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:

\[
\begin{align*}
\text{USERS} &= f(TND, S.QV, O.QV, \text{Eligibles}) \\
\text{CLAIMS/USER} &= f(TND, S.QV, O.QV) \\
$/\text{CLAIM} &= f(TND, S.QV, O.QV)
\end{align*}
\]

WHERE:

\[
\begin{align*}
\text{USERS} &= \text{Monthly Unduplicated users by service and aid category.} \\
\text{CLAIMS/USER} &= \text{Total monthly claims or units divided by total monthly unduplicated users by service and aid category.} \\
$/\text{CLAIM} &= \text{Total monthly dollars divided by total monthly claims or units by service and aid category.} \\
TND &= \text{Linear trend variable.} \\
S.QV &= \text{Seasonally adjusting qualitative variable.} \\
O.QV &= \text{Other qualitative variable (as appropriate) to reflect exogenous shifts in the expenditure function (e.g. rate increases, price indices, etc.)} \\
\text{Eligibles} &= \text{Actual and projected monthly eligibles for each respective aid category incorporating various lag calculations for aid category within the service category.}
\end{align*}
\]
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

County and Community Outpatient
- County Hospital Outpatient
- Community Hospital Outpatient

- 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
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
- 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 ACA establishes a new income eligibility standard for Medi-Cal based upon a Modified Adjusted Gross Income (MAGI) of 133% of the federal poverty level (FPL) for pregnant women, children up to age 19, and parent/caretaker relatives. In addition, the former practice of using various income disregards to adjust family income was replaced with a single 5% income disregard. The ACA simplifies the enrollment process and eliminates the asset test for MAGI eligible. Existing income eligibility rules for aged, blind, and disabled persons did not change.

The new standard allows current recipients of Medi-Cal to continue to enroll in the program and grants the option for states to expand eligibility under MAGI standards to a new group of individuals: primarily adults, age 19-64, without a disability and who do not have minor children.
AFFORDABLE CARE ACT

The ACA also imposes a tax upon those without health coverage, which will likely encourage many individuals who are currently eligible, but not enrolled in Medi-Cal to enroll in the program. Since January 2014, the Department has experienced significant growth in Medi-Cal enrollment as result of the ACA. The tax upon those without health coverage expires January 1, 2019.

For those newly eligible adults in the expansion group, the ACA provides California with enhanced 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) FMAP provided to California by 23 percent, to 88 percent FFP, up from 65 percent.

In response to the federal ACA mandate and State legislative direction, the Department chose the HHS 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 seniors, and persons with disabilities to avoid unnecessary institutionalization. The Department administers these alternatives either as State Plan benefits or through various types of waivers.

State Plan Benefits

In-Home Supportive Services (IHSS)

IHSS helps eligible individuals pay for services so that they can remain safely in their own homes. To be eligible, individuals must meet at least one of the following:

- 65 years of age or older,
- Disabled,
- Blind, or
- Have a medical certification of a chronic, disabling condition that causes functional impairment expected to last 12 consecutive months or longer or result in death within 12 months and be unable to remain safely at home without the services.

Children with disabilities are also eligible for IHSS. IHSS provides housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments, and protective supervision for individuals with a mental impairment(s).

The four IHSS programs are:

1. Personal Care Services Program (PCSP)
   This program provides personal care services including but not limited to non-medical personal services, paramedical services, domestic services, and protective supervision.

2. IHSS Plus Option (IPO)
   This program provides personal care services but also allows the recipient of services to select a family member as a provider.

3. Community First Choice Option (CFCO)
   This program provides personal care services to those who would otherwise be institutionalized in a nursing facility.

4. Residual (beneficiaries are not full-scope Medi-Cal; State-only program with no FFP)
HOME AND COMMUNITY BASED SERVICES

Targeted Case Management (TCM)

The TCM Program provides specialized case management services to Medi-Cal eligible individuals who are developmentally disabled. These clients can gain access to needed medical, social, educational, and other services. TCM services include:

- Needs assessment
- Development of an individualized service plan
- Linkage and consultation
- Assistance with accessing services
- Crisis assistance planning
- Periodic review

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 will be 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 State Plan Amendment (SPA) is approved from October 1, 2011 through September 30, 2016. The Department initiated the 1915(i) renewal process by submitting a State Plan amendment (SPA) SPA renewal to CMS on in May 2016, 2016, which became effective on October 1, 2016.

The DD rate increase, as outlined in ABx2 1, was chaptered in October 2015. The Department and 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 includes several different increase models including a 5% rate increase on services and survey based increases on wages.

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), In-Home Operations (IHO), Home and Community Based (HCB) Alternatives Waiver Alternatives (HCBA), Multipurpose Senior Services Program (MSSP), HCBS Waiver for Persons with (DD) DD, and Pediatric Palliative Care (PPC). A beneficiary may be enrolled in only one 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.
HOME AND COMMUNITY BASED SERVICES

Assisted Living Waiver (ALW)

The ALW pays for assisted services and supports, care coordination, and community transition in 14 counties (Sacramento, San Joaquin, Los Angeles, Riverside, Sonoma, Fresno, San Bernardino, Alameda, Contra Costa, San Diego, Kern, San Mateo, San Francisco, Santa Clara, and Orange). Waiver participants can elect to receive services in a Residential Care Facility for the Elderly (RCFE), an Adult Residential Facility (ARF) or through a home health agency while residing in publicly subsidized housing. Approved capacity of unduplicated recipients for this waiver is 3,744. CMS approved a renewal of the ALW on August 28, 2014 effective from March 1, 2014 through February 28, 2019. On May 26, 2017, CMS approved an amendment to expand the ALW into San Francisco County, effective March 1, 2017. This expansion of ALW into San Francisco County allows all San Francisco Community Living Support Benefit (SF CLSB) Waiver participants the option of transitioning into the ALW. The Governor’s budget released on January 10, 2018 includes funding to add an additional 2,000 slots to the ALW starting June 1, 2018. This funding is contingent upon legislative approval and will also require the Department to submit an amendment to the ALW to CMS for approval.

Community-Based Adult Services (CBAS)

AB 97 (Chapter 3, Statutes of 2011) eliminated Adult Day Health Care (ADHC) a Medi-Cal optional benefit. A lawsuit was filed challenging elimination of ADHC (Darling et al. v. Douglas et al.), resulting in a settlement agreement between DHCS and the plaintiffs. The settlement agreement eliminated the ADHC program effective March 31, 2012, and replaced it with a new program called CBAS. CBAS is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to approved program participants. CBAS provides necessary medical and social services to individuals with intensive health care needs. CBAS became a managed care benefit effective April 1, 2012, through an amendment to the “Bridge to Reform” 1115 Medicaid waiver. Under the Bridge to Reform Waiver, CBAS was authorized for a temporary extension through December 31, 2015. The Department submitted a new waiver called the California Medi-Cal 2020 Demonstration which was approved on December 30, 2015 for five years. CBAS continues to be a waiver benefit under this new waiver until December 31, 2020. There is no cap on enrollment into this service.

Home and Community-Based Alternatives (HCB-Alternatives) (HCBA) Waiver

The HCB Alternatives HCBA Waiver will provide Medi-Cal members with long-term medical conditions, who meet the acute hospital, adult or pediatric subacute or nursing facility (NF) Level of Care (LOC), with the option of returning to and/or remaining in his or her home or home-like setting in the community in lieu of institutionalization. The Department will contract with Care Management Contractors (Waiver Agencies) for the purpose of performing waiver administration functions and directing the Comprehensive Care Management waiver service. The Waiver Agencies are responsible for functions including: participant enrollment, Level of Care (LOC) evaluations, Plan of Treatment (POT) and 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, billing the Fiscal Intermediary (FI), and provider claims adjudication.
HOME AND COMMUNITY BASED SERVICES

The Department will maintain an active role in the waiver administration by determining all waiver participant eligibility, setting enrollment goals, and providing continuous, ongoing monitoring and oversight. The Department received approval of the HCB Alternatives HCBA Waiver on May 16, 2017 with a January 1, 2017 effective date. The Department will implement the Waiver Agency model no sooner that January on July 1, 2018. The waiver renewal will serve up to 8,964 participants by the end of the 5-year waiver term.

In-Home Operations (IHO) Waiver

The IHO waiver serves either: 1) participants previously enrolled in the Nursing Facility A/B Level of Care (LOC) Waiver who have continuously been enrolled in a DHCS administered HCBS waiver since prior to January 1, 2002, and require direct care services provided primarily by a licensed nurse, or 2) those who have been receiving continuous care in a hospital for 36 months or greater and have physician-ordered direct care services that are greater than those available in the Home and Community Based Alternatives HCBA Waiver, for the participant’s assessed LOC. CMS approved the IHO waiver renewal from January 1, 2015 through December 31, 2019. The Department will not renew the IHO Waiver at the expiration of the current waiver term. At the point of annual reassessment for each participant, the Department will offer the option of transitioning to the HCB Alternatives HCBA Waiver. All IHO Waiver participants will be given sufficient notice of the waiver expiration and provided options to transition prior to the expiration of the IHO Waiver.

San Francisco Community Living Support Benefit (CLSB) Waiver

The CLSB Waiver implements AB 2968 (Chapter 830, Statutes of 2006) which allows the San Francisco Department of Public Health (SFDPH) to assist eligible individuals to move into available community settings and to exercise increased control and independence over their lives. A person eligible for the CLSB Waiver must:

- Be a resident of the city and county of San Francisco
- Be at least age 21 years or over
- Be determined to meet nursing facility level of care as defined in relevant sections of the California Code of Regulations
- Be either homeless and at imminent risk of entering a nursing facility, or, reside in a nursing facility and want to be discharged to a community setting
- Have one or more medical co-morbidities
- Be capable of residing in a housing setting with the availability of waiver services that are based on a Community Care Plan

CLSB Waiver community settings are limited to State-approved housing, which includes community care facilities licensed by the California Department of Social Services, Community Care Licensing, and Direct Access to Housing (DAH) sites operated by SFDPH.

CLSB Waiver services consist of Care Coordination, Enhanced Care Coordination, Community Living Support Benefit in licensed settings and DAH sites, Behavior Assessment and Planning, Environmental Accessibility Adaptations in DAH sites, and Home-Delivered Meals in DAH sites.
HOME AND COMMUNITY BASED SERVICES

The waiver was approved from July 1, 2012, through June 30, 2017. Due to the similarity of services offered, the Department expanded the Assisted Living Waiver (ALW) to San Francisco County effective March 1, 2017. The Department did not renew the SF CLSB waiver upon completion of its term on June 30, 2017.

Acquired Immune Deficiency Syndrome (AIDS) Medi-Cal Waiver

Local agencies, under contract with the California Department of Public Health, Office of AIDS, provide home and community-based services as an alternative to nursing facility care or hospitalization.

Services provided include:

- Administrative Expenses
- Attendant care
- Case management
- Financial supplements for foster care
- Home-delivered meals
- Homemaker services
- In-home skilled nursing care
- Minor physical adaptations to the home
- Non-emergency medical transportation
- Nutritional counseling
- Nutritional supplements
- Psychotherapy

Clients eligible for the program must be Medi-Cal recipients whose health status qualifies them for nursing facility care or hospitalization, in an aid code with full benefits and not enrolled in the Program of All-Inclusive Care for the Elderly (PACE). Waiver participants must also have a written diagnosis of HIV disease or AIDS, certified by the nurse case manager to be at the nursing facility level of care, and score 60 or less using the Cognitive and Functional Ability Scale assessment tool. Children under 13 years of age are eligible if they have been certified by the nurse case manager as HIV/AIDS symptomatic. All waiver participants must have a home setting that is safe for both the client and service providers. The Department received approval for the renewal of the HIV/AIDS Waiver on March 27, 2017.

In 2016, Californians approved Proposition 56, which will generate additional revenue for health care programs. AB 120 (Chapter 22, Statutes of 2017) provides an increase to the AIDS Waiver program of up to $8,000,000 Total Fund ($4,000,000 SF). The Department posted the information to its website in July 2017. A waiver amendment addressing these rate increases will be submitted to CMS for approval of the federal match. The proposed effective date for these changes is July 1, 2017, pending CMS approval. 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.
HOME AND COMMUNITY BASED SERVICES

Multipurpose Senior Services Program (MSSP) Waiver

The California Department of Aging currently contracts with local agencies statewide to provide social and health care management for frail elderly clients who are at risk of placement in a nursing facility but who wish to remain in the community. The MSSP arranges for and monitors the use of community services to prevent or delay premature institutional placement of these individuals. Clients eligible for the program must be 65 years of age or older, live within an MSSP site service area, be able to be served within MSSP’s cost limitations, be appropriate for care management services, be currently eligible for Medi-Cal, and can be certified for placement in a nursing facility. Services provided by MSSP include adult day care / support center, housing assistance, household and personal care assistance, protective supervision, care management, respite, transportation, meal services, social services, and communication services. Under the approved waiver, beginning July 1, 2014 through June 30, 2019, capacity of unduplicated recipients is as follows:

- Waiver Year 1: 12,000
- Waiver Year 2: 11,684
- Waiver Year 3: 11,684
- Waiver Year 4: 11,684
- Waiver Year 5: 11,684

The decrease in Waiver capacity is a result of the implementation of the Coordinated Care Initiative (CCI), demonstration program. With the implementation of the CCI program, the total number of MSSP members will be reduced based on the integration of this population into managed care no later sooner than January 1, 2020 in the six of the seven CCI counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Santa Clara. The initial reduction for the unduplicated recipients in Waiver Year 2 was a result of the completed CCI MSSP transition to managed care in San Mateo County.

