
REGULAR POLICY CHANGE NUMBER: 113

4. The costs below reflect the incremental rate adjustments and add-ons for each facility type:

Fee-for-Service	FY 2022-23	FY 2023-24
Rate Adjustment (21-22)		
DP/NF-B	\$21,647,000	
Rural Swing Beds (non-exempt)	\$0	
Rural Swing Beds (exempt)	\$15,000	
DP Adult Subacute	\$4,286,000	
NF-A	\$130,000	
ICF/DDs	\$103,896,000	
DP Pediatric Subacute	\$884,000	
FS Pediatric Subacute	\$5,181,000	
Rate Adjustment (22-23)		
DP/NF-B	\$9,562,000	\$14,342,000
Rural Swing Beds (non-exempt)	\$0	\$0
Rural Swing Beds (exempt)	\$11,000	\$16,000
DP Adult Subacute	\$3,646,000	\$5,469,000
NF-A	\$22,000	\$33,000
ICF/DDs	\$25,252,000	\$37,877,000
DP Pediatric Subacute	\$647,000	\$971,000
FS Pediatric Subacute	\$680,000	\$1,020,000
Rate Adjustment (23-24)		
DP/NF-B		\$9,764,000
Rural Swing Beds (non-exempt)		\$0
Rural Swing Beds (exempt)		\$12,000
DP Adult Subacute		\$2,928,000
NF-A		\$1,000
ICF/DDs		\$32,944,000
DP Pediatric Subacute		\$678,000
FS Pediatric Subacute		\$669,000
Retro Rate Adjustments		
DP/NF-B	\$18,017,000	\$3,662,000
Rural Swing Beds (non-exempt)	\$0	\$0
Rural Swing Beds (exempt)	\$14,000	\$5,000
DP Adult Subacute	\$1,367,000	\$1,098,000
NF-A	\$8,000	\$0
ICF/DDs	\$9,469,000	\$12,354,000
DP Pediatric Subacute	\$979,000	\$254,000
FS Pediatric Subacute	\$4,572,000	\$251,000
Total FFS	\$210,285,000	\$124,348,000

LTC RATE ADJUSTMENT
REGULAR POLICY CHANGE NUMBER: 113

Funding:

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	\$198,862,000	\$99,431,000	\$99,431,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	\$3,248,000	\$325,000	\$2,923,000
65% Title XXI / 35% GF (4260-113-0001 / 0890)	\$8,175,000	\$2,861,000	\$5,314,000
Total	\$210,285,000	\$102,617,000	\$107,668,000

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	\$117,594,000	\$58,797,000	\$58,797,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	\$1,920,000	\$192,000	\$1,728,000
65% Title XXI / 35% GF (4260-101-0001 / 0890)	\$4,834,000	\$1,692,000	\$3,142,000
Total	\$124,348,000	\$60,681,000	\$63,667,000

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

AB 1629 ANNUAL RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 114
IMPLEMENTATION DATE: 8/2014
ANALYST: Thomas Soteros-McNamara
FISCAL REFERENCE NUMBER: 1508

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$98,263,000	\$65,726,000
- STATE FUNDS	\$46,293,500	\$30,965,000
PAYMENT LAG	0.9946	1.0000
% REFLECTED IN BASE	68.38 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$30,903,000	\$0
STATE FUNDS	\$14,558,960	\$0
FEDERAL FUNDS	\$16,344,020	\$0

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 81 (Chapter 13, Statutes of 2020)
 SPA 20-0023

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS

Background:

AB 1629 requires the Department to implement a facility-specific rate methodology and impose a Quality Assurance Fee (QAF) on FS/NF-B, and FSSA/NF-B facilities. The QAF is used to offset a portion of the General Fund (GF) costs associated with paying FS/NF-B and FSSA/NF-B reimbursement rates.

The QAF is used as a means to enhance federal financial participation (FFP) for the Medi-Cal program as well as to provide higher reimbursement to support quality improvement efforts in these facilities.

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, 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,

AB 1629 ANNUAL RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 114

- 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.

AB 186 (Chapter 46, Statutes of 2022) extends the nursing facility financing methodology beginning in January 2023 through January 31, 2026. The impacts of AB 186 are estimated in the Nursing Facility Rate Adjustments policy change.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a net decrease due to:

- Impacts for rate increases from the August-December 2020 rating period and Calendar Year 2021 rating periods are assumed to be in the base and are no longer reflected in this policy change.
- Modestly increased costs for Calendar Year 2022 rates related to revised days assumptions.

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. The rate increase for CY 2022 is 2.4%. This rate implemented in June 2022 for FS/NF-B facilities and in May 2022 for FSSA/NF-B facilities. The retroactive payment for FS/NF-B facilities occurred in August 2022. The retroactive payment for FSSA/NF-B facilities occurred in July 2022.
2. The estimated managed care rate adjustment impact for this rate increase is included in the FY 2021-22 and FY 2022-23 managed care capitation rates.
3. 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

AB 1629 ANNUAL RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 114

4. The estimated payments on a cash basis are:

	FY 2022-23	FY 2023-24
FFS (Rate Increase)		
CY 2022 rate	\$81,113,000	\$81,113,000
Add-Ons		
CY 2022 add-ons	(\$15,388,000)	(\$15,387,000)
Retro		
CY 2022 rate	\$40,207,000	
CY 2022 add-ons	(\$7,669,000)	
Total	\$98,263,000	\$65,726,000
Managed Care	\$65,902,000	\$112,975,000
Total FFS + MC	\$164,165,000	\$178,701,000

Funding:

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	\$91,168,000	\$45,584,000	\$45,584,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	\$7,095,000	\$710,000	\$6,385,000
Total	\$98,263,000	\$46,294,000	\$51,969,000

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	\$60,981,000	\$30,491,000	\$30,490,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	\$4,745,000	\$474,000	\$4,271,000
Total	\$65,726,000	\$30,965,000	\$34,761,000

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

AB 97 ELIMINATIONS

REGULAR POLICY CHANGE NUMBER: 115
IMPLEMENTATION DATE: 7/2022
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2347

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$20,443,000	\$28,407,000
- STATE FUNDS	\$8,061,200	\$11,022,400
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$20,443,000	\$28,407,000
STATE FUNDS	\$8,061,200	\$11,022,400
FEDERAL FUNDS	\$12,381,800	\$17,384,600

Purpose:

This policy change estimates the costs of eliminating the AB 97 (Chapter 3, Statutes of 2011) provider payment reductions for certain providers.

Authority:

SB 184 (Chapter 47, Statutes of 2022)
 Welfare & Institutions Code 14105.192
 Proposed State Plan Amendment 22-0039

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS

Background:

The Budget Act of 2022 and SB 184 (Chapter 47, Statutes of 2022) authorized the exemption of specified services and providers from the AB 97 payment reductions, effective July 1, 2022 and January 1, 2023.

The following services and providers will be exempt from the AB 97 payment reductions for dates of service on or after July 1, 2022:

- Nurses, including certified nurse-midwives, nurse anesthetists, certified pediatric nurse practitioners, certified family nurse practitioners, and group certified pediatric nurse practitioners.
- Alternative Birthing Centers
- Audiologists/hearing aid dispensers
- Respiratory care providers
- Durable Medical Equipment (DME)
- Chronic dialysis clinics
- Emergency medical air transportation services
- Non-emergency medical transportation (NEMT) services (Transition of funding of NEMT providers from a Proposition 56 supplemental payment to an AB 97 exclusion)
- Doula services
- Community health worker services

AB 97 ELIMINATIONS

REGULAR POLICY CHANGE NUMBER: 115

- DME and related supplies or accessories, that is a continuous glucose monitoring system or continuous glucose monitoring system supplies and accessories
- Physician services and services by other licensed practitioners delivered via remote patient monitoring (RPM)
- Asthma prevention services
- Dyadic services
- Medication therapy management services
- Clinical laboratory services, that are 2019 novel coronavirus disease (COVID-19) diagnostic testing or specimen collection services
- Blood Banks
- Occupational Therapy
- Orthotists
- Psychologists
- Medical Social Work or Medical Social Services
- Speech pathologists
- Outpatient heroin detoxification services
- Dispensing opticians
- Optometrists, including optometry groups
- Acupuncturist
- Portable imaging services
- The following primary care or specialty clinics
 - Community clinics
 - Free clinics
 - Surgical clinics
 - Rehabilitation clinics
 - Clinics exempt from licensure under Section 1206 of the Health and Safety Code, including non-hospital county-operated community clinics.
- Services provided under the California Children's Services Program and under the Genetically Handicapped Persons Program

The following services and provider types will be exempt from the AB 97 payment reductions for dates of service on or after January 1, 2023:

- Podiatrists
- Prosthetists

Reason for Change:

The change in FY 2022-23, from the prior estimate, is due to:

- Updated managed care estimate for podiatrists and prosthetists.
- Updated funding splits estimated for the AB 97 exemptions.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to a full year's impact of the AB 97 exemptions.

AB 97 ELIMINATIONS
REGULAR POLICY CHANGE NUMBER: 115

Methodology:

1. The estimated fee-for-service (FFS) and managed care (MC) total funds costs are estimated for the following providers and services in this policy change:

Providers and Services	FFS TF	MC TF	Total FY 2022-23
Nurses, including certified nurse-midwives, nurse anesthetists, certified pediatric nurse practitioners, certified family nurse practitioners, and group certified pediatric nurse practitioners.	\$222,000	\$0	\$222,000
Alternative Birthing Centers	\$6,000	\$0	\$6,000
Audiologists/hearing aid dispensers	\$594,000	\$0	\$594,000
Respiratory care providers	\$0	\$0	\$0
Durable Medical Equipment (DME)	\$8,134,000	\$0	\$8,134,000
Chronic dialysis clinics	\$6,148,000	\$0	\$6,148,000
Emergency medical air transportation services	\$744,000	\$0	\$744,000
Blood Banks	\$12,000	\$0	\$12,000
Occupational Therapy	\$1,000	\$0	\$1,000
Orthotists	\$42,000	\$0	\$42,000
Psychologists	\$43,000	\$0	\$43,000
Medical Social Work or Medical Social Services	\$0	\$0	\$0
Speech pathologists	\$45,000	\$0	\$45,000
Outpatient heroin detoxification services	\$21,000	\$0	\$21,000
Dispensing opticians	\$46,000	\$0	\$46,000
Optometrists, including optometry groups	\$301,000	\$0	\$301,000
Acupuncturist	\$5,000	\$0	\$5,000
Portable imaging services	\$58,000	\$0	\$58,000
Community clinics	\$360,000	\$0	\$360,000
Free clinics	\$0	\$0	\$0
Surgical clinics	\$131,000	\$0	\$131,000

AB 97 ELIMINATIONS
REGULAR POLICY CHANGE NUMBER: 115

Providers and Services	FFS TF	MC TF	Total FY 2022-23
Rehabilitation clinics	\$63,000	\$0	\$63,000
Clinics exempt from licensure under Section 1206 of the Health and Safety Code, including non-hospital county-operated community clinics.	\$99,000	\$0	\$99,000
Services provided under the California Children's Services Program and under the Genetically Handicapped Persons Program	\$2,000	\$0	\$2,000
Podiatrists	\$38,000	\$215,000	\$253,000
Prosthetists	\$461,000	\$2,652,000	\$3,113,000
Total	\$17,576,000	\$2,867,000	\$20,443,000

Providers and Services	FFS TF	MC TF	Total FY 2023-24
Nurses, including certified nurse-midwives, nurse anesthetists, certified pediatric nurse practitioners, certified family nurse practitioners, and group certified pediatric nurse practitioners.	\$253,000	\$0	\$253,000
Alternative Birthing Centers	\$6,000	\$0	\$6,000
Audiologists/hearing aid dispensers	\$695,000	\$0	\$695,000
Respiratory care providers	\$0	\$0	\$0
Durable Medical Equipment (DME)	\$9,800,000	\$0	\$9,800,000
Chronic dialysis clinics	\$7,011,000	\$0	\$7,011,000
Emergency medical air transportation services	\$903,000	\$0	\$903,000
Blood Banks	\$15,000	\$0	\$15,000
Occupational Therapy	\$1,000	\$0	\$1,000
Orthotists	\$51,000	\$0	\$51,000
Psychologists	\$49,000	\$0	\$49,000

AB 97 ELIMINATIONS
REGULAR POLICY CHANGE NUMBER: 115

Providers and Services	FFS TF	MC TF	Total FY 2023-24
Medical Social Work or Medical Social Services	\$0	\$0	\$0
Speech pathologists	\$51,000	\$0	\$51,000
Outpatient heroin detoxification services	\$24,000	\$0	\$24,000
Dispensing opticians	\$56,000	\$0	\$56,000
Optometrists, including optometry groups	\$343,000	\$0	\$343,000
Acupuncturist	\$5,000	\$0	\$5,000
Portable imaging services	\$70,000	\$0	\$70,000
Community clinics	\$411,000	\$0	\$411,000
Free clinics	\$0	\$0	\$0
Surgical clinics	\$149,000	\$0	\$149,000
Rehabilitation clinics	\$71,000	\$0	\$71,000
Clinics exempt from licensure under Section 1206 of the Health and Safety Code, including non-hospital county-operated community clinics.	\$113,000	\$0	\$113,000
Services provided under the California Children's Services Program and under the Genetically Handicapped Persons Program	\$3,000	\$0	\$3,000
Podiatrists	\$108,000	\$516,000	\$624,000
Prosthetists	\$1,338,000	\$6,365,000	\$7,703,000
Total	\$21,526,000	\$6,881,000	\$28,407,000

2. The estimated FY 2022-23 and FY 2023-24 FFS and managed care costs are:

FY 2022-23	TF	GF	FF
FFS	\$17,576,000	\$7,073,000	\$10,503,000
Managed Care	\$2,867,000	\$988,000	\$1,879,000
Total	\$20,443,000	\$8,061,000	\$12,382,000

AB 97 ELIMINATIONS
REGULAR POLICY CHANGE NUMBER: 115

FY 2023-24	TF	GF	FF
FFS	\$21,526,000	\$8,651,000	\$12,875,000
Managed Care	\$6,881,000	\$2,371,000	\$4,510,000
Total	\$28,407,000	\$11,022,000	\$17,385,000

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)

65% Title XXI / 35% GF (4260-101-0001/0890)

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

ACUPUNCTURE RATE INCREASE

REGULAR POLICY CHANGE NUMBER: 116
IMPLEMENTATION DATE: 2/2023
ANALYST: Thomas Soteros-McNamara
FISCAL REFERENCE NUMBER: 2370

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$10,905,000	\$26,724,000
- STATE FUNDS	\$3,300,500	\$8,089,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$10,905,000	\$26,724,000
STATE FUNDS	\$3,300,500	\$8,089,200
FEDERAL FUNDS	\$7,604,500	\$18,634,800

Purpose:

This policy change estimates the costs of increasing acupuncture rates.

Authority:

Budget Act of 2022

Interdependent Policy Changes:

COVID-19 Increased FMAP - DHCS

Background:

The Budget Act of 2022 authorizes reimbursement rate increases for acupuncture services, effective January 1, 2023. The Department plans to submit a SPA in October 2022 to seek authority to increase reimbursement rates, effective January 1, 2023.

Reason for Change:

There is no change in FY 2022-23 from the prior estimate.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to a full year's implementation of the fee-for-service (FFS) increase and an expected 5% growth in the managed care Calendar Year 2024 rates.

Methodology:

1. This estimate captures the increase in rates from \$17.37 maximum per visit, up to \$60.00 per visit for applicable Current Procedural Terminology (CPT) codes.
2. The estimated costs of the acupuncture rate increase is \$10.9 million TF in FY 2022-23 and \$26.7 million TF in FY 2023-24 for managed care.
3. The estimated costs of the acupuncture rate increase is \$17,000 TF in FY 2022-23 and \$49,000 TF in FY 2023-24 for FFS. Implementation of the FFS rate increase is assumed to

ACUPUNCTURE RATE INCREASE

REGULAR POLICY CHANGE NUMBER: 116

occur in April 2023. The retroactive adjustment from January to March 2023 is also assumed to be implemented in April 2023.

4. The estimated expenditures for the increase to acupuncture rates are:

FY 2022-23	TF	GF	FF
FFS (Lagged)	\$17,000	\$8,000	\$9,000
Managed Care	\$10,888,000	\$3,293,000	\$7,595,000
Total	\$10,905,000	\$3,301,000	\$7,604,000

FY 2023-24	TF	GF	FF
FFS (Lagged)	\$49,000	\$22,000	\$27,000
Managed Care	\$26,675,000	\$8,067,000	\$18,608,000
Total	\$26,724,000	\$8,089,000	\$18,635,000

Funding:

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

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

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

LABORATORY RATE METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER: 117
IMPLEMENTATION DATE: 2/2016
ANALYST: Thomas Soteros-McNamara
FISCAL REFERENCE NUMBER: 1703

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$9,849,000	-\$13,047,000
- STATE FUNDS	\$4,188,500	-\$5,548,400
PAYMENT LAG	1.0000	0.8978
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$9,849,000	-\$11,713,600
STATE FUNDS	\$4,188,500	-\$4,981,350
FEDERAL FUNDS	\$5,660,500	-\$6,732,240

Purpose:

This policy change estimates savings and loss of savings from adjustments made to certain clinical laboratories or laboratory services rates.

Authority:

AB 1467 (Chapter 23, Statutes of 2012)
 AB 1494 (Chapter 28, Statutes of 2012)
 AB 1124 (Chapter 8, Statutes of 2014)
 AB 659 (Chapter 346, Statutes of 2017)
 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

Background:

AB 1494 required the Department to develop a new rate methodology for clinical laboratories or laboratory services, as part of the overall reimbursement methodology. In addition to 10% payment reductions pursuant to AB 97 (Chapter 3, Statutes of 2011), AB 1494 allowed for payments to be reduced by 10% for clinical laboratories or laboratory services for dates of service on and after July 1, 2012, through June 30, 2015. The Family Planning, Access, Care, and Treatment Program (FPACT) and outpatient hospital services were exempt from the 10% provider payment reductions per AB 1494.

Effective July 1, 2015, the new reimbursement methodology is applicable to certain clinical laboratory or laboratory service codes, which may include FPACT and outpatient hospital 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.

LABORATORY RATE METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER: 117

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 submitted SPA 21-0052 to seek federal approval to update 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 is submitting SPA 22-0053 to seek federal approval to update the rate setting methodology.

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. The Department will submit a SPA to adjust clinical laboratory or laboratory services reimbursement rates based on the Triennial reimbursement methodology, effective July 1, 2023.

Reason for Change:

The change for FY 2022-23, from the prior estimate, is an increase in costs due to a retroactive adjustment for the 2021 Annual Rate Adjustment paying in FY 2022-23.

LABORATORY RATE METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER: 117

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to savings from the 2023 Annual Rate Adjustment in FY 2023-24 and the 2023 Triennial Rate Adjustment.

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. **Annual rate adjustment:** The annual Medi-Cal rate adjustments will apply to clinical laboratory or laboratory services reimbursement rates exceeding 100% of corresponding Medicare rates.
 - a. As a result of the July 1, 2021 rate study, an annual cost of \$15.7 million TF is assumed and which is reflected in base expenditure projections. A retroactive adjustment for the July 2021 through March 2022 period is to implement in September 2022.
 - b. As a result of the July 1, 2022 rate study, no rates require an adjustment so no fiscal impact is assumed.
 - c. The 2023 annual rate adjustment is effective July 1, 2023. The savings from the adjustment are expected to be \$15.7 million TF and is expected to implement in November 2023. The retroactive adjustment for the July 2023 through October 2023 period is expected to implement in February 2024.
4. **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 2023 rate adjustment is estimated to be \$858,000 TF and is expected to be implemented in November 2023. The retroactive recoupment from July 2023 through October 2023 is expected to implement in February 2024.
5. The expected adjustments are as follows:

FY 2022-23	TF	GF	FF
Prospective Savings			
2023 New Methodology	\$0	\$0	\$0
2023 Rate Adjustment	\$0	\$0	\$0
Retroactive Adjustments			
2021 Rate Adjustment (to 2019 rates)	\$9,849,000	\$4,189,000	\$5,660,000
Total Impact	\$9,849,000	\$4,189,000	\$5,660,000

LABORATORY RATE METHODOLOGY CHANGE
REGULAR POLICY CHANGE NUMBER: 117

FY 2023-24	TF	GF	FF
Prospective Savings			
2023 New Methodology	(\$572,000)	(\$243,000)	(\$329,000)
2023 Rate Adjustment	(\$10,505,000)	(\$4,468,000)	(\$6,037,000)
Retroactive Adjustments			
2021 Rate Adjustment (to 2019 rates)	\$3,283,000	\$1,396,000	\$1,887,000
2023 Rate Adjustment	(\$5,253,000)	(\$2,234,000)	(\$3,019,000)
Total Impact	(\$13,047,000)	(\$5,549,000)	(\$7,498,000)

Funding:

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	\$7,929,000	\$3,965,000	\$3,964,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	\$1,792,000	\$179,000	\$1,613,000
65% Title XXI / 35% GF (4260-113-0001 / 0890)	\$128,000	\$45,000	\$83,000
Total	\$9,849,000	\$4,189,000	\$5,660,000

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	(\$10,503,000)	(\$5,252,000)	(\$5,252,000)
90% Title XIX / 10% GF (4260-101-0001 / 0890)	(\$2,374,000)	(\$238,000)	(\$2,136,000)
65% Title XXI / 35% GF (4260-113-0001 / 0890)	(\$170,000)	(\$59,000)	(\$110,000)
Total	(\$13,047,000)	(\$5,549,000)	(\$7,498,000)

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

GDSP NEWBORN SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 118
IMPLEMENTATION DATE: 7/2022
ANALYST: Thomas Soteros-McNamara
FISCAL REFERENCE NUMBER: 2184

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$10,718,000	\$5,687,000
- STATE FUNDS	\$4,228,020	\$2,244,450
PAYMENT LAG	0.9656	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$10,349,300	\$5,687,000
STATE FUNDS	\$4,082,570	\$2,244,450
FEDERAL FUNDS	\$6,266,730	\$3,442,550

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

Background:

Pursuant to Health & Safety Code, Section 124977, the Newborn Screening (NBS) Program fee shall be periodically adjusted to fully support GDSP. Section 124977(d)(1) outlines the GDSP's ability to adopt emergency regulations surrounding newborn and prenatal screening.

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.

In FY 2022-23, CDPH has proposed an increase of \$33.75 (from \$177.25 to \$211.00), effective July 1, 2022, for the NBS Program fee structure identified in the 2021 Budget Act. The fee change is needed to support the loss of revenue due to the decrease in projected caseload resulting from the projection of live births; increased expenditures related to higher contract rates for screening; higher costs associated with the computer system redesign and the

GDSP NEWBORN SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 118

Screening Information System (SIS) migration to the new Cloud platform; the ongoing cost of software license and maintenance to support the activities of the NBS Program.

The Department has submitted State Plan Amendments (SPA) to seek federal approval of the fee increases.

Reason for Change:

The change in FY 2022-23, from the prior estimate, is due to updating the estimated Medi-Cal FFS costs for the \$33.75 Medi-Cal rate increase.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to the Medi-Cal GDSP NBS retro rate increases being limited to 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; and will implement a \$33.75 fee increase for the GDSP NBS program, effective July 1, 2022. The Department implements corresponding Medi-Cal FFS GDSP NBS rate increases based on the CDPH fee increases.
2. The Medi-Cal FFS rate increase that covers the \$35 increased fee is expected to be implemented in January 2023. The retroactive correction for the July 1, 2020 to December 31, 2022 period is expected to be implemented in March 2023.
3. The Medi-Cal FFS rate increase that covers the \$33.75 increased fee is expected to be implemented in March 2023. The retroactive correction for the July 1, 2022 to February 28, 2023 period, is expected to be implemented in June 2023.
4. The estimated GDSP caseload in California is 432,294 for FY 2022-23 and 432,563 for FY 2023-24.
5. Assume approximately 60% of newborns screened are from the Medi-Cal population. Of the percentage Medi-Cal newborn population, assume approximately 32% are in Medi-Cal FFS.
6. 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.
7. Assume 99% of Medi-Cal FFS claims submitted are paid.
8. The estimated Medi-Cal FFS costs in FY 2022-23 and FY 2023-24 are:

FY 2022-23	TF	GF	FF
FFS Prospective Rate Increase	\$2,354,000	\$929,000	\$1,425,000
FFS Retroactive Payments	\$8,364,000	\$3,299,000	\$5,065,000
Total	\$10,718,000	\$4,228,000	\$6,490,000

GDSP NEWBORN SCREENING PROGRAM FEE INCREASE
REGULAR POLICY CHANGE NUMBER: 118

FY 2023-24	TF	GF	FF
FFS Prospective Rate Increase	\$5,687,000	\$2,245,000	\$3,442,000
Total	\$5,687,000	\$2,245,000	\$3,442,000

Funding:

50% Title XIX/ 50% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)
65% Title XXI / 35% GF (4260-113-0001/0890)
65% Title XXI / 35% GF (4260-101-0001/0890)

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 119
IMPLEMENTATION DATE: 10/2006
ANALYST: Thomas Soteros-McNamara
FISCAL REFERENCE NUMBER: 96

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$7,825,000	-\$11,193,000
- STATE FUNDS	\$3,722,850	-\$5,325,350
PAYMENT LAG	1.0000	0.9928
% REFLECTED IN BASE	7.25 %	5.90 %
APPLIED TO BASE		
TOTAL FUNDS	\$7,257,700	-\$10,456,800
STATE FUNDS	\$3,452,940	-\$4,975,070
FEDERAL FUNDS	\$3,804,740	-\$5,481,700

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

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

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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 received federal approval 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, 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 2022-23, from the prior estimate, is due to updated claims data for hospice services increasing significantly from FY 2019-20 causing negative incremental growth as utilization declines.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to expiration of the COVID temporary increase for room and board.

Methodology:

1. Hospice Services:
 - a. The weighted increase for hospice service rates, excluding RHC and SIA, is 27.40% for RY 2022-23 and 1.85% for FY 2023-24.
 - b. The RY 2021-22 hospice rates were implemented April, 2022. The retroactive payment for the period of October 2021 through April, 2022 was implemented in June 2022.
 - c. The RY 2022-23 hospice rates are estimated to be one to two percent increase from RY 2021-22 hospice rates.

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 119

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 13.51% 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 and 1.85% increase in FY 2023-24.
3. The estimated managed care rate adjustment impacts for RY 2022-23 and RY 2023-24 are included in the FY 2022-23 and FY 2022-23 managed care capitation rates, respectively.
4. The estimated payments on a cash basis are:

Cash Basis	FY 2022-23	FY 2023-24
Hospice Services (20-21)	\$64,000	\$0
RHC & SIA Payments (20-21)	\$541,000	\$0
Hospice Services (21-22)	(\$208,000)	\$0
RHC & SIA Payments (21-22)	(\$1,505,000)	\$0
Room & Board (21-22)	\$15,749,000	\$0
Hospice Services (22-23)	\$184,000	\$368,000
RHC & SIA Payments (22-23)	\$2,998,000	(\$1,505,000)
Room & Board (22-23)	(\$11,589,000)	(\$12,643,000)
Hospice Services Retro (22-23) retro	\$92,000	\$0
RHC & SIA Payments (22-23) retro	\$1,499,000	\$0
Hospice Services (23-24)	\$0	\$16,000
RHC & SIA Payments (23-24)	\$0	\$383,000
Room & Board (23-24)	\$0	\$2,031,000
Hospice Services Retro (23-24) retro	\$0	\$18,000
RHC & SIA Payments (23-24) retro	\$0	\$139,000
TOTAL	\$7,825,000	(\$11,193,000)

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 119

Funding:

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	\$7,349,000	\$3,675,000	\$3,675,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	\$473,000	\$47,000	\$425,000
65% Title XXI / 35% GF (4260-101-0001 / 0890)	\$3,000	\$1,000	\$2,000
Total	\$7,825,000	\$3,723,000	\$4,102,000

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	(\$10,512,000)	(\$5,256,000)	(\$5,256,000)
90% Title XIX / 10% GF (4260-101-0001 / 0890)	(\$676,000)	(\$68,000)	(\$608,000)
65% Title XXI / 35% GF (4260-101-0001 / 0890)	(\$5,000)	(\$2,000)	(\$3,000)
Total	(\$11,193,000)	(\$5,326,000)	(\$5,867,000)

GDSP PRENATAL SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 120
IMPLEMENTATION DATE: 10/2022
ANALYST: Thomas Soteros-McNamara
FISCAL REFERENCE NUMBER: 2336

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	-\$2,264,000	-\$2,716,000
- STATE FUNDS	-\$904,050	-\$1,084,550
PAYMENT LAG	0.7970	0.9990
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$1,804,400	-\$2,713,300
STATE FUNDS	-\$720,530	-\$1,083,460
FEDERAL FUNDS	-\$1,083,880	-\$1,629,820

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. Section 124977 (d)(1) outlines the GDSP's ability to adopt emergency regulations surrounding newborn and prenatal screening.

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 that screens for chromosomal abnormalities. GDSP's screening for neural tube defects (NTD) will remain part of the overall screening process. A total fee increase of \$95.40 is proposed beginning September 2022 and the components are as follows:

- CDPH will charge a fee increase of \$10.40 (\$221.60 to \$232.00) for the GDSP PNS cfDNA test.
- Additionally, the Neural Tube Defect (NTD) screening test in the second trimester, which is currently included in the PNS biochemical screening fees, will now require a new separate fee of \$85.

GDSP PRENATAL SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 120

- These fee structure changes will generate sufficient ongoing revenue to offset CDPH's additional laboratory screening costs.

The Department has submitted a State Plan Amendment for federal approval to increase the corresponding Medi-Cal rate for GDSP.

Reason for Change:

The change in FY 2022-23, from the prior estimate, is due to

- Updating the methodology to reflect savings impact to Medi-Cal,
- Updated fee increase to cite \$95.40 instead of \$105.40, and
- Implementation date for the rate change was delayed to December 2022.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to a 12-month impact of the rate change reflected in FY 2023-24.

Methodology:

1. CDPH implemented a \$95.40 fee increase for the GDSP PNS program, effective September 19, 2022. The Department will implement a corresponding Medi-Cal FFS GDSP PNS rate increase based on the CDPH fee increase and new fee structure pending federal approval.
2. The Medi-Cal FFS rate change that covers the increased fee is expected to be implemented in December 2022. The retroactive correction for the September 2022 to November 2022 period is expected to be implemented in March 2023.
3. Assume the impact of the GDSP PNS rate change is annual savings of estimated to be --\$8,438,000 TF savings.
4. 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. The estimated Medi-Cal FFS costs for FY 2022-23 and FY 2023-24 are:

FY 2022-23	TF	GF	FF
FFS Rate Change	(\$2,264,000)	(\$904,000)	(\$1,360,000)
Total	(\$2,264,000)	(\$904,000)	(\$1,360,000)

FY 2023-24	TF	GF	FF
FFS Rate Change	(\$2,716,000)	(\$1,085,000)	(\$1,631,000)
Total	(\$2,716,000)	(\$1,085,000)	(\$1,631,000)

GDSP PRENATAL SCREENING PROGRAM FEE INCREASE
REGULAR POLICY CHANGE NUMBER: 120

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)

65% Title XXI / 35% GF (4260-101-0001/0890)

DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 121
IMPLEMENTATION DATE: 4/2020
ANALYST: Thomas Soteros-McNamara
FISCAL REFERENCE NUMBER: 2161

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$301,000	-\$1,700,000
- STATE FUNDS	\$140,950	-\$780,850
PAYMENT LAG	0.7663	0.8790
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$230,700	-\$1,494,300
STATE FUNDS	\$108,010	-\$686,370
FEDERAL FUNDS	\$122,650	-\$807,930

Purpose:

This policy change estimates the fiscal impact 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)
 SPA 22-0022

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 (CMS) 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, January 1, 2021, and January 1, 2022 rate adjustments were not found to be necessary; therefore, the Department is not assuming a savings for these years. The Department anticipates submitting a SPA, if required, in February 2023 to adjust rates effective January 1, 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. 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: 121

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) and Complex Rehabilitation Technology Services (CRTS), as required by AB 97, effective January 1, 2022.

CMS approved SPA 22-0022, effective January 1, 2022, on April 21, 2022, which exempts DME CRT and CRTS from AB 97 10 percent payment reductions.

Senate Bill (SB) 184 (Chapter 47, Statutes of 2022), effective July 1, 2022, amended Welfare & Institutions Code (WIC) section 14105.48 to exempt all DME supplies and accessories from the ten percent payment reduction, as required by AB 97.

Reason for Change:

The change in FY 2022-23, from the prior estimate, is due to:

- Delayed implementation of the January 2022 DME CRT AB 97 exemption to October 2022
- Revised estimate for annual rate adjustments for CY 2023

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to:

- Delayed implementation of the January 2022 DME CRT AB 97 exemption
- Revised estimate for annual rate adjustments for CY 2023

Methodology:

1. Any adjustment to FFS DME rates become effective January 1st of each respective year.
2. Reviews of Medi-Cal FFS DME rates for CYs 2020, 2021, and 2022 found no DME FFS rates that required an adjustment.
3. The exemption for the DME CRT payment reduction effective January 1, 2022 is expected to implement in October 2022. The FFS annual cost is estimated to be \$1.52 million TF.
4. The retroactive adjustment for the exemption covering the period between January 2022 and June 2022 is expected to occur in January 2023. Costs associated with the exemption after July 2022 will be captured by a separate PC.
5. The CY 2023 FFS rate adjustments effective January 1, 2023 are estimated to create an expected annual savings of (\$1.43 million) TF. These rates are expected to be implemented in May 2023.
6. The retroactive adjustment for the CY 2023 FFS DME rates during the period January 1, 2023, through April 30, 2023, is estimated to cost (\$475,000) TF. The retroactive adjustment is expected to be implemented in August 2023 over 12 months.
7. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through March 31, 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.

DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 121

8. The FFS annual costs are estimated to be:

FY 2022-23	TF	GF	FFP	FFCRA
FFS Rate Adjustment	(\$75,000)	(\$35,000)	(\$40,000)	\$0
FFS DME CRT Restoration	\$376,000	\$176,000	\$200,000	\$0
Total	\$301,000	\$141,000	\$160,000	\$0

FY 2023-24	TF	GF	FFP	FFCRA
FFS Rate Adjustment	(\$1,700,000)	(\$781,000)	(\$904,000)	(\$15,000)
Total	(\$1,700,000)	(\$781,000)	(\$904,000)	(\$15,000)

Funding:

FY 2022-23	TF	GF	FFP	FFCRA
50% Title XIX / 50% GF	\$259,000	\$130,000	\$129,000	\$0
90% Title XIX / 10% GF	\$13,000	\$1,000	\$12,000	\$0
65% Title XXI / 35% GF	\$29,000	\$10,000	\$19,000	\$0
Total	\$301,000	\$141,000	\$160,000	\$0

FY 2023-24	TF	GF	FFP	FFCRA
50% Title XIX / 50% GF	(\$1,464,000)	(\$732,000)	(\$732,000)	\$0
90% Title XIX / 10% GF	(\$75,000)	(\$8,000)	(\$67,000)	\$0
65% Title XXI / 35% GF	(\$161,000)	(\$56,000)	(\$105,000)	\$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	\$14,000	\$14,000	\$0	\$0
FFCRA 6.2% FF	(\$14,000)	\$0	\$0	(\$14,000)
Total	(\$1,700,000)	(\$781,000)	(\$904,000)	(\$15,000)

DPH INTERIM RATE

REGULAR POLICY CHANGE NUMBER: 122
IMPLEMENTATION DATE: 7/2005
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1161

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$427,546,000	-\$457,809,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$427,546,000	-\$457,809,700
FEDERAL FUNDS	\$427,546,000	\$457,809,700

Purpose:

This policy change estimates the technical adjustment in funding to reimburse Designated Public Hospitals (DPHs) at 100% federal financial participation (FFP).

Authority:

SPA 05-21

Interdependent Policy Changes:

DPH Interim Rate Growth

Background:

As approved on April 25, 2006 through SPA 05-21, effective July 1, 2005, DPHs receive interim per diem rates based on estimated costs using the hospitals' two years prior Medi-Cal costs trended forward. These interim payments are 100% federal funds based on the hospitals' certified public expenditures (CPEs), resulting in 50% FFP and 50% CPE.

The Medi-Cal Estimate FFS base expenditures are calculated at 50% FFP and 50% GF. Since the DPH interim rate receives a 100% FFP, an adjustment to shift from 50% GF to 100% FFP is made.

In addition, the Medi-Cal Estimate makes funding adjustments to inpatient services for the applicable Federal Medical Assistance Percentage (FMAP) for the Affordable Care Act (ACA) optional population. As a result, this policy change will also make adjustments for the ACA optional population to shift from 5% GF / 95% FFP to 100% FFP beginning January 2017 through December 2017, 6% GF / 94% FFP to 100% FFP beginning January 2018 through December 2018, 7% GF / 93% FFP to 100% FFP beginning January 2019, and 10% GF / 90% FFP to 100% FFP beginning January 2020.

DPH INTERIM RATE
REGULAR POLICY CHANGE NUMBER: 122

Reason for Change:

The change in FY 2022-23, from the prior estimate, is due to:

- Updated DPH actual data through July 2022, and
- Lower projected expenditures in FY 2022-23.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to higher projected expenditures in FY 2023-24.

Methodology:

1. The funding adjustment is estimated at:

(Dollars in Thousands)

	Expenditures	GF to FF Shift
FY 2022-23	\$1,406,136	\$427,546
FY 2023-24	\$1,503,493	\$457,809

Funding:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890 / 0001)	(\$717,331)	(\$358,666)	(\$358,665)
100% Title XIX FF (4260-101-0890)	\$1,406,136	\$0	\$1,406,136
90% Title XIX ACA / 10% GF (4260-101-0890 / 0001)	(\$688,805)	(\$68,880)	(\$619,925)
Total Funds	\$0	(\$427,546)	\$427,546

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890 / 0001)	(\$768,651)	(\$384,325)	(\$384,326)
100% Title XIX FF (4260-101-0890)	\$1,503,493	\$0	\$1,503,493
90% Title XIX ACA / 10% GF (4260-101-0890 / 0001)	(\$734,842)	(\$73,484)	(\$661,358)
Total Funds	\$0	(\$457,809)	\$457,809

*Totals may differ due to rounding.

LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES

REGULAR POLICY CHANGE NUMBER: 123
IMPLEMENTATION DATE: 8/2013
ANALYST: Thomas Soteros-McNamara
FISCAL REFERENCE NUMBER: 1784

	<u>FY 2022-23</u>	<u>FY 2023-24</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)
 AB 186 (Chapter 46, Statutes of 2022)

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: 123

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.

AB 186 (Chapter 46, Statutes of 2022) extends the QAF and AB1629 methodology through December 31, 2026.

Reason for Change:

The change for FY 2022-23, from the prior estimate, is a net increase in GF transfers due to updated actual QAF collections during April – June 2022, a lower actual withhold transfer, and an increase in the monthly projections in FY 2022-23.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is an estimated decrease in GF transfers due to:

- FY 2022-23 based partially on actual collections, while FY 2023-24 is projected.
- Decreased withhold transfers estimated in FY 2023-24.

Methodology:

1. Based on collections and transfer data through June 2022; assume \$517.2 million will be transferred to the GF in FY 2022-23 and \$501.3 million in FY 2023-24.
2. The estimated withhold transfers for the AB 1629 QAF and QAF assessed on ICF-DDs expected to occur are \$61.9 million in FY 2022-23 and \$60.7 million in FY 2023-24.
3. The estimated fund adjustment from the LTCQAF to the GF is:

(Dollars in Thousands)

FY 2022-23	TF	GF	LTCQAF
FY 2021-22	\$0	(\$88,145)	\$88,145
FY 2022-23	\$0	(\$367,173)	\$367,173
Subtotal	\$0	(\$455,318)	\$455,318
Withhold Transfers	\$0	(\$61,885)	\$61,885
Total	\$0	(\$517,203)	\$517,203

LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
REGULAR POLICY CHANGE NUMBER: 123

(Dollars in Thousands)

FY 2023-24	TF	GF	LTCQAF
FY 2022-23	\$0	(\$73,435)	\$73,435
FY 2023-24	\$0	(\$367,173)	\$367,173
Subtotal	\$0	(\$440,608)	\$440,608
Withhold Transfers	\$0	(\$60,704)	\$60,704
Total	\$0	(\$501,312)	\$501,312

Funding:

Long Term Care Quality Assurance Fund (4260-601-3213)

100% GF (4260-101-0001)

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 124
IMPLEMENTATION DATE: 12/2011
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1580

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	-\$366,839,000	-\$366,839,000
- STATE FUNDS	-\$129,602,200	-\$129,602,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	99.86 %	99.86 %
APPLIED TO BASE		
TOTAL FUNDS	-\$513,600	-\$513,600
STATE FUNDS	-\$181,440	-\$181,440
FEDERAL FUNDS	-\$332,130	-\$332,130

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.

Per SB 184 (Chapter 47, Statutes of 2022), certain AB 97 provider payment reductions were eliminated in FY 2022-23. See the AB 97 Eliminations policy change for more details.

Reason for Change:

The change in FY 2022-23, from the prior estimate, is due to:

- Updated fee-for-service (FFS) base estimate to display savings for the remaining AB 97 payment reductions;

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 124

- The policy change was updated to display the managed care savings for the remaining AB 97 payment reductions;
- DME/Medical Supply retroactive recoupments were completed in FY 2021-22; and
- A decreased estimate for the pharmacy retroactive recoupments.

There is no change from FY 2022-23 to FY 2023-24 in the current estimate.

Methodology:

1. The 10% Provider Payment Reduction policy change displays the ongoing savings for the remaining providers still subject to the AB 97 payment reductions.
 - **FFS:** The FFS impact of AB 97 is budgeted in the FFS base. For display purposes only, this policy change shows the FFS base savings for the remaining AB 97 payment reductions that were not restored in FY 2022-23.
 - **Managed Care:** The managed care AB 97 impact is budgeted in the managed care base capitation policy changes. For display purposes only, this policy change shows the managed care base savings for the remaining AB 97 payment reductions that were not restored in FY 2022-23.
2. In addition, pharmacy retroactive recoupments are estimated to be \$522,000 TF in FY 2022-23 and FY 2023-24.
3. The savings from the AB 97 payment reductions are estimated to be:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
FFS Ongoing Savings (in FFS Base)	(\$76,798)	(\$29,631)	(\$47,167)
Managed Care Ongoing Savings (in MC Base)	(\$289,519)	(\$99,770)	(\$189,749)
Pharmacy Retro Recoupment	(\$522)	(\$201)	(\$321)
Total	(\$366,839)	(\$129,602)	(\$237,237)

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
FFS Ongoing Savings (in FFS Base)	(\$76,798)	(\$29,631)	(\$47,167)
Managed Care Ongoing Savings (in MC Base)	(\$289,519)	(\$99,770)	(\$189,749)
Pharmacy Retro Recoupment	(\$522)	(\$201)	(\$321)
Total	(\$366,839)	(\$129,602)	(\$237,237)

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)
 65% Title XXI / 35% GF (4260-101-0001/0890)

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER: 125
IMPLEMENTATION DATE: 8/2015
ANALYST: Thomas Soteros-McNamara
FISCAL REFERENCE NUMBER: 1505

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	-\$12,738,000	-\$12,392,000
- STATE FUNDS	-\$5,605,750	-\$5,455,850
PAYMENT LAG	0.9067	0.9870
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$11,549,500	-\$12,230,900
STATE FUNDS	-\$5,082,730	-\$5,384,920
FEDERAL FUNDS	-\$6,466,810	-\$6,845,980

Purpose:

This policy change estimates savings resulting from adjustments made to certain radiology reimbursement rates.

Authority:

SB 853 (Chapter 717, Statutes of 2010)
 SPA 20-0004
 SPA 21-0009
 SPA 22-0006

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS

Background:

SB 853 mandates that Medi-Cal rates for radiology services not exceed 80% of Medicare rates for dates of service on or after October 1, 2010. In light of the AB 97 (Chapter 3, Statutes of 2011) 10% payment reduction, and that a lengthy retroactive recoupment would likely create access to care issues for radiology services, the effective date for retroactive savings shifted from October 1, 2010 to October 1, 2012.

The Centers for Medicare and Medicaid Services (CMS) requires SPA approval for all rate reductions. SPA 20-0004 was approved on April 20, 2020, for rate adjustments effective January 1, 2020. SPA 21-0009 was approved for rate adjustments effective January 1, 2021. SPA 22-0006 was approved on April 29, 2022 for rate adjustments effective January 1, 2022, and the Department anticipates submitting a SPA in February 2023 to adjust rates effective January 1, 2023.

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER: 125

Reason for Change:

The change in FY 2022-23, from the prior estimate, is due to:

- Later assumed implementation of the January 2022 rate adjustments by 2 months
- Later implementation of 2022 retroactive recoupments by 5 months

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to earlier implementation of retroactive recoupments in 2023.

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 implemented July 28, 2021.

The total recoupment of retroactive savings from January 1, 2019, through July 27, 2021, is estimated to be \$8,312,000 TF and was implemented September 30, 2021. Recoupments will be collected over 12 months.

4. The rate adjustments effective January 1, 2020, reflect an annual FFS savings of \$577,000 TF and were implemented July 28, 2021.

The total recoupment of retroactive savings from January 1, 2020, through July 27, 2021, is estimated to be \$914,000 TF and was implemented September 30, 2021. Recoupments will be collected over 12 months.

5. The rate adjustments effective January 1, 2021, reflect an annual FFS savings of \$2,188,000 TF. These rates were implemented September 27, 2021.

The total recoupment of retroactive savings from January 1, 2021, through September 26, 2021, is estimated to be \$1,641,000 TF and were implemented December 14, 2021. These recoupments will be collected over 12 months.

6. The rate adjustments effective January 1, 2022, reflect an annual FFS savings of \$2,545,000 TF. These rates were implemented on August 22, 2022.

The total recoupment of retroactive savings from January 1, 2022 through August 21, 2022, is estimated to be \$1,696,000 TF and is expected to be implemented in November 2022, over 12 months.

7. The annual FFS savings for the rate adjustments effective January 1, 2023 is expected to be \$2,545,000 TF. These rates are expected to be implemented in May 2023.

The total recoupment of retroactive savings from January 2023 through April 30, 2023 is estimated to be \$848,338 TF and is expected to be implemented in August 2023, over 12 months.

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER: 125

8. The estimated savings for the reduction to radiology reimbursement rates are:

FY 2022-23	TF	GF	TITLE XIX FF	TITLE XXI FF	ACA FF
Prospective Savings	(\$8,528,000)	(\$3,690,000)	(\$3,485,000)	(\$127,000)	(\$1,226,000)
Recoupment of Retro Savings	(\$4,210,000)	(\$1,812,000)	(\$1,721,000)	(\$68,000)	(\$609,000)
Total	(\$12,738,000)	(\$5,502,000)	(\$5,206,000)	(\$195,000)	(\$1,835,000)

FY 2023-24	TF	GF	TITLE XIX FF	TITLE XXI FF	ACA FF
Prospective Savings	(\$11,073,000)	(\$4,791,000)	(\$4,525,000)	(\$165,000)	(\$1,592,000)
Recoupment of Retro Savings	(\$1,319,000)	(\$571,000)	(\$539,000)	(\$20,000)	(\$189,000)
Total	(\$12,392,000)	(\$5,362,000)	(\$5,064,000)	(\$185,000)	(\$1,781,000)

Funding:

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

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

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

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

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

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

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

DPH INTERIM & FINAL RECONS

REGULAR POLICY CHANGE NUMBER: 126
IMPLEMENTATION DATE: 10/2007
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1152

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	-\$76,260,000	\$199,784,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$76,260,000	\$199,784,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	-\$76,260,000	\$199,784,000

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: 126

Reason for Change:

The change in FY 2022-23, from the prior estimate, is due to shifting the FY 2011-12 and FY 2014-15 final reconciliations from FY 2021-22 to FY 2022-23 and shifting the FY 2017-18 and FY 2018-19 final reconciliations from FY 2022-23 to FY 2023-24.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to varying reconciliation estimates from different reconciliation years. The final reconciliations estimated to occur in FY 2022-23 result in net recoupments whereas the final reconciliations estimated to occur in FY 2023-24 are mostly payments

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 2022-23	TF	FF	ACA FF
2011-12 Final Reconciliation	\$34,482	\$34,482	\$0
2014-15 Final Reconciliation	(\$40,337)	(\$25,893)	(\$14,444)
2015-16 Final Reconciliation	(\$63,344)	(\$51,684)	(\$11,660)
2016-17 Final Reconciliation	(\$7,061)	\$16,831	(\$23,892)
Total	(\$76,260)	(\$26,264)	(\$49,996)

(Dollars in Thousands)

FY 2023-24	TF	FF	ACA FF
2017-18 Final Reconciliation	\$57,912	\$30,518	\$27,394
2018-19 Final Reconciliation	\$21,548	\$24,849	(\$3,301)
2019-20 Final Reconciliation	\$120,324	\$97,809	\$22,515
Total	\$199,784	\$153,176	\$46,608

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: 127
IMPLEMENTATION DATE: 9/2019
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2055

	FY 2022-23	FY 2023-24
FULL YEAR COST - TOTAL FUNDS	\$3,403,178,000	\$3,617,930,000
- STATE FUNDS	\$1,038,663,000	\$1,107,891,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,403,178,000	\$3,617,930,000
STATE FUNDS	\$1,038,663,000	\$1,107,891,000
FEDERAL FUNDS	\$2,364,515,000	\$2,510,039,000

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: 127

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. On October 8, 2021, the Department received approval from CMS for the Calendar Year (CY) 2021 rating period (January 1 through December 31, 2021). On May 10, 2022, the Department received approval from CMS for the CY 2022 rating period (January 1 through December 31, 2022).

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

Reason for Change:

There is no change in the total fund in FY 2022-23 from the prior estimate. The funding splits, however, have been updated.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to an increase in the total pool size.

Methodology:

1. The total value of the funding for the private hospital directed payment pool on an accrual basis is \$4.92 billion total fund for the Bridge Period rating period, \$3.53 billion total fund for CY 2021 rating period, and \$3.71 billion total fund for the CY 2022 rating period.
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 final six months of the Bridge Period (July 1, 2020 through December 31, 2020) payments are occurred in September 2022. The first six months of the CY 2021 rating period (January 1, 2021 through June 30, 2021) payments are expected to occur in March 2023.
7. The final six months of the CY 2021 rating period (July 1, 2021 through December 31, 2021) payments are expected to occur in September 2023. The first six months of the CY 2022 rating period (January 1, 2022 through June 30, 2022) payments are expected to occur in March 2024.

MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS

REGULAR POLICY CHANGE NUMBER: 127

8. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures for the period from January 1, 2020 to June 30, 2022 in this policy change.

9. On a cash basis, the estimated payments are:

(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	\$1,038,663	\$999,937	\$84,807	\$1,150,348	\$129,423
Total FY 2022-23	\$3,403,178	\$1,038,663	\$999,937	\$84,807	\$1,150,348	\$129,423

(Dollars in Thousands)

FY 2023-24	TF	SF (HQARF)	FF (Title 19)	FF (Title 21)	ACA FF	FFCRA
CY 2021 P2 (July - Dec 2021) +CY 2022 P1 (Jan - June 2022)	\$3,617,930	\$1,107,891	\$1,063,036	\$86,474	\$1,222,939	\$137,590
Total FY 2023-24	\$3,617,930	\$1,107,891	\$1,063,036	\$86,474	\$1,222,939	\$137,590

Funding:

Hospital Quality Assurance Revenue Fund (4260-611-3158)

Title XIX FFP (4260-101-0890)

ACA Title XIX FFP (4260-101-0890)

Title XXI FFP (4260-113-0890)

Title XXI FFP (4260-101-0890)

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

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

FFCRA 4.34% Increased FFP (4260-101-0890)

HOSPITAL QAF - FFS PAYMENTS

REGULAR POLICY CHANGE NUMBER: 128
IMPLEMENTATION DATE: 7/2017
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1475

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$3,032,548,000	\$2,938,988,000
- STATE FUNDS	\$1,483,001,000	\$1,228,407,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,032,548,000	\$2,938,988,000
STATE FUNDS	\$1,483,001,000	\$1,228,407,000
FEDERAL FUNDS	\$1,549,547,000	\$1,710,581,000

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:

Not Applicable

Background:

AB 1383 authorized the implementation of a QAF on applicable general acute care hospitals for the period of April 1, 2009, through December 31, 2010. This QAF program period is referred to as QAF I.

SB 90 extended the Hospital QAF program for the period January 1, 2011, through June 30, 2011, based on a modified amount of payments to hospitals and an increased amount for children’s health care coverage. This QAF program period is referred to as QAF II.

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: 128

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 January 1, 2022 through December 31, 2022. The Department submitted for federal approval for QAF VII in Quarter 2 of FY 2021-22 and are currently awaiting approval. The length of the QAF VII program period is 12-months.

The Department will begin developing the subsequent program period (QAF VIII) in FY 2022-23 Q1 which will include payments for the period beginning January 1, 2023. The length of the QAF VIII program period is currently unknown.

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 2022-23, from the prior estimate, is a net decrease due to:

- Adding QAF VI Upper Payment Limit (UPL) Overage payments in FY 2022-23,
- QAF VI Cycle 9 ACA amounts updated with actual amounts,
- QAF VII Cycle 3-4 FFS estimated payments were re-calculated to include enhanced FMAP attributable to FFCRA of 6.2%,
- QAF VII payments have been revised to reflect Calendar Year (CY) payments instead of State Fiscal Year payments to align with the program periods,
- Enhanced FMAP attributable to FFCRA of 6.2% is assumed to end March 31, 2023, and
- Updated FY 2022-23 FFS estimated payment amounts based on revised QAF VII Fee and Payment model originally submitted to CMS December 31, 2021.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a net decrease due to:

- Fewer periods of enhanced FMAP attributable to FFCRA of 6.2% in FY 2023-24, and
- QAF VI UPL Overage payments expected to be complete in FY 2022-23. There are no overage payments anticipated to occur FY 2023-24.

HOSPITAL QAF - FFS PAYMENTS

REGULAR POLICY CHANGE NUMBER: 128

Methodology:

QAF VI-QAF VIII

1. SB 239 extended the QAF for 36-months from January 1, 2014, through December 31, 2016 (QAF IV). Subsequently, AB 1607 extended the program for a one-year period from January 1, 2017, to December 31, 2017. However, this was superseded by the passage of Proposition 52, which permanently extended the Hospital QAF program. The Hospital QAF V program period covers the 30-month period from January 1, 2017, through June 30, 2019 (QAF V).
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. 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. 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.
5. The QAF VI inpatient (IP) UPL overages payback for FY 2020-21 and FY 2021-22 will take place in FY 2022-23. This was calculated in accordance with State Medicaid Director Letter (SMDL) #13-003 and assumes additional room from the QAF VI outpatient (OP) UPLs can be offset with the paybacks.
6. Assume the QAF VII program period covers a 12-month period from January 1, 2022, through December 31, 2022.
7. QAF VII payments are based on the QAF VII model submitted to CMS in December 2021. The payment schedule and amounts are still pending CMS review and approval, payment timings and amounts are subject to change.
8. QAF VIII payments are currently being developed and assumed amounts are subject to change.
9. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through March 31, 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
10. 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

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11. On a cash basis, the estimated QAF VI- QAF VIII payments are:

(Dollars in Thousands)

FY 2022-23	TF	SF(HQARF)	FF	ACA FF	FFCRA	*Return to Fund 3158
QAF VI						
FY 2020-21 UPL Overage	\$0	\$233,926	(\$99,360)	(\$122,245)	(\$12,321)	\$0
FY 2021-22 UPL Overage	\$0	\$146,931	(\$65,528)	(\$73,277)	(\$8,126)	\$0
QAF VII						
CY 2022	\$3,032,548	\$1,412,948	\$1,440,925	\$0	\$178,675	\$0
QAF VI & QAF VII						
CY 2021 ACA FFCRA Adjustment	\$0	(\$178,358)	(\$263,843)	\$474,917	(\$32,716)	\$178,358
CY 2022 ACA FFCRA Adjustment	\$0	(\$132,446)	(\$195,926)	\$352,667	(\$24,295)	\$132,446
Total FY 2022-23	\$3,032,548	\$1,483,001	\$816,268	\$632,062	\$101,217	\$310,804

(Dollars in Thousands)

FY 2023-24	TF	SF(HQARF)	FF	ACA FF	FFCRA	*Return to Fund 3158
QAF VIII						
CY 2023	\$2,938,988	\$1,501,627	\$1,394,143	\$0	\$43,218	\$0
QAF VII & QAF VIII						
CY 2022 ACA FFCRA Adjustment	\$0	(\$132,447)	(\$195,926)	\$352,668	(\$24,295)	\$132,446
CY 2023 ACA FFCRA Adjustment	\$0	(\$140,773)	(\$190,606)	\$343,091	(\$11,712)	\$140,773
Total FY 2023-24	\$2,938,988	\$1,228,407	\$1,007,611	\$695,759	\$7,211	\$273,219

*The Return to Fund 3158 column is for display purposes only (see QAF VI-QAF VIII Methodology #3 and #10).

Funding:

Hospital Quality Assurance Revenue Fund (4260-611-3158)
 ACA Title XIX FFP (4260-101-0890)
 Title XIX FFP (4260-101-0890)
 FFCRA 6.2% Increased FFP (4260-101-0890)

PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 129
 IMPLEMENTATION DATE: 1/2018
 ANALYST: Thomas Soteros-McNamara
 FISCAL REFERENCE NUMBER: 2048

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$1,348,007,000	\$1,289,079,000
- STATE FUNDS	\$475,148,150	\$506,476,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	4.75 %	4.97 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,283,976,700	\$1,225,011,800
STATE FUNDS	\$452,578,610	\$481,304,330
FEDERAL FUNDS	\$831,398,060	\$743,707,440

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 19-0021
 SPA 21-0004
 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 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 Fee-for-Service (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.

Managed Care Physician Directed Payments

The Centers for Medicare and Medicaid Services (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

PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 129

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 October 8, 2021, the Department received pre-print approval from CMS for the CY 2021 rating period (January 1 through December 31, 2021). The pre-print for the CY 2022 rating period (January 1 through December 31, 2022) has been submitted to CMS.

For FY 2018-19, the directed payments are subject to a minimum medical expenditure percentage (MEP). MCPs that do not achieve a minimum MEP of 95 percent must remit to the Department the difference between their MEP and the 95 percent threshold.

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 2022-23, from the prior estimate, is due to:

- Increased estimated managed care expenditures based on actual FY 2021-22 expenditures, and
- Additional availability of FFCRA funding due to the PHE end date being extended.

The change from FY 2022-23 to FY 2023-24, in the current estimate is due to:

- An expected decline in managed care expenditures in FY 2023-24, and
- No FFCRA funding included in FY 2023-24.

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REGULAR POLICY CHANGE NUMBER: 129

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 \$64,097,000 TF for FY 2022-23 and FY 2023-24 consistent with levels prior to the COVID-19 pandemic.

Managed Care Physician Directed Payments

4. Risk-based capitation rates paid to MCPs will be enhanced, based on anticipated utilization of the specified services, to fund the required provider payments.
5. Assume that the annual estimated value of enhanced capitation rate increases for MCPs to fund the supplemental rate increase, on a cash basis, is \$1,283,910,000 TF in FY 2022-23 and \$1,224,982,000 TF in 2023-24.
6. The impact of the recoupments related to the MEP for FY 2018-19 and two sided risk corridor effective July 1, 2019 are reflected in the Prop 56 – Directed Payment Risk Mitigation policy change.
7. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2023 for this policy change.
8. Funds allocated for the supplemental payments are as follows:

FY 2022-23	TF	GF	Title XXI FF	Title XIX FF	ACA FF	FFCRA
FFS Pmts (ongoing)	\$64,097,000	\$26,843,000	\$7,253,000	\$20,095,000	\$6,930,000	\$2,976,000
Mgd Care Pmts	\$1,283,910,000	\$448,305,000	\$88,710,000	\$363,162,000	\$332,778,000	\$50,955,000
Total	\$1,348,007,000	\$475,148,000	\$95,963,000	\$383,257,000	\$339,708,000	\$53,931,000

FY 2023-24	TF	GF	Title XXI FF	Title XIX FF	ACA FF
FFS Pmts (ongoing)	\$64,097,000	\$29,819,000	\$7,253,000	\$20,095,000	\$6,930,000
Mgd Care Pmts	\$1,224,982,000	\$476,657,000	\$84,697,000	\$346,855,000	\$316,773,000
Total	\$1,289,079,000	\$506,476,000	\$91,950,000	\$366,950,000	\$323,703,000

PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 129

Funding:

FY 2022-23	TF	GF	FF	FFCRA
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$766,513,000	\$383,256,000	\$383,257,000	\$0
90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$377,454,000	\$37,746,000	\$339,708,000	\$0
65% Title XXI FF / 35% GF (4260-113-0001 / 0890)	\$147,635,000	\$51,672,000	\$95,963,000	\$0
100% GF (4260-101-0001)	\$56,405,000	\$56,405,000	\$0	\$0
FFCRA 4.34% GF (4260-113-0001)	(\$6,407,000)	(\$6,407,000)	\$0	\$0
FFCRA 4.34% FF (4260-113-0890)	\$6,407,000	\$0	\$0	\$6,407,000
FFCRA 6.2% GF (4260-101-0001)	(\$47,524,000)	(\$47,524,000)	\$0	\$0
FFCRA 6.2% FF (4260-101-0890)	\$47,524,000	\$0	\$0	\$47,524,000
Total	\$1,348,007,000	\$475,148,000	\$818,928,000	\$53,931,000

FY 2023-24	TF	GF	FF
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$733,899,000	\$366,949,000	\$366,950,000
90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$359,670,000	\$35,967,000	\$323,703,000
65% Title XXI FF / 35% GF (4260-101-0001 / 0890)	\$141,462,000	\$49,512,000	\$91,950,000
100% GF (4260-101-0001)	\$54,048,000	\$54,048,000	\$0
Total	\$1,289,079,000	\$506,476,000	\$782,603,000

GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

REGULAR POLICY CHANGE NUMBER: 130
IMPLEMENTATION DATE: 6/2020
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 2024

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$926,935,000	\$590,330,000
- STATE FUNDS	\$267,794,000	\$256,430,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$926,935,000	\$590,330,000
STATE FUNDS	\$267,794,000	\$256,430,000
FEDERAL FUNDS	\$659,141,000	\$333,900,000

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

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: 130

- 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 2022-23, from the prior estimate, is due to:

- FY 2016-17 through FY 2018-19 ACA adjustments have been shifted from FY 2021-22 to FY 2022-23,
- Revised FY 2019-20 ACA adjustments based on updated data,
- Revised FY 2020-21 final settlements and ACA adjustments based on updated data,
- Revised FY 2021-22 final settlements and Q1 through Q2 ACA adjustments based on updated data,
- Revised FY 2022-23 payments based on updated data,
- Recoupments of overpayments to providers for FY 2019-20 final settlements and FY 2021-22 Q1 through Q3 interim payments, and
- Reflecting FFCRA increased FMAP through March 21, 2023 in this policy change.

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

- Retroactive ACA adjustments from FY 2016-17 through FY 2021-22 Q2 will occur in FY 2022-23, and FY 2021-22 Q3 through FY 2022-23 Q2 ACA adjustments will occur in FY 2023-24,
- Final settlements for FY 2020-21 and FY 2021-22 will occur in FY 2022-23, and final settlements for FY 2022-23 will occur in FY 2023-24, and
- An increase in estimated FY 2023-24 payments over the FY 2022-23 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.

GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

REGULAR POLICY CHANGE NUMBER: 130

3. The GME and IME annual distribution amounts are calculated based on the methodologies outlined in SPA 17-0009.
 - FY 2022-23 payments were calculated based on FY 2020-21 cost report data and are estimated at \$475.5 million TF.
 - FY 2023-24 payments assumed an increase from FY 2022-23 estimated payments based on the CPI annual adjustment. FY 2023-24 payments are estimated to provide \$491 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 has been submitted to CMS and approval is anticipated in the first quarter of FY 2022-23.
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 2021-22, 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 March 31, 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
9. Assume FY 2020-21 and FY 2021-22 final settlements will be paid in FY 2022-23.
10. Assume all four quarters of FY 2022-23 will be paid in FY 2022-23.
11. Assume ACA adjustments for FY 2016-17 through FY 2021-22 Q2 will occur in FY 2022-23.
12. Revised payment models for FY 2019-20 final settlements and FY 2021-22 Q1 through Q3 interim payments resulted in federal financial participation (FFP) overpayments in FY 2021-22. Approximately half the FFP overpayments were recouped from providers in FY 2021-22, and it is estimated the remaining overpayments will be recouped in FY 2022-23.
13. Assume FY 2022-23 final settlements will occur in FY 2023-24.
14. Assume all four quarters of FY 2023-24 will be paid in FY 2023-24.

GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

REGULAR POLICY CHANGE NUMBER: 130

15. Assume ACA adjustments for FY 2021-22 Q3 through FY 2022-23 Q2 will be paid in FY 2023-24.

(Dollars in Thousands)

FY 2022-23	TF	IGT	FF	ACA FF	FFCRA
FY 2016-17 ACA Adjustment	\$28,822	\$0	(\$32,025)	\$60,847	\$0
FY 2017-18 ACA Adjustment	\$62,626	\$0	(\$70,365)	\$132,991	\$0
FY 2018-19 ACA Adjustment	\$60,321	\$0	(\$69,338)	\$129,659	\$0
FY 2019-20 ACA Adjustment	\$69,174	\$0	(\$83,471)	\$152,698	(\$53)
FY 2019-20 FFP Overpayments	(\$10,902)	\$0	(\$10,266)	\$0	(\$636)
FY 2020-21 ACA Adjustment	\$69,164	\$0	(\$102,314)	\$184,165	(\$12,687)
FY 2020-21 Final Settlement	\$94,864	\$41,550	\$47,432	\$0	\$5,882
FY 2021-22 FFP Overpayments	(\$8,654)	\$0	(\$7,699)	\$0	(\$955)
FY 2021-22 Final Settlement & Q1-Q2 ACA Adjustment	\$85,930	\$10,564	(\$17,535)	\$95,075	(\$2,174)
FY 2022-23 Payment	\$475,590	\$215,680	\$237,795	\$0	\$22,115
Total	\$926,935	\$267,794	(\$107,786)	\$755,435	\$11,492

(Dollars in Thousands)

FY 2023-24	TF	IGT	FF	ACA FF	FFCRA
FY 2021-22 Q3-Q4 ACA Adjustment	\$35,706	\$0	(\$52,820)	\$95,076	(\$6,550)
FY 2022-23 Final Settlement & Q1-Q2 ACA Adjustment	\$63,578	\$10,907	(\$41,623)	\$98,165	(\$3,871)
FY 2023-24 Interim Payment	\$491,046	\$245,523	\$245,523	\$0	\$0
Total	\$590,330	\$256,430	\$151,080	\$193,241	(\$10,421)

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)

PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 131
IMPLEMENTATION DATE: 7/2005
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1071

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$733,956,000	\$663,770,000
- STATE FUNDS	\$336,609,000	\$331,885,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$733,956,000	\$663,770,000
STATE FUNDS	\$336,609,000	\$331,885,000
FEDERAL FUNDS	\$397,347,000	\$331,885,000

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:

ACA DSH Reduction

Background:

Beginning July 1, 2005, based on SB 1100, private hospitals receive Medi-Cal DSH replacement payments under the DSH Replacement Program. These payments are determined using the same formulas and methodology that were previously in effect under the prior DSH methodology for the 2004-05 fiscal year. These payments are distributed to private hospitals along with \$160.00, with the federal share of the \$160.00 is funded via the annual DSH allotment, and the non-federal share is via the General Fund (GF). Combined, these payments satisfy the State's payment obligations to private hospitals under the Federal DSH statute.

PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 131

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.

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 preliminary ARP-adjusted FFY 2022 allotment released by CMS on October 13, 2021.

Reason for Change:

The change in FY 2022-23, from the prior estimate, is due to:

- Updated payment amount for the June 2022 payment to be paid in FY 2022-23, and
- Revised FY 2022-23 payments based on using the ARP-adjusted preliminary 2022 DSH allotment with a 2% increase to determine the FFY 2023 DSH allotment.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to:

- Assuming the FY 2023-24 DSH allotment is not subject to ARP adjustments, and therefore resulting in the allotment being lower than the FY 2022-23 DSH allotment.

Methodology:

1. CMS released the preliminary ARP-adjusted FFY 2021-22 DSH allotment on October 13, 2021 and published the FFY 2018 and FFY 2019 final DSH allotments on March 14, 2022.
2. The FY 2022-23 DSH allotment will be subject to ARP adjustments, and therefore assumes a 2% annual increase from the ARP-adjusted preliminary FY 2021-22 allotment.

PRIVATE HOSPITAL DSH REPLACEMENT
REGULAR POLICY CHANGE NUMBER: 131

3. The FY 2023-24 DSH allotment will not be subject to ARP adjustments, and therefore assumes a 2% annual increase from the preliminary non-ARP adjusted FFY 2023 allotment.
4. The remaining 1/12 of the FFY 2021-22 DSH replacement payment will occur in FY 2022-23.
5. Assume 11/12 of the FY 2022-23 DSH replacement payment will occur in FY 2022-23, and the remaining 1/12 will occur in FY 2023-24.
6. Assume 11/12 of the FY 2023-24 DSH replacement payment will occur in FY 2023-24.
7. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through March 31, 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.

It is assumed that the DSH replacement payments will be made as follows on a cash basis:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF	FFCRA
FY 2021-22	\$62,586	\$27,413	\$31,293	\$3,880
FY 2022-23	\$671,370	\$309,196	\$335,685	\$26,489
Total FY 2022-23	\$733,956	\$336,609	\$366,978	\$30,369

FY 2023-24	TF	GF	FF	FFCRA
FY 2022-23	\$61,034	\$30,517	\$30,517	\$0
FY 2023-24	\$602,736	\$301,368	\$301,368	\$0
Total FY 2023-24	\$663,770	\$331,885	\$331,885	\$0

Funding:

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

56.2% Title XIX/ 43.8% GF (4260-101-0001/0890)

DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 132
IMPLEMENTATION DATE: 7/2005
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1073

	FY 2022-23	FY 2023-24
FULL YEAR COST - TOTAL FUNDS	\$464,328,000	\$463,471,000
- STATE FUNDS	\$107,825,500	\$128,683,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$464,328,000	\$463,471,000
STATE FUNDS	\$107,825,500	\$128,683,000
FEDERAL FUNDS	\$356,502,500	\$334,788,000

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:

ACA DSH Reduction

Background:

Effective July 1, 2005, based on State Plan Amendment (SPA) 05-022 and as part of the MH/UCD and BTR, the federal DSH allotment is available to provide funding for uncompensated Medi-Cal and uninsured costs incurred by DSHs. Eligible hospitals are to receive funding through the DSH program in the following manner:

- Designated Public Hospitals (DPHs) receive their allocation of federal DSH payments from the Demonstration DSH Fund based on the hospitals' certified public expenditures (CPEs), up to 100% of uncompensated Medi-Cal and uninsured costs. DPHs may also

DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 132

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 preliminary ARP-adjusted FFY 2022 allotment released on October 13, 2021.

DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 132

Reason for Change:

The change in FY 2022-23, from the prior estimate, is due to:

- Revised FY 2022-23 payments based on using the ARP- adjusted preliminary FFY 2021-22 DSH allotment with a 2% increase to determine the FFY 2023 DSH allotment, and
- Assuming the FFCRA increased FMAP will continue through March 31, 2023.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to assuming the FY 2023-24 estimated DSH allotment is not subject to ARP adjustments, and therefore is lower than the DSH allotments for the previous four DSH years.

Methodology:

1. CMS released the preliminary ARP-adjusted FFY 2021-22 DSH allotment on October 13, 2021, and published the FFY 20218 and FFY 2019 final DSH allotments on March 14, 2022.
2. The FY 2022-23 DSH allotment will be subject to ARP adjustments, and therefore assumes a 2% annual increase from the ARP adjusted preliminary FY 2021-22 allotment.
3. The FY 2023-24 DSH allotment will not be subject to ARP adjustments, and therefore assumes a 2% increase from the non-ARP adjusted estimated FY 2022-23 allotment.
4. 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.
5. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through March 31, 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
6. 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.
7. It is assumed that the DSH payments will be made as follows on a cash basis:

FY 2022-23	TF	GF**	IGT*	FF	FFCRA
DSH 2021-22	\$105,964,000	\$1,691,000	\$20,906,000	\$83,128,000	\$239,000
DSH 2022-23	\$358,364,000	\$21,275,000	\$63,953,000	\$271,398,000	\$1,738,000
Total FY 2022-23	\$464,328,000	\$22,966,000	\$84,859,000	\$354,526,000	\$1,977,000

DSH PAYMENT
REGULAR POLICY CHANGE NUMBER: 132

FY 2023-24	TF	GF**	IGT*	FF	FFCRA
DSH 2022-23	\$114,648,000	\$2,250,000	\$27,353,000	\$85,045,000	\$0
DSH 2023-24	\$348,823,000	\$24,750,000	\$74,330,000	\$249,743,000	\$0
Total FY 2023-24	\$463,471,000	\$27,000,000	\$101,683,000	\$334,788,000	\$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: 133
IMPLEMENTATION DATE: 1/2020
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 2130

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$465,341,000	\$465,341,000
- STATE FUNDS	\$77,408,600	\$77,408,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	5.24 %	5.24 %
APPLIED TO BASE		
TOTAL FUNDS	\$440,957,100	\$440,957,100
STATE FUNDS	\$73,352,390	\$73,352,390
FEDERAL FUNDS	\$367,604,740	\$367,604,740

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:

SPA 19-0027
SPA 21-0034

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. SPA 21-0034 was submitted to CMS to extend the supplemental reimbursements under FFS indefinitely.

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 October 8, 2021, the Department

PROP 56 - MEDI-CAL FAMILY PLANNING

REGULAR POLICY CHANGE NUMBER: 133

received pre-print approval from CMS for the CY 2021 rating period January 1, 2021, through December 31, 2021. The pre-print for the CY 2022 rating period (January 1 through December 31, 2022) has been submitted to CMS.

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 2022-23, is an increase due to using updated FFS and MC actual expenditures to project forward. There is no change in the current estimate for FY 2022-23 to FY 2023-24.

Methodology:

1. Assume an effective date of July 1, 2019.
2. Assume the continuation of the Proposition 56 payments through FY 2023-24, 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)

FY 2022-23	TF	GF	FF
Fee-For-Service	\$24,396	\$6,627	\$17,769
Managed Care	\$440,945	\$70,781	\$370,164
Total	\$465,341	\$77,408	\$387,933

FY 2023-24	TF	GF	FF
Fee-For-Service	\$24,396	\$6,627	\$17,769
Managed Care	\$440,945	\$70,781	\$370,164
Total	\$465,341	\$77,408	\$387,933

*Totals may differ due to rounding.

PROP 56 - MEDI-CAL FAMILY PLANNING
REGULAR POLICY CHANGE NUMBER: 133

Funding:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
90% Title XIX / 10% GF (4260-101-0890/0001)	\$431,037	\$43,104	\$387,933
100% GF (4260-101-0001)	\$34,304	\$34,304	\$0
Total	\$465,341	\$77,408	\$387,933

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
90% Title XIX / 10% GF (4260-101-0890/0001)	\$431,037	\$43,104	\$387,933
100% GF (4260-101-0001)	\$34,304	\$34,304	\$0
Total	\$465,341	\$77,408	\$387,933

*Totals may differ due to rounding.

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 134
IMPLEMENTATION DATE: 7/2005
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1085

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$304,051,000	\$307,494,000
- STATE FUNDS	\$129,661,000	\$143,725,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$304,051,000	\$307,494,000
STATE FUNDS	\$129,661,000	\$143,725,000
FEDERAL FUNDS	\$174,390,000	\$163,769,000

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 21-0014
 Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

Not Applicable

Background:

Effective July 1, 2005, based on the requirements of SB 1100, supplemental reimbursement will be available to private hospitals.

Private hospitals will receive payments from the Private Hospital Supplemental Fund (Item 4260-601-3097) using General Fund (GF), intergovernmental transfers (IGTs), and interest accrued in the Private Hospital Supplemental Fund as the non-federal share of payments. This funding, along with the federal reimbursement, will replace the amount of funding the private hospitals previously received under the Emergency Services and Supplemental Payments Program (SB 1255, Voluntary Governmental Transfers), the Graduate Medical Education Program (GME), and the Small and Rural Hospital Supplemental Payment Program (Fund 0688).

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 134

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 2021-22. The Department will submit SPA 22-0027 in FY 2022-23 quarter 1, to extend the Private Hospital Supplemental Fund Program through June 30, 2023. In the fourth quarter of FY 2022-23, a 4-year SPA to extend the Private Hospital Supplemental Program through FY 2026-27 is anticipated to be submitted to CMS.

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

Reason for Change:

The change in FY 2022-23, from the prior estimate, is due to:

- Updated FY 2021-22 Affordable Care Act (ACA) data,
- Updated FY 2022-23 IGT amounts,
- The distribution of carryover funds has been removed from the current estimate, and
- Updated FY 2022-23 Cash Expenditures to providers due to the extension of the FFCRA increased FMAP through March 31, 2023.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to higher IGT payments in FY 2023-24.

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 that were deposited into the SF for FY 2013-14 through FY 2019-20 were distributed to providers. Beginning in FY 2021-22, the ACA adjustments will be returned to the SF.
2. The FY 2022-23 \$118,400,000 GF appropriation will be adjusted by the enhanced federal funds provided by the FFCRA and the FY 2022-23 and FY 2023-24 \$118,400,000 GF appropriation will be adjusted by the enhanced federal funds provided by the ACA, resulting in carryover funds.
3. IGT payments will be \$47.8 million TF in FY 2022-23 and \$50.7 million TF in FY 2023-24.
4. 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

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 134

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.

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 2021-22 ACA supplemental payments will be claimed in FY 2022-23, and FY 2022-23 ACA supplemental payments will be claimed in FY 2023-24.
 - 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 56.2% FMAP for FY 2021-22 and FY 2022-23 Q1 through Q3 and at the regular 50% FMAP for FY 2022-23 Q4.
 - The SF will be reimbursed for the SF portion (non-federal share) and an adjustment will be made for the federal share processed at the FFCRA 56.2% FMAP for FY 2021-22 and FY 2022-23 Q1 through Q3 and at the regular 50% FMAP for FY 2022-23 Q4.
6. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through March 31, 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
 - The FY 2022-23 Q1 through Q3 payments will be issued at 56.2% FF/ 43.8% SF (GF appropriated); resulting in \$10.42 million carryover funds.
7. The ending balance shown is on a cash basis and does not necessarily mean that the remaining funds are available. Funds in the ending balance may be committed and scheduled to be expended in the following year.
8. The estimated Private Hospital Supplemental payments and ending balance for FY 2022-23 are shown below:

(Dollars in Thousands)

FY 2022-23 Private Hospital Supplemental Fund Summary	SF
FY 2021-22 Ending Balance	\$39,152
Appropriation (GF)	\$118,400
Carryover Funds	\$17,082
2022-23 IGT	\$21,685
FY 2021-22 Interest Earned	\$255
Funds Available	\$196,574
Less: FY 2022-23 Cash Expenditures to Hospitals	(\$129,661)
Est. FY 2022-23 Remaining Balance	\$66,913

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
REGULAR POLICY CHANGE NUMBER: 134

(Dollars in Thousands)

FY 2022-23	TF	SF	FF	ACA FF	FFCRA	Return to SF*	Return to Counties*
FY 2022-23 Cash Expenditures to Providers**	\$284,617	\$129,661	\$142,309	\$0	\$12,647	\$0	\$0
FY 2021-22 ACA FF Adjustment to Special Fund***	\$17,082	\$0	(\$25,268)	\$45,483	(\$3,133)	\$17,082	\$0
FY 2021-22 ACA FF Adjustment to Counties***	\$2,352	\$0	(\$3,481)	\$6,265	(\$432)	\$0	\$2,352
Total	\$304,051	\$129,661	\$113,560	\$51,748	\$9,082	\$17,082	\$2,352

9. The estimated Private Hospital Supplemental payments and ending balance for FY 2023-24 are shown below:

(Dollars in Thousands)

FY 2023-24 Private Hospital Supplemental Fund Summary	SF
FY 2022-23 Ending Balance	\$66,913
Appropriation (GF)	\$118,400
Carryover Funds	\$17,865
2023-24 IGT	\$25,325
Est. FY 2022-23 Interest Earned	\$255
Funds Available	\$228,758
Less: FY 2023-24 Cash Expenditures to Hospitals	(\$143,725)
Est. FY 2023-24 Remaining Balance	\$85,033

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
REGULAR POLICY CHANGE NUMBER: 134

(Dollars in Thousands)

FY 2023-24	TF	SF	FF	ACA FF	FFCRA	Return to SF*	Return to Counties*
FY 2023-24 Cash Expenditures to Providers**	\$287,450	\$143,725	\$143,725	\$0	\$0	\$0	\$0
FY 2022-23 ACA FF Adjustment to Special Fund***	\$17,865	\$0	(\$25,268)	\$45,483	(\$2,350)	\$17,865	\$0
FY 2022-23 ACA FF Adjustment to Counties***	\$2,179	\$0	(\$3,083)	\$5,549	(\$287)	\$0	\$2,179
Total	\$307,494	\$143,725	\$115,374	\$51,032	(\$2,637)	\$17,865	\$2,179

*The Return to SF and Return to Counties columns are for display purposes only (see Methodology #5).

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)

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 135
IMPLEMENTATION DATE: 4/2004
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 78

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$275,925,000	\$222,736,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$275,925,000	\$222,736,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$275,925,000	\$222,736,000

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:

Not Applicable

Background:

AB 915 created a supplemental reimbursement program for publicly owned or operated hospital outpatient departments. Publicly owned or operated hospitals now receive supplemental payments based on CPEs for providing outpatient hospital care to Medi-Cal beneficiaries. The supplemental amount, when combined with the amount received from all other sources of Medi-Cal Fee-for-Service reimbursement, cannot exceed 100% of the costs of providing services to Medi-Cal beneficiaries. The non-federal share used to draw down federal financial participation (FFP) is paid exclusively with funds from the participating facilities.

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: 135

Reason for Change:

There was no change in FY 2022-23, from the prior estimate, is an increase due to:

- Final reconciliation schedules for both Los Angeles County (LAC) hospitals and non-LAC hospitals have been revised.
- Portion of FY 2020-21 payments originally scheduled to occur in FY 2021-22 were shifted to FY 2022-23.
- FY 2020-21 and FY 2021-22 payments revised based on updated data.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to a higher volume of final reconciliations recoupments are scheduled to occur in FY 2023-24.

Methodology:

1. Payments of \$275,925,000 and \$222,736,000 are expected to be made in FY 2022-23 and FY 2023-24 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 2022-23.
 - Final reconciliations for Los Angeles County (LAC) 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 2021-22 and FY 2022-23 Traditional and ACA claims are estimated based on FY 2020-21 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 March 31, 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 135

FY 2022-23	TF	FF	ACA	FFCRA
FY 2013-14 (LAC only Final Rec)	(\$1,951,000)	(\$1,246,000)	(\$705,000)	\$0
FY 2014-15 (LAC only Final Rec)	(\$3,664,000)	(\$1,564,000)	(\$2,100,000)	\$0
FY 2017-18 (Non LAC only Final Rec)	(\$6,221,000)	(\$3,339,000)	(\$2,882,000)	\$0
FY 2020-21 (Delayed Payments)	\$31,375,000	\$13,883,000	\$15,771,000	\$1,721,000
FY 2020-21 (Calendar Year)	\$846,000	\$565,000	\$210,000	\$71,000
FY 2021-22	\$255,540,000	\$121,462,000	\$119,016,000	\$15,062,000
Total	\$275,925,000	\$129,761,000	\$129,310,000	\$16,854,000

FY 2023-24	TF	FF	ACA	FFCRA
FY 2004-05 (Non LAC only Final Rec)	(\$18,316,000)	(\$18,316,000)	\$0	\$0
FY 2005-06 (LAC only Final Rec)	(\$2,972,000)	(\$2,972,000)	\$0	\$0
FY 2015-16 (LAC only Final Rec)	(\$3,599,000)	(\$1,569,000)	(\$2,030,000)	\$0
FY 2016-17 (LAC only Final Rec)	(\$3,381,000)	(\$1,225,000)	(\$2,156,000)	\$0
FY 2016-17 (Non LAC only Final Rec)	(\$6,367,000)	(\$3,485,000)	(\$2,882,000)	\$0
FY 2017-18 (LAC only Final Rec)	(\$4,092,000)	(\$1,556,000)	(\$2,536,000)	\$0
FY 2021-22 (Calendar Year)	\$876,000	\$585,000	\$218,000	\$73,000
FY 2022-23	\$260,587,000	\$125,713,000	\$123,182,000	\$11,692,000
Total	\$222,736,000	\$97,175,000	\$113,796,000	\$11,765,000

Funding:

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

100% Title XIX ACA FF (4260-101-0890)

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

NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 136
IMPLEMENTATION DATE: 12/2022
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2185

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$157,500,000	\$105,000,000
- STATE FUNDS	\$71,426,000	\$52,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$157,500,000	\$105,000,000
STATE FUNDS	\$71,426,000	\$52,500,000
FEDERAL FUNDS	\$86,074,000	\$52,500,000

Purpose:

This policy change (PC) 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:

Not Applicable

Background:

On January 7, 2019, the Governor issued Executive Order N-01-19, which required the Department to transition Medi-Cal pharmacy from Managed Care (MC) to Fee-for-Service (FFS) through Medi-Cal Rx. The Medi-Cal Rx Assumption of Operations (AOO) began 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.

Per Welfare and Institution Code Section 14105.467, the Department convened a stakeholder workgroup to develop the methodology for the distribution of supplemental pool payments to qualifying non-hospital 340B community clinics. The workgroup topics include the eligibility criteria for receipt of supplemental payments, the aggregate amount of pool funding available in a respective fiscal year, and the criteria for apportioning the pool funding among qualifying non-hospital 340B community clinics including the timing, frequency, and amount of the resultant supplemental payments.

NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 136

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 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

- 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 in FY 2022-23, from the prior estimate, is due to an increase in supplemental payments as a result of FY 2021-22 payments shifting to FY 2022-23. The change in the General Fund share is due to including FFCRA increased FMAP through March 31, 2023 in this policy change.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to including a full year of supplemental payments in FY 2023-24 and no FFCRA increased FMAP is assumed in FY 2023-24.

Methodology:

1. The estimated Non-hospital 340B Clinic Supplemental Payment Pool annual cost is \$105,000,000 TF.
2. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through March 31, 2023, for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.

