

2017-18 Governor's Budget

Highlights

Department of Health Care Services



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CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES PROGRAM OVERVIEW

The California Department of Health Care Services' (DHCS) mission is to provide Californians with access to affordable, high-quality health care including medical, dental, mental health, substance use treatment services, and long-term care. Our vision is to preserve and improve the physical and mental health of all Californians.

DHCS helps ensure that Californians have access to quality health care services that are delivered effectively and efficiently. Its programs integrate all spectrums of care primarily via Medi-Cal, California's Medicaid program. Medi-Cal is a federal/state partnership providing comprehensive health care to individuals and families who meet defined eligibility requirements. Medi-Cal coordinates and directs the delivery of important services to approximately 14 million Californians. On January 1, 2014, California implemented the Medi-Cal expansion which extended eligibility to adults without children and parent and caretaker relatives with incomes up to 138 percent of the federal poverty level. This expansion and other increases in enrollment since 2013 have increased Medi-Cal enrollment by 5 million individuals.

In addition to Medi-Cal, the Department offers programs to special populations:

- Low-income and seriously ill children and adults with specific genetic diseases. The various programs include the Genetically Handicapped Persons Program, California Children's Services Program, and Newborn Hearing Screening Program.
- Californians in rural areas and underserved populations including Indian Health, the Rural Health Services Development Program, the Seasonal Agricultural and Migratory Workers Program, the State Office of Rural Health (CalSORH), the Medicare Rural Hospital Flexibility Program / Critical Access Hospital Program, the Small Rural Hospital Improvement Program, and the J-1 Visa Waiver Program.
- Community mental health services and substance use disorder services funded by federal block grants, the Mental Health Services Act and other funding;
- Public health prevention and treatment programs. These services are provided via the Every Woman Counts Program, the Prostate Cancer Treatment Program and the Family Planning, Access, Care, and Treatment (FPACT) Program.

GENERAL BUDGET OVERVIEW

The budget for DHCS supports actions and vital services that reinforce the State’s commitment to protect and improve the health of all Californians. For Fiscal Year (FY) 2017-18, the Governor’s Budget presents a total of \$105.3 billion for the support of DHCS programs and services. Of that amount, \$629 million funds state operations, while \$104.6 billion supports local assistance. The proposed budget affirms the State’s commitment to address the health care needs of Californians while operating within a responsible budgetary structure.

Total DHCS Budget

(includes non-Budget Act appropriations)

Governor’s Budget Fund Source	2016-17 Approved Budget	2016-17 Revised Budget	2017-18 Proposed Budget
General Fund (GF)	\$18,224,198	\$20,142,758	\$19,613,704
Federal Funds (FF)	\$58,462,274	\$67,508,369	\$67,443,202
Special Funds & Reimbursements	\$16,299,047	\$15,222,963	\$18,208,259
Total Funds	\$92,985,519	\$102,874,090	\$105,265,165

*Dollars in thousands

State Operations

State Operations by Fund Source *			
Governor’s Budget Fund Source	2016-17 Approved Budget	2016-17 Revised Budget	2017-18 Proposed Budget
General Fund	\$201,171	\$203,591	\$202,958
Federal Funds	\$371,423	\$374,560	\$373,879
Special Funds & Reimbursements	\$56,140	\$59,638	\$52,232
Total State Operations	\$628,734	\$637,789	\$629,069

*Dollars in thousands

Local Assistance

Local Assistance by Fund Source *			
Governor’s Budget Fund Source	2016-17 Approved Budget	2016-17 Revised Budget	2017-18 Proposed Budget
General Fund	\$18,023,027	\$19,939,167	\$19,410,746
Federal Fund	\$58,090,851	\$67,133,809	\$67,069,323
Special Funds & Reimbursements	\$16,242,907	\$15,163,325	\$18,156,027
Total Local Assistance	\$92,356,785	\$102,236,301	\$104,636,096

*Dollars in thousands

MAJOR POLICY PROPOSALS AND DEPARTMENT PRIORITIES

Coordinated Care Initiative (CCI)

The CCI consists of three core components operating in seven counties: Cal MediConnect allows persons eligible for both Medicare and Medi-Cal (dual eligibles) to receive medical, behavioral health, long-term services and supports, and home and community-based services coordinated through a single health plan; the integration of Medi-Cal funded long-term services and supports into managed care and the mandatory enrollment for most other dual eligibles into Medi-Cal managed care. In addition, as part of CCI, the State assumed bargaining responsibilities for In-Home Supportive Services (IHSS) in these seven counties and included a new maintenance-of-effort requirement in place of the traditional county share of cost for the IHSS program for all counties.

As discussed in the Governor's Budget, the implementing statute for CCI contained a provision requiring the Department of Finance to determine if CCI is cost effective each January, and if not, the program would be discontinued the following year. The Budget estimates that CCI will not be cost effective, thereby triggering the "poison pill" and ceasing all statutory provisions related to CCI.