A technical amendment was submitted to CMS on February 2, 2017, to restore the total number of slots for the MSSP sites in the remaining six counties. This amendment reflected restored the slots to ensure that services continue to be provided to waiver participants due to the delay of the MSSP transition into managed care to no sooner than January 1, 2020, and slots need to be restored to ensure that services continue to be provided to members. CMS approved the amendment on April 27, 2017, with an effective date of July 1, 2016.

Home and Community-Based Waiver for Persons with Developmental Disabilities (DD)

The 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 mentally retarded; in California, Intermediate Care Facility/Developmentally Disabled-type facilities, or a State Developmental Center. As of March 29, 2017, Behavioral Health Treatment (BHT) services for Waiver participants under the age of 21 is a state plan benefit paid through fee-for-service and will implement as a managed care benefit effective July 1, 2018.
HOME AND COMMUNITY BASED SERVICES

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 110,000 in 2013, 115,000 in 2014, 120,000 in 2015, 130,000 in 2018, 135,000 in 2019, and 140,000 in 2020. The waiver is approved from March 29, 2012 through December 31, 2022. Behavioral Health Treatment (BHT) services for Waiver participants under the age of 21 will be 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 Department is in the process of renewing the DD Waiver which expired on March 29, 2017. To ensure a sufficient review period, CMS approved the extension of the current waiver through June 27, 2017. The Department submitted a second extension for the Waiver through September 24, 2017 in order to resolve issues with the revenue application. The proposed effective date of the Waiver Renewal is October 1, 2017.

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.

Home and Community-Based Self Determination Program Waiver for Persons with Developmental Disabilities

The SDP waiver provides home and community-based services to persons with developmental disabilities that are able to self-direct and are Regional Center consumers. The SDP waiver is an alternative to care provided in a facility that meets the federal requirement of an Intermediate Care Facility/Developmentally Disabled-type facility, or a State Developmental Center. The estimated capacity of unduplicated recipients for the SDP is 1,000 for waiver year 1, and 2,500 for waiver years 2 and 3. The SDP will transition DD waiver participants, who can self-direct their care, at no additional cost to the General Fund. This waiver is pending CMS approval.

As of March 29, 2017, Behavioral Health Treatment (BHT) services for Waiver participants under the age of 21 will be 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 is a state plan benefit paid through fee-for-service and will implement as a managed care benefit effective July 1, 2018.

The SDP was expected to be effective July 1, 2016, as a five year waiver, ending June 30, 2021. The SDP Waiver is currently under the CMS Request for Additional Information (RAI) process as CDDS and the Department work to resolve issues with the application. The SDP RAI stops the clock on the application indefinitely until all issues are resolved, and the Department submits the application for final approval. The proposed effective date is yet to be determined.
HOME AND COMMUNITY BASED SERVICES

Pediatric Palliative Care (PPC) Waiver

The PPC provides children hospice-like services, in addition to State Plan services during the course of an illness, even if the child does not have a life expectancy of six months or less. The objective is to minimize the use of institutions, especially hospitals, and improve the quality of life for the participant and family unit (siblings, parent/legal guardian, and others living in the residence). The pilot Waiver was approved for April 1, 2009, through March 31, 2012. CMS has approved renewal of the Pediatric Palliative Care Waiver for a period of five additional years effective April 1, 2012, through December 26, 2017. Approved capacity of unduplicated recipients for this waiver is 1,800. The PPC Waiver is expected to be renewed prior to the December 26, 2017 expiration. Through the renewal, the Department is proposing to shift the waiver program to an Organized Health Care Delivery System (OHCDS). The Department will implement an administrative fee to compensate Waiver Agencies who are responsible for performing waiver administration functions. The Department submitted a waiver renewal application on September 29, 2017 to request a new five year waiver term. CMS approved a temporary extension of the PPC Waiver to May 15, 2018 and the waiver is expected to be renewed prior to the expiration.

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.
HOME AND COMMUNITY BASED SERVICES

Special Grant

California Community Transitions/Money Follows the Person (CCT/MFP) Rebalancing Demonstration Grant

In January 2007, the Centers for Medicare & Medicaid Services awarded the Department a grant for the Money Follows the Person Rebalancing Demonstration Grant, called California Community Transitions. This grant is authorized under section 6071 of the federal Deficit Reduction Act of 2005 and extended by the Patient Protection and Affordable Care Act. Grant funds may be requested from January 1, 2007, through September 30, 2020. The grant requires the Department to develop and implement strategies for transitioning Medi-Cal members who have resided continuously in health care facilities for 90 days or longer back to a federally-qualified residence. **The Department will discontinue processing new transitions effective January 1, 2019 to ensure sufficient time to bill post transition period claims and perform grant close-out functions.**
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.

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. It includes initial federal funding over the five years of $6.2 billion, with the potential for additional federal funding in the Global Payment Program (GPP) after the initial year of the waiver.

Some of the key programmatic elements of Medi-Cal 2020 are:

- Public Hospital Redesign and Incentives in Medi-Cal (PRIME) – This program builds on the success of the state’s Delivery System Reform Incentive Program (DSRIP), which was the first such transformation effort in the nation. Under PRIME, Designated Public Hospital (DPH) systems and District Municipal Public Hospitals (DMPHs) will be required to achieve greater outcomes in areas such as physical and behavioral health integration and outpatient primary and specialty care delivery. Additionally, PRIME requires DPHs to transition managed care payments to alternative payment methodologies, moving them further toward value-based payment structures over the course of the waiver. PRIME offers incentives for meeting certain performance measures for quality and efficiency. Over the course of the five years, federal funding for PRIME for DPHs is $3.27 billion, and for DMPHs is $466.5 million.

- Global Payment Program (GPP) – A new program aimed at improving the way care is delivered to California’s remaining uninsured. GPP transforms traditional hospital funding for DPHs from a system that focuses on hospital-based services and cost-based reimbursement into a value-based payment structure. Under the GPP, DPHs are incentivized to provide ambulatory primary and preventive care to the remaining uninsured through a value-based payment structure that rewards the provision of care in more appropriate settings. This new and innovative approach to restructuring these traditional hospital-focused funds allows California to better target funding for the remaining uninsured and incentivize delivery system change – focusing on the provision of primary and preventive care, and shifting away from avoidable emergency room and hospital utilization. The federal funding for GPP will be a combination of the DSH funding for participating DPHs and $236 million in federal funding for the first year from the prior SNCP. The non-DSH funding for years two through five will continue to be $236 million in federal funding.

- Dental Transformation Initiative (DTI) – For the first time, California’s Waiver also includes opportunities for improvements in the Medi-Cal Dental Program. The DTI
1115 WAIVER-MH/UCD, BTR, & MEDI-CAL 2020

provides incentive payments to Medi-Cal dental providers who meet certain requirements and benchmarks in critical focus areas such as preventive services and continuity of care. Over the course of the waiver, up to $750 million in total funding is available under DTI. The non-federal share for DTI will be funded through State General Fund savings achieved through limited continuation of Designated State Health Program (DSHP) funding.

- Whole Person Care (WPC) Pilots – Another innovative component of Medi-Cal 2020 will allow for county-based pilots to target high-risk populations. The overarching goal of the WPC pilots is the integration of systems that provide physical health, behavioral health, and social services to improve members’ overall health and well-being, with the goals of improved beneficiary health and well-being through more efficient and effective use of resources. WPC Pilots may also choose to expand access to supportive housing options for these high-risk populations. The waiver renewal authorized up to $1.5 billion in federal funding over the five years; WPC Pilot lead entities will provide the non-federal share.

- In addition to these programs, Medi-Cal 2020 continues authorities for the Medi-Cal managed care program, Community-Based Adult Services, the Coordinated Care Initiative (including CalMediConnect), and the Drug Medi-Cal Organized Delivery System.
MANAGED CARE

Medi-Cal Managed Care Rates

Base rates are developed utilizing plan reported costs and utilization data by category of services (i.e. Inpatient, Emergency Room, Pharmacy, Primary Care Provider, Specialist, etc.) for each category of aid (COA). Actuaries review the base data for reasonableness and make adjustments to remove costs for services or populations that are not included in the capitation rates for the future rating period.

Trends and programmatic changes, as well as administrative and underwriting loads, are then applied to arrive at reasonable, appropriate, and attainable plan-specific rates.

Capitation rates are risk adjusted to better reflect the match of a plan’s expected costs to the plan’s risk. Capitation rates are risk adjusted in the Child, Adult/Family, Seniors and Persons with Disabilities (SPD), and ACA Optional Expansion (ACA OE) COAs.

Risk adjustment and county averaging is prepared with plan-specific pharmacy data (with National Drug Codes) gathered for managed care and Fee-For-Service (FFS) enrollment data for the most recent 12-month period.

Risk adjustment is performed using the Medicaid RX risk adjustment software from UC San Diego. Medicaid RX classifies risk by 11 age bands, gender, and 45 disease categories. Each member in the Child, Adult/Family, SPED, and ACA OE rate categories in a specific plan who meets certain eligibility criteria, is assigned a risk score. Member scores are aggregated for each plan operating in a county and a county-specific rate is then developed for each COA based on the sum of the plan-specific rates weighted for each plan’s enrollment. For the FY 2017-18 rates, each plan’s final rate is a blend consisting of 70% of the county-specific rate and 30% of the plan’s plan-specific rate. County Organized Health Systems (COHS) rates are not risk adjusted due to the presence of only one plan in each county. The risk adjustment policy is examined on an ongoing basis and adjusted if necessary.

Occasionally, when deemed necessary, the State will implement supplemental payments to help mitigate risk for unpredictable utilization trends. The State has also implemented supplemental payments for the costs of providing Hepatitis C drug treatment and Behavioral Health Treatment for children diagnosed with Autism Spectrum Disorder.

SBX2-2 (Chapter 2, Statutes of 2016) was signed by the Governor on March 1, 2016, and provides for a statewide tax on managed care plans based on enrollment into these plans. The tax is tiered based on whether the enrollee is a Medi-Cal enrollee, alternate health care service plan enrollee, or other enrollee. The MCO Enrollment tax is effective July 1, 2016 through June 30, 2019.

The 2017 Governor’s Budget estimate of the Coordinated Care Initiative (CCI) projected that it will no longer be cost-effective. Therefore, pursuant to the provisions of current law, the program will discontinue in FY 2017-18. The 2017 Budget Act discontinued the Coordinated Care Initiative (CCI) program, effective January 1, 2018. Based on the lessons learned from the CCI demonstration project, the 2017 Budget proposed the extension of 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 would be removed from capitation rate payments effective January 1, 2018.

Capitation payments for Medi-Cal enrollees participating in CCI are subject to risk corridor calculations that may result in additional payments to or recoupments from participating health plans for historical contract periods. Corridors are in place for CMC and non-CMC full dual members and for non-full dual members enrolled in managed care in CCI counties. Specifically, for CMC, there are limited up-side and down-side risk corridors from April 1, 2014, through December 31, 2017. For non-CMC members, there is a 24-month symmetrical down-side and up-side risk corridor, as specified in W&I Code section 14182.18 and in the existing Medi-Cal MCP contracts.

**Fee-for-Service (FFS) Expenditures for Managed Care Beneficiaries**

Managed care contracts require health plans to provide specific services to Medi-Cal enrolled beneficiaries. Medi-Cal services that are not delegated to contracting health plans remain the responsibility of the Medi-Cal FFS program. When a beneficiary who is enrolled in a Medi-Cal managed care plan is rendered a Medi-Cal service that has been explicitly excluded from their plan’s respective managed care contract, providers must seek payment through the FFS Medi-Cal program. The services rendered in the above scenario are commonly referred to as “carved out” services. “Carved-out” services and their associated expenditures are excluded from the capitation payments and are reflected in the Medi-Cal FFS paid claims data.

In addition to managed care carve-outs, the Department is required to provide additional reimbursement through the FFS Medi-Cal program to Federally Qualified Health Center/Rural Health Clinic providers who have rendered care to beneficiaries enrolled in managed care plans. These providers are reimbursed for the difference between their prospective payment system rate and the amount they receive from managed care health plans. These FFS expenditures are referred to as “wrap-around” payments.

