MEDI-CAL
MAY 2020
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2019-20 *and* 2020-21

The Great Seal

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

MEDI-CAL
MAY 2020
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2019-20 and 2020-21

Fiscal Forecasting Division
State Department of Health Care Services
1501 Capitol Avenue, Suite 6069
Sacramento, CA 95814

GAVIN NEWSOM
Governor
State of California

Mark A. Ghaly, MD, MPH
Secretary
California Health and Human Services Agency

Bradley P. Gilbert, MD, MPP
Director
Department of Health Care Services

MAY 2020 MEDI-CAL ESTIMATE

TABLE OF CONTENTS

The May 2020 Medi-Cal Local Assistance Estimate is organized into several sections, listed below.

MANAGEMENT SUMMARY
The management summary section of the Medi-Cal Local Assistance Estimate provides an overview of projected expenditures by fund and caseload counts for both current and budget years.

CURRENT YEAR
The Current Year section provides a summary of medical assistance benefits (base and regular policy change) expenditures for the current fiscal year. It highlights expenditures by service category, compares current year data to the previous appropriation estimate, and provides an overview of the current year cost per eligible expenditures.

BUDGET YEAR
The Budget Year section provides a summary of medical assistance benefits (base and regular policy change) expenditures for the budget year. It highlights expenditures by service category, compares current year data to the previous appropriation estimate, and provides an overview of the current year cost per eligible expenditures.

CASELOAD
The Caseload section provides the estimated average monthly certified eligible counts for prior, current, and budget years.

FEE-FOR-SERVICE BASE
The Fee-For-Service (FFS) Base section provides a detailed overview of projected FFS benefits expenditures by service category and base aid category.

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

REGULAR POLICY CHANGES
The Regular Policy Changes section provides detailed benefits expenditures information by policy according to program area. This section includes new program policies and other estimated expenditures that are not captured in the base expenditures.

COUNTY ADMINISTRATION
The County Administration section provides a detailed overview of estimated expenditures for counties to determine Medi-Cal eligibility for both current and budget years.

OTHER ADMINISTRATION
The Other Administration section provides a detailed overview of estimated expenditures required to administer the Medi-Cal program for both current and budget years. This section includes both Local Assistance Administrative (other than County Administration) costs and Fiscal Intermediary (FI) costs associated with processing of claims.

ADDITIONAL INFORMATION
The Additional Information section provides supplemental information in support of the Medi-Cal Local Assistance Estimate.

TABLE OF CONTENTS

MANAGEMENT SUMMARY

The management summary section of the Medi-Cal Local Assistance Estimate provides an overview of projected expenditures by fund and caseload counts for both current and budget years.

FY 2020-21 MAY 2020 FINAL VS APPROPRIATION ……. 1-3 APPROPRIATION

CURRENT YEAR VS NOVEMBER 2019 CURRENT YEAR.....1

APPROPRIATION VS CURRENT YEAR.....2

BUDGET YEAR VS CURRENT YEAR 3

BUDGET YEAR VS NOVEMBER 2019 CURRENT YEAR.....4

OVERVIEW OF THE MEDI-CAL ESTIMATE.....5

SUMMARY OF EXPENDITURES BY FUND..... FS 1-12

CURRENT YEAR VS PRIOR ESTIMATE CURRENT YEAR .....FS 1-3
CURRENT YEAR VS APPROPRIATION.....FS 4-6
BUDGET YEAR ESTIMATE CURRENT YEAR .....FS 7-9
BUDGET YEAR VS PRIOR ESTIMATE BUDGET YEAR .....FS 10-12

NOTE: FOR THE MAY 2020 FINAL ESTIMATE:

- CURRENT YEAR = FY 2019-20
- BUDGET YEAR = FY 2020-21
- APPROPRIATION = MAY 2019 ESTIMATE + BUDGET ACT CHANGES, FY 2019-20
- PRIOR ESTIMATE = NOVEMBER 2019 ESTIMATE

Medi-Cal Funding Summary
May 2020 Estimate Compared to FY 2020-21 Appropriation
Fiscal Year 2020 - 2021

TOTAL FUNDS

MEDI-CAL Benefits:	**May 2020 Estimate**	**FY 2020-21 Appropriation**	**Difference Incr./(Decr.)**
4260-101-0001/0890(3)	$80,838,870,000	$84,311,851,000	$3,472,981,000
4260-101-0080 CLPP Funds	$916,000	$916,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$92,170,000	$92,170,000	$0
4260-101-0233 Prop 99 Physician Srvc. Acct	$26,639,000	$26,639,000	$0
4260-101-0236 Prop 99 Unallocated Account	$41,848,000	$41,848,000	$0
4260-101-3168 Emergency Air Transportation Fund	$6,626,000	$6,626,000	$0
4260-101-3305 Healthcare Treatment Fund	$1,339,836,000	$863,756,000	($476,080,000)
4260-101-3366 Electronic Cigarette Product Tax	$9,600,000	$9,600,000	$0
4260-102-0001/0890 Capital Debt	$77,555,000	$77,555,000	$0
4260-102-3305 Prop 56 Loan Forgiveness Program	$15,200,000	$15,200,000	$0
4260-103-3305 Prop 56 Value-Based Payment	$0	$178,281,000	$178,281,000
4260-104-0001 NDPH Hosp Supp *	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$1,900,000	$1,900,000	$0
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	($1,900,000)	($1,900,000)	$0
4260-105-0001 Private Hosp Supp Fund	$118,400,000	$118,400,000	$0
4260-601-3097 Private Hosp Suppl	$132,461,000	$132,461,000	$0
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-106-0890 Money Follows Person Federal Grant	$3,319,000	$3,319,000	$0
4260-111-0001(3) CHDP State Only	$0	$0	
4260-113-0001/0890 Childrens Health Insurance Program	$3,893,556,000	$4,000,566,000	$107,010,000
4260-601-0942142 Local Trauma Centers	$81,883,000	$81,883,000	$0
4260-601-0942 Home Health Program Account	$22,749,000	$22,749,000	$0
4260-601-0995 Reimbursements	$1,777,423,000	$1,777,423,000	$0
4260-601-3156 MCO Tax Fund	$100,000,000	$100,000,000	$0
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$306,000,000	$306,000,000	$0
4260-601-3213 LTC QA Fund	$623,984,000	$623,984,000	$0
4260-601-3293 MCO Tax Fund 2016	$0	$0	$0
4260-601-3311 Healthcare Service Fines and Penalties	$36,552,000	$36,552,000	$0
4260-601-3323 Medi-Cal Emergency Transport Fund	$68,312,000	$68,312,000	$0
4260-601-3331 Medi-Cal Drug Rebates Fund	$1,643,642,000	$1,643,642,000	$0
4260-601-3334 MCO Tax (HCS Special Fund)	$2,769,658,000	$2,769,658,000	$0
4260-601-7502 Demonstration DSH Fund	$58,544,000	$58,544,000	$0
4260-601-7503 Health Care Support Fund	$92,553,000	$92,553,000	$0
4260-601-8107 Whole Person Care Pilot Fund	$335,600,000	$335,600,000	$0
4260-601-8108 Global Payment Program Fund	$876,470,000	$876,470,000	$0
4260-601-8113 DPH GME Special Fund	$378,759,000	$378,759,000	$0
4260-602-0309 Perinatal Insurance Fund	$26,853,000	$26,853,000	$0
4260-605-0001 SNF Quality & Accountability	$46,979,000	$46,979,000	$0
4260-605-3167 SNF Quality & Accountability	$41,000,000	$41,000,000	$0
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($46,979,000)	($46,979,000)	$0
4260-606-0834 SB 1100 DSH	$211,063,000	$211,063,000	$0
4260-607-8502 LIHP IGT (Non-GF)	$0	$0	$0
4260-611-3158/0890 Hospital Quality Assurance	$11,137,757,000	$11,137,757,000	$0
TOTAL MEDI-CAL Benefits	**$107,069,298,000**	**$110,351,490,000**	**$3,282,192,000**
COUNTY ADMINISTRATION:			
4260-101-0001/0890(1)	$4,597,380,000	$4,623,975,000	$26,595,000
4260-102-3305(1) Prop 56 Loan Forgiveness Program	$0	$0	$0
4260-106-0890(1) Money Follow Person Fed. Grant	$360,000	$360,000	$0
4260-113-0001/0890 Childrens Health Insurance Program	$72,964,000	$72,964,000	$0
4260-117-0001/0890 HIPPA	$12,772,000	$12,772,000	$0
4260-601-0942 Home Health Program Account	$163,000	$163,000	$0
4260-601-0995 Reimbursements	$189,000	$189,000	$0
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$489,000	$489,000	$0
4260-605-3167 SNF Quality & Accountability Admin.	$5,432,000	$5,432,000	$0
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$100,000	$100,000	$0
TOTAL COUNTY ADMIN.	**$4,689,849,000**	**$4,716,444,000**	**$26,595,000**
FISCAL INTERMEDIARY:			
4260-101-0001/0890(2)	$347,726,000	$345,960,000	($1,766,000)
4260-111-0001 CHDP State Only	$0	$0	$0
4260-113-0001/0890 Childrens Health Insurance Program	$3,766,000	$3,766,000	$0
4260-117-0001/0890 HIPAA	$1,001,000	$1,001,000	$0
4260-601-0995 Reimbursements	$0	$0	$0
TOTAL FISCAL INTERMEDIARY	**$352,493,000**	**$350,727,000**	**($1,766,000)**
GRAND TOTAL - ALL FUNDS	**$112,111,640,000**	**$115,418,661,000**	**$3,307,021,000**

Medi-Cal Funding Summary
May 2020 Estimate Compared to FY 2020-21 Appropriation
Fiscal Year 2020 - 2021

STATE FUNDS

Benefits:	May 2020 Estimate	FY 2020-21 Appropriation	Difference Incr./(Decr.)
4260-101-0001 Medi-Cal General Fund*	$20,957,179,000	$21,438,108,000	$480,929,000
4260-101-0080 CLPP Funds	$916,000	$916,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$92,170,000	$92,170,000	$0
4260-101-0233 Prop 99 Physician Srvc. Acct	$26,639,000	$26,639,000	$0
4260-101-0236 Prop 99 Unallocated Account	$41,848,000	$41,848,000	$0
4260-101-3168 Emergency Air Transportation Fund	$6,626,000	$6,626,000	$0
4260-101-3305 Healthcare Treatment Fund	$1,339,836,000	$863,756,000	($476,080,000)
4260-101-3366 Electronic Cigarette Product Tax	$9,600,000	$9,600,000	$0
4260-102-0001 Capital Debt *	$26,770,000	$26,770,000	$0
4260-102-3305 Prop 56 Loan Forgiveness Program	$15,200,000	$15,200,000	$0
4260-103-3305 Prop 56 Value-Based Payment	$0	$178,281,000	$178,281,000
4260-104-0001 NDPH Hosp Supp *	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$1,900,000	$1,900,000	$0
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	($1,900,000)	($1,900,000)	$0
4260-105-0001 Private Hosp Supp Fund *	$118,400,000	$118,400,000	$0
4260-601-3097 Private Hosp Suppl	$132,461,000	$132,461,000	$0
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-111-0001 CHDP State Only *	$0	$0	$0
4260-113-0001 Childrens Health Insurance Program *	$973,390,000	$959,057,000	($14,333,000)
4260-601-0942142 Local Trauma Centers	$81,883,000	$81,883,000	$0
4260-601-0942 Home Health Program Account	$22,749,000	$22,749,000	$0
4260-601-0995 Reimbursements	$1,777,423,000	$1,777,423,000	$0
4260-601-3156 MCO Tax Fund	$100,000,000	$100,000,000	$0
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$306,000,000	$306,000,000	$0
4260-601-3213 LTC QA Fund	$623,984,000	$623,984,000	$0
4260-601-3293 MCO Tax Fund 2016	$0	$0	$0
4260-601-3311 Healthcare Service Fines and Penalties	$36,552,000	$36,552,000	$0
4260-601-3323 Medi-Cal Emergency Transport Fund	$68,312,000	$68,312,000	$0
4260-601-3331 Medi-Cal Drug Rebates Fund	$1,643,642,000	$1,643,642,000	$0
4260-601-3334 MCO Tax (HCS Special Fund)	$2,769,658,000	$2,769,658,000	$0
4260-601-8107 Whole Person Care Pilot Fund	$335,600,000	$335,600,000	$0
4260-601-8108 Global Payment Program Fund	$876,470,000	$876,470,000	$0
4260-601-8113 DPH GME Special Fund	$378,759,000	$378,759,000	$0
4260-602-0309 Perinatal Insurance Fund	$26,853,000	$26,853,000	$0
4260-605-0001 SNF Quality & Accountability *	$46,979,000	$46,979,000	$0
4260-605-3167 SNF Quality & Accountability	$41,000,000	$41,000,000	$0
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($46,979,000)	($46,979,000)	$0
4260-606-0834 SB 1100 DSH	$211,063,000	$211,063,000	$0
4260-607-8502 LIHP IGT (Non-GF)	$0	$0	$0
4260-611-3158 Hospital Quality Assurance Revenue	$5,288,065,000	$5,288,065,000	$0
Total Benefits	**$38,212,548,000**	**$38,381,344,000**	**$168,796,000**
Total Benefits General Fund *	**$22,124,618,000**	**$22,591,213,000**	**$466,595,000**
County Administration:			
4260-101-0001 Medi-Cal General Fund *	$886,435,000	$892,630,000	$6,195,000
4260-102-3305(1) Prop 56 Loan Forgiveness Program	$0	$0	$0
4260-113-0001 Childrens Health Insurance Program *	$16,316,000	$14,316,000	($2,000,000)
4260-117-0001 HIPAA *	$2,226,000	$2,226,000	$0
4260-601-0942 Health Homes Program Account	$163,000	$163,000	$0
4260-601-0995 Reimbursements	$189,000	$189,000	$0
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$489,000	$489,000	$0
4260-605-3167 SNF Quality & Accountability Admin.	$5,432,000	$5,432,000	$0
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$100,000	$100,000	$0
Total County Administration	**$911,350,000**	**$915,545,000**	**$4,195,000**
Total County Administration General Fund *	**$904,977,000**	**$909,172,000**	**$4,195,000**
Fiscal Intermediary:			
4260-101-0001(2) *	$122,724,000	$122,132,000	($592,000)
4260-111-0001 CHDP State Only *	$0	$0	$0
4260-113-0001 Childrens Health Insurance Program *	($790,000)	$1,210,000	$2,000,000
4260-117-0001 HIPAA *	$198,000	$198,000	$0
4260-601-0995 Reimbursements	$0	$0	$0
Total Fiscal Intermediary	**$122,132,000**	**$123,540,000**	**$1,408,000**
Total Fiscal Intermediary General Fund *	**$122,132,000**	**$123,540,000**	**$1,408,000**
Grand Total - State Funds	**$39,246,030,000**	**$39,420,429,000**	**$174,399,000**
Grand Total - General Fund*	**$23,151,727,000**	**$23,623,925,000**	**$472,198,000**

Medi-Cal Funding Summary
May 2020 Estimate Compared to FY 2020-21 Appropriation
Fiscal Year 2020 - 2021

FEDERAL FUNDS

	May 2020 Estimate	FY 2020-21 Appropriation	Difference Incr./(Decr.)
Benefits:			
4260-101-0890(3)	$59,881,691,000	$62,873,743,000	$2,992,052,000
4260-102-0890 Capital Debt	$50,785,000	$50,785,000	$0
4260-106-0890 Money Follows Person Federal Grant	$3,319,000	$3,319,000	$0
4260-113-0890 Childrens Health Insurance Program	$2,920,166,000	$3,041,509,000	$121,343,000
4260-601-7502 Demonstration DSH Fund	$58,544,000	$58,544,000	$0
4260-601-7503 Health Care Support Fund	$92,553,000	$92,553,000	$0
4260-611-0890 Hospital Quality Assurance	$5,849,692,000	$5,849,692,000	$0
Total Benefits	**$68,856,750,000**	**$71,970,145,000**	**$3,113,395,000**
County Administration:			
4260-101-0890(1)	$3,710,945,000	$3,731,345,000	$20,400,000
4260-106-0890(1) Money Follows Person Fed. Grant	$360,000	$360,000	$0
4260-113-0890 Childrens Health Insurance Program	$56,648,000	$58,648,000	$2,000,000
4260-117-0890 HIPAA	$10,546,000	$10,546,000	$0
Total County Administration	**$3,778,499,000**	**$3,800,899,000**	**$22,400,000**
Fiscal Intermediary:			
4260-101-0890(2)	$225,002,000	$223,828,000	($1,174,000)
4260-113-0890 Childrens Health Insurance Program	$4,556,000	$2,556,000	($2,000,000)
4260-117-0890 HIPAA	$803,000	$803,000	$0
Total Fiscal Intermediary	**$230,361,000**	**$227,187,000**	**($3,174,000)**
Grand Total - Federal Funds	**$72,865,610,000**	**$75,998,231,000**	**$3,132,621,000**

May 2020 Medi-Cal Estimate

Current Year (FY 2019-20) Projected Expenditures Compared to the November 2019 Estimate

(Dollars in Millions)

Medical Care Services	Nov 2019 Estimate	May 2020 Estimate	Change	
			Amount	Percent
Total Funds	$96,027.5	$94,653.8	($1,373.7)	-1.4%
Federal Funds	$61,270.4	$61,376.3	$105.9	0.2%
General Fund	**$21,935.4**	**$21,603.1**	**($332.3)**	**-1.5%**
Other Non-Federal Funds	$12,821.7	$11,674.4	($1,147.3)	-8.9%

County Administration	Nov 2019 Estimate	May 2020 Estimate	Change	
			Amount	Percent
Total Funds	$4,705.0	$4,455.1	($249.9)	-5.3%
Federal Funds	$3,749.3	$3,464.7	($284.6)	-7.6%
General Fund	**$950.7**	**$985.7**	**$35.0**	**3.7%**
Other Non-Federal Funds	$5.0	$4.7	($0.3)	-6.0%

Fiscal Intermediary	Nov 2019 Estimate	May 2020 Estimate	Change	
			Amount	Percent
Total Funds	$382.9	$380.6	($2.3)	-0.6%
Federal Funds	$256.9	$255.7	($1.2)	-0.5%
General Fund	**$126.0**	**$124.9**	**($1.1)**	**-0.9%**
Other Non-Federal Funds	$0.0	$0.0	$0.0	n/a

Total Expenditures	Nov 2019 Estimate	May 2020 Estimate	Change	
			Amount	Percent
Total Funds	$101,115.4	$99,489.5	($1,625.9)	-1.6%
Federal Funds	$65,276.7	$65,096.7	($179.9)	-0.3%
General Fund	**$23,012.2**	**$22,713.7**	**($298.4)**	**-1.3%**
Other Non-Federal Funds	$12,826.7	$11,679.1	($1,147.6)	-8.9%

Note: Totals may not add due to rounding.

May 2020 Medi-Cal Estimate

Current Year (FY 2019-20) Projected Expenditures Compared to the Appropriation

(Dollars in Millions)

Medical Care Services	FY 2019-20 Appropriation	May 2020 Estimate	Change	
			Amount	Percent
Total Funds	$97,431.9	$94,653.8	($2,778.1)	-2.9%
Federal Funds	$62,176.1	$61,376.3	($799.8)	-1.3%
General Fund	**$22,083.8**	**$21,603.1**	**($480.7)**	**-2.2%**
Other Non-Federal Funds	$13,172.0	$11,674.4	($1,497.6)	-11.4%

County Administration	FY 2019-20 Appropriation	May 2020 Estimate	Change	
			Amount	Percent
Total Funds	$4,614.3	$4,455.1	($159.2)	-3.5%
Federal Funds	$3,708.9	$3,464.7	($244.2)	-6.6%
General Fund	**$899.5**	**$985.7**	**$86.2**	**9.6%**
Other Non-Federal Funds	$5.9	$4.7	($1.2)	-20.3%

Fiscal Intermediary	FY 2019-20 Appropriation	May 2020 Estimate	Change	
			Amount	Percent
Total Funds	$357.0	$380.6	$23.6	6.6%
Federal Funds	$236.5	$255.7	$19.2	8.1%
General Fund	**$120.6**	**$124.9**	**$4.3**	**3.6%**
Other Non-Federal Funds	$0.0	$0.0	($0.0)	n/a

Total Expenditures	FY 2019-20 Appropriation	May 2020 Estimate	Change	
			Amount	Percent
Total Funds	$102,403.3	$99,489.5	($2,913.7)	-2.8%
Federal Funds	$66,121.4	$65,096.7	($1,024.7)	-1.5%
General Fund	**$23,103.9**	**$22,713.7**	**($390.2)**	**-1.7%**
Other Non-Federal Funds	$13,177.9	$11,679.1	($1,498.8)	-11.4%

Note: Totals may not add due to rounding.

May 2020 Medi-Cal Estimate

Budget Year (FY 2020-21) Projected Expenditures Compared to Current Year (FY 2019-20)

(Dollars in Millions)

Medical Care Services	FY 2019-20 Estimate	FY 2020-21 Estimate	Change	
			Amount	Percent
Total Funds	$94,653.8	$107,069.3	$12,415.5	13.1%
Federal Funds	$61,376.3	$68,856.8	$7,480.5	12.2%
General Fund	**$21,603.1**	**$22,124.6**	**$521.5**	**2.4%**
Other Non-Federal Funds	$11,674.4	$16,087.9	$4,413.5	37.8%

County Administration	FY 2019-20 Estimate	FY 2020-21 Estimate	Change	
			Amount	Percent
Total Funds	$4,455.1	$4,689.8	$234.7	5.3%
Federal Funds	$3,464.7	$3,778.5	$313.8	9.1%
General Fund	**$985.7**	**$905.0**	**($80.7)**	**-8.2%**
Other Non-Federal Funds	$4.7	$6.3	$1.6	34.0%

Fiscal Intermediary	FY 2019-20 Estimate	FY 2020-21 Estimate	Change	
			Amount	Percent
Total Funds	$380.6	$352.5	($28.1)	-7.4%
Federal Funds	$255.7	$230.4	($25.3)	-9.9%
General Fund	**$124.9**	**$122.1**	**($2.8)**	**-2.2%**
Other Non-Federal Funds	$0.0	$0.0	$0.0	$0.0

Total Expenditures	FY 2019-20 Estimate	FY 2020-21 Estimate	Change	
			Amount	Percent
Total Funds	$99,489.5	$112,111.6	$12,622.1	12.7%
Federal Funds	$65,096.7	$72,865.6	$7,768.9	11.9%
General Fund	**$22,713.7**	**$23,151.7**	**$438.0**	**1.9%**
Other Non-Federal Funds	$11,679.1	$16,094.2	$4,415.1	37.8%

Note: Totals may not add due to rounding.

May 2020 Medi-Cal Estimate

Budget Year (FY 2020-21) Projected Expenditures Compared to the November 2019 Estimate

(Dollars in Millions)

Medical Care Services	Nov 2019 Estimate	May 2020 Estimate	Change	
			Amount	Percent
Total Funds	$98,548.7	$107,069.3	$8,520.6	8.6%
Federal Funds	$62,815.9	$68,856.8	$6,040.9	9.6%
General Fund	**$24,884.4**	**$22,124.6**	**($2,759.8)**	**-11.1%**
Other Non-Federal Funds	$10,848.4	$16,087.9	$5,239.5	48.3%

County Administration	Nov 2019 Estimate	May 2020 Estimate	Change	
			Amount	Percent
Total Funds	$4,550.1	$4,689.8	$139.7	3.1%
Federal Funds	$3,684.9	$3,778.5	$93.6	2.5%
General Fund	**$860.3**	**$905.0**	**$44.7**	**5.2%**
Other Non-Federal Funds	$4.9	$6.3	$1.4	28.6%

Fiscal Intermediary	Nov 2019 Estimate	May 2020 Estimate	Change	
			Amount	Percent
Total Funds	$363.2	$352.5	($10.7)	-2.9%
Federal Funds	$243.0	$230.4	($12.6)	-5.2%
General Fund	**$120.2**	**$122.1**	**$1.9**	**1.6%**
Other Non-Federal Funds	$0.0	$0.0	$0.0	n/a

Total Expenditures	Nov 2019 Estimate	May 2020 Estimate	Change	
			Amount	Percent
Total Funds	$103,461.9	$112,111.6	$8,649.7	8.4%
Federal Funds	$66,743.9	$72,865.6	$6,121.7	9.2%
General Fund	**$25,864.9**	**$23,151.7**	**($2,713.2)**	**-10.5%**
Other Non-Federal Funds	$10,853.3	$16,094.2	$5,240.9	48.3%

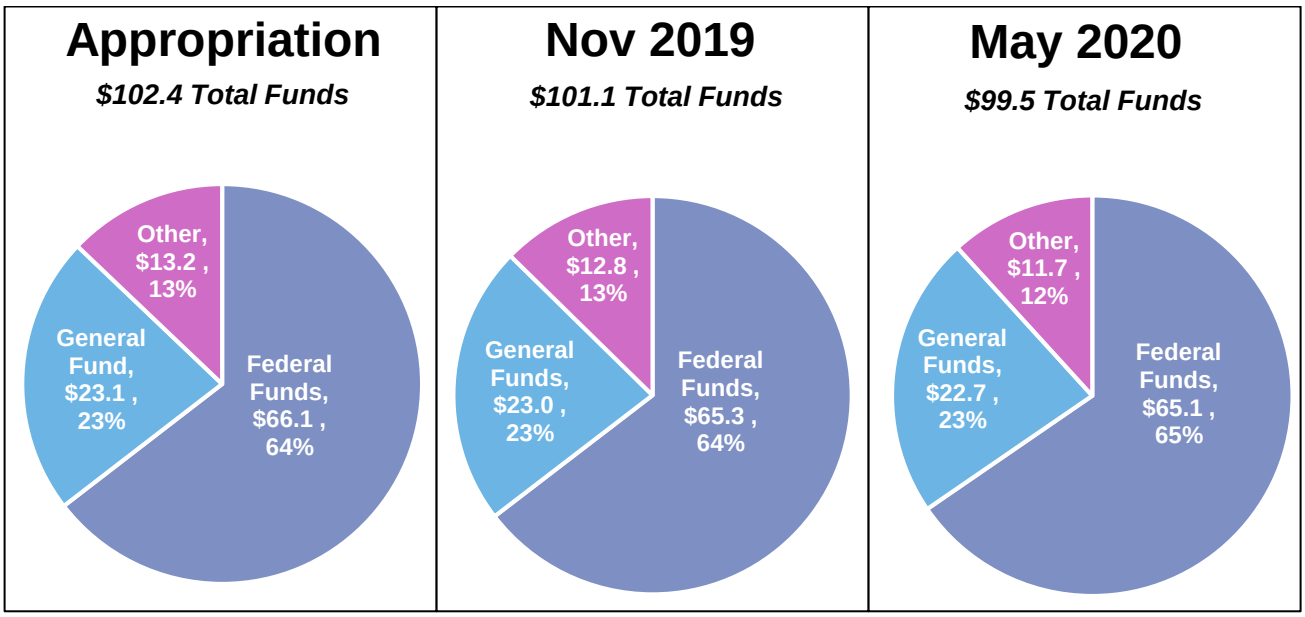
Note: Totals may not add due to rounding.

Medi-Cal Local Assistance Estimate
Management Summary
May 2020

Medi-Cal spending is estimated to be $99.5 billion in Fiscal Year (FY) 2019-20 and $112.1 billion in FY 2020-21. This does not include Certified Public Expenditures of local governments or General Fund of other state departments.

FY 2019-20

(Dollars in Billions, Rounded)



The May 2020 Estimate for FY 2019-20 projects a $390.2 million surplus General Fund compared to the FY 2019-20 Budget Appropriation and a $298.4 million surplus General Fund from November 2019 Estimate.

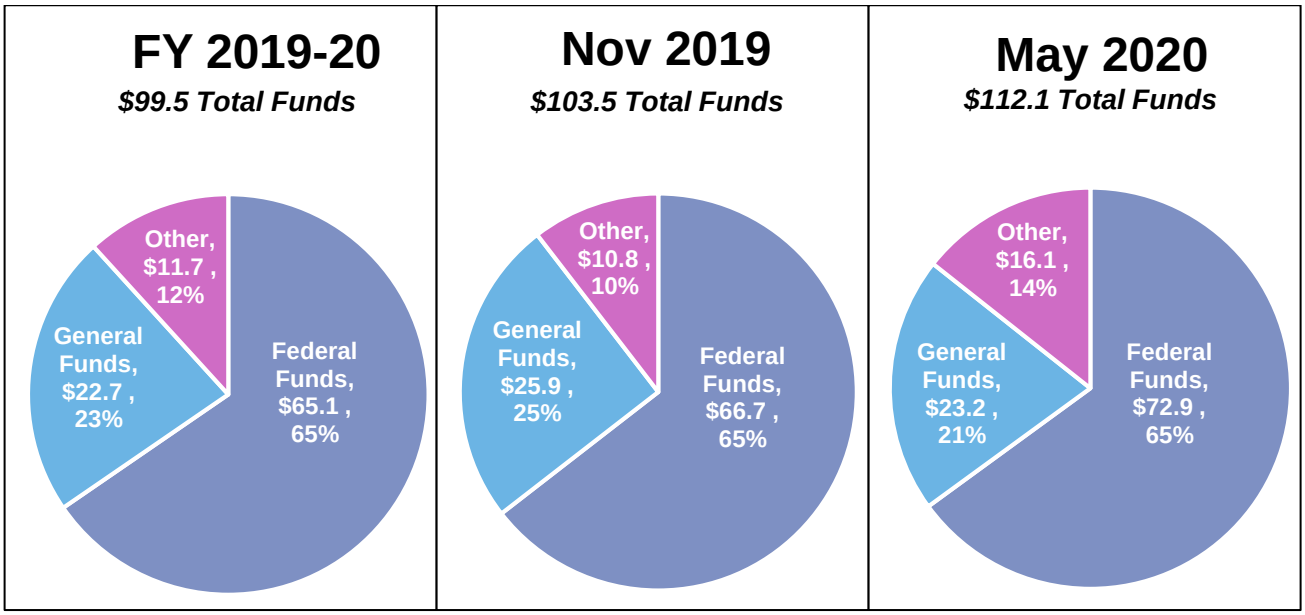
FY 2019-20, General Fund

(Dollars in Millions, Rounded)

	May 20	Appropriation	Change from Approp	Nov 19	Change from Nov 19
Medical Care Services	$21,603.1	$22,083.80	($480.7)	$21,935.40	($332.3)
County Administration	$985.7	$899.50	$86.2	$950.70	$35.0
Fiscal Intermediary	$124.9	$120.60	$4.3	$126.00	($1.1)
Total	$22,713.7	$23,103.90	($390.2)	$23,012.20	($298.4)

FY 2020-21

(Dollars in Billions, Rounded)



The Medi-Cal General Fund costs are estimated to increase by $438 million between FY 2019-20 and FY 2020-21.

FY 2020-21, General Fund

(Dollars in Millions, Rounded)

	May 20	FY 2019-20	Change from FY 2019-20	Nov 19	Change from Nov 19
Medical Care Services	$22,124.6	$21,603.1	$521.5	$24,884.40	($2,759.8)
County Administration	$905.0	$985.7	($80.7)	$860.30	$44.7
Fiscal Intermediary	$122.1	$124.9	($2.8)	$120.20	$1.9
Total	$23,151.7	$22,713.7	$438.0	$25,864.90	($2,713.2)

The following pages briefly describe the significant changes in both FY 2019-20 and FY 2020-21.

SIGNIFICANT ITEMS

CASELOAD

Although Medi-Cal Caseload has gradually declined since 2016, caseload is estimated to increase significantly due to the COVID-19 pandemic and related unprecedented economic downturn, high unemployment, and suspending disenrollment during the federal public health emergency.

Prior to the COVID-19 pandemic, the Medi-Cal caseload was expected to decline as the economy continued to improve. These decreases were mainly in the Families and Optional Expansion categories. These categories are now estimated to experience most of the growth anticipated with the pandemic.

The Medi-Cal Local Assistance Estimate is projecting an increase of eligibles of 0.27 percent from FY 2018-19 to FY 2019-20 and 9.23 percent growth from FY 2019-20 to FY 2020-21. Caseload is expected to increase in May and June 2020 with a peak in monthly certified eligibles of 14.5 million in July 2020 and a gradual decrease during the remainder of FY 2020-21.

FY	Total Average Monthly Caseload
FY 2018-19	13,003,000
FY 2019-20	13,038,000
FY 2020-21	14,241,600

COVID-19

The effects of the COVID-19 pandemic are unprecedented in modern times from a public health emergency and economic perspective. This has a fiscal impact across policy areas and beneficiary populations within the Medi-Cal program. A summary of the major estimated impacts from the COVID-19 pandemic on Medi-Cal is below.

Dollars in Millions						Change from FY 2019-20	
		FY 2019-20		FY 2020-21		FY 2020-21	
Name	**Policy Change Number (PC)**	**Total Funds (TF)**	**General Fund (GF)**	**Total Funds (TF)**	**General Fund (GF)**	**Total Funds (TF)**	**General Fund (GF)**
COVID-19 Caseload Impact	251	$898.6	$319.0	$7,609.6	$2,766.6	$6,711.0	$2,447.6
As a result of the COVID-19 pandemic and related non-pharmaceutical interventions, nonessential businesses have closed and restaurants have scaled back, leading to significant economic disruption and job loss. Some newly unemployed individuals are expected to apply for and qualify for Medi-Cal. In addition, the federal Families First Coronavirus Response Act (FFCRA) requires states to halt disenrollment of Medicaid beneficiaries as a condition of receiving a temporary increase in the federal medical assistance percentage (FMAP). As a result, Medi-Cal enrollment is expected to significantly increase, leading to increased costs.							
COVID-19 Utilization Change	247	($652.4)	($229.0)	($395.7)	($146.8)	$256.7	$82.2
As a result of the COVID-19 pandemic and related non-pharmaceutical interventions, the Department estimates a decrease in Medical and Dental Fee-for-Service (FFS) utilization, resulting in savings.							

Dollars in Millions						Change from FY 2019-20	
		FY 2019-20		FY 2020-21		FY 2020-21	
Name	**Policy Change Number (PC)**	**Total Funds (TF)**	**General Fund (GF)**	**Total Funds (TF)**	**General Fund (GF)**	**Total Funds (TF)**	**General Fund (GF)**
COVID-19 Emergency FMAP - DHCS	250	$0.0	($775.0)	$0.0	($2,554.2)	$0.0	($1,779.2)
The FFCRA increases the FMAP on regular Medicaid 50-percent expenditures by 6.2 percentage points and the Children's Health Insurance Program (CHIP) FMAP by 4.34 percentage points beginning in January 2020 through the last day of the calendar quarter in which the national public health emergency ends. This shifts costs to the federal government that otherwise would be paid for from the state General Fund. The Estimate assumes the increased FMAP continues through June 30, 2021. This policy change budgets General Fund savings from the emergency increased FMAP related to benefit costs in the Department's budget. The increased FMAP has not been applied to supplemental payments and county match funding as of this Estimate. Supplemental payments mainly consist of Intergovernmental Transfers and Certified Public Expenditures. The fiscal impact on a cash basis is pending additional CMS guidance.							
COVID-19 Emergency FMAP – Other Depts	248	$257.7	$0.0	$1,296.0	$0.0	$1,038.3	$0.0
This policy change reflects additional federal funding from the emergency increased FMAP that offsets what otherwise would be General Fund costs in other state departments, including the California Department of Social Services, the California Department of Developmental Services, and the California Department of Aging. (The General Fund savings are reflected in the budgets of these other departments.)							
COVID-19 Emergency FMAP – Other Admin	OA 102	$0.0	($1.0)	$0.0	($2.0)	$0.0	($1.0)
This policy change reflects General Fund savings from the emergency increased FMAP related to other administrative costs in the Department's budget.							
COVID-19 Uninsured Eligibility Group	245	$17.9	$9.5	$10.2	$5.4	($7.8)	($4.2)
The FFCRA provides for the cost of COVID-19 testing and related services provided through Medi-Cal to be fully reimbursed by the federal government. Additionally, FFCRA allows states to provide testing and related services for uninsured individuals, also fully reimbursed by the federal government. California requested, through a Section 1115 waiver, federal approval to provide COVID-19 treatment services with 100 percent federal funding. This request is still pending. This PC reflects federal funding for COVID-19 testing and federal and state funding for COVID-19 treatment. Upon approval of the state's 1115 waiver request, state costs incurred in Medi-Cal for COVID-19 treatment for the uninsured would be replaced with federal funds.							
COVID-19 Behavioral Health	249	$135.3	$13.3	$77.7	$7.7	($57.6)	($5.7)
Due to COVID-19, there has been a significant decrease in utilization of certain Specialty Mental Health and Drug Medi-Cal outpatient services, while costs per unit of service have increased. To account for the higher cost per unit of service and help counties maintain their provider networks, the Department implemented increases to interim reimbursement rates for these services.							
COVID-19 Additional Impacts	246	$233.4	$95.5	$286.6	$126.6	$53.2	$31.1
This policy change estimates the net costs associated with various other Medi-Cal program impacts resulting from the COVID-19 pandemic.							

PROPOSED BUDGET REDUCTIONS

The COVID-19 pandemic has resulted in an economic recession and a severe General Fund budget shortfall. The table below lists major program reductions, fund transfers, and revenue proposals that are proposed in Medi-Cal to address the state's budget situation.

Dollars in Millions		Change from November 2019		Change from November 2019		Change from FY 2019-20	
		FY 2019-20		FY 2020-21		FY 2020-21	
Name	**PC**	**TF**	**GF**	**TF**	**GF**	**TF**	**GF**
CalAIM - Dental Benefits	N/A	$0.0	$0.0	($112.5)	($56.3)	($112.5)	($56.3)
The Department has delayed the implementation of the CalAIM – Dental initiative.							
CalAIM - Enhanced Care Mgmt	N/A	$0.0	$0.0	($225.0)	($112.5)	($225.0)	($112.5)
The Department has delayed the implementation of the CalAIM – Enhanced Care Management initiative.							
CalAIM – In Lieu of Services (ILOS)	N/A	$0.0	$0.0	($357.5)	($178.8)	($357.5)	($178.8)
The Department has delayed the implementation of the CalAIM – In lieu of Services initiative.							
Undocumented Older Californians Expansion	N/A	$0.0	$0.0	($74.5)	($58.3)	($74.5)	($58.3)
The Department proposes to no longer implement coverage of benefit costs to expand full-scope Medi-Cal benefits to adults 65 years of age or older, regardless of immigration status.							
Hearing Aid Coverage	N/A	$0.0	$0.0	($5.0)	($5.0)	$0.0	$0.0
The Department proposes to no longer implement coverage for hearing aids and associated services to non-Medi-Cal children, who otherwise do not have health insurance coverage for these services and are at or below 600% Federal Poverty Level.							
Non-Hospital 340B Clinic Supplemental Payments	N/A	$0.0	$0.0	($52.5)	($26.3)	$0.0	$0.0
The Department proposes to no longer implement supplemental payments to non-hospital 340B clinics.							
Optional Adult Dental Partial Elimination	256	$0.0	$0.0	($67.8)	($22.9)	($67.8)	($22.9)
This new policy change estimates the savings of a partial elimination of optional adult dental services.							
Discontinue Adult Optional Benefits	257	$0.0	$0.0	($284.2)	($125.5)	($284.2)	($125.5)
This policy change estimates the savings from discontinuing Medi-Cal FFS and managed care coverage for audiology, incontinence creams and washes, speech therapy, podiatry, optical lab/optician services, acupuncture, Community-Based Adult Services (CBAS), optometry, nurse anesthetists, occupational therapy, and physical therapy, effective no sooner than July 1, 2020. Refer to separate policy changes for the changes to partial dental services, the Multipurpose Seniors Services Program, certain pharmacist services, and the Diabetes Prevention Program.							
Multipurpose Senior Services Program - CDA	38	$0	$0	($20.2)	($0.5)	($20.2)	$9.1
There is no change from the prior estimate for FY 2019-20. FY 2020-21 is a decrease due to an anticipated reduction in expenditures. The change from FY 2019-20 to FY 2020-21 is a decrease resulting from the proposed elimination of funding and the program ending, effective no sooner than July 1, 2020.							

Dollars in Millions		Change from November 2019		Change from November 2019		Change from FY 2019-20	
		FY 2019-20		FY 2020-21		FY 2020-21	
Name	**PC**	**TF**	**GF**	**TF**	**GF**	**TF**	**GF**
Pharmacist-Delivered Medi-Cal Services	51	($0.9)	($0.3)	($1.9)	($0.7)	($0.9)	($0.4)
AB 1114 (Chapter 602, Statutes of 2016) authorized reimbursement to pharmacies for the provision of the certain pharmacist-delivered Medi-Cal services at 85% of the physician fee schedule. In FY 2019-20, the costs for these certain pharmacist-delivered Medi-Cal services were assumed to be fully captured in the FFS base. Effective no sooner than July 1, 2020, the Department proposes to eliminate coverage for these certain pharmacist-delivered services that were authorized in AB 1114.							
Eliminate Proposition 56 Supplemental Payments	259	$0.0	$0.0	($2,173.4)	$0.0	($2,173.4)	$0.0
This policy change estimates the elimination of Proposition 56 supplemental payment funding for physician services, dental services, Medi-Cal family planning, developmental screenings, Community-Based Adult Services (CBAS), non-emergency medical transportation services, Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs) services, hospital-based pediatric physician services, and women's health services are proposed in FY 2020-21. The effective date of the elimination is proposed to be July 1, 2020 for fee-for-service (FFS) and managed care for all the aforementioned Proposition 56 supplemental payments, except for ICF/DDs and CBAS. The effective date of the elimination for ICF/DDs and CBAS is proposed effective July 1, 2020 for FFS and January 1, 2021 for managed care. Refer to the Proposition 56 Value-Based Payments policy change for details on the VBP changes.							
Prop 56 – Value-Based Payment Program	146	($85.80	($78.9)	($388.8)	($178.6)	($310.1)	($103.0)
FY 2019-20 and FY 2020-21 estimate a decrease due to the removal of Behavioral Health Integration Incentive (BHI) program dollars previously budgeted, as this program will no longer be implemented FY 2020-21, also includes a decrease due to removal of previously budgeted SFY 2020-21 VBP program dollars as the program will now sunset as of June 30, 2020. The change from FY 2019-20 to FY 2020-21 is a decrease due to the removal of the previously budgeted BHI and VBP program dollars.							
Prop 56 – Adverse Childhood Experiences (ACEs) Screenings	158	$0.2	$1.1	($16.1)	($5.8)	($3.9)	($2.5)
The increase in FY 2019-20 from the prior Estimate is due to updated FFS caseload data and managed care capitation costs. Proposition 56 funding for ACEs screenings is estimated to be reduced in FY 2020-21, due to a reduction in the payment amount for each screening.							
Prop 56 – Provider ACES Trainings	189	($13.5)	($6.8)	($40.0)	($20.0)	$3.5	$1.8
In FY 2019-20 the decrease from the prior Estimate is due to reduced consultant activities related to the Provider ACEs Trainings. Proposition 56 funding for provider ACEs screening trainings is estimated to be reduced in FY 2020-21.							

Dollars in Millions		Change from November 2019		Change from November 2019		Change from FY 2019-20	
		FY 2019-20		FY 2020-21		FY 2020-21	
Name	**PC**	**TF**	**GF**	**TF**	**GF**	**TF**	**GF**
Prop 56 Physicians & Dentist Loan Repayment Program	199	$0.0	$0.0	$0.0	$0.0	$13.5	$0
There is no change from the previous estimate for FY 2019-20 and FY 2020-21. The difference from FY 2019-20 to FY 2020-21 is an increase due to the awarded loan repayments beginning payments in FY 2020-21 for cohort 1. The program is now proposed to contain a single cohort and will not include awards for cohorts 2-5 previously expected.							
Use of Prop 56 to Fund Medi-Cal Growth	264	$0.0	$0.0	$0.0	($1,176.6)	$0.0	($1,176.6)
This new policy change identifies Proposition 56 dollars that will be used to fund growth in the Medi-Cal program.							
Health Enrollment Navigators	OA 12	($24.2)	($12.1)	($3.7)	($1.7)	$18.9	$9.4
FY 2019-20 is a decrease due to a shift in the implementation date and a reduction to total expected expenditures. FY 2020-21 is a decrease due to removal of funding for these activities. The change from FY 2019-20 to FY 2020-21, in the current Estimate, is a decrease due to the removal of the funding for activities that would have been provided in FY 2020-21.							
CA Health Information Exchanges Onboarding Program	OA 21	($14.3)	($1.4)	($13.9)	($1.4)	$20.8	$2.1
FY 2019-20 is a decrease due to obtaining federal approvals later than previously anticipated. FY 2020-21, is a decrease due to lower than anticipated expenditures in the budget year because the Department proposes removal of funding. The change from FY 2019-20 to FY 2020-21, in the current Estimate, is an increase due to a full year of program implementation occurring in FY 2020-21.							
Diabetes Prevention Program (DPP)	46	($0.1)	$0.0	($3.2)	($0.9)	($2.2)	($0.5)
The DPP was established as of January 1, 2019; however, no FFS payments are estimated in FY 2019-20 due to delays in DPP provider enrollment. Effective no sooner than July 1, 2020, the Department proposes to eliminate the DPP in FFS and managed care.							
Medi-Cal Interpreters Pilot Project	N/A	($5.0)	($5.0)	$0.0	$0.0	$0.0	$0.0
SB 165 (Chapter 365, Statutes of 2019) appropriated $5 million GF for the support of medical interpreter pilot projects through June 30, 2024. Medical interpreter pilot projects were not established in FY 2019-20. The Department proposes to revert the $5 million GF funding and not implement medical interpreter pilot projects.							
Expansion to Screening for Additional Substances	N/A	$0.0	$0.0	($7.4)	($2.5)	$0.0	$0.0
SB 78 (Chapter 38, Statutes of 2019) required the Department to expand the Medi-Cal benefit for adult Alcohol Misuse Screening and Behavioral Counseling Interventions in Primary Care to include screening for additional substances (i.e., opioids and other drugs). The Department proposes to no longer implement the expansion for screenings for additional substances.							
FPL Increase for Aged and Disabled Person	N/A	$0.0	$0.0	($135.9)	($67.9)	($135.9)	($67.9)
The Department proposes to no longer implement an income disregard for countable income over 100% of the Federal Poverty Level (FPL) up to 138% of the FPL for the Aged, Blind, and Disabled (ABD) FPL program.							

Dollars in Millions		Change from November 2019		Change from November 2019		Change from FY 2019-20	
		FY 2019-20		FY 2020-21		FY 2020-21	
Name	**PC**	**TF**	**GF**	**TF**	**GF**	**TF**	**GF**
Provisional Postpartum Care Extension	N/A	$0.0	$0.0	($45.8)	($45.8)	($45.8)	($45.8)
The Department proposes to no longer implement coverage of beneficiaries who receive pregnancy-related services, and are diagnosed with a mental health condition, to remain eligible for Medi-Cal postpartum care for up to 12 months after the last day of the pregnancy.							
Medicare Part B Disregard	N/A	$0.0	$0.0	($0.3)	($0.3)	($0.3)	($0.3)
This Department proposes to no longer implement coverage of the cost for eligibles in the Aged, Blind, and Disabled (ABD) program to remain eligible for the program regardless of the state's payment of their Medicare Part B premiums, as long as they meet all other Medi-Cal eligibility requirements.							
CHDP Case Management	OA 10	$0	$0	($18.7)	($6.6)	($18.7)	($6.6)
The FY 2020-21 and the FY 2019-20 to FY 2020-21 decreases are due to elimination of funding for the FY 2020-21 allocation.							
Retro Managed Care Rate Adjustments	103	$51.3	$28.6	$96.8	$86.8	$201.0	$192.3
The change for FY 2019-20 is due to updating State-only recoupment amounts to actuals, CY 2019 CCI Full Dual rates based on plan reported base data, and the inclusion of net costs from wire transfer recoupments. The change for FY 2020-21 is updated payment timing for CCI CY 2020 Full Duals, updated MLK and pass-through final payment rates, and rate corrections for CY 2017 and CY 2018 CCI Full Dual rates. The change from FY 2019-20 to FY 2020-21 is due to a payment shift for CCI CY 2020 Full Duals, rate corrections for CY 2017 and CY 2018 CCI Full Duals in FY 2020-21, and 18 months of pass-through payments occurring in FY 2020-21							
Family Mosaic Capitated Case Mgmt. (Other M/C)	109	($0.2)	($3.4)	($1.0)	$1.3	($0.9)	$2.2
FY 2019-20 is a decrease in GF and TF due to a decrease in actual member months and the retroactive federal funding payback for the period of FY 2014-15 through FY 2018-19 now occurring in FY 2020-21. Federal funding is not obtainable since developed capitation rates are not actuarially certifiable due to the small population size. FY 2020-21 and the change from FY 2019-20 to FY 2020-21, in the current Estimate, is a decrease due to the proposed program discontinuance effective July 1, 2020.							
County Admin Allocation	CA 1	$12.7	$0	($42.2)	(21.1)	$12.7	$12.7
The change from the prior estimate for FY 2019-20 is a FF increase due to the $12,731,000 GF augmentation provided by Section 36 and Executive Order No. E 19/20 – 135 (EO 19/20 – 135). The change from the prior estimate for FY 2020-21 is a decrease due to no longer applying a California Consumer Price Index (CCPI) increase. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase based on anticipated county expenditures.							
HIPP Premium Payouts (Misc. Svcs)	196	($0.1)	($0.1)	($0.9)	($0.4)	($0.7)	($0.4)
The Health Insurance Premium Payment (HIPP) program is a voluntary program for full-scope Medi-Cal beneficiaries who have a high cost medical condition. Under the HIPP program, the Department pays for premiums, coinsurance, deductibles, and other cost sharing obligations when it is cost effective. In FY 2019-20, decreased costs for HIPP is estimated due to reduced enrollment based on new eligibility requirements. Effective no sooner than July 1, 2020, the Department proposes to discontinue the HIPP program and transition members to Medi-Cal managed care.							

Dollars in Millions		Change from November 2019		Change from November 2019		Change from FY 2019-20	
		FY 2019-20		FY 2020-21		FY 2020-21	
Name	**PC**	**TF**	**GF**	**TF**	**GF**	**TF**	**GF**
Eliminate FQHC & RHC PPS Carve Outs	254	$0.0	$0.0	($100.0)	($50.0)	($100.0)	($50.0)
This policy change estimates the savings resulting from eliminating Prospective Payment System (PPS) carve-outs for FQHCs and Rural Health Clinics for Medi-Cal services including pharmacy, dental and other services with the exception of Specialty Mental Health and Drug Medi-Cal Services. This is a new policy with an assumed effective date of January 1, 2021.							
Adjust Managed Care Cap Payments for July 2019 – Dec 2020	255	$0.0	$0.0	($585.9)	($182.0)	($585.9)	($182.0)
This PC estimates the savings associated with reducing the managed care capitation rates gross medical expense (GME) by 1.5% for the period July 1, 2019 through December 31, 2020 (Bridge Period) as a result of the COVID-19 pandemic and the related stay at home order. This GME rate reduction is for the Adult, Child, ACA, and Seniors and Persons with Disabilities categories. This is a new PC.							
Managed Care Efficiencies	258	$0.0	$0.0	($283.1)	($91.6)	($283.1)	$91.6)
This PC estimates the savings associated with implementing Managed Care rate adjustments and efficiencies as deemed actuarially appropriate. This is a new PC.							
Medi-Cal Drug Rebate Fund (Reserve)	53	$0.0	$169.9	$0.0	($181.0)	$0.0	($169.6)
The Department established the Medi-Cal Drug Rebate Fund (Fund 3331), effective July 1, 2019. In the current Estimate, FY 2019-20 includes an estimated $169.6 million fund reserve, which is based on updated rebate collections in FY 2019-20. In FY 2020-21, due to the severe State budget shortfall related to the COVID-19 pandemic, all available rebate collections will be transferred to the GF leaving no reserve in the Medi-Cal Drug Rebate Fund in FY 2020-21. The change from the FY 2020-21 reserve from the prior Estimate is a decrease of $181 million.							
Fund 3311 Transfer to the General Fund	262	$0.0	$0.0	$0.0	($36.6)	$0.0	($36.6)
In light of reduced state revenues due to COVID-19, this new policy change utilizes dollars in the Health Care Services Plan Fines and Penalties Fund 3311 to support the Medi-Cal program.							
Fund 3156 to the General Fund	261	$0.0	$0.0	$0.0	($100.0)	$0.0	($100.0)
In light of reduced state revenues due to COVID-19, this new policy change utilizes dollars in the Children's Health and Human Services Special Fund (3156) to fund the Medi-Cal program.							
Medi-Cal Estate Recoveries	253	$0.0	$0.0	($33.8)	($16.9)	($33.8)	($16.9)
The Department proposes to restore Medi-Cal Estate Recoveries to the federal maximum in FY 2020-21.							
Electronic Cigarette Products Tax	263	$0.0	$0.0	$0.0	($9.6)	$0.0	($9.6)
This new policy change reduces the General Fund and replaces those funds with Electronic Cigarette Products Tax funds.							

OTHER SIGNIFICANT CHANGES

Dollars in Millions		Change from November 2019		Change from November 2019		Change from FY 2019-20	
		FY 2019-20		FY 2020-21		FY 2020-21	
Name	**PC**	**TF**	**GF**	**TF**	**GF**	**TF**	**GF**
State Only Claiming Adjustments	244	$0.0	$0.0	$0.0	$1,292.7	$0.0	$1,292.7
This policy change estimates the reimbursement to the federal government for claiming for non-emergency or non-pregnancy related services provided to eligible, nonexempt, qualified immigrants with state only full scope Medi-Cal coverage (excluding behavioral health).							
Behavioral Health State Only Claiming Adjustment	238	$0.0	$0.0	$0.0	$148.5	$0.0	$148.5
This new policy change estimates the reimbursement to the federal government for claiming for Specialty Mental Health Services and Drug Medi-Cal provided for ineligible beneficiaries claimed retroactively from FY 2008-09 to FY 2018-19, and estimated FFP repayments for FY 2019-20 and FY 2020-21.							
Drug Medi-Cal Organized Delivery System Waiver	63	($36.8)	($6.5)	($31.3)	($1.2)	$53.5	$13.8
This policy change estimates the cost of the Drug Medi-Cal Organized Delivery System waiver for opt-in counties to provide Substance Use Disorder (SUD) services. The decrease in FY 2019-20, from the prior estimate, is due to delayed implementation of the Partnership Health Plan (PHP) counties from February 2020 to July 2020, excluding Trinity county due to the county opting out, and including updated claims payment data from more counties. The FY 2020-21 decrease from the prior estimate is due to a decreased estimate based on updated claims payment data from more counties. The increase from CY to BY is due to PHP counties starting in FY 2020-21.							
SMHS Base	71, 72	($265.1)	($8.1)	($355.4)	($14.7)	$93.9	$30.3
These policy changes estimate the base cost for specialty mental health services provided to adults and children. The decrease from the prior estimate for FY 2019-20 and FY 2020-21 is due to updated estimated ACA utilization and cost for SD/MC FFS Inpatient clients based on paid claims data through December 2019.							
Medi-Cal Access Program Mothers 213-322% FPL	4	$28.0	$0.0	$28.3	$0.0	$0.3	$0.0
FY 2019-20 and FY 2020-21 is an increase due to an updated projected per member, per month and supplemental capitation payments. Additionally, the average expected deliveries methodology has been updated to include reported and non-reported deliveries. Previously, only reported deliveries were captured. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a slight increase due to an increase in the projected average monthly caseload in FY 2020-21. Additionally, the FMAP for Title XXI decreases from 76.5% to 65% beginning October 1, 2020.							
Medicare Optional Expansion Adjustment	17	($29.1)	($14.5)	$29.1	$7.3	$57.4	($44.1)
FY 2019-20 is a GF decrease due to shifting the Long Term Care payment from FY 2019-20 to FY 2020-21. FY 2020-21, is a GF increase due to the Long Term Care payment shift and due to utilizing more recent actual memos for the FY 2020-21 projection. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a GF decrease due to fewer months being adjusted for in FY 2020-21.							

Dollars in Millions		Change from November 2019		Change from November 2019		Change from FY 2019-20	
		FY 2019-20		FY 2020-21		FY 2020-21	
Name	**PC**	**TF**	**GF**	**TF**	**GF**	**TF**	**GF**
ACA Disproportionate Share (DSH) Reduction	28	$602.9	$76.4	$664.0	$69.8	($690.5)	($90.0)
Pursuant to the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act, the DSH reductions have been delayed to December 1, 2020 and the nationwide $4 billion FFY 2020 DSH Reduction has been eliminated. The decreased savings in FY 2019-20 is due to the DSH reduction savings, starting with a $4 billion nationwide reduction in FFY 2021 and shifting savings to start in FY 2020-21. The net decrease in savings in FY 2020-21 is based on an increased estimate of the State's share of the estimated FFY 2021 DSH reduction, and the transition of University of California Designated Public Hospital (UC DPH) DSH payments to a quarterly payment cycle. The CY to BY net savings increase is based on an increased estimate of the State's share of the FFY 2021 DSH reductions and updated UC DPH payment schedule.							
Behavioral Health Treatment (BHT)	29	($57.3)	($25.9)	$45.2	$29.9	$130.8	$77.1
This policy change estimates the costs for providing Behavioral Health Treatment services for children under age 21 with a diagnosis of autism spectrum disorder (ASD), or Behavioral Intervention Services for the same age group who do not have an ASD diagnosis. The net change from the prior estimate is due to a lower number of supplemental payments for FY 2018-19 claims and a BHT managed care rate increase for calendar year (CY) 2021. Utilization for BHT services (supplemental capitation payments) is expected to increase for FY 2020-21.							
LEA Expansion	33	($80.5)	$0.0	$0.3	$0.0	$80.5	$0.0
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. SPA 15-021 is still pending approval from CMS. As a result of the delay, expanded LEA claiming has shifted to begin in FY 2020-21 and previously estimated costs in the BY has shifted to the out-year. The change from the prior estimate, for FY 2020-21 is an increase due to the first year costs were estimated to be higher than the subsequent year cost.							
Blood Factor Reimbursement Methodology	54	$0.0	$0.0	($26.2)	($9.6)	($35.6)	($13.1)
This policy change estimates the savings related to the proposed reimbursement methodology for blood factors. The increase in savings for budget year is due to adding the estimated savings for non-Hemophilia Treatment Centers (HTC) clinics.							
Drug Rebates	56, 57, 60, 62, 116	($158.8)	$0.0	$207.4	$0.0	$277.8	$0.0
These policy changes estimate the revenues collected from the Breast and Cervical Cancer Treatment, Family Planning, Access, Care and Treatment, State Supplemental, Federal and Managed Care drug rebates. The Drug rebates savings estimates have been updated based on rebate collections data through December 2019; and FFS and managed care data through January 2020.							
Medi-Cal Rx	OA 48, PCs: 52, 55, 59	$0.0	$0.0	$4.1	$1.4	($174.2)	($68.1)
On January 7, 2019, the Governor issued Executive Order N-01-19, requiring that all Medi-Cal pharmacy services be transitioned from managed care (MC) to fee-for-service (FFS) by January 1, 2021. Transitioning pharmacy services from managed care to Fee-For-Service (FFS) delivery system is referred to as Medi-Cal Rx. The combined impact of the Medi-Cal Rx related policy changes is estimated to be -$174.2 million TF (-$68.1 million GF) savings in FY 2020-21. The change in FY 2020-21 is due to removing savings from Cal MediConnect dual contracts that will not be carved-out of managed care plans.							

Dollars in Millions		Change from November 2019		Change from November 2019		Change from FY 2019-20	
		FY 2019-20		FY 2020-21		FY 2020-21	
Name	**PC**	**TF**	**GF**	**TF**	**GF**	**TF**	**GF**
Pharmacy Retroactive Adjustments	237	$0.0	$0.0	($189.8)	($54.0)	($189.8)	($54.0)
SPA 17-002 approved the Medi-Cal Pharmacy Actual Acquisition Cost (AAC) and Professional Dispensing Fee (PDF) reimbursement methodology, with an effective date of April 1, 2017. Providers continued to be paid under the previous reimbursement methodology until the new methodology was implemented on February 23, 2019. Retroactive adjustments for the 23-month period, from April 1, 2017 to February 23, 2019, was to be implemented via the Erroneous Payment Correction (EPC) process. The first iteration of the EPC for one month of claims (April 2017) and was installed on May 23, 2019. The remaining retroactive adjustments have since been delayed pending the resolution of the lawsuit *California Pharmacists Association, et al. v. Kent, et al.* This new policy change assumes the pharmacy retroactive adjustments will resume in July 2020 for providers that have a Department-approved Alternative Payment Plan (APA) and non-APA providers.							
Low Income Health Program (LIHP)	OA 4, 84, 90, 91	($41.0)	$0.0	$0.0	$0.0	($147.9)	$0.0
Changes to the LIHP final reconciliations resulted in a net decrease of approximately $41 million TF from the prior estimate in FY 2019-20.							
Medi-Cal 2020 Designated State Health Programs	243	$0.0	$0.0	$0.0	($92.3)	$0.0	($92.3)
This policy change estimates the additional federal financial participation (FFP) received for Certified Public Expenditures (CPEs) from state only programs under the California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020). General Fund savings realized under this program will be used as the state share to fund the Dental Transformation Initiative (DTI). The annual limit the State-Only programs may claim for Medi-Cal 2020 DSHP is $75 million in FFP each Demonstration Year (DY) for a five year total of $375 million FFP. In the current estimate, $92.3 million FFP will be claimed in FY 2020-21.							
2020 MCO Enrollment Tax Managed Care Plans	218	$0.0	$0.0	$0.0	($1,686.6)	$0.0	($1,686.6)
This is a new policy change. This policy change estimates the transfer of funds collected from the enrollment tax on managed care organizations (MCOs) to the General Fund (GF) to be retained by the Department beginning January 1, 2020. The change from CY to BY is due to implementation timing of this policy.							
2020 MCO Enrollment Tax Mgd. Care Plans – Funding Adj.	219	$0.0	$0.0	$0.0	($1,038.0)	$0.0	($1,038.0)
This is a new policy change. This policy change estimates the transfer of funds collected from the tax on managed care organizations (MCOs) to the General Fund (GF) to be used by the Department to fund related managed care capitation rate increases. The change from CY to BY is due to implementation timing of this policy.							
2020 MCO Enrollment Tax Mgd. Care Plans – Incr. Cap.	220	$0.0	$0.0	$3,177.1	$1,083.0	$3,177.1	$1,083.0
This is a new policy change. This policy change estimates the cost of capitation rate increases that are offset by managed care organization (MCO) tax proceeds. The tax proceeds will be used for the non-federal share of capitation rate increases. The increase from CY to BY is due to implementation timing of this policy.							

Dollars in Millions		Change from November 2019		Change from November 2019		Change from FY 2019-20	
		FY 2019-20		FY 2020-21		FY 2020-21	
Name	**PC**	**TF**	**GF**	**TF**	**GF**	**TF**	**GF**
Two Plan Model	92	($300.6)	($142.7)	$63.7	$60.8	$541.3	$460.9
FY 2019-20 is a decrease due to lower than previously projected eligibles and applying final weighted rates. The change for FY 2020-21 is due to updated draft weighted rates having been applied to FY 2020-21. The previous estimate used FY 2019-20 weighted draft rates for the FY 2020-21 estimate. The change from FY 2019-20 to FY 2020-21 is due to a rate update between years. FY 2020-21 includes an FMAP adjustment for ACA and Title 21 (T21).							
County Organized Health Systems	93	($196.6)	($100.7)	$5.9	($1.9)	$299.3	$230.0
The FY 2019-20 estimate decreased due to lower than previously projected eligibles and applying final weighted rates. The change for FY 2020-21 is due to updated draft weighted rates having been applied to FY 2020-21. The previous estimate used FY 2019-20 weighted draft rates for the FY 2020-21 estimate. The change from FY 2019-20 to FY 2020-21 is due to a rate update between years. FY 2020-21 includes an FMAP adjustment for ACA and T21.							
Geographic Managed Care	94	($65.2)	($28.0)	($6.5)	$5.9	$83.1	$78.3
The FY 2019-20 estimate decreased due to lower than previously projected eligibles and applying final weighted rates. The change for FY 2020-21 is due to updated draft weighted rates having been applied to FY 2020-21. The previous estimate used FY 2019-20 weighted draft rates for the FY 2020-21 estimate. The change from FY 2019-20 to FY 2020-21 is due to a rate update between years. FY2020-21 includes an FMAP adjustment for ACA and T21.							
Regional Model	98	($22.2)	($8.3)	$1.2	$1.1	$38.6	$26.1
The FY 2019-20 estimate decreased due to lower than previously projected eligibles and applying final weighted rates. The change for FY 2020-21 is due to updated draft weighted rates having been applied to FY 2020-21. The previous estimate used FY 2019-20 weighted draft rates for the FY 2020-21 estimate. The change from FY 2019-20 to FY 2020-21 is due to a rate update between years. FY2020-21 includes an FMAP adjustment for ACA and T21.							
PACE (Other M/C)	99	$27.8	$13.9	$60.5	$30.2	$196.0	$98.0
FY 2019-20 is an increase due to a higher 2020 rate adjustment due to higher than previously estimated eligible enrollment and timing of adjustment. FY 2020-21 is an increase due to higher than estimated actuals through December 2019, the addition of a new plan, higher than actual enrollments from the Family Health Centers of San Diego plan, and a higher 2021 rate adjustment. The change from FY 2019-20 to FY 2020-21, is a net increase due to additional plans being implemented and a full year of enrollment being captured for the newer plans. The 2021 rate adjustment increased from higher than previously estimated based on eligible enrollment and timing of adjustment.							
Coordinated Care Initiative Risk Mitigation	114	$45.7	$22.9	($45.7)	($22.9)	($111.3)	($55.6)
This policy change estimates additional payments to and recoveries from managed care plans participating in the Coordinated Care Initiative related to the risk mitigation strategies. The changes for FY 2019-20 and FY 20-21 are due to recoupments previously budgeted in FY 2019-20 now shifting to FY 2020-21. This results in a decrease in recoupments for CY and in increase in recoupments for BY.							
San Mateo Health Plan Reimbursement	234	$0	$0	$30.0	$30.0	$30.0	$30.0
This new policy change estimates the reimbursement to San Mateo Health Plan for additional costs related to a rate adjustment for Burlingame Long Term Care a Distinct Part Skilled Nursing Facility. This is a one-time reimbursement occurring in FY 2020-21.							

Dollars in Millions		Change from November 2019		Change from November 2019		Change from FY 2019-20	
		FY 2019-20		FY 2020-21		FY 2020-21	
Name	**PC**	**TF**	**GF**	**TF**	**GF**	**TF**	**GF**
Ground Emergency Medical Transportation QAF	117	$27.7	$0.2	$15.3	($0.3)	($27.4)	$7.1
SB 523 (Chapter 773, Statutes of 2017) requires the Department to impose a GEMT QAF, effective July 1, 2018, on all ground emergency medical transports, which will be used to provide an add-on to the reimbursement rates for base ground emergency transport services. This policy change estimates the costs of the fee-for-service (FFS) and managed care add-on payments and the 10% healthcare coverage offset to the General Fund. The change for FY 2019-20 and FY 2020-21, from the prior estimate, is a net increase in the FFS and Managed Care annual estimates due to updated utilization data and revised GF offset estimates. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a net decrease due to the Erroneous Payment Correction (EPC) for the FY 2018-19 FFS add-on occurring in FY 2019-20, less of the GF offset occurring in FY 2020-21, and revised estimates for FY 2020-21 estimates based on updated actual utilization data.							
DPH Interim & Final Recons	124	$203.4	$0.0	($35.9)	$0.0	($60.3)	$0.0
This policy change estimates the funds for the reconciliation of Designated Public Hospital (DPH) interim payments to the DPH's finalized hospital inpatient costs. For FY 2019-20, the increase from the prior estimate is due to the DY 2008-09 payment for $141 million TF/FF, which was expected to occur in FY 2018-19, but was not paid until FY 2019-20. In addition, updated final reconciliation estimates and movements of final reconciliation years, between CY and BY, based on the timing of outstanding cost report appeals and audit completions, added to the changes for FY 2019-20 and FY 2020-21.							
Long Term Care Quality Assurance Fund (LTC QAF) Expenditures	130	$0.0	$1.2	$0.0	($28.1)	$0.0	($115.3)
Effective August 1, 2013, the revenue generated by the Long Term Care (LTC) Quality Assurance (QA) fees are collected and deposited into the Long Term Care Quality Assurance Fund (LTCQAF). This policy change budgets the transfers from the LTCQAF to the General Fund (GF). The decrease in GF savings for FY 2019-20 from the prior estimate is based on updated actual LTC QAF collections and transfer data as of April 2020. The net increase in FY 2020-21 is based on a lower estimated average monthly collection and increased withhold transfers occurring in FY 2020-21.							
Nursing Facility Financing Reform	223	$0.0	$0.0	($59.2	($28.4)	$70.2	$33.7
AB 1629 (Chapter 875, Statutes of 2004), extended by AB 119 (Chapter 17, Statutes of 2015), requires the Department to implement a facility-specific rate methodology on Freestanding Skilled Nursing Facilities, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facilities, Level-B (FSSA/NF-B), with a sunset date of July 31, 2020. The Department proposes to extend and reform this framework by tying a growing portion of future rate increases to quality measures. The FY 2020-21 estimate includes the costs of extending the QAF to FS/NF-Bs, a 3.62% rate increase from August 2020 to December 2020, and a 3.5% rate increase for calendar year (CY) 2021. In the May 2020 Estimate, a net decrease in FY 2020-21, is expected for this policy change due to: • Increased costs from revising the CY 2021 rate increase from 1.5% to 3.5%. This resulted in an overall increased estimate of FFS and managed care costs; • Increased FFS costs due to not assuming CalAIM long term care transitions from FFS to managed care, • Decreased add-ons impact starting Rate Year 2020-21, and • Decreased costs in this policy change due to removing managed care costs from this policy change as these are now budgeted in the managed care base capitation rates.							

Dollars in Millions		Change from November 2019		Change from November 2019		Change from FY 2019-20	
		FY 2019-20		FY 2020-21		FY 2020-21	
Name	**PC**	**TF**	**GF**	**TF**	**GF**	**TF**	**GF**
Prop 56 – Home Health Rate Increase **Prop 56 – Pediatric Day Health Care Health Rate Increase**	121, 125	$17.3	$8.1	$0.0	($0.5)	($21.7)	($9.8)

Effective for dates of services on and after July 1, 2018, the Department increased rates for certain fee-for-service (FFS) home health agency and Private Duty Nursing (PDN) services and Pediatric Day Health Care (PDHC) by 50%. The Home Health and Pediatric Day Health Care (PDHC) rate increases were implemented prospectively in January 2019.

The change from the prior estimate for FY 2019-20 is due to updated estimates of the retroactive claims adjustments. The second Erroneous Payment Correction will adjust Home Health and PDHC payments for providers that did not receive the rate increases for the period from July 2018 to December 2018, and the EPC is expected to occur by the end of FY 2019-20. The change from the prior estimate for FY 2020-21 is due to minor update to the funding splits for the home health payments, but these ongoing prospective rate increases are 100% in the FFS base. The change from CY to BY is due to assuming the retroactive adjustments are completed in FY 2019-20

Hospital Quality Assurance Fee (HQAF)	137, 138, 139, 204	($510.6)	$685.1	$1,424.4	($62.5)	$2,118.7	($584.6)

The HQAF program assesses a fee on applicable general acute care hospitals and matches the fee with federal financial participation providing fee-for-service (FFS) and managed care supplemental payments to hospitals. The HQAF also provides additional funding for children's health care coverage.

Hospital Payments (PCs 137,138,and 139):
The -$510.6 million TF change in FY 2019-20 is due to the updated estimate for the Hospital QAF – FFS payment policy change. The methodology used to estimate the Hospital QAF VI FFS payments is now based on the approved Hospital QAF VI model. In addition, delayed CMS approval of the Hospital QAF VI program (approved in February 2020), resulting in one less quarter of payments. The increase in FY 2020-21, from the prior estimate, is due to shifting the additional quarter of payments to the BY. There was no change in the estimates for the Managed Care Private Hospital Directed payments (PHDP) or Hospital QAF – Managed Care payments, however the funding splits were updated based on actual managed care data.

From CY to BY, the increase in TF is due to increased FFS payments estimated in FY 2020-21, increased managed care payments due to 18 months of HQAF VI payments occurring in FY 2020-21 for the Bridge period (July 2019 to December 2020) and increased PHDP pool amounts for the FY 2018-19 rating period.

Hospital QAF – Children's Health Care – PC 204: The methodology used to estimate the Hospital QAF VI children's health care savings is now based on the approved Hospital QAF VI model. In FY 2019-20, GF savings decreased by $685.1 million GF due to COVID-19 pandemic which cause HQAF VI children's health care payments to be postponed to FY 2020-21. The FY 2020-21 GF savings are estimated to increase by $62.5 million GF based on a reduced estimate of the HQAF VI children's health care payments, which will be reconciled and paid in full at a later date. The increased GF savings, from CY to BY, is due to completion of the HQAF IV reconciliation in FY 2019-20, and higher quarterly payments estimated based shifting HQAF VI payments to start in FY 2020-21.

Dollars in Millions		Change from November 2019		Change from November 2019		Change from FY 2019-20	
		FY 2019-20		FY 2020-21		FY 2020-21	
Name	**PC**	**TF**	**GF**	**TF**	**GF**	**TF**	**GF**
Private Hospital Supplemental Payments **FFP for Local Trauma Centers** **IGT Payments for Hospital Services**	147, 150, 221	$1.0	$0.0	$2.6	$18.0	$32.1	$6.5
These policy changes provide supplemental payments to hospitals. For these hospital supplemental payments, Intergovernmental Transfers (IGTs) and Special Funds provide the non-federal share of the payments. The Private Hospital Supplemental Fund payments also includes funds from a General Fund appropriation into a Special Fund. • In FY 2019-20, adjustments are budgeted to correct the FY 2017-18 Affordable Care Act Optional Expansion (ACA OE) payments. The GF is required to repay overclaimed FFP. There is no change to the GF estimate in FY 2019-20 from the prior estimate. • In FY 2020-21, adjustments have been added in the current estimate to correct FY 2013-14 to FY 2015-16 ACA OE payments. The corrections may require adjustments from the GF to repay funds owed to the Special Funds, adjustments from the GF to repay overclaimed FFP, or adjustments from the Special Funds to repay overclaimed FFP. The change from CY to BY is mainly due to the higher GF estimate for the FY 2013-14 to FY 2015-16 ACA OE adjustments in FY 2020-21.							
Graduate Medical Education (GME) Payments to DPHs **IGT Admin & Processing Fee**	140, 171	($572.1)	$9.7	$143.5	($7.6)	$518.7	($15.)0
The Graduate Medical Education Payments to DPHs policy change estimates direct and indirect GME payments to the Designated Public Hospitals (DPHs).The non-federal share of the payments will be funded with intergovernmental transfers (IGTs). This IGT Admin & Processing Fee policy change estimates the savings to the General Fund due to A 5% administrative fee assessed on the IGTs in order to reimburse the Department for support costs associated with administering the program. The decrease in FY 2019-20 and increase in FY 2020-21 is due to delayed CMS approval of SPA 17-0009 (approved March 2020). GME payments for Affordable Care Act Optional Expansion (ACA OE) adjustments for FY 2016-17 and FY 2017-18; and all of FY 2018-19 payments have shifted to begin in FY 2020-21. In conjunction with the GME payments, the GME GF savings in have shifted to FY 2020-21. Decreased GF savings are estimated in FY 2019-20 and increased savings in FY 2020-21.							

Dollars in Millions		Change from November 2019		Change from November 2019		Change from FY 2019-20	
		FY 2019-20		FY 2020-21		FY 2020-21	
Name	**PC**	**TF**	**GF**	**TF**	**GF**	**TF**	**GF**
CMS Deferred Claims	CA 7, OA 66, OA 97, PC 200	$0.0	($93.8)	$0.0	$230.0	$0.0	$156.0
The Centers for Medicare and Medicaid Services (CMS) reviews claims submitted by Medicaid agencies and may defer payment on claims requiring additional information or claims CMS interprets as not meeting all federal funding requirements. Upon receiving a deferral, the state must promptly return the federal funds to CMS. FY 2019-20 estimates have decreased based on including actual Federal Fiscal Year 2019 Q2 deferrals and shifting three quarters (FFY 2019 Q3 to FFY 2020 Q1) of CMS deferral payments to FY 2020-21 based on a revised CMS deferral schedule. Additionally changes in FY 2019-20 include: (1) the breakout of Fiscal Intermediary (FI) funded deferrals into a new Other Administrative policy change named CMS Deferred Claims – FI and (2) an increase of $2.1 million GF reclaimed for County Administration CMS deferrals in FY 2019-20. The FY 2020-21 net increase is due to the shifting three quarters previously estimated to be paid in FY 2019-20 to FY 2020-21, and including resolved Other Administration deferrals of $301 million that offset the FY 2020-21 costs.							
QAF Withhold Transfer	180	($64.7)	($32.4)	$0.0	$0.0	($98.9)	($49.4)
This policy change budgets for withheld Fee-for-Service payments (FFS) associated with the Hospital Quality Assurance Fee (HQAF), the AB 1629 Quality Assurance Fee (QAF) assessed on Skilled Nursing Facilities (SNF), the QAF assessed on Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs), and the Ground Emergency Medical Transportation (GEMT) QAF. The net decrease in FY 2019-20, from the prior estimate, is due to the delay in the federal approvals for the Hospital Quality Assurance Fee (QAF) VI program and adding the GEMT QAF withhold transfers starting in March 2020. No impact is estimated in FY 2020-21 as it is assumed that FY 2020-21 prior year withhold costs are offset by the increased Hospital QAF, Long Term Care (LTC) QAF, and GEMT QAF withholds transferred in FY 2020-21.							
Repayment to CMS for Contingency Fee Offsets	233	$0.0	$0.0	$0.0	$10.4	$0.0	$10.4
This new policy change estimates the repayment of over-claimed federal financial participation (FFP) for contingency fee offsets reported for the period October 2016 to September 2018.							
Tribal Federally Qualified Health Center	236	$0.0	$0.0	$1.6	$0.3	$1.6	$0.3
The Department is pursuing the development of the Tribal FQHC provider type in Medi-Cal, effective January 1, 2021, to allow for payment of services provided outside of tribal clinics.							

General Information

Medi-Cal, California's Medicaid program, provides health care to Californians and utilizes Federal, State, and local government funding. The Medi-Cal Local Assistance Estimate (Estimate) forecasts the current and budget year expenditures for the Medi-Cal program. Those expenditures are categorized as:

- Benefits: Expenditures for the care of Medi-Cal beneficiaries. These expenditures can be found in the following sections:
  - Fee-For-Service (FFS) Base,
  - Base Policy Changes, and
  - Regular Policy Changes.

  These estimated expenditures are summarized in the Current Year and Budget Year sections.

- County Administration: Expenditures for the counties to determine Medi-Cal eligibility, as well as, additional expenditures required to administer the Medi-Cal program. These estimated expenditures can be found in the following sections:
  - County Administration
  - Other Administration

- Fiscal Intermediary: Expenditures associated with the processing of claims. The expenditures can be found in the Other Administration section. Please see the Other Administration tab for a breakdown of the funding correlated to County Administration and Fiscal Intermediary components.

This estimate is based on actual payment data through January 2018. Estimates for both fiscal years are on a cash basis and include a two-week hold on weekly Fee-for-Service payments at the end of June and a one-month hold on Managed Care June payments. All held payments are anticipated to be paid in July of the following state fiscal year.

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

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

The estimate aggregates expenditures for five sub-categories under a single Managed Care heading. These sub-categories are Two Plan Model, County Organized Health Systems, Geographic Managed Care, Regional Model, and PHP/Other Managed Care. The latter

includes PCCMs, PACE, SCAN, Family Mosaic, Dental Managed Care, and the new Managed Care Expansion models –Imperial and San Benito.