Although CCI was not found to be cost-effective in its entirety, the duals demonstration program has shown the potential to improve the care and quality for those enrolled and help to keep individuals in their homes and community, thereby leading to likely long term cost reductions. Therefore, based on the lessons learned from CCI, the Budget proposes to extend the Cal MediConnect program, continue mandatory enrollment of dual eligibles, and continue to integrate long-term services and supports (except IHSS) into managed care. Although the funding for IHSS will no longer be included in the capitation rates, plans and counties are encouraged to collaborate on care coordination. These three components are proposed to be extended for an additional two years in alignment with the currently offered extension of the Cal MediConnect program from CMS. In addition to the removal of IHSS funding from the capitation rates, the Department, in conjunction with our partner departments of Social Services and Aging, proposes to further delay the full transition of the MSSP waiver into managed care plans for another two years as well as continue to refine the purpose and intent of the universal assessment tool.

New Qualified Immigrants (NQI) Affordability and Benefits Wrap Program

Current law authorizes the transitioning of coverage of NQI adults without children from Medi-Cal to a Qualified Health Plan in the Health Benefit Exchange, with the Department providing premium and out-of-pocket payment assistance and wraparound benefits not covered by the Exchange plan. Because the state-only Medi-Cal program is not formally certified as meeting the minimum essential coverage requirements under the ACA, the adults continuing in state only Medi-Cal may be subject to a tax penalty from the federal government. To mitigate this issue, the Budget proposes that all new qualified immigrant adults that are not pregnant or Medicare-eligible be included in the wrap program effective January 1, 2018. In addition, the Department is proposing statutory changes to align the income thresholds with the Exchange requirements for those who will be eligible for the wrap.

San Francisco Community Living Support Benefit Waiver

The San Francisco Community Living Support Benefit (SF CLSB) Waiver assists eligible individuals to move into available community settings and to exercise increased control and independence over their lives. The Waiver is administered by the City and County of San Francisco, Department of Public Health (SF DPH). SF DPH has notified the Department that it has decided to not renew the Waiver after it expires on June 30, 2017. In order to continue to support beneficiaries in community-based housing, the Department is proposing to transition the participants into the Assisted Living Waiver (ALW) through a limited expansion of the ALW into San Francisco. This expansion will provide for sufficient Waiver slots for those in the SF CLSB and an equivalent number of ALW enrollments from institutional providers within San Francisco.

Nursing Facility/Acute Hospital Transition (NF/AH) and Diversion Waiver Transformation

The Department proposes statutory provisions to align with the NF/AH Waiver renewal proposal developed and released in 2016 and currently under review with CMS. As contained in the Waiver renewal application, these enhancements include the following:

- Implementing local comprehensive care management through one or more “Case Management Contractors”
- Moving to an aggregate cost limit and cost neutrality calculation
- Expanding the number of waiver slots by 5,000
- Implementing a new enrollment standard that at least 60% of enrollments will be from institutional settings
- Transitioning In-Home Operations (IHO) Waiver beneficiaries to the NF/AH Waiver

Elimination of State-Only Eligibility for Child Health and Disability Prevention (CHDP) Services

This Department is proposing to repeal the statutory provisions for eligibility for the state-only CHDP program services. Due to the expansion of full scope benefits to all children under SB 75, CHDP state-only services are no longer needed as these services are now provided by Medi-Cal.

Major Risk Medical Insurance Fund Abolishment

The Major Risk Medical Insurance Fund currently funds expenses related to the Major Risk Medical Insurance Program, which was originally established as a state high-risk pool. The ACA has reduced the need for the high-risk pool because individuals cannot be denied coverage based on a pre-existing health condition. The Budget abolishes the Major Risk Medical Insurance Fund and proposes to transfer the fund balance to the newly established Health Care Services Plans Fines and Penalties Fund. This new fund will support coverage for individuals remaining in the Program and expenses related to health care services for children, seniors, persons with disabilities, and dual eligibles in the Medi-Cal program.

Alternative Birthing Center (ABC) Reimbursement Methodology

The Department proposes to align reimbursement for ABC services with current methodologies for hospital reimbursement. Current statute sets ABC reimbursement based on contracted inpatient hospital rates that have been discontinued since 2013. Under this proposal, ABC rates would instead be based on the current hospital reimbursement methodology which uses Diagnosis Related Groups (DRG).

340B Drug Billing Requirements

The Department proposes clarifying statutory provisions related to the use of and reimbursement for drugs purchased under the 340B program in Medi-Cal. Existing statute requires 340B entities that provide drugs to Medi-Cal beneficiaries to use only drugs purchased under the 340B program and bill at their actual 340B acquisition cost plus any applicable dispensing fee. The Department is proposing clarifying language that explicitly applies these requirements to both Medi-Cal FFS and Medi-Cal managed care.

DHCS Priorities

Given the challenging budget environment and the multitude of new programs, federal regulations and other efforts, the Department must prioritize certain initiatives and delay others. The Department must prioritize the implementation of the various federal regulations that continue to be resource-intensive, such as the Medicaid managed care, Medicaid mental health parity, and home and community based services regulations. In addition, the Department also must prioritize the ongoing stability of our programs and the necessary day-to-day work that enables Medi-Cal and our other programs to operate effectively and serve our beneficiaries.