FQHC “wrap-around” payments and California Children’s Services “carve-out” expenditures account for roughly 70% of all FFS expenditures generated by Medi-Cal beneficiaries enrolled in managed care plans.

**2017-18 and 2018-19 Rates**

Rates for FY 2017-18 represent a 1.86% increase in classic rates over the 2016-17 fiscal year rates and assume the Optional Expansion rates are held constant. Rates for FY 2018-19 represent a 2.75% increase in classic rates over the 2017-18 fiscal year rates.
PROVIDER RATES

Reimbursement Methodology and the Quality Assurance Fee for AB 1629 Facilities

AB 1629 requires the Department to develop a cost-based, facility-specific reimbursement rate methodology for freestanding skilled (level B) nursing facilities, including subacute units which are part of a freestanding skilled nursing facility. 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 SNFs based on five cost categories, which are subject to limits. Limits are set based on expenditures within geographic peer groups. Also, costs specific to one category may not be shifted to another cost category.

**Labor:** This category has two components: direct resident care labor costs and indirect care labor costs.

- Direct resident care labor costs include salaries, wages and benefits related to routine nursing services defined as nursing, social services and personal activities. Costs are limited to the 90th percentile of each facility’s peer group.

- Indirect care labor includes costs related to staff support in the delivery of patient care including, but not limited to, housekeeping, laundry and linen, dietary, medical records, in-service education, and plant operations and maintenance. Costs are limited to the 90th percentile of each facility’s peer group.

**Indirect care non-labor:** This category includes costs related to services that support the delivery of resident care including the non-labor portion of nursing, housekeeping, laundry and linen, dietary, in-service education, pharmacy consulting costs and fees, plant operations and maintenance costs. Costs are limited to the 75th percentile of each facility’s peer group.

**Administrative:** This category includes costs related to allowable administrative and general expenses of operating a facility including: administrator, business office, home office costs that are not directly charged and property insurance. This category excludes costs for caregiver training, liability insurance, facility license fees and medical records. Costs are limited to the 50th percentile.

**Fair rental value system (FRVS):** This category is used to reimburse property costs. The FRVS is used in lieu of actual costs and/or lease payments on land, buildings, fixed equipment and major movable equipment used in providing resident care. The FRVS formula recognizes age and condition of the facility. Facilities receive increased reimbursement when improvements are made.

**Direct pass-through:** This category includes the direct pass-through of proportional Medi-Cal costs for property taxes, facility license fees, caregiver training costs, and new state and federal mandates including the facility’s portion of the QAF.
PROVIDER RATES

Quality and Accountability Supplemental Payment Program

SB 853 (Chapter 717, Statutes of 2010) requires the Department to implement a Quality and Accountability Supplemental Payment (QASP) Program for SNFs by August 1, 2010. The QASP Program will enable SNF reimbursement to be tied to demonstrated quality of care improvements for SNF 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, 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.

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.

Property Taxes (Typically 0.5 percent of total costs). Property taxes are updated 2% annually, as allowed under Proposition 13.

Labor Costs (Typically 65 percent of total costs). Labor costs, i.e., wages, salaries, and benefits, are by far the majority of operating costs in a nursing home. The inflation factor for labor is calculated by DHCS based on reported labor costs.

All Other Costs (Typically 24 percent of total costs). The remaining costs, "all other" costs, are updated by the California Consumer Price Index.

Methodology by Type of LTC Facility

Projected costs for each specific facility are peer grouped by licensure, level of care, and/or geographic area/bed size.

Intermediate Care Facilities (Freestanding Nursing Facilities-Level A, NF-A) are peer-grouped by location. Reimbursements are equal to the median of each peer group.
PROVIDER RATES

Distinct Part (Hospital-Based) Nursing Facilities-Level B (DP/NF-B) are grouped in one statewide peer group. DP/NF-Bs are paid their projected costs up to the median of their peer group. When computing the median, facilities with less than 20 percent Medi-Cal utilization are excluded.

Intermediate Care Facilities for the Developmentally Disabled, Developmentally Disabled-Habilitative, and Developmentally Disabled-Nursing (ICF/DD, ICF/DD-H, ICF/DD-N) are peer grouped by level of care and bed size. Effective June 2014, providers of services to developmentally disabled clients have rates set as follows: Each rate year, individual provider costs are rebased using cost data applicable for the rate year. Each ICF/DD, ICF/DD-H or ICF/DD-N will receive the lower of its projected costs plus 5% or the 65\textsuperscript{th} percentile established in 2008-2009, with none receiving a rate lower than 90% of the 2008-2009 65\textsuperscript{th} percentile.

Effective August 1, 2016, ABX2 1 (Chapter 3, Statutes of 2016) requires the Department to reimburse ICF/DD, ICF/DD-H, and ICF/DD-N providers the rate in effect in 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.

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 and freestanding nursing facility providers. There are different rates for ventilator and non-ventilator patients. Reimbursement is based on a model since historical cost data were not previously available.
### REVENUES

1. **Revenues**

The State is expected to receive the following revenues from quality assurance fees (accrual basis):

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Revenue (in USD)</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td><strong>FY 2016-17:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$27,184,000</td>
<td>ICF-DD Quality Assurance Fee</td>
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<tr>
<td></td>
<td>$520,740,000</td>
<td>Skilled Nursing Facility Quality Assurance Fee (AB 1629)</td>
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<tr>
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<td>$9,874,000</td>
<td>ICF-DD Transportation/Day Care Quality Assurance Fee</td>
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<tr>
<td></td>
<td>$1,267,000</td>
<td>Freestanding Pediatric Subacute Quality Assurance Fee</td>
</tr>
<tr>
<td></td>
<td>$2,283,263,000</td>
<td>MCO Enrollment Tax</td>
</tr>
<tr>
<td></td>
<td>$4,330,242,000</td>
<td>Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)</td>
</tr>
<tr>
<td></td>
<td>$7,800,000</td>
<td>Emergency Medical Air Transportation (EMATA) Fund</td>
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<tr>
<td></td>
<td>$7,180,370,000</td>
<td>Total</td>
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<tr>
<td><strong>FY 2017-18:</strong></td>
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<tr>
<td></td>
<td>$26,351,000</td>
<td>ICF-DD Quality Assurance Fee</td>
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<tr>
<td></td>
<td>$503,746,000</td>
<td>Skilled Nursing Facility Quality Assurance Fee (AB 1629)</td>
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<td></td>
<td>$10,165,000</td>
<td>ICF-DD Transportation/Day Care Quality Assurance Fee</td>
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<tr>
<td></td>
<td>$933,000</td>
<td>Freestanding Pediatric Subacute Quality Assurance Fee</td>
</tr>
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<td></td>
<td>$2,428,921,000</td>
<td>MCO Enrollment Tax</td>
</tr>
<tr>
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<td>$3,790,120,000</td>
<td>Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)</td>
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<td>$7,008,000</td>
<td>Emergency Medical Air Transportation (EMATA) Fund</td>
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<td></td>
<td>$6,767,244,000</td>
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<td><strong>FY 2018-19:</strong></td>
<td></td>
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<tr>
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<td>ICF-DD Quality Assurance Fee</td>
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<td>$533,971,000</td>
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<td>Freestanding Pediatric Subacute Quality Assurance Fee</td>
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<td>$4,047,768,000</td>
<td>Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)</td>
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<tr>
<td></td>
<td>$7,008,000</td>
<td>Emergency Medical Air Transportation (EMATA) Fund</td>
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Effective August 1, 2009, the Department expanded the amount of revenue upon which the quality assurance fee for AB 1629 facilities is assessed, to include Medicare.

Effective January 1, 2012, pursuant to ABX 1 19 (Chapter 4, Statutes of 2011), the Department will implement a QA fee from Freestanding Pediatric Subacute Care facilities, pending CMS 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 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 Quality Assurance Fee (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.

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 532 (Chapter 773, Statutes of 2017) implements a Ground Emergency Medical Transportation (GEMT) Quality Assurance Fee (QAF) on all ground emergency medical transports, effective July 1, 2018. The QAF will be assessed on each GEMT transport for base ground emergency medical services. The revenue generated by the QAF collections will be deposited directly into the Medi-Cal Emergency Medical Transportation Fund (MEMTF).

ELIGIBILITY

1. Impact of SB 708 on Long-Term Care for Aliens

Section 4 of SB 708 (Chapter 148, Statutes of 1999) reauthorizes state-only funded long-term care for eligible aliens currently receiving the benefit (including aliens who are not lawfully present). Further, it places a limit on the provision of state-only long-term care services to aliens who are not entitled to full-scope benefits and who are not legally present. This limit is at 110% of the FY 1999-00 estimate of eligibles, unless the legislature authorizes additional funds. SB 708 does not eliminate the uncoded 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.
2. **Refugee Resettlement Program**

The federal Refugee Resettlement Program provides medical services to refugees during their first eight months in the United States. In California, these medical services are provided through the Medi-Cal delivery system and funded with 100% federal funds through a federal grant. The California Department of Public Health administers the Refugee Resettlement Program federal grant. With the Affordable Care Act, a majority of refugees are expected to be eligible for Medi-Cal and will no longer receive their medical services through the Refugee Resettlement Program. The Department expects the number of eligibles receiving their medical services under the Refugee Resettlement Program to be negligible. All medical costs associated with the Refugee Resettlement Program will be funded 100% through the federal grant.

3. **FFP Claiming Methodology Update for Lawfully Present Pregnant Women and Children**

Under an approved State Plan Amendment, the Department may claim Federal Financial Participation (FFP) for full scope Medi-Cal services provided to eligible documented immigrants who are lawfully present in the United States if they are under 21 years of age or pregnant. This includes New Qualified Immigrants and other lawfully present immigrants as defined by the federal government. The Department has determined that some of these immigrants who are currently claimed at a 50/50 federal/state matching rate are eligible for a higher FFP matching rate (currently 88/12). The Department is reviewing current claiming methodology for this population. When that analysis is completed, the Department will take the steps necessary to claim any additional FFP available.

4. **County Health Initiative Matching (CHIM) – Santa Clara County**

AB 495 created the CHIM fund to provide funds for the County Children’s Health Initiative Program. This program provides health insurance coverage to low income children under the age of 19. Santa Clara County has not submitted claims for quarters following December 2013, due to the funds that they received from a county tax initiative. The Department removed Santa Clara County funding reimbursements from the May 2018 estimate. Since then, Santa Clara County reported that the funds from the tax initiative will no longer available after September 2019, and that the county will begin seeking reimbursement through the Department for future estimate cycles. Santa Clara County will be included in the November 2018 estimate and beyond to estimate the reimbursement for their CHIM program.

**AFFORDABLE CARE ACT**

1. **Realignment**

Under the Affordable Care Act, county costs and responsibilities for indigent care are expected to decrease as uninsured individuals obtain health coverage. The State, in turn will bear increased responsibility for providing care to these newly eligible individuals through the Medi-Cal expansion. The budget sets forth two mechanisms for determining
INFORMATION ONLY

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.

The redirected amounts will be calculated by the Department, but will not be included in the Department’s budget. Savings are estimated to be $1.006 billion for FY 2014-15, $585.9 million for FY 2016-17, $688.8 million for FY 2017-18, and $530.47 $665.26 million for FY 2018-19.

2. Disproportionate Share Hospital Reduction

The ACA reduction in the Disproportionate Share Hospital (DSH) allotments was to have gone into effect on October 1, 2013: instead, HR 2 (2015) was enacted on April 16, 2015, which delayed the start of the reductions until October 1, 2017. HR 1892 was enacted on February 9, 2018, which further postpones the reduction until October 1, 2019. The ACA nationwide reduction of State DSH allotments will begin to occur in FY 2019-20. The reduction for each state will be determined by CMS.

For Federal Fiscal Year 2020, an aggregate of $4 billion in reduction for all states has been determined, but state specific reductions have not been released by CMS.

BENEFITS

1. Pompe Disease and Hurler’s Syndrome Identified through Newborn Screening Program (NBS)

SB 1095 (Chapter 393, Statute of 2016) requires that statewide newborn screening be expanded to include any disease that is detectable in blood samples as soon as practicable, but no later than 2 years after the disease is adopted by the federal Recommended Uniform Screening Panel (RUSP). Hurler’s Syndrome (also known as MPS I) and Pompe Disease are two conditions previously adopted by the RUSP when SB 1095 was enrolled. The Genetic Disease Screening Program (GDSP) is now required to add these two conditions to the NBS Program and anticipates initiation of universal screening of all newborns for Hurler’s Syndrome and Pompe Disease beginning in August 2018.
INFORMATION ONLY

Children identified through the NBS Program as having, or at risk of having, Hurler’s Syndrome or Pompe Disease will require confirmatory testing/diagnostic studies, clinical/medical management, monitoring, and treatment. There could be a potential indeterminate cost impact to the program due to earlier detection and implementation of services.
HOME & COMMUNITY BASED-SERVICES

1. **Electronic Visit Verification**

   Electronic Visit Verification (EVV) must be implemented for Medicaid-funded personal care services by January 2019, and home health care services by January 2023, pursuant to subsection l, section 1903 of the Social Security Act (42 U.S.C. 1396b) enacted in December 2016. EVV must be developed and implemented, including education and training for all IHSS providers and recipients.

