2018-19 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, integrated, 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 overall health and well-being of all Californians.

DHCS helps provide Californians 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 13.5 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 program changes 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 to underserved populations including Indian Health, the Rural Health Services Development Program, the Seasonal Agricultural and Migratory Workers Program, the State Office of Rural Health, 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 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) 2018-19, the Governor's Budget presents a total of $104.5 billion for the support of DHCS programs and services. Of that amount, $685 million funds state operations, while $103.9 billion supports local assistance. The proposed budget attempts to affirm 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*	2017-18 Approved Budget	2017-18 Revised Budget	2018-19 Proposed Budget
General Fund	$19,992,321	$20,514,661	$21,862,524
Federal Funds	$69,664,489	$64,466,719	$67,921,295
Special Fund & Reimbursements	$20,344,119	$18,298,528	$14,759,646
Total Funds	**$110,000,929**	**$103,279,908**	**$104,543,465**

*Dollars in thousands

State Operations

State Operations by Fund Source *			
Governor's Budget Fund Source	**2017-18 Approved Budget**	**2017-18 Revised Budget**	**2018-19 Proposed Budget**
General Fund	$209,741	$220,828	$219,075
Federal Funds	$388,4142	$399,920	$414,138
Special Funds & Reimbursements	$58,703	$58,649	$52,061
Total State Operations	**$656,858**	**$679,397**	**$685,274**

*Dollars in thousands

Local Assistance

Local Assistance by Fund Source *			
Governor's Budget Fund Source	**2017-18 Approved Budget**	**2017-18 Revised Budget**	**2018-19 Proposed Budget**
General Fund	$19,782,580	$20,293,833	$21,643,449
Federal Funds	$69,276,075	$64,066,799	$67,507,157
Special Funds & Reimbursements	$20,285,416	$18,239,879	$14,707,585
Total Local Assistance	**$109,344,071**	**$102,600,511**	**$103,858,191**

*Dollars in thousands

MAJOR PROPOSALS AND ISSUES

Home Health Rate Increase

As a result of DHCS' ongoing fee-for-service (FFS) access monitoring, the Department is proposing to adjust the rates for home health services provided through our FFS system and home and community based waivers. The Department is proposing a fifty percent (50%) increase to home health services rates in these two specified delivery systems, effective July 1, 2018, pending approval of federal financial participation by the Centers for Medicare and Medicaid Services (CMS). The Governor's budget assumes $64.5 million total funds ($31.6 million Prop 56 funds) for this increase in FY18-19.

Proposition 56

As noted in the Governor's budget, the FY18-19 budget proposes an increase of approximately $232 million in Proposition 56 funding for supplemental payments for dental and physician services, and maintains the supplemental payment or rate increases for all other affected providers (ICF-DD, HIV/AIDS Waiver and Women's Health Services). The total FY18-19 Proposition 56 funding for these providers, including the increase for doctors and dentists, is $649.9 million. The Department estimates the total funding (both federal and Proposition 56) in FY17-18 for these payments is $1,147 million and in FY18-19 is $2,025 million.

As noted in the Governor's budget, the Department plans to analyze the impact of the FY17-18 payment changes and may modify or revise the methodologies for payments for services beginning in the budget year. If these payments are not demonstrating the intent of improving access to services for Medi-Cal beneficiaries, the Administration will work with the Legislature to modify the supplemental payments.

In addition, the budget also includes $169.4 million in FY18-19 to support new growth in Medi-Cal expenditures compared to the 2016 Budget Act.

Medi-Cal County Administration

The Department is proposing to increase the allocation for county administration of the Medi-Cal program to $2.01 billion in FY18-19. This proposal will provide an interim funding methodology for county administration activities for the Medi-Cal program while DHCS works with the counties, the County Welfare Director's Association, and the Department of Finance to develop the best mechanism to fund these activities in the future. The proposed amount combines the current-year base appropriation of $1.3 billion with the $655.3 million appropriated for implementation of the Affordable Care Act at the county level. The two items were separate appropriations in previous budgets. In addition to combining the two items, DHCS is proposing a cost-of-doing-business adjustment for counties in FY18-19. The amount of the increase is $54.8 million based on the projected Consumer Pricing Index of 2.8% for FY18-19.

In addition to the funding increase, the Department will be working with the counties to improve county performance in processing timely eligibility determinations and annual renewals, and for county data metrics to be more readily available for state and federal review.

Children's Health Insurance Program (CHIP)

As noted in the Governor's Budget, at the time the Budget was being developed, Congress had not yet reauthorized CHIP for the Federal Fiscal Year 2018 that began October 1, 2017. Therefore, the Budget reflects costs that assume CHIP reauthorization at the historical CHIP federal matching percentage of 65%, effective January 1, 2018 instead of the current enhanced CHIP matching rate of 88%. However, Congress has since included additional funding for CHIP that is projected to provide California with sufficient funding at the 88% matching rate likely through the end of March 2018. The May Revision

will make appropriate adjustments to reflect these changes and, as necessary and appropriate, any subsequent action or lack of action taken by Congress in regards to CHIP.