(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

NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 136

3. The estimated cost in FY 2022-23 is \$157,500,000 TF and \$105,000,000 TF in FY 2023-24.

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Non-hospital 340B Clinic Supplemental Payments	\$157,500	\$71,426	\$86,074
Total	\$157,500	\$71,426	\$86,074

(Dollars in Thousands)

FY 2023-24	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 2022-23	TF	GF	FF
50% Title XIX / 50% GF	\$157,500	\$78,750	\$78,750
FFCRA 6.2% Increased FFP	\$0	(\$7,324)	\$7,324
Total	\$157,500	\$71,426	\$86,074

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF	\$105,000	\$52,500	\$52,500
Total	\$105,000	\$52,500	\$52,500

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER: 137
IMPLEMENTATION DATE: 2/2006
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 104

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$140,698,000	\$173,056,000
- STATE FUNDS	\$56,833,000	\$71,637,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$140,698,000	\$173,056,000
STATE FUNDS	\$56,833,000	\$71,637,000
FEDERAL FUNDS	\$83,865,000	\$101,419,000

Purpose:

This policy change estimates the supplemental reimbursement to specific hospitals that provide trauma care to Medi-Cal beneficiaries, through the use of Intergovernmental Transfers (IGTs).

Authority:

Welfare & Institutions Code, Sections 14164 and 14087.3
 SPA 03-032
 SPA 22-0026 (pending)
 Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

Not Applicable

Background:

This program allows Los Angeles and Alameda counties to submit IGTs used as the non-federal share of costs to draw down Title XIX federal funds. The Department uses the IGTs matched with the federal funds to make supplemental payments to specified hospitals for the costs of trauma care center services provided to Medi-Cal beneficiaries.

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 2022-23, from the prior estimate, is a decrease due to:

- FY 2021-22 payments decreased based on actuals.
- FY 2021-22 ACA adjustment estimate revised based on updated data.

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER: 137

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a net increase due to:

- Higher estimated payments and ACA adjustments to occur in FY 2023-24 as compared to FY 2022-23.
- Fewer periods of FFCRA increased FMAP are estimated in FY 2023-24.

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. ACA payments for FY 2021-22 will be claimed in FY 2022-23 and ACA payments for FY 2022-23 will be claimed in FY 2023-24. 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 2021-22 Q1 through Q4 and FY 2022-23 Q1 through Q3.
4. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through March 31, 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.

(Dollars in Thousands)

FY 2022-23	TF	Special Deposit Fund	FF	ACA FF	FFCRA	*Return to Counties
FY 2021-22 ACA Adjustment to Counties	\$10,942	\$0	(\$16,187)	\$29,136	(\$2,007)	\$10,942
FY 2021-22	\$129,756	\$56,833	\$64,878	\$0	\$8,045	\$0
Total FY 2022-23	\$140,698	\$56,833	\$48,691	\$29,136	\$6,038	\$10,942

(Dollars in Thousands)

FY 2023-24	TF	Special Deposit Fund	FF	ACA FF	FFCRA	*Return to Counties
FY 2022-23 ACA Adjustment to Counties	\$15,092	\$0	(\$21,346)	\$38,423	(\$1,985)	\$15,092
FY 2022-23	\$157,964	\$71,637	\$78,982	\$0	\$7,345	\$0
Total FY 2023-24	\$173,056	\$71,637	\$57,636	\$38,423	\$5,360	\$15,092

*The Return to Counties column is for display purposes only (see Methodology #3).

FFP FOR LOCAL TRAUMA CENTERS
REGULAR POLICY CHANGE NUMBER: 137

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)

DPH PHYSICIAN & NON-PHYS. COST

REGULAR POLICY CHANGE NUMBER: 138
IMPLEMENTATION DATE: 5/2008
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1078

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$140,447,000	\$99,696,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$140,447,000	\$99,696,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$140,447,000	\$99,696,000

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:

Not Applicable

Background:

Effective July 1, 2005, pursuant to SPA 05-023, DPHs are to receive reimbursement based on certified public expenditures (CPEs) for their Medi-Cal uncompensated costs incurred for physician and non-physician practitioner professional services.

SPA 05-023 that authorizes federal funding for this reimbursement was approved by the Centers for Medicare & Medicaid Services (CMS) in December 2007. CMS approved the "Physician and Non-Physician Practitioner Time Study Implementation Plan" on December 15, 2008. Revisions to the "Physician and Non-Physician Practitioner Time Study Implementation Plan" were approved by CMS on September 1, 2020, which updated the language to reflect that in the event of a state of emergency, the alternate random moment time studies in the affected quarters will be statistically invalid.

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

DPH PHYSICIAN & NON-PHYS. COST

REGULAR POLICY CHANGE NUMBER: 138

year end. Payments resulting from the interim or final reconciliation will be based on the hospitals' CPEs and comprised of 100% federal funds.

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 2022-23, from the prior estimate, is due to:

- FY 2015-16 final reconciliations for LA County DPHS have been shifted from FY 2022-23 to FY 2023-24,
- FY 2013-14 and FY 2014-15 final reconciliations for two non-LA County DPHs were shifted from FY 2021-22 to FY 2022-23,
- Final reconciliations, interim reconciliations, and interim payment amounts for all DPHs estimated to occur in FY 2022-23 have been updated based on revised payment calculations, and
- Reflecting FFCRA increased FMAP through March 31, 2023 in this policy change.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to:

- 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 2023-24 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 were issue 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.

DPH PHYSICIAN & NON-PHYS. COST
REGULAR POLICY CHANGE NUMBER: 138

5. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through March 31, 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.

FY 2022-23	TF	FF	ACA FF	FFCRA
FY 2012-13 Final Reconciliation	(\$2,652,000)	(\$2,652,000)	\$0	\$0
FY 2013-14 Final Reconciliation	(\$18,307,000)	(\$18,019,000)	(\$288,000)	\$0
FY 2014-15 Final Reconciliation	(\$10,937,000)	(\$9,735,000)	(\$1,202,000)	\$0
FY 2015-16 Final Reconciliation	(\$12,404,000)	(\$12,404,000)	\$0	\$0
FY 2016-17 Final Reconciliation	\$12,378,000	\$12,378,000	\$0	\$0
FY 2017-18 Final Reconciliation	(\$3,262,000)	(\$3,262,000)	\$0	\$0
FY 2018-19 Final Reconciliation	\$2,273,000	\$2,273,000	\$0	\$0
FY 2019-20 Interim Reconciliation	\$17,135,000	\$16,135,000	\$0	\$1,000,000
FY 2020-21 Interim Reconciliation	\$76,120,000	\$4,699,000	\$70,838,000	\$583,000
FY 2022-23 Interim Payment	\$80,103,000	\$73,287,000	\$0	\$6,816,000
Total	\$140,447,000	\$62,700,000	\$69,348,000	\$8,399,000

FY 2023-24	TF	FF	ACA FF	FFCRA
FY 2005-06 Final Reconciliation	(\$3,383,000)	(\$3,383,000)	\$0	\$0
FY 2006-07 Final Reconciliation	(\$2,032,000)	(\$2,032,000)	\$0	\$0
FY 2007-08 Final Reconciliation	(\$12,750,000)	(\$12,750,000)	\$0	\$0
FY 2008-09 Final Reconciliation	\$7,569,000	\$7,569,000	\$0	\$0
FY 2015-16 Final Reconciliation	(\$14,182,000)	(\$12,423,000)	(\$1,759,000)	\$0
FY 2016-17 Final Reconciliation	(\$11,595,000)	(\$10,018,000)	(\$1,577,000)	\$0
FY 2017-18 Interim Reconciliation	(\$4,944,000)	(\$3,200,000)	(\$1,744,000)	\$0
FY 2021-22 Interim Reconciliation	\$67,726,000	(\$2,769,000)	\$70,838,000	(\$343,000)
FY 2023-24 Interim Payment	\$73,287,000	\$73,287,000	\$0	\$0
Total	\$99,696,000	\$34,281,000	\$65,758,000	(\$343,000)

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)

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 139
 IMPLEMENTATION DATE: 11/2015
 ANALYST: Autumn Recce
 FISCAL REFERENCE NUMBER: 1899

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$118,432,000	\$119,181,000
- STATE FUNDS	\$45,636,000	\$50,339,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$118,432,000	\$119,181,000
STATE FUNDS	\$45,636,000	\$50,339,000
FEDERAL FUNDS	\$72,796,000	\$68,842,000

Purpose:

This policy change estimates the supplemental payments to Martin Luther King, Jr. – Los Angeles (MLK-LA) Healthcare Corporation, a private nonprofit hospital.

Authority:

SB 857 (Chapter 31, Statutes of 2014), Welfare & Institutions (W&I) Code 14165.50
 SPA 18-0021
 SPA 21-0012
 Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

Not Applicable

Background:

SB 857 requires specific funding requirements to facilitate the financial viability of MLK-LA, a private nonprofit hospital that serves 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 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: 139

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 2022-23, from the prior estimate, is due to:

- Updated FY 2021-22 interim reconciliations,
- Updated FY 2019-20 final reconciliations,
- Updated FY 2021-22 ACA optional population payment data, and
- Inclusion of an additional nine months of FFCRA increased FMAP.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to higher ACA payments estimated in FY 2023-24.

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 2022-23 and FY 2023-24.
5. Expenditures for FY 2022-23 and FY 2023-24 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 2022-23 and FY 2023-24, the supplemental payments and DRG add-on payments are limited by the payment cap of \$123.1 million. FY 2022-23 and FY 2023-24 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 2021-22 ACA supplemental payments will be claimed in FY 2022-23. For FY 2022-23, the ACA payment will be claimed in FY 2023-24. 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 March 31, 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

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11. On a cash basis, costs in FY 2022-23 and FY 2023-24 are expected to be:

(Dollars in Thousands)

FY 2022-23	TF	GF	IGT*	FF	ACA FF	FFCRA	Return to County**
Supplemental 2022-23	\$100,000	\$0	\$45,350	\$50,000	\$0	\$4,650	\$0
Supplemental ACA 2021-22	\$16,924	\$0	\$0	(\$25,035)	\$45,063	(\$3,104)	\$16,924
Interim Reconciliation FY 2021-22	\$1,496	\$353	\$0	\$300	\$806	\$37	\$0
Final Reconciliation 2019-20	\$12	\$212	(\$279)	(\$105)	\$195	(\$11)	\$0
Total	\$118,432	\$565	\$45,071	\$25,160	\$46,064	\$1,572	\$16,924

(Dollars in Thousands)

FY 2023-24	TF	GF	IGT*	FF	ACA FF	FFCRA	Return to County**
Supplemental 2023-24	\$100,000	\$0	\$50,000	\$50,000	\$0	\$0	\$0
Supplemental ACA 2022-23	\$17,700	\$0	\$0	(\$25,035)	\$45,063	(\$2,328)	\$18,476
Interim Reconciliation FY 2022-23	\$1,481	\$358	\$0	\$297	\$798	\$28	\$0
Final Reconciliation 2020-21	\$0	\$384	(\$403)	(\$28)	\$50	(\$3)	\$0
Total	\$119,181	\$742	\$49,597	\$25,234	\$45,911	(\$2,303)	\$18,476

**The Return to County column is for display purposes only (see methodology #8)

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS
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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: 140
IMPLEMENTATION DATE: 7/1991
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 82

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$84,231,000	\$79,338,000
- STATE FUNDS	\$19,017,500	\$23,602,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$84,231,000	\$79,338,000
STATE FUNDS	\$19,017,500	\$23,602,000
FEDERAL FUNDS	\$65,213,500	\$55,736,000

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:

Not Applicable

Background:

SB 1732 and SB 2665 authorized Medi-Cal reimbursement of revenue and general obligation bond debt for principal and interest costs incurred in the construction, renovation and replacement of qualifying disproportionate share contract hospitals. The Selective Provider Contracting Program (SPCP) ended June 30, 2013, due to the implementation of the Diagnosis Related Group payment methodology. The Centers for Medicare and Medicaid Services (CMS) approved State Plan Amendment (SPA) 13-011 on December 11, 2013, which maintains the Federal authority for SB 1732.

SB 1128 authorized a distinct part skilled nursing facility (DP-NF) of an acute care hospital providing specified services to receive Medi-Cal reimbursement for debt service incurred for the financing of eligible capital construction projects. The DP-NF must meet other specific hospital and project conditions specified in Section 14105.26 of the Welfare and Institutions Code. The Department claims federal funds using certified public expenditures from eligible DP-NFs. CMS approved SPA 00-010 on July 17, 2001, which maintains the Federal authority for SB 1128.

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: 140

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 2022-23, from the prior estimate, is due to:

For hospitals (SB 1732):

- Updated interim payment amounts for FY 2020-21, FY 2021-22, and FY 2022-23 based on more recent data;
- Updated FY 2020-21 ACA adjustment amounts based on more recent data;
- FY 2016-17 interim reconciliation overpayment shifted from FY 2021-22 to FY 2022-23, and based on actuals;
- Updated FY 2019-20 interim reconciliation amounts based on more recent data; and
- Updated FY 1993-94 through FY 2019-20 final reconciliation amounts based on more recent data.

For DP-NFs (SB 1128):

- Updated FY 2020-21 and FY 2021-22 interim payment amounts based on more recent data.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to:

For hospitals (SB 1732):

- Fewer interim payments occurring in FY 2023-24;
- Interim reconciliations estimated in FY 2022-23 were overpayments compared to additional payments in FY 2023-24; and
- No final reconciliations overpayments are estimated in FY 2023-24.

For DP-NFs (SB 1128):

- Decreased payments are estimated in FY 2023-24.

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 has closed in order to determine the proportion of the hospital's costs for newly eligible Medi-Cal beneficiaries. FY 2020-21 and FY 2021-22 ACA supplemental payments will be claimed in FY 2022-23 and FY 2023-24 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 FFCRA 56.2% FMAP for FY 2020-21 and FY 2021-22.

CAPITAL PROJECT DEBT REIMBURSEMENT

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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 Medicaid Utilization Ratio (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 March 31, 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
6. The estimated payments on a cash basis are:

FY 2022-23	TF	GF	FF	FFCRA	ARRA	ACA
Hospitals (SB 1732)						
Interim Payment						
FY 2020-21	\$40,000	\$18,000	\$20,000	\$2,000	\$0	\$0
FY 2021-22	\$43,650,000	\$19,119,000	\$21,825,000	\$2,706,000	\$0	\$0
FY 2022-23	\$30,765,000	\$13,475,000	\$15,383,000	\$1,907,000	\$0	\$0
ACA Adjustment						
FY 2020-21	\$0	(\$11,313,000)	(\$16,734,000)	(\$2,075,000)	\$0	\$30,122,000
Interim Reconciliation						
FY 2016-17	(\$1,568,000)	(\$445,000)	(\$427,000)	\$0	\$0	(\$696,000)
FY 2019-20	(\$95,000)	\$99,000	(\$13,000)	(\$205,000)	\$0	\$24,000
Final Reconciliation Adjustment						
FY 1989-90 to FY 2019-20	(\$1,307,000)	(\$550,000)	(\$642,000)	\$0	(\$115,000)	\$0
FY 1993-94 to FY 2019-20	(\$2,869,000)	(\$1,222,000)	(\$1,408,000)	\$0	(\$90,000)	(\$149,000)
FY 1996-97 to FY 2019-20	(\$320,000)	(\$164,000)	(\$155,000)	\$0	(\$1,000)	\$0
DP-NF (SB 1128)						
Interim Payment						
FY 2020-21	\$234,000	\$0	\$208,000	\$26,000	\$0	\$0
FY 2021-22	\$15,701,000	\$0	\$13,969,000	\$1,732,000	\$0	\$0
Total FY 2022-23	\$84,231,000	\$19,017,000	\$32,026,000	\$4,093,000	(\$206,000)	\$29,301,000

CAPITAL PROJECT DEBT REIMBURSEMENT
REGULAR POLICY CHANGE NUMBER: 140

FY 2023-24	TF	GF	FF	FFCRA	ACA
Hospitals (SB 1732)					
Interim Payment					
FY 2022-23	\$52,824,000	\$24,686,000	\$26,412,000	\$1,726,000	\$0
FY 2023-24	\$20,846,000	\$10,423,000	\$10,423,000	\$0	\$0
ACA Adjustment					
FY 2021-22	\$0	(\$11,844,000)	(\$17,520,000)	(\$2,172,000)	\$31,536,000
Interim Reconciliation					
FY 2020-21	\$1,055,000	\$337,000	\$342,000	\$42,000	\$334,000
DP-NF (SB 1128)					
Interim Payment					
FY 2021-22	\$320,000	\$0	\$285,000	\$35,000	\$0
FY 2022-23	\$4,293,000	\$0	\$3,826,000	\$467,000	\$0
Total FY 2023-24	\$79,338,000	\$23,602,000	\$23,768,000	\$98,000	\$31,870,000

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)

CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER: 141
IMPLEMENTATION DATE: 6/2002
ANALYST: Donna Lee
FISCAL REFERENCE NUMBER: 86

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$58,660,000	\$52,822,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$58,660,000	\$52,822,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$58,660,000	\$52,822,000

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:

Not Applicable

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: 141

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 2022-23, from the prior estimate, is a net decrease due to:

- Added RY 2012-13 and 2013-14 recoupments that were expected to occur in June 2022;
- RY 2014-15, 2015-16, and 2017-18 final reconciliations were recalculated based on updated data;
- Added RY 2019-20 interim payment that occurred in July 2022;
- RY 2020-21 interim payments were recalculated based on updated data;
- RY 2020-21 interim reconciliation was recalculated based on updated data;
- RY 2021-22 interim payments were recalculated based on updated data;
- RY 2022-23 interim payments were recalculated based on updated data.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a net decrease due to:

- Backlog of the final reconciliations that consists of RY 2014-15 through 2017-18 will be completed in FY 2022-23 and a normal payment schedule will resume in FY 2023-24;
- Updated estimated FY 2022-23 interim payments include FFCRA increased FMAP funding through March 31, 2023.

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: 141

5. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through March 31, 2023, for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.

FY 2022-23	TF	Regular FFP	ACA FF	FFCRA
RY 2012-13 Final Reconciliation	(\$1,263,000)	(\$1,263,000)	\$0	\$0
RY 2013-14 Final Reconciliation	(\$53,000)	(\$53,000)	\$0	\$0
RY 2014-15 Final Reconciliation	(\$2,224,000)	(\$3,292,000)	\$1,068,000	\$0
RY 2015-16 Final Reconciliation	(\$3,625,000)	(\$3,750,000)	\$125,000	\$0
RY 2017-18 Final Reconciliation	(\$3,684,000)	(\$4,045,000)	\$361,000	\$0
RY 2019-20 Interim Payments	\$1,000	\$1,000	\$0	\$0
RY 2020-21 Interim Payments	\$1,832,000	\$1,584,000	\$52,000	\$196,000
RY 2020-21 Interim Reconciliation	\$24,592,000	\$18,692,000	\$3,582,000	\$2,318,000
RY 2021-22 Interim Payments	\$22,025,000	\$16,262,000	\$3,746,000	\$2,017,000
RY 2022-23 Interim Payments	\$21,059,000	\$15,200,000	\$3,974,000	\$1,885,000
Total	\$58,660,000	\$39,336,000	\$12,908,000	\$6,416,000

FY 2023-24	TF	Regular FFP	ACA FF	FFCRA
RY 2018-19 Final Reconciliation	(\$3,923,000)	(\$3,780,000)	(\$143,000)	\$0
RY 2021-22 Interim Reconciliation	\$24,592,000	\$18,692,000	\$3,582,000	\$2,318,000
RY 2022-23 Interim Payments	\$20,116,000	\$15,200,000	\$3,974,000	\$942,000
RY 2023-24 Interim Payments	\$12,037,000	\$9,615,000	\$2,422,000	\$0
Total	\$52,822,000	\$39,727,000	\$9,835,000	\$3,260,000

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 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 142
IMPLEMENTATION DATE: 1/2018
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2049

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$578,569,000	\$580,083,000
- STATE FUNDS	\$199,100,800	\$225,880,950
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	90.08 %	89.85 %
APPLIED TO BASE		
TOTAL FUNDS	\$57,394,000	\$58,878,400
STATE FUNDS	\$19,750,800	\$22,926,920
FEDERAL FUNDS	\$37,643,250	\$35,951,510

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, orthodontic, periodontal, preventative and 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 an increase in supplemental payments ranging from 20-60% and specified dollar amounts for specific procedures, and the addition of other dental 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).

PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 142

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 2022-23, is an increase due to higher check write projections and Dental Managed Care costs. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a slight increase due to the increase in the Prop 56 portion of the Dental Managed Care rate and an increase in the 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, 2023, in this policy change.
5. Funds allocated for the supplemental payments are as follows:

FY 2022-23	TF	SF	FF
Fee-for-Service			
50% Title XIX / 50% GF	\$352,097,000	\$176,049,000	\$176,049,000
ACA 90% FFP/10% GF	\$117,430,000	\$11,743,000	\$105,687,000
Title 21 65% FFP/35% GF	\$65,479,000	\$22,918,000	\$42,561,000
FFCRA 6.2% Increased FFP	\$0	(\$21,830,000)	\$21,830,000
FFCRA 4.34% Increased FFP	\$0	(\$2,842,000)	\$2,842,000
Total Fee-for-Service	\$521,191,000	\$180,388,000	\$340,803,000
Dental Managed Care			
50% Title XIX / 50% GF	\$23,919,000	\$11,960,000	\$11,960,000
ACA 90% FFP/10% GF	\$16,633,000	\$1,663,000	\$14,970,000
Title 21 65% FFP/35% GF	\$3,011,000	\$1,054,000	\$1,957,000
FFCRA 6.2% Increased FFP	\$0	(\$1,483,000)	\$1,483,000
FFCRA 4.34% Increased FFP	\$0	(\$131,000)	\$131,000
Total Dental Managed Care	\$43,563,000	\$13,063,000	\$30,500,000

PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS
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Combined FY 2022-23			
50% Title XIX / 50% GF	\$376,016,000	\$188,008,000	\$188,008,000
ACA 90% FFP/10% GF	\$134,063,000	\$13,406,000	\$120,657,000
Title 21 65% FFP/35% GF	\$68,490,000	\$23,972,000	\$44,518,000
FFCRA 6.2% Increased FFP	\$0	(\$23,313,000)	\$23,313,000
FFCRA 4.34% Increased FFP	\$0	(\$2,972,000)	\$2,972,000
Grand Total	\$578,569,000	\$199,101,000	\$379,468,000

FY 2023-24	TF	SF	FF
Fee-for-Service			
50% Title XIX / 50% GF	\$352,159,000	\$176,080,000	\$176,080,000
ACA 90% FFP/10% GF	\$117,536,000	\$11,754,000	\$105,783,000
Title 21 65% FFP/35% GF	\$65,482,000	\$22,919,000	\$42,563,000
Total Fee-for-Service	\$535,177,000	\$210,753,000	\$324,426,000
Dental Managed Care			
50% Title XIX / 50% GF	\$24,656,000	\$12,328,000	\$12,328,000
ACA 90% FFP/10% GF	\$17,146,000	\$1,715,000	\$15,431,000
Title 21 65% FFP/35% GF	\$3,103,000	\$1,086,000	\$2,017,000
Total Dental Managed Care	\$44,905,000	\$15,129,000	\$29,776,000
Combined FY 2023-24			
50% Title XIX / 50% GF	\$376,816,000	\$188,408,000	\$188,408,000
ACA 90% FFP/10% GF	\$134,682,000	\$13,468,000	\$121,214,000
Title 21 65% FFP/35% GF	\$68,585,000	\$24,005,000	\$44,580,000
Grand Total	\$580,083,000	\$225,881,000	\$354,202,000

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)
65% Title XXI / 35% GF (4260-101-0890/0001)
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)

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 143
IMPLEMENTATION DATE: 4/2014
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1661

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$55,446,000	\$3,480,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$55,446,000	\$3,480,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$55,446,000	\$3,480,000

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:

Not Applicable

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: 143

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, 2023, 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, 2022. However, closeout 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 2022-23, from the prior estimate, is a net increase due to:

- Remaining final reconciliations for FY 2010-11 through FY 2017-18 were shifted from FY 2021-22 to be paid in FY 2022-23.
- FY 2018-19 and FY 2019-20 interim payments have been revised based on updated data.
- FY 2020-21 and FY 2021-22 interim payments have been added to FY 2022-23.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to:

- Higher volume of final reconciliations and interim payments are scheduled to occur in FY 2022-23 in comparison to FY 2023-24.

Methodology:

1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008, through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011, through March 31, 2011, and 56.88% for April 1, 2011, through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.
2. The ACA allows for 100% FMAP for calendar years (CY) 2014 through 2016, 95% FMAP for CY 2017, 94% FMAP for CY 2018, 93% for CY 2019, and 90% for CY 2020 and after for newly eligible Medi-Cal beneficiaries. The ACA methodology has been approved by CMS.
3. Effective July 1, 2018, SB 523 established the GEMT Provider Quality Assurance Fee (QAF) Program. GEMT QAF payments will reduce GEMT CPE reimbursements beginning in FY 2018-19.
4. The GEMT CPE reimbursements will sunset on December 31, 2022.

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 143

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 2023-24.
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 applicable for expenditures through December 31, 2022 for this policy change. The policy change currently only includes expenditures through December 31, 2022.

The estimated payments on a cash basis are:

FY 2022-23	Total FFP	Regular FFP	ARRA	ACA	FFCRA
FY 2010-11 Final Recon.	(\$899,000)	(\$759,000)	(\$140,000)	\$0	\$0
FY 2011-12 Final Recon.	(\$288,000)	(\$288,000)	\$0	\$0	\$0
FY 2012-13 Final Recon.	(\$107,000)	(\$107,000)	\$0	\$0	\$0
FY 2013-14 Final Recon.	(\$20,000)	(\$12,000)	\$0	(\$8,000)	\$0
FY 2015-16 Final Recon.	(\$218,000)	(\$90,000)	\$0	(\$128,000)	\$0
FY 2016-17 Final Recon.	(\$36,000)	(\$12,000)	\$0	(\$24,000)	\$0
FY 2017-18 Final Recon.	(\$916,000)	(\$322,000)	\$0	(\$594,000)	\$0
FY 2018-19 Interim Payment	\$14,322,000	\$5,094,000	\$0	\$9,228,000	\$0
FY 2019-20 Interim Payment	\$15,216,000	\$5,496,000	\$0	\$9,396,000	\$324,000
FY 2020-21 Interim Payment	\$14,196,000	\$5,280,000	\$0	\$8,262,000	\$654,000
FY 2021-22 Interim Payment	\$14,196,000	\$5,280,000	\$0	\$8,262,000	\$654,000
Total FY 2022-23	\$55,446,000	\$19,560,000	(\$140,000)	\$34,394,000	\$1,632,000

FY 2023-24	Total FFP	Regular FFP	ACA	FFCRA
FY 2022-23 Interim Payment	\$7,170,000	\$2,664,000	\$4,176,000	\$330,000
FY 2018-19 Final Recon.	(\$1,164,000)	(\$420,000)	(\$744,000)	\$0
FY 2019-20 Final Recon.	(\$1,275,000)	(\$459,000)	(\$789,000)	(\$27,000)
FY 2020-21 Final Recon.	(\$1,251,000)	(\$459,000)	(\$735,000)	(\$57,000)
Total FY 2023-24	\$3,480,000	\$1,326,000	\$1,908,000	\$246,000

GEMT SUPPLEMENTAL PAYMENT PROGRAM
REGULAR POLICY CHANGE NUMBER: 143

Funding:

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

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

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

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 144
IMPLEMENTATION DATE: 10/2013
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1600

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$46,265,000	\$41,636,000
- STATE FUNDS	\$18,390,000	\$18,582,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$46,265,000	\$41,636,000
STATE FUNDS	\$18,390,000	\$18,582,500
FEDERAL FUNDS	\$27,875,000	\$23,053,500

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:

Not Applicable

Background:

AB 113 established a NDPH supplemental payment program funded by intergovernmental transfers (IGTs). AB 113 authorizes the State to retain nine percent of each IGT to reimburse the administrative costs of operating the program and for the benefit of Medi-Cal children's health programs. This policy change also reflects the portion of the nine percent that is used to offset General Fund (GF) costs of Medi-Cal children's health services.

SPA 16-015 was approved by the Centers for Medicare & Medicaid Services (CMS) on July 20, 2016, to allow for an interim IGT payment in the event that an Upper Payment Limit (UPL) has not been finalized by CMS by April 1st 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: 144

Reason for Change:

The change in FY 2022-23, from the prior estimate, is a net increase due to:

- FY 2021-22 Affordable Care Act (ACA) adjustment shifted to a payment finalization, as the FY 2021-22 UPL was not approved when interim payments were issued; therefore, FY 2021-22 interim payments will be reconciled to the approved FY 2021-22 UPL;
- FY 2021-22 General Fund transfer for the benefit of Children's Services were updated based on more recent data; and
- FY 2022-23 interim payments were updated based on more recent data.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a net decrease due to:

- The addition of FY 2022-23 ACA adjustments in FY 2023-24; and
- No payment finalizations for prior years are expected to occur in FY 2023-24.

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 2021-22 UPL was submitted to CMS for approval on March 15, 2022, and the FY 2022-23 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 2021-22 interim supplemental payments were processed using 80% of the approved UPL room from 2020-21 which was the last approved UPL at the date of payment. Payment finalizations for FY 2021-22 will occur in FY 2022-23. FY 2022-23 and FY 2023-24 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 tentative UPL room for FY 2021-22, which is subject to change and CMS approval.
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 2021-22 ACA supplemental payments will be claimed in FY-2022-23, and FY-2022-23 ACA supplemental payments will be claimed in FY 2023-24. An adjustment will be made for the federal share processed at the FFCRA 56.2% FMAP for FY 2021-22 Q1 through Q4 and FY 2022-23 Q1 and Q2, and at the regular 50% FMAP for FY 2022-23 Q3 and Q4.
6. FY 2021-22 Children's Services amounts that were collected based on the interim payments for the respective FYs will be reconciled to the respective FY's approved UPL room and processed in FY 2022-23. FY 2022-23 Children's Services payments will be processed based on the FY 2022-23 UPL in FY 2023-24.

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 144

7. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through March 31, 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.

8. The estimated NDPH IGT supplemental payments are:

(Dollars in Thousands)

FY 2022-23	TF	GF*	IGT**	FF	ACA	FFCRA	***Return to NDPHs
FY 2021-22 Payment Finalization	\$8,931	\$0	\$1,367	(\$3,397)	\$11,382	(\$421)	\$0
FY 2021-22 Children's Services (Est.)	\$169	(\$1,150)	\$1,319	\$0	\$0	\$0	\$169
FY 2022-23 Interim Payments	\$37,165	\$0	\$16,854	\$18,583	\$0	\$1,728	\$0
Total FY 2022-23	\$46,265	(\$1,150)	\$19,540	\$15,186	\$11,382	\$1,307	\$169

(Dollars in Thousands)

FY 2023-24	TF	GF*	IGT**	FF	ACA	FFCRA	***Return to NDPHs
FY 2022-23 ACA Adjustments	\$4,471	\$0	\$0	(\$6,323)	\$11,382	(\$588)	\$4,471
FY 2022-23 Children's Services (Est.)	\$0	(\$1,161)	\$1,161	\$0	\$0	\$0	\$0
FY 2023-24 Interim Payments	\$37,165	\$0	\$18,583	\$18,582	\$0	\$0	\$0
Total FY 2023-24	\$41,636	(\$1,161)	\$19,744	\$12,259	\$11,382	(\$588)	\$4,471

***The Return to NDPHs column is for display purposes only.

Funding:

50% Title XIX /50% MIPA (4260-606-0834/4260-101-0890)**

100% GF (4260-101-0001)*

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

100% MIPA (4260-606-0834)

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

QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 145
IMPLEMENTATION DATE: 4/2014
ANALYST: Thomas Soteros-McNamara
FISCAL REFERENCE NUMBER: 1563

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$43,393,000	\$0
- STATE FUNDS	\$21,696,500	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$43,393,000	\$0
STATE FUNDS	\$21,696,500	\$0
FEDERAL FUNDS	\$21,696,500	\$0

Purpose:

This policy change estimates 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 Skilled Nursing Facility Quality and Accountability Special Fund (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
 SPA 22-0011
 AB 186 (Chapter 46, Statutes of 2022)

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: 145

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 2022 QASP awards payments will be separated by the three service periods:

- January 1, 2022 through June 30, 2022,
- July 1, 2022 through September 30, 2022, and
- October 1, 2022 through December 31, 2022.

The total pool of funds available for the awards will be prorated according to the number of days in each of the service periods.

AB 186 (Chapter 46, Statutes of 2022) sunsets the QASP program as of December 31, 2022, and authorizes closeout activities after that date.

Reason for Change:

The change in FY 2022-23, from the prior estimate, is due to an updated estimate of the delayed payment pool funds available for FY 2022-23.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to the program sunset date in FY 2022-23.

Methodology:

1. Administrative costs as well as supplemental payments are eligible for an FFP match. CDA Ombudsman costs are not eligible for FFP.

QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 145

2. The estimated incoming funds for the Special Fund are:

Incoming Funds	FY 2022-23
Penalties on Nursing Facilities	\$500,000
QASP GF Appropriation	\$0
PLI savings	\$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 2022-23 includes payments for:

- The July 1, 2022 to September 30, 2022 and October 1, 2022 to December 31, 2022 periods.

7. Supplemental payments are estimated to be:

(Dollars in Thousands)

FY 2022-23	TF	SF	FF
Supplemental Payments***	\$43,393	\$21,696	\$21,697
Total	\$43,393	\$21,696	\$21,697

Funding:

SNF Quality & Accountability (4260-605-3167)***

Title XIX FFP (4260-101-0890)***

PROP 56 - VALUE-BASED PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 146
IMPLEMENTATION DATE: 4/2020
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 2128

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$31,005,000	\$0
- STATE FUNDS	\$9,347,500	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$31,005,000	\$0
STATE FUNDS	\$9,347,500	\$0
FEDERAL FUNDS	\$21,657,500	\$0

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 requires 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: 146

MCPs are required to participate in the VBP program through a directed payment program. Prior to the implementation of a directed payment program, the 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. 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.

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:

There is no change to the Total Fund from the prior estimate, for FY 2022-23; however, there is an increase in the General Fund due to revised MCHIP assumptions. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to the sunset of the VBP program on June 30, 2022, with the final payment completed in July 2022.

Methodology:

1. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2023, for this policy change.
2. On a cash basis, the total directed payments are estimated to be \$31,005,000 in FY 2022-23.
3. Below is the payment table for FY 2022-23, by funding type.

PROP 56 - VALUE-BASED PAYMENT PROGRAM
REGULAR POLICY CHANGE NUMBER: 146

FY 2022-23	TF	GF	FF
50% Title XIX FF / 50% GF	\$16,665,000	\$8,333,000	\$8,333,000
ACA 90% FFP / 10% GF	\$11,368,000	\$1,137,000	\$10,231,000
65% Title XXI / 35% GF	\$2,972,000	\$1,040,000	\$1,932,000
FFCRA 4.34% Increased FFP	\$0	(\$129,000)	\$129,000
FFCRA 6.2% Increased FFP	\$0	(\$1,033,000)	\$1,033,000
Total	\$31,005,000	\$9,347,000	\$21,658,000

*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 4.34% GF (4260-113-0001)
 FFCRA 6.2% Increased FFP (4260-101-0890)
 FFCRA 6.2% GF (4260-101-0001)

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 147
IMPLEMENTATION DATE: 12/2010
ANALYST: Donna Lee
FISCAL REFERENCE NUMBER: 1616

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$15,705,000	\$15,270,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$15,705,000	\$15,270,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$15,705,000	\$15,270,000

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:

Not Applicable

Background:

Under this program, state veterans' homes that are enrolled as Medi-Cal providers and are owned and operated by the State are eligible to receive supplemental payments. Eligible state veterans' homes may claim federal financial participation (FFP) on the difference between their projected costs and the amount Medi-Cal currently pays under the existing program. The non-federal match to draw down FFP will be paid from the public funds of the eligible state veterans' homes.

Supplemental payments to state veterans' homes were effective retroactively beginning with the rate year August 1, 2006. The Department certifies expenditures reported in facilities' cost report before claiming FFP.

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: 147

Reason for Change:

The change in FY 2022-23, from the prior estimate, is a net increase due to:

- Revised estimated FY 2022-23 interim payments based on updated data to include a 10% increase for anticipated claiming of additional days.
- Updated estimated FY 2022-23 Q1 to Q3 interim payments to include FFCRA increased FMAP funding through March 31, 2023.
- Revised FY 2021-22 initial reconciliation based on updated data, using the Certified Public Expenditures (CPE) average of actual FY 2019-20 and FY 2020-21 data.
- Revised estimated FY 2018-19 final reconciliation based on updated data, using the CPE average of actual FY 2019-20 and FY 2020-21 data.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a net decrease due to:

- Increased interim payments based on FY 2022-23 data with a 10% increase to account for anticipated claiming of additional days.
- Lower initial reconciliations and final reconciliations estimated to occur in FY 2023-24.
- Lower FFCRA increased FMAP estimated in FY 2023-24.

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 March 31, 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.

Program payment amounts are estimated to be:

FY 2022-23	TF	Regular FF	ACA FF	FFCRA
Interim Payments				
FY 2022-23	\$12,682,000	\$11,603,000	\$0	\$1,079,000
Initial Reconciliation				
FY 2021-22	\$3,483,000	\$2,396,000	\$790,000	\$297,000
Final Reconciliation				
FY 2018-19	(\$460,000)	(\$445,000)	(\$15,000)	\$0
FY 2022-23 Total	\$15,705,000	\$13,554,000	\$775,000	\$1,376,000

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 147

FY 2023-24	TF	Regular FF	ACA FF	FFCRA
Interim Payments				
FY 2023-24	\$12,762,000	\$12,762,000	\$0	\$0
Initial Reconciliation				
FY 2022-23	\$2,960,000	\$1,886,000	\$899,000	\$175,000
Final Reconciliation				
FY 2019-20	(\$452,000)	(\$408,000)	(\$19,000)	(\$25,000)
FY 2023-24 Total	\$15,270,000	\$14,240,000	\$880,000	\$150,000

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: 148
IMPLEMENTATION DATE: 1/2005
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1038

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$10,000,000	\$10,000,000
- STATE FUNDS	\$4,535,000	\$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	\$4,535,000	\$5,000,000
FEDERAL FUNDS	\$5,465,000	\$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:

Not Applicable

Background:

SB 2563 established a supplemental program for hospitals providing a disproportionate share of outpatient services. The Department calculates payments on a calendar year (CY) basis and reimburses eligible providers on a quarterly basis through a payment action notice (PAN). Each payment represents one quarter of the total annual amount due to each eligible hospital. Due to the payment being made at the end of a quarter, the last quarter of each calendar year will be paid the following calendar year.

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 2022-23, from the prior estimate, is due to the assumption that the increased FMAP is through March 31, 2023, as opposed to June 30, 2022 in the prior estimate.

The change from FY 2022-23 to FY 2023-24, in the current estimate is due to no FFCRA estimated in FY 2023-24. There is no change in total funds from FY 2022-23 to FY 2023-24.

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH

REGULAR POLICY CHANGE NUMBER: 148

Methodology:

1. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through March 31, 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
2. Assume annual reimbursements for disproportionate share of outpatient services are \$10,000,000 TF.

FY 2022-23	TF	GF	FF	FFCRA
CY 2022	\$7,500,000	\$3,285,000	\$3,750,000	\$465,000
CY 2023	\$2,500,000	\$1,250,000	\$1,250,000	\$0
Total	\$10,000,000	\$4,535,000	\$5,000,000	\$465,000

FY 2023-24	TF	GF	FF
CY 2023	\$7,500,000	\$3,750,000	\$3,750,000
CY 2024	\$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)

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH

REGULAR POLICY CHANGE NUMBER: 149
IMPLEMENTATION DATE: 1/2005
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1039

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$8,000,000	\$8,000,000
- STATE FUNDS	\$3,628,000	\$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	\$3,628,000	\$4,000,000
FEDERAL FUNDS	\$4,372,000	\$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:

Not Applicable

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.

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH

REGULAR POLICY CHANGE NUMBER: 149

Reason for Change:

The change in FY 2022-23, from the prior estimate, is due to the assumption that increased FMAP is through March 31, 2023, as opposed to June 30, 2022 in the prior estimate.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to no FFCRA estimated in FY 2023-24. There is no change from FY 2022-23 to FY 2023-24 in the current estimate.

Methodology:

1. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through March 31, 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
2. Assume annual reimbursements to SRHs providing outpatient services are \$8,000,000 TF.

FY 2022-23	TF	GF	FF	FFCRA
CY 2022	\$6,000,000	\$2,628,000	\$3,000,000	\$372,000
CY 2023	\$2,000,000	\$1,000,000	\$1,000,000	\$0
Total	\$8,000,000	\$3,628,000	\$4,000,000	\$372,000

FY 2023-24	TF	GF	FF
CY 2023	\$6,000,000	\$3,000,000	\$3,000,000
CY 2024	\$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)

EMERGENCY MEDICAL AIR TRANSPORTATION ACT

REGULAR POLICY CHANGE NUMBER: 150
IMPLEMENTATION DATE: 11/2012
ANALYST: Thomas Soteros-McNamara
FISCAL REFERENCE NUMBER: 1612

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$6,661,000	\$2,380,000
- STATE FUNDS	\$2,812,000	\$1,076,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$6,661,000	\$2,380,000
STATE FUNDS	\$2,812,000	\$1,076,000
FEDERAL FUNDS	\$3,849,000	\$1,304,000

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 21-0046
 AB 1104 (Chapter 476, Statutes of 2021)

Interdependent Policy Changes:

Not Applicable

Background:

AB 2173 imposed an additional penalty of \$4 upon every conviction involving a vehicle violation, except certain parking offenses, effective January 1, 2011. The bill required 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: 150

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. On December 8, 2021, the Centers for Medicare & Medicaid Services (CMS) approved SPA 21-0046 to continue augmentation payments for FY 2021-22. SPA 22-0052, currently pending CMS approval, will continue augment payments for FY 2022-23.

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.

AB 1104 extends the \$4 penalty assessment for vehicle code violations through December 31, 2022, extends supplemental payments to providers through December 31, 2023, and sunsets the EMATA program as of January 1, 2025.

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 2022-23, from the prior estimate, is due to:

- Repayment to GF for FY 2021-22 augmentation payments
- Updated projected revenue based on updated data
- Updated appropriation amount in FY 2022-23

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to updated augment payments based on the program sunset date.

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 December 31, 2022.
3. The FY 2022-23 estimated payments include the:
 - FFS augmentation payments the second half of FY 2021-22
 - FFS augmentation payments for the first half FY 2022-23

EMERGENCY MEDICAL AIR TRANSPORTATION ACT
REGULAR POLICY CHANGE NUMBER: 150

4. The FY 2023-24 estimated payments include the FFS augmentation payment for the second half of FY 2022-23
5. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through March 31, 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
6. Based on estimated fee collections, the estimated payments on a cash basis are:

FY 2022-23	TF	GF	EMATCC	FFP	FFCRA
Repayment to GF for FY 2021-22	\$0	(\$1,199,000)	\$1,199,000	\$0	\$0
Augment Payment	\$6,661,000	\$0	\$2,812,000	\$3,451,000	\$398,000
Total	\$6,661,000	(\$1,199,000)	\$4,011,000	\$3,451,000	\$398,000

FY 2023-24	TF	EMATCC	FFP	FFCRA
Augment Payment	\$2,380,000	\$1,076,000	\$1,233,000	\$71,000
Total	\$2,380,000	\$1,076,000	\$1,233,000	\$71,000

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)

PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 151
 IMPLEMENTATION DATE: 12/2017
 ANALYST: Sabrina Blank
 FISCAL REFERENCE NUMBER: 2044

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$69,411,000	\$74,045,000
- STATE FUNDS	\$21,664,000	\$22,967,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	92.72 %	92.28 %
APPLIED TO BASE		
TOTAL FUNDS	\$5,053,100	\$5,716,300
STATE FUNDS	\$1,577,140	\$1,773,050
FEDERAL FUNDS	\$3,475,980	\$3,943,220

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)

Interdependent Policy Changes:

Proposition 56 Funding
 SPA 17-029
 SPA 18-0031
 SPA 19-0040

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. SPA 21-0033 was submitted to CMS to extend the supplemental reimbursements under Family PACT indefinitely.

PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 151

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.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a decrease due to updated assumptions for the anticipated end of the Coronavirus Disease 2019 national public health emergency (PHE) that impact the FPACT caseload projections. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to higher projected users of Family PACT Services in FY 2023-24 following the end of the 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 2022-23	TF	GF	FF
Managed Care			
Medical Pregnancy Termination	\$5,055	\$5,055	\$0
Fee-For-Service			
E&M Office Visits	\$62,792	\$15,044	\$47,747
Medical Pregnancy Termination	\$1,565	\$1,565	\$0
Total	\$69,411	\$21,664	\$47,747
FY 2023-24	TF	GF	FF
Managed Care			
Medical Pregnancy Termination	\$5,199	\$5,199	\$0
Fee-For-Service			
E&M Office Visits	\$67,173	\$16,094	\$51,078
Medical Pregnancy Termination	\$1,674	\$1,674	\$0
Total	\$74,045	\$22,967	\$51,078

*Totals may differ due to rounding.

Funding:

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

100% GF (4260-101-0001)

NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 152
IMPLEMENTATION DATE: 7/2005
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1076

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$4,221,000	\$4,240,000
- STATE FUNDS	\$1,723,000	\$1,900,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$4,221,000	\$4,240,000
STATE FUNDS	\$1,723,000	\$1,900,000
FEDERAL FUNDS	\$2,498,000	\$2,340,000

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:

Not Applicable

Background:

Effective July 1, 2005, based on the requirements of SB 1100, supplemental reimbursements will be available to NDPHs.

Payments to the NDPHs will be from the NDPH Supplemental Fund, Item 4260-601-3096, using State General Fund (GF) and interest accrued in the NDPH Supplemental Fund as the non-federal share of costs. It is assumed that interest accrued in a fiscal year will be paid in the subsequent fiscal year. This funding along with the federal reimbursement will replace the amount of funding the NDPHs previously received under the Emergency Services and Supplemental Payments Program (SB 1255, Voluntary Governmental Transfers). Due to the inactivation of the Selective Provider Contracting Program (SPCP) for NDPHs on January 1, 2014, State Plan Amendments (SPAs) were required to continue the NDPH Supplemental Program and secure distributions from the NDPH Supplemental Fund. In September 2016, the Department received SPA approval for a two-year transitional SPA 16-031 from the Centers for Medicare and Medicaid Services (CMS) to continue the NDPH Supplemental Program for

NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 152

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. SPA 22-0025 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 2022-23, from the prior estimate, is due to:

- Carryover funds in the Special Fund resulting from FY 2019-20 through FY 2021-22 FFCRA increased FMAP and FY 2013-14 through FY 2020-21 ACA FFP will not be distributed to providers, and
- Revised FY 2021-22 ACA adjustments based on updated data.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to estimating the FY 2022-23 ACA adjustment will be higher than the FY 2021-22 ACA adjustment.

Methodology:

1. The State Funds (SF) item includes the annual General Fund appropriation, any unspent appropriations from prior years, and interest that has been accrued/estimated. Beginning in FY 2017-18, the SF item will also include ACA adjustments.
2. SB 1100 requires that \$1,900,000 annually be transferred from the General Fund to the NDPH Supplemental Fund to be used for the non-federal share of payments.
3. The ACA allows for 100% FMAP for calendar years 2014 through 2016 for newly eligible Medi-Cal beneficiaries. Beginning January 1, 2017, the ACA optional population FMAP is 95%, and reduces to 94% beginning January 1, 2018. Beginning January 1, 2019, the ACA optional population FMAP reduces to 93%, and further reduces to 90% beginning January 1, 2020. CMS approved the ACA claiming methodology in August 2017.
4. ACA adjustments will be processed nine months after the respective fiscal year's supplemental payments have been issued in order to determine the proportion of the costs for newly eligible Medi-Cal beneficiaries. The FY 2021-22 ACA adjustment will be claimed in FY 2022-23, and the FY 2022-23 ACA adjustment will be claimed in FY 2023-24.
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 March 31, 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.

NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 152

- FY 2019-20 through FY 2021-22 payments were issued at the FFCRA increased FMAP. FY 2022-23 Q1 through Q3 payments are estimated to be issued at the FFCRA increased FMAP.
- The FY 2022-23 Q4 through FY 2023-24 payments will be issued at 50% FF/ 50% SF (GF appropriated); there will be no carryover funds as a result of the FFCRA.

7. 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	\$4,995,000
Appropriation (GF)	\$1,900,000
Carryover Funds	\$421,000
FY 2021-22 Interest Earned	\$21,000
Funds Available	\$7,337,000
Less: FY 2022-23 Cash Expenditures to Hospitals	(\$1,723,000)
Est. FY 2022-23 Remaining Balance	\$5,614,000

FY 2022-23	TF	SF**	FF	ACA FF	FFCRA****	Return to SF*
FY 2022-23 Cash Expenditures to Hospitals**	\$3,800,000	\$1,723,000	\$1,900,000	\$0	\$177,000	\$0
FY 2021-22 ACA FF Adjustment to Special Fund	\$421,000	\$0	(\$622,000)	\$1,120,000	(\$77,000)	\$421,000
Total	\$4,221,000	\$1,723,000	\$1,278,000	\$1,120,000	\$100,000	\$421,000

NDPH SUPPLEMENTAL PAYMENT
REGULAR POLICY CHANGE NUMBER: 152

8. The estimated NDPH Supplemental payments and ending balance for FY 2023-24 are shown below:

FY 2023-24 NDPH Supplemental Fund Summary	SF
FY 2022-23 Ending Balance	\$5,614,000
Appropriation (GF)	\$1,900,000
Carryover Funds	\$440,000
Est. FY 2022-23 Interest Earned	\$21,000
Funds Available	\$7,975,000
Less: FY 2023-24 Cash Expenditures to Hospitals	(\$1,900,000)
Est. FY 2023-24 Remaining Balance	\$6,075,000

FY 2023-24	TF	SF**	FF	ACA FF	FFCRA****	Return to SF*
FY 2023-24 Cash Expenditures to Hospitals**	\$3,800,000	\$1,900,000	\$1,900,000	\$0	\$0	\$0
FY 2022-23 ACA FF Adjustment to Special Fund	\$440,000	\$0	(\$622,000)	\$1,120,000	(\$58,000)	\$440,000
Total	\$4,240,000	\$1,900,000	\$1,278,000	\$1,120,000	(\$58,000)	\$440,000

*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)****

FREE CLINICS AUGMENTATION

REGULAR POLICY CHANGE NUMBER: 153
IMPLEMENTATION DATE: 10/2021
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2303

	<u>FY 2022-23</u>	<u>FY 2023-24</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 2021

Interdependent Policy Changes:

Not Applicable

Background:

AB 128 (Chapter 21, Statutes of 2021), the Budget Act of 2021, 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 2022-23.

There is no change from FY 2022-23 to FY 2023-24 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
FY 2022-23	\$2,000	\$2,000
FY 2023-24	\$2,000	\$2,000

Funding:

100% GF (4260-101-0001)

HOSPITAL QAF - MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 154
IMPLEMENTATION DATE: 7/2023
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1761

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$3,594,800,000
- STATE FUNDS	\$0	\$1,091,021,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$3,594,800,000
STATE FUNDS	\$0	\$1,091,021,000
FEDERAL FUNDS	\$0	\$2,503,779,000

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:

Not Applicable

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 also known as district and municipal public hospitals (DMPHs).

HOSPITAL QAF - MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 154

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 January 1, 2022 through December 31, 2022. The Department submitted for federal approval for QAF VII in Quarter 2 of FY 2021-22 and are currently awaiting approval. The length of the QAF VII program period is 12-months.

The Department will begin developing the subsequent program period (QAF VIII) in SFY 2022-23 Q1 which will include payments for the period beginning January 1, 2023. The length of the QAF VIII program period is currently unknown.

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 2022-23, from the prior estimate, is a decrease due to the Calendar Year (CY) 2022 HQAF pass-through payments previously expected to occur in FY 2022-23 are expected to pay in FY 2023-24.

The change from FY 2022-23 to FY 2023-24 in the current estimate is an increase due to both CY 2022 and CY 2023 being anticipated to be paid in FY 2023-24.

Methodology:

1. Both CY 2022 and CY 2023 HQAF are anticipated to pay in FY 2023-24.
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 2022 total amounts are within the approved HQAF VII fee model.
4. The CY 2023 total amount will be submitted to CMS as part of the HQAF VIII 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 March 31, 2023, for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.

HOSPITAL QAF - MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 154

6. On a cash basis, the estimated QAF payments are:

(Dollars in Thousands)

FY 2023-24	TF	SF (HQARF)	FF (TITLE 19)	FF (TITLE 21)	ACA FF	FFCRA
Managed Care						
Calendar Year 2022	\$1,700,000	\$491,258	\$456,910	\$38,973	\$653,600	\$59,259
Calendar Year 2023	\$97,400	\$28,146	\$26,178	\$2,233	\$37,448	\$3,395
Total MC	\$1,797,400	\$519,404	\$483,088	\$41,206	\$691,048	\$62,654
DMPH IGT						
Calendar Year 2022	\$1,700,000	\$540,641	\$456,910	\$38,973	\$653,600	\$9,876
Calendar Year 2023	\$97,400	\$30,976	\$26,178	\$2,233	\$37,448	\$565
Total DMPH IGT	\$1,797,400	\$571,617	\$483,088	\$41,206	\$691,048	\$10,441
Total FY 2023-24	\$3,594,800	\$1,091,021	\$966,176	\$82,412	\$1,382,096	\$73,095

Funding:

Hospital Quality Assurance Revenue Fund (4260-611-3158)

Title XIX FFP (4260-101-0890)

Title XXI FFP (4260-101-0890)

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

FFCRA 4.34% Increased FFP (4260-101-0890)

PROPOSITION 56 FUNDING

REGULAR POLICY CHANGE NUMBER: 155
IMPLEMENTATION DATE: 7/2018
ANALYST: Ryan Woolsey
FISCAL REFERENCE NUMBER: 2102

	<u>FY 2022-23</u>	<u>FY 2023-24</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)

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 that were previously funded with Proposition 56 funds were transitioned to General Fund support as ongoing rate increases and are reflected in base fee-for-service and managed care expenditure projections:

- Adverse Childhood Experiences Screenings
- AIDS Waiver Supplemental Payments
- CBAS Supplemental Payments
- Developmental Screenings
- FS-PSA Supplemental Payments
- Home Health Rate Increase
- ICF/DD Supplemental Payments
- NEMT Supplemental Payments
- Pediatric Day Health Care Rate Increase

PROPOSITION 56 FUNDING
REGULAR POLICY CHANGE NUMBER: 155

Reason for Change:

The change from the prior estimate for FY 2022-23 is based on updated expenditure projections for Proposition 56 payments and updated projections of available Proposition 56 revenues.

The change from FY 2022-23 to FY 2022-23, in the current estimate, is based on updated expenditure projections for Proposition 56 payments and updated projections of available Proposition 56 revenues.

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. General Fund amounts for Proposition 56 payments, rounded to the nearest thousand dollars, along with the projected amount of available Proposition 56 funding available, are displayed below.

FY 2022-23	Total GF to Proposition 56
PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	\$199,101,000
PROP 56 - MEDI-CAL FAMILY PLANNING	\$77,409,000
PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	\$475,148,000
PROP 56 - PROVIDER ACES TRAININGS	\$3,550,000
PROP 56 - VALUE-BASED PAYMENT PROGRAM	\$9,347,000
PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	\$21,664,000
PROP 56 - BEHAVIORAL HEALTH INCENTIVE PROGRAM	\$39,945,000
PROP 56 - DIRECTED PAYMENT RISK MITIGATION	(\$175,037,000)
Total of GF Dollars in Prop 56 PCs	\$651,127,000
Available Proposition 56 Funding	\$651,127,000
Additional GF Support for Proposition 56 Payments	\$0

*Totals may differ due to rounding

PROPOSITION 56 FUNDING
REGULAR POLICY CHANGE NUMBER: 155

FY 2023-24	Total GF to Proposition 56
PROP 56 - DENTAL SERVICES SUPPLEMENTAL PAYMENTS	\$225,881,000
PROP 56 - MEDI-CAL FAMILY PLANNING	\$77,408,000
PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	\$506,476,000
PROP 56 - PROVIDER ACES TRAININGS	\$0
PROP 56 - VALUE-BASED PAYMENT PROGRAM	\$0
PROP 56 - WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	\$22,967,000
PROP 56 - BEHAVIORAL HEALTH INCENTIVE PROGRAM	\$0
Total of GF Dollars in Prop 56 PCs	\$832,732,000
Available Proposition 56 Funding	\$744,303,000
Additional GF Support for Proposition 56 Payments	\$88,429,000

*Totals may differ due to rounding

- Based on the projected amount of Proposition 56 revenues available, no General Fund support for Proposition 56 payments is required in FY 2022-23.
- Based on the projected amount of Proposition 56 revenues available, an estimated \$88,429,000 is needed from the General Fund to support Proposition 56 payments in FY 2023-24.

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)

IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER: 156
IMPLEMENTATION DATE: 6/2020
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 1601

	<u>FY 2022-23</u>	<u>FY 2023-24</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 2022-23, from the prior estimate is due to:

- Revised FY 2020-21 final settlement amounts based on updated data,
- Revised FY 2021-22 interim payment amounts and support costs based on updated data, and
- Revised FY 2021-22 final settlement amounts based on updated data.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease in administrative fees due to FY 2022-23 includes the processing of two FY final settlements, and FY 2023-24 includes the processing of a single FY's final settlement.

IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER: 156

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.
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 2022-23	IGT Subject to the Fee	5% Admin Fee	Support Costs	Reimbursement to GF
FY 2020-21 Final Settlement	\$47,432,000	\$2,372,000	\$0	\$2,372,000
FY 2021-22 Interim Payment	\$207,531,000	\$10,377,000	\$138,000	\$10,238,000
FY 2021-22 Final Settlement	\$35,285,000	\$1,764,000	\$0	\$1,764,000
Total	\$290,248,000	\$14,513,000	\$138,000	\$14,374,000

FY 2023-24	IGT Subject to the Fee	5% Admin Fee	Support Costs	Reimbursement to GF
FY 2022-23 Interim Payment	\$237,795,000	\$11,890,000	\$152,000	\$11,738,000
FY 2022-23 Final Settlement	\$12,913,000	\$646,000	\$0	\$646,000
Total	\$250,708,000	\$12,536,000	\$152,000	\$12,384,000

Fiscal Year	TF	GF	GME Special Fund Transfer
FY 2022-23	\$0	(\$14,374,000)	\$14,374,000
FY 2023-24	\$0	(\$12,384,000)	\$12,384,000

Funding:

100% State GF (4260-101-0001)

DPH Graduate Medical Education Special Fund (4260-601-8113)

COVID-19 CASELOAD IMPACT

REGULAR POLICY CHANGE NUMBER: 157
IMPLEMENTATION DATE: 4/2020
ANALYST: Ryan Woolsey
FISCAL REFERENCE NUMBER: 2218

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$14,478,464,000	\$12,068,721,000
- STATE FUNDS	\$4,127,988,000	\$3,500,247,900
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$14,478,464,000	\$12,068,721,000
STATE FUNDS	\$4,127,988,000	\$3,500,247,900
FEDERAL FUNDS	\$10,350,476,000	\$8,568,473,100

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 Caseload Impact Base Adjustment

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.

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 of the month the public health emergency ends in order to receive a temporary increase in the

COVID-19 CASELOAD IMPACT

REGULAR POLICY CHANGE NUMBER: 157

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 2022-23, from the prior estimate, is an increase in costs due to:

- The federal PHE is now expected to be extended through mid-April 2023, such that the caseload is now expected to continue to grow through July 2023.
- Recent month to month growth in caseload was higher than previously projected.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to the assumed peak of caseload occurring in July 2023, followed by declines for the rest of FY 2023-24.

Methodology:

1. Continuous Coverage Requirement

- a. Assume that the continuous coverage requirement is adding a declining number of new cases to Medi-Cal each month. Specifically, the assume that the continuous coverage requirement added 130,000 cases to Medi-Cal in April 2020 and has continued to add progressively fewer cases each month since that time (with the number of cases added each month decreasing by 2,000 each month), such than an estimated 52,000 cases would be added due to COVID-19 in July 2023, the last month before cases are expected to begin to decline.
- b. Based on recent growth trends, assume that the additional cases resulting from the continuous coverage requirement consist of, on average, 51.9 percent from the newly eligible aid category, 46.1 percent from families and children aid categories, 2.3 percent from seniors aid categories, with an offsetting reduction of 0.3 percent 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 \$363 in FY 2022-23 and FY 2023-24.
- d. Assume the PHE continues through mid-April 2023. Consistent with guidance from the Centers for Medicare and Medicaid Services, assume the initiation of redetermination activities begins in May and that the first cases expected to be determined no longer eligible for Medi-Cal will occur effective August 1, 2023. This timeline aligns with federal and state policies related to Medi-Cal redeterminations, under which initiation of renewals typically occurs 85 days prior to the redetermination month.
- e. Assume that counties gradually redetermine eligibility over the following 12 months, with individuals found no longer eligible for Medi-Cal leaving the program through July 2024. Following redeterminations, assume that the Medi-Cal caseload returns to approximately 12.9 million. The ongoing level of the Medi-Cal caseload following the

COVID-19 CASELOAD IMPACT

REGULAR POLICY CHANGE NUMBER: 157

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 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 approximately 6,280 each month, beginning July 2020 and continuing through July 2023, due to the continuous coverage requirement.
- b. 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 approximately 5,960 each month, beginning August 2020 and continuing through July 2023, due to the continuous coverage requirement.
- c. 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 August 2023.

3. State Only Costs

- a. To account for estimated state-only costs of services provided to individuals without satisfactory immigration status, \$366 million in FY 2022-23 and \$304 million in FY 2023-24 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 2022-23	\$14,478,464	\$4,127,988	\$2,489,706	-\$69,911	\$7,930,681
FY 2023-24	\$12,068,721	\$3,500,248	\$2,059,101	-\$57,892	\$6,567,264

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 2022. To avoid budgeting these expenditures twice, COVID-19 caseload impacts estimated to be in the base are removed in the COVID-19 Caseload Impact Base Adjustment policy change.

COVID-19 CASELOAD IMPACT
REGULAR POLICY CHANGE NUMBER: 157

Funding:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	\$5,089,843	\$2,544,922	\$2,544,922
90% Title XIX / 10% GF (4260-101-0001 / 0890)	\$9,157,830	\$915,783	\$8,242,047
65% Title XXI / 35% GF (4260-113-0001 / 0890)	-\$110,970	-\$38,839	-\$72,130
100% State General Fund	\$706,122	\$706,122	\$0
100% FFP	-\$364,362	\$0	-\$364,362
Total	\$14,478,464	\$4,127,988	\$10,350,476

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	\$4,209,724	\$2,104,862	\$2,104,862
90% Title XIX / 10% GF (4260-101-0001 / 0890)	\$7,583,446	\$758,345	\$6,825,101
65% Title XXI / 35% GF (4260-101-0001 / 0890)	-\$91,892	-\$32,162	-\$59,730
100% State General Fund	\$669,204	\$669,204	\$0
100% FFP	-\$301,760	\$0	-\$301,760
Total	\$12,068,721	\$3,500,248	\$8,568,473

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 BEHAVIORAL HEALTH

REGULAR POLICY CHANGE NUMBER: 159
IMPLEMENTATION DATE: 7/2020
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2215

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$190,217,000	\$63,080,000
- STATE FUNDS	\$14,381,100	\$4,786,250
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$190,217,000	\$63,080,000
STATE FUNDS	\$14,381,100	\$4,786,250
FEDERAL FUNDS	\$175,835,900	\$58,293,750

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

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, 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.

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

COVID-19 BEHAVIORAL HEALTH

REGULAR POLICY CHANGE NUMBER: 159

(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 2022-23, is an increase due to the following:

- The PHE is assumed to be extended. This policy change assumes the PHE continues through mid-April 2023.
- For SMHS, the payment lag was revised and now shows an increase in prior year payments for FY 2022-23.
- Higher utilization of the increased interim rates for SMHS and DMC State Plan.

The change in the current estimate, from FY 2022-23 to FY 2023-24, is due to assuming the PHE impact ends in mid-April 2023, and FY 2023-24 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: 159

3. For SMHS, assume 63.2% of claims will be paid in the first year, and 36.6% in the second year. For DMC-ODS Waiver and DMC State plan, assume 76% of claim will be paid in the first year, and 24% in the second year.
4. Total cost for SMHS, DMC State Plan, and DMC ODS are as follows:

FY 2022-23	TF	GF	FF	CF
SMHS Interim Rate – Adult	\$180,180,000	\$10,224,000	\$130,986,000	\$38,970,000
SMHS Interim Rate - Children	\$70,090,000	\$2,506,000	\$36,787,000	\$30,797,000
Non-NTP DMC State Plan Interim Rate	\$541,000	\$52,000	\$382,000	\$107,000
Non-NTP DMC-ODS Interim Rate	\$10,001,000	\$1,599,000	\$7,681,000	\$721,000
Total	\$260,812,000	\$14,381,000	\$175,836,000	\$70,595,000

FY 2023-24	TF	GF	FF	CF
SMHS Interim Rate – Adult	\$61,290,000	\$3,535,000	\$44,786,000	\$12,969,000
SMHS Interim Rate - Children	\$22,400,000	\$885,000	\$11,716,000	\$9,799,000
Non-NTP DMC State Plan Interim Rate	\$120,000	\$11,000	\$85,000	\$24,000
Non-NTP DMC-ODS Interim Rate	\$2,222,000	\$355,000	\$1,707,000	\$160,000
Total	\$86,032,000	\$4,786,000	\$58,294,000	\$22,952,000

Funding:

100% GF (4260-101-0001)
 100% Title XIX FF (4260-101-0890)
 100% Title XXI FF (4260-113-0890)
 100% Title XXI FF (4260-101-0890)
 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)
 65% Title XXI FF / 35% GF (4260-101-0001/0890)
 50% Title XIX / 50% GF (4260-101-0001/0890)
 COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 VACCINATION INCENTIVE PROGRAM

REGULAR POLICY CHANGE NUMBER: 160
IMPLEMENTATION DATE: 7/2021
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2281

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$156,822,000	\$0
- STATE FUNDS	\$78,411,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$156,822,000	\$0
STATE FUNDS	\$78,411,000	\$0
FEDERAL FUNDS	\$78,411,000	\$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)

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:

The change from the previous estimate, for FY 2022-23, is an increase due to shifting of expenditures from FY 2021-22 to FY 2022-23. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to all the payments being expected to be paid out in FY 2022-23.

COVID-19 VACCINATION INCENTIVE PROGRAM

REGULAR POLICY CHANGE NUMBER: 160

Methodology:

1. The estimated costs for process and outcome measures for the COVID-19 Vaccination Incentive Program on a cash basis are:

(Dollars in Thousands)

	TF	GF	FF
FY 2022-23	\$156,822	\$78,411	\$78,411

Funding:

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

PHARMACY-BASED COVID-19 TESTS

REGULAR POLICY CHANGE NUMBER: 161
IMPLEMENTATION DATE: 2/2022
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2359

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$83,838,000	\$91,267,000
- STATE FUNDS	\$28,302,300	\$30,810,000
PAYMENT LAG	0.9588	0.9958
% REFLECTED IN BASE	74.21 %	67.73 %
APPLIED TO BASE		
TOTAL FUNDS	\$20,731,000	\$29,328,200
STATE FUNDS	\$6,998,440	\$9,900,630
FEDERAL FUNDS	\$13,732,560	\$19,427,530

Purpose:

This policy change estimates the costs for covering self-administered over the counter (OTC) COVID-19 tests and expands COVID-19 specimen collections to pharmacies.

Authority:

American Rescue Plan Act (ARPA)
SPA CA-22-0004 (Pending)

Interdependent Policy Changes:

COVID-19 Increased FMAP - DHCS

Background:

According to the Centers for Medicare and Medicaid Services (CMS), the ARPA requires state Medicaid and Children Health Insurance Program (CHIP) to cover a broad array of COVID-19 testing, including all types of U.S. Food & Drug Administration (FDA) - authorized COVID-19 tests, without cost-sharing obligations that begins March 11, 2021, and ends on the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the ARPA.

All types of FDA-authorized COVID-19 tests must be covered under CMS' interpretation of the ARPA COVID-19 testing coverage requirements, including self-administered OTC tests provided to a Medicaid or CHIP beneficiary by a qualified Medicaid or CHIP provider of COVID-19 tests and laboratory tests where the specimen is collected via the pharmacy. OTC tests include those where a specimen is collected at home and then sent to a clinical laboratory or other certified testing site for testing, and those that are entirely performed at home, meaning the test system includes the ability to perform the test without involvement of a laboratory.

Both the OTC tests and the pharmacy specimen collection are Fee-for-Service benefits for all Medi-Cal and CHIP beneficiaries and are billed through Medi-Cal Rx.

PHARMACY-BASED COVID-19 TESTS

REGULAR POLICY CHANGE NUMBER: 161

Reason for Change:

The change in FY 2022-23, from the prior estimate, is due to the actual monthly usage of the OTC COVID-19 Tests is higher than previously estimated.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase in costs due to FY 2022-23 estimating nine months of Pharmacy Specimen Collection while FY 2023-24 estimates the Pharmacy Specimen Collection usage for the entire year.

Methodology:

Self-Administered OTC tests:

1. The COVID-19 self-administered OTC tests were implemented on February 1, 2022, retroactive to March 11, 2021.
2. Eight self-administered OTC tests are available to Medi-Cal beneficiaries monthly.
3. Assume self-administered OTC will result in 650,000 tests dispensed and offset 32,500 laboratory tests per month.
4. Assume the average reimbursement is \$11.50 per test.

$$650,000 * \$11.50 = \$7,475 \text{ million per month} - 32,500 * \$72.18 = \$5,129,000 \text{ monthly cost}$$

Pharmacy Specimen Collection:

1. Assume the COVID-19 pharmacy specimen collection will be implemented October 1, 2022 and is retroactive to February 1, 2022. However, minimal claims are expected during the retroactive period.
2. Assume this expansion of services will increase COVID-19 tests 100,000 per month and not offset any existing testing levels.
3. The pharmacy specimen collection cost is \$23.46 and assuming the specimen collection is sent to a laboratory for processing at an average cost of \$63.16. The total cost is \$86.62 per test.
4. An estimated 98% of the beneficiaries receive non-pharmacy services through the managed care delivery system and the laboratory test costs are part of the managed care capitation rate.

PHARMACY-BASED COVID-19 TESTS
REGULAR POLICY CHANGE NUMBER: 161

5. Total costs are estimated to be:

FY 2022-23	TF	GF	FF
Self-Administered OTC Tests	\$61,550,000	\$20,778,000	\$40,772,000
Pharmacy Specimen Collection	\$22,288,000	\$7,524,000	\$14,764,000
Total	\$83,838,000	\$28,302,000	\$55,536,000

FY 2023-24	TF	GF	FF
Self-Administered OTC Tests	\$61,550,000	\$20,778,000	\$40,772,000
Pharmacy Specimen Collection	\$29,717,000	\$10,032,000	\$19,685,000
Total	\$91,267,000	\$30,810,000	\$60,457,000

Funding:

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$47,090,000	\$23,545,000	\$23,545,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$32,418,000	\$3,242,000	\$29,176,000
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$4,330,000	\$1,515,000	\$2,815,000
Total	\$83,838,000	\$28,302,000	\$55,536,000

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$51,262,000	\$25,631,000	\$25,631,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$35,291,000	\$3,529,000	\$31,762,000
65% Title XXI FF / 35% GF (4260-101-0001/0890)	\$4,714,000	\$1,650,000	\$3,064,000
Total	\$91,267,000	\$30,810,000	\$60,457,000

COVID-19 - SICK LEAVE BENEFITS

REGULAR POLICY CHANGE NUMBER: 162
IMPLEMENTATION DATE: 7/2022
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2233

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$6,776,000	\$0
- STATE FUNDS	\$75,500	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$6,776,000	\$0
STATE FUNDS	\$75,500	\$0
FEDERAL FUNDS	\$6,700,500	\$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. 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 emergency sick leave, in certain situations, when it is specifically related to the COVID-19 PHE. Mandatory COVID-19 paid sick leave benefits ended on December 31, 2020. Discretionary COVID-19 paid sick leave was allowed until December 31, 2022, and the California Department

COVID-19 - SICK LEAVE BENEFITS

REGULAR POLICY CHANGE NUMBER: 162

of Social Services (CDSS) requested that this benefit be extended until that date. As a result of SB 95 and the ARP, these emergency sick leave benefits were extended through December 31, 2022.

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

Reason for Change:

There is an increase from the prior estimate for FY 2022-23, and a decrease in the current estimate from FY 2022-23 to FY 2023-24, due to the benefits ending in December 2022.

Methodology:

1. Assume the COVID-19 sick leave benefits continue through December 31, 2022, or the end of the PHE, whichever is sooner.
2. Assume the 6.2% Title XIX FFCRA increased FMAP is for expenditures through June 30, 2023, 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 December 31, 2022:

FY 2022-23	TF	GF	FF
WPCS Sick Leave Benefits	\$173,000	\$87,000	\$86,000
IHSS Sick Leave Benefits	\$6,603,000	\$0	\$6,603,000
FFCRA 6.2% Increased FFP	\$0	(\$11,000)	\$11,000
Total	\$6,776,000	\$76,000	\$6,700,000

*Totals do not include CDSS GF expenditures.

**Totals may differ due to rounding.

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: 163
IMPLEMENTATION DATE: 7/2021
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 2211

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$140,049,000	\$70,505,000
- STATE FUNDS	\$95,277,000	\$35,253,000
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 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)
 SB 154 (Chapter 43, Statutes of 2022)

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. 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 necessary care such as the associated office, clinic, or emergency room visits related to COVID-19 at no cost to the individuals:

COVID-19 ELIGIBILITY

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- 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 American Rescue Plan Act of 2021 enacted March 11, 2021, required COVID-19 vaccine and COVID-19 related treatments to be an included benefit under the COVID-19 Uninsured Eligibility Group. Claiming for the administration of the COVID-19 vaccine and COVID-19 related treatments are now available for the COVID-19 Uninsured Group at 100% FF. California submitted State Plan Amendment 22-0004 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 2022-23, from the prior estimate, is an increase due to updated higher actual expenditures for both groups. Additionally, the coverage period for both groups was extended to align with the assumed end of the PHE occurring in FY 2022-23.

The change for FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to FY 2023-24 containing costs for the HPE expansion group only.

Methodology:

1. Assume the PHE continues through mid-April 2023.
2. Assume coverage for the HPE expansion group will continue after mid-April 2023.
3. Assume 100% GF Funding for Treatment Services and 100% FF Funding for Testing and Testing-Related Services:

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(Dollar in Thousands)

FY 2022-23	TF	GF	FF
Treatment Services	\$95,277	\$95,277	\$0
Testing and Testing-Related Services	\$44,772	\$0	\$44,772
Total	\$140,049	\$95,277	\$44,772

FY 2023-24	TF	GF	FF
Treatment Services	\$35,253	\$35,253	\$0
Testing and Testing-Related Services	\$35,252	\$0	\$35,252
Total	\$70,505	\$35,253	\$35,252

*Totals may differ due to rounding.

4. The Department estimates the following Medi-Cal program costs as a result of the COVID-19:

(Dollar in Thousands)

FY 2022-23	TF	GF	FF
COVID-19 Uninsured Eligibility	\$65,878	\$58,192	\$7,686
COVID-19 HPE Expansion	\$74,171	\$37,085	\$37,086
Total	\$140,049	\$95,277	\$44,772
FY 2023-24	TF	GF	FF
COVID-19 Uninsured Eligibility	\$0	\$0	\$0
COVID-19 HPE Expansion	\$70,505	\$35,253	\$35,252
Total	\$70,505	\$35,253	\$35,252

*Totals may differ due to rounding.

Funding:

100% GF (4260-101-0001)

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

COVID-19 VACCINE ADMINISTRATION

REGULAR POLICY CHANGE NUMBER: 164
IMPLEMENTATION DATE: 1/2021
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2259

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$6,201,000	-\$40,800,000
- STATE FUNDS	\$418,750	-\$2,754,450
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$6,201,000	-\$40,800,000
STATE FUNDS	\$418,750	-\$2,754,450
FEDERAL FUNDS	\$5,782,250	-\$38,045,550

Purpose:

This policy change estimates the cost of reimbursing providers for administering the COVID-19 vaccine to Medi-Cal beneficiaries.

Authority:

American Rescue Plan Act (ARPA)

Interdependent Policy Changes:

COVID-19 Increased FMAP - DHCS

Background:

The Centers for Medicare and Medicaid Services (CMS) purchased the initial and subsequent supply of COVID-19 vaccines. Medicaid programs must provide reimbursement to providers for the administration of the vaccine as required by the American Rescue Plan of 2021 (ARPA). The provider reimbursement of the vaccine administration includes the costs for administering the vaccine, public health reporting, conducting outreach, and patient education.

On March 11, 2021, the President signed ARPA into law. 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). As of April 1, 2021, the Federal Medicaid Assistance Percentage (FMAP) for COVID-19 vaccines and administration of vaccines is increased to 100%.

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.

COVID-19 VACCINE ADMINISTRATION

REGULAR POLICY CHANGE NUMBER: 164

Due to increased costs associated with administration of COVID-19 vaccine administration, California will reimburse Federally Qualified Health Centers, Rural Health Centers and Tribal Federally Qualified Health Center (Tribal FQHCs) providers a supplemental amount (\$67.00) for COVID-19 vaccine only visits. This Alternative Payment Methodology (APM) will be additional reimbursement above the applicable Prospective Payment Systems (PPS)/ APM approved in State Plan Attachment 4.19-B. This additional reimbursement is necessary to account for the significant increase in vaccine only visits and costs due to COVID-19 vaccine administration that were not considered in the PPS calculation.

Vaccine eligibility timeline:

- As of December 2020, COVID-19 vaccines became available for those 16 years of age and older with a staggered prioritization through April 2021,
- Children ages 12-15 became eligible as of May 2021,
- Eligibility was extended to children ages 5-11 on October 2021,
- In August 2021, an additional vaccine dose was authorized for immunocompromised individuals,
- COVID-19 booster dose received authorization between November 2021 and January 2022 for individuals 12 years of age and older,
- An additional vaccine dose was authorized for individuals ages 50 and older in March 2022,
- In June 2022, children ages 6 months through age 4 became eligible to receive COVID vaccinations, and
- In September 2022, booster shot was authorized for individuals 12 years of age and older.

Reason for Change:

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

- Including a decreasing adjustment to the fee-for-service (FFS) base estimate, and
- Including the estimated remaining FQHC retroactive payment corrections, previously estimated to be completed in FY 2021-22, in FY 2022-23.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to only including the adjustment to the FFS base in FY 2023-24 as the FQHC retroactive payments are estimated to be completed in FY 2022-23.

COVID-19 VACCINE ADMINISTRATION

REGULAR POLICY CHANGE NUMBER: 164

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. Additional booster doses have been provided to Medi-Cal beneficiaries throughout 2021, but particularly in the later months of 2021 and early 2022.
4. Assume 100% FMAP for certain expenditures from April 1, 2021, through the last day of the first calendar quarter that begins at least one year after the last day of the PHE, due to the enactment of the ARPA.
5. The April 2021 to June 2021 funding adjustment was completed in August 2021, a total of three quarters were adjusted in FY 2021-22 five quarters are estimated to be adjusted in FY 2022-23. On a cash basis, funding adjustments will occur quarterly with three quarters of the current year adjusted in the same year, and one quarter will be adjusted in the subsequent fiscal year.
6. Assume the rates paid to FQHCs are based on an APM at \$67.00 per dose.
7. The COVID-19 vaccine administration costs are assumed to be fully reflected in the FFS base projections and include the higher costs from the initial doses and booster. It is assumed for FY 2022-23 and FY 2023-24, the ongoing costs would be for booster doses and a decreasing adjustment is needed to the FFS base projections in this policy change.
8. The estimated impact for COVID-19 vaccine administration in FY 2022-23 and FY 2023-24, on a cash basis, after lags is:

FY 2022-23 (Lagged)	TF	GF	FF
COVID-19 Vaccine Administration	\$6,201,000	\$419,000	\$5,782,000
Total	\$6,201,000	\$419,000	\$5,782,000

FY 2023-24 (Lagged)	TF	GF	FF
COVID-19 Vaccine Administration	(\$40,800,000)	(\$2,755,000)	(\$38,045,000)
Total	(\$40,800,000)	(\$2,755,000)	(\$38,045,000)

COVID-19 VACCINE ADMINISTRATION
REGULAR POLICY CHANGE NUMBER: 164

Funding:

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$696,000	\$348,000	\$348,000
90% Title XIX / 10% GF (4260-101-0001/0890)	\$480,000	\$48,000	\$432,000
65% Title XXI / 35% GF (4260-113-0001/0890)	\$65,000	\$23,000	\$42,000
100%Title XIX FF (4260-101-0890)	\$4,960,000	\$0	\$4,960,000
Total	\$6,201,000	\$419,000	\$5,782,000

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	(\$4,583,000)	(\$2,292,000)	(\$2,291,000)
90% Title XIX / 10% GF (4260-101-0001/0890)	(\$3,156,000)	(\$316,000)	(\$2,840,000)
65% Title XXI / 35% GF (4260-101-0001/0890)	(\$421,000)	(\$147,000)	(\$274,000)
100%Title XIX FF (4260-101-0890)	(\$32,640,000)	\$0	(\$32,640,000)
Total	(\$40,800,000)	(\$2,755,000)	(\$38,045,000)

COVID-19 funding is identified in the COVID-19 increased FMAP – DHCS policy change

CONTINUOUS CHIP COVERAGE DURING THE COVID-19 PHE

REGULAR POLICY CHANGE NUMBER: 165
IMPLEMENTATION DATE: 7/2021
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2301

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$86,511,000	\$29,101,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$86,511,000	\$29,101,000
FEDERAL FUNDS	-\$86,511,000	-\$29,101,000

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:

SPA 21-032
 SB 129 (Chapter 69, Statutes of 2021)
 SB 154 (Chapter 43, Statutes of 2022)

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 2022-23, is a General Fund (GF) increase due to the extension of the COVID-19 PHE and due to an update in assumptions for retroactive payments. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a GF decrease as more payments are expected to be completed in FY 2022-23.

Methodology:

1. Assume continuous coverage through the PHE for the MCAP, MCAIP, and CCHIP populations.

CONTINUOUS CHIP COVERAGE DURING THE COVID-19 PHE
REGULAR POLICY CHANGE NUMBER: 165

2. Assume a retroactive payment (covering March 2020 through June 2022) will occur in FY 2022-23.
3. Assume the PHE ends mid-April 2023.
4. The estimated costs for FY 2022-23 and FY 2023-24 are.

(Dollars in Thousands)

Fiscal Years	TF	GF	FF
FY 2022-23	\$0	\$86,511	(\$86,511)
FY 2023-24	\$0	\$29,101	(\$29,101)

Funding:

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

COVID-19 LTC REIMBURSEMENT RATES

REGULAR POLICY CHANGE NUMBER: 166
IMPLEMENTATION DATE: 7/2021
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2246

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	-\$9,056,000	-\$38,662,000
- STATE FUNDS	-\$4,504,400	-\$18,858,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$9,056,000	-\$38,662,000
STATE FUNDS	-\$4,504,400	-\$18,858,000
FEDERAL FUNDS	-\$4,551,600	-\$19,804,000

Purpose:

This policy change estimates the impact of the long term care (LTC) 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
 AB 186 (Chapter 46, Statutes of 2022)

Interdependent Policy Changes:

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 (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.

- 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. The temporary increase amount was based on facilities' total 2019-20 reimbursement and assumed to continue at the same level until the end of the PHE for

COVID-19 LTC REIMBURSEMENT RATES

REGULAR POLICY CHANGE NUMBER: 166

the following facility types: Freestanding Nursing Facilities Level-B (SNF-B); Nursing Facilities Level-A (NF-A); Distinct Part Nursing Facilities Level-B (DP/NF-B); Freestanding Adult Subacute Facilities (FSSA); Distinct Part Adult Subacute Facilities (DP/SA); Distinct Part Pediatric Subacute facilities (DP/PSA); Freestanding Pediatric Subacute facilities (FS/PSA) 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.

Pursuant to AB 186, for SNF-B and FSSA facilities, the COVID-19 temporary 10 percent increase will continue through December 31, 2023 independently of the status of the PHE. See the Nursing Facility Rate Adjustments policy change for the SNF-B and FSSA rate impact.

ICF/DD facilities' rates are assumed to be no lower than they are on the last day of the PHE inclusive of the 10% rate increase. See the LTC Rate Adjustment policy change for the ICF/DD rate impact that includes the 10% rate increase.

Reason for Change:

The change in FY 2022-23, from the prior estimate, is due to:

- Including the ongoing LTC COVID-19 10% increase in the fee-for-service (FFS) base estimate. As a result, this policy change now reflects a decrease to the FFS base for those LTC facilities where the LTC 10% increases end as of the end of the PHE.
- Adding managed care costs through the assumed PHE period.

The change from FY 2022-23 to FY 2023-24, in the current estimate is due to including a full year's impact of the decreasing adjustment to the FFS base estimate.

Methodology:

1. Assume the PHE continues through mid-April 2023.
2. In FY 2022-23 and FY 2023-24, the FFS base estimate assumes the ongoing impact of the LTC COVID-19 10% increases.
3. For certain LTC facility types, the LTC COVID-19 rate increases are assumed to only continue through the end of the PHE. As a result, adjustments to the FFS base estimate will be necessary to reflect the end of the temporary 10% rate increase.
4. Managed care costs are assumed through the end of the PHE in FY 2022-23.