The Department has specifically identified initiatives that must be delayed, as noted below, and will continue to evaluate priorities to most effectively and efficiently operate our programs. In some instances, the Department is proposing specific statutory delays, when necessary, to align the timelines in statute with when the Department will be able to implement. The initiatives that the Department notes must be delayed are:

- Implementation of the Whole Child Model for CCS in COHS counties (SB 586) to no sooner than July 1, 2018
- Implementation of the palliative care program (SB1004) to no sooner than July 1, 2018
- Implementation of the inclusion of marriage and family therapists as billable FQHC providers to (AB 1863) no sooner than July 1, 2018
- Implementation of the FQHC alternative payment methodology pilot to no sooner than January 1, 2018
- Issuance of regulations for out-of-county foster care presumptive transfer (AB 1299) to July 1, 2020
- Issuance of evaluation report for Assisted Outpatient Treatment (AB 59) to no sooner than July 1, 2018

BUDGET ADJUSTMENTS

Budget Change Proposals

The Governor's Budget proposes the establishment of 53.0 new positions, including the conversion of 18.0 existing limited-term positions to permanent.

4260-003-BCP-2017-GB: Ground Emergency Medical Transportation (GEMT) Supplemental Payment Program Audits

Other Fund:	\$196,000
Federal Fund:	\$197,000
TOTAL:	\$393,000

(Conversion of 3.0 limited-term positions to permanent)

DHCS, Audits and Investigations (A&I), requests to convert 3.0 three-year limited-term (LT) positions to permanent full-time positions to perform mandatory audits on local Fire Districts and Ground Emergency Medical Transportation (GEMT) providers throughout California that receive supplemental payments for GEMT services authorized by Assembly Bill (AB) 678 (Chapter 397, Statutes of 2011). AB 678 allows for annual supplemental payments to GEMT providers to help offset the cost of providing emergency medical transports.

4260-005-BCP-2017-GB: AB 959 Public Clinic Supplemental Reimbursement Audit Workload Extension

Other Fund:	\$697,000
Federal Fund:	\$697,000
TOTAL:	\$1,394,000

(Two-year expenditure authority for the extension of an equivalent 10.0 positions)

DHCS, Audits and Investigations (A&I), Office of Legal Services (OLS), and Office of Administrative Hearings and Appeals (OAHA) request extension of limited-term resources for two years to address ongoing workload related to Assembly Bill (AB) 959 (Frommer, Chapter 162, Statutes of 2006). Specifically, the new workload stems from AB 959's expansion of California Welfare & Institutions (W&I) Code, Section 14105.965 to include supplemental Medi-Cal outpatient reimbursement to State veteran homes and clinics operated by state, city, county, the University of California system clinics and public healthcare systems.

4260-010-BCP-2017-GB: Medi-Cal 2020 Contract Funding

Other Fund:	\$980,000
Federal Fund:	\$980,000
TOTAL:	\$1,960,000

(Five-year limited-term expenditure authority)

DHCS requests approval of limited-term contract funding of \$1,960,000 beginning 2017-18 to 2020-21 and \$460,000 in 2021-22. The contract funding is needed to hire subject matter experts to facilitate learning collaboratives, assist participating entities by providing technical assistance, and conduct an independent evaluation. The learning collaboratives are federally required activities for all participating Public Hospital Redesign and Incentives in Medi-Cal entities and for all entities participating in the Whole Person Care Pilot program. The contracts also include an independent evaluation of the Dental

Transformation Initiative. Per the Centers for Medicare and Medicaid Services Special Terms and Conditions of the Section 1115 Medicaid Waiver, known as Medi-Cal 2020, this funding will be needed through the end of the demonstration.

4260-013-BCP-2017-GB: Medi-Cal Managed Care Office of Ombudsman (OMB) Staffing

General Fund:	\$895,000
Federal Fund:	\$894,000
TOTAL:	\$1,789,000

(6.0 permanent positions and conversion of 9.0 limited-term positions to permanent)

DHCS, Managed Care Operations Division (MCO), Office of Ombudsman (OMB), requests a total of 15.0 permanent positions to address an increase in workload to the Ombudsman call center.

4260-016-BCP-2017-GB: County Administration Budgeting Methodology Staffing Extension

General Fund:	\$731,000
Federal Fund:	\$730,000
TOTAL:	\$1,461,000

(Three-year expenditure authority for the extension of an equivalent 2.0 positions)

DHCS, Medi-Cal Eligibility Division (MCE), County Administration Unit, requests limited-term resources to implement the provisions of Senate Bill (SB) 28 (Hernandez, Chapter 442, Statutes of 2013). SB 28 directs DHCS, in consultation with the counties, to design and implement a new budgeting methodology for county administrative costs that reflects the impact of the Affordable Care Act on county administrative work and present that methodology to the Legislature.

4260-017-BCP-2017-GB: Substance Use Disorder (SUD) Licensing Workload

Other Fund:	\$2,547,000
TOTAL:	\$2,547,000

[20.0 permanent positions (includes 14.0 new permanent and 6.0 conversion of limited-term to permanent), two-year expenditure authority for 4.0 positions, and five-year expenditure authority for 4.0 positions]

DHCS, Substance Use Disorder - Compliance Division (SUDCD) resources to address increased workload and carry out new and existing state and federal requirements for the expansion of services from the Affordable Care Act (ACA) and the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver. The Other Fund sources are Reimbursement, Narcotic Treatment Program Licensing Trust Fund, and Residential Outpatient Program Licensing Fund. Substance Abuse Prevention and Treatment Block Grant, federal funding, will also be used to fund these resources.