340B Drug Billing Requirements Trailer Bill

In 2014, the Office of Inspector General for the Department of Health and Human Services published findings that showed an inconsistency in the identification of 340B program eligible prescriptions resulting in duplicative discounts without any process in place that would identify improper multiple discounts. There continues to be scrutiny and concern around the implementation of the 340B program across the nation. To comply with existing federal requirements, the Department is proposing trailer bill related to the use of, and reimbursement for, drugs purchased under the 340B program in Medi-Cal. The Department continues to have significant concerns regarding the use of the 340B program within Medi-Cal and the resulting costs and administrative burden it places on the state. 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. Although this is required in Medi-Cal fee-for-service under existing statute, the Department is aware of instances in the fee-for-service program in which this is not occurring, particularly when the use of "contracting" pharmacies is involved. In addition, based on discussions with various stakeholders, the Department understands that 340B entities are not billing their acquisition cost to Medi-Cal managed care plans and are instead billing a higher price, creating higher managed care pharmacy costs and therefore higher state costs. The Department has also noted in both fee-for-service and managed care that 340B drugs are not being correctly identified on claims to prevent inaccurate rebate billing that can jeopardize drug rebates with manufacturers.

To address these issues, the Department's proposed trailer bill seeks to prohibit the use of 340B drugs in the Medi-Cal program, which will enable the state to comply with existing federal law and eliminate the unnecessary higher costs being paid through Medi-Cal as well as the substantial administrative burden of ensuring 340B entities are appropriately following existing law and regulation. The trailer bill proposes to make this effective no sooner than July 1, 2019. The trailer bill also contains flexibilities for the Department in the circumstance that CMS does not approve the complete prohibition, but does permit other types of limitations.

It is critical to note that this change in statute is not anticipated to alter the pharmacies used by Medi-Cal beneficiaries or the current manner in which they may receive services and is not anticipated to result in a change in beneficiary access to medically-necessary pharmaceuticals. Pharmacies that currently dispense drugs purchased through 340B are anticipated to still be able to dispense the same drugs to the same clients and will receive reimbursement under the standard Medi-Cal drug reimbursement policy.

Hospital Quality Assurance Fee Administrative Cap Trailer Bill

The Department is proposing technical trailer bill changes to increase the funding authorized from the Hospital Quality Assurance Fee Program (HQAF) for the Department's administrative activities related to implementing the new directed payment program. The final Medicaid Managed Care rule issued in 2016 imposed significant changes to the way the QAF operates in the Medi-Cal Managed Care environment, resulting in significantly more complex and workload-intensive processes for implementation. The current statute limits HQAF funding for administrative activities to $250,000 per fiscal quarter. The trailer bill proposes to increase that to $500,000 per fiscal quarter.

Public Freestanding Non-Hospital Based Clinics (PFNC) Supplemental Reimbursement Program Trailer Bill

Under existing state law and the Medicaid State Plan, the Department is authorized to establish the PFNC supplemental reimbursement program. The program was authorized under AB 959 (Chapter 162, Statutes of 2006) and was intended to allow public clinics to obtain additional federal funding

reimbursement without an impact to State General Fund. While this initiative has received federal approval under California's Medicaid State Plan, the Department has worked for many years with eligible entities and CMS to try to obtain approval for a methodology and cost report. Since receiving approval from CMS of a revised cost report in 2017, DHCS sent notification letters to the approximately 300 clinics that may be eligible for this program. The response indicating interest was severely limited due to the strict eligibility and reporting requirements. Therefore, the Department is proposing to repeal the PFNC program from statute as there is insufficient interest for it be administratively feasible for both the department and clinics.

BUDGET ADJUSTMENTS

Budget Change Proposals

The Governor's Budget proposes the establishment of 41.5 permanent new positions, including the conversion of 18.5 existing limited-term resources to permanent positions.

4260-001-BCP-2018-GB: Health Care Reform Financial Reporting

General Fund:	$ 963,000
Federal Fund:	$ 963,000
TOTAL:	$1,926,000

(Three-year limited-term expenditure authority equivalent to 18.0 positions)

DHCS, Administration Division, Financial Management Branch (FMB), requests to extend limited-term funding for staff resources, to address the existing Centers for Medicare and Medicaid Services (CMS) requirements for the Affordable Care Act (ACA) federal reporting. DHCS is the single State agency which administers the Medi-Cal program. Existing federal reporting requirements have doubled the current workload for Medi-Cal reporting. These resources are needed to continue to meet the requirements.

4260-002-BCP-2018-GB: Orange County Office Consolidation

General Fund:	$ 281,000
Federal Fund:	$ 281,000
TOTAL:	$ 562,000

(Permanent expenditure authority)

DHCS, Administration Division, Program Support Branch, requests permanent expenditure authority for new-leased space to relocate staff out of the Santa Ana State Building at 605 W. Santa Ana, in Santa Ana, CA and consolidate with staff from 770 The City Drive South, in Orange, CA, to one location. DHCS is moving out of the Santa Ana State Building due to the building's deficiencies and in coordination with the Department of General Services' efforts to consolidate State programs into a larger leased office building that will better service DHCS and other tenant departments.

4260-005-BCP-2018-GB: Federal Managed Care Regulations Implementation

General Fund:	$1,547,000
Federal Fund:	$1,547,000
TOTAL:	$3,094,000

[9.0 permanent positions (converted from limited-term) and permanent expenditure authority (equivalent to 4.0 positions)]

DHCS requests to convert limited-term resources to permanent (staffing and contract funding) to continue addressing workload associated with the Federal Managed Care Regulations (Final Rule), under Medicaid and Children's Health Insurance Program Managed Care Final Rule CMS-2390-P. The Final Rule made changes to the Medicaid managed care regulations to reflect the increased utilization of managed care as a delivery system and required states to establish comprehensive quality

strategies for their Medicaid and CHIP programs, regardless of how services are provided to beneficiaries.