   While the State intends to comply with the federal law to implement EVV, the process will take time to identify and procure a system that is easy to use for providers and recipients, as well as support more than a million recipients and providers transitioning to an EVV. It is unlikely this will be accomplished by the January 2019 deadline. If the State does not meet the deadline, a federal penalty will be assessed.

   This penalty would reduce the Federal Medical Assistance Percentage rate for the IHSS program by 0.25 percentage points starting in January 2019 and increasing each year by 0.25 percentage points to a maximum of one percent in 2023.

BREAST AND CERVICAL CANCER TREATMENT

PHARMACY

1. **State Supplemental Drug Rebates – Managed Care**

   State supplemental rebates for drugs are negotiated by the Department with drug manufacturers to provide rebates in addition to the mandatory federal rebates already collected. SB 870 (Chapter 40, Statute of 2014) authorizes the Department to include utilization data from MCOs to determine and collect state supplemental rebates for prescription drugs added to the Medi-Cal Statewide Contract Drug List pursuant to Welfare & Institutions Code section 14105.33. Examples of prescription drugs subject to MCO state supplemental rebates may include drugs to treat diseases such as, but not limited to, cancer, HIV/AIDS, hemophilia and hepatitis C. The Department is not actively pursuing contracts for these rebates. **Subsequent to SB 870, the Department is in the process of developing a Regulation Package. The tentative release date for public comments is no sooner than the first quarter of 2018. The Department does not anticipate entering into contracts with manufacturers prior to completion of the regulations. The fiscal impact has not been determined.**

2. **Outpatient Prescription Drug Rule – Blood Factor**

   On February 1, 2016, CMS published the Final Rule for Covered Outpatient Drugs, effective April 1, 2016. In December 2016, CMS required the Department to change its reimbursement methodology for blood factor products and services. The changes require federal approval via a State Plan Amendment (SPA). Appropriate billing codes and a rate
methodology must be determined prior to submission of the SPA and initiation of system changes are necessary to process blood factor claims to meet the directives of CMS. Therefore, implementation of this new reimbursement methodology is expected no sooner than August 2018 in FY 2018-19. The fiscal impact of the change to blood factor reimbursement has yet to be determined.

3. **Pharmacist-Delivered Medi-Cal Services**

AB 1114 (Chapter 602, Statutes of 2016) authorizes pharmacies to bill Medi-Cal for covered pharmacist services provided to Medi-Cal beneficiaries. These services include administering immunizations, furnishing hormonal contraceptives, naloxone, nicotine replacement therapy, and travel medicines, as well as smoking cessation counseling. Implementation of this bill would require:

1) Identifying the proper procedure codes and developing reimbursement rates for pharmacist services at 85% of the fee schedule for physician services;

2) Developing a State Plan Amendment and obtaining CMS approval for a new payment methodology; and

3) System changes to allow processing of pharmacy claims for these specific Medi-Cal covered pharmacist services.

AB 1114 mandates regulations are to be adopted by July 1, 2021. Beginning July 1, 2017, the Department will provide a status report to the Legislature on a semi-annual basis until regulations have been adopted. At this time, the estimated implementation date is unknown. **Given the unknown implementation details and uncertain provider participation, the timing and fiscal impact has not been determined.**

4. **New High Cost Treatments for Specific Conditions**

There are additional treatments approved and ready to be phased into use.

**L-Glutamine oral powder (Endari)** is a lifetime treatment to reduce complications of sickle cell disease in patients 5 years of age and older. The Federal Food and Drug Administration (FDA) approved L-Glutamine oral powder on July 7, 2017, for ages five years and older to reduce complications of this disease.

**Emicizumab-kxwh (Hemlibra)** is a lifetime treatment of Hemophilia A (Factor VIII deficiency) with inhibitors. The FDA approved the treatment on November 16, 2017, for children and adult hemophilia patients to bridge the gap between Factor IX and Factor X in the clotting cascade, to bypass the function of Factor VIII.

**Axicabtagene ciloleucel (Yescarta)** is a one-time treatment for youth and adults, aged 18 and over with refractory or relapsing large B-cell lymphoma. The FDA approved the drug for treatment of individuals with types of refractory or relapsing large B-cell lymphoma (DLBCL), a type of non-Hodgkin lymphoma (NHL) whose cancer has either
not responded to or returned after two or more attempts at standard systemic therapy.

Voretigene neparvovec-rzyl (Luxturna) is a proposed one-time treatment for “biallelic RPE65 mutation-associated retinal dystrophy.” The FDA approved this drug on December 19, 2017, as a new gene therapy to treat children and adults with confirmed “biallelic RPE65 mutation-associated retinal dystrophy,” an inherited form of impaired vision that may progress to complete blindness. There is no age restriction; however, there must be “viable retinal cells” remaining to treat.

On August 30, 2017, the FDA approved the first FDA-approved gene therapy in the United States. The treatment is for children and young adults up to 25 years of age with B-cell acute lymphoblastic leukemia (ALL). The gene therapy is called Chimeric Antigen Receptor T-Cell Therapy (CAR-T) using the drug Kymirah. The therapy is administered in a single treatment and less expensive than some bone marrow transplants. The treatment is estimated to be around $475,000 per patient.

**DRUG MEDI-CAL**

Naltrexone Treatment Services

This assumption has been deleted as this has been withdrawn.

1. **FQHCs and RHCs: DMC and SMHS**

Effective January 1, 2018, SB 323 (Chapter 540, Statute of 2017) allows federally qualified health centers (FQHCs) and rural health clinics (RHCs) to be reimbursed directly from a county or the Department for providing Specialty Mental Health Services (SMHS) and Drug Medi-Cal (DMC) services to Medi-Cal beneficiaries. SB 323 clarifies the process for FQHCs and RHCs to become billable providers for SMHS and DMC services. Per SB 323, costs associated with providing SMHS and DMC services shall not be included in the FQHC’s or RHC’s per-visit PPS rate.

**MENTAL HEALTH**

Mental Health Parity

This assumption has been deleted as this is now a policy change, Managed Care Regulations – MH Parity.

Comprehensive Behavioral Health Data Modernization Project

This assumption has been deleted as this has been withdrawn.

1. **Specialty Mental Health Services (SMHS) Claim Adjudication Errors**

The Department discovered claim adjudication errors resulting from Short-Doyle/Medi-Cal (SDMC) Phase II system coding that prevented SMHS claims from being adjudicated
correctly and/or completely. System issues include claims with multiple aid codes. Beneficiaries can have up to four approved aid codes. Payments were denied because the SDMC II system adjudicates claims based on the aid code with the highest percentage of FFP. If that aid code was denied, the system did not select another aid code listed on the claim and the claim was denied.

The Department will need General Fund to reimburse County Mental Health Plans (MHPs) for SMHS claims that identified as unpaid and are past the two-year FFP claiming limit. The Department is working to identify the total amount.

2. FQHCs and RHCs: DMC and SMHS

Effective January 1, 2018, SB 323 (Chapter 540, Statute of 2017) allows federally qualified health centers (FQHCs) and rural health clinics (RHCs) to be reimbursed directly from a county or the Department for providing Specialty Mental Health Services (SMHS) and Drug Medi-Cal (DMC) services to Medi-Cal beneficiaries. SB 323 clarifies the process for FQHCs and RHCs to become billable providers for SMHS and DMC services.

Per SB 323, costs associated with providing SMHS and DMC services shall not be included in the FQHC’s or RHC’s per-visit PPS rate. The Department initially estimated the number of clinics that may participate in the provision of SMHS to be 15 percent of FQHCs and RHCs in the State.

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 (federal funding) balances and deferred claims.

- Negative PMS subaccount balances: Pursuant to STC 164 of the Medi-Cal 2020 waiver, negative PMS subaccount balances for federal fiscal year (FFY) 2013 and prior must be resolved by the end of the Medi-Cal 2020 waiver period (December 31, 2020). California and 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 requirements had been met and that they would be sending written confirmation. As of January 2018, 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 disallowance 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. Approval of these adjustments will not be realized until CMS finalizes these quarters which is expected to occur in December 2017, at the earliest. If CMS disallows adjustments or claims,
INFORMATION ONLY

California will have the right to appeal them. STC 469 164 further required requires that, if the appeal is unsuccessful, for negative PMS subaccount balances identified in CMS’ demand letter, California will need to repay CMS, in even regular quarterly installments, with interest, during the life by the end of the Medi-Cal 2020 waiver (December 31, 2020) or in three years from CMS’ approval of California’s repayment schedule, whichever is longer. Interest begins on the date of CMS’ demand letter. Until California receives the written confirmation from CMS that the requirements of STC 160 have been fulfilled, it is unknown when interest will begin for repayments.

- 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, after which However, if the appeal is unsuccessful, California will be required to reimburse the remaining 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 will 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 federal fiscal year 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 Special Terms and Conditions 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.

2. BTR Designated State Health Program Reconciliation

The Centers for Medicare & Medicaid Services (CMS) approved the BTR effective November 1, 2010. The Special Terms and Conditions allow the State to claim FFP using the Certified Public Expenditures (CPEs) of approved Designated State Health Programs (DSHP). The annual limit the State-Only programs may claim for DSHP is $400 million each Demonstration Year (DY) for a five-year total of $2 billion. This claiming has first priority on the Safety Net Care Pool funds. In addition to the State-Only programs, the Designated Public Hospitals (DPHs) are allowed to voluntarily provide excess CPEs as necessary for the State to claim the full $400 million.

The DSHP program undergoes a reconciliation to determine expenditures for each DY. Currently DY 8, DY 9, and DY 10 are still undergoing reconciliations. Until the entire Demonstration Period is fully reconciled across all DSHP programs, the State will not
INFORMATION ONLY

able to estimate the final reconciliation amounts; however, it is anticipated to have a fiscal impact.

MANAGED CARE

1. Managed Care Public and Private Directed Payments

CMS is currently reviewing the Department’s proposals for the Public and Private Directed Payment programs, which both begin July 1, 2017 with the FY 2017-18 rating period. All dollars budgeted for these two programs are anticipated to pay in FY 2019-20. As a result of this change, these two policy changes have been removed from the May 2018 Estimate. A combined $3.7B in total funds is estimated to be budgeted in the November 2018 Estimate.

PROVIDER RATES

Ground Emergency Medical Transportation Quality Assurance Fee

This assumption has been deleted as this is now a new policy change, Ground Emergency Medical Transportation QAF.
SUPPLEMENTAL PAYMENTS

1. **Capital Project Debt Reimbursement**

   In February 2014, Los Angeles County requested reimbursement of a $322 million bond project for the Construction, Renovation and Reimbursement Program (CRRP). The project was completed in April 2014. The Department is currently working with Los Angeles County to determine eligibility for this project under the CRRP program.

2. **Local Educational Agency Medi-Cal Billing Option Program (LEA BOP) Expansion**

   SPA 15-021: The Medi-Cal LEA BOP provides federal financial participation (FFP) reimbursement to school districts, county offices of education, community colleges, and university campuses for certain health-related services provided by qualified medical practitioners to students receiving special education services and who are Medi-Cal eligible.

   In September 2015, the Medi-Cal LEA BOP submitted State Plan Amendment (SPA) 15-021 to the Centers for Medicare and Medicaid Services (CMS) for approval to add new assessment/treatment services, and new practitioner types, and to lift the claiming limitation of 24 services in a 12 month period for beneficiaries without an Individualized Education Plan or Individualized Family Service Plan (IEP/IFSP), effective July 1, 2015. Once approved, the Department assumes that LEAs would choose to bill retroactively for new services and practitioners, provided they meet specific documentation requirements. In order for the SPA to be implemented, the new services and practitioners must be administered into the program and published in the LEA Provider Manual, and Xerox must develop and apply an updated rate table and utilization controls. At this time, the Department does not have an estimate of when SPA 15-021 will be approved and implemented. SPA 15-021 is estimated to increase LEA BOP FFP payments. There will be no GF impact.

   SPA 16-001: SB 276 (Chapter 653, Statutes of 2015) amended Welfare and Institutions Code 14132.06 requiring that Targeted Case Management (TCM) Services be available to all Medicaid eligibles regardless of whether they have an IEP/IFSP. On March 29, 2016, SPA 16-001 was submitted to CMS which proposes to amend the population receiving TCM services in the LEA Program to include all Medicaid eligibles, regardless of whether they have an IEP/IFSP under the Individuals with Disabilities Education Act. Approval of SPA 16-001 will align California with the provisions in Welfare and Institutions Code 14132.06.