FY 2022-23	FFS TF	MC TF	Total
DP/NF-B	(\$4,488,000)	\$0	(\$4,488,000)
Rural Swing Bed	(\$6,000)	\$0	(\$6,000)
NF-A	(\$16,000)	\$32,000	\$16,000
DP/SA	(\$2,878,000)	\$0	(\$2,878,000)
DP/PSA	(\$1,160,000)	\$439,000	(\$721,000)
FS/PSA	(\$1,118,000)	\$139,000	(\$979,000)
TOTAL	(\$9,666,000)	\$610,000	(\$9,056,000)

COVID-19 LTC REIMBURSEMENT RATES

REGULAR POLICY CHANGE NUMBER: 166

FY 2023-24	FFS TF
DP/NF-B	(\$17,953,000)
Rural Swing Bed	(\$23,000)
NF-A	(\$65,000)
DP/SA	(\$11,512,000)
DP/PSA	(\$4,639,000)
FS/PSA	(\$4,470,000)
TOTAL	(\$38,662,000)

FY 2022-23	TF	GF	FF
FFS	(\$9,666,000)	(\$4,715,000)	(\$4,951,000)
Managed Care	\$610,000	\$210,000	\$400,000
Total	(\$9,056,000)	(\$4,505,000)	(\$4,551,000)

FY 2023-24	TF	GF	FF
FFS	(\$38,662,000)	(\$18,858,000)	(\$19,804,000)
Total	(\$38,662,000)	(\$18,858,000)	(\$19,804,000)

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)

65% Title XXI / 35% GF (4260-101-0001 / 0890)

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 INCREASED FMAP - DHCS

REGULAR POLICY CHANGE NUMBER: 167
IMPLEMENTATION DATE: 7/2021
ANALYST: Kalanie Coleman
FISCAL REFERENCE NUMBER: 2217

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	-\$254,321,000	-\$35,117,000
- STATE FUNDS	-\$3,794,555,000	-\$278,611,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$254,321,000	-\$35,117,000
STATE FUNDS	-\$3,794,555,000	-\$278,611,000
FEDERAL FUNDS	\$3,540,234,000	\$243,494,000

Purpose:

This policy change estimates the impact on benefits expenditures of assuming the availability of increased federal medical assistance percentage (FMAP) from January 2020 through June 2023. For the estimated impact of assuming increased FMAP from January 2020 through June 2023 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:

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.

The effects of the COVID-19 pandemic are unprecedented in modern times from a public health emergency and economic perspective. This will have fiscal impacts across policy areas and beneficiary populations within the Medi-Cal program.

COVID-19 INCREASED FMAP - DHCS

REGULAR POLICY CHANGE NUMBER: 167

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 an increase in general fund savings from the prior estimate for FY 2022-23 due to policy change updates. There is a decrease in general fund savings from FY 2022-23 to FY 2023-24 due to policy change updates and 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. Eleven months of General Fund savings are assumed for CY because phased-down payments have a two-month lag.
5. The FFCRA is assumed to continue through June 30, 2023.
6. The following estimates reflect a cash basis:

COVID-19 INCREASED FMAP - DHCS
REGULAR POLICY CHANGE NUMBER: 167

(Dollars in Thousands)

FY 2022-23	TF	GF	SF	FF
COVID-19 Increased FMAP - DHCS:				
FFCRA 6.20% Increased FFP	\$0	(\$2,676,571)	\$0	\$2,676,571
FFCRA 4.34% Increased FFP	\$0	(\$116,218)	\$0	\$116,218
Medicare Part D FFCRA 6.20% Incr. FFP	(\$243,437)	(\$243,437)	\$0	\$0
Total Apr-Jun 2023 Qtr For Reg PCs:	(\$10,884)	(\$697,924)	(\$60,405)	\$747,445
Total COVID-19 Incr. FMAP - DHCS:	(\$254,321)	(\$3,734,150)	(\$60,405)	\$3,540,234
COVID-19 Increased FMAP - Other Admin:				
FFCRA 4.34% Increased FFP	\$0	(\$1,240)	\$0	\$1,240
Total Apr-Jun 2023 Qtr For Other Admin:	\$0	(\$423)	\$0	\$423
Total COVID-19 Incr. FMAP - Other Admin:	\$0	(\$1,663)	\$0	\$1,663
COVID-19 Increased FMAP In other PCs:				
FFCRA 6.20% Increased FFP	\$817,708	(\$173,819)	(\$321,346)	1,312,872
FFCRA 4.34% Increased FFP	\$11,791	(\$29,867)	(\$6,407)	\$48,065
BCCTP 4.34% Increased FFP	\$0	\$178	\$0	(\$178)
Medicare Part D FFCRA 6.20% Incr. FFP	(\$88,898)	(\$88,898)	\$0	\$0
Total Apr-Jun 2023 Qtr For In Other PCs:	\$210,206	(\$14,024)	(\$525)	\$224,755
Total COVID-19 Incr. FMAP In other PCs:	\$950,806	(\$306,430)	(\$328,278)	\$1,585,514
Total of PCs including COVID-19 Increased FMAP	\$696,485	(\$4,042,243)	(\$388,683)	\$5,127,411

*Totals may differ due to rounding.

COVID-19 INCREASED FMAP - DHCS
REGULAR POLICY CHANGE NUMBER: 167

(Dollars in Thousands)

FY 2023-24	TF	GF	SF	FF
COVID-19 Increased FMAP - DHCS:				
FFCRA 6.20% Increased FFP	\$0	(\$21,489)	\$0	\$21,489
FFCRA 4.34% Increased FFP	\$0	(\$2,711)	\$0	\$2,711
Medicare Part D FFCRA 6.20% Increased FFP	\$0	\$0	\$0	\$0
Total Apr-Jun 2023 Qtr For Reg PCs:	(\$35,117)	(\$208,017)	(\$46,394)	\$219,294
Total COVID-19 Incr. FMAP - DHCS:	(\$35,117)	(\$232,217)	(\$46,394)	\$243,494
COVID-19 Increased FMAP - Other Admin:				
FFCRA 4.34% Increased FFP	\$0	\$0	\$0	\$0
Total Apr-Jun 2023 Qtr For Other Admin:	\$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	\$9,610	(\$163,866)	(\$213,312)	\$386,788
FFCRA 4.34% Increased FFP	\$0	(\$9,132)	(\$8,988)	\$18,120
BCCTP 4.34% Increased FFP	\$0	\$0	\$0	\$0
Medicare Part D FFCRA 6.20% Incr. FFP	\$0	\$0	\$0	\$0
Total Apr-Jun 2023 Qtr For In Other PCs:	\$115,480	\$0	(\$11,978)	127,458
Total COVID-19 Incr. FMAP In other PCs:	\$125,090	(\$172,998)	(\$234,278)	\$532,366
Total of PCs including COVID-19 Increased FMAP	\$89,973	(\$405,215)	(\$280,672)	\$775,860

*Totals may differ due to rounding.

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)
100% Reimbursement (4260-601-0995)
Hospital Quality Assurance Revenue Fund (4260-611-3158)
Drug Rebates Fund (4260-601-3331)

COVID-19 CASELOAD IMPACT BASE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 168
IMPLEMENTATION DATE: 7/2020
ANALYST: Ryan Woolsey
FISCAL REFERENCE NUMBER: 2273

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	-\$12,520,833,000	-\$13,011,796,000
- STATE FUNDS	-\$3,551,844,200	-\$3,695,376,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$12,520,833,000	-\$13,011,796,000
STATE FUNDS	-\$3,551,844,200	-\$3,695,376,600
FEDERAL FUNDS	-\$8,968,988,800	-\$9,316,419,400

Purpose:

This policy change estimates the portion of expenditure changes due to an increase in caseload related to the COVID-19 pandemic that is reflected both in base projections and the COVID-19 Caseload Impact policy change. This policy change removes these overlapping expenditures to avoid them being budgeted twice.

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 Caseload Impact

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.

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

COVID-19 CASELOAD IMPACT BASE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 168

of the enrollment period or who would have enrolled during the emergency period until the end of the month the public health emergency ends in order to receive a temporary increase in the federal medical assistance percentage (FMAP). The Medi-Cal caseload has increased due to reduced disenrollment under the continuous coverage requirement.

There is considerable uncertainty surrounding the magnitude and duration of COVID-19 caseload impacts.

The fee-for-service (FFS) base projections and base policy changes reflect a significant portion of COVID-19 caseload impacts. For transparency, the full estimated impact of COVID-19 on the Medi-Cal caseload is budgeted in the COVID-19 Caseload Impact policy change. To avoid budgeting expenditures in the base and in the COVID-19 Caseload Impact policy change twice, this policy change removes the impact COVID-19 on caseload that is estimated to be reflected in the base.

Reason for Change:

This is a new policy change.

Methodology:

1. The FFS base and various other base policy changes reflect actual COVID-19 caseload impacts through July 2022.
2. The following amounts related to COVID-19 caseload impacts are estimated to be reflected in base projections:

(Dollars in Thousands)

Fiscal Year	TF	GF	Title XIX FF	Title XXI FF	ACA FF
FY 2022-23	\$12,520,833	\$3,551,844	\$2,130,810	-\$63,004	\$6,901,183
FY 2023-24	\$13,011,796	\$3,695,377	\$2,184,178	-\$66,101	\$7,198,342

3. These amounts are also budgeted in the COVID-19 Caseload Impact policy change, in order to display the full impact of COVID-19 on caseload and related expenditures. This policy change removes the amounts below in order to avoid budgeting twice those expenditures related to COVID-19 caseload impacts that estimated to be in base.

(Dollars in Thousands)

Fiscal Year	TF	GF	Title XIX FF	Title XXI FF	ACA FF
FY 2022-23	-\$12,520,833	-\$3,551,844	-\$2,130,810	\$63,004	-\$6,901,183
FY 2023-24	-\$13,011,796	-\$3,695,377	-\$2,184,178	\$66,101	-\$7,198,342

COVID-19 CASELOAD IMPACT BASE ADJUSTMENT
REGULAR POLICY CHANGE NUMBER: 168

Funding:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	-\$4,355,864	-\$2,177,932	-\$2,177,932
90% Title XIX / 10% GF (4260-101-0001 / 0890)	-\$7,969,033	-\$796,903	-\$7,172,130
65% Title XXI / 35% GF (4260-113-0001 / 0890)	\$100,006	\$35,002	\$65,004
100% State General Fund	-\$612,011	-\$612,011	\$0
100% FFP	\$316,069	\$0	\$316,069
Total	-\$12,520,833	-\$3,551,844	-\$8,968,989

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	-\$4,464,959	-\$2,232,480	-\$2,232,480
90% Title XIX / 10% GF (4260-101-0001 / 0890)	-\$8,312,173	-\$831,217	-\$7,480,956
65% Title XXI / 35% GF (4260-101-0001 / 0890)	\$104,922	\$36,723	\$68,199
100% State General Fund	-\$668,402	-\$668,402	\$0
100% FFP	\$328,817	\$0	\$328,817
Total	-\$13,011,796	-\$3,695,377	-\$9,316,419

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

STATE ONLY CLAIMING ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 169
IMPLEMENTATION DATE: 1/2021
ANALYST: Ryan Woolsey
FISCAL REFERENCE NUMBER: 2210

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$130,720,000	\$130,576,000
- STATE FUNDS	-\$125,345,000	\$3,310,128,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$130,720,000	\$130,576,000
STATE FUNDS	-\$125,345,000	\$3,310,128,000
FEDERAL FUNDS	\$256,065,000	-\$3,179,552,000

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 and 50 years of age and older 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: 169

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 number of deferrals for the state only claiming issue. 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 2022-23, from the prior estimate, is due to:

- Managed care retroactive repayments are shifted from FY 2022-23 to FY 2023-24.
- Additional retroactive reclaiming for the immigration status change population.
- Reduced dental impacts from revised data.
- Pharmacy retroactive repayments shifted from FY 2021-22 to FY 2022-23.
- Prospective immigration status change impacts are now reflected in data used for the Nonemergency Funding Adjustment policy change and therefore are no longer reflected in this policy change.
- Prospective LEA BOP impacts are now reflected in the Local Education Agency (LEA) Providers policy change and therefore are no longer reflected in this policy change.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to:

- Managed care retroactive repayments are shifted from FY 2022-23 to FY 2023-24, and are increased based on updated data and enrollment assumptions.

Methodology:

Retroactive FFP Adjustments

1. Federal repayments are estimated for Managed Care, Pharmacy Rebates, Dental Fee-for-Service (FFS), and Dental Managed Care.
2. Additional retroactive claiming is estimated for the immigration status change population, for the period from July 2017 through June 2019.
3. Estimates of FFP repayments for Pharmacy Rebates cover claims from May 2016 to December 2021.
4. Estimates of FFP repayments for Dental FFS and Dental Managed Care cover claims from January 2010 through September 2022.
5. The estimated net retroactive adjustments are:

STATE ONLY CLAIMING ADJUSTMENTS
REGULAR POLICY CHANGE NUMBER: 169

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
SMHS	\$0	\$0	\$0
Drug Medi-Cal	\$0	\$0	\$0
Subtotal (In PC 170)	\$0	\$0	\$0
Managed Care	\$0	\$0	\$0
Pharmacy	\$0	\$71,368	(\$71,368)
Dental FFS and Managed Care	\$0	\$211,365	(\$211,365)
Immigration Status Change	\$0	(\$587,492)	\$587,492
MAA	\$0	\$0	\$0
LEA	(\$400)	(\$400)	\$0
Subtotal (In PC 169)	(\$400)	(\$305,159)	\$304,759
Grand Total	(\$400)	(\$305,159)	\$304,759

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
SMHS	\$0	\$0	\$0
Drug Medi-Cal	\$0	\$0	\$0
Subtotal (In PC 170)	\$0	\$0	\$0
Managed Care	\$0	\$2,498,203	(\$2,498,203)
Pharmacy	\$0	\$0	\$0
Dental FFS and Managed Care	\$0	\$0	\$0
Immigration Status Change	\$0	\$0	\$0
MAA	\$0	\$0	\$0
LEA	\$0	\$0	\$0
Subtotal (In PC 169)	\$0	\$2,498,203	(\$2,498,203)
Grand Total	\$0	\$2,498,203	(\$2,498,203)

STATE ONLY CLAIMING ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 169

Prospective Adjustments

6. Prospective adjustments are estimated for Managed Care, Pharmacy Rebates, Pharmacy Claims, Dental FFS, Dental Managed Care, and MAA.

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
SMHS	\$0	\$19,679	(\$19,679)
Drug Medi-Cal	\$0	\$4,198	(\$4,198)
Subtotal (In PC 170)	\$0	\$23,877	(\$23,877)
Managed Care	\$0	\$0	\$0
Pharmacy Rebates	\$142,014	\$44,732	\$97,282
Pharmacy Claims	\$0	\$113,172	(\$113,172)
Dental FFS and Managed Care	\$0	\$21,910	(\$21,910)
Immigration Status Change	\$0	\$0	\$0
MAA	(\$10,894)	\$0	(\$10,894)
LEA	\$0	\$0	\$0
Subtotal (In PC 169)	\$131,120	\$179,814	(\$48,694)
Grand Total	\$131,120	\$203,691	(\$72,571)

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
SMHS	\$0	\$20,377	(\$20,377)
Drug Medi-Cal	\$0	\$4,324	(\$4,324)
Subtotal (In PC 170)	\$0	\$24,701	(\$24,701)
Managed Care	\$0	\$624,808	(\$624,808)
Pharmacy Rebates	\$142,014	\$44,732	\$97,282
Pharmacy Claims	\$0	\$113,172	(\$113,172)
Dental FFS and Managed Care	\$0	\$29,213	(\$29,213)
Immigration Status Change	\$0	\$0	\$0
MAA	(\$11,438)	\$0	(\$11,438)
LEA	\$0	\$0	\$0
Subtotal (In PC 169)	\$130,576	\$811,925	(\$681,349)
Grand Total	\$130,576	\$836,626	(\$706,050)

STATE ONLY CLAIMING ADJUSTMENTS
REGULAR POLICY CHANGE NUMBER: 169

7. Total federal repayments and prospective adjustments are estimated to be:

(Dollars In Thousands)	TF	GF	FF
SMHS and DMC (PC 170)	\$0	\$23,877	(\$23,877)
MC, Pharmacy, Dental, Immigration, MAA, LEA (PC 169)	\$130,720	(\$125,345)	\$256,065
FY 2022-23	\$130,720	(\$101,468)	\$232,188

(Dollars In Thousands)	TF	GF	FF
SMHS and DMC (PC 170)	\$0	\$24,701	(\$24,701)
MC, Pharmacy, Dental, Immigration, MAA, LEA (PC 169)	\$130,576	\$3,310,128	(\$3,179,552)
FY 2023-24	\$130,576	\$3,334,829	(\$3,204,253)

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: 170
IMPLEMENTATION DATE: 9/2020
ANALYST: Ryan Woolsey
FISCAL REFERENCE NUMBER: 2198

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$23,877,000	\$24,701,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$23,877,000	\$24,701,000
FEDERAL FUNDS	-\$23,877,000	-\$24,701,000

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 and 50 years of age and older 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: 170

CMS Deferral

CMS has issued a number of deferrals for the state only claiming issue. 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 in FY 2022-23 from the prior estimate is an increase due to increased prospective adjustments for both SMHS and DMC based on revised expenditure data.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to modest projected growth in prospective adjustments over time.

Methodology:

Retroactive FFP Repayments

1. No additional retroactive repayments for SMHS and DMC are anticipated to be made.

Prospective Adjustments

2. Prospective impacts are estimated for SMHS and Drug Medi-Cal in FY 2022-23 and FY 2023-24.

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
SMHS	\$0	\$19,679	(\$19,679)
Drug Medi-Cal	\$0	\$4,198	(\$4,198)
Subtotal (In PC 170)	\$0	\$23,877	(\$23,877)
Managed Care	\$0	\$0	\$0
Pharmacy Rebates	\$142,014	\$44,732	\$97,282
Pharmacy Claims	\$0	\$113,172	(\$113,172)
Dental FFS and Managed Care	\$0	\$21,910	(\$21,910)
Immigration Status Change	\$0	\$0	\$0
MAA	(\$10,894)	\$0	(\$10,894)
LEA	\$0	\$0	\$0
Subtotal (In PC 169)	\$131,120	\$179,814	(\$48,694)
Grand Total	\$131,120	\$203,691	(\$72,571)

STATE ONLY CLAIMING ADJUSTMENTS - SMHS and DMC
REGULAR POLICY CHANGE NUMBER: 170

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
SMHS	\$0	\$20,377	(\$20,377)
Drug Medi-Cal	\$0	\$4,324	(\$4,324)
Subtotal (In PC 170)	\$0	\$24,701	(\$24,701)
Managed Care	\$0	\$624,808	(\$624,808)
Pharmacy Rebates	\$142,014	\$44,732	\$97,282
Pharmacy Claims	\$0	\$113,172	(\$113,172)
Dental FFS and Managed Care	\$0	\$29,213	(\$29,213)
Immigration Status Change	\$0	\$0	\$0
MAA	(\$11,438)	\$0	(\$11,438)
LEA	\$0	\$0	\$0
Subtotal (In PC 169)	\$130,576	\$811,925	(\$681,349)
Grand Total	\$130,576	\$836,626	(\$706,050)

3. Total federal repayments and prospective adjustments are estimated to be:

(Dollars In Thousands)	TF	GF	FF
SMHS and DMC (PC 170)	\$0	\$23,877	(\$23,877)
MC, Pharmacy, Dental, Immigration, MAA, LEA (PC 169)	\$130,720	(\$125,345)	\$256,065
FY 2022-23	\$130,720	(\$101,468)	\$232,188

(Dollars In Thousands)	TF	GF	FF
SMHS and DMC (PC 170)	\$0	\$24,701	(\$24,701)
MC, Pharmacy, Dental, Immigration, MAA, LEA (PC 169)	\$130,576	\$3,310,128	(\$3,179,552)
FY 2023-24	\$130,576	\$3,334,829	(\$3,204,253)

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)

ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

REGULAR POLICY CHANGE NUMBER: 171
IMPLEMENTATION DATE: 5/2013
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1476

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$714,859,000	\$633,783,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$714,859,000	\$633,783,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$714,859,000	\$633,783,000

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:

Not Applicable

Background:

State Plan Amendment (SPA) 09-023A was approved on April 25, 2013, retroactive to October 1, 2009. It authorizes CDDS to claim federal financial participation (FFP) for the provision of certain services by the state's Regional Center (RC) network of nonprofit providers to persons with developmental disabilities. RC consumers who received or currently receive certain services will continue to be eligible for these services even though their institutional level of care requirements for the HCBS waiver for persons with developmental disabilities are not met. Services covered under this SPA include but are not limited to: habilitation, respite care, personal care services, homemaker services, and home health aide services.

On September 29, 2016, SPA 16-016 was approved by the Centers for Medicare and Medicaid Services (CMS) to renew SPA 09-023A with an effective date of October 1, 2016. The SPA will expire on September 30, 2021. 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: 171

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 2022-23, from the prior estimate, is an increase due to a shift in prior year expenditures from FY 2021-22 to FY 2022-23.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a net decrease due to population growth and a higher prior year expenditures in FY 2022-23 than in FY 2023-24.

Methodology:

1. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2023 for this policy change.

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	FF	FFCRA
FY 2022-23	\$1,271,886	\$557,027	\$635,943	\$78,916
FY 2023-24	\$1,233,652	\$599,869	\$616,826	\$16,957

Funding:

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

HCBS SP - IHSS HCBS CARE ECONOMY PMTS

REGULAR POLICY CHANGE NUMBER: 172
IMPLEMENTATION DATE: 1/2023
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2360

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$165,790,000	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$165,790,000	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$165,790,000	\$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)
Families First Coronavirus Response Act (FFCRA)

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 HCBS American Rescue Plan Fund.

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.

HCBS SP - IHSS HCBS CARE ECONOMY PMTS

REGULAR POLICY CHANGE NUMBER: 172

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 prior estimate, for FY 2022-23, is an increase due to FY 2021-22 federal funds now being paid in FY 2022-23. The change from FY 2022-23 to FY 2023-24 in the current estimate is a decrease due to all payments occurring in FY 2022-23.

Methodology:

1. Assume implementation began on January 1, 2022.
2. The non-federal share is budgeted by CDSS.
3. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2023, for this policy change.
4. FY 2022-23 costs are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	HCBS ARP Fund - CDSS	FF
100% Title XIX	\$295,000	\$147,500	\$147,500
FFCRA 6.2% Increased FFP	\$0	(\$18,290)	\$18,290
FY 2022-23	\$295,000	\$129,210	\$165,790

Funding:

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

ELECTRONIC VISIT VERIFICATION FED PENALTIES

REGULAR POLICY CHANGE NUMBER: 173
IMPLEMENTATION DATE: 7/2021
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2163

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	-\$27,822,000	\$0
- STATE FUNDS	\$623,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$27,822,000	\$0
STATE FUNDS	\$623,000	\$0
FEDERAL FUNDS	-\$28,445,000	\$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 (CMS) for a Good Faith Effort Exemption to extend the EVV implementation date without penalty for PCS to January 2021.

California's Phase II EVV solution was successfully implemented and went live on January 1, 2022. The Department completed its Operational Readiness Review (ORR) with CMS on December 21, 2021. The Department worked to address action items resulting from the ORR. The Phase II EVV solution includes personal care services with an agency model offered through various waiver and state plan programs administered by the Department, the California Department of Public Health (CDPH), the California Department of Aging (CDA), and the California Department of Developmental Services (CDDS). The Department received CMS approval of its Phase II EVV solution, and CDPH, CDA, and CDDS will no longer incur any penalties. The Department and the California Department of Social Services (CDSS) continued to incur penalties for self-directed personal care services until December 31, 2022, before the Phase I EVV solution was implemented.

ELECTRONIC VISIT VERIFICATION FED PENALTIES

REGULAR POLICY CHANGE NUMBER: 173

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a net increase due to a revised estimate for CDSS. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to Phase I being implemented at the end of December 2022.

Methodology:

- Phase I: The Department and CDSS received reduced federal funding for the In-Home Supportive Services and Waiver Personal Care Services programs from January 1, 2021, through December 31, 2022.

FY 2022-23	TF	GF	FF
Dept. of Social Services	(\$27,822,000)	\$0	(\$27,822,000)
Dept. of Health Care Services	\$0	\$623,000	(\$623,000)
Total	(\$27,822,000)	\$623,000	(\$28,445,000)

*Totals may differ due to rounding.

Funding:

100% GF (4260-101-0001)

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

HOSPITAL & SNF COVID-19 WORKER RETENTION PAYMENTS

REGULAR POLICY CHANGE NUMBER: 179
IMPLEMENTATION DATE: 7/2022
ANALYST: Ryan Woolsey
FISCAL REFERENCE NUMBER: 2367

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$1,077,600,000	\$0
- STATE FUNDS	\$1,077,600,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,077,600,000	\$0
STATE FUNDS	\$1,077,600,000	\$0
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the costs for Hospital and Skilled Nursing Facility COVID-19 Worker Retention Payments.

Authority:

SB 184 (Chapter 47, Statutes of 2022)

Interdependent Policy Changes:

Not Applicable

Background:

Pursuant to Chapter 47, Statutes of 2022 (SB 184), one-time payments will be provided to workers in qualifying hospitals and skilled nursing facilities as specified, to support their efforts throughout the COVID-19 pandemic to provide 24-hour patient care, despite the exceedingly high workload and difficult conditions. The payments will be funded from the California Emergency Relief Fund starting in FY 2021-22, available for expenditure through June 30, 2024.

Reason for Change:

The change in FY 2022-23, from the prior estimate, is an increase due to payments shifting into FY 2022-23.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is because all payments are expected to be released in 2022-23

Methodology:

1. From the FY 2021-22 appropriation amount, assume \$1,077,600,000 from the California Emergency Relief Fund will be provided to health care workers in FY 2022-23. The table below shows the estimated spending and remaining funds by Appropriation Year:

HOSPITAL & SNF COVID-19 WORKER RETENTION PAYMENTS
REGULAR POLICY CHANGE NUMBER: 179

	TF	California Emergency Relief Fund
Appropriation Year 2021-22		
Prior Years	\$0	\$0
Estimated in FY 2022-23	\$1,077,600	\$1,077,600
Estimated in FY 2023-24	\$0	\$0
Total Estimated Remaining	\$0	\$0

Funding:

California Emergency Relief Fund (4260-101-3398)

BEHAVIORAL HEALTH BRIDGE HOUSING

REGULAR POLICY CHANGE NUMBER: 181
IMPLEMENTATION DATE: 7/2022
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2354

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$907,936,000	\$300,000,000
- STATE FUNDS	\$907,936,000	\$300,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$907,936,000	\$300,000,000
STATE FUNDS	\$907,936,000	\$300,000,000
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the costs for behavioral health bridge housing.

Authority:

AB 179 (Chapter 249, Statutes of 2022)

Interdependent Policy Changes:

Not Applicable

Background:

Funding for behavioral health bridge housing 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:

The change in FY 2022-23, from the prior estimate, is due to updating the allocations between FY 2022-23 and FY 2023-24.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to the completion of contracts in FY 2022-23 and the addition of \$250,000,000 General Fund (GF) to be appropriated in the FY 2023-24 budget bill for behavioral health bridge housing.

Methodology:

1. Of the \$957,936,000 GF appropriated for behavioral health bridge housing, assume \$907,936,000 GF is estimated in FY 2022-23, and \$50,000,000 is estimated in FY 2023-24, available for expenditure through June 30, 2027.
2. Assume \$250,000,000 GF is appropriated to the Department for behavioral health bridge housing in FY 2023-24.

BEHAVIORAL HEALTH BRIDGE HOUSING
REGULAR POLICY CHANGE NUMBER: 181

(Dollars in Thousands)

Behavioral Health Bridge Housing	TF	GF
FY 2022-23	\$907,936	\$907,936
FY 2023-24	\$300,000	\$300,000

3. The table below displays the estimated spending and remaining funds by Appropriation Years:

(Dollars In Thousands)

	TF	GF
Appropriation Year 2022-23	\$957,936	\$957,936
Estimated in FY 2022-23	\$907,936	\$907,936
Estimated in FY 2023-24	\$50,000	\$50,000
Total Estimated Remaining	\$0	\$0
Appropriation Year 2023-24		
New in FY 2023-24	\$250,000	\$250,000
Total Estimated Remaining	\$0	\$0

4. The estimated costs in FY 2022-23 and FY 2023-24 are as follows:

(Dollars In Thousands)

FY 2022-23	TF	GF
Appropriation Year 2022-23	\$907,936	\$907,936
Total FY 2022-23	\$907,936	\$907,936

(Dollars in Thousands)

FY 2023-24	TF	GF
Appropriation Year 2022-23	\$50,000	\$50,000
Appropriation Year 2023-24	\$250,000	\$250,000
Total FY 2023-24	\$300,000	\$300,000

Funding:

100% GF (4260-101-0001)

CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY

REGULAR POLICY CHANGE NUMBER: 182
IMPLEMENTATION DATE: 12/2022
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2292

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$450,000,000	\$100,000,000
- STATE FUNDS	\$450,000,000	\$100,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$450,000,000	\$100,000,000
STATE FUNDS	\$450,000,000	\$100,000,000
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates funding for direct grants 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 schools, school affiliated community-based organizations (CBOs), or school-based health centers. Potential grant recipients include, but may not be limited to, local educational agencies (LEAs), institutions of higher education, publicly funded childcare and preschools, health care service plans, CBOs, tribal entities, behavioral health providers, city mental health authorities, and/or counties.

Authority:

SB 129 (Chapter 69, Statutes of 2021)
 AB 179 (Chapter 249, Statutes of 2022)
 Welfare & Institutions Code 5961.2

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), will enhance the availability of school-based BH services and expand access to BH school counselors, peer supports, and BH coaches. Of the \$550,000,000, \$400,000,000 is allocated to pre-school through 12th grade and \$150,000,000 for higher education (with \$100,000,000 earmarked for community colleges).

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,

CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY

REGULAR POLICY CHANGE NUMBER: 182

innovative, up-stream focused, ecosystem where all children and young adults are routinely screened, supported, and served for emerging behavioral health needs.

Reason for Change:

There is no change for FY 2022-23 from the prior estimate.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to the remaining amount of appropriation is expected to be completely paid in FY 2023-24.

Methodology:

1. Assume \$450,000,000 General Fund (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 2022-23. This funding is available for encumbrance or expenditure until June 30, 2025 per the 2022 Budget Act, item 4260-101-0001, Provision 16.
2. Assume \$100,000,000 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 2023-24. This funding is available for encumbrance or expenditure until June 30, 2024 per the 2021 Budget Act, Item 4260-101-0001, Provision 16(b).
3. Of the \$550,000,000 GF, \$400,000,000 is targeted to pre-school through 12th grade and \$150,000,000 is targeted to higher education.
4. The table below displays the estimated spending and remaining funds by Appropriation Years:

(Dollars in Thousands)

Appropriation Year 2021-22	TF	GF
Prior Years	\$0	\$0
Estimated in FY 2022-23	\$0	\$0
Estimated in FY 2023-24	\$100,000	\$100,000
Total Estimated Remaining	\$0	\$0
Appropriation Year 2022-23		
Estimated in FY 2022-23	\$450,000	\$450,000
Estimated in FY 2023-24	\$0	\$0
Total Estimated Remaining	\$0	\$0

CYBHI - SCHOOL BH PARTNERSHIPS AND CAPACITY
REGULAR POLICY CHANGE NUMBER: 182

5. The estimated costs in FY 2022-23 and FY 2023-24 are as follows:

(Dollars in Thousands)

FY 2022-23	TF	GF
Appropriation Year 2022-23	\$450,000	\$450,000
Total FY 2022-23	\$450,000	\$450,000

(Dollars in Thousands)

FY 2023-24	TF	GF
Appropriation Year 2021-22	\$100,000	\$100,000
Total FY 2023-24	\$100,000	\$100,000

Funding:

100% Title XIX GF (4260-101-0001)

CYBHI - EVIDENCE-BASED BH PRACTICES

REGULAR POLICY CHANGE NUMBER: 183
IMPLEMENTATION DATE: 10/2022
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2323

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$429,000,000	\$0
- STATE FUNDS	\$429,000,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$429,000,000	\$0
STATE FUNDS	\$429,000,000	\$0
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the cost of supporting scaling and spreading of evidence-based interventions and community-defined practices 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 179 (Chapter 249, Statutes of 2022)
Welfare & Institutions Code 5961.5

Interdependent Policy Changes:

Not Applicable

Background:

As part of the Children and Youth Behavioral Health Initiative (CYBHI), the Department, with assistance from a stakeholder workgroup, will select a limited number of evidence-based and/or community-defined practices to scale throughout the state based on robust evidence for effectiveness, positive impact on equity, and sustainability. Funding will be issued through competitive grants to counties, tribal entities, health plans (Medi-Cal and commercial), community-based organizations, and behavioral health providers to support implementation of these evidence-based practices and programs for children and youth. Grants 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.

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 - EVIDENCE-BASED BH PRACTICES

REGULAR POLICY CHANGE NUMBER: 183

Reason for Change:

There is no change for FY 2022-23 from the prior estimate.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to no estimated grant funds for FY 2023-24.

Methodology:

1. The Department will convene 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 available for encumbrance or expenditure until June 30, 2025.
2. \$42.9 million TF, or 10% of the FY 2022-23 \$429 million TF, is carved out for the Mental Health Oversight & Accountability Commission (MHSOAC).
3. The estimate for FY 2022-23 on a cash basis is:

(Dollars in Thousands)

FY 2022-23	TF	GF
MHSOAC	\$42,900	\$42,900
Evidence-Based BH Practice Grants	\$386,100	\$386,100
FY 2022-23	\$429,000	\$429,000

4. The table below displays the estimated spending and remaining funds by Appropriation Years:

(Dollars in Thousands)

Appropriation Year 2022-23	TF	GF
Estimated in FY 2022-23	\$429,000	\$429,000
Estimated in FY 2023-24	\$0	\$0
Total Estimated Remaining	\$0	\$0

5. The estimated costs in FY 2022-23 are as follows:

(Dollars in Thousands)

FY 2022-23	TF	GF
Appropriation Year 2022-23	\$429,000	\$429,000
Total FY 2022-23	\$429,000	\$429,000

Funding:

100% Title XIX GF (4260-101-0001)

CCI IHSS RECONCILIATION

REGULAR POLICY CHANGE NUMBER: 184
IMPLEMENTATION DATE: 4/2022
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 1942

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$428,000,000	\$0
- STATE FUNDS	\$428,000,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$428,000,000	\$0
STATE FUNDS	\$428,000,000	\$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: 184

Reason for Change:

The change from the prior estimate, for FY 2022-23, is an increase due to the IHSS reconciliation shifting from FY 2021-22 to FY 2022-23 and an increase in the amount that CDSS owes the MCPs. Additionally, the Department will be recording an \$86 million General Fund (GF) cost in FY 2022-23 for beneficiaries who were not flagged as receiving IHSS services for MCP capitation. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to the IHSS reconciliation process being completed in FY 2022-23.

Methodology:

1. The 2015, 2016, and 2017 reconciliation for CY 2015, CY 2016, and CY 2017 service months and reimbursement for overpayments and underpayments were completed in FY 2022-23.
2. Based on CY 2015, CY 2016, and CY 2017 data, CDSS owes the MCPs \$342,000,000 TF for IHSS managed care in the seven CCI counties.
3. Additionally, due to the difference between total claims paid by CDSS and claims for beneficiaries who were not flagged as receiving IHSS services for MCP capitation, the Department will be recording an additional \$86 million as a GF cost.
4. Total estimated amount owed to MCPs in FY 2022-23 is \$428,000,000 TF.

Funding:

100% Reimbursement GF (4260-610-0995)
100% State GF (4260-101-0001)

HCBS SP CDDS

REGULAR POLICY CHANGE NUMBER: 186
IMPLEMENTATION DATE: 6/2022
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2348

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$382,513,000	\$199,018,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$382,513,000	\$199,018,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$382,513,000	\$199,018,000

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
 Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

Not Applicable

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 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.

HCBS SP CDDS
REGULAR POLICY CHANGE NUMBER: 186

Reason for Change:

The change in FY 2022-23, from the prior estimate, is an increase due to an updated estimate of the cash expenditures for FY 2022-23 and the inclusion of the FFCRA increased FMAP.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decreased estimate of the cash expenditures and no FFCRA estimated in FY 2023-24.

Methodology:

1. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2023 for this policy change.
2. The cash basis estimate for the HCBS spending plan items for CDDS are:

(Dollars in Thousands)

FY 2022-23	TF	HCBS ARP Fund - CDDS	FF	FFCRA
Coordinated Family Support Service	\$16,666	\$9,173	\$6,666	\$827
Developmental Services Rate Model Implementation	\$775,687	\$428,839	\$308,584	\$38,264
Social Recreation and Camp Services for Individuals with Developmental Disabilities	\$51,868	\$31,191	\$18,396	\$2,281
Language Access and Cultural Competency Orientations and Translations	\$16,668	\$9,173	\$6,668	\$827
Total	\$860,889	\$478,376	\$340,314	\$42,199

(Dollars in Thousands)

FY 2023-24	TF	HCBS ARP Fund - CDDS	FF
Coordinated Family Support Service	\$25,001	\$15,000	\$10,001
Developmental Services Rate Model Implementation	\$609,646	\$440,694	\$168,952
Social Recreation and Camp Services for Individuals with Developmental Disabilities	\$42,700	\$27,600	\$15,100
Language Access and Cultural Competency Orientations and Translations	\$12,465	\$7,500	\$4,965
Total	\$689,812	\$490,794	\$199,018

Funding:

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

EQUITY & PRACTICE TRANSFORMATION PAYMENTS

REGULAR POLICY CHANGE NUMBER: 187
IMPLEMENTATION DATE: 1/2023
ANALYST: Ryan Woolsey
FISCAL REFERENCE NUMBER: 2346

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$140,000,000	\$215,000,000
- STATE FUNDS	\$70,000,000	\$107,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$140,000,000	\$215,000,000
STATE FUNDS	\$70,000,000	\$107,500,000
FEDERAL FUNDS	\$70,000,000	\$107,500,000

Purpose:

This policy change estimates the costs of the Equity & Practice Transformation Payments.

Authority:

AB 179 (Chapter 249, Statutes of 2022)

Interdependent Policy Changes:

COVID-19 Increased FMAP - DHCS

Background:

The Department will provide equity and practice transformation payments to qualifying providers, to improve quality, health equity and primary care infrastructure to support these goals. These practice transformation payments will: advance equity; address gaps in preventive, maternity, and behavioral health care measures; reduce COVID-19 driven care disparities; support upstream interventions to address social drivers of health and improve early childhood outcomes; and prepare practices to accept risk-based contracts and move towards value based care. Such actions align with the goals of the Medi-Cal Comprehensive Quality and Equity Strategy and the Bold Goals 50x2025 initiative.

The multiyear plan for these payments includes \$700 million TF over 5 years to:

- Support a statewide learning collaborative to ensure successful implementation (\$25 million)
- Support practice-level activities. A portion of the funding will be used to support planning for small and independent practices while the majority of the funding will go towards supporting direct implementation (\$25 million)
- Equity and practice transformation payments (\$650 million)

Equity and Practice Transformation Payments will support investment in provider infrastructure, including infrastructure to support data exchange and advanced data analytics, and practice transformation efforts to achieve Medi-Cal's quality and equity goals and support practices to prepare for alternative payment model arrangements. Such interventions include, but are not limited to case management and/or system mechanisms for identifying and addressing underutilization and closing care gaps, clinical infrastructure, electronic medical record system updates, population health improvements, telehealth, remote patient monitoring, etc. and will

EQUITY & PRACTICE TRANSFORMATION PAYMENTS

REGULAR POLICY CHANGE NUMBER: 187

help practices in their work to make it possible for the Department to realize its 50% by 2025 Bold Goals.

Practices are to work on one or more of the following workstreams:

- Maternity and early childhood health transformation: Aimed at identifying and addressing disparities and clinical quality outcomes for pregnant persons and infants
- Childhood and adolescent health transformation: Aimed at identifying and addressing disparities and clinical quality outcomes for school-aged children and adolescents
- Whole person primary care transformation: Aimed at identifying and addressing disparities and clinical quality outcomes for primary care patients (of all ages), especially focused on addressing social and behavioral health needs
- Early childhood health: Aimed at upstream prevention and addressing social drivers of health using evidence-based models of care and partnership with local entities outside of healthcare (e.g. scaling models such as Health Steps or Project Dulce, efforts to coordinate and increase enrollment into home visiting programs, WIC, and CalFresh benefits)

Moreover, \$200 million of the \$650 million will be dedicated towards preparing practices for value-based care. This includes implementing practice infrastructure such as electronic health record systems, data collection, recording capabilities, improved data exchange) and implementation of care management systems. Such funds shall focus on areas located in the first and second quartiles of the Healthy Places Index, to support provider practices to adopt value-based and other payment models that improve health care quality while reducing costs.

Funding will be provided over five fiscal years as follows:

- \$140 million TF (\$70 million GF) in FY 2022-23
- \$215 million TF (\$107.5 million GF) in FY 2023-24
- \$115 million TF (\$57.5 million GF) in FY 2024-25
- \$115 million TF (\$57.5 million GF) in FY 2025-26
- \$115 million TF (\$57.5 million GF) in FY 2026-27

Reason for Change:

There is no change from the prior estimate for FY 2022-23.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is to appropriate the next year of funding in the multiyear plan.

EQUITY & PRACTICE TRANSFORMATION PAYMENTS

REGULAR POLICY CHANGE NUMBER: 187

Methodology:

1. The Budget Act for FY 2022-23 provides \$140 million TF (\$70 million GF), available for expenditure through June 30, 2027. Additional funding is proposed for FY 2023-24. The table below displays the estimated spending and remaining funds by Appropriation Year:

	TF	GF	FF*
Appropriation Year 2022-23			
Estimated in FY 2022-23	\$140,000,000	\$70,000,000	\$70,000,000
Estimated in FY 2023-24	\$0	\$0	\$0
Total Estimated Remaining	\$0	\$0	\$0
Appropriation Year 2023-24			
New in FY 2023-24	\$215,000,000	\$107,500,000	\$107,500,000

2. The estimated costs in FY 2022-23 and FY 2023-24 are as follows:

FY 2022-23	TF	GF	FF*
Appropriation Year 2022-23	\$140,000,000	\$70,000,000	\$70,000,000
Total FY 2022-23	\$140,000,000	\$70,000,000	\$70,000,000

FY 2023-24	TF	GF	FF*
Appropriation Year 2023-24	\$215,000,000	\$107,500,000	\$107,500,000
Total FY 2023-24	\$215,000,000	\$107,500,000	\$107,500,000

*Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.

Funding:

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

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

HOME & COMMUNITY-BASED ALTERNATIVES WAIVER

REGULAR POLICY CHANGE NUMBER: 188
IMPLEMENTATION DATE: 10/2017
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2010

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$285,672,000	\$254,314,000
- STATE FUNDS	\$142,836,000	\$127,157,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	56.50 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$124,267,300	\$254,314,000
STATE FUNDS	\$62,133,660	\$127,157,000
FEDERAL FUNDS	\$62,133,660	\$127,157,000

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

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.

On September 29, 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. The current waiver was to expire on December 31, 2021; however, the Centers for Medicare and Medicaid Services approved a third 90-day extension, to September 30, 2022, for the current waiver.

The rate for Personal Care Agencies was increased on January 1, 2022 to align with the state minimum wage increase.

HOME & COMMUNITY-BASED ALTERNATIVES WAIVER

REGULAR POLICY CHANGE NUMBER: 188

Under the new waiver term, the waiver will:

- Add new waiver services,
- Increase waiver slots beginning January 1, 2024, based on projected enrollment and attrition trends, and
- Increase the rates for Intermediate Care Facilities/Developmentally Disabled – Continuous Nursing Care, retroactive to August 1, 2021.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a decrease primarily due to lowering projected monthly enrollment based on more recent actuals. Additionally, there were some implementation date shifts for new waiver efforts. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to new waiver services implementing in the budget year.

Methodology:

1. Assume there are 7,125 participants in the HCBA Waiver in FY 2021-22.
2. Assume the annual cost per user is \$49,075.
3. Assume 936 new participants will transition in FY 2022-23 and FY 2023-24.
4. Assume the PCA rate increase began on January 1, 2022.
5. Assume 60% will be from long-term skilled nursing facilities and 40% participants will be from the community.
6. Assume the average monthly cost in a skilled nursing facility is \$10,736.

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Waiver Costs	\$324,859	\$162,429	\$162,430
Savings from SNF	(\$39,186)	(\$19,593)	(\$19,593)
Net Cost	\$285,673	\$142,836	\$142,837
FY 2023-24	TF	GF	FF
Waiver Costs	\$365,861	\$182,931	\$182,930
Savings from SNF	(\$111,547)	(\$55,774)	(\$55,774)
Net Cost	\$254,314	\$127,158	\$127,157

*Totals may differ due to rounding.

Funding:

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

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

CYBHI - URGENT NEEDS AND EMERGENT ISSUES

REGULAR POLICY CHANGE NUMBER: 189
IMPLEMENTATION DATE: 7/2021
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2375

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$120,000,000	\$26,000,000
- STATE FUNDS	\$120,000,000	\$26,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$120,000,000	\$26,000,000
STATE FUNDS	\$120,000,000	\$26,000,000
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the program costs to address Urgent Needs and Emergent Issues in Children's Behavioral Health.

Authority:

AB 179 (Chapter 249, Statutes of 2022)

Interdependent Policy Change:

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.

The COVID-19 pandemic has intensified already swelling children's behavioral health issues. Addressing these needs is vital to California's recovery and consistent with the state's priorities to improve behavioral health for all Californians.

The most glaring behavioral health challenges are borne inequitably by communities of color, low-income communities, LGBTQ+ communities, and in places where adverse childhood experiences are widespread and prominent. These investments align with the state's commitment and ongoing efforts to improve health equity.

The significant investment of one-time funds through the Children and Youth Behavioral Health Initiative (CYBHI) will have a meaningful impact on outcomes for children and youth in the long-term. However, as the components of the CYBHI continue to be developed and implemented, there is an urgent and immediate need to continue to invest in efforts that address children's behavioral health. Through this proposal, the Department will invest additional resources in targeted efforts to address urgent and emergent issues in children and youth behavioral health. These proposals are consistent with and complementary of the investments in the Children and Youth Behavioral Health Initiative.

CYBHI - URGENT NEEDS AND EMERGENT ISSUES

REGULAR POLICY CHANGE NUMBER: 189

The Budget Act of 2022 provided \$120.5 million in FY 2022-23, \$25,500,000 in FY 2023-24, and \$29,000,000 in FY 2024-25 from the General Fund as part of a multiyear plan to provide \$175 million from the General Fund for the following:

- Wellness and Resilience Building Supports for Children, Youth, and Parents
- A Video Series to Provide Parents with Resources and Skills to Support their Children's Mental Health
- Leveraging of Emerging Technologies to Develop Next Generation Digital Supports for Remote Mental Health Assessment and Intervention
- School-Based Peer Mental Health Demonstration Project

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a slight decrease based on updated payment timings. The change in the current estimate, from FY 2022-23 to FY 2023-24, is a decrease due to fewer activities planned in FY 2023-24.

Methodology:

1. The Budget Act for FY 2022-23 provides \$120.5 million GF for this item, available through June 30, 2025. Additional funding is proposed for FY 2023-24. The table below displays the estimated spending and remaining funds by Appropriation Year:

	TF	GF	FF
Appropriation Year 2022-23			
Prior Years	\$0	\$0	\$0
Estimated in FY 2022-23	\$120,000,000	\$120,000,000	\$0
Estimated in FY 2023-24	\$500,000	\$500,000	\$0
Total Estimated Remaining	\$0	\$0	\$0
Appropriation Year 2023-24			
Prior Years	\$0	\$0	\$0
Estimated in FY 2023-24	\$25,500,000	\$25,500,000	\$0
Total Estimated Remaining	\$0	\$0	\$0
Appropriation Year 2024-25			
Prior Years	\$0	\$0	\$0
Estimated in FY 2023-24	\$0	\$0	\$0
Total Estimated Remaining	\$29,000,000	\$29,000,000	\$0

Fiscal Year	TF	GF	FF
FY 2022-23	\$120,000,000	\$120,000,000	\$0
FY 2023-24	\$26,000,000	\$26,000,000	\$0

Funding: 100% Title XIX GF (4260-101-0001)

LA COUNTY JUSTICE-INVOLVED POP. SVCS & SUPPORTS

REGULAR POLICY CHANGE NUMBER: 191
IMPLEMENTATION DATE: 10/2022
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2365

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$99,220,000	\$0
- STATE FUNDS	\$99,220,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$99,220,000	\$0
STATE FUNDS	\$99,220,000	\$0
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates grant funding to support and expand access to treatment for individuals with behavioral health disorders that are involved in the justice system, including the misdemeanor incompetent to stand trial (MIST) population in Los Angeles County.

Authority:

AB 179 (Chapter 249, Statutes of 2022)

Interdependent Policy Changes:

Not Applicable

Background:

The Department seeks to address the needs of individuals with behavioral health disorders that are involved in the justice system, including the MIST population in Los Angeles County to access community-based treatment and housing. Of the \$100 million one-time grant funding, \$50 million is to support individuals charged with a misdemeanor and found incompetent to stand trial. The funding would be allocated as follows:

- At least 75% of the funding will be used for capital costs to construct, acquire or rehabilitate treatment and housing facilities which could include, but not limited to, any non-corrections settings including residential treatment settings, clinically enhanced interim housing settings, licensed adult and senior care settings, and permanent supportive housing.
 - Funding may be used for a capitalized operating subsidy reserve.
 - Facilities must commit to providing health care treatment or housing, or both, for the target population in the financed facility or facilities for a minimum of thirty years.
- Up to 25% of the funding will be used for rental subsidies to support placement of justice-involved individuals in residential settings.
- The Department plans to utilize a Department of Finance transfer of \$780,000 from this appropriation for state operation costs.

Los Angeles County would be required to provide a 10% match and the match may include an in-kind match such as the land value where a facility is sited.

LA COUNTY JUSTICE-INVOLVED POP. SVCS & SUPPORTS

REGULAR POLICY CHANGE NUMBER: 191

Reason for Change:

The change from the prior estimate for FY 2022-23 is due to the transfer of \$780,000 to support state operations costs.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to the completion of grant payments in FY 2022-23.

Methodology:

1. Assume \$99,220,000 General Fund (GF) will be provided in FY 2022-23.

(Dollars in Thousands)

FY 2022-23	TF	GF
LA County treatment and housing	\$99,220	\$99,220
Total	\$99,220	\$99,220

2. Funding provided in the Budget Act for FY 2022-23 is available for expenditure through June 30, 2027. The table below displays the estimated spending and remaining funds by Appropriation Years:

(Dollars In Thousands)

Appropriation Year 2022-23	TF	GF
Estimated in FY 2022-23	\$99,220	\$99,220
Estimated in FY 2023-24	\$0	\$0
Total Estimated Remaining	\$0	\$0

3. The estimated costs in FY 2022-23 are as follows:

(Dollars In Thousands)

FY 2022-23	TF	GF
Appropriation Year 2022-23	\$99,220	\$99,220
Total FY 2022-23	\$99,220	\$99,220

Funding:

100% GF (4260-101-0001)

CALHOPE

REGULAR POLICY CHANGE NUMBER: 192
IMPLEMENTATION DATE: 5/2022
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2355

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$105,423,000	\$44,577,000
- STATE FUNDS	\$105,423,000	\$44,577,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$105,423,000	\$44,577,000
STATE FUNDS	\$105,423,000	\$44,577,000
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the costs to temporarily extend support for the CalHOPE program.

Authority:

AB 179 (Chapter 249, Statutes of 2022)

Interdependent Policy Changes:

Not Applicable

Background:

The CalHOPE program, available to all populations including adults, is a component of the crisis continuum of support and care and its elements include:

- Media messaging to destigmatize stress and anxiety and promote help-seeking, including using trusted messengers to reach diverse populations,
- CalHOPE web services,
- CalHOPE Warm Line, and
- CalHOPE Connect partnership with up to 30 community-based organizations, with over 400 peer crisis counselors.

The CalHOPE program was initially funded through grants provided by the Federal Emergency Management Agency (FEMA), and the Substance Abuse and Mental Health Services Administration, with the federal grants expiring August 2022.

Because CalHOPE provides crisis services to a large California population, without additional funding to support the program after federal funding expires, services would abruptly stop, ending employment for 500 peer workers and ceasing the availability of crisis counseling by chat and phone for thousands of Californians currently using the services.

The Department, as part of the Children and Youth Behavioral Health Initiative (CYBHI) will procure a business services vendor to deliver and monitor BH wellness services and treatments through a direct service, virtual platform by January 2024. The behavioral health virtual services platform will provide services, including peer support services, similar to those funded by the CalHOPE program.

CALHOPE

REGULAR POLICY CHANGE NUMBER: 192

In addition, the California Health and Human Services Agency is launching a stakeholder planning process to create a long term plan for the crisis continuum of care.

Until the CYBHI virtual platform launches in January 2024 and further work is done to enhance the behavioral health crisis continuum of care, the General Fund (GF) would fund key services in CalHOPE through January 2024, at which point CalHOPE will continue by integrating into the CYBHI behavioral health virtual services platform.

Reason for Change:

The change for FY 2022-23 in the prior estimate, is due to refining the estimated GF expenditures.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to adding estimated expenditures for FY 2023-24.

Methodology:

- In FY 2022-23, \$110 million TF (\$96.423 million GF, and \$13.577 million Mental Health Services Fund (MHSF) is estimated as follows:
 - \$80 million GF
 - \$16.423 million one-time GF and \$13.577 million one-time MHSF, available for expenditure until June 30, 2025, to support the peer-run warm line, administered by the Mental Health Association of San Francisco.
- Additionally, \$40 million GF is estimated for the first half of FY 2023-24 to prevent gaps in services.
- The table below displays the estimated spending and remaining funds for the one-time peer-run warm line funding, by appropriation year:

(Dollars in Thousands)

Appropriation Year 2022-23	TF	GF	MHSF
Estimated in FY 2022-23	\$25,423	\$16,423	\$9,000
Estimated in FY 2023-24	\$4,577	\$0	\$4,577
Total Estimated Remaining	\$0	\$0	\$0

- The estimated costs in FY 2022-23 and FY 2023-24, specific to the one-time peer-run warm line are as follows:

(Dollars in Thousands)

FY 2022-23	TF	GF	MHSF
Appropriation Year 2022-23	\$25,423	\$16,423	\$9,000
Total FY 2022-23	\$25,423	\$16,423	\$9,000

CALHOPE
REGULAR POLICY CHANGE NUMBER: 192

(Dollars in Thousands)

FY 2023-24	TF	GF	MHSF
Appropriation Year 2022-23	\$4,577	\$0	\$4,577
Total FY 2023-24	\$4,577	\$0	\$4,577

5. This funding is for services that are separate and distinct from those covered in the CYBHI - CalHOPE Student Support Services policy change.

(Dollars in Thousands)

CalHOPE Funding	TF	GF	MHSF
FY 2022-23	\$105,423	\$96,423	\$9,000
FY 2023-24	\$44,577	\$40,000	\$4,577

Funding:

100% State GF (4260-101-0001)

100% Mental Health Services Fund (4260-101-3085)

CARE COURT

REGULAR POLICY CHANGE NUMBER: 193
IMPLEMENTATION DATE: 10/2023
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2396

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$16,496,000
- STATE FUNDS	\$0	\$16,496,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$16,496,000
STATE FUNDS	\$0	\$16,496,000
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the county costs to provide services for the Community Assistance, Recovery, and Empowerment (CARE) Act.

Authority:

SB 1338 (Chapter 319, Statutes of 2022)

Interdependent Policy Changes:

Not Applicable

Background:

The CARE Court framework delivers mental health and substance use disorder services for individuals with schizophrenia spectrum or other psychotic disorders. The framework may include individualized, appropriate range of services and supports consisting of behavioral health (BH) care, stabilization medications, housing, and enumerated services subject to available funding, federal and state requirements, and eligibility criteria.

CARE Court connects a person in crisis with a court-ordered Care Plan for up to 12 months, with the possibility to revise or extend by up to 12 months. If a participant cannot successfully complete a CARE Plan, the Court may utilize existing authority to certify the participant's safety.

The CARE Act requires Counties of Glenn, Orange, Riverside, San Diego, Stanislaus, and Tuolumne and the City and County of San Francisco to implement the program beginning October 1, 2023, and the remaining counties no later than December 1, 2024.

Reason for Change:

This is a new policy change.

Methodology:

1. Assume 12,000 individuals qualify for the CARE process pursuant to Welfare & Institutions Code (WIC) 5972.

CARE COURT
REGULAR POLICY CHANGE NUMBER: 193

2. Assume Cohort 1 counties begin providing services October 1, 2023 with no additional counties joining in FY 2023-24.
3. Clinical assessments are estimated at 85 hours per participant for 12 months. Court time is estimated at 85 hours per participant for 12 months.
4. 50% of participants will have a second year of CARE court, not included in FY 2023-24 estimates.
5. Costs for staffing are based on licensed behavioral health professionals to complete assessments and to prepare for and attend hearings. The wage estimate is \$69.50 per hour.
6. The estimate does not include any costs associated with medically necessary treatments that can be billed to medical insurance or Medi-Cal.

(Dollars in Thousands)

FY 2023-24	TF	GF
Clinical Report (Assessment)	\$7,834	\$7,834
Court time	\$8,662	\$8,662
Total	\$16,496	\$16,496

Funding:

100% GF (4260-101-0001)

QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES

REGULAR POLICY CHANGE NUMBER: 194
IMPLEMENTATION DATE: 1/2023
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2329

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$72,322,000	\$252,590,000
- STATE FUNDS	\$10,848,000	\$37,889,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$72,322,000	\$252,590,000
STATE FUNDS	\$10,848,000	\$37,889,000
FEDERAL FUNDS	\$61,474,000	\$214,701,000

Purpose:

This proposal estimates the cost for counties to provide qualifying community-based mobile crisis intervention services to Medi-Cal beneficiaries in need of Medi-Cal 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, the Department is responsible for administering the Medi-Cal Specialty Mental Health Services (SMHS) Waiver Program that provides SMHS to Medi-Cal beneficiaries through county Mental Health Plans (MHPs). The Department is also responsible for administering substance used disorder (SUD) treatment services through the Drug Medi-Cal Organized Delivery System (DMC-ODS), and the Drug Medi-Cal (DMC) program, for counties not participating in the DMC-ODS.

Crisis intervention services is a current benefit in SMHS, DMC-ODS, and DMC, and counties are required to provide or arrange the services anywhere in the community. However, these services are not currently required to be provided or arranged as "mobile" services, nor are they required to be available in the community 24 hours a day, 7 days a week, with on-call, multidisciplinary teams. Additionally, as currently defined, crisis intervention services does not meet 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 in

QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES

REGULAR POLICY CHANGE NUMBER: 194

SMHS, DMC, and DMC-ODS, available to eligible Medi-Cal beneficiaries, statewide, 24 hours a day, 7 days a week, implemented through the Medi-Cal behavioral health delivery systems by multidisciplinary mobile crisis teams in the community. The Department will develop statewide standards for the new service, including requirements for the multidisciplinary team. 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.

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 behavioral health services meet the federal definition of a qualifying community-based mobile crisis intervention services.

Reason for Change:

There reason for change from the prior estimate for FY 2022-23, is a decrease due to refining the estimate to include a ramp-up of services starting in January 2023.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to projecting the full implementation of services by July 2023.

Methodology:

1. 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.
2. 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, as we expect these calls to be less frequent. (Most SUD-related calls will be due to an overdose, where a paramedic is the appropriate response.) Assume the split between DMC ODS and DMC State Plan counties is 80% and 20%, respectively.
3. 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.

QUALIFYING COMMUNITY-BASED MOBILE CRISIS SERVICES

REGULAR POLICY CHANGE NUMBER: 194

4. Assume the delivery of services will increase by 20% per month, for January 2023 through June 2023, due to roll-out. The accrual estimates for FY 2022-23 and FY 2023-24 are:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Mobile crisis intervention – SMHS	\$98,131	\$14,720	\$83,411
Mobile crisis intervention – DMC-ODS	\$7,850	\$1,177	\$6,673
Mobile crisis intervention – DMC State Plan	\$1,963	\$295	\$1,668
Total	\$107,944	\$16,192	\$91,752

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Mobile crisis intervention – SMHS	\$294,392	\$44,159	\$250,233
Mobile crisis intervention – DMC-ODS	\$23,551	\$3,533	\$20,018
Mobile crisis intervention – DMC State Plan	\$5,888	\$883	\$5,005
Total	\$323,831	\$48,575	\$275,256

5. 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 estimates for FY 2022-23 and FY 2023-24 are:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Mobile crisis intervention – SMHS	\$65,747	\$9,862	\$55,885
Mobile crisis intervention – DMC-ODS	\$5,260	\$789	\$4,471
Mobile crisis intervention – DMC State Plan	\$1,315	\$197	\$1,118
Total	\$72,322	\$10,848	\$61,474

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Mobile crisis intervention – SMHS	\$229,626	\$34,444	\$195,182
Mobile crisis intervention – DMC-ODS	\$18,371	\$2,756	\$15,615
Mobile crisis intervention – DMC State Plan	\$4,593	\$689	\$3,904
Total	\$252,590	\$37,889	\$214,701

Funding:

85% Title XIX FF / 15% GF (4260-101-0001/0890)

CLINIC WORKFORCE STABILIZATION RETENTION PROGRAM

REGULAR POLICY CHANGE NUMBER: 195
IMPLEMENTATION DATE: 7/2022
ANALYST: Ryan Woolsey
FISCAL REFERENCE NUMBER: 2383

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$70,000,000	\$0
- STATE FUNDS	\$70,000,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$70,000,000	\$0
STATE FUNDS	\$70,000,000	\$0
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change budgets funding for the Clinic Workforce Stabilization Retention Program.

Authority:

AB 179 (Chapter 249, Statutes of 2022)

Interdependent Policy Changes:

Not Applicable

Background:

AB 179 provides \$70,000,000 from the General Fund for a Clinic Workforce Stabilization Retention Program beginning in FY 2022-23. Funding is available for expenditure through June 30, 2024. The Department expects to issue all payments in FY 2022-23. Per WIC 14199.72(h), any unexpected funds will be transferred to the Department of Health Access and Information to fund workforce development programs.

Reason for Change:

This is a new policy change.

Methodology:

- Assume \$70,000,000 from the General Fund will be provided in FY 2022-23. The table below displays the estimated spending and remaining funds by Appropriation Year:

	TF	GF
Appropriation Year 2022-23		
Estimated in FY 2022-23	\$70,000,000	\$70,000,000
Estimated in FY 2023-24	\$0	\$0
Total Estimated Remaining	\$0	\$0

Funding:

100% GF (4260-101-0001)

INDIAN HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 196
IMPLEMENTATION DATE: 4/1998
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 111

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$64,061,000	\$55,056,000
- STATE FUNDS	\$21,353,500	\$18,352,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	2.25 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$62,619,600	\$55,056,000
STATE FUNDS	\$20,873,050	\$18,352,000
FEDERAL FUNDS	\$41,746,580	\$36,704,000

Purpose:

This policy change estimates the annual rate change posted in the Federal Register for services in Indian Health facilities.

Authority:

Public Law 93-638
Public Law 102-573 (Title 25, U.S.C. 1665c)

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS

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: 196

Reason for Change:

There is no substantive change from the prior estimate for FY 2022-23. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to a lower projected rate increase in calendar year (CY) 2023 versus CY 2022.

Methodology:

1. Effective CY 2022, the updated per visit rate payable to the Indian health clinics increased by \$121, from \$519 to \$640. The annual rate increase for the additional \$121 is estimated at \$35,298,000 TF.
2. It is estimated, effective CY 2023, the updated per visit rate payable to the Indian health clinics will increase by \$43, from \$640 to \$683. The annual rate increase for the additional \$43 is estimated at \$13,171,000 TF.
3. It is estimated, effective CY 2024, the updated per visit rate payable to the Indian health clinics will increase by \$46, from \$683 to \$729. The annual rate increase for the additional \$46 is estimated at \$14,795,000 TF.
4. On a cash basis, the FY 2022-23 and FY 2023-24 estimates are:

Rate Increase	FY 2022-23	FY 2023-24
CY 2021 Rate Increase	\$11,113,200	\$0
CY 2022 Rate Increase	\$29,415,302	\$35,298,362
CY 2023 Rate Increase	\$0	\$13,171,244
Retro Jan-Aug 2022 Incr.	\$23,532,241	\$0
Retro Jan-June 2023 Incr.	\$0	\$6,586,000
Total Rate Increase	\$64,061,000	\$55,056,000

Fiscal Year	TF	GF	FF
FY 2022-23	\$64,061,000	\$21,354,000	\$42,707,000
FY 2023-24	\$55,056,000	\$18,352,000	\$36,704,000

*Totals may differ due to rounding.

Funding:

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

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

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

REGULAR POLICY CHANGE NUMBER: 198
IMPLEMENTATION DATE: 6/2011
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1232

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$85,442,000	\$58,033,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$85,442,000	\$58,033,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$85,442,000	\$58,033,000

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:

Not Applicable

Background:

Beneficiaries that reside in ICF-DDs receive active treatment services from providers located off-site from the ICF-DD. The active treatment and transportation is currently arranged for and paid by the local Regional Centers, which in turn 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: 198

Reason for Change:

The change in FY 2022-23, from the prior estimate, is an increase due to a shift in payments for prior year expenditures from FY 2021-22 to FY 2022-23.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to the current trend usage of day program and transportation expenditures.

Methodology:

1. FY 2022-23 includes a portion of payments for FY 2020-21 and FY 2021-22 expenditures. FY 2023-24 includes a portion of payments for FY 2022-23 expenditures.
2. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2023, for this 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 2022-23	\$153,222	\$67,780	\$76,611	\$8,831	\$85,442
FY 2023-24	\$112,668	\$54,635	\$56,334	\$1,699	\$58,033

Funding:

100% Title XIX (4260-101-0890)

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

MHSF - PROVIDER ACES TRAININGS

REGULAR POLICY CHANGE NUMBER: 199
IMPLEMENTATION DATE: 7/2022
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2350

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$44,100,000	\$45,500,000
- STATE FUNDS	\$22,050,000	\$22,750,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$44,100,000	\$45,500,000
STATE FUNDS	\$22,050,000	\$22,750,000
FEDERAL FUNDS	\$22,050,000	\$22,750,000

Purpose:

This policy change estimates the cost to train providers on delivering Adverse Childhood Experiences (ACEs) screenings funded with Mental Health Services Funds (MHSF).

Authority:

AB 178 (Chapter 45, Statutes 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 MHSF. A total of \$135.1 million TF (\$67.55 million MHSF) is estimated over a three-year period with \$44.1 million TF (\$22.05 million MHSF) in FY 2022-23, \$45.5 million TF (\$22.75 MHSF) in FY 2023-24, and \$45.5 million TF (\$22.75 million MHSF) in FY 2024-25.

See the Prop 56 – Provider ACEs Trainings policy change for the training costs funded with Proposition 56 funds.

Reason for Change:

There is no change in FY 2022-23 from the prior estimate.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to a slight increase in the appropriation funded with MHSF in FY 2023-24.

MHSF - PROVIDER ACES TRAININGS

REGULAR POLICY CHANGE NUMBER: 199

Methodology:

1. The table below displays the estimated spending and remaining funds by Appropriation Year.

	TF	MHSF	FF*
Appropriation Year 2022-23			
Estimated in FY 2022-23	\$44,100,000	\$22,050,000	\$22,050,000
Estimated in FY 2023-24	\$0	\$0	\$0
Total Estimated Remaining	\$0	\$0	\$0
Appropriation Year 2023-24			
New in FY 2023-24	\$45,500,000	\$22,750,000	\$22,750,000

2. The provider trainings costs, funded with MHSF, are estimated to be \$44,100,000 TF (\$22,050,000 SF) in FY 2022-23 and \$45,500,000 TF (\$22,750,000 SF) in FY 2023-24.

FY 2022-23	TF	MHSF	FF*
Appropriation Year 2022-23	\$44,100,000	\$22,050,000	\$22,050,000
Total FY 2022-23	\$44,100,000	\$22,050,000	\$22,050,000

FY 2023-24	TF	MHSF	FF*
Appropriation Year 2023-24	\$45,500,000	\$22,750,000	\$22,750,000
Total FY 2023-24	\$45,500,000	\$22,750,000	\$22,750,000

*Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.

Funding:

Mental Health Services Fund (4260-101-3085)
100% Title XIX (4260-101-0890)

MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG

REGULAR POLICY CHANGE NUMBER: 200
IMPLEMENTATION DATE: 7/2019
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 2097

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$42,028,000	\$52,466,000
- STATE FUNDS	\$42,028,000	\$52,466,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$42,028,000	\$52,466,000
STATE FUNDS	\$42,028,000	\$52,466,000
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the cost of the Medi-Cal Physicians and Dentists Loan Repayment Program.

Authority:

SB 170 (Chapter 240, Statutes of 2021)
 Welfare & Institutions Code Section 14114
 Revenue & Taxation Code Section 31005
 Contract 18-95474

Interdependent Policy Changes:

Not Applicable

Background:

SB 840 (Chapter 29, Statutes of 2018) appropriated \$220 million in 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.

SB 89 (Chapter 2, Statutes of 2020) appropriated an additional \$120 million in funding and made the combined \$340 million available until June 30, 2029. SB 170 (Chapter 240, Statutes of 2021) transferred the balance of these appropriations to the Loan Repayment Program Account, Healthcare Treatment Fund.

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.

AB 186 (Chapter 46, Statutes of 2022) allocates a portion of remitted amounts of funds collected when Medi-Cal managed care plans do not comply with a minimum 85% medical loss ratio consistent with federal requirements to the program.

MEDI-CAL PHY. & DENTISTS LOAN REPAYMENT PROG

REGULAR POLICY CHANGE NUMBER: 200

The Department has contracted with Physicians for a Healthy California to implement and administer the Medi-Cal Physicians and Dentists Loan Repayment Program pursuant to Welfare and Institutions Code section 14114(g).

Reason for Change:

The change from the previous estimate, for FY 2022-23, is an increase due to updated loan repayment data. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to Cohort 4 beginning payments in FY 2023-24.

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. Cohort 4 is expected to receive \$12.8 million each year for 5 years, with payment beginning in FY 2023-24.
- Awardee payments are issued retrospectively and annually for five years for each Cohort and once the awardees annual review is complete and indicates they are within compliance per the program administrator. Due to some CalHealthCares awardees also receiving retroactive Public Student Loan Forgiveness (PSLF), some CalHealthCares awardees will be returning all or a portions of their CalHealthCares award amounts back to the Department.
- The contract for the administrative costs is approximately \$1.6 million in FY 2022-23 and \$1.7 million FY 2023-24, with the payments being retrospective and invoices processed the month after services have been provided.

Fiscal Years	TF	SF
FY 2022-23	\$42,028,000	\$42,028,000
FY 2023-24	\$52,466,000	\$52,466,000

Funding:

100% Medi-Cal Loan Repayment Program (4260-101-3375)

100% Medi-Cal Loan Repayment Program (4260-601-3375)

SELF-DETERMINATION PROGRAM - CDDS

REGULAR POLICY CHANGE NUMBER: 201
IMPLEMENTATION DATE: 7/2020
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2208

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$86,758,000	\$140,689,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$86,758,000	\$140,689,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$86,758,000	\$140,689,000

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 & Institutions (W&I) Code Section 4585.8
 Interagency Agreement (IA) 19-96260

Interdependent Policy Changes:

Not Applicable

Background:

CDDS, under a federal Home and Community Based Services (HCBS) 1915 (c) waiver, offers and arranges for non-State Plan Medicaid services via the Regional Center system. The SDP 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.

SELF-DETERMINATION PROGRAM - CDDS

REGULAR POLICY CHANGE NUMBER: 201

Reason for Change:

The change in FY 2022-23, from the prior estimate, is due to an increase in prior year invoices due to CDDS releasing a number of invoices that was previously held due to unresolved billing and coding issues.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to an estimated growth in enrollees in FY 2023-24.

Methodology:

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	DHCS FFP
FY 2022-23	\$173,516	\$86,758	\$86,758
FY 2023-24	\$281,377	\$140,688	\$140,689

Funding:

100% Title XIX (4260-101-0890)

EVIDENCE-BASED DENTAL PRACTICES

REGULAR POLICY CHANGE NUMBER: 202
IMPLEMENTATION DATE: 7/2022
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2322

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$30,814,000	\$33,421,000
- STATE FUNDS	\$9,699,500	\$10,348,250
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$30,814,000	\$33,421,000
STATE FUNDS	\$9,699,500	\$10,348,250
FEDERAL FUNDS	\$21,114,500	\$23,072,750

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:

Welfare & Institutions (W&I) Code Section 14132.88(c)
SB 184 (Chapter 47, Statutes of 2022)

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS

Background:

Senate Bill 184 (Chapter 47, Statutes of 2022) amended W&I Code Section 14132.88(c) to reflect coverage of evidence-based dental practices consistent with the American Academy of Pediatric Dentistry (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:

The change from the previous estimate, for FY 2022-23, is a decrease due to updated data and a reduction in estimated Dental Managed Care (DMC) costs. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to a full year of DMC costs and a retroactive DMC payment for FY 2022-23.

EVIDENCE-BASED DENTAL PRACTICES

REGULAR POLICY CHANGE NUMBER: 202

Methodology:

1. Cost estimates for this benefit were developed using claims data from FY 2021-22.
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	\$29,812,000	\$9,450,000	\$20,361,000
Dental Managed Care	\$1,002,000	\$249,000	\$753,000
Total	\$30,814,000	\$9,699,000	\$21,114,000

FY 2023-24	TF	GF	FF
Fee-for-service	\$29,812,000	\$9,450,000	\$20,361,000
Dental Managed Care	\$3,609,000	\$897,000	\$2,711,000
Total	\$33,421,000	\$10,347,000	\$23,072,000

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)

65% Title XXI / 35% GF (4260-101-0890/0001)

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

HCBS SP - CALBRIDGE BH NAVIGATOR PROGRAM

REGULAR POLICY CHANGE NUMBER: 203
IMPLEMENTATION DATE: 4/2022
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2318

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$29,651,000	\$1,296,000
- STATE FUNDS	\$29,651,000	\$1,296,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$29,651,000	\$1,296,000
STATE FUNDS	\$29,651,000	\$1,296,000
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the costs for the CalBridge Behavioral Health Navigator 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 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 Navigator 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 NAVIGATOR PROGRAM

REGULAR POLICY CHANGE NUMBER: 203

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a decrease based on actual monthly deliverables.

The change in the current estimate, from FY 2022-23 to FY 2023-24, is due to a decrease in payments incurring in FY 2023-24 because of the \$40 million allocation cap and no payments for direct services costs in FY 2023-24.

Methodology:

1. The Department entered into a contract with Public Health Institute (PHI), current administrator of the California Bridge Program, in FY 2021-22, and PHI serves as an administrative and technical assistance (TA) entity for the CalBridge Behavioral Health Navigator Program.
2. The total contract amount is \$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 Navigator Program, on a cash basis, is as follows:

(Dollars in Thousands)

FY 2022-23	TF	HCBS ARP Fund
PHI Contractor	\$2,151	\$2,151
Direct Services	\$27,500	\$27,500
Total	\$29,651	\$29,651

(Dollars in Thousands)

FY 2023-24	TF	HCBS ARP Fund
PHI Contractor	\$1,296	\$1,296
Direct Services	\$0	\$0
Total	\$1,296	\$1,296

Funding:

100% Home and Community-Based Services American Rescue Plan Fund (4260-101-8507)

INFANT DEVELOPMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 205
IMPLEMENTATION DATE: 7/2016
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2009

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$27,810,000	\$21,900,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$27,810,000	\$21,900,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$27,810,000	\$21,900,000

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:

Not Applicable

Background:

On October 9, 2015, State Plan Amendment (SPA) 11-040 was approved by the Centers for Medicare and Medicaid Services to extend Medi-Cal coverage for IDP services provided to Medi-Cal eligible infants and toddlers ages 0 to 3 with or at risk of developmental delay under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, retroactive to October 1, 2011. This SPA authorizes 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: 205

Reason for Change:

The change in FY 2022-23, from the prior estimate, is an increase due to a shift in payment of FY 2021-22 invoices to be paid in FY 2022-23.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to decreased eligible participant's enrolled compare to prior year.

Methodology:

1. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2023, for this 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 2022-23	\$49,483	\$21,693	\$24,742	\$3,068	\$27,810
FY 2023-24	\$42,587	\$21,294	\$21,293	\$607	\$21,900

Funding:

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

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

WATSONVILLE COMMUNITY HOSPITAL ACQUISITION

REGULAR POLICY CHANGE NUMBER: 206
IMPLEMENTATION DATE: 7/2022
ANALYST: Ryan Woolsey
FISCAL REFERENCE NUMBER: 2382

	FY 2022-23	FY 2023-24
FULL YEAR COST - TOTAL FUNDS	\$25,000,000	\$0
- STATE FUNDS	\$25,000,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$25,000,000	\$0
STATE FUNDS	\$25,000,000	\$0
FEDERAL FUNDS	\$0	\$0

Purpose:
 This policy change budgets funding for the County of Santa Cruz to support the Pajaro Valley Health Care District acquisition of Watsonville Community Hospital.

Authority:
 Budget Act of 2022

Interdependent Policy Changes:
 Not Applicable

Background:
 The Budget Act of 2022 provides funding for the County of Santa Cruz to support the Pajaro Valley Health Care District acquisition of Watsonville Community Hospital.

Reason for Change:
 This is a new policy change.

Methodology:

- The Budget Act of 2022 provides the funding below for FY 2022-23:

(Dollars in Thousands)

Fiscal Year	TF	GF
FY 2022-23	\$25,000	\$25,000

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

HCBS SP - ASSISTED LIVING WAIVER EXPANSION

REGULAR POLICY CHANGE NUMBER: 207
IMPLEMENTATION DATE: 10/2021
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2054

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$23,367,000	\$22,907,000
- STATE FUNDS	\$10,234,000	\$11,454,000
PAYMENT LAG	0.9970	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$23,296,900	\$22,907,000
STATE FUNDS	\$10,203,300	\$11,454,000
FEDERAL FUNDS	\$13,093,600	\$11,453,000

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)
 Families First Coronavirus Response Act (FFCRA), (P.L. 116-127), Section 6008

Interdependent Policy Changes:

American Rescue Plan Increased FMAP for HCBS

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 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). 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. States must expend the federal funds attributable to the increased FMAP by March 31, 2024.

On July 12, 2021, the Department submitted the Medicaid HCBS Spending Plan to the Centers for Medicare and Medicaid Services (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. On September 3, 2021, CMS responded to the Department's

HCBS SP - ASSISTED LIVING WAIVER EXPANSION

REGULAR POLICY CHANGE NUMBER: 207

plan, which included a request for more information. The Department submitted an updated plan on September 17, 2021. On January 4, 2022, CMS approved California's HCBS Spending Plan, including the ALW Waitlist Elimination initiative.

On October 27, 2021, the Department submitted an ALW technical amendment to increase the maximum number of waiver slots by 7,000 to CMS for approval. On January 7, 2022, CMS approved the amendment with a retroactive implementation date of July 1, 2021. CMS informed the Department that agencies could immediately start enrolling clients on the waitlist. As of June 2022, approximately 1,600 slots have been released for transitioning individuals for placement into the ALW.

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 2022-23, is a net decrease in costs due to revised ALW enrollment data, which decreased the average monthly enrollment. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease in net costs due to additional participants coming from the waitlist and transitioning into the ALW from a skilled nursing facility (SNF).

Methodology:

1. Assume 7,000 new participants will be transitioned.
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 SNF.
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. For FY 2022-23, assume CMS approves the amendment to remove the 60%/40% enrollment ratio.
5. Beginning January 1, 2023, assume an increase in ALW costs due to the minimum wage increase from \$15.00 to \$15.50 an hour. Beginning January 1, 2024, assume an increase in ALW costs due to the minimum wage increase from \$15.50 to \$16.00 per hour.
6. Assume an average of 78 participants will enroll per month.
7. Assume the average annual cost for waiver services is \$29,603.
8. Assume the average annual cost in an SNF is \$77,280.
9. Assume a 10% enhanced FMAP through March 31, 2024.

HCBS SP - ASSISTED LIVING WAIVER EXPANSION
REGULAR POLICY CHANGE NUMBER: 207

10. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2023 for this policy change.

(Dollars in Thousands)

FY 2022-23	TF	HCBS ARP Fund	GF	FF
Total Cost from Waiver Services	\$34,843	\$17,421	\$0	\$17,421
Total Savings from SNF Transitions	(\$11,476)	\$0	(\$5,738)	(\$5,738)
FFCRA 6.2% Increased FFP	\$0	(\$1,449)	\$0	\$1,449
Net Impact	\$23,367	\$15,972	(\$5,738)	\$13,132
FY 2023-24	TF	HCBS ARP Fund	GF	FF
Total Cost from Waiver Services	\$62,552	\$23,457	\$7,819	\$31,276
Total Savings from SNF Transitions	(\$39,645)	\$0	(\$19,822)	(\$19,823)
Net Impact	\$22,907	\$23,457	(\$12,003)	\$11,453

*Totals may differ due to rounding.

Funding:

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

Home and Community-Based Services American Rescue Plan Fund (4260-101-8507)

100% State GF (4260-101-0001)

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

CYBHI - CALHOPE STUDENT SUPPORT

REGULAR POLICY CHANGE NUMBER: 208
IMPLEMENTATION DATE: 12/2021
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2291

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$21,000,000	\$24,000,000
- STATE FUNDS	\$21,000,000	\$24,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$21,000,000	\$24,000,000
STATE FUNDS	\$21,000,000	\$24,000,000
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 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

CYBHI - CALHOPE STUDENT SUPPORT

REGULAR POLICY CHANGE NUMBER: 208

school staff, addressing the behavioral health challenges created by social isolation and the stress of the public health emergency.

Reason for Change:

The change in FY 2022-23, from the prior estimate, is due to funding shifting from FY 2021-22 to FY 2022-23 due to contracting delays.

The change from FY 2022-23 to FY 2023-24, 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 General Fund (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 2022-23, the Department will be paying \$21,000,000 GF, and \$24,000,000 GF in FY 2023-24, for the CalHOPE Student Support program.

(Dollars in Thousands)

CalHOPE Student Support Program	TF	GF
FY 2022-23	\$21,000	\$21,000
FY 2023-24	\$24,000	\$24,000

3. The table below displays the estimated spending and remaining funds by Appropriation Year:

(Dollars in Thousands)

	TF	GF
Appropriation Year 2021-22		
Prior Years	\$0	\$0
Estimated in FY 2022-23	\$21,000	\$21,000
Estimated in FY 2023-24	\$24,000	\$24,000
Total Estimated Remaining	\$0	\$0

4. The estimated costs in FY 2022-23 and FY 2023-24 are as follows:

(Dollars in Thousands)

FY 2022-23	TF	GF
Appropriation Year 2021-22	\$21,000	\$21,000
Total FY 2022-23	\$21,000	\$21,000

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(Dollars in Thousands)

FY 2023-24	TF	GF
Appropriation Year 2021-22	\$24,000	\$24,000
Total FY 2023-24	\$24,000	\$24,000

Funding:

100% Title XIX GF (4260-101-0001)

MINIMUM WAGE INCREASE FOR HCBS WAIVERS

REGULAR POLICY CHANGE NUMBER: 209
IMPLEMENTATION DATE: 1/2017
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1975

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$49,016,000	\$78,698,000
- STATE FUNDS	\$24,508,000	\$39,349,000
PAYMENT LAG	0.9258	0.9158
% REFLECTED IN BASE	54.32 %	45.33 %
APPLIED TO BASE		
TOTAL FUNDS	\$20,729,100	\$39,401,600
STATE FUNDS	\$10,364,570	\$19,700,780
FEDERAL FUNDS	\$10,364,570	\$19,700,780

Purpose:

This policy change estimates the costs of increasing the minimum wage for the Home and Community-Based Services (HCBS) providers.

Authority:

SB 3 (Chapter 4, Statutes of 2016)

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS

Background:

The passage of AB 10 in 2013 set the minimum wage in California to \$10 an hour after January 1, 2016. SB 3 requires a schedule for a phased increase in the minimum wage from \$10.50 per hour to \$15 per hour by January 1, 2022, or January 1, 2023, depending on the size of the employer and general economic conditions, and link the minimum wage to the U.S. Consumer Price Index once the minimum wage reaches \$15 per hour.

Beginning January 1, 2023, an additional set of minimum wage increases will phase in over a 5-year period from \$15 per hour to \$17 per hour by January 1, 2027.

The minimum wage increase will result in increased costs for multiple long term care programs. HCBS are predominantly provided by individuals working for minimum wage, and this increase will raise the overall cost of HCBS for the Assisted Living Waiver (ALW), Waiver Personal Care Services (WPCS), and Personal Care Agencies (PCA).

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.

The Home and Community-Based Alternatives (HCBA) Waiver provides care management services to persons at risk for nursing home or institutional placement. WPCS is a benefit under the HCBA Waiver and was designed to assist waiver participants with remaining safely in their

MINIMUM WAGE INCREASE FOR HCBS WAIVERS

REGULAR POLICY CHANGE NUMBER: 209

residence and continuing to be part of the community. A PCA is a provider that employs individuals who provide services and is enrolled as an HCBA provider in the HCBA Waiver.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a decrease due to a methodology revision that bases projections on actual caseload and expenditures. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to the increase in the minimum wage and in the caseload.

Methodology:

- Beginning January 1, 2022, the minimum wage increased from \$14.00 to \$15.00 per hour. Beginning January 1, 2023, the minimum wage will increase from \$15.00 to \$15.50 per hour. Beginning January 1, 2024, the minimum wage will increase from \$15.50 to \$16.00 per hour.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2022-23	\$49,016	\$24,508	\$24,508
FY 2023-24	\$78,698	\$39,349	\$39,349

Funding:

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

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

LOS ANGELES COUNTY REPRODUCTIVE HEALTH PILOT

REGULAR POLICY CHANGE NUMBER: 210
IMPLEMENTATION DATE: 7/2022
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 2376

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$20,000,000	\$0
- STATE FUNDS	\$20,000,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$20,000,000	\$0
STATE FUNDS	\$20,000,000	\$0
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the costs to establish the Abortion Access Safe Haven Pilot Program (AASHPP) in the County of Los Angeles.

Authority:

AB 178 (Chapter 45, Statutes of 2022)

Interdependent Policy Changes:

Not Applicable

Background:

Effective July 1, 2022, \$20,000,000 one-time General Fund is available to establish the Los Angeles AASHPP for the purpose of expanding and improving access to the full spectrum of sexual and reproductive health care, including abortion, in the County of Los Angeles.

Funds allocated to the County of Los Angeles for the Los Angeles County AASHPP shall be used to administer a pilot project to support innovative approaches and patient-centered collaborations to safeguard patient access to abortions.

Funds may be used for the purpose of implementing recommendations from the County of Los Angeles, including, but not limited to, any of the following, as designated by the county:

- Providing medically accurate education and training tools to the community.
- Providing training to health care workers and abortion providers.
- Building secure infrastructure.
- Countering misinformation campaigns and providing medically accurate information to health care providers and patients.
- Coordinating care and patient support services.
- Advancing and improving access to abortion.

LOS ANGELES COUNTY REPRODUCTIVE HEALTH PILOT

REGULAR POLICY CHANGE NUMBER: 210

Reason for Change:

There is no change from the prior estimate for FY 2022-23. There is a decrease for FY 2022-23 to FY 2023-24, in the current estimate, due to funds being disbursed in FY 2022-23 only.