4260-006-BCP-2018-GB: HIPAA Privacy Rule Compliance

General Fund:	$ 257,000
Federal Fund:	$ 256,000
TOTAL:	$ 513,000

(4.0 permanent positions)

DHCS, Office of Health Insurance Portability and Accountability Act (HIPAA) Compliance, requests permanent positions to address the rapid and continuous increase in privacy and security breaches of protected health information (PHI) and personally identifiable information (PII). DHCS notes the incidents have been increasing since 2012. DHCS is responsible for the management of potential privacy and security incidents, along with notifications to Medi-Cal members impacted by a breach of their PHI/PII.

4260-007-BCP-2018-GB: California Technical Assistance Program Extension

General Fund:	$ 0
Federal Fund:	$ 0
TOTAL:	$ 0

(No-cost two-year extension)

DHCS, Office of Health Information Technology, requests a no cost two-year extension and re-appropriation of remaining funds from the Major Risk Medical Insurance Fund (MRMIF) to allow the four contracted vendors an additional two years to continue achievement of program objectives and milestones. The estimated timeline for California Technical Assistance Program (CTAP) was initially July 1, 2015, through June 30, 2018. The approval of this request will extend, at no additional cost, the CTAP through June 30, 2020. The Administration is including reappropriation language in the proposed FY 2018-19 Budget.

4260-008-BCP-2018-GB: California 1115 Waiver - Medi-Cal 2020

General Fund:	$2,232,000
Federal Fund:	$2,231,000
TOTAL:	$4,463,000

(Two-year expenditure authority for an equivalent 2.0 positions and one-year limited-term expenditure authority for evaluation contracts)

DHCS, Managed Care Quality and Monitoring Division, requests an extension of limited-term expenditure authority for staff resources and contractual services for the continued implementation of the California 1115 Waiver - Medi-Cal 2020. The 2020 Waiver is an extension of the Bridge to Reform (BTR) Section 1115 Waiver that expired on October 31, 2015. BTR enabled California to implement an early expansion of Medicaid under the Affordable Care Act (ACA), improve care coordination for vulnerable populations by mandatorily enrolling Seniors and Persons with Disabilities (SPDs) into Medi-Cal Managed Care, as well as provide funding for health care delivery system reform and uncompensated care in designated public hospital systems.

Limited-term contract funding is needed for independent evaluations, as required by the 2020 Waiver. The evaluations will examine the Whole Person Care Pilot Program, the Seniors and Persons with Disabilities Program, and Whole-Child Model.

4260-009-BCP-2018-GB: Mental Health Services Division: Policy Implementation

General Fund:	$ 665,000
Federal Fund:	$ 664,000
TOTAL:	$1,329,000

(10.0 permanent positions)

DHCS requests 10.0 permanent positions and expenditure authority to: strengthen program monitoring and oversight of the Mental Health Services Act (MHSA); assist with the design and implementation of policies to administer various state and federal mental health programs; and, meet the requirements and specified functions of:

- Assembly Bill (AB) 501 (Ridley-Thomas, Chapter 704, Statutes of 2017) – Allows a Short-Term Residential Therapeutic Program to operate as a Children's Crisis Residential Program.
- Senate Bill (SB) 1291 (Beall, Chapter 844, Statutes of 2016) – Requires each county mental health plan to be monitored and reviewed annually by an External Quality Review Organization beginning July 1, 2018, and for the review to include data for Medi-Cal eligible minor and non-minor dependents in foster care.

4260-012-BCP-2018-GB: Graduate Medical Education Program Oversight and Monitoring

Federal Fund:	$ 122,000
Other Fund:	$ 122,000
TOTAL:	$ 244,000

(2.0 permanent positions)

DHCS, Safety Net Financing Division, requests 2.0 new permanent positions to develop, coordinate, implement and administer the Graduate Medical Education (GME) program. This request will support fiscal oversight and programmatic monitoring requirements related to 42 Code of Federal Regulations (CFR) §438.60. The regulation authorized DHCS to implement the Medicaid GME program under which payments will be made to Designated Public Hospitals and their affiliated government entities participating in the Medi-Cal managed care program.

4260-013-BCP-2018-GB: Hospital Quality Assurance Fee Program

Federal Fund:	$1,134,000
Other Fund:	$1,135,000
TOTAL:	$2,269,000

(11.5 permanent positions (includes 2.0 new permanent and 9.5 conversion of LT to permanent) and three-year limited-term expenditure authority equivalent to 9.5 positions)

DHCS requests permanent positions and expenditure authority for the Hospital Quality Assurance Fee (HQAF) program. The program provides funding for supplemental payments to California hospitals that serve Medi-Cal and uninsured patients. The request includes 2.0 new permanent positions effective July 1, 2018 the conversion of 9.5 existing limited-term (LT) positions to permanent effective January 1, 2019, and permanent contract funding effective July 1, 2019. In addition, DHCS requests 3-year LT

resources equivalent to 9.5 positions effective July 1, 2018. The passage of Proposition 52 during the 2016 California general election made the HQAF program permanent.