   The reimbursement methodology for the TCM services described in SPA 16-001 is under review by CMS, pending approval of SPA 15-021, due to the overlapping nature of these two SPAs. Once SPA 15-021 is approved, the Department will submit reimbursement pages under SPA 16-001, from SPA 15-021, which will reflect the expanded TCM-eligible population to include all Medi-Cal eligible children, regardless of whether they have an IEP/IFSP.

   The expected impact of SPA 16-001 to the LEA Program includes expanded access of care for individuals on school sites receiving TCM services and an increase of FFP for Medi-Cal covered TCM services.
3. **Freestanding Clinics Supplemental Payments**

The Public Freestanding Non-Hospital Based Clinics (PFNC) Supplemental Reimbursement Program, authorized by the California State Plan, Supplement 10 to Attachment 4.19-B, was approved by the Centers for Medicare and Medicaid Services (CMS) on August 8, 2012, with a retroactive date of October 14, 2006.

CMS approved a revised cost report in June 2017. However, despite the efforts undertaken to date to implement the program, there has been little interest from the provider community. Only two clinics have submitted the required program eligibility documents for participation in FY 2017-18. Due to insufficient interest in the program and not enough participants to reimburse the Department for the cost of administering the program, as set forth in the requirements of Welfare and Institutions Code Section 14105.965, the Department proposes to not implement the PFNC program. The Department will propose trailer bill language to remove the PFNC from statute.

**OTHER: AUDITS AND LAWSUITS**

Audit of California’s Claims for Specialty Mental Health Services, Federal Fiscal Year 2014

*This assumption has been deleted as this will be included in a policy change, Audit Settlements.*

1. **SB 1103 Litigation**

   - **OAHA Administrative Appeals and Superior and Appellate Court Actions**

     In 2005, approximately 100 California hospitals sued the Department to challenge the validity of a Medi-Cal reimbursement rate limit for in-patient services provided by non-contract hospitals that was enacted by Senate Bill 1103. During the pendency of this litigation, more than 50 non-contract hospitals filed administrative appeals with the Department’s Office of Administrative Hearings and Appeals (OAHA). All challenge SB 1103’s validity and, so, seek a retroactive reimbursement rate increase for FY 2004-05, based on SB 1103’s alleged invalidity.

     OAHA has been holding these administrative appeals in abeyance during the Mission Hospital Regional Medical Center v. Douglas litigation, which finally terminated in early 2014. OAHA dismissed at least 24 of the SB 1103 administrative appeals on the grounds that these appeals are precluded by res judicata, that is, by the Mission litigation’s challenge to SB 1103. In approximately 16 cases, the dismissed hospitals have filed petitions for writ of mandate with the Los Angeles County Superior Court seeking to compel OAHA to order the Department to recalculate their reimbursement rate and pay the increased rate. In three such cases, the superior court denied the writ petitions and the hospitals appealed. (Dignity Health v. Douglas; Hi-Desert Med. Center v. Douglas & Modoc Med. Center v. Douglas). In four other cases, the superior court granted the writ petitions and the Department appealed one (George L. Mee Mem’l Hosp. v. Douglas). The appellate
court heard these four cases together and, in August 2015, found that each hospital’s case was barred by its participation in the Mission litigation. The hospitals sought rehearing before the appellate court and filed a petition for review with the Supreme Court, both of which were denied. Since the California Supreme Court denied the petition for review, all remaining superior court petitions were dismissed.

The Department also appealed two other cases in which the superior court had granted the hospital’s writ petition. (Desert Valley Hosp. v. Douglas & Ridgecrest Regional Hosp. v. Douglas.) Because Desert Valley Hospital did not participate in the Mission litigation and actively tried to pursue its administrative appeal while Mission was pending, the Department settled this case for $500,000. The Department did, however, pursue the Ridgecrest appeal. In an unpublished opinion, the Second District Court of Appeal affirmed the lower court’s decision granting Ridgecrest’s writ petition. The Department subsequently negotiated a $315,000 settlement with Ridgecrest resolving all outstanding issues, including attorney’s fees, related to the administrative appeal, petition for writ of mandate, and subsequent appeal.

In mid-October 2016, four administrative appeals were still pending before OAHA, all of which involve hospitals that did not participate in the Mission litigation. Given the Court of Appeal’s opinion in Ridgecrest, the Department began negotiating settlements with these providers. A settlement of $220,000 was reached in the Children’s Hospital at Mission consolidated appeal, a $77,895 settlement was obtained in the Community Hospital of Monterey Peninsula matter, and a $1,775,977 settlement was negotiated in Enloe Medical Center. OAHA issued final decisions incorporating the Children’s Hospital at Mission, Community Hospital of Monterey Peninsula, and Enloe Medical Center settlement agreements on November 3, 2016, November 7, 2016, and March 21, 2017, respectively. OAHA discovered a fifth administrative appeal involving Community Hospital of Long Beach, a non-Mission litigant, which was previously unknown to the Department. The Department continues to negotiate settlements in the two administrative appeals that remain before OAHA.

To date, no court has ruled on SB 1103’s substantive validity.

2. Santa Rosa Memorial Hospital, et al. v. Department of Health Care Services and Northbay Healthcare Group, et al. v. Department of Health Care Services (State Court Litigation)

The Plaintiffs in these two state court lawsuits are over 30 hospitals, including the 17 that are Plaintiffs in the federal court Santa Rosa Memorial Hospital case. The two lawsuits have been consolidated for litigation purposes. The Plaintiffs contend that the 10% Medi-Cal payment reduction and larger reduction for some hospitals that the Department implemented for non-contract hospital inpatient services, pursuant to ABX 4 5 (Chapter 3, Statutes of 2008) and AB 1183 (Chapter 758, Statutes of 2008) violate various federal Medicaid laws, including 42 U.S.C. sections 1396(a)(8), 1396a(a)(13), and 1396a(a)(30). The Plaintiffs seek retroactive damages of almost $100 million, including interest based on the Department’s implementation of the AB 5 and AB 1183 reduced payments.
Litigation in this case had been stayed (i.e., placed on hold), until the federal court ruling dismissing the federal court *Santa Rosa Memorial Hospital* lawsuit. After the parties completed briefing on the Plaintiffs' legal claims, there was a court hearing on April 18, 2016. The court tentatively ruled in favor of the Department on July 19, 2016, and a further hearing was held on December 13, 2016. On April 12, 2017, the trial court issued a judgment in favor of the Department. On April 24, 2017, the plaintiffs appealed the judgment, and their opening appellate brief was filed on October 8, 2017. The Department's response brief is due on March 9, 2018. The appellate court has not set a briefing schedule.

3. **AB 97 Rates Litigation**

A few lawsuits challenge the 10% rate reductions enacted by AB 97 (Chapter 3, Statutes of 2011), effective June 1, 2011.


  Plaintiffs include the California Hospital Association and Medi-Cal beneficiaries, who contend that payment reductions enacted by AB 97 for nursing facilities that are distinct parts of hospitals (DP/NFs) violate the takings clause of the U.S. Constitution and 42 U.S.C. sections 1396a(a)(8), (19), and (30). AB 97 provides that rates to DP/NFs effective June 1, 2011, shall be the rates paid in the 2008-09 rate year reduced by 10%. The federal government, which approved a State Plan Amendment (SPA) concerning these reductions, has been named as a co-defendant.

  On December 28, 2011, the district court issued a preliminary injunction against the AB 97 reductions for DP/NFs. On March 8, 2012, the district court issued an order modifying the injunction to exclude from its effect services rendered prior to December 28, 2011, that were not reimbursed prior to that date. On December 13, 2012, the Ninth Circuit issued a decision reversing the preliminary injunction with respect to the AB 97 rate freeze and reduction for DP/NFs. On May 24, 2013, the Ninth Circuit denied the Plaintiffs' request for rehearing and on June 25, 2013, issued an order formally vacating the four court injunctions. On January 13, 2014, the United States Supreme Court denied the Plaintiffs' petition for certiorari asking it to review the Ninth Circuit decision. Now that the injunction is vacated, the Department will implement the AB 97 payment reductions (also rate freeze with respect to the *California Hospital Association* case), as described in the 10% Payment Reduction for LTC Facilities and Non-AB 1629 LTC Rate Freeze policy changes. The lawsuit has been remanded to the federal district court where Plaintiffs have indicated they intend to seek a new court order prohibiting the Department from implementing the AB 97 reduced payments for DP/NFs. On March 1, 2016, the Governor signed into law Assembly Bill X2 1, adopting Welfare and Institutions Code section 14105.195, which prohibits the Department from retroactively implementing the AB 97 payment reductions for DP/NFs. Based on this
INFORMATION ONLY

legislation, California Hospital Association requested that this case be dismissed with prejudice, which the court granted on July 25, 2016.

- **California Medical Transportation Association v. Douglas, et al.**

  Plaintiffs filed a Complaint for Injunctive and Declaratory Relief challenging the validity of the 10% reduction under AB 97 for reimbursements to providers of NEMT services in the Medi-Cal fee-for-service system. Plaintiffs allege that the implementation of the AB 97 reductions for NEMT services violates 42 U.S.C., section 1396a(a)(30)(A). Additionally, Plaintiffs allege that Defendant Secretary Kathleen Sebelius’ approval of the SPA that sets forth the 10% reduction for NEMT services violates 5 U.S.C., sections 701-706.

  On January 10, 2012, the district court issued an injunction enjoining implementation of the reduction on reimbursement for NEMT services on or after June 1, 2011. The court subsequently modified the injunction to allow the Department to implement the 10% reduction for NEMT services rendered prior to January 10, 2012, that had not been reimbursed prior to that date. On December 13, 2012, the Ninth Circuit issued a decision reversing the preliminary injunction with respect to the AB 97 rate freeze and reduction for DP/NFs. On May 24, 2013, the Ninth Circuit denied the Plaintiffs’ request for rehearing and on June 25, 2013 issued an order formally vacating the four court injunctions. On January 13, 2014, the United States Supreme Court denied the Plaintiffs’ petition for certiorari asking it to review the Ninth Circuit decision. Now that the injunction is vacated, the Department will implement the AB 97 payment reductions, as described in the 10% Provider Payment Reduction policy changes. This case has been remanded to the federal district court where the Plaintiffs have indicated they intend to pursue a new court order that would prohibit the Department from implementing the AB 97 payment reductions for NEMT services. The parties are having settlement discussions. The parties have agreed to a briefing schedule in federal district court to occur in the first half of 2018.

- **California Medical Association et al. v. Douglas,**

  Plaintiffs include the California Medical Association, California Dental Association, and California Pharmacy Association. Plaintiffs challenge the validity of a 10% reduction in Medi-Cal payments for physician, dental, pharmacy, and other services, authorized by AB 97. The federal government, which approved a SPA concerning the 10% reductions, is also named as a co-defendant. Plaintiffs contend the reductions violate 42 U.S.C. section 1396a(a)(30)(A).

  On January 31, 2012, the court issued an injunction prohibiting implementation of the payment reductions for physicians, dentists, clinics, non-drug pharmacy services, emergency medical transportation, medical supplies, and durable medical equipment, except for services rendered prior to January 31, 2012, that are not reimbursed at the unreduced rates prior to that date. The Department and Plaintiffs appealed that portion of the district court’s order excluding some services from the injunction. On March 22, 2012, the Ninth Circuit denied the Department’s request for
INFORMATION ONLY

a stay of the injunction pending appeal. On December 13, 2012, the Ninth Circuit issued a decision reversing the preliminary injunction with respect to the AB 97 rate freeze and reduction for DP/NFs. On May 24, 2013, the Ninth Circuit denied the Plaintiffs’ request for rehearing and on June 25, 2013 issued an order formally vacating the four court injunctions. On January 13, 2014, the United States Supreme Court denied the Plaintiffs’ petition for certiorari asking it to review the Ninth Circuit decision. Now that the injunction is vacated, the Department will implement the AB 97 payment reductions, as described in the 10% Provider Payment Reduction policy changes. This case has been remanded to the federal district court where the Plaintiffs have indicated they intend to seek a new court order prohibiting the Department from implementing the AB 97 reduced payments. The parties are having settlement discussions.

The parties have agreed to a briefing schedule in federal district court to occur in the first half of 2018.


Plaintiffs are nine hospitals that operate nursing facilities that are a distinct part of a hospital (DP/NFs). This lawsuit was filed May 2014 in San Francisco Superior Court to challenge the validity of the AB 97 reduced rates for DP/NFs that are to be implemented for the period June 1, 2011, through September 30, 2013, pursuant to the federally approved State Plan. On March 1, 2016, the Governor signed into law Assembly Bill X2 1, adopting Welfare and Institutions Code section 14105.195, which prohibits the Department from retroactively implementing the AB 97 payment reductions for DP/NFs. Based on this legislation, it is anticipated that plaintiffs will soon dismiss this lawsuit. On August 30, 2017, Plaintiffs filed a request for dismissal of the lawsuit without prejudice. This effectively ends this case, and it will no longer be reported in these informational assumptions.