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

Medi-Cal Funding Summary
May 2020 Estimate Compared to November 2019 Estimate
Fiscal Year 2019 - 2020

TOTAL FUNDS

	Nov 2019 Estimate	May 2020 Estimate	Difference Incr./(Decr.)
Benefits:			
4260-101-0001/0890 Medi-Cal General and Federal Funds	$74,340,094,000	$73,707,540,000	($632,554,000)
4260-101-0080 CLPP Funds	$725,000	$916,000	$191,000
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$130,657,000	$130,657,000	$0
4260-101-0233 Prop 99 Physician Srvc. Acct	$40,862,000	$40,862,000	$0
4260-101-0236 Prop 99 Unallocated Account	$60,035,000	$60,035,000	$0
4260-101-3168 Emergency Air Transportation Fund	$6,586,000	$7,299,000	$713,000
4260-101-3305 Healthcare Treatment Fund	$807,890,000	$818,367,000	$10,477,000
4260-101-3366 Electronic Cigarette Product Tax	$0	$0	$0
4260-102-0001/0890 Capital Debt	$123,977,000	$94,995,000	($28,982,000)
4260-102-3305 Prop 56 Loan Forgiveness Program	$1,700,000	$1,700,000	$0
4260-103-3305 Prop 56 Value-Based Payment	$181,833,000	$102,976,000	($78,857,000)
4260-104-0001 NDPH Hosp Supp	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$1,900,000	$1,900,000	$0
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	($1,900,000)	($1,900,000)	$0
4260-105-0001 Private Hosp Supp Fund	$118,400,000	$118,400,000	$0
4260-601-3097 Private Hosp Suppl	$145,400,000	$145,400,000	$0
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-106-0890 Money Follows Person Federal Grant	$22,735,000	$21,985,000	($750,000)
4260-111-0001 CHDP State Only	$2,000	$0	($2,000)
4260-113-0001/0890 Children's Health Insurance Program	$3,359,706,000	$3,815,321,000	$455,615,000
4260-601-0942142 Local Trauma Centers	$60,183,000	$60,183,000	$0
4260-601-0942 Health Homes Program Account	$9,551,000	$9,464,000	($87,000)
4260-601-0995 Reimbursements	$1,375,396,000	$1,373,438,000	($1,958,000)
4260-601-3156 MCO Tax Fund	$0	$0	$0
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$860,392,000	$860,655,000	$263,000
4260-601-3213 LTC QA Fund	$509,884,000	$508,693,000	($1,191,000)
4260-601-3293 MCO Tax Fund 2016	$640,730,000	$640,730,000	$0
4260-601-3311 Healthcare Service Fines and Penalties	$0	$0	$0
4260-601-3323 Medi-Cal Emergency Transport Fund	$88,701,000	$70,517,000	($18,184,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	$1,355,795,000	$1,364,798,000	$9,003,000
4260-601-3334 MCO Tax (HCS Special Fund)	$0	$0	$0
4260-601-7502 Demonstration DSH Fund	$105,320,000	$187,988,000	$82,668,000
4260-601-7503 Health Care Support Fund	($97,373,000)	$28,338,000	$125,711,000
4260-601-8107 Whole Person Care Pilot Fund	$466,323,000	$468,356,000	$2,033,000
4260-601-8108 Global Payment Program Fund	$1,099,297,000	$1,238,511,000	$139,214,000
4260-601-8113 DPH GME Special Fund	$490,491,000	$286,147,000	($204,344,000)
4260-602-0309 Perinatal Insurance Fund	$11,668,000	$19,380,000	$7,712,000
4260-605-0001 SNF Quality & Accountability	$46,979,000	$46,979,000	$0
4260-605-3167 SNF Quality & Accountability	$44,000,000	$44,000,000	$0
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($46,979,000)	($46,979,000)	$0
4260-606-0834 SB 1100 DSH	$152,917,000	$86,343,000	($66,574,000)
4260-607-8502 LIHP IGT (Non-GF)	$0	$21,828,000	$21,828,000
4260-611-3158/0890 Hospital Quality Assurance	$9,630,163,000	$8,434,463,000	($1,195,700,000)
Total Benefits	**$96,027,540,000**	**$94,653,785,000**	**($1,373,755,000)**
County Administration:			
4260-101-0001/0890 Medi-Cal General and Federal Funds	$4,619,175,000	$4,363,401,000	($255,774,000)
4260-102-3305 Prop 56 Loan Forgiveness Program	$0	$0	$0
4260-106-0890 Money Follow Person Fed. Grant	$290,000	$290,000	$0
4260-113-0001/0890 Children's Health Insurance Program	$69,994,000	$77,847,000	$7,853,000
4260-117-0001/0890 HIPPA	$10,574,000	$8,905,000	($1,669,000)
4260-601-0942 Health Homes Program Account	$317,000	$163,000	($154,000)
4260-601-0995 Reimbursements	$180,000	$163,000	($17,000)
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$586,000	$550,000	($36,000)
4260-605-3167 SNF Quality & Accountability Admin.	$3,750,000	$3,750,000	$0
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$92,000	$50,000	($42,000)
Total County Administration	**$4,704,958,000**	**$4,455,119,000**	**($249,839,000)**
Fiscal Intermediary:			
4260-101-0001/0890 Medi-Cal General and Federal Funds	$371,026,000	$339,080,000	($31,946,000)
4260-111-0001 CHDP State Only *	$1,000	$0	$0
4260-113-0001/0890 Healthy Families	$3,762,000	$4,133,000	$371,000
4260-117-0001/0890 HIPAA	$8,124,000	$37,432,000	$29,308,000
4260-601-0995 Reimbursements	$0	$0	$0
Total Fiscal Intermediary	**$382,913,000**	**$380,645,000**	**($2,267,000)**
Grand Total - Total Funds	**$101,115,411,000**	**$99,489,549,000**	**($1,625,861,000)**

Medi-Cal Funding Summary
May 2020 Estimate Compared to November 2019 Estimate
Fiscal Year 2019 - 2020

STATE FUNDS

Benefits:	**Nov 2019 Estimate**	**May 2020 Estimate**	**Difference Incr./(Decr.)**
4260-101-0001 Medi-Cal General Fund*	$21,406,652,000	$21,020,121,000	($386,531,000)
4260-101-0080 CLPP Funds	$725,000	$916,000	$191,000
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$130,657,000	$130,657,000	$0
4260-101-0233 Prop 99 Physician Srvc. Acct	$40,862,000	$40,862,000	$0
4260-101-0236 Prop 99 Unallocated Account	$60,035,000	$60,035,000	$0
4260-101-3168 Emergency Air Transportation Fund	$6,586,000	$7,299,000	$713,000
4260-101-3305 Healthcare Treatment Fund	$807,890,000	$818,367,000	$10,477,000
4260-101-3366 Electronic Cigarette Product Tax	$0	$0	$0
4260-102-0001 Capital Debt *	$43,465,000	$28,352,000	($15,113,000)
4260-102-3305 Prop 56 Loan Forgiveness Program	$1,700,000	$1,700,000	$0
4260-103-3305 Prop 56 Value-Based Payment	$181,833,000	$102,976,000	($78,857,000)
4260-104-0001 NDPH Hosp Supp *	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$1,900,000	$1,900,000	$0
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	($1,900,000)	($1,900,000)	$0
4260-105-0001 Private Hosp Supp Fund *	$118,400,000	$118,400,000	$0
4260-601-3097 Private Hosp Suppl	$145,400,000	$145,400,000	$0
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-111-0001 CHDP State Only *	$2,000	$0	($2,000)
4260-113-0001 Childrens Health Insurance Program *	$318,049,000	$387,344,000	$69,295,000
4260-601-0942142 Local Trauma Centers	$60,183,000	$60,183,000	$0
4260-601-0942 Health Homes Program Account	$9,551,000	$9,464,000	($87,000)
4260-601-0995 Reimbursements	$1,375,396,000	$1,373,438,000	($1,958,000)
4260-601-3156 MCO Tax Fund	$0	$0	$0
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$860,392,000	$860,655,000	$263,000
4260-601-3213 LTC QA Fund	$509,884,000	$508,693,000	($1,191,000)
4260-601-3293 MCO Tax Fund 2016	$640,730,000	$640,730,000	$0
4260-601-3311 Healthcare Service Fines and Penalties	$0	$0	$0
4260-601-3323 Medi-Cal Emergency Transport Fund	$88,701,000	$70,517,000	($18,184,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	$1,355,795,000	$1,364,798,000	$9,003,000
4260-601-3334 MCO Tax (HCS Special Fund)	$0	$0	$0
4260-601-8107 Whole Person Care Pilot Fund	$466,323,000	$468,356,000	$2,033,000
4260-601-8108 Global Payment Program Fund	$1,099,297,000	$1,238,511,000	$139,214,000
4260-601-8113 DPH GME Special Fund	$490,491,000	$286,147,000	($204,344,000)
4260-602-0309 Perinatal Insurance Fund	$11,668,000	$19,380,000	$7,712,000
4260-605-0001 SNF Quality & Accountability *	$46,979,000	$46,979,000	$0
4260-605-3167 SNF Quality & Accountability	$44,000,000	$44,000,000	$0
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($46,979,000)	($46,979,000)	$0
4260-606-0834 SB 1100 DSH	$152,917,000	$86,343,000	($66,574,000)
4260-607-8502 LIHP IGT (Non-GF)	$0	$21,828,000	$21,828,000
4260-611-3158 Hospital Quality Assurance Revenue	$4,446,011,000	$3,478,557,000	($967,454,000)
Total Benefits	**$34,757,095,000**	**$33,277,529,000**	**($1,479,566,000)**
Total Benefits General Fund *	**$21,935,447,000**	**$21,603,096,000**	**($332,351,000)**
County Administration:			
4260-101-0001 Medi-Cal General Fund *	$938,447,000	$973,281,000	$34,834,000
4260-102-3305 Prop 56 Loan Forgiveness Program	$0	$0	$0
4260-113-0001 Childrens Health Insurance Program *	$10,435,000	$10,956,000	$521,000
4260-117-0001 HIPAA *	$1,840,000	$1,464,000	($376,000)
4260-601-0942 Health Homes Program Account	$317,000	$163,000	($154,000)
4260-601-0995 Reimbursements	$180,000	$163,000	($17,000)
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$586,000	$550,000	($36,000)
4260-605-3167 SNF Quality & Accountability Admin.	$3,750,000	$3,750,000	$0
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$92,000	$50,000	($42,000)
Total County Administration	**$955,647,000**	**$990,377,000**	**$34,730,000**
Total County Administration General Fund *	**$950,722,000**	**$985,701,000**	**$34,979,000**
Fiscal Intermediary:			
4260-101-0001 Medi-Cal General Fund *	$123,251,000	$115,761,000	($7,490,000)
4260-111-0001 CHDP State Only *	$1,000	$0	
4260-113-0001 Childrens Health Insurance Program *	$776,000	($137,000)	($913,000)
4260-117-0001 HIPAA *	$1,978,000	$9,305,000	$7,327,000
4260-601-0995 Reimbursements	$0	$0	$0
Total Fiscal Intermediary	**$126,006,000**	**$124,929,000**	**($1,077,000)**
Total Fiscal Intermediary General Fund *	**$126,006,000**	**$124,929,000**	**($1,076,000)**
Grand Total - State Funds	**$35,838,748,000**	**$34,392,835,000**	**($1,445,913,000)**
Grand Total - General Fund*	**$23,012,175,000**	**$22,713,726,000**	**($298,449,000)**

Medi-Cal Funding Summary
May 2020 Estimate Compared to November 2019 Estimate
Fiscal Year 2019 - 2020

FEDERAL FUNDS

	Nov 2019 Estimate	May 2020 Estimate	Difference Incr./(Decr.)
Benefits:			
4260-101-0890 Federal Funds	$52,933,442,000	$52,687,419,000	($246,023,000)
4260-102-0890 Capital Debt	$80,512,000	$66,643,000	($13,869,000)
4260-106-0890 Money Follows Person Federal Grant	$22,735,000	$21,985,000	($750,000)
4260-113-0890 Childrens Health Insurance Fund	$3,041,657,000	$3,427,977,000	$386,320,000
4260-601-7502 Demonstration DSH Fund	$105,320,000	$187,988,000	$82,668,000
4260-601-7503 Health Care Support Fund	($97,373,000)	$28,338,000	$125,711,000
4260-611-0890 Hospital Quality Assurance	$5,184,152,000	$4,955,906,000	($228,246,000)
Total Benefits	**$61,270,445,000**	**$61,376,256,000**	**$105,811,000**
County Administration:			
4260-101-0890 Federal Funds	$3,680,728,000	$3,390,120,000	($290,608,000)
4260-106-0890 Money Follows Person Fed. Grant	$290,000	$290,000	$0
4260-113-0890 Childrens Health Insurance Fund	$59,559,000	$66,891,000	$7,332,000
4260-117-0890 HIPAA	$8,734,000	$7,441,000	($1,293,000)
Total County Administration	**$3,749,311,000**	**$3,464,742,000**	**($284,569,000)**
Fiscal Intermediary:			
4260-101-0890 Federal Funds	$247,775,000	$223,319,000	($24,456,000)
4260-113-0890 Childrens Health Insurance Fund	$2,986,000	$4,270,000	$1,284,000
4260-117-0890 HIPAA	$6,146,000	$28,127,000	$21,981,000
Total Fiscal Intermediary	**$256,907,000**	**$255,716,000**	**($1,191,000)**
Grand Total - Federal Funds	**$65,276,663,000**	**$65,096,714,000**	**($179,949,000)**

Medi-Cal Funding Summary
May 2020 Estimate Compared to Appropriation
Fiscal Year 2019 - 2020

TOTAL FUNDS

Benefits:	**Total Appropriation**	**May 2020 Estimate**	**Difference Incr./(Decr.)**
4260-101-0001/0890 Medi-Cal General and Federal Funds	$75,188,244,000	$73,707,540,000	($1,480,704,000)
4260-101-0080 CLPP Funds	$725,000	$916,000	$191,000
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$130,657,000	$130,657,000	$0
4260-101-0233 Prop 99 Physician Srvc. Acct	$40,862,000	$40,862,000	$0
4260-101-0236 Prop 99 Unallocated Account	$60,035,000	$60,035,000	$0
4260-101-3168 Emergency Air Transportation Fund	$8,468,000	$7,299,000	($1,169,000)
4260-101-3305 Healthcare Treatment Fund	$885,819,000	$818,367,000	($67,452,000)
4260-101-3366 Electronic Cigarette Product Tax	$0	$0	$0
4260-102-0001/0890 Capital Debt	$108,848,000	$94,995,000	($13,853,000)
4260-102-3305 Prop 56 Loan Forgiveness Program	$120,000,000	$1,700,000	($118,300,000)
4260-103-3305 Prop 56 Value-Based Payment	$250,000,000	$102,976,000	($147,024,000)
4260-104-0001 NDPH Hosp Supp	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$1,900,000	$1,900,000	$0
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	($1,900,000)	($1,900,000)	$0
4260-105-0001 Private Hosp Supp Fund	$118,400,000	$118,400,000	$0
4260-601-3097 Private Hosp Suppl	$145,400,000	$145,400,000	$0
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-106-0890 Money Follows Person Federal Grant	$4,891,000	$21,985,000	$17,094,000
4260-111-0001 CHDP State Only	$2,000	$0	($2,000)
4260-113-0001/0890 Children's Health Insurance Program	$3,604,531,000	$3,815,321,000	$210,790,000
4260-601-0942142 Local Trauma Centers	$64,207,000	$60,183,000	($4,024,000)
4260-601-0942 Health Homes Program Account	$8,738,000	$9,464,000	$726,000
4260-601-0995 Reimbursements	$1,619,089,000	$1,373,438,000	($245,651,000)
4260-601-3156 MCO Tax Fund	$0	$0	$0
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$666,000,000	$860,655,000	$194,655,000
4260-601-3213 LTC QA Fund	$395,307,000	$508,693,000	$113,386,000
4260-601-3293 MCO Tax Fund 2016	$816,321,000	$640,730,000	($175,591,000)
4260-601-3311 Healthcare Service Fines and Penalties	$0	$0	$0
4260-601-3323 Medi-Cal Emergency Transport Fund	$91,260,000	$70,517,000	($20,743,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	$1,364,798,000	$1,364,798,000	$0
4260-601-3334 MCO Tax (HCS Special Fund)	$0	$0	$0
4260-601-7502 Demonstration DSH Fund	$112,270,000	$187,988,000	$75,718,000
4260-601-7503 Health Care Support Fund	($109,378,000)	$28,338,000	$137,716,000
4260-601-8107 Whole Person Care Pilot Fund	$485,316,000	$468,356,000	($16,960,000)
4260-601-8108 Global Payment Program Fund	$1,027,797,000	$1,238,511,000	$210,714,000
4260-601-8113 DPH GME Special Fund	$513,810,000	$286,147,000	($227,663,000)
4260-602-0309 Perinatal Insurance Fund	$20,410,000	$19,380,000	($1,030,000)
4260-605-0001 SNF Quality & Accountability	$49,870,000	$46,979,000	($2,891,000)
4260-605-3167 SNF Quality & Accountability	$44,000,000	$44,000,000	$0
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($49,870,000)	($46,979,000)	$2,891,000
4260-606-0834 SB 1100 DSH	$147,294,000	$86,343,000	($60,951,000)
4260-607-8502 LIHP IGT (Non-GF)	$0	$21,828,000	$21,828,000
4260-611-3158/0890 Hospital Quality Assurance	$9,614,308,000	$8,434,463,000	($1,179,845,000)
Total Benefits	**$97,431,929,000**	**$94,653,785,000**	**($2,778,144,000)**
County Administration:			
4260-101-0001/0890 Medi-Cal General and Federal Funds	$4,531,894,000	$4,363,401,000	($168,493,000)
4260-102-3305 Prop 56 Loan Forgiveness Program	$1,100,000	$0	($1,100,000)
4260-106-0890 Money Follow Person Fed. Grant	$340,000	$290,000	($50,000)
4260-113-0001/0890 Children's Health Insurance Program	$66,378,000	$77,847,000	$11,469,000
4260-117-0001/0890 HIPPA	$9,756,000	$8,905,000	($851,000)
4260-601-0942 Health Homes Program Account	$317,000	$163,000	($154,000)
4260-601-0995 Reimbursements	$179,000	$163,000	($16,000)
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$1,023,000	$550,000	($473,000)
4260-605-3167 SNF Quality & Accountability Admin.	$3,250,000	$3,750,000	$500,000
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$92,000	$50,000	($42,000)
Total County Administration	**$4,614,329,000**	**$4,455,119,000**	**($159,210,000)**
Fiscal Intermediary:			
4260-101-0001/0890 Medi-Cal General and Federal Funds	$345,232,000	$339,080,000	($6,152,000)
4260-111-0001 CHDP State Only	$1,000	$0	($1,000)
4260-113-0001/0890 Healthy Families	$4,737,000	$4,133,000	($604,000)
4260-117-0001/0890 HIPAA	$7,051,000	$37,432,000	$30,381,000
4260-601-0995 Reimbursements	$0	$0	$0
Total Fiscal Intermediary	**$357,021,000**	**$380,645,000**	**$23,624,000**
Grand Total - Total Funds	**$102,403,279,000**	**$99,489,549,000**	**($2,913,730,000)**

Medi-Cal Funding Summary
May 2020 Estimate Compared to Appropriation
Fiscal Year 2019 - 2020

STATE FUNDS

Benefits:	**State Funds Appropriation**	**May 2020 Estimate**	**Difference Incr./(Decr.)**
4260-101-0001 Medi-Cal General Fund*	$21,397,237,000	$21,020,121,000	($377,116,000)
4260-101-0080 CLPP Funds	$725,000	$916,000	$191,000
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$130,657,000	$130,657,000	$0
4260-101-0233 Prop 99 Physician Srvc. Acct	$40,862,000	$40,862,000	$0
4260-101-0236 Prop 99 Unallocated Account	$60,035,000	$60,035,000	$0
4260-101-3168 Emergency Air Transportation Fund	$8,468,000	$7,299,000	($1,169,000)
4260-101-3305 Healthcare Treatment Fund	$885,819,000	$818,367,000	($67,452,000)
4260-101-3366 Electronic Cigarette Product Tax	$0	$0	$0
4260-102-0001 Capital Debt *	$37,754,000	$28,352,000	($9,402,000)
4260-102-3305 Prop 56 Loan Forgiveness Program	$120,000,000	$1,700,000	($118,300,000)
4260-103-3305 Prop 56 Value-Based Payment	$250,000,000	$102,976,000	($147,024,000)
4260-104-0001 NDPH Hosp Supp *	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$1,900,000	$1,900,000	$0
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	($1,900,000)	($1,900,000)	$0
4260-105-0001 Private Hosp Supp Fund *	$118,400,000	$118,400,000	$0
4260-601-3097 Private Hosp Suppl	$145,400,000	$145,400,000	$0
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-111-0001 CHDP State Only *	$2,000	$0	($2,000)
4260-113-0001 Childrens Health Insurance Program *	$478,653,000	$387,344,000	($91,309,000)
4260-601-0942142 Local Trauma Centers	$64,207,000	$60,183,000	($4,024,000)
4260-601-0942 Health Homes Program Account	$8,738,000	$9,464,000	$726,000
4260-601-0995 Reimbursements	$1,619,089,000	$1,373,438,000	($245,651,000)
4260-601-3156 MCO Tax Fund	$0	$0	$0
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$666,000,000	$860,655,000	$194,655,000
4260-601-3213 LTC QA Fund	$395,307,000	$508,693,000	$113,386,000
4260-601-3293 MCO Tax Fund 2016	$816,321,000	$640,730,000	($175,591,000)
4260-601-3311 Healthcare Service Fines and Penalties	$0	$0	$0
4260-601-3323 Medi-Cal Emergency Transport Fund	$91,260,000	$70,517,000	($20,743,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	$1,364,798,000	$1,364,798,000	$0
4260-601-3334 MCO Tax (HCS Special Fund)	$0	$0	$0
4260-601-8107 Whole Person Care Pilot Fund	$485,316,000	$468,356,000	($16,960,000)
4260-601-8108 Global Payment Program Fund	$1,027,797,000	$1,238,511,000	$210,714,000
4260-601-8113 DPH GME Special Fund	$513,810,000	$286,147,000	($227,663,000)
4260-602-0309 Perinatal Insurance Fund	$20,410,000	$19,380,000	($1,030,000)
4260-605-0001 SNF Quality & Accountability *	$49,870,000	$46,979,000	($2,891,000)
4260-605-3167 SNF Quality & Accountability	$44,000,000	$44,000,000	$0
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($49,870,000)	($46,979,000)	$2,891,000
4260-606-0834 SB 1100 DSH	$147,294,000	$86,343,000	($60,951,000)
4260-607-8502 LIHP IGT (Non-GF)	$0	$21,828,000	$21,828,000
4260-611-3158 Hospital Quality Assurance Revenue	$4,434,007,000	$3,478,557,000	($955,450,000)
Total Benefits	**$35,255,866,000**	**$33,277,529,000**	**($1,978,337,000)**
Total Benefits General Fund *	**$22,083,816,000**	**$21,603,096,000**	**($480,720,000)**
County Administration:			
4260-101-0001 Medi-Cal General Fund *	$889,399,000	$973,281,000	$83,882,000
4260-102-3305 Prop 56 Loan Forgiveness Program	$1,100,000	$0	($1,100,000)
4260-113-0001 Childrens Health Insurance Program *	$8,414,000	$10,956,000	$2,542,000
4260-117-0001 HIPAA *	$1,689,000	$1,464,000	($225,000)
4260-601-0942 Health Homes Program Account	$317,000	$163,000	($154,000)
4260-601-0995 Reimbursements	$179,000	$163,000	($16,000)
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$1,023,000	$550,000	($473,000)
4260-605-3167 SNF Quality & Accountability Admin.	$3,250,000	$3,750,000	$500,000
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$92,000	$50,000	($42,000)
Total County Administration	**$905,463,000**	**$990,377,000**	**$84,914,000**
Total County Administration General Fund *	**$899,502,000**	**$985,701,000**	**$86,199,000**
Fiscal Intermediary:			
4260-101-0001 Medi-Cal General Fund *	$118,270,000	$115,761,000	($2,509,000)
4260-111-0001 CHDP State Only *	$1,000	$0	($1,000)
4260-113-0001 Childrens Health Insurance Program *	$977,000	($137,000)	($1,114,000)
4260-117-0001 HIPAA *	$1,320,000	$9,305,000	$7,985,000
4260-601-0995 Reimbursements	$0	$0	$0
Total Fiscal Intermediary	**$120,568,000**	**$124,929,000**	**$4,361,000**
Total Fiscal Intermediary General Fund *	**$120,568,000**	**$124,929,000**	**$4,361,000**
Grand Total - State Funds	**$36,281,897,000**	**$34,392,835,000**	**($1,889,062,000)**
Grand Total - General Fund*	**$23,103,886,000**	**$22,713,726,000**	**($390,160,000)**

Medi-Cal Funding Summary

May 2020 Estimate Compared to Appropriation

Fiscal Year 2019 - 2020

FEDERAL FUNDS

	Federal Funds Appropriation	May 2020 Estimate	Difference Incr./(Decr.)
Benefits:			
4260-101-0890 Federal Funds	$53,791,007,000	$52,687,419,000	($1,103,588,000)
4260-102-0890 Capital Debt	$71,094,000	$66,643,000	($4,451,000)
4260-106-0890 Money Follows Person Federal Grant	$4,891,000	$21,985,000	$17,094,000
4260-113-0890 Childrens Health Insurance Fund	$3,125,878,000	$3,427,977,000	$302,099,000
4260-601-7502 Demonstration DSH Fund	$112,270,000	$187,988,000	$75,718,000
4260-601-7503 Health Care Support Fund	($109,378,000)	$28,338,000	$137,716,000
4260-611-0890 Hospital Quality Assurance	$5,180,301,000	$4,955,906,000	($224,395,000)
Total Benefits	**$62,176,063,000**	**$61,376,256,000**	**($799,807,000)**
County Administration:			
4260-101-0890 Federal Funds	$3,642,495,000	$3,390,120,000	($252,375,000)
4260-106-0890 Money Follows Person Fed. Grant	$340,000	$290,000	($50,000)
4260-113-0890 Childrens Health Insurance Fund	$57,964,000	$66,891,000	$8,927,000
4260-117-0890 HIPAA	$8,067,000	$7,441,000	($626,000)
Total County Administration	**$3,708,866,000**	**$3,464,742,000**	**($244,124,000)**
Fiscal Intermediary:			
4260-101-0890 Federal Funds	$226,962,000	$223,319,000	($3,643,000)
4260-113-0890 Childrens Health Insurance Fund	$3,760,000	$4,270,000	$510,000
4260-117-0890 HIPAA	$5,731,000	$28,127,000	$22,396,000
Total Fiscal Intermediary	**$236,453,000**	**$255,716,000**	**$19,263,000**
Grand Total - Federal Funds	**$66,121,382,000**	**$65,096,714,000**	**($1,024,668,000)**

Medi-Cal Funding Summary

May 2020 Estimate Comparison of FY 2019-20 to FY 2020-21

TOTAL FUNDS

Benefits:	**FY 2019-20 Estimate**	**FY 2020-21 Estimate**	**Difference Incr./(Decr.)**
4260-101-0001/0890 Medi-Cal General and Federal Funds	$73,707,540,000	$80,838,870,000	$7,131,330,000
4260-101-0080 CLPP Funds	$916,000	$916,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$130,657,000	$92,170,000	($38,487,000)
4260-101-0233 Prop 99 Physician Srvc. Acct	$40,862,000	$26,639,000	($14,223,000)
4260-101-0236 Prop 99 Unallocated Account	$60,035,000	$41,848,000	($18,187,000)
4260-101-3168 Emergency Air Transportation Fund	$7,299,000	$6,626,000	($673,000)
4260-101-3305 Healthcare Treatment Fund	$818,367,000	$1,339,836,000	$521,469,000
4260-101-3366 Electronic Cigarette Product Tax	$0	$9,600,000	$9,600,000
4260-102-0001/0890 Capital Debt	$94,995,000	$77,555,000	($17,440,000)
4260-102-3305 Prop 56 Loan Forgiveness Program	$1,700,000	$15,200,000	$13,500,000
4260-103-3305 Prop 56 Value-Based Payment	$102,976,000	$0	($102,976,000)
4260-104-0001 NDPH Hosp Supp	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$1,900,000	$1,900,000	$0
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	($1,900,000)	($1,900,000)	$0
4260-105-0001 Private Hosp Supp Fund	$118,400,000	$118,400,000	$0
4260-601-3097 Private Hosp Suppl	$145,400,000	$132,461,000	($12,939,000)
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-106-0890 Money Follows Person Federal Grant	$21,985,000	$3,319,000	($18,666,000)
4260-111-0001 CHDP State Only	$0	$0	$0
4260-113-0001/0890 Children's Health Insurance Program	$3,815,321,000	$3,893,556,000	$78,235,000
4260-601-0942142 Local Trauma Centers	$60,183,000	$81,883,000	$21,700,000
4260-601-0942 Health Homes Program Account	$9,464,000	$22,749,000	$13,285,000
4260-601-0995 Reimbursements	$1,373,438,000	$1,777,423,000	$403,985,000
4260-601-3156 MCO Tax Fund	$0	$100,000,000	$100,000,000
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$860,655,000	$306,000,000	($554,655,000)
4260-601-3213 LTC QA Fund	$508,693,000	$623,984,000	$115,291,000
4260-601-3293 MCO Tax Fund 2016	$640,730,000	$0	($640,730,000)
4260-601-3311 Healthcare Service Fines and Penalties	$0	$36,552,000	$36,552,000
4260-601-3323 Medi-Cal Emergency Transport Fund	$70,517,000	$68,312,000	($2,205,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	$1,364,798,000	$1,643,642,000	$278,844,000
4260-601-3334 MCO Tax (HCS Special Fund)	$0	$2,769,658,000	$2,769,658,000
4260-601-7502 Demonstration DSH Fund	$187,988,000	$58,544,000	($129,444,000)
4260-601-7503 Health Care Support Fund	$28,338,000	$92,553,000	$64,215,000
4260-601-8107 Whole Person Care Pilot Fund	$468,356,000	$335,600,000	($132,756,000)
4260-601-8108 Global Payment Program Fund	$1,238,511,000	$876,470,000	($362,041,000)
4260-601-8113 DPH GME Special Fund	$286,147,000	$378,759,000	$92,612,000
4260-602-0309 Perinatal Insurance Fund	$19,380,000	$26,853,000	$7,473,000
4260-605-0001 SNF Quality & Accountability	$46,979,000	$46,979,000	$0
4260-605-3167 SNF Quality & Accountability	$44,000,000	$41,000,000	($3,000,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($46,979,000)	($46,979,000)	$0
4260-606-0834 SB 1100 DSH	$86,343,000	$211,063,000	$124,720,000
4260-607-8502 LIHP IGT (Non-GF)	$21,828,000	$0	($21,828,000)
4260-611-3158/0890 Hospital Quality Assurance	$8,434,463,000	$11,137,757,000	$2,703,294,000
Total Benefits	**$94,653,785,000**	**$107,069,298,000**	**$12,415,513,000**
County Administration:			
4260-101-0001/0890 Medi-Cal General and Federal Funds	$4,363,401,000	$4,597,380,000	$233,979,000
4260-102-3305 Prop 56 Loan Forgiveness Program	$0	$0	$0
4260-106-0890 Money Follow Person Fed. Grant	$290,000	$360,000	$70,000
4260-113-0001/0890 Children's Health Insurance Program	$77,847,000	$72,964,000	($4,883,000)
4260-117-0001/0890 HIPPA	$8,905,000	$12,772,000	$3,867,000
4260-601-0942 Health Homes Program Account	$163,000	$163,000	$0
4260-601-0995 Reimbursements	$163,000	$189,000	$26,000
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$550,000	$489,000	($61,000)
4260-605-3167 SNF Quality & Accountability Admin.	$3,750,000	$5,432,000	$1,682,000
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$50,000	$100,000	$50,000
Total County Administration	**$4,455,119,000**	**$4,689,849,000**	**$234,730,000**
Fiscal Intermediary:			
4260-101-0001/0890 Medi-Cal General and Federal Funds	$339,080,000	$347,726,000	$8,646,000
4260-111-0001 CHDP State Only	$0	$0	$0
4260-113-0001/0890 Healthy Families	$4,133,000	$3,766,000	($367,000)
4260-117-0001/0890 HIPAA	$37,432,000	$1,001,000	($36,431,000)
4260-601-0995 Reimbursements	$0	$0	$0
Total Fiscal Intermediary	**$380,645,000**	**$352,493,000**	**($28,152,000)**
Grand Total - Total Funds	**$99,489,549,000**	**$112,111,640,000**	**$12,622,091,000**

Medi-Cal Funding Summary
May 2020 Estimate Comparison of FY 2019-20 to FY 2020-21

STATE FUNDS

Benefits:	**FY 2019-20 Estimate**	**FY 2020-21 Estimate**	**Difference Incr./(Decr.)**
4260-101-0001 Medi-Cal General Fund*	$21,020,121,000	$20,957,179,000	($62,942,000)
4260-101-0080 CLPP Funds	$916,000	$916,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$130,657,000	$92,170,000	($38,487,000)
4260-101-0233 Prop 99 Physician Srvc. Acct	$40,862,000	$26,639,000	($14,223,000)
4260-101-0236 Prop 99 Unallocated Account	$60,035,000	$41,848,000	($18,187,000)
4260-101-3168 Emergency Air Transportation Fund	$7,299,000	$6,626,000	($673,000)
4260-101-3305 Healthcare Treatment Fund	$818,367,000	$1,339,836,000	$521,469,000
4260-101-3366 Electronic Cigarette Product Tax	$0	$9,600,000	$9,600,000
4260-102-0001 Capital Debt *	$28,352,000	$26,770,000	($1,582,000)
4260-102-3305 Prop 56 Loan Forgiveness Program	$1,700,000	$15,200,000	$13,500,000
4260-103-3305 Prop 56 Value-Based Payment	$102,976,000	$0	($102,976,000)
4260-104-0001 NDPH Hosp Supp *	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$1,900,000	$1,900,000	$0
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	($1,900,000)	($1,900,000)	$0
4260-105-0001 Private Hosp Supp Fund *	$118,400,000	$118,400,000	$0
4260-601-3097 Private Hosp Suppl	$145,400,000	$132,461,000	($12,939,000)
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-111-0001 CHDP State Only *	$0	$0	$0
4260-113-0001 Childrens Health Insurance Program *	$387,344,000	$973,390,000	$586,046,000
4260-601-0942142 Local Trauma Centers	$60,183,000	$81,883,000	$21,700,000
4260-601-0942 Health Homes Program Account	$9,464,000	$22,749,000	$13,285,000
4260-601-0995 Reimbursements	$1,373,438,000	$1,777,423,000	$403,985,000
4260-601-3156 MCO Tax Fund	$0	$100,000,000	$100,000,000
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$860,655,000	$306,000,000	($554,655,000)
4260-601-3213 LTC QA Fund	$508,693,000	$623,984,000	$115,291,000
4260-601-3293 MCO Tax Fund 2016	$640,730,000	$0	($640,730,000)
4260-601-3311 Healthcare Service Fines and Penalties	$0	$36,552,000	$36,552,000
4260-601-3323 Medi-Cal Emergency Transport Fund	$70,517,000	$68,312,000	($2,205,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	$1,364,798,000	$1,643,642,000	$278,844,000
4260-601-3334 MCO Tax (HCS Special Fund)	$0	$2,769,658,000	$2,769,658,000
4260-601-8107 Whole Person Care Pilot Fund	$468,356,000	$335,600,000	($132,756,000)
4260-601-8108 Global Payment Program Fund	$1,238,511,000	$876,470,000	($362,041,000)
4260-601-8113 DPH GME Special Fund	$286,147,000	$378,759,000	$92,612,000
4260-602-0309 Perinatal Insurance Fund	$19,380,000	$26,853,000	$7,473,000
4260-605-0001 SNF Quality & Accountability *	$46,979,000	$46,979,000	$0
4260-605-3167 SNF Quality & Accountability	$44,000,000	$41,000,000	($3,000,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($46,979,000)	($46,979,000)	$0
4260-606-0834 SB 1100 DSH	$86,343,000	$211,063,000	$124,720,000
4260-607-8502 LIHP IGT (Non-GF)	$21,828,000	$0	($21,828,000)
4260-611-3158 Hospital Quality Assurance Revenue	$3,478,557,000	$5,288,065,000	$1,809,508,000
Total Benefits	**$33,277,529,000**	**$38,212,548,000**	**$4,935,019,000**
Total Benefits General Fund *	**$21,603,096,000**	**$22,124,618,000**	**$521,522,000**
County Administration:			
4260-101-0001 Medi-Cal General Fund *	$973,281,000	$886,435,000	($86,846,000)
4260-102-3305 Prop 56 Loan Forgiveness Program	$0	$0	$0
4260-113-0001 Childrens Health Insurance Program *	$10,956,000	$16,316,000	$5,360,000
4260-117-0001 HIPAA *	$1,464,000	$2,226,000	$762,000
4260-601-0942 Health Homes Program Account	$163,000	$163,000	$0
4260-601-0995 Reimbursements	$163,000	$189,000	$26,000
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$550,000	$489,000	($61,000)
4260-605-3167 SNF Quality & Accountability Admin.	$3,750,000	$5,432,000	$1,682,000
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$50,000	$100,000	$50,000
Total County Administration	**$990,377,000**	**$911,350,000**	**($79,027,000)**
Total County Administration General Fund *	**$985,701,000**	**$904,977,000**	**($80,724,000)**
Fiscal Intermediary:			
4260-101-0001 Medi-Cal General Fund *	$115,761,000	$122,724,000	$6,963,000
4260-111-0001 CHDP State Only *	$0	$0	$0
4260-113-0001 Childrens Health Insurance Program *	($137,000)	($790,000)	($653,000)
4260-117-0001 HIPAA *	$9,305,000	$198,000	($9,107,000)
4260-601-0995 Reimbursements	$0	$0	$0
Total Fiscal Intermediary	**$124,929,000**	**$122,132,000**	**($2,797,000)**
Total Fiscal Intermediary General Fund *	**$124,929,000**	**$122,132,000**	**($2,797,000)**
Grand Total - State Funds	**$34,392,835,000**	**$39,246,030,000**	**$4,853,195,000**
Grand Total - General Fund*	**$22,713,726,000**	**$23,151,727,000**	**$438,001,000**

Medi-Cal Funding Summary

May 2020 Estimate Comparison of FY 2019-20 to FY 2020-21

FEDERAL FUNDS

	FY 2019-20 Estimate	FY 2020-21 Estimate	Difference Incr./(Decr.)
Benefits:			
4260-101-0890 Federal Funds	$52,687,419,000	$59,881,691,000	$7,194,272,000
4260-102-0890 Capital Debt	$66,643,000	$50,785,000	($15,858,000)
4260-106-0890 Money Follows Person Federal Grant	$21,985,000	$3,319,000	($18,666,000)
4260-113-0890 Childrens Health Insurance Fund	$3,427,977,000	$2,920,166,000	($507,811,000)
4260-601-7502 Demonstration DSH Fund	$187,988,000	$58,544,000	($129,444,000)
4260-601-7503 Health Care Support Fund	$28,338,000	$92,553,000	$64,215,000
4260-611-0890 Hospital Quality Assurance	$4,955,906,000	$5,849,692,000	$893,786,000
Total Benefits	**$61,376,256,000**	**$68,856,750,000**	**$7,480,494,000**
County Administration:			
4260-101-0890 Federal Funds	$3,390,120,000	$3,710,945,000	$320,825,000
4260-106-0890 Money Follows Person Fed. Grant	$290,000	$360,000	$70,000
4260-113-0890 Childrens Health Insurance Fund	$66,891,000	$56,648,000	($10,243,000)
4260-117-0890 HIPAA	$7,441,000	$10,546,000	$3,105,000
Total County Administration	**$3,464,742,000**	**$3,778,499,000**	**$313,757,000**
Fiscal Intermediary:			
4260-101-0890 Federal Funds	$223,319,000	$225,002,000	$1,683,000
4260-113-0890 Childrens Health Insurance Fund	$4,270,000	$4,556,000	$286,000
4260-117-0890 HIPAA	$28,127,000	$803,000	($27,324,000)
Total Fiscal Intermediary	**$255,716,000**	**$230,361,000**	**($25,355,000)**
Grand Total - Federal Funds	**$65,096,714,000**	**$72,865,610,000**	**$7,768,896,000**

Medi-Cal Funding Summary
May 2020 Estimate Compared to November 2019 Estimate
Fiscal Year 2020 - 2021

TOTAL FUNDS

Benefits:	**Nov 2019 Estimate**	**May 2020 Estimate**	**Difference Incr./(Decr.)**
4260-101-0001/0890 Medi-Cal General and Federal Funds	$78,736,584,000	$80,838,870,000	$2,102,286,000
4260-101-0080 CLPP Funds	$725,000	$916,000	$191,000
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$99,136,000	$92,170,000	($6,966,000)
4260-101-0233 Prop 99 Physician Srvc. Acct	$28,631,000	$26,639,000	($1,992,000)
4260-101-0236 Prop 99 Unallocated Account	$45,872,000	$41,848,000	($4,024,000)
4260-101-3168 Emergency Air Transportation Fund	$5,929,000	$6,626,000	$697,000
4260-101-3305 Healthcare Treatment Fund	$849,145,000	$1,339,836,000	$490,691,000
4260-101-3366 Electronic Cigarette Product Tax	$0	$9,600,000	$9,600,000
4260-102-0001/0890 Capital Debt	$91,698,000	$77,555,000	($14,143,000)
4260-102-3305 Prop 56 Loan Forgiveness Program	$15,200,000	$15,200,000	$0
4260-103-3305 Prop 56 Value-Based Payment	$178,625,000	$0	($178,625,000)
4260-104-0001 NDPH Hosp Supp	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$1,900,000	$1,900,000	$0
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	($1,900,000)	($1,900,000)	$0
4260-105-0001 Private Hosp Supp Fund	$118,400,000	$118,400,000	$0
4260-601-3097 Private Hosp Suppl	$145,400,000	$132,461,000	($12,939,000)
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-106-0890 Money Follows Person Federal Grant	$385,000	$3,319,000	$2,934,000
4260-111-0001 CHDP State Only *	$2,000	$0	($2,000)
4260-113-0001/0890 Children's Health Insurance Program	$3,212,911,000	$3,893,556,000	$680,645,000
4260-601-0942142 Local Trauma Centers	$74,207,000	$81,883,000	$7,676,000
4260-601-0942 Health Homes Program Account	$23,841,000	$22,749,000	($1,092,000)
4260-601-0995 Reimbursements	$1,453,190,000	$1,777,423,000	$324,233,000
4260-601-3156 MCO Tax Fund	$0	$100,000,000	$100,000,000
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$306,000,000	$306,000,000	$0
4260-601-3213 LTC QA Fund	$595,880,000	$623,984,000	$28,104,000
4260-601-3293 MCO Tax Fund 2016	$0	$0	$0
4260-601-3311 Healthcare Service Fines and Penalties	$0	$36,552,000	$36,552,000
4260-601-3323 Medi-Cal Emergency Transport Fund	$76,920,000	$68,312,000	($8,608,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	$1,315,885,000	$1,643,642,000	$327,757,000
4260-601-3334 MCO Tax (HCS Special Fund)	$0	$2,769,658,000	$2,769,658,000
4260-601-7502 Demonstration DSH Fund	$39,593,000	$58,544,000	$18,951,000
4260-601-7503 Health Care Support Fund	$263,000	$92,553,000	$92,290,000
4260-601-8107 Whole Person Care Pilot Fund	$335,879,000	$335,600,000	($279,000)
4260-601-8108 Global Payment Program Fund	$613,198,000	$876,470,000	$263,272,000
4260-601-8113 DPH GME Special Fund	$436,611,000	$378,759,000	($57,852,000)
4260-602-0309 Perinatal Insurance Fund	$16,128,000	$26,853,000	$10,725,000
4260-605-0001 SNF Quality & Accountability	$46,979,000	$46,979,000	$0
4260-605-3167 SNF Quality & Accountability	$41,000,000	$41,000,000	$0
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($46,979,000)	($46,979,000)	$0
4260-606-0834 SB 1100 DSH	$157,115,000	$211,063,000	$53,948,000
4260-607-8502 LIHP IGT (Non-GF)	$0	$0	$0
4260-611-3158/0890 Hospital Quality Assurance	$9,650,820,000	$11,137,757,000	$1,486,937,000
Total Benefits	**$98,548,673,000**	**$107,069,298,000**	**$8,520,625,000**
County Administration:			
4260-101-0001/0890 Medi-Cal General and Federal Funds	$4,489,467,000	$4,597,380,000	$107,913,000
4260-102-3305 Prop 56 Loan Forgiveness Program	$0	$0	$0
4260-106-0890 Money Follow Person Fed. Grant	$0	$360,000	$360,000
4260-113-0001/0890 Children's Health Insurance Program	$45,802,000	$72,964,000	$27,162,000
4260-117-0001/0890 HIPPA	$10,005,000	$12,772,000	$2,767,000
4260-601-0942 Health Homes Program Account	$317,000	$163,000	($154,000)
4260-601-0995 Reimbursements	$172,000	$189,000	$17,000
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$489,000	$489,000	$0
4260-605-3167 SNF Quality & Accountability Admin.	$3,750,000	$5,432,000	$1,682,000
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$92,000	$100,000	$8,000
Total County Administration	**$4,550,094,000**	**$4,689,849,000**	**$139,747,000**
Fiscal Intermediary:			
4260-101-0001/0890 Medi-Cal General and Federal Funds	$340,464,000	$347,726,000	$7,262,000
4260-111-0001 CHDP State Only	$1,000	$0	($1,000)
4260-113-0001/0890 Healthy Families	$21,716,000	$3,766,000	($17,950,000)
4260-117-0001/0890 HIPAA	$1,001,000	$1,001,000	$0
4260-601-0995 Reimbursements	$0	$0	$0
Total Fiscal Intermediary	**$363,182,000**	**$352,493,000**	**($10,689,000)**
Grand Total - Total Funds	**$103,461,949,000**	**$112,111,640,000**	**$8,649,683,000**

Medi-Cal Funding Summary
May 2020 Estimate Compared to November 2019 Estimate
Fiscal Year 2020 - 2021

STATE FUNDS

Benefits:	Nov 2019 Estimate	May 2020 Estimate	Difference Incr./(Decr.)
4260-101-0001 Medi-Cal General Fund*	$23,932,027,000	$20,957,179,000	($2,974,848,000)
4260-101-0080 CLPP Funds	$725,000	$916,000	$191,000
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$99,136,000	$92,170,000	($6,966,000)
4260-101-0233 Prop 99 Physician Srvc. Acct	$28,631,000	$26,639,000	($1,992,000)
4260-101-0236 Prop 99 Unallocated Account	$45,872,000	$41,848,000	($4,024,000)
4260-101-3168 Emergency Air Transportation Fund	$5,929,000	$6,626,000	$697,000
4260-101-3305 Healthcare Treatment Fund	$849,145,000	$1,339,836,000	$490,691,000
4260-101-3366 Electronic Cigarette Product Tax	$0	$9,600,000	$9,600,000
4260-102-0001 Capital Debt *	$30,130,000	$26,770,000	($3,360,000)
4260-102-3305 Prop 56 Loan Forgiveness Program	$15,200,000	$15,200,000	$0
4260-103-3305 Prop 56 Value-Based Payment	$178,625,000	$0	($178,625,000)
4260-104-0001 NDPH Hosp Supp *	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$1,900,000	$1,900,000	$0
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	($1,900,000)	($1,900,000)	$0
4260-105-0001 Private Hosp Supp Fund *	$118,400,000	$118,400,000	$0
4260-601-3097 Private Hosp Suppl	$145,400,000	$132,461,000	($12,939,000)
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-111-0001 CHDP State Only *	$2,000	$0	($2,000)
4260-113-0001 Childrens Health Insurance Program *	$754,967,000	$973,390,000	$218,423,000
4260-601-0942142 Local Trauma Centers	$74,207,000	$81,883,000	$7,676,000
4260-601-0942 Health Homes Program Account	$23,841,000	$22,749,000	($1,092,000)
4260-601-0995 Reimbursements	$1,453,190,000	$1,777,423,000	$324,233,000
4260-601-3156 MCO Tax Fund	$0	$100,000,000	$100,000,000
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$306,000,000	$306,000,000	$0
4260-601-3213 LTC QA Fund	$595,880,000	$623,984,000	$28,104,000
4260-601-3293 MCO Tax Fund 2016	$0	$0	$0
4260-601-3311 Healthcare Service Fines and Penalties	$0	$36,552,000	$36,552,000
4260-601-3323 Medi-Cal Emergency Transport Fund	$76,920,000	$68,312,000	($8,608,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	$1,315,885,000	$1,643,642,000	$327,757,000
4260-601-3334 MCO Tax (HCS Special Fund)	$0	$2,769,658,000	$2,769,658,000
4260-601-8107 Whole Person Care Pilot Fund	$335,879,000	$335,600,000	($279,000)
4260-601-8108 Global Payment Program Fund	$613,198,000	$876,470,000	$263,272,000
4260-601-8113 DPH GME Special Fund	$436,611,000	$378,759,000	($57,852,000)
4260-602-0309 Perinatal Insurance Fund	$16,128,000	$26,853,000	$10,725,000
4260-605-0001 SNF Quality & Accountability *	$46,979,000	$46,979,000	$0
4260-605-3167 SNF Quality & Accountability	$41,000,000	$41,000,000	$0
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($46,979,000)	($46,979,000)	$0
4260-606-0834 SB 1100 DSH	$157,115,000	$211,063,000	$53,948,000
4260-607-8502 LIHP IGT (Non-GF)	$0	$0	$0
4260-611-3158 Hospital Quality Assurance Revenue	$4,199,181,000	$5,288,065,000	$1,088,884,000
Total Benefits	**$35,732,724,000**	**$38,212,548,000**	**$2,479,824,000**
Total Benefits General Fund *	**$24,884,405,000**	**$22,124,618,000**	**($2,759,785,000)**
		$0	
County Administration:			
4260-101-0001 Medi-Cal General Fund *	$850,068,000	$886,435,000	$36,367,000
4260-102-3305 Prop 56 Loan Forgiveness Program	$0	$0	$0
4260-113-0001 Childrens Health Insurance Program *	$8,560,000	$16,316,000	$7,756,000
4260-117-0001 HIPAA *	$1,720,000	$2,226,000	$506,000
4260-601-0942 Health Homes Program Account	$317,000	$163,000	($154,000)
4260-601-0995 Reimbursements	$172,000	$189,000	$17,000
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$489,000	$489,000	$0
4260-605-3167 SNF Quality & Accountability Admin.	$3,750,000	$5,432,000	$1,682,000
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	$92,000	$100,000	$8,000
Total County Administration	**$865,168,000**	**$911,350,000**	**$46,182,000**
Total County Administration General Fund *	**$860,348,000**	**$904,977,000**	**$44,629,000**
Fiscal Intermediary:			
4260-101-0001 Medi-Cal General Fund *	$112,502,000	$122,724,000	$10,222,000
4260-111-0001 CHDP State Only *	$1,000	$0	($1,000)
4260-113-0001 Childrens Health Insurance Program *	$7,492,000	($790,000)	($8,282,000)
4260-117-0001 HIPAA *	$198,000	$198,000	$0
4260-601-0995 Reimbursements	$0	$0	$0
Total Fiscal Intermediary	**$120,193,000**	**$122,132,000**	**$1,939,000**
Total Fiscal Intermediary General Fund *	**$120,193,000**	**$122,132,000**	**$1,939,000**
Grand Total - State Funds	**$36,718,085,000**	**$39,246,030,000**	**$2,527,945,000**
Grand Total - General Fund*	**$25,864,946,000**	**$23,151,727,000**	**($2,713,219,000)**

Medi-Cal Funding Summary
May 2020 Estimate Compared to November 2019 Estimate
Fiscal Year 2020 - 2021

FEDERAL FUNDS

	Nov 2019 Estimate	May 2020 Estimate	Difference Incr./(Decr.)
Benefits:			
4260-101-0890 Federal Funds	$54,804,557,000	$59,881,691,000	$5,077,134,000
4260-102-0890 Capital Debt	$61,568,000	$50,785,000	($10,783,000)
4260-106-0890 Money Follows Person Federal Grant	$385,000	$3,319,000	$2,934,000
4260-113-0890 Childrens Health Insurance Fund	$2,457,944,000	$2,920,166,000	$462,222,000
4260-601-7502 Demonstration DSH Fund	$39,593,000	$58,544,000	$18,951,000
4260-601-7503 Health Care Support Fund	$263,000	$92,553,000	$92,290,000
4260-611-0890 Hospital Quality Assurance	$5,451,639,000	$5,849,692,000	$398,053,000
Total Benefits	**$62,815,949,000**	**$68,856,750,000**	**$6,040,801,000**
County Administration:			
4260-101-0890 Federal Funds	$3,639,399,000	$3,710,945,000	$71,546,000
4260-106-0890 Money Follows Person Fed. Grant	$0	$360,000	$360,000
4260-113-0890 Childrens Health Insurance Fund	$37,242,000	$56,648,000	$19,406,000
4260-117-0890 HIPAA	$8,285,000	$10,546,000	$2,261,000
Total County Administration	**$3,684,926,000**	**$3,778,499,000**	**$93,573,000**
Fiscal Intermediary:			
4260-101-0890 Federal Funds	$227,962,000	$225,002,000	($2,960,000)
4260-113-0890 Childrens Health Insurance Fund	$14,224,000	$4,556,000	($9,668,000)
4260-117-0890 HIPAA	$803,000	$803,000	$0
Total Fiscal Intermediary	**$242,989,000**	**$230,361,000**	**($12,628,000)**
Grand Total - Federal Funds	**$66,743,864,000**	**$72,865,610,000**	**$6,121,746,000**

TABLE OF CONTENTS

CURRENT YEAR

The Current Year section provides a summary of medical assistance benefits (base and regular policy change) expenditures for the current fiscal year. It highlights expenditures by service category, compares current year data to the previous appropriation estimate, and provides an overview of the current year cost per eligible expenditures.

MEDI-CAL PROGRAM ESTIMATE SUMMARY EXPENDITURES.....1

SUMMARY OF REGULAR POLICY CHANGES 2-8

ELIGIBILITY 2
AFFORDABLE CARE ACT 2
BENEFITS.....2-3
PHARMACY 3
DRUG MEDI-CAL 3
MENTAL HEALTH.....3-4
WAIVER-MH/UCD & BTR 4
MANAGED CARE 4
PROVIDER RATES 5
SUPPLEMENTAL PAYMENTS.....5-6
COVID-19.....6-7
OTHER 7
GRAND TOTAL 7

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY AND FUND TYPE 8

MEDI-CAL TOTAL FUND EXPENDITURES BY SERVICE CATEGORY, CURRENT YEAR ESTIMATE COMPARISONS 9-10

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES, CURRENT YEAR ESTIMATE COMPARISONS 11-19

ELIGIBILITY 11
AFFORDABLE CARE ACT 11-12
BENEFITS 12-13
PHARMACY 13
DRUG MEDI-CAL 13
MENTAL HEALTH.....13-14
WAIVER-MH/UCD & BTR 14
MANAGED CARE 14-15
PROVIDER RATES 15-16
SUPPLEMENTAL PAYMENTS.....16-18
COVID-19 18
OTHER 19
GRAND TOTAL 19

COST PER ELIGIBLE BY SERVICE CATEGORY 20-26

MEDI-CAL PROGRAM ESTIMATE SUMMARY
FISCAL YEAR 2019-20

	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
I. BASE ESTIMATES				
A. C/Y FFS BASE	$17,432,459,040	$8,716,229,520	$8,716,229,520	$0
B. C/Y BASE POLICY CHANGES	$47,946,336,990	$32,092,966,330	$15,713,879,660	$139,491,000
C. BASE ADJUSTMENTS	($185,412,000)	($240,788,600)	$55,376,590	$0
D. ADJUSTED BASE	**$65,193,384,030**	**$40,568,407,250**	**$24,485,485,780**	**$139,491,000**
II. REGULAR POLICY CHANGES				
A. ELIGIBILITY	$102,598,660	($482,519,260)	$583,165,920	$1,952,000
B. AFFORDABLE CARE ACT	$3,365,245,000	$3,422,898,310	($57,653,310)	$0
C. BENEFITS	$1,820,177,520	$1,294,920,390	$501,134,130	$24,123,000
D. PHARMACY	($1,703,853,000)	($1,693,539,000)	($1,375,112,000)	$1,364,798,000
E. DRUG MEDI-CAL	$341,060,000	$293,413,120	$47,646,870	$0
F. MENTAL HEALTH	$95,010,000	$76,942,500	$17,867,500	$200,000
G. WAIVER--MH/UCD & BTR	$5,762,097,000	$2,857,557,000	$315,190,500	$2,589,349,500
H. MANAGED CARE	$5,308,300,450	$2,843,349,190	$637,235,560	$1,827,715,700
I. PROVIDER RATES	$596,158,270	$778,925,780	($769,276,820)	$586,509,310
J. SUPPLEMENTAL PMNTS.	$12,929,485,730	$8,061,524,650	$353,278,580	$4,514,682,500
K. COVID-19	$890,581,000	$1,457,285,000	($566,704,000)	$0
L. OTHER	($46,459,890)	$1,897,091,690	($2,569,162,580)	$625,611,000
M. TOTAL CHANGES	**$29,460,400,740**	**$20,807,849,370**	**($2,882,389,640)**	**$11,534,941,000**
III. TOTAL MEDI-CAL ESTIMATE	**$94,653,784,770**	**$61,376,256,620**	**$21,603,096,140**	**$11,674,432,000**

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2019-20

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	ELIGIBILITY				
1	UNDOCUMENTED YOUNG ADULTS FULL SCOPE EXPANSION	$104,218,090	$30,782,870	$73,435,220	$0
2	MEDI-CAL STATE INMATE PROGRAMS	$62,206,000	$62,206,000	$0	$0
3	BREAST AND CERVICAL CANCER TREATMENT	$65,373,000	$24,239,650	$41,133,350	$0
8	MEDI-CAL COUNTY INMATE PROGRAMS	$0	$0	$0	$0
10	CS3 PROXY ADJUSTMENT	$0	$316,999,420	($316,999,420)	$0
11	MEDI-CAL COUNTY INMATE REIMBURSEMENT	$0	$0	($1,952,000)	$1,952,000
12	CDCR RETRO REPAYMENT	$0	($1,466,000)	$1,466,000	$0
13	NON-OTLICP CHIP	$0	$170,168,730	($170,168,730)	$0
14	NON-EMERGENCY FUNDING ADJUSTMENT	$0	($987,242,000)	$987,242,000	$0
15	SCHIP FUNDING FOR PRENATAL CARE	$0	$90,190,810	($90,190,810)	$0
16	CCHIP DELIVERY SYSTEM	($1,921,000)	($1,469,560)	($451,440)	$0
17	MEDICARE OPTIONAL EXPANSION ADJUSTMENT	($42,464,000)	($113,947,650)	$71,483,650	$0
18	CHIP PREMIUMS	($62,286,000)	($49,439,460)	($12,846,540)	$0
19	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	($25,419,420)	($20,564,060)	($4,855,370)	$0
232	DISABLED ADULT CHILDREN PROGRAM CLEANUP	$2,892,000	($2,978,000)	$5,870,000	$0
	ELIGIBILITY SUBTOTAL	**$102,598,660**	**($482,519,250)**	**$583,165,920**	**$1,952,000**
	AFFORDABLE CARE ACT				
20	COMMUNITY FIRST CHOICE OPTION	$3,718,574,000	$3,718,574,000	$0	$0
21	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	$28,134,000	$28,134,000	$0	$0
23	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	$0	$44,894,710	($44,894,710)	$0
24	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	$3,225,000	($3,225,000)	$0
25	ACA MAGI SAVINGS	$0	$0	$0	$0
26	PAYMENTS TO PRIMARY CARE PHYSICIANS	($120,000)	($120,000)	$0	$0
27	ACA OPTIONAL EXPANSION MLR RISK CORRIDOR	($381,343,000)	($371,809,400)	($9,533,600)	$0
	AFFORDABLE CARE ACT SUBTOTAL	**$3,365,245,000**	**$3,422,898,310**	**($57,653,310)**	**$0**
	BENEFITS				
29	BEHAVIORAL HEALTH TREATMENT	$863,002,000	$470,773,290	$392,228,710	$0
30	FAMILY PACT PROGRAM	$371,873,000	$283,311,300	$88,561,700	$0
31	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$356,323,000	$356,323,000	$0	$0
32	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$130,696,000	$130,696,000	$0	$0
34	RESTORATION OF ADULT OPTICIAN & OPTICAL LAB SVCS	$11,438,870	$7,385,880	$4,053,000	$0
35	MSSP SUPPLEMENTAL PAYMENTS	$4,933,000	$4,933,000	($4,933,000)	$4,933,000

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2019-20

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	BENEFITS				
36	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$28,189,000	$21,810,000	$6,379,000	$0
37	OPTIONAL BENEFITS RESTORATION	$6,180,920	$3,990,970	$2,189,950	$0
38	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	$20,232,000	$10,116,000	($9,074,000)	$19,190,000
39	CCS DEMONSTRATION PROJECT	$11,122,000	$6,047,520	$5,074,480	$0
40	MEDI-CAL NONMEDICAL TRANSPORTATION	$2,041,730	$1,264,170	$777,560	$0
41	MEDICALLY TAILORED MEALS PILOT PROGRAM	$2,500,000	$0	$2,500,000	$0
42	YOUTH REGIONAL TREATMENT CENTERS	$2,061,000	$2,045,000	$16,000	$0
43	PEDIATRIC PALLIATIVE CARE WAIVER	$1,033,000	$0	$1,033,000	$0
44	FREE CLINIC OF SIMI VALLEY	$700,000	$0	$700,000	$0
45	CCT FUND TRANSFER TO CDSS	$175,000	$175,000	$0	$0
47	ASTHMA MITIGATION PROJECT	$15,000,000	$0	$15,000,000	$0
50	WHOLE CHILD MODEL IMPLEMENTATION	($7,323,000)	($3,950,740)	($3,372,260)	$0
	BENEFITS SUBTOTAL	**$1,820,177,520**	**$1,294,920,390**	**$501,134,130**	**$24,123,000**
	PHARMACY				
53	MEDI-CAL DRUG REBATE FUND	$0	$0	($1,364,798,000)	$1,364,798,000
56	BCCTP DRUG REBATES	($4,464,000)	($4,464,000)	$0	$0
57	FAMILY PACT DRUG REBATES	($22,612,000)	($22,612,000)	$0	$0
58	LITIGATION SETTLEMENTS	($302,000)	$0	($302,000)	$0
59	MEDICAL SUPPLY REBATES	($20,024,000)	($10,012,000)	($10,012,000)	$0
60	STATE SUPPLEMENTAL DRUG REBATES	($101,891,000)	($101,891,000)	$0	$0
62	FEDERAL DRUG REBATES	($1,554,560,000)	($1,554,560,000)	$0	$0
	PHARMACY SUBTOTAL	**($1,703,853,000)**	**($1,693,539,000)**	**($1,375,112,000)**	**$1,364,798,000**
	DRUG MEDI-CAL				
63	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	$341,222,000	$293,575,120	$47,646,880	$0
70	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	($162,000)	($162,000)	$0	$0
	DRUG MEDI-CAL SUBTOTAL	**$341,060,000**	**$293,413,120**	**$47,646,880**	**$0**
	MENTAL HEALTH				
73	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT	$125,573,000	$125,573,000	$0	$0
74	MHP COSTS FOR CONTINUUM OF CARE REFORM	$24,184,000	$11,210,500	$12,973,500	$0
75	PATHWAYS TO WELL-BEING	$448,000	$448,000	$0	$0
76	LATE CLAIMS FOR SMHS	$535,000	$0	$535,000	$0
77	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	$0	$0	($200,000)	$200,000
79	CHART REVIEW	($1,107,000)	($1,107,000)	$0	$0
80	INTERIM AND FINAL COST SETTLEMENTS - SMHS	($54,623,000)	($59,182,000)	$4,559,000	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2019-20

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	MENTAL HEALTH SUBTOTAL	**$95,010,000**	**$76,942,500**	**$17,867,500**	**$200,000**
	WAIVER--MH/UCD & BTR				
81	GLOBAL PAYMENT PROGRAM	$2,477,024,000	$1,238,513,000	$0	$1,238,511,000
82	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL	$1,721,309,000	$860,654,500	$0	$860,654,500
83	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS	$936,711,000	$468,355,000	$0	$468,356,000
84	BTR - LIHP - MCE	$189,824,000	$172,386,000	$0	$17,438,000
85	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	$196,179,000	$98,089,500	$98,089,500	$0
86	MH/UCD—STABILIZATION FUNDING	$117,101,000	$0	$117,101,000	$0
87	WHOLE PERSON CARE HOUSING SERVICES	$100,000,000	$0	$100,000,000	$0
88	MH/UCD—SAFETY NET CARE POOL	$73,784,000	$73,784,000	$0	$0
89	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$531,000	$531,000	$0	$0
90	MH/UCD—HEALTH CARE COVERAGE INITIATIVE	$1,003,000	$1,003,000	$0	$0
91	BTR - LOW INCOME HEALTH PROGRAM - HCCI	($51,369,000)	($55,759,000)	$0	$4,390,000
	WAIVER--MH/UCD & BTR SUBTOTAL	**$5,762,097,000**	**$2,857,557,000**	**$315,190,500**	**$2,589,349,500**
	MANAGED CARE				
95	CCI-MANAGED CARE PAYMENTS	$2,660,450,450	$1,330,225,220	$1,330,225,220	$0
96	MANAGED CARE HEALTH CARE FINANCING PROGRAM	$1,821,706,000	$1,236,473,060	$585,232,940	$0
97	MANAGED CARE PUBLIC HOSPITAL EPP	$1,476,865,000	$1,139,027,990	$337,837,010	$0
100	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	$640,000,000	$495,325,350	$144,674,650	$0
101	MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES	$187,991,000	$129,518,170	$58,472,830	$0
103	RETRO MC RATE ADJUSTMENTS	$148,805,000	$134,392,460	$14,412,540	$0
104	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS	$94,637,000	$85,173,300	$0	$9,463,700
107	CCI-QUALITY WITHHOLD REPAYMENTS	$8,260,000	$4,130,000	$4,130,000	$0
108	GENERAL FUND REIMBURSEMENTS FROM DPHS	$4,981,000	$0	$4,981,000	$0
111	MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.	$0	$0	($58,473,000)	$58,473,000
112	MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	$0	($582,257,000)	$582,257,000
113	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	$0	$0	($1,177,522,000)	$1,177,522,000
115	RECOUPMENT OF UNALLOWED CAPITATION PAYMENTS	($68,245,000)	($43,766,360)	($24,478,640)	$0
116	MANAGED CARE DRUG REBATES	($1,667,150,000)	($1,667,150,000)	$0	$0
	MANAGED CARE SUBTOTAL	**$5,308,300,450**	**$2,843,349,190**	**$637,235,560**	**$1,827,715,700**

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2019-20

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	PROVIDER RATES				
117	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	$184,960,650	$125,925,230	($11,481,880)	$70,517,310
118	RATE INCREASE FOR FQHCS/RHCS/CBRCS	$88,254,850	$54,654,540	$33,600,300	$0
119	AB 1629 ANNUAL RATE ADJUSTMENTS	$80,571,770	$40,285,890	$40,285,890	$0
120	FQHC/RHC/CBRC RECONCILIATION PROCESS	$50,545,430	$31,301,620	$19,243,800	$0
121	PROP 56 - HOME HEALTH RATE INCREASE	$20,747,980	$10,807,600	$9,940,380	$0
122	DPH INTERIM RATE GROWTH	$2,648,890	$1,324,440	$1,324,440	$0
123	LTC RATE ADJUSTMENT	$21,503,400	$10,751,700	$10,751,700	$0
124	DPH INTERIM & FINAL RECONS	$220,014,000	$220,014,000	$0	$0
125	PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE	$944,820	$489,900	$454,920	$0
127	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	$10,992,000	$5,496,000	($1,803,000)	$7,299,000
128	HOSPICE RATE INCREASES	$2,989,820	$1,494,910	$1,494,910	$0
129	DPH INTERIM RATE	$0	$362,258,460	($362,258,460)	$0
130	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	$0	($508,693,000)	$508,693,000
131	AB 97-RELATED ADJUSTMENT	$0	($40,508,000)	$40,508,000	$0
132	DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT	($350,300)	($189,140)	($161,160)	$0
133	LABORATORY RATE METHODOLOGY CHANGE	($8,568,170)	($4,284,080)	($4,284,080)	$0
134	10% PROVIDER PAYMENT REDUCTION	($13,936,310)	($6,968,150)	($6,968,150)	$0
135	DENTAL RETROACTIVE RATE CHANGES	($11,368,000)	($7,032,860)	($4,335,140)	$0
136	REDUCTION TO RADIOLOGY RATES	($53,792,550)	($26,896,280)	($26,896,280)	$0
	PROVIDER RATES SUBTOTAL	**$596,158,270**	**$778,925,780**	**($769,276,820)**	**$586,509,310**
	SUPPLEMENTAL PMNTS.				
137	HOSPITAL QAF - FFS PAYMENTS	$4,045,622,000	$2,236,706,000	$0	$1,808,916,000
138	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	$2,100,000,000	$1,398,808,000	$0	$701,192,000
139	HOSPITAL QAF - MANAGED CARE PAYMENTS	$1,897,400,000	$1,320,392,000	$0	$577,008,000
140	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	$545,042,000	$272,521,000	$0	$272,521,000
141	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	$1,128,175,290	$746,108,670	$382,066,610	$0
142	PRIVATE HOSPITAL DSH REPLACEMENT	$592,134,000	$296,067,000	$296,067,000	$0
143	PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES	$564,521,000	$351,007,360	$213,513,640	$0
144	PROP 56 - MEDI-CAL FAMILY PLANNING	$85,335,960	$76,802,360	$8,533,600	$0
145	DSH PAYMENT	$318,440,000	$253,214,000	$24,184,000	$41,042,000
146	PROP 56 - VALUE-BASED PAYMENT PROGRAM	$310,065,000	$207,089,060	$102,975,940	$0
147	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	$313,011,000	$165,917,000	$120,094,000	$27,000,000

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2019-20

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	SUPPLEMENTAL PMNTS.				
148	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$247,723,000	$247,723,000	$0	$0
149	CAPITAL PROJECT DEBT REIMBURSEMENT	$111,082,000	$82,730,000	$28,352,000	$0
150	FFP FOR LOCAL TRAUMA CENTERS	$131,604,000	$61,769,500	$9,652,000	$60,182,500
151	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	$118,278,000	$69,018,750	($270,750)	$49,530,000
152	NDPH IGT SUPPLEMENTAL PAYMENTS	$94,555,000	$51,469,000	($2,215,000)	$45,301,000
153	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	$82,304,000	$82,304,000	$0	$0
154	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	$88,000,000	$44,000,000	$46,979,000	($2,979,000)
155	GEMT SUPPLEMENTAL PAYMENT PROGRAM	$3,272,000	$3,272,000	$0	$0
156	PROP 56 - DEVELOPMENTAL SCREENINGS	$34,692,730	$19,987,650	$14,705,080	$0
157	PROP 56 - CBAS SUPPLEMENTAL PAYMENTS	$30,992,000	$15,496,000	$15,496,000	$0
158	PROP 56 - ADVERSE CHILDHOOD EXPERIENCES SCREENINGS	$25,327,900	$15,639,990	$9,687,910	$0
159	DPH PHYSICIAN & NON-PHYS. COST	$14,471,000	$14,471,000	$0	$0
160	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$5,000,000	$5,000,000	$0
161	PROP 56 - NEMT SUPPLEMENTAL PAYMENTS	$6,458,880	$3,839,290	$2,619,590	$0
162	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$5,331,000	$5,331,000	$0	$0
163	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$4,000,000	$4,000,000	$0
164	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS	$7,409,490	$3,949,000	$3,460,490	$0
165	NDPH SUPPLEMENTAL PAYMENT	$4,299,000	$2,399,000	$1,900,000	$0
167	PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS	$1,774,660	$970,440	$804,220	$0
168	PROPOSITION 56 FUNDS TRANSFER	$0	$0	($921,343,000)	$921,343,000
169	PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$4,164,830	$3,640,570	$524,260	$0
170	PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS	$0	$0	$0	$0
171	IGT ADMIN. & PROCESSING FEE	$0	$0	($13,626,000)	$13,626,000
221	IGT PAYMENTS FOR HOSPITAL SERVICES	$0	($118,000)	$118,000	$0
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$12,929,485,730**	**$8,061,524,650**	**$353,278,580**	**$4,514,682,500**
	COVID-19				
245	COVID-19 UNINSURED ELIGIBILITY GROUP	$17,931,000	$8,385,000	$9,546,000	$0
246	COVID-19 ADDITIONAL IMPACTS	$233,424,000	$137,920,000	$95,504,000	$0
247	COVID-19 UTILIZATION CHANGE	($652,397,000)	($423,368,000)	($229,029,000)	$0
248	COVID-19 EMERGENCY FMAP - OTHER DEPTS	$257,717,000	$257,717,000	$0	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2019-20

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	COVID-19				
249	COVID-19 BEHAVIORAL HEALTH	$135,303,000	$121,979,000	$13,324,000	$0
250	COVID-19 EMERGENCY FMAP - DHCS	$0	$775,000,000	($775,000,000)	$0
251	COVID-19 CASELOAD IMPACT	$898,603,000	$579,652,000	$318,951,000	$0
	COVID-19 SUBTOTAL	**$890,581,000**	**$1,457,285,000**	**($566,704,000)**	**$0**
	OTHER				
178	CCI IHSS RECONCILIATION	$142,263,000	$142,263,000	$0	$0
180	QAF WITHHOLD TRANSFER	$98,871,000	$49,435,500	$49,435,500	$0
181	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$84,915,000	$84,915,000	$0	$0
182	ARRA HITECH - PROVIDER PAYMENTS	$49,029,000	$49,029,000	$0	$0
186	PAYMENT FOR REPROCESSED CLAIMS FOR FQHC/RHC	$7,300,000	$3,650,000	$3,650,000	$0
188	INFANT DEVELOPMENT PROGRAM	$40,739,000	$40,739,000	$0	$0
189	PROP 56 - PROVIDER ACES TRAININGS	$16,470,000	$8,235,000	$8,235,000	$0
190	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	$12,877,170	$6,438,580	$6,438,580	$0
191	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$14,316,000	$7,876,000	$6,440,000	$0
192	OVERTIME FOR WPCS PROVIDERS	$8,031,000	$4,015,500	$4,015,500	$0
193	INDIAN HEALTH SERVICES	$10,584,000	$7,038,500	$3,545,500	$0
194	WPCS WORKERS' COMPENSATION	$3,323,000	$1,661,500	$1,661,500	$0
198	FUNDING ADJUST.—OTLICP	$0	$171,066,160	($171,066,160)	$0
199	PROP 56 PHYSICIANS & DENTISTS LOAN REPAYMENT PROG	$1,700,000	$0	$0	$1,700,000
200	CMS DEFERRED CLAIMS	$0	($52,385,000)	$52,385,000	$0
201	INDIAN HEALTH SERVICES FUNDING SHIFT	$0	$13,000,000	($13,000,000)	$0
202	FUNDING ADJUST.—ACA OPT. EXPANSION	$0	$1,816,431,580	($1,816,431,580)	$0
203	CLPP FUND	$0	$0	($916,000)	$916,000
204	HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	$0	($391,441,000)	$391,441,000
205	AUDIT SETTLEMENTS	$0	($77,697,000)	$77,697,000	$0
206	IMD ANCILLARY SERVICES	$0	($9,685,000)	$9,685,000	$0
207	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	$0	($231,554,000)	$231,554,000
208	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER RENEWAL	($12,731,000)	($6,365,500)	($6,365,500)	$0
210	COUNTY SHARE OF OTLICP-CCS COSTS	($14,917,000)	$0	($14,917,000)	$0
211	ASSISTED LIVING WAIVER EXPANSION	($7,505,070)	($3,752,530)	($3,752,530)	$0
213	PURE PREMIUM FUND CLOSEOUT	($501,725,000)	($358,817,610)	($142,907,390)	$0
	OTHER SUBTOTAL	**($46,459,900)**	**$1,897,091,680**	**($2,569,162,590)**	**$625,611,000**
	GRAND TOTAL	**$29,460,400,730**	**$20,807,849,370**	**($2,882,389,650)**	**$11,534,941,010**

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

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
FISCAL YEAR 2019-20

SERVICE CATEGORY	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
PROFESSIONAL	$7,089,691,180	$4,347,046,460	$1,824,664,460	$917,980,260
PHYSICIANS	$684,258,780	$421,414,580	$230,159,460	$32,684,730
OTHER MEDICAL	$4,333,213,150	$2,632,458,030	$1,609,920,570	$90,834,560
CO. & COMM. OUTPATIENT	$2,072,219,250	$1,293,173,850	($15,415,570)	$794,460,970
PHARMACY	$1,731,588,810	$542,301,240	($193,685,410)	$1,382,972,980
HOSPITAL INPATIENT	$12,808,038,540	$8,023,195,360	$1,682,976,270	$3,101,866,900
COUNTY INPATIENT	$3,613,857,610	$2,261,036,890	$94,703,250	$1,258,117,460
COMMUNITY INPATIENT	$9,194,180,930	$5,762,158,470	$1,588,273,020	$1,843,749,440
LONG TERM CARE	$3,294,555,490	$1,782,218,210	$1,390,487,420	$121,849,860
NURSING FACILITIES	$2,845,956,590	$1,545,096,730	$1,206,463,920	$94,395,950
ICF-DD	$448,598,900	$237,121,480	$184,023,510	$27,453,910
OTHER SERVICES	$1,323,206,570	$797,080,250	$488,704,310	$37,422,000
MEDICAL TRANSPORTATION	$147,938,520	$91,450,390	$48,553,570	$7,934,570
OTHER SERVICES	$897,733,030	$556,078,610	$313,530,900	$28,123,520
HOME HEALTH	$277,535,010	$149,551,250	$126,619,840	$1,363,910
TOTAL FEE-FOR-SERVICE	**$26,247,080,590**	**$15,491,841,530**	**$5,193,147,060**	**$5,562,092,000**
MANAGED CARE	$47,387,790,130	$30,536,162,560	$11,932,858,800	$4,918,768,770
TWO PLAN MODEL	$28,636,076,380	$18,473,875,940	$7,203,175,860	$2,959,024,590
COUNTY ORGANIZED HEALTH SYSTEMS	$11,456,477,710	$7,520,578,870	$2,734,036,050	$1,201,862,790
GEOGRAPHIC MANAGED CARE	$4,805,265,270	$3,018,755,110	$1,242,345,150	$544,165,010
PHP & OTHER MANAG. CARE	$923,671,620	$500,412,030	$402,254,870	$21,004,720
REGIONAL MODEL	$1,566,299,160	$1,022,540,610	$351,046,880	$192,711,670
DENTAL	$1,156,799,580	$665,584,640	$457,112,180	$34,102,760
MENTAL HEALTH	$2,911,018,840	$2,643,677,250	$114,545,230	$152,796,360
AUDITS/ LAWSUITS	$37,712,990	($111,074,500)	$148,787,500	$0
EPSDT SCREENS	$0	$0	$0	$0
MEDICARE PAYMENTS	$5,635,187,830	$1,804,497,380	$3,830,690,450	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$66,041,760	$65,778,480	$263,280	$0
MISC. SERVICES	$11,249,443,780	$10,180,306,150	$62,465,520	$1,006,672,110
RECOVERIES	($430,248,780)	($241,392,550)	($188,856,230)	$0
DRUG MEDI-CAL	$392,958,050	$340,875,690	$52,082,360	$0
GRAND TOTAL MEDI-CAL	**$94,653,784,770**	**$61,376,256,620**	**$21,603,096,140**	**$11,674,432,000**

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
MAY 2020 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2019-20

SERVICE CATEGORY	2019-20 APPROPRIATION	MAY 2020 EST. FOR 2019-20	DOLLAR DIFFERENCE	% CHANGE
PROFESSIONAL	$8,070,465,680	$7,089,691,180	($980,774,500)	-12.15%
PHYSICIANS	$1,176,716,600	$684,258,780	($492,457,830)	-41.85%
OTHER MEDICAL	$4,516,790,530	$4,333,213,150	($183,577,380)	-4.06%
CO. & COMM. OUTPATIENT	$2,376,958,550	$2,072,219,250	($304,739,290)	-12.82%
PHARMACY	$1,832,953,570	$1,731,588,810	($101,364,760)	-5.53%
HOSPITAL INPATIENT	$13,294,460,620	$12,808,038,540	($486,422,080)	-3.66%
COUNTY INPATIENT	$3,547,419,060	$3,613,857,610	$66,438,550	1.87%
COMMUNITY INPATIENT	$9,747,041,560	$9,194,180,930	($552,860,630)	-5.67%
LONG TERM CARE	$3,211,457,510	$3,294,555,490	$83,097,980	2.59%
NURSING FACILITIES	$2,765,598,240	$2,845,956,590	$80,358,350	2.91%
ICF-DD	$445,859,270	$448,598,900	$2,739,630	0.61%
OTHER SERVICES	$1,388,397,020	$1,323,206,570	($65,190,450)	-4.70%
MEDICAL TRANSPORTATION	$194,309,660	$147,938,520	($46,371,130)	-23.86%
OTHER SERVICES	$910,150,410	$897,733,030	($12,417,370)	-1.36%
HOME HEALTH	$283,936,950	$277,535,010	($6,401,940)	-2.25%
TOTAL FEE-FOR-SERVICE	**$27,797,734,400**	**$26,247,080,590**	**($1,550,653,820)**	**-5.58%**
MANAGED CARE	$49,304,821,760	$47,387,790,130	($1,917,031,630)	-3.89%
TWO PLAN MODEL	$29,500,807,730	$28,636,076,380	($864,731,350)	-2.93%
COUNTY ORGANIZED HEALTH SYSTEMS	$12,038,810,590	$11,456,477,710	($582,332,880)	-4.84%
GEOGRAPHIC MANAGED CARE	$5,212,921,830	$4,805,265,270	($407,656,570)	-7.82%
PHP & OTHER MANAG. CARE	$902,859,100	$923,671,620	$20,812,520	2.31%
REGIONAL MODEL	$1,649,422,510	$1,566,299,160	($83,123,350)	-5.04%
DENTAL	$1,123,268,440	$1,156,799,580	$33,531,140	2.99%
MENTAL HEALTH	$3,161,494,980	$2,911,018,840	($250,476,140)	-7.92%
AUDITS/ LAWSUITS	$32,350,000	$37,712,990	$5,363,000	16.58%
EPSDT SCREENS	$121,090	$0	($121,090)	-100.00%
MEDICARE PAYMENTS	$5,687,264,000	$5,635,187,830	($52,076,170)	-0.92%
STATE HOSP./DEVELOPMENTAL CNTRS.	$65,357,490	$66,041,760	$684,270	1.05%
MISC. SERVICES	$10,225,590,680	$11,249,443,780	$1,023,853,110	10.01%
RECOVERIES	($368,304,000)	($430,248,780)	($61,944,770)	16.82%
DRUG MEDI-CAL	$402,230,760	$392,958,050	($9,272,710)	-2.31%
GRAND TOTAL MEDI-CAL	**$97,431,929,580**	**$94,653,784,770**	**($2,778,144,810)**	**-2.85%**
GENERAL FUNDS	**$22,083,816,090**	**$21,603,096,140**	**($480,719,950)**	**-2.18%**
OTHER STATE FUNDS	**$13,172,050,300**	**$11,674,432,000**	**($1,497,618,290)**	**-11.37%**

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
MAY 2020 ESTIMATE COMPARED TO NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2019-20

SERVICE CATEGORY	NOV. 2019 EST. FOR 2019-20	MAY 2020 EST. FOR 2019-20	DOLLAR DIFFERENCE	% CHANGE
PROFESSIONAL	$7,712,083,560	$7,089,691,180	($622,392,380)	-8.07%
PHYSICIANS	$732,794,210	$684,258,780	($48,535,430)	-6.62%
OTHER MEDICAL	$4,458,404,870	$4,333,213,150	($125,191,710)	-2.81%
CO. & COMM. OUTPATIENT	$2,520,884,490	$2,072,219,250	($448,665,230)	-17.80%
PHARMACY	$1,959,780,260	$1,731,588,810	($228,191,450)	-11.64%
HOSPITAL INPATIENT	$13,026,136,860	$12,808,038,540	($218,098,330)	-1.67%
COUNTY INPATIENT	$3,679,037,290	$3,613,857,610	($65,179,680)	-1.77%
COMMUNITY INPATIENT	$9,347,099,580	$9,194,180,930	($152,918,650)	-1.64%
LONG TERM CARE	$3,230,497,510	$3,294,555,490	$64,057,980	1.98%
NURSING FACILITIES	$2,782,666,170	$2,845,956,590	$63,290,420	2.27%
ICF-DD	$447,831,350	$448,598,900	$767,550	0.17%
OTHER SERVICES	$1,362,411,610	$1,323,206,570	($39,205,050)	-2.88%
MEDICAL TRANSPORTATION	$186,732,030	$147,938,520	($38,793,510)	-20.77%
OTHER SERVICES	$885,462,330	$897,733,030	$12,270,700	1.39%
HOME HEALTH	$290,217,250	$277,535,010	($12,682,240)	-4.37%
TOTAL FEE-FOR-SERVICE	**$27,290,909,810**	**$26,247,080,590**	**($1,043,829,230)**	**-3.82%**
MANAGED CARE	$47,852,413,420	$47,387,790,130	($464,623,290)	-0.97%
TWO PLAN MODEL	$28,851,748,260	$28,636,076,380	($215,671,880)	-0.75%
COUNTY ORGANIZED HEALTH SYSTEMS	$11,635,228,530	$11,456,477,710	($178,750,820)	-1.54%
GEOGRAPHIC MANAGED CARE	$4,905,695,540	$4,805,265,270	($100,430,280)	-2.05%
PHP & OTHER MANAG. CARE	$879,119,420	$923,671,620	$44,552,200	5.07%
REGIONAL MODEL	$1,580,621,670	$1,566,299,160	($14,322,510)	-0.91%
DENTAL	$1,159,457,500	$1,156,799,580	($2,657,930)	-0.23%
MENTAL HEALTH	$2,932,056,500	$2,911,018,840	($21,037,660)	-0.72%
AUDITS/ LAWSUITS	$20,551,000	$37,712,990	$17,161,990	83.51%
EPSDT SCREENS	$240,000	$0	($240,000)	-100.00%
MEDICARE PAYMENTS	$5,620,329,000	$5,635,187,830	$14,858,830	0.26%
STATE HOSP./DEVELOPMENTAL CNTRS.	$65,300,000	$66,041,760	$741,760	1.14%
MISC. SERVICES	$11,126,571,000	$11,249,443,780	$122,872,780	1.10%
RECOVERIES	($455,650,000)	($430,248,780)	$25,401,220	-5.57%
DRUG MEDI-CAL	$415,360,640	$392,958,050	($22,402,590)	-5.39%
GRAND TOTAL MEDI-CAL	**$96,027,538,870**	**$94,653,784,770**	**($1,373,754,100)**	**-1.43%**
GENERAL FUNDS	**$21,935,446,670**	**$21,603,096,140**	**($332,350,530)**	**-1.52%**
OTHER STATE FUNDS	**$12,821,647,400**	**$11,674,432,000**	**($1,147,215,400)**	**-8.95%**

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2019-20

NOV.	MAY		2019-20 APPROPRIATION		NOV. 2019 EST. FOR 2019-20		MAY 2020 EST. FOR 2019-20		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
NO.	NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		ELIGIBILITY										
1	1	UNDOCUMENTED YOUNG ADULTS FULL SCOPE EXPANSION	$95,466,000	$72,150,000	$107,647,000	$76,296,000	$109,842,000	$77,398,000	$14,376,000	$5,248,000	$2,195,000	$1,102,000
2	2	MEDI-CAL STATE INMATE PROGRAMS	$91,878,000	$0	$85,413,000	$0	$62,206,000	$0	($29,672,000)	$0	($23,207,000)	$0
3	3	BREAST AND CERVICAL CANCER TREATMENT	$73,371,000	$48,425,900	$66,276,000	$41,524,900	$65,373,000	$41,133,350	($7,998,000)	($7,292,550)	($903,000)	($391,550)
8	8	MEDI-CAL COUNTY INMATE PROGRAMS	$148,134,000	$1,451,670	$45,029,000	$1,492,940	$45,042,000	$2,201,580	($103,092,000)	$749,910	$13,000	$708,640
10	10	CS3 PROXY ADJUSTMENT	$0	$0	$0	($305,367,640)	$0	($316,999,420)	$0	($316,999,420)	$0	($11,631,780)
11	11	MEDI-CAL COUNTY INMATE REIMBURSEMENT	$0	($1,398,000)	$0	($1,420,000)	$0	($1,952,000)	$0	($554,000)	$0	($532,000)
12	12	CDCR RETRO REPAYMENT	$0	$0	$0	$1,466,000	$0	$1,466,000	$0	$1,466,000	$0	$0
13	13	NON-OTLICP CHIP	$0	($314,738,980)	$0	($168,301,660)	$0	($170,168,730)	$0	$144,570,240	$0	($1,867,080)
14	14	NON-EMERGENCY FUNDING ADJUSTMENT	$0	$918,066,000	$0	$980,737,000	$0	$987,242,000	$0	$69,176,000	$0	$6,505,000
15	15	SCHIP FUNDING FOR PRENATAL CARE	$0	($86,404,450)	$0	($90,304,230)	$0	($90,190,810)	$0	($3,786,360)	$0	$113,420
16	16	CCHIP DELIVERY SYSTEM	($2,944,000)	($630,320)	($1,838,000)	($431,930)	($1,921,000)	($451,440)	$1,023,000	$178,880	($83,000)	($19,500)
17	17	MEDICARE OPTIONAL EXPANSION ADJUSTMENT	$0	$0	($13,370,000)	$86,030,650	($42,464,000)	$71,483,650	($42,464,000)	$71,483,650	($29,094,000)	($14,547,000)
18	18	CHIP PREMIUMS	($62,567,000)	($12,904,420)	($62,607,000)	($12,912,660)	($62,286,000)	($12,846,540)	$281,000	$57,870	$321,000	$66,120
19	19	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	($270,996,000)	($54,199,000)	($270,996,000)	($56,635,000)	($270,996,000)	($51,763,000)	$0	$2,436,000	$0	$4,872,000
--	232	DISABLED ADULT CHILDREN PROGRAM CLEANUP	$0	$0	$0	$0	$2,892,000	$5,870,000	$2,892,000	$5,870,000	$2,892,000	$5,870,000
--	--	FPL INCREASE FOR AGED AND DISABLED PERSONS	$62,904,000	$31,459,000	$0	$0	$0	$0	($62,904,000)	($31,459,000)	$0	$0
--	--	HEALTH ENROLLMENT NAVIGATORS	$29,842,000	$14,921,000	$0	$0	$0	$0	($29,842,000)	($14,921,000)	$0	$0
		ELIGIBILITY SUBTOTAL	**$165,088,000**	**$616,198,420**	**($44,446,000)**	**$552,174,380**	**($92,312,000)**	**$542,422,640**	**($257,400,000)**	**($73,775,770)**	**($47,866,000)**	**($9,751,730)**
		AFFORDABLE CARE ACT										
20	20	COMMUNITY FIRST CHOICE OPTION	$3,818,990,000	$0	$3,981,120,000	$0	$3,718,574,000	$0	($100,416,000)	$0	($262,546,000)	$0
21	21	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	$11,678,000	$0	$24,875,000	$0	$28,134,000	$0	$16,456,000	$0	$3,259,000	$0
23	23	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	$0	($44,958,640)	$0	($42,377,180)	$0	($44,894,710)	$0	$63,930	$0	($2,517,530)
24	24	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	($2,278,000)	$0	($3,238,000)	$0	($3,225,000)	$0	($947,000)	$0	$13,000
25	25	ACA MAGI SAVINGS	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2019-20

NOV.	MAY		2019-20 APPROPRIATION		NOV. 2019 EST. FOR 2019-20		MAY 2020 EST. FOR 2019-20		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
NO.	NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		AFFORDABLE CARE ACT										
26	26	PAYMENTS TO PRIMARY CARE PHYSICIANS	($2,144,000)	$0	($111,000)	$0	($120,000)	$0	$2,024,000	$0	($9,000)	$0
27	27	ACA OPTIONAL EXPANSION MLR RISK CORRIDOR	($100,000,000)	($2,500,000)	($328,105,000)	($8,202,600)	($381,343,000)	($9,533,600)	($281,343,000)	($7,033,600)	($53,238,000)	($1,331,000)
28	--	ACA DSH REDUCTION	($602,622,000)	($76,239,000)	($602,924,000)	($76,390,000)	$0	$0	$602,622,000	$76,239,000	$602,924,000	$76,390,000
--	--	HEALTH INSURER FEE	$11,739,000	$3,933,160	$0	$0	$0	$0	($11,739,000)	($3,933,160)	$0	$0
		AFFORDABLE CARE ACT SUBTOTAL	**$3,137,641,000**	**($122,042,480)**	**$3,074,855,000**	**($130,207,780)**	**$3,365,245,000**	**($57,653,310)**	**$227,604,000**	**$64,389,170**	**$290,390,000**	**$72,554,470**
		BENEFITS										
29	29	BEHAVIORAL HEALTH TREATMENT	$698,117,000	$321,693,080	$920,334,000	$418,101,360	$863,002,000	$392,228,710	$164,885,000	$70,535,640	($57,332,000)	($25,872,640)
30	30	FAMILY PACT PROGRAM	$402,048,000	$94,769,800	$366,811,000	$86,664,100	$371,873,000	$88,561,700	($30,175,000)	($6,208,100)	$5,062,000	$1,897,600
31	31	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$298,042,000	$0	$351,584,000	$0	$356,323,000	$0	$58,281,000	$0	$4,739,000	$0
32	32	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$135,275,000	$0	$117,711,000	$0	$130,696,000	$0	($4,579,000)	$0	$12,985,000	$0
34	34	RESTORATION OF ADULT OPTICIAN & OPTICAL LAB SVCS	$33,360,890	$11,283,130	$30,076,360	$10,417,060	$12,134,160	$4,299,350	($21,226,730)	($6,983,780)	($17,942,200)	($6,117,710)
35	35	MSSP SUPPLEMENTAL PAYMENTS	$29,600,000	$0	$4,933,000	($4,933,000)	$4,933,000	($4,933,000)	($24,667,000)	($4,933,000)	$0	$0
36	36	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$6,260,000	$1,526,000	$29,189,000	$6,629,000	$28,189,000	$6,379,000	$21,929,000	$4,853,000	($1,000,000)	($250,000)
37	37	OPTIONAL BENEFITS RESTORATION	$45,058,000	$6,117,000	$24,414,220	$8,384,780	$6,805,680	$2,411,300	($38,252,320)	($3,705,700)	($17,608,540)	($5,973,470)
38	38	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	$20,125,000	($9,826,500)	$20,232,000	($9,074,000)	$20,232,000	($9,074,000)	$107,000	$752,500	$0	$0
39	39	CCS DEMONSTRATION PROJECT	$14,354,000	$6,571,300	$11,115,000	$5,077,710	$11,122,000	$5,074,480	($3,232,000)	($1,496,810)	$7,000	($3,220)
40	40	MEDI-CAL NONMEDICAL TRANSPORTATION	$8,653,480	$3,325,770	$9,030,200	$3,451,460	$9,030,200	$3,439,010	$376,720	$113,240	$0	($12,450)
41	41	MEDICALLY TAILORED MEALS PILOT PROGRAM	$2,500,000	$2,500,000	$2,500,000	$2,500,000	$2,500,000	$2,500,000	$0	$0	$0	$0
42	42	YOUTH REGIONAL TREATMENT CENTERS	$2,064,000	$18,000	$2,061,000	$16,000	$2,061,000	$16,000	($3,000)	($2,000)	$0	$0
43	43	PEDIATRIC PALLIATIVE CARE WAIVER	$1,339,000	$1,339,000	$1,258,000	$1,258,000	$1,033,000	$1,033,000	($306,000)	($306,000)	($225,000)	($225,000)
44	44	FREE CLINIC OF SIMI VALLEY	$700,000	$700,000	$700,000	$700,000	$700,000	$700,000	$0	$0	$0	$0
45	45	CCT FUND TRANSFER TO CDSS	$157,000	$0	$175,000	$0	$175,000	$0	$18,000	$0	$0	$0
47	47	ASTHMA MITIGATION PROJECT	$15,000,000	$15,000,000	$15,000,000	$15,000,000	$15,000,000	$15,000,000	$0	$0	$0	$0
50	50	WHOLE CHILD MODEL IMPLEMENTATION	($84,610,000)	($39,300,430)	($31,324,000)	($14,459,610)	($7,323,000)	($3,372,260)	$77,287,000	$35,928,160	$24,001,000	$11,087,340
33	--	LEA EXPANSION	$121,969,000	$0	$80,468,000	$0	$0	$0	($121,969,000)	$0	($80,468,000)	$0