4260-015-BCP-2018-GB: Federally Qualified Health Center Audits (AB 1863)

General Fund:	$ 141,000
Federal Fund:	$ 141,000
TOTAL:	$ 282,000

(One and a half year limited-term expenditure authority equivalent to 4.0 positions and one-year limited-term expenditure authority equivalent to 9.0 positions)

DHCS, Audits and Investigations, requests limited-term resources to perform new audit workload associated with Assembly Bill (AB) 1863 (Wood, Chapter 610, Statutes of 2016). AB 1863 added marriage and family therapists to the list of health care professionals whose services are reimbursed through Medi-Cal on a per-visit basis to federally qualified health centers (FQHCs) or rural health clinics (RHCs). Year 1 staff resources requested effective January 1, 2019.

4260-019-BCP-2018-GB: Drug Medi-Cal and Specialty Mental Health Services: Federally Qualified Health Centers and Rural Health Centers (SB 323)

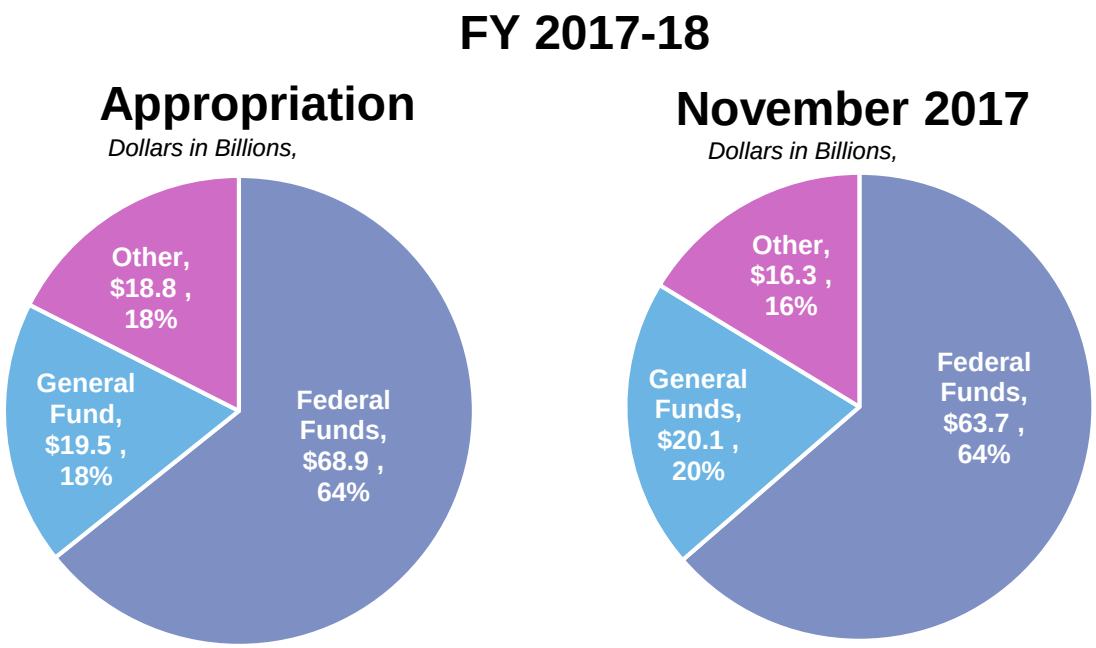
General Fund:	$ 446,000
Federal Fund:	$ 445,000
TOTAL:	$ 891,000

(5.0 permanent positions and two-year limited-term expenditure authority equivalent to 21.0 positions)

DHCS requests 5.0 permanent positions as well as two-year limited-term resources and expenditure authority equivalent to 21.0 positions to perform the new workload as a result of Senate Bill (SB) 323 (Chapter 540, Statutes of 2017). SB 323 allows federally qualified health centers (FQHCs) and rural health clinics (RHCs) to be reimbursed directly from a county or the DHCS for providing Specialty Mental Health Services (SMHS) and Drug Medi-Cal (DMC) services to Medi-Cal beneficiaries.

ESTIMATE ADJUSTMENTS

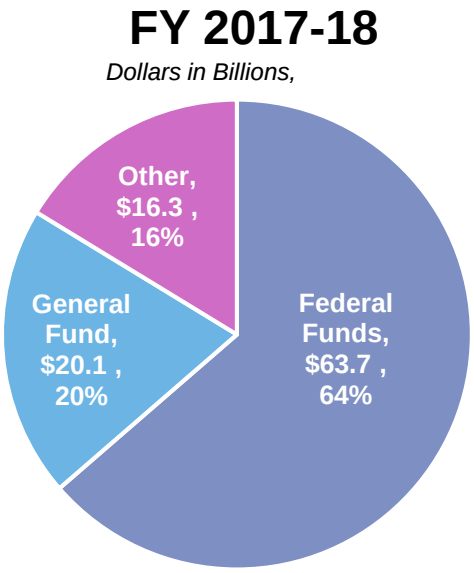
Medi-Cal spending is estimated to be $100.0 billion in FY 2017-18 and $101.5 billion in FY 2018-19. This does not include Certified Public Expenditures of local governments or General Fund of other state departments.