4260-018-BCP-2017-GB: Federal Managed Care Regulations

General Fund:	\$4,460,000
Federal Fund:	\$4,460,000
TOTAL:	\$8,920,000

(15.0 permanent positions and limited-term expenditure authority for an equivalent 40.0 positions). DHCS requests the establishment of permanent positions and four-year limited-term resources to support the implementation of the Medicaid and CHIP Managed Care Final Rule CMS-2390-P. Within the expenditure authority requested, \$2,378,000 will be used for contractual services.

Joint BCP (Other Departments)

0530-003-BCP-2107-GB: Medi-Cal Eligibility Data System (MEDS) Modernization

General Fund:	\$ 727,000
Federal Fund:	<u>\$5,903,000</u>
TOTAL:	\$6,630,000

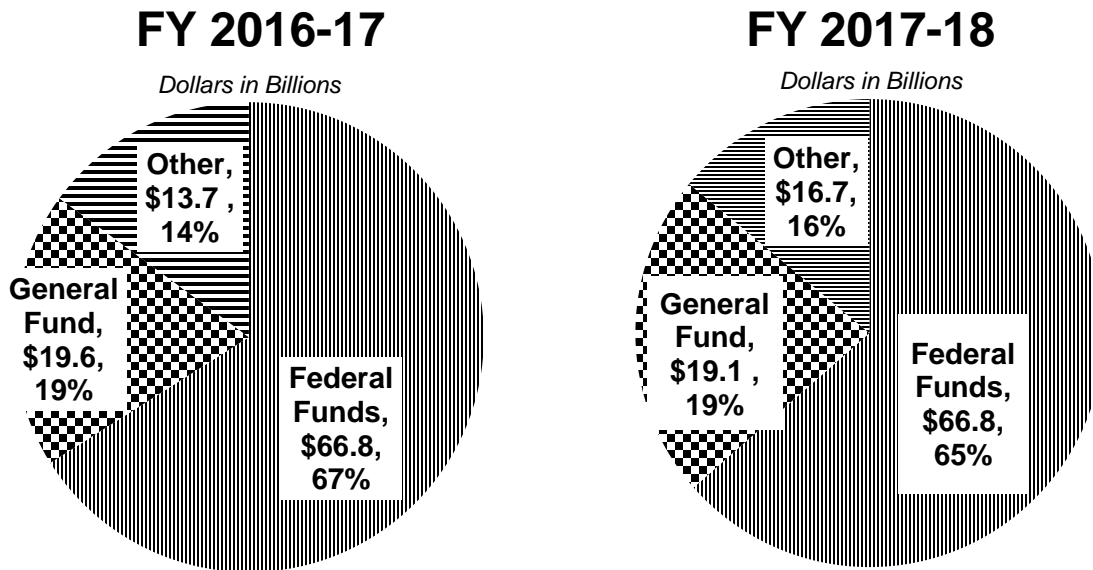
(Two-year limited-term expenditure authority)

This proposal requests resources for the Agency-wide planning effort for MEDS Modernization. Office of Systems Integration (OSI) is the lead department.

DHCS requests \$6.6 million to continue to support 3.0 of the 16.0 positions and provide reimbursement of costs to OSI. These staffing and other resources are needed during FY 2017-18 and FY 2018-19 to support completion of activities required by the state's project approval lifecycle stage gate requirements.

ESTIMATE ADJUSTMENTS

Medi-Cal spending is estimated to be \$100.1 billion in FY 2016-17 and \$102.6 billion in FY 2017-18. This does not include Certified Public Expenditures of local governments or General Fund of other state departments.



The November 2016 Estimate for FY 2016-17 is \$1,805.1 million General Fund more than the FY 2016-17 Budget Appropriation.

FY 2016-17			
	Appropriation	November 2016	Change
Medical Care Services	\$ 16,786.7	\$ 18,580.3	\$ 1,793.6
County Administration	\$ 861.4	\$ 859.2	\$ (2.2)
Fiscal Intermediary	\$ 106.9	\$ 120.5	\$ 13.6
Total	\$ 17,755.0	\$ 19,560.0	\$ 1,805.1

*Dollars in millions, rounded

The Medi-Cal General Fund costs are estimated to decrease by \$430 million between FY 2016-17 and FY 2017-18.

November 2016 General Fund			
	FY 2016-17	FY 2017-18	Change
Medical Care Services	\$ 18,580.3	\$ 18,118.3	\$ (462.0)
County Administration	\$ 859.2	\$ 858.8	\$ (.4)
Fiscal Intermediary	\$ 120.5	\$ 153.0	\$ 32.5
Total	\$ 19,560.0	\$ 19,130.0	\$ (430.0)

*Dollars in millions, rounded

SIGNIFICANT ITEMS

Medi-Cal continues to experience significant increases in caseload, growing from 13.4 million average monthly in FY 2015-16 to a projected 14.3 million in FY 2017-18. This is an increase of over 6.5 percent. Much of this growth has been in the ACA Optional Expansion category which has increased by over 650,000 during this same period. This growth, along with the increasing non-federal share of expenses for this category, contributes to overall Medi-Cal cost increases.

Other major changes in the projections include:

- A miscalculation of costs associated with the Coordinated Care Initiative in prior estimates.
- Beginning January 1, 2018, IHSS will no longer be included in the managed care rates in the CCI counties.
- A delay in identifying and returning federal funds for drug rebates for the ACA Optional Expansion population.