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2019-20

NOV.	MAY		2019-20 APPROPRIATION		NOV. 2019 EST. FOR 2019-20		MAY 2020 EST. FOR 2019-20		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
NO.	NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		BENEFITS										
46	--	DIABETES PREVENTION PROGRAM	$518,240	$183,030	$125,580	$44,570	$0	$0	($518,240)	($183,030)	($125,580)	($44,570)
49	--	MEDICAL INTERPRETERS PILOT PROJECT	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$0	$0	($5,000,000)	($5,000,000)	($5,000,000)	($5,000,000)
--	--	BEHAVIORAL HEALTH TREATMENT - BIS DDS TRANSITION	$152,858,000	$70,437,860	$0	$0	$0	$0	($152,858,000)	($70,437,860)	$0	$0
		BENEFITS SUBTOTAL	**$1,908,388,610**	**$491,337,030**	**$1,961,393,350**	**$534,777,430**	**$1,828,486,040**	**$504,263,290**	**($79,902,570)**	**$12,926,270**	**($132,907,310)**	**($30,514,140)**
		PHARMACY										
53	53	MEDI-CAL DRUG REBATE FUND	$0	($1,364,798,000)	$0	($1,355,795,000)	$0	($1,364,798,000)	$0	$0	$0	($9,003,000)
56	56	BCCTP DRUG REBATES	($6,793,000)	$0	($5,781,000)	$0	($4,464,000)	$0	$2,329,000	$0	$1,317,000	$0
57	57	FAMILY PACT DRUG REBATES	($17,857,000)	$0	($11,066,000)	$0	($22,612,000)	$0	($4,755,000)	$0	($11,546,000)	$0
58	58	LITIGATION SETTLEMENTS	$0	$0	($14,061,000)	($14,061,000)	($302,000)	($302,000)	($302,000)	($302,000)	$13,759,000	$13,759,000
59	59	MEDICAL SUPPLY REBATES	($27,408,000)	($13,704,000)	($20,024,000)	($10,012,000)	($20,024,000)	($10,012,000)	$7,384,000	$3,692,000	$0	$0
60	60	STATE SUPPLEMENTAL DRUG REBATES	($160,679,000)	$0	($130,829,000)	$0	($101,891,000)	$0	$58,788,000	$0	$28,938,000	$0
62	62	FEDERAL DRUG REBATES	($1,831,044,000)	$0	($1,630,906,000)	$0	($1,554,560,000)	$0	$276,484,000	$0	$76,346,000	$0
51	--	PHARMACIST-DELIVERED MEDI-CAL SERVICES	$911,320	$346,760	$911,320	$336,900	$0	$0	($911,320)	($346,760)	($911,320)	($336,900)
--	--	PHARMACY REIMBURSEMENT & DISPENSING FEE	($187,955,000)	($68,221,700)	$0	$0	$0	$0	$187,955,000	$68,221,700	$0	$0
--	--	HEPATITIS C REVISED CLINICAL GUIDELINES	$70,387,000	$22,763,800	$0	$0	$0	$0	($70,387,000)	($22,763,800)	$0	$0
		PHARMACY SUBTOTAL	**($2,160,437,680)**	**($1,423,613,130)**	**($1,811,755,680)**	**($1,379,531,100)**	**($1,703,853,000)**	**($1,375,112,000)**	**$456,584,680**	**$48,501,130**	**$107,902,680**	**$4,419,100**
		DRUG MEDI-CAL										
63	63	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	$301,371,000	$46,642,580	$378,062,000	$54,101,540	$341,222,000	$47,646,880	$39,851,000	$1,004,300	($36,840,000)	($6,454,670)
70	70	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	$0	$0	($137,000)	$0	($162,000)	$0	($162,000)	$0	($25,000)	$0
67	--	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	$1,311,980	$68,450	$1,153,500	$160,050	$0	$0	($1,311,980)	($68,450)	($1,153,500)	($160,050)
		DRUG MEDI-CAL SUBTOTAL	**$302,682,980**	**$46,711,030**	**$379,078,500**	**$54,261,590**	**$341,060,000**	**$47,646,880**	**$38,377,020**	**$935,850**	**($38,018,500)**	**($6,614,720)**
		MENTAL HEALTH										
73	73	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT	$114,091,000	$0	$137,312,000	$0	$125,573,000	$0	$11,482,000	$0	($11,739,000)	$0
74	74	MHP COSTS FOR CONTINUUM OF CARE REFORM	$21,693,000	$11,660,500	$22,415,000	$12,044,000	$24,184,000	$12,973,500	$2,491,000	$1,313,000	$1,769,000	$929,500

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2019-20

NOV.	MAY		2019-20 APPROPRIATION		NOV. 2019 EST. FOR 2019-20		MAY 2020 EST. FOR 2019-20		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
NO.	NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		MENTAL HEALTH										
75	75	PATHWAYS TO WELL-BEING	$20,452,000	$0	$448,000	$0	$448,000	$0	($20,004,000)	$0	$0	$0
76	76	LATE CLAIMS FOR SMHS	$207,000	$207,000	$1,033,000	$1,033,000	$535,000	$535,000	$328,000	$328,000	($498,000)	($498,000)
77	77	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	$0	($200,000)	$0	($200,000)	$0	($200,000)	$0	$0	$0	$0
79	79	CHART REVIEW	($1,494,000)	$0	($1,111,000)	$0	($1,107,000)	$0	$387,000	$0	$4,000	$0
80	80	INTERIM AND FINAL COST SETTLEMENTS - SMHS	$15,616,000	$6,183,000	($155,153,000)	$5,139,000	($54,623,000)	$4,559,000	($70,239,000)	($1,624,000)	$100,530,000	($580,000)
		MENTAL HEALTH SUBTOTAL	**$170,565,000**	**$17,850,500**	**$4,944,000**	**$18,016,000**	**$95,010,000**	**$17,867,500**	**($75,555,000)**	**$17,000**	**$90,066,000**	**($148,500)**
		WAIVER--MH/UCD & BTR										
81	81	GLOBAL PAYMENT PROGRAM	$2,439,899,000	$0	$2,582,899,000	$0	$2,477,024,000	$0	$37,125,000	$0	($105,875,000)	$0
82	82	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL	$1,332,000,000	$0	$1,720,783,000	$0	$1,721,309,000	$0	$389,309,000	$0	$526,000	$0
83	83	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS	$970,632,000	$0	$932,646,000	$0	$936,711,000	$0	($33,921,000)	$0	$4,065,000	$0
84	84	BTR - LIHP - MCE	$187,741,000	$0	$177,789,000	$0	$189,824,000	$0	$2,083,000	$0	$12,035,000	$0
85	85	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	$188,788,000	$94,394,000	$178,663,000	$89,331,500	$196,179,000	$98,089,500	$7,391,000	$3,695,500	$17,516,000	$8,758,000
86	86	MH/UCD—STABILIZATION FUNDING	$0	$0	$110,930,000	$110,930,000	$117,101,000	$117,101,000	$117,101,000	$117,101,000	$6,171,000	$6,171,000
87	87	WHOLE PERSON CARE HOUSING SERVICES	$100,000,000	$100,000,000	$100,000,000	$100,000,000	$100,000,000	$100,000,000	$0	$0	$0	$0
88	88	MH/UCD—SAFETY NET CARE POOL	$0	$0	$10,832,000	$0	$73,784,000	$0	$73,784,000	$0	$62,952,000	$0
89	89	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$393,000	$0	$503,000	$0	$531,000	$0	$138,000	$0	$28,000	$0
90	90	MH/UCD—HEALTH CARE COVERAGE INITIATIVE	$0	$0	($6,428,000)	$0	$1,003,000	$0	$1,003,000	$0	$7,431,000	$0
91	91	BTR - LOW INCOME HEALTH PROGRAM - HCCI	($109,771,000)	$0	($102,280,000)	$0	($51,369,000)	$0	$58,402,000	$0	$50,911,000	$0
		WAIVER--MH/UCD & BTR SUBTOTAL	**$5,109,682,000**	**$194,394,000**	**$5,706,337,000**	**$300,261,500**	**$5,762,097,000**	**$315,190,500**	**$652,415,000**	**$120,796,500**	**$55,760,000**	**$14,929,000**
		MANAGED CARE										
95	95	CCI-MANAGED CARE PAYMENTS	$8,353,591,000	$4,176,795,500	$8,096,381,000	$4,048,190,500	$8,071,755,000	$4,035,877,500	($281,836,000)	($140,918,000)	($24,626,000)	($12,313,000)
96	96	MANAGED CARE HEALTH CARE FINANCING PROGRAM	$1,821,706,000	$585,232,940	$1,821,706,000	$585,232,940	$1,821,706,000	$585,232,940	$0	$0	$0	$0
97	97	MANAGED CARE PUBLIC HOSPITAL EPP	$1,476,865,000	$452,092,670	$1,476,865,000	$336,648,870	$1,476,865,000	$337,837,010	$0	($114,255,660)	$0	$1,188,140
100	100	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	$640,000,000	$195,914,480	$640,000,000	$144,675,120	$640,000,000	$144,674,650	$0	($51,239,830)	$0	($470)

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2019-20

NOV.	MAY		2019-20 APPROPRIATION		NOV. 2019 EST. FOR 2019-20		MAY 2020 EST. FOR 2019-20		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
NO.	NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		MANAGED CARE										
101	101	MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES	$187,902,000	$58,690,230	$187,991,000	$58,472,830	$187,991,000	$58,472,830	$89,000	($217,400)	$0	$0
103	103	RETRO MC RATE ADJUSTMENTS	$257,059,000	$123,808,240	$97,485,000	($14,155,260)	$148,805,000	$14,412,540	($108,254,000)	($109,395,700)	$51,320,000	$28,567,800
104	104	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS	$87,383,000	$0	$95,509,000	$0	$94,637,000	$0	$7,254,000	$0	($872,000)	$0
107	107	CCI-QUALITY WITHHOLD REPAYMENTS	$16,822,000	$8,411,000	$8,260,000	$4,130,000	$8,260,000	$4,130,000	($8,562,000)	($4,281,000)	$0	$0
108	108	GENERAL FUND REIMBURSEMENTS FROM DPHS	$4,981,000	$4,981,000	$4,981,000	$4,981,000	$4,981,000	$4,981,000	$0	$0	$0	$0
111	111	MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.	$0	($234,282,000)	$0	($58,473,000)	$0	($58,473,000)	$0	$175,809,000	$0	$0
112	112	MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	($582,039,000)	$0	($582,257,000)	$0	($582,257,000)	$0	($218,000)	$0	$0
113	113	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	$0	($1,410,500,000)	$0	($1,179,970,000)	$0	($1,177,522,000)	$0	$232,978,000	$0	$2,448,000
115	115	RECOUPMENT OF UNALLOWED CAPITATION PAYMENTS	$0	$0	($71,000,000)	($17,600,000)	($68,245,000)	($24,478,640)	($68,245,000)	($24,478,640)	$2,755,000	($6,878,640)
116	116	MANAGED CARE DRUG REBATES	($1,519,496,000)	$0	($1,413,340,000)	$0	($1,667,150,000)	$0	($147,654,000)	$0	($253,810,000)	$0
114	--	COORDINATED CARE INITIATIVE RISK MITIGATION	($70,000,000)	($35,000,000)	($45,723,000)	($22,861,500)	$0	$0	$70,000,000	$35,000,000	$45,723,000	$22,861,500
--	--	PALLIATIVE CARE SERVICES IMPLEMENTATION	$100,000	$50,000	$0	$0	$0	$0	($100,000)	($50,000)	$0	$0
--	--	CAPITATED RATE ADJUSTMENT FOR FY 2019-20	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
		MANAGED CARE SUBTOTAL	**$11,256,913,000**	**$3,344,155,060**	**$10,899,115,000**	**$3,307,014,500**	**$10,719,605,000**	**$3,342,887,840**	**($537,308,000)**	**($1,267,220)**	**($179,510,000)**	**$35,873,340**
		PROVIDER RATES										
117	117	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	$238,351,000	($7,613,000)	$215,199,000	($15,258,000)	$242,858,000	($15,076,000)	$4,507,000	($7,463,000)	$27,659,000	$182,000
118	118	RATE INCREASE FOR FQHCS/RHCS/CBRCS	$216,038,220	$82,277,460	$258,811,860	$98,534,610	$258,811,860	$98,534,610	$42,773,640	$16,257,140	$0	$0
119	119	AB 1629 ANNUAL RATE ADJUSTMENTS	$188,115,790	$94,057,890	$165,060,720	$82,530,360	$185,265,060	$92,632,530	($2,850,730)	($1,425,370)	$20,204,340	$10,102,170
120	120	FQHC/RHC/CBRC RECONCILIATION PROCESS	$131,378,000	$50,034,370	$80,826,000	$30,771,720	$92,591,000	$35,251,520	($38,787,000)	($14,782,850)	$11,765,000	$4,479,800
121	121	PROP 56 - HOME HEALTH RATE INCREASE	$64,834,000	$31,210,960	$97,115,000	$46,753,100	$113,501,000	$54,378,440	$48,667,000	$23,167,480	$16,386,000	$7,625,350
122	122	DPH INTERIM RATE GROWTH	$71,026,380	$35,513,190	$32,588,010	$16,294,000	$2,648,890	$1,324,440	($68,377,490)	($34,188,750)	($29,939,120)	($14,969,560)
123	123	LTC RATE ADJUSTMENT	$38,438,350	$19,219,170	$22,519,360	$11,259,680	$29,709,030	$14,854,510	($8,729,320)	($4,364,660)	$7,189,670	$3,594,830
124	124	DPH INTERIM & FINAL RECONS	($7,237,000)	$0	$16,612,000	$0	$220,014,000	$0	$227,251,000	$0	$203,402,000	$0
125	125	PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE	$14,246,000	$6,880,060	$14,266,000	$6,873,240	$15,190,000	$7,313,780	$944,000	$433,720	$924,000	$440,540

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2019-20

NOV.	MAY		2019-20 APPROPRIATION		NOV. 2019 EST. FOR 2019-20		MAY 2020 EST. FOR 2019-20		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
NO.	NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		PROVIDER RATES										
127	127	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	$13,000,000	($1,968,000)	$10,000,000	($1,586,000)	$10,992,000	($1,803,000)	($2,008,000)	$165,000	$992,000	($217,000)
128	128	HOSPICE RATE INCREASES	$15,294,930	$7,647,460	$3,081,050	$1,540,530	$2,989,820	$1,494,910	($12,305,110)	($6,152,550)	($91,230)	($45,620)
129	129	DPH INTERIM RATE	$0	($388,058,550)	$0	($373,371,840)	$0	($362,258,460)	$0	$25,800,090	$0	$11,113,380
130	130	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	($395,307,000)	$0	($509,884,000)	$0	($508,693,000)	$0	($113,386,000)	$0	$1,191,000
131	131	AB 97-RELATED ADJUSTMENT	$0	$0	$0	$40,520,000	$0	$40,508,000	$0	$40,508,000	$0	($12,000)
132	132	DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT	$0	$0	($1,089,290)	($497,020)	($350,300)	($161,160)	($350,300)	($161,160)	$738,980	$335,850
133	133	LABORATORY RATE METHODOLOGY CHANGE	($5,620,000)	($2,810,000)	($6,273,230)	($3,136,620)	($8,568,170)	($4,284,080)	($2,948,170)	($1,474,080)	($2,294,930)	($1,147,470)
134	134	10% PROVIDER PAYMENT REDUCTION	($194,418,000)	($97,209,000)	($171,841,000)	($85,920,500)	($171,841,000)	($85,920,500)	$22,577,000	$11,288,500	$0	$0
135	135	DENTAL RETROACTIVE RATE CHANGES	$0	$0	($19,548,000)	($7,453,200)	($11,368,000)	($4,335,140)	($11,368,000)	($4,335,140)	$8,180,000	$3,118,060
136	136	REDUCTION TO RADIOLOGY RATES	($48,505,450)	($24,252,720)	($59,312,330)	($29,656,160)	($54,303,000)	($27,151,500)	($5,797,550)	($2,898,780)	$5,009,330	$2,504,660
126	--	ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE	$11,724,680	($3,904,080)	$8,385,000	($4,372,850)	$0	$0	($11,724,680)	$3,904,080	($8,385,000)	$4,372,850
		PROVIDER RATES SUBTOTAL	**$746,666,900**	**($594,281,770)**	**$666,400,150**	**($696,058,950)**	**$928,140,180**	**($663,390,100)**	**$181,473,280**	**($69,108,330)**	**$261,740,030**	**$32,668,860**
		SUPPLEMENTAL PMNTS.										
137	137	HOSPITAL QAF - FFS PAYMENTS	$4,540,342,000	$0	$4,556,197,000	$0	$4,045,622,000	$0	($494,720,000)	$0	($510,575,000)	$0
138	138	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	$2,100,000,000	$0	$2,100,000,000	$0	$2,100,000,000	$0	$0	$0	$0	$0
139	139	HOSPITAL QAF - MANAGED CARE PAYMENTS	$1,897,400,000	$0	$1,897,400,000	$0	$1,897,400,000	$0	$0	$0	$0	$0
140	140	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	$1,271,328,000	$0	$1,117,136,000	$0	$545,042,000	$0	($726,286,000)	$0	($572,094,000)	$0
141	141	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	$1,387,168,980	$454,183,520	$1,194,089,000	$393,135,260	$1,194,089,000	$404,388,880	($193,079,980)	($49,794,640)	$0	$11,253,620
142	142	PRIVATE HOSPITAL DSH REPLACEMENT	$595,111,000	$297,555,500	$596,198,000	$298,099,000	$592,134,000	$296,067,000	($2,977,000)	($1,488,500)	($4,064,000)	($2,032,000)
143	143	PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES	$518,325,000	$195,710,160	$559,032,000	$210,868,290	$564,521,000	$213,513,640	$46,196,000	$17,803,480	$5,489,000	$2,645,350
144	144	PROP 56 - MEDI-CAL FAMILY PLANNING	$500,000,000	$50,000,000	$375,519,000	$37,551,900	$363,906,000	$36,390,600	($136,094,000)	($13,609,400)	($11,613,000)	($1,161,300)
145	145	DSH PAYMENT	$424,326,000	$22,492,000	$431,784,000	$22,696,000	$318,440,000	$24,184,000	($105,886,000)	$1,692,000	($113,344,000)	$1,488,000
146	146	PROP 56 - VALUE-BASED PAYMENT PROGRAM	$544,209,000	$250,000,000	$395,820,000	$181,832,870	$310,065,000	$102,975,940	($234,144,000)	($147,024,060)	($85,755,000)	($78,856,940)

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2019-20

NOV.	MAY		2019-20 APPROPRIATION		NOV. 2019 EST. FOR 2019-20		MAY 2020 EST. FOR 2019-20		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
NO.	NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		SUPPLEMENTAL PMNTS.										
147	147	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	$312,095,000	$118,400,000	$312,049,000	$120,094,000	$313,011,000	$120,094,000	$916,000	$1,694,000	$962,000	$0
148	148	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$240,916,000	$0	$241,650,000	$0	$247,723,000	$0	$6,807,000	$0	$6,073,000	$0
149	149	CAPITAL PROJECT DEBT REIMBURSEMENT	$126,348,000	$37,754,000	$140,977,000	$43,465,000	$111,082,000	$28,352,000	($15,266,000)	($9,402,000)	($29,895,000)	($15,113,000)
150	150	FFP FOR LOCAL TRAUMA CENTERS	$139,036,000	$0	$131,605,000	$9,652,000	$131,604,000	$9,652,000	($7,432,000)	$9,652,000	($1,000)	$0
151	151	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	$118,918,000	$0	$118,327,000	$0	$118,278,000	($270,750)	($640,000)	($270,750)	($49,000)	($270,750)
152	152	NDPH IGT SUPPLEMENTAL PAYMENTS	$172,387,000	($13,235,000)	$94,594,000	($2,211,000)	$94,555,000	($2,215,000)	($77,832,000)	$11,020,000	($39,000)	($4,000)
153	153	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	$108,213,000	$0	$93,911,000	$0	$82,304,000	$0	($25,909,000)	$0	($11,607,000)	$0
154	154	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	$88,000,000	$49,870,000	$88,000,000	$46,979,000	$88,000,000	$46,979,000	$0	($2,891,000)	$0	$0
155	155	GEMT SUPPLEMENTAL PAYMENT PROGRAM	$43,257,000	$0	$39,804,000	$0	$3,272,000	$0	($39,985,000)	$0	($36,532,000)	$0
156	156	PROP 56 - DEVELOPMENTAL SCREENINGS	$0	$0	$35,029,450	$16,328,800	$34,811,090	$14,755,250	$34,811,090	$14,755,250	($218,360)	($1,573,550)
157	157	PROP 56 - CBAS SUPPLEMENTAL PAYMENTS	$13,700,000	$13,700,000	$30,992,000	$15,496,000	$30,992,000	$15,496,000	$17,292,000	$1,796,000	$0	$0
158	158	PROP 56 - ADVERSE CHILDHOOD EXPERIENCES SCREENINGS	$94,706,740	$36,669,200	$25,318,050	$8,642,690	$25,485,910	$9,748,350	($69,220,830)	($26,920,850)	$167,870	$1,105,670
159	159	DPH PHYSICIAN & NON-PHYS. COST	$216,187,000	$0	$14,471,000	$0	$14,471,000	$0	($201,716,000)	$0	$0	$0
160	160	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$5,000,000	$10,000,000	$5,000,000	$10,000,000	$5,000,000	$0	$0	$0	$0
161	161	PROP 56 - NEMT SUPPLEMENTAL PAYMENTS	$5,600,000	$5,600,000	$9,146,740	$3,714,090	$6,458,880	$2,619,590	$858,880	($2,980,410)	($2,687,870)	($1,094,500)
162	162	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$7,278,000	$0	$9,079,000	$0	$5,331,000	$0	($1,947,000)	$0	($3,748,000)	$0
163	163	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$4,000,000	$8,000,000	$4,000,000	$8,000,000	$4,000,000	$0	$0	$0	$0
164	164	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS	$27,819,000	$13,048,060	$32,015,000	$14,986,360	$32,713,000	$15,278,100	$4,894,000	$2,230,040	$698,000	$291,740
165	165	NDPH SUPPLEMENTAL PAYMENT	$4,263,000	$1,900,000	$4,299,000	$1,900,000	$4,299,000	$1,900,000	$36,000	$0	$0	$0
167	167	PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS	$5,811,000	$4,883,020	$8,734,000	$3,984,960	$9,013,000	$4,084,410	$3,202,000	($798,610)	$279,000	$99,450
168	168	PROPOSITION 56 FUNDS TRANSFER	$0	($1,135,819,000)	$0	($989,723,000)	$0	($921,343,000)	$0	$214,476,000	$0	$68,380,000
169	169	PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$143,325,000	$43,534,000	$215,705,000	$29,435,000	$216,918,000	$27,305,000	$73,593,000	($16,229,000)	$1,213,000	($2,130,000)
170	170	PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS	$6,800,000	$3,400,000	$6,800,000	$3,400,000	$6,800,000	$3,400,000	$0	$0	$0	$0
171	171	IGT ADMIN. & PROCESSING FEE	$0	($31,783,000)	$0	($23,357,000)	$0	($13,626,000)	$0	$18,157,000	$0	$9,731,000

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2019-20

NOV.	MAY		2019-20 APPROPRIATION		NOV. 2019 EST. FOR 2019-20		MAY 2020 EST. FOR 2019-20		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
NO.	NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		SUPPLEMENTAL PMNTS.										
221	221	IGT PAYMENTS FOR HOSPITAL SERVICES	$0	$0	$0	$118,000	$0	$118,000	$0	$118,000	$0	$0
--	--	PROP 56 - HOSP-BASED PEDIATRIC PHYS SUPPL PYMTS	$2,000,000	$2,000,000	$0	$0	$0	$0	($2,000,000)	($2,000,000)	$0	$0
		SUPPLEMENTAL PMNTS. SUBTOTAL	**$15,672,869,720**	**$428,862,470**	**$14,893,681,240**	**$456,088,210**	**$13,526,340,880**	**$448,847,010**	**($2,146,528,840)**	**$19,984,540**	**($1,367,340,360)**	**($7,241,200)**
		COVID-19										
--	245	COVID-19 UNINSURED ELIGIBILITY GROUP	$0	$0	$0	$0	$17,931,000	$9,546,000	$17,931,000	$9,546,000	$17,931,000	$9,546,000
--	246	COVID-19 ADDITIONAL IMPACTS	$0	$0	$0	$0	$233,424,000	$95,504,000	$233,424,000	$95,504,000	$233,424,000	$95,504,000
--	247	COVID-19 UTILIZATION CHANGE	$0	$0	$0	$0	($652,397,000)	($229,029,000)	($652,397,000)	($229,029,000)	($652,397,000)	($229,029,000)
--	248	COVID-19 EMERGENCY FMAP - OTHER DEPTS	$0	$0	$0	$0	$257,717,000	$0	$257,717,000	$0	$257,717,000	$0
--	249	COVID-19 BEHAVIORAL HEALTH	$0	$0	$0	$0	$135,303,000	$13,324,000	$135,303,000	$13,324,000	$135,303,000	$13,324,000
--	250	COVID-19 EMERGENCY FMAP - DHCS	$0	$0	$0	$0	$0	($775,000,000)	$0	($775,000,000)	$0	($775,000,000)
--	251	COVID-19 CASELOAD IMPACT	$0	$0	$0	$0	$898,603,000	$318,951,000	$898,603,000	$318,951,000	$898,603,000	$318,951,000
		COVID-19 SUBTOTAL	**$0**	**$0**	**$0**	**$0**	**$890,581,000**	**($566,704,000)**	**$890,581,000**	**($566,704,000)**	**$890,581,000**	**($566,704,000)**
		OTHER										
178	178	CCI IHSS RECONCILIATION	$342,263,000	$0	$342,263,000	$0	$142,263,000	$0	($200,000,000)	$0	($200,000,000)	$0
180	180	QAF WITHHOLD TRANSFER	$124,322,000	$62,161,000	$163,604,000	$81,802,000	$98,871,000	$49,435,500	($25,451,000)	($12,725,500)	($64,733,000)	($32,366,500)
181	181	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$110,454,000	$0	$99,755,000	$0	$84,915,000	$0	($25,539,000)	$0	($14,840,000)	$0
182	182	ARRA HITECH - PROVIDER PAYMENTS	$38,001,000	$0	$73,549,000	$0	$49,029,000	$0	$11,028,000	$0	($24,520,000)	$0
186	186	PAYMENT FOR REPROCESSED CLAIMS FOR FQHC/RHC	$0	$0	$36,000,000	$18,000,000	$7,300,000	$3,650,000	$7,300,000	$3,650,000	($28,700,000)	($14,350,000)
188	188	INFANT DEVELOPMENT PROGRAM	$31,482,000	$0	$42,425,000	$0	$40,739,000	$0	$9,257,000	$0	($1,686,000)	$0
189	189	PROP 56 - PROVIDER ACES TRAININGS	$50,000,000	$25,000,000	$30,000,000	$15,000,000	$16,470,000	$8,235,000	($33,530,000)	($16,765,000)	($13,530,000)	($6,765,000)
190	190	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	$37,258,720	$18,629,360	$35,901,680	$17,950,840	$33,905,130	$16,952,560	($3,353,590)	($1,676,790)	($1,996,550)	($998,280)
191	191	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$18,153,000	$7,908,000	$16,257,000	$7,041,000	$14,316,000	$6,440,000	($3,837,000)	($1,468,000)	($1,941,000)	($601,000)
192	192	OVERTIME FOR WPCS PROVIDERS	$7,039,000	$3,519,500	$7,451,000	$3,725,500	$8,031,000	$4,015,500	$992,000	$496,000	$580,000	$290,000
193	193	INDIAN HEALTH SERVICES	$1,995,000	($10,000,000)	$7,125,000	$0	$10,584,000	$3,545,500	$8,589,000	$13,545,500	$3,459,000	$3,545,500
194	194	WPCS WORKERS' COMPENSATION	$3,649,000	$1,824,500	$3,323,000	$1,661,500	$3,323,000	$1,661,500	($326,000)	($163,000)	$0	$0

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2019-20

NOV.	MAY		2019-20 APPROPRIATION		NOV. 2019 EST. FOR 2019-20		MAY 2020 EST. FOR 2019-20		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
NO.	NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER										
198	198	FUNDING ADJUST.—OTLICP	$580,000	($167,468,450)	$234,000	($170,935,260)	$0	($171,066,160)	($580,000)	($3,597,720)	($234,000)	($130,900)
199	199	PROP 56 PHYSICIANS & DENTISTS LOAN REPAYMENT PROG	$120,000,000	$0	$1,700,000	$0	$1,700,000	$0	($118,300,000)	$0	$0	$0
200	200	CMS DEFERRED CLAIMS	$0	$350,000,000	$0	$226,925,000	$0	$52,385,000	$0	($297,615,000)	$0	($174,540,000)
201	201	INDIAN HEALTH SERVICES FUNDING SHIFT	$0	$0	$0	($13,000,000)	$0	($13,000,000)	$0	($13,000,000)	$0	$0
202	202	FUNDING ADJUST.—ACA OPT. EXPANSION	$0	($1,889,605,980)	$0	($1,863,385,800)	$0	($1,816,431,580)	$0	$73,174,400	$0	$46,954,220
203	203	CLPP FUND	$0	($725,000)	$0	($725,000)	$0	($916,000)	$0	($191,000)	$0	($191,000)
204	204	HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	($1,076,566,000)	$0	($1,076,566,000)	$0	($391,441,000)	$0	$685,125,000	$0	$685,125,000
205	205	AUDIT SETTLEMENTS	$0	$84,000	$0	$77,781,000	$0	$77,697,000	$0	$77,613,000	$0	($84,000)
206	206	IMD ANCILLARY SERVICES	$0	$25,777,000	$0	$17,100,000	$0	$9,685,000	$0	($16,092,000)	$0	($7,415,000)
207	207	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	($231,554,000)	$0	($231,554,000)	$0	($231,554,000)	$0	$0	$0	$0
208	208	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER RENEWAL	($1,047,000)	($523,500)	($5,721,000)	($2,860,500)	($12,731,000)	($6,365,500)	($11,684,000)	($5,842,000)	($7,010,000)	($3,505,000)
210	210	COUNTY SHARE OF OTLICP-CCS COSTS	$0	$0	($14,917,000)	($14,917,000)	($14,917,000)	($14,917,000)	($14,917,000)	($14,917,000)	$0	$0
211	211	ASSISTED LIVING WAIVER EXPANSION	($47,525,760)	($23,762,880)	($33,726,520)	($16,863,260)	($31,012,680)	($15,506,340)	$16,513,080	$8,256,540	$2,713,830	$1,356,920
213	213	PURE PREMIUM FUND CLOSEOUT	$0	$0	($501,725,000)	($142,907,390)	($501,725,000)	($142,907,390)	($501,725,000)	($142,907,390)	$0	$0
--	--	RECOUPMENT OF SMHS AUDIT SETTLEMENT	($45,172,000)	($45,172,000)	$0	$0	$0	$0	$45,172,000	$45,172,000	$0	$0
		OTHER SUBTOTAL	**$791,451,960**	**($2,950,474,450)**	**$303,498,160**	**($3,066,727,370)**	**($48,939,550)**	**($2,570,402,410)**	**($840,391,510)**	**$380,072,040**	**($352,437,720)**	**$496,324,960**
		GRAND TOTAL	**$37,101,511,490**	**$49,096,660**	**$36,033,100,740**	**($49,931,600)**	**$35,611,460,550**	**($14,136,170)**	**($1,490,050,950)**	**($63,232,830)**	**($421,640,190)**	**$35,795,430**

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

FISCAL YEAR 2019-20 COST PER ELIGIBLE BASED ON MAY 2020 ESTIMATE

SERVICE CATEGORY	PA-OAS	NEWLY	PA-ATD	PA-AFDC	LT-OAS	H-PE
PHYSICIANS	$5,726,540	$138,061,220	$62,619,700	$37,550,490	$1,623,390	$49,041,780
OTHER MEDICAL	$88,836,420	$1,114,035,250	$404,416,230	$290,265,290	$5,630,650	$41,228,010
CO. & COMM. OUTPATIENT	$3,933,030	$138,854,230	$115,029,080	$24,571,090	$638,640	$47,553,480
PHARMACY	$5,005,700	$569,989,950	$612,531,180	$69,383,260	$2,614,870	$21,448,000
COUNTY INPATIENT	$4,557,340	$477,883,610	$32,005,930	$27,831,410	$1,639,540	$56,578,940
COMMUNITY INPATIENT	$52,760,860	$1,125,609,840	$510,988,270	$229,020,480	$16,211,390	$290,007,000
NURSING FACILITIES	$196,976,290	$156,709,350	$489,879,100	$3,023,270	$1,254,980,420	$1,424,790
ICF-DD	$1,678,560	$10,279,410	$173,518,960	$1,240,310	$61,488,130	$920
MEDICAL TRANSPORTATION	$3,998,500	$47,303,170	$20,392,040	$5,144,910	$2,358,750	$11,281,630
OTHER SERVICES	$82,878,330	$35,566,850	$314,189,640	$38,591,590	$71,085,230	$1,279,120
HOME HEALTH	$2,742,750	$2,183,560	$143,287,940	$7,222,370	$30,790	$184,340
FFS SUBTOTAL	**$449,094,320**	**$3,816,476,440**	**$2,878,858,060**	**$733,844,470**	**$1,418,301,800**	**$520,028,020**
DENTAL	$108,435,570	$441,131,480	$123,926,360	$125,932,760	$16,191,470	$0
MENTAL HEALTH	$8,962,460	$314,362,500	$950,328,200	$697,175,760	$677,400	$7,920,070
TWO PLAN MODEL	$1,666,647,150	$8,708,612,110	$5,013,904,220	$1,367,277,300	$0	$0
COUNTY ORGANIZED HEALTH SYSTEMS	$333,318,910	$3,459,909,330	$1,499,572,480	$372,080,980	$806,747,470	$0
GEOGRAPHIC MANAGED CARE	$219,127,720	$1,323,534,910	$1,010,708,640	$206,264,930	$0	$0
PHP & OTHER MANAG. CARE	$335,175,250	$25,880,000	$161,655,920	$15,070,680	$16,072,010	$0
MEDICARE PAYMENTS	$1,745,441,540	$0	$1,612,743,200	$0	$162,788,940	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$3,731,990	$0	$8,157,740	$9,077,770	$389,860	$0
MISC. SERVICES	$761,245,770	$294,670	$5,970,245,020	$5,299,430	$2,690	$0
DRUG MEDI-CAL	$11,818,050	$124,039,690	$37,648,010	$30,426,250	$1,174,770	$19,860
REGIONAL MODEL	$14,955,340	$478,238,790	$312,115,680	$75,534,150	$0	$0
NON-FFS SUBTOTAL	**$5,208,859,740**	**$14,876,003,480**	**$16,701,005,480**	**$2,904,140,010**	**$1,004,044,600**	**$7,939,930**
TOTAL DOLLARS (1)	**$5,657,954,060**	**$18,692,479,920**	**$19,579,863,540**	**$3,637,984,480**	**$2,422,346,400**	**$527,967,960**
ELIGIBLES ***	**421,800**	**3,714,400**	**917,000**	**1,053,300**	**44,300**	**38,400**
ANNUAL $/ELIGIBLE	**$13,414**	**$5,032**	**$21,352**	**$3,454**	**$54,681**	**$13,749**
AVG. MO. $/ELIGIBLE	**$1,118**	**$419**	**$1,779**	**$288**	**$4,557**	**$1,146**

(1) Does not include Audits & Lawsuits and Recoveries.
*** Eligibles include the estimated impact of eligibility policy changes.
Refer to page following for listing of excluded policy changes.

FISCAL YEAR 2019-20 COST PER ELIGIBLE BASED ON MAY 2020 ESTIMATE

SERVICE CATEGORY	LT-ATD	POV 250	MN-OAS	MN-ATD	MN-AFDC	MI-C
PHYSICIANS	$1,130,320	$18,574,500	$17,137,450	$9,328,170	$106,746,250	$29,999,960
OTHER MEDICAL	$3,385,260	$214,090,660	$167,363,670	$84,542,100	$926,119,890	$100,509,510
CO. & COMM. OUTPATIENT	$479,560	$25,376,480	$17,257,760	$10,011,380	$111,994,760	$12,251,520
PHARMACY	$3,181,100	$75,489,540	$20,011,440	$37,523,860	$211,436,270	$35,196,590
COUNTY INPATIENT	$1,001,540	$3,337,490	$59,205,120	$15,641,320	$141,352,890	$9,752,180
COMMUNITY INPATIENT	$10,115,020	$88,005,800	$145,756,930	$57,155,880	$719,578,200	$70,908,980
NURSING FACILITIES	$223,421,880	$3,514,170	$203,293,870	$53,265,910	$26,299,170	$8,881,900
ICF-DD	$173,440,580	$158,240	$2,263,690	$11,161,860	$1,281,150	$3,264,510
MEDICAL TRANSPORTATION	$891,950	$709,990	$9,291,530	$6,571,680	$11,840,920	$3,841,980
OTHER SERVICES	$10,230,650	$25,820,420	$76,769,440	$68,427,010	$84,585,390	$17,827,980
HOME HEALTH	$11,820	$16,259,980	$1,776,400	$55,367,930	$15,738,320	$16,204,860
FFS SUBTOTAL	**$427,289,680**	**$471,337,260**	**$720,127,310**	**$408,997,100**	**$2,356,973,200**	**$308,639,970**
DENTAL	$16,191,470	$150,637,360	$15,490,800	$15,741,600	$425,977,110	$15,741,600
MENTAL HEALTH	$1,597,960	$74,042,510	$12,644,720	$89,284,510	$499,982,390	$72,290,910
TWO PLAN MODEL	$0	$678,722,240	$1,899,638,380	$698,105,930	$3,550,533,740	$27,788,040
COUNTY ORGANIZED HEALTH SYSTEMS	$181,759,390	$328,469,570	$514,459,190	$389,445,580	$1,610,634,750	$29,207,130
GEOGRAPHIC MANAGED CARE	$0	$115,833,330	$253,927,780	$151,493,860	$625,625,070	$3,574,310
PHP & OTHER MANAG. CARE	$507,790	$4,483,990	$288,173,700	$39,443,290	$7,952,640	$7,848,200
MEDICARE PAYMENTS	$0	$0	$1,427,774,150	$572,558,190	$113,881,810	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$92,150	$0	$4,697,760	$1,653,610	$30,189,650	$1,368,410
MISC. SERVICES	$950	($42,314,130)	$958,244,310	$1,191,844,290	$17,542,390	$796,880
DRUG MEDI-CAL	$280,120	$24,238,870	$14,857,630	$6,383,040	$98,128,050	$4,255,400
REGIONAL MODEL	$0	$38,415,690	$41,236,470	$44,046,030	$243,896,880	$1,047,940
NON-FFS SUBTOTAL	**$200,429,830**	**$1,372,529,440**	**$5,431,144,890**	**$3,199,999,910**	**$7,224,344,480**	**$163,918,820**
TOTAL DOLLARS (1)	**$627,719,510**	**$1,843,866,700**	**$6,151,272,210**	**$3,608,997,020**	**$9,581,317,680**	**$472,558,790**
ELIGIBLES ***	**10,300**	**948,500**	**540,800**	**225,000**	**3,445,400**	**152,600**
ANNUAL $/ELIGIBLE	**$60,944**	**$1,944**	**$11,374**	**$16,040**	**$2,781**	**$3,097**
AVG. MO. $/ELIGIBLE	**$5,079**	**$162**	**$948**	**$1,337**	**$232**	**$258**

(1) Does not include Audits & Lawsuits and Recoveries.
*** Eligibles include the estimated impact of eligibility policy changes.
Refer to page following for listing of excluded policy changes.

FISCAL YEAR 2019-20 COST PER ELIGIBLE BASED ON MAY 2020 ESTIMATE

SERVICE CATEGORY	MI-A	REFUGEE	OBRA	POV 185	POV 133	POV 100
PHYSICIANS	$428,900	$39,720	$102,920	$85,587,680	$13,430,980	$5,880,200
OTHER MEDICAL	$855,680	$436,610	$87,710	$227,276,780	$187,650,510	$88,568,300
CO. & COMM. OUTPATIENT	$182,730	$69,240	$28,430	$23,000,720	$13,671,360	$10,503,830
PHARMACY	$875,960	$95,720	$119,900	$15,188,850	$21,546,160	$25,600,330
COUNTY INPATIENT	$2,378,910	$13,610	$63,420	$87,078,910	$3,328,650	$1,525,290
COMMUNITY INPATIENT	$1,361,980	$109,370	$1,121,590	$648,233,040	$72,775,130	$34,107,390
NURSING FACILITIES	$17,753,800	$0	$4,412,600	$1,534,140	$8,934,270	$1,179,240
ICF-DD	$1,082,530	$0	$170,230	$174,520	$628,210	$34,710
MEDICAL TRANSPORTATION	$122,370	$8,870	$34,030	$2,507,200	$696,080	$288,090
OTHER SERVICES	$462,470	$1,310	$34,500	$9,497,330	$18,895,350	$9,959,750
HOME HEALTH	$870	$0	$0	$4,187,980	$9,626,370	$2,322,810
FFS SUBTOTAL	**$25,506,200**	**$774,450**	**$6,175,310**	**$1,104,267,140**	**$351,183,070**	**$179,969,920**
DENTAL	$15,490,800	$16,191,470	$16,191,470	$15,776,930	$94,449,570	$47,224,790
MENTAL HEALTH	$0	$149,910	$0	$1,609,320	$22,588,990	$34,335,880
TWO PLAN MODEL	$9,640	$370,290	$0	$222,944,400	$524,021,780	$283,505,300
COUNTY ORGANIZED HEALTH SYSTEMS	$244,120	$100,920	$13,370	$125,527,010	$208,891,340	$120,853,230
GEOGRAPHIC MANAGED CARE	$2,030	$282,660	$0	$41,440,900	$85,494,040	$46,620,620
PHP & OTHER MANAG. CARE	$7,645,990	$0	$0	$7,876,520	$7,846,980	$7,846,980
MEDICARE PAYMENTS	$0	$0	$0	$0	$0	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$55,820	$0	$1,770	$3,094,900	$0	$3,530,340
MISC. SERVICES	$219,220	$0	$0	$64,480	$3,722,050	$1,956,730
DRUG MEDI-CAL	$169,000	$16,020	$0	$9,264,780	$19,914,980	$10,593,810
REGIONAL MODEL	$0	$9,100	$0	$16,182,940	$27,541,150	$13,944,120
NON-FFS SUBTOTAL	**$23,836,610**	**$17,120,360**	**$16,206,610**	**$443,782,180**	**$994,470,890**	**$570,411,790**
TOTAL DOLLARS (1)	**$49,342,820**	**$17,894,810**	**$22,381,930**	**$1,548,049,310**	**$1,345,653,950**	**$750,381,720**
ELIGIBLES ***	**3,700**	**600**	**300**	**347,000**	**759,400**	**409,700**
ANNUAL $/ELIGIBLE	**$13,336**	**$29,825**	**$74,606**	**$4,461**	**$1,772**	**$1,832**
AVG. MO. $/ELIGIBLE	**$1,111**	**$2,485**	**$6,217**	**$372**	**$148**	**$153**

(1) Does not include Audits & Lawsuits and Recoveries.
*** Eligibles include the estimated impact of eligibility policy changes.
Refer to page following for listing of excluded policy changes.

FISCAL YEAR 2019-20 COST PER ELIGIBLE BASED ON MAY 2020 ESTIMATE

SERVICE CATEGORY	TOTAL
PHYSICIANS	$583,010,170
OTHER MEDICAL	$3,945,298,490
CO. & COMM. OUTPATIENT	$555,407,340
PHARMACY	$1,727,238,680
COUNTY INPATIENT	$925,176,090
COMMUNITY INPATIENT	$4,073,827,150
NURSING FACILITIES	$2,655,484,170
ICF-DD	$441,866,510
MEDICAL TRANSPORTATION	$127,283,680
OTHER SERVICES	$866,102,360
HOME HEALTH	$277,149,100
FFS SUBTOTAL	**$16,177,843,730**
DENTAL	$1,660,722,600
MENTAL HEALTH	$2,787,953,490
TWO PLAN MODEL	$24,642,080,520
COUNTY ORGANIZED HEALTH SYSTEMS	$9,981,234,770
GEOGRAPHIC MANAGED CARE	$4,083,930,790
PHP & OTHER MANAG. CARE	$933,479,930
MEDICARE PAYMENTS	$5,635,187,830
STATE HOSP./DEVELOPMENTAL CNTRS.	$66,041,760
MISC. SERVICES	$8,869,164,750
DRUG MEDI-CAL	$393,228,340
REGIONAL MODEL	$1,307,164,290
NON-FFS SUBTOTAL	**$60,360,189,070**
TOTAL DOLLARS (1)	**$76,538,032,800**
ELIGIBLES ***	**13,032,500**
ANNUAL $/ELIGIBLE	**$5,873**
AVG. MO. $/ELIGIBLE	**$489**

(1) Does not include Audits & Lawsuits and Recoveries.
*** Eligibles include the estimated impact of eligibility policy changes.
Refer to page following for listing of excluded policy changes.

FISCAL YEAR 2019-20 COST PER ELIGIBLE BASED ON MAY 2020 ESTIMATE

EXCLUDED POLICY CHANGES: 89

3	BREAST AND CERVICAL CANCER TREATMENT
4	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
5	COUNTY HEALTH INITIATIVE MATCHING (CHIM)
6	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL
10	CS3 PROXY ADJUSTMENT
13	NON-OTLICP CHIP
17	MEDICARE OPTIONAL EXPANSION ADJUSTMENT
24	1% FMAP INCREASE FOR PREVENTIVE SERVICES
25	ACA MAGI SAVINGS
28	ACA DSH REDUCTION
30	FAMILY PACT PROGRAM
44	FREE CLINIC OF SIMI VALLEY
57	FAMILY PACT DRUG REBATES
58	LITIGATION SETTLEMENTS
70	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
73	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT
77	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT
81	GLOBAL PAYMENT PROGRAM
82	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL
83	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS
84	BTR - LIHP - MCE
86	MH/UCD—STABILIZATION FUNDING
87	WHOLE PERSON CARE HOUSING SERVICES
88	MH/UCD—SAFETY NET CARE POOL
89	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG
90	MH/UCD—HEALTH CARE COVERAGE INITIATIVE
91	BTR - LOW INCOME HEALTH PROGRAM - HCCI
108	GENERAL FUND REIMBURSEMENTS FROM DPHS
109	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)
111	MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.
112	MCO ENROLLMENT TAX MANAGED CARE PLANS
113	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND
117	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF
127	EMERGENCY MEDICAL AIR TRANSPORTATION ACT

FISCAL YEAR 2019-20 COST PER ELIGIBLE BASED ON MAY 2020 ESTIMATE

EXCLUDED POLICY CHANGES: 89

130	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
135	DENTAL RETROACTIVE RATE CHANGES
137	HOSPITAL QAF - FFS PAYMENTS
138	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS
139	HOSPITAL QAF - MANAGED CARE PAYMENTS
140	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS
141	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS
142	PRIVATE HOSPITAL DSH REPLACEMENT
144	PROP 56 - MEDI-CAL FAMILY PLANNING
145	DSH PAYMENT
146	PROP 56 - VALUE-BASED PAYMENT PROGRAM
147	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
148	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
149	CAPITAL PROJECT DEBT REIMBURSEMENT
150	FFP FOR LOCAL TRAUMA CENTERS
151	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS
152	NDPH IGT SUPPLEMENTAL PAYMENTS
153	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS
154	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
155	GEMT SUPPLEMENTAL PAYMENT PROGRAM
159	DPH PHYSICIAN & NON-PHYS. COST
160	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
161	PROP 56 - NEMT SUPPLEMENTAL PAYMENTS
162	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
163	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
164	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS
165	NDPH SUPPLEMENTAL PAYMENT
166	PROP 56 - HOSP-BASED PEDIATRIC PHYS SUPPL PYMTS
167	PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS
168	PROPOSITION 56 FUNDS TRANSFER
169	PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS
170	PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS
171	IGT ADMIN. & PROCESSING FEE
182	ARRA HITECH - PROVIDER PAYMENTS

FISCAL YEAR 2019-20 COST PER ELIGIBLE BASED ON MAY 2020 ESTIMATE

EXCLUDED POLICY CHANGES: 89

184	MEDI-CAL TCM PROGRAM
187	LAWSUITS/CLAIMS
189	PROP 56 - PROVIDER ACES TRAININGS
199	PROP 56 PHYSICIANS & DENTISTS LOAN REPAYMENT PROG
200	CMS DEFERRED CLAIMS
203	CLPP FUND
204	HOSPITAL QAF - CHILDREN'S HEALTH CARE
205	AUDIT SETTLEMENTS
207	CIGARETTE AND TOBACCO SURTAX FUNDS
212	BASE RECOVERIES
213	PURE PREMIUM FUND CLOSEOUT
218	2020 MCO ENROLLMENT TAX MANAGED CARE PLANS
219	2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ
220	2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.
221	IGT PAYMENTS FOR HOSPITAL SERVICES
232	DISABLED ADULT CHILDREN PROGRAM CLEANUP
243	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM
244	STATE ONLY CLAIMING ADJUSTMENTS
245	COVID-19 UNINSURED ELIGIBILITY GROUP
248	COVID-19 EMERGENCY FMAP - OTHER DEPTS
265	RECONCILIATION

TABLE OF CONTENTS

BUDGET YEAR

The Budget Year section provides a summary of medical assistance benefits (base and regular policy change) expenditures for the budget year. It highlights expendtures by service category, compares current year data to the previous appropriation estimate, and provides an overview of the current year cost per eligible expenditures.

MEDI-CAL PROGRAM ESTIMATE SUMMARY EXPENDITURES.....1

SUMMARY OF REGULAR POLICY CHANGES 2-8

ELIGIBILITY 2
AFFORDABLE CARE ACT 2
BENEFITS 2-3
PHARMACY 3-4
DRUG MEDI-CAL 4
MENTAL HEALTH.....3-4
WAIVER- MH/UCD & BTR.....4
MANAGED CARE 4-5
PROVIDER RATES 5
SUPPLEMENTAL PAYMENTS.....5-7
COVID-19 7
OTHER DEPARTMENTS.....7
OTHER 7-8
GRAND TOTAL 8

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY AND FUND TYPE 9

MEDI-CAL TOTAL FUND EXPENDITURES BY SERVICE CATEGORY COMPARISONS 10-11

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES, BUDGET YEAR COMPARISONS 12-22

ELIGIBILITY 12
AFFORDABLE CARE ACT.....13
BENEFITS 13-14
PHARMACY 14-15
DRUG MEDI-CAL 15
MENTAL HEALTH.....15
WAIVER-MH/UCD & BTR 15-16
MANAGED CARE 16-17
PROVIDER RATES 17-18
SUPPLEMENTAL PAYMENTS.....18-20
COVID-19 20
OTHER DEPARTMENTS.....20-21
OTHER. 21-22
GRAND TOTAL 22

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES, MAY 2020 COMPARISONS 23-33

COST PER ELIGIBLE BY SERVICE CATEGORY 34-40

MEDI-CAL PROGRAM ESTIMATE SUMMARY
FISCAL YEAR 2020-21

	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
I. BASE ESTIMATES				
A. B/Y FFS BASE	$17,897,436,120	$8,948,718,060	$8,948,718,060	$0
B. B/Y BASE POLICY CHANGES	$49,711,025,010	$32,655,454,920	$16,900,324,090	$155,246,000
C. BASE ADJUSTMENTS	($179,703,000)	($237,883,080)	$58,180,080	$0
D. ADJUSTED BASE	**$67,428,758,130**	**$41,366,289,900**	**$25,907,222,230**	**$155,246,000**
II. REGULAR POLICY CHANGES				
A. ELIGIBILITY	$402,244,990	($606,316,980)	$1,006,045,960	$2,516,000
B. AFFORDABLE CARE ACT	$3,929,640,990	$4,199,275,500	($45,815,500)	($223,819,000)
C. BENEFITS	$2,055,345,340	$1,462,432,560	$578,384,780	$14,528,000
D. PHARMACY	($2,027,284,570)	($1,862,993,250)	($1,807,933,320)	$1,643,642,000
E. DRUG MEDI-CAL	$397,003,610	$186,816,720	$210,186,890	$0
F. MENTAL HEALTH	($28,945,000)	($42,182,000)	$13,037,000	$200,000
G. WAIVER--MH/UCD & BTR	$3,658,272,000	$1,921,558,000	($5,175,000)	$1,741,889,000
H. MANAGED CARE	$8,488,740,720	$4,782,819,090	($370,538,080)	$4,076,459,700
I. PROVIDER RATES	$882,547,780	$991,691,320	($808,065,200)	$698,921,650
J. SUPPLEMENTAL PMNTS.	$16,269,970,740	$9,825,066,740	$361,016,000	$6,083,888,000
K. COVID-19	$8,104,678,000	$8,257,740,000	($153,062,000)	$0
L. OTHER DEPARTMENTS	$433,513,000	$433,096,000	$417,000	$0
M. OTHER	$357,002,380	$1,054,851,780	($2,294,507,400)	$1,596,658,000
N. TOTAL CHANGES	**$42,922,729,980**	**$30,603,855,490**	**($3,316,008,870)**	**$15,634,883,350**
III. TOTAL MEDI-CAL ESTIMATE	**$110,351,488,100**	**$71,970,145,390**	**$22,591,213,360**	**$15,790,129,350**

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2020-21

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	ELIGIBILITY				
1	UNDOCUMENTED YOUNG ADULTS FULL SCOPE EXPANSION	$335,282,280	$102,310,420	$232,971,870	$0
2	MEDI-CAL STATE INMATE PROGRAMS	$84,662,000	$84,662,000	$0	$0
3	BREAST AND CERVICAL CANCER TREATMENT	$65,865,000	$24,460,100	$41,404,900	$0
7	FPL INCREASE FOR AGED AND DISABLED PERSONS	$135,468,000	$67,734,000	$67,734,000	$0
8	MEDI-CAL COUNTY INMATE PROGRAMS	$15,660,960	$15,001,640	$659,320	$0
9	PROVISIONAL POSTPARTUM CARE EXTENSION	$34,291,000	$0	$34,291,000	$0
10	CS3 PROXY ADJUSTMENT	$0	$122,728,680	($122,728,680)	$0
11	MEDI-CAL COUNTY INMATE REIMBURSEMENT	$0	$0	($2,516,000)	$2,516,000
13	NON-OTLICP CHIP	$0	$101,316,930	($101,316,930)	$0
14	NON-EMERGENCY FUNDING ADJUSTMENT	$0	($969,518,000)	$969,518,000	$0
15	SCHIP FUNDING FOR PRENATAL CARE	$0	$76,358,720	($76,358,720)	$0
16	CCHIP DELIVERY SYSTEM	($3,097,000)	($2,127,480)	($969,520)	$0
17	MEDICARE OPTIONAL EXPANSION ADJUSTMENT	$14,940,000	($12,431,410)	$27,371,410	$0
18	CHIP PREMIUMS	($62,224,000)	($42,234,540)	($19,989,460)	$0
19	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	($222,168,260)	($174,578,050)	($47,590,210)	$0
216	MEDICARE PART B DISREGARD	$478,000	$0	$478,000	$0
232	DISABLED ADULT CHILDREN PROGRAM CLEANUP	$2,892,000	$0	$2,892,000	$0
266	HEARING AID COVERAGE - ADMIN	$195,000	$0	$195,000	$0
	ELIGIBILITY SUBTOTAL	**$402,244,990**	**($606,316,980)**	**$1,006,045,960**	**$2,516,000**
	AFFORDABLE CARE ACT				
20	COMMUNITY FIRST CHOICE OPTION	$4,423,366,000	$4,423,366,000	$0	$0
21	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	$12,504,000	$12,504,000	$0	$0
22	HEALTH INSURER FEE	$284,312,000	$187,160,260	$97,151,740	$0
23	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	$0	$44,211,240	($44,211,240)	$0
24	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	$3,212,000	($3,212,000)	$0
26	PAYMENTS TO PRIMARY CARE PHYSICIANS	($69,000)	($69,000)	$0	$0
27	ACA OPTIONAL EXPANSION MLR RISK CORRIDOR	($100,000,000)	($94,500,000)	($5,500,000)	$0
28	ACA DSH REDUCTION	($690,472,000)	($376,609,000)	($90,044,000)	($223,819,000)
	AFFORDABLE CARE ACT SUBTOTAL	**$3,929,641,000**	**$4,199,275,500**	**($45,815,500)**	**($223,819,000)**
	BENEFITS				
29	BEHAVIORAL HEALTH TREATMENT	$993,767,000	$524,402,570	$469,364,430	$0
30	FAMILY PACT PROGRAM	$366,733,000	$279,395,400	$87,337,600	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2020-21

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	BENEFITS				
31	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$388,005,000	$388,005,000	$0	$0
32	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$129,016,000	$129,016,000	$0	$0
33	LEA EXPANSION	$80,468,000	$80,468,000	$0	$0
34	RESTORATION OF ADULT OPTICIAN & OPTICAL LAB SVCS	$33,726,250	$21,810,140	$11,916,110	$0
35	MSSP SUPPLEMENTAL PAYMENTS	$4,933,000	$4,933,000	($4,933,000)	$4,933,000
36	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$4,074,000	$3,144,000	$930,000	$0
37	OPTIONAL BENEFITS RESTORATION	$15,337,270	$9,917,880	$5,419,380	$0
38	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	$20,232,000	$10,116,000	$521,000	$9,595,000
39	CCS DEMONSTRATION PROJECT	$6,456,000	$3,429,920	$3,026,080	$0
40	MEDI-CAL NONMEDICAL TRANSPORTATION	$6,959,110	$4,261,570	$2,697,540	$0
41	MEDICALLY TAILORED MEALS PILOT PROGRAM	$1,430,000	$0	$1,430,000	$0
42	YOUTH REGIONAL TREATMENT CENTERS	$2,203,000	$2,184,000	$19,000	$0
45	CCT FUND TRANSFER TO CDSS	$175,000	$175,000	$0	$0
46	DIABETES PREVENTION PROGRAM	$536,740	$346,820	$189,920	$0
48	EXPANSION TO SCREENING FOR ADDITIONAL SUBSTANCES	$1,293,970	$827,260	$466,710	$0
	BENEFITS SUBTOTAL	**$2,055,345,340**	**$1,462,432,560**	**$578,384,780**	**$14,528,000**
	PHARMACY				
52	MEDI-CAL RX - MANAGED CARE PHARMACY BENEFIT TO FFS	($132,951,000)	($78,380,200)	($54,570,800)	$0
53	MEDI-CAL DRUG REBATE FUND	$0	$0	($1,643,642,000)	$1,643,642,000
54	BLOOD FACTOR REIMBURSEMENT METHODOLOGY	($35,642,570)	($22,575,700)	($13,066,870)	$0
55	MEDI-CAL RX - ADDITIONAL SAVINGS FROM MAIC IN FFS	($57,381,000)	($36,292,400)	($21,088,600)	$0
56	BCCTP DRUG REBATES	($5,081,000)	($5,081,000)	$0	$0
57	FAMILY PACT DRUG REBATES	($10,016,000)	($10,016,000)	$0	$0
59	MEDICAL SUPPLY REBATES	($43,098,000)	($21,549,000)	($21,549,000)	$0
60	STATE SUPPLEMENTAL DRUG REBATES	($114,100,000)	($114,100,000)	$0	$0
62	FEDERAL DRUG REBATES	($1,439,215,000)	($1,439,215,000)	$0	$0
237	PHARMACY RETROACTIVE ADJUSTMENTS	($189,800,000)	($135,783,950)	($54,016,050)	$0
	PHARMACY SUBTOTAL	**($2,027,284,570)**	**($1,862,993,250)**	**($1,807,933,320)**	**$1,643,642,000**
	DRUG MEDI-CAL				
63	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	$394,701,000	$333,226,940	$61,474,060	$0
67	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	$1,791,110	$1,608,790	$182,330	$0
69	DRUG MEDI-CAL MAT BENEFIT	$511,500	$495,000	$16,500	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2020-21

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DRUG MEDI-CAL				
238	DMC & SMHS STATE ONLY CLAIMING ADJUSTMENT	$0	($148,514,000)	$148,514,000	$0
	DRUG MEDI-CAL SUBTOTAL	**$397,003,610**	**$186,816,720**	**$210,186,890**	**$0**
	MENTAL HEALTH				
74	MHP COSTS FOR CONTINUUM OF CARE REFORM	$24,651,000	$11,444,000	$13,207,000	$0
75	PATHWAYS TO WELL-BEING	$484,000	$484,000	$0	$0
76	LATE CLAIMS FOR SMHS	$30,000	$0	$30,000	$0
77	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	$0	$0	($200,000)	$200,000
79	CHART REVIEW	($371,000)	($371,000)	$0	$0
80	INTERIM AND FINAL COST SETTLEMENTS - SMHS	($53,739,000)	($53,739,000)	$0	$0
	MENTAL HEALTH SUBTOTAL	**($28,945,000)**	**($42,182,000)**	**$13,037,000**	**$200,000**
	WAIVER--MH/UCD & BTR				
81	GLOBAL PAYMENT PROGRAM	$2,200,578,000	$1,100,289,000	$0	$1,100,289,000
82	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL	$612,000,000	$306,000,000	$0	$306,000,000
83	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS	$671,201,000	$335,601,000	$0	$335,600,000
85	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	$174,230,000	$87,115,000	$87,115,000	$0
89	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$263,000	$263,000	$0	$0
243	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM	$0	$92,290,000	($92,290,000)	$0
	WAIVER--MH/UCD & BTR SUBTOTAL	**$3,658,272,000**	**$1,921,558,000**	**($5,175,000)**	**$1,741,889,000**
	MANAGED CARE				
95	CCI-MANAGED CARE PAYMENTS	$2,954,613,720	$1,477,306,860	$1,477,306,860	$0
96	MANAGED CARE HEALTH CARE FINANCING PROGRAM	$1,917,686,000	$1,264,019,180	$653,666,820	$0
97	MANAGED CARE PUBLIC HOSPITAL EPP	$1,541,109,000	$1,179,547,150	$361,561,850	$0
100	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	$667,840,000	$512,918,960	$154,921,040	$0
103	RETRO MC RATE ADJUSTMENTS	$363,335,000	$152,181,110	$211,153,890	$0
104	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS	$203,895,000	$181,146,300	$0	$22,748,700
107	CCI-QUALITY WITHHOLD REPAYMENTS	$16,822,000	$8,411,000	$8,411,000	$0
110	CAPITATED RATE ADJUSTMENT FOR FY 2020-21	$0	$0	$0	$0
113	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	$0	$0	($1,284,053,000)	$1,284,053,000
114	COORDINATED CARE INITIATIVE RISK MITIGATION	($111,260,000)	($55,630,000)	($55,630,000)	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2020-21

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	MANAGED CARE				
116	MANAGED CARE DRUG REBATES	($1,504,444,000)	($1,504,444,000)	$0	$0
218	2020 MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	$0	($1,686,645,000)	$1,686,645,000
219	2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	$0	$0	($1,083,013,000)	$1,083,013,000
220	2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	$3,177,119,000	$2,094,106,240	$1,083,012,760	$0
234	SAN MATEO HEALTH PLAN REIMBURSEMENT	$30,000,000	$0	$30,000,000	$0
255	ADJUST MC CAP PAYMENTS FOR JULY 2019-DEC 2020	($585,917,000)	($403,938,700)	($181,978,300)	$0
258	MANAGED CARE EFFICIENCIES	($182,058,000)	($122,805,000)	($59,253,000)	$0
	MANAGED CARE SUBTOTAL	**$8,488,740,720**	**$4,782,819,090**	**($370,538,080)**	**$4,076,459,700**
	PROVIDER RATES				
117	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	$185,402,470	$123,957,610	($6,866,790)	$68,311,650
118	RATE INCREASE FOR FQHCS/RHCS/CBRCS	$242,308,100	$149,012,040	$93,296,060	$0
119	AB 1629 ANNUAL RATE ADJUSTMENTS	$96,040,400	$48,020,200	$48,020,200	$0
120	FQHC/RHC/CBRC RECONCILIATION PROCESS	$73,390,000	$45,132,600	$28,257,400	$0
121	PROP 56 - HOME HEALTH RATE INCREASE	$0	$0	$0	$0
122	DPH INTERIM RATE GROWTH	$35,388,120	$17,694,060	$17,694,060	$0
123	LTC RATE ADJUSTMENT	$40,283,380	$20,141,690	$20,141,690	$0
124	DPH INTERIM & FINAL RECONS	$159,698,000	$159,698,000	$0	$0
125	PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE	$0	$0	$0	$0
127	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	$10,000,000	$5,000,000	($1,626,000)	$6,626,000
128	HOSPICE RATE INCREASES	$7,393,260	$3,696,630	$3,696,630	$0
129	DPH INTERIM RATE	$0	$401,766,100	($401,766,100)	$0
130	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	$0	($623,984,000)	$623,984,000
132	DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT	($2,366,570)	($1,276,980)	($1,089,590)	$0
133	LABORATORY RATE METHODOLOGY CHANGE	($19,524,430)	($9,762,220)	($9,762,220)	$0
134	10% PROVIDER PAYMENT REDUCTION	($13,936,310)	($6,968,150)	($6,968,150)	$0
136	REDUCTION TO RADIOLOGY RATES	($8,688,400)	($4,344,200)	($4,344,200)	$0
223	NURSING FACILITY FINANCING REFORM	$70,171,540	$36,429,840	$33,741,700	$0
226	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	$6,988,220	$3,494,110	$3,494,110	$0
	PROVIDER RATES SUBTOTAL	**$882,547,780**	**$991,691,320**	**($808,065,200)**	**$698,921,650**
	SUPPLEMENTAL PMNTS.				
137	HOSPITAL QAF - FFS PAYMENTS	$4,989,101,000	$2,369,045,000	$0	$2,620,056,000
138	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	$2,326,556,000	$1,541,906,000	$0	$784,650,000

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2020-21

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	SUPPLEMENTAL PMNTS.				
139	HOSPITAL QAF - MANAGED CARE PAYMENTS	$2,846,100,000	$1,938,741,000	$0	$907,359,000
140	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	$1,063,771,000	$713,664,000	$0	$350,107,000
141	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	$1,125,395,500	$722,895,190	$402,500,300	$0
142	PRIVATE HOSPITAL DSH REPLACEMENT	$608,335,000	$304,167,500	$304,167,500	$0
143	PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES	$522,826,000	$315,533,850	$207,292,150	$0
144	PROP 56 - MEDI-CAL FAMILY PLANNING	$111,481,460	$100,333,310	$11,148,150	$0
145	DSH PAYMENT	$495,326,000	$308,308,000	$24,952,000	$162,066,000
146	PROP 56 - VALUE-BASED PAYMENT PROGRAM	$459,503,000	$281,223,360	$178,279,640	$0
147	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	$312,824,000	$163,921,000	$126,275,000	$22,628,000
148	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$253,433,000	$253,433,000	$0	$0
149	CAPITAL PROJECT DEBT REIMBURSEMENT	$94,555,000	$67,785,000	$26,770,000	$0
150	FFP FOR LOCAL TRAUMA CENTERS	$163,862,000	$81,978,000	$0	$81,884,000
151	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	$118,812,000	$68,812,000	$0	$50,000,000
152	NDPH IGT SUPPLEMENTAL PAYMENTS	$83,684,000	$40,543,000	($5,856,000)	$48,997,000
153	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	$85,239,000	$85,239,000	$0	$0
154	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	$82,000,000	$41,000,000	$46,979,000	($5,979,000)
155	GEMT SUPPLEMENTAL PAYMENT PROGRAM	$80,700,000	$80,700,000	$0	$0
156	PROP 56 - DEVELOPMENTAL SCREENINGS	$48,838,510	$26,699,830	$22,138,680	$0
157	PROP 56 - CBAS SUPPLEMENTAL PAYMENTS	$30,992,000	$15,496,000	$15,496,000	$0
158	PROP 56 - ADVERSE CHILDHOOD EXPERIENCES SCREENINGS	$36,781,580	$21,950,070	$14,831,510	$0
159	DPH PHYSICIAN & NON-PHYS. COST	$224,686,000	$224,686,000	$0	$0
160	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$5,000,000	$5,000,000	$0
161	PROP 56 - NEMT SUPPLEMENTAL PAYMENTS	$7,935,410	$4,675,600	$3,259,810	$0
162	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$8,271,000	$8,271,000	$0	$0
163	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$4,000,000	$4,000,000	$0
164	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS	$6,090,440	$3,219,330	$2,871,110	$0
165	NDPH SUPPLEMENTAL PAYMENT	$4,273,000	$2,373,000	$1,900,000	$0
166	PROP 56 - HOSP-BASED PEDIATRIC PHYS SUPPL PYMTS	$2,000,000	$0	$2,000,000	$0
167	PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS	$1,809,600	$982,400	$827,200	$0
168	PROPOSITION 56 FUNDS TRANSFER	$0	$0	($1,042,035,000)	$1,042,035,000

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2020-21

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	SUPPLEMENTAL PMNTS.				
169	PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$4,289,250	$3,745,290	$543,960	$0
170	PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS	$0	$0	$0	$0
171	IGT ADMIN. & PROCESSING FEE	$0	$0	($28,652,000)	$28,652,000
221	IGT PAYMENTS FOR HOSPITAL SERVICES	$0	($1,510,000)	$10,077,000	($8,567,000)
227	NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS	$52,500,000	$26,250,000	$26,250,000	$0
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$16,269,970,740**	**$9,825,066,740**	**$361,016,000**	**$6,083,888,000**
	COVID-19				
245	COVID-19 UNINSURED ELIGIBILITY GROUP	$10,177,000	$4,815,000	$5,362,000	$0
246	COVID-19 ADDITIONAL IMPACTS	$286,584,000	$159,962,000	$126,622,000	$0
247	COVID-19 UTILIZATION CHANGE	($395,693,000)	($248,913,000)	($146,780,000)	$0
248	COVID-19 EMERGENCY FMAP - OTHER DEPTS	$1,296,027,000	$1,296,027,000	$0	$0
249	COVID-19 BEHAVIORAL HEALTH	$77,705,000	$70,053,000	$7,652,000	$0
250	COVID-19 EMERGENCY FMAP - DHCS	$0	$2,554,167,000	($2,554,167,000)	$0
251	COVID-19 CASELOAD IMPACT	$6,829,878,000	$4,421,629,000	$2,408,249,000	$0
	COVID-19 SUBTOTAL	**$8,104,678,000**	**$8,257,740,000**	**($153,062,000)**	**$0**
	OTHER DEPARTMENTS				
172	ELECTRONIC VISIT VERIFICATION PHASE II FED PENALTY	($5,130,000)	($5,547,000)	$417,000	$0
267	ADDITIONAL FEDERAL FUNDING TO OTHER DEPT.	$438,643,000	$438,643,000	$0	$0
	OTHER DEPARTMENTS SUBTOTAL	**$433,513,000**	**$433,096,000**	**$417,000**	**$0**
	OTHER				
178	CCI IHSS RECONCILIATION	$100,000,000	$100,000,000	$0	$0
181	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$95,060,000	$95,060,000	$0	$0
182	ARRA HITECH - PROVIDER PAYMENTS	$15,268,000	$15,268,000	$0	$0
188	INFANT DEVELOPMENT PROGRAM	$32,746,000	$32,746,000	$0	$0
189	PROP 56 - PROVIDER ACES TRAININGS	$61,924,000	$30,962,000	$30,962,000	$0
190	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	$49,175,020	$24,587,510	$24,587,510	$0
191	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$15,797,000	$8,869,000	$6,928,000	$0
192	OVERTIME FOR WPCS PROVIDERS	$8,444,000	$4,222,000	$4,222,000	$0
193	INDIAN HEALTH SERVICES	$20,174,000	$13,415,500	$6,758,500	$0
194	WPCS WORKERS' COMPENSATION	$3,324,000	$1,662,000	$1,662,000	$0
198	FUNDING ADJUST.—OTLICP	$0	$109,194,740	($109,194,740)	$0
199	PROP 56 PHYSICIANS & DENTISTS LOAN REPAYMENT PROG	$15,200,000	$0	$0	$15,200,000
200	CMS DEFERRED CLAIMS	$0	($350,000,000)	$350,000,000	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2020-21

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
201	INDIAN HEALTH SERVICES FUNDING SHIFT	$0	$13,000,000	($13,000,000)	$0
202	FUNDING ADJUST.—ACA OPT. EXPANSION	$0	$1,824,254,400	($1,824,254,400)	$0
203	CLPP FUND	$0	$0	($916,000)	$916,000
204	HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	$0	($976,000,000)	$976,000,000
205	AUDIT SETTLEMENTS	$0	($734,000)	$734,000	$0
206	IMD ANCILLARY SERVICES	$0	($20,807,000)	$20,807,000	$0
207	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	$0	($160,657,000)	$160,657,000
208	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER RENEWAL	($27,215,000)	($13,607,500)	($13,607,500)	$0
210	COUNTY SHARE OF OTLICP-CCS COSTS	($22,660,000)	$0	($22,660,000)	$0
211	ASSISTED LIVING WAIVER EXPANSION	($31,440,640)	($15,720,320)	($15,720,320)	$0
233	REPAYMENT TO CMS FOR CONTINGENCY FEE OFFSETS	$0	($10,370,000)	$10,370,000	$0
236	TRIBAL FEDERALLY QUALIFIED HEALTH CENTER	$1,576,000	$1,225,450	$350,550	$0
242	SELF-DETERMINATION PROGRAM - CDDS	$17,139,000	$17,139,000	$0	$0
244	STATE ONLY CLAIMING ADJUSTMENTS	$0	($817,325,000)	$519,592,000	$297,733,000
261	FUND 3156 TRANSFER TO THE GENERAL FUND	$0	$0	($100,000,000)	$100,000,000
262	FUND 3311 TRANSFER TO THE GENERAL FUND	$0	$0	($36,552,000)	$36,552,000
263	ELECTRONIC CIGARETTE PRODUCTS TAX	$0	$0	($9,600,000)	$9,600,000
265	RECONCILIATION	$2,491,000	($8,190,000)	$10,681,000	$0
	OTHER SUBTOTAL	**$357,002,380**	**$1,054,851,780**	**($2,294,507,400)**	**$1,596,658,000**
	GRAND TOTAL	**$42,922,729,990**	**$30,603,855,500**	**($3,316,008,860)**	**$15,634,883,350**

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

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
FISCAL YEAR 2020-21

SERVICE CATEGORY	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
PROFESSIONAL	$8,355,086,150	$5,043,043,160	$2,156,126,710	$1,155,916,280
PHYSICIANS	$1,124,228,240	$791,775,800	$275,548,460	$56,903,980
OTHER MEDICAL	$4,797,309,140	$2,839,698,840	$1,810,385,320	$147,224,980
CO. & COMM. OUTPATIENT	$2,433,548,770	$1,411,568,520	$70,192,930	$951,787,320
PHARMACY	$4,452,172,270	$2,241,097,550	$497,402,940	$1,713,671,780
HOSPITAL INPATIENT	$13,857,015,080	$8,632,081,060	$1,612,485,040	$3,612,448,980
COUNTY INPATIENT	$3,576,744,770	$2,347,738,110	$37,457,630	$1,191,549,030
COMMUNITY INPATIENT	$10,280,270,310	$6,284,342,950	$1,575,027,410	$2,420,899,950
LONG TERM CARE	$3,399,855,600	$1,999,354,160	$1,256,908,750	$143,592,690
NURSING FACILITIES	$2,906,025,140	$1,700,768,920	$1,094,511,800	$110,744,420
ICF-DD	$493,830,460	$298,585,230	$162,396,950	$32,848,270
OTHER SERVICES	$1,633,170,590	$1,106,144,430	$491,647,740	$35,378,420
MEDICAL TRANSPORTATION	$225,769,070	$175,332,390	$42,551,190	$7,885,490
OTHER SERVICES	$1,123,792,330	$763,983,610	$335,620,290	$24,188,430
HOME HEALTH	$283,609,200	$166,828,430	$113,476,270	$3,304,500
TOTAL FEE-FOR-SERVICE	**$31,697,299,680**	**$19,021,720,350**	**$6,014,571,180**	**$6,661,008,150**
MANAGED CARE	$55,317,226,190	$35,576,339,260	$11,542,137,420	$8,198,749,510
TWO PLAN MODEL	$33,242,204,480	$21,371,069,390	$6,962,408,110	$4,908,726,970
COUNTY ORGANIZED HEALTH SYSTEMS	$13,283,347,610	$8,644,475,470	$2,594,656,300	$2,044,215,830
GEOGRAPHIC MANAGED CARE	$5,723,858,550	$3,636,738,120	$1,189,101,620	$898,018,810
PHP & OTHER MANAG. CARE	$1,109,634,160	$639,779,330	$439,019,530	$30,835,300
REGIONAL MODEL	$1,958,181,400	$1,284,276,940	$356,951,860	$316,952,590
DENTAL	$1,815,068,960	$962,727,590	$739,219,910	$113,121,450
MENTAL HEALTH	$3,151,709,200	$2,620,329,760	$322,182,150	$209,197,290
AUDITS/ LAWSUITS	$32,350,000	($334,559,000)	$366,909,000	$0
EPSDT SCREENS	$0	$0	$0	$0
MEDICARE PAYMENTS	$6,173,798,800	$2,445,272,750	$3,728,526,060	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$33,774,000	$32,258,510	$1,515,500	$0
MISC. SERVICES	$12,179,412,170	$11,550,460,510	$20,898,710	$608,052,950
RECOVERIES	($500,822,280)	($287,471,510)	($213,350,770)	$0
DRUG MEDI-CAL	$451,671,380	$383,067,180	$68,604,210	$0
GRAND TOTAL MEDI-CAL	**$110,351,488,100**	**$71,970,145,390**	**$22,591,213,360**	**$15,790,129,350**

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2019-20 AND 2020-21

SERVICE CATEGORY	MAY 2020 EST. FOR 2019-20	MAY 2020 EST. FOR 2020-21	DOLLAR DIFFERENCE	% CHANGE
PROFESSIONAL	$7,089,691,180	$8,355,086,150	$1,265,394,970	17.85%
PHYSICIANS	$684,258,770	$1,124,228,240	$439,969,470	64.30%
OTHER MEDICAL	$4,333,213,150	$4,797,309,140	$464,095,990	10.71%
CO. & COMM. OUTPATIENT	$2,072,219,250	$2,433,548,770	$361,329,510	17.44%
PHARMACY	$1,731,588,810	$4,452,172,270	$2,720,583,460	157.11%
HOSPITAL INPATIENT	$12,808,038,540	$13,857,015,080	$1,048,976,540	8.19%
COUNTY INPATIENT	$3,613,857,610	$3,576,744,770	($37,112,840)	-1.03%
COMMUNITY INPATIENT	$9,194,180,930	$10,280,270,310	$1,086,089,380	11.81%
LONG TERM CARE	$3,294,556,360	$3,399,855,600	$105,299,240	3.20%
NURSING FACILITIES	$2,845,956,590	$2,906,025,140	$60,068,550	2.11%
ICF-DD	$448,599,770	$493,830,460	$45,230,690	10.08%
OTHER SERVICES	$1,323,210,430	$1,633,170,590	$309,960,160	23.42%
MEDICAL TRANSPORTATION	$147,938,520	$225,769,070	$77,830,540	52.61%
OTHER SERVICES	$897,736,900	$1,123,792,330	$226,055,430	25.18%
HOME HEALTH	$277,535,010	$283,609,200	$6,074,190	2.19%
TOTAL FEE-FOR-SERVICE	**$26,247,085,310**	**$31,697,299,680**	**$5,450,214,370**	**20.77%**
MANAGED CARE	$47,387,790,130	$55,317,226,190	$7,929,436,060	16.73%
TWO PLAN MODEL	$28,637,877,130	$33,242,204,480	$4,604,327,350	16.08%
COUNTY ORGANIZED HEALTH SYSTEMS	$11,454,660,220	$13,283,347,610	$1,828,687,390	15.96%
GEOGRAPHIC MANAGED CARE	$4,805,313,990	$5,723,858,550	$918,544,560	19.12%
PHP & OTHER MANAG. CARE	$923,671,620	$1,109,634,160	$185,962,540	20.13%
REGIONAL MODEL	$1,566,267,170	$1,958,181,400	$391,914,220	25.02%
DENTAL	$1,156,799,580	$1,815,068,960	$658,269,380	56.90%
MENTAL HEALTH	$2,911,018,840	$3,151,709,200	$240,690,360	8.27%
AUDITS/ LAWSUITS	$37,712,990	$32,350,000	($5,363,000)	-14.22%
MEDICARE PAYMENTS	$5,635,187,830	$6,173,798,800	$538,610,970	9.56%
STATE HOSP./DEVELOPMENTAL CNTRS.	$66,041,760	$33,774,000	($32,267,750)	-48.86%
MISC. SERVICES	$11,253,686,250	$12,179,412,170	$925,725,920	8.23%
RECOVERIES	($429,495,970)	($500,822,280)	($71,326,310)	16.61%
DRUG MEDI-CAL	$392,958,050	$451,671,380	$58,713,340	14.94%
GRAND TOTAL MEDI-CAL	**$94,658,784,770**	**$110,351,488,100**	**$15,692,703,330**	**16.58%**
GENERAL FUNDS	**$21,608,096,140**	**$22,591,213,360**	**$983,117,220**	**4.55%**
OTHER STATE FUNDS	**$11,674,432,000**	**$15,790,129,350**	**$4,115,697,350**	**35.25%**

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
MAY 2020 ESTIMATE COMPARED TO NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2020-21

SERVICE CATEGORY	NOV. 2019 EST. FOR 2020-21	MAY 2020 EST. FOR 2020-21	DOLLAR DIFFERENCE	% CHANGE
PROFESSIONAL	$8,250,520,560	$8,355,086,150	$104,565,590	1.27%
PHYSICIANS	$1,073,469,300	$1,124,228,240	$50,758,940	4.73%
OTHER MEDICAL	$4,741,078,140	$4,797,309,140	$56,231,000	1.19%
CO. & COMM. OUTPATIENT	$2,435,973,120	$2,433,548,770	($2,424,360)	-0.10%
PHARMACY	$4,351,778,010	$4,452,172,270	$100,394,260	2.31%
HOSPITAL INPATIENT	$11,005,523,290	$13,857,015,080	$2,851,491,790	25.91%
COUNTY INPATIENT	$3,187,407,730	$3,576,744,770	$389,337,040	12.21%
COMMUNITY INPATIENT	$7,818,115,570	$10,280,270,310	$2,462,154,750	31.49%
LONG TERM CARE	$3,238,044,190	$3,399,855,600	$161,811,410	5.00%
NURSING FACILITIES	$2,785,820,390	$2,906,025,140	$120,204,750	4.31%
ICF-DD	$452,223,800	$493,830,460	$41,606,660	9.20%
OTHER SERVICES	$1,357,626,040	$1,633,170,590	$275,544,540	20.30%
MEDICAL TRANSPORTATION	$198,202,980	$225,769,070	$27,566,090	13.91%
OTHER SERVICES	$879,224,230	$1,123,792,330	$244,568,100	27.82%
HOME HEALTH	$280,198,830	$283,609,200	$3,410,360	1.22%
TOTAL FEE-FOR-SERVICE	**$28,203,492,090**	**$31,697,299,680**	**$3,493,807,590**	**12.39%**
MANAGED CARE	$49,185,990,930	$55,317,226,190	$6,131,235,260	12.47%
TWO PLAN MODEL	$29,576,205,140	$33,242,204,480	$3,665,999,340	12.40%
COUNTY ORGANIZED HEALTH SYSTEMS	$11,823,967,370	$13,283,347,610	$1,459,380,240	12.34%
GEOGRAPHIC MANAGED CARE	$5,168,023,950	$5,723,858,550	$555,834,600	10.76%
PHP & OTHER MANAG. CARE	$962,448,970	$1,109,634,160	$147,185,180	15.29%
REGIONAL MODEL	$1,655,345,500	$1,958,181,400	$302,835,900	18.29%
DENTAL	$1,830,893,210	$1,815,068,960	($15,824,250)	-0.86%
MENTAL HEALTH	$3,144,771,390	$3,151,709,200	$6,937,810	0.22%
AUDITS/ LAWSUITS	$32,350,000	$32,350,000	$0	0.00%
EPSDT SCREENS	$240,000	$0	($240,000)	-100.00%
MEDICARE PAYMENTS	$6,055,584,670	$6,173,798,800	$118,214,130	1.95%
STATE HOSP./DEVELOPMENTAL CNTRS.	$29,476,000	$33,774,000	$4,298,000	14.58%
MISC. SERVICES	$10,156,433,000	$12,179,412,170	$2,022,979,170	19.92%
RECOVERIES	($558,485,000)	($500,822,280)	$57,662,720	-10.32%
DRUG MEDI-CAL	$467,926,730	$451,671,380	($16,255,350)	-3.47%
GRAND TOTAL MEDI-CAL	**$98,548,673,010**	**$110,351,488,100**	**$11,802,815,090**	**11.98%**
GENERAL FUNDS	**$24,884,404,100**	**$22,591,213,360**	**($2,293,190,740)**	**-9.22%**
OTHER STATE FUNDS	**$10,848,318,700**	**$15,790,129,350**	**$4,941,810,650**	**45.55%**

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2020-21

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2019 EST. FOR 2020-21		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		ELIGIBILITY						
1	1	UNDOCUMENTED YOUNG ADULTS FULL SCOPE EXPANSION	$331,786,000	$232,231,000	$343,844,000	$238,921,000	$12,058,000	$6,690,000
2	2	MEDI-CAL STATE INMATE PROGRAMS	$62,957,000	$0	$84,662,000	$0	$21,705,000	$0
3	3	BREAST AND CERVICAL CANCER TREATMENT	$66,777,000	$41,800,900	$65,865,000	$41,404,900	($912,000)	($396,000)
7	7	FPL INCREASE FOR AGED AND DISABLED PERSONS	$135,862,000	$67,931,000	$135,468,000	$67,734,000	($394,000)	($197,000)
8	8	MEDI-CAL COUNTY INMATE PROGRAMS	$150,538,000	$1,706,400	$62,295,000	$2,622,600	($88,243,000)	$916,200
9	9	PROVISIONAL POSTPARTUM CARE EXTENSION	$45,812,000	$45,812,000	$34,291,000	$34,291,000	($11,521,000)	($11,521,000)
10	10	CS3 PROXY ADJUSTMENT	$0	($114,362,700)	$0	($122,728,680)	$0	($8,365,980)
11	11	MEDI-CAL COUNTY INMATE REIMBURSEMENT	$0	($1,653,000)	$0	($2,516,000)	$0	($863,000)
13	13	NON-OTLICP CHIP	$0	($102,413,320)	$0	($101,316,930)	$0	$1,096,400
14	14	NON-EMERGENCY FUNDING ADJUSTMENT	$0	$966,354,000	$0	$969,518,000	$0	$3,164,000
15	15	SCHIP FUNDING FOR PRENATAL CARE	$0	($76,385,220)	$0	($76,358,720)	$0	$26,500
16	16	CCHIP DELIVERY SYSTEM	($2,756,000)	($885,360)	($3,097,000)	($969,520)	($341,000)	($84,160)
17	17	MEDICARE OPTIONAL EXPANSION ADJUSTMENT	($14,154,000)	$20,081,930	$14,940,000	$27,371,410	$29,094,000	$7,289,480
18	18	CHIP PREMIUMS	($62,613,000)	($20,114,460)	($62,224,000)	($19,989,460)	$389,000	$125,000
19	19	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	($542,006,000)	($122,380,000)	($542,006,000)	($116,102,000)	$0	$6,278,000
216	216	MEDICARE PART B DISREGARD	$308,000	$308,000	$478,000	$478,000	$170,000	$170,000
--	232	DISABLED ADULT CHILDREN PROGRAM CLEANUP	$0	$0	$2,892,000	$2,892,000	$2,892,000	$2,892,000
--	266	HEARING AID COVERAGE - ADMIN	$0	$0	$195,000	$195,000	$195,000	$195,000
215	--	UNDOCUMENTED OLDER CALIFORNIANS EXPANSION	$74,547,000	$58,337,000	$0	$0	($74,547,000)	($58,337,000)
		ELIGIBILITY SUBTOTAL	**$247,058,000**	**$996,368,160**	**$137,603,000**	**$945,446,580**	**($109,455,000)**	**($50,921,580)**