Methodology:

1. Assume funding is available beginning July 1, 2022.
2. The Budget Act for FY 2022-23 provided \$20 million GF for this item, available through June 30, 2028. Assume AASHPP disbursements occur in FY 2022-23:

(Dollars in Thousands)

Appropriation Year 2022-23	TF	GF	FF
Estimated in FY 2022-23	\$20,000	\$20,000	\$0
Total Estimated Remaining	\$0	\$0	\$0

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Appropriation Year 2022-23	\$20,000	\$20,000	\$0
Total FY 2022-23	\$20,000	\$20,000	\$0

Funding:

Title XIX 100% GF (4260-101-0001)

PEER SUPPORT SPECIALIST SERVICES

REGULAR POLICY CHANGE NUMBER: 212
IMPLEMENTATION DATE: 7/2022
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2337

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$12,867,000	\$25,417,000
- STATE FUNDS	\$0	\$6,787,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$12,867,000	\$25,417,000
STATE FUNDS	\$0	\$6,787,000
FEDERAL FUNDS	\$12,867,000	\$18,630,000

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)
Families First Coronavirus Response Act (FFCRA)

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

PEER SUPPORT SPECIALIST SERVICES

REGULAR POLICY CHANGE NUMBER: 212

services as a Medi-Cal benefit. The bill also allows counties to establish certification fee 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.

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 2022-23, is a net decrease due to the following:

- This policy change assumes the FFCRA impact through the end of March 2023.
- Annual estimated cost assumptions decreased based on updated program information.

The change in the current estimate, from FY 2022-23 to FY 2023-24, is due to FY 2023-24 including the following:

- Prior year costs due to payment lags, and
- Addition of inter-governmental transfers (IGTs) for claims with dates of service of on or after July 1, 2023.

Methodology:

1. Peer support specialist services was implemented in July 2022.
2. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through March 31, 2023 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
3. The Department will implement the CalAIM Behavioral Health Payment Reform and a new IGT process. For all claims with dates of service of on or after July 1, 2023, counties will transfer the county portion of the submitted claims before FF can be used for payment.

PEER SUPPORT SPECIALIST SERVICES
REGULAR POLICY CHANGE NUMBER: 212

4. Effective July 1, 2023, non-federal share of costs that was initially funded with county funds (CF), will be funded through an IGT.
5. Total cost for both SMHS and DMC are as follows:

(Dollars in Thousands)

FY 2022-23	TF	IGT*	FF	FFCRA	CF
SMHS Interim Rate – Adult	\$6,686	\$0	\$4,404	\$188	\$2,094
SMHS Interim Rate - Children	\$5,956	\$0	\$3,187	\$256	\$2,513
Non-NTP DMC State Plan Interim Rate	\$399	\$0	\$284	\$9	\$106
Non-NTP DMC-ODS Interim Rate	\$5,819	\$0	\$4,477	\$62	\$1,280
Total	\$18,860	\$0	\$12,352	\$515	\$5,993

(Dollars in Thousands)

FY 2023-24	TF	IGT*	FF	FFCRA	CF
SMHS Interim Rate – Adult	\$10,996	\$2,336	\$7,281	\$0	\$1,379
SMHS Interim Rate - Children	\$9,433	\$2,945	\$4,923	\$0	\$1,565
Non-NTP DMC State Plan Interim Rate	\$537	\$118	\$383	\$0	\$36
Non-NTP DMC-ODS Interim Rate	\$7,855	\$1,388	\$6,043	\$0	\$424
Total	\$28,821	\$6,787	\$18,630	\$0	\$3,404

Funding:

100% Title XIX FF (4260-101-0890)
 100% Title XXI FF (4260-113-0890)
 100% Title XXI FF (4260-101-0890)
 100% ACA Title XIX FF (4260-101-0890)
 Medi-Cal County Behavioral Health Fund (4260-601-3420)*
 90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)
 FFCRA 6.2% Increased FFP (4260-101-0890)
 FFCRA 4.34% Increased FFP (4260-113-0890)

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

REGULAR POLICY CHANGE NUMBER: 213
IMPLEMENTATION DATE: 7/2010
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1526

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$15,281,000	\$7,786,000
- STATE FUNDS	\$6,985,000	\$3,561,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$15,281,000	\$7,786,000
STATE FUNDS	\$6,985,000	\$3,561,000
FEDERAL FUNDS	\$8,296,000	\$4,225,000

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: 213

Reason for Change:

The change in FY 2022-23, from the prior estimate, is a net increase due to a slight decrease from anticipated utilization of services for FY 2022-23 expenditures and increase in prior year expenditures.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to a slight decrease from anticipated utilization of services.

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 2022-23	\$1,311	\$6,985	16,592	\$1,311	\$6,985	\$8,296
FY 2023-24	\$662	\$3,561	\$8,448	\$662	\$3,561	\$4,225

Funding:

100% GF (4260-101-0001)

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

PACE INFRASTRUCTURE FUNDING

REGULAR POLICY CHANGE NUMBER: 214
IMPLEMENTATION DATE: 7/2022
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2377

	<u>FY 2022-23</u>	<u>FY 2023-24</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 for health information technology, housing, or wellness infrastructure projects for the St. Paul's Program for All-Inclusive Care for the Elderly (PACE) organization in San Diego.

Authority:

AB 178 (Chapter 45, Statutes of 2022)

Interdependent Policy Changes:

Not Applicable

Background:

The PACE program is a capitated benefit that provides a comprehensive medical/social delivery system. Services are provided in a PACE center to older adults who would otherwise reside in nursing facilities. To be eligible, a person must be 55 years or older, reside in a PACE service area, be determined eligible at the nursing home level of care by the Department, and be able to live safely in their home or community at the time of enrollment. PACE providers assume full financial risk for participants' care without limits on amount, duration, or scope of services.

The Department 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.

Reason for Change:

There is no change, from the prior estimate, for FY 2022-23. The change in the current estimate, from FY 2022-23 to FY 2023-24, is a decrease due to being a one-time funding.

Methodology:

1. Assume the cost for **FY 2022-23** is **\$10,000,000 GF**.

Funding:

Title XIX 100% GF (4260-101-0001)

ALAMEDA COUNTY SUPPORTIVE HOUSING

REGULAR POLICY CHANGE NUMBER: 215
IMPLEMENTATION DATE: 5/2023
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2372

	<u>FY 2022-23</u>	<u>FY 2023-24</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 costs of the payment to the Alameda County Health Care Services Agency to fund supportive services provided to chronically homeless and special needs residents.

Authority:

SB 154 (Chapter 43, Statutes of 2022)

Interdependent Policy Changes:

Not Applicable

Background:

SB 154 provides for a one-time payment to the Alameda County Health Care Services Agency to fund support services for chronically homeless and special needs residents.

Reason for Change:

There is no change in FY 2022-23 from the prior estimate.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to the completion of the one-time payment in FY 2022-23.

Methodology:

1. Assume a one-time payment to the Alameda County Health Care Services Agency will occur in FY 2022-23 for \$10 million General Fund (GF).

(Dollars in Thousands)

FY 2022-23	TF	GF
Alameda County Supportive Housing	\$10,000	\$10,000
Total	\$10,000	\$10,000

Funding:

100% GF (4260-101-0001)

BACKFILL LOST TITLE X FAMILY PLANNING FUNDING

REGULAR POLICY CHANGE NUMBER: 216
IMPLEMENTATION DATE: 7/2022
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 2374

	<u>FY 2022-23</u>	<u>FY 2023-24</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 costs to backfill the loss of federal Title X funding for family planning.

Authority:

AB 179 (Chapter 249, Statutes of 2022)

Interdependent Policy Changes:

Not Applicable

Background:

Effective July 1, 2022, \$10,000,000 one-time General Fund is available to backfill the loss of federal Title X family planning funding to maintain and support the delivery of equitable, affordable, high quality, client-centered family planning services to patients with low-incomes across the state.

The Department shall receive and provide the funds to Essential Access Health (EAH), the designated statewide federal Title X grantee, no later than September 30, 2022.

1. Funding provided to EAH may be used for the following purposes:
 - Meetings between parties at the beginning of a project.
 - Facilitating the subcontract agreement and transfer of funds to EAH from the Department.
 - Distributing funds to current members of the state's statewide federal Title X network to make up for the unexpected loss of federal funding and prevent any disruption in the delivery of family planning and related services during FY 2022-23.
 - Drafting and submission of a final report.
2. EAH shall prepare and submit a report of expenditures, numbers of patient served, and other information that aligns with Title X Family Planning Annual Report requirements and guidelines, to the Department no later June 1, 2023.
3. The Department shall submit the report to the Legislature no later than June 30, 2023.

BACKFILL LOST TITLE X FAMILY PLANNING FUNDING

REGULAR POLICY CHANGE NUMBER: 216

Distribution for the allocated funds is as follows: 92% is for members of the current statewide Title X provider network that includes federally qualified health centers, city and county health departments, Urban Indian Health Centers, universities, hospitals, Planned Parenthood affiliates, and other stand-alone family planning and women's health centers; and 8% is for EAH to cover administrative costs related to completing the activities outlined above.

Reason for Change:

There is no change from the prior estimate for FY 2022-23. There is a decrease for FY 2022-23 to FY 2023-24, in the current estimate, due to a one-time payment being disbursed in FY 2022-23 only.

Methodology:

1. Assume the Department will provide all funding to EAH by September 30, 2022.
2. Assume 92% of funds will be allocated to the current statewide Title X provider network and 8% of funds will be allocated to EAH for administrative costs.
3. Assume a one-time payment for **\$10,000,000 GF** occurs in **FY 2022-23**.

Funding:

Title XIX 100% GF (4260-101-0001)

HCBS SP - NON-IHSS CARE ECONOMY PMTS

REGULAR POLICY CHANGE NUMBER: 217
IMPLEMENTATION DATE: 1/2023
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2314

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$12,250,000	\$0
- STATE FUNDS	\$5,365,000	\$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	\$5,365,000	\$0
FEDERAL FUNDS	\$6,885,000	\$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) during the specific timeframe of at least two months between March 2020 and March 2021.

Authority:

American Rescue Plan (ARP) Act of 2021
Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

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. States must expend the federal funds attributable to the increased FMAP by March 31, 2024.

On July 12, 2021, the Department submitted the Medicaid HCBS Spending Plan to the Centers for Medicare & Medicaid Services (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. On September 3, 2021, CMS responded to the Department's plan, which included a request for more information. The Department submitted a further updated plan on September 17, 2021. On January 4, 2022, CMS approved California's HCBS Spending Plan, including the Non-IHSS Care Economy Payments initiative.

HCBS SP - NON-IHSS CARE ECONOMY PMTS

REGULAR POLICY CHANGE NUMBER: 217

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.

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 total funds from the prior estimate, for FY 2022-23. There is a state fund decrease for FY 2022-23, from the prior estimate, due to including FFCRA increased FMAP in this policy change. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to a one-time incentive payment to providers that the Department plans to process and pay by FY 2022-23.

Methodology:

1. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2023, for this policy change.
2. Assume a December 31, 2022, effective date.

Fiscal Year	TF	HCBS ARP Fund	FF
FY 2022-23	\$12,250,000	\$6,125,000	\$6,125,000
FFCRA 6.2% Increased FFP	\$0	(\$760,000)	\$760,000
FY 2022-23 Total	\$12,250,000	\$5,365,000	\$6,885,000

Funding:

100% Title XIX FFP (4260-101-0890)
 Home and Community-Based Services American Rescue Plan Fund (4260-101-8507)
 FFCRA 6.2% Increased FFP (4260-101-0890)

INFRASTRUCTURE PYMT FOR CLINIC ABORTION PROVIDERS

REGULAR POLICY CHANGE NUMBER: 219
IMPLEMENTATION DATE: 1/2023
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 2373

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$7,425,000	\$22,282,000
- STATE FUNDS	\$7,425,000	\$22,282,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$7,425,000	\$22,282,000
STATE FUNDS	\$7,425,000	\$22,282,000
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the supplemental payment program for nonhospital community clinics that incur significant costs associated with providing abortion services to Medi-Cal beneficiaries.

Authority:

AB 179 (Chapter 249, Statutes of 2022)

Interdependent Policy Changes:

Not Applicable

Background:

No earlier than January 1, 2023, the Department will make available supplemental payments to qualifying nonhospital community clinics that incur costs associated with providing abortion services to Medi-Cal beneficiaries.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a decrease due to updated payment timing. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to remaining funds being expended primarily in FY 2023-24.

Methodology:

1. Assume the policy implements no sooner than January 1, 2023, and all funding must be expended by June 30, 2024.
2. The Budget Act for FY 2022-23 includes \$14,849,000 GF for this item, available for expenditure through June 30, 2024. Additional funding is proposed for FY 2023-24. The table below displays the estimated spending and remaining funds by Appropriations Years:

INFRASTRUCTURE PYMT FOR CLINIC ABORTION PROVIDERS

REGULAR POLICY CHANGE NUMBER: 219

(Dollars in Thousands)

Appropriation Year 2022-23	TF	GF	FF*
Estimated in FY 2022-23	\$7,425	\$7,425	\$0
Estimated in FY 2023-24	\$7,424	\$7,424	\$0
Total Estimated Remaining	\$0	\$0	\$0
Appropriation Year 2023-24	TF	GF	FF*
New in FY 2023-24	\$14,858	\$14,858	\$0

* Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.

**Totals differ due to rounding.

3. The estimated costs in FY 2022-23 and FY 2023-24 are as follows:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF*
Appropriation Year 2022-23	\$7,425	\$7,425	\$0
Total FY 2022-23	\$7,425	\$7,425	\$0
FY 2023-24	TF	GF	FF*
Appropriation Year 2022-23	\$7,424	\$7,424	\$0
Appropriation Year 2023-24	\$14,858	\$14,858	\$0
Total FY 2023-24	\$22,282	\$22,282	\$0

*Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.

** Totals differ due to rounding.

Funding:

100% GF (4260-101-0001)

PROP 56 - PROVIDER ACES TRAININGS

REGULAR POLICY CHANGE NUMBER: 220
IMPLEMENTATION DATE: 12/2019
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2138

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$7,100,000	\$0
- STATE FUNDS	\$3,550,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$7,100,000	\$0
STATE FUNDS	\$3,550,000	\$0
FEDERAL FUNDS	\$3,550,000	\$0

Purpose:

This policy change estimates the cost to train providers on delivering Adverse Childhood Experiences (ACEs) screenings.

Authority:

Budget Act of 2022

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. Future funding will be through the Mental Health Services Fund (MHSF). See the MHSF Provider ACES Training policy change for training costs funded with the MHSF.

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.

Reason for Change:

There is no change in FY 2022-23, from the prior estimate.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to Proposition 56 Funding ending and will be funded through the MHSF.

PROP 56 - PROVIDER ACES TRAININGS
REGULAR POLICY CHANGE NUMBER: 220

Methodology:

1. Payments for ACEs provider trainings began in December 2019.
2. The table below displays the estimated spending and remaining funds by Appropriation Years:

	TF	GF	FF
Appropriation Year 2019-20			
Prior Years	\$111,093,000	\$55,546,000	\$55,547,000
Estimated in FY 2022-23	\$7,100,000	\$3,550,000	\$3,550,000
Estimated in FY 2023-24	\$0	\$0	\$0
Total Estimated Remaining	\$1,807,000	\$904,000	\$903,000

3. The provider trainings costs are estimated to be \$7,100,000 TF (\$3,550,000 GF) in FY 2022-23.

FY 2022-23	TF	GF	FF
Appropriation Year 2019-20	\$7,100,000	\$3,550,000	\$3,550,000
Total FY 2022-23	\$7,100,000	\$3,550,000	\$3,550,000

*Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.

Funding:

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

CALAIM - DENTAL INITIATIVES

REGULAR POLICY CHANGE NUMBER: 221
IMPLEMENTATION DATE: 1/2022
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2188

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$258,451,000	\$259,302,000
- STATE FUNDS	\$124,204,950	\$124,491,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	97.33 %	97.01 %
APPLIED TO BASE		
TOTAL FUNDS	\$6,900,600	\$7,753,100
STATE FUNDS	\$3,316,270	\$3,722,300
FEDERAL FUNDS	\$3,584,370	\$4,030,830

Purpose:

This policy change estimates the cost of the dental benefits and performance payments covered under the California Advancing and Innovating Medi-Cal (CalAIM) policy. These costs include the estimated performance 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:

SPA 21-0019

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS

Background:

Starting January 1, 2022, the CalAIM policy provides performance 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 as well as increase utilization for adults. In order to progress towards achieving that goal, the Department offers 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: 221

Reason for Change:

The change from the prior estimate, for FY 2022-23, is an increase due to updated data and an increase in Dental Managed Care eligibles. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to Dental Managed Care rates.

Methodology:

- For Preventive Services, a flat rate performance payment equivalent to 75% of the SMA will be paid for specific preventive services rendered.

FY 2022-23	TF	GF	FF
Fee-for-service	\$121,975,000	\$60,988,000	\$60,988,000
Dental Managed Care	\$4,953,000	\$1,669,000	\$3,284,000
Total	\$126,928,000	\$62,657,000	\$64,272,000

FY 2023-24	TF	GF	FF
Fee-for-service	\$121,975,000	\$60,987,000	\$60,988,000
Dental Managed Care	\$5,562,000	\$1,874,000	\$3,688,000
Total	\$127,537,000	\$62,861,000	\$64,676,000

- 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 2022-23	TF	GF	FF
Fee-for-service	\$45,355,000	\$18,822,000	\$26,533,000
Dental Managed Care	\$1,709,000	\$576,000	\$1,133,000
Total	\$47,064,000	\$19,398,000	\$27,666,000

FY 2023-24	TF	GF	FF
Fee-for-service	\$45,355,000	\$18,822,000	\$26,533,000
Dental Managed Care	\$1,919,000	\$647,000	\$1,273,000
Total	\$47,274,000	\$19,469,000	\$27,806,000

- 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. The performance payment is not applicable to dental managed care. The performance payment is not applicable to dental managed care.

FY 2022-23	TF	GF	FF
Fee-for-service	\$82,573,000	\$41,287,000	\$41,287,000
Dental Managed Care	\$0	\$0	\$0
Total	\$82,573,000	\$41,287,000	\$41,287,000

CALAIM - DENTAL INITIATIVES

REGULAR POLICY CHANGE NUMBER: 221

FY 2023-24	TF	GF	FF
Fee-for-service	\$82,573,000	\$41,287,000	\$41,287,000
Dental Managed Care	\$0	\$0	\$0
Total	\$82,573,000	\$41,287,000	\$41,287,000

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 2022-23	TF	GF	FF
Fee-for-service	\$1,636,000	\$780,000	\$856,000
Dental Managed Care	\$251,000	\$84,000	\$166,000
Total	\$1,887,000	\$864,000	\$1,022,000

FY 2023-24	TF	GF	FF
Fee-for-service	\$1,636,000	\$780,000	\$856,000
Dental Managed Care	\$281,000	\$95,000	\$187,000
Total	\$1,917,000	\$875,000	\$1,043,000

5. The CalAIM Dental rates portion of the Health Plan of San Mateo are estimated to be (for display purposes only):

	TF	GF	FF
FY 2022-23	\$885,000	\$403,000	\$482,000
FY 2023-24	\$926,000	\$419,000	\$506,000

6. On a cash basis, the FY 2022-23 and FY 2023-24 total costs are:

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF	\$229,379,000	\$114,690,000	\$114,690,000
ACA 90% FF / 10% GF	\$2,639,000	\$264,000	\$2,375,000
Title XXI 65% FF/35% GF	\$26,433,000	\$9,252,000	\$17,182,000
Total	\$258,451,000	\$124,206,000	\$134,247,000

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF	\$229,846,000	\$114,923,000	\$114,923,000
ACA 90% FF / 10% GF	\$2,964,000	\$296,000	\$2,668,000
Title XXI 65% FF/35% GF	\$26,492,000	\$9,272,000	\$17,220,000
Total	\$259,302,000	\$124,491,000	\$134,811,000

*Totals may differ due to rounding.

CALAIM - DENTAL INITIATIVES
REGULAR POLICY CHANGE NUMBER: 221

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 (4260-113-0001/0890)

65% Title XXI / 35% GF (4260-101-0001/0890)

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

QAF WITHHOLD TRANSFER

REGULAR POLICY CHANGE NUMBER: 222
IMPLEMENTATION DATE: 7/2017
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2092

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$2,877,000	\$2,238,000
- STATE FUNDS	\$817,500	\$1,119,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,877,000	\$2,238,000
STATE FUNDS	\$817,500	\$1,119,000
FEDERAL FUNDS	\$2,059,500	\$1,119,000

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.

QAF WITHHOLD TRANSFER

REGULAR POLICY CHANGE NUMBER: 222

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 2022-23, from the prior estimate, is due to:

- For HQAF, the estimate decreased due to FY 2021-22 withholds coming in lower than previously expected.
- For LTC QAF, the estimate increased due to the Prior Year Withhold Transfers at year end coming in higher than expected and decrease in the estimate for FY 2022-23 New Withhold Pending Transfer. The estimate for FY 2022-23 New Withhold Pending Transfer was revised downward due to the lower than expected average withholds for prior year.
- For GEMT, the changes are insignificant.

The change from FY 2022-23 to FY 2023-24, in the current estimate is due to:

- For HQAF, the prior year withhold transfers decreased in FY 2023-24 as the withhold transfer in FY 2022-23 is scheduled to occur later in the FY than the withhold transfer in FY 2023-24, resulting in additional weeks of withholds in FY 2023-24.
- For LTC QAF, the estimate decreased due to an expectation that there will be a decrease in withheld payments following the shift from FFS to managed care under CalAIM.
- For GEMT QAF, the estimate decreased due to prior year withhold transfers for FY 2022-23 coming in higher than previously expected.
- FFCRA increased FMAP estimated in FY 2022-23 in this policy change.

Methodology:

HQAF

1. Prior year FY 2021-22 HQAF withheld payments totaling \$1.17 million TF will be transferred in FY 2022-23.
2. An estimated \$1.29 million TF in HQAF withholds will occur in FY 2022-23. These withholds are pending transfer in the next FY and offsets a portion of the \$1.17 million HQAF withhold transfer.
3. An estimated \$1.29 million of FY 2022-23 HQAF withheld payments will be paid in FY 2023-24. This prior year withhold transfer is offset by \$1.95 million in withholds that are estimated to occur in FY 2023-24, but are pending transfer in FY 2024-25.

LTC QAF

4. Prior year FY 2021-22 LTC QAF withheld payments totaling \$8.74 million TF will be transferred in FY 2022-23.
5. An estimated \$5.77 million in LTC QAF withholds will occur in FY 2022-23. These withholds are pending transfer in the next FY and offsets a portion of the \$8.74 million LTC QAF withhold transfer.

QAF WITHHOLD TRANSFER
REGULAR POLICY CHANGE NUMBER: 222

6. An estimated \$5.77 million of FY 2022-23 LTC QAF withheld payments will be paid in FY 2023-24. This prior year withhold transfer is offset by \$2.89 million in withholds that are estimated to occur in FY 2023-24, but are pending transfer in FY 2024-25.

GEMT QAF

7. Prior year FY 2021-22 GEMT withheld payments totaling \$0.10 million TF will be transferred in FY 2022-23.
8. An estimated \$0.068 million in GEMT QAF withholds will occur in FY 2022-23. These withholds are pending transfer in the next FY and offsets a portion of the \$0.10 million GEMT QAF withhold transfer.
9. An estimated \$0.068 million of FY 2022-23 GEMT QAF withheld payments will be paid in FY 2023-24. This prior year withhold transfer is offset by \$0.068 million in withholds that are estimated to occur in FY 2023-24, but are pending transfer in FY 2024-25.

FFCRA

10. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through March 31, 2023, for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.

(Dollars in Thousands)

FY 2022-23	TF	GF	FF	FFCRA
HQAF				
HQAF Prior Year Withhold Transfers	\$1,171	\$513	\$585	\$73
HQAF FY 2022-23 New Withholds Pending Transfer	(\$1,298)	(\$649)	(\$649)	\$0
Subtotal HQAF for FY 2022-23	(\$127)	(\$136)	(\$64)	\$73
LTC QAF				
LTC QAF Prior Year Withhold Transfers	\$8,742	\$3,829	\$4,371	\$542
LTC QAF FY 2022-23 New Withholds Pending Transfer	(\$5,774)	(\$2,887)	(\$2,887)	\$0
Subtotal LTC QAF for FY 2022-23	\$2,968	\$942	\$1,484	\$542
GEMT QAF				
GEMT QAF Prior Year Withhold Transfers	\$104	\$46	\$52	\$6
GEMT QAF FY 2022-23 New Withholds Pending Transfer	(\$68)	(\$34)	(\$34)	\$0
Subtotal GEMT QAF for FY 2022-23	\$36	\$12	\$18	\$6
Total FY 2022-23	\$2,877	\$818	\$1,438	\$621

QAF WITHHOLD TRANSFER
REGULAR POLICY CHANGE NUMBER: 222

(Dollars in Thousands)

FY 2023-24	TF	GF	FF	FFCRA
HQAF				
HQAF Prior Year Withhold Transfers	\$1,298	\$649	\$649	\$0
HQAF FY 2023-24 New Withholds Pending Transfer	(\$1,948)	(\$974)	(\$974)	\$0
Subtotal HQAF for FY 2023-24	(\$650)	(\$325)	(\$325)	\$0
LTC QAF				
LTC QAF Prior Year Withhold Transfers	\$5,774	\$2,887	\$2,887	\$0
LTC QAF FY 2023-24 New Withholds Pending Transfer	(\$2,886)	(\$1,443)	(\$1,443)	\$0
Subtotal LTC QAF for FY 2023-24	\$2,888	\$1,444	\$1,444	\$0
GEMT QAF				
GEMT QAF Prior Year Withhold Transfers	\$68	\$34	\$34	\$0
GEMT QAF FY 2023-24 New Withholds Pending Transfer	(\$68)	(\$34)	(\$34)	\$0
Subtotal GEMT QAF for FY 2023-24	\$0	\$0	\$0	\$0
Total FY 2023-24	\$2,238	\$1,119	\$1,119	\$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)

FOSTER YOUTH SUBSTANCE USE DISORDER GRANT PROGRAM

REGULAR POLICY CHANGE NUMBER: 223
IMPLEMENTATION DATE: 2/2023
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2371

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$1,500,000	\$3,500,000
- STATE FUNDS	\$1,500,000	\$3,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,500,000	\$3,500,000
STATE FUNDS	\$1,500,000	\$3,500,000
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the cost of the Foster Youth Substance Use Disorder (SUD) Evidence-Based and Promising Practices grant program.

Authority:

AB 179 (Chapter 249, Statutes of 2022)

Interdependent Policy Changes:

Not Applicable

Background:

The Budget Act of 2022 provides \$5 million General Fund for the Department to implement the Foster Youth SUD Evidence-Based and Promising Practices Program to serve foster youth with substance used disorders, including those who are residing in family-based settings.

In establishing the grant program, the Department will:

- Develop an application process for eligible applicants, which includes county child welfare agencies, county probation agencies, county behavioral health agencies, foster family agencies, short term residential therapeutic programs, and wraparound service providers;
- Develop criteria for awarding funding which includes establishing requirements for models and practices that have at the minimum:
 - Trauma-informed approaches to serving foster youth,
 - Harm-reduction approaches in service delivery,
 - Post treatment support planning, and
 - Training for clinical service providers to support foster youth with co-occurring substance use and mental health needs.
- Require grantees to collect data relating to the models and practices; and
- Require grantees to submit reports, including reports that address the grantee's implementation activities, the number and characteristics of youth served, and completion rates, and an outcome report.

FOSTER YOUTH SUBSTANCE USE DISORDER GRANT PROGRAM

REGULAR POLICY CHANGE NUMBER: 223

Reason for Change:

The change from the prior estimate for FY 2022-23, is due to a shift from a one-time lump sum payment in FY 2022-23, to incremental payments based on deliverables over two years.

The change in the current estimate, from FY 2022-23 to FY 2023-24, is due to FY 2023-24 including an increased ramped-up cost for a full year.

Methodology:

1. Assume the Department will enter into a contract to administer the grant program in December 2022 with payments starting in February 2023.
2. The Budget Act for FY 2022-23 provides \$5 million GF for this item, available for expenditure through June 30, 2025. The table below displays the estimated spending and remaining funds by Appropriation Year:

(Dollars in Thousands)

	TF	GF
Appropriation Year 2022-23		
Estimated in FY 2022-23	\$1,500	\$1,500
Estimated in FY 2023-24	\$3,500	\$3,500
Total Estimated Remaining	\$0	\$0

3. The estimated costs in FY 2022-23 and FY 2023-24 are as follows:

(Dollars in Thousands)

FY 2022-23	TF	GF
Appropriation Year 2022-23	\$1,500	\$1,500
Total FY 2022-23	\$1,500	\$1,500

FY 2023-24	TF	GF
Appropriation Year 2022-23	\$3,500	\$3,500
Total FY 2023-24	\$3,500	\$3,500

Funding:

100% GF (4260-101-0001)

CLPP FUND

REGULAR POLICY CHANGE NUMBER: 224
IMPLEMENTATION DATE: 7/2005
ANALYST: Erik Stacey
FISCAL REFERENCE NUMBER: 1633

	FY 2022-23	FY 2023-24
FULL YEAR COST - TOTAL FUNDS	\$902,000	\$902,000
- STATE FUNDS	\$902,000	\$902,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$902,000	\$902,000
STATE FUNDS	\$902,000	\$902,000
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: 224

The 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 four-year agreement provides for annual costs.

Reason for Change:

There is no significant change from the prior estimate for FY 2022-23 and there is no change between fiscal years in the current estimate.

Methodology:

The CLPP Funding for FY 2022-23 and FY 2023-24 is assumed to be \$902,000.

Funding:

100% CLPP Fund (4260-101-0080)

WPCS WORKERS' COMPENSATION

REGULAR POLICY CHANGE NUMBER: 225
IMPLEMENTATION DATE: 11/2016
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1866

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$620,000	\$620,000
- STATE FUNDS	\$310,000	\$310,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$620,000	\$620,000
STATE FUNDS	\$310,000	\$310,000
FEDERAL FUNDS	\$310,000	\$310,000

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) 22-20032

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS

Background:

The WPCS benefit is designed to assist the Home and Community-Based Alternatives Waiver participant in gaining independence in his or her activities of daily living and preventing social isolation. These services assist the waiver participant in remaining in his or her residence and continuing to be part of the community. A waiver participant must be enrolled in and receiving personal care services through the federally funded State Plan Personal Care Services program in order to be eligible for WPCS benefits. WPCS providers receive payment via the Case Management Information Payrolling System. The California Department of Social Services (CDSS) pays for the insurance claims for the WPCS providers and the Department reimburses CDSS for the costs. The current Workers' Compensation contract, IA 22-20032, was implemented effective July 1, 2022. The contract will be an evergreen contract and can only be terminated by CDSS or the Department.

Reason for Change:

There is no change from the prior estimate, for FY 2022-23. There is no change from FY 2022-23 to FY 2023-24, in the current estimate.

Methodology:

1. The Department will reimburse CDSS monthly for the costs of any WPCS program worker's compensation claims filed by eligible WPCS providers.

WPCS WORKERS' COMPENSATION

REGULAR POLICY CHANGE NUMBER: 225

2. 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.
3. 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.
4. Based on data provided by the CDSS, the total cost to be paid for workers' compensation is \$620,000 TF in FY 2022-23 and FY 2023-24.

Fiscal Year	TF	GF	FF
FY 2022-23	\$620,000	\$310,000	\$310,000
FY 2023-24	\$620,000	\$310,000	\$310,000

Funding:

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

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

HCBS SP - ETSB FOR LAGUNA HONDA HOSPITAL RESIDENTS

REGULAR POLICY CHANGE NUMBER: 227
IMPLEMENTATION DATE: 7/2022
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2393

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$600,000	\$0
- STATE FUNDS	\$600,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$600,000	\$0
STATE FUNDS	\$600,000	\$0
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the cost to provide Enhanced Transition Service Bundles (ETSB) to Laguna Honda Hospital (LHH) residents who need “bridge services” to support safe and sustainable transfers to alternate settings.

Authority:

American Rescue Plan (ARP) 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 HCBS American Rescue Plan Fund.

On July 12, 2021, the Department submitted the Medicaid HCBS Spending Plan to the Centers for Medicare and Medicaid Services (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. On September 3, 2021, CMS responded to the Department’s plan, which included a request for more information. The Department submitted a further updated plan on September 17, 2021. On January 4, 2022, CMS approved California’s HCBS Spending Plan.

HCBS SP - ETSB FOR LAGUNA HONDA HOSPITAL RESIDENTS

REGULAR POLICY CHANGE NUMBER: 227

On July 22, 2022, the Department received approval from CMS to amend California’s HCBS Spending Plan and utilize section 9817 funding to provide ETSBs to LHH residents who need “bridge services” to transition from LHH to community-based placements and enrollment into a Medi-Cal Managed Care Plan, HCBS Waiver, Program of All-Inclusive Care for the Elderly, In-Home Supportive Services, etc. The intent of the service bundles is to combine intensive care management and housing navigation services to facilitate safe and sustainable transitions and continued access to care, for an extremely vulnerable population with complex care needs. If these services are not provided, some of the State’s most vulnerable residents could experience limited access to essential services, homelessness, reduced quality of life, and other adverse events, including death.

Reason for Change:

This is a new policy change.

Methodology:

1. Assume a September 1, 2022, effective date.

Fiscal Year	TF	HCBS ARP Fund	FF
FY 2022-23	\$600,000	\$600,000	\$0

Funding:

Home and Community-Based Services American Rescue Plan Fund (4260-101-8507)

CALAIM - BH PAYMENT REFORM

REGULAR POLICY CHANGE NUMBER: 228
IMPLEMENTATION DATE: 7/2023
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2386

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$375,000,000
- STATE FUNDS	\$0	\$375,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$375,000,000
STATE FUNDS	\$0	\$375,000,000
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change provides one-time General Funds (GF) to initially fund the non-federal share of behavioral health-related services at the start of the CalAIM Behavioral Health (BH) Payment Reform implementation.

Authority:

Budget Act of 2023

Interdependent Policy Changes:

Not Applicable

Background:

The Short-Doyle Medi-Cal (SD/MC) claims payment system processes the fee-for-service claims, that include Drug Medi-Cal (DMC) State Plan, Drug Medi-Cal Organized Delivery System (DMC ODS), and Specialty Mental Health Services (SMHS). Currently, counties are reimbursed for these programs through the interim rate payment process according to Medicaid Certified Public Expenditure (CPE) methodologies. The county reimbursements are later reconciled through cost settlements.

As the Department implements the CalAIM BH payment reform and the new Intergovernmental Transfer (IGT) process in FY 2023-24, counties will need to transfer the county portion of the submitted claims before Federal Financial Participation can be used for payment. Counties have raised concerns that the IGT process will create a significant cash flow issue for counties.

To address the counties' cash flow concerns, initial one-time GF will be transferred to the Medi-Cal County Behavioral Health Fund to provide counties support for the non-federal share of behavioral health-related services at the start of the CalAIM BH payment reform implementation, effective July 1, 2023. The GF will be used as the non-federal share for direct services payments in lieu of intergovernmental transfers (IGTs) during the first ninety (90) days of the BH payment reform implementation. After the first ninety days or when the \$375,000,000 is exhausted, counties will begin reimbursing the state using intergovernmental transfers on an ongoing basis.

CALAIM - BH PAYMENT REFORM

REGULAR POLICY CHANGE NUMBER: 228

Reason for Change:

This is a new policy change.

Methodology:

1. Assume a one-time \$375,000,000 GF appropriation to the Medi-Cal County Behavioral Health Fund in FY 2023-24.
2. Funds will be allocated to SMHS Mental Health Plans (MHP) and DMC county providers.
3. The estimated payments in FY 2023-24 are:

(Dollars in Thousands)

FY 2023-24	TF	SF*
CalAIM BH Payment Reform	\$375,000	\$375,000
Total	\$375,000	\$375,000

Funding:

100% General Fund* (4260-119-0001)

Medi-Cal County Behavioral Health Payment Reform (less funded by GF) (4260-695-3420)

Medi-Cal County Behavioral Health Payment Reform* (4260-601-3420)

URBAN INDIAN ORGANIZATIONS FUNDING SHIFT

REGULAR POLICY CHANGE NUMBER: 229
IMPLEMENTATION DATE: 1/2022
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2351

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$16,539,000	-\$8,064,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$16,539,000	-\$8,064,000
FEDERAL FUNDS	\$16,539,000	\$8,064,000

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:

The change from prior estimate, for FY 2022-23, is a decrease in General Fund (GF) savings due to increasing the lag on when claims will be adjusted. The lag on when claims will be adjusted was revised from one quarter to three quarters, which shifted some adjustments to FY 2023-24. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease in GF savings due adjustments ending December 2023, which accounts for only two quarters of adjustments.

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 three quarter lag for claims that are adjusted to 100% FFP.

URBAN INDIAN ORGANIZATIONS FUNDING SHIFT
REGULAR POLICY CHANGE NUMBER: 229

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2022-23	\$0	(\$16,539)	\$16,539
FY 2023-24	\$0	(\$8,064)	\$8,064

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% GF (4260-101-0001)
Title XXI 100% FFP (4260-113-0890)
Title XXI 100% FFP (4260-101-0890)

AMERICAN RESCUE PLAN INCREASED FMAP FOR HCBS

REGULAR POLICY CHANGE NUMBER: 230
IMPLEMENTATION DATE: 7/2022
ANALYST: Ryan Woolsey
FISCAL REFERENCE NUMBER: 2338

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$761,745,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$761,745,000	\$0
FEDERAL FUNDS	\$761,745,000	\$0

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:

The change in FY 2022-23, from the prior estimate, is an increase in the amount of increased FMAP estimated to be claimed, due to updated projections of the timing of increased FMAP claims.

AMERICAN RESCUE PLAN INCREASED FMAP FOR HCBS

REGULAR POLICY CHANGE NUMBER: 230

The change from FY 2022-23 to FY 2023-24 in the current estimate is due to no additional increased FMAP is assumed to be claimed in FY 2023-24.

Methodology:

1. An estimated \$2.0 billion was claimed during FY 2021-22 and \$762 million is anticipated to 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 2022-23	TF	FF	GF	SF
100% HCBS 611-100% FF (4260-611-0890)	\$761,745	\$761,745	\$0	\$0
100% HCBS 698-0001 (4260-698-0001)	-\$761,745	\$0	-\$761,745	\$0
100% HCBS 611-0001 (4260-611-0001)	\$761,745	\$0	\$761,745	\$0
100% HCBS 698-8507 (4260-698-8507)	-\$761,745	\$0	\$0	-\$761,745
Total	\$0	\$761,745	\$0	-\$761,745

IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER: 231
IMPLEMENTATION DATE: 4/2017
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 35

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$37,244,000	\$44,564,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$37,244,000	\$44,564,000
FEDERAL FUNDS	-\$37,244,000	-\$44,564,000

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: 231

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 2022-23, is an increase due to adjusting the projected repayments based on actual IMD amounts from FY 2020-21 Q3 through FY 2021-22 Q3.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to the estimated repayments that will occur in FY 2023-24.

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 2022-23 and FY 2023-24 are based on actual deferral repayment amounts for the last twelve quarters, using an average estimated repayments to future quarters.
3. The managed care estimated amounts for FY 2022-23 and FY 2023-24 are based on estimates of the past quarters.
4. For FY 2022-23, the Department estimates to repay FFS deferrals from January 2021 through March 2022 and managed care deferrals from July 2022 through June 2023.
5. For FY 2023-24, the Department estimates to repay FFS deferrals from April 2022 through March 2023 and managed care deferrals July 2023 through June 2024.

IMD ANCILLARY SERVICES
REGULAR POLICY CHANGE NUMBER: 231

6. The estimated IMD repayments are:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Fee-For-Service (FFS)			
FY2020-21 Q3 (Jan-Mar 2021)	\$0	\$5,747	(\$5,747)
FY2020-21 Q4 (Apr-Jun 2021)	\$0	\$7,144	(\$7,144)
Subtotal FY 2020-21	\$0	\$12,891	(\$12,891)
FY2021-22 Q1 (July-Sept 2021)	\$0	\$4,501	(\$4,501)
FY2021-22 Q2 (Oct-Dec 2021)	\$0	\$4,990	(\$4,990)
FY2021-22 Q3 (Jan-Mar 2022)	\$0	\$6,876	(\$6,876)
Subtotal FY 2021-22	\$0	\$16,367	(\$16,367)
Subtotal FFS	\$0	\$29,258	(\$29,258)
Managed Care			
FY 2022-23 Q1 and Q2 (Jul- Dec 2022)	\$0	\$3,993	(\$3,993)
FY 2022-23 Q3 and Q4 (Jan-Jun 2023)	\$0	\$3,993	(\$3,993)
Subtotal Managed Care	\$0	\$7,986	(\$7,986)
Total FY 2022-23	\$0	\$37,244	(\$37,244)

IMD ANCILLARY SERVICES
REGULAR POLICY CHANGE NUMBER: 231

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
Fee-For-Service (FFS)			
FY2021-22 Q4 (Apr-Jun 2022)	\$0	\$7,584	(\$7,584)
Subtotal FY 2021-22	\$0	\$7,584	(\$7,584)
FY 2022-23 Q1 (Jul-Sep 2022)	\$0	\$5,376	(\$5,376)
FY 2022-23 Q2 (Oct-Dec 2022)	\$0	\$5,867	(\$5,867)
FY 2022-23 Q3 (Jan-Mar 2023)	\$0	\$7,751	(\$7,751)
Subtotal FY 2022-23		\$18,994	(\$18,994)
FY2022-23 Q4 (Apr-Jun 2023)	\$0	\$4,800	(\$4,800)
FY 2023-24 Q1 (Jul-Sep 2023)	\$0	\$4,800	(\$4,800)
Subtotal FY 2023-24		\$9,600	(\$9,600)
Subtotal FFS		\$36,178	(\$36,178)
Managed Care			
FY 2023-24 Q1 and Q2 (Jul- Dec 2023)	\$0	\$4,193	(\$4,193)
FY 2023-24 Q3 and Q4 (Jan-Jun 2024)	\$0	\$4,193	(\$4,193)
Subtotal Managed Care		\$8,386	(\$8,386)
Total FY 2023-24	\$0	\$44,564	(\$44,564)

Funding:

100% General Fund (4260-101-0001)

Title XIX FFP (4260-101-0890)

CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER: 232
IMPLEMENTATION DATE: 1/2006
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1087

	<u>FY 2022-23</u>	<u>FY 2023-24</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: 232

Methodology:

FY 2022-23	
Hospital Services Account	\$77,350,000
Physicians' Services Account	\$22,249,000
Unallocated Account	\$31,753,000
Total CTPS/Prop. 99	\$131,352,000
GF	(\$131,352,000)
Net Impact	\$0

FY 2023-24	
Hospital Services Account	\$73,748,000
Physicians' Services Account	\$21,842,000
Unallocated Account	\$30,200,000
Total CTPS/Prop. 99	\$125,790,000
GF	(\$125,790,000)
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)

FUNDING ADJUST.—ACA OPT. EXPANSION

REGULAR POLICY CHANGE NUMBER: 233
IMPLEMENTATION DATE: 7/2015
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1915

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$3,974,797,200	-\$4,020,145,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$3,974,797,200	-\$4,020,145,200
FEDERAL FUNDS	\$3,974,797,200	\$4,020,145,200

Purpose:

This policy change estimates the adjustment to accurately reflect the enhanced percentage of federal funding match for the Affordable Care Act (ACA) optional expansion population.

Authority:

ACA

Interdependent Policy Changes:

COVID-19 Increased FMAP – DHCS

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 2022-23, is an increase in general fund savings due to updated estimates and data. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase in general fund savings due to updated estimates and data.

Methodology:

- 1) The Department identified funds allocated to beneficiaries in the Newly aid category that were Title XIX funding with 50% federal match.
- 2) The federal match for FY 2022-23 and FY 2023-24 is 90%.
- 3) The total amount of unadjusted ACA optional expansion funding in FY 2022-23 is estimated as \$9,936,992,642 and \$10,050,362,893 in FY 2023-24. These amounts are credited to the Title XIX fund.

FUNDING ADJUST.—ACA OPT. EXPANSION
REGULAR POLICY CHANGE NUMBER: 233

4) The amounts adjusted are as follows:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX / 50%GF	(\$9,936,993)	(\$4,968,496)	(\$4,968,496)
90% Title XIX ACA FF / 10% GF	\$9,936,993	\$993,699	\$8,943,293
Total	\$0	(\$3,974,797)	\$3,974,797

*Totals may differ due to rounding

FY 2023-24	TF	GF	FF
50% Title XIX / 50%GF	(\$10,050,363)	(\$5,025,181)	(\$5,025,181)
90% Title XIX ACA FF / 10% GF	\$10,050,363	\$1,005,036	\$9,045,327
Total	\$0	(\$4,020,145)	\$4,020,145

*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 is identified in the COVID-19 Increased FMAP – DHCS policy change

FUNDING ADJUST.—OTLICP

REGULAR POLICY CHANGE NUMBER: 234
IMPLEMENTATION DATE: 7/2015
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1926

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$109,124,550	-\$114,884,250
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$109,124,550	-\$114,884,250
FEDERAL FUNDS	\$109,124,550	\$114,884,250

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:

COVID-19 Increased FMAP – DHCS

Background:

The Balanced Budget Act of 1997 added Title XXI to the Social Security Act creating CHIP to provide new coverage opportunities for children in families with incomes too high to qualify for Medicaid. States administer the CHIP program and they are jointly funded by federal and state governments.

The ACA provides enhanced federal funding to Title XXI. The California federal funding match was 65 percent through September 30, 2015. Effective October 1, 2015, the ACA extended and increased the enhanced federal matching rate for the CHIP program by 23 percent to 88 percent. Congress reauthorized the CHIP program in January, 2018, reducing the federal matching rate to 76.5 percent effective October 1, 2019, and further reducing the match rate to 65 percent effective October 1, 2020.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a general fund savings increase due to updated estimates and data. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a general fund savings increase due to updated estimates and data.

Methodology:

- 1) The Department identified funds allocated to CHIP beneficiaries in the OTLICP aid category that were not adjusted for additional Title XXI funding.
- 2) The total amount of unadjusted CHIP funding in FY 2022-23 is estimated as \$727,496,710 and \$765,894,730 in FY 2023-24. These amounts are credited to the Title XIX fund.

FUNDING ADJUST.—OTLICP
REGULAR POLICY CHANGE NUMBER: 234

- 3) The funds are then broken out according to reimbursement rates based on when the Department estimates the expenditure.
- a. In FY 2022-23, the Department estimates the additional CHIP funding will offset general fund spending by \$109.1 million.
 - b. In FY 2023-24, the Department estimates the additional CHIP funding will offset general fund spending by \$114.9 million.
- 4) The amounts adjusted are as follows:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX / 50%GF	(\$727,497)	(\$363,748)	(\$363,748)
65% Title XXI FF / 35% GF	\$727,497	\$254,624	\$472,873
Total	\$0	(\$109,125)	\$109,125

*Totals may differ due to rounding

FY 2023-24	TF	GF	FF
50% Title XIX / 50%GF	(\$765,895)	(\$382,947)	(\$382,947)
65% Title XXI FF / 35% GF	\$765,895	\$268,063	\$497,832
Total	\$0	(\$114,884)	\$114,884

*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)

65% Title XXI FF / 35% GF (4260-101-0890/0001)

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 235
IMPLEMENTATION DATE: 4/2015
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1760

	<u>FY 2022-23</u>	<u>FY 2023-24</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: 235

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 January 1, 2022 through December 31, 2022. The Department will seek federal approval for QAF VII in Quarter 2 of FY 2021-22 and are currently awaiting approval. The length of the QAF VII program period is 12-months.

The Department will begin developing the subsequent program period (HQAF VIII) in FY 2022-23 Q1 which will include payments for the period beginning January 1, 2023. The length of the QAF VIII program period is currently unknown.

Reason for Change:

The change in FY 2022-23, from the prior estimate, is an increase in General Fund (GF) savings due to updated estimates in the proposed HQAF VII model.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase in GF savings in FY 2023-24 due to FY 2023-24 includes postponed payments to the GF from the HQAF VI program period.

Methodology:

1. Payments for children's health care are estimated through the period ending December 31, 2022 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.
5. Assume the HQAF VII program period covers a 12-month period from January 1, 2022, through December 31, 2022.
6. Assume the HQAF VIII program period covers a 12-month period from January 1, 2023, through December 31, 2023.
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.
8. HQAF VIII estimated payments are based on the HQAF VII model that is pending approval by CMS. HQAF VIII payments are estimated with reductions anticipated due to CalAIM

HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 235

transition from FFS to MC. The payment schedule and amounts for HQAF VIII are still under development. Payment timing and amounts are subject to change.

9. 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)	Remaining Amount
FY 2019-20	Proposition 52	7/1/19 to 6/30/20	\$489,000
FY 2020-21	Proposition 52	7/1/20 to 6/30/21	\$201,896
FY 2021-22	Proposition 52	7/1/21 to 12/31/21	\$0

(Dollars in Thousands)

Calendar Year (CY)	Authority	HQAF VII Period (Pending)	Amount
CY 2022	Proposition 52	01/01/22 to 12/31/22	\$1,115,200

(Dollars in Thousands)

CY	Authority	HQAF VIII Period (Pending)	Amount
CY 2023	Proposition 52	01/01/23 to 12/31/23	\$1,115,200

10. Four quarters of HQAF VII Children's Health Care payments will be paid in FY 2022-23.
11. Four quarters of HQAF VIII Children's Health Care payments will be paid in FY 2023-24.
12. HQAF VI Children's Health Care coverage payments of approximately \$690M for Cycles 1-7 were postponed due to the COVID-19 emergency. The payments are scheduled to be paid to the General Fund in Quarter 4 of FY 2023-24.
13. On a cash basis, the payments to health care coverage for children and the funding adjustment are:

(Dollars in Thousands)

FY 2022-23	TF	GF	Hosp. QA Rev Fund
Calendar Year 2022	\$0	(\$1,115,200)	\$1,115,200
Total FY 2022-23	\$0	(\$1,115,200)	\$1,115,200

(Dollars in Thousands)

FY 2023-24	TF	GF	Hosp. QA Rev Fund
FY 2019-20 & FY 2020-21	\$0	(\$690,896)	\$690,896
Calendar Year 2023	\$0	(\$1,115,200)	\$1,115,200
Total FY 2023-24	\$0	(\$1,806,096)	\$1,806,096

HOSPITAL QAF - CHILDREN'S HEALTH CARE
REGULAR POLICY CHANGE NUMBER: 235

Funding:

100% GF (4260-101-0001)

100% Hospital Quality Assurance Revenue Fund (4260-611-3158)

INDIAN HEALTH SERVICES FUNDING SHIFT

REGULAR POLICY CHANGE NUMBER: 236
IMPLEMENTATION DATE: 7/2019
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2156

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$14,845,000	-\$15,846,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$14,845,000	-\$15,846,000
FEDERAL FUNDS	\$14,845,000	\$15,846,000

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

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: 236

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a decrease based on one additional quarter of actual expenditures that were lower than previously estimated. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to growth in the estimated rate for CY 2022 and CY 2023.

Methodology:

1. Assume a one quarter lag when the claims from 50% GF / 50% FF to 100% FFP is adjusted.
2. In FY 2022-23, it is estimated the Department will spend \$29,690,000 TF (\$14,845,000 GF). In FY 2023-24, it is estimated the Department will spend \$31,692,000 TF (\$15,846,000 GF).
3. Estimated expenditures for FY 2022-23 and FY 2023-24 are in the table below.

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
IHS FY 2022-23 Base exp. (50% GF / 50% FF)	(\$29,690)	(\$14,845)	(\$14,845)
IHS total expenditures (100% FF)	\$29,690	\$0	\$29,690
FY 2022-23 Total	\$0	(\$14,845)	\$14,845
FY 2023-24	TF	GF	FF
IHS FY 2023-24 Base exp. (50% GF / 50% FF)	(\$31,692)	(\$15,846)	(\$15,846)
IHS total expenditures (100% FF)	\$31,692	\$0	\$31,692
FY 2023-24 Total	\$0	(\$15,846)	\$15,846

*Totals may differ due to rounding.

Funding:

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

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

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change.

CMS DEFERRED CLAIMS

REGULAR POLICY CHANGE NUMBER: 237
IMPLEMENTATION DATE: 4/2017
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 2034

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$193,141,000	-\$267,911,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$193,141,000	-\$267,911,000
FEDERAL FUNDS	\$193,141,000	\$267,911,000

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: 237

Reason for Change:

The change in FY 2022-23, from the prior estimate, is due to:

- Including the actual FFY 2022 Quarter 1 and FFY 2022 Quarter 2 deferral repayments,
- Estimating state only cost deferrals related to pharmacy claims will continue through FFY 2022 Q4,
- Resolved deferrals estimated to be returned to the GF in May 2022 were shifted to FY 2022-23, and
- Including additional actual resolved deferrals returned to the GF in FY 2022-23.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to:

- Actual CMS deferral repayment amounts in FY 2022-23,
- Actual resolved deferrals returned to the GF in FY 2022-23,
- Estimating the remaining state only cost deferrals related to state only costs, specifically those related to issues other than managed care and pharmacy, not yet returned to the GF, will be resolved and returned to the GF in FY 2023-24,
- Estimating state only cost deferrals related to pharmacy claims will not continue after FFY 2022 Q4 and will be returned to the GF in FY 2023-24, and
- Estimating state only cost deferrals related to the managed care proxy will not continue after FFY 2023 Q3 and a portion of the deferrals will be returned to the GF in FY 2023-24.

Methodology:

1. The Department received CMS deferrals for FFY 2015 Quarter 1 through FFY 2022 Quarter 2.
2. In FY 2022-23, the Department estimates to repay a total of \$269.11 million FF, which includes \$109.5 million of actual CMS deferrals issued for FFY 2022 Quarter 1 and FFY 2022 Quarter 2.
3. Repayment actuals for state only costs deferrals totaling \$109.5 million FF for FFY 2022 Quarter 1 and FFY 2022 Quarter 2 are included in FY 2022-23.
4. Repayments for state only costs deferrals are estimated to be \$219.12 million in FY 2022-23 consisting of \$42.7 million per quarter from FFY 2022 Quarter 1 through FFY 2022 Quarter 4 related to the managed care proxy and \$12 million per quarter from FFY 2022 Quarter 1 through FFY 2022 Quarter 4 related to pharmacy claims.
5. Repayments for state only cost deferrals are estimated to be \$128.34 million in FY 2023-24 consisting of \$42.7 million per quarter from FFY 2023 Quarter 1 through FFY 2023 Quarter 3 related to the managed care proxy. Deferrals for pharmacy claims are not assumed for FFY 2023 Quarter 1 and later quarters and deferrals for the managed care proxy are not assumed for FFY 2023 Quarter 4 and later quarters, consistent with the expected implementation of correct claiming for these items.
6. An additional reserve amount of \$25 million per quarter for future deferrals is estimated for all quarters from FFY 2022 Quarter 3 through FFY 2023 Quarter 4.
7. The Department has recovered \$462.26 million in actual resolved deferrals during FY 2022-23.

CMS DEFERRED CLAIMS
REGULAR POLICY CHANGE NUMBER: 237

8. The Department estimates recovering \$496.25 million in resolved deferrals during FY 2023-24 related to state only cost deferrals including pharmacy claims, the managed care proxy, and state only costs, specifically those related to issues other than managed care and pharmacy.
9. The Department will repay the following estimated deferred claims:

(Dollars in Thousands)

FY 2022-23	Total Estimated Repayment
FFY 2022 Quarter 1 (Oct-Dec 2021)	\$54,779
FFY 2022 Quarter 2 (Jan-Mar 2022)	\$54,779
FFY 2022 Quarter 3 (Apr-Jun 2022)	\$79,779
FFY 2022 Quarter 4 (Jul-Sep 2022)	\$79,779
Subtotal Estimated Repayments	\$269,116
Estimated Resolved Deferrals	(\$462,257)
Total FY 2022-23	(\$193,141)

FY 2023-24	Total Estimated Repayment
FFY 2023 Quarter 1 (Oct-Dec 2022)	\$67,779
FFY 2023 Quarter 2 (Jan-Mar 2023)	\$67,779
FFY 2023 Quarter 3 (Apr-Jun 2023)	\$67,779
FFY 2023 Quarter 4 (Jul-Sep 2023)	\$25,000
Subtotal Estimated Repayments	\$228,337
Estimated Resolved Deferrals	(\$496,249)
Total FY 2023-24	(\$267,911)

Funding:

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

100% Title XIX GF (4260-101-0001)

DENTAL MANAGED CARE MLR RISK CORRIDOR

REGULAR POLICY CHANGE NUMBER: 238
IMPLEMENTATION DATE: 12/2021
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2356

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	-\$18,950,000	\$0
- STATE FUNDS	-\$5,868,600	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$18,950,000	\$0
STATE FUNDS	-\$5,868,600	\$0
FEDERAL FUNDS	-\$13,081,400	\$0

Purpose:

This policy change budgets recoveries from managed care plans related to the Medical Loss Ratio (MLR) risk corridor calculations applicable to the Medi-Cal Dental Managed Care (DMC) plans.

Authority:

Title 42, Code of Federal Regulations, Part 438.8
 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
 Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

Not Applicable

Background:

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

Each dental plan receives a 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.

The Medi-Cal DMC plan contracts establish a single-sided risk corridor in the form of a minimum MLR of 85% beginning with the FY 2019-20 rating period. The Department will require DMC plans to remit necessary funds that do not meet the 85% threshold.

DENTAL MANAGED CARE MLR RISK CORRIDOR

REGULAR POLICY CHANGE NUMBER: 238

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, in FY 2022-23, is an increase in recoupments due to a shift in recoupment timing for portions of FY 2019-20, July through December 2020, and CY 2021 recoupments from FY 2021-22. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease in recoupments due to the fact that the value of the recoupments anticipated in FY 2023-24 are not known at this time.

Methodology:

1. The Department estimates total collections of \$18.95 million in FY 2022-23. Of this amount, \$10.0 million is associated with the FY 2019-20 and July through December 2020 rating periods, and the remaining \$8.95 million is associated with the CY 2021 rating period.
2. The Department estimates any remittances for the CY 2022 rating period will be collected in FY 2023-24. At this time, an estimated remittance amount is not available as the data needed to perform the calculations can be collected only after the end of the rating period.

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF	(\$10,329,000)	(\$5,164,000)	(\$5,164,000)
93% ACA Title XIX FF / 7% GF	(\$898,000)	(\$63,000)	(\$835,000)
90% ACA Title XIX FF / 10% GF	(\$5,080,000)	(\$508,000)	(\$4,572,000)
88% Title XXI / 12% GF	(\$229,000)	(\$28,000)	(\$202,000)
76.5% Title XXI / 23.5% GF	(\$923,000)	(\$217,000)	(\$706,000)
65% Title XXI / 35% GF	(\$1,491,000)	(\$522,000)	(\$969,000)
FFCRA 6.2% Increased FFP	\$0	\$536,000	(\$536,000)
FFCRA 4.34% Increased FFP	\$0	\$97,000	(\$97,000)
Total	(\$18,950,000)	(\$5,869,000)	(\$13,081,000)

*Totals may differ due to rounding.

DENTAL MANAGED CARE MLR RISK CORRIDOR
REGULAR POLICY CHANGE NUMBER: 238**Funding:**

50% Title XIX / 50% GF (4260-101-0890/0001)
93% ACA Title XIX FF / 7% GF (4260-101-0890/0001)
90% ACA Title XIX FF / 10% GF (4260-101-0890/0001)
88% Title XXI / 12% GF (4260-113-0890/0001)
76.5% Title XXI / 23.5% GF (4260-113-0890/0001)
65% Title XXI / 35% GF (4260-113-0890/0001)
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)

COUNTY SHARE OF OTLICP-CCS COSTS

REGULAR POLICY CHANGE NUMBER: 239
IMPLEMENTATION DATE: 7/2014
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 1906

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	-\$22,981,000	-\$21,300,000
- STATE FUNDS	-\$22,981,000	-\$21,300,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$22,981,000	-\$21,300,000
STATE FUNDS	-\$22,981,000	-\$21,300,000
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 – DHCS

Background:

AB 1494 authorized the transition of all Healthy Family Program (HFP) subscribers into the Medi-Cal OTLICP. Effective January 1, 2013, HFP subscribers transitioned into OTLICP through a phase-in methodology.

Of the subscribers, an estimated 23,381 California Children Services (CCS) – HFP eligibles shifted to CCS-OTLICP in FY 2013-14. CCS-HFP was funded with 65% FFP, 17.5% GF, and 17.5% county funds through September 30, 2015. From October 1, 2015, to September 30, 2019, CCS-HFP 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: 239

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a decrease in county share reimbursement for OTLICP-CCS due to capturing FFCRA increased FMAP through March 31, 2023, in this policy change.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to a projected decline in county OTLICP-CCS expenditures in FY 2023-24.

Methodology:

1. 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.
2. The county share reimbursement for OTLICP-CCS in FY 2023-24, at 17.5% for quarter 1 through 4, is estimated to be \$21,300,000.
3. For FY 2022-23, assume the increased FMAP for COVID-19 is 4.34% for Title XXI through March 31, 2023. The increased FMAP reduces the county share of reimbursement for OTLICP-CCS costs by \$2,356,000 for this policy change. The impact of FFCRA increased FMAP extension is roughly accounted for in the COVID-19 Increased FMAP – DHCS policy change.
4. The county share of OTLICP-CCS costs is estimated in the table below:

Fiscal Year	TF	GF	CF
FY 2022-23	\$22,981,000	\$22,981,000	(\$22,981,000)
FY 2023-24	\$21,300,000	\$21,300,000	(\$21,300,000)

* County Funds are not included in the Total Fund.

Funding:

100% Title XXI State GF (4260-113-0001)

100% Title XXI State GF (4260-101-0001)

FFCRA 4.34% Increased GF (4260-113-0001)

COVID-19 funding is identified in the COVID-19 Increased FMAP – DHCS policy change

CALIFORNIA BEHAVIORAL HEALTH CBC DEMONSTRATION

REGULAR POLICY CHANGE NUMBER: 243
IMPLEMENTATION DATE: 1/2024
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2394

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$4,095,000
- STATE FUNDS	\$0	\$1,308,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$4,095,000
STATE FUNDS	\$0	\$1,308,000
FEDERAL FUNDS	\$0	\$2,787,000

Purpose:

This policy change estimates the cost of the California Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration, to expand access and strengthen the continuum of mental health services for Medi-Cal beneficiaries living with serious mental illness (SMI) and serious emotional disturbance (SED).

Authority:

Medicaid Section 1115 Demonstration Waiver
 Welfare & Institutions Code 14184.400(c)

Interdependent Policy Changes:

Not Applicable

Background:

California is facing a growing mental health crisis exacerbated by the COVID-19 pandemic. Since the pandemic, California hospitals are reporting significant increases in the number of adolescents seeking psychiatric treatment in emergency departments, as well as long waitlists for psychiatric inpatient beds for children and adolescents. For adults, the situation is similarly serious. More than one in 20 adult residents in California is living with SMI, and the evidence continues to mount that individuals who are experiencing or at risk of homelessness and those involved in the justice system experience high rates of untreated mental illness and/or substance use disorder. Even so, approximately one-third of individuals enrolled in Medi-Cal and who are living with SMI do not receive any Medi-Cal Specialty Mental Health Services. As a result, the Department has made strengthening California's behavioral health system a top priority, and is already making many investments in expanding behavioral health services. The CalBH-CBC Demonstration was designed to expand on these investments, complement existing major behavioral health initiatives, and strengthen the continuum of care for Medi-Cal beneficiaries.

The Department will apply for a new Medicaid Section 1115 demonstration, titled the CalBH-CBC Demonstration, to expand access to and strengthen the continuum of mental health services for Medi-Cal beneficiaries living with SMI and SED. The disparities addressed in the demonstration are based largely off California's 2022 Assessment, titled Assessing the Continuum of Care for Behavioral Health Services in California.

CALIFORNIA BEHAVIORAL HEALTH CBC DEMONSTRATION

REGULAR POLICY CHANGE NUMBER: 243

The proposed CalBH-CBC Demonstration approach includes five key components:

- Strengthening the statewide continuum of community-based services and evidence-based practices available through Medi-Cal for individuals living with SMI or SED.
- Supporting statewide practice transformations and improvements in the county-administered behavioral health system.
- Improving statewide county accountability for meeting service improvement requirements and implementing new benefits through incentives, robust technical assistance, and oversight.
- Establishing a county option to provide enhanced community-based services.
- Establishing a county option to receive Federal Funds Participation (FFP) for services provided during short-term stays in Institutes of Mental Disease (IMDs), contingent on counties meeting robust accountability requirements.

If counties opt-in to participate, counties will be required to reinvest the FFP they receive through the demonstration into expanding Medi-Cal behavioral health service provision and capacity.

Counties participating in the demonstration will be required to submit an implementation plan, which among other requirements, is expected to outline how the county intends to reinvest the FFP received.

Reason for Change:

This is a new policy change.

Methodology:

1. Assume the CalBH-CBC demonstration will be implemented in January 2024.
2. The demonstration relies upon updated guidance from Centers for Medicare & Medicaid Services and the new availability of FFP for services in IMDs. Milestones must be met to qualify for this FFP.
3. Some features of the demonstration will be available starting FY 2023-24, however, features that require more lead-in time will be phased in over FY 2024-25 and FY 2025-26.
4. The Department and counties will partner to provide the non-federal share of the demonstration features. The share differs between features of the demonstration. The Department will need to submit a demonstration application and implementation plan in order to secure the FFP.
5. Total estimated costs for the CalBH-CBC Demonstration, on a cash basis, is as follows:

FY 2023-24	TF	GF	FFP	IGT*
SMHS - Statewide	\$274,000	\$137,000	\$137,000	\$0
SMHS - Opt-in	\$3,821,000	\$0	\$2,650,000	\$1,171,000
Total	\$4,095,000	\$137,000	\$2,787,000	\$1,171,000

Funding:

100% GF (4260-101-0001)

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

Medi-Cal County Behavioral Health Fund (4260-601-3420)*

COUNTY BH RECOUPMENTS

REGULAR POLICY CHANGE NUMBER: 249
IMPLEMENTATION DATE: 9/2023
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2343

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$63,468,000
- STATE FUNDS	\$0	-\$63,468,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$63,468,000
STATE FUNDS	\$0	-\$63,468,000
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 SMHS 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: 249

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. In FY 2021-22, the Department identified incorrect claiming for Medicare Children's Health Insurance Program (MCHIP) beneficiaries in which claims for emergency services were paid at an enhanced rate instead of 50% FMAP. The recoupment associated with these claims is \$255,000.

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 FY 2023-24.
2. The psychiatric inpatient claim recoupments total \$190,335,000.
3. The recoupment for claims related to beneficiaries with UIS is \$63,536,000.
4. The Department will recoup funds over a four year period via weekly checkwrites to counties.

(Dollars in Thousands)

Recoupment Period	Total	Psychiatric Inpatient	Specialty Mental Health UIS	Drug Medi-Cal UIS
FY 2023-24 – Q1	\$15,867	\$11,896	\$3,867	\$104
FY 2023-24 – Q2	\$15,867	\$11,896	\$3,867	\$104
FY 2023-24 – Q3	\$15,867	\$11,896	\$3,867	\$104
FY 2023-24 – Q4	\$15,867	\$11,896	\$3,867	\$104
Total	\$63,468	\$47,584	\$15,469	\$415

(Dollars in Thousands)

BH Recoupments	TF	GF
FY 2023-24	(\$63,468)	(\$63,468)

Funding:

100% Title XIX GF (4260-101-0001)

CALAIM- DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER: 251
IMPLEMENTATION DATE: 2/2023
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 2317

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$22,710,000
- STATE FUNDS	-\$40,402,000	-\$152,972,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$22,710,000
STATE FUNDS	-\$40,402,000	-\$152,972,000
FEDERAL FUNDS	\$40,402,000	\$175,682,000

Purpose:

This policy change estimates the net impact for additional federal financial participation (FFP) received for Certified Public Expenditures (CPEs) from certain DSHPs (Designated State Health Programs), the savings to the General Fund (GF) from the reduction in state spending, and the impacts of fee-for-service (FFS) and managed care provider rate increases.

Authority:

California Advancing and Innovating Medi-Cal (CalAIM) Section 1115(a) Medicaid Demonstration 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 assumes the DSHP would be effective January 1, 2023, 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 DSHP proposal within the CalAIM Section 1115 Demonstration renewal is pending CMS approval. If approved, DSHP would allow the Department to claim up to a total of \$646.425 million FFP over the four-year demonstration period using the CPEs of the approved DSHPs listed below:

CALAIM- DESIGNATED STATE HEALTH PROGRAMS
REGULAR POLICY CHANGE NUMBER: 251

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)

DSHPs are funded by state funds (GF). Those expenditures are used to draw FFP which is then used to credit the GF.

As a requirement for the CalAIM DSHP, states must increase rates for certain services if the average Medicaid to Medicare provider payment rate ratio for these services is below 80 percent. If rates are below the 80 percent threshold, states must increase rates to close the gap by a certain percentage point by the first rating period of Demonstration Year 3 (January 1, 2024).

Reason for Change:

This is a new policy change.

Methodology:

1. Assume DSHP claiming will be approved effective January 1, 2023.
2. Assume provider rate increases will be provided for primary care services and obstetric care services, effective January 1, 2024.
 - For primary care services, assume rates increase for FFS only.
 - For obstetric care services, assume rate increases for FFS and managed care.

CALAIM- DESIGNATED STATE HEALTH PROGRAMS
REGULAR POLICY CHANGE NUMBER: 251

3. The estimated total net impact on a cash basis is:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
DSHP	\$0	(\$40,402)	\$40,402

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
DSHP	\$0	(\$161,606)	\$161,606
Provider Rate Increases			
Primary Care FFS (Lagged)	\$9,120	\$3,496	\$5,624
Obstetric Care FFS (Lagged)	\$2,090	\$777	\$1,313
Obstetric Care Managed Care	\$11,500	\$4,361	\$7,139
Subtotal Obstetric	\$13,590	\$5,138	\$8,452
Subtotal Provider Rate Increases	\$22,710	\$8,634	\$14,076
Total DSHP + Provider Rate Increases	\$22,710	(\$152,972)	\$175,682

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
 90% Title XIX / 10% GF (4260-101-0001/0890)
 65% Title XXI / 35% GF (4260-101-0001/0890)
 100% Title XIX (4260-101-0890)
 100% GF (4260-101-0001)
 100% Health Care Support Fund (4260-601-7503)

2024 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ

REGULAR POLICY CHANGE NUMBER: 252
IMPLEMENTATION DATE: 5/2024
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2406

	<u>FY 2022-23</u>	<u>FY 2023-24</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:

Not Applicable

Interdependent Policy Changes:

2024 MCO Enrollment Tax Mgd. Care Plans-Incr. Cap. Rates
 2024 MCO Enrollment Tax Managed Care Plans

Background:

Effective January 1, 2024, the department will implement 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, 2021, and December 31, 2021, and adjusted for enrollment changes to managed care plans anticipated on January 1, 2024. The tax is tiered based on whether the enrollee is a Medi-Cal enrollee or other enrollee.

This policy change estimates the offset of GF costs for the capitated rate increases.

Reason for Change:

This is a new policy change.

Methodology:

1. Total revenues for Medi-Cal managed care plans are based on the number of Medi-Cal enrollees and "all-other" enrollees.
2. Only tax relating to Medi-Cal enrollees are budgeted in this PC.

2024 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ
REGULAR POLICY CHANGE NUMBER: 252

3. The Managed Care Enrollment Fund transfers to the GF are expected to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	MCO Tax
FY 2023-24	\$0	(\$467,914)	\$467,914

Funding:

3428 Managed Care Enrollment Fund

2024 MCO ENROLLMENT TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER: 253
IMPLEMENTATION DATE: 5/2024
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2407

	<u>FY 2022-23</u>	<u>FY 2023-24</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, 2024.

Authority:

Not Applicable

Interdependent Policy Changes:

2024 MCO Enrollment Tax Mgd. Care Plans-Incr. Cap. Rates
 2024 MCO Enrollment Tax Mgd. Care Plans-Funding Adj.

Background:

Effective January 1, 2024, the department will implement 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, 2021, and December 31, 2021, and adjusted for enrollment changes to managed care plans anticipated on January 1, 2024. The tax is tiered based on whether the enrollee is a Medi-Cal enrollee or other enrollee.

This policy change estimates GF savings resulting from the imposition of the MCO Enrollment Tax.

Reason for Change:

This is a new policy change.

Methodology:

1. The 2024 MCO Enrollment Tax is based on the cumulative enrollment of health plans during the 12-month period between January 1, 2021, and December 31, 2021.
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:

2024 MCO ENROLLMENT TAX MANAGED CARE PLANS
REGULAR POLICY CHANGE NUMBER: 253

FY 2023-24 Medi-Cal		FY 2023-24 Non-Medi-Cal	
Enrollees	Rate	Enrollees	Rate
0-675,000	\$0.00	0-675,000	\$0.00
675,001-4,000,000	\$62.50	675,001-4,000,000	\$1.50
Over 4,000,000	\$0.00	Over 4,000,000	\$0.00

The total Medi-Cal and Non-Medi-Cal MCO Enrollment Tax on an accrual basis is:

FY 2023-24: \$1,568,901,000

4. The impact of the increase in capitation payments related to the tax is included in the 2024 MCO Enrollment Tax Mgd. Care Plans-Incr. Cap. Rates policy change.
5. The Managed Care Enrollment Fund transfers to the GF are expected to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	MCO Tax
FY 2023-24	\$0	(\$316,536)	\$316,536

Funding:

3428 Managed Care Enrollment Fund

2024 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.

REGULAR POLICY CHANGE NUMBER: 254
IMPLEMENTATION DATE: 2/2024
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2408

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$1,293,487,000
- STATE FUNDS	\$0	\$467,914,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$1,293,487,000
STATE FUNDS	\$0	\$467,914,300
FEDERAL FUNDS	\$0	\$825,572,700

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:

Not Applicable

Interdependent Policy Changes:

2024 MCO Enrollment Tax Mgd. Care Plans
 2024 MCO Enrollment Tax Mgd. Care Plans-Funding Adj.

Background:

Effective January 1, 2024, the department will implement 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, 2021, and December 31, 2021, and adjusted for enrollment changes to managed care plans anticipated on January 1, 2024. The tax is tiered based on whether the enrollee is a Medi-Cal enrollee or other enrollee.

Reason for Change:

This is a new policy change.

Methodology:

1. The MCO Enrollment Tax proceeds are required to be used to offset the capitation rate development process and payments made to the State that result directly from the imposition of the tax.
2. Enrollment for managed care plans are based on the number of Medi-Cal enrollees and "all-other" enrollees.
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

2024 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.
REGULAR POLICY CHANGE NUMBER: 254

reimbursement is budgeted in the MCO Enrollment Tax Mgd. Care Plans-Funding Adjustment policy change.

5. Starting FY 2023-24, assume a one-month payment lag for all plans subject to MCO tax.
6. 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 2023-24	\$1,293,487	\$467,914	\$825,572

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 (4260-101-0001/0890)

PROP 56 - DIRECTED PAYMENT RISK MITIGATION

REGULAR POLICY CHANGE NUMBER: 255
IMPLEMENTATION DATE: 6/2022
ANALYST: Ryan Woolsey
FISCAL REFERENCE NUMBER: 2333

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
FULL YEAR COST - TOTAL FUNDS	-\$500,000,000	\$0
- STATE FUNDS	-\$175,037,080	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$500,000,000	\$0
STATE FUNDS	-\$175,037,080	\$0
FEDERAL FUNDS	-\$324,962,920	\$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 risk corridor calculations applicable to 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.

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

PROP 56 - DIRECTED PAYMENT RISK MITIGATION

REGULAR POLICY CHANGE NUMBER: 255

upon the MCPs' receipt of providers' actual utilization for these codes reported through encounter data.

For the Bridge Period rating period (July 1, 2019 through December 31, 2020), there are a subset of Proposition 56 directed payment programs that were subject to one of three two-sided risk corridors. The first risk corridor applied to the Proposition 56 Physicians Services, Proposition 56 Developmental Screening Services, and Proposition 56 Adverse Childhood Experiences Screening Services programs. The second risk corridor applied to the Proposition 56 Family Planning Services program. The third risk corridor will apply to the Proposition 56 Value-Based Payment program. The same risk corridors were also in effect for the calendar year (CY) 2021 and CY 2022 rating periods.

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:

The change in FY 2022-23, from the prior estimate, the addition of recoupments associated with the Bridge Period risk corridors.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is from no additional recoupments assumed for FY 2023-24. At this time, adequate data are not available to budget remittances or payments associated with CY 2021 or subsequent rating periods.

Methodology:

1. The two-sided risk corridors for the Bridge Period are based on the aggregate MEPS achieved by each MCP and utilize MCP-submitted encounters and/or other utilization data. These recoupments are estimated to be \$500 million TF (\$175 million state funds) and anticipated to be collected in FY 2022-23.
2. An estimate of payments or recoupments occurring in FY 2023-24 for rating periods subsequent to the Bridge Period is not available at this time.

PROP 56 - DIRECTED PAYMENT RISK MITIGATION
REGULAR POLICY CHANGE NUMBER: 255

Funding:

FY 2022-23	TF	GF	FF
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	(\$303,026,000)	(\$151,513,000)	(\$151,513,000)
ACA 93% Title XIX FF / 7% GF (4260-101-0001 / 0890)	(\$29,698,000)	(\$2,079,000)	(\$27,619,000)
ACA 90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	(\$60,091,000)	(\$6,009,000)	(\$54,082,000)
88% Title XXI FF / 12% GF (4260-113-0001 / 0890)	(\$5,760,000)	(\$691,000)	(\$5,069,000)
76.5% Title XXI FF / 23.5% GF (4260-113-0001 / 0890)	(\$23,455,000)	(\$5,512,000)	(\$17,943,000)
65% Title XXI FF / 35% GF (4260-113-0001 / 0890)	(\$5,744,000)	(\$2,010,000)	(\$3,734,000)
Family Planning 90% Title XIX FF / 10% GF (4260-101-0001/0890)	(\$72,226,000)	(\$7,223,000)	(\$65,003,000)
Total	(\$500,000,000)	(\$175,037,000)	(\$324,963,000)

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**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	\$2,267,136,000	\$1,133,568,000	\$1,133,568,000	\$0
2	SAWS	\$188,139,000	\$187,905,500	\$233,500	\$0
3	FUNDING FOR COUNTY REDETERMINATIONS	\$109,523,000	\$54,761,500	\$54,761,500	\$0
4	CALWORKS APPLICATIONS	\$81,594,000	\$40,797,000	\$40,797,000	\$0
5	CASE MANAGEMENT FOR OTLICP	\$43,206,000	\$21,603,000	\$21,603,000	\$0
6	LOS ANGELES COUNTY HOSPITAL INTAKES	\$37,808,000	\$34,513,500	\$3,294,500	\$0
7	ENHANCED FEDERAL FUNDING	\$0	\$496,226,000	(\$496,226,000)	\$0
8	SAVE	\$0	\$4,000,000	(\$4,000,000)	\$0
	OTHER SUBTOTAL	\$2,727,406,000	\$1,973,374,500	\$754,031,500	\$0
	GRAND TOTAL	\$2,727,406,000	\$1,973,374,500	\$754,031,500	\$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		
	OTHER						
1	COUNTY ADMINISTRATION ALLOCATION	\$0	\$0	\$2,267,136,000	\$0	\$2,267,136,000	\$1,133,568,000
2	SAWS	\$188,139,000	\$0	\$0	\$0	\$188,139,000	\$233,500
3	FUNDING FOR COUNTY REDETERMINATIONS	\$109,523,000	\$0	\$0	\$0	\$109,523,000	\$54,761,500
4	CALWORKS APPLICATIONS	\$0	\$0	\$81,594,000	\$0	\$81,594,000	\$40,797,000
5	CASE MANAGEMENT FOR OTLICP	\$0	\$0	\$0	\$43,206,000	\$43,206,000	\$21,603,000
6	LOS ANGELES COUNTY HOSPITAL INTAKES	\$0	\$0	\$0	\$37,808,000	\$37,808,000	\$3,294,500
7	ENHANCED FEDERAL FUNDING	\$0	\$0	\$0	\$0	\$0	(\$496,226,000)
8	SAVE	\$0	\$0	\$0	\$0	\$0	(\$4,000,000)
	OTHER SUBTOTAL	\$297,662,000	\$0	\$2,348,730,000	\$81,014,000	\$2,727,406,000	\$754,031,500
	GRAND TOTAL	\$297,662,000	\$0	\$2,348,730,000	\$81,014,000	\$2,727,406,000	\$754,031,500

**SUMMARY OF COUNTY ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2023-24**

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
1	COUNTY ADMINISTRATION ALLOCATION	\$2,350,566,000	\$1,175,283,000	\$1,175,283,000	\$0
2	SAWS	\$161,565,000	\$161,012,000	\$553,000	\$0
4	CALWORKS APPLICATIONS	\$89,803,000	\$44,901,500	\$44,901,500	\$0
5	CASE MANAGEMENT FOR OTLICP	\$40,938,000	\$20,469,000	\$20,469,000	\$0
6	LOS ANGELES COUNTY HOSPITAL INTAKES	\$37,808,000	\$34,513,500	\$3,294,500	\$0
7	ENHANCED FEDERAL FUNDING	\$0	\$502,884,750	(\$502,884,750)	\$0
8	SAVE	\$0	\$4,000,000	(\$4,000,000)	\$0
	OTHER SUBTOTAL	\$2,680,680,000	\$1,943,063,750	\$737,616,250	\$0
	GRAND TOTAL	\$2,680,680,000	\$1,943,063,750	\$737,616,250	\$0

**MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE COST BREAKDOWN
FISCAL YEAR 2023-24**

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	\$2,350,566,000	\$0	\$2,350,566,000	\$1,175,283,000
2	SAWS	\$161,565,000	\$0	\$0	\$0	\$161,565,000	\$553,000
4	CALWORKS APPLICATIONS	\$0	\$0	\$89,803,000	\$0	\$89,803,000	\$44,901,500
5	CASE MANAGEMENT FOR OTLICP	\$0	\$0	\$0	\$40,938,000	\$40,938,000	\$20,469,000
6	LOS ANGELES COUNTY HOSPITAL INTAKES	\$0	\$0	\$0	\$37,808,000	\$37,808,000	\$3,294,500
7	ENHANCED FEDERAL FUNDING	\$0	\$0	\$0	\$0	\$0	(\$502,884,750)
8	SAVE	\$0	\$0	\$0	\$0	\$0	(\$4,000,000)
	OTHER SUBTOTAL	\$161,565,000	\$0	\$2,440,369,000	\$78,746,000	\$2,680,680,000	\$737,616,250
	GRAND TOTAL	\$161,565,000	\$0	\$2,440,369,000	\$78,746,000	\$2,680,680,000	\$737,616,250

**COMPARISON OF FISCAL IMPACTS OF COUNTY ADMINISTRATION POLICY CHANGES
NOVEMBER 2022 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2022-23**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2022-23 APPROPRIATION		NOV. 2022 EST. FOR 2022-23		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
1	1	COUNTY ADMINISTRATION ALLOCATION	\$2,267,136,000	\$1,133,568,000	\$2,267,136,000	\$1,133,568,000	\$0	\$0
2	2	SAWS	\$141,318,000	\$5,324,500	\$188,139,000	\$233,500	\$46,821,000	(\$5,091,000)
3	3	FUNDING FOR COUNTY REDETERMINATIONS	\$109,523,000	\$54,761,500	\$109,523,000	\$54,761,500	\$0	\$0
4	4	CALWORKS APPLICATIONS	\$64,321,000	\$32,160,500	\$81,594,000	\$40,797,000	\$17,273,000	\$8,636,500
5	5	CASE MANAGEMENT FOR OTLICP	\$43,206,000	\$21,603,000	\$43,206,000	\$21,603,000	\$0	\$0
6	6	LOS ANGELES COUNTY HOSPITAL INTAKES	\$38,919,000	\$4,824,500	\$37,808,000	\$3,294,500	(\$1,111,000)	(\$1,530,000)
7	7	ENHANCED FEDERAL FUNDING	\$0	(\$510,813,000)	\$0	(\$496,226,000)	\$0	\$14,587,000
8	8	SAVE	\$0	(\$4,000,000)	\$0	(\$4,000,000)	\$0	\$0
		OTHER SUBTOTAL	\$2,664,423,000	\$737,429,000	\$2,727,406,000	\$754,031,500	\$62,983,000	\$16,602,500
		COUNTY ADMINISTRATION GRAND TOTAL	\$2,664,423,000	\$737,429,000	\$2,727,406,000	\$754,031,500	\$62,983,000	\$16,602,500

**COMPARISON OF FISCAL IMPACTS OF COUNTY ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2022-23 AND 2023-24**

NO.	POLICY CHANGE TITLE	NOV. 2022 EST. FOR 2022-23		NOV. 2022 EST. FOR 2023-24		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER						
1	COUNTY ADMINISTRATION ALLOCATION	\$2,267,136,000	\$1,133,568,000	\$2,350,566,000	\$1,175,283,000	\$83,430,000	\$41,715,000
2	SAWS	\$188,139,000	\$233,500	\$161,565,000	\$553,000	(\$26,574,000)	\$319,500
3	FUNDING FOR COUNTY REDETERMINATIONS	\$109,523,000	\$54,761,500	\$0	\$0	(\$109,523,000)	(\$54,761,500)
4	CALWORKS APPLICATIONS	\$81,594,000	\$40,797,000	\$89,803,000	\$44,901,500	\$8,209,000	\$4,104,500
5	CASE MANAGEMENT FOR OTLICP	\$43,206,000	\$21,603,000	\$40,938,000	\$20,469,000	(\$2,268,000)	(\$1,134,000)
6	LOS ANGELES COUNTY HOSPITAL INTAKES	\$37,808,000	\$3,294,500	\$37,808,000	\$3,294,500	\$0	\$0
7	ENHANCED FEDERAL FUNDING	\$0	(\$496,226,000)	\$0	(\$502,884,750)	\$0	(\$6,658,750)
8	SAVE	\$0	(\$4,000,000)	\$0	(\$4,000,000)	\$0	\$0
	OTHER SUBTOTAL	\$2,727,406,000	\$754,031,500	\$2,680,680,000	\$737,616,250	(\$46,726,000)	(\$16,415,250)
	COUNTY ADMINISTRATION GRAND TOTAL	\$2,727,406,000	\$754,031,500	\$2,680,680,000	\$737,616,250	(\$46,726,000)	(\$16,415,250)

**MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE INDEX****POLICY CHANGE
NUMBER****POLICY CHANGE TITLE**

OTHER

1	COUNTY ADMINISTRATION ALLOCATION
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5	CASE MANAGEMENT FOR OTLICP
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7	ENHANCED FEDERAL FUNDING
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COUNTY ADMINISTRATION ALLOCATION

COUNTY ADMIN. POLICY CHANGE NUMBER: 1
IMPLEMENTATION DATE: 7/2012
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 1704

	FY 2022-23		FY 2023-24	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$2,267,136,000	\$0	\$2,350,566,000
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$2,267,136,000	\$0	\$2,350,566,000
STATE FUNDS	\$0	\$1,133,568,000	\$0	\$1,175,283,000
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$2,267,136,000	\$0	\$2,350,566,000
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$2,267,136,000	\$0	\$2,350,566,000
STATE FUNDS	\$0	\$1,133,568,000	\$0	\$1,175,283,000

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 2022-23. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to the Department increasing the total allocation by 3.68% for the projected California CPI, resulting in an \$83M increase.