Petitioners and Plaintiffs, which are Federally Qualified Health Centers (FQHC), filed a Petition for Writ of Mandate and Complaint for Declaratory and Injunctive Relief in Sacramento Superior Court. Petitioners and Plaintiffs sought an order requiring the Department to process and pay claims for adult dental, podiatry, and chiropractic services that Petitioners provided to eligible Medi-Cal beneficiaries during the period July 1, 2009, to September 26, 2013, pursuant to 42 U.S.C. sections 1396a(a)(10)(A), 1396d(l)(1) and (20), 1395x(aa)(1)(A) and 1395x(r), and the Ninth Circuit decision in California Association of Rural Health Clinics, et al v. Douglas (9th Cir. 2013) 738 F.3d 1007. On December 8, 2015, the court granted the Petition for Writ of Mandate. The court further directed Counsel for Petitioners to prepare a formal judgment and writ, submit it to the Department’s counsel for approval as to form, and thereafter submit it to the court for signature and entry of judgment. On January 11, 2016, the Court issued the final formal judgment and writ. On February 19, 2016, Counsel for Petitioners sent a letter to Counsel for Respondents; this letter set forth an informal settlement proposal. Counsel for Respondents responded in April 2016, via letter, reflecting the Department’s disinterest in pursuing the proposal. The Department appealed the final judgment. Appellate briefing was completed in the Fall of 2017 and the parties await
5. 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 periods provided in the settlement terms: will be completed on the following schedule: Molina (January 1, 2018); Blue Cross (January 1, 2019); Health Net (January 1, 2020).


This 2009 class action lawsuit was brought by five physician groups who allege that the Medi-Cal reimbursement rates for emergency room physicians are inadequate and that the Department has the duty to review these rates annually. Plaintiffs allege the following causes of action:

- Violation of the Equal Protection Clause,
- Violation of 42 U.S.C. section 1396a(a)(30)(A) of the Federal Medicaid Act, and
- Violation of Welfare & Institutions Code section 14079 (duty to review rates annually).

The court granted Petitioners’ writ on the third cause of action (duty to review rates annually) and ordered the Department to conduct an annual review of reimbursement rates for all physician and dental services. On October 24, 2014, the court found the Department’s 2011 rate review report and the analyses of the five third-party payer rates data satisfactory, and discharged the Department’s ministerial duty under Welfare and Institutions Code section 14079. The court also found that the Department satisfactorily demonstrated its intention of conducting this rate review on an annual basis. On May 22, 2015, Petitioners filed a motion for attorneys’ fees and costs in the amount of $2.5 million. On February 5, 2016, the court denied the plaintiff’s motion for attorneys’ fees. Plaintiff filed a notice of appeal on February 24, 2016, and filed their opening brief.
on December 27, 2016. The Department filed its response brief on April 14, 2017. The plaintiffs’ reply brief was filed on May 4, 2017. Oral arguments have not been set.


Plaintiffs are 19 out-of-state border hospitals that challenge the validity of Medi-Cal reimbursement paid to out-of-state hospitals for hospital inpatient services. They filed this lawsuit in June 2014 in San Francisco Superior Court. The Department removed the case to federal court, so it would be litigated in that forum. Plaintiffs contend that aspects of the new diagnosis-related group (DRG) reimbursement policy discriminate against out-of-state hospitals in violation of the Interstate Commerce clause and Equal Protection clause of the United States Constitution. They seek an injunction to eliminate the alleged discriminatory DRG policies with respect to both fee-for-service reimbursement, and in the DRG based rates that managed care plans pay to out-of-network hospitals. They further contend that the Department is violating federal Medicaid law and discriminating against out-of-state hospitals in violation of the Commerce Clause and Equal Protection Clause by not making disproportionate share hospital (DSH) payments to qualifying out-of-state hospitals. In addition to injunctive relief, the Plaintiffs seek damages back to July 1, 2013.

On December 21, 2015, the federal court granted the Plaintiffs’ motion for partial summary judgment, ruling that certain aspects of the DRG rate methodology and the Department’s policy of not making DSH payments to qualifying out-of-state hospitals constituted discrimination against out-of-state hospitals in violation of the Commerce Clause. On March 24, 2016, the district court issued an order requiring the Department to implement changes in the DRG rate policies for plaintiffs and to make DSH payments to any plaintiff hospital that meets the same eligibility standards that apply to California hospitals, with respect to admissions on or after December 21, 2015. On October 12, 2016, the district court issued a final judgment, which incorporated the terms of the court’s March 24, 2016 order, as well as an April 2016 ruling denying the plaintiffs’ claim for retroactive relief with respect to admissions July 1, 2013-December 20, 2015.

The Department appealed Both parties appealed the final judgment. The plaintiffs also appealed the final judgment because it did not grant relief for admissions July 1, 2013-December 20, 2015, and because it requires the plaintiffs to submit the same information that California hospitals are required to submit to establish eligibility to DSH payments under the Medi-Cal program. Appellate briefing concluded in late 2017 is to begin March 4, 2017 and end on or about May 24, 2017. In addition, the plaintiffs have filed a motion for attorney fees and costs totaling $890,407. On February 24, 2017, the district court issued an order awarding the plaintiffs $735,712 for their attorney fees and costs. The Department appealed the attorney fee award and the district court stayed its enforcement of the fee award pending the Department’s appeal. On October 18, 2017, the Ninth Circuit granted the Department’s motion to consolidate the merits appeals and the attorney fee appeal. Oral argument in the Ninth Circuit was scheduled for March 14, 2018. The parties are concurrently in the process of preparing and filing briefs related to both the Department’s appeal and the plaintiffs’ appeal of the final judgment.

On July 22, 2014, Riverside Recovery Resources filed an amended writ of administrative mandamus and complaint in Riverside County Superior Court against the Department and Riverside County Department of Mental Health contesting disallowances of monies for Drug Medi-Cal services provided to minors in Riverside County schools. A Post Service Post Payment audit found that Plaintiff, Riverside Recovery Resources, submitted claims for services provided at uncertified satellite sites, which were not eligible for reimbursement. As a result, Riverside County withheld reimbursement for services during the period of time Riverside Recovery Resources was found to be in non-compliance. Plaintiff disputes the facts upon which the non-compliance findings were based, and alleges denial of due process in the administrative appeal process.

Plaintiff filed their opening brief in support of the writ of administrative mandamus on May 1, 2015. Plaintiff argues the Department should be equitably estopped from disallowing the claims because of a lack of clarity in the certification standards. The Department filed its opposition on June 30, 2015. Plaintiff filed its reply brief on July 31, 2015. On August 20, 2015 the court issued a tentative ruling holding the Department violated Welfare & Institutions code section 14171 by failing to provide Plaintiff with an administrative appeal pursuant to the Administrative Procedures Act. The tentative ruling remanded the case back to the Department for a formal evidentiary hearing before an administrative law judge. On November 19, 2015, pursuant to a stipulation, the court remanded the case back to the Department to provide Plaintiff with a formal evidentiary hearing. The Department has filed a return in superior court showing that the Department has complied with the writ of mandate by vacating its decision on the second level appeal and setting the date for a formal hearing on Riverside Recovery’s appeal. Although the hearing was originally set for March 15, 2016, at plaintiff’s request, it was continued to November 18, 2016, and, at the request of Riverside Recovery Resources, continued again to January 20, 2017. Based on documents that the Riverside Recovery Resources received in discovery and just completed reviewing, it was requested that the Department review a small portion of the recoupment. Review of this contention involves reviewing numerous documents. The hearing on remand occurred on March 9, 2017. **A proposed decision in favor of the Department was issued on January 3, 2018, and the parties await the final decision.** Post-hearing briefing has commenced and should conclude by August 14, 2017.

9. *Placentia-Linda Hospital, et al. v. California Department of Health Care Services*

The lawsuit was filed in San Francisco County Superior Court on April 9, 2014. Plaintiffs are five hospitals that contend that the Department implemented Medi-Cal payment reductions for non-contract hospital inpatient services from July 1, 2008, through April 12, 2011, as required by Assembly Bill 5 (statutes 2008) and Assembly Bill 1183 (statutes 2008), in violation of 42 United States Code sections 1396a(a)(13) and 1396a(a)(30)(A). Plaintiffs seek a court order requiring the Department to retroactively pay them the additional money they would have received if the Department had not implemented the reductions. **This case was stayed pending final resolution of the federal court Santa Rosa Memorial Hospital, et al. v. Douglas, et al. case, which has**
INFORMATION ONLY

since ended and thus that stay was lifted. The parties have agreed to another litigation stay, pending resolution of the state court Santa Rosa Memorial Hospital/Northbay v. DHCS case listed above.


Petitioners sought a preliminary injunction and writ of mandate preventing DHCS from terminating Medi-Cal benefits for those beneficiaries who failed to return any renewal information during the 2014 renewals, until the renewal form (the Request for Tax Household Information or RFTHI) is translated into all threshold languages and 90 day cure period is included in all notices of action issued by the counties. Petitioners also claim that the ex parte process required by state and federal law is not being utilized and fails to comply with the law.

Petitioners sought a temporary restraining order to prevent counties from terminating beneficiaries.

After a hearing on the request for preliminary injunction, the court denied in part and granted in part Petitioner’s request for Preliminary Injunction. In response, the Department filed a motion for reconsideration. The court denied the motion and issued the preliminary injunction on June 23, 2015, enjoining the termination of beneficiaries for failure to respond or provide requested information who do not have compliant 90 day cure period language in the notices of action and do not have requisite specificity regarding the information required for redetermination but not provided. The Department has directed the Statewide Automated Welfare System (SAWS) and the counties to cease terminations effective June 23, 2015, until the SAWS is able to issue notices with compliant language.

Currently, the parties continue to operate under a temporary stay to provide time for settlement discussions. The parties appear to have reached a full and final settlement on July 6, 2017, including attorneys’ fees and costs. The matter has been resolved via settlement and will no longer be reported in these Informational Assumptions.


Plaintiffs are disabled Medi-Cal beneficiaries receiving nursing care and other services in their homes under the Medi-Cal Home and Community Based Alternatives Waiver (formally named Nursing Facility/Acute Hospital Waiver, or NF/AH Waiver). Plaintiffs allege that they are unable to obtain needed services to continue living safely in their homes because of the Waiver’s individual cost limitations for each level of care, which are below the cost for the individual to live in an equivalent institution. Plaintiffs allege that the individual cost cap places the Plaintiffs and other similarly situated Medi-Cal beneficiaries at risk of institutionalization, and therefore violates the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, and California Government Code section 11135. Plaintiffs ask the US District Court to:

• Declare the Waiver’s individual cost limitations unlawful;
INFORMATION ONLY

- Enjoin the Department from reducing services, discriminating against Plaintiffs, and putting them at risk of institutionalization through the cost and eligibility limitations;
- Order the Department to provide Plaintiffs needed services, and amend policies and procedures to meet Plaintiffs’ needs and federal cost neutrality requirements. (By, among other things, amending the waiver to an aggregate cap, increasing the total cost of the waiver, and adding additional participant slots to the waiver.)

The court denied Plaintiffs’ three Motions for Summary Judgment (MSJs), and failed to rule on the Department’s Motion to Dismiss based on the Waiver amendment mooting out the second amended complaint allegations. The court reopened discovery regarding the renewed Home and Community Based Alternatives Waiver, which replaced the NF/AH Waiver, and is allowing plaintiffs to file a third amended complaint. The parties are currently contemplating a voluntary dismissal of the case, without prejudice. If dismissed in this fashion, plaintiffs intend to continue litigating against the Department to recover associated attorney’s fees and costs. Plaintiffs indicate they will refocus their case to allege insufficient provider rates and may convert the case to a class action. The parties have exchanged settlement offers to resolve the plaintiffs’ demands along with attorney’s fee claims. If the matter is not settled, discovery will continue and ultimately a trial will likely be set in 2018.

12. Nooraldeen Kathem and Llal Tluang v. CDSS and DHCS

Petitioners are unaccompanied refugee minors, and as such are beneficiaries of the United States Office of Refugee Resettlement’s (ORR) Unaccompanied Refugee Minor (URM) program. The URM program ensures that eligible unaccompanied refugee minors receive foster care and other services, such as health care, upon arrival in the U.S. The California Department of Social Services (CDSS) is responsible for overseeing California’s URM program. URMs are not part of California’s dependency program and the state does not take legal responsibility for these children. Rather, URMs in California are the legal responsibility of either Catholic Charities or Crittenton, two non-profit agencies selected by ORR that contract with the state. Under current law, URMs may be eligible to receive full, limited, or restricted scope Medi-Cal administered by the Department. URMs assert that they must be given the option to select fee for service Medi-Cal rather than a managed care plan. Foster youth are also eligible for “former foster youth” Medi-Cal if they are (1) in foster care under the responsibility of the state and (2) are Medi-Cal beneficiaries at age 18 or when they age out of foster care, with no income eligibility or annual renewal, until age 26.