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2020-21

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2019 EST. FOR 2020-21		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		AFFORDABLE CARE ACT						
20	20	COMMUNITY FIRST CHOICE OPTION	$4,486,094,000	$0	$4,423,366,000	$0	($62,728,000)	$0
21	21	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	$10,956,000	$0	$12,504,000	$0	$1,548,000	$0
22	22	HEALTH INSURER FEE	$284,312,000	$97,525,430	$284,312,000	$97,151,740	$0	($373,690)
23	23	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	$0	($40,120,400)	$0	($44,211,240)	$0	($4,090,840)
24	24	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	($3,238,000)	$0	($3,212,000)	$0	$26,000
26	26	PAYMENTS TO PRIMARY CARE PHYSICIANS	($74,000)	$0	($69,000)	$0	$5,000	$0
27	27	ACA OPTIONAL EXPANSION MLR RISK CORRIDOR	($100,000,000)	($5,500,000)	($100,000,000)	($5,500,000)	$0	$0
28	28	ACA DSH REDUCTION	($1,354,431,000)	($159,871,500)	($690,472,000)	($90,044,000)	$663,959,000	$69,827,500
		AFFORDABLE CARE ACT SUBTOTAL	**$3,326,857,000**	**($111,204,470)**	**$3,929,641,000**	**($45,815,500)**	**$602,784,000**	**$65,388,970**
		BENEFITS						
29	29	BEHAVIORAL HEALTH TREATMENT	$948,601,000	$439,430,260	$993,767,000	$469,364,430	$45,166,000	$29,934,160
30	30	FAMILY PACT PROGRAM	$372,154,000	$87,926,100	$366,733,000	$87,337,600	($5,421,000)	($588,500)
31	31	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$371,486,000	$0	$388,005,000	$0	$16,519,000	$0
32	32	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$116,127,000	$0	$129,016,000	$0	$12,889,000	$0
33	33	LEA EXPANSION	$80,151,000	$0	$80,468,000	$0	$317,000	$0
34	34	RESTORATION OF ADULT OPTICIAN & OPTICAL LAB SVCS	$58,563,340	$20,345,090	$34,913,300	$12,335,520	($23,650,040)	($8,009,570)
35	35	MSSP SUPPLEMENTAL PAYMENTS	$4,933,000	($4,933,000)	$4,933,000	($4,933,000)	$0	$0
36	36	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$513,000	$128,000	$4,074,000	$930,000	$3,561,000	$802,000
37	37	OPTIONAL BENEFITS RESTORATION	$39,415,180	$13,582,320	$16,202,480	$5,725,100	($23,212,700)	($7,857,220)
38	38	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	$20,232,000	$521,000	$20,232,000	$521,000	$0	$0
39	39	CCS DEMONSTRATION PROJECT	$6,452,000	$3,030,530	$6,456,000	$3,026,080	$4,000	($4,460)

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2020-21

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2019 EST. FOR 2020-21		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		BENEFITS						
40	40	MEDI-CAL NONMEDICAL TRANSPORTATION	$24,625,300	$9,575,730	$24,625,300	$9,545,450	$0	($30,270)
41	41	MEDICALLY TAILORED MEALS PILOT PROGRAM	$1,430,000	$1,430,000	$1,430,000	$1,430,000	$0	$0
42	42	YOUTH REGIONAL TREATMENT CENTERS	$2,203,000	$19,000	$2,203,000	$19,000	$0	$0
--	45	CCT FUND TRANSFER TO CDSS	$0	$0	$175,000	$0	$175,000	$0
46	46	DIABETES PREVENTION PROGRAM	$1,035,240	$367,100	$536,740	$189,920	($498,490)	($177,180)
48	48	EXPANSION TO SCREENING FOR ADDITIONAL SUBSTANCES	$7,389,200	$2,533,070	$1,293,970	$466,710	($6,095,230)	($2,066,360)
50	--	WHOLE CHILD MODEL IMPLEMENTATION	$0	$0	$0	$0	$0	$0
230	--	HEARING AID COVERAGE	$5,000,000	$5,000,000	$0	$0	($5,000,000)	($5,000,000)
		BENEFITS SUBTOTAL	**$2,060,310,260**	**$578,955,210**	**$2,075,063,800**	**$585,957,810**	**$14,753,540**	**$7,002,600**
		PHARMACY						
52	52	MEDI-CAL RX - MANAGED CARE PHARMACY BENEFIT TO FFS	($137,068,000)	($55,945,350)	($132,951,000)	($54,570,800)	$4,117,000	$1,374,550
53	53	MEDI-CAL DRUG REBATE FUND	$0	($1,315,885,000)	$0	($1,643,642,000)	$0	($327,757,000)
54	54	BLOOD FACTOR REIMBURSEMENT METHODOLOGY	($9,430,000)	($3,457,110)	($35,642,570)	($13,066,870)	($26,212,570)	($9,609,760)
55	55	MEDI-CAL RX - ADDITIONAL SAVINGS FROM MAIC IN FFS	($57,381,000)	($21,088,600)	($57,381,000)	($21,088,600)	$0	$0
56	56	BCCTP DRUG REBATES	($6,078,000)	$0	($5,081,000)	$0	$997,000	$0
57	57	FAMILY PACT DRUG REBATES	($11,542,000)	$0	($10,016,000)	$0	$1,526,000	$0
59	59	MEDICAL SUPPLY REBATES	($43,098,000)	($21,549,000)	($43,098,000)	($21,549,000)	$0	$0
60	60	STATE SUPPLEMENTAL DRUG REBATES	($139,806,000)	$0	($114,100,000)	$0	$25,706,000	$0
62	62	FEDERAL DRUG REBATES	($1,742,004,000)	$0	($1,439,215,000)	$0	$302,789,000	$0
--	237	PHARMACY RETROACTIVE ADJUSTMENTS	$0	$0	($189,800,000)	($54,016,050)	($189,800,000)	($54,016,050)
51	--	PHARMACIST-DELIVERED MEDI-CAL SERVICES	$949,000	$355,300	$0	$0	($949,000)	($355,300)

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2020-21

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2019 EST. FOR 2020-21		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		PHARMACY SUBTOTAL	**($2,145,458,000)**	**($1,417,569,760)**	**($2,027,284,570)**	**($1,807,933,320)**	**$118,173,430**	**($390,363,560)**
		DRUG MEDI-CAL						
63	63	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	$426,044,000	$62,654,400	$394,701,000	$61,474,060	($31,343,000)	($1,180,340)
67	67	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	$3,267,860	$332,650	$3,267,860	$332,650	$0	$0
69	69	DRUG MEDI-CAL MAT BENEFIT	$477,000	$29,920	$511,500	$16,500	$34,500	($13,420)
--	238	DMC & SMHS STATE ONLY CLAIMING ADJUSTMENT	$0	$0	$0	$148,514,000	$0	$148,514,000
		DRUG MEDI-CAL SUBTOTAL	**$429,788,860**	**$63,016,970**	**$398,480,360**	**$210,337,210**	**($31,308,500)**	**$147,320,240**
		MENTAL HEALTH						
74	74	MHP COSTS FOR CONTINUUM OF CARE REFORM	$22,716,000	$12,194,500	$24,651,000	$13,207,000	$1,935,000	$1,012,500
75	75	PATHWAYS TO WELL-BEING	$484,000	$0	$484,000	$0	$0	$0
--	76	LATE CLAIMS FOR SMHS	$0	$0	$30,000	$30,000	$30,000	$30,000
77	77	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	$0	($200,000)	$0	($200,000)	$0	$0
79	79	CHART REVIEW	($371,000)	$0	($371,000)	$0	$0	$0
--	80	INTERIM AND FINAL COST SETTLEMENTS - SMHS	$0	$0	($53,739,000)	$0	($53,739,000)	$0
		MENTAL HEALTH SUBTOTAL	**$22,829,000**	**$11,994,500**	**($28,945,000)**	**$13,037,000**	**($51,774,000)**	**$1,042,500**
		WAIVER--MH/UCD & BTR						
81	81	GLOBAL PAYMENT PROGRAM	$2,123,375,000	$0	$2,200,578,000	$0	$77,203,000	$0
82	82	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL	$612,000,000	$0	$612,000,000	$0	$0	$0
83	83	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS	$671,758,000	$0	$671,201,000	$0	($557,000)	$0

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2020-21

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2019 EST. FOR 2020-21		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		WAIVER--MH/UCD & BTR						
85	85	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	$204,462,000	$102,231,000	$174,230,000	$87,115,000	($30,232,000)	($15,116,000)
89	89	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$263,000	$0	$263,000	$0	$0	$0
--	243	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM	$0	$0	$0	($92,290,000)	$0	($92,290,000)
224	--	HEALTHIER CALIFORNIA FOR ALL - ENHANCED CARE MGMT	$225,000,000	$112,500,000	$0	$0	($225,000,000)	($112,500,000)
225	--	HEALTHIER CALIFORNIA FOR ALL - ILOS	$357,500,000	$178,750,000	$0	$0	($357,500,000)	($178,750,000)
		WAIVER--MH/UCD & BTR SUBTOTAL	**$4,194,358,000**	**$393,481,000**	**$3,658,272,000**	**($5,175,000)**	**($536,086,000)**	**($398,656,000)**
		MANAGED CARE						
95	95	CCI-MANAGED CARE PAYMENTS	$8,483,315,000	$4,241,657,500	$8,539,346,000	$4,269,673,000	$56,031,000	$28,015,500
96	96	MANAGED CARE HEALTH CARE FINANCING PROGRAM	$1,847,087,000	$628,225,440	$1,917,686,000	$653,666,820	$70,599,000	$25,441,380
97	97	MANAGED CARE PUBLIC HOSPITAL EPP	$1,541,109,000	$360,354,860	$1,541,109,000	$361,561,850	$0	$1,206,990
100	100	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	$667,840,000	$154,921,240	$667,840,000	$154,921,040	$0	($200)
103	103	RETRO MC RATE ADJUSTMENTS	$252,973,000	$119,919,000	$363,335,000	$211,153,890	$110,362,000	$91,234,880
104	104	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS	$203,895,000	$0	$203,895,000	$0	$0	$0
107	107	CCI-QUALITY WITHHOLD REPAYMENTS	$16,822,000	$8,411,000	$16,822,000	$8,411,000	$0	$0
110	110	CAPITATED RATE ADJUSTMENT FOR FY 2020-21	$668,558,000	$227,997,870	$0	$0	($668,558,000)	($227,997,870)
113	113	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	$0	($1,261,125,000)	$0	($1,284,053,000)	$0	($22,928,000)
114	114	COORDINATED CARE INITIATIVE RISK MITIGATION	($65,537,000)	($32,768,500)	($111,260,000)	($55,630,000)	($45,723,000)	($22,861,500)
116	116	MANAGED CARE DRUG REBATES	($1,380,815,000)	$0	($1,504,444,000)	$0	($123,629,000)	$0
--	218	2020 MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	$0	$0	($1,686,645,000)	$0	($1,686,645,000)

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2020-21

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2019 EST. FOR 2020-21		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		MANAGED CARE						
--	219	2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	$0	$0	$0	($1,083,013,000)	$0	($1,083,013,000)
--	220	2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	$0	$0	$3,177,119,000	$1,083,012,760	$3,177,119,000	$1,083,012,760
--	234	SAN MATEO HEALTH PLAN REIMBURSEMENT	$0	$0	$30,000,000	$30,000,000	$30,000,000	$30,000,000
--	255	ADJUST MC CAP PAYMENTS FOR JULY 2019-DEC 2020	$0	$0	($585,917,000)	($181,978,300)	($585,917,000)	($181,978,300)
--	258	MANAGED CARE EFFICIENCIES	$0	$0	($182,058,000)	($59,253,000)	($182,058,000)	($59,253,000)
217	--	RESTORATION OF DENTAL FFS IN SAC AND LA COUNTIES	($22,132,000)	($8,839,900)	$0	$0	$22,132,000	$8,839,900
		MANAGED CARE SUBTOTAL	**$12,213,115,000**	**$4,438,753,520**	**$14,073,473,000**	**$2,421,828,060**	**$1,860,358,000**	**($2,016,925,450)**
		PROVIDER RATES						
117	117	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	$200,129,000	($7,697,000)	$215,459,000	($7,980,000)	$15,330,000	($283,000)
118	118	RATE INCREASE FOR FQHCS/RHCS/CBRCS	$259,929,790	$100,081,410	$263,435,630	$101,430,810	$3,505,850	$1,349,400
119	119	AB 1629 ANNUAL RATE ADJUSTMENTS	$180,036,000	$90,018,000	$205,698,000	$102,849,000	$25,662,000	$12,831,000
120	120	FQHC/RHC/CBRC RECONCILIATION PROCESS	$69,637,000	$26,812,500	$73,390,000	$28,257,400	$3,753,000	$1,444,900
121	121	PROP 56 - HOME HEALTH RATE INCREASE	$92,754,000	$45,423,540	$92,754,000	$44,971,860	$0	($451,680)
122	122	DPH INTERIM RATE GROWTH	$83,997,900	$41,998,950	$35,388,120	$17,694,060	($48,609,780)	($24,304,890)
123	123	LTC RATE ADJUSTMENT	$46,174,390	$23,087,190	$56,443,020	$28,221,510	$10,268,630	$5,134,310
124	124	DPH INTERIM & FINAL RECONS	$195,615,000	$0	$159,698,000	$0	($35,917,000)	$0
125	125	PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE	$14,246,000	$6,959,800	$14,246,000	$6,959,800	$0	$0
127	127	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	$9,486,000	($1,186,000)	$10,000,000	($1,626,000)	$514,000	($440,000)
128	128	HOSPICE RATE INCREASES	$7,534,290	$3,767,150	$7,393,260	$3,696,630	($141,030)	($70,510)
129	129	DPH INTERIM RATE	$0	($403,108,900)	$0	($401,766,100)	$0	$1,342,800

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2020-21

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2019 EST. FOR 2020-21		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		PROVIDER RATES						
130	130	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	($595,880,000)	$0	($623,984,000)	$0	($28,104,000)
132	132	DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT	($2,564,180)	($1,182,520)	($2,366,570)	($1,089,590)	$197,610	$92,930
133	133	LABORATORY RATE METHODOLOGY CHANGE	($9,105,040)	($4,552,520)	($19,524,430)	($9,762,220)	($10,419,390)	($5,209,700)
134	134	10% PROVIDER PAYMENT REDUCTION	($171,841,000)	($85,920,500)	($171,841,000)	($85,920,500)	$0	$0
136	136	REDUCTION TO RADIOLOGY RATES	($5,321,340)	($2,660,670)	($9,162,080)	($4,581,040)	($3,840,750)	($1,920,370)
223	223	NURSING FACILITY FINANCING REFORM	$129,335,880	$62,190,560	$70,171,540	$33,741,700	($59,164,340)	($28,448,860)
226	226	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	$7,170,730	$3,585,370	$6,988,220	$3,494,110	($182,510)	($91,250)
		PROVIDER RATES SUBTOTAL	**$1,107,214,420**	**($698,263,650)**	**$1,008,170,710**	**($765,392,580)**	**($99,043,710)**	**($67,128,930)**
		SUPPLEMENTAL PMNTS.						
137	137	HOSPITAL QAF - FFS PAYMENTS	$3,564,664,000	$0	$4,989,101,000	$0	$1,424,437,000	$0
138	138	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	$2,326,556,000	$0	$2,326,556,000	$0	$0	$0
139	139	HOSPITAL QAF - MANAGED CARE PAYMENTS	$2,846,100,000	$0	$2,846,100,000	$0	$0	$0
140	140	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	$920,264,000	$0	$1,063,771,000	$0	$143,507,000	$0
141	141	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	$1,191,399,000	$406,821,910	$1,191,399,000	$426,106,610	$0	$19,284,700
142	142	PRIVATE HOSPITAL DSH REPLACEMENT	$609,832,000	$304,916,000	$608,335,000	$304,167,500	($1,497,000)	($748,500)
143	143	PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES	$532,873,000	$210,878,040	$522,826,000	$207,292,150	($10,047,000)	($3,585,890)
144	144	PROP 56 - MEDI-CAL FAMILY PLANNING	$399,166,000	$39,916,600	$394,485,000	$39,448,500	($4,681,000)	($468,100)
145	145	DSH PAYMENT	$434,887,000	$22,500,000	$495,326,000	$24,952,000	$60,439,000	$2,452,000
146	146	PROP 56 - VALUE-BASED PAYMENT PROGRAM	$388,837,000	$178,624,600	$459,503,000	$178,279,640	$70,666,000	($344,960)
147	147	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	$311,839,000	$118,400,000	$312,824,000	$126,275,000	$985,000	$7,875,000

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2020-21

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2019 EST. FOR 2020-21		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		SUPPLEMENTAL PMNTS.						
148	148	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$243,936,000	$0	$253,433,000	$0	$9,497,000	$0
149	149	CAPITAL PROJECT DEBT REIMBURSEMENT	$108,697,000	$30,129,500	$94,555,000	$26,770,000	($14,142,000)	($3,359,500)
150	150	FFP FOR LOCAL TRAUMA CENTERS	$162,283,000	$0	$163,862,000	$0	$1,579,000	$0
151	151	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	$117,484,000	$0	$118,812,000	$0	$1,328,000	$0
152	152	NDPH IGT SUPPLEMENTAL PAYMENTS	$141,726,000	($9,145,000)	$83,684,000	($5,856,000)	($58,042,000)	$3,289,000
153	153	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	$76,444,000	$0	$85,239,000	$0	$8,795,000	$0
154	154	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	$82,000,000	$46,979,000	$82,000,000	$46,979,000	$0	$0
155	155	GEMT SUPPLEMENTAL PAYMENT PROGRAM	$47,509,000	$0	$80,700,000	$0	$33,191,000	$0
156	156	PROP 56 - DEVELOPMENTAL SCREENINGS	$49,435,890	$23,610,940	$49,039,570	$22,229,820	($396,320)	($1,381,110)
157	157	PROP 56 - CBAS SUPPLEMENTAL PAYMENTS	$30,992,000	$15,496,000	$30,992,000	$15,496,000	$0	$0
158	158	PROP 56 - ADVERSE CHILDHOOD EXPERIENCES SCREENINGS	$37,721,110	$13,101,790	$37,593,600	$15,158,940	($127,500)	$2,057,150
159	159	DPH PHYSICIAN & NON-PHYS. COST	$271,208,000	$0	$224,686,000	$0	($46,522,000)	$0
160	160	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$5,000,000	$10,000,000	$5,000,000	$0	$0
161	161	PROP 56 - NEMT SUPPLEMENTAL PAYMENTS	$11,223,000	$4,610,410	$7,935,410	$3,259,810	($3,287,590)	($1,350,600)
162	162	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$8,621,000	$0	$8,271,000	$0	($350,000)	$0
163	163	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$4,000,000	$8,000,000	$4,000,000	$0	$0
164	164	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS	$32,041,000	$15,052,260	$31,394,000	$14,799,530	($647,000)	($252,730)
165	165	NDPH SUPPLEMENTAL PAYMENT	$4,274,000	$1,900,000	$4,273,000	$1,900,000	($1,000)	$0
166	166	PROP 56 - HOSP-BASED PEDIATRIC PHYS SUPPL PYMTS	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$0	$0

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2020-21

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2019 EST. FOR 2020-21		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		SUPPLEMENTAL PMNTS.						
167	167	PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS	$8,870,000	$4,072,760	$9,048,000	$4,135,980	$178,000	$63,220
168	168	PROPOSITION 56 FUNDS TRANSFER	$0	($1,027,770,000)	$0	($1,042,035,000)	$0	($14,265,000)
169	169	PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$201,168,000	$27,713,500	$211,293,000	$26,796,000	$10,125,000	($917,500)
170	170	PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS	$6,800,000	$3,400,000	$6,800,000	$3,400,000	$0	$0
171	171	IGT ADMIN. & PROCESSING FEE	$0	($21,098,000)	$0	($28,652,000)	$0	($7,554,000)
--	221	IGT PAYMENTS FOR HOSPITAL SERVICES	$0	$0	$0	$10,077,000	$0	$10,077,000
227	227	NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS	$52,500,000	$26,250,000	$52,500,000	$26,250,000	$0	$0
		SUPPLEMENTAL PMNTS. SUBTOTAL	**$15,241,350,000**	**$447,360,300**	**$16,866,336,590**	**$458,230,490**	**$1,624,986,580**	**$10,870,180**
		COVID-19						
--	245	COVID-19 UNINSURED ELIGIBILITY GROUP	$0	$0	$10,177,000	$5,362,000	$10,177,000	$5,362,000
--	246	COVID-19 ADDITIONAL IMPACTS	$0	$0	$286,584,000	$126,622,000	$286,584,000	$126,622,000
--	247	COVID-19 UTILIZATION CHANGE	$0	$0	($395,693,000)	($146,780,000)	($395,693,000)	($146,780,000)
--	248	COVID-19 EMERGENCY FMAP - OTHER DEPTS	$0	$0	$1,296,027,000	$0	$1,296,027,000	$0
--	249	COVID-19 BEHAVIORAL HEALTH	$0	$0	$77,705,000	$7,652,000	$77,705,000	$7,652,000
--	250	COVID-19 EMERGENCY FMAP - DHCS	$0	$0	$0	($2,554,167,000)	$0	($2,554,167,000)
--	251	COVID-19 CASELOAD IMPACT	$0	$0	$6,829,878,000	$2,408,249,000	$6,829,878,000	$2,408,249,000
		COVID-19 SUBTOTAL	**$0**	**$0**	**$8,104,678,000**	**($153,062,000)**	**$8,104,678,000**	**($153,062,000)**
		OTHER DEPARTMENTS						
172	172	ELECTRONIC VISIT VERIFICATION PHASE II FED PENALTY	($5,130,000)	$417,000	($5,130,000)	$417,000	$0	$0
--	267	ADDITIONAL FEDERAL FUNDING TO OTHER DEPT.	$0	$0	$438,643,000	$0	$438,643,000	$0

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2020-21

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2019 EST. FOR 2020-21		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER DEPARTMENTS SUBTOTAL	**($5,130,000)**	**$417,000**	**$433,513,000**	**$417,000**	**$438,643,000**	**$0**
		OTHER						
--	178	CCI IHSS RECONCILIATION	$0	$0	$100,000,000	$0	$100,000,000	$0
181	181	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$60,362,000	$0	$95,060,000	$0	$34,698,000	$0
182	182	ARRA HITECH - PROVIDER PAYMENTS	$18,454,000	$0	$15,268,000	$0	($3,186,000)	$0
188	188	INFANT DEVELOPMENT PROGRAM	$33,381,000	$0	$32,746,000	$0	($635,000)	$0
189	189	PROP 56 - PROVIDER ACES TRAININGS	$60,000,000	$30,000,000	$61,924,000	$30,962,000	$1,924,000	$962,000
190	190	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	$51,639,260	$25,819,630	$50,193,960	$25,096,980	($1,445,300)	($722,650)
191	191	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$10,681,000	$4,888,000	$15,797,000	$6,928,000	$5,116,000	$2,040,000
192	192	OVERTIME FOR WPCS PROVIDERS	$7,839,000	$3,919,500	$8,444,000	$4,222,000	$605,000	$302,500
193	193	INDIAN HEALTH SERVICES	$15,622,000	$0	$20,174,000	$6,758,500	$4,552,000	$6,758,500
194	194	WPCS WORKERS' COMPENSATION	$3,324,000	$1,662,000	$3,324,000	$1,662,000	$0	$0
198	198	FUNDING ADJUST.—OTLICP	$144,000	($107,849,980)	$0	($109,194,740)	($144,000)	($1,344,760)
199	199	PROP 56 PHYSICIANS & DENTISTS LOAN REPAYMENT PROG	$15,200,000	$0	$15,200,000	$0	$0	$0
200	200	CMS DEFERRED CLAIMS	$0	$200,000,000	$0	$350,000,000	$0	$150,000,000
201	201	INDIAN HEALTH SERVICES FUNDING SHIFT	$0	($13,000,000)	$0	($13,000,000)	$0	$0
202	202	FUNDING ADJUST.—ACA OPT. EXPANSION	$0	($1,887,884,000)	$0	($1,824,254,400)	$0	$63,629,600
203	203	CLPP FUND	$0	($725,000)	$0	($916,000)	$0	($191,000)
204	204	HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	($913,500,000)	$0	($976,000,000)	$0	($62,500,000)
--	205	AUDIT SETTLEMENTS	$0	$0	$0	$734,000	$0	$734,000
206	206	IMD ANCILLARY SERVICES	$0	$13,392,000	$0	$20,807,000	$0	$7,415,000

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2020-21

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2019 EST. FOR 2020-21		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
207	207	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	($173,639,000)	$0	($160,657,000)	$0	$12,982,000
208	208	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER RENEWAL	($18,032,000)	($9,016,000)	($27,215,000)	($13,607,500)	($9,183,000)	($4,591,500)
210	210	COUNTY SHARE OF OTLICP-CCS COSTS	($22,660,000)	($22,660,000)	($22,660,000)	($22,660,000)	$0	$0
211	211	ASSISTED LIVING WAIVER EXPANSION	($59,140,000)	($29,570,000)	($56,144,000)	($28,072,000)	$2,996,000	$1,498,000
--	233	REPAYMENT TO CMS FOR CONTINGENCY FEE OFFSETS	$0	$0	$0	$10,370,000	$0	$10,370,000
--	236	TRIBAL FEDERALLY QUALIFIED HEALTH CENTER	$0	$0	$1,576,000	$350,550	$1,576,000	$350,550
--	242	SELF-DETERMINATION PROGRAM - CDDS	$0	$0	$17,139,000	$0	$17,139,000	$0
--	244	STATE ONLY CLAIMING ADJUSTMENTS	$0	$0	$0	$519,592,000	$0	$519,592,000
--	261	FUND 3156 TRANSFER TO THE GENERAL FUND	$0	$0	$0	($100,000,000)	$0	($100,000,000)
--	262	FUND 3311 TRANSFER TO THE GENERAL FUND	$0	$0	$0	($36,552,000)	$0	($36,552,000)
--	263	ELECTRONIC CIGARETTE PRODUCTS TAX	$0	$0	$0	($9,600,000)	$0	($9,600,000)
--	265	RECONCILIATION	$0	$0	$2,491,000	$10,681,000	$2,491,000	$10,681,000
229	--	HEALTHIER CALIFORNIA FOR ALL - DENTAL BENEFITS	$112,500,000	$56,250,000	$0	$0	($112,500,000)	($56,250,000)
		OTHER SUBTOTAL	**$289,314,260**	**($2,821,912,850)**	**$333,317,960**	**($2,306,349,610)**	**$44,003,700**	**$515,563,240**
		GRAND TOTAL	**$36,981,606,790**	**$1,881,395,930**	**$48,962,319,840**	**($448,473,850)**	**$11,980,713,040**	**($2,329,869,780)**

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2019-20 AND 2020-21

		MAY 2020 EST. FOR 2019-20		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	ELIGIBILITY						
1	UNDOCUMENTED YOUNG ADULTS FULL SCOPE EXPANSION	$109,842,000	$77,398,000	$343,844,000	$238,921,000	$234,002,000	$161,523,000
2	MEDI-CAL STATE INMATE PROGRAMS	$62,206,000	$0	$84,662,000	$0	$22,456,000	$0
3	BREAST AND CERVICAL CANCER TREATMENT	$65,373,000	$41,133,350	$65,865,000	$41,404,900	$492,000	$271,550
7	FPL INCREASE FOR AGED AND DISABLED PERSONS	$0	$0	$135,468,000	$67,734,000	$135,468,000	$67,734,000
8	MEDI-CAL COUNTY INMATE PROGRAMS	$45,042,000	$2,201,580	$62,295,000	$2,622,600	$17,253,000	$421,020
9	PROVISIONAL POSTPARTUM CARE EXTENSION	$0	$0	$34,291,000	$34,291,000	$34,291,000	$34,291,000
10	CS3 PROXY ADJUSTMENT	$0	($316,999,420)	$0	($122,728,680)	$0	$194,270,730
11	MEDI-CAL COUNTY INMATE REIMBURSEMENT	$0	($1,952,000)	$0	($2,516,000)	$0	($564,000)
12	CDCR RETRO REPAYMENT	$0	$1,466,000	$0	$0	$0	($1,466,000)
13	NON-OTLICP CHIP	$0	($170,168,730)	$0	($101,316,930)	$0	$68,851,800
14	NON-EMERGENCY FUNDING ADJUSTMENT	$0	$987,242,000	$0	$969,518,000	$0	($17,724,000)
15	SCHIP FUNDING FOR PRENATAL CARE	$0	($90,190,810)	$0	($76,358,720)	$0	$13,832,080
16	CCHIP DELIVERY SYSTEM	($1,921,000)	($451,440)	($3,097,000)	($969,520)	($1,176,000)	($518,090)
17	MEDICARE OPTIONAL EXPANSION ADJUSTMENT	($42,464,000)	$71,483,650	$14,940,000	$27,371,410	$57,404,000	($44,112,240)
18	CHIP PREMIUMS	($62,286,000)	($12,846,540)	($62,224,000)	($19,989,460)	$62,000	($7,142,920)
19	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	($270,996,000)	($51,763,000)	($542,006,000)	($116,102,000)	($271,010,000)	($64,339,000)
216	MEDICARE PART B DISREGARD	$0	$0	$478,000	$478,000	$478,000	$478,000
232	DISABLED ADULT CHILDREN PROGRAM CLEANUP	$2,892,000	$5,870,000	$2,892,000	$2,892,000	$0	($2,978,000)
266	HEARING AID COVERAGE - ADMIN	$0	$0	$195,000	$195,000	$195,000	$195,000
	ELIGIBILITY SUBTOTAL	**($92,312,000)**	**$542,422,640**	**$137,603,000**	**$945,446,580**	**$229,915,000**	**$403,023,940**
	AFFORDABLE CARE ACT						
20	COMMUNITY FIRST CHOICE OPTION	$3,718,574,000	$0	$4,423,366,000	$0	$704,792,000	$0

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2019-20 AND 2020-21

		MAY 2020 EST. FOR 2019-20		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	AFFORDABLE CARE ACT						
21	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	$28,134,000	$0	$12,504,000	$0	($15,630,000)	$0
22	HEALTH INSURER FEE	$0	$0	$284,312,000	$97,151,740	$284,312,000	$97,151,740
23	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	$0	($44,894,710)	$0	($44,211,240)	$0	$683,470
24	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	($3,225,000)	$0	($3,212,000)	$0	$13,000
25	ACA MAGI SAVINGS	$0	$0	$0	$0	$0	$0
26	PAYMENTS TO PRIMARY CARE PHYSICIANS	($120,000)	$0	($69,000)	$0	$51,000	$0
27	ACA OPTIONAL EXPANSION MLR RISK CORRIDOR	($381,343,000)	($9,533,600)	($100,000,000)	($5,500,000)	$281,343,000	$4,033,600
28	ACA DSH REDUCTION	$0	$0	($690,472,000)	($90,044,000)	($690,472,000)	($90,044,000)
	AFFORDABLE CARE ACT SUBTOTAL	**$3,365,245,000**	**($57,653,310)**	**$3,929,641,000**	**($45,815,500)**	**$564,396,000**	**$11,837,810**
	BENEFITS						
29	BEHAVIORAL HEALTH TREATMENT	$863,002,000	$392,228,710	$993,767,000	$469,364,430	$130,765,000	$77,135,720
30	FAMILY PACT PROGRAM	$371,873,000	$88,561,700	$366,733,000	$87,337,600	($5,140,000)	($1,224,100)
31	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$356,323,000	$0	$388,005,000	$0	$31,682,000	$0
32	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$130,696,000	$0	$129,016,000	$0	($1,680,000)	$0
33	LEA EXPANSION	$0	$0	$80,468,000	$0	$80,468,000	$0
34	RESTORATION OF ADULT OPTICIAN & OPTICAL LAB SVCS	$12,134,160	$4,299,350	$34,913,300	$12,335,520	$22,779,140	$8,036,170
35	MSSP SUPPLEMENTAL PAYMENTS	$4,933,000	($4,933,000)	$4,933,000	($4,933,000)	$0	$0
36	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$28,189,000	$6,379,000	$4,074,000	$930,000	($24,115,000)	($5,449,000)
37	OPTIONAL BENEFITS RESTORATION	$6,805,680	$2,411,300	$16,202,480	$5,725,100	$9,396,800	$3,313,800
38	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	$20,232,000	($9,074,000)	$20,232,000	$521,000	$0	$9,595,000
39	CCS DEMONSTRATION PROJECT	$11,122,000	$5,074,480	$6,456,000	$3,026,080	($4,666,000)	($2,048,410)
40	MEDI-CAL NONMEDICAL TRANSPORTATION	$9,030,200	$3,439,010	$24,625,300	$9,545,450	$15,595,100	$6,106,440

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2019-20 AND 2020-21

		MAY 2020 EST. FOR 2019-20		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	BENEFITS						
41	MEDICALLY TAILORED MEALS PILOT PROGRAM	$2,500,000	$2,500,000	$1,430,000	$1,430,000	($1,070,000)	($1,070,000)
42	YOUTH REGIONAL TREATMENT CENTERS	$2,061,000	$16,000	$2,203,000	$19,000	$142,000	$3,000
43	PEDIATRIC PALLIATIVE CARE WAIVER	$1,033,000	$1,033,000	$0	$0	($1,033,000)	($1,033,000)
44	FREE CLINIC OF SIMI VALLEY	$700,000	$700,000	$0	$0	($700,000)	($700,000)
45	CCT FUND TRANSFER TO CDSS	$175,000	$0	$175,000	$0	$0	$0
46	DIABETES PREVENTION PROGRAM	$0	$0	$536,740	$189,920	$536,740	$189,920
47	ASTHMA MITIGATION PROJECT	$15,000,000	$15,000,000	$0	$0	($15,000,000)	($15,000,000)
48	EXPANSION TO SCREENING FOR ADDITIONAL SUBSTANCES	$0	$0	$1,293,970	$466,710	$1,293,970	$466,710
49	MEDICAL INTERPRETERS PILOT PROJECT	$5,000,000	$5,000,000	$0	$0	($5,000,000)	($5,000,000)
50	WHOLE CHILD MODEL IMPLEMENTATION	($7,323,000)	($3,372,260)	$0	$0	$7,323,000	$3,372,260
	BENEFITS SUBTOTAL	**$1,833,486,040**	**$509,263,290**	**$2,075,063,800**	**$585,957,810**	**$241,577,760**	**$76,694,520**
	PHARMACY						
52	MEDI-CAL RX - MANAGED CARE PHARMACY BENEFIT TO FFS	$0	$0	($132,951,000)	($54,570,800)	($132,951,000)	($54,570,800)
53	MEDI-CAL DRUG REBATE FUND	$0	($1,364,798,000)	$0	($1,643,642,000)	$0	($278,844,000)
54	BLOOD FACTOR REIMBURSEMENT METHODOLOGY	$0	$0	($35,642,570)	($13,066,870)	($35,642,570)	($13,066,870)
55	MEDI-CAL RX - ADDITIONAL SAVINGS FROM MAIC IN FFS	$0	$0	($57,381,000)	($21,088,600)	($57,381,000)	($21,088,600)
56	BCCTP DRUG REBATES	($4,464,000)	$0	($5,081,000)	$0	($617,000)	$0
57	FAMILY PACT DRUG REBATES	($22,612,000)	$0	($10,016,000)	$0	$12,596,000	$0
58	LITIGATION SETTLEMENTS	($302,000)	($302,000)	$0	$0	$302,000	$302,000
59	MEDICAL SUPPLY REBATES	($20,024,000)	($10,012,000)	($43,098,000)	($21,549,000)	($23,074,000)	($11,537,000)
60	STATE SUPPLEMENTAL DRUG REBATES	($101,891,000)	$0	($114,100,000)	$0	($12,209,000)	$0
62	FEDERAL DRUG REBATES	($1,554,560,000)	$0	($1,439,215,000)	$0	$115,345,000	$0
237	PHARMACY RETROACTIVE ADJUSTMENTS	$0	$0	($189,800,000)	($54,016,050)	($189,800,000)	($54,016,050)
	PHARMACY SUBTOTAL	**($1,703,853,000)**	**($1,375,112,000)**	**($2,027,284,570)**	**($1,807,933,320)**	**($323,431,570)**	**($432,821,320)**

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2019-20 AND 2020-21

		MAY 2020 EST. FOR 2019-20		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DRUG MEDI-CAL						
63	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	$341,222,000	$47,646,880	$394,701,000	$61,474,060	$53,479,000	$13,827,190
67	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	$0	$0	$3,267,860	$332,650	$3,267,860	$332,650
69	DRUG MEDI-CAL MAT BENEFIT	$0	$0	$511,500	$16,500	$511,500	$16,500
70	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	($162,000)	$0	$0	$0	$162,000	$0
238	DMC & SMHS STATE ONLY CLAIMING ADJUSTMENT	$0	$0	$0	$148,514,000	$0	$148,514,000
	DRUG MEDI-CAL SUBTOTAL	**$341,060,000**	**$47,646,880**	**$398,480,360**	**$210,337,210**	**$57,420,360**	**$162,690,340**
	MENTAL HEALTH						
73	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT	$125,573,000	$0	$0	$0	($125,573,000)	$0
74	MHP COSTS FOR CONTINUUM OF CARE REFORM	$24,184,000	$12,973,500	$24,651,000	$13,207,000	$467,000	$233,500
75	PATHWAYS TO WELL-BEING	$448,000	$0	$484,000	$0	$36,000	$0
76	LATE CLAIMS FOR SMHS	$535,000	$535,000	$30,000	$30,000	($505,000)	($505,000)
77	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	$0	($200,000)	$0	($200,000)	$0	$0
79	CHART REVIEW	($1,107,000)	$0	($371,000)	$0	$736,000	$0
80	INTERIM AND FINAL COST SETTLEMENTS - SMHS	($54,623,000)	$4,559,000	($53,739,000)	$0	$884,000	($4,559,000)
	MENTAL HEALTH SUBTOTAL	**$95,010,000**	**$17,867,500**	**($28,945,000)**	**$13,037,000**	**($123,955,000)**	**($4,830,500)**
	WAIVER--MH/UCD & BTR						
81	GLOBAL PAYMENT PROGRAM	$2,477,024,000	$0	$2,200,578,000	$0	($276,446,000)	$0
82	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL	$1,721,309,000	$0	$612,000,000	$0	($1,109,309,000)	$0
83	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS	$936,711,000	$0	$671,201,000	$0	($265,510,000)	$0
84	BTR - LIHP - MCE	$189,824,000	$0	$0	$0	($189,824,000)	$0

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2019-20 AND 2020-21

		MAY 2020 EST. FOR 2019-20		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	WAIVER--MH/UCD & BTR						
85	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	$196,179,000	$98,089,500	$174,230,000	$87,115,000	($21,949,000)	($10,974,500)
86	MH/UCD—STABILIZATION FUNDING	$117,101,000	$117,101,000	$0	$0	($117,101,000)	($117,101,000)
87	WHOLE PERSON CARE HOUSING SERVICES	$100,000,000	$100,000,000	$0	$0	($100,000,000)	($100,000,000)
88	MH/UCD—SAFETY NET CARE POOL	$73,784,000	$0	$0	$0	($73,784,000)	$0
89	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$531,000	$0	$263,000	$0	($268,000)	$0
90	MH/UCD—HEALTH CARE COVERAGE INITIATIVE	$1,003,000	$0	$0	$0	($1,003,000)	$0
91	BTR - LOW INCOME HEALTH PROGRAM - HCCI	($51,369,000)	$0	$0	$0	$51,369,000	$0
243	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM	$0	$0	$0	($92,290,000)	$0	($92,290,000)
	WAIVER--MH/UCD & BTR SUBTOTAL	**$5,762,097,000**	**$315,190,500**	**$3,658,272,000**	**($5,175,000)**	**($2,103,825,000)**	**($320,365,500)**
	MANAGED CARE						
95	CCI-MANAGED CARE PAYMENTS	$8,071,755,000	$4,035,877,500	$8,539,346,000	$4,269,673,000	$467,591,000	$233,795,500
96	MANAGED CARE HEALTH CARE FINANCING PROGRAM	$1,821,706,000	$585,232,940	$1,917,686,000	$653,666,820	$95,980,000	$68,433,880
97	MANAGED CARE PUBLIC HOSPITAL EPP	$1,476,865,000	$337,837,010	$1,541,109,000	$361,561,850	$64,244,000	$23,724,840
100	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	$640,000,000	$144,674,650	$667,840,000	$154,921,040	$27,840,000	$10,246,390
101	MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES	$187,991,000	$58,472,830	$0	$0	($187,991,000)	($58,472,830)
103	RETRO MC RATE ADJUSTMENTS	$148,805,000	$14,412,540	$363,335,000	$211,153,890	$214,530,000	$196,741,350
104	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS	$94,637,000	$0	$203,895,000	$0	$109,258,000	$0
107	CCI-QUALITY WITHHOLD REPAYMENTS	$8,260,000	$4,130,000	$16,822,000	$8,411,000	$8,562,000	$4,281,000
108	GENERAL FUND REIMBURSEMENTS FROM DPHS	$4,981,000	$4,981,000	$0	$0	($4,981,000)	($4,981,000)
110	CAPITATED RATE ADJUSTMENT FOR FY 2020-21	$0	$0	$0	$0	$0	$0

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2019-20 AND 2020-21

		MAY 2020 EST. FOR 2019-20		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	MANAGED CARE						
111	MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.	$0	($58,473,000)	$0	$0	$0	$58,473,000
112	MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	($582,257,000)	$0	$0	$0	$582,257,000
113	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	$0	($1,177,522,000)	$0	($1,284,053,000)	$0	($106,531,000)
114	COORDINATED CARE INITIATIVE RISK MITIGATION	$0	$0	($111,260,000)	($55,630,000)	($111,260,000)	($55,630,000)
115	RECOUPMENT OF UNALLOWED CAPITATION PAYMENTS	($68,245,000)	($24,478,640)	$0	$0	$68,245,000	$24,478,640
116	MANAGED CARE DRUG REBATES	($1,667,150,000)	$0	($1,504,444,000)	$0	$162,706,000	$0
218	2020 MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	$0	$0	($1,686,645,000)	$0	($1,686,645,000)
219	2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	$0	$0	$0	($1,083,013,000)	$0	($1,083,013,000)
220	2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	$0	$0	$3,177,119,000	$1,083,012,760	$3,177,119,000	$1,083,012,760
234	SAN MATEO HEALTH PLAN REIMBURSEMENT	$0	$0	$30,000,000	$30,000,000	$30,000,000	$30,000,000
255	ADJUST MC CAP PAYMENTS FOR JULY 2019-DEC 2020	$0	$0	($585,917,000)	($181,978,300)	($585,917,000)	($181,978,300)
258	MANAGED CARE EFFICIENCIES	$0	$0	($182,058,000)	($59,253,000)	($182,058,000)	($59,253,000)
	MANAGED CARE SUBTOTAL	**$10,719,605,000**	**$3,342,887,840**	**$14,073,473,000**	**$2,421,828,060**	**$3,353,868,000**	**($921,059,770)**
	PROVIDER RATES						
117	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	$242,858,000	($15,076,000)	$215,459,000	($7,980,000)	($27,399,000)	$7,096,000
118	RATE INCREASE FOR FQHCS/RHCS/CBRCS	$258,811,860	$98,534,610	$263,435,630	$101,430,810	$4,623,770	$2,896,210
119	AB 1629 ANNUAL RATE ADJUSTMENTS	$185,265,060	$92,632,530	$205,698,000	$102,849,000	$20,432,940	$10,216,470
120	FQHC/RHC/CBRC RECONCILIATION PROCESS	$92,591,000	$35,251,520	$73,390,000	$28,257,400	($19,201,000)	($6,994,120)
121	PROP 56 - HOME HEALTH RATE INCREASE	$113,501,000	$54,378,440	$92,754,000	$44,971,860	($20,747,000)	($9,406,590)
122	DPH INTERIM RATE GROWTH	$2,648,890	$1,324,440	$35,388,120	$17,694,060	$32,739,230	$16,369,620

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2019-20 AND 2020-21

		MAY 2020 EST. FOR 2019-20		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	PROVIDER RATES						
123	LTC RATE ADJUSTMENT	$29,709,030	$14,854,510	$56,443,020	$28,221,510	$26,733,990	$13,366,990
124	DPH INTERIM & FINAL RECONS	$220,014,000	$0	$159,698,000	$0	($60,316,000)	$0
125	PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE	$15,190,000	$7,313,780	$14,246,000	$6,959,800	($944,000)	($353,990)
127	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	$10,992,000	($1,803,000)	$10,000,000	($1,626,000)	($992,000)	$177,000
128	HOSPICE RATE INCREASES	$2,989,820	$1,494,910	$7,393,260	$3,696,630	$4,403,440	$2,201,720
129	DPH INTERIM RATE	$0	($362,258,460)	$0	($401,766,100)	$0	($39,507,640)
130	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	($508,693,000)	$0	($623,984,000)	$0	($115,291,000)
131	AB 97-RELATED ADJUSTMENT	$0	$40,508,000	$0	$0	$0	($40,508,000)
132	DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT	($350,300)	($161,160)	($2,366,570)	($1,089,590)	($2,016,270)	($928,430)
133	LABORATORY RATE METHODOLOGY CHANGE	($8,568,170)	($4,284,080)	($19,524,430)	($9,762,220)	($10,956,260)	($5,478,130)
134	10% PROVIDER PAYMENT REDUCTION	($171,841,000)	($85,920,500)	($171,841,000)	($85,920,500)	$0	$0
135	DENTAL RETROACTIVE RATE CHANGES	($11,368,000)	($4,335,140)	$0	$0	$11,368,000	$4,335,140
136	REDUCTION TO RADIOLOGY RATES	($54,303,000)	($27,151,500)	($9,162,080)	($4,581,040)	$45,140,920	$22,570,460
223	NURSING FACILITY FINANCING REFORM	$0	$0	$70,171,540	$33,741,700	$70,171,540	$33,741,700
226	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	$0	$0	$6,988,220	$3,494,110	$6,988,220	$3,494,110
	PROVIDER RATES SUBTOTAL	**$928,140,180**	**($663,390,100)**	**$1,008,170,710**	**($765,392,580)**	**$80,030,530**	**($102,002,480)**
	SUPPLEMENTAL PMNTS.						
137	HOSPITAL QAF - FFS PAYMENTS	$4,045,622,000	$0	$4,989,101,000	$0	$943,479,000	$0
138	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	$2,100,000,000	$0	$2,326,556,000	$0	$226,556,000	$0
139	HOSPITAL QAF - MANAGED CARE PAYMENTS	$1,897,400,000	$0	$2,846,100,000	$0	$948,700,000	$0
140	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	$545,042,000	$0	$1,063,771,000	$0	$518,729,000	$0

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2019-20 AND 2020-21

		MAY 2020 EST. FOR 2019-20		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	SUPPLEMENTAL PMNTS.						
141	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	$1,194,089,000	$404,388,880	$1,191,399,000	$426,106,610	($2,690,000)	$21,717,730
142	PRIVATE HOSPITAL DSH REPLACEMENT	$592,134,000	$296,067,000	$608,335,000	$304,167,500	$16,201,000	$8,100,500
143	PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES	$564,521,000	$213,513,640	$522,826,000	$207,292,150	($41,695,000)	($6,221,490)
144	PROP 56 - MEDI-CAL FAMILY PLANNING	$363,906,000	$36,390,600	$394,485,000	$39,448,500	$30,579,000	$3,057,900
145	DSH PAYMENT	$318,440,000	$24,184,000	$495,326,000	$24,952,000	$176,886,000	$768,000
146	PROP 56 - VALUE-BASED PAYMENT PROGRAM	$310,065,000	$102,975,940	$459,503,000	$178,279,640	$149,438,000	$75,303,700
147	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	$313,011,000	$120,094,000	$312,824,000	$126,275,000	($187,000)	$6,181,000
148	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$247,723,000	$0	$253,433,000	$0	$5,710,000	$0
149	CAPITAL PROJECT DEBT REIMBURSEMENT	$111,082,000	$28,352,000	$94,555,000	$26,770,000	($16,527,000)	($1,582,000)
150	FFP FOR LOCAL TRAUMA CENTERS	$131,604,000	$9,652,000	$163,862,000	$0	$32,258,000	($9,652,000)
151	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	$118,278,000	($270,750)	$118,812,000	$0	$534,000	$270,750
152	NDPH IGT SUPPLEMENTAL PAYMENTS	$94,555,000	($2,215,000)	$83,684,000	($5,856,000)	($10,871,000)	($3,641,000)
153	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	$82,304,000	$0	$85,239,000	$0	$2,935,000	$0
154	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	$88,000,000	$46,979,000	$82,000,000	$46,979,000	($6,000,000)	$0
155	GEMT SUPPLEMENTAL PAYMENT PROGRAM	$3,272,000	$0	$80,700,000	$0	$77,428,000	$0
156	PROP 56 - DEVELOPMENTAL SCREENINGS	$34,811,090	$14,755,250	$49,039,570	$22,229,820	$14,228,480	$7,474,570
157	PROP 56 - CBAS SUPPLEMENTAL PAYMENTS	$30,992,000	$15,496,000	$30,992,000	$15,496,000	$0	$0
158	PROP 56 - ADVERSE CHILDHOOD EXPERIENCES SCREENINGS	$25,485,910	$9,748,350	$37,593,600	$15,158,940	$12,107,690	$5,410,590
159	DPH PHYSICIAN & NON-PHYS. COST	$14,471,000	$0	$224,686,000	$0	$210,215,000	$0
160	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$5,000,000	$10,000,000	$5,000,000	$0	$0
161	PROP 56 - NEMT SUPPLEMENTAL PAYMENTS	$6,458,880	$2,619,590	$7,935,410	$3,259,810	$1,476,540	$640,220

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2019-20 AND 2020-21

		MAY 2020 EST. FOR 2019-20		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	SUPPLEMENTAL PMNTS.						
162	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$5,331,000	$0	$8,271,000	$0	$2,940,000	$0
163	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$4,000,000	$8,000,000	$4,000,000	$0	$0
164	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS	$32,713,000	$15,278,100	$31,394,000	$14,799,530	($1,319,000)	($478,570)
165	NDPH SUPPLEMENTAL PAYMENT	$4,299,000	$1,900,000	$4,273,000	$1,900,000	($26,000)	$0
166	PROP 56 - HOSP-BASED PEDIATRIC PHYS SUPPL PYMTS	$0	$0	$2,000,000	$2,000,000	$2,000,000	$2,000,000
167	PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS	$9,013,000	$4,084,410	$9,048,000	$4,135,980	$35,000	$51,570
168	PROPOSITION 56 FUNDS TRANSFER	$0	($921,343,000)	$0	($1,042,035,000)	$0	($120,692,000)
169	PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$216,918,000	$27,305,000	$211,293,000	$26,796,000	($5,625,000)	($509,000)
170	PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS	$6,800,000	$3,400,000	$6,800,000	$3,400,000	$0	$0
171	IGT ADMIN. & PROCESSING FEE	$0	($13,626,000)	$0	($28,652,000)	$0	($15,026,000)
221	IGT PAYMENTS FOR HOSPITAL SERVICES	$0	$118,000	$0	$10,077,000	$0	$9,959,000
227	NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS	$0	$0	$52,500,000	$26,250,000	$52,500,000	$26,250,000
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$13,526,340,880**	**$448,847,010**	**$16,866,336,590**	**$458,230,490**	**$3,339,995,710**	**$9,383,480**
	COVID-19						
245	COVID-19 UNINSURED ELIGIBILITY GROUP	$17,931,000	$9,546,000	$10,177,000	$5,362,000	($7,754,000)	($4,184,000)
246	COVID-19 ADDITIONAL IMPACTS	$233,424,000	$95,504,000	$286,584,000	$126,622,000	$53,160,000	$31,118,000
247	COVID-19 UTILIZATION CHANGE	($652,397,000)	($229,029,000)	($395,693,000)	($146,780,000)	$256,704,000	$82,249,000
248	COVID-19 EMERGENCY FMAP - OTHER DEPTS	$257,717,000	$0	$1,296,027,000	$0	$1,038,310,000	$0
249	COVID-19 BEHAVIORAL HEALTH	$135,303,000	$13,324,000	$77,705,000	$7,652,000	($57,598,000)	($5,672,000)
250	COVID-19 EMERGENCY FMAP - DHCS	$0	($775,000,000)	$0	($2,554,167,000)	$0	($1,779,167,000)
251	COVID-19 CASELOAD IMPACT	$898,603,000	$318,951,000	$6,829,878,000	$2,408,249,000	$5,931,275,000	$2,089,298,000
	COVID-19 SUBTOTAL	**$890,581,000**	**($566,704,000)**	**$8,104,678,000**	**($153,062,000)**	**$7,214,097,000**	**$413,642,000**

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2019-20 AND 2020-21

		MAY 2020 EST. FOR 2019-20		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER DEPARTMENTS						
172	ELECTRONIC VISIT VERIFICATION PHASE II FED PENALTY	$0	$0	($5,130,000)	$417,000	($5,130,000)	$417,000
267	ADDITIONAL FEDERAL FUNDING TO OTHER DEPT.	$0	$0	$438,643,000	$0	$438,643,000	$0
	OTHER DEPARTMENTS SUBTOTAL	**$0**	**$0**	**$433,513,000**	**$417,000**	**$433,513,000**	**$417,000**
	OTHER						
178	CCI IHSS RECONCILIATION	$142,263,000	$0	$100,000,000	$0	($42,263,000)	$0
180	QAF WITHHOLD TRANSFER	$98,871,000	$49,435,500	$0	$0	($98,871,000)	($49,435,500)
181	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$84,915,000	$0	$95,060,000	$0	$10,145,000	$0
182	ARRA HITECH - PROVIDER PAYMENTS	$49,029,000	$0	$15,268,000	$0	($33,761,000)	$0
186	PAYMENT FOR REPROCESSED CLAIMS FOR FQHC/RHC	$7,300,000	$3,650,000	$0	$0	($7,300,000)	($3,650,000)
188	INFANT DEVELOPMENT PROGRAM	$40,739,000	$0	$32,746,000	$0	($7,993,000)	$0
189	PROP 56 - PROVIDER ACES TRAININGS	$16,470,000	$8,235,000	$61,924,000	$30,962,000	$45,454,000	$22,727,000
190	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	$33,905,130	$16,952,560	$50,193,960	$25,096,980	$16,288,830	$8,144,420
191	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$14,316,000	$6,440,000	$15,797,000	$6,928,000	$1,481,000	$488,000
192	OVERTIME FOR WPCS PROVIDERS	$8,031,000	$4,015,500	$8,444,000	$4,222,000	$413,000	$206,500
193	INDIAN HEALTH SERVICES	$10,584,000	$3,545,500	$20,174,000	$6,758,500	$9,590,000	$3,213,000
194	WPCS WORKERS' COMPENSATION	$3,323,000	$1,661,500	$3,324,000	$1,662,000	$1,000	$500
198	FUNDING ADJUST.—OTLICP	$0	($171,066,160)	$0	($109,194,740)	$0	$61,871,420
199	PROP 56 PHYSICIANS & DENTISTS LOAN REPAYMENT PROG	$1,700,000	$0	$15,200,000	$0	$13,500,000	$0
200	CMS DEFERRED CLAIMS	$0	$52,385,000	$0	$350,000,000	$0	$297,615,000
201	INDIAN HEALTH SERVICES FUNDING SHIFT	$0	($13,000,000)	$0	($13,000,000)	$0	$0
202	FUNDING ADJUST.—ACA OPT. EXPANSION	$0	($1,816,431,580)	$0	($1,824,254,400)	$0	($7,822,820)
203	CLPP FUND	$0	($916,000)	$0	($916,000)	$0	$0
204	HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	($391,441,000)	$0	($976,000,000)	$0	($584,559,000)

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2019-20 AND 2020-21

		MAY 2020 EST. FOR 2019-20		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER						
205	AUDIT SETTLEMENTS	$0	$77,697,000	$0	$734,000	$0	($76,963,000)
206	IMD ANCILLARY SERVICES	$0	$9,685,000	$0	$20,807,000	$0	$11,122,000
207	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	($231,554,000)	$0	($160,657,000)	$0	$70,897,000
208	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER RENEWAL	($12,731,000)	($6,365,500)	($27,215,000)	($13,607,500)	($14,484,000)	($7,242,000)
210	COUNTY SHARE OF OTLICP-CCS COSTS	($14,917,000)	($14,917,000)	($22,660,000)	($22,660,000)	($7,743,000)	($7,743,000)
211	ASSISTED LIVING WAIVER EXPANSION	($31,012,680)	($15,506,340)	($56,144,000)	($28,072,000)	($25,131,320)	($12,565,660)
213	PURE PREMIUM FUND CLOSEOUT	($501,725,000)	($142,907,390)	$0	$0	$501,725,000	$142,907,390
233	REPAYMENT TO CMS FOR CONTINGENCY FEE OFFSETS	$0	$0	$0	$10,370,000	$0	$10,370,000
236	TRIBAL FEDERALLY QUALIFIED HEALTH CENTER	$0	$0	$1,576,000	$350,550	$1,576,000	$350,550
242	SELF-DETERMINATION PROGRAM - CDDS	$0	$0	$17,139,000	$0	$17,139,000	$0
244	STATE ONLY CLAIMING ADJUSTMENTS	$0	$0	$0	$519,592,000	$0	$519,592,000
261	FUND 3156 TRANSFER TO THE GENERAL FUND	$0	$0	$0	($100,000,000)	$0	($100,000,000)
262	FUND 3311 TRANSFER TO THE GENERAL FUND	$0	$0	$0	($36,552,000)	$0	($36,552,000)
263	ELECTRONIC CIGARETTE PRODUCTS TAX	$0	$0	$0	($9,600,000)	$0	($9,600,000)
265	RECONCILIATION	$0	$0	$2,491,000	$10,681,000	$2,491,000	$10,681,000
	OTHER SUBTOTAL	**($48,939,550)**	**($2,570,402,410)**	**$333,317,960**	**($2,306,349,610)**	**$382,257,510**	**$264,052,800**
	GRAND TOTAL	**$35,616,460,550**	**($9,136,170)**	**$48,962,319,840**	**($448,473,850)**	**$13,345,859,290**	**($439,337,680)**

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

FISCAL YEAR 2020-21 COST PER ELIGIBLE BASED ON MAY 2020 ESTIMATE

SERVICE CATEGORY	PA-OAS	NEWLY	PA-ATD	PA-AFDC	LT-OAS	H-PE
PHYSICIANS	$8,037,200	$185,305,380	$78,811,860	$60,905,590	$2,137,190	$54,846,810
OTHER MEDICAL	$101,274,260	$1,258,274,670	$454,144,300	$336,167,430	$5,718,150	$44,661,340
CO. & COMM. OUTPATIENT	$4,211,560	$175,840,560	$118,970,840	$32,012,290	$630,230	$55,131,250
PHARMACY	$10,297,160	$1,733,430,640	$1,372,235,350	$188,002,220	$5,689,820	$21,604,250
COUNTY INPATIENT	$6,453,860	$617,028,830	$37,124,280	$34,781,700	$3,726,670	$66,760,630
COMMUNITY INPATIENT	$51,481,690	$1,350,967,410	$484,467,640	$264,560,810	$16,892,520	$309,394,450
NURSING FACILITIES	$196,704,700	$187,479,220	$479,919,110	$3,413,390	$1,278,961,050	$1,317,470
ICF-DD	$1,747,540	$12,320,060	$172,392,840	$987,400	$66,844,840	$2,170
MEDICAL TRANSPORTATION	$4,088,330	$50,673,020	$17,226,680	$4,944,810	$2,270,610	$9,922,520
OTHER SERVICES	$80,726,430	$44,874,210	$359,187,560	$47,303,710	$70,634,950	$1,450,840
HOME HEALTH	$2,980,380	$2,433,510	$133,673,140	$8,380,270	$32,420	$178,130
FFS SUBTOTAL	**$468,003,140**	**$5,618,627,520**	**$3,708,153,600**	**$981,459,610**	**$1,453,538,450**	**$565,269,860**
DENTAL	$108,692,490	$498,811,010	$124,219,990	$139,568,290	$15,680,640	$0
MENTAL HEALTH	$9,291,350	$381,658,280	$965,672,250	$826,334,090	$702,250	$8,041,420
TWO PLAN MODEL	$1,643,401,260	$9,760,774,950	$5,006,620,220	$1,530,890,530	$0	$0
COUNTY ORGANIZED HEALTH SYSTEMS	$310,572,680	$3,804,896,780	$1,404,009,290	$400,644,290	$805,762,840	$0
GEOGRAPHIC MANAGED CARE	$218,793,310	$1,601,817,600	$1,004,680,390	$231,181,200	$0	$0
PHP & OTHER MANAG. CARE	$393,180,630	$29,606,420	$190,421,190	$17,560,110	$19,481,220	$0
MEDICARE PAYMENTS	$1,861,276,190	$0	$1,719,759,710	$0	$173,589,740	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$1,678,550	$0	$3,670,000	$4,819,910	$175,390	$0
MISC. SERVICES	$927,101,640	$137,560	$6,826,713,710	$9,232,900	$12,580	$0
DRUG MEDI-CAL	$13,553,490	$143,059,130	$41,730,040	$34,868,810	$1,354,040	$18,140
REGIONAL MODEL	$15,663,820	$610,864,130	$317,758,340	$89,015,080	$0	$0
NON-FFS SUBTOTAL	**$5,503,205,410**	**$16,831,625,860**	**$17,605,255,130**	**$3,284,115,200**	**$1,016,758,700**	**$8,059,570**
TOTAL DOLLARS (1)	**$5,971,208,550**	**$22,450,253,380**	**$21,313,408,730**	**$4,265,574,810**	**$2,470,297,150**	**$573,329,430**
ELIGIBLES ***	**421,800**	**3,850,900**	**914,800**	**1,204,900**	**44,400**	**43,100**
ANNUAL $/ELIGIBLE	**$14,156**	**$5,830**	**$23,298**	**$3,540**	**$55,637**	**$13,302**
AVG. MO. $/ELIGIBLE	**$1,180**	**$486**	**$1,942**	**$295**	**$4,636**	**$1,109**

(1) Does not include Audits & Lawsuits and Recoveries.
*** Eligibles include the estimated impact of eligibility policy changes.
Refer to page following for listing of excluded policy changes.

FISCAL YEAR 2020-21 COST PER ELIGIBLE BASED ON MAY 2020 ESTIMATE

SERVICE CATEGORY	LT-ATD	POV 250	MN-OAS	MN-ATD	MN-AFDC	MI-C
PHYSICIANS	$1,438,290	$27,457,400	$24,173,140	$14,831,550	$155,556,450	$44,809,000
OTHER MEDICAL	$3,574,070	$236,071,360	$198,736,690	$96,568,380	$1,035,149,250	$112,323,320
CO. & COMM. OUTPATIENT	$423,400	$34,344,290	$19,585,110	$12,820,530	$137,415,850	$15,449,310
PHARMACY	$6,884,170	$94,047,930	$48,148,260	$94,705,630	$575,084,690	$95,150,070
COUNTY INPATIENT	$1,324,090	$4,370,210	$71,307,300	$19,579,440	$173,277,900	$12,208,730
COMMUNITY INPATIENT	$10,945,180	$107,658,130	$147,802,470	$70,421,700	$841,045,350	$85,318,520
NURSING FACILITIES	$225,140,450	$4,365,720	$198,666,130	$59,885,190	$30,579,120	$10,383,480
ICF-DD	$177,173,820	$214,820	$2,355,310	$13,455,970	$1,674,160	$3,059,050
MEDICAL TRANSPORTATION	$807,260	$836,200	$9,413,100	$7,724,940	$11,695,950	$3,501,080
OTHER SERVICES	$10,137,670	$31,962,650	$79,727,060	$71,871,490	$93,897,020	$22,379,190
HOME HEALTH	$9,980	$19,199,130	$1,904,490	$60,782,300	$17,381,200	$18,111,490
FFS SUBTOTAL	**$437,858,370**	**$560,527,830**	**$801,819,050**	**$522,647,120**	**$3,072,756,940**	**$422,693,240**
DENTAL	$15,680,640	$162,533,880	$15,773,700	$17,692,240	$474,162,820	$17,446,040
MENTAL HEALTH	$1,656,600	$85,868,930	$13,441,900	$108,012,100	$596,736,940	$83,726,010
TWO PLAN MODEL	$0	$789,956,230	$1,995,162,170	$813,376,970	$3,958,613,270	$31,615,210
COUNTY ORGANIZED HEALTH SYSTEMS	$179,662,380	$359,044,050	$511,107,280	$428,807,530	$1,719,065,770	$310,460,000
GEOGRAPHIC MANAGED CARE	$0	$134,566,670	$268,318,910	$174,776,400	$693,946,230	$4,041,320
PHP & OTHER MANAG. CARE	$618,790	$5,279,290	$344,293,170	$54,770,100	$9,224,350	$8,925,690
MEDICARE PAYMENTS	$0	$0	$1,553,122,540	$724,356,490	$141,694,130	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$41,460	$0	$2,208,300	$877,910	$16,016,390	$724,590
MISC. SERVICES	$3,580	($51,763,480)	$1,168,235,530	$1,362,821,740	$30,608,330	$1,386,520
DRUG MEDI-CAL	$322,600	$27,836,150	$17,788,830	$7,374,240	$112,767,850	$4,864,670
REGIONAL MODEL	$0	$46,925,240	$46,072,710	$53,303,690	$286,898,690	$1,252,010
NON-FFS SUBTOTAL	**$197,986,030**	**$1,560,246,970**	**$5,935,525,060**	**$3,746,169,410**	**$8,039,734,770**	**$464,442,070**
TOTAL DOLLARS (1)	**$635,844,400**	**$2,120,774,800**	**$6,737,344,110**	**$4,268,816,540**	**$11,112,491,710**	**$887,135,310**
ELIGIBLES ***	**10,200**	**1,083,500**	**565,100**	**324,000**	**3,900,700**	**152,700**
ANNUAL $/ELIGIBLE	**$62,338**	**$1,957**	**$11,922**	**$13,175**	**$2,849**	**$5,810**
AVG. MO. $/ELIGIBLE	**$5,195**	**$163**	**$994**	**$1,098**	**$237**	**$484**

(1) Does not include Audits & Lawsuits and Recoveries.
*** Eligibles include the estimated impact of eligibility policy changes.
Refer to page following for listing of excluded policy changes.

FISCAL YEAR 2020-21 COST PER ELIGIBLE BASED ON MAY 2020 ESTIMATE

SERVICE CATEGORY	MI-A	REFUGEE	OBRA	POV 185	POV 133	POV 100
PHYSICIANS	$405,800	$51,040	$128,240	$122,409,070	$17,795,390	$8,479,180
OTHER MEDICAL	$856,740	$441,180	$70,590	$250,999,110	$193,762,000	$96,941,990
CO. & COMM. OUTPATIENT	$171,700	$37,370	$37,810	$28,311,020	$15,016,160	$12,483,900
PHARMACY	$1,794,010	$94,260	$241,510	$42,735,910	$70,455,950	$59,783,800
COUNTY INPATIENT	$3,943,100	$170	$77,920	$108,687,240	$4,031,340	$1,779,100
COMMUNITY INPATIENT	$1,048,620	$56,920	$393,690	$772,390,140	$87,545,940	$41,828,370
NURSING FACILITIES	$18,302,490	$0	$4,038,890	$1,570,560	$11,107,620	$1,250,370
ICF-DD	$1,102,520	$0	$149,650	$199,930	$813,150	$5,590
MEDICAL TRANSPORTATION	$119,920	$5,440	$29,380	$2,518,220	$662,050	$326,500
OTHER SERVICES	$548,270	$190	$25,750	$10,702,870	$19,985,840	$11,419,580
HOME HEALTH	$560	$0	$0	$4,983,760	$10,372,820	$2,789,470
FFS SUBTOTAL	**$28,293,730**	**$686,570**	**$5,193,440**	**$1,345,507,810**	**$431,548,260**	**$237,087,860**
DENTAL	$15,527,500	$15,680,640	$15,680,640	$17,788,940	$104,676,210	$52,338,110
MENTAL HEALTH	$0	$158,310	$1,583,380	$1,999,480	$26,162,160	$39,767,190
TWO PLAN MODEL	$12,880	$337,760	$0	$251,741,320	$570,887,650	$310,467,530
COUNTY ORGANIZED HEALTH SYSTEMS	$227,780	$81,330	$28,670	$136,277,890	$217,786,430	$127,019,810
GEOGRAPHIC MANAGED CARE	$5,600	$318,550	$0	$47,363,720	$92,840,650	$51,536,460
PHP & OTHER MANAG. CARE	$7,455,750	$0	$0	$9,184,450	$8,922,320	$8,922,320
MEDICARE PAYMENTS	$0	$0	$0	$0	$0	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$25,110	$0	$400	$1,667,460	$0	$1,868,550
MISC. SERVICES	$6,180,030	$0	$0	$99,840	$6,783,330	$3,566,520
DRUG MEDI-CAL	$194,700	$18,460	$0	$10,832,290	$22,889,510	$12,151,440
REGIONAL MODEL	$0	$11,120	$0	$18,840,850	$31,996,780	$16,320,820
NON-FFS SUBTOTAL	**$29,629,350**	**$16,606,170**	**$17,293,090**	**$495,796,240**	**$1,082,945,050**	**$623,958,750**
TOTAL DOLLARS (1)	**$57,923,080**	**$17,292,740**	**$22,486,530**	**$1,841,304,060**	**$1,514,493,310**	**$861,046,610**
ELIGIBLES ***	**3,100**	**500**	**300**	**394,400**	**855,200**	**466,300**
ANNUAL $/ELIGIBLE	**$18,685**	**$34,585**	**$74,955**	**$4,669**	**$1,771**	**$1,847**
AVG. MO. $/ELIGIBLE	**$1,557**	**$2,882**	**$6,246**	**$389**	**$148**	**$154**

(1) Does not include Audits & Lawsuits and Recoveries.
*** Eligibles include the estimated impact of eligibility policy changes.
Refer to page following for listing of excluded policy changes.

FISCAL YEAR 2020-21 COST PER ELIGIBLE BASED ON MAY 2020 ESTIMATE

SERVICE CATEGORY	TOTAL
PHYSICIANS	**$807,578,590**
OTHER MEDICAL	**$4,425,734,840**
CO. & COMM. OUTPATIENT	**$662,893,170**
PHARMACY	**$4,420,385,650**
COUNTY INPATIENT	**$1,166,462,520**
COMMUNITY INPATIENT	**$4,644,219,540**
NURSING FACILITIES	**$2,713,084,960**
ICF-DD	**$454,498,820**
MEDICAL TRANSPORTATION	**$126,766,010**
OTHER SERVICES	**$956,835,270**
HOME HEALTH	**$283,213,050**
FFS SUBTOTAL	**$20,661,672,420**
DENTAL	**$1,811,953,780**
MENTAL HEALTH	**$3,150,812,640**
TWO PLAN MODEL	**$26,663,857,950**
COUNTY ORGANIZED HEALTH SYSTEMS	**$10,715,454,810**
GEOGRAPHIC MANAGED CARE	**$4,524,187,020**
PHP & OTHER MANAG. CARE	**$1,107,845,800**
MEDICARE PAYMENTS	**$6,173,798,800**
STATE HOSP./DEVELOPMENTAL CNTRS.	**$33,774,000**
MISC. SERVICES	**$10,291,120,350**
DRUG MEDI-CAL	**$451,624,410**
REGIONAL MODEL	**$1,534,923,280**
NON-FFS SUBTOTAL	**$66,459,352,840**
TOTAL DOLLARS (1)	**$87,121,025,260**
ELIGIBLES ***	**14,235,900**
ANNUAL $/ELIGIBLE	**$6,120**
AVG. MO. $/ELIGIBLE	**$510**

(1) Does not include Audits & Lawsuits and Recoveries.
*** Eligibles include the estimated impact of eligibility policy changes.
Refer to page following for listing of excluded policy changes.

FISCAL YEAR 2020-21 COST PER ELIGIBLE BASED ON MAY 2020 ESTIMATE

EXCLUDED POLICY CHANGES: 90

3	BREAST AND CERVICAL CANCER TREATMENT
4	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
5	COUNTY HEALTH INITIATIVE MATCHING (CHIM)
6	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL
10	CS3 PROXY ADJUSTMENT
13	NON-OTLICP CHIP
17	MEDICARE OPTIONAL EXPANSION ADJUSTMENT
24	1% FMAP INCREASE FOR PREVENTIVE SERVICES
25	ACA MAGI SAVINGS
28	ACA DSH REDUCTION
30	FAMILY PACT PROGRAM
44	FREE CLINIC OF SIMI VALLEY
57	FAMILY PACT DRUG REBATES
58	LITIGATION SETTLEMENTS
70	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
73	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT
77	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT
81	GLOBAL PAYMENT PROGRAM
82	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL
83	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS
84	BTR - LIHP - MCE
86	MH/UCD—STABILIZATION FUNDING
87	WHOLE PERSON CARE HOUSING SERVICES
88	MH/UCD—SAFETY NET CARE POOL
89	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG
90	MH/UCD—HEALTH CARE COVERAGE INITIATIVE
91	BTR - LOW INCOME HEALTH PROGRAM - HCCI
108	GENERAL FUND REIMBURSEMENTS FROM DPHS
109	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)
111	MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.
112	MCO ENROLLMENT TAX MANAGED CARE PLANS
113	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND
117	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF
127	EMERGENCY MEDICAL AIR TRANSPORTATION ACT

FISCAL YEAR 2020-21 COST PER ELIGIBLE BASED ON MAY 2020 ESTIMATE

EXCLUDED POLICY CHANGES: 90

130	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
135	DENTAL RETROACTIVE RATE CHANGES
137	HOSPITAL QAF - FFS PAYMENTS
138	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS
139	HOSPITAL QAF - MANAGED CARE PAYMENTS
140	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS
141	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS
142	PRIVATE HOSPITAL DSH REPLACEMENT
144	PROP 56 - MEDI-CAL FAMILY PLANNING
145	DSH PAYMENT
146	PROP 56 - VALUE-BASED PAYMENT PROGRAM
147	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
148	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
149	CAPITAL PROJECT DEBT REIMBURSEMENT
150	FFP FOR LOCAL TRAUMA CENTERS
151	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS
152	NDPH IGT SUPPLEMENTAL PAYMENTS
153	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS
154	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
155	GEMT SUPPLEMENTAL PAYMENT PROGRAM
159	DPH PHYSICIAN & NON-PHYS. COST
160	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
161	PROP 56 - NEMT SUPPLEMENTAL PAYMENTS
162	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
163	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
164	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS
165	NDPH SUPPLEMENTAL PAYMENT
166	PROP 56 - HOSP-BASED PEDIATRIC PHYS SUPPL PYMTS
167	PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS
168	PROPOSITION 56 FUNDS TRANSFER
169	PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS
170	PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS
171	IGT ADMIN. & PROCESSING FEE
182	ARRA HITECH - PROVIDER PAYMENTS

FISCAL YEAR 2020-21 COST PER ELIGIBLE BASED ON MAY 2020 ESTIMATE

EXCLUDED POLICY CHANGES: 90

184	MEDI-CAL TCM PROGRAM
187	LAWSUITS/CLAIMS
189	PROP 56 - PROVIDER ACES TRAININGS
199	PROP 56 PHYSICIANS & DENTISTS LOAN REPAYMENT PROG
200	CMS DEFERRED CLAIMS
203	CLPP FUND
204	HOSPITAL QAF - CHILDREN'S HEALTH CARE
205	AUDIT SETTLEMENTS
207	CIGARETTE AND TOBACCO SURTAX FUNDS
212	BASE RECOVERIES
213	PURE PREMIUM FUND CLOSEOUT
216	MEDICARE PART B DISREGARD
218	2020 MCO ENROLLMENT TAX MANAGED CARE PLANS
219	2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ
220	2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.
221	IGT PAYMENTS FOR HOSPITAL SERVICES
232	DISABLED ADULT CHILDREN PROGRAM CLEANUP
243	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM
244	STATE ONLY CLAIMING ADJUSTMENTS
245	COVID-19 UNINSURED ELIGIBILITY GROUP
248	COVID-19 EMERGENCY FMAP - OTHER DEPTS
265	RECONCILIATION

TABLE OF CONTENTS

CASELOAD

The Caseload section provides the estimated average monthly certified eligible counts for prior, current, and budget years.

ESTIMATED AVERAGE MONTHLY CERTIFIED ELIGIBLES BY AID CATEGORY .A-E

CURRENT YEAR COMPARED TO PRIOR YEAR ACTUAL ELIGIBLE COUNTS AND BUDGET YEAR.... .....A
CASELOAD CHANGES IDENTIFIED IN POLICY CHANGES.....B
CURRENT YEAR ESTIMATE COMPARISONS C
BUDGET YEAR COMPARISON .....D
AVERAGE MONTHLY CASELOAD IN MANAGED CARE .....E
AVERAGE MONTHLY CASELOAD IN FEE-FOR-SERVICE .....F

CASELOAD GRAPHS.....CL 1-6

STATEWIDE ELIGIBLES: ALL AID CATEGORIES ..... CL 1
STATEWIDE ELIGIBLES: FAMILIES AND CHILDREN ..... CL 2
STATEWIDE ELIGIBLES: SENIORS ..... CL 3
STATEWIDE ELIGIBLES: PERSONS WITH DISABILITIES ..... CL 4
STATEWIDE ELIGIBLES: ACA OPTIONAL EXPANSION ..... CL 5

MEDI-CAL AID CATEGORY DEFINITIONS.....CL 6

Estimated Average Monthly Certified Eligibles
May 2020 Estimate
Fiscal Years 2018-2019, 2019-2020 & 2020-2021

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

	2018-2019	2019-2020	2020-2021	18-19 To 19-20 % Change	19-20 To 20-21 % Change
Public Assistance	**2,451,900**	**2,392,100**	**2,541,500**	**-2.44%**	**6.25%**
Seniors	430,700	421,800	421,800	-2.07%	0.00%
Persons with Disabilities	954,200	917,000	914,800	-3.90%	-0.24%
Families [1]	1,067,000	1,053,300	1,204,900	-1.28%	14.39%
Long Term	**53,600**	**54,600**	**54,600**	**1.87%**	**0.00%**
Seniors	43,000	44,300	44,400	3.02%	0.23%
Persons with Disabilities	10,600	10,300	10,200	-2.83%	-0.97%
Medically Needy	**4,090,200**	**4,197,200**	**4,775,900**	**2.62%**	**13.79%**
Seniors	503,000	532,400	556,800	5.84%	4.58%
Persons with Disabilities	168,500	219,400	318,400	30.21%	45.12%
Families [1]	3,418,700	3,445,400	3,900,700	0.78%	13.21%
Medically Indigent	**163,400**	**156,300**	**155,800**	**-4.35%**	**-0.32%**
Children	154,800	152,600	152,700	-1.42%	0.07%
Adults	8,600	3,700	3,100	-56.98%	-16.22%
Other	**6,243,900**	**6,237,800**	**6,713,800**	**-0.10%**	**7.63%**
Refugees	500	600	500	20.00%	-16.67%
OBRA [2]	400	300	300	-25.00%	0.00%
185% Poverty [3]	351,500	347,000	394,400	-1.28%	13.66%
133% Poverty	755,300	759,400	855,200	0.54%	12.62%
100% Poverty	393,400	409,700	466,300	4.14%	13.81%
Opt. Targeted Low Income Children	916,800	948,500	1,083,500	3.46%	14.23%
ACA Optional Expansion	3,772,600	3,714,400	3,850,900	-1.54%	3.67%
Hospital PE	34,200	38,400	43,100	12.28%	12.24%
Medi-Cal Access Program	5,500	5,500	5,700	0.00%	3.64%
QMB	13,700	14,000	13,900	2.19%	-0.71%
GRAND TOTAL [4]	**13,003,000**	**13,038,000**	**14,241,600**	**0.27%**	**9.23%**
Seniors	**976,700**	**998,500**	**1,023,000**	2.23%	2.45%
Persons with Disabilities	**1,133,300**	**1,146,700**	**1,243,400**	1.18%	8.43%
Families and Children [5]	**7,057,500**	**7,115,900**	**8,057,700**	0.83%	13.24%
ACA Optional Expansion	**3,772,600**	**3,714,400**	**3,850,900**	-1.54%	3.67%

Note: Graphs of eligibles represent base projections only and do not reflect estimated impact of policy changes.
***** See CL Page B reflecting impact of Policy Changes.**

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

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

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

	2018-2019	2019-2020	2020-2021
Presumptive Eligibility	33,500	37,600	37,500

[4] The following Medi-Cal special program eligibles (average monthly during FY 2016-17 shown in parenthesis are not included above: BCCTP (6,794), Tuberculosis (81), Dialysis (154), TPN (2). Family PACT eligibles are also not included above.