Methodology:

- The total rounded estimated FY 2022-23 and FY 2023-24 county administration costs are:

(Dollars in Thousands)

Total Allocation	TF	GF	FF
FY 2022-23	\$2,267,136	\$1,133,568	\$1,133,568
FY 2023-24	\$2,350,566	\$1,175,283	\$1,175,283

* Totals may differ due to rounding

Funding:

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

Medicaid Management Information Systems Enhanced Funding identified in the Enhanced Federal Funding policy change

SAWS

COUNTY ADMIN. POLICY CHANGE NUMBER: 2
IMPLEMENTATION DATE: 7/1987
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 214

	FY 2022-23		FY 2023-24	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$188,139,000	\$0	\$161,565,000	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$188,139,000	\$0	\$161,565,000	\$0
STATE FUNDS	\$233,500	\$0	\$553,000	\$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.	\$188,139,000	\$0	\$161,565,000	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$188,139,000	\$0	\$161,565,000	\$0
STATE FUNDS	\$233,500	\$0	\$553,000	\$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.

Authority:

Welfare & Institutions Code 14154
 Interagency Agreement # 04-35639
 Interagency Agreement CalHEERS # 14-90510
 Affordable Care Act (ACA)
 SIRFRA 1099

Interdependent Policy Changes:

Not Applicable

Background:

The Statewide Automated Welfare Systems (SAWS) consists of two county consortium systems: California Statewide Automated Welfare System (CalSAWS) and the 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.

CalSAWS is the automated system used in Los Angeles County and the 39 counties that formerly used the Consortium-IV (C-IV) system; it is currently in the maintenance and operations phase. The CalWIN consortium is used by 18 counties and currently in the maintenance and operation phase.

SAWS

COUNTY ADMIN. POLICY CHANGE NUMBER: 2

The State Strategy for Eligibility Systems and ABX1 16 (Chapter 13, Statutes of 2011) dictate the migration of the 39 C-IV counties into a system jointly designed by the C-IV counties and Los Angeles County under the LRS contract. LRS was developed using the C-IV system as the baseline. The C-IV migration to a modified LRS in September 2021, resulted in a new consortium system called CalSAWS (originally named CalACES). CalSAWS replaced both LRS and C-IV.

The process of migrating the CalWIN counties to CalSAWS is scheduled to begin in October 2022 and continue through October 2023, after modifications are made to meet CalWIN county needs.

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. With the introduction of the new forms, DHCS will be instructing CalSAWS to program forms and notices in six additional threshold languages (an increase from the current 12, plus English).

Reason for Change:

The change from the prior estimate, for FY 2022-23, is an increase in total funds and decrease in general funds due to updated expenditure data provided by CDSS.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to updated expenditure data provided by CDSS, with some expenditure data costs only occurring in FY 2022-23.

SAWS
COUNTY ADMIN. POLICY CHANGE NUMBER: 2

Methodology:

- The following estimate was provided by CDSS on a cash basis:

(Dollars in Thousands)

Line Item	FY 2022-23	FY 2023-24
CalSAWS M&O	\$3,433	\$4,383
CalSAWS Project	\$120,665	\$132,195
Global Telephonic Signature	\$1,968	\$0
Medi-Cal Renewal Packet Printing	\$241	\$419
Cost of Annual Redetermination Forms	\$9,701	\$0
PHE Additional Contact Attempt	\$1,435	\$1,781
Resume Pre-Pandemic Medi-Cal Operations	\$1,366	\$0
Shared Application Forms Revisions	\$2,588	\$0
SB 1341 Medi-Cal/SAWS	\$5,580	\$0
Statewide Project Management	\$2,637	\$3,216
Californians Full Scope Expansion - Ages 26 through 49	\$0	\$553
Older Californians Full Scope Expansion	\$89	\$0
WCDS-CalWIN	\$37,859	\$19,017
Adult M/C Redeterminations	\$578	\$0
Total	\$188,139	\$161,565

*Totals may differ due to rounding.

- There is a \$233,000 GF expenditure in FY 2022-23 for the undocumented older Californians full-scope expansion and for the Medi-Cal redeterminations alignment. In FY 2023-24, there is a \$553,000 GF expenditure for the undocumented Californians ages 26 through 49 full-scope expansion.
- Assume an estimated cost of **\$188,139,000 TF (\$233,000 GF)** in **FY 2022-23** and **\$161,565,000 TF (\$553,000 GF)** in **FY 2023-24**.

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: 7/2022
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 2282

	FY 2022-23		FY 2023-24	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$109,523,000	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$109,523,000	\$0	\$0	\$0
STATE FUNDS	\$54,761,500	\$0	\$0	\$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$109,523,000	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$109,523,000	\$0	\$0	\$0
STATE FUNDS	\$54,761,500	\$0	\$0	\$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.

The PHE is assumed to end in FY 2022-23. Some funding has already been distributed to counties based on the May 2021 Appropriation. Additionally, if the federal government does not further extend the federal PHE, redeterminations will be required to begin in May 2023, requiring DHCS to start flowing this funding to counties in the current year.

Reason for Change:

There is no change from the prior estimate for FY 2022-23. There is a decrease for FY 2022-23 to FY 2023-24, in the current estimate, to align with the assumed end of the PHE occurring in FY 2022-23.

Methodology:

1. Assume the PHE continues through mid-April 2023.
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 costs associated with the processing of the redeterminations caseload are:

(Dollars in Thousands)

Fiscal Years	TF	GF	FF
FY 2022-23	\$109,523	\$54,762	\$54,761
FY 2023-24	\$0	\$0	\$0

*Totals may differ due to rounding.

Funding:

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

CALWORKS APPLICATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER: 4
IMPLEMENTATION DATE: 7/1998
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 217

	FY 2022-23		FY 2023-24	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$81,594,000	\$0	\$89,803,000
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$81,594,000	\$0	\$89,803,000
STATE FUNDS	\$0	\$40,797,000	\$0	\$44,901,500
% 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	\$81,594,000	\$0	\$89,803,000
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$81,594,000	\$0	\$89,803,000
STATE FUNDS	\$0	\$40,797,000	\$0	\$44,901,500

Purpose:

This policy change estimates the Medi-Cal portion of the shared costs for processing applications which are submitted through CalWORKS and/or CalFresh programs. These costs include staff and support costs.

Authority:

Welfare & Institutions Code 14154

Interdependent Policy Changes:

Not Applicable

Background:

Since 1998, the Department has shared in the costs for CalWORKS applications with the California Department of Social Services (CDSS). CDSS amended the claim forms and time study documents completed by the counties to allow CalWORKS application costs that are also necessary for Medi-Cal and CalFresh eligibility, to be shared between the three programs.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is an increase due to an updated cash estimate provided by CDSS. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to a projected increase in expenditures based on the most recent quarters of available data.

Methodology:

1. The estimated costs for FY 2022-23 and FY 2023-24 are provided on a cash basis by CDSS:

CALWORKS APPLICATIONS
COUNTY ADMIN. POLICY CHANGE NUMBER: 4

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2022-23	\$81,594	\$40,797	\$40,797
FY 2023-24	\$89,803	\$44,902	\$44,901

*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: Sabrina Blank
FISCAL REFERENCE NUMBER: 1598

	FY 2022-23		FY 2023-24	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$43,206,000	\$0	\$40,938,000
TOTAL FUNDS	\$0	\$43,206,000	\$0	\$40,938,000
STATE FUNDS	\$0	\$21,603,000	\$0	\$20,469,000
% 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	\$43,206,000	\$0	\$40,938,000
TOTAL FUNDS	\$0	\$43,206,000	\$0	\$40,938,000
STATE FUNDS	\$0	\$21,603,000	\$0	\$20,469,000

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 2022-23 from the prior estimate. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to lower estimated eligible trends in FY 2023-24.

Methodology:

1. The Department currently estimates the case management and redetermination for the former OTLICP beneficiaries at \$4.00 Per Member Per Month.

CASE MANAGEMENT FOR OTLICP
COUNTY ADMIN. POLICY CHANGE NUMBER: 5

2. The estimated average monthly OTLICP eligibles for FY 2022-23 is 900,122 and 825,885 for FY 2023-24.

3. The estimated costs are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2022-23	\$43,206	\$21,603	\$21,603
FY 2023-24	\$40,938	\$20,469	\$20,469

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: Sabrina Blank
FISCAL REFERENCE NUMBER: 213

	FY 2022-23		FY 2023-24	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$37,808,000	\$0	\$37,808,000
TOTAL FUNDS	\$0	\$37,808,000	\$0	\$37,808,000
STATE FUNDS	\$0	\$3,294,500	\$0	\$3,294,500
% 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	\$37,808,000	\$0	\$37,808,000
TOTAL FUNDS	\$0	\$37,808,000	\$0	\$37,808,000
STATE FUNDS	\$0	\$3,294,500	\$0	\$3,294,500

Purpose:

The policy change estimates the costs for Patient Financial Services Workers (PFSWs) to process Medi-Cal applications taken in Los Angeles County hospitals.

Authority:

Welfare & Institutions Code (W&I) 14154

Interdependent Policy Changes:

Not Applicable

Background:

Los Angeles County uses PFSWs to collect and process Medi-Cal applications taken in Los Angeles County hospitals. Los Angeles County hospitals send applications processed by the PFSWs to the Los Angeles County Human Services Agency for final eligibility determination. W&I Section 14154 limits the reimbursement amount for PFSW intakes to the amount paid to Los Angeles County Department of Social Services (DPSS) eligibility workers for regular Medi-Cal intakes. The Department passes through the federal share for any costs not covered by the DPSS rate to the county.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a decrease due to a decrease in expenditure data. There is no change from FY 2022-23 to FY 2023-24 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 2022-23 and FY 2023-24, PFSWs will continue processing a base caseload of 2,215 per month.

FY 2022-23: 2,215 x \$268 x 12 = \$7,123,000 TF (\$3,562,000 GF)

FY 2023-24: 2,215 x \$268 x 12 = \$7,123,000 TF (\$3,562,000 GF)

2. The Department completed the FY 2020-21 reconciliation in FY 2021-22. The FY 2022-23 and FY 2023-24 reconciliation amounts are placeholders.

(Dollars in Thousands)

Line Item	FY 2022-23			FY 2023-24		
	TF	GF	FF	TF	GF	FF
PFSW Base	\$7,123	\$3,561	\$3,562	\$7,123	\$3,561	\$3,562
FY 2020-21 Recon.	\$15,076	(\$267)	\$15,343			
FY 2020-21 Pass.	\$15,609	\$0	\$15,609			
FY 2021-22 Recon.				\$15,076	(\$267)	\$15,343
FY 2021-22 Pass.				\$15,609	\$0	\$15,609
Total	\$37,808	\$3,294	\$34,514	\$37,808	\$3,294	\$34,514

Funding:

(Dollars in Thousands)

FY 2022-23	Fund Number	TF	GF	FF
50% Title XIX FF/ 50% GF	4260-101-0890/0001	\$7,123	\$3,561	\$3,562
100% Title XIX FF	4260-101-0890	\$30,952	\$0	\$30,952
100% GF	4260-101-0001	(\$267)	(\$267)	\$0
Total		\$37,808	\$3,294	\$34,514

FY 2023-24	Fund Number	TF	GF	FF
50% Title XIX FF/ 50% GF	4260-101-0890/0001	\$7,123	\$3,561	\$3,562
100% Title XIX FF	4260-101-0890	\$30,952	\$0	\$30,952
100% GF	4260-101-0001	(\$267)	(\$267)	\$0
Total		\$37,808	\$3,294	\$34,514

ENHANCED FEDERAL FUNDING

COUNTY ADMIN. POLICY CHANGE NUMBER: 7
IMPLEMENTATION DATE: 7/2022
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 1835

	FY 2022-23		FY 2023-24	
	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	-\$496,226,000	\$0	-\$502,884,750	\$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	-\$496,226,000	\$0	-\$502,884,750	\$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 2022 on September 21, 2021.

Reason for Change:

The change from the prior estimate, for FY 2022-23, 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 2022-23 to FY 2023-24, in the current estimate, is an increase in GF savings due to updated estimated claim funding projections that utilize the expenditure trends from prior claim actuals for 2 quarters of FY 2020-21 and 2 quarters of FY 2021-22.

Methodology:

1. The effective date for the Department's APD was August 3, 2021.
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 2022-23, the Department will claim payments for FY 2021-22 quarters 2 through 4 and FY 2022-23 quarter 1. In FY 2023-24, the Department will claim payments for FY 2022-23 quarters 2 through 4 and FY 2023-24 quarter 1.
5. The savings are estimated to be:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Title XIX at 50% FFP	(\$1,984,904)	(\$992,452)	(\$992,452)
Title XIX at 75% FFP	\$1,984,904	\$496,226	\$1,488,678
Total	\$0	(\$496,226)	\$496,226

FY 2023-24	TF	GF	FF
Title XIX at 50% FFP	(\$2,011,539)	(\$1,005,770)	(\$1,005,770)
Title XIX at 75% FFP	\$2,011,539	\$502,885	\$1,508,654
Total	\$0	(\$502,885)	\$502,885

*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: Sabrina Blank
FISCAL REFERENCE NUMBER: 215

	FY 2022-23		FY 2023-24	
	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 2022-23, or in the current estimate for FY 2022-23 to FY 2023-24.

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 2017-18	\$7,747,115	FY 2020-21	\$8,000,000
FY 2018-19	\$8,115,482	FY 2021-22	\$8,000,000
FY 2019-20	\$7,514,685	FY 2022-23	\$8,000,000
*FY 2020-21	\$8,000,000	FY 2023-24	\$8,000,000

* Actual costs for FY 2020-21 still pending final reconciliation.

3. Based on claims through June 2020, federal funds will be:

(Dollars in Thousands)

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

FY 2023-24	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 2022 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 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	\$3,691,179,000	\$2,711,935,000	\$879,646,000	\$99,598,000
Fiscal Intermediary	\$525,323,000	\$362,920,000	\$162,403,000	\$0
Total Other Administration Tab	\$4,216,502,000	\$3,074,855,000	\$1,042,049,000	\$99,598,000

Management Summary:

COUNTY ADMINISTRATION	\$6,418,586,000	\$4,685,310,000	\$1,633,678,000	\$99,598,000
Shown in Other Administration Tab	\$3,691,179,000	\$2,711,935,000	\$879,646,000	\$99,598,000
Shown in County Administration Tab	\$2,727,407,000	\$1,973,375,000	\$754,032,000	\$0
FISCAL INTERMEDIARY	\$525,323,000	\$362,920,000	\$162,403,000	\$0
Shown in Other Administration Tab	\$525,323,000	\$362,920,000	\$162,403,000	\$0

<u>FY 2023-2024 Estimate:</u>	<u>Total Funds</u>	<u>Federal Funds</u>	<u>General Funds</u>	<u>Other State Funds</u>
OTHER ADMINISTRATION				
County Administration	\$3,396,642,000	\$2,633,525,000	\$673,949,000	\$89,168,000
Fiscal Intermediary	\$591,874,000	\$427,949,000	\$163,925,000	\$0
Total Other Administration Tab	\$3,988,516,000	\$3,061,474,000	\$837,874,000	\$89,168,000

Management Summary:

COUNTY ADMINISTRATION	\$6,077,322,000	\$4,576,589,000	\$1,411,565,000	\$89,168,000
Shown in Other Administration Tab	\$3,396,642,000	\$2,633,525,000	\$673,949,000	\$89,168,000
Shown in County Administration Tab	\$2,680,680,000	\$1,943,064,000	\$737,616,000	\$0
FISCAL INTERMEDIARY	\$591,874,000	\$427,949,000	\$163,925,000	\$0
Shown in Other Administration Tab	\$591,874,000	\$427,949,000	\$163,925,000	\$0

**SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2022-23**

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>DHCS-OTHER</u>					
1	CALAIM - MEDI-CAL PATH	\$711,900,000	\$355,950,000	\$271,215,000	\$84,735,000
2	CYBHI - BH SERVICES AND SUPPORTS PLATFORM	\$230,000,000	\$0	\$230,000,000	\$0
3	COUNTY SPECIALTY MENTAL HEALTH ADMIN	\$211,566,000	\$205,845,000	\$5,721,000	\$0
4	CCS CASE MANAGEMENT	\$180,198,000	\$114,276,350	\$65,921,650	\$0
5	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$164,305,000	\$164,305,000	\$0	\$0
6	CALAIM - POPULATION HEALTH MANAGEMENT	\$49,601,000	\$44,640,900	\$4,960,100	\$0
7	INTERIM AND FINAL COST SETTLEMENTS-SMHS	\$130,710,000	\$130,710,000	\$0	\$0
8	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$120,155,000	\$120,155,000	\$0	\$0
9	MEDI-CAL RX - ADMINISTRATIVE COSTS	\$116,208,000	\$86,138,150	\$30,069,850	\$0
10	COVID-19 VACCINATION INCENTIVE PROGRAM ADMIN	\$100,000,000	\$50,000,000	\$50,000,000	\$0
11	SMH MAA	\$49,608,000	\$49,608,000	\$0	\$0
12	COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE	\$48,143,000	\$28,942,000	\$19,201,000	\$0
13	DRUG MEDI-CAL COUNTY ADMINISTRATION	\$44,734,000	\$44,642,000	\$92,000	\$0
14	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	\$43,371,000	\$20,295,150	\$23,075,850	\$0
15	DATA REPORTING AND ANALYTICS SUPPORT SYSTEMS	\$41,618,000	\$31,882,350	\$9,735,650	\$0
16	CHDP COUNTY ALLOCATION	\$33,962,000	\$23,387,000	\$10,575,000	\$0
17	POSTAGE & PRINTING	\$32,331,000	\$16,037,000	\$16,294,000	\$0
18	ACTUARIAL COSTS FOR RATE DEVELOPMENT	\$29,995,000	\$14,997,500	\$14,847,500	\$150,000
19	HITECH AND PUBLIC HEALTH REGISTRIES SUPPORT	\$20,711,000	\$20,673,000	\$38,000	\$0
20	HEALTH ENROLLMENT NAVIGATORS	\$19,106,000	\$9,553,000	\$9,553,000	\$0
21	MEDI-CAL RECOVERY CONTRACTS	\$17,957,000	\$13,467,750	\$4,489,250	\$0
22	HCBA WAIVER ADMINISTRATIVE COST	\$17,484,000	\$8,742,000	\$8,742,000	\$0
23	PAVE SYSTEM	\$16,413,000	\$11,886,850	\$4,526,150	\$0
24	CAPMAN	\$12,210,000	\$9,036,550	\$3,173,450	\$0
25	MITA	\$11,571,000	\$10,101,600	\$1,469,400	\$0
26	LITIGATION RELATED SERVICES	\$9,980,000	\$4,990,000	\$4,990,000	\$0
27	PASRR	\$9,399,000	\$7,049,250	\$2,349,750	\$0
28	LA COUNTY PUBLIC HEALTH NURSING PILOT	\$8,250,000	\$8,250,000	\$0	\$0
29	ELECTRONIC ASSET VERIFICATION PROGRAM	\$7,841,000	\$3,920,500	\$3,920,500	\$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>DHCS-OTHER</u>					
30	NEWBORN HEARING SCREENING PROGRAM	\$6,273,000	\$3,136,500	\$3,136,500	\$0
31	CCI-ADMINISTRATIVE COSTS	\$5,958,000	\$2,979,000	\$2,979,000	\$0
32	STATEWIDE VERIFICATION HUB	\$5,188,000	\$4,669,200	\$518,800	\$0
33	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	\$5,014,000	\$3,192,000	\$1,822,000	\$0
34	MFP/CCT SUPPLEMENTAL FUNDING	\$5,000,000	\$5,000,000	\$0	\$0
35	DRUG MEDI-CAL PARITY RULE ADMINISTRATION	\$4,407,000	\$2,938,000	\$1,469,000	\$0
36	MEDCOMPASS SOLUTION	\$3,973,000	\$3,554,550	\$418,450	\$0
37	PACES	\$3,327,000	\$2,637,650	\$689,350	\$0
38	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	\$2,862,000	\$377,000	\$2,485,000	\$0
39	T-MSIS	\$2,748,000	\$2,311,250	\$436,750	\$0
40	SDMC SYSTEM M&O SUPPORT	\$2,285,000	\$1,142,500	\$1,142,500	\$0
41	HCBS SP - CONTINGENCY MANAGEMENT ADMIN	\$2,084,000	\$1,042,000	\$0	\$1,042,000
42	FIELD TESTING OF MEDI-CAL MATERIALS	\$2,000,000	\$1,000,000	\$1,000,000	\$0
43	PROTECTION OF PHI DATA	\$1,861,000	\$930,500	\$930,500	\$0
44	CALIFORNIA HEALTH INTERVIEW SURVEY	\$1,464,000	\$1,432,000	\$32,000	\$0
45	SSA COSTS FOR HEALTH COVERAGE INFO.	\$1,317,000	\$658,500	\$658,500	\$0
46	FAMILY PACT PROGRAM ADMIN.	\$1,207,000	\$1,086,300	\$120,700	\$0
47	MMA - DSH ANNUAL INDEPENDENT AUDIT	\$795,000	\$397,500	\$397,500	\$0
48	MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM	\$667,000	\$333,500	\$333,500	\$0
49	CCT OUTREACH - ADMINISTRATIVE COSTS	\$340,000	\$340,000	\$0	\$0
50	CARE COURT - OTHER ADMIN	\$57,000,000	\$0	\$57,000,000	\$0
51	CMS DEFERRED CLAIMS - OTHER ADMIN	\$0	\$5,760,000	(\$5,760,000)	\$0
52	COVID-19 INCREASED FMAP - OTHER ADMIN	\$0	\$1,663,000	(\$1,663,000)	\$0
90	EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.	\$15,233,000	\$15,233,000	\$0	\$0
93	OUTREACH & ENROLLMENT ASSIST. FOR DUAL BENES	\$8,600,000	\$4,300,000	\$4,300,000	\$0
	DHCS-OTHER SUBTOTAL	\$2,628,930,000	\$1,675,595,850	\$867,407,150	\$85,927,000
<u>DHCS-MEDICAL FI</u>					
53	MEDICAL FI BO & IT COST REIMBURSEMENT	\$50,389,000	\$36,358,450	\$14,030,550	\$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-MEDICAL FI</u>					
54	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	\$47,640,000	\$35,117,750	\$12,522,250	\$0
55	MEDICAL FI IT INFRASTRUCTURE SERVICES	\$32,762,000	\$24,150,200	\$8,611,800	\$0
56	MEDICAL FI BO & IT CHANGE ORDERS	\$30,081,000	\$21,922,800	\$8,158,200	\$0
57	MEDICAL FI BO OTHER ESTIMATED COSTS	\$23,880,000	\$16,630,950	\$7,249,050	\$0
58	MEDICAL FI BO TELEPHONE SERVICE CENTER	\$17,002,000	\$11,913,300	\$5,088,700	\$0
59	MEDICAL FI BUSINESS OPERATIONS	\$15,498,000	\$11,424,600	\$4,073,400	\$0
60	MEDICAL FI BO HOURLY REIMBURSEMENT	\$11,215,000	\$8,267,500	\$2,947,500	\$0
61	MEDICAL FI BO MISCELLANEOUS EXPENSES	\$2,355,000	\$1,607,350	\$747,650	\$0
	DHCS-MEDICAL FI SUBTOTAL	\$230,822,000	\$167,392,900	\$63,429,100	\$0
<u>DHCS-HEALTH CARE OPT</u>					
62	HCO OPERATIONS 2017 CONTRACT	\$40,662,000	\$20,635,950	\$20,026,050	\$0
63	HCO COST REIMBURSEMENT 2017 CONTRACT	\$31,960,000	\$16,219,700	\$15,740,300	\$0
64	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	\$15,642,000	\$7,938,300	\$7,703,700	\$0
	DHCS-HEALTH CARE OPT SUBTOTAL	\$88,264,000	\$44,793,950	\$43,470,050	\$0
<u>DHCS-DENTAL FI</u>					
65	DENTAL ASO ADMINISTRATION 2016 CONTRACT	\$52,773,000	\$33,599,500	\$19,173,500	\$0
66	DENTAL FI ADMINISTRATION 2016 CONTRACT	\$21,479,000	\$15,531,000	\$5,948,000	\$0
67	DENTAL FI-DBO ADMIN 2022 CONTRACT	\$15,411,000	\$13,869,900	\$1,541,100	\$0
	DHCS-DENTAL FI SUBTOTAL	\$89,663,000	\$63,000,400	\$26,662,600	\$0
<u>OTHER DEPARTMENTS</u>					
68	PERSONAL CARE SERVICES	\$453,963,000	\$453,963,000	\$0	\$0
69	HEALTH-RELATED ACTIVITIES - CDSS	\$315,336,000	\$315,336,000	\$0	\$0
70	CALHEERS DEVELOPMENT	\$152,282,000	\$111,750,850	\$40,531,150	\$0
71	CDDS ADMINISTRATIVE COSTS	\$101,320,000	\$101,320,000	\$0	\$0
72	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	\$54,682,000	\$41,011,000	\$0	\$13,671,000
73	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	\$28,357,000	\$28,357,000	\$0	\$0
74	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	\$4,147,000	\$4,147,000	\$0	\$0

**SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2022-23**

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
OTHER DEPARTMENTS					
75	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	\$5,803,000	\$5,803,000	\$0	\$0
76	CLPP CASE MANAGEMENT SERVICES	\$650,000	\$650,000	\$0	\$0
77	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG	\$5,316,000	\$5,316,000	\$0	\$0
78	HCBS SP CDDS - OTHER ADMIN	\$2,833,000	\$2,833,000	\$0	\$0
79	CALIFORNIA SMOKERS' HELPLINE	\$2,400,000	\$2,400,000	\$0	\$0
80	KIT FOR NEW PARENTS	\$1,044,000	\$1,044,000	\$0	\$0
81	MEDI-CAL INPATIENT SERVICES FOR INMATES	\$1,121,000	\$1,121,000	\$0	\$0
82	VETERANS BENEFITS	\$1,100,000	\$1,100,000	\$0	\$0
83	CALHHS AGENCY HIPAA FUNDING	\$1,037,000	\$1,037,000	\$0	\$0
84	VITAL RECORDS	\$883,000	\$881,000	\$2,000	\$0
85	MATERNAL AND CHILD HEALTH	\$45,269,000	\$45,269,000	\$0	\$0
86	MERIT SYSTEM SERVICES FOR COUNTIES	\$190,000	\$95,000	\$95,000	\$0
87	CDPH I&E PROGRAM AND EVALUATION	\$187,000	\$187,000	\$0	\$0
88	PIA EYEWEAR COURIER SERVICE	\$903,000	\$451,500	\$451,500	\$0
	OTHER DEPARTMENTS SUBTOTAL	\$1,178,823,000	\$1,124,072,350	\$41,079,650	\$13,671,000
	GRAND TOTAL	\$4,216,502,000	\$3,074,855,450	\$1,042,048,550	\$99,598,000

**SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2023-24**

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	<u>DHCS-OTHER</u>				
1	CALAIM - MEDI-CAL PATH	\$599,900,000	\$299,950,000	\$271,950,000	\$28,000,000
2	CYBHI - BH SERVICES AND SUPPORTS PLATFORM	\$124,900,000	\$0	\$124,900,000	\$0
3	COUNTY SPECIALTY MENTAL HEALTH ADMIN	\$296,894,000	\$259,567,000	\$6,975,000	\$30,352,000
4	CCS CASE MANAGEMENT	\$193,761,000	\$122,425,600	\$71,335,400	\$0
5	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$156,458,000	\$156,458,000	\$0	\$0
6	CALAIM - POPULATION HEALTH MANAGEMENT	\$52,668,000	\$47,401,200	\$5,266,800	\$0
7	INTERIM AND FINAL COST SETTLEMENTS-SMHS	\$128,674,000	\$128,674,000	\$0	\$0
8	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$111,318,000	\$111,318,000	\$0	\$0
9	MEDI-CAL RX - ADMINISTRATIVE COSTS	\$102,395,000	\$94,683,000	\$7,712,000	\$0
11	SMH MAA	\$55,325,000	\$55,325,000	\$0	\$0
12	COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE	\$48,143,000	\$28,942,000	\$19,201,000	\$0
13	DRUG MEDI-CAL COUNTY ADMINISTRATION	\$64,360,000	\$51,247,000	\$99,000	\$13,014,000
14	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	\$40,987,000	\$19,238,900	\$21,748,100	\$0
15	DATA REPORTING AND ANALYTICS SUPPORT SYSTEMS	\$43,405,000	\$31,984,850	\$11,420,150	\$0
16	CHDP COUNTY ALLOCATION	\$33,962,000	\$23,387,000	\$10,575,000	\$0
17	POSTAGE & PRINTING	\$32,331,000	\$16,037,000	\$16,294,000	\$0
18	ACTUARIAL COSTS FOR RATE DEVELOPMENT	\$32,175,000	\$16,087,500	\$15,937,500	\$150,000
19	HITECH AND PUBLIC HEALTH REGISTRIES SUPPORT	\$20,328,000	\$20,328,000	\$0	\$0
20	HEALTH ENROLLMENT NAVIGATORS	\$19,329,000	\$9,664,500	\$9,664,500	\$0
21	MEDI-CAL RECOVERY CONTRACTS	\$14,651,000	\$10,988,250	\$3,662,750	\$0
22	HCBA WAIVER ADMINISTRATIVE COST	\$20,504,000	\$10,252,000	\$10,252,000	\$0
23	PAVE SYSTEM	\$21,899,000	\$15,924,250	\$5,974,750	\$0
24	CAPMAN	\$16,081,000	\$11,963,100	\$4,117,900	\$0
25	MITA	\$14,111,000	\$12,319,000	\$1,792,000	\$0
26	LITIGATION RELATED SERVICES	\$9,980,000	\$4,990,000	\$4,990,000	\$0
27	PASRR	\$9,600,000	\$7,200,000	\$2,400,000	\$0
29	ELECTRONIC ASSET VERIFICATION PROGRAM	\$3,955,000	\$1,977,500	\$1,977,500	\$0
30	NEWBORN HEARING SCREENING PROGRAM	\$6,392,000	\$3,196,000	\$3,196,000	\$0
32	STATEWIDE VERIFICATION HUB	\$1,446,000	\$1,301,400	\$144,600	\$0

**SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2023-24**

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>DHCS-OTHER</u>					
33	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	\$3,083,000	\$1,751,250	\$1,331,750	\$0
35	DRUG MEDI-CAL PARITY RULE ADMINISTRATION	\$7,345,000	\$3,917,000	\$1,959,000	\$1,469,000
36	MEDCOMPASS SOLUTION	\$4,350,000	\$3,206,650	\$1,143,350	\$0
37	PACES	\$3,600,000	\$2,701,400	\$898,600	\$0
38	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	\$512,000	\$418,000	\$94,000	\$0
39	T-MSIS	\$2,458,000	\$2,092,300	\$365,700	\$0
40	SDMC SYSTEM M&O SUPPORT	\$1,992,000	\$996,000	\$996,000	\$0
41	HCBS SP - CONTINGENCY MANAGEMENT ADMIN	\$3,750,000	\$1,875,000	\$0	\$1,875,000
42	FIELD TESTING OF MEDI-CAL MATERIALS	\$100,000	\$50,000	\$50,000	\$0
43	PROTECTION OF PHI DATA	\$1,861,000	\$930,500	\$930,500	\$0
44	CALIFORNIA HEALTH INTERVIEW SURVEY	\$1,653,000	\$1,526,500	\$126,500	\$0
45	SSA COSTS FOR HEALTH COVERAGE INFO.	\$1,220,000	\$610,000	\$610,000	\$0
46	FAMILY PACT PROGRAM ADMIN.	\$1,207,000	\$1,086,300	\$120,700	\$0
47	MMA - DSH ANNUAL INDEPENDENT AUDIT	\$800,000	\$400,000	\$400,000	\$0
48	MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM	\$2,000,000	\$1,000,000	\$1,000,000	\$0
49	CCT OUTREACH - ADMINISTRATIVE COSTS	\$340,000	\$340,000	\$0	\$0
50	CARE COURT - OTHER ADMIN	\$0	\$0	\$0	\$0
89	CALIFORNIA BH CBC DEMONSTRATION ADMIN	\$1,556,000	\$745,000	\$174,000	\$637,000
90	EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.	\$15,770,000	\$15,770,000	\$0	\$0
92	GENDER-AFFIRMING CARE	\$1,500,000	\$750,000	\$750,000	\$0
93	OUTREACH & ENROLLMENT ASSIST. FOR DUAL BENES	\$8,600,000	\$4,300,000	\$4,300,000	\$0
	DHCS-OTHER SUBTOTAL	\$2,339,629,000	\$1,617,295,950	\$646,836,050	\$75,497,000
<u>DHCS-MEDICAL FI</u>					
53	MEDICAL FI BO & IT COST REIMBURSEMENT	\$56,483,000	\$40,816,400	\$15,666,600	\$0
54	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	\$47,012,000	\$34,655,250	\$12,356,750	\$0
55	MEDICAL FI IT INFRASTRUCTURE SERVICES	\$22,388,000	\$16,501,850	\$5,886,150	\$0
56	MEDICAL FI BO & IT CHANGE ORDERS	\$38,783,000	\$28,591,000	\$10,192,000	\$0
57	MEDICAL FI BO OTHER ESTIMATED COSTS	\$26,381,000	\$18,275,250	\$8,105,750	\$0

**SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2023-24**

<u>NO.</u>	<u>POLICY CHANGE TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>GENERAL FUNDS</u>	<u>OTHER STATE FUNDS</u>
<u>DHCS-MEDICAL FI</u>					
58	MEDICAL FI BO TELEPHONE SERVICE CENTER	\$18,197,000	\$12,750,600	\$5,446,400	\$0
59	MEDICAL FI BUSINESS OPERATIONS	\$16,582,000	\$12,223,400	\$4,358,600	\$0
60	MEDICAL FI BO HOURLY REIMBURSEMENT	\$12,000,000	\$8,845,600	\$3,154,400	\$0
61	MEDICAL FI BO MISCELLANEOUS EXPENSES	\$2,317,000	\$1,579,900	\$737,100	\$0
	DHCS-MEDICAL FI SUBTOTAL	\$240,143,000	\$174,239,250	\$65,903,750	\$0
<u>DHCS-HEALTH CARE OPT</u>					
62	HCO OPERATIONS 2017 CONTRACT	\$42,568,000	\$21,603,200	\$20,964,800	\$0
63	HCO COST REIMBURSEMENT 2017 CONTRACT	\$37,351,000	\$18,955,550	\$18,395,450	\$0
64	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	\$16,097,000	\$8,169,250	\$7,927,750	\$0
	DHCS-HEALTH CARE OPT SUBTOTAL	\$96,016,000	\$48,728,000	\$47,288,000	\$0
<u>DHCS-DENTAL FI</u>					
65	DENTAL ASO ADMINISTRATION 2016 CONTRACT	\$53,049,000	\$33,777,750	\$19,271,250	\$0
66	DENTAL FI ADMINISTRATION 2016 CONTRACT	\$21,690,000	\$15,687,000	\$6,003,000	\$0
67	DENTAL FI-DBO ADMIN 2022 CONTRACT	\$76,780,000	\$59,663,550	\$17,116,450	\$0
	DHCS-DENTAL FI SUBTOTAL	\$151,519,000	\$109,128,300	\$42,390,700	\$0
<u>OTHER DEPARTMENTS</u>					
68	PERSONAL CARE SERVICES	\$462,476,000	\$462,476,000	\$0	\$0
69	HEALTH-RELATED ACTIVITIES - CDSS	\$318,138,000	\$318,138,000	\$0	\$0
70	CALHEERS DEVELOPMENT	\$132,496,000	\$97,727,650	\$34,768,350	\$0
71	CDDS ADMINISTRATIVE COSTS	\$68,754,000	\$68,754,000	\$0	\$0
72	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	\$54,682,000	\$41,011,000	\$0	\$13,671,000
73	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	\$28,357,000	\$28,357,000	\$0	\$0
74	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	\$21,680,000	\$21,680,000	\$0	\$0
75	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	\$6,743,000	\$6,743,000	\$0	\$0
76	CLPP CASE MANAGEMENT SERVICES	\$3,897,000	\$3,897,000	\$0	\$0
77	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG	\$9,297,000	\$9,297,000	\$0	\$0
78	HCBS SP CDDS - OTHER ADMIN	\$632,000	\$632,000	\$0	\$0

**SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2023-24**

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
OTHER DEPARTMENTS					
79	CALIFORNIA SMOKERS' HELPLINE	\$2,400,000	\$2,400,000	\$0	\$0
80	KIT FOR NEW PARENTS	\$593,000	\$593,000	\$0	\$0
81	MEDI-CAL INPATIENT SERVICES FOR INMATES	\$1,166,000	\$1,166,000	\$0	\$0
82	VETERANS BENEFITS	\$1,100,000	\$1,100,000	\$0	\$0
83	CALHHS AGENCY HIPAA FUNDING	\$1,089,000	\$1,089,000	\$0	\$0
84	VITAL RECORDS	\$883,000	\$881,000	\$2,000	\$0
85	MATERNAL AND CHILD HEALTH	\$45,269,000	\$45,269,000	\$0	\$0
86	MERIT SYSTEM SERVICES FOR COUNTIES	\$190,000	\$95,000	\$95,000	\$0
87	CDPH I&E PROGRAM AND EVALUATION	\$187,000	\$187,000	\$0	\$0
88	PIA EYEWEAR COURIER SERVICE	\$1,180,000	\$590,000	\$590,000	\$0
	OTHER DEPARTMENTS SUBTOTAL	\$1,161,209,000	\$1,112,082,650	\$35,455,350	\$13,671,000
	GRAND TOTAL	\$3,988,516,000	\$3,061,474,150	\$837,873,850	\$89,168,000

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2022 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2022-23**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2022-23 APPROPRIATION		NOV. 2022 EST. FOR 2022-23		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		<u>DHCS-OTHER</u>						
--	1	CALAIM - MEDI-CAL PATH	\$0	\$0	\$711,900,000	\$271,215,000	\$711,900,000	\$271,215,000
25	2	CYBHI - BH SERVICES AND SUPPORTS PLATFORM	\$230,000,000	\$230,000,000	\$230,000,000	\$230,000,000	\$0	\$0
2	3	COUNTY SPECIALTY MENTAL HEALTH ADMIN	\$255,593,000	\$7,207,000	\$211,566,000	\$5,721,000	(\$44,027,000)	(\$1,486,000)
3	4	CCS CASE MANAGEMENT	\$145,299,000	\$51,027,450	\$180,198,000	\$65,921,650	\$34,899,000	\$14,894,200
4	5	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$162,149,000	\$0	\$164,305,000	\$0	\$2,156,000	\$0
7	6	CALAIM - POPULATION HEALTH MANAGEMENT	\$300,000,000	\$30,000,000	\$49,601,000	\$4,960,100	(\$250,399,000)	(\$25,039,900)
1	7	INTERIM AND FINAL COST SETTLEMENTS-SMHS	\$198,935,000	\$0	\$130,710,000	\$0	(\$68,225,000)	\$0
5	8	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$119,435,000	\$0	\$120,155,000	\$0	\$720,000	\$0
6	9	MEDI-CAL RX - ADMINISTRATIVE COSTS	\$98,801,000	\$19,400,100	\$116,208,000	\$30,069,850	\$17,407,000	\$10,669,750
83	10	COVID-19 VACCINATION INCENTIVE PROGRAM ADMIN	\$100,000,000	\$50,000,000	\$100,000,000	\$50,000,000	\$0	\$0
10	11	SMH MAA	\$46,714,000	\$0	\$49,608,000	\$0	\$2,894,000	\$0
44	12	COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE	\$48,143,000	\$19,201,000	\$48,143,000	\$19,201,000	\$0	\$0
8	13	DRUG MEDI-CAL COUNTY ADMINISTRATION	\$51,137,000	\$94,000	\$44,734,000	\$92,000	(\$6,403,000)	(\$2,000)
16	14	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	\$27,489,000	\$14,715,150	\$43,371,000	\$23,075,850	\$15,882,000	\$8,360,700
12	15	DATA REPORTING AND ANALYTICS SUPPORT SYSTEMS	\$29,846,000	\$7,504,600	\$41,618,000	\$9,735,650	\$11,772,000	\$2,231,050
14	16	CHDP COUNTY ALLOCATION	\$33,962,000	\$10,575,000	\$33,962,000	\$10,575,000	\$0	\$0
15	17	POSTAGE & PRINTING	\$30,696,000	\$15,476,500	\$32,331,000	\$16,294,000	\$1,635,000	\$817,500
17	18	ACTUARIAL COSTS FOR RATE DEVELOPMENT	\$29,417,000	\$14,561,500	\$29,995,000	\$14,847,500	\$578,000	\$286,000
13	19	HITECH AND PUBLIC HEALTH REGISTRIES SUPPORT	\$20,457,000	\$6,500	\$20,711,000	\$38,000	\$254,000	\$31,500
9	20	HEALTH ENROLLMENT NAVIGATORS	\$74,195,000	\$37,097,500	\$19,106,000	\$9,553,000	(\$55,089,000)	(\$27,544,500)

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2022 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2022-23**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2022-23 APPROPRIATION		NOV. 2022 EST. FOR 2022-23		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DHCS-OTHER						
23	21	MEDI-CAL RECOVERY CONTRACTS	\$10,139,000	\$2,534,750	\$17,957,000	\$4,489,250	\$7,818,000	\$1,954,500
18	22	HCBA WAIVER ADMINISTRATIVE COST	\$25,502,000	\$12,751,000	\$17,484,000	\$8,742,000	(\$8,018,000)	(\$4,009,000)
20	23	PAVE SYSTEM	\$16,721,000	\$4,613,200	\$16,413,000	\$4,526,150	(\$308,000)	(\$87,050)
21	24	CAPMAN	\$16,528,000	\$4,222,900	\$12,210,000	\$3,173,450	(\$4,318,000)	(\$1,049,450)
24	25	MITA	\$12,381,000	\$1,572,650	\$11,571,000	\$1,469,400	(\$810,000)	(\$103,250)
26	26	LITIGATION RELATED SERVICES	\$9,980,000	\$4,990,000	\$9,980,000	\$4,990,000	\$0	\$0
29	27	PASRR	\$6,666,000	\$1,666,500	\$9,399,000	\$2,349,750	\$2,733,000	\$683,250
19	28	LA COUNTY PUBLIC HEALTH NURSING PILOT	\$8,250,000	\$0	\$8,250,000	\$0	\$0	\$0
30	29	ELECTRONIC ASSET VERIFICATION PROGRAM	\$7,621,000	\$3,810,500	\$7,841,000	\$3,920,500	\$220,000	\$110,000
28	30	NEWBORN HEARING SCREENING PROGRAM	\$6,273,000	\$3,136,500	\$6,273,000	\$3,136,500	\$0	\$0
22	31	CCI-ADMINISTRATIVE COSTS	\$5,958,000	\$2,979,000	\$5,958,000	\$2,979,000	\$0	\$0
89	32	STATEWIDE VERIFICATION HUB	\$4,644,000	\$464,400	\$5,188,000	\$518,800	\$544,000	\$54,400
27	33	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	\$7,404,000	\$2,412,000	\$5,014,000	\$1,822,000	(\$2,390,000)	(\$590,000)
--	34	MFP/CCT SUPPLEMENTAL FUNDING	\$0	\$0	\$5,000,000	\$0	\$5,000,000	\$0
31	35	DRUG MEDI-CAL PARITY RULE ADMINISTRATION	\$4,407,000	\$1,469,000	\$4,407,000	\$1,469,000	\$0	\$0
32	36	MEDCOMPASS SOLUTION	\$3,984,000	\$1,262,950	\$3,973,000	\$418,450	(\$11,000)	(\$844,500)
33	37	PACES	\$3,389,000	\$751,100	\$3,327,000	\$689,350	(\$62,000)	(\$61,750)
11	38	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	\$2,853,000	\$2,484,000	\$2,862,000	\$2,485,000	\$9,000	\$1,000
35	39	T-MSIS	\$3,377,000	\$479,950	\$2,748,000	\$436,750	(\$629,000)	(\$43,200)
36	40	SDMC SYSTEM M&O SUPPORT	\$3,044,000	\$1,522,000	\$2,285,000	\$1,142,500	(\$759,000)	(\$379,500)
90	41	HCBS SP - CONTINGENCY MANAGEMENT ADMIN	\$11,330,000	\$0	\$2,084,000	\$0	(\$9,246,000)	\$0
88	42	FIELD TESTING OF MEDI-CAL MATERIALS	\$100,000	\$50,000	\$2,000,000	\$1,000,000	\$1,900,000	\$950,000
39	43	PROTECTION OF PHI DATA	\$1,888,000	\$944,000	\$1,861,000	\$930,500	(\$27,000)	(\$13,500)

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2022 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2022-23**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2022-23 APPROPRIATION		NOV. 2022 EST. FOR 2022-23		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		<u>DHCS-OTHER</u>						
38	44	CALIFORNIA HEALTH INTERVIEW SURVEY	\$1,400,000	\$0	\$1,464,000	\$32,000	\$64,000	\$32,000
37	45	SSA COSTS FOR HEALTH COVERAGE INFO.	\$1,328,000	\$664,000	\$1,317,000	\$658,500	(\$11,000)	(\$5,500)
40	46	FAMILY PACT PROGRAM ADMIN.	\$1,207,000	\$120,700	\$1,207,000	\$120,700	\$0	\$0
41	47	MMA - DSH ANNUAL INDEPENDENT AUDIT	\$800,000	\$400,000	\$795,000	\$397,500	(\$5,000)	(\$2,500)
45	48	MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM	\$1,000,000	\$500,000	\$667,000	\$333,500	(\$333,000)	(\$166,500)
42	49	CCT OUTREACH - ADMINISTRATIVE COSTS	\$340,000	\$0	\$340,000	\$0	\$0	\$0
--	50	CARE COURT - OTHER ADMIN	\$0	\$0	\$57,000,000	\$57,000,000	\$57,000,000	\$57,000,000
--	51	CMS DEFERRED CLAIMS - OTHER ADMIN	\$0	\$0	\$0	(\$5,760,000)	\$0	(\$5,760,000)
46	52	COVID-19 INCREASED FMAP - OTHER ADMIN	\$0	(\$1,469,000)	\$0	(\$1,663,000)	\$0	(\$194,000)
--	90	EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.	\$0	\$0	\$15,233,000	\$0	\$15,233,000	\$0
--	93	OUTREACH & ENROLLMENT ASSIST. FOR DUAL BENES	\$0	\$0	\$8,600,000	\$4,300,000	\$8,600,000	\$4,300,000
34	--	MEDI-CAL NONMEDICAL TRANSPORTATION	\$833,000	\$218,650	\$0	\$0	(\$833,000)	(\$218,650)
91	--	CRISIS CONTINUUM OF CARE	\$1,500,000	\$1,500,000	\$0	\$0	(\$1,500,000)	(\$1,500,000)
		DHCS-OTHER SUBTOTAL	\$2,183,115,000	\$562,917,050	\$2,628,930,000	\$867,407,150	\$445,815,000	\$304,490,100
		<u>DHCS-MEDICAL FI</u>						
49	53	MEDICAL FI BO & IT COST REIMBURSEMENT	\$49,348,000	\$14,005,200	\$50,389,000	\$14,030,550	\$1,041,000	\$25,350
48	54	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	\$50,613,000	\$13,303,900	\$47,640,000	\$12,522,250	(\$2,973,000)	(\$781,650)
50	55	MEDICAL FI IT INFRASTRUCTURE SERVICES	\$32,724,000	\$8,600,400	\$32,762,000	\$8,611,800	\$38,000	\$11,400
51	56	MEDICAL FI BO & IT CHANGE ORDERS	\$38,515,000	\$10,123,350	\$30,081,000	\$8,158,200	(\$8,434,000)	(\$1,965,150)

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2022 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2022-23**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2022-23 APPROPRIATION		NOV. 2022 EST. FOR 2022-23		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		<u>DHCS-MEDICAL FI</u>						
52	57	MEDICAL FI BO OTHER ESTIMATED COSTS	\$21,496,000	\$6,533,450	\$23,880,000	\$7,249,050	\$2,384,000	\$715,600
53	58	MEDICAL FI BO TELEPHONE SERVICE CENTER	\$14,580,000	\$4,363,650	\$17,002,000	\$5,088,700	\$2,422,000	\$725,050
54	59	MEDICAL FI BUSINESS OPERATIONS	\$13,929,000	\$3,660,600	\$15,498,000	\$4,073,400	\$1,569,000	\$412,800
55	60	MEDICAL FI BO HOURLY REIMBURSEMENT	\$11,131,000	\$2,925,050	\$11,215,000	\$2,947,500	\$84,000	\$22,450
56	61	MEDICAL FI BO MISCELLANEOUS EXPENSES	\$2,380,000	\$754,200	\$2,355,000	\$747,650	(\$25,000)	(\$6,550)
		DHCS-MEDICAL FI SUBTOTAL	\$234,716,000	\$64,269,800	\$230,822,000	\$63,429,100	(\$3,894,000)	(\$840,700)
		<u>DHCS-HEALTH CARE OPT</u>						
57	62	HCO OPERATIONS 2017 CONTRACT	\$34,800,000	\$17,139,000	\$40,662,000	\$20,026,050	\$5,862,000	\$2,887,050
58	63	HCO COST REIMBURSEMENT 2017 CONTRACT	\$20,520,000	\$10,106,100	\$31,960,000	\$15,740,300	\$11,440,000	\$5,634,200
59	64	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	\$15,817,000	\$7,789,850	\$15,642,000	\$7,703,700	(\$175,000)	(\$86,150)
		DHCS-HEALTH CARE OPT SUBTOTAL	\$71,137,000	\$35,034,950	\$88,264,000	\$43,470,050	\$17,127,000	\$8,435,100
		<u>DHCS-DENTAL FI</u>						
60	65	DENTAL ASO ADMINISTRATION 2016 CONTRACT	\$52,385,000	\$18,833,500	\$52,773,000	\$19,173,500	\$388,000	\$340,000
61	66	DENTAL FI ADMINISTRATION 2016 CONTRACT	\$21,398,000	\$5,913,750	\$21,479,000	\$5,948,000	\$81,000	\$34,250
--	67	DENTAL FI-DBO ADMIN 2022 CONTRACT	\$0	\$0	\$15,411,000	\$1,541,100	\$15,411,000	\$1,541,100
		DHCS-DENTAL FI SUBTOTAL	\$73,783,000	\$24,747,250	\$89,663,000	\$26,662,600	\$15,880,000	\$1,915,350
		<u>OTHER DEPARTMENTS</u>						
62	68	PERSONAL CARE SERVICES	\$441,406,000	\$0	\$453,963,000	\$0	\$12,557,000	\$0
63	69	HEALTH-RELATED ACTIVITIES - CDSS	\$352,197,000	\$0	\$315,336,000	\$0	(\$36,861,000)	\$0
65	70	CALHEERS DEVELOPMENT	\$150,773,000	\$40,124,750	\$152,282,000	\$40,531,150	\$1,509,000	\$406,400

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2022 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2022-23**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2022-23 APPROPRIATION		NOV. 2022 EST. FOR 2022-23		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>OTHER DEPARTMENTS</u>								
66	71	CDDS ADMINISTRATIVE COSTS	\$72,791,000	\$0	\$101,320,000	\$0	\$28,529,000	\$0
68	72	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	\$54,682,000	\$0	\$54,682,000	\$0	\$0	\$0
69	73	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	\$28,669,000	\$0	\$28,357,000	\$0	(\$312,000)	\$0
70	74	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	\$7,741,000	\$0	\$4,147,000	\$0	(\$3,594,000)	\$0
71	75	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	\$6,426,000	\$0	\$5,803,000	\$0	(\$623,000)	\$0
73	76	CLPP CASE MANAGEMENT SERVICES	\$5,444,000	\$0	\$650,000	\$0	(\$4,794,000)	\$0
72	77	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG	\$5,316,000	\$0	\$5,316,000	\$0	\$0	\$0
86	78	HCBS SP CDDS - OTHER ADMIN	\$2,456,000	\$0	\$2,833,000	\$0	\$377,000	\$0
74	79	CALIFORNIA SMOKERS' HELPLINE	\$2,400,000	\$0	\$2,400,000	\$0	\$0	\$0
75	80	KIT FOR NEW PARENTS	\$816,000	\$0	\$1,044,000	\$0	\$228,000	\$0
77	81	MEDI-CAL INPATIENT SERVICES FOR INMATES	\$1,121,000	\$0	\$1,121,000	\$0	\$0	\$0
76	82	VETERANS BENEFITS	\$1,100,000	\$0	\$1,100,000	\$0	\$0	\$0
78	83	CALHHS AGENCY HIPAA FUNDING	\$1,037,000	\$0	\$1,037,000	\$0	\$0	\$0
79	84	VITAL RECORDS	\$885,000	\$5,000	\$883,000	\$2,000	(\$2,000)	(\$3,000)
--	85	MATERNAL AND CHILD HEALTH	\$0	\$0	\$45,269,000	\$0	\$45,269,000	\$0
80	86	MERIT SYSTEM SERVICES FOR COUNTIES	\$190,000	\$95,000	\$190,000	\$95,000	\$0	\$0
81	87	CDPH I&E PROGRAM AND EVALUATION	\$187,000	\$0	\$187,000	\$0	\$0	\$0
82	88	PIA EYEWEAR COURIER SERVICE	\$941,000	\$470,500	\$903,000	\$451,500	(\$38,000)	(\$19,000)
OTHER DEPARTMENTS SUBTOTAL			\$1,136,578,000	\$40,695,250	\$1,178,823,000	\$41,079,650	\$42,245,000	\$384,400

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2022 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2022-23**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2022-23 APPROPRIATION		NOV. 2022 EST. FOR 2022-23		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER ADMINISTRATION TOTAL	\$3,699,329,000	\$727,664,300	\$4,216,502,000	\$1,042,048,550	\$517,173,000	\$314,384,250
		GRAND TOTAL COUNTY AND OTHER ADMINISTRATION	\$6,363,752,000	\$1,465,093,300	\$6,943,908,000	\$1,796,080,050	\$580,156,000	\$330,986,750

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2022-23 AND 2023-24**

NO.	POLICY CHANGE TITLE	NOV. 2022 EST. FOR 2022-23		NOV. 2022 EST. FOR 2023-24		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	<u>DHCS-OTHER</u>						
1	CALAIM - MEDI-CAL PATH	\$711,900,000	\$271,215,000	\$599,900,000	\$271,950,000	(\$112,000,000)	\$735,000
2	CYBHI - BH SERVICES AND SUPPORTS PLATFORM	\$230,000,000	\$230,000,000	\$124,900,000	\$124,900,000	(\$105,100,000)	(\$105,100,000)
3	COUNTY SPECIALTY MENTAL HEALTH ADMIN	\$211,566,000	\$5,721,000	\$296,894,000	\$6,975,000	\$85,328,000	\$1,254,000
4	CCS CASE MANAGEMENT	\$180,198,000	\$65,921,650	\$193,761,000	\$71,335,400	\$13,563,000	\$5,413,750
5	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$164,305,000	\$0	\$156,458,000	\$0	(\$7,847,000)	\$0
6	CALAIM - POPULATION HEALTH MANAGEMENT	\$49,601,000	\$4,960,100	\$52,668,000	\$5,266,800	\$3,067,000	\$306,700
7	INTERIM AND FINAL COST SETTLEMENTS-SMHS	\$130,710,000	\$0	\$128,674,000	\$0	(\$2,036,000)	\$0
8	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$120,155,000	\$0	\$111,318,000	\$0	(\$8,837,000)	\$0
9	MEDI-CAL RX - ADMINISTRATIVE COSTS	\$116,208,000	\$30,069,850	\$102,395,000	\$7,712,000	(\$13,813,000)	(\$22,357,850)
10	COVID-19 VACCINATION INCENTIVE PROGRAM ADMIN	\$100,000,000	\$50,000,000	\$0	\$0	(\$100,000,000)	(\$50,000,000)
11	SMH MAA	\$49,608,000	\$0	\$55,325,000	\$0	\$5,717,000	\$0
12	COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE	\$48,143,000	\$19,201,000	\$48,143,000	\$19,201,000	\$0	\$0
13	DRUG MEDI-CAL COUNTY ADMINISTRATION	\$44,734,000	\$92,000	\$64,360,000	\$99,000	\$19,626,000	\$7,000
14	OTLIPC, MCAP, SPECIAL POPULATIONS ADMIN COSTS	\$43,371,000	\$23,075,850	\$40,987,000	\$21,748,100	(\$2,384,000)	(\$1,327,750)
15	DATA REPORTING AND ANALYTICS SUPPORT SYSTEMS	\$41,618,000	\$9,735,650	\$43,405,000	\$11,420,150	\$1,787,000	\$1,684,500
16	CHDP COUNTY ALLOCATION	\$33,962,000	\$10,575,000	\$33,962,000	\$10,575,000	\$0	\$0
17	POSTAGE & PRINTING	\$32,331,000	\$16,294,000	\$32,331,000	\$16,294,000	\$0	\$0
18	ACTUARIAL COSTS FOR RATE DEVELOPMENT	\$29,995,000	\$14,847,500	\$32,175,000	\$15,937,500	\$2,180,000	\$1,090,000
19	HITECH AND PUBLIC HEALTH REGISTRIES SUPPORT	\$20,711,000	\$38,000	\$20,328,000	\$0	(\$383,000)	(\$38,000)
20	HEALTH ENROLLMENT NAVIGATORS	\$19,106,000	\$9,553,000	\$19,329,000	\$9,664,500	\$223,000	\$111,500
21	MEDI-CAL RECOVERY CONTRACTS	\$17,957,000	\$4,489,250	\$14,651,000	\$3,662,750	(\$3,306,000)	(\$826,500)

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2022-23 AND 2023-24**

NO.	POLICY CHANGE TITLE	NOV. 2022 EST. FOR 2022-23		NOV. 2022 EST. FOR 2023-24		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	<u>DHCS-OTHER</u>						
22	HCBA WAIVER ADMINISTRATIVE COST	\$17,484,000	\$8,742,000	\$20,504,000	\$10,252,000	\$3,020,000	\$1,510,000
23	PAVE SYSTEM	\$16,413,000	\$4,526,150	\$21,899,000	\$5,974,750	\$5,486,000	\$1,448,600
24	CAPMAN	\$12,210,000	\$3,173,450	\$16,081,000	\$4,117,900	\$3,871,000	\$944,450
25	MITA	\$11,571,000	\$1,469,400	\$14,111,000	\$1,792,000	\$2,540,000	\$322,600
26	LITIGATION RELATED SERVICES	\$9,980,000	\$4,990,000	\$9,980,000	\$4,990,000	\$0	\$0
27	PASRR	\$9,399,000	\$2,349,750	\$9,600,000	\$2,400,000	\$201,000	\$50,250
28	LA COUNTY PUBLIC HEALTH NURSING PILOT	\$8,250,000	\$0	\$0	\$0	(\$8,250,000)	\$0
29	ELECTRONIC ASSET VERIFICATION PROGRAM	\$7,841,000	\$3,920,500	\$3,955,000	\$1,977,500	(\$3,886,000)	(\$1,943,000)
30	NEWBORN HEARING SCREENING PROGRAM	\$6,273,000	\$3,136,500	\$6,392,000	\$3,196,000	\$119,000	\$59,500
31	CCI-ADMINISTRATIVE COSTS	\$5,958,000	\$2,979,000	\$0	\$0	(\$5,958,000)	(\$2,979,000)
32	STATEWIDE VERIFICATION HUB	\$5,188,000	\$518,800	\$1,446,000	\$144,600	(\$3,742,000)	(\$374,200)
33	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	\$5,014,000	\$1,822,000	\$3,083,000	\$1,331,750	(\$1,931,000)	(\$490,250)
34	MFP/CCT SUPPLEMENTAL FUNDING	\$5,000,000	\$0	\$0	\$0	(\$5,000,000)	\$0
35	DRUG MEDI-CAL PARITY RULE ADMINISTRATION	\$4,407,000	\$1,469,000	\$7,345,000	\$1,959,000	\$2,938,000	\$490,000
36	MEDCOMPASS SOLUTION	\$3,973,000	\$418,450	\$4,350,000	\$1,143,350	\$377,000	\$724,900
37	PACES	\$3,327,000	\$689,350	\$3,600,000	\$898,600	\$273,000	\$209,250
38	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	\$2,862,000	\$2,485,000	\$512,000	\$94,000	(\$2,350,000)	(\$2,391,000)
39	T-MSIS	\$2,748,000	\$436,750	\$2,458,000	\$365,700	(\$290,000)	(\$71,050)
40	SDMC SYSTEM M&O SUPPORT	\$2,285,000	\$1,142,500	\$1,992,000	\$996,000	(\$293,000)	(\$146,500)
41	HCBS SP - CONTINGENCY MANAGEMENT ADMIN	\$2,084,000	\$0	\$3,750,000	\$0	\$1,666,000	\$0
42	FIELD TESTING OF MEDI-CAL MATERIALS	\$2,000,000	\$1,000,000	\$100,000	\$50,000	(\$1,900,000)	(\$950,000)
43	PROTECTION OF PHI DATA	\$1,861,000	\$930,500	\$1,861,000	\$930,500	\$0	\$0
44	CALIFORNIA HEALTH INTERVIEW SURVEY	\$1,464,000	\$32,000	\$1,653,000	\$126,500	\$189,000	\$94,500
45	SSA COSTS FOR HEALTH COVERAGE INFO.	\$1,317,000	\$658,500	\$1,220,000	\$610,000	(\$97,000)	(\$48,500)
46	FAMILY PACT PROGRAM ADMIN.	\$1,207,000	\$120,700	\$1,207,000	\$120,700	\$0	\$0

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2022-23 AND 2023-24**

NO.	POLICY CHANGE TITLE	NOV. 2022 EST. FOR 2022-23		NOV. 2022 EST. FOR 2023-24		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>DHCS-OTHER</u>							
47	MMA - DSH ANNUAL INDEPENDENT AUDIT	\$795,000	\$397,500	\$800,000	\$400,000	\$5,000	\$2,500
48	MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM	\$667,000	\$333,500	\$2,000,000	\$1,000,000	\$1,333,000	\$666,500
49	CCT OUTREACH - ADMINISTRATIVE COSTS	\$340,000	\$0	\$340,000	\$0	\$0	\$0
50	CARE COURT - OTHER ADMIN	\$57,000,000	\$57,000,000	\$0	\$0	(\$57,000,000)	(\$57,000,000)
51	CMS DEFERRED CLAIMS - OTHER ADMIN	\$0	(\$5,760,000)	\$0	\$0	\$0	\$5,760,000
52	COVID-19 INCREASED FMAP - OTHER ADMIN	\$0	(\$1,663,000)	\$0	\$0	\$0	\$1,663,000
89	CALIFORNIA BH CBC DEMONSTRATION ADMIN	\$0	\$0	\$1,556,000	\$174,000	\$1,556,000	\$174,000
90	EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.	\$15,233,000	\$0	\$15,770,000	\$0	\$537,000	\$0
92	GENDER-AFFIRMING CARE	\$0	\$0	\$1,500,000	\$750,000	\$1,500,000	\$750,000
93	OUTREACH & ENROLLMENT ASSIST. FOR DUAL BENES	\$8,600,000	\$4,300,000	\$8,600,000	\$4,300,000	\$0	\$0
	DHCS-OTHER SUBTOTAL	\$2,628,930,000	\$867,407,150	\$2,339,629,000	\$646,836,050	(\$289,301,000)	(\$220,571,100)
<u>DHCS-MEDICAL FI</u>							
53	MEDICAL FI BO & IT COST REIMBURSEMENT	\$50,389,000	\$14,030,550	\$56,483,000	\$15,666,600	\$6,094,000	\$1,636,050
54	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	\$47,640,000	\$12,522,250	\$47,012,000	\$12,356,750	(\$628,000)	(\$165,500)
55	MEDICAL FI IT INFRASTRUCTURE SERVICES	\$32,762,000	\$8,611,800	\$22,388,000	\$5,886,150	(\$10,374,000)	(\$2,725,650)
56	MEDICAL FI BO & IT CHANGE ORDERS	\$30,081,000	\$8,158,200	\$38,783,000	\$10,192,000	\$8,702,000	\$2,033,800
57	MEDICAL FI BO OTHER ESTIMATED COSTS	\$23,880,000	\$7,249,050	\$26,381,000	\$8,105,750	\$2,501,000	\$856,700
58	MEDICAL FI BO TELEPHONE SERVICE CENTER	\$17,002,000	\$5,088,700	\$18,197,000	\$5,446,400	\$1,195,000	\$357,700
59	MEDICAL FI BUSINESS OPERATIONS	\$15,498,000	\$4,073,400	\$16,582,000	\$4,358,600	\$1,084,000	\$285,200
60	MEDICAL FI BO HOURLY REIMBURSEMENT	\$11,215,000	\$2,947,500	\$12,000,000	\$3,154,400	\$785,000	\$206,900
61	MEDICAL FI BO MISCELLANEOUS EXPENSES	\$2,355,000	\$747,650	\$2,317,000	\$737,100	(\$38,000)	(\$10,550)
	DHCS-MEDICAL FI SUBTOTAL	\$230,822,000	\$63,429,100	\$240,143,000	\$65,903,750	\$9,321,000	\$2,474,650

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2022-23 AND 2023-24**

NO.	POLICY CHANGE TITLE	NOV. 2022 EST. FOR 2022-23		NOV. 2022 EST. FOR 2023-24		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>DHCS-HEALTH CARE OPT</u>							
62	HCO OPERATIONS 2017 CONTRACT	\$40,662,000	\$20,026,050	\$42,568,000	\$20,964,800	\$1,906,000	\$938,750
63	HCO COST REIMBURSEMENT 2017 CONTRACT	\$31,960,000	\$15,740,300	\$37,351,000	\$18,395,450	\$5,391,000	\$2,655,150
64	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	\$15,642,000	\$7,703,700	\$16,097,000	\$7,927,750	\$455,000	\$224,050
	DHCS-HEALTH CARE OPT SUBTOTAL	\$88,264,000	\$43,470,050	\$96,016,000	\$47,288,000	\$7,752,000	\$3,817,950
<u>DHCS-DENTAL FI</u>							
65	DENTAL ASO ADMINISTRATION 2016 CONTRACT	\$52,773,000	\$19,173,500	\$53,049,000	\$19,271,250	\$276,000	\$97,750
66	DENTAL FI ADMINISTRATION 2016 CONTRACT	\$21,479,000	\$5,948,000	\$21,690,000	\$6,003,000	\$211,000	\$55,000
67	DENTAL FI-DBO ADMIN 2022 CONTRACT	\$15,411,000	\$1,541,100	\$76,780,000	\$17,116,450	\$61,369,000	\$15,575,350
	DHCS-DENTAL FI SUBTOTAL	\$89,663,000	\$26,662,600	\$151,519,000	\$42,390,700	\$61,856,000	\$15,728,100
<u>OTHER DEPARTMENTS</u>							
68	PERSONAL CARE SERVICES	\$453,963,000	\$0	\$462,476,000	\$0	\$8,513,000	\$0
69	HEALTH-RELATED ACTIVITIES - CDSS	\$315,336,000	\$0	\$318,138,000	\$0	\$2,802,000	\$0
70	CALHEERS DEVELOPMENT	\$152,282,000	\$40,531,150	\$132,496,000	\$34,768,350	(\$19,786,000)	(\$5,762,800)
71	CDDS ADMINISTRATIVE COSTS	\$101,320,000	\$0	\$68,754,000	\$0	(\$32,566,000)	\$0
72	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	\$54,682,000	\$0	\$54,682,000	\$0	\$0	\$0
73	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	\$28,357,000	\$0	\$28,357,000	\$0	\$0	\$0
74	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	\$4,147,000	\$0	\$21,680,000	\$0	\$17,533,000	\$0
75	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	\$5,803,000	\$0	\$6,743,000	\$0	\$940,000	\$0
76	CLPP CASE MANAGEMENT SERVICES	\$650,000	\$0	\$3,897,000	\$0	\$3,247,000	\$0
77	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG	\$5,316,000	\$0	\$9,297,000	\$0	\$3,981,000	\$0
78	HCBS SP CDDS - OTHER ADMIN	\$2,833,000	\$0	\$632,000	\$0	(\$2,201,000)	\$0

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2022-23 AND 2023-24**

NO.	POLICY CHANGE TITLE	NOV. 2022 EST. FOR 2022-23		NOV. 2022 EST. FOR 2023-24		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>OTHER DEPARTMENTS</u>							
79	CALIFORNIA SMOKERS' HELPLINE	\$2,400,000	\$0	\$2,400,000	\$0	\$0	\$0
80	KIT FOR NEW PARENTS	\$1,044,000	\$0	\$593,000	\$0	(\$451,000)	\$0
81	MEDI-CAL INPATIENT SERVICES FOR INMATES	\$1,121,000	\$0	\$1,166,000	\$0	\$45,000	\$0
82	VETERANS BENEFITS	\$1,100,000	\$0	\$1,100,000	\$0	\$0	\$0
83	CALHHS AGENCY HIPAA FUNDING	\$1,037,000	\$0	\$1,089,000	\$0	\$52,000	\$0
84	VITAL RECORDS	\$883,000	\$2,000	\$883,000	\$2,000	\$0	\$0
85	MATERNAL AND CHILD HEALTH	\$45,269,000	\$0	\$45,269,000	\$0	\$0	\$0
86	MERIT SYSTEM SERVICES FOR COUNTIES	\$190,000	\$95,000	\$190,000	\$95,000	\$0	\$0
87	CDPH I&E PROGRAM AND EVALUATION	\$187,000	\$0	\$187,000	\$0	\$0	\$0
88	PIA EYEWEAR COURIER SERVICE	\$903,000	\$451,500	\$1,180,000	\$590,000	\$277,000	\$138,500
	OTHER DEPARTMENTS SUBTOTAL	\$1,178,823,000	\$41,079,650	\$1,161,209,000	\$35,455,350	(\$17,614,000)	(\$5,624,300)
	OTHER ADMINISTRATION TOTAL	\$4,216,502,000	\$1,042,048,550	\$3,988,516,000	\$837,873,850	(\$227,986,000)	(\$204,174,700)
	GRAND TOTAL COUNTY AND OTHER ADMINISTRATION	\$6,943,908,000	\$1,796,080,050	\$6,669,196,000	\$1,575,490,100	(\$274,712,000)	(\$220,589,950)

MEDI-CAL OTHER ADMINISTRATION POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	<u>DHCS-OTHER</u>
1	CALAIM - MEDI-CAL PATH
2	CYBHI - BH SERVICES AND SUPPORTS PLATFORM
3	COUNTY SPECIALTY MENTAL HEALTH ADMIN
4	CCS CASE MANAGEMENT
5	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES
6	CALAIM - POPULATION HEALTH MANAGEMENT
7	INTERIM AND FINAL COST SETTLEMENTS-SMHS
8	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES
9	MEDI-CAL RX - ADMINISTRATIVE COSTS
10	COVID-19 VACCINATION INCENTIVE PROGRAM ADMIN
11	SMH MAA
12	COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE
13	DRUG MEDI-CAL COUNTY ADMINISTRATION
14	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS
15	DATA REPORTING AND ANALYTICS SUPPORT SYSTEMS
16	CHDP COUNTY ALLOCATION
17	POSTAGE & PRINTING
18	ACTUARIAL COSTS FOR RATE DEVELOPMENT
19	HITECH AND PUBLIC HEALTH REGISTRIES SUPPORT
20	HEALTH ENROLLMENT NAVIGATORS
21	MEDI-CAL RECOVERY CONTRACTS
22	HCBA WAIVER ADMINISTRATIVE COST
23	PAVE SYSTEM
24	CAPMAN
25	MITA
26	LITIGATION RELATED SERVICES
27	PASRR
28	LA COUNTY PUBLIC HEALTH NURSING PILOT
29	ELECTRONIC ASSET VERIFICATION PROGRAM
30	NEWBORN HEARING SCREENING PROGRAM
31	CCI-ADMINISTRATIVE COSTS
32	STATEWIDE VERIFICATION HUB
33	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)
34	MFP/CCT SUPPLEMENTAL FUNDING
35	DRUG MEDI-CAL PARITY RULE ADMINISTRATION
36	MEDCOMPASS SOLUTION
37	PACES
38	HEALTH INFORMATION EXCHANGE INTEROPERABILITY

MEDI-CAL OTHER ADMINISTRATION POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	<u>DHCS-OTHER</u>
39	T-MSIS
40	SDMC SYSTEM M&O SUPPORT
41	HCBS SP - CONTINGENCY MANAGEMENT ADMIN
42	FIELD TESTING OF MEDI-CAL MATERIALS
43	PROTECTION OF PHI DATA
44	CALIFORNIA HEALTH INTERVIEW SURVEY
45	SSA COSTS FOR HEALTH COVERAGE INFO.
46	FAMILY PACT PROGRAM ADMIN.
47	MMA - DSH ANNUAL INDEPENDENT AUDIT
48	MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM
49	CCT OUTREACH - ADMINISTRATIVE COSTS
50	CARE COURT - OTHER ADMIN
51	CMS DEFERRED CLAIMS - OTHER ADMIN
52	COVID-19 INCREASED FMAP - OTHER ADMIN
89	CALIFORNIA BH CBC DEMONSTRATION ADMIN
90	EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.
92	GENDER-AFFIRMING CARE
93	OUTREACH & ENROLLMENT ASSIST. FOR DUAL BENES
	<u>DHCS-MEDICAL FI</u>
53	MEDICAL FI BO & IT COST REIMBURSEMENT
54	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES
55	MEDICAL FI IT INFRASTRUCTURE SERVICES
56	MEDICAL FI BO & IT CHANGE ORDERS
57	MEDICAL FI BO OTHER ESTIMATED COSTS
58	MEDICAL FI BO TELEPHONE SERVICE CENTER
59	MEDICAL FI BUSINESS OPERATIONS
60	MEDICAL FI BO HOURLY REIMBURSEMENT
61	MEDICAL FI BO MISCELLANEOUS EXPENSES
	<u>DHCS-HEALTH CARE OPT</u>
62	HCO OPERATIONS 2017 CONTRACT
63	HCO COST REIMBURSEMENT 2017 CONTRACT
64	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT
	<u>DHCS-DENTAL FI</u>
65	DENTAL ASO ADMINISTRATION 2016 CONTRACT
66	DENTAL FI ADMINISTRATION 2016 CONTRACT

**MEDI-CAL OTHER ADMINISTRATION
POLICY CHANGE INDEX**

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	<u>DHCS-DENTAL FI</u>
67	DENTAL FI-DBO ADMIN 2022 CONTRACT
	<u>OTHER DEPARTMENTS</u>
68	PERSONAL CARE SERVICES
69	HEALTH-RELATED ACTIVITIES - CDSS
70	CALHEERS DEVELOPMENT
71	CDDS ADMINISTRATIVE COSTS
72	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN
73	DEPARTMENT OF SOCIAL SERVICES ADMIN COST
74	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS
75	DEPARTMENT OF AGING ADMINISTRATIVE COSTS
76	CLPP CASE MANAGEMENT SERVICES
77	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG
78	HCBS SP CDDS - OTHER ADMIN
79	CALIFORNIA SMOKERS' HELPLINE
80	KIT FOR NEW PARENTS
81	MEDI-CAL INPATIENT SERVICES FOR INMATES
82	VETERANS BENEFITS
83	CALHHS AGENCY HIPAA FUNDING
84	VITAL RECORDS
85	MATERNAL AND CHILD HEALTH
86	MERIT SYSTEM SERVICES FOR COUNTIES
87	CDPH I&E PROGRAM AND EVALUATION
88	PIA EYEWEAR COURIER SERVICE

CALAIM - MEDI-CAL PATH

OTHER ADMIN. POLICY CHANGE NUMBER: 1
IMPLEMENTATION DATE: 1/2022
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2389

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$711,900,000	\$599,900,000
STATE FUNDS	\$355,950,000	\$299,950,000
FEDERAL FUNDS	\$355,950,000	\$299,950,000

Purpose:

This policy change estimates the funding available for the CalAIM Providing Access and Transforming Health (PATH) Initiative.

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)
AB 128 (Chapter 21, Statutes of 2021)
CalAIM Section 1115(a) Medicaid Demonstration

Interdependent Policy Changes:

Not Applicable

Background:

On December 29, 2021, the Centers for Medicare and Medicaid Services (CMS) approved the CalAIM Section 1115 Waiver Demonstration, which provided funding for the CalAIM PATH Initiative through December 31, 2026. PATH is currently approved for \$1.44 billion, with an additional \$410 million pending CMS approval, for a total budget of \$1.85 billion. The PATH Initiative is to build up the capacity and infrastructure of on-the-ground partners and providers to successfully participate in CalAIM Enhanced Care Management (ECM) and Community Supports, and Justice Involved Services. PATH is comprised of the following efforts.

ECM and Community Supports Capacity and Infrastructure Building

PATH will provide funding to transition, build, expand, and maintain infrastructure/capacity to support the implementation of ECM and Community Supports. This goal will be achieved through four initiatives:

- Whole Person Care (WPC) Services and Transition to Managed Care Mitigation Initiative: Services provided by former Whole Person Care Pilots will be funded until the services transition to managed care coverage under CalAIM. This funding will end by January 1, 2024.
- Technical Assistance Initiative: Virtual "marketplace" will be developed to provide technical support and off-the-shelf resources from vendors to establish the infrastructure development.
- Collaborative Planning and Implementation Initiative: Provide funding to regional facilitators approved by the Department. Support for regional collaborative planning and implementation efforts will include among managed care plans, providers, Community-Based Organizations (CBOs), county agencies, public hospitals, tribes, and others to assess gaps and promote readiness.

CALAIM - MEDI-CAL PATH

OTHER ADMIN. POLICY CHANGE NUMBER: 1

- Capacity and Infrastructure Transition, Expansion and Development (CITED) Initiative: Direct funding to support the delivery of services. Entities, such as providers, CBOs, county agencies, public hospitals, tribes, and other, that are contracted or plan to contract with a managed care plan can apply to receive funding for specific capacity needs to support the transition, expansion, and development of these specific services.

PATH initiatives consider other efforts such as the Incentive Payment Program and the Housing and Homeless Incentive Program to ensure alignment and nonduplication of funding. The CITED Initiative supports are aligned with the Homeless and Home and Community Based Service Provider Investments Program, to contribute to the investment goal of expanding workforce by creating 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.

Justice-Involved Capacity Building Program

PATH funding will support the implementation of statewide CalAIM justice-involved initiatives. This includes support for implementation of pre-release Medi-Cal applications, enrollment, and suspension processes, as well as the delivery of Medi-Cal services in the 90 days prior to release. This goal will be achieved through two parts:

- Collaborative planning: Support for correctional agencies, county social services departments, county behavioral health agencies, managed care plans, and others so they can jointly design, modify, and launch new processes aimed at increasing enrollment in Medi-Cal and continuous access to care for justice-involved youths and adults.
- Capacity and Infrastructure: Support for correctional agencies, institutions, and other justice-involved stakeholders as they implement pre-release Medi-Cal enrollment and suspension processes.

Effective July 1, 2022, the Department has contracted with a Third-Party Administrator (TPA) to support the implementation of the PATH initiatives and serve as a fiscal administrator.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a slight increase due to an updated timeline launch for several PATH initiatives, the onboarding of the PATH TPA, and payments from FY 2021-22 shifting into FY 2022-23. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to FY 2021-22 funds shifting into FY 2022-23 for payment.

Methodology:

1. DHCS has awarded eight former WPC Lead Entities to receive PATH Whole Person Care Services and Transition to Managed Care Mitigation Initiative funding. Invoices will be processed in September and May for expenditures up till end of 2023.
2. Justice Involved collaborative planning funds have been awarded. Payments are made within 60 days of application approval.
3. The PATH TPA will facilitate the implementation, administer, and serve as the fiscal intermediary for several initiatives, including: Technical Assistance Initiative, Collaborative Planning and Implementation Initiative, CITED Initiative, and the Justice-Involved Capacity Building Program Capacity and Infrastructure. The TPA has been contracted to provide

CALAIM - MEDI-CAL PATH
OTHER ADMIN. POLICY CHANGE NUMBER: 1

these services from July 1, 2022, through June 30, 2027. Payment for the TPA services will be based on approved rates, completion of deliverables, and milestone accomplishments.

4. As a result of AB 128, the Department received an appropriation for \$100,000,000 General Fund (\$100,000,000 Federal Fund) for Justice-Involved initiatives within the Medi-Cal PATH program and is available to spend through June 30, 2024. The table below displays the estimated spending and remaining funds by Appropriation Years:

(Dollars in Thousands)

Appropriation Year 2021-22	TF	GF	FF*
Prior Years	\$0	\$0	\$0
Estimated in FY 2022-23	\$200,000	\$100,000	\$100,000
Estimated in FY 2023-24	\$0	\$0	\$0
Total Estimated Remaining	\$0	\$0	\$0

*Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.

5. The table below estimates the funding for the remaining PATH initiatives:

(Dollars in Thousands)

Fiscal Year	TF	GF	GF Reimb.	SF	FF
FY 2022-23	\$511,900	\$171,215	\$40,500	\$44,235	\$255,950
FY 2023-24	\$599,900	\$271,950	\$28,000	\$0	\$299,950

6. On a cash basis, all PATH Program costs are estimated to be:

(Dollars in Thousands)

Fiscal Years	TF	GF	GF Reimb.	SF	FF
FY 2022-23	\$711,900	\$271,215	\$40,500	\$44,235	\$355,950
FY 2023-24	\$599,900	\$271,950	\$28,000	\$0	\$299,950

CALAIM - MEDI-CAL PATH
OTHER ADMIN. POLICY CHANGE NUMBER: 1

Funding:

(Dollars in Thousands)

FY 2022-23	TF	GF	GF Reimb.	SF	FF
100% Title XIX FF (4260-101-0890)	\$84,735	\$0	\$0	\$0	\$84,735
HCBS ARP Fund (4260-101-8507)	\$44,235	\$0	\$0	\$44,235	\$0
50% Title XIX / 50% GF (4260-101-0890/0001)	\$542,430	\$271,215	\$0	\$0	\$271,215
Reimbursement GF (4260-601-0995)	\$40,500	\$0	\$40,500	\$0	\$0
Total	\$711,900	\$271,215	\$40,500	\$44,235	\$355,950
FY 2023-24	TF	GF	GF Reimb.	SF	FF
100% Title XIX FF (4260-101-0890)	\$28,000	\$0	\$0	\$0	\$28,000
50% Title XIX / 50% GF (4260-101-0890/0001)	\$543,900	\$271,950	\$0	\$0	\$271,950
Reimbursement GF (4260-601-0995)	\$28,000	\$0	\$28,000	\$0	\$0
Total	\$599,900	\$271,950	\$28,000	\$0	\$299,950

CYBHI - BH SERVICES AND SUPPORTS PLATFORM

OTHER ADMIN. POLICY CHANGE NUMBER: 2
IMPLEMENTATION DATE: 1/2022
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2289

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$230,000,000	\$124,900,000
STATE FUNDS	\$230,000,000	\$124,900,000
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)
 W&I Code 5961.1
 Agreement Number 2021-51-CHHS

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 platforms 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 behavioral health providers, so assessments can be

CYBHI - BH SERVICES AND SUPPORTS PLATFORM

OTHER ADMIN. POLICY CHANGE NUMBER: 2

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-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. 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 2022-23. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to the updated timeline for remaining contracted activities.

Methodology:

- The Budget Act for FY 2022-23 provided \$230 million GF, available for expenditure through June 30, 2025. Additional funding is proposed for FY 2023-24. The table below displays the estimated spending and remaining funds by Appropriation Year:

	TF	GF	FF
Appropriation Year 2022-23			
Prior Years	\$0	\$0	\$0
Estimated in FY 2022-23	\$230,000,000	\$230,000,000	\$0
Total Estimated Remaining	\$0	\$0	\$0
Appropriation Year 2023-24			
Prior Years	\$0	\$0	\$0
Estimated in FY 2023-24	\$124,900,000	\$124,900,000	\$0
Total Estimated Remaining	\$0	\$0	\$0

- Total costs are estimated to be:

Fiscal Year	TF	GF	FF
FY 2022-23	\$230,000,000	\$230,000,000	\$0
FY 2023-24	\$124,900,000	\$124,900,000	\$0

Funding:

100% General Fund (4260-101-0001)

COUNTY SPECIALTY MENTAL HEALTH ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 3
IMPLEMENTATION DATE: 7/2012
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1721

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$211,566,000	\$296,894,000
STATE FUNDS	\$5,721,000	\$37,327,000
FEDERAL FUNDS	\$205,845,000	\$259,567,000

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.

Beginning in FY 2023-24, the Department will implement the California Advancing and Innovating Medi-Cal (CalAIM) Behavioral Health (BH) payment reform, a new intergovernmental transfers (IGTs) process, whereby counties will transfer the county portion of the fee-for-service claims to the Department, before Federal Financial Participation can be used for payment. The IGT process will replace the current Certified Public Expenditure (CPE) method, that reimbursed counties through the interim rate payment process for Short Doyle/Medi-Cal (SD/MC) claims

COUNTY SPECIALTY MENTAL HEALTH ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 3

that include Drug Medi-Cal (DMC) State Plan, Drug Medi-Cal Organized Delivery System (DMC ODS), and SMHS.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a decrease due to:

- Updated base expenditures for FY 2020-21 and FY 2021-22 decreased from prior estimate;
- Updated payment lags based on actual claims received for FY 2019-20 and FY 2020-21; and
- Updated forecasts for FY 2022-23.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to updated payment lags and budgeting IGT funding for payment of SD/MC SMHS claims for the dates of service in FY 2023-24.