CDSS and the Department filed a demurrer in this matter which was not sustained. The matter has since been resolved via settlement and will no longer be reported in these Informational Assumptions.

13. Rivera v. Douglas, Director of DHCS

There were a significant number of Medi-Cal applicants whose applications had not been processed within 45 days of the application date (“backlog”) and that were still pending when Petitioners filed suit. Petitioners filed a writ seeking an order that this backlog is in
INFORMATION ONLY

violation of state law and that state law requires that all Medi-Cal applicants that appear to be eligible should be granted eligibility for Medi-Cal benefits while any necessary verifications are being completed; and specifically that the Department (1) give notice to all applicants in the backlog that they have a right to hearing on the delay, and (2) grant all pending applicants that appear eligible conditional eligibility for Medi-Cal benefits.

Petitioners’ Motion for Preliminary Injunction (PI) Motion was granted on January 20, 2015. The Preliminary Injunction prohibited the Department from failing to comply with its duty to make eligibility determinations within 45 days unless certain specified legal exceptions apply. It further ordered that when an application has not been determined within 45 days, the Department may comply with the injunction by (1) for applicants who appear likely eligible for Medi-Cal, granting Medi-Cal benefits, including a notice of action, pending completion of the final eligibility determination, and (2) for each applicant who has not been granted these benefits and to whom none of the exceptions apply, provide with a notice of hearing rights. Petitioners’ claim that all applicants that appear to be eligible should be granted conditional eligibility while verification is completed was not determined in the PI ruling. The PI no longer binds the Department because final Judgment has been entered.

The writ was heard on May 18, 2015 and largely granted on August 15, 2015. The court ruled in favor of the Petitioners on all but one claim and issued its Judgment on December 2, 2015. This Judgment ordered the Department to comply with its duty to make eligibility determinations within 45 days unless certain specified legal exceptions apply. It further ordered that the Department may, as an alternative means of complying with this duty, (1) for applicants who appear likely eligible for Medi-Cal, grant provisional Medi-Cal benefits until those applications have received an eligibility determination, and (2) for each applicant who has not been granted these benefits and to whom none of the exceptions apply, provide him/her with a notice of hearing rights that includes a statement of the specific reason or reasons why the application has not been determined within 45 days. The court denied without prejudice Petitioners’ request that the Department be required to grant “conditional benefits” as early in the 45 day period as the county finds an applicant for whom income verification is pending is otherwise eligible. The injunction and writ were stayed by 61 days to allow the Department time to file an appeal.

The Department appealed the Judgment/Writ. The Notice of Appeal was filed on February 1, 2016. Petitioners originally cross-appealed but have dismissed that cross-appeal.

Petitioners filed a motion to enforce the Writ claiming that the filing of the appeal did not automatically stay enforcement. This motion was heard by the court March 9, 2016 and was denied on May 9, 2016. The Department’s opening brief in the appeal was filed on October 11, 2016, and Petitioners’ response brief was filed on December 8, 2016. The Department filed its reply brief on February 1, 2017. The appellate court has notified the parties that the case has been placed on the conference list and of their right to waive hearing; both parties filed a request for a hearing. The appellate court has not yet scheduled a hearing.

Costs attributable to the writ are currently unknown. If the Appeal is not successful, the costs attributable to the writ will likely be one or more of the following: (1) for granting
provisional eligibility to applicants whose applications have not been determined within 45 days whenever the Department is unable to timely determine eligibility, and (2) for sending out notices to applicants not granted provisional eligibility and that have not had their eligibility determined within 45 days, with the specific reason(s) for the delay specified in each notice.

14. Educationally Necessary Statewide Occupational Therapy and Physical Therapy Services

The Department engaged in litigation in State and Federal courts with the Department of General Services’ Office of Administrative Hearings (OAH) to address a fundamental difference in the interpretation of the mandates of Part B of the Individuals with Disabilities Education Act (IDEA) and Government Code 7570 et. seq. relating to Special Education. This litigation follows from four county level IDEA due process complaint decisions by OAH Administrative Law Judges in which the California Children’s Services (CCS)/Medical Therapy Program (MTP) was made responsible for the provision of educationally necessary occupational therapy (OT) and physical therapy (PT) without regard to medical necessity. Three cases were litigated up to the appellate court level, but the Department did not prevail. The Department is currently negotiating the attorney fee award in one case with an adverse trial court ruling and will not appeal further. These cases have established a precedent that has the potential to obligate the CCS/MTP to provide ongoing educationally necessary OT/PT services statewide at an annual and ongoing cost of many millions of dollars.


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. DHHS OCR may conduct its own investigation of the Department pursuant to the administrative complaint. 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 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
INFORMATION ONLY

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 November 22, 2017, the Department filed a Demurrer, which was scheduled for hearing on February 9, 2018.

On December 11, 2017, another lawsuit filed by an individual plaintiff made substantially similar allegations as the class action suit, though the allegations are based on disability status.

16. Quest Diagnostics Inc., et al. v. Department of Health Care Services

Plaintiffs in this case are clinical laboratory testing providers, specifically Quest Diagnostics Inc. and the California Clinical Laboratory Association.

On June 29, 2016, Plaintiffs filed a Complaint in the Sacramento Superior Court for Injunctive and Declaratory Relief, challenging reimbursement paid by DHCS for Medi-Cal laboratory testing services. Plaintiffs contend that the Department violated Assembly Bill (AB) 1494 (codified at Section 14105.22 of the Welfare and Institutions Code) by continuing to apply the AB 97 10% reduction to payments to clinical laboratories under the new market-based rate methodology established pursuant to AB 1494. Plaintiffs contend that AB 1494 required the Department to discontinue the AB 97 10% payment reduction once the new AB 1494 methodology was implemented.

Plaintiffs seek to compel the Department to eliminate the AB 97 10% payment reduction applied to the AB 1494 methodology, to reimburse petitioners for the reductions already applied to applicable laboratory services reimbursement, and to obtain a declaration that the Department has violated AB 1494.

Plaintiffs’ petition for writ of mandate was heard on October 28, 2016. The Court denied the writ petition and complaint, ruling in favor of the Department. On November 16, 2016,
Plaintiffs filed a notice of appeal. Appellate briefing concluded in late 2017 and the parties await scheduling of oral argument.


The lawsuit was filed in Los Angeles Superior Court on July 22, 2016. The Plaintiffs, all of whom are licensed Registered Dental Hygienists in Alternative Practice (RDHAP), brought this action to challenge the Department's new policy regarding prior authorization requirements for scaling and root planning for Medi-Cal beneficiaries residing in skilled nursing facilities or intermediate care facilities. The new policy went into effect on July 15, 2016, and it was published via a Medi-Cal Dental provider bulletin. Plaintiffs challenge the substantive validity of the policy, as well as the administrative steps that the Department took prior to implementing the policy. Medi-Cal Dental provider bulletin decreases the periodontal maintenance rate which the lawsuit alleges will put providers out of business as their costs will exceed reimbursement. The Plaintiff's also assert the Department has no authority for imposing prior authorization requirements on RDHAPs aligning them to prior authorization requirements already in place for Dentists.

A trial setting conference (TSC) was held on December 1, 2016. At the TSC, Plaintiffs sought an alternative writ and preliminary injunction (1) staying the provider bulletin and the reimbursement changes contained therein until the Department receives CMS SPA approval; (2) directing the Department to pay providers the rates previously approved by CMS for services provided since July 14, 2016; and (3) setting an expedited briefing schedule and preferential hearing date on the petition.

Subsequent to the December 1, 2016 TSC, the parties engaged in settlement discussions; however, those negotiations stalled and have become the subject of a new cause of action filed by Plaintiffs. Based on this new cause of action, Plaintiffs brought an unsuccessful motion for summary adjudication claiming the Department entered into an oral agreement with Plaintiffs to settle the matter and seeking specific performance. The court denied Plaintiffs' motion and set the complaint causes of action for hearing on March 21, 2018. The writ petition will be heard in a different courtroom on January 23 February 8, 2018.

18. *Dental Managed Care Plans Notifications of Dispute with the Department*

The three dental managed care plans (the Plans) filed notifications of dispute (NOD) with the Department alleging the Department breached the managed care contracts. The contracts permitted the Department to withhold 10% of the monthly capitation rate and allowed the Plans to recover some or all of the withheld amount should it satisfy the agreed upon performance measures, plus earn an up to 5% as a bonus for exceptional performance. In the NODs, the Plans disputed the formula used to calculate the recoverable amount of the withhold because it rendered the withheld amounts unattainable, and, due to the Plans’ inability to recover any portion of the withheld amounts, the capitation rates paid fell below the actuarially sound range.

On August 1, 2016, the Department issued All Plan Letter 16-009, waiving the Department’s contractual right to withhold 10% of the monthly capitation payment from
INFORMATION ONLY

July 1, 2014, through July 31, 2016. For the service periods that remain at issue, the parties are engaged in settlement discussions.


Blue Cross of California and Blue Shield of California (Plaintiff) 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.) in the event that Myers action results in the Plaintiff being subject to the GPT and exempt from assessment of the SBx2 2 version of the MCO tax. The Blue Cross action has been formally stayed after being designated a related case to Myers, and a status conference has been scheduled for May 29, 2018. The Department awaits the court’s ruling on the relatedness of the Blue Shield action to Myers, but it is expected that action will be stayed as well.


The OIG reviewed $237,533,773 of California’s fee-for-service claims for physician-administered drugs paid for the quarter April through June 2008, July through September 2009, and October through December 2010. Of the amount paid, OIG reviewed $58,907,969 that was not billed for rebates. Of the remaining $178,625,804 that was billed for rebates, OIG reviewed $61,432,295 to verify that the claims were properly billed. OIG recommended that the State refund to the Federal Government $4,392,568 (Federal Share) for claims for single-source and top-20 multiple-source physician-administered drugs, and $27,349,486 (Federal Share) for other claims, all of which were ineligible for Federal reimbursement.

The Department has completed a review of 1.4 million claims, and has identified those not eligible for rebates.

21. California Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals

OIG reviewed and reconciled hospital incentive payments reported for the period of October 1, 2011 through December 31, 2015. Although the State made Medicaid EHR incentive payments to eligible hospitals, it did not always make them in accordance with Federal Requirements. The OIG is requesting the Department refund CMS $28,361,240 in net overpayments to the 64 hospitals.
Department staff have started auditing the hospitals reviewed by OIG to determine actual overpayment amounts based on adjudicated claims. Subsequently, the Department’s initial audit findings suggest the OIG’s overpayment findings were significantly overstated.

The Department intends to offset identified overpayments against the hospitals’ future EHR incentive payments.

22. California Did Not Bill Manufacturers for Rebates for Physician Administered Drugs Dispensed to Enrollees of Some Medicaid Managed Care Organizations

OIG reviewed drug utilization data or encounter data for physician administered drugs for 20 of CA’s 28 MCO’s from April 1, 2010 through December 31, 2010. After reviewing records for physician-administered drugs in the encounter data for the 13 MCOs, OIG estimated that the State agency Department paid $157,157,582 ($96,793,355 Federal share) for drugs that were eligible or may have been eligible for rebates. On the basis of this amount, OIG estimated that the State agency Department did not bill for and collect from manufacturer rebates of $69,109,297 ($42,564,416 Federal share).

The Department is performing an ongoing review of the information received from OIG; the review is estimated to be completed in September 2018.

23. Audit of California’s Medicaid Inpatient Disproportionate Share Hospital (DSH) Payments for University of California, San Diego Medical Center, San Diego, California State Fiscal Year 2008 1998

The Office of the Inspector General (OIG) worked to verify that State Fiscal Year (SFY) 1998 DSH Payments to the University of California, San Diego Medical Center (UCSDMC) did not exceed the hospital specific limit as mandated by Omnibus Reconciliation Act (OBRA) of 1993. The Department made DSH payments to UCSDMC that exceeded the limit for SFY 1998. The UCSDMC limit determined by the state did not comply with federal statutes and CMS requirements and implementing guidance. The limit determined by the state, based on projected data, was $54,218,316. The state made DSH payments to UCSDMC totaling $50,363,032 ($3,855,284 less than the state determined limit) for SFY 1998. The limit based on audit results, however, was $34,437,864. As a result, UCSDMC received a payment of $15,925,168 ($7,999,212 federal share) in excess of the limit based on the audit.

State law requires that any DSH payment exceeding the limit as determined by an audit or federal disallowance should be recouped by the state for payments that exceeded the limit. The Department disagreed with this finding and subsequent repayment. The Department submitted the required disallowance package to CMS but is still waiting on final approvals. Should the package be denied, the Department will work with CMS on the appropriate next steps.