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

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

Policy Change	Budget Aid Category	Caseload Change Average Monthly Eligibles *not* in the Base Estimate 2018-19	2019-20	2020-21
PC 2 Medi-Cal State Inmates	LT Seniors	4	7	7
	MN Seniors	35	35	35
	MN Persons with Disabilities	7	7	7
	MI Children	2	3	3
	185% Poverty	2	2	2
	ACA Optional Expansion	266	261	261
	Total	**316**	**315**	**315**
PC 4 Medi-Cal Access Program Mothers 213-322%	MCAP Mothers	4,720	4,676	4,766
	Total	**4,720**	**4,676**	**4,766**
PC 6 Medi-Cal Access Program Infants 266-322%	MCAP Infants	822	869	888
	Total	**822**	**869**	**888**
PC 19 Minimum Wage Increase - Caseload Savings	MN Families		(1,467)	(9,590)
	MI Children		(67)	(434)
	185% Poverty		(150)	(999)
	133% Poverty		(326)	(2,128)
	100% Poverty		(172)	(1,118)
	OTLICP		(395)	(2,576)
	ACA Optional Expansion		(1,644)	(10,826)
	Total		**(4,221)**	**(27,671)**
PC 251 COVID - 19 Caseload Impact	MN Persons with Disabilities		29,614	126,566
	MN Families		151,278	644,893
	PA Families		46,332	199,511
	185% Poverty		41,738	179,837
	133% Poverty		14,966	63,161
	100% Poverty		33,420	141,966
	OTLICP		18,030	77,406
	ACA Optional Expansion		53,377	228,125
	Total		**388,755**	**1,661,466**
PC 246 COVID - 19 Additional Impact	HPE		3,709	7,418
	Total		**3,709**	**7,418**
PC 1 Undocumented Young Adults Full Scope Expansion	MN Families		7,794	15,719
	185% Poverty		6,919	13,954
	ACA Optional Expansion		416	838
	Total		**15,129**	**30,511**

	Budget Aid Category	2018-19	2019-20	2020-21
Total by Aid Category	PA Seniors	0	0	0
	PA Persons with Disabilities	0	0	0
	PA Families	0	46,332	199,511
	LT Seniors	4	7	7
	LT Persons with Disabilities	0	0	0
	MN Seniors	35	35	35
	MN Persons with Disabilities	7	29,621	126,573
	MN Families	0	157,605	651,022
	MI Children	2	(64)	(431)
	MI Adults	0	0	0
	Undocumented Persons	0	0	0
	185% Poverty	2	48,510	192,794
	133% Poverty	0	14,640	61,033
	100% Poverty	0	33,248	140,848
	OTLICP	0	17,635	74,830
	ACA Optional Expansion	266	52,410	218,398
	HPE	0	3,709	7,418
	MCAP Infants	822	869	888
	MCAP Mothers	4,720	4,676	4,766
	Total	**5,858**	**409,231**	**1,677,692**

Comparison of Average Monthly Certified Eligibles
May 2020 Estimate
Fiscal Year 2019-20

(With Estimated Impact of Eligibility Policy Changes)

	Appropriaton 2019-2020	Nov 2019 2019-2020	May 2020 2019-2020	Appropriation to Nov % Change	Nov to May % Change
Public Assistance	**2,441,300**	**2,350,900**	**2,392,100**	**-3.70%**	**1.75%**
Seniors	431,200	421,200	421,800	-2.32%	0.14%
Persons with Disabilities	956,800	920,700	917,000	-3.77%	-0.40%
Families	1,053,300	1,009,000	1,053,300	-4.21%	4.39%
Long Term	**52,900**	**54,400**	**54,600**	**2.84%**	**0.37%**
Seniors	42,400	44,000	44,300	3.77%	0.68%
Persons with Disabilities	10,500	10,400	10,300	-0.95%	-0.96%
Medically Needy	**4,085,900**	**4,069,600**	**4,197,200**	**-0.40%**	**3.14%**
Seniors	519,200	530,200	532,400	2.12%	0.41%
Persons with Disabilities	166,600	183,800	219,400	10.32%	19.37%
Families	3,400,100	3,355,600	3,445,400	-1.31%	2.68%
Medically Indigent	**164,800**	**158,400**	**156,300**	**-3.88%**	**-1.33%**
Children	156,300	152,100	152,600	-2.69%	0.33%
Adults	8,500	6,300	3,700	-25.88%	-41.27%
Other	**6,264,900**	**6,201,400**	**6,237,800**	**-1.01%**	**0.59%**
Refugees	500	600	600	20.00%	0.00%
OBRA	400	200	300	-50.00%	50.00%
185% Poverty	353,000	344,000	347,000	-2.55%	0.87%
133% Poverty	745,700	745,900	759,400	0.03%	1.81%
100% Poverty	390,600	392,400	409,700	0.46%	4.41%
Opt. Targeted Low Income Children	909,700	903,500	948,500	-0.68%	4.98%
ACA Optional Expansion	3,812,100	3,760,500	3,714,400	-1.35%	-1.23%
Hospital PE	33,600	34,800	38,400	3.57%	10.34%
Medi-Cal Access Program	5,600	5,700	5,500	1.79%	-3.51%
QMB	13,700	13,800	14,000	0.73%	1.45%
GRAND TOTAL	**13,009,800**	**12,834,700**	**13,038,000**	**-1.35%**	**1.58%**
Seniors	992,800	995,400	998,500	0.26%	0.31%
Persons with Disabilities	1,133,900	1,114,900	1,146,700	-1.68%	2.85%
Families and Children	7,008,700	6,902,500	7,115,900	-1.52%	3.09%
ACA Optional Expansion	3,812,100	3,760,500	3,714,400	-1.35%	-1.23%

Comparison of Average Monthly Certified Eligibles
May 2020 Estimate
Fiscal Year 2020-21

(With Estimated Impact of Eligibility Policy Changes)

	November 2019 2020-2021	May 2020 2020-2021	% Change
Public Assistance	**2,350,900**	**2,541,500**	**8.11%**
Seniors	421,100	421,800	0.17%
Persons with Disabilities	920,700	914,800	-0.64%
Families	1,009,100	1,204,900	19.40%
Long Term	**54,400**	**54,600**	**0.37%**
Seniors	44,000	44,400	0.91%
Persons with Disabilities	10,400	10,200	-1.92%
Medically Needy	**4,091,000**	**4,775,900**	**16.74%**
Seniors	554,000	556,800	0.51%
Persons with Disabilities	183,800	318,400	73.23%
Families	3,353,200	3,900,700	16.33%
Medically Indigent	**158,000**	**155,800**	**-1.39%**
Children	151,700	152,700	0.66%
Adults	6,300	3,100	-50.79%
Other	**6,226,100**	**6,713,800**	**7.83%**
Refugees	600	500	-16.67%
OBRA	100	300	200.00%
185% Poverty	349,100	394,400	12.98%
133% Poverty	743,800	855,200	14.98%
100% Poverty	391,200	466,300	19.20%
Opt. Targeted Low Income Children	900,900	1,083,500	20.27%
ACA Optional Expansion	3,786,000	3,850,900	1.71%
Hospital PE	34,900	43,100	23.50%
Medi-Cal Access Program	5,700	5,700	0.00%
QMB	13,800	13,900	0.72%
GRAND TOTAL	**12,880,400**	**14,241,600**	**10.57%**
Seniors	**1,019,100**	**1,023,000**	**0.38%**
Persons with Disabilities	**1,114,900**	**1,243,400**	**11.53%**
Families and Children	**6,899,000**	**8,057,700**	**16.80%**
ACA Optional Expansion	**3,786,000**	**3,850,900**	**1.71%**

Estimated Average Monthly Certified Eligibles
May 2020 Estimate
Fiscal Years 2018-2019, 2019-2020 & 2020-2021

Managed Care[1]
(With Estimated Impact of Eligibility Policy Changes)*

	2018-2019	2019-2020	2020-2021	18-19 To 19-20 % Change	19-20 To 20-21 % Change
Public Assistance	**2,117,187**	**2,062,760**	**2,187,656**	**-2.57%**	**6.05%**
Seniors	329,377	322,433	324,353	-2.11%	0.60%
Persons with Disabilities	820,696	791,341	790,199	-3.58%	-0.14%
Families	967,114	948,987	1,073,103	-1.87%	13.08%
Long Term	**29,902**	**31,003**	**31,146**	**3.68%**	**0.46%**
Seniors	24,321	25,532	25,716	4.98%	0.72%
Persons with Disabilities	5,581	5,471	5,429	-1.96%	-0.77%
Medically Needy	**3,174,860**	**3,287,719**	**3,773,392**	**3.55%**	**14.77%**
Seniors	362,154	385,812	402,474	6.53%	4.32%
Persons with Disabilities	117,965	159,742	242,212	35.41%	51.63%
Families	2,694,741	2,742,165	3,128,707	1.76%	14.10%
Medically Indigent	**45,160**	**47,099**	**47,304**	**4.29%**	**0.43%**
Children	45,110	47,045	47,247	4.29%	0.43%
Adults	50	54	57	8.78%	5.46%
Other	**5,261,826**	**5,257,599**	**5,649,767**	**-0.08%**	**7.46%**
Refugees	290	388	395	33.64%	1.85%
OBRA	4	4	10	-2.16%	140.00%
185% Poverty	198,601	205,641	248,654	3.54%	20.92%
133% Poverty	714,125	716,427	797,943	0.32%	11.38%
100% Poverty	378,170	392,379	440,008	3.76%	12.14%
Opt. Targeted Low Income Children	861,640	884,896	995,985	2.70%	12.55%
ACA Optional Expansion	3,103,703	3,052,556	3,161,352	-1.65%	3.56%
Medi-Cal Access Program	5,293	5,308	5,420	0.28%	2.11%
GRAND TOTAL [1]	**10,628,935**	**10,686,180**	**11,689,265**	**0.54%**	**9.39%**
Percent of Statewide	**81.74%**	**81.96%**	**82.08%**		
Seniors	715,852	733,777	752,543	2.50%	2.56%
Persons with Disabilities	944,242	956,553	1,037,841	1.30%	8.50%
Families and Children	5,859,501	5,937,540	6,731,647	1.33%	13.37%
ACA Optional Expansion	3,103,703	3,052,556	3,161,352	-1.65%	3.56%

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

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

Estimated Average Monthly Certified Eligibles
May 2020 Estimate
Fiscal Years 2018-2019, 2019-2020 & 2020-2021

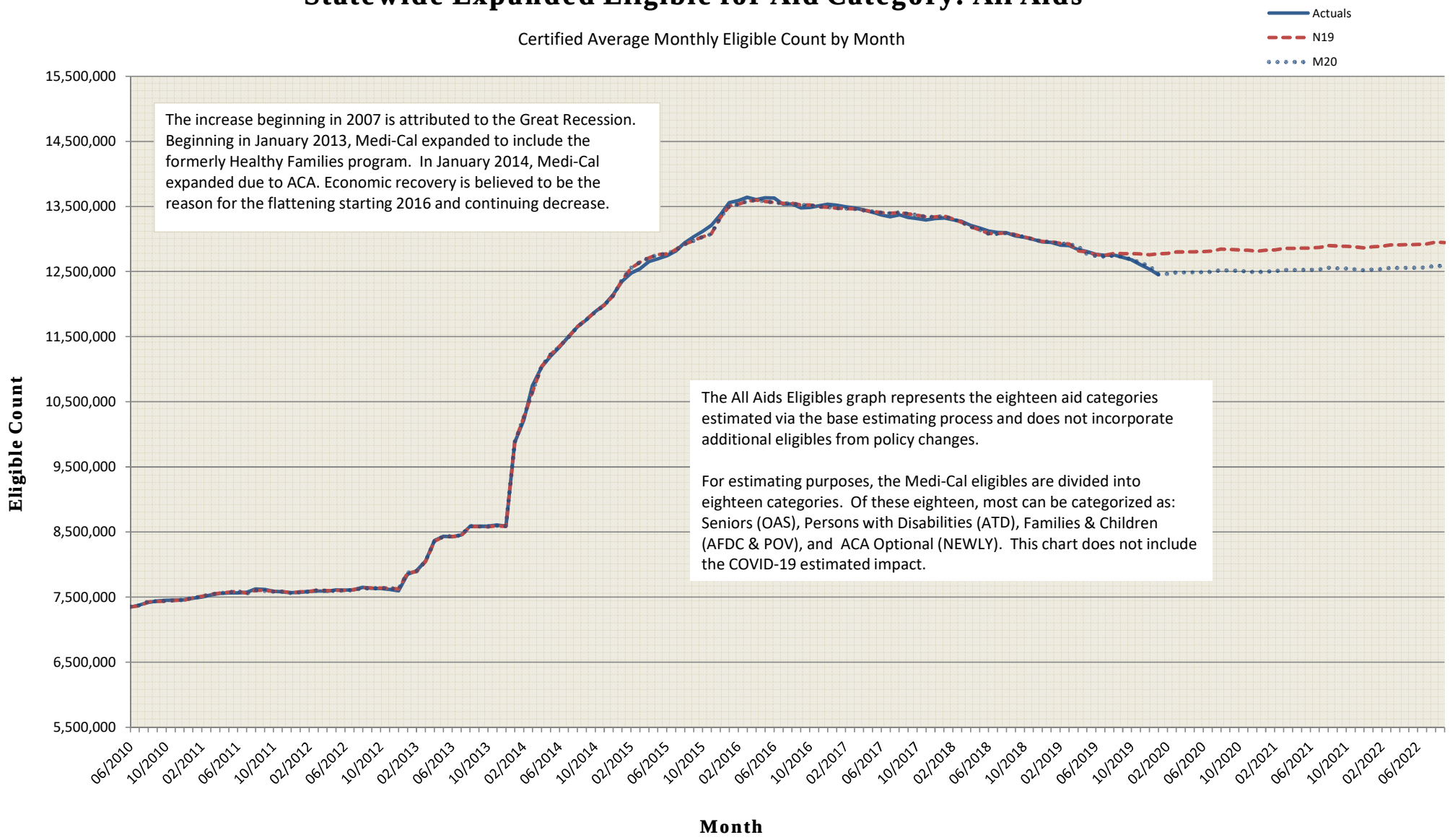
Fee-For-Service
(With Estimated Impact of Eligibility Policy Changes)*

	2018-2019	2019-2020	2020-2021	18-19 To 19-20 % Change	19-20 To 20-21 % Change
Public Assistance	**334,713**	**329,340**	**353,844**	**-1.61%**	**7.44%**
Seniors	101,323	99,367	97,447	-1.93%	-1.93%
Persons with Disabilities	133,504	125,659	124,601	-5.88%	-0.84%
Families	99,886	104,313	131,797	4.43%	26.35%
Long Term	**23,698**	**23,597**	**23,454**	**-0.43%**	**-0.61%**
Seniors	18,679	18,768	18,684	0.48%	-0.45%
Persons with Disabilities	5,019	4,829	4,771	-3.79%	-1.20%
Medically Needy	**915,340**	**909,481**	**1,002,508**	**-0.64%**	**10.23%**
Seniors	140,846	146,588	154,326	4.08%	5.28%
Persons with Disabilities	50,535	59,658	76,188	18.05%	27.71%
Families	723,959	703,235	771,993	-2.86%	9.78%
Medically Indigent	**118,240**	**109,201**	**108,496**	**-7.65%**	**-0.65%**
Children	109,690	105,555	105,453	-3.77%	-0.10%
Adults	8,550	3,646	3,043	-57.36%	-16.54%
Other	**982,074**	**980,201**	**1,064,033**	**-0.19%**	**8.55%**
Refugees	210	212	105	1.17%	-50.44%
OBRA	396	296	290	-25.26%	-2.05%
185% Poverty	152,899	141,359	145,746	-7.55%	3.10%
133% Poverty	41,175	42,973	57,257	4.37%	33.24%
100% Poverty	15,230	17,321	26,292	13.73%	51.80%
Opt. Targeted Low Income Children	55,161	63,604	87,515	15.31%	37.59%
ACA Optional Expansion	668,897	661,844	689,548	-1.05%	4.19%
Hospital PE	34,200	38,400	43,100	12.28%	12.24%
Medi-Cal Access Program	207	192	280	-7.25%	45.83%
QMB	13,700	14,000	13,900	2.19%	-0.71%
GRAND TOTAL	**2,374,065**	**2,351,820**	**2,552,335**	**-0.94%**	**8.53%**
Percent of Statewide	**18.26%**	**18.04%**	**17.92%**		
Seniors	260,848	264,723	270,457	1.49%	2.17%
Persons with Disabilities	189,058	190,147	205,559	0.58%	8.11%
Families and Children	1,197,999	1,178,360	1,326,053	-1.64%	12.53%
ACA Optional Expansion	668,897	661,844	689,548	-1.05%	4.19%

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

Statewide Expanded Eligible for Aid Category: All Aids

Certified Average Monthly Eligible Count by Month



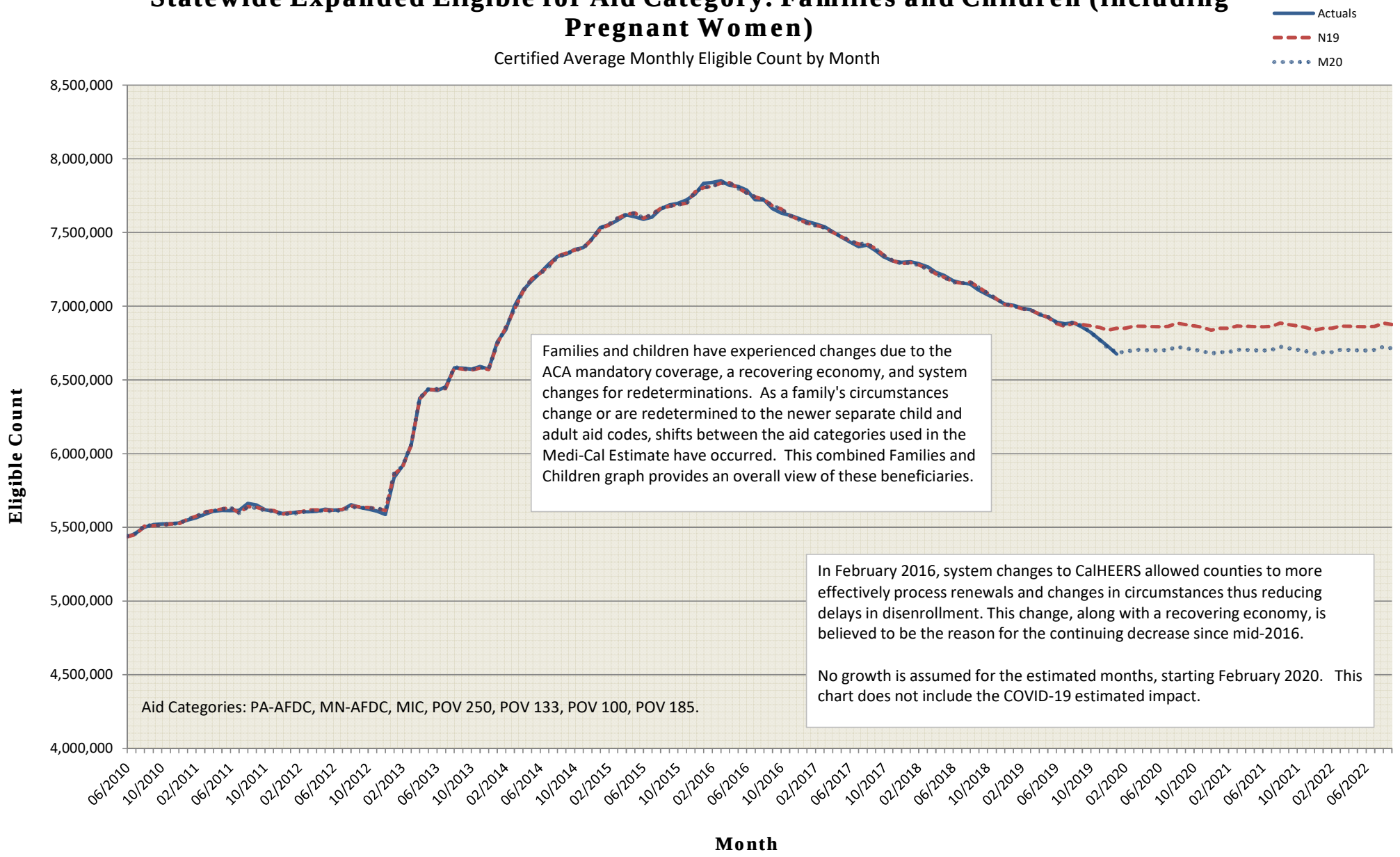
The increase beginning in 2007 is attributed to the Great Recession. Beginning in January 2013, Medi-Cal expanded to include the formerly Healthy Families program. In January 2014, Medi-Cal expanded due to ACA. Economic recovery is believed to be the reason for the flattening starting 2016 and continuing decrease.

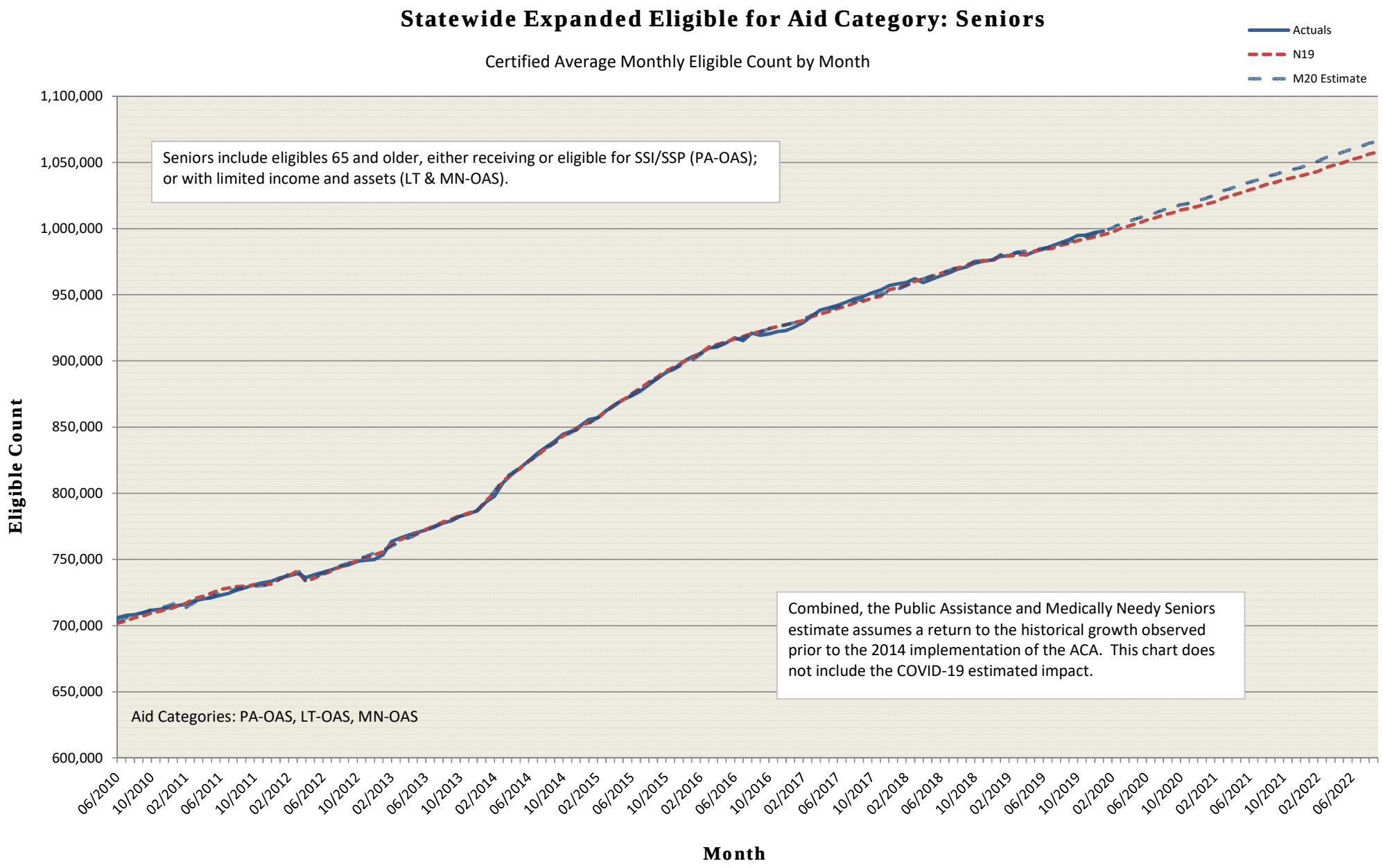
The All Aids Eligibles graph represents the eighteen aid categories estimated via the base estimating process and does not incorporate additional eligibles from policy changes.

For estimating purposes, the Medi-Cal eligibles are divided into eighteen categories. Of these eighteen, most can be categorized as: Seniors (OAS), Persons with Disabilities (ATD), Families & Children (AFDC & POV), and ACA Optional (NEWLY). This chart does not include the COVID-19 estimated impact.

Statewide Expanded Eligible for Aid Category: Families and Children (including Pregnant Women)

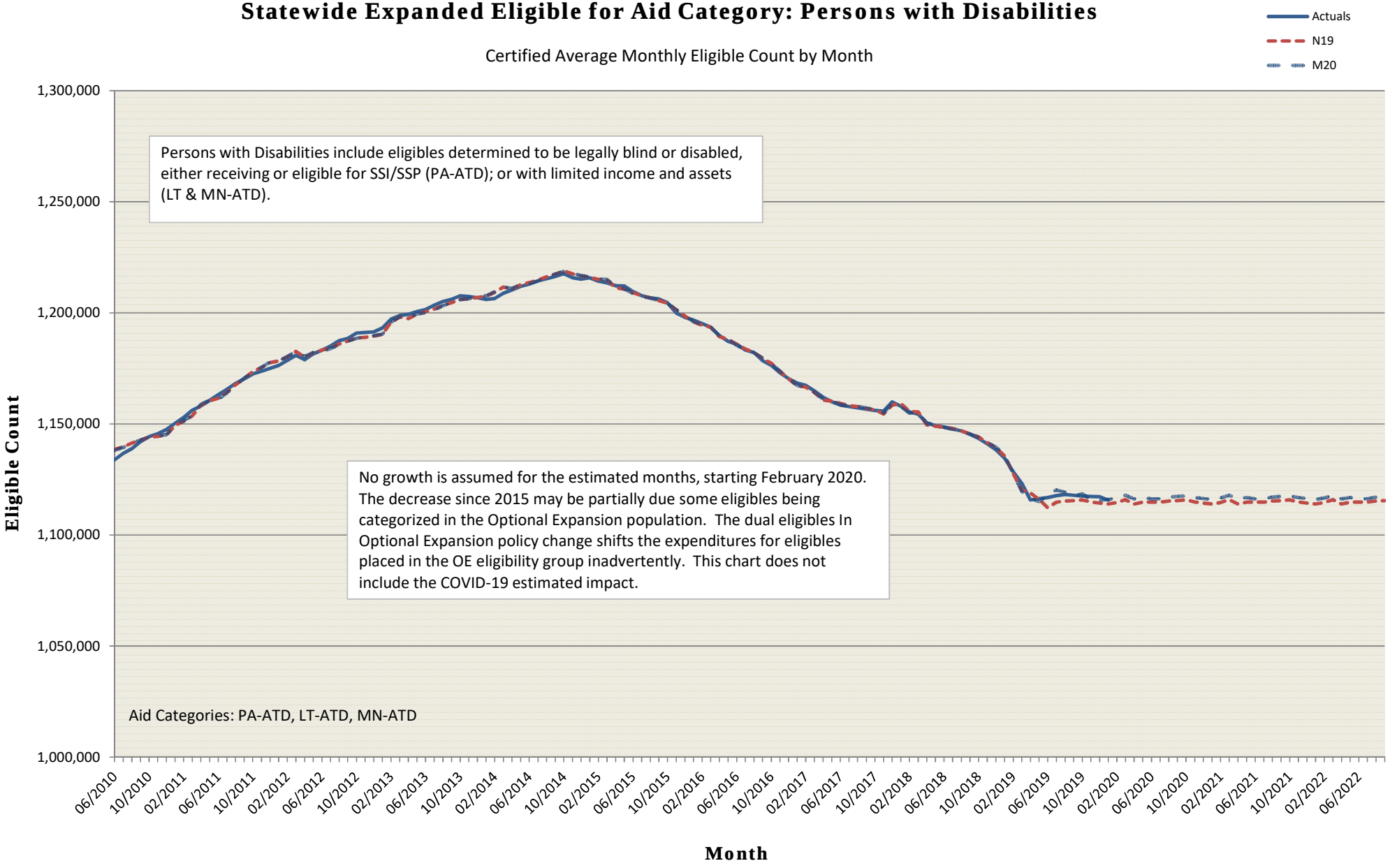
Certified Average Monthly Eligible Count by Month




Statewide Expanded Eligible for Aid Category: Seniors
Certified Average Monthly Eligible Count by Month
Actuals
N19
M20 Estimate
Seniors include eligibles 65 and older, either receiving or eligible for SSI/SSP (PA-OAS); or with limited income and assets (LT & MN-OAS).
Combined, the Public Assistance and Medically Needy Seniors estimate assumes a return to the historical growth observed prior to the 2014 implementation of the ACA. This chart does not include the COVID-19 estimated impact.
Aid Categories: PA-OAS, LT-OAS, MN-OAS
Eligible Count
1,100,000
1,050,000
1,000,000
950,000
900,000
850,000
800,000
750,000
700,000
650,000
600,000
06/2010
10/2010
02/2011
06/2011
10/2011
02/2012
06/2012
10/2012
02/2013
06/2013
10/2013
02/2014
06/2014
10/2014
02/2015
06/2015
10/2015
02/2016
06/2016
10/2016
02/2017
06/2017
10/2017
02/2018
06/2018
10/2018
02/2019
06/2019
10/2019
02/2020
06/2020
10/2020
02/2021
06/2021
10/2021
02/2022
06/2022
Month

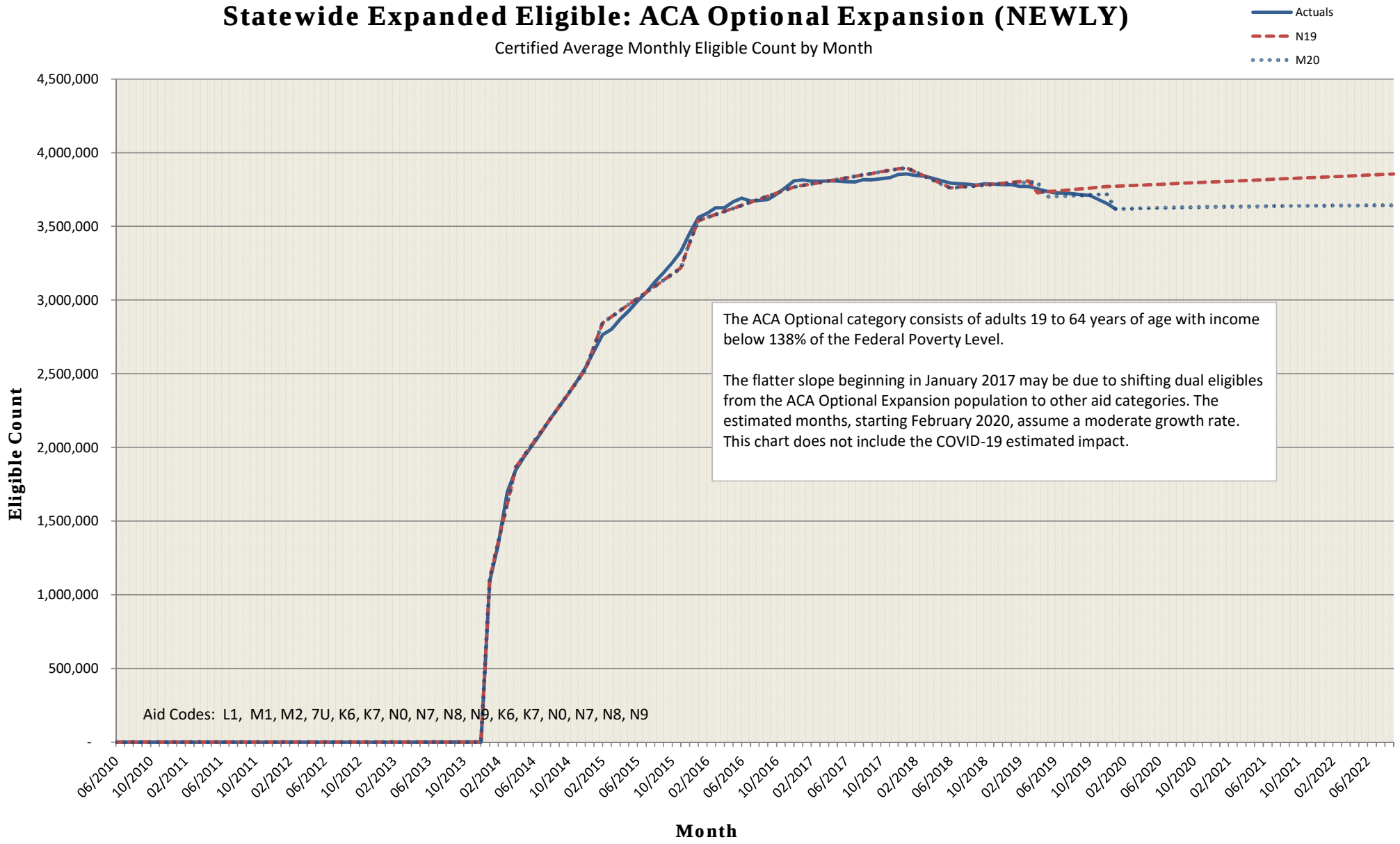
Statewide Expanded Eligible for Aid Category: Persons with Disabilities

Certified Average Monthly Eligible Count by Month



Statewide Expanded Eligible: ACA Optional Expansion (NEWLY)

Certified Average Monthly Eligible Count by Month



MEDI-CAL AID CATEGORY DEFINITIONS

Aid Category	Aid Category Detail	System Name	Aid Codes
Public Assistance	Seniors	PA-OAS	10, 16, 1E
Public Assistance	Persons with Disabilities	PA-ATD	20, 26, 2E, 36, 60, 66, 6A, 6C, 6E, 6N, 6P
Public Assistance	Families	PA-AFDC	2S, 2T, 2U, 30, 32, 33, 35, 38, 3A, 3C, 3E, 3F, 3G, 3H, 3L, 3M, 3P, 3R, 3U, 3W, 40, 42, 43, 49, 4F, 4G, 4H, 4N, 4S, 4T, 4W, 5L,K1, R1
Long-Term	Seniors	LT-OAS	13, D2, D3 J5, J6
Long-Term	Persons with Disabilities	LT-ADT	23, 63, D4, D5, D6, D7, J7, J8
Medically Needy	Seniors	MN-OAS	14, 17, 1H, 1U, 1X, 1Y, C1, C2
Medically Needy	Persons with Disabilities	MN-ATD	24, 27, 2H, 64, 67, 6G, 6H, 6S, 6U, 6V, 6W, 6X, 6Y, 8G, C3, C4, C7, C8, K8, K9, L6, L7
Medically Needy	Families	MN-AFDC	34, 37, 39, 3D, 3N, 3T, 3V, 54, 59, 5J, 5R, 5T, 5W, 6J, 6R, 7J, 7K, 7S, 7W, C5, C6, M3, M4, P5, P6
Medically Indigent	Children	MI-C	03, 04, 06, 07, 2A, 2P, 2R, 45, 46, 4A, 4L, 4M, 5E, 5K, 7M, 7N, 7P, 7R, 7T, 82, 83, 8E, 8W, C9, D1,G5, G6, G7, G8
Medically Indigent	Adults	MI-A	53, 81, 86, 87, 8L, F3, F4, G3, G4, J1, J2, J3, J4
Other	Refugees	REFUGEE	01, 02, 08, 0A
Other	OBRA	OBRA	55, 58
Other	POV 185	POV 185	44, 47, 48, 5F, 69, 76, 7F, 7G, 8U, 8V, D8, D9, M0, M7, M8, M9, P0, P9
Other	POV 133	POV 133	72, 74, 8N, 8P, P7, P8
Other	POV 100	POV 100	7A, 7C, 8R, 8T, M5, M6,
Other	Opt. Targeted Low Income	POV 250	5C, 5D, 8X, E6, H1, H2, H3, H4, H5, T0, T1, T2, T3, T4, T5, T6, T7, T8, T9
Other	ACA Optional Expansion	Newly	7U, K6, K7, L1, M1, M2, N0, N7, N8, N9
Other	Hopsital PE	HP-E	4E, H0, H6, H7, H8, H9, P1, P2, P3, P4
Other	Medi-Cal Access Program	Medi-Cal Access Program	OE, OG, E7, E9
Other	QMB	QMB	80

TABLE OF CONTENTS

FEE-FOR-SERVICE BASE

The Fee-For-Service (FFS) Base section provides a detailed overview of projected FFS benefits expenditures by service category and base aid category.

QUARTERLY OF SUMMARY OF FFS UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY 1-12

TOTAL FOR ALL SERVICES ACROSS ALL AID CATEGORIES 1
PHYSICIANS BASE ESTIMATE 2
OTHER MEDICAL BASE ESTIMATE 3
COUNTY & COMMUNITY OUTPATIENT BASE ESTIMATE 4
PHARMACY BASE ESTIMATE 5
COUNTY INPATIENT BASE ESTIMATE 6
COMMUNITY INPATIENT BASE ESTIMATE 7
NURSING FACILITIES BASE ESTIMATE 8
ICF-DD BASE ESTIMATE 9
MEDICAL TRANSPORTATION BASE ESTIMATE.....10
OTHER SERVICES BASE ESTIMATE 11
HOME HEALTH BASE ESTIMATE 12

QUARTERLY OF SUMMARY OF FFS UTILIZATION AND EXPENDITURES BY AID CATEGORY 13-30

PUBLIC ASSISTANCE - SENIORS (PA-OAS).....13
ACA OPTIONAL EXPANSION (NEWLY) 14
PUBLIC ASSISTANCE - PERSONS WITH DISABILITIES (PA-ATD) 15
PUBLIC ASSISTANCE - FAMILIES (PA-AFDC) 16
LONG-TERM CARE - SENIORS (LT-OAS).....17
HOSPITAL PRESUMPTIVE ELIGIBILITY (H-PE) 18
LONG-TERM CARE - PERSONS WITH DISABILITIES (LT-ATD).....19
POVERTY 250 (POV 250) 20
MEDICALLY NEEDY - SENIORS (MN-OAS).....21
MEDICALLY NEEDY - PERSONS WITH DISABILITIES (MN-ATD).....22
MEDICALLY NEEDY - FAMILIES (MN-AFDC).....23
MEDICALLY INDIGENT - CHILDREN (MI-C) 24
MEDICALLY INDIGENT - ADULT (MI-A).....25
REFUGEES.....26
OBRA 27
POVERTY 185 (POV 185) 28
POVERTY 133 (POV 133) 29
POVERTY 100 (POV 100) 30

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

TOTAL FOR ALL SERVICES ACROSS ALL BASE AID CATEGORIES

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	2,107,680	3.35	$230.94	$773.66	$4,891,877,900
2017-18 *	2	1,910,640	3.12	$230.61	$720.54	$4,130,113,200
2017-18 *	3	2,031,840	3.09	$224.55	$693.35	$4,226,333,400
2017-18 *	4	1,816,470	2.94	$229.64	$674.71	$3,676,766,000
2017-18 *	TOTAL	1,966,660	3.13	$228.95	$717.17	$16,925,090,500
2018-19 *	1	2,036,100	3.29	$240.56	$790.39	$4,827,950,200
2018-19 *	2	1,908,320	3.03	$242.90	$736.56	$4,216,771,000
2018-19 *	3	1,932,850	3.09	$238.08	$735.39	$4,264,201,300
2018-19 *	4	1,811,770	2.99	$236.60	$708.35	$3,850,128,500
2018-19 *	TOTAL	1,922,260	3.10	$239.61	$743.87	$17,159,051,000
2019-20 *	1	2,089,650	3.33	$241.29	$803.16	$5,034,956,100
2019-20 *	2	1,947,270	3.03	$238.18	$722.12	$4,218,498,600
2019-20 **	3	1,936,230	3.14	$238.21	$748.67	$4,348,809,000
2019-20 **	4	1,797,430	3.01	$236.13	$710.31	$3,830,195,100
2019-20 **	TOTAL	1,942,650	3.13	$238.62	$747.80	$17,432,458,800
2020-21 **	1	2,102,240	3.36	$245.49	$825.46	$5,205,983,400
2020-21 **	2	2,018,210	3.17	$243.53	$772.89	$4,679,579,000
2020-21 **	3	1,831,440	3.07	$241.70	$741.16	$4,072,197,300
2020-21 **	4	1,816,470	3.02	$239.33	$722.95	$3,939,674,400
2020-21 **	TOTAL	1,942,090	3.16	$242.74	$767.96	$17,897,434,100

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

PHYSICIANS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	370,290	2.41	$73.71	$177.39	$197,053,500
2017-18 *	2	334,880	2.27	$74.05	$168.32	$169,099,400
2017-18 *	3	417,130	2.21	$76.94	$170.20	$212,989,000
2017-18 *	4	304,170	2.20	$72.84	$159.96	$145,962,900
2017-18 *	TOTAL	356,620	2.27	$74.53	$169.44	$725,104,800
2018-19 *	1	341,200	2.41	$79.51	$191.69	$196,211,000
2018-19 *	2	318,750	2.37	$82.80	$195.96	$187,387,800
2018-19 *	3	330,340	2.32	$79.17	$183.45	$181,806,700
2018-19 *	4	286,170	2.28	$80.32	$183.33	$157,386,700
2018-19 *	TOTAL	319,120	2.35	$80.43	$188.75	$722,792,200
2019-20 *	1	343,510	2.48	$76.78	$190.33	$196,138,600
2019-20 *	2	297,060	2.39	$82.97	$198.01	$176,466,700
2019-20 **	3	319,920	2.36	$81.06	$191.28	$183,580,800
2019-20 **	4	274,610	2.33	$80.15	$187.09	$154,127,800
2019-20 **	TOTAL	308,770	2.39	$80.09	$191.70	$710,314,000
2020-21 **	1	334,680	2.54	$83.01	$210.95	$211,807,000
2020-21 **	2	317,160	2.44	$82.74	$202.21	$192,396,300
2020-21 **	3	301,810	2.31	$80.81	$186.51	$168,876,000
2020-21 **	4	278,130	2.34	$80.06	$187.47	$156,419,900
2020-21 **	TOTAL	307,950	2.41	$81.78	$197.41	$729,499,200

* ACTUAL
** ESTIMATED
NOTE: UNITS = Number of claims

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

OTHER MEDICAL

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	1,289,670	1.60	$159.18	$255.22	$987,436,800
2017-18 *	2	1,119,010	1.53	$157.16	$239.73	$804,789,400
2017-18 *	3	1,187,540	1.55	$159.69	$246.94	$879,740,800
2017-18 *	4	1,080,500	1.50	$162.42	$243.47	$789,203,300
2017-18 *	TOTAL	1,169,180	1.55	$159.56	$246.69	$3,461,170,400
2018-19 *	1	1,285,960	1.62	$164.34	$266.17	$1,026,856,800
2018-19 *	2	1,174,050	1.55	$166.09	$257.84	$908,143,500
2018-19 *	3	1,186,890	1.56	$168.63	$262.81	$935,782,700
2018-19 *	4	1,117,640	1.56	$170.38	$265.25	$889,364,400
2018-19 *	TOTAL	1,191,130	1.57	$167.23	$263.06	$3,760,147,400
2019-20 *	1	1,331,970	1.62	$170.79	$276.63	$1,105,399,200
2019-20 *	2	1,216,610	1.55	$173.53	$268.56	$980,200,200
2019-20 **	3	1,208,160	1.56	$174.42	$271.90	$985,488,400
2019-20 **	4	1,122,790	1.54	$173.79	$267.72	$901,762,900
2019-20 **	TOTAL	1,219,880	1.57	$173.03	$271.40	$3,972,850,700
2020-21 **	1	1,369,560	1.65	$174.28	$288.43	$1,185,049,900
2020-21 **	2	1,282,300	1.59	$175.19	$277.73	$1,068,406,500
2020-21 **	3	1,140,430	1.53	$174.36	$267.36	$914,710,400
2020-21 **	4	1,137,470	1.54	$173.79	$268.02	$914,607,400
2020-21 **	TOTAL	1,232,440	1.58	$174.43	$276.06	$4,082,774,200

* ACTUAL
** ESTIMATED
NOTE: UNITS = Number of claims

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

CO. & COMM. OUTPATIENT

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	260,500	1.58	$136.08	$215.58	$168,473,600
2017-18 *	2	218,420	1.50	$137.38	$205.80	$134,849,000
2017-18 *	3	214,570	1.50	$145.52	$217.85	$140,230,100
2017-18 *	4	200,770	1.48	$136.65	$201.58	$121,415,600
2017-18 *	TOTAL	223,570	1.52	$138.75	$210.59	$564,968,300
2018-19 *	1	226,560	1.56	$156.86	$244.24	$166,006,900
2018-19 *	2	216,300	1.52	$141.81	$215.34	$139,736,100
2018-19 *	3	204,770	1.51	$155.83	$235.22	$144,496,100
2018-19 *	4	183,890	1.51	$149.05	$224.42	$123,806,800
2018-19 *	TOTAL	207,880	1.52	$151.00	$230.12	$574,045,800
2019-20 *	1	224,390	1.57	$151.30	$238.01	$160,222,400
2019-20 *	2	200,690	1.54	$153.81	$237.44	$142,952,500
2019-20 **	3	202,690	1.52	$156.24	$237.65	$144,508,700
2019-20 **	4	184,100	1.51	$149.21	$225.36	$124,465,300
2019-20 **	TOTAL	202,970	1.54	$152.68	$234.91	$572,149,000
2020-21 **	1	226,500	1.59	$164.38	$261.77	$177,875,700
2020-21 **	2	213,620	1.56	$154.08	$240.47	$154,107,400
2020-21 **	3	191,420	1.50	$156.01	$233.49	$134,085,200
2020-21 **	4	186,270	1.51	$148.97	$225.50	$126,007,400
2020-21 **	TOTAL	204,450	1.54	$156.32	$241.33	$592,075,800

* ACTUAL
** ESTIMATED
NOTE: UNITS = Number of claims

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

PHARMACY

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	481,820	2.97	$233.29	$692.10	$1,000,411,000
2017-18 *	2	456,550	2.76	$231.87	$639.23	$875,521,700
2017-18 *	3	466,300	2.79	$234.95	$654.74	$915,916,400
2017-18 *	4	410,900	2.61	$245.73	$641.84	$791,198,100
2017-18 *	TOTAL	453,890	2.79	$236.00	$657.84	$3,583,047,200
2018-19 *	1	470,970	2.98	$255.77	$762.61	$1,077,495,000
2018-19 *	2	444,370	2.75	$255.03	$702.53	$936,547,500
2018-19 *	3	453,030	2.76	$249.55	$689.40	$936,961,800
2018-19 *	4	393,800	2.67	$240.49	$642.94	$759,565,000
2018-19 *	TOTAL	440,540	2.80	$250.75	$701.89	$3,710,569,300
2019-20 *	1	469,700	3.01	$225.32	$677.96	$955,309,600
2019-20 *	2	443,160	2.75	$219.14	$603.01	$801,689,600
2019-20 **	3	447,790	2.78	$221.99	$616.92	$828,742,700
2019-20 **	4	403,400	2.67	$228.82	$610.02	$738,243,700
2019-20 **	TOTAL	441,010	2.81	$223.72	$628.10	$3,323,985,500
2020-21 **	1	474,950	3.06	$239.11	$730.57	$1,040,962,800
2020-21 **	2	461,160	2.85	$235.49	$671.61	$929,155,600
2020-21 **	3	429,450	2.69	$237.64	$639.89	$824,412,800
2020-21 **	4	407,460	2.68	$243.67	$653.77	$799,159,200
2020-21 **	TOTAL	443,260	2.83	$238.82	$675.62	$3,593,690,500

* ACTUAL
** ESTIMATED
NOTE: UNITS = Number of prescriptions

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

COUNTY INPATIENT

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	5,120	5.14	$2,668.86	$13,728.13	$211,056,300
2017-18 *	2	4,080	5.10	$2,831.25	$14,430.74	$176,545,700
2017-18 *	3	4,550	5.29	$2,923.19	$15,468.24	$210,940,400
2017-18 *	4	3,700	5.33	$2,916.55	$15,542.08	$172,703,600
2017-18 *	TOTAL	4,360	5.21	$2,827.01	$14,730.52	$771,245,900
2018-19 *	1	4,700	5.26	$2,947.41	$15,513.77	$218,759,600
2018-19 *	2	4,320	4.93	$3,128.12	$15,427.86	$199,852,500
2018-19 *	3	4,360	4.79	$3,238.62	$15,517.60	$203,109,900
2018-19 *	4	11,900	1.61	$3,217.29	$5,175.34	$184,827,100
2018-19 *	TOTAL	6,320	3.40	$3,122.86	$10,632.49	$806,549,100
2019-20 *	1	4,540	4.92	$3,222.64	$15,865.90	$216,046,000
2019-20 *	2	4,140	4.40	$3,462.91	$15,237.05	$189,137,500
2019-20 **	3	4,380	5.06	$3,377.74	$17,079.91	$224,298,900
2019-20 **	4	3,730	5.06	$3,392.17	$17,154.01	$191,992,200
2019-20 **	TOTAL	4,200	4.86	$3,357.59	$16,313.80	$821,474,600
2020-21 **	1	4,770	5.00	$3,358.89	$16,804.49	$240,526,300
2020-21 **	2	4,470	4.87	$3,416.83	$16,639.23	$222,931,700
2020-21 **	3	4,090	5.01	$3,425.46	$17,168.75	$210,855,800
2020-21 **	4	3,800	5.06	$3,396.77	$17,186.19	$195,686,900
2020-21 **	TOTAL	4,280	4.98	$3,398.18	$16,933.06	$870,000,800

* ACTUAL
** ESTIMATED
NOTE: UNITS = Number of days stay

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

COMMUNITY INPATIENT

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	35,410	4.76	$2,285.34	$10,884.19	$1,156,368,800
2017-18 *	2	28,970	5.01	$2,353.89	$11,800.67	$1,025,430,800
2017-18 *	3	27,660	4.85	$2,362.20	$11,446.34	$949,874,100
2017-18 *	4	25,430	4.75	$2,342.92	$11,138.12	$849,816,000
2017-18 *	TOTAL	29,370	4.84	$2,333.19	$11,297.51	$3,981,489,700
2018-19 *	1	30,520	4.96	$2,360.61	$11,702.66	$1,071,554,300
2018-19 *	2	27,120	4.89	$2,353.25	$11,510.31	$936,317,700
2018-19 *	3	27,580	4.92	$2,313.40	$11,371.75	$940,830,100
2018-19 *	4	26,300	4.59	$2,400.69	$11,015.90	$869,154,300
2018-19 *	TOTAL	27,880	4.84	$2,355.91	$11,412.09	$3,817,856,400
2019-20 *	1	31,110	5.09	$2,384.60	$12,136.41	$1,132,545,300
2019-20 *	2	26,510	4.99	$2,366.52	$11,800.56	$938,628,600
2019-20 **	3	27,170	4.96	$2,382.96	$11,810.81	$962,641,000
2019-20 **	4	24,120	4.85	$2,413.36	$11,699.00	$846,607,700
2019-20 **	TOTAL	27,230	4.98	$2,385.99	$11,876.54	$3,880,422,600
2020-21 **	1	31,800	5.03	$2,378.06	$11,953.13	$1,140,479,400
2020-21 **	2	28,450	5.00	$2,388.10	$11,949.10	$1,019,980,900
2020-21 **	3	25,330	4.97	$2,383.96	$11,844.20	$900,078,100
2020-21 **	4	24,480	4.84	$2,422.92	$11,733.53	$861,628,300
2020-21 **	TOTAL	27,520	4.97	$2,391.76	$11,878.18	$3,922,166,800

* ACTUAL
** ESTIMATED
NOTE: UNITS = Number of days stay

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

NURSING FACILITIES

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	30,910	36.14	$232.89	$8,416.67	$780,570,200
2017-18 *	2	28,910	31.86	$222.46	$7,086.75	$614,683,600
2017-18 *	3	27,760	31.42	$220.69	$6,933.59	$577,408,200
2017-18 *	4	25,930	28.15	$230.01	$6,474.91	$503,741,700
2017-18 *	TOTAL	28,380	32.07	$226.75	$7,271.69	$2,476,403,800
2018-19 *	1	28,030	35.45	$225.98	$8,010.39	$673,545,500
2018-19 *	2	27,020	31.82	$224.92	$7,157.63	$580,297,300
2018-19 *	3	25,870	31.72	$231.04	$7,328.50	$568,743,200
2018-19 *	4	23,260	30.67	$230.47	$7,069.37	$493,322,200
2018-19 *	TOTAL	26,050	32.52	$227.88	$7,409.77	$2,315,908,200
2019-20 *	1	28,510	37.42	$246.34	$9,216.76	$788,355,700
2019-20 *	2	27,070	30.95	$231.64	$7,168.72	$582,193,600
2019-20 **	3	26,480	32.13	$240.51	$7,728.12	$613,823,200
2019-20 **	4	25,010	29.37	$235.52	$6,918.05	$519,164,800
2019-20 **	TOTAL	26,770	32.59	$239.11	$7,793.84	$2,503,537,400
2020-21 **	1	27,900	36.84	$236.71	$8,719.45	$729,902,400
2020-21 **	2	27,660	34.10	$232.83	$7,938.99	$658,800,000
2020-21 **	3	26,050	29.71	$235.09	$6,984.43	$545,930,600
2020-21 **	4	25,100	29.72	$235.38	$6,994.68	$526,791,100
2020-21 **	TOTAL	26,680	32.71	$235.02	$7,687.88	$2,461,424,100

* ACTUAL
** ESTIMATED
NOTE: UNITS = Number of days stay

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

ICF-DD

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	4,970	36.20	$209.44	$7,581.57	$113,094,300
2017-18 *	2	4,890	31.44	$209.37	$6,581.94	$96,497,800
2017-18 *	3	4,870	32.58	$209.82	$6,835.79	$99,952,900
2017-18 *	4	4,750	26.51	$261.01	$6,918.19	$98,522,000
2017-18 *	TOTAL	4,870	31.74	$220.02	$6,982.54	$408,066,900
2018-19 *	1	4,870	35.81	$221.62	$7,935.19	$115,830,000
2018-19 *	2	4,810	32.09	$222.28	$7,133.03	$102,901,100
2018-19 *	3	4,790	31.04	$228.06	$7,078.17	$101,685,000
2018-19 *	4	4,550	27.62	$223.57	$6,175.08	$84,326,800
2018-19 *	TOTAL	4,750	31.71	$223.78	$7,095.15	$404,743,000
2019-20 *	1	4,800	36.37	$224.63	$8,168.93	$117,681,600
2019-20 *	2	4,730	31.28	$232.83	$7,283.12	$103,245,500
2019-20 **	3	4,750	31.93	$231.62	$7,394.93	$105,278,500
2019-20 **	4	4,640	26.87	$232.02	$6,233.52	$86,733,900
2019-20 **	TOTAL	4,730	31.65	$229.96	$7,278.69	$412,939,500
2020-21 **	1	4,820	36.51	$231.25	$8,442.11	$122,065,100
2020-21 **	2	4,790	33.67	$230.95	$7,774.99	$111,768,300
2020-21 **	3	4,760	29.55	$231.54	$6,842.35	$97,778,100
2020-21 **	4	4,690	27.28	$231.93	$6,326.06	$88,992,100
2020-21 **	TOTAL	4,770	31.78	$231.38	$7,354.23	$420,603,700

* ACTUAL
** ESTIMATED
NOTE: UNITS = Number of days stay

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

MEDICAL TRANSPORTATION

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	31,700	2.90	$70.66	$205.16	$19,510,900
2017-18 *	2	25,390	2.93	$86.18	$252.58	$19,235,800
2017-18 *	3	30,500	2.68	$76.79	$206.15	$18,860,800
2017-18 *	4	23,040	2.72	$75.23	$204.73	$14,151,500
2017-18 *	TOTAL	27,660	2.81	$76.91	$216.22	$71,759,000
2018-19 *	1	26,920	3.02	$85.69	$259.12	$20,922,400
2018-19 *	2	22,510	2.96	$83.50	$247.16	$16,692,400
2018-19 *	3	22,830	2.93	$82.08	$240.20	$16,453,600
2018-19 *	4	21,300	2.85	$77.97	$222.43	$14,211,100
2018-19 *	TOTAL	23,390	2.95	$82.58	$243.27	$68,279,600
2019-20 *	1	26,150	2.92	$183.08	$534.17	$41,908,000
2019-20 *	2	27,540	2.63	$164.98	$434.08	$35,866,600
2019-20 **	3	26,060	2.70	$126.45	$340.98	$26,655,700
2019-20 **	4	23,270	2.66	$123.66	$328.77	$22,955,600
2019-20 **	TOTAL	25,760	2.73	$151.16	$412.15	$127,386,000
2020-21 **	1	28,820	2.87	$124.76	$357.88	$30,939,000
2020-21 **	2	28,930	2.72	$127.16	$345.92	$30,022,200
2020-21 **	3	25,380	2.63	$125.91	$330.86	$25,193,500
2020-21 **	4	23,580	2.66	$123.49	$328.43	$23,234,000
2020-21 **	TOTAL	26,680	2.72	$125.40	$341.70	$109,388,600

* ACTUAL
** ESTIMATED
NOTE: UNITS = Number of claims

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

OTHER SERVICES

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	190,810	3.43	$100.32	$344.50	$197,202,200
2017-18 *	2	195,290	2.97	$93.93	$278.56	$163,198,200
2017-18 *	3	191,520	3.13	$92.87	$290.94	$167,155,900
2017-18 *	4	189,180	3.18	$82.24	$261.83	$148,597,700
2017-18 *	TOTAL	191,700	3.18	$92.50	$293.93	$676,154,000
2018-19 *	1	171,750	3.36	$117.46	$394.67	$203,350,500
2018-19 *	2	157,690	2.54	$132.38	$335.93	$158,917,700
2018-19 *	3	173,980	3.34	$99.20	$331.07	$172,797,500
2018-19 *	4	183,020	3.51	$98.03	$343.88	$188,813,700
2018-19 *	TOTAL	171,610	3.20	$109.68	$351.52	$723,879,400
2019-20 *	1	177,610	3.69	$122.14	$451.14	$240,386,400
2019-20 *	2	190,340	2.91	$123.03	$357.44	$204,105,400
2019-20 **	3	191,420	3.36	$108.24	$363.98	$209,013,100
2019-20 **	4	185,220	3.27	$102.67	$336.17	$186,792,800
2019-20 **	TOTAL	186,150	3.30	$113.90	$376.18	$840,297,700
2020-21 **	1	188,140	3.43	$129.61	$444.05	$250,634,800
2020-21 **	2	200,640	2.88	$128.02	$368.83	$222,011,300
2020-21 **	3	175,960	3.30	$108.02	$355.94	$187,897,300
2020-21 **	4	187,230	3.27	$102.94	$336.68	$189,107,600
2020-21 **	TOTAL	187,990	3.21	$117.28	$376.63	$849,651,000

* ACTUAL
** ESTIMATED
NOTE: UNITS = Number of claims

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

HOME HEALTH

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	4,560	4.44	$999.88	$4,442.04	$60,700,500
2017-18 *	2	3,960	5.47	$774.44	$4,235.78	$50,261,800
2017-18 *	3	4,240	5.49	$762.25	$4,186.17	$53,264,800
2017-18 *	4	3,840	4.78	$753.06	$3,596.20	$41,453,400
2017-18 *	TOTAL	4,150	5.03	$820.97	$4,131.62	$205,680,500
2018-19 *	1	4,090	6.18	$757.76	$4,682.99	$57,418,100
2018-19 *	2	4,030	5.51	$749.76	$4,132.41	$49,977,300
2018-19 *	3	3,880	5.47	$965.10	$5,282.85	$61,534,600
2018-19 *	4	3,570	5.51	$1,443.85	$7,961.05	$85,350,400
2018-19 *	TOTAL	3,890	5.68	$958.45	$5,442.18	$254,280,500
2019-20 *	1	4,120	6.30	$1,040.40	$6,550.42	$80,963,200
2019-20 *	2	4,050	5.24	$1,006.15	$5,268.96	$64,012,500
2019-20 **	3	4,090	5.23	$1,009.66	$5,280.49	$64,777,800
2019-20 **	4	3,910	4.96	$985.02	$4,888.34	$57,348,200
2019-20 **	TOTAL	4,040	5.44	$1,012.45	$5,506.34	$267,101,800
2020-21 **	1	4,280	5.85	$1,007.04	$5,895.38	$75,740,900
2020-21 **	2	4,090	5.69	$1,004.16	$5,708.80	$69,998,800
2020-21 **	3	4,000	5.02	$1,035.31	$5,192.53	$62,379,500
2020-21 **	4	3,930	5.00	$985.26	$4,927.85	$58,040,300
2020-21 **	TOTAL	4,080	5.40	$1,007.87	$5,442.89	$266,159,600

* ACTUAL
** ESTIMATED
NOTE: UNITS = Number of claims

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

PA-OAS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	66,250	3.86	$168.38	$649.68	$129,119,500
2017-18 *	2	59,690	3.55	$162.09	$575.76	$103,104,200
2017-18 *	3	81,100	3.16	$133.97	$423.36	$103,002,400
2017-18 *	4	56,650	3.31	$160.49	$531.54	$90,337,400
2017-18 *	TOTAL	65,920	3.46	$155.62	$537.96	$425,563,400
2018-19 *	1	63,530	3.76	$168.51	$633.77	$120,782,000
2018-19 *	2	55,200	3.58	$170.62	$611.40	$101,248,500
2018-19 *	3	59,110	3.48	$169.16	$589.25	$104,495,100
2018-19 *	4	55,740	3.38	$168.92	$570.16	$95,351,400
2018-19 *	TOTAL	58,400	3.56	$169.27	$602.04	$421,876,900
2019-20 *	1	62,990	3.74	$182.23	$681.04	$128,695,300
2019-20 *	2	58,470	3.41	$173.30	$590.78	$103,630,000
2019-20 **	3	59,890	3.50	$175.10	$612.84	$110,116,400
2019-20 **	4	55,450	3.37	$174.64	$588.54	$97,912,100
2019-20 **	TOTAL	59,200	3.51	$176.58	$619.84	$440,353,800
2020-21 **	1	63,470	3.81	$181.98	$692.84	$131,915,900
2020-21 **	2	60,010	3.62	$178.34	$645.29	$116,178,000
2020-21 **	3	56,540	3.41	$172.97	$589.72	$100,025,200
2020-21 **	4	54,440	3.42	$175.73	$600.15	$98,018,700
2020-21 **	TOTAL	58,610	3.57	$177.57	$634.28	$446,137,900

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

NEWLY

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	509,600	2.61	$286.94	$749.42	$1,145,714,800
2017-18 *	2	450,910	2.47	$288.02	$712.26	$963,496,600
2017-18 *	3	473,090	2.49	$288.09	$716.10	$1,016,338,200
2017-18 *	4	440,950	2.34	$297.04	$695.76	$920,392,000
2017-18 *	TOTAL	468,640	2.48	$289.73	$719.45	$4,045,941,600
2018-19 *	1	513,170	2.62	$299.22	$782.95	$1,205,360,500
2018-19 *	2	483,920	2.47	$295.86	$731.76	$1,062,335,100
2018-19 *	3	481,490	2.48	$300.35	$744.52	$1,075,446,200
2018-19 *	4	444,740	2.41	$300.38	$723.78	$965,679,500
2018-19 *	TOTAL	480,830	2.50	$298.93	$746.77	$4,308,821,300
2019-20 *	1	535,850	2.65	$296.71	$785.81	$1,263,235,300
2019-20 *	2	484,060	2.48	$294.13	$729.28	$1,059,030,800
2019-20 **	3	475,140	2.50	$301.29	$753.34	$1,073,826,600
2019-20 **	4	443,490	2.44	$301.70	$735.52	$978,582,300
2019-20 **	TOTAL	484,630	2.52	$298.29	$752.23	$4,374,675,000
2020-21 **	1	540,360	2.72	$301.10	$817.51	$1,325,263,800
2020-21 **	2	507,440	2.58	$300.48	$776.23	$1,181,679,600
2020-21 **	3	452,410	2.43	$308.39	$750.24	$1,018,259,700
2020-21 **	4	448,910	2.45	$308.04	$753.40	$1,014,610,900
2020-21 **	TOTAL	487,280	2.55	$304.08	$776.38	$4,539,814,100

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

PA-ATD

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	275,880	4.80	$266.42	$1,278.78	$1,058,357,400
2017-18 *	2	255,820	4.36	$266.81	$1,162.43	$892,125,100
2017-18 *	3	277,860	4.25	$257.70	$1,096.18	$913,761,400
2017-18 *	4	243,510	4.13	$256.87	$1,062.04	$775,841,100
2017-18 *	TOTAL	263,270	4.39	$262.21	$1,152.22	$3,640,084,900
2018-19 *	1	261,510	4.76	$279.28	$1,329.63	$1,043,128,000
2018-19 *	2	240,510	4.29	$283.35	$1,215.72	$877,195,200
2018-19 *	3	247,180	4.30	$277.88	$1,195.76	$886,685,700
2018-19 *	4	232,570	4.18	$270.48	$1,131.64	$789,561,700
2018-19 *	TOTAL	245,440	4.39	$277.92	$1,221.12	$3,596,570,600
2019-20 *	1	258,070	4.81	$268.85	$1,293.26	$1,001,243,000
2019-20 *	2	246,380	4.12	$263.38	$1,085.74	$802,513,000
2019-20 **	3	243,960	4.36	$260.40	$1,134.09	$830,014,400
2019-20 **	4	229,740	4.09	$258.69	$1,058.66	$729,636,500
2019-20 **	TOTAL	244,540	4.35	$263.20	$1,146.19	$3,363,407,000
2020-21 **	1	256,750	4.75	$274.74	$1,305.09	$1,005,246,100
2020-21 **	2	250,560	4.35	$271.40	$1,180.20	$887,136,400
2020-21 **	3	233,580	4.16	$266.58	$1,108.30	$776,618,300
2020-21 **	4	230,650	4.11	$262.51	$1,079.94	$747,264,400
2020-21 **	TOTAL	242,880	4.35	$269.26	$1,172.11	$3,416,265,200

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

PA-AFDC

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	163,510	2.32	$199.70	$464.09	$227,648,100
2017-18 *	2	152,840	2.19	$200.04	$437.33	$200,528,300
2017-18 *	3	158,890	2.20	$193.34	$424.54	$202,365,800
2017-18 *	4	140,560	2.13	$188.50	$400.89	$169,050,300
2017-18 *	TOTAL	153,950	2.21	$195.69	$432.82	$799,592,500
2018-19 *	1	149,690	2.28	$213.60	$486.50	$218,470,500
2018-19 *	2	142,080	2.11	$216.78	$456.66	$194,646,800
2018-19 *	3	141,290	2.23	$201.25	$448.38	$190,051,900
2018-19 *	4	132,540	2.22	$196.80	$435.92	$173,328,900
2018-19 *	TOTAL	141,400	2.21	$207.30	$457.63	$776,498,100
2019-20 *	1	144,740	2.33	$210.35	$489.79	$212,671,400
2019-20 *	2	140,750	2.20	$209.97	$461.62	$194,924,800
2019-20 **	3	146,210	2.24	$204.81	$459.41	$201,505,300
2019-20 **	4	138,130	2.18	$191.92	$417.68	$173,079,500
2019-20 **	TOTAL	142,460	2.24	$204.49	$457.56	$782,181,000
2020-21 **	1	157,300	2.33	$216.43	$503.53	$237,620,600
2020-21 **	2	154,810	2.22	$214.03	$474.22	$220,237,400
2020-21 **	3	141,290	2.20	$204.59	$449.63	$190,583,700
2020-21 **	4	140,210	2.19	$194.07	$424.24	$178,443,800
2020-21 **	TOTAL	148,400	2.23	$207.87	$464.33	$826,885,500

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

LT-OAS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	19,500	32.36	$205.38	$6,645.75	$388,796,400
2017-18 *	2	18,450	28.63	$195.97	$5,611.10	$310,512,900
2017-18 *	3	21,550	24.14	$191.96	$4,633.32	$299,558,400
2017-18 *	4	17,160	24.93	$206.68	$5,153.32	$265,215,600
2017-18 *	TOTAL	19,160	27.49	$199.97	$5,496.97	$1,264,083,200
2018-19 *	1	18,330	31.97	$201.58	$6,444.50	$354,473,400
2018-19 *	2	17,830	28.49	$200.12	$5,702.10	$304,982,700
2018-19 *	3	17,610	28.13	$201.61	$5,671.33	$299,678,700
2018-19 *	4	16,110	26.48	$205.59	$5,443.26	$263,061,700
2018-19 *	TOTAL	17,470	28.85	$202.07	$5,829.45	$1,222,196,500
2019-20 *	1	18,670	33.89	$221.83	$7,517.34	$421,136,300
2019-20 *	2	18,270	27.89	$207.82	$5,795.76	$317,624,800
2019-20 **	3	18,040	28.95	$214.04	$6,196.05	$335,264,200
2019-20 **	4	16,660	26.57	$210.84	$5,601.28	$279,906,200
2019-20 **	TOTAL	17,910	29.41	$214.20	$6,300.10	$1,353,931,500
2020-21 **	1	18,760	33.02	$212.16	$7,006.28	$394,236,000
2020-21 **	2	18,560	30.82	$209.44	$6,454.58	$359,318,500
2020-21 **	3	17,690	26.74	$209.65	$5,605.17	$297,547,800
2020-21 **	4	16,740	26.96	$210.96	$5,688.21	$285,617,600
2020-21 **	TOTAL	17,940	29.49	$210.61	$6,210.53	$1,336,719,900

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

H-PE

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	46,050	3.58	$254.52	$910.53	$125,794,600
2017-18 *	2	40,840	3.49	$248.69	$868.89	$106,456,000
2017-18 *	3	44,280	3.37	$231.43	$780.75	$103,714,700
2017-18 *	4	40,260	3.16	$252.98	$798.16	$96,391,900
2017-18 *	TOTAL	42,860	3.41	$246.85	$840.70	$432,357,200
2018-19 *	1	45,410	3.63	$254.02	$921.89	$125,597,800
2018-19 *	2	44,730	3.41	$244.74	$834.64	$112,007,800
2018-19 *	3	46,780	3.45	$256.43	$884.42	$124,125,000
2018-19 *	4	41,130	3.29	$253.41	$832.61	$102,724,700
2018-19 *	TOTAL	44,510	3.45	$252.22	$869.50	$464,455,400
2019-20 *	1	49,250	3.67	$264.03	$968.72	$143,140,500
2019-20 *	2	42,860	3.64	$271.06	$985.36	$126,707,800
2019-20 **	3	48,730	3.67	$274.61	$1,007.50	$147,291,000
2019-20 **	4	42,590	3.52	$278.81	$982.30	$125,504,900
2019-20 **	TOTAL	45,860	3.63	$271.86	$986.06	$542,644,100
2020-21 **	1	51,430	3.82	$270.05	$1,032.20	$159,250,200
2020-21 **	2	48,760	3.71	$271.94	$1,008.44	$147,519,400
2020-21 **	3	46,540	3.54	$278.36	$985.91	$137,658,000
2020-21 **	4	42,980	3.53	$279.09	$985.59	$127,078,700
2020-21 **	TOTAL	47,430	3.66	$274.49	$1,004.17	$571,506,200

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

LT-ATD

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	6,470	31.41	$221.74	$6,963.94	$135,093,400
2017-18 *	2	5,870	27.53	$218.97	$6,029.23	$106,222,900
2017-18 *	3	6,770	24.49	$206.17	$5,049.35	$102,527,000
2017-18 *	4	5,480	23.96	$239.02	$5,726.84	$94,080,500
2017-18 *	TOTAL	6,150	26.92	$220.59	$5,937.95	$437,923,800
2018-19 *	1	5,670	31.92	$218.44	$6,971.85	$118,528,400
2018-19 *	2	5,510	28.77	$219.85	$6,325.89	$104,522,700
2018-19 *	3	5,360	27.95	$222.78	$6,226.50	$100,066,100
2018-19 *	4	4,990	24.88	$226.10	$5,625.21	$84,254,300
2018-19 *	TOTAL	5,380	28.49	$221.42	$6,308.70	$407,371,500
2019-20 *	1	5,380	33.37	$230.29	$7,684.34	$123,971,400
2019-20 *	2	5,260	28.07	$228.80	$6,422.56	$101,258,100
2019-20 **	3	5,130	29.53	$227.16	$6,709.21	$103,227,000
2019-20 **	4	4,730	26.31	$229.32	$6,032.59	$85,673,100
2019-20 **	TOTAL	5,120	29.42	$228.94	$6,735.28	$414,129,600
2020-21 **	1	5,170	33.95	$230.28	$7,818.56	$121,213,200
2020-21 **	2	5,120	31.51	$227.39	$7,164.48	$110,077,800
2020-21 **	3	4,950	27.81	$222.59	$6,190.63	$92,012,000
2020-21 **	4	4,740	26.68	$230.19	$6,142.15	$87,319,400
2020-21 **	TOTAL	5,000	30.08	$227.72	$6,849.74	$410,622,400

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

POV 250

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	105,920	2.23	$202.31	$451.38	$143,434,400
2017-18 *	2	99,890	2.11	$194.75	$410.93	$123,140,400
2017-18 *	3	105,580	2.13	$194.06	$414.18	$131,186,700
2017-18 *	4	96,790	2.09	$182.63	$381.22	$110,698,100
2017-18 *	TOTAL	102,050	2.14	$193.81	$415.22	$508,459,600
2018-19 *	1	106,840	2.14	$213.39	$456.94	$146,463,900
2018-19 *	2	99,100	1.91	$220.37	$421.87	$125,419,300
2018-19 *	3	103,800	2.18	$193.64	$421.51	$131,262,200
2018-19 *	4	101,520	2.19	$186.30	$407.19	$124,016,300
2018-19 *	TOTAL	102,820	2.11	$202.83	$427.27	$527,161,700
2019-20 *	1	113,050	2.20	$208.99	$459.62	$155,882,200
2019-20 *	2	110,400	2.04	$198.78	$406.05	$134,482,400
2019-20 **	3	112,180	2.17	$189.86	$411.76	$138,579,200
2019-20 **	4	105,060	2.15	$183.29	$394.20	$124,244,200
2019-20 **	TOTAL	110,170	2.14	$195.46	$418.42	$553,187,900
2020-21 **	1	116,980	2.26	$205.30	$463.15	$162,538,400
2020-21 **	2	115,620	2.12	$199.00	$421.57	$146,220,400
2020-21 **	3	106,100	2.18	$190.35	$414.37	$131,895,600
2020-21 **	4	106,240	2.17	$183.28	$396.94	$126,508,700
2020-21 **	TOTAL	111,230	2.18	$194.92	$424.90	$567,163,100

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

MN-OAS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	82,510	4.14	$194.21	$804.59	$199,169,600
2017-18 *	2	72,410	3.82	$187.22	$714.83	$155,288,600
2017-18 *	3	82,800	3.58	$179.61	$643.58	$159,859,300
2017-18 *	4	70,810	3.50	$189.29	$662.13	$140,649,600
2017-18 *	TOTAL	77,130	3.77	$187.77	$707.62	$654,967,100
2018-19 *	1	82,270	3.82	$194.22	$742.58	$183,282,300
2018-19 *	2	74,220	3.61	$190.23	$687.53	$153,079,700
2018-19 *	3	77,030	3.54	$193.50	$685.77	$158,469,000
2018-19 *	4	75,040	3.41	$193.22	$658.82	$148,312,300
2018-19 *	TOTAL	77,140	3.60	$192.85	$694.78	$643,143,200
2019-20 *	1	89,520	3.81	$202.52	$771.40	$207,159,900
2019-20 *	2	82,510	3.44	$195.76	$672.92	$166,557,900
2019-20 **	3	83,380	3.49	$201.42	$703.17	$175,882,400
2019-20 **	4	79,700	3.43	$198.44	$680.18	$162,624,000
2019-20 **	TOTAL	83,770	3.55	$199.70	$708.48	$712,224,300
2020-21 **	1	94,180	3.78	$202.95	$768.04	$217,001,200
2020-21 **	2	89,920	3.55	$198.49	$705.39	$190,288,400
2020-21 **	3	84,640	3.37	$197.22	$664.39	$168,700,100
2020-21 **	4	85,220	3.39	$196.33	$664.89	$169,986,400
2020-21 **	TOTAL	88,490	3.53	$198.97	$702.51	$745,976,200

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

MN-ATD

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	42,770	4.55	$182.61	$830.44	$106,554,000
2017-18 *	2	37,760	4.27	$175.22	$747.36	$84,659,000
2017-18 *	3	43,950	4.09	$163.20	$668.05	$88,089,200
2017-18 *	4	36,800	4.09	$170.49	$697.21	$76,962,500
2017-18 *	TOTAL	40,320	4.25	$173.12	$736.33	$356,264,700
2018-19 *	1	39,320	4.56	$190.52	$869.48	$102,554,700
2018-19 *	2	33,720	4.07	$189.57	$771.05	$77,996,100
2018-19 *	3	37,000	4.24	$169.83	$719.94	$79,916,500
2018-19 *	4	38,100	4.18	$184.21	$770.79	$88,098,500
2018-19 *	TOTAL	37,030	4.27	$183.60	$784.34	$348,565,900
2019-20 *	1	44,770	4.61	$192.35	$886.71	$119,096,400
2019-20 *	2	43,910	4.00	$199.86	$800.12	$105,403,100
2019-20 **	3	44,110	4.44	$182.40	$810.26	$107,232,100
2019-20 **	4	42,000	4.28	$179.92	$770.70	$97,106,000
2019-20 **	TOTAL	43,700	4.34	$188.57	$817.79	$428,837,600
2020-21 **	1	46,870	4.70	$196.81	$925.08	$130,088,900
2020-21 **	2	45,150	4.27	$199.04	$850.37	$115,179,100
2020-21 **	3	42,470	4.28	$183.73	$786.14	$100,154,300
2020-21 **	4	42,320	4.30	$180.75	$776.81	$98,632,500
2020-21 **	TOTAL	44,200	4.39	$190.54	$837.14	$444,054,800

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

MN-AFDC

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	455,320	2.51	$202.04	$508.00	$693,914,000
2017-18 *	2	413,420	2.36	$201.27	$474.90	$589,002,200
2017-18 *	3	425,890	2.36	$199.30	$470.05	$600,576,800
2017-18 *	4	392,770	2.24	$192.62	$431.39	$508,311,300
2017-18 *	TOTAL	421,850	2.37	$199.09	$472.48	$2,391,804,300
2018-19 *	1	441,100	2.46	$206.96	$509.60	$674,348,900
2018-19 *	2	420,940	2.27	$213.05	$484.46	$611,783,800
2018-19 *	3	418,640	2.35	$206.55	$485.69	$609,980,800
2018-19 *	4	396,150	2.30	$201.25	$462.24	$549,344,200
2018-19 *	TOTAL	419,200	2.35	$207.02	$486.13	$2,445,457,700
2019-20 *	1	456,570	2.47	$207.06	$511.38	$700,446,400
2019-20 *	2	423,910	2.29	$206.21	$473.13	$601,697,400
2019-20 **	3	416,150	2.36	$208.68	$492.00	$614,242,400
2019-20 **	4	390,610	2.28	$202.11	$460.13	$539,199,800
2019-20 **	TOTAL	421,810	2.35	$206.14	$485.13	$2,455,586,000
2020-21 **	1	453,120	2.52	$216.33	$545.25	$741,195,000
2020-21 **	2	436,070	2.38	$215.11	$510.98	$668,471,800
2020-21 **	3	390,050	2.32	$213.89	$496.41	$580,863,300
2020-21 **	4	394,030	2.28	$206.68	$471.46	$557,309,400
2020-21 **	TOTAL	418,320	2.38	$213.28	$507.56	$2,547,839,500

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

MI-C

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	60,760	2.75	$151.68	$417.63	$76,124,500
2017-18 *	2	58,210	2.58	$151.63	$391.53	$68,373,900
2017-18 *	3	56,120	2.70	$157.88	$426.72	$71,846,900
2017-18 *	4	48,290	2.57	$155.67	$400.84	$58,070,600
2017-18 *	TOTAL	55,850	2.66	$154.09	$409.48	$274,416,000
2018-19 *	1	58,730	2.70	$161.36	$435.35	$76,702,500
2018-19 *	2	55,330	2.57	$166.28	$428.02	$71,046,300
2018-19 *	3	54,020	2.69	$172.62	$465.03	$75,360,000
2018-19 *	4	47,490	2.66	$169.81	$451.48	$64,321,000
2018-19 *	TOTAL	53,890	2.66	$167.31	$444.46	$287,429,800
2019-20 *	1	61,810	2.76	$175.80	$485.10	$89,959,100
2019-20 *	2	59,580	2.62	$184.90	$485.33	$86,742,200
2019-20 **	3	59,110	2.73	$181.24	$495.27	$87,822,600
2019-20 **	4	53,720	2.60	$181.43	$471.35	$75,958,700
2019-20 **	TOTAL	58,550	2.68	$180.72	$484.57	$340,482,600
2020-21 **	1	64,780	2.80	$187.09	$524.21	$101,869,400
2020-21 **	2	63,350	2.69	$182.19	$489.50	$93,027,300
2020-21 **	3	56,290	2.66	$183.82	$489.52	$82,666,200
2020-21 **	4	54,110	2.61	$183.44	$479.52	$77,841,800
2020-21 **	TOTAL	59,630	2.70	$184.23	$496.67	$355,404,700

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

MI-A

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	450	26.62	$221.87	$5,905.38	$7,889,600
2017-18 *	2	1,360	10.06	$178.56	$1,795.52	$7,334,700
2017-18 *	3	1,930	8.14	$186.62	$1,518.36	$8,804,900
2017-18 *	4	1,550	7.35	$214.17	$1,574.30	$7,326,800
2017-18 *	TOTAL	1,320	9.96	$198.42	$1,975.31	$31,356,000
2018-19 *	1	1,460	9.52	$215.01	$2,047.93	$8,965,800
2018-19 *	2	1,240	8.57	$216.17	$1,851.74	$6,873,700
2018-19 *	3	1,140	9.51	$225.66	$2,145.86	$7,330,200
2018-19 *	4	1,020	8.83	$226.61	$2,001.85	$6,155,700
2018-19 *	TOTAL	1,220	9.13	$220.25	$2,011.21	$29,325,400
2019-20 *	1	950	11.35	$234.49	$2,660.69	$7,556,300
2019-20 *	2	590	13.59	$240.25	$3,265.05	$5,733,400
2019-20 **	3	530	15.94	$244.86	$3,903.74	$6,205,300
2019-20 **	4	520	13.81	$242.44	$3,348.96	$5,231,700
2019-20 **	TOTAL	650	13.30	$240.04	$3,191.47	$24,726,700
2020-21 **	1	680	15.14	$271.42	$4,108.38	$8,337,000
2020-21 **	2	620	13.79	$257.27	$3,546.76	$6,585,000
2020-21 **	3	510	15.70	$241.81	$3,797.41	$5,830,000
2020-21 **	4	530	13.88	$241.64	$3,353.64	$5,309,300
2020-21 **	TOTAL	580	14.62	$254.52	$3,720.76	$26,061,400

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

REFUGEE

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	640	2.31	$104.95	$242.31	$467,700
2017-18 *	2	340	2.36	$120.40	$284.70	$290,400
2017-18 *	3	260	2.30	$109.24	$251.33	$198,000
2017-18 *	4	200	2.28	$111.68	$254.47	$148,900
2017-18 *	TOTAL	360	2.32	$110.34	$255.60	$1,105,000
2018-19 *	1	180	2.49	$151.93	$378.55	$201,800
2018-19 *	2	140	2.50	$174.03	$434.46	$186,400
2018-19 *	3	160	2.51	$102.93	$258.09	$120,000
2018-19 *	4	180	2.85	$138.54	$395.03	$212,500
2018-19 *	TOTAL	160	2.59	$141.34	$366.76	$720,700
2019-20 *	1	240	2.69	$140.12	$377.14	$272,700
2019-20 *	2	220	2.66	$131.50	$349.94	$228,200
2019-20 **	3	130	3.50	$169.54	$594.16	$224,200
2019-20 **	4	110	3.44	$119.08	$409.65	$129,300
2019-20 **	TOTAL	170	2.94	$140.30	$413.13	$854,400
2020-21 **	1	260	2.26	$125.16	$283.18	$224,100
2020-21 **	2	210	2.36	$141.37	$332.93	$210,500
2020-21 **	3	120	2.91	$131.48	$382.56	$134,400
2020-21 **	4	110	3.11	$116.85	$363.14	$118,100
2020-21 **	TOTAL	170	2.53	$129.34	$327.16	$687,000

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

OBRA

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	440	9.09	$241.07	$2,190.45	$2,893,600
2017-18 *	2	240	14.47	$313.23	$4,532.94	$3,286,400
2017-18 *	3	160	18.01	$263.67	$4,749.83	$2,341,700
2017-18 *	4	120	16.06	$283.97	$4,561.40	$1,664,900
2017-18 *	TOTAL	240	12.82	$273.55	$3,507.76	$10,186,500
2018-19 *	1	130	20.03	$260.34	$5,214.25	$2,002,300
2018-19 *	2	130	17.18	$254.02	$4,362.82	$1,644,800
2018-19 *	3	110	17.86	$278.22	$4,970.24	$1,689,900
2018-19 *	4	90	18.48	$293.16	$5,416.93	$1,451,700
2018-19 *	TOTAL	110	18.40	$269.48	$4,958.86	$6,788,700
2019-20 *	1	130	18.09	$306.52	$5,546.14	$2,179,600
2019-20 *	2	90	18.27	$320.65	$5,857.53	$1,640,100
2019-20 **	3	120	14.20	$283.99	$4,033.14	$1,415,400
2019-20 **	4	120	11.45	$235.05	$2,691.96	$964,800
2019-20 **	TOTAL	120	15.42	$290.88	$4,485.12	$6,199,900
2020-21 **	1	110	17.46	$247.72	$4,325.85	$1,483,800
2020-21 **	2	120	16.08	$253.23	$4,071.71	$1,472,700
2020-21 **	3	120	13.15	$247.87	$3,258.62	$1,134,400
2020-21 **	4	120	11.88	$239.89	$2,851.07	$992,900
2020-21 **	TOTAL	120	14.65	$247.74	$3,628.49	$5,083,800

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

POV 185

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	136,910	2.94	$252.81	$743.19	$305,242,900
2017-18 *	2	115,840	2.82	$293.76	$827.94	$287,719,000
2017-18 *	3	115,020	2.91	$280.51	$816.39	$281,706,400
2017-18 *	4	100,530	2.71	$284.04	$770.40	$232,356,800
2017-18 *	TOTAL	117,070	2.85	$276.12	$787.97	$1,107,025,100
2018-19 *	1	112,510	3.05	$281.56	$857.67	$289,488,200
2018-19 *	2	106,030	2.90	$297.72	$864.69	$275,039,000
2018-19 *	3	107,570	2.95	$293.95	$867.78	$280,045,800
2018-19 *	4	93,750	2.85	$325.93	$927.75	$260,925,200
2018-19 *	TOTAL	104,960	2.94	$298.36	$877.68	$1,105,498,200
2019-20 *	1	104,260	3.19	$297.99	$950.53	$297,319,100
2019-20 *	2	93,070	3.04	$315.09	$956.93	$267,187,400
2019-20 **	3	92,610	3.12	$316.81	$989.07	$274,796,500
2019-20 **	4	78,510	2.99	$327.65	$979.50	$230,714,900
2019-20 **	TOTAL	92,120	3.09	$313.12	$968.01	$1,070,018,000
2020-21 **	1	96,650	3.35	$309.98	$1,037.35	$300,768,800
2020-21 **	2	92,800	3.18	$320.68	$1,019.94	$283,944,500
2020-21 **	3	85,050	3.09	$326.16	$1,007.53	$257,070,000
2020-21 **	4	79,010	3.02	$328.72	$991.66	$235,053,300
2020-21 **	TOTAL	88,380	3.17	$320.59	$1,015.39	$1,076,836,600

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

POV 133

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	91,170	1.95	$175.74	$343.31	$93,901,800
2017-18 *	2	85,390	1.91	$170.65	$325.82	$83,467,300
2017-18 *	3	93,210	1.92	$173.28	$333.22	$93,177,200
2017-18 *	4	83,710	1.87	$180.00	$335.84	$84,335,300
2017-18 *	TOTAL	88,370	1.91	$174.85	$334.66	$354,881,600
2018-19 *	1	91,200	1.91	$194.70	$371.45	$101,625,500
2018-19 *	2	85,260	1.77	$197.55	$349.03	$89,276,100
2018-19 *	3	90,980	1.99	$170.18	$337.96	$92,245,900
2018-19 *	4	88,100	1.98	$167.29	$330.66	$87,399,400
2018-19 *	TOTAL	88,890	1.91	$181.79	$347.40	$370,546,800
2019-20 *	1	95,090	2.00	$179.07	$358.93	$102,387,800
2019-20 *	2	91,150	1.88	$177.97	$335.30	$91,684,100
2019-20 **	3	88,050	2.06	$172.04	$355.24	$93,836,100
2019-20 **	4	76,500	1.95	$177.87	$346.30	$79,473,800
2019-20 **	TOTAL	87,690	1.98	$176.69	$349.11	$367,381,800
2020-21 **	1	87,450	2.06	$195.21	$402.70	$105,644,300
2020-21 **	2	83,310	2.02	$193.14	$389.63	$97,383,100
2020-21 **	3	75,360	2.10	$184.42	$387.75	$87,660,400
2020-21 **	4	76,230	1.95	$188.58	$368.61	$84,297,200
2020-21 **	TOTAL	80,590	2.03	$190.57	$387.76	$374,985,100

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND MAY 2020 BASE ESTIMATES)

POV 100

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2017-18 *	1	43,530	2.03	$195.14	$396.39	$51,761,700
2017-18 *	2	41,360	1.93	$188.37	$363.54	$45,105,400
2017-18 *	3	43,360	1.94	$187.48	$363.41	$47,278,300
2017-18 *	4	40,340	1.93	$192.32	$371.28	$44,932,500
2017-18 *	TOTAL	42,150	1.96	$190.89	$373.84	$189,077,900
2018-19 *	1	45,070	1.99	$208.51	$414.01	$55,973,600
2018-19 *	2	42,440	1.78	$209.82	$372.94	$47,487,200
2018-19 *	3	43,580	2.03	$177.78	$361.27	$47,232,100
2018-19 *	4	42,510	2.04	$176.92	$360.17	$45,929,500
2018-19 *	TOTAL	43,400	1.96	$192.76	$377.55	$196,622,400
2019-20 *	1	48,310	2.04	$198.36	$404.40	$58,603,300
2019-20 *	2	45,810	1.92	$195.34	$374.39	$51,453,100
2019-20 **	3	42,760	2.11	$174.73	$368.93	$47,327,800
2019-20 **	4	39,800	2.03	$182.99	$370.60	$44,253,300
2019-20 **	TOTAL	44,170	2.02	$188.17	$380.42	$201,637,600
2020-21 **	1	47,920	2.13	$202.80	$431.84	$62,086,800
2020-21 **	2	45,780	2.03	$196.15	$397.94	$54,649,000
2020-21 **	3	37,740	2.15	$177.91	$383.22	$43,383,800
2020-21 **	4	39,900	2.03	$186.27	$378.21	$45,271,300
2020-21 **	TOTAL	42,830	2.08	$191.66	$399.59	$205,390,900

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

TABLE OF CONTENTS

BASE POLICY CHANGES

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

BASE POLICY CHANGES INTRODUCTION ..... COVER PAGE

CURRENT YEAR SUMMARY OF BASE POLICY CHANGE EXPENDITURES 1-2

BUDGET YEAR SUMMARY OF BASE POLICY CHANGE EXPENDITURES 3-4

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES, CURRENT YEAR ESTIMATE COMPARISONS 5-6

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES, BUDGET YEAR COMPARISONS 7-9

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES, CURRENT YEAR COMPARED TO BUDGET YEAR 10-11

MEDI-CAL PROGRAM BASE POLICY CHANGES.....12-104

POLICY CHANGE INDEX 12-13
ELIGIBILITY 14
DRUG MEDI-CAL 22
MENTAL HEALTH.....34
MANAGED CARE 42
OTHER 76

Medi-Cal Base Policy Changes

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

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

The second type of base estimate, which had traditionally been called the Non-Fee-for-Service (Non-FFS) Base Estimate, is displayed in this section. Because some of these base estimates include services paid on a fee-for-service basis, that name is technically not correct. As a result, this second type of base estimate will be called Base Policy Changes because as in the past they are entered into the Medi-Cal Estimate and displayed using the policy change format. These Base Policy Changes form the base estimates for the last 14 service categories (Managed Care through Drug Medi-Cal) as displayed in most tables throughout this binder and listed below. The data used for these projections come from a variety of sources, such as other claims processing systems, managed care enrollments, and other payment data. Also, some of the projections in this group come directly from other State departments.