Methodology:

1. Mental Health administration costs are based on historical claims payment data. Assume 12.97% of each fiscal year claims will be paid in the year the services occur, 69.56% is paid in the following year, and 17.47% in the third year. The estimate costs are:

(Dollars in Thousands)

Fiscal Year	Type	Accrual	FY 2022-23	FY 2023-24
FY 2021-22	Other Admin	\$335,558	\$233,414	\$58,622
	MCHIP	\$26,059	\$18,127	\$4,553
	QAUR	\$60,652	\$42,190	\$10,596
	POS	\$3,330	\$2,316	\$582
	Parity	\$23,526	\$16,365	\$4,110
	Managed Care	\$7,173	\$4,990	\$1,253
Subtotal		\$456,298	\$317,402	\$79,716
FY 2022-23	Other Admin	\$352,665	\$45,741	\$245,314
	MCHIP	\$27,388	\$3,552	\$19,051
	QAUR	\$63,745	\$8,268	\$44,341
	POS	\$3,500	\$454	\$2,434
	Parity	\$24,726	\$3,207	\$17,199
	Managed Care	\$7,539	\$978	\$5,244
Subtotal		\$479,563	\$62,200	\$333,583

COUNTY SPECIALTY MENTAL HEALTH ADMIN
OTHER ADMIN. POLICY CHANGE NUMBER: 3

FY 2023-24	Other Admin	\$370,645	\$0	\$48,073
	MCHIP	\$28,784	\$0	\$3,733
	QAUR	\$66,996	\$0	\$8,689
	POS	\$3,678	\$0	\$477
	Parity	\$25,987	\$0	\$3,370
	Managed Care	\$7,923	\$0	\$1,028
	Subtotal	\$504,013	\$0	\$65,370
Total	Other Admin	\$1,439,872	\$379,602	\$478,669

- 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 65% federal enhanced reimbursement.
- 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.
- POS expenditures are eligible for reimbursement at 50%, and costs for clinical staffing is eligible for enhanced FF at 75%.
- 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).
- 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 2022-23			
	TF	FF	GF	CF
Other Admin	\$279,155	\$139,578	\$0	\$139,577
MCHIP	\$21,679	\$14,091	\$0	\$7,588
QAUR	\$50,457	\$33,201	\$777	\$16,479
POS	\$2,770	\$2,219	\$551	\$0
Parity	\$19,572	\$13,652	\$2,960	\$2,960
Managed Care Regulations	\$5,968	\$3,104	\$1,432	\$1,432
Total	\$379,601	\$205,845	\$5,721	\$168,035

COUNTY SPECIALTY MENTAL HEALTH ADMIN
OTHER ADMIN. POLICY CHANGE NUMBER: 3

(Dollars in Thousands)

Claim Type	FY 2023-24				
	TF	FF	GF	IGT*	CF
Other Admin	\$352,009	\$176,005	\$0	\$24,036	\$151,968
MCHIP	\$27,337	\$17,769	\$0	\$1,307	\$8,261
QAUR	\$63,627	\$41,866	\$980	\$2,838	\$17,943
POS	\$3,493	\$2,798	\$456	\$239	\$0
Parity	\$24,680	\$17,216	\$3,733	\$1,685	\$2,046
Managed Care Regulations	\$7,525	\$3,913	\$1,806	\$247	\$1,559
Total	\$478,671	\$259,567	\$6,975	\$30,352	\$181,777

Funding:

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

100% Title XXI FFP (4260-113-0890)

100% Title XIX GF (4260-101-0001)

Medi-Cal County Behavioral Health Fund* (4260-601-3420)

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 4
IMPLEMENTATION DATE: 7/1999
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 230

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$180,198,000	\$193,761,000
STATE FUNDS	\$65,921,650	\$71,335,400
FEDERAL FUNDS	\$114,276,350	\$122,425,600

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

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 and adjudicating the medical need for specific services, and determining appropriate providers. For counties with populations under 200,000 (dependent counties), the state shares case management activities. Dependent counties are responsible for the financial and residential verification and the CCS state employees in Sacramento and Los Angeles are responsible for the review and adjudication of service authorization requests. The Children's Medical Services Network (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 2022-23, is an increase due to revising CCS caseload assumptions; inclusive of a revised estimated end of the national public health emergency (PHE).

The change for FY 2022-23 to FY 2023-24, in the current estimate, is an increase based on an estimated caseload and member mix after the PHE ends in FY 2022-23.

Methodology:

1. The county administrative estimate for the budget year is updated every May based on additional data collected.
2. The CCS case management costs for FY 2022-23 are \$173,650,000 and \$187,192,000 for FY 2023-24.

CCS CASE MANAGEMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 4

3. Assume administrative costs of \$1,057,000 in both FY 2022-23 and FY 2023-24 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 \$3,018,000 in FY 2022-23 and \$3,016,000 in FY 2023-24.
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 2022-23	FY 2023-24
County Administration:	\$31,394,000	\$31,337,000
County share of cost:	<u>(\$2,902,000)</u>	<u>(\$2,897,000)</u>
Total Medi-Cal OTLICP:	\$28,492,000	\$28,440,000

6. County data processing costs associated with CMS Net for OTLICP are estimated to be \$382,000 in FY 2022-23 and \$382,000 FY 2023-24.
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 \$22,986,000 in FY 2022-23 and \$22,986,000 in FY 2023-24.
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 \$131,000 in FY 2022-23. The cost to CCS case management is \$61,000 in FY 2023-24. The Rady Pilot program expired on December 31, 2021. The costs to CCS case management in FY 2022-23 and FY 2023-24 are to complete the final capitation payments for December 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 2022-23 and FY 2023-24.

CCS CASE MANAGEMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 4

(Dollars in Thousands)

FY 2022-23				
CCS Medi-Cal/OTLICP	TF*	GF	FF	CF**
CCS Case Management	\$25,590	\$5,879	\$19,711	\$2,902
CMS Net	\$382	\$134	\$248	\$0
Subtotal	\$25,972	\$6,013	\$19,959	\$2,902
CCS Medi-Cal				
CCS Case Management	\$173,650	\$68,679	\$104,971	\$0
Medi-Cal Expansion	\$1,057	\$1,057	\$0	\$0
CMS Net	\$2,636	\$1,318	\$1,318	\$0
Subtotal	\$177,343	\$71,054	\$106,289	\$0
WCM Implementation	(\$22,986)	(\$11,079)	(\$11,907)	\$0
Rady Children's Hospital Demo Pilot	(\$131)	(\$66)	(\$65)	\$0
Total	\$180,198	\$65,922	\$114,276	\$2,902

FY 2023-24				
CCS Medi-Cal/OTLICP	TF*	GF	FF	CF**
CCS Case Management	\$25,543	\$5,869	\$19,674	\$2,897
CMS Net	\$382	\$134	\$248	\$0
Subtotal	\$25,925	\$6,003	\$19,922	\$2,897
CCS Medi-Cal				
CCS Case Management	\$187,192	\$74,035	\$113,157	\$0
Medi-Cal Expansion	\$1,057	\$1,057	\$0	\$0
CMS Net	\$2,634	\$1,317	\$1,317	\$0
Subtotal	\$190,883	\$76,409	\$114,474	\$0
WCM Implementation	(\$22,986)	(\$11,045)	(\$11,941)	\$0
Rady Children's Hospital Demo Pilot	(\$61)	(\$30)	(\$31)	\$0
Total*	\$193,761	\$71,335	\$122,426	\$2,897

* Totals may differ due to rounding

** County Funds are not included in the Total Fund

CCS CASE MANAGEMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 4

Funding:

(Dollars in Thousands)

FY 2022-23	TF*	GF	FF	CF**
50% FF Title XIX/50% GF (4260-101-0890/0001)	\$83,342	\$41,671	\$41,671	\$0
100% FF Title XXI (4260-113-0890)	\$10,779	\$0	\$10,779	\$0
100% GF Title XXI (4260-113-0001)	\$2,902	\$2,902	\$0	\$2,902
75% FF Title XIX/25% GF (4260-101-0890/0001)	\$84,495	\$21,124	\$63,371	\$0
100% GF Title XIX (4260-101-0001)	\$1,057	\$1,057	\$0	\$0
65% FF Title XXI/35% GF (4260-113-0890/0001)	(\$2,376)	(\$832)	(\$1,544)	\$0
Total	\$180,198	\$65,922	\$114,276	\$2,902

FY 2023-24	TF*	GF	FF	CF**
50% FF Title XIX/50% GF (4260-101-0890/0001)	\$91,521	\$45,761	\$45,761	\$0
100% FF Title XXI (4260-101-0890)	\$10,759	\$0	\$10,759	\$0
100% GF Title XXI (4260-101-0001)	\$2,897	\$2,897	\$0	\$2,897
75% FF Title XIX/25% GF (4260-101-0890/0001)	\$90,134	\$22,534	\$67,601	\$0
100% GF Title XIX (4260-101-0001)	\$1,057	\$1,057	\$0	\$0
65% FF Title XXI/35% GF (4260-101-0890/0001)	(\$2,606)	(\$912)	(\$1,694)	\$0
Total	\$193,761	\$71,335	\$122,426	\$2,897

* Totals differ due to rounding.

** County Funds are not included in the Total Fund

*** COVID-19 funding is identified in the COVID-19 Increased FMAP – Other Admin policy change

SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 5
IMPLEMENTATION DATE: 7/1992
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 235

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$164,305,000	\$156,458,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$164,305,000	\$156,458,000

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 2022-23, from the prior estimate, is due to:

- FY 2020-21 Q1 outstanding invoice claims being received later than expected and processed, so payments will be issued in FY 2022-23.
- Revised invoice claims received for FY 2019-20 Q2, which resulted in a lower estimate for FY 2020-21 Q2 as well as a lower estimate for FY 2021-22 Q2.
- Additional invoice claims were received for FY 2019-20 Q4, which resulted in a higher estimate for FY 2020-21 Q4 as well as a higher estimates for FY 2021-22 Q4.
- The FY 2021-22 Q1 estimate is based on FY 2020-21 Q1 actual invoice claims, plus a 2.10 percent Employment Cost Index (ECI) adjustment factor, instead of using an average of the prior three quarters.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a net increase due to no outstanding FY 2020-21 Q1 invoices in FY 2023-24 and including a Employment Cost Index (ECI) growth factor in FY 2023-24.

SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 5

Methodology:

The FY 2022-23 estimate includes:

1. The FY 2020-21 Q1 amount is based on the actual outstanding invoice claims for FY 2020-21 Q1 that were budgeted to be paid in FY 2021-22. Instead, those invoices will be paid in FY 2022-23 Q1. This was due to a halt in the Data Match process that was required to be updated, and some regions did not get their MER processed timely which then delayed their invoice submission.
2. The FY 2020-21 Q2-Q4 and FY 2021-22 Q1 amount is based on the actual invoice claims for FY 2019-20 Q2-Q4 and FY 2020-21 Q1, plus a 2.10 percent ECI adjustment factor.

The FY 2023-24 estimate includes:

1. The FY 2021-22 Q2- Q4 and FY 2022-23 Q1 amount is based on the estimated invoice claims for FY 2020-21 Q2-Q4 and FY 2021-22 Q1, plus a 2.10 percent ECI adjustment factor.

FY 2022-23	TF	FF
FY 2020-21 Q1 Outstanding Invoices	\$11,062,000	\$11,062,000
FY 2020-21 Q2, Q3, & Q4	\$121,690,000	\$121,690,000
FY 2021-22 Q1	\$31,553,000	\$31,553,000
Total	\$164,305,000	\$164,305,000

FY 2023-24	TF	FF
FY 2021-22 Q2, Q3, & Q4	\$124,243,000	\$124,243,000
FY 2022-23 Q1	\$32,215,000	\$32,215,000
Total	\$156,458,000	\$156,458,000

Funding:

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

CALAIM - POPULATION HEALTH MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 6
IMPLEMENTATION DATE: 7/2022
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2288

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$49,601,000	\$52,668,000
STATE FUNDS	\$4,960,100	\$5,266,800
FEDERAL FUNDS	\$44,640,900	\$47,401,200

Purpose:

This policy change estimates the cost for creating the Population Health Management (PHM) service under the California Advancing and Innovating Medi-Cal (CalAIM) policy.

Authority:

SB 129 (Chapter 69, Statutes of 2021)

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: 6

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a decrease due to contract costs being spread over multiple fiscal years. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to updated contract costs.

Methodology:

- The Budget Act for 2021-22 provided \$30 million from the General Fund and \$270 million in federal funds for this item, available to be spent through June 30, 2024. The table below displays the estimated spending and remaining funds by Appropriation Year:

	TF	GF	FF
Appropriation Year 2021-22			
Estimated in FY 2022-23	\$49,601,000	\$4,960,000	\$44,641,000
Estimated in FY 2023-24	\$52,668,000	\$5,267,000	\$47,401,000
Total Estimated Remaining	\$197,731,000	\$19,773,000	\$177,958,000

- 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 2022-23	\$49,601,000	\$4,960,000	\$44,641,000
FY 2023-24	\$52,668,000	\$5,267,000	\$47,401,000

Funding:

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

INTERIM AND FINAL COST SETTLEMENTS-SMHS

OTHER ADMIN. POLICY CHANGE NUMBER: 7
IMPLEMENTATION DATE: 7/2016
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1757

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$130,710,000	\$128,674,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$130,710,000	\$128,674,000

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 in FY 2022-23, from the prior estimate, is due to lower than expected number of cost and audit settlements received and forecasting that average number of settlements forward in to the upcoming fiscal year.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to projected cost estimates are based on the overall number of settlements.

INTERIM AND FINAL COST SETTLEMENTS-SMHS

OTHER ADMIN. POLICY CHANGE NUMBER: 7

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 2022-23 and FY 2023-24 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.
 - The percentage of each fund type of settlements processed in FY 2020-21 was used to determine the estimated amounts of Title XIX and Title XXI for the interim and audit settlement types for FY 2022-23 and FY 2023-24. Assuming that FY 2022-23 and FY 2023-24 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 funding splits.
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 2021-22 that will be processed in FY 2022-23.

INTERIM AND FINAL COST SETTLEMENTS-SMHS
OTHER ADMIN. POLICY CHANGE NUMBER: 7

6. 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 2014-15	\$18,785	\$18,825	(\$40)
FY 2015-16	\$41,925	\$42,011	(\$86)
FY 2016-17	\$63,112	\$63,242	(\$130)
FY 2018-19	\$7,048	\$7,063	(\$15)
Subtotal	\$130,870	\$131,141	(\$271)

(Dollars in Thousands)

Audit Settlements	Total FF	Title XIX FF	Title XXI FF
FY 2015-16	(\$45)	(\$45)	\$0
FY 2018-19	(\$104)	(\$104)	\$0
FY 2019-20	(\$11)	(\$11)	\$0
Subtotal	(\$160)	(\$160)	\$0
Total FY 2022-23	\$130,710	\$130,981	(\$271)

7. The net FF to be reimbursed and/or recouped in FY 2023-24 for interim settlements and audit settlements is shown below:

(Dollars in Thousands)

Interim Settlements	Total FF	Title XIX FF	Title XXI FF
FY 2018-19	\$59,906	\$60,030	(\$124)
FY 2019-20	\$68,965	\$69,106	(\$141)
Subtotal	\$128,871	\$129,136	(\$265)

INTERIM AND FINAL COST SETTLEMENTS-SMHS
OTHER ADMIN. POLICY CHANGE NUMBER: 7

(Dollars in Thousands)

Audit Settlements	Total FF	Title XIX FF	Title XXI FF
FY 2017-18	(\$101)	(\$101)	\$0
FY 2019-20	(\$96)	(\$96)	\$0
Subtotal	(\$197)	(\$197)	\$0.
Total FY 2023-24	\$128,674	\$128,939	(\$265)

Funding:

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

100% Title XXI FFP (4260-113-0890)

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

COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 8
IMPLEMENTATION DATE: 7/1992
ANALYST: Donna Lee
FISCAL REFERENCE NUMBER: 1963

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$120,155,000	\$111,318,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$120,155,000	\$111,318,000

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 2022-23, from the prior estimate, is a net increase:

- Increase from FY 2020-21 Q1 invoices that were previously estimated to be paid in FY 2021-22 but were delayed to be paid in FY 2022-23.
- Decrease from actual billings received for reimbursement for CMAA and TMAA for FY 2020-21 Q1, and a resulting projected decrease in CMAA and TMAA invoices expected in FY 2022-23.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to:

- Actual billings received for reimbursement for CMAA and TMAA for FY 2020-21 Q1 and a resulting projected decrease in CMAA and TMAA invoices expected in FY 2023-24.
- Delayed FY 2020-21 Q1 invoices were completed in FY 2022-23.

COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 8

Methodology:

County Medi-Cal Administrative Activities

- The CMAA FY 2022-23 estimate includes the remaining FY 2020-21 Q1 to Q4 claims and FY 2021-22 Q1 claims. The estimated base payments for FY 2020-21 assumes that claims for FY 2020-21 Q2-Q4 will be reflective of actual claims received for FY 2020-21 Q1. The estimated base payments for FY 2021-22 claims assumes a six percent growth factor from FY 2020-21, based on growth in CMAA claims from FY 2015-16 through FY 2019-20.

CMAA FY 2022-23 Estimated Payments	
FY 2020-21	\$92,191,000
FY 2021-22	\$27,302,000
Total	\$119,493,000

- The CMAA FY 2023-24 estimate includes FY 2021-22 Q2 to Q4 claims and FY 2022-23 Q1. The estimated base payments for FY 2021-22 and FY 2022-23 claims assume a six percent growth factor, based on CMAA growth in claims from FY 2015-16 through FY 2019-20.

CMAA FY 2023-24 Estimated Payments	
FY 2021-22	\$81,906,000
FY 2022-23	\$28,940,000
Total	\$110,846,000

Tribal Medi-Cal Administrative Activities

- The TMAA FY 2022-23 estimate includes FY 2020-21 Q1 to Q4 claims and FY 2021-22 Q1 to Q2 claims. The estimated base payments for FY 2020-21 assumes that claims for FY 2020-21 Q2-Q4 will be reflective of actual claims received for FY 2020-21 Q1. The estimated base payments for FY 2021-22 claims assume a six percent growth factor, based on growth in TMAA claims from FY 2015-16 through FY 2019-20.

TMAA FY 2022-23 Estimated Payments	
FY 2020-21	\$433,000
FY 2021-22	\$229,000
Total	\$662,000

COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 8

2. The TMAA FY 2023-24 estimate includes FY 2021-22 Q3 to Q4 and FY 2022-23 Q1 to Q2 claims. The estimated base payments for FY 2021-22 and FY 2022-23 claims assume a six percent growth factor based on growth in TMAA claims from FY 2015-16 through FY 2019-20.

TMAA FY 2023-24 Estimated Payments	
FY 2021-22	\$229,000
FY 2022-23	\$243,000
Total	\$472,000

3. Total CMAA and TMAA reimbursements for FY 2022-23 and FY 2023-24 on a cash basis are:

FY 2022-23	TF	FF
County MAA	\$119,493,000	\$119,493,000
Tribal MAA	\$662,000	\$662,000
Total	\$120,155,000	\$120,155,000

FY 2023-24	TF	FF
County MAA	\$110,846,000	\$110,846,000
Tribal MAA	\$472,000	\$472,000
Total	\$111,318,000	\$111,318,000

Funding:

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

MEDI-CAL RX - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 9
IMPLEMENTATION DATE: 7/2020
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2167

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$116,208,000	\$102,395,000
STATE FUNDS	\$30,069,850	\$7,712,000
FEDERAL FUNDS	\$86,138,150	\$94,683,000

Purpose:

This policy change estimates the net cost impact of the cost of the Medi-Cal Rx administrative services contract and the prior Fee-for-Service (FFS) pharmacy claims administrator.

Authority:

Executive Order N-01-19
Families First Coronavirus Response Act (FFCRA)

Interdependent Policy Changes:

Medi-Cal Supply Rebates

Background:

Executive Order N-01-19 required the Department to transition Medi-Cal pharmacy services into a FFS benefit. With this change, Medi-Cal pharmacy benefits are provided and managed through Medi-Cal Rx. To facilitate and support the managed care carve-out and ongoing management of the Medi-Cal pharmacy benefit, the Department procured, Magellan Medicaid Administration, Inc., to provide administrative services for Medi-Cal Rx.

Medi-Cal Rx will provide modern pharmacy support systems, including:

- claims administration and utilization management services,
- pharmacy drug rebate administration, and
- provider and beneficiary support.

The Medi-Cal Rx Assumption of Operations (AOO) began January 1, 2022 and the Medi-Cal Rebate component is anticipated to begin July 1, 2023. During 2021, Medi-Cal Rx provided transitional services and supports (TSS) which includes Customer Service Center, Clinical Staff Support, Pharmacy Service Portal, as well as Outreach and Education and other services.

The Department estimates a cost savings for the administrative services compared to the prior FFS pharmacy claims administration. Effective July 1, 2020, a consulting and project management contractor was put in place to support the takeover of operations from the current Medi-Cal Fiscal Intermediary (FI) and managed care (MC) plans related to Medi-Cal Rx. The consultant contractor work efforts will be extended through FY 2023-24.

MEDI-CAL RX - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 9

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

The Department will be seeking necessary federal approvals for enhanced federal funding for applicable periods and costs, as outlined below:

Vendor

FY 2022-23 and FY 2023-24:

- Vendor costs are allocated to all programs administered by Medi-Cal Rx. For Medi-Cal, the following funding is used: Title XIX at 50% FF / 50% GF, 75% FF / 25% GF, and 90% FF / 10% GF; Title XXI 65% FF / 35% GF; and 100% GF.

Consulting

FY 2022-23 and FY 2023-24:

- Consulting costs are funded at Title XIX 50% FF / 50% GF and 75% FF / 25% GF.

The policy changes (PC) related to Medi-Cal Rx are:

Regular

- 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 in FY 2022-23, from the prior estimate, is due to:

- Shifting of invoices previously estimated to be paid in FY 2021-22 that are now estimated to be paid in FY 2022-23,
- Reduced FFS related administrative savings as a result of runout activities that include program requesting systems, infrastructure and data to be held for a period of time for risk mitigation.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to:

- Assuming just one-year of invoices and payments.

MEDI-CAL RX - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 9

Methodology:

1. Assume the prior FFS related administrative cost is an annual savings of \$6,783,000 TF.
2. Contractor costs are included in FY 2022-23 and FY 2023-24.
3. Assume the federal certification of the claims operations and the rebate operations will occur separately. Assume the claims operation certification will occur by January 2023 and be retroactive to January 2022. This allows the retroactive claiming of the claims services and the supporting contractor services to receive Title XIX 75% FF / 25% GF. This retroactive claiming for the initial claiming of Title XIX 50% FF / 50% GF is estimated to occur in March 2023.
4. The estimated cost for FY 2022-23 and FY 2023-24 is:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
FFS Related Administrative Cost Savings	(\$965)	(\$241)	(\$724)
New Pharmacy Related Administrative Costs	\$117,173	\$30,310	\$86,863
Total	\$116,208	\$30,069	\$86,139

FY 2023-24	TF	GF	FF
FFS Related Administrative Cost Savings	(\$965)	(\$241)	(\$724)
New Pharmacy Related Administrative Costs	\$103,360	\$7,953	\$95,407
Total	\$102,395	\$7,712	\$94,683

MEDI-CAL RX - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 9

Funding:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
FI 75% Title XIX / 25% GF	(\$965)	(\$241)	(\$724)
FI 75% Title XIX / 25% GF	\$40,577	\$10,144	\$30,433
FI 50% Title XIX / 50% GF	\$72,533	\$36,266	\$36,267
90% Title XIX / 10% GF	\$0	\$0	\$0
Certification -FI 50/50	(\$72,333)	(\$36,167)	(\$36,166)
Certification +FI 75/25	\$72,333	\$18,083	\$54,250
FI T21 65/35	\$11	\$4	\$7
65% Title XXI / 35% GF	\$0	\$0	\$0
FI 100% GF	\$603	\$603	\$0
100% GF	\$18	\$18	\$0
50% Title XIX / 50% GF	\$2,004	\$1,002	\$1,002
75% Title XIX / 25% GF	\$1,427	\$357	\$1,070
Total	\$116,208	\$30,069	\$86,139

(Dollars in Thousands)

FY 2023-24	TF	GF	FF
FI 75% Title XIX / 25% GF	(\$965)	(\$241)	(\$724)
FI 75% Title XIX / 25% GF	\$99,378	\$24,844	\$74,534
FI 50% Title XIX / 50% GF	\$0	\$0	\$0
90% Title XIX / 10% GF	\$0	\$0	\$0
Certification -FI 50/50	(\$73,195)	(\$36,597)	(\$36,598)
Certification +FI 75/25	\$73,195	\$18,299	\$54,896
FI T21 65/35	\$10	\$3	\$7
65% Title XXI / 35% GF	\$0	\$0	\$0
FI 100% GF	\$530	\$530	\$0
100% GF	\$18	\$18	\$0
50% Title XIX / 50% GF	\$0	\$0	\$0
75% Title XIX / 25% GF	\$3,424	\$856	\$2,568
Total	\$102,395	\$7,712	\$94,683

COVID-19 VACCINATION INCENTIVE PROGRAM ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 10
IMPLEMENTATION DATE: 7/2022
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2339

	<u>FY 2022-23</u>	<u>FY 2023-24</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 reimbursing Medi-Cal managed care plans (MCPs) for qualifying direct member incentives issued as part of 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 implemented the Medi-Cal COVID-19 Vaccination Incentive Program effective September 1, 2021, through February 28, 2022.

The Department adopted vaccination performance measures for MCPs that included both process and outcome measures. Participating MCPs developed and submitted a Vaccination Response Plan that outlined their strategies for improving vaccination rates including for the target populations. A \$100 million pool of funds was made 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:

There is no change in the FY 2022-23 from the prior estimate. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to all the payments being expected to be paid out in FY 2022-23.

Methodology:

1. The estimated costs for direct member incentives for the COVID-19 Vaccination Incentive Program on a cash basis are:

COVID-19 VACCINATION INCENTIVE PROGRAM ADMIN
OTHER ADMIN. POLICY CHANGE NUMBER: 10

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF	\$100,000	\$50,000	\$50,000
Total	\$100,000	\$50,000	\$50,000

Funding:

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

SMH MAA

OTHER ADMIN. POLICY CHANGE NUMBER: 11
IMPLEMENTATION DATE: 7/2012
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1722

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$49,608,000	\$55,325,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$49,608,000	\$55,325,000

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 MAA Claiming Process. The Specialty Mental Health (SMH) waiver program submits claims on behalf of MHPs to obtain federal financial participation (FFP) for MAA necessary for the proper and efficient administration of the SMH waiver program. These activities ensure that assistance is provided to Medi-Cal eligible individuals and their families for the receipt of SMH services.

Reason for Change:

The change in FY 2022-23, in the prior estimate, is a net increase due to two new MAA counties expected to make claims for FY 2021-22 and onwards, and Los Angeles did not submit any MAA claims in FY 2020-21 as previously projected.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to an estimated increase in claiming based on historical averages.

Methodology:

1. County MHPs submit claims for reimbursement on a quarterly basis. Claims may be submitted up to six months after the close of a fiscal year.
2. Actual SMH MAA claims for FY 2021-22 are estimated to increase by 17.86% due to the addition of two new MAA counties, growth thereafter is estimated to increase by 11.52% based on historical trends.
3. Adjustments for the expected reduction in claiming for Unsatisfactory Immigration Status (UIS) population beneficiaries are reflected in PC 169 State Only Claiming Adjustments policy change.

SMH MAA
OTHER ADMIN. POLICY CHANGE NUMBER: 11

4. This policy change will continue to use the current Certified Public Expenditure methodology and will not be included in the Intergovernmental Transfer methodology being implemented for the California Advancing and innovating Medi-Cal (CalAIM).
5. Based on historical claims received, assume 3.43% of FY 2022-23 and FY 2023-23 claims will be paid in the year services occur and 96.57% are paid in the following year.

(Dollars in Thousands)

Fiscal Years	Accrual	FY 2022-23	FY 2023-24
2021-22	\$90,196	\$87,105	\$0
2022-23	\$100,590	\$3,447	\$97,143
2023-24	\$112,182	\$0	\$3,844
Total	\$302,968	\$90,552	\$100,987

*Totals may differ due to rounding

6. The 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 2021-22, assume 19.13% of costs are eligible for 75% reimbursement and the remaining 80.87% are eligible for 50% reimbursement. SMH MAA total expenditures are shared between federal funds (FF) and county funds (CF).

(Dollars in Thousands)

Expenditures	FY 2022-23			FY 2023-24		
	TF	FF	CF	TF	FF	CF
SPMP (75/25)	\$17,327	\$12,995	\$4,332	\$19,323	\$14,493	\$4,830
Other (50/50)	\$73,225	\$36,613	\$36,612	\$81,664	\$40,832	\$40,832
Total	\$90,552	\$49,608	\$40,944	\$100,987	\$55,325	\$45,662

*Totals may differ due to rounding

Funding:

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

COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE

OTHER ADMIN. POLICY CHANGE NUMBER: 12
IMPLEMENTATION DATE: 11/2022
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2334

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$48,143,000	\$48,143,000
STATE FUNDS	\$19,201,000	\$19,201,000
FEDERAL FUNDS	\$28,942,000	\$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 “Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, Children’s Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health Care Providers,” (referred to as “CMS Interoperability and Patient Access final rule”) to further advance interoperability for Medicaid and CHIP providers and improve beneficiaries’ access to their data. State Medicaid agencies, Medicaid managed care plans, CHIP agencies, and CHIP managed care entities must implement this final rule in a manner consistent with existing guidance and the recently published “21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program” final rule (referred to as the ONC 21st Century Cures Act final rule), by the Office of the National Coordinator for Health Information Technology, published in the Federal Register on May 1, 2020.

CMS Interoperability and Patient Access final rule requires counties at a minimum:

- Implementation and maintenance of a standards-based patient access application program interface (API);
- Standardizing information about provider networks available via a Fast Healthcare Interoperability Resources (FHIR) Provider Directory API coordination of care between payers by exchanging the information contained in the United States Core Data for Interoperability (USCDI); and
- Improving the dual eligible experience.

The CMS Interoperability and Patient Access final rule requires Medicaid managed care plans and CHIP managed care entities to comply with a beneficiary’s request to have their health data transferred from payer to payer by January 1, 2022. Given the federal mandate, this proposal results in a Proposition 30 impact where the non-federal share of costs for counties to come into

COUNTY COMPLIANCE WITH INTEROPERABILITY FINAL RULE

OTHER ADMIN. POLICY CHANGE NUMBER: 12

compliance is split between counties and the state. Federal law already requires Medicaid managed care plans to comply with the data exchange standards and regulations, which includes various Medi-Cal programs including the Medi-Cal behavioral health programs.

Reason for Change:

There is no change from the prior estimate for FY 2022-23.

There is no change in the current estimate from FY 2022-23 to FY 2023-24.

Methodology:

1. Assume reimbursements to counties for incurred expenses 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 and FY 2023-24 are:

(Dollars in Thousands)

Interoperability Final Rule	TF	GF	FF	CF
FY 2022-23	\$67,344	\$19,201	\$28,942	\$19,201
FY 2023-24	\$67,344	\$19,201	\$28,942	\$19,201

Funding:

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

100% General Fund (4260-101-0001)

DRUG MEDI-CAL COUNTY ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 13
IMPLEMENTATION DATE: 7/2014
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1813

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$44,734,000	\$64,360,000
STATE FUNDS	\$92,000	\$13,113,000
FEDERAL FUNDS	\$44,642,000	\$51,247,000

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: 13

- 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, FY 2022-23, is a net decrease due to the following:

- Fewer than originally forecasted annual settlements are expected to be processed.
- Net decrease in county admin claims projections based on actual claims received.
- UR and QA Admin projection increased slightly based on actual claims received.

The change in the current estimate, from FY 2022-23 to FY 2023-24, is due to an ongoing increase in the number of counties submitting quarterly claims for both County Admin and UR and QA Admin, and an increase in annual settlements projected for FY 2023-24.

Methodology:

1. DMC county administration and UR and QA administration expenditures are split between Federal, State and County Funds (CF).
2. For DMC county admin and UR and QA admin claims, assume 76% of the claims will be paid in the first year, 26% in the second year.
3. For counties that submit claims annually, assume claims will be submitted and paid during interim cost settlement.
4. 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.
5. UR and QA costs for SPMP will receive enhanced federal reimbursement of 75%. All other personnel will receive 50% federal reimbursement.
6. The Department will implement the CalAIM Behavioral Health Payment Reform and a new Intergovernmental Transfers (IGTs) process. For all claims with dates of service of on or after July 1, 2023, counties will transfer the county portion of the submitted claims before FF can be used for payment.

DRUG MEDI-CAL COUNTY ADMINISTRATION
OTHER ADMIN. POLICY CHANGE NUMBER: 13

7. 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 2022-23	FY 2023-24
FY 2020-21 Claims	\$18,092	\$1,809	\$0
FY 2021-22 Claims	\$15,985	\$3,836	\$1,598
FY 2022-23 Claims	\$16,913	\$12,854	\$4,059
FY 2023-24 Claims	\$18,590	\$0	\$14,128
Total		\$18,499	\$19,785

(Dollars in Thousands)

Annual Settlements	Accrual	FY 2022-23	FY 2023-24
FY 2016-17 Claims	\$26,366	\$15,820	\$0
FY 2017-18 Claims	\$27,157	\$13,340	\$0
FY 2018-19 Claims	\$27,972	\$12,759	\$15,213
FY 2019-20 Claims	\$28,811	\$0	\$28,811
Total		\$41,919	\$44,024

(Dollars in Thousands)

DMC UR and QA Admin.	Accrual	FY 2022-23	FY 2023-24
FY 2020-21 Claims	\$13,229	\$1,323	\$0
FY 2021-22 Claims	\$16,190	\$3,886	\$3,886
FY 2022-23 Claims	\$20,769	\$15,784	\$4,985
FY 2023-24 Claims	\$25,348	\$0	\$19,264
Total		\$20,993	\$28,135

FY 2022-23	TF	GF	IGT*	FF	CF
County Administration	\$18,499,000	\$92,000	\$0	\$9,250,000	\$9,157,000
UR and QA Administration	\$20,993,000	\$0	\$0	\$14,433,000	\$6,560,000
Annual Settlements	\$41,919,000	\$0	\$0	\$20,959,000	\$20,960,000
Total	\$81,411,000	\$92,000	\$0	\$44,642,000	\$36,677,000

FY 2023-24	TF	GF	IGT*	FF	CF
County Administration	\$19,785,000	\$99,000	\$6,993,000	\$9,893,000	\$2,800,000
UR and QA Administration	\$28,135,000	\$0	\$6,021,000	\$19,342,000	\$2,772,000
Annual Settlements	\$44,024,000	\$0	\$0	\$22,012,000	\$22,012,000
Total	\$91,944,000	\$99,000	\$13,014,000	\$51,247,000	\$27,584,000

DRUG MEDI-CAL COUNTY ADMINISTRATION
OTHER ADMIN. POLICY CHANGE NUMBER: 13

Funding:

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

100% GF (4260-101-0001)

Medi-Cal County Behavioral Health Fund (4260-601-3420)*

OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 14
IMPLEMENTATION DATE: 1/2013
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 1748

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$43,371,000	\$40,987,000
STATE FUNDS	\$23,075,850	\$21,748,100
FEDERAL FUNDS	\$20,295,150	\$19,238,900

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

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: 14

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. 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. 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) proposed creating 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.

The MAXIMUS contract is being amended to remove premium collection services due to Senate Bill 184 (Omnibus Health Bill 2022) which authorized the Department of Health Care Services to reduce premiums for Medi-Cal programs to zero.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is an increase due to higher Medi-Cal publications and batch of mailings shifting to follow the end of the national public health emergency. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due lower projected average Medi-Cal publications.

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.

OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS
OTHER ADMIN. POLICY CHANGE NUMBER: 14

4. Contract costs and administrative vendor service costs by program are as follows:

(Dollars in Thousands)

Program	FY 2022-23	FY 2023-24
OTLICP	\$19,785	\$18,319
MCAP	\$5,397	\$4,231
CCHIP	\$4,418	\$4,241
Hearing Aids	\$6,711	\$6,195

5. Contract costs and administrative vendor service costs by cost category are as follows:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Contract Costs	\$13,831	\$4,950	\$8,881
Applications Processing, Printing and Courier Services, Letters and Notices, Transaction Forwarding Fee	\$2,910	\$1,455	\$1,455
Call Minute Rate per Minute	\$4,148	\$2,074	\$2,074
Implementation Costs	\$2,000	\$1,000	\$1,000
Hearing Aids	\$6,711	\$6,711	\$0
Medi-Cal Publications	\$13,772	\$6,886	\$6,886
Total	\$43,371	\$23,076	\$20,295

FY 2023-24	TF	GF	FF
Contract Costs	\$13,016	\$4,665	\$8,351
Applications Processing, Printing and Courier Services, Letters and Notices, Transaction Forwarding Fee	\$2,658	\$1,329	\$1,329
Call Minute Rate per Minute	\$3,829	\$1,914	\$1,915
Implementation Costs	\$2,000	\$1,000	\$1,000
Hearing Aids	\$6,195	\$6,195	\$0
Medi-Cal Publications	\$13,289	\$11,780	\$1,509
Total	\$40,987	\$26,883	\$14,104

* Totals may differ due to rounding.

OTLIPC, MCAP, SPECIAL POPULATIONS ADMIN COSTS
OTHER ADMIN. POLICY CHANGE NUMBER: 14

Funding:

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890/0001)	\$23,559	\$11,780	\$11,779
65% Title XXI / 35% GF (4260-113-0890/0001)	\$13,101	\$4,585	\$8,516
100% GF (4260-101-0001)	\$6,711	\$6,711	\$0
Total	\$43,371	\$23,076	\$20,295

FY 2023-24	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890/0001)	\$22,506	\$11,253	\$11,253
65% Title XXI / 35% GF (4260-101-0890/0001)	\$12,286	\$4,300	\$7,986
100% GF (4260-101-0001)	\$6,195	\$6,195	\$0
Total	\$40,987	\$21,748	\$19,239

* Totals may differ due to rounding.

** COVID-19 funding is identified in the COVID-19 Increased FMAP – Other Admin policy change.

DATA REPORTING AND ANALYTICS SUPPORT SYSTEMS

OTHER ADMIN. POLICY CHANGE NUMBER: 15
IMPLEMENTATION DATE: 7/2002
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 252

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$41,618,000	\$43,405,000
STATE FUNDS	\$9,735,650	\$11,420,150
FEDERAL FUNDS	\$31,882,350	\$31,984,850

Purpose:

The policy change estimates the contract costs associated with the data reporting and analytics support systems. The support systems include the Management Information System/Decision Support System (MIS/DSS), the Management Administration Reporting Subsystem (MARS), the Surveillance Utilization Reporting System (SURS), and the Enterprise Data Platform.

Authority:

Contract #14-90129
 Centers for Medicaid Services (CMS) Transformed Medicaid Statistical Information System (T-MSIS) Requirements
 Contract #15-92272
 Contract #20-10369
 Contract #21-10284
 Contract #23-30004

Interdependent Policy Changes:

COVID-19 Increased FMAP – Other Admin

Background:

The data reporting and analytics support systems manage a variety of Medicaid-related data and incorporate it into an integrated business intelligence system. The MIS/DSS, MARS, SURS, and Enterprise Data Platform are critical components of gathering the insight necessary to make recommendations; adjust strategic initiatives; and better capture revenue. Data is a critical component of good decision-making; and good decision-making comes from comprehensive reporting, effective analytics, and subsequent implementation.

These systems 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 these systems 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.

DATA REPORTING AND ANALYTICS SUPPORT SYSTEMS

OTHER ADMIN. POLICY CHANGE NUMBER: 15

Ongoing maintenance and operations (M&O) is accomplished through a multi-year contract. This contract includes M&O of the data warehouse, help desk support, training, and refreshing of hardware and software to maintain peak performance.

The SURS subsystem was implemented on April 3, 2017, and the MARS subsystem was implemented on February 15, 2019. CMS requires implemented projects to be funded at 50%/50% Federal Medical Assistance Percentage until certified. Both systems received certification on August 31, 2020. The systems are now receiving enhanced funding of 75%/25%. The Department is currently seeking recoupment of \$5,010,000 in enhanced funding for MARS and SURS; anticipated to be completed in May 2023.

The primary contract will expire in June 2025. Amendment 4 addresses mandatory mission-critical state and federal requirements that influence the volume and complexity of data to be stored in the warehouse. The increased data will accommodate larger operational data loads, which satisfy T-MSIS requirements now mandated by CMS.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is an increase due to delayed payments due to fiscal year-end closeout activities, the system refresh delay from the execution of Amendment 4, and the Enterprise Data Platform contract takeover activities. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to the Enterprise Data Platform contract takeover activities.

Methodology:

1. MIS/DSS total contract Amendment #4 costs began in September 2022, and will end on June 30, 2025, which includes a two-year extension from the date of the original contract.
2. SURS and MARS contract Amendment #4 costs began in September 2022 and will end on June 30, 2025, which includes a two-year extension from the date of the original contract.
3. The Department is currently working to procure a new Enterprise Data Platform contract to take over support of the current data environment and transition the existing workload supported by the expiring contract for the Data Reporting and Analytics Support Systems. This will result in a twelve-month transition takeover period during which both contracts will be in place
4. The estimated breakdown of the SURS costs are:

SURS	FY 2022-23	FY 2023-24
Operational Costs (75%/25%)	\$14,057,000	\$7,011,000
Total	\$14,057,000	\$7,011,000

*Totals may differ due to rounding

5. The estimated breakdown of the MARS costs are:

MARS	FY 2022-23	FY 2023-24
Operational Costs (75%/25%)	\$3,425,000	\$2,853,000
Total	\$3,425,000	\$2,853,000

*Totals may differ due to rounding

DATA REPORTING AND ANALYTICS SUPPORT SYSTEMS

OTHER ADMIN. POLICY CHANGE NUMBER: 15

6. The estimated breakdown of the MIS/DSS costs are:

MIS/DSS	FY 2022-23	FY 2023-24
DD&I Cost (90%/10%)	\$984,000	\$984,000
Operational Costs (75%/25%)	\$19,857,000	\$15,871,000
Operational Costs (50%/50%)	\$795,000	\$631,000
Total	\$21,636,000	\$17,486,000

*Totals may differ due to rounding

7. The estimated breakdown of the Enterprise Data Platform costs are:

Enterprise Data Platform	FY 2022-23	FY 2023-24
Operational Costs (75%/25%)	\$2,500,000	\$16,055,000
Total	\$2,500,000	\$16,055,000

*Totals may differ due to rounding

8. The estimated total costs for SURS, MARS, MIS/DSS, and Enterprise Data Platform are:

SURS, MARS, MIS/DSS, and Enterprise Data Platform	TF	GF	FF
DD&I Cost (90%/10%)	\$892,000	\$89,000	\$803,000
Operational Costs (75%/25%)	\$41,104,000	\$10,276,000	\$30,828,000
Operational Costs Recoupment of Funds Post Certification (50%/50%)	(\$4,290,000)	(\$2,145,000)	(\$2,145,000)
Operational Costs (65%/35%)	\$3,687,000	\$1,291,000	\$2,396,000
100% State GF	\$225,000	\$225,000	\$0
Total FY 2022-23	\$41,618,000	\$9,736,000	\$31,882,000

*Totals may differ due to rounding

SURS, MARS, MIS/DSS, and Enterprise Data Platform	TF	GF	FF
DD&I Cost (90%/10%)	\$892,000	\$89,000	\$803,000
Operational Costs (75%/25%)	\$37,862,000	\$9,466,000	\$28,396,000
Operational Costs (50%/50%)	\$570,000	\$286,000	\$284,000
Operational Costs (65%/35%)	\$3,847,000	\$1,346,000	\$2,500,000
100% State GF	\$234,000	\$234,000	\$0
Total FY 2023-24	\$43,405,000	\$11,421,000	\$31,983,000

*Totals may differ due to rounding

DATA REPORTING AND ANALYTICS SUPPORT SYSTEMS

OTHER ADMIN. POLICY CHANGE NUMBER: 15

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)

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

65% Title XXI / 35% GF (4260-101-0890/0001)

100% GF (4260-101-0001)

COVID-19 funding is identified in the COVID-19 Increased FMAP – Other Admin policy change

CHDP COUNTY ALLOCATION

OTHER ADMIN. POLICY CHANGE NUMBER: 16
IMPLEMENTATION DATE: 7/1996
ANALYST: Erik Stacey
FISCAL REFERENCE NUMBER: 229

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$33,962,000	\$33,962,000
STATE FUNDS	\$10,575,000	\$10,575,000
FEDERAL FUNDS	\$23,387,000	\$23,387,000

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
 California Code of Regulations Subchapter 13
 SB 75 (Chapter 709, Statutes of 2015)

Interdependent Policy Changes:

Not Applicable

Background:

The CHDP County Allocation is provided to individual local government agencies and controlled on an accrual basis. The purpose of the funding is for local government activities for CHDP care management and conducting CHDP provider oversight, training and enrollment.

Medi-Cal eligible children are entitled to Title XIX EPSDT provisions, including access to case management services. Most children in Medi-Cal receive these care management services through their Medi-Cal managed care plan. CHDP provides care management to children and youth who are uninsured or enrolled in Fee-for-Service Medi-Cal. In addition, eligible children receive care 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.

Per signed Budget Trailer Bill SB 184, the sunset of the CHDP Program and the implementation of the Children's Presumptive Eligibility Program will be effective July 1, 2024. Before sunseting the CHDP program, DHCS must conduct a stakeholder engagement process. The process will inform DHCS in the development and implementation of a transition plan and defined milestones to guide the transition of CHDP to other existing Medi-Cal delivery systems or services. DHCS shall strive to ensure the stakeholder engagement process reflects participation from the various regions throughout the state, including large urban and rural jurisdictions. DHCS will launch the stakeholder engagement process by convening the first meeting no later than October 1, 2022.

CHDP COUNTY ALLOCATION

OTHER ADMIN. POLICY CHANGE NUMBER: 16

DHCS will facilitate the transition of the following current CHDP activities and responsibilities into existing Medi-Cal systems:

- Early and Periodic Screening, Diagnostic, and Treatment benefits
- Coordination of care, including dental and behavioral health services
- Presumptive eligibility
- Provider oversight and training
- CHDP - HCPCFC and CCS program activities

Additionally, DHCS will redirect a part of the CHDP budget allocation to fund the administrative and services costs of the Health Care Program for Children in Foster Care (HCPCFC) and the CCS Program to retain existing local CHDP positions through the exploration of new partnerships and roles and/or through bolstering existing programs that can leverage CHDP expertise.

Reason for Change:

There is no change from the prior estimate for FY 2022-23 or between fiscal years in the current estimate.

Methodology:

The allocation amount for both FY 2022-23 and FY 2023-24 is \$33,962,000 (\$10,575,000 GF)

Funding:

FY 2022-23	TF	GF	FF	County Funds
Title XIX (50% FF / 50% GF)	\$13,338,000	\$6,669,000	\$6,669,000	
Title XIX (75% FF / 25% GF)	\$15,624,000	\$3,906,000	\$11,718,000	
Title XIX (100% FF)	\$5,000,000	\$0	\$5,000,000	\$5,000,000
Total	\$33,962,000	\$10,575,000	\$23,387,000	\$5,000,000

FY 2023-24	TF	GF	FF	County Funds
Title XIX (50% FF / 50% GF)	\$13,338,000	\$6,669,000	\$6,669,000	
Title XIX (75% FF / 25% GF)	\$15,624,000	\$3,906,000	\$11,718,000	
Title XIX (100% FF)	\$5,000,000	\$0	\$5,000,000	\$5,000,000
Total	\$33,962,000	\$10,575,000	\$23,387,000	\$5,000,000

POSTAGE & PRINTING

OTHER ADMIN. POLICY CHANGE NUMBER: 17
IMPLEMENTATION DATE: 7/1993
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 231

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$32,331,000	\$32,331,000
STATE FUNDS	\$16,294,000	\$16,294,000
FEDERAL FUNDS	\$16,037,000	\$16,037,000

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: 17

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 2022-23, is an increase due to an increase in estimated 1095-B mailings. There is no change from FY 2022-23 to FY 2023-24 in the current estimate.

Methodology:

1. Based on actuals, and estimated increases to the reported population receiving Form 1095-B mailings, assume that 14,500,000 mailings will be conducted for FY 2022-23.

2. Assume that the cost per mailing is \$0.76:

$$14,500,000 \text{ mailings} \times \$0.76 \text{ per mailing} = \$11,020,000 \text{ (rounded)}$$

3. Based on FY 2021-22 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 \$0.76 per unit.

$$3\% \times 14,500,000 \text{ mailings} = 435,000 \text{ returned mailings}$$

$$435,000 \text{ returned mailings} \times \$0.76 \text{ per unit} = \$331,000 \text{ (rounded)}$$

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 \$0.76 per unit and based on FY 2021-22 actuals, assume 131,000 mailers will be sent out to beneficiaries.

$$131,000 \text{ mailings} \times \$0.76 \text{ per mailing} = \$100,000 \text{ (rounded)}$$

5. TAR postage costs for Medi-Cal are assumed to be \$80,000 for FY 2022-23 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 2022-23 and \$150,000 FY 2023-24.
7. The Department estimates the printing and postage costs for FY 2022-23 and FY 2023-24 are:

POSTAGE & PRINTING
OTHER ADMIN. POLICY CHANGE NUMBER: 17

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Base Mass Mailing	\$18,200	\$9,229	\$8,971
1095B			
1095 Mailings	\$11,020	\$5,510	\$5,510
Reprinted/Corrected Form 1095-B	\$331	\$166	\$165
Notice for Requested Action	\$100	\$50	\$50
1095 B Subtotal	\$11,451	\$5,726	\$5,725
Emergency Mailings	\$2,600	\$1,300	\$1,300
TAR Postage	\$80	\$40	\$40
Total	\$32,331	\$16,295	\$16,036
FY 2023-24	TF	GF	FF
Base Mass Mailing	\$18,200	\$9,229	\$8,971
1095B			
1095 Mailings	\$11,020	\$5,510	\$5,510
Reprinted/Corrected Form 1095-B	\$331	\$166	\$165
Notice for Requested Action	\$100	\$50	\$50
1095 B Subtotal	\$11,451	\$5,726	\$5,725
Emergency Mailings	\$2,600	\$1,300	\$1,300
TAR Postage	\$80	\$40	\$40
Total	\$32,331	\$16,295	\$16,036

*Totals may differ due to rounding.

Funding:

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

100% GF (4260-101-0001)

ACTUARIAL COSTS FOR RATE DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 18
IMPLEMENTATION DATE: 8/2015
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1937

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$29,995,000	\$32,175,000
STATE FUNDS	\$14,997,500	\$16,087,500
FEDERAL FUNDS	\$14,997,500	\$16,087,500

Purpose:

This policy change estimates the costs for contracted actuarial rate development services.

Authority:

Welfare & Institutions Code 14301.1
 Title 42, Code of Federal Regulations 438.4

Interdependent Policy Changes:

Not Applicable

Background:

Federal requirements for obtaining federal financial participation require that managed care capitation rates be actuarially sound. Actuarially sound capitation rates require:

- Having been developed in accordance with standards specified in Title 42, Code of Federal Regulations (CFR) 438.5, and generally accepted actuarial principles and practices,
- Being appropriate for the populations to be covered and the services to be furnished under the contract, and
- Being certified by an actuary as meeting applicable federal requirements specified in Title 42 CFR 438.4.

The Department entered into a contract with an actuarial services consultant to ensure development of actuarially sound capitation rates.

Reason for Change:

The change from the prior estimate for FY 2022-23, and the change from FY 2022-23 to FY 2023-24 in the current estimate, is an increase due to a higher workload in actuarial services related to rate development and shift of covered services and populations into the managed care delivery system.

Methodology:

1. This policy change collectively budgets for all actuarial services received for different managed care programs.
2. Per payment terms, 10% of the contractor's fees are withheld for six months pending completion of outstanding projects.
3. Per payment terms, the contractor fees overlap fiscal years due to billing for projects in the subsequent invoice month.

ACTUARIAL COSTS FOR RATE DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 18

4. Specific costs are identified for existing workloads Hospital Quality Assurance Fee (HQAF) program and Federally Qualified Health Centers Alternative Payment Methodology (FQHC APM); however, ongoing actuarial services are needed as these, and other new programs are integrated into the overall managed care delivery system rate setting process.
5. CCI has been rolled into Ongoing Actuarial Services as of FY 2022-23.
6. Actuarial costs related to the AB 1705 GEMT Public Provider IGT Program are paid using State GF, but supported by a 10% administrative fee that applies to AB 1705 IGT collections. These amounts are captured in Ongoing Actuarial Services.
7. The FY 2022-23 and FY 2023-24 amounts on an accrual basis are estimated to be:

Policy	FY 2022-23	FY 2023-24
Ongoing Actuarial Services	\$29,484,000	\$32,700,000
HQAF Program	\$300,000	\$300,000
FQHC APM	\$216,000	\$0
Total	\$30,000,000	\$33,000,000

The FY 2022-23 and FY 2023-24 amounts on a cash basis are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	HQAF	FF
FY 2022-23	\$29,995	\$14,847	\$150	\$14,998
FY 2023-24	\$32,175	\$15,937	\$150	\$16,088

Funding:

50% Title XIX FF / 50% GF (4260-101-0890/0001)
Hospital Quality Assurance Revenue Fund (4260-611-3158)

HITECH AND PUBLIC HEALTH REGISTRIES SUPPORT

OTHER ADMIN. POLICY CHANGE NUMBER: 19
IMPLEMENTATION DATE: 7/2021
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1370

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$20,711,000	\$20,328,000
STATE FUNDS	\$38,000	\$0
FEDERAL FUNDS	\$20,673,000	\$20,328,000

Purpose:

This policy change estimates the administrative costs associated with the advancement of the Health Information Technology for Economic and Clinical Health (HITECH) Incentive Act under the American Recovery and Reinvestment Act (ARRA) of 2009. The Centers for Medicare and Medicaid Services (CMS) has encouraged states to continue to support programs that have been funded under the HITECH Act to funding under Medicaid Enterprise Systems (MES) as the HITECH funding ends. This policy change additionally estimates administrative costs for California Department of Public Health (CDPH) and Emergency Medical Services Authority (EMSA) programs that the Department has supported under HITECH and has transitioned to MES funding.

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
 Code of Federal Regulations, Title 42, Part 433
 Interagency Agreement (IA) # 21-10135
 Interagency Agreement SHIELD # 20-10492
 Interagency Agreement EMSA (Pending)
 Interagency Agreement CAIR (Pending)
 Interagency Agreement CalREDIE (Pending)

Interdependent Policy Changes:

Not Applicable

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. 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 CMS for approval of continued funding. CMS approved the Department's IAPD-U

HITECH AND PUBLIC HEALTH REGISTRIES SUPPORT

OTHER ADMIN. POLICY CHANGE NUMBER: 19

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. An IAPD-U for FFY 2022 was approved by CMS on September 15, 2021, and is considered retroactive to August 25, 2021. The current IAPD-U will expire on September 30, 2022. An IAPD-U has been submitted in August 2022 to extend funding authority for the HIT Landscape Assessment under HITECH into the next federal fiscal year. The Department works with partner departments to support the California Immunization Registry (CAIR), California Reportable Disease Information Exchange (CaREDIE), and Surveillance, Health, Intervention, and Environmental Lead Database (SHIELD) projects under the CA-2021-01-26-MMIS-IAPD-Public Health Registries APD and to transition the HITEMS project to a new emergency medical services APD. The Department is currently working with CDPH and EMSA to draft Interagency Agreements for CAIR, CaREDIE, SHIELD, and EMSA.

- 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.
- CaREDIE electronic Case Reports (eCR) program initiates electronic case reporting to public health in support of MU Stage 3.
- Health Information Technology for EMS (HITEMS) targets improvements on two critical components of the health care system, emergency medical services (EMS), and disaster response. Under the scope of HITEMS, the Department provides support for the Patient Unified Lookup System for Emergencies (Pulse) and the Physician Orders for Life Sustaining Treatment (POLST) system.
- SHIELD implements a new data system to coordinate the public health and environmental services for children exposed to lead poisoning.

CMS requires the Department to conduct a detailed landscape assessment of the state of health information technology in California. This assessment will be completed at the end of the program and will serve as a bookend to the assessment that was completed in 2010, when the program began.

This policy change was previously titled ARRA HITECH – MES Transition.

Reasons for Change:

The change from the prior estimate, for FY 2022-23, is an increase due to additional amendments and delays in submittal of invoices from the vendor for the HIT Landscape Assessment contract.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to the absence of costs for the HIT Landscape Assessment in FY 2023-24.

Methodology:

1. The SHIELD project is eligible for Title XIX 90% FF during the design, development, and implementation phase.
2. The HITEMS project anticipates eligibility for Title XIX 75% funding.
3. For the CAIR Onboarding, CaREDIE eCR, and SHIELD projects, the non-federal share is budgeted by CDPH. This policy change budgets the Title XIX FF that will be provided to CDPH per the contracts through an interagency agreement.

HITECH AND PUBLIC HEALTH REGISTRIES SUPPORT

OTHER ADMIN. POLICY CHANGE NUMBER: 19

4. For the HITEMS project, the non-federal share is budgeted by EMSA. This policy change budgets the Title XIX FF that will be provided to EMSA per the contracts through an IA.
5. The HIT Landscape Assessment costs are eligible for Title XIX 90% FF. The 10% non-federal share is provided by outside entities. The California Health Care Foundation will provide funding for the state share of this contract via reimbursement.

FY 2022-23	TF	Reimburs.	FF
HIT Landscape Assessment (90% FF/10% GF)	\$383,000	\$38,000	\$345,000
HITEMS (+EMS, PULSE, POLST) (75% FF/25% GF)	\$10,142,000	\$0	\$10,142,000
CaIREMIE M&O (50% FF/50% GF)	\$524,000	\$0	\$524,000
CAIR M&O & CAIR MyVFC Enhancement (50% FF/50% GF)	\$3,497,000	\$0	\$3,497,000
SHIELD DDI (90% FF/10% GF)	\$6,165,000	\$0	\$6,165,000
Total FY 2022-23	\$20,711,000	\$38,000	\$20,673,000

FY 2023-24	TF	Reimburs.	FF
HIT Landscape Assessment (90% FF/10% GF)	\$0	\$0	\$0
HITEMS (+EMS, PULSE, POLST) (75% FF/25% GF)	\$10,142,000	\$0	\$10,142,000
CaIREMIE M&O (50% FF/50% GF)	\$524,000	\$0	\$524,000
CAIR M&O & CAIR MyVFC Enhancement (50% FF/50% GF)	\$3,497,000	\$0	\$3,497,000
SHIELD DDI (90% FF/10% GF)	\$6,165,000	\$0	\$6,165,000
Total FY 2023-24	\$20,328,000	\$0	\$20,328,000

*Note: some slight variations due to rounding

Funding:

100% Title XIX (4260-101-0890)

100% State GF (4260-101-0001)

HEALTH ENROLLMENT NAVIGATORS

OTHER ADMIN. POLICY CHANGE NUMBER: 20
IMPLEMENTATION DATE: 7/2021
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2144

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$19,106,000	\$19,329,000
STATE FUNDS	\$9,553,000	\$9,664,500
FEDERAL FUNDS	\$9,553,000	\$9,664,500

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)
 AB 178 (Chapter 45, Statutes of 2022)

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.

Starting July 2022, the Department proposes to continue the Health Enrollment Navigators Project through FY 2025-2026 and continue project activities with an emphasis on COVID-19 Public Health Emergency (PHE)-related activities to help beneficiaries retain Medi-Cal coverage by assisting with annual renewals, reporting updated contact information, and engage in outreach, application assistance, enrollment, and retention of difficult-to-reach target populations and support more focused targeted outreach and enrollment for Medi-Cal program and benefit expansions.

Reason for Change:

The change in FY 2022-23, from the prior estimate, is a decrease due to shifting all the program extension dollars from FY 2022-23 into FY 2023-24 and beyond. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to anticipating more claims being processed in FY 2023-24.

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.

HEALTH ENROLLMENT NAVIGATORS

OTHER ADMIN. POLICY CHANGE NUMBER: 20

3. The budget agreement for FY 2019-20 provided \$60 million TF (\$30 million GF) for this item. The Budget Act for FY 2022-23 provided an additional \$60 million TF (\$30 million GF). The table below displays the estimated spending and remaining funds by Appropriation Years:

	TF	GF	FF*
Appropriation Year 2019-20			
Prior Years	\$42,654,000	\$21,327,000	\$21,327,000
Estimated in FY 2022-23	\$11,966,000	\$5,983,000	\$5,983,000
Estimated in FY 2023-24	\$3,705,000	\$1,852,500	\$1,852,500
Total Estimated Remaining	\$1,675,000	\$837,500	\$837,500
Appropriation Year 2022-23			
Estimated in FY 2022-23	\$7,140,000	\$3,570,000	\$3,570,000
Estimated in FY 2023-24	\$15,624,000	\$7,812,000	\$7,812,000
Total Estimated Remaining	\$37,236,000	\$18,618,000	\$18,618,000

*Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.

4. Total estimated costs for FY 2022-23 and FY 2023-24 are:

FY 2022-23	TF	GF	FF*
Appropriation Year 2019-20	\$11,966,000	\$5,983,000	\$5,983,000
Appropriation Year 2022-23	\$7,140,000	\$3,570,000	\$3,570,000
Total FY 2022-23	\$19,106,000	\$9,553,000	\$9,553,000

FY 2023-24	TF	GF	FF*
Appropriation Year 2019-20	\$3,705,000	\$1,852,500	\$1,852,500
Appropriation Year 2022-23	\$15,624,000	\$7,812,000	\$7,812,000
Total FY 2023-24	\$19,329,000	\$9,664,500	\$9,664,500

*Federal funds authority is newly requested for the fiscal year in which funds are anticipated to be expended.

Funding:

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

MEDI-CAL RECOVERY CONTRACTS

OTHER ADMIN. POLICY CHANGE NUMBER: 21
IMPLEMENTATION DATE: 2/2008
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1551

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$17,957,000	\$14,651,000
STATE FUNDS	\$4,489,250	\$3,662,750
FEDERAL FUNDS	\$13,467,750	\$10,988,250

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)	22-20079
Dept. of Industrial Relations – Workers' Compensation Information System (WCIS)	19-96030
Department of Social Services	20-10026
Health Management Systems Inc. (HI)	18-95310 A01
RELX Inc.	17-94636 A02
RELX Inc.	17-94636 A03
RELX Inc.	Pending

Interdependent Policy Changes:

Not Applicable

Background:

Since Medi-Cal is the payer of last resort, all legally responsible third parties must first be billed before the Medi-Cal program, unless certain restrictions apply. The above contracts provide:

- Data matches between the Department's Medi-Cal beneficiary eligibility file and the carrier's policy holder/subscriber file,
- Identification of private/group health coverage and the recovery of Medi-Cal expenditures when the private/group health coverage is the primary payer,
- Online access to research database services for public records of Medi-Cal beneficiaries,
- Access to disability determinations for applicants requesting an exemption from estate recovery claims on the basis of a disability, and
- Cost avoidance activities.

For contingency-based contracts, when such insurance is identified, the vendor retroactively bills the third party to recover Medi-Cal paid claims. Payment to the vendor is contingent upon recoveries, and may exceed the vendor's estimated recovery projections. Recoveries due to third party liability vendor activities are incorporated into the Base Recoveries policy change.

MEDI-CAL RECOVERY CONTRACTS

OTHER ADMIN. POLICY CHANGE NUMBER: 21

The Department awarded the Health Insurance contract (18-95310) to Health Management Systems, Inc. (HMS). This contract became effective on December 1, 2018, and will run through November 30, 2023. The contingency fee is 8.5 percent.

Reason for Change:

The change in FY 2022-23, from the prior estimate, is due to:

- For the HMS – Health Insurance contract, there is an increase due to the ongoing success of Managed Care Organization (MCO) Direct Bill recoveries. In addition, the Department anticipates three Kaiser settlements in FY 2022-23 with a recovery total of approximately \$45 million.
- For the Online Database Contracts, there is no change from the prior estimate.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to:

- For the HMS – Health Insurance contract, there is a decrease due to the stabilization of MCO recoveries. Kaiser settlements will cease and Kaiser recoveries will be integrated into the monthly Direct Bill process.
- For the Online Database Contracts – there is no change from FY 2022-23 to FY 2023-24.

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 2022-23 Recoveries	FY 2023-24 Recoveries	Contingency Fee %	FY 2022-23 Contingency Fee	FY 2023-24 Contingency Fee
HMS 18	\$210,800,000	\$171,900,000	8.50%	\$17,918,000	\$14,612,000

MEDI-CAL RECOVERY CONTRACTS

OTHER ADMIN. POLICY CHANGE NUMBER: 21

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 2022-23	FY 2023-24
Department of Industrial Relations - EAMS	\$5,000	\$5,000
Department of Industrial Relations – WCIS	\$2,000	\$2,000
Department of Social Services	\$4,000	\$4,000
RELX Inc.	\$28,000	\$28,000
Total	\$39,000	\$39,000

3. The payments shown below include recent recovery activity.

FY 2022-23	TF	GF	FF
Health Insurance	\$17,918,000	\$4,479,000	\$13,439,000
Online Database Contracts	\$39,000	\$10,000	\$29,000
Total	\$17,957,000	\$4,489,000	\$13,468,000

FY 2023-24	TF	GF	FF
Health Insurance	\$14,612,000	\$3,653,000	\$10,959,000
Online Database Contracts	\$39,000	\$10,000	\$29,000
Total	\$14,651,000	\$3,663,000	\$10,988,000

Funding:

75% Title XIX / 25% GF (4260-101-0001/0890)

HCBA WAIVER ADMINISTRATIVE COST

OTHER ADMIN. POLICY CHANGE NUMBER: 22
IMPLEMENTATION DATE: 7/2019
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2152

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$17,484,000	\$20,504,000
STATE FUNDS	\$8,742,000	\$10,252,000
FEDERAL FUNDS	\$8,742,000	\$10,252,000

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.

On September 29, 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. The current waiver was to expire on December 31, 2021; however, the Centers for Medicare and Medicaid Services have approved three 90-day extensions to September 30, 2022, for the current waiver. The Department's renewal application proposes to add waiver slots beginning on January 1, 2024, based on projected enrollment and attrition trends. Although administrative payments will increase with higher enrollment into the waiver, the State will ultimately save funding with more beneficiaries receiving services in a community setting instead of in an institution.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a decrease primarily due to lowering monthly enrollment projections based on more recent data. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase in costs due to projecting additional enrollments of beneficiaries into the HCBA Waiver.

Methodology:

1. Assume there are 7,125 participants in the HCBA Waiver in FY 2021-22.
2. Assume 936 new participants will be enrolled in FY 2022-23 and FY 2023-24.

HCBA WAIVER ADMINISTRATIVE COST
OTHER ADMIN. POLICY CHANGE NUMBER: 22

3. Assume 98% of all current and new waiver participants will enroll with a Waiver Agency and receive administrative services.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2022-23	\$17,484	\$8,742	\$8,742
FY 2023-24	\$20,504	\$10,252	\$10,252

*Totals may differ due to rounding.

Funding:

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

PAVE SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 23
IMPLEMENTATION DATE: 4/2016
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1932

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$16,413,000	\$21,899,000
STATE FUNDS	\$4,526,150	\$5,974,750
FEDERAL FUNDS	\$11,886,850	\$15,924,250

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
Contract # 15-92256

Interdependent Policy Changes:

COVID-19 Increased FMAP – 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. PAVE received certification on April 1, 2021, from the Centers for Medicare and Medicaid Services (CMS).

Reason for Change:

The change from the prior estimate for FY 2022-23, is a decrease due to updated actuals from paid invoices. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to the ongoing PAVE M&O activities, which include an anticipated increase in the number of providers in PAVE.

Methodology:

1. The Department continues 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: 23

2. The Department received CMS certification in April 2021. This allows the M&O Federal Financial Participation (FFP) to be claimed at 75% FF / 25% GF on the Provider cost and 50% FF / 50% GF on the Help Desk cost.
3. Funds are based on the monthly service fee associated with using the PAVE system, which is influenced by the number of providers in the system, the number of calls received in the call center, and other key metrics. With these numbers constantly increasing, the monthly rates continuously increase as more providers apply and are enrolled.
4. The FY 2022-23 and FY 2023-24 costs are as follows:

FY 2022-23	TF	GF	FF
Help Desk Cost	\$930,000	\$455,000	\$475,000
Provider Cost	\$15,483,000	\$4,071,000	\$11,412,000
Total	\$16,413,000	\$4,526,000	\$11,887,000

*Totals may differ due to rounding

FY 2023-24	TF	GF	FF
Help Desk Cost	\$960,000	\$470,000	\$490,000
Provider Cost	\$20,939,000	\$5,505,000	\$15,434,000
Total	\$21,899,000	\$5,975,000	\$15,924,000

*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)

65% Title XXI / 35% GF (4260-101-0001/0890)

COVID-19 funding is identified in the COVID-19 Increased FMAP – Other Admin policy change

CAPMAN

OTHER ADMIN. POLICY CHANGE NUMBER: 24
IMPLEMENTATION DATE: 10/2012
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1318

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$12,210,000	\$16,081,000
STATE FUNDS	\$3,173,450	\$4,117,900
FEDERAL FUNDS	\$9,036,550	\$11,963,100

Purpose:

This policy change estimates the contract costs to make improvements, maintain, and operate the existing Capitation Payment Reporting system (CAPMAN).

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
 Current CAPMAN Prime Vendor #17-94399
 New CAPMAN Prime Vendor #22-20001
 CAPMAN CPO #18-95355
 CAPMAN Support Services #21-10305
 CAPMAN WSE #19-96060
 CAPMAN Discovery & Planning #21-10306
 State Controller's Office #17-94695
 State Controller's Office #22-20159

Interdependent Policy Changes:

COVID-19 Increased FMAP – 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 ACA and the expansion of Medi-Cal Managed Care, the Department must implement additional functionalities in CAPMAN to accommodate the influx of new beneficiaries. Modifications to the accounting interface are being made to enhance the system to incorporate Electronic Funds Transfer (EFT). The paperless accounting interface increases the Department's efficiency. 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

OTHER ADMIN. POLICY CHANGE NUMBER: 24

CAPMAN Prime Vendor Contracts

The CAPMAN Prime Vendor Contracts provides services, which include continuing enhancements and maintenance, needed to keep up with current technology, new federal and state mandates, and a paperless accounting interface. The current contract will be out of funds in October 2022 although the contract's effective period is April 1, 2018, through March 31, 2023. The Department entered into a new contract with the current vendor as the result of the competitive bidding process. The contract is effective for the period October 3, 2022, through October 2, 2027.

CAPMAN Certified Product Owner (CPO)

The CAPMAN CPO contract is responsible for optimizing the 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 December 31, 2022, but the contract funds were depleted in October 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 2023 through January 2027. The contract will provide services in the area of product management, infrastructure performance monitoring, and 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 June 30, 2023.

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. The department is currently working towards a new Interagency Agreement to be effective from December 14, 2022, to December 13, 2027.

Hardware/Software

In FY 2022-23, the costs include licensed software used by the CAPMAN system and cloud infrastructure.

Discovery & Planning

The CAPMAN system requires planning for continuously increasing healthcare policies and populations to be able to support complex growth. The contract will provide technical, business, and solution expertise to evaluate the current and future Managed Care Capitation Payment business needs and the supporting technology system(s).

Reason for Change:

The change from the prior estimate for FY 2022-23 is a decrease due to CAPMAN Operation and Support Services contract delays, updated actuals, and projection adjustments. The

CAPMAN
OTHER ADMIN. POLICY CHANGE NUMBER: 24

change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to the re-procurement of CAPMAN Prime Vendor Contract, vendor takeover activities, and a planned increase in capacity to deliver the needs of the managed care program.

Methodology:

Total costs are estimated to be:

FY 2022-23	TF	GF	FF
CAPMAN Prime Vendor	\$9,371,000	\$2,464,000	\$6,907,000
Support Services/CPO Contract	\$629,000	\$165,000	\$463,000
CAPMAN WSE	\$579,000	\$152,000	\$427,000
Discovery & Planning	\$270,000	\$34,000	\$236,000
SCO IAA	\$7,000	\$2,000	\$5,000
Hardware/Software	\$1,354,000	\$356,000	\$998,000
Total	\$12,210,000	\$3,173,000	\$9,036,000

*Totals differ due to rounding

FY 2023-24	TF	GF	FF
CAPMAN Prime Vendor	\$11,379,000	\$2,992,000	\$8,388,000
Support Services/CPO Contract	\$2,008,000	\$528,000	\$1,480,000
CAPMAN WSE	\$98,000	\$26,000	\$72,000
Discovery & Planning	\$810,000	\$103,000	\$707,000
SCO IAA	\$11,000	\$3,000	\$8,000
Hardware/Software	\$1,775,000	\$467,000	\$1,308,000
Total	\$16,081,000	\$4,119,000	\$11,963,000

*Totals differ due to rounding.

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)

65% Title XXI / 35% GF (4260-101-0001/0890)

100% State GF (4260-101-0001)

COVID-19 funding is identified in the COVID-19 Increased FMAP – Other Admin policy change

MITA

OTHER ADMIN. POLICY CHANGE NUMBER: 25
IMPLEMENTATION DATE: 1/2011
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1137

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$11,571,000	\$14,111,000
STATE FUNDS	\$1,469,400	\$1,792,000
FEDERAL FUNDS	\$10,101,600	\$12,319,000

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) 18-95338
 Contract #21-10069
 Contract #20-10388
 Contract #21-10021
 Contract #20-10321

Interdependent Policy Changes:

Not Applicable

Background:

CMS requires the Department to create 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 Enterprise MITA support services 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: 25

Integral in the Department's MITA governance is the Portfolio Management tool, which houses MITA data/roadmap information, and overall facilitates the Department's project portfolio and governance process.

Pursuant to an IA with the Regents of the University of California, San Diego (UCSD), an analyst and programmer provides support for data management and analytics to assist the Department in reaching MITA maturity.

MITA planning activities to improve provider management information will occur and will assess efforts necessary for a consolidated provider data repository, improving consumer-facing provider directories, and collecting provider network information from behavioral health and managed care dental plans.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a decrease due to updated actuals and projection adjustments. The change for FY 2023-24 from FY 2022-23, in the current estimate, is an increase due to updated actuals and projection adjustments.

Methodology:

1. FY 2022-23 and FY 2023-24 contract amounts are associated with the MITA initiative throughout the Department in order to meet federal regulations and guidelines.
2. FY 2022-23 and FY 2023-24 includes the cost of the MITA support services and UCSD IA estimates.
3. The projected FY 2022-23 and FY 2023-24 costs are:

FY 2022-23	APD	TF	GF	FF
Enterprise MITA Support Services	MITA	\$6,240,000	\$793,000	\$5,447,000
UCSD IA	MITA	\$487,000	\$62,000	\$425,000
Provider Management (274)	PROV.	\$250,000	\$32,000	\$218,000
Enterprise Certification Support Services	MITA	\$4,594,000	\$583,000	\$4,011,000
Total		\$11,571,000	\$1,470,000	\$10,101,000

*Totals may differ due to rounding

FY 2023-24	APD	TF	GF	FF
Enterprise MITA Support Services	MITA	\$8,106,000	\$1,029,000	\$7,077,000
UCSD IA	MITA	\$833,000	\$106,000	\$727,000
Provider Management (274)	PROV.	\$250,000	\$32,000	\$218,000
Enterprise Certification Support Services	MITA	\$4,922,000	\$625,000	\$4,297,000
Total		\$14,111,000	\$1,792,000	\$12,319,000

*Totals may differ due to rounding.

MITA
OTHER ADMIN. POLICY CHANGE NUMBER: 25

Funding:

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

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

65% Title XXI / 35% GF (4260-101-0001/0890)

100% State GF (4260-101-0001)

LITIGATION RELATED SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 26
IMPLEMENTATION DATE: 7/2009
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 1381

	<u>FY 2022-23</u>	<u>FY 2023-24</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 from the prior estimate for FY 2022-23. There is no change in the current estimate from FY 2022-23 to FY 2023-24.

Methodology:

1. Based on prior Department of Justice litigation costs and projected workload, costs are projected to be \$7,880,000 for both FY 2022-23 and FY 2023-24.
2. Based on prior actuary costs and the Department's projected workload, costs will be \$2,100,000 in both FY 2022-23 and FY 2023-24.

(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

LITIGATION RELATED SERVICES
OTHER ADMIN. POLICY CHANGE NUMBER: 26

(Dollars in Thousands)

FY 2023-24	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)

PASRR

OTHER ADMIN. POLICY CHANGE NUMBER: 27
IMPLEMENTATION DATE: 7/2013
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 1720

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$9,399,000	\$9,600,000
STATE FUNDS	\$2,349,750	\$2,400,000
FEDERAL FUNDS	\$7,049,250	\$7,200,000

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. 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:

The change in FY 2022-23, from the prior estimate is an increase due to the contractor having an adequate number of staff to complete a higher volume of evaluations to meet 10,000 cases a month.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due higher than anticipated monthly evaluations for FY 2023-24 based on the actuals paid in FY 2021-22.

Methodology:

1. Expenditures for the service contract started in August 2020 and is effective until June 30, 2023. Payments for the new Evaluations contract are estimated to begin July 2023.

PASRR
OTHER ADMIN. POLICY CHANGE NUMBER: 27

2. The PASRR payments on a cash basis are estimated at:

FY 2022-23	TF	GF	FF
Evaluations	\$9,399,000	\$2,350,000	\$7,049,000

FY 2023-24	TF	GF	FF
Evaluations	\$9,600,000	\$2,400,000	\$7,200,000

Funding:

75% Title XIX / 25% GF (4260-101-0001/0890)

LA COUNTY PUBLIC HEALTH NURSING PILOT

OTHER ADMIN. POLICY CHANGE NUMBER: 28
IMPLEMENTATION DATE: 12/2022
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2271

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$8,250,000	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$8,250,000	\$0

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 & Institutions Code, Section 16521.8

Interdependent Policy Changes:

Not Applicable

Background:

In FY 2022-23, 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 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 in FY 2022-23 from the prior estimate.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to payments expected to be completed in FY 2022-23.

LA COUNTY PUBLIC HEALTH NURSING PILOT

OTHER ADMIN. POLICY CHANGE NUMBER: 28

Methodology:

1. Assume payments for administrative costs for program year FY 2022-23 will begin December 2022.
2. The estimated administrative cost reimbursements for FY 2022-23, on a cash basis are:

(Dollars in Thousands)

FY 2022-23	TF	FF
FY 2022-23 Claims	\$8,250	\$8,250
Total	\$8,250	\$8,250

Funding:

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

ELECTRONIC ASSET VERIFICATION PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 29
IMPLEMENTATION DATE: 12/2017
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2002

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$7,841,000	\$3,955,000
STATE FUNDS	\$3,920,500	\$1,977,500
FEDERAL FUNDS	\$3,920,500	\$1,977,500

Purpose:

This policy change estimates the administrative costs associated with implementing an electronic asset verification program (AVP) with LexisNexis Risk Solutions (LNRS). The current contract for AVP services with LNRS is required under federal law and continues until California assets limits are eliminated. In addition to current AVP data matching activities required under federal law, an amendment to the current AVP contract with LNRS will include adding additional scope of work to obtain data matching files for Death, Residency Verification Program (RVP), and Commercial Mail Receiving Agency (CMRA) to provide the Department necessary eligibility data for program integrity.

Authority:

Welfare & Institutions Code (W&I), Section 14013.5, 14043.5
 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.

ELECTRONIC ASSET VERIFICATION PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 29

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. Due to changes in federal law, and unforeseen delays in internal and external work efforts due to the ongoing COVID-19 public health emergency, the Department's objective is full electronic implementation by the end of 2021.

A contract amendment was executed on June 28, 2022. This amendment extended the contract by an additional six months from June 2023 to December 31, 2023 for all services stated in the contract. The contract amendment also increases the scope of data matching activities for FY 2022-23 to include Death, RVP, and CMRA matching activities. This additional scope of contract work is needed to obtain data matching files that will leverage high value data sources to prevent fraud and abuse by identifying Medi-Cal eligible beneficiaries who are deceased, residing out-of-state, or have a residential address that is identified as a CMRA.

The Department will receive from LNRS additional Death, RVP and CMRA Match files which are produced by mapping the Monthly Medi-Cal Eligibility File (MMEF) against LNRS data sources, and then applying business rules to refine the result set to the most actionable leads to prevent fraud and abuse. The MMEF is provided to LNRS each quarter and identifies Medi-Cal beneficiaries that are actively eligible.

Reason for Change:

The change in FY 2022-23, from the prior estimate, is an increase due to incorporating the final contract amendment amount executed on June 28, 2022.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to 12 months of payments budgeted in FY 2022-23, whereas only six months of payments are budgeted for FY 2023-24.

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. The volume of verifications for death and out of state residency is 1,400 and 68,000 per FY 2021-2022.
4. The reimbursement rate, based on estimated query volume, is estimated to be \$653,400 per month for FY 2022-23. The increased rate from FY 2021-22 to FY 2022-23 is due to the addition of death, out-of-state, and CMRA matching services to the vendor agreement.

ELECTRONIC ASSET VERIFICATION PROGRAM
OTHER ADMIN. POLICY CHANGE NUMBER: 29

5. The reimbursement rate for FY 2023-24 is expected to be \$659,150 per month, due to the death and residency matches added in FY 2022-23 and an extended 6-month term period.
5. The estimated vendor costs are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2022-23	\$7,841	\$3,920	\$3,921
FY 2023-24	\$3,955	\$1,977	\$1,978

Funding:

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

NEWBORN HEARING SCREENING PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 30
IMPLEMENTATION DATE: 7/2014
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1824

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$6,273,000	\$6,392,000
STATE FUNDS	\$3,136,500	\$3,196,000
FEDERAL FUNDS	\$3,136,500	\$3,196,000

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
 - Contract # 18-95011 expires June 30, 2023. The Department is in process of developing a new Request for Proposal (RFP) for the new data management contract. The same terms and conditions in the current contract are expected to be requested in the new RFP.
- HCC contract #19-96295 began June 1, 2020, and expires June 30, 2024.

Reason for Change:

There is no change from prior estimate for FY 2022-23. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to a scheduled annual adjustment in the current HCC contract.

NEWBORN HEARING SCREENING PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 30

Methodology:

1. The HCC contract for tracking and monitoring services costs for FY 2022-23 is \$5,193,000 and \$5,312,000 for FY 2023-24.
2. The Data Management Contract for the use of a vendor's data management system cost for FY 2022-23 is \$1,080,000. Costs for FY 2023-24 are estimated to be \$1,080,000, which is pending award of the new contract through an RFP.
3. The estimated costs for FY 2022-23 and FY 2023-24 are as follows:

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

FY 2023-24	TF	GF	FF
HCC Contract	\$5,312,000	\$2,656,000	\$2,656,000
Data Management Contract	\$1,080,000	\$540,000	\$540,000
Total	\$6,392,000	\$3,196,000	\$3,196,000

Funding:

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

CCI-ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 31
IMPLEMENTATION DATE: 7/2012
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 1677

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$5,958,000	\$0
STATE FUNDS	\$2,979,000	\$0
FEDERAL FUNDS	\$2,979,000	\$0

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 carved out from managed care effective January 1, 2022, and re-implemented as a fee-for-service Home and Community-Based Services MSSP Waiver program in the CCI counties.

CCI-ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 31

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 2022-23. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to 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 2022-23 will be funded at 50/50 FMAP.
3. There are no costs for FY 2023-24 due to the CCI pilot program ending December 31, 2022.

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)

STATEWIDE VERIFICATION HUB

OTHER ADMIN. POLICY CHANGE NUMBER: 32
IMPLEMENTATION DATE: 2/2022
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2358

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$5,188,000	\$1,446,000
STATE FUNDS	\$518,800	\$144,600
FEDERAL FUNDS	\$4,669,200	\$1,301,400

Purpose:

This policy change estimates the Statewide Verification Hub (SVH) funding for the multi-departmental effort that will see the planning, design, development, and implementation of a data repository service hub in order to facilitate better data matches and enhance efficiency of programmatic administration.

Authority:

Welfare & Institutions Code 14005.37 and 14013.3
 42 Code of Federal Regulations 435.945, 435.948, 435.949 and 435.952
 22 California Code of Regulations 50167, 50167.2 and 50168
 Contract #21-10308
 Contract #21-10312

Interdependent Policy Changes:

Not Applicable

Background:

The SVH is multi-departmental effort that will see the planning, design, development, and implementation of a data repository service hub, able to be securely called by eligibility systems, providing near real-time verification data, using class-leading technology to resolve customer and case identity to facilitate better data matches and enhance efficiency of programmatic administration.

Over the next two federal fiscal years, the project will work to create a holistic view of the current business process across the CalFresh, CalWORKs, child care programs, and Medi-Cal program areas, which includes creating detailed process maps, county and customer worker journey maps, detailed data maps, and existing technical architecture. At the end of the planning phase, the project will be able to identify:

- Documents to create and guide the need for the future SVH by identifying the to-be functional and service architectures, while developing a robust alternative analysis of proposed solutions for the SVH.
- A recommended solution approach that aligns the needs of county users while prioritizing customer experience.
- Features and functionality that will substantially enhance transparency around eligibility verification/determination and benefit/aiding-level determinations, while improving the capacity of the State to report upon utilization rates, measures, and outcomes of eligibility verifications for means-tested human services programs.

The project anticipates the approval of the Stage 2 Alternatives Analysis documentation from CDT by February 2023, which will allow the project to begin the procurement phase of planning.

STATEWIDE VERIFICATION HUB

OTHER ADMIN. POLICY CHANGE NUMBER: 32

Reason for Change:

The change from the prior estimate, for FY 2023-23, is an increase due to additional project management and technical services contracting costs. The change in the current estimate, from FY 2022-23 to FY 2023-24, is a decrease due to project management and technical service contracts being completed on September 30, 2023.

Methodology:

1. Assume the policy implemented February 2022.
2. The Department estimates SVH costs for FY 2022-23 and FY 2023-24 to be:

Fiscal Years	TF	GF	FF
FY 2022-23	\$5,188,000	\$519,000	\$4,669,000
FY 2023-24	\$1,446,000	\$145,000	\$1,301,000

Funding:

90% FF/10% GF (4260-101-0001/0890) (Design, Development, and Implementation of Medicaid Management Information System)

MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)

OTHER ADMIN. POLICY CHANGE NUMBER: 33
IMPLEMENTATION DATE: 7/2009
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1441

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$5,014,000	\$3,083,000
STATE FUNDS	\$1,822,000	\$1,331,750
FEDERAL FUNDS	\$3,192,000	\$1,751,250

Purpose:

This policy change estimates the maintenance and operations (M&O) expenses resulting from legislative mandates, federal and/or state directives, and Medi-Cal program policy changes, which impact the Medi-Cal Eligibility Data System (MEDS).