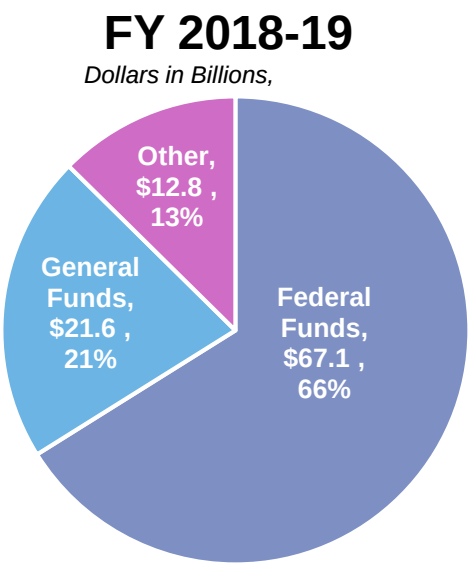


The November 2017 Estimate for FY 2017-18 projects an additional $543.7 million General Fund in expenditures than the FY 2017-18 Budget Appropriation.

	FY 2017-18, General Fund		
	Appropriation	November 2017	Change
Medical Care Services	$ 18,399.7	$ 18,866.7	$ 467.0
County Administration	$ 960.6	$ 1,031.0	$ 70.4
Fiscal Intermediary	$ 154.5	$ 160.7	$ 6.2
Total	$ 19,514.8	$ 20,058.4	$ 543.7

(Dollars in Millions, Rounded)





The Medi-Cal General Fund costs are estimated to increase by $1,530.7 million between FY 2017-18 and FY 2018-19.

November 2017 General Fund

	FY 2017-18	FY 2018-19	Change
Medical Care Services	$ 18,866.7	$ 20,388.7	$ 1,522.0
County Administration	$ 1,031.0	$ 1,083.6	$ 52.6
Fiscal Intermediary	$ 160.7	$ 116.8	$ (43.9)
Total	$ 20,058.4	$ 21,589.1	$ 1,530.7

(Dollars in Millions, Rounded)

SIGNIFICANT ITEMS

The following pages briefly describe the significant changes in both FY 2017-18 and FY 2018-19.

Significant Items
Dollars in Millions

		Change from Appropriation		Change from FY 2017-18	
		FY 2017-18		FY 2018-19	
Name	**PC**	**TF**	**GF**	**TF**	**GF**
Non-OTLICP CHIP	9	($401.0)	($38.1)	$0.0	($107.6)
This policy change (PC) 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). This PC includes changes to the CS3-Proxy adjustment, expenditures for the Resource Disregard, HPE, and Medicaid Expansion populations.					
Title XXI Federal Match Reduction	24	($1.8)	($97.0)	($41.7)	$295.0
This policy estimates the funding adjustment for the Children's Health Insurance Program (CHIP) to reflect a reduction of the federal match from 88% to 65% as of January 1, 2018, given the continuing uncertainty regarding full Congressional reauthorization of CHIP.					
Medi-Cal Inmate Programs	1, 3	($257.9)	($29.3)	$122.2	$10.9
These policy changes estimate the federal funding provided to both the State and Counties for eligible inmates who receive inpatient hospital care. Both State and County inmate costs are estimated based upon actual State claims. Counties will reimbursement the State for the state share of the county inmate expenditures.					
MEC Optional Expansion Adjustment	16	$97.0	($10.9)	$326.3	($120.4)
This policy change adjusts the funding from the ACA Optional Expansion funding to the Medi-Cal 50/50 funding for eligibles with Minimum Essential Coverage (MEC) who are not eligible for the ACA Optional Expansion aid category. This PC reflects updated recoupment amounts and timelines.					
Behavioral Health Treatment	27	$87.1	$38.3	($24.9)	($10.9)
Medi-Cal covers Behavioral Health Treatment (BHT) services for children under age 21. Beginning February 1, 2016, the Department, in collaboration with the Department of Developmental Services (DDS), transitioned responsibility for BHT services provided to existing Medi-Cal eligible DDS Regional Center clients to Medi-Cal. With the November 2017 Estimate, BHT costs for transitioned DDS RC clients are combined in this PC with the costs for others receiving BHT. Additionally, the current BHT estimate updates FFS and managed care costs based on actual payments and estimated managed care capitation rates.					