The following pages briefly describe the significant changes in both FY 2016-17 and FY 2017-18.

Significant Items

Dollars in Millions

Name	PC	Change from Appropriation		Change from FY 2016-17	
		FY 2016-17		FY 2017-18	
		TF	GF	TF	GF
BASE PCs					
Managed Care Base PCs	96,97,99,102	\$1,204.5	(\$42.2)	\$526.5	\$42.2
REGULAR PCs					
Undocumented Children Full Scope Expansion	2	\$48.4	\$42.2	\$62.1	\$49.2
Resource Disregard - % Children	10	\$0.0	\$199.2	\$0.0	(\$332.1)
Minimum Wage Increase - Caseload Savings	15	(\$4.0)	(\$0.8)	(\$132.6)	(\$28.4)
New Qualified Immigrants	11	\$0.0	\$73.2	\$0.0	(\$13.1)
Transition of NQI Adults to Covered California	27	\$0.0	\$0.0	(\$120.8)	(\$48.0)
ACA Optional Expansion	18	\$173.4	\$9.7	\$1,070.4	\$78.1
ACA DSH Reduction	28	\$0.0	\$0.0	(\$137.9)	(\$16.2)
Title XXI Federal Match Reduction	209	\$0.0	\$0.0	(\$56.0)	\$530.9
Behavioral Health Treatment	29, 31	\$164.3	\$73.2	\$72.2	\$29.5
Nursing Facility/Acute Hospital Waiver Renewal	190	\$0.0	\$0.0	\$9.8	\$4.9
Integration of the SF CLSB into the ALW	206	\$0.0	\$0.0	(\$0.7)	(\$0.4)
Drug Rebates*	57, 58, 61, 62, 123	(\$523.2)	(\$25.5)	(\$130.7)	(\$58.0)
Drug Rebates - Retroactive ACA Adjustments	204	\$0.0	\$487.3	\$0.0	(\$487.3)

Significant Items

Dollars in Millions

Name	PC	Change from Appropriation		Change from FY 2016-17	
		FY 2016-17		FY 2017-18	
		TF	GF	TF	GF
Drug Medi-Cal Organized Delivery System Waiver	64	\$19.9	\$3.1	\$642.0	\$138.5
Medi-Cal 2020 Waiver	80, 81, 82, 86, 95	\$1,215.2	\$16.1	(\$647.2)	\$35.8
CCI**	98, 197, 210	(\$3,467.3)	(\$685.3)	(\$1,429.4)	\$85.3
MCO Enrollment Tax Managed Care Plans	115	\$0.0	(\$6.5)	\$0.0	(\$564.8)
General Fund Reimbursement from DPHs	119	\$0.0	\$117.3	\$0.0	(\$31.7)
Retro Managed Care Rate Adjustments	124	\$689.0	\$225.9	(\$650.7)	\$16.4
AB 1629 Annual Rate Adjustments	128	(\$276.5)	(\$138.3)	\$31.6	\$15.8
LTC Rate Adjustment	132	(\$107.1)	(\$53.5)	\$17.8	\$8.9
Discontinue Pharmacy Rate Reductions	136	\$5.0	\$2.5	\$20.0	\$10.0
Laboratory Rate Methodology Change	144	\$17.3	\$8.7	(\$18.9)	(\$9.4)
Radiology Rate Reductions	145	\$4.9	\$2.4	(\$36.7)	(\$18.4)
10% Provider Payment Reduction	146	\$9.5	\$4.8	(\$4.4)	(\$2.2)
Medicare Part B Premium Increase	125	\$80.5	\$43.4	(\$75.7)	(\$41.1)
Extend Hospital QAF	147, 198	\$5,351.5	\$0.0	\$1,403.1	(\$381.1)
Medi-Cal Recovery Fifty Percent Rule	200	\$0.0	\$0.0	(\$12.2)	(\$12.2)
Proposition 56 Funding for New Program Growth	96, 97, 99, 102, 104, 112, 167, 168	\$0.0	\$0.0	\$1,237.4	
Health Care Services Plans Fines and Penalties Fund	212	\$0.0	\$0.0	\$0.0	(\$65.7)
COUNTY ADMINISTRATION PCs					
OTHER ADMINISTRATION PCs					
CCI OA	17,72	\$1.8	\$0.9	\$0.7	\$0.3
HCO Contract	68, 69, 70, 71, 73, 74	\$0.8	\$0.4	\$10.5	\$5.1
Dental New Contracts	76,80,87,88	\$9.3	\$2.3	\$40.8	\$12.8
Managed Care Regulations - Mental Health	112	\$0.0	\$0.0	\$28.0	\$9.3
Electronic Asset Verification Program	57	\$0.0	\$0.0	\$2.4	\$1.2

*FY 2016-17 change includes elimination of separate Aged and Disputed Rebates PC

**FY 2016-17 change includes elimination of separate CCI-Transfer of IHSS costs to CDSS PC

SIGNIFICANT ITEMS

BASE PCs

Managed Care Base PCs (PC 97, 96, 99, 102)

The Managed Care Base PCs estimate the managed care capitation costs of the four managed care models. These PCs, where appropriate, include the ACA expansion population, Title XXI 88/12 funding, and the impact of CCI. Additionally, these PCs include the ACA 95/5 funding. Increases reflect a growth in managed care eligibles which are expected to be 79% of total eligibles in FY 2017-18.