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

The MEDS is a statewide database containing eligibility information for public assistance programs administered by the Department and other departments. MEDS provides users with the ability to perform multi-program application searches, verify program eligibility status, enroll beneficiaries in multiple programs, and validate information on application status. Funding is required for the following M&O functions:

- MEDS Master Client Index maintenance;
- Data matches from various federal and state agencies;
- Supplemental Security Income termination process support;
- Medi-Cal application alerts;
- Medicare Modernization Act Part D buy-in process improvements;
- Eligibility renewal process;
- Reconciling county eligibility data used to support the counties in Medi-Cal eligibility determination;
- Supporting eligibility and enrollment functions; and
- Enabling counties to perform online statistical analysis and MEDS-alert reporting as well as allowing them to track and report county workers' MEDS transactions.

MEDS generate 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

MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)

OTHER ADMIN. POLICY CHANGE NUMBER: 33

Department for all associated data storage, processing, networking, data archiving, and backup costs. CDT invoices the Department on a monthly basis for the services provided. CDT data center charges remain consistent and change based on the volume of beneficiaries enrolled within the MEDS system.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a decrease due to corrections to previous invoice billings. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to no retro-correction in FY 2023-24.

Methodology:

1. Reporting and tracking costs include non-production support costs consisting of CDT data center charges for development, testing, quality assurance, and not all system-related charges 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. M&O and Reporting and Tracking costs include retro-correction costs related to the reconciliation of OTECH invoices from January 2021 to June 2022 services incorrectly billed, resulting in retro-corrections of expenses.
4. The projected costs for FY 2022-23 and FY 2023-24 are:

FY 2022-23	TF	GF	FF
Reporting and Tracking (50% FF / 50% GF)	\$2,274,000	\$1,137,000	\$1,137,000
Maintenance & Operations (75% FF / 25% GF)	\$2,740,000	\$1,636,000	\$1,104,000
Total	\$5,014,000	\$2,773,000	\$2,241,000

*Totals may differ due to rounding

FY 2023-24	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)	\$839,000	\$210,000	\$629,000
Total	\$3,083,000	\$1,332,000	\$1,751,000

*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)

MFP/CCT SUPPLEMENTAL FUNDING

OTHER ADMIN. POLICY CHANGE NUMBER: 34
IMPLEMENTATION DATE: 9/2022
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2392

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
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.

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 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.

Reason for Change:

There is no change from the prior estimate, for FY 2022-23. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to a one-time cost in the current year.

MFP/CCT SUPPLEMENTAL FUNDING

OTHER ADMIN. POLICY CHANGE NUMBER: 34

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.
2. Assume the Department will receive a one-time MFP supplemental funding up to **\$5,000,000 TF** in **FY 2022-23**.

Funding:

MFP Federal Grant (4260-106-0890)

DRUG MEDI-CAL PARITY RULE ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 35
IMPLEMENTATION DATE: 11/2022
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2206

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$4,407,000	\$7,345,000
STATE FUNDS	\$1,469,000	\$3,428,000
FEDERAL FUNDS	\$2,938,000	\$3,917,000

Purpose:

This policy change estimates the administration cost related to Parity Rule activities for Drug Medi-Cal (DMC) counties.

Authority:

42 Code of Federal Regulations (CFR) Part 438
Welfare & Institutions (W&I) Code, Section 14197.1

Interdependent Policy Changes:

Not Applicable

Background:

The federal Parity Rule prescribes requirements states must address to ensure Medicaid beneficiaries are able to access mental health and substance use disorder (SUD) services in the same way they are able to access physical health services.

Specifically, according to Title 42 of the CFR, Part 438.910 and 438.920, parity applies to DMC counties because parity protects the enrollees of medical/surgical Medi-Cal Managed Care Plan, and those Managed Care Plan enrollees could be receiving their substance use disorder services in either a DMC-ODS or DMC county. Furthermore, the W&I Code, Section 14197.1 gives the Department the authority to ensure that all SUD benefits are provided in compliance with the Parity Rule.

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, 2022, the Department will standardize and align requirements for SUD services with the requirements for medical/surgical health services for the DMC counties, as specified in the DMC county contracts.

Reason for Change:

There is no change from the prior estimate for FY 2022-23.

The change in the current estimate, from FY 2022-23 to FY 2023-24, is an increase due to the following:

- FY 2023-24 including an additional quarters cost, and
- The addition of inter-governmental transfers (IGTs) to fund for costs incurred beginning July 1, 2023.

DRUG MEDI-CAL PARITY RULE ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 35

Methodology:

1. Payments for the Parity Rule activities will begin in November 2022.
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% CF for Parity Rule activities through June 30, 2023. Effective July 1, 2023, the 50% of non-federal share funded through CF, will be paid through IGTs.
4. The estimated Parity Rule administrative costs for FY 2022-23 and FY 2023-24 are:

FY 2022-23	TF	GF	IGT*	FF	CF
DMC Administration - Regular	\$5,655,000	\$1,414,000	\$0	\$2,827,000	\$1,414,000
DMC Administration - UR & QA	\$221,000	\$55,000	\$0	\$111,000	\$55,000
Total	\$5,876,000	\$1,469,000	\$0	\$2,938,000	\$1,469,000

FY 2023-24	TF	GF	IGT*	FF	CF
DMC Administration - Regular	\$7,540,000	\$1,886,000	\$1,414,000	\$3,769,000	\$471,000
DMC Administration - UR & QA	\$295,000	\$73,000	\$55,000	\$148,000	\$19,000
Total	\$7,835,000	\$1,959,000	\$1,469,000	\$3,917,000	\$490,000

Funding:

100% General Fund (4260-101-0001)

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

Medi-Cal County Behavioral Health Fund (4260-601-3420)*

MEDCOMPASS SOLUTION

OTHER ADMIN. POLICY CHANGE NUMBER: 36
IMPLEMENTATION DATE: 7/2017
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1982

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$3,973,000	\$4,350,000
STATE FUNDS	\$418,450	\$1,143,350
FEDERAL FUNDS	\$3,554,550	\$3,206,650

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:

COVID-19 Increased FMAP – Other Admin

Background:

The MedCompass is a Software-as-a-Service solution that was implemented for the Integrated Systems of Care Division (ISCD) with a 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 for 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 in August 2022. The recoupment request included eligible costs for the timeframe of October 1, 2019, to May 14, 2021. CMS approved the cost recoupment change in September 2022.

Reason for Change:

The change from the prior estimate for FY 2022-23 is a decrease due to the completion of the M&O cost recoupment, updated actuals, and shifts within the year for payment timing, most notably those related to licensing costs. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to an increase in the number of licenses.

Methodology:

1. The estimated costs are based upon the MedCompass solution provider contract provisions, as amended in July 2021, to exercise the contract's provision for three optional years ending on July 31, 2024.
2. All costs, from October 1, 2019, to May 14, 2021, reflect payment at 50% FF/ 50% GF. Now that the system is certified, applicable costs will be claimed at 75% FF/ 25% GF.

MEDCOMPASS SOLUTION
OTHER ADMIN. POLICY CHANGE NUMBER: 36

FY 2022-23	TF	GF	FF
M&O	\$3,973,000	\$1,044,000	\$2,928,000
M&O Recoupment of Funds Post Certification	\$0	(\$626,000)	\$626,000
Total FY 2022-23	\$3,973,000	\$419,000	\$3,554,000

*Totals may differ due to rounding

FY 2023-24	TF	GF	FF
M&O	\$4,350,000	\$1,144,000	\$3,206,000
Total FY 2023-24	\$4,350,000	\$1,144,000	\$3,206,000

*Totals may differ due to rounding.

Funding:

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)

65% Title XXI / 35% GF (4260-101-0890/0001)

COVID-19 funding is identified in the COVID-19 Increased FMAP – Other Admin policy change

PACES

OTHER ADMIN. POLICY CHANGE NUMBER: 37
IMPLEMENTATION DATE: 9/2016
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1972

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$3,327,000	\$3,600,000
STATE FUNDS	\$689,350	\$898,600
FEDERAL FUNDS	\$2,637,650	\$2,701,400

Purpose:

This policy change estimates the costs to modify the Department's existing Post Adjudicated Claims and Encounters 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

Interdependent Policy Changes:

COVID-19 Increased FMAP – 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 plays a vital role in the collection of encounter and provider network data from Medi-Cal's numerous managed care plans. PACES accepts encounter transactions from both medical and dental managed care plans as well as encounter-related pharmacy transactions. PACES also accepts medical and dental provider network data from Medi-Cal's managed care plans. This data is used to ensure that managed care plans are meeting the department's network adequacy requirements.

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 transactions to cover behavioral health. The Department has completed the analysis to expand the use of the 274 transactions to the county mental health plans and the Drug Medi-Cal Organized Delivery System counties. Extending the 274 processes to behavioral health will allow the Department to monitor the networks within those models.

PACES

OTHER ADMIN. POLICY CHANGE NUMBER: 37

State projects seeking Medicaid enhanced 75/25 federal funding for maintenance & operations (M&O) after development must meet the Centers for Medicare & Medicaid Service (CMS) System Certification requirements. PACES completed the CMS Final Certification Review on July 12, 2021, and received the Certification Approval Letter dated October 25, 2021.

Reason for Change:

The change from the prior estimate for FY 2022-23 is a decrease due to the completion of the design, development, and implementation (DD&I) contract, updated actuals, and adjusted projection calculations. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to new M&O service contracts.

Methodology:

1. Effective November 1, 2017, a vendor concurrently provides DD&I and M&O services. The first phase of implementation was completed in December 2018. This contract expired in October 2022.
2. A Technical Architect contractor supported new efforts to extend PACES interfaces and process new data sources in September 2020 and continued through August 2022.
3. Includes ongoing cloud platform and service costs.
4. A new 5-year contract for a vendor to provide M&O services began in October 2022 and will continue through September 2027.
5. Total costs are estimated to be:

FY 2022-23	TF	GF	FF
M&O	\$1,962,000	\$516,000	\$1,446,000
DD&I	\$1,015,000	\$129,000	\$886,000
Cloud Services	\$350,000	\$44,000	\$306,000
Total	\$3,327,000	\$689,000	\$2,637,000

*Totals may differ due to rounding

FY 2023-24	TF	GF	FF
M&O	\$3,250,000	\$854,000	\$2,396,000
Cloud Services	\$350,000	\$45,000	\$305,000
Total	\$3,600,000	\$899,000	\$2,701,000

*Totals may differ due to rounding

Funding:

90% Title XIX / 10% GF (4260-117-0001/0890)

75% Title XIX / 25% GF (4260-117-0001/0890)

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

65% Title XXI / 35% GF (4260-101-0001/0890)

100% State GF (4260-101-0001)

COVID-19 funding is identified in the COVID-19 Increased FMAP –Other Admin policy change

HEALTH INFORMATION EXCHANGE INTEROPERABILITY

OTHER ADMIN. POLICY CHANGE NUMBER: 38
IMPLEMENTATION DATE: 6/2020
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2159

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$2,862,000	\$512,000
STATE FUNDS	\$2,485,000	\$94,000
FEDERAL FUNDS	\$377,000	\$418,000

Purpose:

This policy change estimates the cost to administer data exchange activities to support care for Medi-Cal beneficiaries. The policy change also estimates the cost to deploy and operate the Department's health information exchange (HIE) platform for Clinical Data Exchange (CDE).

Authority:

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
 AB 128 (Chapter 21, Statutes of 2021)

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 California Health Information Exchanges (HIE) Onboarding Program (Cal-HOP), approved by CMS in February 2020, was constructed based on the CMS guidance and supported 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 aimed to support the connectivity of HIOs and providers to the state Prescription Drug Monitoring Program. DOJ established application programming interfaces and web components necessary to optimize the CURES system and comply with legislative mandates.

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. While the current contract with the SaaS contract is anticipated to conclude in FY 2022-23, the Department anticipates a re-procurement of some services affiliated with the clinical data exchange project to occur in FY 2023-24.

The Cal-HOP, which used state and federal funds, ended in September 2021. The state funds were originally appropriated as part of a stakeholder proposal to support data exchange in Medi-Cal. The Department received budget authority to spend the unused general funds share of the

HEALTH INFORMATION EXCHANGE INTEROPERABILITY

OTHER ADMIN. POLICY CHANGE NUMBER: 38

Cal-HOP funding to support other interoperability and data exchange efforts during FY 2021-22, which was extended in the May 2022 Appropriations Budget until the end of FY 2022-23.

In FY 2022-23, the Department is utilizing contract resources to leverage the remaining Cal-HOP general fund in assessing provider directory data sources within and outside the Department that would support data exchange with providers. The Department will work to develop a protocol/process that would leverage managed care network data and claims data to identify providers needing to receive notifications for patients as well as plan to support data exchange components such as consent, digital identities, and provider directories.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is an increase due to revised CDE projections. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to the planning for data exchange components finishing in FY 2022-23.

Methodology:

1. Estimated expenditures for planning for data exchange components managed by the Department infrastructure uses the remaining Cal-HOP funds are \$2,400,000 TF (\$2,400,000 GF) in FY 2022-23.
2. Estimated expenditures for the CDE project are \$462,370 TF (\$85,354 GF) in FY 2022-23 and \$512,060 TF (\$94,526 GF) in FY 2023-24.

CDE Cost Estimates - Source of Cost	FY 2022-23	FY 2023-24	Total
NextGen Health Data Hub SaaS	\$55,250	\$132,600	\$187,850
HIE SME	\$200,000	\$180,000	\$380,000
NextGen Health Data Hub System Administration	\$207,120	\$199,460	\$406,580
Total	\$462,370	\$512,060	\$974,430

FY 2022-23	TF	GF	FF
Data Exchange Planning	\$2,400,000	\$2,400,000	\$0
Clinical Data Exchange	\$462,000	\$85,000	\$377,000
Total	\$2,862,000	\$2,485,000	\$377,000

FY 2023-24	TF	GF	FF
Clinical Data Exchange	\$512,000	\$94,000	\$418,000
Total	\$512,000	\$94,000	\$418,000

*Note: some slight variations due to rounding

Funding:

100% State GF (4260-101-0001)

100% Title XIX (4260-101-0890)

T-MSIS

OTHER ADMIN. POLICY CHANGE NUMBER: 39
IMPLEMENTATION DATE: 9/2013
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1768

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$2,748,000	\$2,458,000
STATE FUNDS	\$436,750	\$365,700
FEDERAL FUNDS	\$2,311,250	\$2,092,300

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
 #22-20232

Interdependent Policy Changes:

COVID-19 Increased FMAP – Other Admin

Background:

The CMS requires 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 the 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 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;

T-MSIS

OTHER ADMIN. POLICY CHANGE NUMBER: 39

- States resolve data quality issues for the 12 Top Priority Items no later than six months after the release of SHO letter #18-008.

CMS approved the T-MSIS IAPD for FFY 2022-23 in January 2022.

Reason for Change:

The change for FY 2022-23, from the prior estimate, and the change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to delays in payments from fiscal year-end closeout activities and in contract start and payment dates.

Methodology:

- The approved FFY 2022-23 IAPD includes funding for ongoing M&O (75% Title XIX / 25% GF) activities, which include the annual renewal of software licenses for T-MSIS ETL data solutions and staff training costs. In addition, the Department will be requesting enhanced federal funding (90% Title XIX / 10% GF f) for Design, Development, and Implementation (DDI) activities for the next phase of the 35C migration work. Planning, analysis, and SOP testing will continue to achieve technical compliance as defined in the CMS Standard Operating Procedures (SOP) guidelines for production implementations that impact T-MSIS reporting.
- For the DDI activities, it is estimated that twelve (12) contractor staff will be needed to perform Quality Assurance and data analysis; plan the replacement of the 35C file format with the HIPAA standard format, with payments beginning in October 2022; 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, with payments beginning in November 2022.

FY 2022-23	TF	GF	FF
M&O	\$644,000	\$169,000	\$475,000
DD&I	\$2,104,000	\$267,000	\$1,837,000
Total	\$2,748,000	\$437,000	\$2,312,000

*Totals may differ due to rounding.

FY 2023-24	TF	GF	FF
M&O	\$395,000	\$104,000	\$291,000
DD&I	\$2,063,000	\$262,000	\$1,801,000
Total	\$2,458,000	\$366,000	\$2,092,000

*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)

65% Title XXI / 35% GF (4260-101-0890/0001)

100% State GF (4260-101-0001)

COVID-19 funding is identified in the COVID-19 Increased FMAP – Other Admin policy change

SDMC SYSTEM M&O SUPPORT

OTHER ADMIN. POLICY CHANGE NUMBER: 40
IMPLEMENTATION DATE: 7/2013
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1732

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$2,285,000	\$1,992,000
STATE FUNDS	\$1,142,500	\$996,000
FEDERAL FUNDS	\$1,142,500	\$996,000

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 #18-95231
Contract #22-20171

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 has secured a new five-year contract. The new contract began on July 1, 2022, and ends on June 30, 2027, assuming option years are executed.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a net decrease mainly due to lower projections related to a new contract and adjusted withhold payment. The change from FY 2022-23 to FY 2023-24 in the current estimate, is a decrease due to vendor turnover activities only occurring in FY 2022-23.

Methodology:

1. The contractor cost for the five (5) years that began on July 1, 2022, is \$11,954,800.
2. Projections include the contractor cost related to processing SMHS and SUDS claims payments.

SDMC SYSTEM M&O SUPPORT
OTHER ADMIN. POLICY CHANGE NUMBER: 40

FY 2022-23	TF	GF	FF
M&O	\$2,285,000	\$1,143,000	\$1,143,000
Total	\$2,285,000	\$1,143,000	\$1,143,000

*Totals may differ due to rounding

FY 2023-24	TF	GF	FF
M&O	\$1,992,000	\$996,000	\$996,000
Total	\$1,992,000	\$996,000	\$996,000

*Totals may differ due to rounding

Funding:

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

HCBS SP - CONTINGENCY MANAGEMENT ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 41
IMPLEMENTATION DATE: 1/2023
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2362

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$2,084,000	\$3,750,000
STATE FUNDS	\$1,042,000	\$1,875,000
FEDERAL FUNDS	\$1,042,000	\$1,875,000

Purpose:

This policy change estimates the administrative costs of adding Contingency Management as an optional evidence-based Medi-Cal benefit under the Drug Medi-Cal Organized Delivery System (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:

Not Applicable

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 (HCBS ARP) 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 Centers for Medicare and Medicaid Services (CMS) approved the addition of contingency management as an optional benefit in DMC-ODS counties as part of the 1115 Demonstration Waiver renewal, as a pilot, beginning July 1, 2022 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. Contingency management was approved in the 2021 Budget Act, funded from the HCBS ARP Fund.

This policy change budgets administrative costs for contingency management services under the DMC-ODS waiver.

HCBS SP - CONTINGENCY MANAGEMENT ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 41

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a decrease due to the following:

- Services start date is delayed from July 2022 to November 2022, with payments starting in January 2023.
- Contingency management vendor costs, previously budgeted in this policy change, is now budgeted in State Support.

The change in the current estimate, from FY 2022-23 to FY 2023-24, is due to more payments occurring in FY 2023-24 due to payment lag.

Methodology:

1. Contingency management was added as an optional service to the DMC-ODS Waiver effective January 1, 2022, and the services will begin effective November 1, 2022.
2. Reimbursements for the county administrative costs will begin in January 2023.
3. Total estimated administrative costs for contingency management, on a cash basis, is as follows:

(Dollars in Thousands)

Contingency Management Admin	TF	HCBS ARP Fund	FF
FY 2022-23	\$2,084	\$1,042	\$1,042
FY 2023-24	\$3,750	\$1,875	\$1,875

Funding:

100% Title XIX (4260-101-0890)

Home and Community-Based Services American Rescue Plan Fund (4260-101-8507)

FIELD TESTING OF MEDI-CAL MATERIALS

OTHER ADMIN. POLICY CHANGE NUMBER: 42
IMPLEMENTATION DATE: 5/2022
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 2357

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$2,000,000	\$100,000
STATE FUNDS	\$1,000,000	\$50,000
FEDERAL FUNDS	\$1,000,000	\$50,000

Purpose:

This policy change estimates the cost to provide funding for the California Pan-ethnic Health Network to manage a community based process to review and evaluate Medi-Cal materials for correctness of foreign language translations and cultural appropriateness.

Authority:

AB 128 (Chapter 21, Statutes of 2021)

Interdependent Policy Changes:

Not Applicable

Background:

The stakeholder community has expressed concerns about the accuracy and cultural appropriateness of the translations of many of the most common and most often used notices, letters, and forms utilized by Medi-Cal beneficiaries and county eligibility workers.

The purpose is to provide funding for the California Pan-ethnic Health Network to manage a community based process, allowing a group of community-based translators and institutions, to:

- Review and evaluate Medi-Cal notices, letters, forms, and publications for correctness of foreign language translations and cultural appropriateness;
- Help the Department determine if changes need to be made; and
- Assist with making necessary changes.

The funding includes costs for services and time of those individuals engaged in this effort.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is an increase due to a shift in implementation for the programs and contracts associated with the review of Medi-Cal materials. The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to only including ongoing program costs in FY 2023-24.

Methodology:

1. Assume the policy implements July 2022.
2. The Department estimates Field Testing costs for FY 2022-23 and FY 2023-24 to be:

FIELD TESTING OF MEDI-CAL MATERIALS
OTHER ADMIN. POLICY CHANGE NUMBER: 42

(Dollars in Thousands)

Fiscal Years	TF	GF	FF
FY 2022-23	\$2,000	\$1,000	\$1,000
FY 2023-24	\$100	\$50	\$50

Funding:

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

PROTECTION OF PHI DATA

OTHER ADMIN. POLICY CHANGE NUMBER: 43
IMPLEMENTATION DATE: 5/2010
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1452

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$1,861,000	\$1,861,000
STATE FUNDS	\$930,500	\$930,500
FEDERAL FUNDS	\$930,500	\$930,500

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 processes, technologies, 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 by protecting the confidentiality and privacy of the information that it maintains on its customers.

The Department is continuing its effort in protecting PHI data and will continue to implement and improve security processes and technologies to ensure the Confidentiality, Integrity, and Availability of PHI data and establish accountability for the Department's administrators and employees with access to PHI data. These ongoing efforts will also ensure that new and current systems will adhere to the Principles of Confidentiality, Integrity, and Availability in the most secure manner available. Privileged Access Management (PAM) looks into the entire privileged account lifecycle, starting from granting and revoking permissions of these accounts to having a fail-proof password change cycle.

The Department is also continuing to enhance current security tools and services to reduce its 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.

PROTECTION OF PHI DATA

OTHER ADMIN. POLICY CHANGE NUMBER: 43

Reason for Change:

The change from the prior estimate, in FY 2022-23, is a decrease due to updated actuals and projection adjustments. There is no change in the current estimate from FY 2022-23 to FY 2023-24.

Methodology:

1. The costs include annual hardware and software maintenance and support for:
 - a. Data Domain is 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.
 - b. Backup and Recovery System is 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.
 - c. Database Activity Monitoring (DAM) system is a database firewall that has data security profiles designed to protect databases, monitor activities, provide staff access control, and capture security events. The department is looking to upgrade the software and anticipates additional costs on top of the licensing fees.
2. The annual costs include licensing, software maintenance, implementation, and contracted personnel to perform the administrative functions of the solution.
 - a. PAM is a solution that requires privileged users to “check out” their individual privileged account that logs all actions performed by that user in the privileged session.
3. The following amounts are based upon the latest projections of cost:

Fiscal Year	TF	GF	FF
FY 2022-23	\$1,861,000	\$930,000	\$930,000
FY 2023-24	\$1,861,000	\$930,000	\$930,000

*Totals may differ due to rounding

Funding:

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

CALIFORNIA HEALTH INTERVIEW SURVEY

OTHER ADMIN. POLICY CHANGE NUMBER: 44
IMPLEMENTATION DATE: 7/2015
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1902

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$1,464,000	\$1,653,000
STATE FUNDS	\$32,000	\$126,500
FEDERAL FUNDS	\$1,432,000	\$1,526,500

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 the CHIS for program needs and performance. The current contract is funded by federal funds; 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, 2024, plus one three-year extension.

Beginning January 2023, the Department will contract with UCLA to fund the addition of a Caregiving Module to the CHIS. The Department is currently working with UCLA to draft the Interagency Agreement for the Caregiving Module. The contract will be funded with 50% FF and 50% General Fund; the non-federal share will not be paid through CPEs.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is an increase due to the addition of the Caregiving Module. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to budgeting a full year of the Caregiving Module in the CHIS.

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.

CALIFORNIA HEALTH INTERVIEW SURVEY
OTHER ADMIN. POLICY CHANGE NUMBER: 44

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 CHIS is \$1,400,000 FF annually.
4. On a cash basis, assume two quarters will be paid in the current fiscal year and the remaining two quarters will be paid in the subsequent fiscal year.
5. Beginning January 2023, funding from the Department for the Caregiving Module will be added to the CHIS. This portion of CHIS funding will not be eligible for CPEs.
6. On an accrual basis, the FY 2022-23 amount for the Caregiving Module is estimated to be \$127,000. One quarter will be paid in FY 2022-23 and remaining will be paid in subsequent fiscal year. The FY 2023-24 amount is estimated to be \$252,000. Three quarters will be paid in FY 2023-24 and remaining will be paid in subsequent fiscal year.
7. The estimated administrative costs reimbursements for FY 2022-23 and FY 2023-24, on a cash basis, are:

FY 2022-23	TF	GF	FF
FY 2021-22 Claims	\$700,000	\$0	\$700,000
FY 2022-23 Claims	\$700,000	\$0	\$700,000
FY 2022-23 Caregiving Module Invoices	\$64,000	\$32,000	\$32,000
Total	\$1,464,000	\$32,000	\$1,432,000

FY 2023-24	TF	GF	FF
FY 2021-22 Claims	\$700,000	\$0	\$700,000
FY 2022-23 Claims	\$700,000	\$0	\$700,000
FY 2022-23 Caregiving Module Invoices	\$64,000	\$32,000	\$32,000
FY 2023-24 Caregiving Module Invoices	\$189,000	\$95,000	\$95,000
Total	\$1,653,000	\$126,000	\$1,527,000

*Totals may differ due to rounding.

Funding:

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

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

SSA COSTS FOR HEALTH COVERAGE INFO.

OTHER ADMIN. POLICY CHANGE NUMBER: 45
IMPLEMENTATION DATE: 1/1989
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 237

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$1,317,000	\$1,220,000
STATE FUNDS	\$658,500	\$610,000
FEDERAL FUNDS	\$658,500	\$610,000

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 2022-23, from the prior estimate, is a decrease based on updated actual billings from SSA for FY 2019-20 through FY 2021-22 that were used for the FY 2022-23 projections.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease based on updated actual billings from SSA from FY 2020-21 through FY 2021-22, and projected FY 2022-23 billings that were used for the FY 2023-24 projections

Methodology:

- The following projections are averaged based upon the most current actual billings from SSA.

Fiscal Year	TF	GF	FF
FY 2022-23	\$1,317,000	\$659,000	\$658,000
FY 2023-24	\$1,220,000	\$610,000	\$610,000

Funding:

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

FAMILY PACT PROGRAM ADMIN.

OTHER ADMIN. POLICY CHANGE NUMBER: 46
IMPLEMENTATION DATE: 7/2012
ANALYST: Sabrina Blank
FISCAL REFERENCE NUMBER: 1675

	FY 2022-23	FY 2023-24
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 2022-23, or in the current estimate for FY 2022-23 to FY 2023-24.

FAMILY PACT PROGRAM ADMIN.
OTHER ADMIN. POLICY CHANGE NUMBER: 46**Methodology:**

1. The administrative costs for the Family PACT program are estimated in the table below:

Fiscal Year	TF	GF	FF
FY 2022-23	\$1,207,000	\$120,700	\$1,086,300
FY 2023-24	\$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: 47
IMPLEMENTATION DATE: 7/2009
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 266

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$795,000	\$800,000
STATE FUNDS	\$397,500	\$400,000
FEDERAL FUNDS	\$397,500	\$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 2022-23, from the prior estimate, is due to lower actual invoice amounts for December 2021 through June 2022 than originally estimated.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to higher estimated payments in FY 2023-24, which is based on an estimated monthly average of the full contracted amount.

Methodology:

1. The initial contract period began on January 1, 2020, and was valid through June 30, 2022, for a total amount of \$2,000,000. The Department has exercised an extension through December 31, 2024 for an additional \$2,000,000.

MMA - DSH ANNUAL INDEPENDENT AUDIT
OTHER ADMIN. POLICY CHANGE NUMBER: 47

2. In FY 2022-23, the Department will make payments for the FY 2018-19 and FY 2019-20 audit invoices.
3. In FY 2023-24, the Department will make payments for the FY 2019-20 and FY 2020-21 audit invoices.

Fiscal Year	TF	GF	FF
FY 2022-23	\$795,000	\$398,000	\$397,000
FY 2023-24	\$800,000	\$400,000	\$400,000

Funding:

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

MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 48
IMPLEMENTATION DATE: 3/2022
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2321

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$667,000	\$2,000,000
STATE FUNDS	\$333,500	\$1,000,000
FEDERAL FUNDS	\$333,500	\$1,000,000

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, and
- 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 statewide in 2023.

Reason for Change:

The change FY 2022-23, from the prior estimate, is a decrease due to a shift in the anticipated initial payment. The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to four months of payments budgeted in FY 2022-23, whereas 12 months of payments are budgeted for FY 2023-24.

Methodology:

1. Annual contract costs are expected to be \$2,000,000.
2. The contract is expected to begin January 2023, and the initial invoice is expected to be paid in March 2023.

MEDICARE - MEDI-CAL OMBUDSPERSON PROGRAM
OTHER ADMIN. POLICY CHANGE NUMBER: 48

3. The anticipated costs for FY 2022-23 and FY 2023-24 of this contract are:

Fiscal Year	TF	GF	FF
FY 2022-23	\$667,000	\$333,000	\$334,000
FY 2023-24	\$2,000,000	\$1,000,000	\$1,000,000

Funding:

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

CCT OUTREACH - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 49
IMPLEMENTATION DATE: 4/2011
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1556

	FY 2022-23	FY 2023-24
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
 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.

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.

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 OUTREACH - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 49

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 2022-23. There is no change, in the current estimate, from FY 2022-23 to FY 2023-24.

Methodology:

1. Assume \$340,000 from the MFP grant administrative funding is expected to be paid in FY 2022-23 and FY 2023-24.
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.

FY 2022-23	TF	GF	FF
CCT Costs (PC 28):			
GF costs and Total FFP	\$18,613,000	\$4,514,000	\$14,099,000
State-Funded CCT Population	\$13,000	\$10,000	\$3,000
ALW Transition Costs	\$28,397,000	\$5,739,000	\$22,657,000
FFCRA 3.1% Increased FFP	\$0	(\$1,093,000)	\$1,093,000
Total Costs	\$47,022,000	\$9,169,000	\$37,853,000
CCT Savings:			
Total GF savings and Total FFP	(\$22,497,000)	(\$11,248,000)	(\$11,248,000)
CCT Fund Transfer to CDSS (PC 42):			
CCT Fund Transfer Costs	\$239,000	\$0	\$239,000
FFCRA 3.1% Increased FFP	\$141,000	\$0	\$141,000
Total Costs	\$380,000	\$0	\$380,000
CCT Outreach - Admin costs (OA 49)	\$340,000	\$0	\$340,000
Total of CCT PCs including pass through	\$25,245,000	(\$2,079,000)	\$27,325,000

*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: 49

FY 2023-24	TF	GF	FF
CCT Costs (PC 28):			
GF costs and Total FFP	\$28,014,000	\$6,794,000	\$21,220,000
State-Funded CCT Population	\$21,000	\$16,000	\$5,000
ALW Transition Costs	\$38,041,000	\$7,688,000	\$30,353,000
Total Cost	\$66,077,000	\$14,498,000	\$51,579,000
CCT Savings:			
Total GF savings and Total FFP	(\$26,149,000)	(\$13,075,000)	(\$13,075,000)
CCT Fund Transfer to CDSS (PC 42):	\$278,000	\$0	\$278,000
CCT Outreach - Admin costs (OA 49)	\$340,000	\$0	\$340,000
Total of CCT PCs including pass through	\$40,546,000	\$1,423,000	\$39,122,000

*The savings are included in the total, however, they are fully reflected in the base estimates.

Funding:

MFP Federal Grant (4260-106-0890)

CARE COURT - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 50
IMPLEMENTATION DATE: 1/2023
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2391

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$57,000,000	\$0
STATE FUNDS	\$57,000,000	\$0
FEDERAL FUNDS	\$0	\$0

Purpose:

This policy change estimates the administrative costs to provide funding to implement the Community Assistance, Recovery, and Empowerment Act (CARE) Court framework.

Authority:

AB 179 (Chapter 319, Statutes of 2022)
 SB 1338 (Chapter 319, Statutes of 2022)

Interdependent Policy Changes:

Not Applicable

Background:

The CARE Court framework delivers mental health and substance use disorder services for individuals with schizophrenia spectrum or other psychotic disorders. The framework may include individualized, appropriate range of services and supports consisting of behavioral health care, stabilization medications, housing, and enumerated services subject to available funding, federal and state requirements, and eligibility criteria.

CARE Court connects a person in crisis with a court-ordered Care Plan for up to 12 months, with the possibility to revise or extend for up to 12 months. If a participant cannot successfully complete a CARE Plan, the Court may utilize existing authority to certify the participant's safety.

The Department is responsible for components of the training, technical assistance, data collection, reporting, and the independent evaluation for CARE Court.

AB 179 includes \$57,000,000 one-time General Fund (GF) CARE Court funding. The funding shall be distributed by the Controller pursuant to a county schedule provided by the Department created in consultation with the California State Association of Counties. Of the \$57,000,000 appropriation:

- \$31,000,000 GF is available to support planning and preparation activities, including, but not limited to, hiring, training, and development of policies and procedures, information technology infrastructure costs, including but not limited to, changes to electronic medical record systems, changes to collect needed reporting data, case tracking and new billing processes to bill commercial plans and excluding capital expenses.
- \$26,000,000 GF is available for encumbrance to support Cohort I county planning and preparation to implement the CARE Act.

CARE COURT - OTHER ADMIN
OTHER ADMIN. POLICY CHANGE NUMBER: 50**Reason for Change:**

This is a new policy change.

Methodology:

1. Assume \$57,000,000 million GF in FY 2022-23 to support CARE Act planning and preparation activities.

(Dollars in Thousands)

Fiscal Year	TF	GF
FY 2022-23	\$57,000	\$57,000

Funding:

100% GF (4260-101-0001)

CMS DEFERRED CLAIMS - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 51
IMPLEMENTATION DATE: 7/2021
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 2123

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$5,760,000	\$0
FEDERAL FUNDS	\$5,760,000	\$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.

CMS DEFERRED CLAIMS - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 51

Reason for Change:

The change in FY 2022-23, from the prior estimate is due to reclaimed FF transferred to the GF in FY 2022-23 from actual resolved deferrals.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to no administrative CMS deferrals or resolved deferrals are estimated in FY 2023-24.

Methodology:

1. In FY 2022-23, the Department has reclaimed \$5.76 million FF in resolved deferrals.

FY 2022-23	Total Estimated Resolved Deferrals
Resolved Deferrals	\$5,760,000
Total FY 2022-23	\$5,760,000

Funding:

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

100% Title XIX GF (4260-101-0001)

COVID-19 INCREASED FMAP - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 52
IMPLEMENTATION DATE: 7/2022
ANALYST: Kalandie Coleman
FISCAL REFERENCE NUMBER: 2216

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$1,663,000	\$0
FEDERAL FUNDS	\$1,663,000	\$0

Purpose:

This policy change estimates the impact on administrative expenditures of assuming the availability of increased federal medical assistance percentage (FMAP) from January 2020 through June 2023. For the estimated impact of assuming increased FMAP from January 2020 through June 2023 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:

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.

The effects of the COVID-19 pandemic are unprecedented in modern times from a public health emergency and economic perspective. This will have fiscal impacts across policy areas and beneficiary populations within the Medi-Cal program.

The increased FMAP is effective January 1, 2020, and extends through the last day of the calendar quarter of the Health and Human Services COVID-19 national public health emergency.

COVID-19 INCREASED FMAP - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 52

Reason for Change:

For dollars budgeted in this policy change, there is an increase in general fund savings from the prior estimate for FY 2022-23 due to policy change updates. There is an decrease in general fund savings from FY 2022-23 to FY 2023-24, in the current estimate, due to policy change updates and overall impacts due to capturing FFCRA funding through June 30, 2023, in this 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 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. Eleven months of General Fund savings are assumed for CY because phased-down payments have a two-month lag.
5. The FFCRA is assumed to continue through June 30, 2023.
6. The following estimates reflect a cash basis:

COVID-19 INCREASED FMAP - OTHER ADMIN
OTHER ADMIN. POLICY CHANGE NUMBER: 52

(Dollars in Thousands)

FY 2022-23	TF	GF	SF	FF
COVID-19 Increased FMAP - DHCS:				
FFCRA 6.20% Increased FFP	\$0	(\$2,676,571)	\$0	\$2,676,571
FFCRA 4.34% Increased FFP	\$0	(\$116,218)	\$0	\$116,218
Medicare Part D FFCRA 6.20% Incr. FFP	(\$243,437)	(\$243,437)	\$0	\$0
Total Apr-Jun 2023 Qtr For Reg PCs:	(\$10,884)	(\$697,924)	(\$60,405)	\$747,445
Total COVID-19 Incr. FMAP - DHCS:	(\$254,321)	(\$3,734,150)	(\$60,405)	\$3,540,234
COVID-19 Increased FMAP - Other Admin:				
FFCRA 4.34% Increased FFP	\$0	(\$1,240)	\$0	\$1,240
Total Apr-Jun 2023 Qtr For Other Admin:	\$0	(\$423)	\$0	\$423
Total COVID-19 Incr. FMAP - Other Admin:	\$0	(\$1,663)	\$0	\$1,663
COVID-19 Increased FMAP In other PCs:				
FFCRA 6.20% Increased FFP	\$817,708	(\$173,819)	(\$321,346)	1,312,872
FFCRA 4.34% Increased FFP	\$11,791	(\$29,867)	(\$6,407)	\$48,065
BCCTP 4.34% Increased FFP	\$0	\$178	\$0	(\$178)
Medicare Part D FFCRA 6.20% Incr. FFP	(\$88,898)	(\$88,898)	\$0	\$0
Total Apr-Jun 2023 Qtr For In Other PCs:	\$210,206	(\$14,024)	(\$525)	\$224,755
Total COVID-19 Incr. FMAP In other PCs:	\$950,806	(\$306,430)	(\$328,278)	\$1,585,514
Total of PCs including COVID-19 Increased FMAP	\$696,485	(\$4,042,243)	(\$388,683)	\$5,127,411

*Totals may differ due to rounding.

COVID-19 INCREASED FMAP - OTHER ADMIN
OTHER ADMIN. POLICY CHANGE NUMBER: 52

(Dollars in Thousands)

FY 2023-24	TF	GF	SF	FF
COVID-19 Increased FMAP - DHCS:				
FFCRA 6.20% Increased FFP	\$0	(\$21,489)	\$0	\$21,489
FFCRA 4.34% Increased FFP	\$0	(\$2,711)	\$0	\$2,711
Medicare Part D FFCRA 6.20% Increased FFP	\$0	\$0	\$0	\$0
Total Apr-Jun 2023 Qtr For Reg PCs:	(\$35,117)	(\$208,017)	(\$46,394)	\$219,294
Total COVID-19 Incr. FMAP - DHCS:	(\$35,117)	(\$232,217)	(\$46,394)	\$243,494
COVID-19 Increased FMAP - Other Admin:				
FFCRA 4.34% Increased FFP	\$0	\$0	\$0	\$0
Total Apr-Jun 2023 Qtr For Other Admin:	\$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	\$9,610	(\$163,866)	(\$213,312)	\$386,788
FFCRA 4.34% Increased FFP	\$0	(\$9,132)	(\$8,988)	\$18,120
BCCTP 4.34% Increased FFP	\$0	\$0	\$0	\$0
Medicare Part D FFCRA 6.20% Incr. FFP	\$0	\$0	\$0	\$0
Total Apr-Jun 2023 Qtr For In Other PCs:	\$115,480	\$0	(\$11,978)	127,458
Total COVID-19 Incr. FMAP In other PCs:	\$125,090	(\$172,998)	(\$234,278)	\$532,366
Total of PCs including COVID-19 Increased FMAP	\$89,973	(\$405,215)	(\$280,672)	\$775,860

*Totals may differ due to rounding.

Funding:

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

FFCRA 4.34% GF (4260-113-0001)

MEDICAL FI BO & IT COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 53
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2115

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$50,389,000	\$56,483,000
STATE FUNDS	\$14,030,550	\$15,666,600
FEDERAL FUNDS	\$36,358,450	\$40,816,400

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

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 two 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: 53

- 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.
 - The demand for the Telehealth Nurse Advice Line (COVID-19 consultations) will continue beyond the planned expiration date of April 30, 2022. As a result, there will be a \$1.5 million increase to FY 2022-23.

MEDICAL FI BO & IT COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 53

- 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 in FY 2022-23 from the prior estimate is due to:

- Additional FY 2022-23 contracts for DevOps Provider Portal support and future applications,
- The addition of FY 2022-23 MOC Disaster Recovery cost to the Facilities Improvement and Modification line item, and
- The reduction in the Equipment and Services line item in FY 2022-23.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to:

- Increase in the Telecommunications and Data Center line item in FY 2023-24 due to IT realignment shift from the Medical FI IT Infrastructure Services policy change and
- Adjustment of the Postage and Parcel line item for inflation in FY 2023-24.

Methodology:

1. Contract costs are shared between Federal Funds (FF) and General Funds (GF).
2. 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: 53

FY 2022-23	TF	GF	FF
Postage (50% FF / 50% GF)	\$1,749,000	\$855,000	\$894,000
Parcel Services & Common Carriers (50% FF / 50% GF)	\$354,000	\$173,000	\$181,000
Equipment & Services (75% FF / 25% GF)	\$6,464,000	\$1,699,000	\$4,765,000
Facilities Improvement & Modification (75% FF / 25% GF)	\$11,403,000	\$2,997,000	\$8,406,000
Consultant Contracts (50% FF / 50% GF, 75% FF / 25% GF, 90% FF / 10% GF)	\$25,267,000	\$6,587,000	\$18,680,000
Telecommunications & Data Center (75% FF / 25% GF)	\$1,600,000	\$444,000	\$1,156,000
Other Cost Reimbursable Items (50% FF / 50% GF, 75% FF / 25% GF)	\$3,552,000	\$1,275,000	\$2,277,000
Total	\$50,389,000	\$14,030,000	\$36,359,000

FY 2023-24	TF	GF	FF
Postage (50% FF / 50% GF)	\$1,871,000	\$916,000	\$955,000
Parcel Services & Common Carriers (50% FF / 50% GF)	\$379,000	\$186,000	\$193,000
Equipment & Services (75% FF / 25% GF)	\$3,507,000	\$922,000	\$2,585,000
Facilities Improvement & Modification (75% FF / 25% GF)	\$10,938,000	\$2,875,000	\$8,063,000
Consultant Contracts (50% FF / 50% GF, 75% FF / 25% GF, 90% FF / 10% GF)	\$26,191,000	\$6,828,000	\$19,363,000
Telecommunications & Data Center (75% FF / 25% GF)	\$11,507,000	\$3,050,000	\$8,457,000
Other Cost Reimbursable Items (50% FF / 50% GF, 75% FF / 25% GF)	\$2,090,000	\$890,000	\$1,200,000
Total	\$56,483,000	\$15,667,000	\$40,816,000

MEDICAL FI BO & IT COST REIMBURSEMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 53

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 65% Title XXI / 35% GF (4260-101-0001/0890)

FI 50% HIPAA FF / 50% GF (4260-117-0001/0890)

FI 75% HIPAA FF / 25% GF (4260-117-0001/0890)

FI 90% HIPAA FF / 10% GF (4260-117-0001/0890)

COVID-19 funding is identified in the COVID-19 Increased FMAP – Other Admin policy change

MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 54
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2119

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$47,640,000	\$47,012,000
STATE FUNDS	\$12,522,250	\$12,356,750
FEDERAL FUNDS	\$35,117,750	\$34,655,250

Purpose:

This policy change estimates the cost of the IBM Medical Fiscal Intermediary (FI) contract IT Development and Operations Services.

Authority:

IBM Contract # 18-95302

Interdependent Policy Changes:

COVID-19 Increased FMAP – 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:

The change in FY 2022-23, from the prior estimate, is a decrease in costs due to rebalancing Application Development Services to remove Testing Hours.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to an Economic Change Adjustment (ECA).

MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 54

Methodology:

1. Costs are paid under an hourly rate or via a fixed price negotiated during the procurement phase of the contract.
2. 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 2022-23	TF	GF	FF
Application Development Services	\$28,890,000	\$7,593,000	\$21,297,000
Application M&O Services	\$11,074,000	\$2,911,000	\$8,163,000
Project Management Office	\$7,676,000	\$2,018,000	\$5,658,000
Total	\$47,640,000	\$12,522,000	\$35,118,000

FY 2023-24	TF	GF	FF
Application Development Services	\$28,620,000	\$7,523,000	\$21,097,000
Application M&O Services	\$10,653,000	\$2,800,000	\$7,853,000
Project Management Office	\$7,739,000	\$2,034,000	\$5,705,000
Total	\$47,012,000	\$12,357,000	\$34,655,000

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)

FI 65% Title XXI / 35% GF (4260-101-0001/0890)

COVID-19 funding is identified in the COVID-19 Increased FMAP – Other Admin policy change

MEDICAL FI IT INFRASTRUCTURE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 55
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2118

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$32,762,000	\$22,388,000
STATE FUNDS	\$8,611,800	\$5,886,150
FEDERAL FUNDS	\$24,150,200	\$16,501,850

Purpose:

This policy change estimates the cost of the IBM Medical Fiscal Intermediary (FI) contract Information Technology (IT) Infrastructure Services.

Authority:

IBM Contract # 18-95302

Interdependent Policy Changes:

COVID-19 Increased FMAP – 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:

The change in FY 2022-23, from the prior estimate, is an increase due to the Economic Change Adjustment (ECA).

MEDICAL FI IT INFRASTRUCTURE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 55

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to an IT realignment from the Medical FI IT Infrastructure policy change to the Medical FI BO & IT Cost Reimbursement policy change.

Methodology:

1. Costs are paid under an hourly rate or via a fixed price negotiated during the procurement phase of the contract.
2. 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 2022-23	TF	GF	FF
Mainframe Data Center Operations Services	\$5,752,000	\$1,513,000	\$4,239,000
Midrange Data Center Operations Services	\$3,007,000	\$791,000	\$2,216,000
Midrange Storage Operations Services	\$279,000	\$73,000	\$206,000
Managed Network Services	\$4,121,000	\$1,083,000	\$3,038,000
Disaster Recovery	\$1,961,000	\$516,000	\$1,445,000
Service Delivery Mgmt, Asset Mgmt, and Facilities	\$6,792,000	\$1,785,000	\$5,007,000
Fixed Security Services	\$2,641,000	\$694,000	\$1,947,000
Hardware and Refresh	\$600,000	\$157,000	\$443,000
Software	\$7,609,000	\$2,000,000	\$5,609,000
Total	\$32,762,000	\$8,612,000	\$24,150,000

FY 2023-24	TF	GF	FF
Mainframe Data Center Operations Services	\$128,000	\$33,000	\$95,000
Midrange Data Center Operations Services	\$3,231,000	\$850,000	\$2,381,000
Midrange Storage Operations Services	\$268,000	\$71,000	\$197,000
Managed Network Services	\$4,176,000	\$1,097,000	\$3,079,000
Disaster Recovery	\$1,308,000	\$344,000	\$964,000
Service Delivery Mgmt, Asset Mgmt, and Facilities	\$5,307,000	\$1,395,000	\$3,912,000
Fixed Security Services	\$2,557,000	\$673,000	\$1,884,000
Hardware and Refresh	\$475,000	\$125,000	\$350,000
Software	\$4,938,000	\$1,298,000	\$3,640,000
Total	\$22,388,000	\$5,886,000	\$16,502,000

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)

FI 65% Title XXI / 35% GF (4260-101-0001/0890)

COVID-19 funding is identified in the COVID-19 Increased FMAP – Other Admin policy change

MEDICAL FI BO & IT CHANGE ORDERS

OTHER ADMIN. POLICY CHANGE NUMBER: 56
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2117

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$30,081,000	\$38,783,000
STATE FUNDS	\$8,158,200	\$10,192,000
FEDERAL FUNDS	\$21,922,800	\$28,591,000

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
 SB 853 (Chapter 717, Statutes of 2010)
 Welfare & Institutions Code Section 14105.05

Interdependent Policy Changes:

COVID-19 Increased FMAP – 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 BO FI contract term is five years with two 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: 56

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. The items were termed “unanticipated tasks” by the Department of General Services when they approved the contract.

Reason for Change:

The change in FY 2022-23, from the prior estimate, is a net decrease due to a shift of costs from FY 2022-23 to FY 2023-24 for the delayed implementation of stabilization programs and a one year renewal for the COVID-19 Campus Sanitation COs.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to costs for stabilization programs shifting from FY 2022-23 to FY 2023-24 and the addition of Gainwell Notice of Claims (NOCs) COs for Conlon claim, mass mailers and litigation processes.

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: 56

FY 2022-23	TF	GF	FF
COVID-19	\$1,112,000	\$545,000	\$567,000
Conlon claim/ language interpretation	\$67,000	\$17,000	\$50,000
Mass Mailers/return processing	\$67,000	\$17,000	\$50,000
Litigation processes	\$67,000	\$17,000	\$50,000
Contract Innovations	\$178,000	\$47,000	\$131,000
Stabilization	\$3,000,000	\$788,000	\$2,212,000
Level 1 Help Desk	\$971,000	\$255,000	\$716,000
COGNOS	\$271,000	\$71,000	\$200,000
File Maintenance	\$4,333,000	\$1,139,000	\$3,194,000
State Level Registry Services	\$978,000	\$257,000	\$721,000
Security Services	\$4,356,000	\$1,145,000	\$3,211,000
Testing Services	\$8,804,000	\$2,314,000	\$6,490,000
Formulary Liaison Services	\$1,366,000	\$359,000	\$1,007,000
FOAG	\$2,200,000	\$578,000	\$1,622,000
TPL Liaison	\$284,000	\$75,000	\$209,000
API Connect	\$373,000	\$98,000	\$275,000
Red Hat	\$869,000	\$229,000	\$640,000
Dallas - Mid-Range Storage Refresh	\$785,000	\$207,000	\$578,000
Total	\$30,081,000	\$8,158,000	\$21,923,000

FY 2023-24	TF	GF	FF
Conlon claim/language interpretation	\$267,000	\$71,000	\$196,000
Mass Mailers/return processing	\$267,000	\$71,000	\$196,000
Litigation processes	\$267,000	\$71,000	\$196,000
Contract Innovations	\$137,000	\$36,000	\$101,000
Stabilization	\$13,650,000	\$3,588,000	\$10,062,000
Level 1 Help Desk	\$1,003,000	\$263,000	\$740,000
COGNOS	\$278,000	\$73,000	\$205,000
File Maintenance	\$4,195,000	\$1,102,000	\$3,093,000
State Level Registry Services	\$830,000	\$218,000	\$612,000
Security Services	\$4,356,000	\$1,145,000	\$3,211,000
Testing Services	\$9,089,000	\$2,389,000	\$6,700,000
Formulary Liaison Services	\$1,370,000	\$360,000	\$1,010,000
FOAG	\$2,200,000	\$578,000	\$1,622,000
TPL Liaison	\$290,000	\$74,000	\$216,000
API Connect	\$257,000	\$67,000	\$190,000
Dallas - Mid-Range Storage Refresh	\$327,000	\$86,000	\$241,000
Total	\$38,783,000	\$10,192,000	\$28,591,000

MEDICAL FI BO & IT CHANGE ORDERS
OTHER ADMIN. POLICY CHANGE NUMBER: 56

Funding:

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

FI 75% Title XIX / 25% GF (4260-101-0001/0890)

FI 100% GF (4260-101-0001)

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

FI 65% Title XXI / 35% GF (4260-101-0001/0890)

COVID-19 funding is identified in the COVID-19 Increased FMAP –Other Admin policy change

MEDICAL FI BO OTHER ESTIMATED COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 57
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2112

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$23,880,000	\$26,381,000
STATE FUNDS	\$7,249,050	\$8,105,750
FEDERAL FUNDS	\$16,630,950	\$18,275,250

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

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 two 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: 57

- 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, information technology, 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:

The change in FY 2022-23, from the prior estimate, is due to an increase in the CPI adjustment and adding Alternative Format costs to the Print and Mail Medi-Cal Information costs.

MEDICAL FI BO OTHER ESTIMATED COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 57

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to an increase in FY 2023-24 to the CPI adjustment and adding Alternative Format costs to the Print and Mail Medi-Cal Information costs.

Methodology:

1. Other estimated costs are paid using fixed pricing methodology. The contract stipulates an annual rate for each of the services defined above.
2. Costs are shared between Federal Funds (FF) and General Funds (GF).
3. 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 2022-23	TF	GF	FF
Process Appeals (75% FF/25% GF, 100% GF)	\$823,000	\$217,000	\$606,000
Support Audits (75% FF/25% GF)	\$176,000	\$46,000	\$130,000
Process Drug Rebates (75% FF/25% GF)	\$1,246,000	\$327,000	\$919,000
Provide Litigation Support (75% FF/25% GF)	\$180,000	\$48,000	\$132,000
Service Delivery Support (75% FF/25% GF)	\$10,329,000	\$2,714,000	\$7,615,000
Publish Provider Communication Materials (75% FF/25% GF, 50% FF/50% GF)	\$3,351,000	\$1,412,000	\$1,939,000
Conduct Provider Outreach and Education (75% FF/25% GF)	\$4,810,000	\$1,265,000	\$3,545,000
Print and Mail Medi-Cal Information (75% FF/25% GF, 50% FF/50% GF)	\$2,778,000	\$1,171,000	\$1,607,000
Perform Proactive Provider Research (75% FF/25% GF)	\$187,000	\$49,000	\$138,000
Total	\$23,880,000	\$7,249,000	\$16,631,000

MEDICAL FI BO OTHER ESTIMATED COSTS
OTHER ADMIN. POLICY CHANGE NUMBER: 57

FY 2023-24	TF	GF	FF
Process Appeals (75% FF/25% GF, 100% GF)	\$880,000	\$231,000	\$649,000
Support Audits (75% FF/25% GF)	\$188,000	\$50,000	\$138,000
Process Drug Rebates (75% FF/25% GF)	\$1,333,000	\$350,000	\$983,000
Provide Litigation Support (75% FF/25% GF)	\$192,000	\$51,000	\$141,000
Service Delivery Support (75% FF/25% GF)	\$11,053,000	\$2,905,000	\$8,148,000
Publish Provider Communication Materials (75% FF/25% GF, 50% FF/50% GF)	\$3,585,000	\$1,510,000	\$2,075,000
Conduct Provider Outreach and Education (75% FF/25% GF)	\$5,147,000	\$1,353,000	\$3,794,000
Print and Mail Medi-Cal Information (75% FF/25% GF, 50% FF/50% GF)	\$3,803,000	\$1,603,000	\$2,200,000
Perform Proactive Provider Research (75% FF/25% GF)	\$200,000	\$52,000	\$148,000
Total	\$26,381,000	\$8,105,000	\$18,276,000

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)

FI 65% Title XXI / 35% GF (4260-101-0001/0890)

COVID-19 funding is identified in the COVID-19 Increased FMAP – Other Admin policy change

MEDICAL FI BO TELEPHONE SERVICE CENTER

OTHER ADMIN. POLICY CHANGE NUMBER: 58
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2116

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$17,002,000	\$18,197,000
STATE FUNDS	\$5,088,700	\$5,446,400
FEDERAL FUNDS	\$11,913,300	\$12,750,600

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

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 two 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: 58

Reason for Change:

The change in FY 2022-23, from the prior estimate, is due to a Consumer Price Index (CPI) adjustment increase in inflation and an increase in costs for Member Customer Services to account for the high volume of call minutes.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to a CPI adjustment increase in inflation.

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. 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 cost.

FY 2022-23	TF	GF	FF
TSC – Conduct Provider Customer Services (75% FF/25% GF, 50% FF/50% GF)	\$9,228,000	\$2,762,000	\$6,466,000
TSC – Conduct Member Customer Services (75% FF/25% GF, 50% FF/50% GF)	\$6,033,000	\$1,806,000	\$4,227,000
TSC – Provide Financial Services (75% FF/25% GF, 50% FF/50% GF)	\$1,741,000	\$521,000	\$1,220,000
Total	\$17,002,000	\$5,089,000	\$11,913,000

FY 2023-24	TF	GF	FF
TSC – Conduct Provider Customer Services (75% FF/25% GF, 50% FF/50% GF)	\$9,874,000	\$2,955,000	\$6,919,000
TSC – Conduct Member Customer Services (75% FF/25% GF, 50% FF/50% GF)	\$6,460,000	\$1,934,000	\$4,526,000
TSC – Provide Financial Services (75% FF/25% GF, 50% FF/50% GF)	\$1,863,000	\$558,000	\$1,305,000
Total	\$18,197,000	\$5,447,000	\$12,750,000

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)

FI 65% Title XXI / 35% GF (4260-101-0001/0890)

COVID-19 is identified in the COVID-19 Increased FMAP – Other Admin policy change

MEDICAL FI BUSINESS OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 59
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2111

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$15,498,000	\$16,582,000
STATE FUNDS	\$4,073,400	\$4,358,600
FEDERAL FUNDS	\$11,424,600	\$12,223,400

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

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 two 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: 59

- **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:

The change in FY 2022-23, from the prior estimate, is due to a Consumer Price Index (CPI) adjustment increase in inflation and an adjustment to the FY 2022-23 baseline estimate.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to a CPI adjustment increase in inflation.

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. 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.

MEDICAL FI BUSINESS OPERATIONS
OTHER ADMIN. POLICY CHANGE NUMBER: 59

FY 2022-23	TF	GF	FF
Process Paper Claims	\$8,540,000	\$2,244,000	\$6,296,000
Process Suspended Claims	\$3,395,000	\$892,000	\$2,503,000
Manage Records	\$1,335,000	\$351,000	\$984,000
Process Member Card Requests	\$1,841,000	\$484,000	\$1,357,000
Process Paper TAR	\$387,000	\$102,000	\$285,000
Total	\$15,498,000	\$4,073,000	\$11,425,000

FY 2023-24	TF	GF	FF
Process Paper Claims	\$9,138,000	\$2,402,000	\$6,736,000
Process Suspended Claims	\$3,633,000	\$955,000	\$2,678,000
Manage Records	\$1,428,000	\$376,000	\$1,052,000
Process Member Card Requests	\$1,969,000	\$517,000	\$1,452,000
Process Paper TAR	\$414,000	\$109,000	\$305,000
Total	\$16,582,000	\$4,359,000	\$12,223,000

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)

FI 65% Title XXI / 35% GF (4260-101-0001/0890)

COVID-19 funding is identified in the COVID-19 Increased FMAP – Other Admin policy change

MEDICAL FI BO HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 60
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2113

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$11,215,000	\$12,000,000
STATE FUNDS	\$2,947,500	\$3,154,400
FEDERAL FUNDS	\$8,267,500	\$8,845,600

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

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 two 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: 60

Reason for Change:

The change in FY 2022-23, from the prior estimate, is an increase due to minor fiscal impacts to the Medical Review Services and Service Change costs.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to the Consumer Price Index (CPI) adjustment to the estimate.

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 2022-23	TF	GF	FF
Perform Medical Review Services	\$6,365,000	\$1,673,000	\$4,692,000
Service Changes (formerly Systems Group)	\$4,850,000	\$1,274,000	\$3,576,000
Total	\$11,215,000	\$2,947,000	\$8,268,000

FY 2023-24	TF	GF	FF
Perform Medical Review Services	\$6,810,000	\$1,790,000	\$5,020,000
Service Changes (formerly Systems Group)	\$5,190,000	\$1,364,000	\$3,826,000
Total	\$12,000,000	\$3,154,000	\$8,846,000

Funding:

FI 75% Title XIX / 25% GF (4260-101-0001/0890)

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

FI 65% Title XXI / 35% GF (4260-101-0001/0890)

FI 100% GF (4260-101-0001)

COVID-19 funding is identified in the COVID-19 Increased FMAP – Other Admin policy change

MEDICAL FI BO MISCELLANEOUS EXPENSES

OTHER ADMIN. POLICY CHANGE NUMBER: 61
IMPLEMENTATION DATE: 11/2019
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 2114

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$2,355,000	\$2,317,000
STATE FUNDS	\$747,650	\$737,100
FEDERAL FUNDS	\$1,607,350	\$1,579,900

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

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 two 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: 61

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 in FY 2022-23, from the prior estimate, is due to a decrease in Warrant Redemption and Non-Medical Transportation costs.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to a decrease in Non-Medical Transportation costs.

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 2022-23	TF	GF	FF
Interagency Agreements (75% FF/25% GF, 50% FF/50% GF)	\$2,355,000	\$748,000	\$1,607,000
Total	\$2,355,000	\$748,000	\$1,607,000

FY 2023-24	TF	GF	FF
Interagency Agreements (75% FF/25% GF, 50% FF/50% GF)	\$2,317,000	\$737,000	\$1,580,000
Total	\$2,317,000	\$737,000	\$1,580,000

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)

FI 65% Title XXI / 35% GF (4260-101-0001/0890)

COVID-19 funding is identified in the COVID-19 Increased FMAP – Other Admin policy change

HCO OPERATIONS 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 62
IMPLEMENTATION DATE: 11/2018
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 2051

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$40,662,000	\$42,568,000
STATE FUNDS	\$20,026,050	\$20,964,800
FEDERAL FUNDS	\$20,635,950	\$21,603,200

Purpose:

This policy change estimates the operational costs of the Health Care Options (HCO) program for the #17-94437 contract with Maximus.

Authority:

HCO Contract #17-94437

Interdependent Policy Changes:

Not Applicable

Background:

The enrollment broker contractor for the HCO program is responsible for enrolling Medi-Cal beneficiaries into managed care health plans within three Medi-Cal managed care health plan models including Two-Plan, Regional, and Geographic Managed Care. The broker also enrolls beneficiaries with two Dental Managed Care plan models; one in Sacramento County where enrollment is mandatory, and one in Los Angeles County, where enrollment is voluntary. The contractor assumed operations on October 1, 2018. Operations for the contractor are based on a fixed-price bid.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is an increase due to updated actuals and adjusted projection calculations. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to adjusted projection calculations.

Methodology:

1. Operations costs are fixed price rates based on volumes within the minimum and maximum ranges under the HCO contract. These are based on agreed-upon contracted bid rates in the contract.

HCO OPERATIONS 2017 CONTRACT
OTHER ADMIN. POLICY CHANGE NUMBER: 62

FY 2022-23	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced Title XXI	Enhanced Title XXI
Transactions	\$7,726,000	\$3,670,000	\$3,670,000	\$135,000	\$251,000
Packet Mailings	\$7,726,000	\$3,670,000	\$3,670,000	\$135,000	\$251,000
BDA/Call Center	\$25,210,000	\$11,975,000	\$11,975,000	\$441,000	\$819,000
Total	\$40,662,000	\$19,315,000	\$19,315,000	\$711,000	\$1,321,000

*Totals may differ due to rounding

FY 2023-24	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced Title XXI	Enhanced Title XXI
Transactions	\$8,088,000	\$3,842,000	\$3,842,000	\$141,000	\$263,000
Packet Mailings	\$8,088,000	\$3,842,000	\$3,842,000	\$141,000	\$263,000
BDA/Call Center	\$26,392,000	\$12,536,000	\$12,536,000	\$462,000	\$858,000
Total	\$42,568,000	\$20,220,000	\$20,220,000	\$744,000	\$1,384,000

*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)

FI 65% Title XXI / 35% GF (4260-101-0001/0890)

HCO COST REIMBURSEMENT 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 63
IMPLEMENTATION DATE: 11/2018
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 2052

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$31,960,000	\$37,351,000
STATE FUNDS	\$15,740,300	\$18,395,450
FEDERAL FUNDS	\$16,219,700	\$18,955,550

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:

Not Applicable

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 2022-23, is an increase due to updated actuals and adjusted projection calculations. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to new projects and adjusted projection calculations.

Methodology:

1. Contract costs are shared between GF and FF.

HCO COST REIMBURSEMENT 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 63

FY 2022-23	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced Title XXI	Enhanced Title XXI
Postage	\$16,233,000	\$7,710,000	\$7,710,000	\$284,000	\$529,000
Printing	\$4,777,000	\$2,269,000	\$2,269,000	\$84,000	\$155,000
Materials Maintenance and Development	\$3,966,000	\$1,884,000	\$1,884,000	\$69,000	\$129,000
Mass Mailings	\$1,258,000	\$597,000	\$597,000	\$22,000	\$42,000
Other Cost Reimb.	\$1,587,000	\$753,000	\$753,000	\$28,000	\$53,000
Additional Systems Group Staff	\$3,417,000	\$1,623,000	\$1,623,000	\$60,000	\$111,000
Miscellaneous	\$722,000	\$343,000	\$343,000	\$13,000	\$23,000
Total*	\$31,960,000	\$15,179,000	\$15,179,000	\$560,000	\$1,042,000

*Totals may differ due to rounding

FY 2023-24	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced Title XXI	Enhanced Title XXI
Postage	\$18,971,000	\$9,011,000	\$9,011,000	\$332,000	\$617,000
Printing	\$5,582,000	\$2,652,000	\$2,652,000	\$97,000	\$181,000
Materials Maintenance and Development	\$4,636,000	\$2,202,000	\$2,202,000	\$81,000	\$151,000
Mass Mailings	\$1,470,000	\$698,000	\$698,000	\$26,000	\$48,000
Other Cost Reimb.	\$1,854,000	\$881,000	\$881,000	\$32,000	\$60,000
Additional Systems Group Staff	\$3,994,000	\$1,897,000	\$1,897,000	\$70,000	\$130,000
Miscellaneous	\$844,000	\$401,000	\$401,000	\$15,000	\$27,000
Total*	\$37,351,000	\$17,742,000	\$17,742,000	\$653,000	\$1,214,000

*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)

FI 65% Title XXI / 35% GF (4260-101-0001/0890)

HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 64
IMPLEMENTATION DATE: 11/2018
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 2053

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$15,642,000	\$16,097,000
STATE FUNDS	\$7,703,700	\$7,927,750
FEDERAL FUNDS	\$7,938,300	\$8,169,250

Purpose:

This policy change estimates the Enrollment Services Representative's (ESRs) hourly reimbursement for the Health Care Options (HCO) program under the #17-94437 contract with Maximus.

Authority:

HCO contract # 17-94437

Interdependent Policy Changes:

Not Applicable

Background:

The enrollment broker contractor for the HCO program is responsible for enrolling Medi-Cal beneficiaries into managed care health plans within three Medi-Cal managed care health plan models including Two-Plan, Regional, and Geographic Managed Care. The broker also enrolls beneficiaries into two Dental Managed Care plan models; one in Sacramento County, where enrollment is mandatory, and one in Los Angeles County, where enrollment is voluntary. Assumption of operations for the new contractor began October 1, 2018. An important goal of the HCO program is to provide every Medi-Cal applicant/beneficiary, who shall be required or is eligible to enroll in a medical and/or dental plan under the Medi-Cal Managed Care program, with the opportunity to receive a face-to-face presentation describing that individual's rights and enrollment choices as well as a fundamental introduction to the managed health care delivery system. The primary objective of the HCO presentation is to educate applicants/beneficiaries to make an informed plan choice. An effective educational program ultimately increases the number of potential eligible enrollees who choose a plan prior to or during the informing process, thereby avoiding auto-assignment (default assignment) to a plan. This program is conducted by the enrollment contractor with the use of ESRs in county offices statewide.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a decrease due to updated actuals and projections. The change from FY 2022-23 to FY 2023-24 in the current estimate, is an increase due to adjusted projection calculations.

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 2022-23 and FY 2023-24 are based on 217.5 ESRs per year.

HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 64

FY 2022-23	TF	GF	FF
Title XIX (50% FF / 50% GF)	\$14,860,000	\$7,430,000	\$7,430,000
Title XXI (65% FF / 35% GF)	\$782,000	\$274,000	\$508,000
Total	\$15,642,000	\$7,704,000	\$7,938,000

*Totals may differ due to rounding

FY 2023-24	TF	GF	FF
Title XIX (50% FF / 50% GF)	\$15,292,000	\$7,646,000	\$7,646,000
Title XXI (65% FF / 35% GF)	\$805,000	\$282,000	\$523,000
Total	\$16,097,000	\$7,928,000	\$8,169,000

*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)

FI 65% Title XXI / 35% GF (4260-101-0001/0890)

DENTAL ASO ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 65
IMPLEMENTATION DATE: 3/2018
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2007

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$52,773,000	\$53,049,000
STATE FUNDS	\$19,173,500	\$19,271,250
FEDERAL FUNDS	\$33,599,500	\$33,777,750

Purpose:

This policy change estimates the total cost for reimbursable items, operations, turnover, and runout 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 cost reimbursables, operations, turnover, and runout.

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: 65

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.

With the release of the Notice of Intent to Award for the Fiscal Intermediary – Dental Business Operations (FI-DBO) contract, the Department expects to utilize the one-time period of extended operations to extend ASO operations into FY 2024-25 to allow the ASO to remain in operations during the FI-DBO Takeover phase. The addition of the period of extended operations, the Turnover and Runout phases under the ASO contract will be pushed back as a result.

Turnover constitutes all work activities required of the ASO as defined in the contract documents for with Delta. Turnover ensures the orderly transfer of services from the ASO to the successor Fiscal Intermediary-Dental Business Operations (FI-DBO) contract. The schedule of payments for turnover to the ASO is contractually agreed upon. 55% of the turnover bid price is paid in nine equal installments, with nine percent withheld from each installment. One final installment of 45% and withholds is made upon completion of all turnover requirements. These payments are expected to be paid starting in August 2024.

Following turnover of the ASO contract is runout. Runout constitutes all work activities required of the ASO during runout, as defined in the contract documents with Delta. Runout ensures the orderly decommissioning of systems and closeout of the ASO contract. The schedule of payments for runout services to the ASO is contractually agreed upon. 55% of the runout bid price is paid in seven equal installments, with seven percent withheld from each installment. One final installment of 45% and withholds is made upon completion of all runout requirements. These payments are expected to be paid starting in June 2025.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is an increase due revised estimates for several categories of services. The change from FY 2022-23 to FY 2023-24, 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.

DENTAL ASO ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 65

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 September 2022.
4. TSC minutes are based on actual invoices funded at 50% FF and 50% GF.

FY 2022-23	TF	GF	FF
Administration/Operations (75% FF / 25% GF)	\$25,671,000	\$6,418,000	\$19,253,000
Provider Enrollment (50% FF / 50% GF & 75% FF / 25% GF)	\$4,530,000	\$1,608,000	\$2,922,000
2% Withhold (net of prior year withhold release)	-\$25,000	-\$7,000	-\$18,000
Total ACSL/TAR	\$30,176,000	\$8,019,000	\$22,157,000
TSC – Provider (50% FF / 50% GF)	\$7,352,000	\$3,676,000	\$3,676,000
TSC – Beneficiary (50% FF / 50% GF)	\$11,816,000	\$5,908,000	\$5,908,000
Total TSC	\$19,168,000	\$9,584,000	\$9,584,000
Total Operations Costs	\$49,344,000	\$17,603,000	\$31,741,000

FY 2023-24	TF	GF	FF
Administration/Operations (75% FF / 25% GF)	\$25,796,000	\$6,449,000	\$19,347,000
Provider Enrollment (50% FF / 50% GF & 75% FF / 25% GF)	\$4,552,000	\$1,616,000	\$2,936,000
2% Withhold (net of prior year withhold release)	\$0	\$0	\$0
Total ACSL/TAR	\$30,348,000	\$8,065,000	\$22,283,000
TSC – Provider (50% FF / 50% GF)	\$7,398,000	\$3,699,000	\$3,699,000
TSC – Beneficiary (50% FF / 50% GF)	\$11,874,000	\$5,937,000	\$5,937,000
Total TSC	\$19,272,000	\$9,636,000	\$9,636,000
Total Operations Costs	\$49,620,000	\$17,701,000	\$31,919,000

5. Cost reimbursements are based on actual invoices with a caseload growth factor.

Cost Reimbursable	TF	GF	FF
FY 2022-23	\$3,429,000	\$1,571,000	\$1,858,000
FY 2023-24	\$3,429,000	\$1,570,000	\$1,859,000

DENTAL ASO ADMINISTRATION 2016 CONTRACT
OTHER ADMIN. POLICY CHANGE NUMBER: 65

6. Total Administration Cost

Fiscal Year	TF	GF	FF
FY 2022-23	\$52,773,000	\$19,174,000	\$33,599,000
FY 2023-24	\$53,049,000	\$19,271,000	\$33,778,000

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: 66
IMPLEMENTATION DATE: 11/2017
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2006

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$21,479,000	\$21,690,000
STATE FUNDS	\$5,948,000	\$6,003,000
FEDERAL FUNDS	\$15,531,000	\$15,687,000

Purpose:

This policy change estimates the total cost for operations, cost reimbursable items, and hourly reimbursables for the 2016 Dental Fiscal Intermediary (FI).

Authority:

Contract 16-93286

Interdependent Policy Changes:

Not Applicable

Background:

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: 66

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 2022-23, is an increase due to scanning volumes. The change from FY 2022-23 to FY 2023-24, 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 2021-22 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 2022-23	TF	GF	FF
Scanned Claims/TAR	\$11,956,000	\$2,989,000	\$8,967,000
Check Write	\$263,000	\$66,000	\$197,000
Change Orders	\$250,000	\$125,000	\$125,000
Total	\$12,469,000	\$3,180,000	\$9,289,000

FY 2023-24	TF	GF	FF
Scanned Claims/TAR	\$12,005,000	\$3,001,000	\$9,004,000
Check Write	\$267,000	\$67,000	\$200,000
Change Orders	\$258,000	\$129,000	\$129,000
Total	\$12,530,000	\$3,197,000	\$9,333,000

4. Cost reimbursements are based on actual invoices.

Fiscal Year	TF	GF	FF
FY 2022-23	\$2,062,000	\$1,031,000	\$1,031,000
FY 2023-24	\$2,064,000	\$1,032,000	\$1,032,000

DENTAL FI ADMINISTRATION 2016 CONTRACT
OTHER ADMIN. POLICY CHANGE NUMBER: 66

5. Hourly Reimbursables:

System Group	TF	GF	FF
FY 2022-23	\$6,948,000	\$1,737,000	\$5,211,000
FY 2023-24	\$7,096,000	\$1,774,000	\$5,322,000

6. Total Administration Cost:

Fiscal Year	TF	GF	FF
FY 2022-23	\$21,479,000	\$5,948,000	\$15,531,000
FY 2023-24	\$21,690,000	\$6,003,000	\$15,687,000

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-DBO ADMIN 2022 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 67
IMPLEMENTATION DATE: 10/2022
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2380

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$15,411,000	\$76,780,000
STATE FUNDS	\$1,541,100	\$17,116,450
FEDERAL FUNDS	\$13,869,900	\$59,663,550

Purpose:

This policy change estimates the total administrative cost for operations, cost reimbursable items, and billable labor for the Fiscal Intermediary-Dental Business Operations (FI-DBO) contract. This policy change includes the total cost of Fiscal Intermediary-Dental Business Operations (FI-DBO) contract Takeover, which facilitates the orderly transition of required business services from the incumbent dental Administrative Services Organization (ASO) contract 16-93287 and dental Fiscal Intermediary (FI) contract 16-93286 to the FI-DBO.

Authority:

RFP 20-10354

Interdependent Policy Changes:

Not Applicable

Background:

The Department selected Gainwell Technologies LLC as the FI-DBO vendor, and the resulting Contract Effective Date (CED) was October 1, 2022. FI-DBO Takeover began on CED and continues until the FI-DBO Contractor assumes operations of all required business services from the ASO and FI Contractors, as approved by the Department, with a maximum Takeover completion date of December 31, 2024.

Takeover constitutes all contractual responsibilities required for the FI-DBO Contractor to assume administrative responsibilities, as defined in Exhibit A, Attachment I – Takeover, as well as any work that occurs during Takeover that is required under Exhibit C – General Terms and Conditions, Exhibit D(F) – Special Terms and Conditions, and Exhibit E – Additional Provisions.

The Department is evaluating Additional Contractual Services (ACS) solicited during the request for proposal, and after CED may direct the FI-DBO to implement one or more ACS items, in accordance with Exhibit A, Attachment V – Additional Contractual Services. ACS are services related to the contract Scope of Work that enhance the support for, or increase the efficiency and effectiveness of, administering the Medi-Cal program.

The FI-DBO is a multi-year contract that provides business operations services for the Medi-Cal Dental Program including, but not limited to, claim and Treatment Authorization Request adjudication, Customer Service Center operations, and member and provider outreach. The administrative cost of the FI-DBO consists of reimbursement for operations, cost reimbursement, and billable labor. The administrative cost will be paid through a combination of payment methods including fixed price, variable price, cost reimbursement, and billable labor.

DENTAL FI-DBO ADMIN 2022 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 67

Operations, anticipated to begin October 1, 2023, constitutes all contractual responsibilities required for the contractor to administer and operate the FI-DBO. Operations cost are reimbursed through a combination of fixed price and fixed plus variable price payment methods, across payment categories as defined in Exhibit B, Attachment I, Provision 3.

A two percent (2%) withhold will be administered on Member Outreach and Provider Outreach invoices, to account for performance standards evaluating year-over-year increases in volume, in accordance with Exhibit B, Attachment I, Provision 7.A. The 2% withhold will be held from each monthly invoice until the end of each Contract Year, pending contractor substantiation that annual performance outcomes are met. If the FI-DBO does not meet required performance standards, the 2% withhold will not be released.

The Department will reimburse various cost, in arrears, incurred by the FI-DBO in fulfilling its requirements under the contract, referred to as cost reimbursement. These items are in addition to operations and are not part of the contract bid price. The cost reimbursement payment method is limited to direct cost within the following categories, as defined in Exhibit B, Attachment I, Provision 4:

- Postage
- Parcel Services and Common Carriers
- Office Automation
- Printing
- Travel and Special Training Sessions
- Facilities Improvements
- Audits and Research
- Sales/Use Tax
- Change Orders and/or Contract Amendments
- Consultant Contracts
- Services and Subscriptions
- Annual Risk Assessments
- Conventions, Provider Enrollment Workshops, and Health Fairs
- Telephone Toll Charges
- Language Line
- Clinical Screening
- Translation and Alternative Format Services
- Other Cost Reimbursable Items

In addition, certain activities are reimbursed as billable labor by the Department, subject to written pre-approval from the Department. The rate paid to the contractor consists of all direct and indirect costs required to support these activities.

Reason for Change:

This is a new policy change.

Methodology:

1. Takeover will be paid on a fixed price basis up to a maximum of thirty million dollars (\$30,000,000), and subject to validation of submitted documentation by the Department.
2. Eighty percent (80%) of the Takeover bid will be paid in equal monthly installments, as defined by the Department approved Contractor's project schedule. Twenty percent (20%)

DENTAL FI-DBO ADMIN 2022 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 67

of the Takeover bid will be paid upon completion of Takeover as approved by the Department Contracting Officer.

3. ACS items approved for implementation by the Department will be paid on a fixed price basis, in addition to the Takeover maximum, and subject to validation of submitted documentation by the Department.
4. Eighty percent (80%) of each ACS bid will be paid in equal monthly installments, as defined by the Department approved Contractor's project schedule. Twenty percent (20%) of each ACS bid will be paid upon completion of the ACS as approved by the Department Contracting Officer.
5. Takeover Costs:

Fiscal Year	TF	GF	FF
FY 2022-23	\$15,411,000	\$1,541,000	\$13,869,000
FY 2023-24	\$17,612,000	\$1,761,000	\$15,851,000

6. Operations cost are a combination of fixed price and fixed plus variable price for defined payment categories under the FI-DBO contract.
7. A two percent (2%) withhold will be held from monthly Perform Member Outreach and Conduct Provider Outreach invoices, until the end of each Contract Year pending Contractor substantiation that annual performance outcomes are met. The withhold is based on actual invoices received. If performance requirements are met for Contract Year 1, the funds will be released in FY 2024-25.
8. Operations Costs:

Fiscal Year	TF	GF	FF
FY 2022-23	\$0	\$0	\$0
FY 2023-24	\$53,609,000	\$13,402,000	\$40,207,000

9. Cost Reimbursements:

Fiscal Year	TF	GF	FF
FY 2022-23	\$0	\$0	\$0
FY 2023-24	\$3,700,000	\$1,488,000	\$2,212,000

10. Billable Labor Costs:

Fiscal Year	TF	GF	FF
FY 2022-23	\$0	\$0	\$0
FY 2023-24	\$1,859,000	\$465,000	\$1,394,000

DENTAL FI-DBO ADMIN 2022 CONTRACT
OTHER ADMIN. POLICY CHANGE NUMBER: 67

11. Total Administration Costs:

Fiscal Year	TF	GF	FF
FY 2022-23	\$15,411,000	\$1,541,000	\$13,869,000
FY 2023-24	\$76,780,000	\$17,116,000	\$59,664,000

Funding:

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

FI 75% Title XIX / 25% GF (4260-101-0001/0890)

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

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

PERSONAL CARE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 68
IMPLEMENTATION DATE: 4/1993
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 236

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$453,963,000	\$462,476,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$453,963,000	\$462,476,000

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 2022-23, from the prior estimate, is an increase due to updated expenditure data provided by CDSS. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to updated expenditure data provided by CDSS.

PERSONAL CARE SERVICES
OTHER ADMIN. POLICY CHANGE NUMBER: 68

Methodology:

1. On an accrual basis, CDSS estimated FY 2022-23 expenditures at \$456,230,000 FF and at \$474,618,000 FF in FY 2023-24.
2. On a cash basis, the estimates below were provided by CDSS.

(Dollars in Thousands)

FY 2022-23	TF	DHCS FFP	CDSS GF/ County Match
EW Time & Health Related	\$757,621	\$380,383	\$377,238
CMIPS II	\$105,165	\$52,583	\$52,583
CMIPS II EVV	\$23,331	\$20,998	\$2,333
Total	\$886,117	\$453,963	\$432,154
FY 2023-24	TF	DHCS FFP	CDSS GF/ County Match
EW Time & Health Related	\$792,957	\$398,117	\$394,840
CMIPS II	\$104,698	\$52,349	\$52,349
CMIPS II EVV	\$13,344	\$12,010	\$1,334
Total	\$911,000	\$462,476	\$448,524

*Totals may differ due to rounding.

Funding:

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

HEALTH-RELATED ACTIVITIES - CDSS

OTHER ADMIN. POLICY CHANGE NUMBER: 69
IMPLEMENTATION DATE: 7/1992
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 233

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$315,336,000	\$318,138,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$315,336,000	\$318,138,000

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.

Authority:

CWS Interagency Agreement (IA) 01-15931
 CWS/CMS 06-55834
 CSBG/APS 01-15931

Interdependent Policy Changes:

Not Applicable

Background:

The health-related services involve helping Medi-Cal eligibles to access covered medical services or maintain current treatment levels in these program areas: 1) Child Welfare Services (CWS); 2) Child Welfare Services/Case Management System (CWS/CMS); 3) County Services Block Grant (CSBG); 4) Adult Protective Services (APS) and; 5) Psychotropic Medications Medical Review.

Reason for Change:

There is a decrease from the prior estimate for FY 2022-23 due to updated expenditure data provided by CDSS. The change from FY 2022-23 to FY 2023-24, 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: 69

(Dollars in Thousands)

FY 2022-23	TF	DHCS FFP	CDSS GF/ County Match
CWS	\$338,474	\$169,237	\$169,237
CWS/CMS	\$8,786	\$4,393	\$4,393
CSBG/APS	\$286,708	\$141,706	\$145,002
TOTAL	\$633,968	\$315,336	\$318,632
FY 2023-24	TF	DHCS FFP	CDSS GF/ County Match
CWS	\$341,159	\$170,579	\$170,579
CWS/CMS	\$8,544	\$4,272	\$4,272
CSBG/APS	\$286,573	\$143,287	\$143,287
TOTAL	\$636,276	\$318,138	\$318,138

*Totals may differ due to rounding.

Funding:

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

CALHEERS DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 70
IMPLEMENTATION DATE: 6/2012
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1679

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$152,282,000	\$132,496,000
STATE FUNDS	\$40,531,150	\$34,768,350
FEDERAL FUNDS	\$111,750,850	\$97,727,650

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
 Contract # 18-95333
 Contract # 18-95359
 Contract # 21-10137
 Contract # 21-10171

Interdependent Policy Changes:

Not Applicable

Background:

California established Covered California to provide competitive health care coverage for individuals and small employers. CalHEERS determines an applicant's eligibility for subsidized coverage. In creating this one-stop-shop experience, states are required to use a single, streamlined application for the applicants to apply for all applicable health subsidy programs. The application may be filed online, in person at a county social services agency, by mail, or by telephone. To meet this requirement, the Department and Covered California formed a partnership to acquire a Systems Integrator to design and implement the CalHEERS as the business solution that allows the required one-stop shopping, making health insurance eligibility purchasing easier and more understandable.

The Department is responsible for the coordination, clarification, and implementation of Medi-Cal regulations, policies, and procedures to ensure the 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

CALHEERS DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 70

and implemented technology solutions for the ongoing maintenance of MEDS and Health Exchange and Medi-Cal Interface (HEMI) web services.

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 receives enhanced federal funding for the requirements validation, design, development, testing, and implementation of MEDS-related system changes needed to interface with CalHEERS. The majority of CalHEERS' costs are shared between Covered California and Medi-Cal. For any design, development, and implementation (DD&I) or maintenance and operations (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 HEMI which CMS approved. The Department will submit an Operational Advanced Planning Document in order to seek approval for HEMI funding. For CalHEERS, the Department submitted an As Needed Advanced Planning Document in July of 2022 to seek approval for increased funding for FFY 2023 and through subsequent fiscal years, as well as approval of a new proposed cost share effective October 1, 2022, between the Department (86.677%) and Covered California (13.323%).

Reason for Change:

CalHEERS

The change in FY 2022-23 from the prior estimate is an increase due to updated actuals and adjusted projections for OSI indirect overhead. The change from FY 2022-23 to FY 2023-24 in the current estimate is a decrease due to the completion of technical enhancements and the conclusion of the GetInsured contract in August 2023.