24. Audit of California’s Medicaid Inpatient Disproportionate Share Hospital (DSH) Payments to Kern Medical Center, Bakersfield, California, State Fiscal Year 1998
The OIG worked to verify that State Fiscal SFY 1998 DSH Payments to Kern Medical Center (KMC) did not exceed the hospital specific limit as mandated by OBRA of 1993.

The audit showed that the Department made DSH payments to KMC that exceeded the limit by $38,714,784 ($19,446,435 federal share) for SFY 1998. Payment in excess of the limit occurred primarily because the limit for KMC determined by the state did not comply with federal statutes and regulations and CMS implementing guidance.

The overstatement of the KMC limit consisted of the following items:
- Using projected amounts instead of actual incurred expenses and payments
- Not limiting total operating expenses to amounts that would be allowable under Medicare cost principles;
- Including bad debts as an additional operating expense;
- Double counting charges for the Short Doyle program and including charges for services provided to inmates and Kern County employees.

OIG recommended the Department refund to the CMS $14,165,950 representing the federal share of the KMC overpayment associated with the findings for Medicare cost principles, bad debts, Short Doyle program, and services provided to Kern County employees.

The Department disagreed with the findings and submitted a disallowance package to CMS for review and approval. Should the package be denied, the Department will work with CMS on the appropriate next steps.

25. California Made Unallowable Medicaid Payments for Items and Services Furnished, Ordered or Prescribed by Excluded Providers

The Department made unallowable Medicaid payments of $1,900,466 ($1,170,497 Federal share) for items and services furnished, ordered, or prescribed by excluded providers. The Department made these payments because it did not have policies and procedures to (1) ensure that all agencies within California responsible for enrolling providers or processing Medicaid claims for reimbursement performed monthly review to identify excluded providers and (2) identify whether any furnishing, ordering, or prescribing providers listed on a claim were excluded. Of the $1,170,497 amount, the Department still owes $139,778 FFP.

The Department made unallowable Medicaid payments for services claimed by excluded providers the Department paid $1,134,529 ($698,756 Federal share) for additional items or services that may have been furnished, ordered, or prescribed by excluded providers and therefore may have been unallowable. The claim data provided by the Department did not always include sufficient detail to verify whether some furnishing or prescribing providers were excluded or to determine the specific roles of some providers listed on the claims (i.e., ordering, prescribing, or referring). Because the exclusion status of some providers could not be verified and some providers may have been acting only as referring physicians and may
not have ordered or prescribed the items or services claimed, Medicaid payments are to be non-excluded.

The audit period occurred between July 1, 2009 and June 30, 2010.

OTHER: REIMBURSEMENTS

1. Federal Upper Payment Limit

The Upper Payment Limit (UPL) is computed in the aggregate by hospital category, as defined in federal regulations. The federal UPL limits the total amount paid to each category of facilities to not exceed a reasonable estimate of the amount that would be paid for the services furnished by the category of facilities under Medicare payment principles. Payments cannot exceed the UPL for each of the three hospital categories.

2. Accrual Costs Under Generally Accepted Accounting Principles

Medi-Cal has been on a cash basis for budgeting and accounting since FY 2004-05. On a cash basis, expenditures are budgeted and accounted for based on the fiscal year in which payments are made, regardless of when the services were provided. On an accrual basis, expenditures are budgeted and accounted for based on the fiscal year in which the services are rendered, regardless of when the payments are made. Under Generally Accepted Accounting Principles (GAAP), the state’s fiscal year-end financial statements must include an estimate of the amount the state is obligated to pay for services provided but not yet paid. This can be thought of as the additional amount that would have to be budgeted in the next fiscal year if the Medi-Cal program were to be switched to an accrual basis.

3. Refund of Recovery

CMS requested the Department prepare reconciliations of grant awards vs. federal draws for all fiscal years. The Department determined FFP was overpaid on some recovery activities. As a result of this determination, the Department is correcting the reporting of overpayments on the CMS 64 report. The Department expects a one-time refund of $240 million FFP for federal FY 2007 through 2011 and $34 million FFP ongoing each month.

4. Payment Deferrals

The Department issues weekly payments for Fee-For-Service providers. This process is referred to as the checkwrite. Starting in FY 2004-05, the Department implemented (1) an additional week of claim review prior to the release of provider payments starting in July 2004, this shifts the payments of the Fee-For-Service checkwrite by one week, and (2) the last checkwrite in June of each fiscal year has been delayed until the start of the next fiscal year. Beginning in FY 2012-13, an additional checkwrite and the last month of managed care capitation payments are delayed at the end of each fiscal year until the start of the next fiscal year.
INFORMATION ONLY

OTHER: RECOVERIES

1. Additional Personal Injury Recoveries

In Arkansas Department of Health and Human Services v. Ahlborn (2006) 547 U.S. 268, the United States Supreme Court held that a Medicaid agency’s lien recovery from a Medicaid beneficiary’s tort settlement is limited to the portion of the settlement that represents payment for medical expenses, or medical care, provided on behalf of the beneficiary. Then, in Wos v. E.M.A. (2013) 133 S.Ct. 1391, the U.S. Supreme Court held that states may not adopt a one-size-fits-all mechanism for allocating medical expenses, such as deeming a specific percentage of a tort settlement or award to be the medical expenses portion. Instead, states must have processes for determining and recovering only that portion that is attributable to medical expenses.

In response to the Ahlborn ruling, California amended Welfare & Institutions (W&I) Code Section 14124.76 and enacted W&I Code Section 14124.785.

On December 26, 2013, H.J. Res. 59 (federal Budget Act) was signed into law. Section 202 of the Act addresses Medicaid third party liability. Section 202, effective October 1, 2014, essentially supersedes Ahlborn and Wos by allowing states to recover from the full amount of a beneficiary’s tort settlement, instead of only the portion designated for medical expenses. The implementation date has been delayed to October 1, 2017. The nullification of the Ahlborn ruling makes W&I Code Section 14124.76 non-compliant with federal code. A future effort to bring this code into compliance with federal law may increase savings for the Department. In conjunction with aligning W&I Code Section 14124.76 to federal code and improving program efficiency, an alternative fixed percentage recovery option may be proposed to allow Medi-Cal members to receive their settlement more quickly.

2. Refund to Express Scripts

The Department contracts with a third party vendor, Health Management Systems Inc. (HMS), to identify and recover Medi-Cal expenditures from responsible third parties. HMS was notified by health insurance carrier, Express Scripts (ESI), that a nationwide error occurred within the ESI payment system, resulting in an overpayment to the Department. ESI is requesting the Department to return this overpaid amount. The timeframe to refund this overpayment to ESI is unknown at this time.

3. The Qualified Achieving a Better Life Experience (ABLE) Program

SB 218 (Chapter 482, Statutes of 2017) may impact the Department’s recoveries as related to ABLE accounts. ABLE accounts are tax-advantaged savings accounts that allow for individuals with disabilities to save funds for health related expenses while allowing the savings to not disqualify their eligibility for disability benefits. The introduction of ABLE accounts may cause a decrease in the Department’s Special Needs Trust (SNT) program recoveries, because monies that may have otherwise funded a SNT may be placed into an ABLE account and become exempt from collections. ABLE account asset limits, however, are relatively low, and not all
INFORMATION ONLY

individuals are eligible to open ABLE accounts. Therefore, a minimal fiscal impact is expected for SNT recoveries.

Furthermore, provisions of SB 218 prohibit the Department from seeking direct ABLE account recovery upon a beneficiary’s death. The fiscal impact from this barrier to recovery is also expected to be minimal because ABLE account funds are highly transactional and may be used to pay for funeral or other administrative expenses, which is likely to leave little for recovery. Also, according to recent guidance from the Centers for Medicare and Medicaid Services, Estate Recovery (ER) is still required for individuals aged 55 and older on the date of death and against ABLE account funds that enter a beneficiary’s probate estate.

OTHER: INFORMATION MANAGEMENT

1. Certified Vital Records
The Department is creating a new contract with CDPH to obtain vital records data. The current contract allows the Third Party Liability Recovery Division (TPLRD) to request records from CDPH. The new contract will continue to allow TPLRD to request records, and expand contract scope to include Audits & Investigations Division and Med-Cal Eligibility Division. The Department may amend the new contract to include other divisions as appropriate.

FISCAL INTERMEDIARY: MEDICAL

1. Medical Fiscal Intermediary Contract and Business Operations

The current Medical Fiscal Intermediary (FI) contract expires March 31, 2020. In preparation, the Department has begun activities to issue, award, and successfully transition to a new FI contract by September 30, 2019. The new FI contracts will separate the business operations and maintenance and operations (M&O) functions.
   - Takeover for the business operations contract is anticipated to begin in February 2019, and operations will be assumed in October 2019. The business operations contract will expire in October 2029.
   - Takeover for the M&O contract is anticipated to begin in October 2018. Operations will be assumed in October 2019. The M&O contract will expire in October 2026.

2. Advance Payment Authority

The Department proposes to seek legislative authority which authorizes the State Controller’s Office to make advance payments pursuant to the California Medicaid Management Information Systems Fiscal Intermediary (FI) contract contingency payment process. This would allow advanced interim payments to providers in the event there are issues with checkwrite production during any of the System Replacement Releases. If approved, this legislation would reduce the State’s potential risk of losing Federal Financial Participation due to non-compliance with federal and the California’s Prompt Payment Act requirements, and allows up to twenty thousand
INFORMATION ONLY

providers to receive payment for services rendered to ensure California’s 12 million Medi-Cal beneficiaries continue to receive health care services.
INFORMATION ONLY

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL

1. Dental Program Utilization Controls Assessment

   In an effort to improve the provider experience and to encourage further provider participation, the Department is evaluating program utilization controls and administrative requirements to improve and streamline the provider experience while maintaining program integrity. The objective of these efforts is to increase provider participation and increase beneficiary utilization.

2. Allied Dental Professionals Enrollment

   The Department allowed Registered Dental Hygienists (RDHs) Registered Dental Hygienists in Extended Functions (RDHEFs) employed by a public health program created by Federal, State, or local law or administered by a Federal, State, county, or local governmental entity to enroll as billing providers in the Medi-Cal Dental Services Program. Reimbursement for services provided by the allied dental professionals is limited to services provided to the extent permitted by the applicable professional licensing statutes and regulations outlined by State law and the requirements delineated in the dental Manual of Criteria. While the Department will continue to allow RDHs, RDHEFs, and Registered Dental Hygienists in Alternative Practice (RDHAPs) in the Medi-Cal Dental Services Program, enrollment for these allied dental professionals has not significantly increased, and this policy change has been withdrawn.
DISCONTINUED POLICY CHANGES

Fully Incorporated into Base Data/Ongoing

ELIGIBILITY
PC 7 State-Only BCCTP Coverage Extension

AFFORDABLE CARE ACT

BENEFITS
PC 42 End of Life Services

HOME & COMMUNITY-BASED SERVICES

BREAST AND CERVICAL CANCER

PHARMACY
PC 210 Drug Rebates – Retroactive ACA Adjustments

DRUG MEDI-CAL

MENTAL HEALTH

1115 WAIVER—MH/UCD & BTR

MANAGED CARE

PROVIDER RATES
PC 128 GDSP Prenatal Screening Fee Increase

SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

OTHER: RECOVERIES

FISCAL INTERMEDIARY: MEDICAL

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL

SYSTEMS OF CARE
DISCONTINUED POLICY CHANGES

ELIGIBILITY

AFFORDABLE CARE ACT
PC 24 Title XXI Federal Match Reduction
OA 54 Title XXI Federal Match Reduction Other Admin

BENEFITS

HOME & COMMUNITY-BASED SERVICES

BREAST AND CERVICAL CANCER

PHARMACY

DRUG MEDI-CAL

MENTAL HEALTH

1115 WAIVER—MH/UCD & BTR

MANAGED CARE

PROVIDER RATES

SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

OTHER: RECOVERIES

OTHER

FISCAL INTERMEDIARY: MEDICAL

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL
DISCONTINUED POLICY CHANGES

Withdrawn

ELIGIBILITY

AFFORDABLE CARE ACT
PC 26 ACA DSH Reduction

BENEFITS

HOME & COMMUNITY-BASED SERVICES

BREAST AND CERVICAL CANCER

PHARMACY

DRUG MEDI-CAL

MENTAL HEALTH

1115 WAIVER—MH/UCD & BTR

MANAGED CARE
PC 104 Managed Care Public Hospital Directed Payments

PROVIDER RATES

SUPPLEMENTAL PAYMENTS
PC 163 Managed Care Private Hospital Directed Payments

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

OTHER: RECOVERIES

FISCAL INTERMEDIARY: MEDICAL

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL
OA 82 Dental Treatment Authorization Request Processing