REGULAR PCs

ELIGIBILITY

Undocumented Children Full Scope Expansion (PC 2)

SB 75 (Chapter 18, Statutes of 2015) directs the Department to provide full-scope Medi-Cal coverage to eligible children under the age of 19, regardless of immigration status, effective May 16, 2016. Federal financial participation (FFP) is available for emergency and pregnancy-related services; however, any non-emergency services are funded solely by the State's General Fund. Increased costs result primarily from updated cost estimates as well as estimated caseload growth in the Budget Year.

Resource Disregard - % Children (PC 10)

This funding adjustment substitutes Title XXI federal funding for a portion of the GF cost associated with these children. Much of the adjustment assumed to be made in the Current Year has shifted to the Budget Year.

Minimum Wage Increase – Caseload Savings (PC 15)

SB 3 (Chapter 4, Statutes of 2016) authorized a phased-in increase in the minimum wage, effective January 2017. This policy change estimates the caseload reduction (savings) that occurs due to the increase in minimum wage. As the minimum wage increases, the savings also increase.

Transition of Newly Qualified Immigrant (NQI) Adults to Covered California (PC 27)

This policy change estimates the savings from shifting eligible NQI populations who have been in the country less than five years to Covered California beginning January 1, 2018.

AFFORDABLE CARE ACT

ACA Optional Expansion (PC 18)

This policy change estimates the costs of the Affordable Care Act (ACA) optional expansion of coverage to newly eligible beneficiaries above the base estimate. Continued eligible growth is the primary reason for the increase in total cost. GF costs grow as the federal share for this population decreases.

ACA Disproportionate Share Hospital (DSH) Reduction (PC 28)

The ACA requires the aggregate, nationwide reduction of the DSH allotments to begin in FY 2017-18 in the amount of \$2 billion (representing a 4.65% national reduction). Scheduled reductions for each

federal fiscal year are expected to increase through Federal Fiscal Year 2025. The distribution of the aggregate reductions is determined by the Centers for Medicare & Medicaid Services.

Title XXI Federal Match Reduction (PC 209)

Effective October 1, 2017, the Estimate assumes the ACA enhanced federal match of 88% for the Children's Health Insurance Program (CHIP) is discontinued and the matching rate returns to 65%. This policy change reflects the added cost under the assumption that Congress will re-authorize the program but at the pre-ACA level of 65%.

BENEFITS

Behavioral Health Treatment (BHT) (PC 29 and 31)

The Department implemented BHT services under the federal interpretation of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for children under age 21. Beginning February 1, 2016, the Department, in collaboration with the Department of Developmental Services (DDS), transitioned responsibility for BHT services provided to existing Medi-Cal eligible DDS Regional Center clients to Medi-Cal. These policy changes reflect updated fee-for-service and managed care costs for Medi-Cal BHT services.

HOME & COMMUNITY-BASED SERVICES

Nursing Facility/Acute Hospital Waiver Renewal (PC 190)

This policy change estimates the cost of renewing the Nursing Facility / Acute Hospital (NF/AH) Waiver, effective January 2017. Under the Waiver, the Department plans to increase Waiver capacity, localize care management, shift to an aggregate cost neutrality, integrate the In-Home Operations Waiver (IHO) and rename the Waiver to the Home and Community Based (HCB) Alternatives Waiver.

Integration of the SF CLSB into the ALW (PC 206)

The Department plans to integrate the San Francisco Community Living Support Benefit (SF CLSB) into the Assisted Living Waiver (ALW) with the transition of beneficiaries occurring in July 2017. The Department also proposes to double the existing waiver capacity in San Francisco to transition institutionalized individuals into the community.

PHARMACY

Drug Rebates (PC 57, 58, 61, 62, and 123)

Rebates estimates were updated based on actual pharmacy drug rebate collections data through June 30, 2016. The Aged and Disputed drug rebates are included in the main rebate policy changes and are no longer identified separately.

Drug Rebates - Retroactive ACA Adjustment (PC 204)

This adjustment is to pay the federal government for the rebate savings that were owed for the Affordable Care Act (ACA) optional expansion population for the April 2015 to June 2016 period. Because of delays, this funding adjustment was not made until FY 2016-17.

DRUG MEDI-CAL

Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver (PC 64)

Sixteen counties have submitted implementation plans requesting to participate in the

DMC-ODS waiver. DMC-ODS waiver services will include existing DMC treatment modalities and additional new and expanded services. Interim payments to the opt-in counties will be based on submitted certified public expenditures (CPEs) reimbursed at the approved interim rates and State-established Narcotic Treatment Program rates. An interim and final reconciliation will be conducted to settle the payments to actual county costs. The Department estimates 6 counties to begin implementation of the DMC-ODS waiver in FY 2016-17 and an additional 10 counties in FY 2017-18.

1115 WAIVER

Medi-Cal 2020 Waiver (PC 80, 81, 82, 86, and 95)

The Section 1115(a) Medicaid Demonstration (Medi-Cal 2020) was approved effective January 1, 2016, for five years. This Estimate updates payments under Public Hospital Redesign and Incentives in Medi-Cal (PRIME), funding for the Global Payment Program (GPP), and decreases savings in the Medi-Cal 2020 Designated State Health Program (DSHP), under the waiver. Additionally, under the Medi-Cal 2020 Waiver are the Dental Transformation Initiative (DTI) and the Whole Person Care Pilot Program.