HEMI

The change in FY 2022-23 from the prior estimate is an increase due to the HEMI team having an entire team of contractors and corrections to previous invoice billings. The change from FY 2022-23 to FY 2023-24 in the current estimate is a decrease due to adjusted projections and no retro-correction in FY 2023-24.

The overall change from the prior estimate for FY 2022-23 is an increase due to the HEMI team having an entire team of contractors and corrections to previous invoice billings, as well as CalHEERS' updated actuals and adjusted projections for OSI indirect overhead. The overall change from FY 2022-23 to FY 2023-24 is a decrease due to no retro-correction in FY 2023-24 for HEMI and CalHEERS' completion of technical enhancements and the conclusion of the Get Insured contract.

Methodology:

1. CalHEERS' costs are shared between Covered California and Medi-Cal based on the approved Cost Allocation Plan.
 - Effective October 1, 2021, the cost share was 13.030% from Covered California and 86.970% from the Department. This cost share was approved by CMS in September 2021 to continue through September 30, 2022.
 - Effective October 1, 2022, the cost share is 13.323% from Covered California and 86.677% 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: 70

- 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 DD&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 2022-23 and FY 2023-24 are as follows:

FY 2022-23	TF	GF	FF
Title XIX (90% FF / 10% GF)	\$26,658,000	\$2,666,000	\$23,992,000
Title XIX (75% FF / 25% GF)	\$96,234,000	\$24,059,000	\$72,176,000
Title XXI (65% FF / 35% GF)	\$19,559,000	\$6,845,000	\$12,713,000
DHCS – 100% State GF	\$5,935,000	\$5,935,000	\$0
CalHEERS Subtotal	\$148,386,000	\$39,505,000	\$108,881,000
75% Title XIX FF / 25% GF	\$3,374,000	\$844,000	\$2,531,000
65% Title XXI FF / 35% GF	\$522,000	\$183,000	\$339,000
ETS Subtotal	\$3,896,000	\$1,027,000	\$2,870,000
Total	\$152,282,000	\$40,532,000	\$111,751,000

*Totals may differ due to rounding.

FY 2023-24	TF	GF	FF
Title XIX (90% FF / 10% GF)	\$26,643,000	\$2,664,000	\$23,979,000
Title XIX (75% FF / 25% GF)	\$80,850,000	\$20,213,000	\$60,638,000
Title XXI (65% FF / 35% GF)	\$17,108,000	\$5,988,000	\$11,120,000
DHCS – 100% State GF	\$5,192,000	\$5,192,000	\$0
CalHEERS Subtotal	\$129,793,000	\$34,056,000	\$95,736,000
75% Title XIX FF / 25% GF	\$2,343,000	\$586,000	\$1,757,000
65% Title XXI FF / 35% GF	\$360,000	\$126,000	\$234,000
ETS Subtotal	\$2,703,000	\$712,000	\$1,991,000
Total	\$132,496,000	\$34,768,000	\$97,727,000

*Totals may differ due to rounding.

CALHEERS DEVELOPMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 70

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)

65% Title XXI / 35% GF (4260-101-0001/0890)

100% GF (4260-101-0001)

CDDS ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 71
IMPLEMENTATION DATE: 7/1997
ANALYST: Pang Moua
FISCAL REFERENCE NUMBER: 243

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$101,320,000	\$68,754,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$101,320,000	\$68,754,000

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 2022-23, from the prior estimate, is due to updated expenditure data due to having more recent expenditure trends for an updated estimate.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to FY 2022-23 and FY 2023-24 accrual estimates reflecting updated expenditure trend data. Updated paid expenditure data informs changes to assumptions on timing of future paid expenditures.

CDDS ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 71

Methodology:

CDDS provides the following cash estimates of its administrative cost components:

FY 2022-23		DHCS FFP	CDDS GF	IA #
1	DC/SOF Medi-Cal Admin.	\$1,477,000	\$1,477,000	03-75282/83
	DC/SOF HIPAA*	\$180,000	\$0	03-75282/83
2	DC/SOF Medi-Cal Elig	\$569,000	\$569,000	01-15378
3	HCBS Waiver Admin.	\$47,567,000	\$47,567,000	01-15834
4	RC Medicaid Admin.	\$38,026,000	\$12,675,000	03-75734
5	NHR Admin.	\$238,000	\$238,000	03-75285
6	TCM Headquarters Admin.	\$12,625,000	\$12,625,000	03-75284
	TCM HIPAA*	\$638,000	\$0	03-75284
	Total	\$101,320,000	\$75,151,000	

FY 2023-24		DHCS FFP	CDDS GF	IA #
1	DC/SOF Medi-Cal Admin.	\$1,750,000	\$1,750,000	03-75282/83
	DC/SOF HIPAA*	\$180,000	\$0	03-75282/83
2	DC/SOF Medi-Cal Elig	\$597,000	\$597,000	01-15378
3	HCBS Waiver Admin.	\$37,284,000	\$37,284,000	01-15834
4	RC Medicaid Admin.	\$20,618,000	\$6,873,000	03-75734
5	NHR Admin.	\$190,000	\$190,000	03-75285
6	TCM Headquarters Admin.	\$7,496,000	\$7,496,000	03-75284
	TCM HIPAA*	\$638,000	\$0	03-75284
	Total	\$68,753,000	\$54,190,000	

Funding:

100% Title XIX (4260-101-0890)

100% HIPAA FFP (4260-117-0890)*

HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN

OTHER ADMIN. POLICY CHANGE NUMBER: 72
IMPLEMENTATION DATE: 7/1999
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 246

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$54,682,000	\$54,682,000
STATE FUNDS	\$13,671,000	\$13,671,000
FEDERAL FUNDS	\$41,011,000	\$41,011,000

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
 Welfare & Institutions Code, Section 16501.4(d)
 Welfare & Institutions Code, Section 5328.04(a), (b), and (f)
 Civil Code, Section 56.103
 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
 Budget Act of 2017
 SB 184 (Chapter 47, Statutes of 2022)

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.

HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN

OTHER ADMIN. POLICY CHANGE NUMBER: 72

The responsibility for HCPCFC was realigned to the counties in 2011 as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, legislation enacted after September 30, 2012, that has an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by 2011 Realignment shall apply to local agencies only to the extent that the state provides annual funding for the cost increase. Local agencies are not obligated to provide programs or levels of 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.

SB 184 will make the HCPCFC a standalone program once the CHDP Program sunsets on July 1, 2024. Effective July 1, 2024, the Department will redirect a portion of the CHDP budget allocation to fund the administrative and services costs of the HCPCFC program.

Reason for Change:

There is no change from the prior estimate, for FY 2022-23. There is no change from FY 2022-23 to FY 2023-24 in the current estimate.

Methodology:

1. CDSS provides the annual Local Revenue Fund of \$13,671,000 for FY 2022-23 and FY 2023-24.

(Dollars in Thousands)

FY 2022-23	TF	GF	FF
Base Allocation	\$32,682	\$8,171	\$24,512
Psychotropic Medication Monitoring and Oversight	\$6,600	\$1,650	\$4,950
Caseload Relief	\$15,400	\$3,850	\$11,550
Total	\$54,682	\$13,671	\$41,011
FY 2023-24	TF	GF	FF
Base Allocation	\$32,682	\$8,171	\$24,512
Psychotropic Medication Monitoring and Oversight	\$6,600	\$1,650	\$4,950
Caseload Relief	\$15,400	\$3,850	\$11,550
Total	\$54,682	\$13,671	\$41,011

*Totals may differ due to rounding.

HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN

OTHER ADMIN. POLICY CHANGE NUMBER: 72

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	CF*
FY 2022-23	\$54,682	\$41,011	\$13,671	\$13,671	\$3,882
FY 2023-24	\$54,682	\$41,011	\$13,671	\$13,671	\$3,882

*County funds and CDSS GF are not included in the Total Fund.

Funding:

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

GF Reimbursement (4260-610-0995)

DEPARTMENT OF SOCIAL SERVICES ADMIN COST

OTHER ADMIN. POLICY CHANGE NUMBER: 73
IMPLEMENTATION DATE: 7/2002
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 256

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$28,357,000	\$28,357,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$28,357,000	\$28,357,000

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), Electronic Visit Verification, Coordinated Care Initiative (CCI) IA, and the California Community Transitions-Money Follows the Persons (CCT). The Department provides FFP to CDSS for services related to Medi-Cal beneficiaries. CDSS budgets the matching General Fund (GF).

Reason for Change:

The change for FY 2022-23, from the prior estimate, is a decrease due to updated cash estimates provided by CDSS. There is no change from FY 2022-23 to FY 2023-24 in the current estimate.

Methodology:

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

DEPARTMENT OF SOCIAL SERVICES ADMIN COST
OTHER ADMIN. POLICY CHANGE NUMBER: 73

(Dollars in Thousands)

FY 2021-22	TF	DHCS FFP	CDSS GF
IHSS PCSP	\$17,950	\$8,975	\$8,975
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	\$480	\$240	\$240
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	\$2,444	\$2,200	\$244
TOTAL	\$54,758	\$28,357	\$26,401
FY 2022-23	TF	DHCS FFP	CDSS GF
IHSS PCSP	\$17,950	\$8,975	\$8,975
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	\$480	\$240	\$240
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	\$2,444	\$2,200	\$244
TOTAL	\$54,758	\$28,357	\$26,401

* 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: 74
IMPLEMENTATION DATE: 7/2007
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1192

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$4,147,000	\$21,680,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$4,147,000	\$21,680,000

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 07-65642
 IA 07-65592
 IA 07-65693 A01
 IA 10-87042 A02
 IA 18-95089
 IA 20-10272
 AB 1559 (Chapter 565, Statutes of 2014)
 SB 853 (Chapter 717, Statutes of 2010)

Interdependent Policy Changes:

Not Applicable

Background:

The Department has existing IAs with CDPH to allow for the provision of Title XIX federal funds as reimbursement to CDPH. The non-federal matching funds will be budgeted by CDPH. This policy change is for the following program support costs:

- Office of Acquired Immunodeficiency Syndrome (AIDS)
- Center for Health Care Quality (CHCQ)
- Skilled Nursing Facilities (SNF)

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 AIDS to remain in their homes, stabilize their health, improve their quality of life, and avoid costly institutional care.

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,

FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 74

- 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.

Reason for Change:

The change from the prior estimate for FY 2022-23 is a decrease due to updated actuals and delays in anticipated payments. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to projections of anticipated payments.

Methodology:

1. CDPH provides the General Fund match.
2. The following estimates have been provided on a cash basis by CDPH.
3. Cash basis expenditures vary from year to year based on when claims are actually paid.
4. The costs for FY 2022-23 are estimated to be \$4,146,000 and FY 2023-24 \$21,680,000.

FY 2022-23	TF	FF
FY 2021-22 Claims	\$196,000	\$196,000
FY 2022-23 Claims	\$3,951,000	\$3,951,000
Total	\$4,147,000	\$4,147,000

FY 2023-24	TF	FF
FY 2022-23 Claims	\$227,000	\$227,000
FY 2023-24 Claims	\$21,453,000	\$21,453,000
Total	\$21,680,000	\$21,680,000

Funding:

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

DEPARTMENT OF AGING ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 75
IMPLEMENTATION DATE: 7/1984
ANALYST: Ryan Chin
FISCAL REFERENCE NUMBER: 253

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$5,803,000	\$6,743,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$5,803,000	\$6,743,000

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 for FY 2022-23, from the prior estimate, is a decrease due to updated invoices and accounting data. The change for FY 2022-23 to FY 2023-24, in the current estimate is an increase due to expenditure projections based on updated invoices and accounting data.

Methodology:

The estimates below were provided by CDA on a cash basis.

DEPARTMENT OF AGING ADMINISTRATIVE COSTS
OTHER ADMIN. POLICY CHANGE NUMBER: 75

(Dollars in Thousands)

Program Support	FY 2022-23		FY 2023-24	
CBAS Support	CDA GF	FFP	CDA GF	FFP
FY 2021-22 DOS	\$572	\$627	\$0	\$0
FY 2022-23 DOS	\$2,709	\$3,601	\$973	\$1,263
FY 2023-24 DOS	\$0	\$0	\$2,863	\$3,658
Total CBAS	\$3,281	\$4,227	\$3,836	\$4,921
MSSP Support				
FY 2021-22 DOS	\$189	\$220	\$0	\$0
FY 2022-23 DOS	\$1,193	\$1,356	\$404	\$457
FY 2023-24 DOS	\$0	\$0	\$1,202	\$1,365
Total MSSP	\$1,381	\$1,576	\$1,607	\$1,822
Grand Total	\$4,662	\$5,803	\$5,443	\$6,743

Totals may differ due to rounding.

Funding:

100% Title XIX (4260-101-0890)

CLPP CASE MANAGEMENT SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 76
IMPLEMENTATION DATE: 7/1997
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 239

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$650,000	\$3,897,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$650,000	\$3,897,000

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 2022-23 is a decrease due to delays in invoicing for FY 2021. The change from the prior estimate for FY 2022-23 and FY 2023-24 is an increase due to the projection of anticipated payments.

Methodology:

1. Cash basis expenditures vary from year to year based on when claims are actually paid.
2. The estimates are provided by CDPH on a cash basis.
3. The costs for FY 2022-23 are estimated to be \$650,000 and FY 2023-24 \$3,897,000.

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

FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG

OTHER ADMIN. POLICY CHANGE NUMBER: 77
IMPLEMENTATION DATE: 7/2020
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2244

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$5,316,000	\$9,297,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$5,316,000	\$9,297,000

Purpose:

This policy change estimates the federal reimbursement process between the Department and the Department of Health Care Access and Information (HCAI) for the Health Care Payments Data Program (HPD).

Authority:

Health & Safety Code
Interagency Agreement (IA) # 20-10306

Interdependent Policy Changes:

Not Applicable

Background:

The HPD creates a process to collect health care data in a standardized format in one statewide system and provides greater transparency regarding health care costs, quality, and equity. The system is managed by HCAI and includes 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 HPD system costs to HCAI. HCAI is providing the state share.

In FY 2023-24, additional funds will be allocated in order to compensate the All Payer Claims Database (APCD) platform vendor for completed deliverables as outlined in the contract.

Reason for Change:

There is no change from the prior estimate for FY 2022-23. The change from FY 2022-23 to FY 2023-24, in the current estimate, is an increase due to estimated costs of the contract for the APCD platform vendor.

Methodology:

- Costs are estimated at \$5,316,351 for FY 2022-23 and \$9,296,864 for FY 2023-24.

Fiscal Years	TF	GF	FF
FY 2022-23	\$5,316,000	\$0	\$5,316,000
FY 2023-24	\$9,297,000	\$0	\$9,297,000

FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG
OTHER ADMIN. POLICY CHANGE NUMBER: 77

Funding:

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

100% Title XXI FF (4260-113-0890)

100% Title XXI FF (4260-101-0890)

HCBS SP CDDS - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 78
IMPLEMENTATION DATE: 6/2022
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 2349

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$2,833,000	\$632,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$2,833,000	\$632,000

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:

Not Applicable

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:

The change in FY 2022-23, from the prior estimate, is due to an updated estimate of the cash expenditures in FY 2022-23.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is a decrease due to updating the HCBS spending plan administrative spending plan items and an updated estimated cash expenditures in FY 2023-24.

HCBS SP CDDS - OTHER ADMIN
OTHER ADMIN. POLICY CHANGE NUMBER: 78

Methodology:

1. The cash basis estimate for the HCBS spending plan administrative items for CDDS are:

(Dollars in Thousands)

FY 2022-23	TF	HCBS ARP Fund-CDDS	FF
Developmental Services Rate Model Implementation (Other Admin)	\$7,250	\$5,800	\$1,450
Modernize Regional Center Information Technology Systems	\$6,913	\$5,530	\$1,383
Enhanced Community Integration for Children and Adolescents	\$3,125	\$3,125	\$0
Total	\$17,288	\$14,455	\$2,833

(Dollars in Thousands)

FY 2023-24	TF	HCBS ARP Fund-CDDS	FF
Developmental Services Rate Model Implementation (Other Admin)	\$4,382	\$3,750	\$632
Enhanced Community Integration for Children and Adolescents	\$9,375	\$9,375	\$0
Total	\$13,757	\$13,125	\$632

Funding:

100% Title XIX (4260-101-0890)

CALIFORNIA SMOKERS' HELPLINE

OTHER ADMIN. POLICY CHANGE NUMBER: 79
IMPLEMENTATION DATE: 1/2014
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 1680

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$2,400,000	\$2,400,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$2,400,000	\$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 include specially trained counselors to provide free telephone-based counseling, education, and support to Medi-Cal beneficiaries who currently smoke or have recently quit smoking.

The Department has an existing IA with CDPH to enable the State to receive 50% FFP for Helpline services administrative costs beginning July 1, 2013.

Reason for Change:

There is no change from the prior estimate for FY 2022-23 and no change from FY 2022-23 to FY 2023-24 in the current estimate.

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. The estimates are budgeted on a cash basis based on the anticipated payment timing of invoices.
3. The estimated administrative cost reimbursements, for FY 2022-23 and FY2023-24, on a cash basis are:

CALIFORNIA SMOKERS' HELPLINE
OTHER ADMIN. POLICY CHANGE NUMBER: 79

FY 2022-23	TF	FF
FY 2021-22 Claims	\$1,505,000	\$1,505,000
FY 2022-23 Claims	\$895,000	\$895,000
Total	\$2,400,000	\$2,400,000

FY 2023-24	TF	FF
FY 2022-23 Claims	\$1,505,000	\$1,505,000
FY 2023-24 Claims	\$895,000	\$895,000
Total	\$2,400,000	\$2,400,000

Funding:

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

KIT FOR NEW PARENTS

OTHER ADMIN. POLICY CHANGE NUMBER: 80
IMPLEMENTATION DATE: 7/2001
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 249

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$1,044,000	\$593,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,044,000	\$593,000

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 in FY 2022-23, from the prior estimate, is due to an update to invoice schedule. FY 2022-23 will include invoices from prior years and quarterly invoices in the current year and paid one month later.

There is no change from FY 2022-23 to FY 2023-24, in the current estimate.

Methodology:

1. CCFC distributed 95,239 kits in FY 2020-21 and 81,472 kits in FY 2021-22 that will be paid in FY 2022-23. An estimated 131,250 kits is estimated to be distributed and paid in FY 2022-23. An estimated 175,000 kits are expected to be distributed in FY 2023-24. 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. In prior years, CCFC invoiced DHCS on a yearly basis. In FY 2022-23, CCFC will invoice on a quarterly basis with first invoice to begin October 2022.
4. The annual number of kits estimated at full ramp up is 175,000.

KIT FOR NEW PARENTS
OTHER ADMIN. POLICY CHANGE NUMBER: 80

5. The Department will pay for the estimated cost of kits distributed to parents of Medi-Cal eligible newborns, shown in the table below.

	Annual Number of Kits	Medi-Cal	Total Medi-Cal Kits	Cost per kit	Total Cost (Accrual)
FY 2020-21	95,239	43.38%	41,314	\$15.63	\$645,748
FY 2021-22	81,472	43.38%	35,343	\$15.63	\$552,404
FY 2022-23	175,000	43.38%	75,915	\$15.63	\$1,186,551
FY 2023-24	175,000	43.38%	75,915	\$15.63	\$1,186,551

6. Assume the Department will pay \$1,044,000 TF in FY 2022-23 and \$593,000 TF in FY 2023-24 for kits to new parents of Medi-Cal eligible newborns.

FY 2022-23	TF	FF
FY 2020-21	\$646,000	\$646,000
FY 2021-22	\$552,000	\$552,000
FY 2022-23	\$890,000	\$890,000
Total	\$2,088,000	\$2,088,000
Total (50%)	\$1,044,000	\$1,044,000

FY 2023-24	TF	FF
FY 2022-23	\$297,000	\$297,000
FY 2023-24	\$890,000	\$890,000
Total	\$1,187,000	\$1,187,000
Total (50%)	\$593,000	\$593,000

Fiscal Year	TF	FF
FY 2022-23	\$1,044,000	\$1,044,000
FY 2023-24	\$593,000	\$593,000

Funding:

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

MEDI-CAL INPATIENT SERVICES FOR INMATES

OTHER ADMIN. POLICY CHANGE NUMBER: 81
IMPLEMENTATION DATE: 3/2011
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 1665

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$1,121,000	\$1,166,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,121,000	\$1,166,000

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

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: 81

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:

There is no change from the prior estimate for FY 2022-23. The change from FY 2022-23 to FY 2023-24, 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 **\$1,121,000** in **FY 2022-23** and **\$1,166,000** in **FY 2023-24**.

Funding:

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

VETERANS BENEFITS

OTHER ADMIN. POLICY CHANGE NUMBER: 82
IMPLEMENTATION DATE: 12/1988
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 232

	FY 2022-23	FY 2023-24
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 A1

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 2022-23. There is no change from FY 2022-23 to FY 2023-24 in the current estimate.

Methodology:

- The contract amount is estimated to be \$1,100,000 for FY 2022-23 and FY 2023-24. The non-federal match is budgeted by CDVA.

FY	FY 2022-23			FY 2023-24		
	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)

CALHHS AGENCY HIPAA FUNDING

OTHER ADMIN. POLICY CHANGE NUMBER: 83
IMPLEMENTATION DATE: 7/2001
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 257

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$1,037,000	\$1,089,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,037,000	\$1,089,000

Purpose:

This policy change estimates and reimburses the California Health and Human Services (CalHHS) Agency the federal funds for qualifying Health Insurance Portability and Accountability Act (HIPAA) activities related to Medi-Cal.

Authority:

Interagency Agreement (IA) 20-10133 A01

Interdependent Policy Changes:

Not Applicable

Background:

A HIPAA office has been established at the CalHHS 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. The current IA is set to expire on June 30, 2023. A new IA is planned to start on July 1, 2023.

Reason for Change:

There is no change from the prior estimate for FY 2022-23. The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to increased contract costs from the associated IA with CalHHS.

Methodology:

The CalHHS Agency prioritizes HIPAA projects so that the most critical projects are implemented first.

Cash Basis	DHCS FF	CalHHS GF
FY 2022-23	\$1,037,000	\$1,037,000
FY 2023-24	\$1,089,000	\$1,089,000

Funding:

100% HIPAA (4260-117-0890)

VITAL RECORDS

OTHER ADMIN. POLICY CHANGE NUMBER: 84
IMPLEMENTATION DATE: 5/2016
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1774

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$883,000	\$883,000
STATE FUNDS	\$2,000	\$2,000
FEDERAL FUNDS	\$881,000	\$881,000

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 22-20189

Interdependent Policy Changes:

Not Applicable

Background:

California birth, death, fetal death, still birth, marriage, and divorce records are maintained by the CDPH Vital Records. Information collected in these records is necessary to support core functions of the Department as represented in the Medicaid Information Technology Architecture (MITA) business functions. The MITA, a Centers for Medicare and Medicaid Services (CMS) initiative, fosters an integrated business and information technology transformation across the Medicaid enterprise in an effort to improve the administration and operation of the Medicaid program.

Historically, the Department has received Vital Records data from CDPH in a case-by-case and manual manner. In order to improve efficiency and advance MITA maturity, the Department has received CMS approval for enhanced FFP to establish automated and timely processes to receive Vital Record data from CDPH. CMS approved the contract in June 2016.

Beginning July 2018, the Department entered into a contract with CDPH to provide certified copies of vital records as required for business needs.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is a slight decrease due to lower projections for FY 2022-23 certified copies. There is no change from FY 2022-23 to FY 2023-24 in the current estimate.

Methodology:

1. On a cash basis, the estimated cost to deliver records data is \$1,177,000 TF in FY 2022-23 and \$1,177,000 TF in FY 2023-24. 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).

VITAL RECORDS
OTHER ADMIN. POLICY CHANGE NUMBER: 84

2. On a cash basis, the annual contract to provide certified copies is \$4,000 TF (\$2,000 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 2022-23 and FY 2023-24 on a cash basis are:

FY 2022-23	TF	HSSF	GF	FF
FY 2021-22 Records Data	\$295,000	\$73,000	\$0	\$222,000
FY 2021-22 Certified Copies	\$2,000	\$0	\$1,000	\$1,000
FY 2022-23 Records Data	\$878,000	\$219,000	\$0	\$659,000
FY 2022-23 Certified Copies	\$2,000	\$0	\$1,000	\$1,000
Total	\$1,177,000	\$292,000	\$2,000	\$883,000

FY 2023-24	TF	HSSF	GF	FF
FY 2022-23 Records Data	\$295,000	\$73,000	\$0	\$222,000
FY 2022-23 Certified Copies	\$2,000	\$0	\$1,000	\$1,000
FY 2023-24 Records Data	\$878,000	\$219,000	\$0	\$659,000
FY 2023-24 Certified Copies	\$2,000	\$0	\$1,000	\$1,000
Total	\$1,177,000	\$292,000	\$2,000	\$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)

MATERNAL AND CHILD HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER: 85
IMPLEMENTATION DATE: 7/2022
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 234

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$45,269,000	\$45,269,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$45,269,000	\$45,269,000

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, 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: 85

- 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 the promotion of positive youth development, focusing on and building upon the adolescents' strengths and resources to work toward:
 - 1) Improving the health of the pregnant and parenting adolescent;
 - 2) Improving graduation rates;
 - 3) Reducing repeat pregnancies; and
 - 4) Improving linkages and creating networks for pregnant and parenting adolescents.

Reason for Change:

The change from the prior estimate, for FY 2022-23, is an increase due to updates to reflect actual payments made in FY 2022-23 as well as updated projections of anticipated payments. There is no change from FY 2022-23 to FY 2023-24 in the current estimate.

Methodology:

1. The Department claims Title XIX federal funds with Certified Public Expenditures from local agencies.
2. The estimates are budgeted on a cash basis based on the anticipated payment timing of invoices.
3. The costs for FY 2022-23 and FY 2023-24 are estimated to be \$45,269,000 per fiscal year.

Funding:

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

MERIT SYSTEM SERVICES FOR COUNTIES

OTHER ADMIN. POLICY CHANGE NUMBER: 86
IMPLEMENTATION DATE: 7/2003
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 263

	FY 2022-23	FY 2023-24
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 the scope of work affecting the cost.

Reason for Change:

There is no change from the prior estimate for FY 2022-23. There is no change from FY 2022-23 to FY 2023-24 in the current estimate.

Methodology:

1. CalHR provided the estimates on a cash basis.
2. The estimated reimbursement is \$190,000 TF (\$95,000 GF) in FY 2022-23 and \$190,000 TF (\$95,000 GF) in FY 2023-24.

Funding:

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

CDPH I&E PROGRAM AND EVALUATION

OTHER ADMIN. POLICY CHANGE NUMBER: 87
IMPLEMENTATION DATE: 7/2021
ANALYST: Ami Perry-Donaldson
FISCAL REFERENCE NUMBER: 261

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$187,000	\$187,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$187,000	\$187,000

Purpose:

This policy change estimates the federal financial participation (FFP) provided to the California Department of Public Health (CDPH) for providing Information and Education (I&E) Adolescent Sexual Health and Pregnancy Prevention Program services to Medi-Cal beneficiaries.

Authority:

Interagency Agreement (IA) 07-65592
 AB 1762 (Chapter 230, Statutes of 2003)

Interdependent Policy Changes:

Not Applicable

Background:

AB 1762 authorized the Department to require contractors and grantees, under the Office of Family Planning and the I&E program, to establish and implement clinical linkages to the Family Planning, Access, Care, and Treatment program. This linkage includes the 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 meet the growing and diverse needs of Californians today. The program provides funding for educational programs that emphasize primary prevention to enhance the 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 no change from the prior estimate for FY 2022-23 and no change from FY 2022-23 to FY 2023-24 in the current estimate.

Methodology:

1. CDPH budgets the non-federal matching funds.
2. The estimates are budgeted on a cash basis based on the anticipated payment timing of invoices.

CDPH I&E PROGRAM AND EVALUATION
OTHER ADMIN. POLICY CHANGE NUMBER: 87

3. The costs for FY 2022-23 are estimated to be \$187,000 Federal Funds and FY 2023-24 \$187,000 Federal Funds.

FY 2022-23	TF	FF
FY 2021-22 Claims	\$121,000	\$121,000
FY 2022-23 Claims	\$66,000	\$66,000
Total	\$187,000	\$187,000

FY 2023-24	TF	FF
FY 2022-23 Claims	\$121,000	\$121,000
FY 2023-24 Claims	\$66,000	\$66,000
Total	\$187,000	\$187,000

Funding:

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

PIA EYEWEAR COURIER SERVICE

OTHER ADMIN. POLICY CHANGE NUMBER: 88
IMPLEMENTATION DATE: 7/2003
ANALYST: Shan Tang
FISCAL REFERENCE NUMBER: 1114

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$903,000	\$1,180,000
STATE FUNDS	\$451,500	\$590,000
FEDERAL FUNDS	\$451,500	\$590,000

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 2022-23, from the prior estimate is due to a downward recalibration of the estimated utilization, and rate increase in the courier service.

The change from FY 2022-23 to FY 2023-24, in the current estimate, is due to the assumed stabilized demand for optical lab services, and a full year of the rate increase in the courier service.

PIA EYEWEAR COURIER SERVICE

OTHER ADMIN. POLICY CHANGE NUMBER: 88

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 current incurred cost of \$2.13 per package is expected to increase to \$2.95 per package on September 1, 2022 with the start of the new contract. The new contract is from September 1, 2022 to August 31, 2024, with a one-year extension.
3. Assume 344,300 packages will be paid in FY 2022-23 and 400,000 will be paid in FY 2023-24 based upon an assumed post-COVID-19 estimated utilization.

Service Quarter	Packages (rounded)
FY 2021-22 Q4	79,300
FY 2022-23 Q1	87,500
FY 2022-23 Q2	87,500
FY 2022-23 Q3	90,000
Total FY 2022-23	344,300

Service Quarter	Packages (rounded)
FY 2022-23 Q4	100,000
FY 2023-24 Q1	100,000
FY 2023-24 Q2	100,000
FY 2023-24 Q3	100,000
Total FY 2023-24	400,000

Fiscal Year	TF	GF	FF
FY 2022-23	\$903,000	\$451,000	\$452,000
FY 2023-24	\$1,180,000	\$590,000	\$590,000

Funding:

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

CALIFORNIA BH CBC DEMONSTRATION ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 89
IMPLEMENTATION DATE: 1/2024
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2398

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$0	\$1,556,000
STATE FUNDS	\$0	\$811,000
FEDERAL FUNDS	\$0	\$745,000

Purpose:

This policy change estimates the administrative costs of the California Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration, which expands access and strengthen the continuum of mental health services for Medi-Cal beneficiaries living with serious mental illness (SMI) and serious emotional disturbance (SED).

Authority:

Medicaid Section 1115 Demonstration Waiver
Welfare and Institutions Code 14184.400(c)

Interdependent Policy Changes:

Not Applicable

Background:

California is facing a growing mental health crisis exacerbated by the COVID-19 pandemic. Since the pandemic, California hospitals are reporting significant increases in the number of adolescents seeking psychiatric treatment in emergency departments, as well as long waitlists for psychiatric inpatient beds for children and adolescents. For adults, the situation is similarly serious. More than one in 20 adult residents in California is living with SMI, and the evidence continues to mount that individuals who are experiencing or at risk of homelessness and those involved in the justice system experience high rates of untreated mental illness and/or substance use disorder. Even so, approximately one-third of individuals enrolled in Medi-Cal and who are living with SMI do not receive any Medi-Cal Specialty Mental Health Services. As a result, the Department has made strengthening California's behavioral health system a top priority, and is already making many investments in expanding behavioral health services. The CalBH-CBC Demonstration was designed to expand on these investments, complement existing major behavioral health initiatives, and strengthen the continuum of care for Medi-Cal beneficiaries.

The Department will apply for a new Medicaid Section 1115 demonstration, titled the CalBH-CBC Demonstration, to expand access to and strengthen the continuum of mental health services for Medi-Cal beneficiaries living with SMI and SED. The disparities addressed in the demonstration are based largely off California's 2022 Assessment, titled Assessing the Continuum of Care for Behavioral Health Services in California.

The proposed CalBH-CBC Demonstration approach includes five key components:

- Strengthening the statewide continuum of community-based services and evidence-based practices available through Medi-Cal for individuals living with SMI or SED.

CALIFORNIA BH CBC DEMONSTRATION ADMIN
OTHER ADMIN. POLICY CHANGE NUMBER: 89

- Supporting statewide practice transformations and improvements in the county-administered behavioral health system.
- Improving statewide county accountability for meeting service improvement requirements and implementing new benefits through incentives, robust technical assistance, and oversight.
- Establishing a county option to provide enhanced community-based services.
- Establishing a county option to receive Federal Funds Participation (FFP) for services provided during short-term stays in IMDs, contingent on counties meeting robust accountability requirements.

This policy change budgets administrative costs for the CalBH-CBC Demonstration.

Reason for Change:

This is a new policy change.

Methodology:

1. Assume the CalBH-CBC demonstration will be implemented in January 2024.
2. Total estimated administrative costs for the CalBH-CBC Demonstration, on a cash basis, is as follows:

FY 2023-24	TF	GF	FFP	IGT*
SMHS - Statewide	\$1,534,000	\$174,000	\$734,000	\$626,000
SMHS -Opt-in	\$22,000	\$0	\$11,000	\$11,000
Total	\$1,556,000	\$174,000	\$745,000	\$637,000

Funding:

100% GF (4260-101-0001)

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

Medi-Cal County Behavioral Health Fund (4260-601-3420)*

EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.

OTHER ADMIN. POLICY CHANGE NUMBER: 90
IMPLEMENTATION DATE: 8/2022
ANALYST: Autumn Recce
FISCAL REFERENCE NUMBER: 2402

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$15,233,000	\$15,770,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$15,233,000	\$15,770,000

Purpose:

This policy change estimates the federal match to the Emergency Medical Services Authority (EMSA) via an interagency agreement (IA) for providing services to Medi-Cal beneficiaries offered by the California Poison Control System (CPCS).

Authority:

Interagency Agreement 19-96235

Interdependent Policy Changes:

Not Applicable

Background:

CPCS is a statewide network of health care professionals that provides free treatment advice and assistance to people over the telephone in case of exposure to poisonous or hazardous substances. CPCS, through a contract between EMSA and the University of California at San Francisco, manages more than 245,000 poison cases each year. CPCS reduces morbidity and mortality associated with harmful exposure and ingestions; it also decreases utilization of Emergency Medical Services (EMS) and emergency department resources. The population served includes everyone with any type of exposure, children and limited-resource populations benefit extensively. CPCS provides poison prevention help and information to the public and health professionals through a toll-free hotline that is accessible 24-hours per day, seven days a week. Calls received by CPCS include ingestion of potentially toxic products, potential allergic reactions to products, and over-the-counter medications.

Uninsured and Medi-Cal population uses constitute 21% and 20%, respectively, of the cases managed by CPCS. The Department and EMSA provides services for Medi-Cal beneficiaries through utilization of Title XXI Social Security Act reimbursable services offered by the CPCS.

The Department has an existing IA, funded in State Operations, with EMSA to provide the aforementioned services. The funding authority has been moved from State Operations to the Medi-Cal Local Assistance Estimate. The cost for such services may vary year to year. The current IA was executed in May 2021 and is effective from the start of FY 2019-20 through FY 2023-24. The Department draws down and passes through the Medicaid federal funds to EMSA. The non-federal share of the reimbursement is paid for by EMSA.

Reason for Change:

This is a new policy change

EMSA - CALIFORNIA POISON CONTROL SYSTEM SVCS.

OTHER ADMIN. POLICY CHANGE NUMBER: 90

Methodology:

1. The Department provides Federal Financial Participation (FFP) reimbursements to EMSA based on invoices received in accordance with the signed IA.
2. Contracted annual expenditures 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.
3. It is assumed the payments to EMSA will be made as follows on a cash basis:

(Dollars in Thousands)

FY 2022-23	TF	FF
FY 2021-22 Q4	\$3,711	\$3,711
FY 2022-23 Q1-Q3	\$11,522	\$11,522
Total	\$15,233	\$15,233

(Dollars in Thousands)

FY 2023-24	TF	FF
FY 2022-23 Q4	\$3,841	\$3,841
FY 2023-24 Q1-Q3	\$11,929	\$11,929
Total	\$15,770	\$15,770

Funding:

100% Title XXI FF (4260-101-0890)

100% Title XXI FF (4260-113-0890)

GENDER-AFFIRMING CARE

OTHER ADMIN. POLICY CHANGE NUMBER: 92
IMPLEMENTATION DATE: 11/2023
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 2404

	<u>FY 2022-23</u>	<u>FY 2023-24</u>
TOTAL FUNDS	\$0	\$1,500,000
STATE FUNDS	\$0	\$750,000
FEDERAL FUNDS	\$0	\$750,000

Purpose:

This policy change estimates expenditures related to a developing a quality standard to measure cultural competency and a training for evidence-based cultural competency training for Medi-Cal managed care plans (MCP) and Program of All-Inclusive Care for the Elderly (PACE) organizations.

Authority:

SB 923 of Budget Act of 2022

Interdependent Policy Changes:

Not Applicable

Background:

SB 923 ensures that California prioritizes the delivery of inclusive healthcare by requiring that health plans ensure their contracted providers and staff who interact with transgender, gender diverse, or intersex (TGI) people undergo cultural competency training. By requiring that a health plan's online directories include a search feature that shows providers who offer gender affirming services, SB 923 will help TGI individuals to make informed decisions regarding their primary care and health needs.

The Department will participate in a working group no later than March 1, 2023, to develop a quality standard to measure cultural competency and a training for the purpose of providing trans-inclusive health care for individuals who identify as TGI. If a complaint has been filed and a decision has been made in favor of the complainant, Medi-Cal MCPs and PACE organization subcontractors, downstream subcontractors, and staff in direct contact with beneficiaries will need to complete a refresher course for not providing trans-inclusive health care. The Department will also develop and implement procedures and impose sanctions to ensure compliance with the above-described provisions. The Department will track and monitor complaints received related to trans-inclusive health care and publicly report this data with other complaint data on its website. Medi-Cal MCPs and PACE organizations will include information, within or accessible from their provider directories, and accessible from their call centers, that identifies which of their in-network providers have affirmed that they offer and have provided gender-affirming services. The Department will adopt regulations by July 1, 2027, and implement these provisions by means of guidance letters or similar instructions without taking any regulatory action before that date. The Department is required to provide semiannual status reports to the Legislature until regulations are adopted.

Reason for Change:

This is a new PC.

GENDER-AFFIRMING CARE

OTHER ADMIN. POLICY CHANGE NUMBER: 92

Methodology:

1. The implementation costs inclusive of planning and development for gender-affirming care are estimated at \$1,500,000 TF (\$750,000 GF) in FY 2023-24.
2. Assume any associated managed care costs are sufficiently captured in the managed care base rates. Any adjustments necessary will be updated accordingly in future rate updates.

	TF	GF	FF
FY 2023-24	\$1,500,000	\$750,000	\$750,000

Funding:

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

OUTREACH & ENROLLMENT ASSIST. FOR DUAL BENES

OTHER ADMIN. POLICY CHANGE NUMBER: 93
IMPLEMENTATION DATE: 6/2022
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2405

	FY 2022-23	FY 2023-24
TOTAL FUNDS	\$8,600,000	\$8,600,000
STATE FUNDS	\$4,300,000	\$4,300,000
FEDERAL FUNDS	\$4,300,000	\$4,300,000

Purpose:

This policy change estimates the costs for Medi-Cal eligibility outreach and enrollment for beneficiaries dually eligible for Medicare and Medi-Cal.

Authority:

SB 129 (Chapter 69, Statute of 2021)
Contract: 21-10405

Interdependent Policy Changes:

Not Applicable

Background:

Per SB 129 (Chapter 69, Statutes of 2021), the Department is contracting with a nonprofit agency for Medi-Cal eligibility outreach and enrollment of \$24 million total funds requested as needed in each Budget Act. The population of focus for this contract is low-income older adults. The outreach and enrollment is conducted in coordination with the California Department of Aging and the Health Insurance Counseling and Advocacy Program.

Reason for Change:

The change in FY 2022-23, from the prior estimate, is a decrease due to a cost shift beyond FY 2022-23. There is no change from FY 2022-23 to FY 2023-24 in the current estimate.

Methodology:

1. This policy change budgets for a Department contract for Medi-Cal outreach and enrollment assistance for dually eligible individuals.
2. The estimated costs in FY 2022-23 and FY 2023-24 are as follows:

Fiscal Year	TF	GF	FF
FY 2022-23	\$8,600	\$4,300	\$4,300
FY 2023-24	\$8,600	\$4,300	\$4,300

Funding:

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

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MEDI-CAL INFORMATION ONLY
November 2022
FISCAL YEARS 2022-23 & 2023-24

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) 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 simplified the enrollment process and eliminated the asset test for MAGI eligible. Existing income eligibility rules for aged, blind, and disabled persons did not change.

The ACA allows current recipients of Medi-Cal to continue to enroll in the program and 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 ACA also 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 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.

HOME AND COMMUNITY BASED SERVICES

Long-Term Care Alternatives

Medi-Cal includes various Long-Term Services and Supports (LTSS) that allow medically needy, frail older adults, and persons with disabilities to avoid unnecessary institutionalization. The Department administers these alternatives either as State Plan benefits or through various types of waivers.

State Plan Benefits

In-Home Supportive Services (IHSS)

IHSS helps eligible individuals pay for services so that they can remain safely in their own homes. To be eligible, individuals must meet at least one of the following:

- 65 years of age or older,
- Disabled,
- Blind, or
- Have a medical certification of a chronic, disabling condition that causes functional impairment expected to last 12 consecutive months or longer or result in death within 12 months and be unable to remain safely at home without the services.

Children with disabilities are also eligible for IHSS. IHSS provides housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments, and protective supervision for individuals with a mental impairment(s).

The four IHSS programs are:

1. Personal Care Services Program (PCSP)
This program provides personal care services including but not limited to non-medical personal services, paramedical services, domestic services, and protective supervision.
2. IHSS Plus Option (IPO)
This program provides personal care services but also allows the recipient of services to select a family member as a provider.
3. Community First Choice Option (CFCO)
This program provides personal care services to those who would otherwise be institutionalized in a nursing facility.
4. Residual (beneficiaries are not full-scope Medi-Cal; State-only program with no FFP)

The Department submitted CA DR SPA 21-0042 to include payment in the individual provider rate for Coronavirus Disease 2019 (COVID-19) sick leave benefits for IHSS and extend these payments through 9/30/21. The DR SPA was approved by Centers for Medicare & Medicaid Services (CMS) on July 28, 2021.

The Department submitted CA DR SPA 21-0055 (IHSS Incentive Payments) to create a one-time payment for IHSS providers who provided IHSS care during the COVID-19 Public Health Emergency (PHE). The DR SPA was approved by CMS on December 21, 2021. The California

HOME AND COMMUNITY BASED SERVICES

Department of Social Services (CDSS) ~~plans to process~~ **processed** the one-time payments during the first quarter of calendar year 2022.

Senate Bill 114 (Chapter 4, Statutes of 2022) was enacted on February 9, 2022, retroactive to January 1, 2022, to provide additional leave benefits related to COVID-19. Supplemental sick leave (SPSL) 2022 applies to all IHSS workers, and provides an IHSS worker with two separate supplemental pay leave banks, each up to 40 hours. The first 40 hour bank is related to COVID-19 in general while the second 40 hour bank is related to a positive test for COVID-19.

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 submitted a SPA to renew the 1915(i) Waiver, effective October 1, 2016, through September 30, 2021. 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.

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The Department submitted a SPA to update the service specifications for respite care as required by CMS' companion letter to:

- Remove group-supported employment and specialized therapeutic services,
- Add housing access, family support, occupational therapy, physical therapy, and family/consumer training services, and
- Add Enhanced Behavioral Supports Home (EBSH) as a new setting for habilitation-community living arrangement services.

This amendment also established reimbursement methodologies for EBSH and incentive payments for individual supported employment providers, effective July 1, 2018.

The Department submitted a SPA to add the following:

- Community Crisis as a provider type under Behavioral Intervention Services,
- Categorically and medically needy limits, and
- The associated rate methodology.

The approved effective date was October 2, 2018.

The Department submitted a SPA to make changes to the reimbursement methodology to implement a one-year rate increase for certain services in high cost counties. CMS approved the SPA, effective May 1, 2019.

The Department submitted a SPA renewal for the 1915(i) Home and Community-Based Service State Plan Benefit. CMS approved the State Plan for a five-year term effective October 1, 2021, through September 30, 2026.

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.

The Department submitted DR SPA 21-0031 to implement a rate increase for minimum wage that is pending with CMS, and is seeking an effective date of January 1, 2022. **CMS approved the SPA, effective January 1, 2022.**

The Department submitted a SPA 21-0040 to begin implementation of the rate models as described in the 2019 Rate Study. CMS approved the SPA, effective April 1, 2022.

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The Department submitted a DR SPA 22-0037 for a temporary modification of the service scope for selected services in response to the public health emergency. This DR SPA requests a retro-effective date of September 1, 2020.

The Department is anticipating submitting a DR SPA 22-0038 to add Self-Directed Services and Technology Services, as well as the increase to incentive payments for Prevocational and Supported Employment Services. This SPA will request a retro-effective date of July 1, 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 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.

HOME AND COMMUNITY BASED SERVICES

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,~~ **On January 7, 2022, CMS approved the amendment with a retroactive implementation date of July 1, 2021.** 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.~~ **As of June 2022, approximately 1,600 slots have been released for transitioning individuals for placement into the Program.**

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.

HOME AND COMMUNITY BASED SERVICES

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 an 1115 waiver called the California Medi-Cal 2020 Demonstration, which was approved on December 30, 2015, for five years. CBAS continued 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. On December 29, 2021, the Department received approval of the new CalAIM Section 1115 demonstration waiver. This new waiver period is January 1, 2022 through December 31, 2026 and maintains the CBAS benefit.

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 ~~March 31~~ **September 30, 2022, at which point CBAS will return to full congregate in-person service delivery.**

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. **CBAS ERS will be available beginning October 1, 2022.**

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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 was subject to suspension on June 30, 2021. 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 **third** 90-day temporary extension of the current waiver that was set to expire December 31, 2021. The temporary extension expires ~~March 31~~ **September 30**, 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.

Medi-Cal Waiver Program (MCWP) (Previously known as the Acquired Immune Deficiency Syndrome (AIDS) Medi-Cal Waiver)

Local agencies, under contract with the California Department of Public Health (CDPH), Office of AIDS, (CDPH/OA) 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

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- 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, on behalf of CDPH, submitted a waiver renewal application for the ~~AIDS Waiver~~ **MCWP** for a new five-year term, effective January 1, 2022, through December 31, 2026. ~~The~~ **In June, the** Department received a **its third** 90-day temporary extension of the current waiver that was set to expire December 31, 2021. ~~The~~ **This** temporary extension expires ~~March 31~~ **September 27, 2022.**

AB 120 (Chapter 22, Statutes of 2017) provides an increase to the AIDS Waiver 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~~ **The Budget Act of 2022** shifted 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.

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The MSSP benefit was scheduled to be carved out from the 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 carved 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.

The Department is soliciting public comment for a future waiver amendment submission proposing the transition of MSSP billing codes to be converted to the National HCPCS codes. This initiative is prospective with a proposed effective date of January 1, 2023.

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

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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 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.

The Department submitted a Waiver Amendment to implement a rate model as described in the 2019 DDS Rate Study. The Waiver Amendment is ~~pending with CMS and is effective on the date of approval~~ **was approved by CMS with an effective date of April 1, 2022.**

The Department submitted an Appendix K to implement a rate increase for minimum wage that is ~~pending with CMS, and is seeking~~ **was approved by CMS with** an effective date of January 1, 2022.

The Department is anticipating submitting an Appendix K to increase incentive payments which will be paid to service providers of Supported Employment (Individual) and Prevocational Services. The Department will request a retro-effective date of July 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

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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 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

HOME AND COMMUNITY BASED SERVICES

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 April 18, 2018, the federal Medicaid Services Investment and Accountability Act of 2019 was signed into law and appropriated additional federal funding for CMS to allocate state grantees for FY 2019-20.

On January 24, 2019, the Medicaid Extenders Act of 2019 was signed and authorized MFP state grantees to continue to transition eligibles through December 31, 2019, using available MFP funding. The Extenders Act provided CMS with the authority to allocate new funding to state grantees for calendar year 2019, to allow funding appropriated through the Extenders Act to be spent through 2023.

On August 6, 2019, the Sustaining Excellence in Medicaid Act of 2019 was signed and appropriated additional federal funds for allocation to MFP state grantees.

On December 20, 2019, the Further Consolidated Appropriations Act, 2020 amended the DRA of 2005 to extended the term of the MFP grant by five months, from January 1, 2020, to May 22, 2020.

On March 18, 2020, the Families First Coronavirus Response Act (FFCRA) was enacted. Section 6008 of the FFCRA provides a temporary 6.2% Federal Medical Assistance Percentage (FMAP) increase to MFP services under Section 1905(b) of the Social Security Act. The increase is being applied retroactively beginning January 1, 2020, and extends through the last day of the calendar quarter in which the COVID-19 public health emergency period, including any extensions, terminates.

On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security Act extended the term of the MFP grant from May 22, 2020, to November 30, 2020.

On 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 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. 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. **The Department selected Mathematica as its contractor to perform the Gap Analysis and prepare the**

HOME AND COMMUNITY BASED SERVICES

Multi-year Roadmap. The Department finalized the contract on October 6, 2022, with a retroactive start date of September 1, 2022.

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, effective January 26, 2021, the 90 day minimum stay requirement was reduced to 60 days.

In April 2022, CMS issued a Memorandum to state grantees to announce a change to the FFP available for MFP supplemental services as well as the types of allowable services. Effective January 1, 2022, CMS-approved supplemental services will be fully covered by MFP grant funds at a federal reimbursement rate of 100%. The projected implementation date of CCT supplemental services is in the Spring of 2023.

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.

On July 27, 2021, AB 133 was approved by the Governor and chaptered by the Secretary of State. Approval of AB 133 allowed for the roll out of a state-funded, California Community Transitions (CCT)-like program. AB 133 aligns state statute with the amended federal statute, by reducing the required period of residence in an inpatient facility from 90 days to 60 days. The State-funded, CCT-like program allows CCT Lead Organizations to provide transition services to Medi-Cal beneficiaries who have not yet met the federal, MFP residency eligibility criteria, as a way to help reduce the amount of time beneficiaries are required to remain in an institution during the COVID-19 PHE.

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

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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.

1115 WAIVER-MH/UCD, BTR, MEDI-CAL 2020, AND CALAIM 1915(b) WAIVER

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 approved a one-year extension. ~~of~~ The Medi-Cal 2020 waiver, **ended on** to December 31, 2021.

The CalAIM Section 1115 Demonstration, for the service period of January 1, 2022, through December 31, 2026, has been approved by CMS. In addition, the CalAIM Section 1915(b) Demonstration was also approved for the same January 1, 2022, through December 31, 2026, service period. Together, the CalAIM Section 1115 and the 1915(b) waivers, along with State Plan Amendments approved by CMS, move tested initiatives from prior federal waivers to statewide rollout, benefiting all Medi-Cal enrollees. **More information about CalAIM impacts is included in the CalAIM section later in this document.**

With the 1115 and 1915(b) waiver renewals, nearly all elements of the Medi-Cal managed care, SMHS, dental managed care, and the DMC-ODS delivery systems are streamlined to a single authority under the CalAIM Section 1915(b) Waiver. **See the Department's website for more information about the CalAIM waivers:** <https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx>.

~~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.~~

~~The Global Payment Program (GPP) is renewed in CalAIM and includes initial federal funding of \$14.5 billion over the five years, January 1, 2022, through December 31, 2026. A key change to the GPP is the incorporation of equity-enhancing services.~~

~~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~~

1115 WAIVER-MH/UCD, BTR, MEDI-CAL 2020, AND CALAIM 1915(b) WAIVER

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) ended June 30, 2020 (PY 5). On October 9, 2020, the Department 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 programs are separate and distinct from the previous PRIME program. The goal of the programs is to enable hospitals to continue quality improvement efforts that have been underway at all 52 PRIME entities after PRIME expired on June 30, 2020. This transition will promote value-based purchasing and ties funding to quality outcomes. Additionally, the Department 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.

- Global Payment Program (GPP) – The GPP aims to support lower cost, efficient, and equitable health care services to the uninsured population in California. California's GPP is funded through a combination of: (1) a portion of the state's annual Disproportionate Share Hospital (DSH) allotment and (2) its Uncompensated Care (UC) Pool funding for value-based payments to participating California Public Health Care Systems (PCHS) providing care for California's uninsured. These payments support efforts to provide services for the uninsured, promote the delivery of higher-value care, and incentivize more appropriate and cost-effective care. GPP will be adding new services that may facilitate addressing health disparities for the uninsured population, as well as align GPP service offerings with those available to Medicaid beneficiaries. Such alignment of services across populations may facilitate addressing health disparities. 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 included opportunities for improvements in the Medi-Cal Dental Program. The DTI provided incentive payments to Medi-Cal dental providers who met 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 was available under DTI. The non-federal share for DTI was funded through State General Fund savings achieved through limited continuation of Designated State Health Program (DSHP) funding.

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As part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, DTI sunset on December 31, 2021.

- ~~Whole Person Care (WPC) Pilots—Another innovative component of Medi-Cal 2020 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

Managed care capitation rates paid to Medi-Cal managed care plans are developed to provide for the reasonable, appropriate, and attainable projected costs under the plan's contract. 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 **rating** category of aid (COA). Actuaries review the base data for reasonableness and make adjustments to ~~add or remove costs for~~ **remove identified inefficiencies, inapplicable, and align the base data to the** services ~~or~~ **and** populations that are covered in the future rating period, ~~but not included in the base data.~~

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.

In counties with more than one non-specialty plan, Capitation ~~capitation~~ rates are risk adjusted to better reflect the match of a plan's expected costs to ~~the plan's~~ **their members' health** risk. Capitation rates are risk adjusted for the Child, Adult, 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.~~

Historically, Risk ~~risk~~ adjustment is **has been** performed using the Medicaid ~~RX~~ **Rx** risk adjustment model developed by ~~UC~~ **the University of California,** San Diego. Medicaid ~~RX~~ **Rx** classifies risk by 11 age bands, gender, and 45 disease categories. Each member in the Child, Adult, 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~~ **county-average** rate is then developed for each COA **in a budget-neutral manner** 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~~ **that gives** 75% of **weight to** the ~~county-specific~~ **county-average** rate and 25% of **weight to** 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. ~~For several years, the Department has been exploring a potential transition to reliance on the CDPS+Rx risk adjustment model, which uses both diagnosis and pharmacy data to calculate risk scores.~~ **As of January 2023, the Department will transition toward the CDPS+Rx risk adjustment model, which combines the diagnostic-based Chronic Illness and Disability Payment System (CDPS) model and the pharmacy-based Medicaid Rx model. For more information on CDPS+Rx, see <https://cdps.ucsd.edu/>.**

For the calendar year (CY) 2023 rating period, subject to federal approval, the Department will consider plans' performance on select quality measures to inform adjustments to the 75%/25% blend. In all Two-Plan and Regional Model counties (except San Benito) where a

MANAGED CARE

significant difference in quality performance between the two plans is observed, the blend will be adjusted in the direction that is favorable to the higher-performing plan. The weight given to the county-average rate may be reduced to as little as 50% or increase to as much as 100%

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 (**BHT**) for children. **BHT supplemental payments will be discontinued, and associated costs will be captured within base rates, as of the CY 2023 rating period.**

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 2022-23.

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 was 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.

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 "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.

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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 managed care plans’ 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~~ **provided** procurement information and a sample of the updated and restructured MCP Contract. The RFP process ~~will be~~ **was** used to procure commercial health plans in the following Plan Model types: Two-Plan, Geographic Managed Care (GMC), and Regional Models. The Department released the final RFP on February 9, 2022. ~~Contract awards are anticipated Fall 2022~~ **and announced the intent to award contracts to selected managed care plans on August 25, 2022. On December 30, 2022, the Department cancelled RFP #20-10029 for the Medi-Cal Managed Care Plans and announced an agreement to deliver Medi-Cal services to Medi-Cal managed care members in 21 counties across the state** with an operational start date of January 1, 2024, ~~once MCPs have successfully demonstrated operational readiness.~~

The RFP ~~will~~ **was** not be used to procure the COHS Plans, or Local Initiative Plans in Non-COHS counties, or Plans operating in Single-Plan Model counties. Based on conditional approvals for County Plan Model changes that will be effective January 1, 2024, San Benito County and Mariposa County will join Central California Alliance for Health (CCAH) and Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba Counties will join Partnership Health Plan as part of the COHS Plan model. As with the commercial plans in the Managed Care Procurement, all final County Plans Model changes will have an operational start date of January 1, 2024, contingent on passing all Plan operational readiness activities.

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 Medi-Cal Long-Term Care Reimbursement Act (Article 3.8 of Chapter 7 of Part 3 of Division 9 of Welfare and Institutions Code, beginning with section 14126)** requires 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, e~~Costs specific to one category may not be shifted to another cost category. **Additionally, the budget and authorizing legislation sets maximum annual year-over-year increases.**

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 **95th** 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 **95th** 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.

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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.

Mandates & Quality Assurance Fee. The Department projects the cost of complying with new state or federal mandates and the Quality Assurance Fee (QAF).

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. **Reimbursements are established at the 65th percentile of the group's projected costs.**

~~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. 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.~~

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Adult 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. **The FS/PSA reimbursement rates equal the lesser of the facility's costs as projected by the Department, or the rate based on the class median rates, broken down by ventilator and non-ventilator.**

COVID-19 Impact on LTC Nursing Long-Term Care 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 **long-term care** facilities with rate increase equal to 10 percent of their regular 2019-20 total reimbursement amount:

- Freestanding **Skilled** Nursing Facilities Level-B (**FS/SNF-B**)
- **Skilled** Nursing Facilities Level-A (**SNF-B**)
- Distinct Part **Skilled** Nursing Facilities Level-B (**DP/SNF-B**)
- Freestanding Adult Subacute Facilities (**FSSA**)
- 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 **COVID-19** rate increases are effective March 1, 2020 **For FS/SNF-Bs and FSSAs, the COVID-19 rate increase will continue through December 31, 2023, and For ICF-DDs, rates after the end of the public health emergency (PHE) will be the greater of the annually updated regular rate or the total reimbursement on the last day of the PHE, inclusive of the COVID-19 rate increase. For all other facilities, the COVID-19 rate increase** will continue until the expiration of the public health emergency or national emergency, whichever occurs first **PHE**. Upon this, LTC reimbursements **and thereafter** will revert back to their regular facility-specific levels.

CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM)

CalAIM is a comprehensive set of proposals that ~~collective~~ **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 **Initial** components of CalAIM **launched in the beginning of 2022** ~~are proposed to be implemented during 2021-22 and~~ **the remaining components will go live over the next several** 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 **the Medi-Cal Estimate** at this time, but are described hereafter:

1. Behavioral Health Payment Reform
This assumption has been deleted as this is now a new policy change.

2. **Managed Care Specialty Mental Health Services Carve-Out**

Under CalAIM, the Department is standardizing benefits provided through Medi-Cal managed care plans statewide. With some exceptions, regardless of a beneficiary's county of residence or the plan they are enrolled in, they will have the same set of benefits delivered through their Medi-Cal managed care plan as they would in another county or plan. Effective July 1, 2023, the Specialty Mental Health Services benefits that are currently within the scope of services delivered by Kaiser Permanente in Solano and Sacramento Counties will be carved out and instead provided through the Specialty Mental Health Services delivery system. This will result in a reduction in capitation paid to managed care plans, accounted for the appropriated managed care base policy changes in the Estimate.

3. Updated Criteria for Specialty Mental Health Services

The Department is 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 tools that shall be used to determine the appropriate level of care for mental health services, effective January 1, 2023.

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

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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.

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6. Enhancing CCS Oversight and Monitoring

The California Children's Services (CCS) program provides case management, diagnostic, treatment, and physical and occupational therapy services to children and youth with special health care needs.

CCS beneficiaries are best served when their care is delivered in a standardized and consistent manner across the State. Through the CalAIM initiative, the State shall ensure consistent high quality standard of care, compliant with federal and State guidelines, is provided to all qualified beneficiaries. As part of this initiative, the Department will implement new processes and procedures to provide enhanced monitoring and oversight of all 58 counties to ensure optimal care is provided for this medically fragile population. To implement this enhanced monitoring and oversight, the Department will develop a robust strategic compliance program that includes, but is not limited to review of all current standards and guidelines for the CCS program; development and implementation of auditing tools to assess county operations and compliance; analysis and evaluation of the findings gathered during audits (desk, on-site and/or virtual) to identify gaps and vulnerabilities across counties within 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 conducting provider oversight and providing the necessary medical and dental care for beneficiaries. The Department will also enter into a Memorandum of Understanding with each county that will outline the State and county responsibilities to hold both entities accountable for action/in-action.

After initial deployment of the enhanced monitoring and oversight, the Department will continue to conduct ongoing audits/surveys, be proactive with emerging developments, and monitor trends to ensure high-quality consistent care. The Department will allow sufficient time for counties to implement and adjust to this new structure prior to engaging in any sort of progressive action. 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 and no additional funds will be added to the county budgets.~~

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

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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.

Effective January 1, 2022, the rest of the DMC-ODS ~~transitions~~ **transitioned** from the 1115 Waiver Demonstration to the 1915(b) waiver authority, and corresponding State Plan Amendments (SPA) and Behavioral Health Information Notices, 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.~~

CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM)

10. Enhanced Care Management (ECM) Risk Corridor

Effective January 1, 2022, the Department implemented a new ECM benefit in the Medi-Cal managed care delivery system. Medi-Cal managed care plans in counties without Whole Person Care pilots and/or Health Homes Programs will implement the new ECM benefit on July 1, 2022, for certain mandated populations of focus.

To protect the managed care health plans and the State against excessive gains/losses due to the implementation of ~~these~~ **the new services benefits**, the Department has established a two-sided, symmetrical risk corridor for the CY 2022 rating period, subject to CMS approval. Calculations are anticipated to begin no sooner than January 1, 2024. **A risk corridor will also be in place for the CY 2023 rating period, with calculations starting no sooner than January 1, 2025.**

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 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. 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 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. 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 pandemic (e.g., training the mental and behavioral health workforce using telehealth to deliver services).

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

AMERICAN RESCUE PLAN ACT

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 2022-23:	\$25,319,000 <u>\$27,217,000</u>	ICF-DD Quality Assurance Fee
	\$550,554,000	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	\$8,893,000 <u>\$8,879,000</u>	ICF-DD Transportation/Day Care Quality Assurance Fee
	\$1,419,526,000 <u>\$2,065,534,000</u>	MCO Enrollment Tax (Item 4260-601-3334)
	\$2,618,509,000 <u>\$3,907,533,000</u>	Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
	\$519,000 <u>\$3,382,000</u>	Emergency Medical Air Transportation (EMATA) Fund (Item 4260-101-3168)
	\$82,494,000 <u>\$76,127,000</u>	Medi-Cal Emergency Medical Transport (MEMTF) (Item 4260-601-3323)
	\$1,659,321,000 <u>\$1,603,735,000</u>	Medi-Cal Drug Rebates Fund (Item 4260-601-3331)
	\$6,365,135,000 <u>\$8,242,961,000</u>	Total
FY 2023-24:	<u>\$23,760,000</u>	ICF-DD Quality Assurance Fee
	<u>\$550,554,000</u>	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	<u>\$8,879,000</u>	ICF-DD Transportation/Day Care Quality Assurance Fee
	<u>\$784,450,000</u>	2024 MCO Enrollment Tax (Item 4260-601-3428)
	<u>\$5,005,540,000</u>	Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
	<u>\$329,000</u>	Emergency Medical Air Transportation (EMATA) Fund (Item 4260-101-3168)
	<u>\$51,492,000</u>	Medi-Cal Emergency Medical Transport (MEMTF) (Item 4260-601-3323)
	<u>\$2,075,824,000</u>	Medi-Cal Drug Rebates Fund (Item 4260-601-3331)
	<u>\$8,500,828,000</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.

INFORMATION ONLY

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 Individuals with Unsatisfactory Immigration Status

Section 4 of SB 708 (Chapter 148, Statutes of 1999) reauthorizes state-only funded long-term care for 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 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.

5. 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. 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

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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 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. The Affordable Care Act (ACA) DSH Reduction
This item has been deleted as this item is now a new policy change.
2. 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.

BENEFITS

1. 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.

The Department is ~~proposing to sunset CHDP by July 1, 2023~~ **will be sunseting CHDP effective July 1, 2024. A transition planning process, including key stakeholders, commenced on September 22, 2022. Transition planning will ensure the successful continuity of current CHDP activities beyond July 1, 2024, as well as identify necessary supplemental administrative and fiscal resources necessary to replace the**

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services CHDP currently performs for other programs. 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) **as a standalone program.** On July 1, 2023 **2024**, 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.

2. Palliative Care Services Implementation

SB 1004 (Chapter 574, Statutes of 2014) requires the Department to:

- Establish standards and provide technical assistance for Medi-Cal managed care plans to ensure delivery of palliative care services;
- Establish guidance on the medical conditions and prognoses that render a beneficiary eligible for the palliative care services;
- Develop a palliative care policy that, to the extent practicable, is cost neutral to the General Fund on an ongoing basis;
- Define palliative care services; and
- Provide access to curative care for beneficiaries eligible for palliative care.

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. Best Price
This assumption has been withdrawn; therefore, it has been deleted.

DRUG MEDI-CAL

1. Early Intervention for Beneficiaries Under 21 Years Old

INFORMATION ONLY

The Department 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 DMC-ODS program, effective January 1, 2022. Most substance use disorders start in adolescence, yet the DMC-ODS Waiver did not include any services for adolescents at high risk of developing substance use disorders. Adding this mandatory benefit to the DMC-ODS Waiver 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.

2. Traditional Healers and Natural Helpers

The Department proposes to add Traditional Healers and Natural Helpers as allowable provider types of DMC-ODS services when delivered by DMC-certified Indian Health Care Providers (IHCPs). IHCPs are limited to a health care program operated by the Indian Health Service (IHS), or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). The purpose of this request is to support the Department's focus on advancing health equity and provide culturally appropriate options and improve access to SUD treatment for American Indians and Alaska Natives with SUD. In the CalAIM Section 1115 demonstration renewal request submitted June 30, 2021, DHCS requested that CMS grant expenditure authority as necessary for federal reimbursement for covered DMC-ODS services delivered to DMC-ODS beneficiaries by Natural Helpers and Traditional Healers at DMC-certified IHCPs. CMS did not approve this request as part of their December 29, 2021 CalAIM Section 1115 demonstration approval. This proposal to add Traditional Healers and Natural Helpers is still contingent on CMS approval.

MENTAL HEALTH

1. Short-Term Residential Therapeutic Program/Qualified Residential Treatment Programs

Congress enacted the Family First Prevention Services Act (FFPSA) on February 9, 2018. 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 equivalent to QRTPs. QRTPs may be determined to meet criteria as an Institution for Mental Disease (IMD) in 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 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

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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 required the counties to have mobile services in place no later than six months after January 1, 2021, as long as an extension was requested and approved. All counties complied with the law and had mobile units in place 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 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 16, 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; funding was granted to the Department, and the Department in turn contracted with the Lifeline Call Centers, with Didi Hirsch as lead, to lead a stakeholder process that started on February 1, 2021 and ended on January 31, 2022, with a final report by February 15, 2022. 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.

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- Negative PMS subaccount balances: Pursuant to STC 164 of the Medi-Cal 2020 waiver, negative PMS subaccount balances for federal fiscal year (FFY) 2013 and prior must be resolved by the end of the Medi-Cal 2020 waiver period (December 31, 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 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

INFORMATION ONLY

Demonstration Year (DY) for a five-year total of \$2 billion. This claiming has first priority on the Safety Net Care Pool funds. In addition to the State-Only programs, the Designated Public Hospitals (DPHs) are allowed to voluntarily provide excess CPEs as necessary for the State to claim the full \$400 million.

The DSHP program undergoes a reconciliation to determine expenditures for each DY. Currently DY 8, DY 9, and DY 10 are still undergoing reconciliations. Until the entire Demonstration Period is fully reconciled across all DSHP programs, the State will not be able to estimate the final reconciliation amounts; however, it is anticipated to have a fiscal impact.

MANAGED CARE

1. 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. Aligning Rate Review with the Access Monitoring Review Plan **This assumption is not estimated to have a fiscal impact and has been deleted.**

2. Newborn Screening Program Fee Increase

SB 1095 (Chapter 393, Statutes of 2016) requires the California Department of Public Health (CDPH) Genetic Disease Screening Program (GDSP) to expand statewide newborn screenings to include any disease that is detectable in blood samples as soon as practicable, but no later than two years after the disease is adopted by the Federal Recommended Uniform Screening Panel (RUSP). To comply with Health and Safety Code (HSC) 125001(d), CDPH plans to expand newborn screening to include mucopolysaccharidosis type II (MPS II) and guanidinoacetate methyltransferase (GAMT) deficiency. The impact to Medi-Cal rates is expected no sooner than FY 2024-25 and a fee increase has yet to be determined.

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 determined Los Angeles County's Harbor UCLA Surgery Emergency Replacement project was eligible under the CRRP and proceeded to provide CRRP

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supplemental reimbursement of \$176M in allowable principal, with an effective date of April 1, 2018.

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 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 in FY 2022-23.

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

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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. 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

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granted Plaintiffs leave to amend their complaint. Plaintiffs filed their first amended complaint on May 18, 2018, and the Department demurred on June 20, 2018. On September 21, 2018, the court sustained the Department's demurrer to the first amended complaint but granted Plaintiffs leave to amend. Plaintiffs filed their second amended complaint on October 29, 2018, and the Department demurred on November 30, 2018. On January 31, 2019, the court again sustained the Department's demurrer with leave to amend. On June 21, 2019, the court overruled the Department's demurrer allowing the case to continue to discovery. The Department filed its answer to the third amended complaint on August 30, 2019. Discovery had commenced, but was later stayed under multiple stipulations due to the COVID-19 public health emergency. The stay was lifted on April 9, 2021, and discovery is continuing. - The Department filed a Motion for Judgment on the Pleadings (MJOP) which was heard on December 17, 2021. The parties stipulated to continue the class certification motion deadline until after the MJOP is decided. On March 9, 2022, the court granted the Departments' MJOP with respect to plaintiffs' disparate impact claim, but allowed plaintiffs' other claims to advance. ~~The next case management conference is scheduled for April 26, 2022.~~ **On June 8, 2022, the court of appeal denied plaintiffs' writ petition seeking review of the court's dismissals of the disparate impact claim. On June 29, 2022, plaintiffs filed a request for dismissal of their disparate treatment, substantive due process, and derivative claims, and the court entered judgment dismissing those claims without prejudice on the same day. Plaintiffs sought dismissal as they now intend to seek appellate review of the court's rulings as to their disparate impact theories.**

On December 11, 2017, another lawsuit (Deuschel) was filed by an individual plaintiff against the Department, CHHS, and the Department of Social Services making similar discrimination allegations as the class action suit, though the allegations are based on disability status. Plaintiff seeks injunctive relief and writ of mandate requiring the Department to increase Medi-Cal rates and to monitor and enforce network adequacy and timely access, as well as compensatory damages. The Department filed a demurrer on February 9, 2018. Plaintiff filed an amended complaint on September 18, 2018. The Department filed its demurrer to the amended complaint on November 9, 2018. The court has since issued multiple continuances, and the entire case was stayed until January 24, 2021. - On October 14, 2021, the court ruled in favor of the Department, granting the demurrer and dismissing the plaintiff's complaint without leave to amend.

3. 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

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Blue Shield, and Health Net actions have all been formally stayed after being designated related cases to Myers.

4. Shield California Health Care Center, Inc. v. Department of Health Care Services

~~The lawsuit was filed in Los Angeles County Superior Court on May 22, 2018. Plaintiff seeks to enjoin the Department from recouping overpayments made to Plaintiff for medical supplies furnished to Medi-Cal patients between June 1, 2011, and October 24, 2013. The overpayments were the result of a since-lifted injunction on the ten percent Medi-Cal payment reductions made pursuant to Assembly Bill (AB) 97 (Chapter 3, Statutes 2011; codified at Welf. & Inst. Code § 14015.192). Plaintiff asserts that the Department unreasonably delayed the retroactive recoupment. Plaintiff asserts that the doctrine of laches should be applied to invalidate the Department's continuing recoupment of the AB 97 overpayments. The Department's demurrer was denied November 1, 2018, and its answer was filed on November 12, 2018. 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.~~

5. 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. The latest mediation session occurred on December 9, 2021. On March 15, 2022, plaintiffs filed to dismiss their remaining claims in this lawsuit without prejudice, subject to the Department providing at least thirty days' notice before it resumes retroactive recoupments at any point through the end of the 2021-22 regular legislative session. **The 2022 Budget Act authorized the Department to forego recoupment against certain independent pharmacies for overpayments associated with the April 1, 2017 through February 22, 2019 service period.**

6. 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

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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 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. 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. On December 15, 2021, the appellate commissioner awarded an additional \$2.37 million related to the fee appeal. On December 28, 2021, attorney Friedman filed a request for additional appellate fees and pre- and post-judgment interest, which is pending with the Ninth Circuit. **On May 17, 2022, the Ninth Circuit denied the request for additional fees and interest as untimely. The final judgment relating to attorney Friedman's awarded fees was entered on June 7, 2022.** The total amount of fees and costs awarded to date to attorney Friedman (approximately \$10.563 million) is now **was** displayed in the Lawsuits/Claims policy change in this Estimate **the 2022 May Revise Local Assistance Medi-Cal Estimate. After receiving payment in June 2022, attorney Friedman filed a motion with the district court requesting approximately \$20,000 in additional costs, which remains pending. The Department filed its objection to this motion for additional costs on July 29, 2022.**

7. 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

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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.

8. 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. On October 27, 2021, the court denied the Department's Motion for Summary Judgement, and the Department appealed. The class certification hearing date is scheduled for ~~May 18, 2022, but the parties will determine whether a further stay is merited in January~~ **November 16, 2022**. No trial date has been set, and discovery is ongoing.

9. 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

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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.

On December 29, 2021, the federal Centers for Medicare and Medicaid Services (CMS) announced its approval of the State’s CalAIM Section 1915(b) waiver, including the transition of pharmacy coverage from managed care to the fee-for-service delivery system. As a result, on December 30, 2021, plaintiffs filed an amended complaint against both the Department and CMS seeking to enjoin the Medi-Cal Rx transition. On January 10, 2022, the court denied Plaintiffs’ motion for a temporary restraining order. The Department filed a motion to dismiss on February 8, 2022, and a hearing has been scheduled for May 3, 2022. **No hearing on the Department’s motion was held and the parties await the court’s ruling.**

10. **AHMC Anaheim Regional Medical Center, et al. v. DHCS, et al.**

On April 13, 2022, 31 California hospitals filed a petition for writ of mandate under California Code of Civil Procedure section 1085 challenging the Department’s payments to hospitals for inpatient services under the All Patients Refined Diagnosis Related Groups (APR-DRG) methodology. Under APR-DRG, some hospitals receive cost outlier payments, which are add-on payments to the APR-DRG base payment for hospital stays that are exceptionally expensive. Petitioners assert that the Department failed to follow procedural requirements prior to implementing this methodology, exceeded statutory authority and failed to ensure the APR-DRG program, including outlier payments, remained budget neutral. Prior to filing their writ petition, Petitioners filed approximately 30 administrative appeals with the Department’s Office of Administrative Hearings and Appeals (OAHA) wherein they disputed the Department’s implementation of APR-DRG and the outlier policy.

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Appeals that reached the formal appeal level were dismissed by OAH for lack of jurisdiction or withdrawn by the Petitioners. On May 24, 2022, petitioners filed an Amended Verified Writ Petition and Complaint adding an allegation that the challenged policy is arbitrary and capricious.

11. 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.

12. Audit of California Department of Health Care System's Medicaid Capitation Payments (A-04-21-07097)

The Office of Inspector General (OIG) is conducting an audit to determine whether California's Department of Health Care systems (State agency) made unallowable capitation payments on behalf of beneficiaries with multiple Client Index Numbers (CINs). The audit period covered Medicaid capitation payments made from July 1, 2015, to June 30, 2019, for beneficiaries who may have been assigned more than one CIN. The sample population consisted of 100 beneficiaries. The total estimated capitation payments claimed is \$31,445,148, of which the federal share is \$15,722,587.

OIG held an exit conference with the Department on May 13, 2022, in which OIG recommended the Department refund the Federal Government for the incorrectly claimed Medicaid capitation payments total of \$15,722,587. Additionally, OIG recommended the Department identify other unallowable portions of federal reimbursement which were not included in OIG's audit period. OIG has not yet issued the draft audit report but expects to do so by September 2022. Further, Program has not indicated whether the Department will agree with the amount or whether any concerns exist with the calculation or methodology used to determine the amount. Internal Audits will revisit the potential payment once the draft report is issued.

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

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of facilities to not exceed a reasonable estimate of the amount that would be paid for the services furnished by the category of facilities under Medicare payment principles. Payments cannot exceed the UPL for each of the three hospital categories.

2. Accrual Costs Under Generally Accepted Accounting Principles

Medi-Cal has been on a cash basis for budgeting and accounting since FY 2004-05. On a cash basis, expenditures are budgeted and accounted for based on the fiscal year in which payments are made, regardless of when the services were provided. On an accrual basis, expenditures are budgeted and accounted for based on the fiscal year in which the services are rendered, regardless of when the payments are made. Under Generally Accepted Accounting Principles (GAAP), the state's fiscal year-end financial statements must include an estimate of the amount the state is obligated to pay for services provided but not yet paid. This can be thought of as the additional amount that would have to be budgeted in the next fiscal year if the Medi-Cal program were to be switched to an accrual basis.

3. Refund of Recovery

CMS requested the Department prepare reconciliations of grant awards vs. federal draws for all fiscal years. The Department determined FFP was overpaid on some 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. 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

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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. Vital Records**

The Department has 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 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, CDSS, the California Department of Developmental Services (CDDS), the California Department of Aging (CDA), and the California Department of Public Health (CDPH).

States must require EVV use for all Medicaid-funded PCS by January 1, 2020, and HHCS by January 1, 2023. Otherwise, a state is subject to incremental Federal Medical Assistance Percentage (FMAP) reductions from 0.25% and up to 1%. The Centers for Medicare and Medicaid Services (CMS) approved California's request for a one-year good faith exemption for PCS on October 22, 2019. As a result of the exemption, California will not be subject to FMAP reductions in 2020 for PCS, however they will be subject to incremental FMAP reductions beginning with 0.5% starting January 1, 2021. Federal penalties for not complying with EVV requirements increase each calendar year by 0.25 percentage points to a maximum of one percent in 2023 for PCS. There is a similar penalty for HHCS if EVV for HHCS is not implemented by January 1, 2023.

~~While the~~ **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 **which** will require extensive multi-agency planning, collaboration, and coordination. The Department is collaborating with CDSS, DDS, CDPH, and CDA to develop, **implement, and manage** a cross-department EVV solution that meets federal requirements.

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The State is implementing two EVV systems, known as EVV Phase I (CMIPS) and EVV Phase II (CalEVV). EVV Phase I is being implemented via the existing Case Management Information Payrolling System for PCS with a self-directed model and primarily impacts self-directed In-Home Supportive Services and Waiver Personal Care Services. The projected date for EVV Phase I implementation is ~~July 1, 2022~~ **January 1, 2023**. EVV Phase II ~~is on track to be~~ **was** implemented by ~~on~~ January 1, 2022 via a new California Electronic Visit Verification (CalEVV) solution for PCS with an agency model. This model includes Medicaid waiver programs administered by the Department, DDS, CDA, and CDPH.

After the initial go-live of CalEVV by January 1, 2022, the ~~The~~ EVV Phase II project will implement **is now focused on implementing the** EVV requirements for Home Health Care Services (HHCS) by January 1, 2023.

FISCAL INTERMEDIARY: MEDICAL

1. ~~No additional information.~~ **Medi-Cal Non Medi-Cal Transportation**

In response to AB 2394 (Chapter 615, Statutes of 2016), the Department developed a multi-phase plan to implement enhancements in four categories as follows: 1) Implementation of a dedicated call line for Non Medi-Cal Transportation (NMT) ride fulfillment, expanding access to NMT services, 2) Focus on continuous business process improvement; including, but not limited to, Customer Relationship Management solution and a web-based ride fulfillment option, 3) Expanding NMT provider coverage by integrating Transportation Network Companies (TNC) (such as Lyft/Uber) previously not permitted as NMT providers and 4) Creation of a beneficiary reimbursement technical solution.

The beneficiary reimbursement technical solution enhancement is not yet implemented. It is specific to the Department's strategy to reimburse beneficiaries for mileage, mass transit, and other approved modalities. The Department negotiated and signed an Interagency Agreement with the State Controller's Office (SCO) to enable the transfer of beneficiary reimbursement files to the SCO for payment.

The Department recommends an Enterprise solution that meets the needs of other Departmental programs and the NMT beneficiary reimbursement. Upon the identification of an Enterprise approach, the Department will begin requisite planning and implementation activities for the creation of a beneficiary reimbursement technical solution.

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

1. No additional information.

FISCAL INTERMEDIARY: DENTAL

1. State Controller's Office Interagency Agreement

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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.

2. Fiscal Intermediary-Dental Business Operations (FI-DBO) Takeover

~~The Department solicited vendor proposals via Request for Proposal (RFP) 20-10354 for FI-DBO services, including claim and Treatment Authorization Request (TAR) adjudication, Customer Service Center (CSC) operations, and member and provider outreach for the Medi-Cal Dental Program.~~

~~The Department anticipates the resulting FI-DBO Contract Effective Date (CED) to be approximately October 1, 2022. FI-DBO Takeover facilitates the orderly transition of business services from the incumbent Dental Administrative Services Organization (ASO) Contract 16-93287 and coordinates the services going between the existing Dental FI contractor and the FI-DBO contractor, as approved by the Department. The cost and timing of Takeover payments will not be known until an FI-DBO contract is awarded.~~

DISCONTINUED POLICY CHANGES

Fully Incorporated into Base Data/Ongoing

ELIGIBILITY

PC 3 FPL Increase for Aged and Disabled Persons
PC 4 Undocumented Older Californians Expansion
PC 6 Undocumented Young Adults Full Scope Expansion
PC 8 Medi-Cal County Inmate Programs
PC 17 CDCR Retro Repayment

AFFORDABLE CARE ACT

Not applicable.

BENEFITS

PC 231 Tribal Federally Qualified Health Center

HOME & COMMUNITY-BASED SERVICES

PC 180 Prop 56 – AIDS Waiver Rate Increase
PC 114 MSSP Carve-out of CCI

BREAST AND CERVICAL CANCER

Not applicable.

PHARMACY

PC 54 Medi-Cal Rx – Managed Care Pharmacy Benefit to FFS
PC 60 Medi-Cal Rx – Additional Savings from MAIC in FFS

DRUG MEDI-CAL

PC 69 Drug Medi-Cal MAT Benefit

MENTAL HEALTH

Not applicable.

1115 WAIVER—MH/UCD & BTR

Not applicable.

MANAGED CARE

PC 122 Managed Care Efficiencies
PC 85 Medi-Cal 2020 Whole Person Care Pilots

PROVIDER RATES

PC 138 Prop 56 – Pediatric Day Health Care Rate Increase
PC 139 Prop 56 – Home Health Rate Increase

DISCONTINUED POLICY CHANGES

Fully Incorporated into Base Data/Ongoing

SUPPLEMENTAL PAYMENTS

PC 164 Prop 56 – Developmental Screenings
PC 166 Prop 56 – Adverse Childhood Experiences Screenings
PC 168 Prop 56 – CBAS Supplemental Payments
PC 171 Prop 56 – ICF/DD Supplemental Payments
PC 177 Prop 56 – FS-PSA Supplemental Payments
PC 178 Prop 56 – NEMT Supplemental Payments

COVID-19

PC 187 COVID-19 FFS DME Respiratory Rates

OTHER: AUDITS AND LAWSUITS

Not applicable.

OTHER: REIMBURSEMENTS

Not applicable.

OTHER: RECOVERIES

Not applicable.

OTHER: MISCELLANEOUS

PC 233 HPSM Dental Integration Pilot Program

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 13 Disabled Adult Children Program Cleanup
PC 24 CHIP Premiums
PC 274 Premiums Reduction

AFFORDABLE CARE ACT

Not applicable.

BENEFITS

Not applicable.

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 89 Medi-Cal 2020 Designated State Health Program
PC 91 MH/UCD Safety Net Care Pool
PC 183 Designated Public Hospital Direct Grants

MANAGED CARE

PC 107 Health Homes for Patients with Complex Needs
PC 111 San Mateo Health Plan Reimbursement

PROVIDER RATES

Not applicable.

SUPPLEMENTAL PAYMENTS

Not applicable.

COVID-19

Not applicable.

DISCONTINUED POLICY CHANGES

Time Limited/No Longer Available

STATE ONLY CLAIMING

Not applicable.

OTHER: AUDITS AND LAWSUITS

Not applicable.

OTHER: REIMBURSEMENTS

Not applicable.

OTHER: RECOVERIES

Not applicable.

OTHER: MISCELLANEOUS

OA 43 LTSS Actuarial Study
PC 217 Kedren Community Health & Acute Psychiatric Hosp.
PC 221 Alameda Wellness Campus
PC 229 MLK Jr. Hospital Improvement
PC 230 ARRA HITECH – Provider Payments

FISCAL INTERMEDIARY: MEDICAL

OA 34 Medi-Cal Nonmedical Transportation

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

Not applicable.

FISCAL INTERMEDIARY: DENTAL

Not applicable.

DISCONTINUED POLICY CHANGES

Withdrawn

ELIGIBILITY

Not applicable.

AFFORDABLE CARE ACT

PC 30 Payments to Primary Care Physicians

BENEFITS

Not applicable.

HOME & COMMUNITY-BASED SERVICES

Not applicable.

BREAST AND CERVICAL CANCER

Not applicable.

PHARMACY

Not applicable.

DRUG MEDI-CAL

Not applicable.

MENTAL HEALTH

OA 91 Crisis Continuum of Care

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

PC 240 Audit Settlements

OTHER: REIMBURSEMENTS

Not applicable.

DISCONTINUED POLICY CHANGES

Withdrawn

OTHER: RECOVERIES

Not applicable.

OTHER: MISCELLANEOUS

PC 197 Section 19.56 Legislative Priorities

FISCAL INTERMEDIARY: MEDICAL

PC 180 End-of-FY 2 Week Checkwrite Hold Buyback

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

Not applicable.

FISCAL INTERMEDIARY: DENTAL

Not applicable.