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

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2019-20

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	ELIGIBILITY				
4	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	$68,082,000	$48,702,000	$0	$19,380,000
5	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	$21,443,000	$18,348,080	$3,094,920	$0
6	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	$3,948,000	$3,133,610	$814,390	$0
	ELIGIBILITY SUBTOTAL	**$93,473,000**	**$70,183,700**	**$3,909,300**	**$19,380,000**
	DRUG MEDI-CAL				
64	NARCOTIC TREATMENT PROGRAM	$22,127,000	$21,058,210	$1,068,790	$0
65	OUTPATIENT DRUG FREE TREATMENT SERVICES	$3,746,000	$3,522,790	$223,210	$0
66	INTENSIVE OUTPATIENT TREATMENT SERVICES	$1,638,000	$1,167,770	$470,230	$0
68	RESIDENTIAL TREATMENT SERVICES	$399,000	$386,420	$12,580	$0
	DRUG MEDI-CAL SUBTOTAL	**$27,910,000**	**$26,135,190**	**$1,774,810**	**$0**
	MENTAL HEALTH				
71	SMHS FOR ADULTS	$1,462,846,000	$1,332,017,190	$56,720,810	$74,108,000
72	SMHS FOR CHILDREN	$1,196,776,000	$1,099,672,770	$51,100,230	$46,003,000
	MENTAL HEALTH SUBTOTAL	**$2,659,622,000**	**$2,431,689,960**	**$107,821,040**	**$120,111,000**
	MANAGED CARE				
92	TWO PLAN MODEL	$20,037,588,000	$13,535,544,540	$6,502,043,460	$0
93	COUNTY ORGANIZED HEALTH SYSTEMS	$8,565,819,000	$5,717,515,340	$2,848,303,660	$0
94	GEOGRAPHIC MANAGED CARE	$3,602,517,000	$2,423,301,040	$1,179,215,960	$0
98	REGIONAL MODEL	$1,237,347,000	$848,640,260	$388,706,740	$0
99	PACE (Other M/C)	$682,939,000	$341,469,500	$341,469,500	$0
102	DENTAL MANAGED CARE (Other M/C)	$106,947,000	$64,861,400	$42,085,600	$0
105	SENIOR CARE ACTION NETWORK (Other M/C)	$70,176,000	$35,088,000	$35,088,000	$0
106	AIDS HEALTHCARE CENTERS (Other M/C)	$15,424,000	$7,712,000	$7,712,000	$0
109	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$1,427,000	$713,500	$713,500	$0
	MANAGED CARE SUBTOTAL	**$34,320,184,000**	**$22,974,845,570**	**$11,345,338,430**	**$0**
	OTHER				
173	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$3,403,315,000	$1,596,441,500	$1,806,873,500	$0
174	MEDICARE PAYMENTS - PART D PHASED-DOWN	$2,213,849,000	$0	$2,213,849,000	$0
175	HOME & COMMUNITY-BASED SVCS.- CDDS (Misc.)	$2,270,028,000	$2,270,028,000	$0	$0
176	PERSONAL CARE SERVICES (Misc. Svcs.)	$1,938,182,000	$1,938,182,000	$0	$0
177	DENTAL SERVICES	$1,002,205,000	$618,176,920	$384,028,080	$0
179	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$247,737,000	$247,737,000	$0	$0

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2019-20

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
183	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$65,300,000	$65,300,000	$0	$0
184	MEDI-CAL TCM PROGRAM	$44,549,000	$44,549,000	$0	$0
185	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$47,030,000	$23,515,000	$23,515,000	$0
187	LAWSUITS/CLAIMS	$38,015,000	$19,007,500	$19,007,500	$0
195	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$2,160,000	$2,160,000	$0	$0
196	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$744,000	$372,000	$372,000	$0
212	BASE RECOVERIES	($427,966,000)	($235,357,000)	($192,609,000)	$0
	OTHER SUBTOTAL	**$10,845,148,000**	**$6,590,111,920**	**$4,255,036,080**	**$0**
	GRAND TOTAL	**$47,946,337,000**	**$32,092,966,330**	**$15,713,879,670**	**$139,491,000**

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2020-21

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	ELIGIBILITY				
4	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	$68,383,000	$41,530,000	$0	$26,853,000
5	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	$8,769,000	$5,936,520	$2,832,480	$0
6	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	$3,967,000	$2,692,630	$1,274,370	$0
	ELIGIBILITY SUBTOTAL	**$81,119,000**	**$50,159,150**	**$4,106,850**	**$26,853,000**
	DRUG MEDI-CAL				
64	NARCOTIC TREATMENT PROGRAM	$30,087,000	$28,301,100	$1,785,900	$0
65	OUTPATIENT DRUG FREE TREATMENT SERVICES	$3,828,000	$3,559,300	$268,700	$0
66	INTENSIVE OUTPATIENT TREATMENT SERVICES	$1,531,000	$1,097,700	$433,300	$0
68	RESIDENTIAL TREATMENT SERVICES	$533,000	$514,000	$19,000	$0
	DRUG MEDI-CAL SUBTOTAL	**$35,979,000**	**$33,472,100**	**$2,506,900**	**$0**
	MENTAL HEALTH				
71	SMHS FOR ADULTS	$1,544,652,000	$1,390,055,810	$77,135,190	$77,461,000
72	SMHS FOR CHILDREN	$1,208,875,000	$1,096,988,970	$60,954,030	$50,932,000
	MENTAL HEALTH SUBTOTAL	**$2,753,527,000**	**$2,487,044,780**	**$138,089,220**	**$128,393,000**
	MANAGED CARE				
92	TWO PLAN MODEL	$20,578,936,000	$13,615,948,030	$6,962,987,970	$0
93	COUNTY ORGANIZED HEALTH SYSTEMS	$8,865,094,000	$5,786,779,960	$3,078,314,040	$0
94	GEOGRAPHIC MANAGED CARE	$3,685,633,000	$2,428,140,520	$1,257,492,480	$0
98	REGIONAL MODEL	$1,275,951,000	$861,143,600	$414,807,400	$0
99	PACE (Other M/C)	$878,983,000	$439,491,500	$439,491,500	$0
102	DENTAL MANAGED CARE (Other M/C)	$109,892,000	$65,787,160	$44,104,840	$0
105	SENIOR CARE ACTION NETWORK (Other M/C)	$60,230,000	$30,115,000	$30,115,000	$0
106	AIDS HEALTHCARE CENTERS (Other M/C)	$16,544,000	$8,272,000	$8,272,000	$0
109	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$1,655,000	($2,309,000)	$3,964,000	$0
	MANAGED CARE SUBTOTAL	**$35,472,918,000**	**$23,233,368,770**	**$12,239,549,230**	**$0**
	OTHER				
173	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$3,624,292,000	$1,699,966,000	$1,924,326,000	$0
174	MEDICARE PAYMENTS - PART D PHASED-DOWN	$2,365,613,000	$0	$2,365,613,000	$0
175	HOME & COMMUNITY-BASED SVCS.- CDDS (Misc.)	$2,312,584,000	$2,312,584,000	$0	$0
176	PERSONAL CARE SERVICES (Misc. Svcs.)	$2,153,343,000	$2,153,343,000	$0	$0
177	DENTAL SERVICES	$1,015,986,000	$606,526,620	$409,459,380	$0
179	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$248,594,000	$248,594,000	$0	$0

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2020-21

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
183	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$29,476,000	$29,476,000	$0	$0
184	MEDI-CAL TCM PROGRAM	$32,950,000	$32,950,000	$0	$0
185	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$48,467,000	$24,233,500	$24,233,500	$0
187	LAWSUITS/CLAIMS	$32,350,000	$16,175,000	$16,175,000	$0
195	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$1,028,000	$1,028,000	$0	$0
196	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$672,000	$336,000	$336,000	$0
212	BASE RECOVERIES	($497,873,000)	($273,802,000)	($224,071,000)	$0
	OTHER SUBTOTAL	**$11,367,482,000**	**$6,851,410,120**	**$4,516,071,880**	**$0**
	GRAND TOTAL	**$49,711,025,000**	**$32,655,454,920**	**$16,900,324,080**	**$155,246,000**

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2019-20

NOV.	MAY		2019-20 APPROPRIATION		NOV. 2019 EST. FOR 2019-20		MAY 2020 EST. FOR 2019-20		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
NO.	NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		ELIGIBILITY										
4	4	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	$62,128,000	$0	$40,054,000	$0	$68,082,000	$0	$5,954,000	$0	$28,028,000	$0
5	5	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	$20,144,000	$4,354,220	$23,943,000	$3,682,420	$21,443,000	$3,094,920	$1,299,000	($1,259,310)	($2,500,000)	($587,500)
6	6	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	$4,036,000	$832,420	$4,422,000	$912,100	$3,948,000	$814,390	($88,000)	($18,040)	($474,000)	($97,700)
		ELIGIBILITY SUBTOTAL	**$86,308,000**	**$5,186,650**	**$68,419,000**	**$4,594,510**	**$93,473,000**	**$3,909,300**	**$7,165,000**	**($1,277,340)**	**$25,054,000**	**($685,200)**
		DRUG MEDI-CAL										
64	64	NARCOTIC TREATMENT PROGRAM	$85,833,000	$4,607,510	$31,133,000	$1,656,140	$22,127,000	$1,068,790	($63,706,000)	($3,538,720)	($9,006,000)	($587,350)
65	65	OUTPATIENT DRUG FREE TREATMENT SERVICES	$9,813,000	$535,330	$3,427,000	$203,320	$3,746,000	$223,210	($6,067,000)	($312,120)	$319,000	$19,890
66	66	INTENSIVE OUTPATIENT TREATMENT SERVICES	$3,275,000	$865,680	$1,191,000	$298,380	$1,638,000	$470,230	($1,637,000)	($395,440)	$447,000	$171,850
68	68	RESIDENTIAL TREATMENT SERVICES	$681,000	$19,210	$575,000	$18,700	$399,000	$12,580	($282,000)	($6,630)	($176,000)	($6,120)
		DRUG MEDI-CAL SUBTOTAL	**$99,602,000**	**$6,027,720**	**$36,326,000**	**$2,176,540**	**$27,910,000**	**$1,774,810**	**($71,692,000)**	**($4,252,920)**	**($8,416,000)**	**($401,730)**
		MENTAL HEALTH										
71	71	SMHS FOR ADULTS	$1,707,213,000	$69,236,320	$1,631,316,000	$64,662,210	$1,462,846,000	$56,720,810	($244,367,000)	($12,515,510)	($168,470,000)	($7,941,400)
72	72	SMHS FOR CHILDREN	$1,323,716,000	$51,625,910	$1,293,454,000	$51,216,690	$1,196,776,000	$51,100,230	($126,940,000)	($525,680)	($96,678,000)	($116,460)
		MENTAL HEALTH SUBTOTAL	**$3,030,929,000**	**$120,862,230**	**$2,924,770,000**	**$115,878,900**	**$2,659,622,000**	**$107,821,040**	**($371,307,000)**	**($13,041,190)**	**($265,148,000)**	**($8,057,860)**
		MANAGED CARE										
92	92	TWO PLAN MODEL	$20,590,375,000	$6,685,944,180	$20,338,170,000	$6,644,767,700	$20,037,588,000	$6,502,043,460	($552,787,000)	($183,900,720)	($300,582,000)	($142,724,240)
93	93	COUNTY ORGANIZED HEALTH SYSTEMS	$8,987,519,000	$2,929,776,560	$8,762,451,000	$2,949,009,660	$8,565,819,000	$2,848,303,660	($421,700,000)	($81,472,900)	($196,632,000)	($100,706,000)
94	94	GEOGRAPHIC MANAGED CARE	$3,703,087,000	$1,199,152,890	$3,667,740,000	$1,207,203,160	$3,602,517,000	$1,179,215,960	($100,570,000)	($19,936,930)	($65,223,000)	($27,987,200)
98	98	REGIONAL MODEL	$1,254,534,000	$397,654,070	$1,259,524,000	$397,039,360	$1,237,347,000	$388,706,740	($17,187,000)	($8,947,320)	($22,177,000)	($8,332,610)
99	99	PACE (Other M/C)	$615,165,000	$307,582,500	$655,171,000	$327,585,500	$682,939,000	$341,469,500	$67,774,000	$33,887,000	$27,768,000	$13,884,000
102	102	DENTAL MANAGED CARE (Other M/C)	$109,541,000	$42,446,460	$101,635,000	$39,980,170	$106,947,000	$42,085,600	($2,594,000)	($360,860)	$5,312,000	$2,105,430
105	105	SENIOR CARE ACTION NETWORK (Other M/C)	$72,769,000	$36,384,500	$71,861,000	$35,930,500	$70,176,000	$35,088,000	($2,593,000)	($1,296,500)	($1,685,000)	($842,500)
106	106	AIDS HEALTHCARE CENTERS (Other M/C)	$15,471,000	$7,735,500	$15,766,000	$7,883,000	$15,424,000	$7,712,000	($47,000)	($23,500)	($342,000)	($171,000)
109	109	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$1,776,000	$888,000	$1,599,000	$4,129,000	$1,427,000	$713,500	($349,000)	($174,500)	($172,000)	($3,415,500)

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2019-20

NOV.	MAY		2019-20 APPROPRIATION		NOV. 2019 EST. FOR 2019-20		MAY 2020 EST. FOR 2019-20		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
NO.	NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		MANAGED CARE SUBTOTAL	**$35,350,237,000**	**$11,607,564,660**	**$34,873,917,000**	**$11,613,528,040**	**$34,320,184,000**	**$11,345,338,430**	**($1,030,053,000)**	**($262,226,230)**	**($553,733,000)**	**($268,189,620)**
		OTHER										
173	173	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$3,422,979,000	$1,820,256,500	$3,403,297,000	$1,806,653,000	$3,403,315,000	$1,806,873,500	($19,664,000)	($13,383,000)	$18,000	$220,500
174	174	MEDICARE PAYMENTS - PART D PHASED-DOWN	$2,264,285,000	$2,264,285,000	$2,217,032,000	$2,217,032,000	$2,213,849,000	$2,213,849,000	($50,436,000)	($50,436,000)	($3,183,000)	($3,183,000)
175	175	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	$2,020,293,000	$0	$2,252,480,000	$0	$2,270,028,000	$0	$249,735,000	$0	$17,548,000	$0
176	176	PERSONAL CARE SERVICES (Misc. Svcs.)	$1,623,590,000	$0	$1,674,023,000	$0	$1,938,182,000	$0	$314,592,000	$0	$264,159,000	$0
177	177	DENTAL SERVICES	$462,552,000	$200,482,630	$976,819,000	$371,069,140	$1,002,205,000	$384,028,080	$539,653,000	$183,545,460	$25,386,000	$12,958,950
179	179	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$245,441,000	$0	$245,721,000	$0	$247,737,000	$0	$2,296,000	$0	$2,016,000	$0
183	183	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$65,300,000	$0	$65,300,000	$0	$65,300,000	$0	$0	$0	$0	$0
184	184	MEDI-CAL TCM PROGRAM	$25,540,000	$0	$50,333,000	$2,693,000	$44,549,000	$0	$19,009,000	$0	($5,784,000)	($2,693,000)
185	185	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$47,774,000	$22,976,000	$43,065,000	$21,532,500	$47,030,000	$23,515,000	($744,000)	$539,000	$3,965,000	$1,982,500
187	187	LAWSUITS/CLAIMS	$32,350,000	$16,175,000	$34,612,000	$17,306,000	$38,015,000	$19,007,500	$5,665,000	$2,832,500	$3,403,000	$1,701,500
195	195	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$1,028,000	$0	$2,160,000	$0	$2,160,000	$0	$1,132,000	$0	$0	$0
196	196	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$1,252,000	$626,000	$844,000	$422,000	$744,000	$372,000	($508,000)	($254,000)	($100,000)	($50,000)
212	212	BASE RECOVERIES	($368,304,000)	($161,241,000)	($455,650,000)	($205,068,000)	($427,966,000)	($192,609,000)	($59,662,000)	($31,368,000)	$27,684,000	$12,459,000
197	--	EPSDT SCREENS	$121,000	$59,680	$240,000	$113,420	$0	$0	($121,000)	($59,680)	($240,000)	($113,420)
		OTHER SUBTOTAL	**$9,844,201,000**	**$4,163,619,810**	**$10,510,276,000**	**$4,231,753,060**	**$10,845,148,000**	**$4,255,036,080**	**$1,000,947,000**	**$91,416,280**	**$334,872,000**	**$23,283,030**
		GRAND TOTAL	**$48,411,277,000**	**$15,903,261,080**	**$48,413,708,000**	**$15,967,931,050**	**$47,946,337,000**	**$15,713,879,670**	**($464,940,000)**	**($189,381,400)**	**($467,371,000)**	**($254,051,380)**

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2020-21

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2019 EST. FOR 2020-21		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		ELIGIBILITY						
4	4	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	$40,080,000	$0	$68,383,000	$0	$28,303,000	$0
5	5	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	$9,382,000	$3,014,020	$8,769,000	$2,832,480	($613,000)	($181,540)
6	6	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	$4,423,000	$1,420,980	$3,967,000	$1,274,370	($456,000)	($146,600)
		ELIGIBILITY SUBTOTAL	**$53,885,000**	**$4,435,000**	**$81,119,000**	**$4,106,850**	**$27,234,000**	**($328,150)**
		DRUG MEDI-CAL						
64	64	NARCOTIC TREATMENT PROGRAM	$32,538,000	$2,017,400	$30,087,000	$1,785,900	($2,451,000)	($231,500)
65	65	OUTPATIENT DRUG FREE TREATMENT SERVICES	$3,703,000	$260,000	$3,828,000	$268,700	$125,000	$8,700
66	66	INTENSIVE OUTPATIENT TREATMENT SERVICES	$1,270,000	$330,000	$1,531,000	$433,300	$261,000	$103,300
68	68	RESIDENTIAL TREATMENT SERVICES	$639,000	$24,600	$533,000	$19,000	($106,000)	($5,600)
		DRUG MEDI-CAL SUBTOTAL	**$38,150,000**	**$2,632,000**	**$35,979,000**	**$2,506,900**	**($2,171,000)**	**($125,100)**
		MENTAL HEALTH						
71	71	SMHS FOR ADULTS	$1,782,550,000	$91,918,190	$1,544,652,000	$77,135,190	($237,898,000)	($14,783,000)
72	72	SMHS FOR CHILDREN	$1,326,426,000	$60,887,660	$1,208,875,000	$60,954,030	($117,551,000)	$66,370
		MENTAL HEALTH SUBTOTAL	**$3,108,976,000**	**$152,805,850**	**$2,753,527,000**	**$138,089,220**	**($355,449,000)**	**($14,716,630)**
		MANAGED CARE						
92	92	TWO PLAN MODEL	$20,515,234,000	$6,902,187,340	$20,578,936,000	$6,962,987,970	$63,702,000	$60,800,620
93	93	COUNTY ORGANIZED HEALTH SYSTEMS	$8,859,239,000	$3,080,184,200	$8,865,094,000	$3,078,314,040	$5,855,000	($1,870,150)
94	94	GEOGRAPHIC MANAGED CARE	$3,692,172,000	$1,251,594,840	$3,685,633,000	$1,257,492,480	($6,539,000)	$5,897,640
98	98	REGIONAL MODEL	$1,274,790,000	$413,713,920	$1,275,951,000	$414,807,400	$1,161,000	$1,093,480
99	99	PACE (Other M/C)	$818,499,000	$409,249,500	$878,983,000	$439,491,500	$60,484,000	$30,242,000
102	102	DENTAL MANAGED CARE (Other M/C)	$104,250,000	$41,830,340	$109,892,000	$44,104,840	$5,642,000	$2,274,500

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2020-21

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2019 EST. FOR 2020-21		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		MANAGED CARE						
105	105	SENIOR CARE ACTION NETWORK (Other M/C)	$64,486,000	$32,243,000	$60,230,000	$30,115,000	($4,256,000)	($2,128,000)
106	106	AIDS HEALTHCARE CENTERS (Other M/C)	$16,854,000	$8,427,000	$16,544,000	$8,272,000	($310,000)	($155,000)
109	109	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$1,595,000	$1,595,000	$1,655,000	$3,964,000	$60,000	$2,369,000
		MANAGED CARE SUBTOTAL	**$35,347,119,000**	**$12,141,025,140**	**$35,472,918,000**	**$12,239,549,230**	**$125,799,000**	**$98,524,090**
		OTHER						
173	173	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$3,624,701,000	$1,924,224,500	$3,624,292,000	$1,924,326,000	($409,000)	$101,500
174	174	MEDICARE PAYMENTS - PART D PHASED-DOWN	$2,379,052,000	$2,379,052,000	$2,365,613,000	$2,365,613,000	($13,439,000)	($13,439,000)
175	175	HOME & COMMUNITY-BASED SVCS.- CDDS (Misc.)	$2,287,880,000	$0	$2,312,584,000	$0	$24,704,000	$0
176	176	PERSONAL CARE SERVICES (Misc. Svcs.)	$1,909,418,000	$0	$2,153,343,000	$0	$243,925,000	$0
177	177	DENTAL SERVICES	$985,240,000	$394,582,140	$1,015,986,000	$409,459,380	$30,746,000	$14,877,240
179	179	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$227,503,000	$0	$248,594,000	$0	$21,091,000	$0
183	183	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$29,476,000	$0	$29,476,000	$0	$0	$0
184	184	MEDI-CAL TCM PROGRAM	$32,374,000	$0	$32,950,000	$0	$576,000	$0
185	185	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$44,660,000	$22,330,000	$48,467,000	$24,233,500	$3,807,000	$1,903,500
187	187	LAWSUITS/CLAIMS	$32,350,000	$16,175,000	$32,350,000	$16,175,000	$0	$0
195	195	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$1,028,000	$0	$1,028,000	$0	$0	$0
196	196	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$886,000	$443,000	$672,000	$336,000	($214,000)	($107,000)
212	212	BASE RECOVERIES	($558,485,000)	($251,350,000)	($497,873,000)	($224,071,000)	$60,612,000	$27,279,000

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2020-21

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2019 EST. FOR 2020-21		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
197	--	EPSDT SCREENS	$240,000	$116,410	$0	$0	($240,000)	($116,410)
		OTHER SUBTOTAL	**$10,996,323,000**	**$4,485,573,060**	**$11,367,482,000**	**$4,516,071,880**	**$371,159,000**	**$30,498,820**
		GRAND TOTAL	**$49,544,453,000**	**$16,786,471,040**	**$49,711,025,000**	**$16,900,324,080**	**$166,572,000**	**$113,853,040**

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2019-20 AND 2020-21

		MAY 2020 EST. FOR 2019-20		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	ELIGIBILITY						
4	MEDI-CAL ACCESS PROGRAM MOTHERS 213 -322% FPL	$68,082,000	$0	$68,383,000	$0	$301,000	$0
5	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	$21,443,000	$3,094,920	$8,769,000	$2,832,480	($12,674,000)	($262,440)
6	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	$3,948,000	$814,390	$3,967,000	$1,274,370	$19,000	$459,980
	ELIGIBILITY SUBTOTAL	**$93,473,000**	**$3,909,300**	**$81,119,000**	**$4,106,850**	**($12,354,000)**	**$197,540**
	DRUG MEDI-CAL						
64	NARCOTIC TREATMENT PROGRAM	$22,127,000	$1,068,790	$30,087,000	$1,785,900	$7,960,000	$717,110
65	OUTPATIENT DRUG FREE TREATMENT SERVICES	$3,746,000	$223,210	$3,828,000	$268,700	$82,000	$45,490
66	INTENSIVE OUTPATIENT TREATMENT SERVICES	$1,638,000	$470,230	$1,531,000	$433,300	($107,000)	($36,930)
68	RESIDENTIAL TREATMENT SERVICES	$399,000	$12,580	$533,000	$19,000	$134,000	$6,420
	DRUG MEDI-CAL SUBTOTAL	**$27,910,000**	**$1,774,810**	**$35,979,000**	**$2,506,900**	**$8,069,000**	**$732,090**
	MENTAL HEALTH						
71	SMHS FOR ADULTS	$1,462,846,000	$56,720,810	$1,544,652,000	$77,135,190	$81,806,000	$20,414,380
72	SMHS FOR CHILDREN	$1,196,776,000	$51,100,230	$1,208,875,000	$60,954,030	$12,099,000	$9,853,800
	MENTAL HEALTH SUBTOTAL	**$2,659,622,000**	**$107,821,040**	**$2,753,527,000**	**$138,089,220**	**$93,905,000**	**$30,268,180**
	MANAGED CARE						
92	TWO PLAN MODEL	$20,037,588,000	$6,502,043,460	$20,578,936,000	$6,962,987,970	$541,348,000	$460,944,500
93	COUNTY ORGANIZED HEALTH SYSTEMS	$8,565,819,000	$2,848,303,660	$8,865,094,000	$3,078,314,040	$299,275,000	$230,010,380
94	GEOGRAPHIC MANAGED CARE	$3,602,517,000	$1,179,215,960	$3,685,633,000	$1,257,492,480	$83,116,000	$78,276,520
98	REGIONAL MODEL	$1,237,347,000	$388,706,740	$1,275,951,000	$414,807,400	$38,604,000	$26,100,650
99	PACE (Other M/C)	$682,939,000	$341,469,500	$878,983,000	$439,491,500	$196,044,000	$98,022,000
102	DENTAL MANAGED CARE (Other M/C)	$106,947,000	$42,085,600	$109,892,000	$44,104,840	$2,945,000	$2,019,240
105	SENIOR CARE ACTION NETWORK (Other M/C)	$70,176,000	$35,088,000	$60,230,000	$30,115,000	($9,946,000)	($4,973,000)

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2019-20 AND 2020-21

		MAY 2020 EST. FOR 2019-20		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	MANAGED CARE						
106	AIDS HEALTHCARE CENTERS (Other M/C)	$15,424,000	$7,712,000	$16,544,000	$8,272,000	$1,120,000	$560,000
109	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$1,427,000	$713,500	$1,655,000	$3,964,000	$228,000	$3,250,500
	MANAGED CARE SUBTOTAL	**$34,320,184,000**	**$11,345,338,430**	**$35,472,918,000**	**$12,239,549,230**	**$1,152,734,000**	**$894,210,800**
	OTHER						
173	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$3,403,315,000	$1,806,873,500	$3,624,292,000	$1,924,326,000	$220,977,000	$117,452,500
174	MEDICARE PAYMENTS - PART D PHASED-DOWN	$2,213,849,000	$2,213,849,000	$2,365,613,000	$2,365,613,000	$151,764,000	$151,764,000
175	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	$2,270,028,000	$0	$2,312,584,000	$0	$42,556,000	$0
176	PERSONAL CARE SERVICES (Misc. Svcs.)	$1,938,182,000	$0	$2,153,343,000	$0	$215,161,000	$0
177	DENTAL SERVICES	$1,002,205,000	$384,028,080	$1,015,986,000	$409,459,380	$13,781,000	$25,431,300
179	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$247,737,000	$0	$248,594,000	$0	$857,000	$0
183	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$65,300,000	$0	$29,476,000	$0	($35,824,000)	$0
184	MEDI-CAL TCM PROGRAM	$44,549,000	$0	$32,950,000	$0	($11,599,000)	$0
185	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$47,030,000	$23,515,000	$48,467,000	$24,233,500	$1,437,000	$718,500
187	LAWSUITS/CLAIMS	$38,015,000	$19,007,500	$32,350,000	$16,175,000	($5,665,000)	($2,832,500)
195	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$2,160,000	$0	$1,028,000	$0	($1,132,000)	$0
196	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$744,000	$372,000	$672,000	$336,000	($72,000)	($36,000)
212	BASE RECOVERIES	($427,966,000)	($192,609,000)	($497,873,000)	($224,071,000)	($69,907,000)	($31,462,000)
	OTHER SUBTOTAL	**$10,845,148,000**	**$4,255,036,080**	**$11,367,482,000**	**$4,516,071,880**	**$522,334,000**	**$261,035,800**
	GRAND TOTAL	**$47,946,337,000**	**$15,713,879,670**	**$49,711,025,000**	**$16,900,324,080**	**$1,764,688,000**	**$1,186,444,410**

MEDI-CAL PROGRAM BASE
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	ELIGIBILITY
4	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
5	COUNTY HEALTH INITIATIVE MATCHING (CHIM)
6	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL
	DRUG MEDI-CAL
64	NARCOTIC TREATMENT PROGRAM
65	OUTPATIENT DRUG FREE TREATMENT SERVICES
66	INTENSIVE OUTPATIENT TREATMENT SERVICES
68	RESIDENTIAL TREATMENT SERVICES
	MENTAL HEALTH
71	SMHS FOR ADULTS
72	SMHS FOR CHILDREN
	MANAGED CARE
92	TWO PLAN MODEL
93	COUNTY ORGANIZED HEALTH SYSTEMS
94	GEOGRAPHIC MANAGED CARE
98	REGIONAL MODEL
99	PACE (OTHER M/C)
102	DENTAL MANAGED CARE (OTHER M/C)
105	SENIOR CARE ACTION NETWORK (OTHER M/C)
106	AIDS HEALTHCARE CENTERS (OTHER M/C)
109	FAMILY MOSAIC CAPITATED CASE MGMT. (OTH. M/C)
	OTHER
173	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS
174	MEDICARE PAYMENTS - PART D PHASED-DOWN
175	HOME & COMMUNITY-BASED SVCS.-CDDS (MISC.)
176	PERSONAL CARE SERVICES (MISC. SVCS.)
177	DENTAL SERVICES
179	TARGETED CASE MGMT. SVCS. - CDDS (MISC. SVCS.)
183	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC
184	MEDI-CAL TCM PROGRAM
185	WAIVER PERSONAL CARE SERVICES (MISC. SVCS.)
187	LAWSUITS/CLAIMS
195	CLPP CASE MANAGEMENT SERVICES (MISC. SVCS.)
196	HIPP PREMIUM PAYOUTS (MISC. SVCS.)

MEDI-CAL PROGRAM BASE
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	OTHER
212	BASE RECOVERIES

MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL

BASE POLICY CHANGE NUMBER:	4
IMPLEMENTATION DATE:	7/2014
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1837

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$68,082,000	$68,383,000
- STATE FUNDS	$19,380,000	$26,853,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$68,082,000	$68,383,000
STATE FUNDS	$19,380,000	$26,853,000
FEDERAL FUNDS	$48,702,000	$41,530,000

DESCRIPTION

Purpose:
This policy change estimates the benefits cost for the Medi-Cal Access Program (MCAP) mothers with incomes between 213-322% of the federal poverty level (FPL).

Authority:
AB 99 (Chapter 278, Statutes of 1991)
SB 800 (Chapter 448, Statutes of 2013)
SPA CA 18-0028

Interdependent Policy Changes:
Not Applicable

Background:
MCAP covers pregnant women in families with incomes between 213-322% of the FPL. These pregnant and post-partum women are subject to premiums fixed at 1.5% of their adjusted annual income. The Department integrated eligibility rules for MCAP into the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) in October 2015. The Department maintained a health plan delivery system for MCAP that was separate from the Medi-Cal delivery system until September 30, 2016. The Department made final reconciliation payments to health plans under the erstwhile delivery system in FY 2018-19.

Effective October 1, 2016, the Department enrolled new MCAP mothers in the Fee-for-Service (FFS) delivery system. The Centers for Medicare and Medicaid Services (CMS) approved State Plan Amendment (SPA) CA 18-0028, authorizing the Department to enroll MCAP mothers in the Medi-Cal managed care (MMC) plans, beginning July 1, 2017. All MCAP mothers will remain in the delivery system in which they enrolled until the end of the post-partum period to maintain continuity of care.

MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL

BASE POLICY CHANGE NUMBER: 4

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is an increase due to an updated projected PMPM and supplemental capitation payment. Additionally, the average expected deliveries methodology has been updated to include reported and non-reported deliveries. Previously, only reported deliveries were being captured.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is a slight increase due to an increase in the projected average monthly caseload in FY 2020-21. Additionally, the federal matching rate for Title XXI decreases from 76.5% to 65% beginning October 1, 2020.

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

Program Forecast	FY 2019-20	FY 2020-21
Average Monthly Caseload	4,676	4,766
Average Expected Deliveries	624	624
Per Member Per Month (PMPM)	$279.88	$279.88
Supplemental Capitation Payment	$7,383	$7,383

2. Approximately 7% of new enrollees are initially enrolled in FFS. These enrollees are estimated to be reclassified to Managed Care within two months.

3. MCAP subscribers are subject to premiums fixed at 1.5% of their adjusted annual income. Premiums are estimated to total $2,835,000 in FY 2019-20, and FY 2020-21.

4. The Department assumes 10% of monthly subscribers have a maternity only deductible exceeding $500 and are ineligible for FFP.

5. The total estimated costs for MCAP mothers in FY 2019-20 and FY 2020-21 are:

(Dollars in Thousands)

FY 2019-20	TF	SF	FF
88% Title XXI FFP / 12% Perinatal Insurance Fund	$21,423	$2,571	$18,852
76.5% Title XXI FFP / 23.5% Perinatal Insurance Fund	$42,354	$9,953	$32,401
100% Perinatal Insurance Fund	$7,140	$7,140	$0
Premium Payments	($2,835)	($284)	($2,551)
Total	**$68,082**	**$19,380**	**$48,702**

MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL

BASE POLICY CHANGE NUMBER: 4

(Dollars in Thousands)

FY 2020-21	TF	SF	FF
76.5% Title XXI FFP / 23.5% Perinatal Insurance Fund	$21,347	$5,017	$16,330
65% Title XXI FFP / 35% Perinatal Insurance Fund	$42,694	$14,943	$27,751
100% Perinatal Insurance Fund	$7,177	$7,177	$0
Premium Payments	($2,835)	($284)	($2,551)
Total	**$68,383**	**$26,853**	**$41,530**

Funding:
Perinatal Insurance Fund (4260-602-0309)
Title XXI FFP (4260-113-0890)

COUNTY HEALTH INITIATIVE MATCHING (CHIM)

BASE POLICY CHANGE NUMBER:	5
IMPLEMENTATION DATE:	7/2014
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1823

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$21,443,000	$8,769,000
- STATE FUNDS	$3,094,920	$2,832,480
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$21,443,000	$8,769,000
STATE FUNDS	$3,094,920	$2,832,480
FEDERAL FUNDS	$18,348,080	$5,936,520

DESCRIPTION

Purpose:
This policy change estimates the costs for the County Health Initiative Matching (CHIM) fund for the County Children's Health Initiative Program (CCHIP), as well as Medi-Cal costs and premium collection.

Authority:
AB 495 (Chapter 648, Statutes of 2001)
SB 800 (Chapter 448, Statutes of 2013)
SB 857 (Chapter 31, Statutes of 2014)

Interdependent Policy Changes:
Not Applicable

Background:
AB 495 created the CHIM fund, which funds the CCHIP, to provide health insurance coverage to low income children under the age of 19. The program had been administered by the Managed Risk Medical Insurance Board (MRMIB), funded with county local funds received via intergovernmental transfers (IGTs), and matched with Title XXI federal funding. Currently, the CHIM funds CCHIPs in three counties: San Francisco, San Mateo, and Santa Clara.

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

COUNTY HEALTH INITIATIVE MATCHING (CHIM)

BASE POLICY CHANGE NUMBER: 5

On March 7, 2016, CCHIP integrated into the California Healthcare Eligibility, Enrollment, and Retention System.

Effective October 1, 2019, the Department transitioned CCHIP beneficiaries into the Medi-Cal Managed Care (MCMC) delivery system and also transitioned all administrative functions, such as premium collection and case management, for CCHIP to MAXIMUS. MAXIMUS is the current administrator vendor for the Medi-Cal Access Program (MCAP) and the Optional Targeted Low Income Program (OTLICP). The OTLICP, MCAP, Special Populations Admin Costs policy change contains costs for MAXIMUS' administrative functions and contract transition responsibilities. CCHIP premium collections and benefit costs for CCHIP eligibles are still reflected in this policy change.

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is a decrease as MCMC eligibles are projected to be slightly lower than previously estimated. Additionally, premiums collected for CCHIP will now be reflected in this policy change. The premiums were previously estimated in the CHIP Premiums policy change.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease due to all prior payments to the counties being completed in FY 2019-20.

Methodology:

1. Beginning January 1, 2014, Santa Clara and San Mateo Counties elected not to provide funding for the non-federal share of the IGTs. Beginning January 1, 2015, San Francisco County elected not to provide funding for the non-federal share of the IGTs.

2. Assume a multi-year reconciliation will be completed in FY 2019-20.

3. Assume annual premiums collected for CCHIP will be $1,700,000 in both FY 2019-20 and FY 2020-21.

4. Effective October 2019, CCHIP beneficiaries transitioned into the MCMC delivery system and all administrative functions transitioned to MAXIMUS.

5. Assume a one-month lag in costs for Managed Care.

6. Assume there will be approximately 8,700 CCHIP beneficiaries by FY 2020-21.

COUNTY HEALTH INITIATIVE MATCHING (CHIM)

BASE POLICY CHANGE NUMBER: 5

FY 2019-20	TF	GF	FF
FY 2015-16	$159,000	$19,000	$140,000
Benefits Title XXI 88/12 GF	$144,000	$17,000	$127,000
Admin Title XXI 88/12 GF	$15,000	$2,000	$13,000
FY 2016-17	$3,752,000	$450,000	$3,302,000
Benefits Title XXI 88/12 GF	$3,411,000	$409,000	$3,002,000
Admin Title XXI 88/12 GF	$341,000	$41,000	$300,000
FY 2017-18	$6,386,000	$767,000	$5,619,000
Benefits Title XXI 88/12 GF	$5,805,000	$697,000	$5,108,000
Admin Title XXI 88/12 GF	$581,000	$70,000	$511,000
FY 2018-19	$3,627,000	$436,000	$3,191,000
Benefits Title XXI 88/12 GF	$3,297,000	$396,000	$2,901,000
Admin Title XXI 88/12 GF	$330,000	$40,000	$290,000
FY 2019-20	$2,982,000	$357,000	$2,625,000
Benefits Title XXI 88/12 GF	$2,693,000	$323,000	$2,370,000
Admin Title XXI 88/12 GF	$289,000	$34,000	$255,000
FY 2019-20			
Benefits Title XXI 76.5/23.5 GF	$4,537,000	$1,066,000	$3,471,000
Total FY 2019-20	**$21,443,000**	**$3,095,000**	**$18,348,000**

FY 2020-21	TF	GF	FF
Benefits Title XXI 76.5/23.5 GF	$2,058,000	$484,000	$1,574,000
Benefits Title XXI 65/35 GF	$6,711,000	$2,349,000	$4,362,000
Total FY 2020-21	**$8,769,000**	**$2,833,000**	**$5,936,000**

*Totals may differ due to rounding.

Funding:
88% Title XXI FF / 12% GF (4260-113-0890/0001)
76.5% Title XXI FF / 23.5% GF (4260-113-0890/0001)
65% Title XXI FF / 35% GF (4260-113-0890/0001)

MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL

BASE POLICY CHANGE NUMBER:	6
IMPLEMENTATION DATE:	11/2013
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1797

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$3,948,000	$3,967,000
- STATE FUNDS	$814,390	$1,274,370
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,948,000	$3,967,000
STATE FUNDS	$814,390	$1,274,370
FEDERAL FUNDS	$3,133,610	$2,692,630

DESCRIPTION

Purpose:
This policy change estimates the fee-for-service (FFS) benefit cost, Medi-Cal managed care carve-out costs, and premium payments for the Medi-Cal Access Infant Program (MCAIP) infants with family incomes between 266-322% of the federal poverty level (FPL).

Authority:
AB 82 (Chapter 23, Statutes of 2013)

Interdependent Policy Changes:
Not Applicable

Background:
Effective November 1, 2013, MCAIP infants transitioned into the Medi-Cal delivery system through a phase-in methodology. MCAIP infants began enrollment into Medi-Cal Managed Care in July 2014.

The Department integrated eligibility rules for MCAIP into the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) in October 2015, with additional updates targeted to occur in 2020. Similar to subscribers enrolled in the Optional Targeted Low Income Children's Program (OTLICP) with family incomes at or above 160% of the FPL, subscribers enrolled in MCAIP are subject to premiums.

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is due to a decrease in eligibles and change in the weighted average PMPM. The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to a slight increase in enrolled eligibles.

MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL

BASE POLICY CHANGE NUMBER: 6

Methodology:

1. The Department estimates the following average monthly infants with family income between 266% and 322% FPL will enroll in FY 2019-20 and FY 2020-21:

Delivery System	FY 2019-20	FY 2020-21
FFS	237	233
Medi-Cal Managed Care	632	654
Total Monthly Enrollment	**869**	**887**

2. The Department estimates the weighted average PMPM cost in FY 2019-20 and FY 2020-21 is $859.94 for FFS infants and $215.99 for Medi-Cal Managed Care infants.

3. MCAIP subscribers are subject to monthly premiums. Premiums are estimated to total $136,000 in FY 2019-20 and $138,000 in FY 2020-21.

4. The Federal Financial Participation (FFP) for Title XXI funding will decrease from 88% to 76.5% on October 1, 2019, and decrease again to 65% on October 1, 2020.

5. The total estimated costs for MCAIP infants in FY 2019-20 and FY 2020-21 are:

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
Benefits	$4,084	$842	$3,242
Premiums	($136)	($28)	($108)
Net	**$3,948**	**$814**	**$3,134**

FY 2020-21	TF	GF	FF
Benefits	$4,105	$1,319	$2,786
Premiums	($138)	($44)	($94)
Net	**$3,967**	**$1,275**	**$2,692**

*Totals may differ due to rounding.

Funding:

88% Title XXI FFP/12% GF (4260-113-0890/0001)
76.5% Title XXI FFP/23.5% GF (4260-113-0890/0001)
65% Title XXI FFP/35% GF (4260-113-0890/0001)

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER:	64
IMPLEMENTATION DATE:	7/2012
ANALYST:	Devon Dyer
FISCAL REFERENCE NUMBER:	1728

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$22,127,000	$30,087,000
- STATE FUNDS	$1,068,790	$1,785,900
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$22,127,000	$30,087,000
STATE FUNDS	$1,068,790	$1,785,900
FEDERAL FUNDS	$21,058,210	$28,301,100

DESCRIPTION

Purpose:
This policy change estimates the Drug Medi-Cal (DMC), Narcotic Treatment Program's (NTP) daily methadone dosing and counseling services expenditures..

Authority:
Title 22, California Code of Regulations 51341.1(b)(17); 51341.1(d)(1); 51516.1(b)

Interdependent Policy Changes:
Drug Medi-Cal Organized Delivery System Waiver

Background:
The NTP provides outpatient methadone maintenance services directed at stabilization and rehabilitation of persons with opioid dependency and substance use disorder diagnoses. The program includes daily medication dosing, a medical evaluation, treatment planning, and a minimum of fifty minutes per month of face-to-face counseling sessions. These services are provided by certified providers under contract with the counties or the State.

The responsibility for Drug Medi-Cal services was realigned to the counties as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, new state requirements enacted after September 30, 2012, increase the costs beyond the 2011 Realignment programs or levels of service, shall apply to the extent that the state provides funding for the increase.

On August 13, 2015, the Department received approval from the Centers for Medicare and Medicaid Services to implement the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver. The DMC-ODS is a pilot program for the organized delivery of health care services for Medicaid eligible individuals with a Substance Use Disorder. DMC-ODS waiver services will include the existing treatment modalities (NTP, Intensive Outpatient Treatment), Outpatient Drug Free, and Perinatal Residential Treatment Services), and additional new and expanded services.

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 64

County participation in the waiver is voluntary. NTP services expenditures for participating counties will be shifted to the Drug Medi-Cal Organized Delivery System Waiver policy change as implementation occurs.

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is a decrease due expenditures shifting to the DMC-ODS waiver and a decrease in users for the most recent months of actual data dampening the historical trend.

The methodology for calculating users in item #1 was updated to more accurately reflect total projected users.

The increase between FY 2019-20 to FY 2020-21 is due to a projected increase in users based on the historical trend.

Methodology:

1. Expenditures are estimated using 36-months of cash-basis expenditure data (February 2017-January 2020) and trending the Users, Units/User, and Rate.

	FY 2019-20				FY 2020-21			
	Average Monthly				Average Monthly			
	Users	Units/ User	Rate	Total	Users	Units/ User	Rate	Total
Regular								
All Others	1,781	62.1	$14.34	$19,019,000	2,473	56.9	$14.41	$24,318,000
ACA Optional	1,211	60.3	$14.34	$12,553,000	1,810	57.0	$14.39	$17,825,000
Regular Subtotal				$31,573,000				$42,143,000
Perinatal								
All Others	12	39.0	$15.12	$84,000	22	34.5	$15.14	$136,000
ACA Optional	4	31.8	$15.08	$21,000	6	32.1	$15.10	$36,000
Perinatal Subtotal				$105,000				$172,000
Total				**$31,678,000**				**$42,315,000**

2. Rates include Final RY 2019-20 rate increases. RY 2020-21 rate increases are not included in this policy change. RY 2020-21 rate increases are budgeted in the Drug Medi-Cal Annual Rate Adjustment PC.

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 64

3. Funding for services is generally 50% County Funds (CF) and 50% Title XIX Federal Funds (FF). Certain aid codes are eligible for Title XXI federal reimbursement at 88% until September 30, 2019, 76.5% October 2019 through September 2020, and 65% October 2020 and thereafter. Funding for the ACA Optional beneficiaries 93% FF / 7% GF in 2019 and 90% FF / 10% GF 2020 and thereafter.

   Total estimated reimbursements for NTP services are:

FY 2019-20	TF	GF	FF	CF*
Title XIX 100%	$9,551,000	$0	$9,551,000	$9,551,000
ACA 93% FFP/7% GF	$6,287,000	$440,000	$5,847,000	$0
ACA 90% FFP/10% GF	$6,287,000	$629,000	$5,658,000	$0
Title XXI 100%	$2,000	$0	$2,000	$0
Total	**$22,127,000**	**$1,069,000**	**$21,058,000**	$9,551,000

FY 2020-21	TF	GF	FF	CF*
Title XIX 100%	$12,226,000	$0	$12,226,000	$12,226,000
ACA 90% FFP/10% GF	$17,859,000	$1,785,000	$16,074,000	$0
Title XXI 100%	$2,000	$0	$2,000	$1,000
Total	**$30,087,000**	**$1,785,000**	**$28,302,000**	$12,227,000

Funding:
Title XIX FF (4260-101-0890)
Title XXI FF (4260-113-0890)
93% ACA Title XIX FF / 7% GF (4260-101-001/0890)
90% ACA Title XIX FF / 10% GF (4260-101-001/0890)
* County Funds are not included in Total Fund
** Totals may differ due to rounding

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER:	65
IMPLEMENTATION DATE:	7/2012
ANALYST:	Devon Dyer
FISCAL REFERENCE NUMBER:	1727

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$3,746,000	$3,828,000
- STATE FUNDS	$223,210	$268,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,746,000	$3,828,000
STATE FUNDS	$223,210	$268,700
FEDERAL FUNDS	$3,522,790	$3,559,300

DESCRIPTION

Purpose:
This policy change estimates the Drug Medi-Cal (DMC), Outpatient Drug Free (ODF) counseling treatment service expenditures.

Authority:
Title 22, California Code of Regulations 51341.1 (b)(18); 51341.1 (d)(2); 51516.1 (a)

Interdependent Policy Changes:
Drug Medi-Cal Organized Delivery System Waiver

Background:
ODF counseling treatment services are designed to stabilize and rehabilitate Medi-Cal beneficiaries with substance use disorder diagnosis in an outpatient setting. This includes services under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Each ODF participant receives at least two group counseling sessions per month. Counseling and rehabilitation services include:

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

These services are provided by certified providers under contract with the counties or with the State.

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 65

The responsibility for Drug Medi-Cal services was realigned to the counties as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, new state requirements enacted after September 30, 2012, increase the costs beyond the 2011 Realignment programs or levels of service, shall apply to the extent that the state provides funding for the increase.

On August 13, 2015, the Department received approval from the Centers for Medicare and Medicaid Services to implement the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver. The DMC-ODS is a pilot program to test a new paradigm for the organized delivery of health care services for Medicaid eligible individuals with a Substance Use Disorder. DMC-ODS waiver services will include the existing treatment modalities (Narcotic Treatment Program, IOT, Outpatient Drug Free, and Perinatal Residential Treatment Services), and additional new and expanded services.

County participation in the waiver is voluntary. ODF services expenditures for participating counties will be shifted to the Drug Medi-Cal Organized Delivery System Waiver policy change as implementation occurs.

Reason for Change:
Expenditures remain fairly stable from the prior estimate and between fiscal years in the current estimate.

The methodology for calculating users in item #1 was updated to more accurately reflect total projected users.

Methodology:

1. Expenditures are estimated using 36-months of cash-basis expenditure data (February 2017-January 2020) and trending the Users, Units/User, and Rate.

	FY 2019-20				FY 2020-21			
	Average Monthly				Average Monthly			
	Users	Units/ User	Rate	Total	Users	Units/ User	Rate	Total
Regular								
All Others	761	6.0	$39.46	$2,170,000	848	5.6	$39.25	$2,216,000
ACA Optional	804	7.2	$37.84	$2,617,000	913	6.3	$38.78	$2,677,000
Regular Total				$4,787,000				$4,893,000
Perinatal								
All Others	10	3.5	$48.98	$22,000	11	3.6	$51.01	$23,000
ACA Optional	4	3.6	$52.75	$8,000	4	4.1	$54.42	$10,000
Perinatal Total				$30,000				$33,000
Total				**$4,815,000**				**$4,926,000**

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 65

2. Rates include Final RY 2019-20 rate decreases. RY 2020-21 rate increases are budgeted in the Drug Medi-Cal Annual Rate Adjustment PC and are not included in this policy change.

3. Funding for services is generally 50% County Funds (CF) and 50% Title XIX Federal Funds (FF). Certain aid codes are eligible for Title XXI federal reimbursement at 88% September 30, 2019, 76.5% October 2019 through September 2020, and 65% October 2020 and thereafter. Funding for the ACA Optional beneficiaries 93% FF / 7% GF in 2019 and 90% FF / 10% GF 2020 and thereafter.

   Total estimated reimbursements for ODF services are:

FY 2019-20	TF	GF	FF	CF*
Title XIX 100%	$1,054,000	$0	$1,054,000	$1,054,000
ACA 93% FFP/7% GF	$1,313,000	$92,000	$1,221,000	$0
ACA 90% FFP/10% GF	$1,313,000	$132,000	$1,181,000	$0
Title XXI 100%	$66,000	$0	$66,000	$17,000
Total	**$3,746,000**	**$224,000**	**$3,522,000**	$1,071,000

FY 2020-21	TF	GF	FF	CF*
Title XIX 100%	$1,062,000	$0	$1,062,000	$1,061,000
ACA 90% FFP/10% GF	$2,687,000	$269,000	$2,418,000	$0
Title XXI 100%	$79,000	$0	$79,000	$38,000
Total	**$3,828,000**	**$269,000**	**$3,559,000**	$1,099,000

Funding:
Title XIX FF (4260-101-0890)
Title XXI FF (4260-113-0890)
93% ACA Title XIX FF / 7% GF (4260-101-0001/0890)
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)
* County Funds are not included in Total Fund
** Totals may differ due to rounding

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER:	66
IMPLEMENTATION DATE:	7/2012
ANALYST:	Devon Dyer
FISCAL REFERENCE NUMBER:	1726

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$1,638,000	$1,531,000
- STATE FUNDS	$470,230	$433,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,638,000	$1,531,000
STATE FUNDS	$470,230	$433,300
FEDERAL FUNDS	$1,167,770	$1,097,700

DESCRIPTION

Purpose:
This policy change estimates the Drug Medi-Cal (DMC), Intensive Outpatient Treatment (IOT) services expenditures.

Authority:
Title 22, California Code of Regulations 51341.1(b)(8); 51341.1(d)(3), and 51516.1(a)

Interdependent Policy Changes:
Drug Medi-Cal Organized Delivery System Waiver

Background:
IOT services are provided to beneficiaries with substance use disorder diagnoses. These outpatient counseling and rehabilitation services are provided at least three hours per day, three days per week. Services include:

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

These services are provided by certified providers under contract with the counties or with the State.

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 66

The responsibility for Drug Medi-Cal services was realigned to the counties as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, new state requirements enacted after September 30, 2012, increase the costs beyond the 2011 Realignment programs or levels of service, shall apply to the extent that the state provides funding for the increase.

On August 13, 2015, the Department received approval from the Centers for Medicare and Medicaid Services to implement the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver. The DMC-ODS is a pilot program to test a new paradigm for the organized delivery of health care services for Medicaid eligible individuals with a Substance Use Disorder. DMC-ODS waiver services will include the existing treatment modalities (Narcotic Treatment Program, IOT, Outpatient Drug Free, and Perinatal Residential Treatment Services), and additional new and expanded services.

County participation in the waiver is voluntary. IOT services expenditures for participating counties will be shifted to the Drug Medi-Cal Organized Delivery System Waiver policy change as implementation occurs.

Reason for Change:
Expenditures remain fairly stable from the prior estimate for FY 2019-20 or FY 2020-21. The methodology for calculating users in item #1 was updated to more accurately reflect total projected users.

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

Methodology:

1. Expenditures are estimated using 36-months of cash-basis expenditure data (February 2017-January 2020) and trending the Users, Units/User, and Rate.

	FY 2019-20				FY 2020-21			
	Average Monthly				Average Monthly			
	Users	Units/ User	Rate	Total	Users	Units/ User	Rate	Total
Regular								
All Others	106	10.3	$61.57	$806,000	104	8.9	$63.53	$709,000
ACA Optional	102	10.5	$61.76	$788,000	113	8.9	$64.31	$775,000
Regular Total				$1,594,000				$1,484,000
Perinatal								
All Others	8	8.1	$86.33	$71,000	9	7.0	$86.61	$67,000
ACA Optional	1	5.6	$84.39	$7,000	1	9.1	$84.35	$13,000
Perinatal Total				$78,000				$80,000
Total				**$1,672,000**				**$1,564,000**

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 66

2. Rates include Final RY 2019-20 rate increases. RY 2020-21 rate increases are budgeted in the Drug Medi-Cal Annual Rate Adjustment PC and are not included in this policy change.

3. Funding for services is generally 50% County Funds (CF) and 50% Title XIX Federal Funds (FF). Funding for the ACA Optional beneficiaries 93% FF / 7% GF in 2019 and 90% FF / 10% GF 2020 and thereafter.

Total estimated reimbursements for IOT services are:

FY 2019-20	TF	GF	FF	CF*
Title XIX 100%	$36,000	$0	$36,000	$36,000
50% Title XIX / 50% GF	$805,000	$402,000	$403,000	$0
ACA 93% FFP/7% GF	$399,000	$29,000	$370,000	$0
ACA 90% FFP/10% GF	$398,000	$40,000	$358,000	$0
Total	**$1,638,000**	**$471,000**	**$1,167,000**	$36,000

FY 2020-21	TF	GF	FF	CF*
Title XIX 100%	$34,000	$0	$34,000	$34,000
50% Title XIX / 50% GF	$709,000	$354,000	$355,000	$0
ACA 90% FFP/10% GF	$788,000	$79,000	$709,000	$0
Total	**$1,531,000**	**$433,000**	**$1,098,000**	**$34,000**

Funding:
Title XIX FF (4260-101-0890)
50% Title XIX FF / 50% GF (4260-101-0001/0890)
93% ACA Title XIX FF / 7% GF (4260-101-0001/0890)
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)
* County Funds are not included in Total Fund
** Totals may differ due to rounding

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER:	68
IMPLEMENTATION DATE:	7/2012
ANALYST:	Devon Dyer
FISCAL REFERENCE NUMBER:	1725

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$399,000	$533,000
- STATE FUNDS	$12,580	$19,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$399,000	$533,000
STATE FUNDS	$12,580	$19,000
FEDERAL FUNDS	$386,420	$514,000

DESCRIPTION

Purpose:
This policy change estimates the Drug Medi-Cal (DMC) Residential Treatment Services (RTS) expenditures.

Authority:
Title 22, California Code of Regulations 51341.1(b)(20); 51341.1(d)(4); 51516.1(a)

Interdependent Policy Changes:
Drug Medi-Cal Organized Delivery System Waiver

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

Supervision and treatment services are available day and night, seven days a week. The service provides a range of activities:

- Mother/Child habilitative and rehabilitative services,
- Service access (i.e. transportation to treatment),
- Education to reduce harmful effects of alcohol and drugs on the mother and fetus or infant, and/or
- Coordination of ancillary services.

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

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 68

The responsibility for Drug Medi-Cal services was realigned to the counties as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, new state requirements enacted after September 30, 2012, increase the costs beyond the 2011 Realignment programs or levels of service, shall apply to the extent that the state provides funding for the increase.

On August 13, 2015, the Department received approval from the Centers for Medicare and Medicaid Services to implement the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver. The DMC-ODS is a pilot program to test a new paradigm for the organized delivery of health care services for Medicaid eligible individuals with a Substance Use Disorder. DMC-ODS waiver services will include the existing treatment modalities (Narcotic Treatment Program, IOT, Outpatient Drug Free, and Perinatal Residential Treatment Services), and additional new and expanded services.

County participation in the waiver is voluntary. Residential services expenditures for participating counties will be shifted to the Drug Medi-Cal Organized Delivery System Waiver policy change as implementation occurs.

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is a decrease due expenditures shifting to the DMCODS waiver and a decrease in users for the most recent months of actual data dampening the historical trend.

The methodology for calculating users in item #1 was updated to more accurately reflect total projected users.

The increase between FY 2019-20 and FY 2020-21 in the current estimate is due a projected growth in users based on the historical trend and the inclusion of Final RY 2019-20 rate increases.

Methodology:

1. Expenditures are estimated using 36-months of cash-basis expenditure data (February 2017-January 2020) and trending the Users, Units/User, and Rate.

	FY 2019-20				FY 2020-21			
	Average Monthly				Average Monthly			
	Users	Units/ User	Rate	Total	Users	Units/ User	Rate	Total
Perinatal								
All Others	15	27.1	$100.37	$502,000	22	24.9	$104.15	$687,000
ACA Optional	5	24.2	$103.65	$148,000	7	19.3	$109.73	$189,000
Total				**$650,000**				**$876,000**

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 68

2. Rates include Final RY 2019-20 rate increases. RY 2020-21 rate increases are budgeted in the Drug Medi-Cal Annual Rate Adjustment PC and are not included in this policy change.

3. Funding for RTS perinatal service is 50% County Funds (CF) and 50% Title XIX Federal Funds (FF). Funding for the ACA Optional beneficiaries 93% FF / 7% GF in 2019, and 90% FF / 10% GF 2020 and thereafter.

Total estimate reimbursements for Residential services are:

FY 2019-20	TF	GF	FF	CF*
Title XIX 100%	$251,000	$0	$251,000	$251,000
ACA 93% FFP/6% GF	$74,000	$5,000	$69,000	$0
ACA 90% FFP/7% GF	$74,000	$7,000	$67,000	$0
Total	**$399,000**	**$12,000**	**$387,000**	$251,000

FY 2020-21	TF	GF	FF	CF*
Title XIX 100%	$343,000	$0	$343,000	$343,000
ACA 90% FFP/10% GF	$190,000	$20,000	$170,000	$0
Total	**$533,000**	**$20,000**	**$513,000**	$343,000

Funding:
Title XIX FF (4260-101-0890)
93% ACA Title XIX FF / 7% GF (4260-101-0001/0890)
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)
* County Funds are not included in Total Fund
** Totals may differ due to rounding

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER:	71
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1780

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$1,462,846,000	$1,544,652,000
- STATE FUNDS	$130,828,810	$154,596,190
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,462,846,000	$1,544,652,000
STATE FUNDS	$130,828,810	$154,596,190
FEDERAL FUNDS	$1,332,017,190	$1,390,055,810

DESCRIPTION

Purpose:
This policy change estimates the base cost for specialty mental health services (SMHS) provided to adults (21 years of age and older).

Authority:
Welfare & Institutions Code 14680-14685.1
Specialty Mental Health Consolidation Program Waiver

Interdependent Policy Changes:
Not Applicable

Background:
The Medi-Cal SMHS program is “carved-out” of the broader Medi-Cal program and is administered by the Department under the authority of a waiver approved by the Centers for Medicare and Medicaid Services (CMS). The Department contracts with a Mental Health Plan (MHP) in each county to provide or arrange for the provision of Medi-Cal SMHS. All MHPs are county mental health departments.

SMHS are Medi-Cal entitlement services for adults and children that meet medical necessity criteria, which consist of having a specific covered diagnosis, functional impairment, and meeting intervention criteria. MHPs must certify that they incurred a cost before seeking reimbursement through claims to the State. MHPs are responsible for most of the non-federal share of Medi-Cal SMHS. Mental health services for Medi-Cal beneficiaries who do not meet the criteria for SMHS are provided under the broader Medi-Cal program either through Medi-Cal managed care (MC) plans or the fee-for-service Medi-Cal (FFS/MC) program for beneficiaries not enrolled in a MC plan.

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

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER: 71

The following Medi-Cal SMHS are available for adults:

- Adult Residential Treatment Services
- Crisis Intervention
- Crisis Stabilization
- Crisis Residential Treatment Services
- Day Rehabilitation
- Day Treatment Intensive
- Medication Support Services
- Psychiatric Health Facility Services
- Psychiatric Inpatient Hospital Services
- Targeted Case Management
- Therapy and Other Service Activities

The responsibility for SMHS was realigned to the counties in 2011 as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, state requirements enacted after September 30, 2012, that have an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by 2011 Realignment shall apply to local agencies only to the extent that the state provides annual funding for the cost increase.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a net decrease due to updated estimated Affordable Care Act (ACA) utilization and costs for Short Doyle/Medi-Cal (SD/MC) and Fee-For-Service (FFS) Inpatient clients, based on additional paid claims data through December 31, 2019.

The change from the prior estimate, for FY 2020-21, is a net decrease due to updated estimated ACA SD/MC utilization and ACA FFS utilization.

The change between FY 2019-20 and FY 2020-21, in the current estimate, is an increase due to an overall increase of SD/MC, FFS Inpatient, and ACA utilization for FY 2020-21, based on projections for SD/MC claims.

Methodology:

1. The costs and clients are developed using 70 months of SD/MC and 70 months FFS/MC approved claims data, excluding disallowed claims. The SD/MC data is current as of December 31, 2019, with dates of service from October 2013 through September 2019. The FFS data is current as of December 31, 2019, with dates of service from October 2013 through July 2019.

2. Due to the lag in reporting of claims data, the six most recent months of data are weighted (Lag Weights) based on observed claiming trends to create projected final claims data.

3. Applying more weight to recent data necessitates the need to ensure that lag weight adjusted claims data (a process by which months of partial data reporting is extrapolated to create estimates of final monthly claims) is as complete and accurate as possible. Therefore, the most recent months of data are weighted (Lag Weights) based on observed claiming trends to create projected final claims and client data. The development and application of lag weights is based upon historical reporting trends of the counties.

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER: 71

4. This table displays the forecast of Medi-Cal beneficiaries who will receive SD/MC SMHS and FFS/MC psychiatric inpatient hospital services.

Adult	FY 2019-20 Utilization	FY 2020-21 Utilization
SD/MC	198,210	192,089
SD/MC ACA	140,027	141,717
FFS	13,038	12,954
FFS ACA	18,273	20,089
Total	369,548	366,849

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

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2017-18	$2,043,665	$1,774,592	$269,073
FY 2018-19	$1,970,245	$1,684,015	$286,230
FY 2019-20	$2,047,781	$1,732,137	$315,644
FY 2020-21	$2,149,479	$1,806,355	$343,124

6. On a cash basis for FY 2019-20, the Department will be paying 1% of FY 2017-18 claims, 61% of FY 2018-19 claims, and 38% of FY 2019-20 claims for SD/MC claims. For FFS Inpatient claims, the Department will be paying 1% of FY 2017-18 claims, 52% of FY 2018-19 claims, and 47% of FY 2019-20 claims. The cash amounts (rounded) for Adult's SMHS are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2017-18	$20,437	$17,746	$2,691
FY 2018-19	$1,181,813	$1,027,249	$154,564
FY 2019-20	$800,252	$658,212	$142,040
Total FY 2019-20	$2,002,502	$1,703,207	$299,295

7. On a cash basis for FY 2020-21, the Department will be paying 1% of FY 2018-19 claims, 61% of FY 2019-20 claims, and 38% of FY 2020-21 claims for SD/MC claims. For FFS Inpatient claims, the Department will be paying 1% of FY 2018-19 claims, 52% of FY 2019-20 claims, and 47% of FY 2020-21 claims. The cash amounts (rounded) for Adult's SMHS are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2018-19	$19,702	$16,840	$2,862
FY 2019-20	$1,227,051	$1,056,603	$170,448
FY 2020-21	$840,821	$686,415	$154,406
Total FY 2020-21	$2,087,574	$1,759,858	$327,716

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER: 71

8. The chart below shows the FY 2019-20 and FY 2020-21 estimate with the following funding adjustments:
   - Medi-Cal claims are eligible for 50% federal reimbursement;
   - ACA is funded by 100% federal funds (FF) until December 31, 2016, 95% FF and 5% GF until December 31, 2017, and 94% FF and 6% GF until December 31, 2018, 93% FF and 7% GF until December 31, 2019, and 90% FF and 10% GF beginning January 2020;
   - GF reimbursement authority is needed to account for the timing of the reimbursement from the county realignment funds to the Department.

(Dollars in Thousands)

Fiscal Year	TF	FF	ACA FF	ACA GF	GF Reimbursement	County
FY 2019-20	$2,002,502	**$613,766**	**$718,251**	**$56,721**	**$74,108**	$539,656
FY 2020-21	$2,087,575	**$620,383**	**$769,673**	**$77,135**	**$77,461**	$542,923

Funding:
100% Title XIX FFP (4260-101-0890)
100% Reimbursement (4260-601-0995)
95% Title XIX FF / 5% GF (4260-101-0001/0890)
94% Title XIX FF / 6% GF (4260-101-0001/0890)
93% Title XIX FF / 7% GF (4260-101-0001/0890)
90% Title XIX FF / 10% GF (4260-101-0001/0890)

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER:	72
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1779

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$1,196,776,000	$1,208,875,000
- STATE FUNDS	$97,103,230	$111,886,030
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,196,776,000	$1,208,875,000
STATE FUNDS	$97,103,230	$111,886,030
FEDERAL FUNDS	$1,099,672,770	$1,096,988,970

DESCRIPTION

Purpose:
This policy change estimates the base cost for specialty mental health services (SMHS) provided to children (birth through 20 years of age).

Authority:
Welfare & Institutions Code 14680-14685.1
Specialty Mental Health Consolidation Program Waiver

Interdependent Policy Changes:
Not Applicable

Background:
The Medi-Cal SMHS program is “carved-out” of the broader Medi-Cal program and is administered by the Department under the authority of a waiver approved by the Centers for Medicare and Medicaid Services (CMS). The Department contracts with a Mental Health Plan (MHP) in each county to provide or arrange for the provision of Medi-Cal SMHS. All MHPs are county mental health departments.

SMHS are Medi-Cal entitlement services for adults and children that meet medical necessity criteria, which consist of having a specific covered diagnosis, functional impairment, and meeting intervention criteria. MHPs must certify that they incurred a cost before seeking reimbursement through claims to the State. MHPs are responsible for most of the non-federal share of Medi-Cal SMHS. Mental health services for Medi-Cal beneficiaries who do not meet the criteria for SMHS are provided under the broader Medi-Cal program either through Medi-Cal managed care (MC) plans or the fee-for-service Medi-Cal (FFS/MC) program for beneficiaries not enrolled in a MC plan.

Children’s SMHS are provided under the federal requirements of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which is available to full-scope beneficiaries under age 21. The EPSDT benefit is designed to meet the special physical, emotional, and developmental needs of low income children. This policy change budgets the costs associated with SMHS for children. A separate policy change budgets the costs associated with SMHS for adults.

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 72

The following Medi-Cal SMHS are available for children:

- Adult Residential Treatment Services*
- Crisis Intervention
- Crisis Stabilization
- Crisis Residential Treatment Services*
- Day Rehabilitation
- Day Treatment Intensive
- Medication Support Services
- Psychiatric Health Facility Services
- Psychiatric Inpatient Hospital Services
- Targeted Case Management
- Therapeutic Behavioral Services
- Therapy and Other Service Activities

*Children - Age 18 through 20

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is a net decrease due to:

- Updated estimated utilization and costs for Short Doyle/Medi-Cal (SD/MC) and Fee-For-Service (FFS) Inpatient clients, based on additional paid claims data through June 30, 2019, and
- Updated estimated funding for full scope undocumented children at 100% General Fund (GF).

The change between FY 2019-20 and FY 2020-21, in the current estimate, is a net increase due to an increase of SD/MC, FFS Inpatient, and ACA utilization for FY 2020-21 based on projections.

Methodology:

1. The costs and clients are developed using 70 months of SD/MC and 70 months FFS/MC approved claims data, excluding disallowed claims. The SD/MC data is current as of December 31, 2019, with dates of service from October 2013 through September 2019. The FFS data is current as of December 31, 2019, with dates of service from October 2013 through July 2019.

2. Applying more weight to recent data necessitates the need to ensure that lag weight adjusted claims data (a process by which months of partial data reporting is extrapolated to create estimates of final monthly claims) is as complete and accurate as possible. Therefore, the most recent months of data are weighted (Lag Weights) based on observed claiming trends to create projected final claims and client data. The development and application of lag weights is based upon historical reporting trends of the counties.

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 72

3. This table displays the forecast of Medi-Cal beneficiaries who will receive SD/MC SMHS and FFS/MC psychiatric inpatient hospital services.

Children	FY 2019-20 Utilization	FY 2020-21 Utilization
SD/MC	270,262	272,446
SD/MC ACA	9,479	10,737
FFS	13,111	13,250
FFS ACA	1,848	2,124
Total	294,700	298,557

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

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2017-18	$2,062,069	$1,956,010	$106,059
FY 2018-19	$1,965,100	$1,849,927	$115,173
FY 2019-20	$2,004,061	$1,879,799	$124,262
FY 2020-21	$2,065,731	$1,932,806	$132,925

5. On a cash basis for FY 2019-20, the Department will be paying 1% of FY 2017-18 claims, 61% of FY 2018-19 claims, and 38% of FY 2019-20 claims for SD/MC claims. For FFS Inpatient children's claims, the Department will be paying 1% of FY 2017-18 claims, 54% of FY 2018-19 claims, and 45% of FY 2019-20 claims. The cash amounts (rounded) for Children's SMHS are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2017-18	$20,621	$19,560	$1,061
FY 2018-19	$1,190,198	$1,128,455	$61,743
FY 2019-20	$770,727	$714,324	$56,403
Total FY 2019-20	$1,981,546	$1,862,339	$119,207

6. On a cash basis for FY 2020-21, the Department will be paying 1% of FY 2018-19 claims, 61% of FY 2019-20 claims, and 38% of FY 2020-21 claims for SD/MC claims. For FFS Inpatient children's claims, the Department will be paying 1% of FY 2018-19 claims, 54% of FY 2019-20 claims, and 45% of FY 2020-21 claims. The cash amounts (rounded) for Children's SMHS are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2018-19	$19,651	$18,499	$1,152
FY 2019-20	$1,213,293	$1,146,677	$66,616
FY 2020-21	$794,802	$734,467	$60,335
Total FY 2020-21	$2,027,746	$1,899,643	$128,103

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 72

7. On a cash basis, the Department estimates SD/MC costs of $47,148,000 in FY 2019-20 and $55,350,000 in FY 2020-21, for full scope undocumented children funded with 100% GF.

8. The chart below shows the FY 2019-20 and FY 2020-21 estimate with the following funding adjustments:
   - Individuals under age 19, who do not have satisfactory immigration status or are unable to verify satisfactory immigration status or citizenship, full scope Medi-Cal benefits effective May 1, 2016, are reimbursed with 100% GF.
   - Medi-Cal claims are eligible for 50% federal reimbursement,
   - MCHIP claims are eligible for 88% federal reimbursement (through September 30, 2019), 76.5% federal reimbursement (beginning October 1, 2019), and 65% federal reimbursement (beginning October 1, 2020,
   - ACA is funded by 100% federal funds (FF) until December 31, 2016, 95% FF / 5% GF until December 31, 2017, 94% FF / 6% GF until December 31, 2018, 93% FF / 7% GF until December 31, 2019, and 90% FF / 10% GF beginning January 1, 2020, and
   - GF reimbursement authority is needed to account for the timing of the reimbursement from the county realignment funds to the Department.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF	MCHIP	ACA FF	ACA GF	GF Reimb.	CF
FY 2019-20	$1,981,546	**$47,148**	**$781,567**	**$268,277**	**$49,829**	**$3,952**	**$46,003**	$784,770
FY 2020-21	$2,027,746	**$55,350**	**$782,560**	**$258,654**	**$55,775**	**$5,604**	**$50,932**	$818,871

Funding:
100% GF (4260-101-0001)
100% Title XIX FFP (4260-101-0890)
100% Title XXI FFP (4260-113-0890)
100% Reimbursement (4260-601-0995)
95% Title XIX FF / 5% GF (4260-101-0001/0890)
94% Title XIX FF / 6% GF (4260-101-0001/0890)
93% Title XIX FF / 7% GF (4260-101-0001/0890)
90% Title XIX FF / 10% GF (4260-101-0001/0890)

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER:	92
IMPLEMENTATION DATE:	7/2000
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	56

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$20,037,588,000	$20,578,936,000
- STATE FUNDS	$6,502,043,460	$6,962,987,970
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$20,037,588,000	$20,578,936,000
STATE FUNDS	$6,502,043,460	$6,962,987,970
FEDERAL FUNDS	$13,535,544,540	$13,615,948,030

DESCRIPTION

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

Authority:
Welfare & Institutions Code 14087.3
AB 120 (Chapter 22, Statutes of 2017)

Interdependent Policy Changes:
Capitated Rate Adjustment for FY 2020-21

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

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a decrease due to lower than previously expected eligible months. FY 2019-20 weighted draft rates have been updated to final rates.

The change from the prior estimate, for FY 2020-21, is an increase due to incorporating FY 2020-21 weighted draft rates. The prior estimate used FY 2019-20 weighted draft rates for FY 2020-21.

The change from FY 2019-20 to FY 2020-21, is an increase due to updated weighted rates for both FY 2019-20 and FY 2020-21.

Methodology:
1. Capitation rates are typically rebased annually. However, the Department has implemented a onetime 18-month rating period for the period of July 1, 2019, through December 31, 2020 (Bridge Period), to aid in future prospective rate development as federally required. Rates will be developed

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 92

and rebased annually on a calendar year (CY) basis thereafter. Federal rules require that the rates be developed according to generally accepted actuarial principles and must be certified by an actuary as actuarially sound in order to ensure federal financial participation (FFP). The rebasing process includes refreshed data and adjustments to trends.

2. For the pre-weighted rates on an accrual basis, the first 12 months of the post-risk adjusted Bridge Period rates apply to FY 2019-20. It has been actuarially determined the last 6 months of the Bridge Period rates will require a secondary risk adjustment update, which is budget neutral. On an accrual basis, the last 6 months of the Bridge Period rates (prior to the secondary risk adjustment update) and the first 6 months of the draft CY 2021 rates (prior to risk adjustment) have been budgeted for FY 2020-21.

3. FY 2019-20 weighted rates have been updated from the previous estimate.

4. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of $186,000,000 for FY 2019-20 and $187,700,000 for FY 2020-21 were included in the rates.

5. The savings from AB 97 are included in the rates. Savings of $217,100,000 for FY 2019-20 and $220,500,000 for FY 2020-21 were included in the rates.

6. Hepatitis C, Indian Health Services, and Maternity supplemental payments are budgeted in the base PCs.

7. Acupuncture services are included in the rates as of July 1, 2016.

8. Non-Medical Transportation (NMT) for covered Managed Care services are included in the base rate as of July 1, 2017. NMT for non-covered Managed Care services are included in the base rate as of October 1, 2017.

9. Services provided through the LA Mobile Vision Pilot Project are no longer included in the base rates, as of July 1, 2018.

10. Services covered through the Pediatric Palliative Care Waiver transitioned to Medi-Cal Managed Care on January 1, 2019. The anticipated costs associated with this transition are reflected in the base rates.

11. The Diabetes Prevention Program new benefit implemented on January 1, 2019. The costs associated with these services are reflected in the rates. This benefit will be discontinued effective January 1, 2021 in managed care.

12. As of July 1, 2019, the care coordination costs associated with Home and Community-Based Services (HCBS) High supplemental payments for CCI counties are currently reflected in this PC.

13. The County Children's Health Insurance Program (CCHIP) is anticipated to be transitioned to Medi-Cal Managed Care for Santa Clara and San Francisco counties on October 1, 2019. The costs associated with CCHIP are not currently reflected in this PC.

14. As of January 1, 2020, audiology and speech therapy service, incontinence creams and washes, optician and optical lab services, and podiatric services were restored as managed care benefits. The costs associated with the restoration of these benefits are currently reflected in this PC. These

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 92

benefits will be discontinued effective January 1, 2021 in managed care.

15. As of January 1, 2020, undocumented young adults aged 19 through 25 became eligible for full-scope Medi-Cal. The costs associated with these beneficiaries are not reflected in this PC.

16. The Department receives federal reimbursement of 90% for family planning services.

17. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted in the managed care model policy changes. Beginning October 1, 2015, a FMAP of 88/12 was budgeted for OTLICP. This FMAP split became 76.5/23.5 on October 1, 2019, and will become 65/35 on October 1, 2020.

18. Two-Plan Model costs on an accrual basis are:

(Dollars in Thousands)

FY 2019-20	Eligible Months	Total
Alameda	3,643,012	$1,045,359
Contra Costa	2,389,382	$668,550
Kern	3,889,642	$927,865
Los Angeles	35,291,215	$8,639,953
Riverside	8,264,462	$2,045,695
San Bernardino	8,147,356	$2,042,086
San Francisco	1,702,710	$556,047
San Joaquin	2,731,413	$652,612
Santa Clara	3,573,956	$884,612
Stanislaus	2,268,726	$594,275
Tulare	2,431,528	$454,764
Fresno	4,694,992	$1,115,882
Kings	584,641	$125,395
Madera	683,401	$131,888
Total	80,296,434	$19,884,983
Hepatitis C Adjustment		$168,194
Total FY 2019-20		**$20,053,177**

(Dollars in Thousands)

Included in the Above Dollars	FY 2019-20
Mental Health	$186,000
AB 97	($217,100)

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 92

(Dollars in Thousands)

FY 2020-21	Eligible Months	Total
Alameda	3,611,010	$1,083,695
Contra Costa	2,372,241	$703,088
Kern	3,887,720	$952,903
Los Angeles	35,182,375	$8,820,686
Riverside	8,264,197	$2,133,947
San Bernardino	8,115,648	$2,126,858
San Francisco	1,698,132	$580,621
San Joaquin	2,711,900	$675,800
Santa Clara	3,540,886	$906,596
Stanislaus	2,263,802	$626,278
Tulare	2,427,189	$463,369
Fresno	4,658,521	$1,126,584
Kings	586,206	$129,401
Madera	685,206	$136,435
Total	80,005,031	$20,466,261
Hepatitis C Adjustment		$151,492
Total FY 2020-21		**$20,617,753**

(Dollars in Thousands)

Included in the Above Dollars	FY 2020-21
Mental Health	$187,700
AB 97	($220,500)

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 92

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

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$11,355,731	$5,677,865	$5,677,866
100% GF (4260-101-0001)	$25,148	$25,148	$0
90% Family Planning / 10% GF (4260-101-0001/0890)	$132,461	$13,246	$119,215
88% Title XXI / 12% GF (4260-113-0001/0890)	$264,770	$31,772	$232,998
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)	$480,729	$112,972	$367,757
ACA 90% FFP / 10% GF (2020)	$3,237,270	$323,727	$2,913,543
ACA 93% FFP / 7% GF (2019)	$4,533,045	$317,313	$4,215,732
Title XIX 100% FFP	$8,434	$0	$8,434
Total	**$20,037,588**	**$6,502,043**	**$13,535,545**

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$11,818,860	$5,909,430	$5,909,430
100% GF (4260-101-0001)	$25,335	$25,335	$0
90% Family Planning / 10% GF (4260-101-0001/0890)	$72,619	$7,262	$65,357
65% Title XXI / 35% GF (4260-113-0001/0890)	$490,510	$171,679	$318,831
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)	$244,032	$57,347	$186,685
ACA 90% FFP / 10% GF (2020)	$7,919,349	$791,935	$7,127,414
Title XIX 100% FFP	$8,231	$0	$8,231
Total	**$20,578,936**	**$6,962,988**	**$13,615,948**

COUNTY ORGANIZED HEALTH SYSTEMS

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

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$8,565,819,000	$8,865,094,000
- STATE FUNDS	$2,848,303,660	$3,078,314,040
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$8,565,819,000	$8,865,094,000
STATE FUNDS	$2,848,303,660	$3,078,314,040
FEDERAL FUNDS	$5,717,515,340	$5,786,779,960

DESCRIPTION

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

Authority:
Welfare & Institutions Code 14087.3
AB 120 (Chapter 22, Statutes of 2017)

Interdependent Policy Changes:
Capitated Rate Adjustment for FY 2020-21

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

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a decrease due to lower than previously expected eligible months. FY 2019-20 weighted draft rates have been updated to final rates.

The change from the prior estimate, for FY 2020-21, is an increase due to incorporating FY 2020-21 weighted draft rates. The prior estimate used FY 2019-20 weighted draft rates for FY 2020-21.

The change from FY 2019-20 to FY 2020-21, is an increase due to updated weighted rates for both FY 2019-20 and FY 2020-21.

Methodology:
1. Capitation rates are typically rebased annually. However, DHCS has implemented a onetime 18-month rating period for the period of July 1, 2019 through December 31, 2020 (Bridge Period), to aid in future prospective rate development as federally required. Rates will be developed and

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 93

rebased annually on a calendar year (CY) basis thereafter. Federal rules require that the rates be developed according to generally accepted actuarial principles and must be certified by an actuary as actuarially sound in order to ensure federal financial participation (FFP). The rebasing process includes refreshed data and adjustments to trends.

2. For the pre-weighted rates on an accrual basis, the first 12 months of the Bridge Period rates apply to FY 2019-20. On an accrual basis, the last 6 months of the Bridge Period rates and the first 6 months of the draft CY 2021 rates have been budgeted for FY 2020-21.

3. FY 2019-20 weighted rates have been updated from the previous estimate.

4. Currently, all COHS plans have assumed risk for long term care services. The Partnership Health Plan of California (PHC) includes undocumented residents and documented alien beneficiaries (OBRA).

5. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of $98,500,000 for FY 2019-20 and $107,400,000 for FY 2020-21 were included in the rates.

6. The savings from AB 97 are included in the rates. Savings of $77,100,000 for FY 2019-20 and $68,100,000 for FY 2020-21 were included in the rates.

7. Indian Health Services and Hepatitis C costs are reflected in this PC.

8. Acupuncture services are included in the rates as of July 1, 2016.

9. The MCAP services are included in the rates as of July 1, 2017.

10. Non-Medical Transportation (NMT) for covered Managed Care services are included in the rates as of July 1, 2017. NMT for non-covered Managed Care services are included in the rates as of October 1, 2017.

11. The Diabetes Prevention Program benefit implemented on January 1, 2019. The costs associated with these services are included in the rates. This benefit will be discontinued effective January 1, 2021 in managed care.

12. Services covered through the Pediatric Palliative Care Waiver Program were transitioned to Medi-Cal Managed Care January 1, 2019. The anticipated costs associated with this transition are included in the rates.

13. As of July 1, 2018, WCM implemented on the following phase-in schedule by county:
    - July 1, 2018: Monterey, Santa Cruz, Merced, Santa Barbara, San Luis Obispo, and San Mateo
    - January 1, 2019: Napa, Solano, Yolo, Marin, Lake, Mendocino, Sonoma, Humboldt, Lassen, Modoc, Shasta, Siskiyou, Trinity, and Del Norte
    - July 1, 2019: Orange
    - Ventura County is not part of the WCM

14. As of July 1, 2019, the care coordination costs associated with Home and Community-Based Services (HCBS) High supplemental payments for CCI counties are reflected in this PC.

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 93

15. The County Children's Health Insurance Program (CCHIP) transitioned to Medi-Cal Managed Care for San Mateo County on October 1, 2019. The costs associated with CCHIP are not currently reflected in this PC.

16. As of January 1, 2020, audiology and speech therapy service, incontinence creams and washes, optician and optical lab services, and podiatric services were restored as managed care benefits. The costs associated with the restoration of these benefits are reflected in this PC. These benefits will be discontinued effective January 1, 2021 in managed care.

17. As of January 1, 2020, lens fabrication services have been removed from the rates for Santa Barbara, San Luis Obispo, and San Mateo counties.

18. As of January 1, 2020, undocumented young adults aged 19 through 25 became eligible for full-scope Medi-Cal. The costs associated with these beneficiaries are not reflected in this PC.

19. The Department receives 90% federal reimbursement for family planning services.

20. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted in the managed care model policy changes. Beginning October 1, 2015, a FMAP split of 88/12 was budgeted for OTLICP. This FMAP split became 76.5/23.5 on October 1, 2019, and will become 65/35 on October 1, 2020.

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 93

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

(Dollars in Thousands)

FY 2019-20	Eligible Months	Total
501- San Luis Obispo	612,797	$193,092
502- Santa Barbara	1,481,819	$437,497
503- San Mateo	1,188,297	$379,947
504- Solano	1,258,097	$477,653
505- Santa Cruz	777,037	$265,799
506-Orange	8,573,355	$2,622,935
507- Napa	331,536	$123,448
508-Monterey	1,796,904	$478,405
509- Yolo	599,971	$227,778
513- Sonoma	1,230,331	$449,237
514- Merced	1,445,223	$390,139
510 - Marin	441,175	$176,272
512 - Mendocino	425,117	$152,820
515 - Ventura	2,323,755	$771,436
523 - Del Norte	133,475	$53,782
517 - Humboldt	623,235	$238,245
511 - Lake	354,335	$135,496
518 - Lassen	85,197	$32,943
519 - Modoc	38,659	$16,820
520 - Shasta	699,327	$287,920
521 - Siskiyou	202,029	$74,406
522 - Trinity	49,594	$19,902
Total FY 2019-20	24,671,267	$8,005,972
Hepatitis C Adjustment		$53,551
Total with Adjustments		**$8,059,523**

(Dollars in Thousands)

Included in Above Dollars	FY 2019-20
Mental Health	$98,500
AB 97	($77,100)

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 93

(Dollars in Thousands)

FY 2020-21	Eligible Months	Total
501- San Luis Obispo	609,807	$196,755
502- Santa Barbara	1,481,705	$446,613
503- San Mateo	1,173,989	$398,630
504- Solano	1,250,897	$491,901
505- Santa Cruz	774,217	$279,149
506-Orange	8,442,869	$2,664,739
507- Napa	332,097	$127,681
508-Monterey	1,792,109	$504,270
509- Yolo	596,238	$234,705
513- Sonoma	1,221,232	$460,729
514- Merced	1,439,410	$410,892
510 - Marin	438,626	$181,482
512 - Mendocino	418,995	$155,647
515 - Ventura	2,311,164	$801,308
523 - Del Norte	133,609	$55,484
517 - Humboldt	623,081	$245,032
511 - Lake	351,706	$138,879
518 - Lassen	85,275	$33,902
519 - Modoc	38,920	$17,764
520 - Shasta	696,099	$295,570
521 - Siskiyou	200,622	$76,110
522 - Trinity	49,545	$20,446
Total FY 2020-21	24,462,212	$8,237,688
Hepatitis C Adjustment		$48,233
Total with Adjustments		**$8,285,921**

(Dollars in Thousands)

Included in Above Dollars	FY 2020-21
Mental Health	$107,400
AB 97	($68,100)

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 93

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

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$5,023,928	$2,511,964	$2,511,964
100% GF (4260-101-0001)	$5,025	$5,025	$0
90% Family Planning / 10% GF (4260-101-0001/0890)	$59,655	$5,965	$53,690
88% Title XXI / 12% GF (4260-113-0001/0890)	$135,100	$16,213	$118,887
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)	$247,940	$58,266	$189,674
ACA 93% FFP / 7% GF (2019)	$1,777,428	$124,420	$1,653,008
ACA 90% FFP / 10% GF (2020)	$1,264,513	$126,451	$1,138,062
Title XIX 100% FFP	$52,230	$0	$52,230
Total	**$8,565,819**	**$2,848,304**	**$5,717,515**

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$5,280,714	$2,640,357	$2,640,357
100% GF (4260-101-0001)	$4,913	$4,913	$0
90% Family Planning / 10% GF (4260-101-0001/0890)	$31,251	$3,125	$28,126
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)	$125,807	$29,564	$96,243
65% Title XXI / 35% GF (4260-113-0001/0890)	$252,842	$88,495	$164,347
ACA 90% FFP / 10% GF (2020)	$3,118,596	$311,860	$2,806,736
Title XIX 100% FFP	$50,971	$0	$50,971
Total	**$8,865,094**	**$3,078,314**	**$5,786,780**

GEOGRAPHIC MANAGED CARE

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

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$3,602,517,000	$3,685,633,000
- STATE FUNDS	$1,179,215,960	$1,257,492,480
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,602,517,000	$3,685,633,000
STATE FUNDS	$1,179,215,960	$1,257,492,480
FEDERAL FUNDS	$2,423,301,040	$2,428,140,520

DESCRIPTION

Purpose:
This policy change estimates the managed care capitation costs for the Geographic Managed Care (GMC) model plans.

Authority:
Welfare & Institutions Code 14087.3
AB 120 (Chapter 22, Statutes of 2017)

Interdependent Policy Changes:
Capitated Rate Adjustment for FY 2020-21

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

The Department implemented two new health plans in Sacramento and San Diego, United Healthcare Community Plan of California (United) and Aetna Better Health of California (Aetna). United began providing services on October 1, 2017, and Aetna began providing services on January 1, 2018. Effective November 1, 2018, United will no longer provide services in Sacramento County. United will continue to provide services in San Diego County.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a decrease due to lower than expected eligibles. FY 2019-20 weighted draft rates have been updated to final rates.

The change from the prior estimate, for FY 2020-21, is a decrease due to lower than expected eligibles. The current estimate incorporates FY 2020-21 weighted draft rates. The prior estimate used FY 2019-20 weighted draft rates for FY 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to updated weighted rates for both FY 2019-20 and FY 2020-21.

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 94

Methodology:

1. Capitation rates are typically rebased annually. However, DHCS has implemented a onetime 18-month rating period for the period of July 1, 2019 through December 31, 2020 (Bridge Period), to aid in future prospective rate development as federally required. Rates will be developed and rebased annually on a calendar year (CY) basis thereafter. Federal rules require that the rates be developed according to generally accepted actuarial principles and must be certified by an actuary as actuarially sound in order to ensure federal financial participation (FFP). The rebasing process includes refreshed data and adjustments to trends.

2. For the pre-weighted rates on an accrual basis, the first 12 months of the post-risk adjusted Bridge Period rates apply to FY 2019-20. It has been actuarially determined the last 6 months of the Bridge Period rates will require a secondary risk adjustment update, which is budget neutral. On an accrual basis, the last 6 months of the Bridge Period rates (prior to the secondary risk adjustment update) and the first 6 months of the draft CY 2021 rates (prior to risk adjustment) have been budgeted for FY 2020-21.

3. FY 2019-20 weighted rates have been updated from the previous estimate.

4. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of $34,900,000 for FY 2019-20 and $38,700,000 for FY 2020-21 were included in the rates.

5. The savings from AB 97 are included in the rates. Savings of $40,600,000 for FY 2019-20 and $37,500,000 for FY 2020-21 were included in the rates.

6. Hepatitis C, Indian Health Services, and Maternity supplemental payments are budgeted in the base PCs.

7. Acupuncture services are included in the base rates as of July 1, 2016.

8. Non-Medical Transportation (NMT) for covered Managed Care Service are included in the base rate as of July 1, 2017. NMT for non-covered Managed Care services are included in the base rate as of October 1, 2017.

9. Services covered through the Pediatric Palliative Care Waiver transitioned to Medi-Cal Managed Care on January 1, 2019. The anticipated costs associated with this transition are reflected in the base rates.

10. The Diabetes Prevention Program new benefit implemented on January 1, 2019. The costs associated with these services are reflected in the rates. This benefit will be discontinued effective January 1, 2021 in managed care.