MANAGED CARE

CCI (PC 98, 210, 197, 213; OA 17, 72)

The CCI mandatorily enrolls dual and Medi-Cal only eligibles into managed care for their Medi-Cal benefits. Those benefits include LTC institutional services, In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), Multi-Purpose Senior Services Program (MSSP) services, and other Home and Community-Based Services (HCBS). Savings in the Medi-Cal Estimate 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 Budget estimate of CCI projects that it will no longer be cost-effective on a statewide basis. Therefore, pursuant to the provisions of current law, the program will be discontinued in 2017-18. Effective January 2018, IHSS services currently routing through CCI will go back to the traditional funding arrangements between DHCS and the Department of Social Services. Based on the lessons learned from CCI, the Budget proposes to extend the Cal MediConnect program, continue mandatory enrollment of dual eligibles, and integrate long-term services and supports (except IHSS) into managed care.

MCO Enrollment Tax Managed Care Plans (PC 115)

The savings to the GF in this PC increases in FY 2017-18. Due to the timing of collecting this tax, FY 2016-17 has three quarters of tax revenue while FY 2017-18 includes four quarters.

General Fund Reimbursements from Designated Public Hospitals (DPH) (PC 119)

DPHs reimburse the GF for costs for Seniors and Persons with Disabilities built into the managed care rates that were previously paid through fee-for-service. The change in the fiscal estimate reflects changes in timing of payments and reconciliations as well as changes in projected amounts.

Retro Managed Care Payments (PC 124)

This policy change estimates retroactive managed care capitation rate adjustments. Retroactive rate adjustments are typically due to delays in implementation of managed care rates, and include such items as, retroactive payments, CCI recast recoupments, ACA optional recoupments, etc.

PROVIDER RATES

AB 1629 Annual Rate Adjustments (PC 128)

AB 1629 requires the Department to implement a facility-specific rate methodology and impose a QAF on freestanding skilled nursing facilities (NF-Bs), including adult and pediatric subacute facilities. The QAF is used to offset some of the GF cost of the reimbursement rates. This policy change updates the cost of the AB 1629 rate increases and add-ons for NF-Bs based on actual utilization, and delays in implementation.

LTC Rate Adjustment (PC 132)

This policy change updates the cost of the rate adjustments for LTC facilities based on actual utilization, updated rates, delays in retroactive recoupments, and increased add-on costs.

Discontinue Pharmacy Rate Reductions (PC 136)

AB 97 (Chapter 3, Statutes of 2011) enacted provider rate reductions. This policy change estimates the costs to discontinue Fee-for-Service (FFS) 10% pharmacy provider payment reductions when the Department moves to an actual acquisition cost (AAC) and dispensing fee reimbursement methodology, effective April 1, 2017.

Laboratory Rate Methodology Change (PC 144)

This policy change revises savings amounts and implementation dates for the AB 1494 10% reduction retroactive recoupment, the July 2015 new rate methodology retroactive recoupment, and the new rate methodology prospective savings.

Reduction to Radiology Rates (PC 145)

This policy change updates the retroactive recoupment savings amount, implementation, and schedule for the reduction to radiology rates. In addition, this policy change reflects savings based on proposed annual adjustments to prospective radiology reimbursement rates with implementation in February 2017.

10% Provider Payment Reduction (PC 146)

AB 97 (Chapter 3, Statutes of 2011) enacted provider rate reductions. This policy change updates the retroactive recoupment implementation for Durable Medical Equipment/Medical Supplies providers, and prospective Pharmacy reduction amounts.

Medicare Part B Premium Increase (PC 125)

Medi-Cal pays the full Medicare Part B monthly premium and annual deductible for Medi-Cal eligibles who are also eligible for Medicare Part B. This policy change estimates the impact of the adjustment in the annual Medicare Part B premium and deductible for calendar years 2017 and 2018.

SUPPLEMENTAL PAYMENTS

Extend Hospital QAF (PC 147 and 198)

The Hospital Quality Assurance Fee (QAF) program assesses a fee on applicable general acute care hospitals and matches the fee with federal financial participation. The fee also provides additional funding for children's health care coverage. AB 1607 (Chapter 27, Statutes of 2016) extended the Hospital QAF program through December 31, 2017. Proposition 52, approved by California voters on November 8, 2016, permanently extended the Hospital QAF program.

OTHER: RECOVERIES

Medi-Cal Recovery Fifty Percent Rule (PC 200)

This policy change estimates the fiscal impact associated with repeal of the Medi-Cal Recoveries Fifty Percent Rule which requires the Department to take no more than half of a settlement after all attorney's fees and legal costs are paid. This rule conflicted with the federal statute that requires the federal government's share of financing for injury-related services in a third party liability action to be fully reimbursed prior to the Medi-Cal beneficiary receiving funds. The Department has been reimbursing the FFP share for cases settled under the Fifty Percent Rule from the General Fund (GF). Amending W&I Code Section 14124.78 to revise the Fifty Percent Rule will increase the GF savings, as the Department will no longer use the GF to subsidize the federal repayment obligation.