		Change from Appropriation		Change from FY 2017-18	
		FY 2017-18		FY 2018-19	
Name	**PC**	**TF**	**GF**	**TF**	**GF**
Behavioral Health Treatment - BIS DDS Transition	44	($10.3)	($4.5)	$93.1	$40.7
This policy change estimates costs for additional DDS Regional Center (RC) clients with a diagnosis other than Autism Spectrum Disorder (ASD) transitioning to Medi-Cal. The current estimate updates the number of BHT/Behavioral Intervention Services beneficiaries that are estimated to transition to Medi-Cal fee-for-service and managed care. In addition, the transition dates have been shifted to March 2018 and July 2018 for FFS and managed care, respectively.					
Diabetes Prevention Program	45	$0.0	$0.0	$0.5	$0.1
This new policy change estimates the costs of the Diabetes Prevention Program (DPP). The DPP is a 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. The program consists of core sessions, core maintenance sessions, and ongoing maintenance sessions. The DPP is projected to begin January 1, 2019.					
Drug Rebates Prior Year Funding Adjustment	48	($60.3)	$256.6	$60.3	($256.6)
Drug rebate collections are initially recorded as 50% GF/50% FF. The funding for the Affordable Care Act (ACA) optional population, ACA Offset, and Children's Health Insurance Program (CHIP) populations are adjusted once the various funding allocations are determined. Four quarterly funding adjustments are typically made in a fiscal year. This policy change estimates an additional funding adjustment for FY 2016-17 drug rebate collections that was made in FY 2017-18.					
Drug Rebates	51, 52, 54, 55, 116	($946.9)	($280.7)	($195.0)	($74.0)
Rebate estimates were updated based on actual pharmacy drug rebate collections data through June 2017.					
Pharmacy Reimbursement & Dispensing Fee	49	N/A	N/A	($66.0)	($26.6)
This policy change estimates the savings from reimbursing pharmacy drugs based on the Actual Acquisition Cost (AAC) for Covered Outpatient Drugs and the cost associated with adopting the new Professional Dispensing Fee (PDF) methodology. Although the effective date of the new AAC and PDF reimbursement methodology is April 1, 2017, implementation is estimated to begin August 1, 2018.					
Drug Rebates - Retroactive ACA Adjustments	210	$0.0	$46.5	$0.0	($46.5)
Prior to April 2016, the Rebate Accounting and Information System (RAIS) was not able to identify ACA claims for pharmacy drugs and rebate invoices were blended with non-ACA claims. A system change to allow RAIS to calculate the ACA claims for the blended period, January 2014 to April 2016, has been delayed resulting in additional ACA rebates being owed to the federal government. This adjustment estimates repayments for the additional ACA rebate savings owed for the blended period.					

		Change from Appropriation		Change from FY 2017-18	
		FY 2017-18		FY 2018-19	
Name	**PC**	**TF**	**GF**	**TF**	**GF**
New High Cost Treatments for Specific Conditions	47	($45.5)	($21.0)	$72.3	$32.8
This policy change estimates new high cost services and treatments recently approved by the FDA. The updated dollars reflect phase-in changes and the addition of new treatments.					
Drug Medi-Cal ODS Waiver	56	($207.7)	($48.2)	$666.7	$133.6
DMC-ODS waiver services include existing DMC treatment modalities and additional new and expanded services. DMC-ODS waiver services for opt-in counties began in February 2017 on a phase-in basis. Five counties implemented the DMC-ODS waiver in FY 2016-17. The Department estimates an additional 15 counties will implement the DMC-ODS waiver in FY 2017-18 and an additional 20 counties in FY 2018-19. The estimated costs reflect changes in phase-in schedule, payment lags, and rates.					
SMHS Base	63 ,64	$182.8	($13.8)	$20.4	$22.7
The Specialty Mental Health Services (SMHS) base policy changes have been revised based on updated utilization and cost data through June 2017. Due to delayed implementation of a Short Doyle Medi-Cal (SD/MC) system change, a portion of FY 2016-17 claims shifted for payment in FY 2017-18.					
Managed Care Regulations - Mental Health Parity	OA 109	N/A	N/A	$21.3	$3.0
The federal Parity Final Rule requires parity in access to mental health and substance use disorder services for Medicaid beneficiaries with physical health services. County Mental Health Plans will be required to shorten times for the authorization of treatment plans for both outpatient and inpatient services. The current estimate includes costs related to shortening authorization of outpatient services, beginning July 1, 2018.					
Medi-Cal 2020 Waiver - Global Payment Program (GPP)	73	($108.5)	$0.0	$207.6	$0.0
The GPP converted Disproportionate Share Hospital (DSH) and Safety Net Care Pool (SNCP) uncompensated care funding from a hospital-focused, cost-based system to one that is focused on value and improved care delivery. Intergovernmental transfers (IGTs) provide the non-federal share of the GPP payments. Estimated expenditures for GPP have been updated for FY 2017-18 and FY 2018-19.					

		Change from Appropriation		Change from FY 2017-18	
		FY 2017-18		FY 2018-19	
Name	**PC**	**TF**	**GF**	**TF**	**GF**
Medi-Cal 2020 Waiver - Public Hospital Redesign & Incentives in Medi-Cal (PRIME)	74	$171.0	$0.0	($251.0)	$0.0
The Medi-Cal 2020 demonstration provides up to $1.4 billion TF annually for the Designated Public Hospitals (DPHs) systems and up to $200 TF million annually for the District/Municipal Hospitals (DMPH) systems for the first three years of the demonstration. The funding phases down by 10% in the fourth year of the demonstration and by an additional 15% in the fifth year of the demonstration. The estimate has been updated to pay remaining Demonstration Year (DY) 2016-17 payments and 50% of the annual DY 2017-18 payment in FY 2017-18. The remaining 50% of DY 2017-18 and the first DY 2018-19 payments, which includes the 10% phased down allocation, are estimated to be paid in FY 2018-19.					
Medi-Cal 2020 Whole Person Care Pilots	75	($138.2)	$0.0	$64.9	$0.0
Medi-Cal 2020 Waiver Whole Person Care Pilots allow city, county, state, tribal, and federal entities, as well as Medi-Cal Managed care plans, hospitals, and provider organizations, to align communication and integrate services to prevent fragmentation of the delivery system that can result in duplicative or inappropriate care for Medi-Cal beneficiaries. Pilots may also focus on Housing and Supportive Services. This PC includes updates to when various programs will begin. The estimated costs reflect lower amounts allocated to waiver entities through the first application process.					
Medi-Cal 2020 Waiver - DTI and DSHP	76, 83	($35.2)	($17.6)	$52.9	$26.4
The Dental Transformation Initiative (DTI) in the Medi-Cal 2020 Waiver includes incentive payments for the provision of preventive services, caries risk assessment and disease management, continuity of care and funding for the Local Dental Pilot Programs (LDPPs). Federal claiming of $75 million FFP for Medi-Cal 2020 Designated State Health Program expenditures provides for an offset to the GF costs for the DTI in FY 2017-18 and FY 2018-19.					
Managed Care Base	87, 88, 89, 94	($183.1)	$327.5	$425.8	$652.6
The four managed care base PCs estimate the managed care capitation costs for managed care health plans. In FY 2017-18, California Healthcare, Research, and Prevention Tobacco Tax Act of 2016 (Proposition 56) funds a portion of the growth as compared to the 2016 Budget Act in the four PCs. In 2018-19, only growth as compared to the 2016 Budget Act in the Two Plan Model base PC will be funded with Proportion 56 revenue.					
Retro MC Rate Adjustment	117	($52.2)	$143.6	$4,188.4	($289.6)
This policy change estimates retroactive managed care capitation rate adjustments. These dollars reflect updated payment and recoupment timeframes. FY 2017-18 includes significant ACA optional expansion rate recoupments while FY 2018-19 does not.					