11. As of July 1, 2019, the care coordination costs associated with Home and Community-Based Services (HCBS) High supplemental payments for CCI counties are reflected in this PC.

12. As of January 1, 2020, audiology and speech therapy service, incontinence creams and washes, optician and optical lab services, and podiatric services were restored as managed care benefits. The costs associated with the restoration of these benefits are reflected in this PC. These benefits will be discontinued effective January 1, 2021 in managed care.

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 94

13. As of January 1, 2020, undocumented young adults aged 19 through 25 became eligible for full-scope Medi-Cal. The costs associated with these beneficiaries are not reflected in this PC.

14. The Department receives 90% federal reimbursement for family planning services.

15. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted in the managed care model policy changes. Beginning October 1, 2015, a FMAP split of 88/12 was budgeted for OTLICP. This FMAP split became 76.5/23.5 on October 1, 2019, and will become 65/35 on October 1, 2020.

16. GMC dollars on an accrual basis are:

(Dollars in Thousands)

FY 2019-20	Eligible Months	Total
Sacramento	5,130,409	$1,399,922
San Diego	8,063,463	$2,180,786
Total	13,193,872	$3,580,708
Hepatitis C Adjustment		$28,175
Total FY 2019-20		**$3,608,883**

(Dollars in Thousands)

Included in Dollars Above	FY 2019-20
Mental Health	$34,900
AB 97	($40,600)

(Dollars in Thousands)

FY 2020-21	Eligible Months	Total
Sacramento	5,122,202	$1,431,206
San Diego	7,953,771	$2,235,381
Total	13,075,973	$3,666,587
Hepatitis C Adjustment		$25,377
Total FY 2020-21		**$3,691,964**

(Dollars in Thousands)

Included in Dollars Above	FY 2020-21
Mental Health	$38,700
AB 97	($37,500)

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 94

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

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$2,067,170	$1,033,585	$1,033,585
100% GF (4260-101-0001)	$4,642	$4,642	$0
90% Family Planning / 10% GF (4260-101-0001/0890)	$23,506	$2,350	$21,156
88% Title XXI / 12% GF (4260-113-0001/0890)	$44,421	$5,330	$39,091
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)	$83,076	$19,523	$63,554
ACA 90% FFP / 10% GF (2020)	$574,942	$57,494	$517,448
ACA 93% FFP / 7% GF (2019)	$804,154	$56,292	$747,862
Title XIX 100% FFP	$606	$0	$606
***Total**	**$3,602,517**	**$1,179,215**	**$2,423,301**

*Difference due to rounding.

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$2,144,382	$1,072,191	$1,072,191
100% GF (4260-101-0001)	$4,688	$4,688	$0
90% Family Planning / 10% GF (4260-101-0001/0890)	$12,816	$1,282	$11,534
65% Title XXI / 35% GF (4260-113-0001/0890)	$85,201	$29,820	$55,381
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)	$42,335	$9,948	$32,387
ACA 90% FFP / 10% GF (2020)	$1,395,620	$139,563	$1,256,057
Title XIX 100% FFP	$591	$0	$591
Total	**$3,685,633**	**$1,257,492**	**$2,428,141**

REGIONAL MODEL

BASE POLICY CHANGE NUMBER:	98
IMPLEMENTATION DATE:	11/2013
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1842

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$1,237,347,000	$1,275,951,000
- STATE FUNDS	$388,706,740	$414,807,400
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,237,347,000	$1,275,951,000
STATE FUNDS	$388,706,740	$414,807,400
FEDERAL FUNDS	$848,640,260	$861,143,600

DESCRIPTION

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

Authority:
AB 1467 (Chapter 23, Statutes of 2012)
AB 120 (Chapter 22, Statutes of 2017)

Interdependent Policy Changes:
Capitated Rate Adjustment for FY 2020-21

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

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

Reason for Change:
The change from the prior estimate for FY 2019-20 is a decrease due to lower than previously expected eligibles. FY 2019-20 weighted draft rates are updated to final rates. The change from the prior estimate for FY 2020-21 is an increase due to incorporating FY 2020-21 weighted draft rates. The prior estimate used FY 2019-20 weighted draft rates for FY 2020-21. The change from FY 2019-20 to FY 2020-21 is due to updated weighted rates for FY 2019-20 and FY 2020-21.

Methodology:
1. Capitation rates are typically rebased annually. However, the Department implemented a onetime 18-month rating period for the period of July 1, 2019 through December 31, 2020 (Bridge Period) to aid in future prospective rate development as federally required. Rates will be developed and

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 98

rebased annually on a calendar year basis thereafter. Federal rules require that the rates be developed according to generally accepted actuarial principles and must be certified by an actuary as actuarially sound in order to ensure federal financial participation (FFP). The rebasing process includes refreshed data and adjustments to trends.

2. For the pre-weighted rates on an accrual basis, the first 12 months of the post-risk adjusted Brdge Period rates apply to FY 2019-20. It has been actuarially determined the last 6 months of the Bridge Period rates will require a secondary risk adjustment update, which is budget neutral. On an accrual basis, the last 6 months of the Bridge Period rates (prior to the secondary risk adjustment update) and the first 6 months of the draft CY 2021 rates (prior to risk adjustment) have been budgeted for FY 2020-21.

3. FY 2019-20 weighted rates have been updated from the previous estimate.

4. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of $20,100,000 for FY 2019-20 and $19,900,000 for FY 2020-21 were included in the rates.

5. The savings from AB 97 are included in the rates. Savings of $10,000,000 for FY 2019-20 and FY 2020-21 were included in the rates. Rates include the savings for application to the primary care providers effective January 1, 2015.

6. Hepatitis C, Indian Health Services, and Maternity supplemental payments are reflected in this PC.

7. Acupuncture services are included in the rates as of July 1, 2016.

8. Non-Medi-cal Transportation (NMT) for covered Managed Care services are included in the base rate as of July 1, 2017. NMT for non-covered Managed Care services are included in the base rate as of October 1, 2017.

9. Services covered through the Pediatric Palliative Care Waiver transitioned to Medi-Cal Managed Care on January 1, 2019. The costs associated with this transition are reflected in the rates.

10. The Diabetes Prevention Program new benefit implemented on January 1, 2019. The costs associated with these services are reflected in the rates. This benefit will be discontinued effective January 1, 2021 in managed care.

11. As of July 1, 2019, the care coordination costs associated with Home and Community-Based Services (HCBS) High supplemental payments for CCI counties are reflected in this PC.

12. As of January 1, 2020, audiology and speech therapy service, incontinence creams and washes, optician and optical lab services, and podiatric services were restored as managed care benefits. The costs associated with the restoration of these benefits are reflected in this PC. These benefits will be discontinued effective January 1, 2021 in managed care.

13. As of January 1, 2020, undocumented young adults aged 19 through 25, became eligible for full-scope Medi-Cal. The costs associated with these beneficiaries are not reflected in this PC.

14. The Department receives 90% federal reimbursement for family planning services.

15. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted in the

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 98

managed care model policy changes. Beginning October 1, 2015, a FMAP split of 88/12 was budgeted for OTLICP. This FMAP split became 76.5/23.5 on October 1, 2019 and will become 65/35 on October 1, 2020.

16. Regional Model dollars on an accrual basis are:

(Dollars in Thousands)

FY 2019-20	Eligible Months	Total
Alpine	2,604	$729
Amador	72,109	$18,294
Butte	737,354	$222,748
Calaveras	111,287	$30,136
Colusa	93,796	$19,621
El Dorado	337,851	$91,424
Glenn	120,057	$29,399
Inyo	45,291	$10,764
Mariposa	47,351	$12,596
Mono	29,606	$6,431
Nevada	232,219	$61,095
Placer	532,735	$141,615
Plumas	61,842	$17,183
Sierra	6,723	$1,848
Sutter	375,060	$93,799
Tehama	238,809	$64,119
Tuolumne	118,910	$34,575
Yuba	299,753	$79,988
Imperial	901,714	$220,022
San Benito	92,564	$14,462
Total FY 2019-20	4,457,635	$1,170,848
Hepatitis C Adjustment		$10,019
Total with Adjustments		**$1,180,867**

(Dollars in Thousands)

Included in Dollars Above	FY 2019-20
Mental Health	$20,100
AB 97	($10,000)

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 98

(Dollars in Thousands)

FY 2020-21	Eligible Months	Total
Alpine	2,572	$746
Amador	71,888	$18,720
Butte	732,967	$233,383
Calaveras	110,833	$31,460
Colusa	94,044	$20,579
El Dorado	335,241	$96,018
Glenn	120,430	$31,311
Inyo	45,429	$11,283
Mariposa	47,560	$12,996
Mono	29,422	$6,649
Nevada	228,165	$62,825
Placer	530,975	$145,623
Plumas	61,674	$17,841
Sierra	6,716	$1,914
Sutter	374,095	$96,803
Tehama	239,600	$67,068
Tuolumne	118,058	$35,870
Yuba	299,333	$82,394
Imperial	902,188	$225,792
San Benito	92,340	$15,549
Total FY 2020-21	4,443,529	$1,214,824
Hepatitis C Adjustment		$9,024
Total with Adjustments		**$1,223,848**

(Dollars in Thousands)

Included in Dollars Above	FY 2020-21
Mental Health	$19,900
AB 97	($10,000)

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 98

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

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$683,679	$341,839	$341,839
100% GF (4260-101-0001)	$1,456	$1,456	$0
ACA 93% FFP / 7% GF (2019)	$260,676	$18,247	$242,429
ACA 90% FFP / 10% GF (2020)	$185,588	$18,559	$167,029
90% Family Planning / 10% GF (4260-101-0001/0890)	$8,524	$853	$7,671
88% Title XXI / 12% GF (4260-113-0001/0890)	$15,070	$1,808	$13,262
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)	$25,295	$5,944	$19,351
Title XIX 100% (4260-101-0890)	$57,059	$0	$57,059
***Total**	**$1,237,347**	**$388,706**	**$848,640**

*Difference due to rounding.

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$708,045	$354,022	$354,023
100% GF (4260-101-0001)	$1,453	$1,453	$0
ACA 90% FFP / 10% GF (2020)	$467,225	$46,722	$420,503
90% Family Planning / 10% GF (4260-101-0001/0890)	$4,576	$457	$4,119
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)	$12,927	$3,038	$9,889
65% Title XXI / 35% GF (4260-113-0001/0890)	$26,041	$9,115	$16,926
Title XIX 100% (4260-101-0890)	$55,684	$0	$55,684
Total	**$1,275,951**	**$414,807**	**$861,144**

PACE (Other M/C)

BASE POLICY CHANGE NUMBER:	99
IMPLEMENTATION DATE:	7/1992
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	62

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$682,939,000	$878,983,000
- STATE FUNDS	$341,469,500	$439,491,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$682,939,000	$878,983,000
STATE FUNDS	$341,469,500	$439,491,500
FEDERAL FUNDS	$341,469,500	$439,491,500

DESCRIPTION

Purpose:
This policy change estimates the capitation payments under the Program of All-Inclusive Care for the Elderly (PACE).

Authority:
Welfare & Institutions Code 14591-14594
Welfare & Institutions Code 14301.1(n)
Balanced Budget Act of 1997 (BBA)
SB 870 (Chapter 40, Statutes 2014)
SB 840 (Chapter 29, Statutes 2018)

Interdependent Policy Changes:
Not Applicable

Background:
The PACE program is a capitated benefit that provides a comprehensive medical/social delivery system. Services are provided in a PACE center to older adults who would otherwise reside in nursing facilities. To be eligible, a person must be 55 years or older, reside in a PACE service area, be determined eligible at the nursing home level of care by the Department, and be able to live safely in their home or community at the time of enrollment. PACE providers assume full financial risk for participants' care without limits on amount, duration, or scope of services.

The Department currently has sixteen contracts with PACE organizations for risk-based capitated lifetime care for the frail elderly. PACE rates are developed using actuarial principles, including actual experience of the PACE population, in a manner consistent with Welfare and Institutions Code Section 14301.1(n), effective January 1, 2018.

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 99

Below is a list of PACE organizations:

PACE Organization	County	Operational
On Lok Lifeways	San Francisco	November 1, 1983
	Alameda	July 1, 2002
	Santa Clara	January 1, 2009
Centers for Elders' Independence	Alameda	June 1, 1992
	Contra Costa	June 1, 1992
Sutter Senior Care	Sacramento	August 1, 1992
AltaMed Senior BuenaCare	Los Angeles	January 1, 1996
St. Paul's PACE	San Diego	February 1, 2008
Los Angeles Jewish Home (Brandman)	Los Angeles	February 1, 2013
CalOptima PACE	Orange	September 1, 2013
InnovAge	San Bernardino	April 1, 2014
	Riverside	April 1, 2014
Innovative Integrated Health	Fresno	August 1, 2014
	Kern	January 1, 2020
	Tulare	January 1, 2020
Redwood Coast	Humboldt	September 1, 2014
San Ysidro	San Diego	April 1, 2015
Stockton PACE	San Joaquin	January 1, 2019
	Stanislaus	January 1, 2019
Gary & Mary West	San Diego	July 1, 2019
Family Health Centers of San Diego	San Diego	July 1, 2019
Pacific PACE	Los Angeles	July 1, 2019
Sequoia	Fresno	July 1, 2020
	Kings	July 1, 2020
	Madera	July 1, 2020
	Tulare	July 1, 2020
InnovAge	Sacramento	July 1, 2020
	Placer	July 1, 2020
	Sutter	July 1, 2020
	Yuba	July 1, 2020
	El Dorado	July 1, 2020
	San Joaquin	July 1, 2020
LA Coast	Los Angeles	January 1, 2020
Central Valley	San Joaquin	July 1, 2020
	Stanislaus	July 1, 2020
North East Medical Services (NEMS)	San Francisco	January 1, 2021

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 99

Reason for Change:
The change from the prior estimate, for FY 2019-20, is an increase due to a higher 2020 rate adjustment. The 2020 rate adjustment increased as a result of higher than previously estimated eligible enrollment data and timing of the adjustment.

The change from the prior estimate, for FY 2020-21, is an increase due to higher than estimated actuals through December 2019, the addition of the NEMS plan, the revision of higher actual enrollment from the Family Health Centers of San Diego plan, and a higher 2021 rate adjustment.

The change from FY 2019-20 to FY 2020-21, is a net increase due to additional plans being implemented and a full year of enrollment being captured for the newer plans. Additionally, the 2021 rate adjustment increased from higher than previously estimated eligible enrollment data and timing of the adjustment.

Methodology:

1. Assume the January 2019 through December 2019 rates are calculated using plan specific experienced-based data to build actuarially sound prospective rates.

2. Assume the CY 2020 and CY 2021 rates will be calculated using plan specific experienced-based data to build actuarially sound prospective rates.

3. FY 2019-20 and FY 2020-21 estimated funding is based on CMS approved CY 2019 rates and projected CY 2020 and CY 2021 rates.

4. Assume enrollment will increase based on past enrollment in PACE organizations by county and plan and projected enrollments for new PACE organizations.

5. The Department plans to implement the CY 2020 rates during the April 2020 capitation cycle. A retroactive repayment of approximately $36,444,000 will be paid to the PACE organizations during the April 2020 capitation.

6. The Department plans to implement the CY 2021 rates during the March 2021 capitation cycle. A retroactive repayment of approximately $34,130,000 will be paid to the PACE organizations during the March 2021 capitation.

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 99

FY 2019-20	TF Cost (Rounded)	Eligible Months	Avg. Monthly Enrollment
Centers for Elders' Independence (Alameda and Contra Costa)	$55,381,000	9,518	793
Sutter Senior Care	$29,024,000	5,223	435
AltaMed Senior BuenaCare	$160,654,000	32,483	2,707
OnLok (SF, Alameda and Santa Clara)	$130,869,000	19,280	1,607
St. Paul's PACE	$54,344,000	11,551	963
Los Angeles Jewish Homes	$15,415,000	3,082	257
CalOptima PACE	$27,824,000	4,600	383
InnovAge (San Bernardino and Riverside)	$44,984,000	8,421	702
Redwood Coast (Humboldt)	$11,894,000	2,278	190
Innovative Integrated Health (Fresno, Kern, Tulare)	$49,550,000	9,203	767
San Ysidro San Diego	$46,845,000	8,294	691
Stockton PACE (San Joaquin and Stanislaus)	$9,945,000	1,698	142
Gary & Mary West (San Diego)	$1,968,000	360	36
Family Health Centers of San Diego	$3,457,000	572	48
LA Coast (Los Angeles)	$778,000	150	38
Pacific PACE (Los Angeles)	$3,563,000	687	57
Total Capitation Payments	$646,495,000	117,400	9,816
2020 Rate Adjustment	$36,444,000		
Total FY 2019-20	**$682,939,000**		

*Totals may differ due to rounding.

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 99

FY 2020-21	TF Cost (Rounded)	Eligible Months	Avg. Monthly Enrollment
Centers for Elders' Independence (Alameda and Contra Costa)	$61,844,000	10,128	844
Sutter Senior Care	$41,429,000	7,050	588
AltaMed Senior BuenaCare	$175,585,000	34,290	2,858
OnLok (SF, Alameda and Santa Clara)	$143,042,000	19,908	1,659
St. Paul's PACE	$66,472,000	13,902	1,159
Los Angeles Jewish Homes	$16,670,000	3,234	270
CalOptima PACE	$36,122,000	5,772	481
InnovAge (San Bernardino and Riverside)	$50,476,000	9,108	759
Redwood Coast (Humboldt)	$14,326,000	2,592	216
Innovative Integrated Health (Fresno, Kern, Tulare)	$69,649,000	12,174	1,015
San Ysidro San Diego	$78,657,000	13,770	1,148
Stockton PACE (San Joaquin and Stanislaus)	$23,153,000	3,765	314
Gary & Mary West (San Diego)	$7,760,000	1,369	114
Family Health Centers of San Diego	$14,943,000	2,422	202
Central Valley (San Joaquin and Stanislaus)	$7,519,000	1,171	98
LA Coast (Los Angeles)	$10,122,000	1,890	158
Pacific PACE (Los Angeles)	$14,401,000	2,673	223
Sequoia (Fresno, Kings, Madera, & Tulare)	$6,380,000	1,178	98
InnovAge (Sacramento, Placer, El Dorado, Sutter, San Joaquin, & Yuba)	$5,304,000	894	75
North East Medical Services (San Francisco)	$999,000	126	21
Total Capitation Payments	$844,853,000	147,416	12,300
2021 Rate Adjustment	$34,130,000		
Total FY 2020-21	**$878,983,000**		

*Totals may differ due to rounding.

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

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER:	102
IMPLEMENTATION DATE:	7/2004
ANALYST:	Matt Wong
FISCAL REFERENCE NUMBER:	1029

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$106,947,000	$109,892,000
- STATE FUNDS	$42,085,600	$44,104,840
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$106,947,000	$109,892,000
STATE FUNDS	$42,085,600	$44,104,840
FEDERAL FUNDS	$64,861,400	$65,787,160

DESCRIPTION

Purpose:
The policy change estimates the cost of dental capitation rates for the Dental Managed Care (DMC) program.

Authority:
Social Security Act, Title XIX
AB 82 (2013, Chapter 23), Section 14131.10 of the Welfare & Institutions Code
Access Dental Plan Contract #12-89341
Access Dental Plan Contract #13-90115
Health Net of California Contract #12-89342
Health Net of California Contract #13-90116
Liberty Dental Plan of California, Inc. Contract #12-89343
Liberty Dental Plan of California, Inc. Contract #13-90117

Interdependent Policy Changes:
Not Applicable

Background:
The DMC program provides a comprehensive approach to dental health care, combining clinical services and administrative procedures that are organized to provide timely access to primary care and other necessary services in a cost effective manner. The Department contracts with three Geographic Managed Care (GMC) plans and three Prepaid Health Plans (PHP). These plans provide dental services to Medi-Cal beneficiaries in Sacramento and Los Angeles counties.

Each dental plan receives a negotiated monthly per capita rate for every recipient enrolled in their plan. DMC program recipients enrolled in contracting plans are entitled to receive dental benefits from dentists within the plan's provider network.

AB 82 restored partial adult optional dental benefits, including full mouth dentures. Effective May 1, 2014, the scope of covered adult dental services offered at any dental service-rendering location that serves Medi-Cal beneficiaries, including Federally Qualified Health Centers (FQHCs) and Rural Health

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 102

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

Reason for Change:
The changes from the prior estimate, for FY 2019-20 and FY 2020-21, are an increase due the increase in the capitation rates. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to an increase in the capitation rate and an in-year retroactive payment.

Methodology:

1. Effective July 1, 2009, separate dental managed care rates have been established for those enrollees under age 21. Beginning March 2011, these rates are paid on an ongoing basis.

2. The retroactive adjustments of the rates for prior years are shown in the Dental Retroactive Rate Changes policy change.

3. Any portion of the rate attributable to Proposition 56 Supplemental Payments is captured in its respective policy change.

4. HIPF payments will be paid in FY 2019-20 for $1,256,900 and in FY 2020-21 for $1,141,653.

5. A 3% withhold is held back every month per the contract with the health plans. The withhold amount is returned no sooner than April of the following fiscal year if performance measures in the contract are met.

FY 2019-20	Total Member Months	Average Monthly Eligibles	Total Costs
Adult - GMC	2,635,734	219,645	$25,837,081
Child - GMC	2,354,208	196,184	$30,999,879
Adult - PHP	2,805,966	233,831	$26,778,068
Child - PHP	1,581,838	131,820	$22,321,965

FY 2020-21	Total Member Months	Average Monthly Eligibles	Total Costs
Adult - GMC	2,620,560	218,380	$29,189,264
Child - GMC	2,350,380	195,865	$32,899,738
Adult - PHP	2,766,420	230,535	$27,296,382
Child - PHP	1,544,928	128,744	$18,792,311

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 102

Funding:

FY 2019-20	TF	GF	FF
Regular FMAP T19	$78,315,000	$39,158,000	$39,157,000
ACA 93% FFP/7% GF (2019)	$12,277,000	$859,000	$11,418,000
ACA 90% FFP/10% GF (2020)	$12,278,000	$1,228,000	$11,050,000
Title 21 88% FFP/12% GF	$1,019,000	$122,000	$897,000
Title 21 76.5% FFP/23.5% GF	$3,058,000	$719,000	$2,339,000
Total	**$106,947,000**	**$42,086,000**	**$64,861,000**

FY 2020-21	TF	GF	FF
Regular FMAP T19	$80,472,000	$40,236,000	$40,236,000
ACA 90% FFP/10% GF (2020)	$25,231,000	$2,523,000	$22,708,000
Title 21 76.5% FFP/23.5% GF	$1,047,000	$246,000	$801,000
Title 21 65% FFP/35% GF	$3,142,000	$1,100,000	$2,042,000
Total	**$109,892,000**	**$44,105,000**	**$65,787,000**

*Totals may differ due to rounding.

SENIOR CARE ACTION NETWORK (Other M/C)

BASE POLICY CHANGE NUMBER:	105
IMPLEMENTATION DATE:	2/1985
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	61

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$70,176,000	$60,230,000
- STATE FUNDS	$35,088,000	$30,115,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$70,176,000	$60,230,000
STATE FUNDS	$35,088,000	$30,115,000
FEDERAL FUNDS	$35,088,000	$30,115,000

DESCRIPTION

Purpose:
This policy change estimates the capitated payments associated with enrollment of dual eligible Medicare/Medi-Cal beneficiaries in the Senior Care Action Network (SCAN) health plan.

Authority:
Welfare & Institutions Code 14200

Interdependent Policy Changes:
Not Applicable

Background:
SCAN is a Medicare Advantage Special Needs Plan that contracts with the Department to coordinate and provide health care services on a capitated basis for persons aged 65 and older with both Medicare and Medi-Cal coverage in Los Angeles, San Bernardino, and Riverside Counties. Enrollees who are certified for Skilled Nursing Facility (SNF) and Intermediate Care Facility (ICF) level of care are eligible for additional Home and Community Based Services (HCBS) through the SCAN Health Plan Independent Living Power program.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a decrease due to lower than previously expected CY 2020 rates. The change from the prior estimate, for FY 2020-21, is a decrease to due revised CY 2021 rates. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease due to a CY 2018 and 2019 retroactive rate payment occurring in FY 2019-20.

Methodology:
1. Estimated SCAN costs are calculated by multiplying the actual and estimated monthly eligible counts for each county by the capitated rates for each county and beneficiary type – Aged and Disabled or Long-Term Care.

2. Assume an average monthly enrollment of 13,384 in FY 2019-20 and 13,544 in FY 2020-21.

SENIOR CARE ACTION NETWORK (Other M/C)

BASE POLICY CHANGE NUMBER: 105

3. The CY 2018, CY 2019, and CY 2020 rates are final rates.
4. The CY 2021 rates were projected by trending forward the CY 2020 final rates.
5. The CY 2018 rate repayment of $6,632,000 and CY 2019 rate repayment of $4,921,000 will occur in FY 2019-20.
6. Assume one month of FY 2018-19 payments and 11 months of FY 2019-20 are paid in FY 2019-20.
7. Assume one month of FY 2019-20 payments and 11 months of FY 2020-21 are paid in FY 2020-21.
8. Anticipated costs on a cash basis are:

(Dollars in Thousands)

FY 2019-20	**Costs**	**Eligible Months**	**Avg. Monthly Enrollment**
Los Angeles	$36,167	109,757	9,146
Riverside	$11,142	30,324	2,527
San Bernardino	$7,166	20,527	1,711
FY 2019-20*	$54,475	160,608	13,384
FY 2018-19**	$4,147		
2018 Rate Repayment	$6,632		
2019 Rate Repayment	$4,921		
Total FY 2019-20	***$70,176**		

(Dollars in Thousands)

FY 2020-21	**Costs**	**Eligible Months**	**Avg. Monthly Enrollment**
Los Angeles	$36,619	111,062	9,255
Riverside	$11,361	30,282	2,523
San Bernardino	$7,377	21,183	1,765
FY 2020-21*	***$55,356	162,527	13,544
FY 2019-20**	$4,894		
Total FY 2020-21	**$60,250**		

*Assumes 11 months of capitation payments.
**Assumes 1 month of capitation payments.
***Difference due to rounding.

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

AIDS HEALTHCARE CENTERS (Other M/C)

BASE POLICY CHANGE NUMBER:	106
IMPLEMENTATION DATE:	5/1985
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	63

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$15,424,000	$16,544,000
- STATE FUNDS	$7,712,000	$8,272,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$15,424,000	$16,544,000
STATE FUNDS	$7,712,000	$8,272,000
FEDERAL FUNDS	$7,712,000	$8,272,000

DESCRIPTION

Purpose:
This policy change estimates the cost of capitation rates and the savings sharing for AIDS Healthcare centers.

Authority:
Welfare & Institutions Code 14088.85

Interdependent Policy Changes:
Not Applicable

Background:
The HIV/AIDS capitated case management project in Los Angeles became operational in April 1995. The Department held a contract with AIDS Healthcare Centers as a Primary Care Case Management (PCCM) plan through June 30, 2019. Effective July 1, 2019, AIDS Healthcare Foundation transitioned to a full risk-managed care plan as approved by the Department. The Department developed a full-risk amendment that added inpatient services as a benefit, changed plan pharmacy coverage, and extended the contract to December 31, 2020. The Department anticipates further contract extensions.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a decrease due to lower than previously expected dual and non-dual Bridge Period rates.

The change from the prior estimate, for FY 2020-21, is a decrease due to lower than previously expected dual and non-dual Bridge Period and Calendar Year 2021 rate projections.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to higher projected enrollment and rate growth.

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

AIDS HEALTHCARE CENTERS (Other M/C)

BASE POLICY CHANGE NUMBER: 106

Member Months	Dual	Medi-Cal Only
FY 2018-19	4,020	4,231
FY 2019-20	3,850	4,065
FY 2020-21	3,908	4,126

2) Assume the following paid rates:

Paid Rates	Dual	Medi-Cal Only
FY 2018-19*	$114.82	$2,228.29
FY 2019-20	$161.88	$3,765.01
FY 2020-21	$171.75	$3,994.68

*One month of FY 2018-19 rates to pay in FY 2019-20

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

FY 2019-20	Year	Paid Rate	MM	TF
Dual	FY 2018-19	$114.82	335	$38,000
Medi-Cal Only	FY 2018-19	$2,228.29	353	$786,000
Dual	FY 2019-20	$161.88	3,529	$571,000
Medi-Cal Only	FY 2019-20	$3,765.01	3,726	$14,029,000
Total	N/A	N/A	N/A	$15,424,000

FY 2020-21	Year	Paid Rate	MM	TF
Dual	FY 2019-20	$161.88	321	$52,000
Medi-Cal Only	FY 2019-20	$3,765.01	339	$1,275,000
Dual	FY 2020-21	$161.88	1,925	$312,000
Medi-Cal Only	FY 2020-21	$3,765.01	2,033	$7,652,000
Dual**	FY 2020-21	$171.75	1,652	$284,000
Medi-Cal Only**	FY 2020-21	$3,994.68	1,745	$6,969,000
Total	N/A	N/A	N/A	$16,544,000

**Paid rate change due to shift to Calendar Year 2021 rate.

FY 2019-20	TF	GF	FF
Dual	$609,000	$304,000	$305,000
Medi-Cal Only	$14,815,000	$7,408,000	$7,407,000
Total FY 2019-20	**$15,424,000**	**$7,712,000**	**$7,712,000**

FY 2020-21	TF	GF	FF
Dual	$647,000	$324,000	$324,000
Medi-Cal Only	$15,897,000	$7,948,000	$7,948,000
Total FY 2020-21	**$16,544,000**	**$8,272,000**	**$8,272,000**

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

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

BASE POLICY CHANGE NUMBER:	109
IMPLEMENTATION DATE:	3/2018
ANALYST:	Latoya Brown
FISCAL REFERENCE NUMBER:	66

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$1,427,000	$1,655,000
- STATE FUNDS	$713,500	$3,964,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,427,000	$1,655,000
STATE FUNDS	$713,500	$3,964,000
FEDERAL FUNDS	$713,500	-$2,309,000

DESCRIPTION

Purpose:
This policy change estimates the cost of the contract with the Family Mosaic Project.

Authority:
Welfare & Institutions Code 14087.3

Interdependent Policy Changes:
Not Applicable

Background:
The Department's contract with the Family Mosaic Project was effective January 1, 2008. The Family Mosaic Project, located in San Francisco, case manages children diagnoses with emotional disturbance who are at risk for out-of-home placement.

Family Mosaic has historical served a small population, due to the small size of the population, actuarial sound capitation rates are unable to be developed pursuant to actuarial standards. In order to obtain federal funding, capitation rates must be actuarially sound and approved by the Centers for Medicaid and Medicare (CMS).

It has been determined Family Mosaic capitation rates for FY 2014-15 to current are not compliant with actuarial standards, therefore, federal funding is unable to be claimed for this program retroactive back to FY 2014-15. DHCS historically claimed federal funding for all capitation payments issued for this program, therefore, State General Fund will be used to pay back the previously claimed federal funding for 2014-15 through FY 2018-19. FY 2019-20 capitation rates will be funded solely by State General Fund.

DHCS will continue to calculate annual capitation rates for this program; however, annually developed rates will be unable to be actuarially certified and will not be submitted to CMS for review and approval.

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

BASE POLICY CHANGE NUMBER: 109

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a decrease in GF and TF due to a decrease in actual member months and the retroactive federal funding payback for the period of FY 2014-15 through FY 2018-19 now occurring in FY 2020-21. Federal funding is not obtainable since developed capitation rates are not actuarially certifiable due to the small population size.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to retroactive payments anticipated to occur in FY 2020-21.

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

- 413 in FY 2018-19
- 413 in FY 2019-20
- 413 in FY 2020-21

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

- $3,558.41 in FY 2018-19
- $3,665.17 for July 1, 2019 through December 31, 2020 (Bridge Period)
- $3,775.12 in Calendar Year 2021

3) The retroactive federal funding payback is estimated to be a total of $2,530,000 for the periods FY 2014-15 through FY 2018-19. The FY 2017-18 rate was paid through the FY 2018-19 and FY 2019-20 service periods.

4) A retroactive rate adjustment for FY 2018-19 and the Bridge Period are expected to be made in FY 2020-21.

5) Anticipated costs on a cash basis are:

FY 2019-20	TF	GF	FF
FY 2018-19 (Retro)	$119,000	$60,000	$59,000
FY 2019-20	$1,308,000	$654,000	$654,000
Total FY 2019-20	**$1,427,000**	**$714,000**	**$713,000**

One month of FY 2018-19 capitation pays in FY 2019-20

FY 2020-21	TF	GF	FF
Prior Years Retro	$443,000	$221,000	$222,000
2014/15 to 2018/19 FFP Payback	$0	$2,530,000	($2,530,000)
Rating Period 2020/21	$1,212,000	$1,212,000	$0
Total FY 2020-21	**$1,655,000**	**$3,963,000**	**($2,308,000)**

One month of FY 2019-20 capitation paying in FY 2020-21
*Totals may differ due to rounding.

Funding:
100% State GF (4260-101-0001)
100% Federal Funds (4260-101-0890)

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

BASE POLICY CHANGE NUMBER:	173
IMPLEMENTATION DATE:	7/1988
ANALYST:	Joulia Dib
FISCAL REFERENCE NUMBER:	76

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$3,403,315,000	$3,624,292,000
- STATE FUNDS	$1,806,873,500	$1,924,326,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,403,315,000	$3,624,292,000
STATE FUNDS	$1,806,873,500	$1,924,326,000
FEDERAL FUNDS	$1,596,441,500	$1,699,966,000

DESCRIPTION

Purpose:
This policy change estimates Medi-Cal's expenditures for Medicare Part A and Part B premiums.

Authority:
Title 22, California Code of Regulations 50777
Social Security Act 1843

Interdependent Policy Changes:
Not applicable

Background:
This policy change estimates the costs for Part A and Part B premiums for Medi-Cal beneficiaries that are also eligible for Medicare coverage.

Reason for Change:
There is no significant change in projected beneficiaries and expenditures for FY 2019-20 and FY 2020-21 from the previous estimate.

Expenditures are projected to grow 6.5% between FY 2019-20 and FY 2020-21 due to a moderate expected growth in beneficiaries of 1.4% based on the historical trend and a projected increase in the Part A premium of $21.00 and Part B premium of $5.40 between 2021 and 2020.

Premiums:

Calendar Year	2019	2020		2021	
	Actual	Nov 2019 Actual	May 2020 Actual	Nov 2019 Estimate	May 2020 Estimate
Part A	$437.00	$458.00	$458.00	$479.00	$479.00
Part B	$135.50	$144.60	$144.60	$150.00	$150.00

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

BASE POLICY CHANGE NUMBER: 173

Average Monthly Beneficiaries:

FY	2018-19	2019-20		2020-21	
	Actual	Nov 2019 Estimate	May 2020 Estimate	Nov 2019 Estimate	May 2020 Estimate
Part A	174,800	173,700	173,300	174,700	174,300
Part B	1,399,200	1,404,800	1,404,700	1,425,700	1,425,300

Methodology:

1. The Centers for Medicare and Medicaid set the following premiums for 2019 and 2020.

Calendar Year	Part A	Part B
2019	$ 437.00	$ 135.50
2020	$ 458.00	$ 144.60

2. For 2021, the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance, is projecting a 4.59% growth in the Medicare Part A premium. Applying this growth to prior year Part A premium calculates as $458.00 x 1.0459 = $479.00 (rounded).

3. For 2021, the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance, is projecting a 3.73% growth in the Medicare Part B premium. Applying this growth to prior year Part B premium calculates as $144.60 x 1.0373 = $150.00 (rounded).

FY 2019-20	**Part A**	**Part B**
Average Monthly Beneficiaries	173,300	1,404,700
Rate 07/2019-12/2019	$437.00	$135.50
Rate 01/2020-06/2020	$458.00	$144.60

FY 2020-21	**Part A**	**Part B**
Average Monthly Beneficiaries	174,300	1,425,300
Rate 07/2020-12/2020	$458.00	$144.60
Rate 01/2021-06/2021	$479.00	$150.00

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

BASE POLICY CHANGE NUMBER: 173

Funding:

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
Title XIX 50/50	$3,085,297	$1,542,649	$1,542,649
State GF 100%	$264,225	$264,225	$0
Title XIX 100% FFP	$53,793	$0	$53,793
Total	**$3,403,315**	**$1,806,874**	**$1,596,442**

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
Title XIX 50/50	$3,285,226	$1,642,613	$1,642,613
State GF 100%	$281,713	$281,713	$0
Title XIX 100% FFP	$57,353	$0	$57,353
Total	**$3,624,292**	**$1,924,326**	**$1,699,966**

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER:	174
IMPLEMENTATION DATE:	1/2006
ANALYST:	Joulia Dib
FISCAL REFERENCE NUMBER:	1019

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$2,213,849,000	$2,365,613,000
- STATE FUNDS	$2,213,849,000	$2,365,613,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,213,849,000	$2,365,613,000
STATE FUNDS	$2,213,849,000	$2,365,613,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates Medi-Cal's Medicare Part D expenditures.

Authority:
The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003.

Interdependent Policy Changes:
Not Applicable

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

To help pay for this benefit, the federal government requires the states to contribute part of their savings for no longer providing the drug benefit to dual eligible beneficiaries. This is called the Phased-down Contribution or "clawback". In 2006, states were required to contribute 90% of their savings. This percentage decreased by 1 ⅔% each year until it reached 75% in 2015. The MMA of 2003 sets forth a formula to determine a state's "savings". The formula uses 2003 as a base year for states' dual eligible population drug expenditures and increases the average dual eligible drug costs by a growth factor to reach an average monthly phased-down contribution cost per dual eligible or the per member per month (PMPM) rate.

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

Calendar Year	PMPM rate
2017	$123.38
2018	$124.89
2019	$127.31
2020	$133.94
2021	$137.76 (estimated)

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER: 174

Medi-Cal's total payments on a cash basis and average monthly eligible beneficiaries by fiscal year:

Fiscal Year	Total Payment	Ave. Monthly Beneficiaries
FY 2016-17	$1,911,686,565	1,390,393
FY 2017-18	$2,094,822,127	1,409,284
FY 2018-19	$2,138,142,285	1,417,617

Reason for Change:
The change from the prior estimate for FY 2019-20 is due to a decrease in average monthly eligibles of approximately 1,900 or 0.1% based on six months of additional data. The change from the prior estimate for FY 2020-21 is due to a decrease in the estimated calendar year 2021 PMPM rate of $139.81 to $137.76.

The change between FY 2019-20 and FY 2020-21 is due to an estimated increase of $3.82 PMPM for calendar year 2021 and an estimated historical growth in average monthly eligibles of 33,500 or 2.4%.

Methodology:

1. The 2019 growth increased 1.94% over 2018 amounts per the *Centers for Medicare & Medicaid Services*. Medi-Cal's PMPM rate for 2019 is $127.31.

2. The 2020 growth increased 5.21% over 2019 amounts per the *Centers for Medicare & Medicaid Services*. Medi-Cal's PMPM rate for 2020 is $133.94.

3. The 2021 growth is estimated to increase 2.85% over 2020 amounts per the *Centers for Medicare & Medicaid Services*. Medi-Cal's estimated PMPM rate for 2021 is $137.76.

4. Phase-down payments have a two-month lag (i.e. the invoice for January is received in February and due in March).

5. The average monthly eligible beneficiaries are estimated using the growth trend in the monthly Part D enrollment data from May 2014 to January 2020.

6. The Phased-down Contribution is funded 100% by State General Fund.

	Payment Months	Est. Ave. Monthly Beneficiaries	Est. Ave. Monthly Cost	Total Cost
FY 2019-20	12	1,424,370	$184,487,440	**$2,213,849,000**
FY 2020-21	12	1,457,850	$197,134,450	**$2,365,613,000**

Funding:
100% GF (4260-101-0001)

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

BASE POLICY CHANGE NUMBER:	175
IMPLEMENTATION DATE:	7/1990
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	23

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$2,270,028,000	$2,312,584,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,270,028,000	$2,312,584,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$2,270,028,000	$2,312,584,000

DESCRIPTION

Purpose:
This policy change estimates the federal match for the California Department of Developmental Services (CDDS) for the Home & Community Based Services (HCBS) program.

Authority:
Interagency Agreement 01-15834

Interdependent Policy Changes:
Not Applicable

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

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

Reason for Change:
The change for FY 2019-20 and 2020-21, from the prior estimate, is an increase due to HCBS waiver population growth and higher service utilization.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is a net increase due to updated HCBS waiver caseload projections and expenditures expected in FY 2020-21.

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

BASE POLICY CHANGE NUMBER: 175

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	DHCS FFP
FY 2019-20	$4,540,056	$2,270,028	**$2,270,028**
FY 2020-21	$4,625,168	$2.312,584	**$2,312,584**

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

PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	176
IMPLEMENTATION DATE:	4/1993
ANALYST:	Manvir Lallian
FISCAL REFERENCE NUMBER:	22

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$1,938,182,000	$2,153,343,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,938,182,000	$2,153,343,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,938,182,000	$2,153,343,000

DESCRIPTION

Purpose:
This policy change provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS) for Medi-Cal beneficiaries participating in the In-Home Supportive Services (IHSS) programs: the Personal Care Services Program (PCSP) and the IHSS Plus Option (IPO) program administered by CDSS.

Authority:
Social Security Act (42 U.S.C., Section 1396, et. seq.)
PCSP Interagency Agreements (IA) 03-75676
IPO IA 09-86307
SB 1036 (Chapter 45, Statutes of 2012)
SB 1008 (Chapter 33, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

Background:
Eligible services are authorized under Title XIX of the federal Social Security Act (42 U.S.C., Section 1396, et. seq.). The Department draws down and provides FFP to CDSS through IA's for the IHSS PCSP and the IPO program.

SB 1008 enacted the Coordinated Care Initiative (CCI) which requires, in part, to mandatorily enroll dual eligibles into managed care for their Medi-Cal benefits. Those benefits include IHSS; see policy change CCI-Managed Care Payments for more information. Beginning April 1, 2014, some IHSS costs were paid through managed care capitation due to IHSS recipients transitioning into managed care. IHSS costs related to the recipients transitioning to managed care are budgeted in the CCI-Managed Care Payments policy change. Effective January 1, 2018, IHSS are no longer included in the managed care capitation, thus all costs for IHSS eligible services are captured in this policy change.

FFP for the county cost of administering the PCSP is in the Personal Care Services policy change located in the Other Administration section of the Estimate.

PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 176

The Governor's Budget estimates the CCI project will no longer be cost-effective. Therefore, pursuant to the provisions of current law, the program will be discontinued in 2017-18. Based on the lessons learned from the CCI demonstration project, the Budget proposes the extension of the Cal MediConnect program and the mandatory enrollment of dual eligible and integrating of long-term services and support, except IHSS, into managed care. IHSS were removed from capitation rate payments effective January 1, 2018.

Reason for Change:
The change for FY 2019-20 and FY 2020-21, from the previous estimate, is an increase due to updated expenditure data provided by CDSS. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to updated expenditure data provided by CDSS.

Methodology:
1) The following estimates were provided by CDSS on a cash basis.

(Dollars in Thousands)

Fiscal Years	TF	FFP	CDSS GF/ County Share
FY 2019-20	$3,876,364	**$1,938,182**	$1,938,182
FY 2020-21	$4,306,686	**$2,153,343**	$2,153,343

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

DENTAL SERVICES

BASE POLICY CHANGE NUMBER:	177
IMPLEMENTATION DATE:	7/1988
ANALYST:	Matt Wong
FISCAL REFERENCE NUMBER:	135

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$1,002,205,000	$1,015,986,000
- STATE FUNDS	$384,028,080	$409,459,380
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,002,205,000	$1,015,986,000
STATE FUNDS	$384,028,080	$409,459,380
FEDERAL FUNDS	$618,176,920	$606,526,620

DESCRIPTION

Purpose:
The policy change estimates the cost of dental services.

Authority:
Social Security Act, Title XIX
AB 82 (2013, Chapter 23), Section 14131.10 of the Welfare & Institutions Code

Interdependent Policy Changes:
N/A

Background:
These dental costs are for fee-for-service (FFS) Medi-Cal beneficiaries. Dental costs for beneficiaries with dental managed care plans are shown in the Dental Managed Care policy change.

Delta was awarded a multi-year Administrative Services Organization (ASO) contract in 2016. The ASO contractor is responsible for duties including claims processing, provider enrollment, and outreach of the Medi-Cal Dental Program. DXC Technology Services (DXC) was awarded a multi-year FI contract in 2016. DXC is responsible for all the FI services of the Medi-Cal Dental Program.

AB 82 restored partial adult optional dental benefits, including full mouth dentures. Effective May 1, 2014, the scope of covered adult dental services offered at any dental service-rendering location that serves Medi-Cal beneficiaries, including Federally Qualified Health Clinics (FQHCs) and Rural Health Centers (RHCs), is limited to the adult optional benefits restored May 1, 2014, in addition to adult dental benefits which include services for pregnant women, emergency services, Federally Required Adult Dental Services (FRADs), services provided at an Intermediate Care Facility/Skilled Nursing Facility, and services for Department of Developmental Services consumers. Effective January 1, 2018, the full restoration of adult dental benefits includes the remaining services which were not restored in 2014, such as restorative services (crowns), prosthodontic services (partial dentures), and endodontic services (root canals).

DENTAL SERVICES

BASE POLICY CHANGE NUMBER: 177

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is an increase due to updated increased check write actuals. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to the changes with the check write projection.

Methodology:
1. The FY 2019-20 and FY 2020-21 estimate for dental services assumes the average of the monthly check write invoice amounts since January 2019.

2. The estimates for Proposition 56 Supplemental Payments and Domain 2 of Dental Transformation Initiative are removed.

Funding (Totals may differ due to rounding):

FY 2019-20	**TF**	**GF**	**FF**
50% Title XIX / 50% GF	$675,444,000	$337,722,000	$337,722,000
ACA 93% (2019)	$88,170,000	$6,172,000	$81,998,000
ACA 90% (2020)	$88,170,000	$8,817,000	$79,353,000
Title 21 88% FFP	$37,462,000	$4,495,000	$32,967,000
Title 21 76.5% FFP	$112,387,000	$26,411,000	$85,976,000
T19 BCCTP 65% FFP	$168,000	$59,000	$109,000
100% GF	$352,000	$352,000	$0
100% FFP	$52,000	$0	$52,000
Total	**$1,002,205,000**	**$384,028,000**	**$618,177,000**
FY 2020-21	**TF**	**GF**	**FF**
50% Title XIX / 50% GF	$684,730,000	$342,365,000	$342,365,000
ACA 90% (2020)	$178,765,000	$17,876,000	$160,889,000
Title 21 76.5% FFP	$37,978,000	$8,925,000	$29,053,000
Title 21 65% FFP	$113,932,000	$39,876,000	$74,056,000
T19 BCCTP 65% FFP	$171,000	$60,000	$111,000
100% GF	$357,000	$357,000	$0
100% FFP	$53,000	$0	$53,000
Total	**$1,015,986,000**	**$409,459,000**	**$606,527,000**

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

BASE POLICY CHANGE NUMBER:	179
IMPLEMENTATION DATE:	7/1991
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	26

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$247,737,000	$248,594,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$247,737,000	$248,594,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$247,737,000	$248,594,000

DESCRIPTION

Purpose:
This policy change estimates the federal match for the California Department of Developmental Services (CDDS) for regional center targeted case management services provided to eligible developmentally disabled clients.

Authority:
Interagency Agreement (IA) 03-75284

Interdependent Policy Changes:
Not Applicable

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

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

Reason for Change:
The change for FY 2019-20, from the prior estimate, is an increase due to increased previous year expenditures based on actual claims.

The change for FY 2020-21, from the prior estimate, is an increase based on new services funded by this program.

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

BASE POLICY CHANGE NUMBER: 179

The change from FY 2019-20 to FY 2020-21, in the current estimate, is a net increase due to higher projected budget year paid expenditures coupled with a reduction in expected previous year expenditures in FY 2020-21.

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	DHCS FFP
FY 2019-20	$495,474	$247,737	**$247,737**
FY 2020-21	$497,188	$248,594	**$248,594**

Funding:
100% Title XIX (4260-101-0890)

DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

BASE POLICY CHANGE NUMBER:	183
IMPLEMENTATION DATE:	7/1997
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	77

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$65,300,000	$29,476,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$65,300,000	$29,476,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$65,300,000	$29,476,000

DESCRIPTION

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

Authority:
Interagency Agreement (IA) 03-75282
IA 03-75283

Interdependent Policy Changes:
Not Applicable

Background:
The Department entered into an IA with CDDS to reimburse the Federal Financial Participation (FFP) for Medi-Cal clients served at DCs and SOCFs. There are two DCs and one SOCF statewide. The Budget Act of 2003 included the implementation of a quality assurance (QA) fee on the entire gross receipts of any intermediate care facility. DCs and SOCFs are licensed as intermediate care facilities. This policy change also includes reimbursement for the federal share of the QA fee.

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

Reason for Change:
There is no change for FY 2019-20 or FY 2020-21, from the prior estimate. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease due to the reduction in Medi-Cal reimbursable facilities and decline in DC population.

DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

BASE POLICY CHANGE NUMBER: 183

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

(Dollars in Thousands)

Fiscal Year	Total Funds	CDDS GF	FFP Regular
FY 2019-20	$130,600	$65,300	**$65,300**
FY 2020-21	$58,952	$29,476	**$29,476**

Funding:
100% Title XIX (4260-101-0890)

MEDI-CAL TCM PROGRAM

BASE POLICY CHANGE NUMBER:	184
IMPLEMENTATION DATE:	6/1995
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	27

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$44,549,000	$32,950,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$44,549,000	$32,950,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$44,549,000	$32,950,000

DESCRIPTION

Purpose:
This policy change estimates the federal match provided to Local Government Agencies (LGAs) for the Targeted Case Management (TCM) program.

Authority:
Welfare & Institutions Code 14132.44
SB 910 (Chapter 1179, Statutes of 1991)

Interdependent Policy Changes:
Not Applicable

Background:
The TCM program provides funding to LGAs based on certified public expenditures incurred for assisting Medi-Cal beneficiaries in gaining access to needed medical, social, educational, and other services. TCM services include needs assessment, individualized service plans, referral, and monitoring/follow-up. Through rates established in the annual cost reports, LGAs submit invoices to the Department to claim federal financial participation (FFP) and receive interim payments. Counties are then required to submit annual cost reports which are audited by the Department and are used to reconcile those interim payments with a county's audited costs. Counties either receive additional funding if costs exceeded the interim payments or counties are required to reimburse the federal funds if interim payments exceeded their costs.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is due to a decrease in regular claims base and reconciliation estimates based on additional months of audit data.

FY 2020-21 increased from the prior estimate due higher projected regular claims reconciliation payments partially offset by a decrease in the regular claims base estimates based on additional months of audit data.

The change in FY 2019-20 to FY 2020-21, in the current estimate, is due to increased reconciliation recoupments and decreased reconciliation payments estimated in FY 2020-21.

MEDI-CAL TCM PROGRAM

BASE POLICY CHANGE NUMBER: 184

Methodology:

1. SPA #10-010, approved on December 19, 2013, and effective October 16, 2010, included interim and final reconciliations of LGAs costs for providing TCM.

2. The projected base payment amounts of $30,955,000 (regular invoices) and $2,944,000 (ACA invoices) for FY 2019-20 and FY 2020-21, are based on average expenditures from FY 2015-16 through the first half of FY 2019-20 for regular and ACA payments.

3. The Department will complete reconciliations for FY 2010-11 through FY 2017-18 in FYs 2019-20 and FY 2020-21.

FY 2019-20	**TF**	**FF**
FY 2019-20 Base (Average Expenditures)	$30,955,000	$30,955,000
FY 2019-20 Base (ACA Expenditures)	$2,994,000	$2,994,000
Reconciliation		
Regular Claims	$10,127,000	$10,127,000
ACA Claims	$473,000	$473,000
Total FY 2019-20	**$44,549,000**	**$44,549,000**

FY 2020-21	**TF**	**FF**
FY 2019-20 Base (Average Expenditures)	$30,955,000	$30,955,000
FY 2019-20 Base (ACA Expenditures)	$2,994,000	$2,994,000
Reconciliation		
Regular Claims	($953,000)	($953,000)
ACA Claims	($46,000)	($46,000)
Total FY 2020-21	**$32,950,000**	**$32,950,000**

Funding:

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

WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	185
IMPLEMENTATION DATE:	4/2000
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	32

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$47,030,000	$48,467,000
- STATE FUNDS	$23,515,000	$24,233,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$47,030,000	$48,467,000
STATE FUNDS	$23,515,000	$24,233,500
FEDERAL FUNDS	$23,515,000	$24,233,500

DESCRIPTION

Purpose:
This policy change estimates the costs associated with adding personal care services (PCS) to the Home and Community-Based Alternatives (HCBA) and In-Home Operations (IHO) Waivers.

Authority:
AB 668 (Chapter 896, Statutes of 1998)
Interagency Agreement (IA) 19-96360
AB 1811 (Chapter 35, Statutes of 2018)

Interdependent Policy Changes:
California Community Transitions (CCT) Costs

Background:
AB 668 authorized additional hours on behalf of eligible PCS program recipients if they needed more than the monthly hours allowed under the In-Home Supportive Services Program (IHSS) and qualified for the Medi-Cal Skilled Nursing Facility (NF) Level of Care (LOC) Home and Community Based Services (HCBS) Waiver program. NF Level A/B, NF Subacute (SA), and In-Home Medical Care Waivers were merged into two waivers called the HCBA Waiver and the IHO Waiver. These waivers provide HCBS to Medi-Cal eligible waiver participants using specific LOC criteria. Waiver Personal Care Services (WPCS) under these two waivers include services that differ from those in the State Plan which allow beneficiaries to remain at home. Although there is no longer a requirement that waiver consumers receive a maximum of 283 hours of IHSS prior to receiving WPCS, waiver consumers must be eligible to receive State Plan IHSS hours prior to accessing this waiver service. These services are provided by the counties' IHSS program providers and paid via an IA with the Department or will be provided by home health agencies and other qualified HCBS waiver provider types paid via the Medi-Cal fiscal intermediary.

The IHO Waiver ended on December 31, 2019. IHO Waiver beneficiaries were provided the option to transition into the HCBA Waiver, which covers all services they received on the IHO Waiver.

WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 185

On January 1, 2019, the minimum wage increased from $11.00 to $12.00 per hour. On January 1, 2020, the minimum wage increased from $12.00 to $13.00 per hour. Beginning January 1, 2021, the minimum wage will increase from $13.00 to $14.00 per hour.

Beginning FY 2018-19, the county, or the public authority or nonprofit consortium, as defined, deems to be the employer to meet and confer in good faith regarding wages, benefits, and other terms and conditions of employment of individuals providing WPCS. For service dates on or after the effective date of federal approval obtained by the Department, wages, benefits, and all other terms and conditions of employment for individuals providing WPCS would be required to be equal to the wages, benefits, and other terms and conditions of employment in the respective county for the individual provider mode of services in the IHSS program. If eligibility for benefits requires a provider to work a threshold number of hours, eligibility would be required to be determined based on the aggregate number of monthly hours worked between IHSS and WPCS. Beginning FY 2019-20, WPCS care providers will be able to access sick leave time.

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is an increase due to higher projected hours than initially expected based on FY 2018-19 actual data. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to anticipated minimum wage increases each calendar year through 2022.

Methodology:

1. Assume the number of current HCBA waiver beneficiaries using WPCS is estimated at 1,514 per month in FY 2019-20 and FY 2020-21.

2. Assume the number of IHO beneficiaries using WPCS is estimated at 40 per month through December 31, 2019.

3. The Department's CCT Demonstration Project expects to transition 195 beneficiaries out of inpatient extended health care facilities in FY 2019-20 and FY 2020-21. Based on actual data from July 2017 through June 2018, the Department assumes 3.43% of CCT beneficiaries will use WPCS in CY 2019, CY 2020, and CY 2021.

4. Assume the Department of Social Services will pay approximately 66% of benefit costs for providers that use IHSS and WPCS hours to qualify for benefits.

5. The average cost/hour is $13.02 for FY 2019-20 and $13.69 FY 2020-21.

6. The chart below displays the estimate on an accrual basis.

FY 2019-20	Total Hours	Cost/Hour	TF	GF	FF
HCBA Waiver	3,541,724	$13.02	$46,113,000	$23,057,000	$23,056,000
IHO Waiver	70,080	$13.02	$912,000	$456,000	$456,000
Total			**$47,025,000**	**$23,513,000**	**$23,512,000**

WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 185

FY 2020-21	Total Hours	Cost/Hour	TF	GF	FF
HCBA Waiver	3,541,724	$13.69	$48,486,000	$24,243,000	$24,243,000
Total			**$48,486,000**	**$24,243,000**	**$24,243,000**

7. The chart below is adjusted on a cash basis.

(Dollars in Thousands)	TF	GF	FF
FY 2019-20 Total	**$47,030**	**$23,515**	**$23,515**
FY 2020-21 Total	**$48,467**	**$24,234**	**$24,233**

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

LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER:	187
IMPLEMENTATION DATE:	7/2017
ANALYST:	Latoya Brown
FISCAL REFERENCE NUMBER:	2080

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$38,015,000	$32,350,000
- STATE FUNDS	$19,007,500	$16,175,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$38,015,000	$32,350,000
STATE FUNDS	$19,007,500	$16,175,000
FEDERAL FUNDS	$19,007,500	$16,175,000

DESCRIPTION

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

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
State Legislature appropriates State dollars to pay the costs related to Medi-Cal lawsuits and claims. Larger lawsuit settlement amounts require both State Legislature and the Governor's approval for payment. Federal financial participation is claimed for all eligible lawsuit settlements approved by the Legislature and the Governor.

Reason for Change:
The change from FY 2019-20, from the prior estimate, is due to an increase in the number of matters subject to settlement and lawsuit payments. The increase for FY 2019-20, in the current estimate, is due to additional legal matters requiring payment having been concluded.

LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER: 187

Methodology:

FY 2019-20	**Total Amount**
Attorney Fees	
Mark Lazerson v. Partnership Health Plan & DHCS	$21,000
Centinela Freeman Emergency Medical Association, et al. v. DHCS	$6,000
Powers v. Kent	$10,000
Total	$37,000
Provider Settlements	
CHA Hollywood Medical Center, L.P., et al. v. DHCS	$16,000
Total	$16,000
Other Attorney Fees	
Ivory N. and James B. v. Kent, et al.	$435,000
Thomas v. Kent	$1,450,000
Evan F. v. Kent	$100,000
Centinela Freeman Medical Associates, et al. v. Maxwell-Jolly	$775,000
Tran, et al. v. Kent	$126,000
Independent Living Center, et al. v. Kent, et al. (Hooper, Lundy and Bookman)	$4,255,000
Jane H. v. Kent	$445,000
Total	$7,586,000
Other Provider Settlements	
LA Care	$31,000,000
AHF	($624,000)
Total	$30,376,000
FY 2019-20 Total	**$38,015,000**
FY 2020-21	**Total Amount**
Other Provider Settlements	
LA Care	$31,000,000
Total	$31,000,000
FY 2020-21 Total	**$31,000,000**

LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER: 187

FY 2019-20			
	Committed	**Balance**	**Budgeted**
Attorney Fees <$30,000	$37,000	$163,000	$200,000
Provider Settlements <$100,000	$16,000	$984,000	$1,000,000
Beneficiary Settlements <$10,000	$0	$150,000	$150,000
Small Claims Court	$0	$0	$0
Other Attorney Fees	$7,586,000	$0	$7,586,000
Other Provider Settlements	$30,376,000	$0	$30,376,000
Other Beneficiary Settlements	$0	$0	$0
Interest Paid	$0	$0	$0
Totals (Rounded)	**$38,015,000**	**$1,297,000**	**$39,312,000**

FY 2020-21	
	Budgeted
Attorney Fees<$30,000;Provider Settlements<$100,000; Beneficiary Settlements<$10,000	$1,350,000
Other Attorney Fees	$0
Other Provider Settlements	$31,016,000
Other Beneficiary Settlements	$0
Interest Paid	$0
Totals (Rounded)	**$32,350,000**

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

CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	195
IMPLEMENTATION DATE:	7/1997
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1083

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$2,160,000	$1,028,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,160,000	$1,028,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$2,160,000	$1,028,000

DESCRIPTION

Purpose:
This policy change estimates the federal match provided to the California Department of Public Health (CDPH) for benefit costs associated with the Childhood Lead Poisoning Prevention (CLPP) program.

Authority:
Interagency Agreement (IA) 07-65689

Interdependent Policy Changes:
Not Applicable

Background:
The CLPP program provides case management services utilizing revenues collected from fees. County governments receive the CLPP revenues matched with the federal funds for case management services provided to Medi-Cal beneficiaries. The federal match is provided to CDPH through an IA.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21.

The change in the current estimate, from FY 2019-20 to FY 2020-21, is due to more prior year claims paid in FY 2019-20.

Methodology:
1. Annual expenditures on an accrual basis are $1,028,000. Cash basis expenditures vary from year-to-year based on when claims are actually paid.

CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 195

2. The estimates are provided by CDPH on a cash basis.

FY 2019-20	DHCS FFP	CDPH CLPP Fee Funds
FY 2017-18 Benefits Costs	$618,000	$618,000
FY 2018-19 Benefits Costs	$771,000	$771,000
FY 2019-20 Benefits Costs	$771,000	$771,000
Total for FY 2019-20	**$2,160,000**	$2,160,000

FY 2020-21	DHCS FFP	CDPH CLPP Fee Funds
FY 2019-20 Benefits Costs	$257,000	$257,000
FY 2020-21 Benefits Costs	$771,000	$771,000
Total for FY 2020-21	**$1,028,000**	$1,028,000

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

HIPP PREMIUM PAYOUTS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	196
IMPLEMENTATION DATE:	7/2019
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	91

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$744,000	$672,000
- STATE FUNDS	$372,000	$336,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$744,000	$672,000
STATE FUNDS	$372,000	$336,000
FEDERAL FUNDS	$372,000	$336,000

DESCRIPTION

Purpose:
This policy change estimates the cost of the payouts for the Department's Health Insurance Premium Payment (HIPP) program.

Authority:
Welfare & Institutions Code 14124.91
Social Security Act 1905(a), 1906(a)(3), 1906A(e), and 1916(e)
Title 22 California Code of Regulations 50778 (Chapter 2, Article 15)
State Plan Amendment 19-0045

Interdependent Policy Changes:
Not Applicable

Background:
The HIPP program is a voluntary program for full-scope Medi-Cal beneficiaries who have a high cost medical condition. Under the HIPP program, the Department pays for premiums, coinsurance, deductibles, and other cost sharing obligations when it is cost effective. HIPP program costs are budgeted separately from other Medi-Cal benefits since these are paid outside of the regular Medi-Cal claims payment procedures. The Centers for Medicare and Medicaid Services (CMS) approved State Plan Amendment (SPA) 19-0045 allowing the Department to revise the methodology for determining cost effectiveness and introduce new eligibility criteria for the HIPP program. The Department will begin operating under the new methodology beginning January 2021.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is based on a decrease of actual expenditures from July 2019 to January 2020 and reduced program enrollment.

The decrease in FY 2020-21, from the prior estimate, is due to the new eligibility criteria that will limit the number of program enrollments starting January 2021.

HIPP PREMIUM PAYOUTS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 196

The decrease from FY 2019-20 to FY 2020-21, in the current estimate, is due to the new eligibility criteria that will limit the number of program enrollments starting January 2021.

Methodology:

1. HIPP premium costs are determined by:
   - Actual premium expense for the first half of FY 2019-20,
   - Projected premium expense for the remainder of FY 2019-20,
   - The average monthly per member per month (PMPM) premium amount,
   - Current member count, and
   - The assumption that premium costs will increase by 5% each fiscal year based on historical trends.

2. The average monthly PMPM premium cost including ancillary costs is estimated to be $443 in FY 2019-20 and $465 in FY 2020-21.

3. The average monthly HIPP enrollment is estimated to be 140 in FY 2019-20. Due to the new eligibility criteria beginning in January 2021, program enrollment is expected to decrease by 95% over the course of the 2021 calendar year (CY). As a result, it is estimated there will be a decline of 8% per month from January 2021 through June 2021 (95% / 12 months = 7.92% monthly, rounded to 8%).

4. Costs for FY 2019-20 and FY 2020-21 are estimated to be:

   FY 2019-20: $372,000 (actuals for July to December 2019) + $372,000 (projection for January to June 2020) = **$744,000 TF ($372,000 GF)**

   FY 2020-21: $390,600 (projection for July to December 2020) + $281,000 (projection for January to June 2021 = **$672,000 TF ($336,000 GF)**

Funding:

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

BASE RECOVERIES

BASE POLICY CHANGE NUMBER:	212
IMPLEMENTATION DATE:	7/1987
ANALYST:	Stephanie Hockman
FISCAL REFERENCE NUMBER:	127

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$427,966,000	-$497,873,000
- STATE FUNDS	-$192,609,000	-$224,071,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$427,966,000	-$497,873,000
STATE FUNDS	-$192,609,000	-$224,071,000
FEDERAL FUNDS	-$235,357,000	-$273,802,000

DESCRIPTION

Purpose:
This policy change estimates estate, personal injury, workers' compensation, provider/beneficiary overpayments, and other insurance recoveries used to offset the cost of Medi-Cal services.

Authority:
- Welfare & Institutions Code 10022, 14009, 14009.5, 14024, 14124.70 – 14124.795, 14124.81-14124.86, 14124.90-14124.94, 14172, 14172.5, 14173, 14176, and 14177
- Probate Code Sections 215, 9202, 19202, 3600-3605, and 3610-3613
- Title 22, California Code of Regulations Chapter 2.5 and Sections 50489.9, 50781-50791, 51045, 51047, and 51458.1
- United States Code 42, 1396a(25)

Interdependent Policy Changes:
Not Applicable

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

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

BASE RECOVERIES

BASE POLICY CHANGE NUMBER: 212

Overall, FY 2019-20 and FY 2020-21 recoveries are projected to be lower than the prior estimate.

- The expansion of health insurance recoveries for Mental Health/Substance Use Disorder (MH/SUD), Dental, and Managed Care plans are postponed due to operational delays in implementation,
  - MH/SUD and Dental recoveries have shifted to FY 2020-21 and future fiscal years,
  - Managed Care recoveries are projected to begin later in FY 2020-21, shifting some recoveries into future fiscal years,
- Estate recoveries continue to decline due to changes in the Medi-Cal Estate Recovery program, limiting the types of estates and services the Department is allowed to collect pursuant to Senate Bill 833 implemented January 1, 2017, and
- Decreases are partially offset by multiple one-time high value audits in provider overpayment collections in FY 2019-20.

Recoveries are projected to grow approximately 16% between fiscal years due to:

- The delayed expansion of health insurance recoveries to FY 2020-21, and
- Lower FY 2020-21 projected provider overpayment collections excluding one-time recoveries occurring in FY 2019-20 offset some of the projected health insurance recoveries expansion.

(Dollars in Thousands)

Recovery Type	FY 2019-20	FY 2020-21
Personal Injury Collections	($120,672)	($119,727)
Workers' Comp. Collections	($2,120)	($2,120)
Health Insurance Contingency Contract	($83,000)	($170,000)
General Collections	($222,174)	($206,026)
TOTAL	**($427,966)**	**($497,873)**

Methodology:

1. The recoveries estimate uses the trend in monthly recoveries for July 2016 – January 2020.

2. The General Fund ratio for collections is estimated to be 45.01% in FY 2019-20 and FY 2020-21.

Funding:

100% GF (4260-101-0001)
100% Title XIX (4260-101-0890)

TABLE OF CONTENTS

REGULAR POLICY CHANGES

The Regular Policy Changes section provides detailed benefits expenditures information by policy according to program area. This section includes new program policies and other estimated expenditures that are not captured in the base expenditures.

MEDI-CAL PROGRAM REGULAR POLICY CHANGES 1-528

POLICY CHANGE INDEX 1-7
ELIGIBILITY 8
AFFORDABLE CARE ACT 41
BENEFITS 61
PHARMACY 105
DRUG MEDI-CAL 130
MENTAL HEALTH 142
WAIVER-MH/UCD & BTR 160
MANAGED CARE 200
PROVIDER RATES 231
SUPPLEMENTAL PAYMENTS 286
OTHER DEPARTMENTS 390
OTHER 391
COVID-19 490

MEDI-CAL PROGRAM REGULAR
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	ELIGIBILITY
1	UNDOCUMENTED YOUNG ADULTS FULL SCOPE EXPANSION
2	MEDI-CAL STATE INMATE PROGRAMS
3	BREAST AND CERVICAL CANCER TREATMENT
7	FPL INCREASE FOR AGED AND DISABLED PERSONS
8	MEDI-CAL COUNTY INMATE PROGRAMS
9	PROVISIONAL POSTPARTUM CARE EXTENSION
10	CS3 PROXY ADJUSTMENT
11	MEDI-CAL COUNTY INMATE REIMBURSEMENT
12	CDCR RETRO REPAYMENT
13	NON-OTLICP CHIP
14	NON-EMERGENCY FUNDING ADJUSTMENT
15	SCHIP FUNDING FOR PRENATAL CARE
16	CCHIP DELIVERY SYSTEM
17	MEDICARE OPTIONAL EXPANSION ADJUSTMENT
18	CHIP PREMIUMS
19	MINIMUM WAGE INCREASE - CASELOAD SAVINGS
216	MEDICARE PART B DISREGARD
232	DISABLED ADULT CHILDREN PROGRAM CLEANUP
266	HEARING AID COVERAGE - ADMIN
	AFFORDABLE CARE ACT
20	COMMUNITY FIRST CHOICE OPTION
21	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS
22	HEALTH INSURER FEE
23	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.
24	1% FMAP INCREASE FOR PREVENTIVE SERVICES
25	ACA MAGI SAVINGS
26	PAYMENTS TO PRIMARY CARE PHYSICIANS
27	ACA OPTIONAL EXPANSION MLR RISK CORRIDOR
28	ACA DSH REDUCTION
	BENEFITS
29	BEHAVIORAL HEALTH TREATMENT
30	FAMILY PACT PROGRAM
31	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS
32	LOCAL EDUCATION AGENCY (LEA) PROVIDERS
33	LEA EXPANSION
34	RESTORATION OF ADULT OPTICIAN & OPTICAL LAB SVCS

MEDI-CAL PROGRAM REGULAR
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	BENEFITS
35	MSSP SUPPLEMENTAL PAYMENTS
36	CALIFORNIA COMMUNITY TRANSITIONS COSTS
37	OPTIONAL BENEFITS RESTORATION
38	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA
39	CCS DEMONSTRATION PROJECT
40	MEDI-CAL NONMEDICAL TRANSPORTATION
41	MEDICALLY TAILORED MEALS PILOT PROGRAM
42	YOUTH REGIONAL TREATMENT CENTERS
43	PEDIATRIC PALLIATIVE CARE WAIVER
44	FREE CLINIC OF SIMI VALLEY
45	CCT FUND TRANSFER TO CDSS
46	DIABETES PREVENTION PROGRAM
47	ASTHMA MITIGATION PROJECT
48	EXPANSION TO SCREENING FOR ADDITIONAL SUBSTANCES
49	MEDICAL INTERPRETERS PILOT PROJECT
50	WHOLE CHILD MODEL IMPLEMENTATION
	PHARMACY
52	MEDI-CAL RX - MANAGED CARE PHARMACY BENEFIT TO FFS
53	MEDI-CAL DRUG REBATE FUND
54	BLOOD FACTOR REIMBURSEMENT METHODOLOGY
55	MEDI-CAL RX - ADDITIONAL SAVINGS FROM MAIC IN FFS
56	BCCTP DRUG REBATES
57	FAMILY PACT DRUG REBATES
58	LITIGATION SETTLEMENTS
59	MEDICAL SUPPLY REBATES
60	STATE SUPPLEMENTAL DRUG REBATES
62	FEDERAL DRUG REBATES
237	PHARMACY RETROACTIVE ADJUSTMENTS
	DRUG MEDI-CAL
63	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER
67	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT
69	DRUG MEDI-CAL MAT BENEFIT
70	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
238	DMC & SMHS STATE ONLY CLAIMING ADJUSTMENT

MEDI-CAL PROGRAM REGULAR
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	MENTAL HEALTH
73	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT
74	MHP COSTS FOR CONTINUUM OF CARE REFORM
75	PATHWAYS TO WELL-BEING
76	LATE CLAIMS FOR SMHS
77	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT
79	CHART REVIEW
80	INTERIM AND FINAL COST SETTLEMENTS - SMHS
	WAIVER--MH/UCD & BTR
81	GLOBAL PAYMENT PROGRAM
82	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL
83	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS
84	BTR - LIHP - MCE
85	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE
86	MH/UCD—STABILIZATION FUNDING
87	WHOLE PERSON CARE HOUSING SERVICES
88	MH/UCD—SAFETY NET CARE POOL
89	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG
90	MH/UCD—HEALTH CARE COVERAGE INITIATIVE
91	BTR - LOW INCOME HEALTH PROGRAM - HCCI
243	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM
	MANAGED CARE
95	CCI-MANAGED CARE PAYMENTS
96	MANAGED CARE HEALTH CARE FINANCING PROGRAM
97	MANAGED CARE PUBLIC HOSPITAL EPP
100	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL
101	MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES
103	RETRO MC RATE ADJUSTMENTS
104	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS
107	CCI-QUALITY WITHHOLD REPAYMENTS
108	GENERAL FUND REIMBURSEMENTS FROM DPHS
110	CAPITATED RATE ADJUSTMENT FOR FY 2020-21
111	MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.
112	MCO ENROLLMENT TAX MANAGED CARE PLANS
113	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND
114	COORDINATED CARE INITIATIVE RISK MITIGATION
115	RECOUPMENT OF UNALLOWED CAPITATION PAYMENTS

MEDI-CAL PROGRAM REGULAR
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	MANAGED CARE
116	MANAGED CARE DRUG REBATES
218	2020 MCO ENROLLMENT TAX MANAGED CARE PLANS
219	2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ
220	2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.
234	SAN MATEO HEALTH PLAN REIMBURSEMENT
255	ADJUST MC CAP PAYMENTS FOR JULY 2019-DEC 2020
258	MANAGED CARE EFFICIENCIES
	PROVIDER RATES
117	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF
118	RATE INCREASE FOR FQHCS/RHCS/CBRCS
119	AB 1629 ANNUAL RATE ADJUSTMENTS
120	FQHC/RHC/CBRC RECONCILIATION PROCESS
121	PROP 56 - HOME HEALTH RATE INCREASE
122	DPH INTERIM RATE GROWTH
123	LTC RATE ADJUSTMENT
124	DPH INTERIM & FINAL RECONS
125	PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE
127	EMERGENCY MEDICAL AIR TRANSPORTATION ACT
128	HOSPICE RATE INCREASES
129	DPH INTERIM RATE
130	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
131	AB 97-RELATED ADJUSTMENT
132	DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT
133	LABORATORY RATE METHODOLOGY CHANGE
134	10% PROVIDER PAYMENT REDUCTION
135	DENTAL RETROACTIVE RATE CHANGES
136	REDUCTION TO RADIOLOGY RATES
223	NURSING FACILITY FINANCING REFORM
226	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE
	SUPPLEMENTAL PMNTS.
137	HOSPITAL QAF - FFS PAYMENTS
138	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS
139	HOSPITAL QAF - MANAGED CARE PAYMENTS
140	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS
141	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS
142	PRIVATE HOSPITAL DSH REPLACEMENT

MEDI-CAL PROGRAM REGULAR
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	SUPPLEMENTAL PMNTS.
143	PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES
144	PROP 56 - MEDI-CAL FAMILY PLANNING
145	DSH PAYMENT
146	PROP 56 - VALUE-BASED PAYMENT PROGRAM
147	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
148	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
149	CAPITAL PROJECT DEBT REIMBURSEMENT
150	FFP FOR LOCAL TRAUMA CENTERS
151	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS
152	NDPH IGT SUPPLEMENTAL PAYMENTS
153	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS
154	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
155	GEMT SUPPLEMENTAL PAYMENT PROGRAM
156	PROP 56 - DEVELOPMENTAL SCREENINGS
157	PROP 56 - CBAS SUPPLEMENTAL PAYMENTS
158	PROP 56 - ADVERSE CHILDHOOD EXPERIENCES SCREENINGS
159	DPH PHYSICIAN & NON-PHYS. COST
160	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
161	PROP 56 - NEMT SUPPLEMENTAL PAYMENTS
162	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
163	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
164	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS
165	NDPH SUPPLEMENTAL PAYMENT
166	PROP 56 - HOSP-BASED PEDIATRIC PHYS SUPPL PYMTS
167	PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS
168	PROPOSITION 56 FUNDS TRANSFER
169	PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS
170	PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS
171	IGT ADMIN. & PROCESSING FEE
221	IGT PAYMENTS FOR HOSPITAL SERVICES
227	NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS
	COVID-19
245	COVID-19 UNINSURED ELIGIBILITY GROUP
246	COVID-19 ADDITIONAL IMPACTS
247	COVID-19 UTILIZATION CHANGE
248	COVID-19 EMERGENCY FMAP - OTHER DEPTS
249	COVID-19 BEHAVIORAL HEALTH

MEDI-CAL PROGRAM REGULAR
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	COVID-19
250	COVID-19 EMERGENCY FMAP - DHCS
251	COVID-19 CASELOAD IMPACT
	OTHER DEPARTMENTS
172	ELECTRONIC VISIT VERIFICATION PHASE II FED PENALTY
267	ADDITIONAL FEDERAL FUNDING TO OTHER DEPT.
	OTHER
178	CCI IHSS RECONCILIATION
180	QAF WITHHOLD TRANSFER
181	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS
182	ARRA HITECH - PROVIDER PAYMENTS
186	PAYMENT FOR REPROCESSED CLAIMS FOR FQHC/RHC
188	INFANT DEVELOPMENT PROGRAM
189	PROP 56 - PROVIDER ACES TRAININGS
190	MINIMUM WAGE INCREASE FOR HCBS WAIVERS
191	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS
192	OVERTIME FOR WPCS PROVIDERS
193	INDIAN HEALTH SERVICES
194	WPCS WORKERS' COMPENSATION
198	FUNDING ADJUST.—OTLICP
199	PROP 56 PHYSICIANS & DENTISTS LOAN REPAYMENT PROG
200	CMS DEFERRED CLAIMS
201	INDIAN HEALTH SERVICES FUNDING SHIFT
202	FUNDING ADJUST.—ACA OPT. EXPANSION
203	CLPP FUND
204	HOSPITAL QAF - CHILDREN'S HEALTH CARE
205	AUDIT SETTLEMENTS
206	IMD ANCILLARY SERVICES
207	CIGARETTE AND TOBACCO SURTAX FUNDS
208	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER RENEWAL
210	COUNTY SHARE OF OTLICP-CCS COSTS
211	ASSISTED LIVING WAIVER EXPANSION
213	PURE PREMIUM FUND CLOSEOUT
233	REPAYMENT TO CMS FOR CONTINGENCY FEE OFFSETS
236	TRIBAL FEDERALLY QUALIFIED HEALTH CENTER
242	SELF-DETERMINATION PROGRAM - CDDS

MEDI-CAL PROGRAM REGULAR
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	OTHER
244	STATE ONLY CLAIMING ADJUSTMENTS
261	FUND 3156 TRANSFER TO THE GENERAL FUND
262	FUND 3311 TRANSFER TO THE GENERAL FUND
263	ELECTRONIC CIGARETTE PRODUCTS TAX
265	RECONCILIATION

UNDOCUMENTED YOUNG ADULTS FULL SCOPE EXPANSION

REGULAR POLICY CHANGE NUMBER:	1
IMPLEMENTATION DATE:	1/2020
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	2127

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$109,842,000	$343,844,000
- STATE FUNDS	$77,398,000	$238,921,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	5.12 %	2.49 %
APPLIED TO BASE		
TOTAL FUNDS	$104,218,100	$335,282,300
STATE FUNDS	$73,435,220	$232,971,870
FEDERAL FUNDS	$30,782,870	$102,310,420

DESCRIPTION

Purpose:
This policy change estimates the benefit costs to expand full-scope Medi-Cal benefits to adults 19-25 years of age, regardless of immigration status.

Authority:
SB 104 (Chapter 67, Statutes of 2019)

Interdependent Policy Changes:
Not Applicable

Background:
California provides restricted-scope Medi-Cal coverage (emergency and pregnancy related services only) to low income undocumented adults. Federal financial participation (FFP) is available, regardless of immigration status, for emergency and pregnancy related services. Individuals who are between 19-25 years of age and who do not have satisfactory immigration status or are unable to verify satisfactory immigration status or citizenship will be eligible for full scope Medi-Cal benefits. California will continue to receive FFP for the emergency and pregnancy related services; however, any non-emergency services provided will be ineligible for FFP and funded solely by the State's General Fund.

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is an increase due to updated eligible and restricted scope expenditures data. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to FY 2020-21 projecting a full year of costs.

Methodology:
1. Program implementation occurred on January 1, 2020.

2. In-Home Supportive Services (IHSS) are not budgeted in this policy change as they are included in the budget for the Department of Social Services. IHSS costs are estimated to be $2,231,000 in FY 2019-20 and $31,213,000 in FY 2020-21.

UNDOCUMENTED YOUNG ADULTS FULL SCOPE EXPANSION

REGULAR POLICY CHANGE NUMBER: 1

3. The Department assumes approximately 105,000 adults from two populations will transition to full-scope benefits by FY 2020-21, current restricted-scope adults and adults that are currently eligible, but have not enrolled into Medi-Cal.

4. Undocumented full-scope children turning 19 and current restricted-scope undocumented adults aged 19-25 will be passively enrolled into full-scope Medi-Cal.

5. Assume 100% of the undocumented adults that are eligible, but not enrolled will take up phased-in coverage over 12 months.

6. Assume offsetting cost savings for those currently enrolled in restricted-scope Medi-Cal that will transition into full-scope Medi-Cal.

7. Net expenditures are expected to be:

(Dollars in Thousands)

Full-Scope Costs for Young Adults	TF	GF	FF
FY 2019-20	$109,842	$77,398	$32,444
FY 2020-21	$343,844	$238,921	$104,923

Funding:
100%Title XIX FFP (4260-101-0890)
100% GF (4260-101-0001)

MEDI-CAL STATE INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER:	2
IMPLEMENTATION DATE:	12/2016
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1569

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$62,206,000	$84,662,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$62,206,000	$84,662,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$62,206,000	$84,662,000

DESCRIPTION

Purpose:
This policy change estimates the federal financial participation (FFP) provided to the California Department of Corrections and Rehabilitation (CDCR)/California Correctional Health Care Services (CCHCS) for the costs of providing inpatient services for adult and juvenile inmates who are deemed eligible for Medi-Cal. This includes health care services to former inmates who have been granted medical parole.

Authority:
AB 1628 (Chapter 729, Statutes of 2010)
SB 1399 (Chapter 405, Statutes of 2010)
AB 396 (Chapter 394, Statutes of 2011)

Interdependent Policy Changes:
Not Applicable

Background:
AB 1628 (Chapter 729, Statutes of 2010) authorizes the Department and the CDCR to:

- Claim FFP for inpatient hospital services to Medi-Cal eligible adult inmates in State correctional facilities when these services are provided off the grounds of the facility. Previously these services were paid by the CDCR with 100% GF. Effective April 1, 2011, the Department began accepting Medi-Cal applications from the CCHCS for eligibility determinations for State inmates, retroactive to November 1, 2010. The Department will budget the FFP for services and CCHCS administrative costs and the CCHCS will continue to budget the General Fund (GF).

SB 1399 (Chapter 405, Statutes of 2010) authorizes the Board of Parole Hearings to:

- Grant medical parole to permanently medically incapacitated State inmates. State inmates granted medical parole are potentially eligible for Medi-Cal. When a State inmate is granted medical parole, the CCHCS submits a Medi-Cal application to the Department to determine eligibility. Previously these services were funded through the CDCR with 100% GF.

MEDI-CAL STATE INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 2

AB 396 (Chapter 394, Statutes of 2011) authorizes the Department and the CDCR to:

- Claim FFP for inpatient hospital services provided to Medi-Cal eligible juvenile inmates, in State correctional facilities, when these services are provided off the grounds of the facility. Previously these services were paid by the CDCR with 100% GF.

For State inmates, with implementation of the Affordable Care Act (ACA), the CDCR utilizes the Single Streamlined Application, currently used by counties, and the Department makes an eligibility determination according to current standard Medi-Cal eligibility rules. Federal Medicaid regulations and federal guidance provided to states, allow for coverage of specified services to eligible inmates when provided off the grounds of a correctional facility. The Department currently has an interagency agreement with the CCHCS in order to claim Title XIX FFP.

These programs require adherence to the utilization review requirements established by the Superior System Waiver.

Reason for Change:
The change in FY 2019-20 and FY 2020-21, from the prior estimate, is due to shifting the Retroactive Payments from FY 2019-20 to FY 2020-21. Additionally, there is an overall decrease in FY 2019-20 and FY 2020-21 due to updating the estimates with actuals based on current invoices from FY 2019-20.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to completing all the Retroactive Payments in FY 2020-21.

Methodology:

1. The adult State inmate program began in November 2010. Eligibility began in April 2011 with claiming beginning in April 2012. The Medical Parole program began in June 2011 with claiming beginning in April 2013. The juvenile State inmate program began in January 2012 with claiming beginning in April 2013.

2. Estimated costs for FY 2019-20 and FY 2020-21 are annualized projections primarily based on actual claims data for FY 2019-20 quarter 1 and quarter 2.

3. Assume $22,456,000 FF in retroactive payments will be paid in FY 2020-21 starting in October 2020.

4. The Department will continue to pay ACA payments based on the Federal Medical Assistance Percentage of 100% for calendar years 2014 through 2016, 95% for calendar year 2017, 94% for calendar year 2018, 93% for calendar year 2019, and 90% for calendar year 2020 and beyond.

5. Assume a six-month lag in ongoing payments.

6. The Non-Federal share for this policy change is budgeted in the CDCR's budget. Included below is the total estimated FFP, including retroactive payments, for the Medi-Cal Inpatient Hospital Costs for all eligible (Non-ACA and ACA) adult and juvenile inmates in FY 2019-20 and FY 2020-21:

MEDI-CAL STATE INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 2

FY 2019-20	TF	FF
Adults - Non ACA	$17,321,000	$8,660,000
Adults - ACA	$58,778,000	$52,900,000
Medical Parole	$1,282,000	$641,000
Juveniles	$9,000	$5,000
Total FY 2019-20	$77,390,000	**$62,206,000**

FY 2020-21	TF	FF
Adults - Non ACA	$17,321,000	$8,660,000
Adults - ACA	$58,778,000	$52,900,000
Medical Parole	$1,282,000	$641,000
Juveniles	$9,000	$5,000
Total Retroactive Payments ACA	$7,490,000	$7,490,000
Total Retroactive Payments Non-ACA	$29,932,000	$14,966,000
Total FY 2019-20	$114,812,000	**$84,662,000**

*Totals may differ due to rounding.

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

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER:	3
IMPLEMENTATION DATE:	1/2002
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	3

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$65,373,000	$65,865,000
- STATE FUNDS	$41,133,350	$41,404,900
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$65,373,000	$65,865,000
STATE FUNDS	$41,133,350	$41,404,900
FEDERAL FUNDS	$24,239,650	$24,460,100

DESCRIPTION

Purpose:
This policy change estimates the fee-for-service (FFS) costs of the Breast and Cervical Cancer Treatment Program (BCCTP).

Authority:
AB 430 (Chapter 171, Statutes of 2001)
AB 1810 (Chapter 34, Statutes of 2018)

Interdependent Policy Changes:
Not Applicable

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

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

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

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER: 3

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is a slight decrease due to updating the enrollment data for May 2019 through October 2019. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a slight increase due to higher expenditures anticipated in FY 2020-21.

Methodology:

1. As of July 2019, there were a total of 4,863 beneficiaries, of which 3,302 were in FFS and 1,561 were in managed care. Additionally, 1,927 of the FFS beneficiaries were eligible for State-Only services.

2. As of July 2019, 128 of the FFS beneficiaries were in accelerated enrollment.

3. Assume the State will pay Medicare and other health coverage premiums for an average of 295 beneficiaries monthly in FY 2019-20 and FY 2020-21. Assume an average monthly premium cost per beneficiary of $165.06.

4. Assume 45% of beneficiaries will require a third year of treatment, and 20% of those beneficiaries will require a fourth year of treatment.

5. In FY 2017-18, AB 1795 increased State-Only BCCTP coverage necessary for the treatment of breast/cervical cancer recurrences with coverage limits of 18 to 24 months.