OTHER:

Proposition 56 Funding (PC 96, 97, 99, 102, 104, 112, 167, 168)

Proposition 56, passed by the voters in November 2016, increases the excise tax rate on cigarettes and tobacco products, effective April 1, 2017. This tax is also applicable to electronic cigarettes for the first time. The excise tax increases by \$2 from 87 cents to \$2.87 per pack of 20 cigarettes on distributors selling cigarettes in California. Proposition 56 requires backfills to Proposition 99, Proposition 10, the Breast Cancer Fund, and to state and local governments to address revenue declines that result from the additional tax. After backfills, and specified allocations, Proposition 56 requires 82 percent of the remaining funds be transferred to the Healthcare Treatment Fund for the Department of Health Care Services to support new growth in Medi-Cal expenditures as compared to the 2016 Budget Act. The Budget includes \$1.2 billion for this purpose.

Health Care Services Plans Fines and Penalties Fund (PC 212)

The Budget abolishes the Major Risk Medical Insurance Fund, and proposes to transfer the fund balance, and ongoing administrative fines and penalties revenue, to the Health Care Services Plans Fines and Penalties Fund to support coverage for individuals remaining in the Major Risk Medical Insurance Program and health care services for children, seniors, persons with disabilities, and dual eligibles in the Medi-Cal program.

OTHER ADMINISTRATION PCs

HCO Contract (OA 68, 69, 70, 71, 73, 74)

Operations for the current HCO contract with MAXIMUS began on January 1, 2009, for three years and nine months, and six one-year optional extension years, with current operations ending September 30, 2018. A new HCO contract is anticipated with takeover extending through December 31, 2018, including a 12-month turnover period.

New Dental Contracts (OA 76, 80, 87, 88)

Delta Dental (Delta) currently has an at-risk contract to provide dental services to most Medi-Cal beneficiaries at a prepaid capitated rate per eligible. These dental costs are for fee-for-service (FFS) Medi-Cal beneficiaries. The Department is seeking approval of a contract extension amendment which would extend the contract through December 31, 2017, for end of operations and through March 31,

2019, for turnover. Delta was awarded a multi-year Administrative Services Organization (ASO) contract in 2016. The ASO contractor is responsible for duties including claims processing, provider enrollment, and outreach of the Medi-Cal Dental Program. Hewlett Packard Enterprise (HPE) was awarded a multi-year Fiscal Intermediary (FI) contract in 2016. HPE is responsible for all the FI services of the Medi-Cal Dental Program. ASO and FI Operations are expected to begin on the first day of thirteen months after the Contract Effective Date (CED), assumed to be January 1, 2017.

Managed Care Regulations – Mental Health (OA 112)

This policy change estimates the cost to reimburse County Mental Health Plans (MHPs) for administrative activities arising from the implementation of the new federal managed care regulations. The non-federal share of these costs is assumed to be 50% County Funds and 50% State General Fund.

Electronic Asset Verification Program (OA 57)

This policy change estimates the administrative costs associated with implementing a new Asset Verification Program (AVP) through a financial vendor for use in eligibility determinations or redeterminations for all Aged, Blind or Disabled (ADP) applicants and beneficiaries.

General Information

This estimate is based on actual payment data through July 2016. Estimates for both fiscal years are on a cash basis and include a two-week hold on weekly Fee-for-Service payments at the end of June and a one-month hold on Managed Care June payments. All held payments are anticipated to be paid in July of the following state fiscal year.

The Medi-Cal Program has many funding sources. These funding sources are shown by budget item number on the State Funds and Federal Funds pages of the Medi-Cal Funding Summary in the Management Summary tab. The budget items, which are made up of State General Fund, are identified with an asterisk and are shown in separate totals.

The Miscellaneous Non-Fee-For-Service Category includes expenditures for Home and Community Based Services -- DDS, Case Management Services -- DDS, Personal Care Services, HIPP premiums, Targeted Case Management, and Hospital Financing—Health Care Coverage Initiative.

The estimate aggregates expenditures for five sub-categories under a single Managed Care heading. These sub-categories are Two Plan Model, County Organized Health Systems, Geographic Managed Care, Regional Model, and PHP/Other Managed Care. The latter includes PCCMs, PACE, SCAN, Family Mosaic, Dental Managed Care, and the new Managed Care Expansion models –Imperial and San Benito.

Should a projected deficiency exist, Section 14157.6 of the Welfare and Institutions Codes authorizes appropriation, subject to 30-day notification to the Legislature, of any federal or county funds received for expenditures in prior years. At this time, no prior year General Funds have been identified to be included in the above estimates as abatements against current year costs.

There is considerable uncertainty associated with projecting Medi-Cal expenditures for medical care services, which vary according to the number of persons eligible for Medi-Cal, the number and type of services these people receive, and the cost of providing these services. Additional uncertainty is created by monthly fluctuations in claims processing, federal audit exceptions, and uncertainties in the implementation dates for policy changes which often require approval of federal waivers or state plan amendments, changes in regulations, and in some cases, changes in the adjudication process at the fiscal intermediary. Provider payment reductions, injunctions, and restorations add to this uncertainty as it affects the regular flow of the FI checkwrite payments.

A 1% variation in total Medi-Cal expenditures would result in an \$1,001 million TF (\$196 million General Funds) change in expenditures in FY 2016-17 and \$1,026 million TF (\$191 million General Funds) in FY 2017-18.