		Change from Appropriation		Change from FY 2017-18	
		FY 2017-18		FY 2018-19	
Name	**PC**	**TF**	**GF**	**TF**	**GF**
ACA Optional Expansion MLR Risk Corridor	25	($176.6)	$0.0	($88.3)	$0.0
This new 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.					
Managed Care Health Care Financing Program	105	N/A	N/A	$1,515.0	$454.5
This new policy change estimates increased payments to managed care plans (MCPs) designed to support payment levels to counties and/or public entities serving Medi-Cal beneficiaries.					
Managed Care Public Hospital Directed Payments	104	N/A	N/A	$1,569.0	$457.6
This new policy change budgets managed care directed payments to fund enhanced managed care capitation payments to managed care plans (MCPs) for Designated Public Hospitals (DPHs) and University of California Health Systems (UCs) to support delivery system reform.					
Managed Care Reimbursements to the General Fund	113	$0.0	($15.5)	$0.0	($1,258.7)
This policy change budgets reimbursements to the General Fund (GF) by Intergovernmental Transfer (IGT) from allowable public entities for Medi-Cal payment contributions and administration and processing fees.					
Mgd. Care Public Hospital Quality Incentive Pool	106	N/A	N/A	$640.0	$186.7
This new policy change budgets managed care directed payments to fund Quality Incentive Pool (QIP) payments by managed care plans (MCPs) to Designated Public Hospitals (DPHs) and University of California Health Systems (UCs), based on their performance on designated performance metrics.					
Managed Care Public Hospital IGTs	93	($1,162.5)	$0.0	($1,717.6)	$0.0
This policy change estimates the Intergovernmental Transfer (IGT) from Designated Public Hospitals (DPHs) to the Department that will be used as the non-federal share of capitation rate increases, as well as the related federal match portion of the capitation rate increases. FY 2017-18 is the last year for this item.					
Managed Care Rate Range IGTs	90	$409.8	$0.0	($3,409.9)	$0.0
This policy change estimates the rate range intergovernmental transfers (IGTs) from the counties or other approved public entities to the Department for providing capitation rate increases to the managed care plans. This program ends in FY 2017-18 but some payments occur in FY 2018-19.					

		Change from Appropriation		Change from FY 2017-18	
		FY 2017-18		FY 2018-19	
Name	**PC**	**TF**	**GF**	**TF**	**GF**
Managed Care IGT Admin. & Processing Fee	111	$0.0	$8.5	$0.0	$235.3
This policy change estimates the savings to the General Fund due to the rate range intergovernmental transfers (IGTs) administrative and processing fees assessed to the counties or other approved public entities. The rate range IGT portion of this PC ends in FY 2017-18.					
HQAF Rate Range Increases	96	$33.3	$0.0	($265.3)	$0.0
This policy change estimates the amount of increased rate range payments to the managed care plans because of the extension of the Hospital Quality Assurance Fee (QAF) program. The decrease in the budget year is due to the completion of payments for this program.					
CCI Managed Care Payments	91	$44.9	$22.5	($2,212.4)	($1,106.2)
This policy change estimates the capitation payments for Medi-Cal beneficiaries transitioning primarily 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 in seven counties. Effective January 1, 2018, In-Home Supportive Services is no longer included in the managed care plans, resulting in a significant decrease in FY 2018-19 costs. Changes from the prior estimate include an overall decrease in CCI beneficiaries and changes in rates.					
Home Health Rate Increase	204	N/A	N/A	$64.5	$0.0
The new proposal would increase home health agency and private duty nursing rates that are provided by fee-for-service (FFS) and Home and Community-Based Waiver providers by 50%, effective July 1, 2018. California Healthcare, Research, and Prevention Tobacco Tax Act of 2016 (Proposition 56) revenue will be used to fund the non-federal share of the home health agency rate increases.					
Hospital Quality Assurance Fee Payments	138, 139, 163, 196	($3,935.6)	$168.7	($2,470.7)	($33.0)
The HQAF 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. The HQAF estimates have been adjusted based on including a new Private Hospital Directed Payments methodology in managed care, conducting an Upper Payment Limit (UPL) review on prior years, and removing prior fee-for-service HQAF payments.					

		Change from Appropriation		Change from FY 2017-18	
		FY 2017-18		FY 2018-19	
Name	**PC**	**TF**	**GF**	**TF**	**GF**
Prop. 56 Supplemental Payments	141, 147, 148, 156, 160	($12.1)	$0.0	$878.3	$0.0
Effective April 2017, the California Healthcare, Research, and Prevention Tobacco Tax Act of 2016, or Proposition 56, increases taxes on cigarettes and tobacco. AB 120 appropriates a portion of Proposition 56 revenues to provide supplemental payments for specific physician, dental, women's health, HIV/AIDS and Intermediate Care Facilities for the developmentally disabled (ICF/DD) services. This policy change estimates the expenditures related to providing supplemental payments for specific services. FY 2017-18 includes updated costs with appropriate payment lags and FY 2018-19 includes full year costs. Additionally, FY 2018-19 includes an increase of $232.8 million Prop. 56 revenue for supplemental payments and rate increases approved in the 2017 Budget Act. Of the increased amount, $163 million is for physician payments and $70 million is for dental payments.					
Dental Retroactive Rate Changes	119	$163.0	$64.3	($186.7)	($73.4)
This policy change for FY 2017-18 only budgets the retroactive adjustments to dental managed care and Fee-for-Service rates affecting prior fiscal years and incorporates shifts in payment timing.					
Medi-Cal Estate Recoveries	185	($61.7)	($30.8)	$18.7	$9.3
The Medi-Cal ER program is one of several controls to mitigate Medi-Cal costs for care. Upon death of a Medi-Cal beneficiary, the decedent's estate or any recipient of the decedent's estate may have to pay back the costs of services through the ER program. As of January 1, 2017, SB 833 (Chapter 30, Statutes of 2016) limited the ER program to the probated estates of deceased Medi-Cal members 55 years of age and older, for only federally mandated services and also eliminated recovery if a Medi-Cal beneficiary is survived by a spouse/registered domestic partner. The change between years and from appropriation is due to an adjustment to the methodology based on recent experience.					
CMS Deferral Payments	84	$0.0	$59.3	$0.0	($65.3)
The Centers for Medicare and Medicaid Services (CMS) reviews claims submitted by Medicaid agencies and may defer payment on claims requiring additional information or claims CMS interprets as not meeting all federal funding requirements. Upon receiving a deferral, the state must immediately return the federal funds to CMS. This policy change estimates the repayment of deferred amounts, issued for Federal Fiscal Year (FFY) 2015 and after, to CMS in FY 2017-18 and FY 2018-19.					
CMS Deferral and Negative Balance Repayment	85	N/A	N/A	$0.0	$139.4
As part of the California Medi-Cal 2020 Demonstration Waiver, the Department must settle all outstanding deferrals and negative balances with the Centers for Medicare and Medicaid (CMS). The Department estimates to repay $139.4 million GF, related to negative balances, to CMS in FY 2018-19.					

		Change from Appropriation		Change from FY 2017-18	
		FY 2017-18		FY 2018-19	
Name	**PC**	**TF**	**GF**	**TF**	**GF**
School-Based Medi-Cal Administrative Activities (SMAA)	OA 1	($226.4)	$53.2	($10.7)	$110.2
The SMAA program reimburses Local Educational Agencies (LEAs), or school districts, for the federal share of certain costs for administering the Medi-Cal program. Under the 2014 CMS agreement, deferred SMAA claims from FY 2009-10 through FY 2014-15 (Quarters 1 and 2) are subject to backcasting, utilizing the newly established Random Moment Time Study (RMTS) methodology. Based on recent RMTS claims data, that backcasting may result in the collection of overpayments to LEAs. Due to the repayment timing agreed upon with CMS, the Department proposes to repay CMS with General Fund (GF) in FY 2017-18 and FY 2018-19.					
Local Education Agency (LEA) Providers	30	($10.3)	$5.2	$4.2	($5.2)
The LEA Medi-Cal Billing Option Program provides a fee-for-service model for LEAs to claim Title XIX federal funds through the Department for health-related direct services provided by qualified medical practitioners to students who are on Medi-Cal. On February 24, 2016, the independent federal auditor discovered that the LEA Billing Option Program paid out $5.213 million in ineligible Title XXI expenditures. The Department estimates to repay these funds to the Centers of Medicare and Medicaid Services with General Fund (GF) in FY 2017-18.					
County Administration	CA 1, 2	N/A	N/A	$54.8	$18.5
These policy changes reflect the allocation provided to counties for costs associated with Medi-Cal eligibility determination activities. For FY 2018-19, the separate amount for ACA implementation activities is merged with the main allocation PC. As an interim methodology, the Estimate proposes a funding increase in FY 2018-19 based on an adjustment to the existing funding level using the increase in the Consumer Price Index.					

General Information

This estimate is based on actual payment data through July 2017. 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 billion TF ($200.1 million General Funds) change in expenditures in FY 2017-18 and $1,015 million TF ($215.9 million General Funds) in FY 2018-19.