6. In FY 2018-19, AB 1810 removed the coverage limits for State-Only BCCTP.

7. Managed Care costs associated with the BCCTP are budgeted in the Two-Plan, County Organized Health Systems, Geographic Managed Care, and Regional Model policy changes.

8. FFS costs are estimated as follows:

(Dollars in Thousands)

FFS Costs	FY 2019-20			FY 2020-21		
	TF	GF	FF	TF	GF	FF
Full Scope Costs	$37,481	$13,241	$24,240	$37,822	$13,362	$24,460
State-Only Services	$27,308	$27,308	$0	$27,459	$27,459	$0
State-Only Premiums	$584	$584	$0	$584	$584	$0
Total	**$65,373**	**$41,133**	**$24,240**	**$65,865**	**$41,405**	**$24,460**

Funding:

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
General Fund 4260-101-0001	$27,892	$27,892	$0
50 Title XIX FF / 50 GF (4260-101-0890/0001)	$820	$410	$410
Title XIX 65 FF / 35 GF (4260-101-0890/0001)	$36,661	$12,831	$23,830
Total	**$65,373**	**$41,133**	**$24,240**

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER: 3

FY 2020-21	TF	GF	FF
General Fund 4260-101-0001	$28,043	$28,043	$0
50 Title XIX FF / 50 GF (4260-101-0890/0001)	$828	$414	$414
Title XIX 65 FF / 35 GF (4260-101-0890/0001)	$36,994	$12,948	$24,046
Total	**$65,865**	**$41,405**	**$24,460**

FPL INCREASE FOR AGED AND DISABLED PERSONS

REGULAR POLICY CHANGE NUMBER:	7
IMPLEMENTATION DATE:	9/2020
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	2140

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$135,468,000
- STATE FUNDS	$0	$67,734,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$135,468,000
STATE FUNDS	$0	$67,734,000
FEDERAL FUNDS	$0	$67,734,000

DESCRIPTION

Purpose:
This policy change estimates the benefit and premium costs to disregard countable income up to 138% of the Federal Poverty Level (FPL) for the Aged, Blind, and Disabled (ABD) FPL program.

Authority:
SB 104 (Chapter 67, Statutes of 2019)
SPA 19-005

Interdependent Policy Changes:
Not Applicable

Background:
State law requires the Department to exercise its option under federal law to implement a program for aged and disabled persons. The law requires an individual under these provisions to satisfy certain financial eligibility requirements, including, among other things, that the individual's countable income does not exceed an income standard equal to 100% of the applicable FPL, plus an income disregard of $230 for an individual, or $310 in the case of a couple, except that the income standard determined shall not be less than the Supplemental Security Income/State Supplementary Payment level for a disabled individual or couple, as applicable.

SB 104 requires, upon receipt of federal approval, all countable income over 100% and up to 138% of the FPL to be disregarded after taking all other disregards, deductions, and exclusions into account for those persons eligible under the program for aged and disabled persons.

On September 30, 2019, the Department submitted State Plan Amendment 19-0050 to the Centers for Medicare & Medicaid Services (CMS) to obtain approval for program implementation. The Department received CMS approval on December 20, 2019. Formal guidance was published on January 31, 2020, and the Statewide Automated Welfare Systems begun system changes for the program updates.

FPL INCREASE FOR AGED AND DISABLED PERSONS

REGULAR POLICY CHANGE NUMBER: 7

Reason for Change:
There is no change from the prior estimate for FY 2019-20. The change for FY 2020-21, in the current estimate, is a slight decrease due to a slight change in projected eligibles and their costs. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase as the program is scheduled to implement no sooner than FY 2020-21.

Methodology:

1. Assume program implementation no sooner than FY 2020-21.
2. Assume beneficiaries with incomes between 124%-138% FPL who have met their share of cost (SOC) will shift into aid codes without a SOC requirement.
3. Assume the Department will pay Medicare Part B premiums for dual eligibles.
4. Assume an estimated cost of **$135,468,000 ($67,734,000 GF)** in FY 2020-21 for premiums and benefits.

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

MEDI-CAL COUNTY INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER:	8
IMPLEMENTATION DATE:	4/2017
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1755

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$45,042,000	$62,295,000
- STATE FUNDS	$2,201,580	$2,622,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	100.00 %	74.86 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$15,661,000
STATE FUNDS	$0	$659,320
FEDERAL FUNDS	$0	$15,001,640

DESCRIPTION

Purpose:
This policy change estimates the federal financial participation (FFP) provided to the counties for the cost of inpatient services for adult and juvenile inmates who are deemed eligible for Medi-Cal. This includes health care services to former inmates who have been compassionately released or granted medical probation.

Authority:
AB 1628 (Chapter 729, Statutes of 2010)
AB 396 (Chapter 394, Statutes of 2011)
SB 1462 (Chapter 837, Statutes of 2012)
AB 720 (Chapter 646, Statutes of 2013)

Interdependent Policy Changes:
Not Applicable

Background:
AB 1628 (Chapter 729, Statutes of 2010) authorizes the Department and counties to:

- Claim FFP for inpatient hospital services to Low Income Health Program (LIHP) eligible adult inmates in county correctional facilities when these services are provided off the grounds of the facility. Previously these services were paid by the county.

AB 396 (Chapter 394, Statutes of 2011) authorizes the Department and counties to:

- Claim FFP for inpatient hospital services provided to Medi-Cal eligible juvenile inmates, in county correctional facilities, when these services are provided off the grounds of the facility. Previously these services were paid by the county.

SB 1462 (Chapter 837, Statutes of 2012) authorizes a county sheriff, or his/her designee, to:

- Release certain prisoners (compassionate release) from a county correctional facility and request that a court grant medical probation, or resentencing in lieu of jail time, to certain county inmates. Counties are responsible for paying the non-federal share of costs associated with providing care to inmates compassionately released or granted medical probation. Counties are

MEDI-CAL COUNTY INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 8

responsible for determining Medi-Cal eligibility for county inmates seeking medical probation or compassionate release.

AB 720 (Chapter 646, Statutes of 2013) authorizes the board of supervisors in each county, in consultation with the county sheriff, to:

- Designate an entity or entities to assist county jail inmates to apply for a health insurance affordability program.
- Authorize this entity to act on behalf of a county jail inmate for the purpose of applying for, or determinations of, Medi-Cal eligibility for acute inpatient hospital services as specified.

For county inmates, effective April 1, 2017, counties may participate in the Medi-Cal County Inmate Program (MCIP) that will allow for coverage of specified services to eligible inmates when provided off the grounds of a county correctional facility. MCIP is a voluntary program that allows providers to directly bill the Department's Fiscal Intermediary for allowable MCIP services, consistent with standard Medi-Cal claiming upon an executed MCIP Agreement in which Counties will reimburse the Department for the nonfederal share of the medical costs associated with the county Medi-Cal eligible inmate. County welfare departments will process Medi-Cal eligibility applications submitted by incarcerating counties on behalf of their eligible inmates.

These programs require adherence to the utilization review requirements established by the Superior System Waiver.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is a slight decrease due to utilizing more recent payment data to project FY 2019-20. The change from FY 2020-21, in the current estimate, is a decrease due to utilizing more recent payment data and a reduction in the retro estimate as the retro payment methodology was updated.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to expected growth in the program and paying the retro payments in FY 2020-21.

Methodology:

1. The adult county inmate program began in November 2010. The juvenile county inmate program began in January 2012. The compassionate release inmate program began in January 2013.

2. Claims with dates of services prior to April 1, 2017, retroactive to the beginning of the adult, compassionate release, and juvenile programs, will be part of the retroactive claiming process that will begin in FY 2020-21. Previously, counties paid for these services. The retroactive claiming will be processed manually and the counties will be reimbursed with federal funds (FF) for non GF payment portions made for dates of services prior to April 1, 2017.

3. Assume $15,000,000 in retroactive payments will be paid in FY 2020-21.

4. Claims with dates of services starting April 1, 2017, are processed by the fiscal intermediary and paid with GF and FF. The Department will invoice counties for the GF share of the medical costs associated with the county Medi-Cal eligible inmate on a quarterly basis. The fourth quarter reimbursement will be received the following fiscal year; therefore a GF impact will occur, see the Medi-Cal County Inmate Reimbursement policy change for more information.

5. The Department will continue to pay Affordable Care Act (ACA) payments based on the Federal Medical Assistance Percentage of 100% for calendar years 2014 through 2016, 95% for calendar

MEDI-CAL COUNTY INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 8

year 2017, 94% for calendar year 2018, 93% for calendar year 2019, and 90% for calendar year 2020 and beyond.

6. County inmate claims data for FY 2019-20 and FY 2020-21 is based on actual claims paid from April 2019 through September 2019. To project for FY 2019-20 and FY 2020-21, program applied a consumer price index growth to the most recent actual claims data.

7. Total estimated costs for Medi-Cal inpatient hospital and psychiatric services for county adult, compassionate release, and juvenile inmates in FY 2019-20 and FY 2020-21 are:

(Dollars in Thousands)	FY 2019-20			FY 2020-21		
County Adult	**TF**	**GF**	**FF**	**TF**	**GF**	**FF**
Adult County - Non ACA	$4,471	$473	$3,998	$4,695	$497	$4,198
Adult County - ACA	$40,245	$1,679	$38,566	$42,257	$2,074	$40,183
Compassionate Release	$36	$18	$18	$38	$19	$19
Juvenile	$290	$31	$259	$305	$33	$272
Total Retroactive Payments	$0	$0	$0	$15,000	$0	$15,000
Retro ACA	$0	$0	$0	$7,102	$0	$7,102
Retro Non-ACA	$0	$0	$0	$7,898	$0	$7,898
Grand Total	**$45,042**	**$2,201**	**$42,841**	**$62,295**	**$2,623**	**$59,672**

*Difference in totals is due to rounding.

Funding:
50% Title XIX / 50% GF (4260-101-0890/0001)
100% Title XIX FFP (4260-101-0890)
100% Title XIX ACA FF (4260-101-0890)
95% Title XIX ACA / 5% GF (4260-101-0890/0001)
94% Title XIX ACA / 6% GF (4260-101-0890/0001)
93% Title XIX ACA / 7% GF (4260-101-0890/0001)
90% Title XIX ACA / 10% GF (4260-101-0890/0001)

PROVISIONAL POSTPARTUM CARE EXTENSION

REGULAR POLICY CHANGE NUMBER:	9
IMPLEMENTATION DATE:	7/2020
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	2141

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$34,291,000
- STATE FUNDS	$0	$34,291,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$34,291,000
STATE FUNDS	$0	$34,291,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the benefit costs associated with allowing beneficiaries who receive pregnancy-related services, and are diagnosed with a mental health condition, to remain eligible for Medi-Cal postpartum care for up to 12 months after the last day of the pregnancy.

Authority:
SB 104 (Chapter 67, Statutes of 2019)

Interdependent Policy Changes:
Not Applicable

Background:
For those that qualify, Medi-Cal offers coverage for pregnancy and pregnancy-related services as well as postpartum care. Services include prenatal care, labor, delivery, care after delivery, family planning services, care related to pregnancy loss and services for conditions that might complicate the pregnancy. Additionally, mental health services are also included in the coverage. Due to income limitations and other factors, postpartum care may terminate 60 days after the last day of pregnancy.

SB 104 allows an eligible individual who is receiving pregnancy-related services and is diagnosed with a mental health condition to remain eligible for Medi-Cal postpartum care for up to 12 months after the last day of the pregnancy.

Reason for Change:
There is no change from the prior estimate for FY 2019-20. The change from the prior estimate, for FY 2020-21, is a decrease due to updated projected enrollment into the program. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to the program implementing in FY 2020-21.

PROVISIONAL POSTPARTUM CARE EXTENSION

REGULAR POLICY CHANGE NUMBER: 9

Methodology:

1. Assume this population would have otherwise not been eligible to receive services after the 60 day postpartum period.

2. Assume these eligibles will receive services for up to an additional 10 months for a max coverage term of 12 months postpartum care.

3. Assume implementation no sooner than July 1, 2020.

4. Assume an estimated cost of **$34,291,000 General Fund** in **FY 2020-21**.

Funding:

100% GF (4260-101-0001)

CS3 PROXY ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	10
IMPLEMENTATION DATE:	4/2017
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	2155

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$316,999,420	-$122,728,680
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$316,999,420	-$122,728,680
FEDERAL FUNDS	$316,999,420	$122,728,680

DESCRIPTION

Purpose:
This policy change estimates the technical adjustment in funding for the Non-Optional Targeted Low Income Children's Program (OTLICP) population of the Children's Health Insurance Program (CHIP) as described below. Expenditures are adjusted from Title XIX 50% federal financial participation (FFP) to enhanced Title XXI FFP.

Authority:
SB 903 (Chapter 624, Statutes of 1997)
42 CFR 435.907(e)

Interdependent Policy Changes:
Not Applicable.

Background:
Medi-Cal has multiple CHIP eligibility categories. The largest is OTLICP which is budgeted throughout the Estimate.

California was granted a proxy methodology (CS3-Proxy) to claim enhanced FMAP for children formerly eligible for CHIP who are now eligible for Medicaid. Due to the ACA and pursuant to 42 CFR 435.907(e), California may not collect information concerning asset eligibility. Due to the modified asset test rules, the State cannot determine which children are only eligible for Medicaid and would have received CHIP funding. The CS3-Proxy aims to provide the same level of CHIP funding as before this change.

Reason for Change:
The decrease from the prior estimate, for FY 2019-20 and FY 2020-21, is due to updating the estimate with more current adjustment memos.

CS3 PROXY ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 10

The decrease from FY 2019-20 to FY 2020-2021, in the current estimate, is a General Fund (GF) increase due to the reduction in the Title XXI Federal Medical Assistance Percentage in FY 2020-21. Also, the Department will process additional claiming memos in FY 2019-20 in order to reduce the current adjustment lag.

Methodology:

1. The Department started claiming under the CS3-Proxy in March 2016 with a two-year adjustment lag. Starting in FY 2019-20, the Department began to accelerate the claiming schedule for the CS3-Proxy in order to begin claiming the adjustments within a two-quarter lag by FY 2020-21.

2. This adjustment shifts funding from Title XIX federal funds with a 50% GF match to Title XXI federal funds with a 12% GF match for claims dated before October 1, 2019. Beginning October 1, 2019, the Title XXI GF match will be 23.5%. Beginning October 1, 2020, the Title XXI GF match will be 35%.

3. Previously, the CS3 Proxy adjustments were budgeted in the Non-OTLICP CHIP policy change.

4. Total estimated costs for FY 2019-20 and FY 2020-21 are:

Funding:

(Dollars in Thousands)

FY 2019-20	Fund Number	TF	GF	FF
50 % Title XIX /50 % GF	4260-101-0890/0001	($561,134)	($280,567)	($280,567)
88 % Title XXI /12 % GF	4260-113-0890/0001	$535,147	$64,218	$470,929
76.5 % Title XXI /23.5 % GF	4260-113-0890/0001	$25,987	$6,107	$19,880
Title XIX FF	4260-101-0890	($145,996)	$0	($145,996)
Title XIX GF	4260-101-0001	$145,996	$145,996	$0
Title XXI FF	4260-113-0890	$252,753	$0	$252,753
Title XXI GF	4260-113-0001	($252,753)	($252,753)	$0
Net Impact (rounded)		**$0**	**($316,999)**	**$316,999**

FY 2020-21	Fund Number	TF	GF	FF
50 % Title XIX /50 % GF	4260-101-0890/0001	($344,155)	($172,078)	($172,078)
88 % Title XXI /12 % GF	4260-113-0890/0001	$40,035	$4,804	$35,231
76.5 % Title XXI /23.5 % GF	4260-113-0890/0001	$238,099	$55,954	$182,145
65 % Title XXI /35 % GF	4260-113-0890/0001	$66,021	$23,107	$42,914
Title XIX FF	4260-101-0890	($73,049)	$0	($73,049)
Title XIX GF	4260-101-0001	$73,049	$73,049	$0
Title XXI FF	4260-113-0890	$107,565	$0	$107,565
Title XXI GF	4260-113-0001	($107,565)	($107,565)	$0
Net Impact (rounded)		**$0**	**($122,729)**	**$122,729**

* Totals may differ due to rounding

MEDI-CAL COUNTY INMATE REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER:	11
IMPLEMENTATION DATE:	2/2018
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	2029

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the reimbursement from counties for the General Fund (GF) share of the medical costs associated with the Medi-Cal County Inmate Program (MCIP).

Authority:
AB 1628 (Chapter 729, Statutes of 2010)
AB 396 (Chapter 394, Statutes of 2011)
SB 1462 (Chapter 837, Statutes of 2012)
AB 720 (Chapter 646, Statutes of 2013)

Interdependent Policy Changes:
Medi-Cal County Inmate Programs

Background:
For county inmates, counties may participate in the MCIP that will allow coverage for specified services to eligible inmates when provided off the grounds of a county correctional facility. MCIP is a voluntary program that allows providers to directly bill the Department's Fiscal Intermediary (FI) for allowable MCIP services, consistent with standard Medi-Cal claiming upon an executed MCIP Agreement in which counties will reimburse the Department for the nonfederal share of the medical costs associated with county Medi-Cal eligible inmates.

Claims processed by the FI are paid with GF and federal funds (FF). The Department will invoice counties for the GF share of the medical costs associated with the county Medi-Cal eligible inmate on a quarterly basis. The fourth quarter reimbursement will be received the following fiscal year; therefore, a GF impact will occur each year.

Reason for Change:
The change in FY 2019-20 and FY 2020-21, from the prior estimate, is an increase due to actual MCIP payment data for FY 2018-19 quarter 4 and FY 2019-20 quarter 1 being used to project payments.

MEDI-CAL COUNTY INMATE REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 11

The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to projected growth in the program. Additionally, the non-federal share for the Affordable Care Act (ACA) payments increases each fiscal year through FY 2019-20.

Methodology:

1. Claims with dates of services beginning April 1, 2017, will be processed by the FI.

2. The Department will invoice the counties on a quarterly basis for the GF share of the medical costs; therefore, the fourth quarter reimbursement will be received the following fiscal year, and as a result the GF impact and reimbursement per FY will not match.

3. The Department estimates payments of $45,042,000 TF ($42,841,000 FF) and $62,295,000 TF ($59,672,000 FF) will be paid in FY 2019-20 and FY 2020-21, respectively. The FY 2020-21 estimated payment amount includes retroactive federal fund payments for $15,000,000 which do not have a GF share of medical costs, therefore the GF will not be collected from the counties for this amount.

4. The total estimated GF reimbursement in FY 2019-20 and FY 2020-21 will be:

FY 2019-20	GF	Reimbursement
Non ACA	$474,000	$461,000
ACA	$1,679,000	$1,367,000
Juvenile	$31,000	$82,000
Compassionate Release	$18,000	$42,000
Total	$2,202,000	**$1,952,000**

FY 2020-21	GF	Reimbursement
Non ACA	$497,000	$491,000
ACA	$2,074,000	$1,975,000
Juvenile	$33,000	$32,000
Compassionate Release	$19,000	$18,000
Total	$2,623,000	**$2,516,000**

*Totals may differ due to rounding.

Funding:

100% GF (4260-101-0001)
Reimbursement GF (4260-610-0995)

CDCR RETRO REPAYMENT

REGULAR POLICY CHANGE NUMBER:	12
IMPLEMENTATION DATE:	1/2019
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	2109

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$1,466,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$1,466,000	$0
FEDERAL FUNDS	-$1,466,000	$0

DESCRIPTION

Purpose:
The purpose of this policy change is to repay monies to the Centers for Medicare and Medicaid Services (CMS) for State inmates that were erroneously enrolled into Medi-Cal.

Authority:
AB 1628 (Chapter 729, Statutes of 2010)
SB 1399 (Chapter 405, Statutes of 2010)
AB 396 (Chapter 394, Statutes of 2011)

Interdependent Policy Changes:
Not Applicable

Background:
California Department of Corrections and Rehabilitation's State inmate participants of the Custody to Community Transitional Reentry Program (CCTRP) and the Male Community Reentry Program (MCRP) may have been erroneously enrolled in Medi-Cal during any period of their participation in the CCTRP/MCRP programs. The Department will repay any federal monies associated with the Fee-For-Service Claims or Medi-Cal Managed Care Capitation Payments (calendar year 2011-current) for this specific population of inmates (approximately 6,100 inmates) that participated in the CCTRP and MCRP programs.

Federal Funds must be returned for the inmates that were erroneously enrolled into Medi-Cal. Upon completion of the data match by the Department, funds will be returned to CMS.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease as all payments are expected to be completed in FY 2019-20.

CDCR RETRO REPAYMENT

REGULAR POLICY CHANGE NUMBER: 12

Methodology:

1. Approximately $1,466,000 will be returned to the appropriate federal fund sources below.

FY 2019-20	TF	GF	FF
Title XIX ACA Recoupment	$0	$1,335,000	($1,335,000)
Title XIX Recoupment	$0	$131,000	($131,000)
Total FY 2019-20	**$0**	**$1,466,000**	**($1,466,000)**

Funding:
100% GF (4260-101-0001)
100% Title XIX ACA FF (4260-101-0890)
100% Title XIX FF (4260-101-0890)

NON-OTLICP CHIP

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

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$170,168,730	-$101,316,930
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$170,168,730	-$101,316,930
FEDERAL FUNDS	$170,168,730	$101,316,930

DESCRIPTION

Purpose:
This policy change estimates the technical adjustment in funding for the Non-Optional Targeted Low Income Children's Program (OTLICP) population of the Children's Health Insurance Program (CHIP) as described below. Expenditures are adjusted from Title XIX 50% federal financial participation (FFP) to enhanced Title XXI FFP.

Authority:
SB 903 (Chapter 624, Statutes of 1997)
42 CFR 435.907(e)

Interdependent Policy Changes:
Not Applicable.

Background:
Medi-Cal has multiple CHIP eligibility categories. The largest is OTLICP which is budgeted throughout the Estimate. The other CHIP eligibility categories are budgeted in this policy change.

- Resource Disregard Program: Prior to the implementation of the Affordable Care Act (ACA), Medi-Cal had asset limitations where families that exceeded it were eligible through the CHIP Resource Disregard Program. However, the ACA requires that states raise the minimum income level to at least 133 percent of the federal poverty level (FPL) and remove the Medicaid asset test for children, effective January 1, 2014. These changes allow certain children who would not have been eligible for Medicaid under the State Plan in effect on March 31, 1997, to now be eligible for Medicaid. Until these children transition out of the associated aid codes, the Department continues to budget the adjustment in this policy change (aid codes 8N, 8P, 8R, 8T).

- Medicaid Expansion: This CHIP population exceeds the Medicaid FPL limit and are below the OTLICP FPL (aid codes M5, M6).

NON-OTLICP CHIP

REGULAR POLICY CHANGE NUMBER: 13

- Hospital Presumptive Eligibility (HPE): Effective January 1, 2016, the ACA requires the Department to give hospitals the option to determine HPE for Medicaid. The HPE Program offers qualified individuals immediate access to temporary Medi-Cal while applying for permanent Medi-Cal coverage or other health coverage. CHIP coverage extends to a portion of HPE (aid codes H0, H6, H9).

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a General Fund (GF) decrease due to an increase in estimated expenditures for the HPE and Medicaid Expansion populations. The change from the prior estimate, for FY 2020-21, is a GF increase due to a decrease in estimated expenditures for the Resource Disregard and Medicaid Expansion populations

The change from FY 2019-20 to FY 2020-21, in the current estimate, is a GF increase due to the reduction in the Title XXI Federal Medical Assistance Percentage (FMAP) in FY 2020-21.

Methodology:
1. It is assumed the estimated costs of the HPE, Medicaid Expansion, and Resource Disregard aid codes will be $579,298,000 TF and $566,808,000 TF in FY 2019-20 and FY 2020-21, respectively.

2. Enhanced federal funding under Title XXI Medicaid Children's Health Insurance Program (M-CHIP) may be claimed for children eligible under these aid codes. From October 1, 2015, through September 30, 2019, estimated costs are eligible for Title XXI 88/12 FMAP. From October 1, 2019, through September 30, 2020, estimated costs are eligible for Title XXI 76.5/23.5 FMAP. Beginning October 1, 2020, estimated costs are eligible for Title XXI 65/35 FMAP.

3. Total estimated costs for FY 2019-20 and FY 2020-21 are:

(Dollars in Thousands)

FY 2019-20	TF	GF
Resource Disregard	$1,298	($381)
HPE	$7,993	($2,348)
Medicaid Expansion	$570,007	($167,440)
Total Cost	**$579,298**	**($170,169)**

FY 2020-21	TF	GF
Resource Disregard	$1,279	($229)
HPE	$7,425	($1,327)
Medicaid Expansion	$558,104	($99,761)
Total Cost	**$566,808**	**($101,317)**

Funding:
(Dollars in Thousands)

FY 2019-20	Fund Number	TF	GF	FF
50 % Title XIX / 50 % GF	4260-101-0890/0001	($579,298)	($289,649)	($289,649)
88 % Title XXI / 12 % GF	4260-113-0890/0001	$144,824	$17,379	$127,445
76.5 % Title XXI / 23.5 % GF	4260-113-0890/0001	$434,474	$102,101	$332,373
Net Impact (rounded)		**$0**	**($170,169)**	**$170,169**

NON-OTLICP CHIP

REGULAR POLICY CHANGE NUMBER: 13

FY 2020-21	Fund Number	TF	GF	FF
50 % Title XIX / 50 % GF	4260-101-0890/0001	($566,808)	($283,404)	($283,404)
76.5 % Title XXI / 23.5 % GF	4260-113-0890/0001	$141,702	$33,300	$108,402
65 % Title XXI / 35 % GF	4260-113-0890/0001	$425,106	$148,787	$276,319
Net Impact (rounded)		**$0**	**($101,317)**	**$101,317**

NON-EMERGENCY FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	14
IMPLEMENTATION DATE:	12/1997
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	15

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$987,242,000	$969,518,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$987,242,000	$969,518,000
FEDERAL FUNDS	-$987,242,000	-$969,518,000

DESCRIPTION

Purpose:
This policy change is a technical adjustment to shift funds from Title XIX and Title XXI federal financial participation (FFP) to 100% General Fund (GF) because the Department cannot claim FFP for non-emergency health care expenditures for nonexempt New Qualified Immigrants (NQI) subject to the five-year bar, Permanent Residence Under the Color of Law (PRUCOL), and undocumented children.

Authority:
HR 3734 (1996), Personal Responsibility and Work Opportunity Act (PRWORA)
Welfare & Institutions Code 14007.5
SB 75 (Chapter 18, Statutes of 2015)

Interdependent Policy Changes:
Not Applicable

Background:
HR 3734 (1996), PRWORA, specifies that FFP is not available for full-scope Medi-Cal services for qualified, nonexempt immigrants who have resided in the United States for less than five years. Currently, FFP is only available for emergency and pregnancy services. California provides full scope Medi-Cal services to eligible, nonexempt, qualified immigrants; however, non-emergency services that are not pregnancy related are 100% State funded.

Previously, California provided restricted-scope Medi-Cal coverage (emergency and pregnancy related services only) to many low income undocumented children. FFP was available, regardless of immigration status, for emergency and pregnancy related services. Effective May 16, 2016, individuals under age 19 and who do not have satisfactory immigration status or are unable to verify satisfactory immigration status or citizenship are eligible for full scope Medi-Cal benefits. California will continue to receive FFP for the emergency and pregnancy related services; however, any non-emergency services provided will be ineligible for FFP and funded solely by the State's GF.

NON-EMERGENCY FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 14

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is a slight increase due to an increase in managed care expenditures. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a slight decrease due to changes in the FMAP for Title XXI and Title XIX ACA expenditures.

Methodology:

1. Based on updated July 2019 through December 2019 Fee-for-Service (FFS) expenditure reports of non-emergency services provided to this population, the Department estimates non-emergency FFS costs will be $363,240,000 TF in FY 2019-20 and $350,396,000 in FY 2020-21.

2. Based on July 2019 through December 2019 managed care reports of non-emergency services provided to this population, the Department estimates non-emergency managed care capitation costs for the ACA Optional Expansion population will be $434,551,000 TF in FY 2019-20 and $436,497,000 in FY 2020-21. The repayment for this group will be 93% FFP for FY 2019-20 until January 2020, when FFP changes to 90%. For FY 2020-21, the repayment for this group will be 90%.

3. Based on July 2019 through December 2019 managed care reports of non-emergency services provided to this population, the Department estimates non-emergency managed care capitation costs for the non-ACA (all others) population will be $665,595,000 TF in FY 2019-20 and $669,356,000 in FY 2020-21. The repayment for this group is at 50/50 FMAP, 88/12 FMAP, 76.5/23.5 FMAP, and 65/35 FMAP.

4. The impact of the State Children's Health Insurance Program (SCHIP) funding for prenatal care for new qualified immigrants is included in the SCHIP Funding for the Prenatal Care policy change.

5. The estimated FFP Repayment in FY 2019-20 and FY 2020-21:

(Dollars in Thousands)

	FY 2019-20		FY 2020-21	
FFS and MC costs	**TF**	**FF Repayment**	**TF**	**FF Repayment**
All Others (50% FF / 50% GF)	$829,562	$414,781	$822,231	$411,115
All Others (65% FF / 35% GF)	$7,237	$4,704	$7,451	$4,843
All Others (Title XXI)	$45,941	$36,466	$46,776	$31,749
ACA	$580,646	$531,291	$579,791	$521,811
Total	$1,463,386	**$987,242**	$1,456,249	**$969,518**

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XIX ACA FFP (4260-101-0890)
100% Title XXI FFP (4260-113-0890)
100% GF (4260-101-0001)
100% GF (4260-113-0001)

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER:	15
IMPLEMENTATION DATE:	7/2005
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1007

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$90,190,810	-$76,358,720
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$90,190,810	-$76,358,720
FEDERAL FUNDS	$90,190,810	$76,358,720

DESCRIPTION

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

Authority:
AB 131 (Chapter 80, Statutes of 2005)

Interdependent Policy Changes:
Not Applicable

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

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is a slight decrease due to updated expenditure reports showing decreased prenatal costs for undocumented and legal immigrant women. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease due to a decrease in estimated prenatal costs for undocumented women. Additionally, the Title XXI Federal Medical Assistance Percentage (FMAP) begins decreasing in FY 2019-20 and continues through FY 2020-21.

Methodology:
1. The cost of prenatal care for undocumented women is estimated to be $101,073,000 TF in FY 2019-20 and $99,840,000 TF in FY 2020-21.

2. Assume estimated prenatal costs for undocumented women beginning October 1, 2015, are eligible for Title XXI 88/12 FMAP. Assume the FMAP for Title XXI is 76.5% FF and 23.5% GF beginning

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER: 15

October 1, 2019, and 65% FF and 35% GF on October 1, 2020.

(Dollars in Thousands)

FY 2019-20:	$25,269 TF x .88 =	**$22,237 FFP**
FY 2019-20:	$75,804 TF x .765 =	**$57,990 FFP**
FY 2020-21:	$24,960 TF x .765 =	**$19,094 FFP**
FY 2020-21:	$74,880 TF x .65 =	**$48,672 FFP**

3. The cost of prenatal care for legal immigrant women is estimated to be $12,553,000 TF in FY 2019-20 and $12,659,000 in FY 2020-21.

4. Assume estimated prenatal costs for legal immigrant women beginning October 1, 2015, are eligible for Title XXI 88/12 FMAP. Assume the FMAP for Title XXI is 76.5% FF and 23.5% GF beginning October 1, 2019, and 65% FF and 35% GF on October 1, 2020.

(Dollars in Thousands)

FY 2019-20:	$3,139 x .88 =	**$2,762 FFP**
FY 2019-20:	$9,414 x .765 =	**$7,202 FFP**
FY 2020-21:	$3,165 x .765 =	**$2,421 FFP**
FY 2020-21:	$9,494 x .65 =	**$6,171 FFP**

5. The federal funding received on a cash basis will be:

(Dollars in Thousands)

Fiscal Year	Calculation	GF Savings
FY 2019-20:	$22,237 + $57,990 + $2,762 + $7,202 =	**$90,191**
FY 2020-21:	$19,094 + $48,672 + $2,421 + $6,171 =	**$76,358**

Funding:
65 % Title XXI FF /35% GF (4260-113-0890/0001)
76.5% Title XXI FF /23.5% GF (4260-113-0890/0001)
88% Title XXI FF /12% GF (4260-113-0890/0001)
100% GF (4260-101-0001)

CCHIP DELIVERY SYSTEM

REGULAR POLICY CHANGE NUMBER:	16
IMPLEMENTATION DATE:	11/2019
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	2122

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$1,921,000	-$3,097,000
- STATE FUNDS	-$451,440	-$969,520
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,921,000	-$3,097,000
STATE FUNDS	-$451,440	-$969,520
FEDERAL FUNDS	-$1,469,560	-$2,127,480

DESCRIPTION

Purpose:
This policy change estimates the savings achieved resulting from integrating County Children's Health Initiative Program (CCHIP) beneficiaries into the Medi-Cal Managed Care (MMC) delivery system.

Authority:
Welfare & Institution Code, 15803, 15826, and 15858

Interdependent Policy Changes:
Not Applicable

Background:
CCHIP provides affordable and comprehensive health, dental, and vision insurance for children who meet certain eligibility criteria. Effective October 1, 2019, the Department integrated CCHIP beneficiaries into the Medi-Cal Managed Care delivery system. In compliance with Maintenance of Efforts requirements, the CCHIP program is provided through the three county plans: San Francisco, Santa Clara, and San Mateo.

Effective October 1, 2019, the Department transitioned all administrative functions, such as premium collection and case management, for CCHIP to MAXIMUS, the current administrator vendor for the Medi-Cal Access Program (MCAP) and the Optional Targeted Low Income Program (OTLICP). The costs for the administrative functions are budgeted in the OTLICP, MCAP, Special Populations Admin Costs policy change.

Reason for Change:
The change from the prior estimate for FY 2019-20 and FY 2020-21 is due to updated enrollment data. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to a full year of savings in FY 2020-21.

CCHIP DELIVERY SYSTEM

REGULAR POLICY CHANGE NUMBER: 16

Methodology:

1. Assume the transition occurred in October 2019.

2. As a result of the transition, **$1,921,000** in **FY 2019-20** and **$3,097,000** in **FY 2020-21** is expected to be saved.

Funding:

Title XXI 76.5% FF/ 23.5% GF (4260-113-0890/0001)
Title XXI 65% FF/ 35% GF (4260-113-0890/0001)

MEDICARE OPTIONAL EXPANSION ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	17
IMPLEMENTATION DATE:	7/2017
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	2033

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$42,464,000	$14,940,000
- STATE FUNDS	$71,483,650	$27,371,410
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$42,464,000	$14,940,000
STATE FUNDS	$71,483,650	$27,371,410
FEDERAL FUNDS	-$113,947,650	-$12,431,410

DESCRIPTION

Purpose:
This policy change adjusts the funding from the Optional Expansion Federal Medical Assistance Percentage (FMAP) to Medi-Cal's 50/50 FMAP for beneficiaries eligible or already enrolled in Medicare Part A and/or Part B and enrolled in the Optional Expansion eligibility group.

Authority:
Affordable Care Act

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2014, the Affordable Care Act (ACA) expanded Medicaid coverage to previously ineligible persons, primarily adults at or below 138 percent of the federal poverty level. To be eligible for the Optional Expansion, a beneficiary cannot be eligible or enrolled in Medicare Part A and/or Part B. Due to system limitations and other contributing factors, certain Optional Expansion beneficiaries with Medicare Part A and/or Part B were enrolled in the Optional Expansion group. Enrollment systems were corrected in August 2016 to reduce further enrollment of Medicare Part A and/or Part B eligibles into the Optional Expansion eligibility group. The Department initiated additional work efforts to address the various causes of the erroneous enrollments.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a General Fund (GF) decrease due to shifting the Long Term Care payment from FY 2019-20 to FY 2020-21. The change from the prior estimate, for FY 2020-21, is a GF increase due to the Long Term Care payment shift and due to utilizing more recent actual memos for the FY 2020-21 projection. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a GF decrease due to fewer months being adjusted for in FY 2020-21.

MEDICARE OPTIONAL EXPANSION ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 17

Methodology:

1. Medicare Part A and/or Part B eligibles currently enrolled in Optional Expansion are assumed to be eligible for Medi-Cal with a 50% FFP. The Optional Expansion eligibility group's FFP is:

CY 2014 – CY 2016	100% FFP
CY 2017	95% FFP
CY 2018	94% FFP
CY 2019	93% FFP
CY 2020	90% FFP

2. Adjustments will continue for Medicare Part A and/or Part B eligibles remaining in the Optional Expansion aid codes. The Department is researching claiming methodologies that will reduce or eliminate the need for adjustments. For January 2014 – June 2016, the actual expenditures were adjusted for in FY 2018-19 and FY 2019-20. For July 2016 – June 2019, the expenditures will be adjusted for in FY 2019-20. For July 2019 – June 2020, the expenditures will be adjusted for in FY 2020-21

3. Those Medi-Cal eligibles with Part A and/or Part B are estimated in the Optional Expansion aid category.

4. Assume the Department will reimburse any Long Term Care services these duals may have received from managed care plans participating in the Coordinated Care Initiative. This will be a one-time payment made at 50/50 FMAP.

5. The overall adjustment is estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	FF	GF
FY 2019-20	**($42,464)**	**($113,948)**	**$71,484**
FY 2020-21	**$14,940**	**($12,432)**	**$27,372**

Funding:

(Dollars in Thousands)

FY 2019-20	TF	FF	GF
100% ACA Title XIX FF (4260-101-0890)	($53,094)	($53,094)	$0
95% ACA Title XIX FF /5% GF (4260-101-0890/0001)	($69,474)	($66,000)	($3,474)
94% ACA Title XIX FF /6% GF (4260-101-0890/0001)	($61,055)	($57,392)	($3,663)
93% ACA Title XIX FF /7% GF (4260-101-0890/0001)	($21,405)	($19,907)	($1,498)
50 % Title XIX FF / 50% GF (4260-101-0890/0001)	$162,564	$81,282	$81,282
100% Title XIX FF (4260-101-0890)	$1,163	$1,163	$0
100% GF (4260-101-0001)	($1,163)	$0	($1,163)
Total	**($42,464)**	**($113,948)**	**$71,484**

MEDICARE OPTIONAL EXPANSION ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 17

FY 2020-21	TF	FF	GF
93% ACA Title XIX FF /7% GF (4260-101-0890/0001)	($25,427)	($23,647)	($1,780)
90% ACA Title XIX FF /10% GF (4260-101-0890/0001)	($25,427)	($22,885)	($2,542)
50 % Title XIX FF / 50% GF (4260-101-0890/0001)	$65,794	$32,897	$32,897
100% Title XIX FF (4260-101-0890)	$1,203	$1,203	$0
100% GF (4260-101-0001)	($1,203)	$0	($1,203)
Total	**$14,940**	**($12,432)**	**$27,372**

* Totals may differ due to rounding

CHIP PREMIUMS

REGULAR POLICY CHANGE NUMBER:	18
IMPLEMENTATION DATE:	7/2014
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1879

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$62,286,000	-$62,224,000
- STATE FUNDS	-$12,846,540	-$19,989,460
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$62,286,000	-$62,224,000
STATE FUNDS	-$12,846,540	-$19,989,460
FEDERAL FUNDS	-$49,439,460	-$42,234,540

DESCRIPTION

Purpose:
This policy change estimates the premium revenue associated with the Medicaid Children's Health Insurance Program (MCHIP).

Authority:
AB 1494 (Chapter 28, Statutes of 2012)

Interdependent Policy Change:
Not Applicable

Background:
Effective January 1, 2013, Healthy Families Program (HFP) subscribers began a transition into Medi-Cal through a phase-in methodology. The Department implemented Optional Targeted Low Income Children's Program (OTLICP), an MCHIP program that covers children who would have been previously enrolled in HFP. OTLICP covers children with family incomes above 133% of the federal poverty level (FPL), and up to and including 266% of the FPL. Those children with family incomes over 160% FPL are required to pay monthly premiums for coverage.

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is a decrease due to removing the Children's Health Insurance Program premiums from this policy change. These premiums are now budgeted in the County Health Initiative Matching policy change.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is a slight decrease due to an estimated decrease of average monthly eligibles.

Methodology:
1. The Department estimates in FY 2019-20 there will be 907,111 average monthly OTLICP eligibles and 906,218 in FY 2020-21. Based on FY 2017-18 data, 57.99% of the OTLICP population has family incomes over 160% of the FPL.

CHIP PREMIUMS

REGULAR POLICY CHANGE NUMBER: 18

2. In FY 2019-20, the Department estimates there are 6,312,280 member months subject to monthly premiums and 6,306,066 in FY 2020-21.
   FY 2019-20: 907,111 x 12 months x 57.99% = **6,312,404** member months
   FY 2020-21: 906,218 x 12 months x 57.99% = **6,306,190** member months

3. Children under 1 year of age and American Indians/Alaskan Natives are exempt from paying monthly premiums. The Department estimates the following member months are exempt from the OTLICP premium calculation:

Exempt Member Months	FY 2019-20	FY 2020-21
Total Exempt Member Months	69,369	69,369

4. The Department provides discounts to individuals who prepay, establish automatic electronic fund transfers, and those families with multiple children. The Department estimates the following member months reduce total premium eligible member months:

Loss of Premiums	FY 2019-20	FY 2020-21
Discount Program	820,596	819,789
Delinquent Premiums	631,228	630,607
Total Loss of Premium Member Months	**1,451,824**	**1,450,395**

5. The net member months for the OTLICP premium calculation are:

Member Months	FY 2019-20	FY 2020-21
Eligible Member Months	6,312,404	6,306,190
Exempt Member Months	(69,369)	(69,369)
Loss Member Months	(1,451,824)	(1,450,395)
Net Member Months	**4,791,211**	**4,786,426**

6. Premium requirement for children with incomes between 160-266% FPL is $13 per month.

7. Beginning October 1, 2015, assume estimated costs are eligible for Title XXI 88/12 FMAP.
   Beginning October 1, 2019, assume estimated costs are eligible for Title XXI 76.5/23.5 FMAP.
   Beginning October 1, 2020, assume estimated costs are eligible for Title XXI 65/35 FMAP.
   The total estimated premium revenue for OTLICP are:

   (Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2019-20	**$62,286**	**$12,847**	**$49,439**
FY 2020-21	**$62,224**	**$19,990**	**$42,234**

Funding:
88% Title XXI / 12% GF (4260-113-0890/0001)
76.5% Title XXI / 23.5% GF (4260-113-0890/0001)
65% Title XXI / 35% GF (4260-113-0890/0001)

MINIMUM WAGE INCREASE - CASELOAD SAVINGS

REGULAR POLICY CHANGE NUMBER:	19
IMPLEMENTATION DATE:	4/2017
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1979

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$270,996,000	-$542,006,000
- STATE FUNDS	-$51,763,000	-$116,102,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	90.62 %	59.01 %
APPLIED TO BASE		
TOTAL FUNDS	-$25,419,400	-$222,168,300
STATE FUNDS	-$4,855,370	-$47,590,210
FEDERAL FUNDS	-$20,564,060	-$174,578,050

DESCRIPTION

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

Authority:
SB 3 (Chapter 4, Statutes of 2016)

Interdependent Policy Changes:
Not Applicable

Background:
SB 3 authorized a phased-in increase in the minimum wage from $10.50 per hour to $15.00 per hour beginning January 1, 2017, through January 1, 2022. The incremental minimum wage increases may be temporarily suspended by the governor based on certain determinations, such as determination of a General Fund (GF) deficit. From January 2022 (or 2023 for employers with 25 employees or fewer) or once the minimum wage reaches $15 per hour, the minimum wage will be adjusted annually. The minimum wage will increase by the lesser of 3.5% or by the rate of change to the U.S. Consumer Price Index.

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

- From January 1, 2017 to December 31, 2017, inclusive, $10.50 per hour
- From January 1, 2018 to December 31, 2018, inclusive, $11.00 per hour
- From January 1, 2019 to December 31, 2019, inclusive, $12.00 per hour
- From January 1, 2020 to December 31, 2020, inclusive, $13.00 per hour
- From January 1, 2021 to December 31, 2021, inclusive, $14.00 per hour
- From January 1, 2022, until adjusted, $15.00 per hour.

The minimum wage increase for employers with 25 employees or fewer began on January 1, 2018, with the minimum wage reaching $15 per hour on January 1, 2023, excluding any suspensions.

MINIMUM WAGE INCREASE - CASELOAD SAVINGS

REGULAR POLICY CHANGE NUMBER: 19

Reason for Change:
The change for FY 2019-20 and FY 2020-21, in the current estimate, is a decrease in GF savings due to utilizing more recent caseload data which impacts the GF and federal fund splits. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to caseload reduction and an increase in incremental savings as a result of the minimum wage increasing to $14 per hour.

Methodology:

1. Minimum wage was increased to $11.00 as of January 1, 2018, to $12 as of January 1, 2019, and to $13.00 as of January 1, 2020. The implementation date for the increase to $14.00 is January 1, 2021. The implementation date for the increase to $15.00 is January 1, 2022.

2. Assume a delay in savings to account for individuals not reporting a change in income immediately. In addition, if individuals are deemed ineligible during redetermination, the individual receives a 90 day period in which they can provide additional information to remain eligible. The combination of these items is assumed to be 6 months.

3. Assume a 45,000 caseload reduction in FY 2019-20 and a 67,500 caseload reduction in FY 2020-21.

4. Assume 60% of the caseload reduction would be considered part of the Optional Expansion population. The remaining caseload would fall into other non-elderly aid categories.

5. The caseload population is approximately split 18% Fee-for-Service and 82% Managed Care. Corresponding payment lags are applied accordingly to calculate the estimated savings.

6. On a cash basis, savings are estimated to be:

(Dollars in Thousands)

FISCAL YEAR	TF	GF	FF
FY 2019-20	($270,996)	($51,763)	($219,233)
FY 2020-21	($542,006)	($116,102)	($425,904)

Funding:
50%Title XIX FF / 50% GF (4260-101-0890/0001)
94% Title XIX ACA FF / 6% GF (4260-101-0890/0001)
93% Title XIX ACA FF / 7% GF (4260-101-0890/0001)
90% Title XIX ACA FF / 10% GF (4260-101-0890/0001)
88% Title XXI FF /12% GF (4260-113-0890/0001)
76.5% Title XXI FF /23.5% GF (4260-113-0890/0001)
65 % Title XXI FF /35% GF (4260-113-0890/0001)

COMMUNITY FIRST CHOICE OPTION

REGULAR POLICY CHANGE NUMBER:	20
IMPLEMENTATION DATE:	12/2012
ANALYST:	Manvir Lallian
FISCAL REFERENCE NUMBER:	1595

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$3,718,574,000	$4,423,366,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,718,574,000	$4,423,366,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$3,718,574,000	$4,423,366,000

DESCRIPTION

Purpose:
This policy change budgets Title XIX federal funding for the Department of Social Services (CDSS) associated with the Community First Choice Option (CFCO).

Authority:
Welfare & Institutions Code 14132.956
Affordable Care Act (ACA) 2401
Interagency Agreement 11-88407

Interdependent Policy Changes:
Not Applicable

Background:
The ACA established a new State Plan option, which became available to states on October 1, 2010, to provide home and community-based attendant services and supports through CFCO. CFCO allows States to receive a 6% increase in federal match for expenditures related to this option. The state submitted a State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) which proposed moving federally eligible Personal Care Services Program (PCSP) and In-Home Supportive Services (IHSS) Plus Option program participants into CFCO. The Department budgets Title XIX FFP for the provision of IHSS Plus Option and PCSP services to Medi-Cal beneficiaries.

The SPA was approved on August 31, 2012, with an effective date of December 1, 2011. In addition, CMS approved SPA 13-007, effective July 1, 2013, which updated eligibility language for compliance with the Social Security Act section 1915(k)(1) and 42 CFR section 441.510.

The CFCO generates new federal funds and creates General Fund savings to the State and counties who provide matching funds. The anticipated savings would be offset by cost increases to administer CFCO.

COMMUNITY FIRST CHOICE OPTION

REGULAR POLICY CHANGE NUMBER: 20

Reason for Change:
The change for FY 2019-20 and FY 2020-21, from the previous estimate, is a decrease due to updated expenditure data provided by CDSS. The change from FY 2019-20 to 2020-21, in the current estimate, is an increase due to updated expenditure data provided by CDSS.

Methodology:
1. Costs for Medi-Cal beneficiaries enrolled in CFCO are eligible for an additional enhanced Federal Medical Assistance Percentage rate of 6%. The CFCO policy change include 56% Federal Financial Participation.

2. The estimated costs were provided by CDSS on a cash basis.

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

HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS

REGULAR POLICY CHANGE NUMBER:	21
IMPLEMENTATION DATE:	2/2016
ANALYST:	Sabrina Blank
FISCAL REFERENCE NUMBER:	1967

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$28,134,000	$12,504,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$28,134,000	$12,504,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$28,134,000	$12,504,000

DESCRIPTION

Purpose:
This policy change estimates the payment and technical adjustment in funding from Title XIX 50/50 Federal Medical Assistance Percentage (FMAP) to the enhanced Title XIX Affordable Care Act (ACA) FMAP for services provided at Designated Public Hospitals (DPHs) for Hospital Presumptive Eligibility (HPE) to the ACA Optional Expansion Population. HPE is a required provision of the ACA.

Authority:
Title 42, CFR, Section 435.1110
Social Security Act 1902(a)(47)
SB 28 (Chapter 442, Statutes of 2013)
California State Plan Amendment 13-0027-MM7

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2014, the ACA requires the Department to give hospitals the option to determine HPE for Medicaid. The HPE program offers qualified individuals immediate access to temporary Medi-Cal while applying for permanent Medi-Cal coverage or other health coverage. Individuals complete the HPE application on-line with a qualified HPE provider at a participating, qualified hospital. Eligibility is determined in real-time.

Individuals granted temporary HPE must complete the Medi-Cal application process in order to enroll in a permanent Medi-Cal program.

HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS

REGULAR POLICY CHANGE NUMBER: 21

Reason for Change:
The change from the prior estimate, for FY 2019-20, is an increase based on updated actual data showing an increase in expenditures. The change from the prior estimate, for FY 2020-21, is an increase due to higher projected averages for FY 2020-21 based on actual and projected payment amounts for FY 2019-20.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease due to FY 2019-20 capturing 8 quarters of expenditures, while FY 2020-21 is only capturing 4 quarters of expenditures.

Methodology:

1. The Department assumes enhanced Title XIX ACA FMAP is available for services provided under the temporary HPE program to those individuals who enroll in temporary HPE at a qualified hospital, then successfully complete the Medi-Cal application process, and are enrolled in the ACA Optional Expansion program.

2. The Department submits claims for beneficiaries receiving services in DPHs and makes payments to DPHs for the enhanced FFP. The Department generates reports six months after the last day of the quarter to allow for lagged claims submission. The estimated average quarterly payment for enhanced Title XIX ACA FFP is $3,593,000 for FY 2019-20 and $3,126,000 for FY 2020-21.

3. The Department will also claim the enhanced Title XIX ACA FMAP for beneficiaries receiving services in DPHs and estimates to pay DPHs $28,134,000 in FY 2019-20 and $12,504,000 in FY 2020-21. The estimated pass-through costs are included in the chart below.

(Dollars in Thousands)

FY 2019-20	TF	FF
FY 2017-18 Q1	$4,862	$4,862
FY 2017-18 Q2	$2,469	$2,469
FY 2017-18 Q3	$2,973	$2,973
FY 2017-18 Q1-3 Recoupment	($609)	($609)
FY 2017-18 Q4	$1,901	$1,901
FY 2018-19 Q1	$2,192	$2,192
FY 2018-19 Q2	$3,046	$3,046
FY 2018-19 Q3	$3,056	$3,056
FY 2018-19 Q4	$8,244	$8,244
Net Impact	**$28,134**	**$28,134**

FY 2020-21	TF	FF
FY 2019-20 Q1	$3,126	$3,126
FY 2019-20 Q2	$3,126	$3,126
FY 2019-20 Q3	$3,126	$3,126
FY 2019-20 Q4	$3,126	$3,126
Net Impact	**$12,504**	**$12,504**

HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS

REGULAR POLICY CHANGE NUMBER: 21

Funding:
(Dollars in Thousands)

FY 2019-20	TF	FF
95% Title XIX ACA FF / 5% GF (4260-101-0890/0001)	$7,331	$7,331
94% Title XIX ACA FF / 6% GF (4260-101-0890/0001)	$10,112	$10,112
93% Title XIX ACA FF / 7% GF (4260-101-0890/0001)	$11,300	$11,300
Net Impact	**$28,134**	**$28,134**

FY 2020-21	TF	FF
93% Title XIX ACA FF / 7% GF (4260-101-0890/0001)	$6,251	$6,251
90% Title XIX ACA FF / 10% GF (4260-101-0890/0001)	$6,252	$6,252
Net Impact	**$12,504**	**$12,504**

HEALTH INSURER FEE

REGULAR POLICY CHANGE NUMBER:	22
IMPLEMENTATION DATE:	3/2021
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1831

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$284,312,000
- STATE FUNDS	$0	$97,151,740
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$284,312,000
STATE FUNDS	$0	$97,151,740
FEDERAL FUNDS	$0	$187,160,260

DESCRIPTION

Purpose:
This policy change estimates the cost of Medi-Cal managed care capitation rate increases to fund the federally required Health Insurer Provider Fee (HIPF).

Authority:
Affordable Care Act (ACA)

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2014, the ACA placed an $8 billion fee on the health insurance industry nationwide. The fee grew to $14.3 billion in 2018 and is trended based on the rate of premium growth after 2018. The applicable fee amount estimated for the 2020 fee year is $15.5 billion. The fee is allocated to qualifying health insurers based on their market share of premium revenue in the previous year. Market share is based on commercial, Medicare, Medicaid, and State Children Health Insurance Plan (SCHIP) premium revenues. Nonprofit insurers that receive more than 80% of their premium from non-commercial business (Medicare, Medicaid and SCHIP) are exempt from the fee. The fee is not exempt from corporate income tax, therefore the cost to the plans will be compounded by the tax that must be assessed to the revenue from the additional premium to the managed care plans to account for the HIPF.

Federal spending legislation signed in 2015 suspended the HIPF for the calendar year (CY) 2017 fee year, the tax on CY 2016 (data year) revenues. This moratorium precluded collection of the HIPF as required under the ACA for this period. The moratorium eliminated the CY 2016 data year HIPF payments. Subsequently, additional federal legislation was signed on January 22, 2018, that suspended the HIPF for the CY 2019 fee year (the tax to be paid on CY 2018 data year). Recent federal legislative changes have indefinitely repealed HIPF, beginning in CY 2021 fee year (CY 2020 data year). Therefore, no provider fee payments will occur post fee year CY 2020 (data year 2019).

HEALTH INSURER FEE

REGULAR POLICY CHANGE NUMBER: 22

Reason for Change:
There is no change in total funds from the prior estimate for FY 2019-20 and FY 2020-21. Funding levels were updated with more recent member mix data.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase as CY 2019 HIPF payments are anticipated to occur in FY 2020-21. No payments are budgeted for FY 2019-20.

Methodology:
1. This fee applies to Medi-Cal premiums for existing Medi-Cal beneficiaries and the ACA expansion population.

2. Payments for CY 2018 data year have been suspended due to the federal budget moratorium.

3. Assume the following amounts:

(Dollars in Thousands)

HIPF	FY 2019-20	FY 2020-21
CY 2019 (data year) Payments	$0	$284,312
Total	**$0**	**$284,312**

4. The Internal Revenue Service determines the effective rate and amount of tax on each plan for each taxable year. The total tax will be assessed on the plan's net premium.

Funding:
(Dollars in Thousands)

FY 2020-21	TF	GF	FF
50% Title XIX FF/ 50% GF (4260-101-0001/0890)	$177,080	$88,540	$88,540
93% Title XIX ACA / 7% GF (4260-101-0890)	$85,122	$5,959	$79,163
88% Title XXI FF/ 12% GF (4260-101-0001/0890)	$22,110	$2,653	$19,457
Total	**$284,312**	**$97,152**	**$187,160**

HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.

REGULAR POLICY CHANGE NUMBER:	23
IMPLEMENTATION DATE:	1/2014
ANALYST:	Sabrina Blank
FISCAL REFERENCE NUMBER:	1821

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$44,894,710	-$44,211,240
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$44,894,710	-$44,211,240
FEDERAL FUNDS	$44,894,710	$44,211,240

DESCRIPTION

Purpose:
This policy change estimates the technical adjustment in funding from Title XIX 50/50 Federal Medical Assistance Percentage (FMAP) to the enhanced Title XIX Affordable Care Act (ACA) FMAP for providing Hospital Presumptive Eligibility (HPE) to the ACA Optional Expansion Population. HPE is a required provision of the ACA.

Authority:
Title 42, CFR, Section 435.1110
Social Security Act 1902(a)(47)
SB 28 (Chapter 442, Statutes of 2013)
California State Plan Amendment 13-0027-MM7

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2014, the ACA requires the Department to give hospitals the option to determine HPE for Medicaid. The HPE Program offers qualified individuals immediate access to temporary Medi-Cal while applying for permanent Medi-Cal coverage or other health coverage. Individuals complete the HPE application on-line with a qualified HPE Provider at a participating, qualified hospital. Eligibility is determined in real-time.

Individuals granted temporary HPE must complete the Medi-Cal application process in order to enroll in a permanent Medi-Cal program.

HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.

REGULAR POLICY CHANGE NUMBER: 23

Reason for Change:
The change from the prior estimate, for FY 2019-20, is an increase based on updated higher FY 2017-18 Q1 through FY 2017-18 Q4 claims actuals. The change from the prior estimate, for FY 2020-21, is an increase based on updated higher FY 2018-19 Q1 through FY 2018-19 Q3 claims actuals and projected FY 2018-19 Q4 claim. The change from FY 2019-20 to FY 2020-21, in the current estimate, is slight decrease due to the enhanced ACA FMAP changing from 95% and 94% to 94% and 93% enhanced ACA FMAP for the adjustment periods.

Methodology:
1. The Department assumes enhanced Title XIX ACA Federal Funding (FF) is available for services provided under the HPE program to those individuals who enroll in HPE at a qualified hospital, then successfully complete the Medi-Cal application process, and are enrolled in the ACA Optional Expansion program.

2. Based on actual claims for individuals identified above, the Department retroactively requests enhanced Title XIX ACA FF.

3. Using claims from FY 2017 Q1 through FY 2017 Q4, the estimated average quarterly adjustment for FY 2019-20 is $25,075,000. Using claims from FY 2018 Q1 through FY 2018 Q3, and a projected average from FY 2018 Q1 through FY 2018 Q3 claims for FY 2018 Q4, the estimated average quarterly adjustment for FY 2020-21 is $24,660,000.

4. The Department estimates to adjust $100,301,000 TF claims from Title XIX 50/50 FMAP to claim the enhanced Title XIX ACA FMAP in FY 2019-20 and $100,106,000 TF in FY 2020-21. The estimated funding adjustment is included in the chart below.

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
50% Title XIX FF / 50% GF	($100,301)	($50,151)	($50,151)
95% Title XIX FF / 5% GF	$76,227	$3,811	$72,415
94% Title XIX FF / 6% GF	$24,074	$1,444	$22,630
Net Impact	**$0**	**($44,895)**	**$44,895**

FY 2020-21	TF	GF	FF
50% Title XIX FF / 50% GF	($101,106)	($50,553)	($50,553)
94% Title XIX FF / 6% GF	$73,566	$4,414	$69,152
93% Title XIX FF / 7% GF	$27,540	$1,928	$25,612
Net Impact	**$0**	**($44,211)**	**$44,211**

Funding:
95% Title XIX FF/5% GF (4260-101-0890/0001)
94% Title XIX FF/6% GF (4260-101-0890/0001)
93% Title XIX FF/7% GF (4260-101-0890/0001)
50% Title XIX FF/ 50% GF (4260-101-0890/0001)

1% FMAP INCREASE FOR PREVENTIVE SERVICES

REGULAR POLICY CHANGE NUMBER:	24
IMPLEMENTATION DATE:	1/2016
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1791

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$3,225,000	-$3,212,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$3,225,000	-$3,212,000
FEDERAL FUNDS	$3,225,000	$3,212,000

DESCRIPTION

Purpose:
This policy change estimates an additional 1% in federal medical assistance percentage (FMAP) for specified preventive services.

Authority:
Affordable Care Act (ACA), Section 4106

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2013, the ACA provides states with the option to receive an additional 1% in FMAP for providing specified preventive services. Eligible preventive services are those assigned Grade A or B by the United States Preventive Services Task Force (USPSTF), and approved adult vaccines and their administration as recommended by the Advisory Committee on Immunization Practices (ACIP). To be eligible to receive the enhanced FMAP, States must cover the specified preventive services in their standard Medicaid benefit package and cannot impose cost sharing for these services. States may only claim the 1% FMAP on services that adhere to the USPSTF Grade A and B recommendations on age, gender, periodicity and other criteria as indicated in the summary of recommendations. The Department previously incorporated, and continues to provide USPSTF recommended Grade A and B preventative services and ACIP approved adult vaccines as part of the Medi-Cal benefit package without cost-sharing.

The majority of the USPSTF Grade A and B recommendations include preventive screening services for adults only. The 1% FMAP policy does not apply to family planning services that are eligible for 90% match and prescription drugs (including over-the-counter).

For Fee-for-Service (FFS) beneficiaries, many of the 1% FMAP eligible services for children, such as those for newborns prior to discharge from the hospital, cannot be pulled from the bundled rate. Additionally, the 1% FMAP can only be claimed if the primary purpose of the visit is the delivery of preventive services under USPSTF and ACIP.

1% FMAP INCREASE FOR PREVENTIVE SERVICES

REGULAR POLICY CHANGE NUMBER: 24

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is due to a decrease in the updated savings data for FFS.

The change in the current estimate, from FY 2019-20 to FY 2020-21, is due to a decrease in FFS savings in FY 2020-21.

Methodology:
1. The 1% FMAP savings for period July 1, 2018 through June 30, 2019, for both FFS and managed care, will occur in FY 2019-20. For FY 2020-21, both FFS and managed care savings will include the period from July 1, 2019 through June 30, 2020.

2. Total savings for the 1% FMAP increase for preventive services are as follows:

FY 2019-20	TF	GF	FF
FFS:			
FY 2018-19 Savings	$0	($217,000)	$217,000
Total FFS	$0	($217,000)	$217,000
Managed Care:			
FY 2018-19 Savings	$0	($3,008,000)	$3,008,000
Total Managed Care	$0	($3,008,000)	$3,008,000
Total FY 2019-20	**$0**	**($3,225,000)**	**$3,225,000**

FY 2020-21	TF	GF	FF
FFS:			
FY 2019-20 Savings	$0	($204,000)	$204,000
Total FFS	$0	($204,000)	$204,000
Managed Care:			
FY 2019-20 Savings	$0	($3,008,000)	$3,008,000
Total Managed Care	$0	($3,008,000)	$3,008,000
Total FY 2020-21	**$0**	**($3,212,000)**	**$3,212,000**

Funding:
100% Title XIX (4260-101-0890)
100% GF (4260-101-0001)

ACA MAGI SAVINGS

REGULAR POLICY CHANGE NUMBER:	25
IMPLEMENTATION DATE:	1/2014
ANALYST:	Sabrina Blank
FISCAL REFERENCE NUMBER:	1845

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the savings from receiving enhanced Title XIX Federal Financial Participation (FFP) instead of the standard Title XIX FFP for newly eligible Medi-Cal beneficiaries who would have qualified under old Medi-Cal rules and subject to the standard Title XIX FFP.

Authority:
AB 82 (Chapter 23, Statutes of 2013)

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2014, the Affordable Care Act (ACA) expands Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level (FPL). The expansion of Medicaid coverage to previously ineligible persons is referred to as the ACA optional expansion. In addition, the ACA requires enrollment simplification for several current coverage groups, and imposes a penalty upon the uninsured which will be in force through calendar year 2018. Currently eligible but not enrolled beneficiaries who enroll in Medi-Cal as a result of enrollment simplification efforts are considered part of the ACA mandatory expansion. Since January 2014, the Department has experienced significant growth in Medi-Cal enrollment as a result of both the ACA optional and mandatory expansions.

Beginning in 2014, the ACA establishes an enhanced Federal Medical Assistance Percentage (FMAP) for expenditures related to the optional expansion population. Between 2014 and 2016, the federal government was responsible for 100 percent of the optional expansion expenditures, gradually phasing down to 90 percent in 2020 and beyond. The Department estimates select populations will naturally shift into the optional expansion at the time of enrollment, and this policy change estimates the savings related to the difference of receiving the standard Title XIX 50/50 FMAP and the enhanced ACA FMAP.

As of the November 2015 Estimate, the estimated savings are assumed to be 100% in the ACA Optional Expansion base trends. This policy change is informational only.

ACA MAGI SAVINGS

REGULAR POLICY CHANGE NUMBER: 25

Reason for Change:
There is no change from the previous estimate for FY 2019-20 and FY 2020-21. There is no change in the current estimate from FY 2019-20 to FY 2020-21. Pursuant to AB 85, this policy change must be displayed through FY 2019-20.

Methodology:
1. Effective January 1, 2014, the ACA simplified eligibility for several coverage groups (Children, Pregnant Women, and 1931(b)).

2. The Department estimates six select populations who were eligible prior to the ACA, that will take-up coverage as part of the ACA expansion group. Following are the six select populations and the estimated General Fund savings associated with each population:

(Dollars in Thousands)

Select Populations:	**FY 2019-20**
Individuals who forego applying for disability	($6,228)
Disabled not enrolled in Medicare but need LTSS	($4,885)
Medically Needy 19/20 no SOC not *Sneede v. Kizer*	($1,459)
Medically Needy parents with SOC	($25,777)
Pregnant women income 109-138% FPL	($1,759)
SB 87 pending disability individuals	($27,938)
TOTAL	**($68,046)**

3. The Department assumes for each select population only a portion of the new enrollment beginning January 1, 2014, and thereafter, will elect to shift into the enhanced ACA group.

Funding:

(Dollars in Thousands)

FY 2019-20	**TF**	**GF**
50% Title XIX FF / 50% GF (4260-101-0890/0001)	($136,092)	($68,046)
93% Title XIX ACA FF / 5% GF (4260-101-0890/0001)	$68,046	$4,763
90% Title XIX ACA FF / 6% GF(4260-101-0890/0001)	$68,046	$6,805
Net Impact	**$0**	**($56,478)**

PAYMENTS TO PRIMARY CARE PHYSICIANS

REGULAR POLICY CHANGE NUMBER:	26
IMPLEMENTATION DATE:	11/2013
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1659

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$120,000	-$69,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$120,000	-$69,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$120,000	-$69,000

DESCRIPTION

Purpose:
This policy change estimates the recoupment of the overpayment provided for the incremental increase in rates from the 2009 Medi-Cal levels to 100% of Medicare for primary care physician (PCP) services provided from January 1, 2013 to December 31, 2014.

Authority:
Section 1202 of the Affordable Care Act (ACA) (H.R. 4872, Health Care and Education Reconciliation Act of 2010)

Interdependent Policy Changes:
Not Applicable

Background:
Section 1202 of the ACA required Medi-Cal to provide increased reimbursement for primary care physician (PCP) services. The rates were increased to 100% of the Medicare rate for services provided from January 1, 2013 through December 31, 2014. The increased rate reimbursement amounts were determined by using Medi-Cal rates that were in effect as of July 1, 2009 compared to the 2013 and 2014 Medicare rates respectively. The Department received 100% FFP for the increased reimbursements for PCP services.

The primary care service codes subject to the ACA provisions were evaluation and management (E&M) codes: 99201-99499 and immunization administration procedure codes 90460, 90461, 90471, 90472, 90473, and 90474. This provision extended to any subsequent modifications to the coding of these services.

The increased reimbursement applied to eligible primary care services furnished by attested physicians with a specialty designation of family medicine, general internal medicine, or pediatric medicine and subspecialists related to the primary care specialists, recognized in accordance with the American Board of Medical Specialties, American Board of Physician Specialties, and American Osteopathic Association. The increased reimbursement was applied to primary care services that were billed under the provider number of a physician who eligibly attested as one of the specified

PAYMENTS TO PRIMARY CARE PHYSICIANS

REGULAR POLICY CHANGE NUMBER: 26

primary care specialists, regardless of whether furnished by the physician directly or under the physician's personal supervision.

The Department continues the process to recoup the overpayments paid to primary care physician providers who received payments they were not eligible for. The period for which the overpayments occurred are for the dates of service from January 1, 2013 through December 31, 2014. The Department will continue recouping by implementing withholds from providers' weekly check writes until the Accounts Receivable for the overpayment is satisfied. The recoupments are expected to continue through FY 2020-21.

Reason for Change:
The change for FY 2019-20, from the prior estimate, is an increase in recoupments due to updated actual recoupment data through February 2020 and a revised estimate of the remaining monthly recoupment amounts occurring in FY 2019-20.

The change for FY 2020-21, from the prior estimate, is an increase due to a revised estimate of the remaining monthly recoupment amounts based on data through February 2020.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to a decreased projection of the remaining recoupments expected to occur in FY 2020-21.

Methodology:
1. Implementation began November 4, 2013, and the increase was retroactive to January 1, 2013.

2. The Department is in the process of reconciling claims for the ACA increase against interim payments to determine the amount of true-up payments that need to be completed.

3. A total of $120,000 TF is estimated to be recouped in FY 2019-20. A total of $69,000 TF is expected to be recouped in FY 2020-21.

Recoupments	TF	FF
FY 2019-20	($120,000)	($120,000)
FY 2020-21	($69,000)	($69,000)

Funding:
100% Title XIX (4260-101-0890)

ACA OPTIONAL EXPANSION MLR RISK CORRIDOR

REGULAR POLICY CHANGE NUMBER:	27
IMPLEMENTATION DATE:	7/2018
ANALYST:	Latoya Brown
FISCAL REFERENCE NUMBER:	2064

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$381,343,000	-$100,000,000
- STATE FUNDS	-$9,533,600	-$5,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$381,343,000	-$100,000,000
STATE FUNDS	-$9,533,600	-$5,500,000
FEDERAL FUNDS	-$371,809,400	-$94,500,000

DESCRIPTION

Purpose:
This policy change budgets additional federally funded payments to and recoveries from managed care health plans (MCPs) related to the Medical Loss Ratio (MLR) risk corridor calculations for ACA Optional Expansion (ACA OE) members.

Authority:
Affordable Care Act (ACA)

Interdependent Policy Changes:
N/A

Background:
Full-risk Medi-Cal MCP contracts establish a risk corridor pertaining to MLR for ACA OE members, for the incurred periods of January 1, 2014, through June 30, 2015, FY 2015-16, and FY 2016-17. The Department, under the direction of the Centers for Medicare and Medicaid Services (CMS), is required to contractually extend the risk corridor to FY 2017-18. The Department is currently working through establishing the contractual requirement for this time period.

MCPs are required to expend at least 85% of net capitation payments received for ACA OE members on allowed medical expenses for ACA OE members, for each county or region. An MCP which does not meet the minimum 85% threshold for a given county or region must return to the Department the difference between 85% of total net capitation payments and actual allowed medical expenses. If an MCP's MLR exceeds 95% of total net capitation payments, then the Department must make additional payment to the MCP equal to the difference between the MCP's allowed medical expenses and 95% of net capitation payments.

This policy change budgets additional payments to and recoveries from MCPs related to the ACA OE MLR risk corridor calculations, as required by the existing Medi-Cal MCP contracts. On aggregate, the Department expects to recover funds from MCPs following the completion of the ACA OE MLR calculations.

ACA OPTIONAL EXPANSION MLR RISK CORRIDOR

REGULAR POLICY CHANGE NUMBER: 27

Reason for Change:
The change from the prior estimate for FY 2019-20 is an increase in expected net recoupments based on updated FY 2016-17 rating period MCP reported MLR data.

The change from FY 2019-20 to FY 2020-21 in the current estimate, is a decrease as anticipated MLR net recoupments are expected to decline from the MLR rating period of FY 2016-17 to FY 2017-18.

Methodology:
1. For each MLR period, the Department will determine which MCPs do not meet the minimum MLR threshold of 85% and which MCPs exceed the maximum MLR threshold of 95%. Any dollar amount below the 85% threshold will be recouped from the MCPs and any dollar amount over the 95% threshold will be paid to MCPs.

2. Any recoupments and repayments identified as a result of the final MLR calculations will be collected or paid out at the appropriate federal Medicaid assistance and corresponding State General Fund percentages for the MLR rating period.

3. The estimated FY 2016-17 MLR rating period recoupments and repayments have been adjusted based on updated MCP reported data and results of final MLR calculations for a subset of plans. At this time, it is assumed net recoupments of $381,343,000 will be collected from MCPs in FY 2019-20 for the FY 2016-17 MLR rating period.

4. FY 2017-18 MLR rating period recoupments and repayments are expected to occur in FY 2020-21. At this time, the Department has incorporated a placeholder net recoupment amount, as the FY 2017-18 MCP reported data has not been collected. The collection of the necessary MCP MLR data is tied to the timing of future FY 2017-18 rating period hospital directed payments. The Department will update the FY 2017-18 placeholder once MCP reported data is collected.

5. The ACA OE MLR risk corridor estimated recoupments are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2019-20	($381,343)	($9,534)	($371,809)
FY 2020-21	($100,000)	($5,500)	($94,500)

Funding:
ACA 100% FFP (2014-2016) Title XIX 100% FF
ACA 95% FFP / 5% GF (2017)
ACA 94% FFP / 6% GF (2018)

ACA DSH REDUCTION

REGULAR POLICY CHANGE NUMBER:	28
IMPLEMENTATION DATE:	12/2020
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	2105

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	-$690,472,000
- STATE FUNDS	$0	-$313,863,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$690,472,000
STATE FUNDS	$0	-$313,863,000
FEDERAL FUNDS	$0	-$376,609,000

DESCRIPTION

Purpose:
This policy change estimates the reductions to Disproportionate Share Hospitals (DSHs), as required under the Affordable Care Act (ACA).

Authority:
Affordable Care Act (ACA), HR 3590, Section 2551
HR 2 (2015)
HR 1892 (2018)
HR 4378 (2019)
HR 3055 (2019)
HR 1865 (2019)
HR 748 (2020)

Interdependent Policy Changes:
Not Applicable

Background:
The federal DSH allotment is available for uncompensated Medi-Cal and uninsured costs incurred by DSHs. The Affordable Care Act (ACA) requires the aggregate, nationwide reduction of DSH allotments in the amount of $4 billion in Federal Fiscal Year (FFY) 2021 and $8 billion annually through FFY 2025, for a total aggregate reduction of $36 billion. The distribution of the aggregate reductions is determined by the Centers for Medicare & Medicaid Services (CMS).

ACA DSH REDUCTION

REGULAR POLICY CHANGE NUMBER: 28

The original effective date of the reduction was October 1, 2013; however, HR 2 (2015) delayed the start date of the reduction until October 1, 2017. HR 1892 (2018) was enacted on February 9, 2018, which postponed the reduction until October 1, 2019. Subsequently, HR 4378 (2019) and HR 3055 (2019) were enacted, postponing the reduction until November 22, 2019, and December 21, 2019, respectively. On December 20, 2019, HR 1865 further delayed the ACA DSH reduction until May 23, 2020. On March 27, 2020, HR 748 (2020) was enacted which eliminated the FFY 2020 reduction and postponed the start of the FFY 2021 reduction until December 1, 2020.

In October 2017, CMS released a simulated California DSH reduction amount of $166 million, which represented 8.35% of the total national reduction. In October 2019, CMS released a preliminary California DSH reduction amount of $389.5 million for FFY 2020, representing 9.74% of that year's total national reduction of $4 billion. Although the FFY 2020 reduction was eliminated, for estimation purposes for FFY 2021 and going forward, California's percent share of the national reduction is assumed to be 9.74%.

The non-federal share of the payment is funded via the General Fund, certified public expenditures (CPEs), or intergovernmental transfers (IGTs). However, private hospitals receive Medi-Cal DSH replacement payment adjustments from Title XIX funding, along with $160.00 from the annual DSH allotment. The $160.00 of the annual DSH allotment satisfies the State's payment obligations under the Federal DSH statute. See the Private Hospital DSH Replacement, DSH Payment, and Global Payment Program (GPP) policy changes for more information.

Reason for Change:
The change in FY 2019-20 and FY 2020-21, from the prior estimate, is due to:

- DSH reduction start date shifted from October 1, 2019 to December 1, 2020,
- Elimination of the FFY 2020 reduction,
- Increased estimated percentage of California's share of the national reduction, and
- University of California Designated Public Hospital (UC DPH) DSH reductions transitioned to a quarterly payment cycle.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to the start of the DSH reduction in FY 2020-21.

Methodology:

1. California's DSH allotment is estimated to be $1.282 billion for FY 2019-20 and $1.308 billion for FY 2020-21.

2. California's reduction results in a total reduction of $390 million FF for FY 2020-21 for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs). The DSH allotment reduction will offset DSH payments for NDPHs, University of California (UC) DPHs in the DSH Payment policy change, and the remaining DPHs in the Global Payment Program (GPP) policy change.

3. The DSH allotment amount is applied in the DSH payment methodology to determine the reduction amount for the estimated aggregate DSH replacement funding. That amount is estimated to be $91 million FF for FY 2020-21. The Private DSH replacement reduction will offset Private DSH replacement payments in the Private Hospital DSH Replacement policy change.

ACA DSH REDUCTION

REGULAR POLICY CHANGE NUMBER: 28

4. Assume the following DSH reduction on an accrual basis:

(Dollars in Thousands)

FY 2020-21	TF	GF	FF	IGT
Private DSH Replacement	($181,564)	($90,782)	($90,782)	$0
DSH NDPH	($14,896)	($7,448)	($7,448)	$0
DSH UC	($83,662)	$0	($83,662)	$0
GPP	($596,852)	$0	($298,426)	($298,426)
Total Reduction FY 2020-21	($876,974)	($98,230)	($480,318)	($298,426)

5. For Private Hospital DSH Replacement and DSH NDPH:
   - Assume 11/12 of the FY 2020-21 DSH payment reduction will occur in FY 2020-21 and 1/12 will occur in FY 2021-22.

6. For GPP and UC DSH:
   - Assume 3/4 of the FY 2020-21 DSH payment reduction will occur in FY 2020-21 and 1/4 will occur in FY 2021-22.

The aggregate DSH reduction is as follows on a cash basis:

(Dollars in Thousands)

FY 2020-21	TF	GF***	FF	IGT
FY 2020-21 Private DSH Replacement	($166,434)	($83,217)	($83,217)	$0
FY 2020-21 DSH NDPH	($13,654)	($6,827)	($6,827)	$0
FY 2020-21 DSH UC*	($62,746)	$0	($62,746)	$0
FY 2020-21 GPP**	($447,638)	$0	($223,819)	($223,819)
Total Reduction FY 2020-21	**($690,472)**	**($90,044)**	**($376,609)**	**($223,819)**

Funding:
100% Demonstration DSH Fund (4260-601-7502)*
100% Title XIX FFP (4260-101-0890)**
100% Global Payment Program Special Fund (4260-601-8108)**
50% Title XIX / 50% GF (4260-101-0001/0890)***

BEHAVIORAL HEALTH TREATMENT

REGULAR POLICY CHANGE NUMBER:	29
IMPLEMENTATION DATE:	10/2016
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1855

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$863,002,000	$993,767,000
- STATE FUNDS	$392,228,710	$469,364,430
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$863,002,000	$993,767,000
STATE FUNDS	$392,228,710	$469,364,430
FEDERAL FUNDS	$470,773,290	$524,402,570

DESCRIPTION

Purpose:
This policy change estimates the costs for providing Behavioral Health Treatment (BHT) services for children under age 21 with a diagnosis of autism spectrum disorder (ASD), or Behavioral Intervention Services (BIS) for the same age group who do not have an ASD diagnosis.

Authority:
Social Security Act Section 1905(a)(13)
SB 870 (Chapter 40, Statutes of 2014)
State Plan Amendment (SPA) 14-026
Welfare & Institutions (W&I) Code 14132.56
Interagency Agreement (IA) 15-92451

Interdependent Policy Changes:
Not Applicable

Background:
SB 870 added W&I Code, Section 14132.56 to direct the Department to implement BHT services to the extent it is required by the federal government to be covered by Medi-Cal for individuals under 21 years of age. On July 7, 2014, the Centers for Medicare and Medicaid Services (CMS) released guidance for states to cover BHT services for Medicaid beneficiaries with an ASD diagnosis.

On September 15, 2014, the Department issued interim guidance to Medi-Cal managed care health plans (MCPs) requiring the MCPs to cover all medically necessary BHT services effective on or after September 15, 2014. The Department received approval of SPA 14-026 on January 21, 2016, to include BHT as a covered Medi-Cal benefit.

Prior to the addition of BHT as a Medi-Cal benefit, BHT and other Medi-Cal related services were provided under the Medicaid 1915(c) and (i) waivers for individuals with developmental disabilities that met certain eligibility criteria. These services were provided through a system of Regional Centers (RC) contracted with the Department of Developmental Services (DDS).

BEHAVIORAL HEALTH TREATMENT

REGULAR POLICY CHANGE NUMBER: 29

The Department, in collaboration with DDS, began transitioning responsibility for BHT services starting February 1, 2016 in both Medi-Cal Fee-for-Service (FFS) and managed care. The transition was completed in September 2016. Medi-Cal beneficiaries age 21 and over receiving BHT services from RCs will continue to receive those services from the RCs pursuant to the 1915(c) and (i) waivers.

Additional RC clients, without an ASD diagnosis, have been receiving BHT Behavioral Intervention Services (BIS) through the RCs. On March 1, 2018, the Department transitioned these additional RC clients enrolled in FFS Medi-Cal to Medi-Cal coverage for BHT/BIS. The transition of Medi-Cal managed care clients began on July 1, 2018 and was completed by December 1, 2018.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a decrease due to the following:

- For FFS, due to invoice processing delays, all claims for FY 2019-20 will be paid in FY 2020-21.
- For managed care, claims data for FY 2018-19 supplemental capitation payments projections was lower than previously projected.

The change from the prior estimate, for FY 2020-21, is an increase due to the following:

- For FFS, FY 2019-20 claims increased, therefore, FY 2020-21 projections were increased, and increased prior year projections due to invoice processing delays.
- For managed care, total cost for FY 2020-21 increased due to an increased in the January 2020 through June 2021 Bridge Period rate.

The change in the current estimate, from FY 2019-20 to FY 2020-21, is an increase due to the following:

- FFS – More prior year payments estimated for FY 2020-21.
- Managed care – Utilization for BHT services (capitation payments) is expected to increase for FY 2020-21, along with an assumed rate increase.

Methodology:

1. Coverage for BHT began on September 15, 2014.

<u>Fee-for-Service</u>

2. A total of 1,683 FFS beneficiaries transitioned from DDS on February 1, 2016.

3. On March 1, 2018, an additional 461 RC clients enrolled in BHT/BIS transitioned from DDS.

4. The IA contract between the Department and DDS was executed in July 2017, with a retroactive effective date of February 1, 2016.

5. The Department amended the BHT IA contract to include BHT/BIS. The amended contract was executed on October 29, 2018 and DDS began submitting claims starting April 2019.

6. The estimate includes the rate increases to RC providers authorized by ABX2 1 (Chapter 3, Statutes of 2016), effective July 1, 2016.

7. The FFS cost reimbursement estimates were provided by DDS. The estimated annual cost on an accrual basis is $13,821,000 TF.

BEHAVIORAL HEALTH TREATMENT

REGULAR POLICY CHANGE NUMBER: 29

8. On a cash basis, FFS reimbursements are estimated to be paid as follows:

Fee-for-Service Claims	Accrual	FY 2019-20	FY 2020-21
FY 2017-18 claims	$11,138,000	$36,000	$0
FY 2018-19 claims	$13,531,000	$5,243,000	$0
FY 2019-20 claims	$13,821,000	$0	$13,821,000
FY 2020-21 claims	$13,821,000	$0	$12,669,000
Total		**$5,279,000**	**$26,490,000**

Managed Care

9. Managed care payments began in October 2016 for BHT services based on a supplemental capitation payment methodology, retroactive to the implementation date.

10. For BHT/BIS clients, a total of 4,729 managed care beneficiaries transitioned on a phase-in basis starting July 1, 2018 through December 1, 2018.

11. Capitation rates are typically rebased annually. However, the Department has implemented a one-time 18-month rating period for the period of July 1, 2019 through December 31, 2020 (Bridge Period) to aid in future prospective rate development as federally required. Similar to the corresponding base capitation rates, the BHT supplemental rate will be developed and rebased annually on a calendar year (CY) basis thereafter.

12. Beginning January 2021, managed care rates will be updated on a calendar year basis.

13. Assume 38,459 members received BHT services in FY 2018-19; not all members received BHT services each month. The estimated number of supplemental capitation payments for FY 2018-19 is 258,209.

    FY 2018-19: 258,209 x $2,551.23 = $658,751,000 TF

14. Assume 45,008 members received BHT services in FY 2019-20; not all members received BHT services each month. The estimated number of supplemental capitation payments for FY 2019-20 is 343,140.

    FY 2019-20: 343,140 x $2,468.19 = $846,934,000 TF

15. Assume 52,867 members received BHT services in FY 2020-21; not all members received BHT services each month. The estimated number of supplemental capitation payments for FY 2020-21 is 407,917.

    FY 2020-21 (Jul 20 – Dec 20): 195,824 x $2,468.19 = $483,331,000 TF
    FY 2020-21 (Jan 21– Jul 21): 212,093 x $2,566.92 = $544,425,000 TF

16. Due to the supplemental capitation payment methodology, assume the following payment lags:
    - For FY 2018-19, assume 66% of payments was paid in the same fiscal year and the remaining 34% of payments will be paid in the following fiscal year, due to a delay in supplemental capitation payments.

BEHAVIORAL HEALTH TREATMENT

REGULAR POLICY CHANGE NUMBER: 29

- For FY 2019-20 and FY 2020-21, assume 75% of payments will be paid in the same fiscal year and 25% of payments will be paid the following fiscal year.

Rate Year	Accrual	FY 2019-20	FY 2020-21
FY 2017-18 - FFS	$11,138,000	$36,000	$0
FY 2018-19 - FFS	$13,531,000	$5,243,000	$0
FY 2018-19 - Managed Care	$658,751,000	$222,522,000	$0
FY 2019-20 - FFS	$13,821,000	$0	$13,821,000
FY 2019-20 - Managed Care	$846,934,000	$635,201,000	$211,733,000
FY 2020-21 - FFS	$13,821,000	$0	$12,669,000
FY 2020-21 - Managed Care	$1,027,756,000	$0	$755,544,000
Total		**$863,002,000**	**$993,767,000**

(Dollars in Thousands)

FY 2019-20	**TF**	**GF**	**FF XIX**	**FF XXI**
Fee-for-Service	$5,279	$2,400	$2,231	$648
Managed Care	$857,723	$389,829	$362,423	$105,471
Total	**$863,002**	**$392,229**	**$364,654**	**$106,119**

(Dollars in Thousands)

FY 2020-21	**TF**	**GF**	**FF XIX**	**FF XXI**
Fee-for-Service	$26,490	$12,511	$11,193	$2,786
Managed Care	$967,277	$456,853	$408,714	$101,710
Total	**$993,767**	**$469,364**	**$419,907**	**$104,496**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
65% Title XXI / 35% GF (4260-113-0001/0890)
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)

FAMILY PACT PROGRAM

REGULAR POLICY CHANGE NUMBER:	30
IMPLEMENTATION DATE:	1/1997
ANALYST:	Sabrina Blank
FISCAL REFERENCE NUMBER:	1

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$371,873,000	$366,733,000
- STATE FUNDS	$88,561,700	$87,337,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$371,873,000	$366,733,000
STATE FUNDS	$88,561,700	$87,337,600
FEDERAL FUNDS	$283,311,300	$279,395,400

DESCRIPTION

Purpose:
This policy change estimates the costs of family planning services provided by the Family Planning, Access, Care, and Treatment (Family PACT) program.

Authority:
Welfare & Institutions Code 14132(aa)

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 1997, family planning services expanded under the Family PACT program to provide contraceptive services to persons in need of such services with incomes under 200% of the Federal Poverty Level. The Centers for Medicare & Medicaid Services (CMS) approved a Section 1115 demonstration project waiver, effective December 1, 1999.

On March 24, 2011, CMS approved a State Plan Amendment (SPA), in accordance with the Affordable Care Act, to transition the current Family PACT waiver into the State Plan. Under the SPA, eligible family planning services and supplies, formerly reimbursed exclusively with 100% State General Fund, receive a 90% federal financial participation (FFP), and family planning-related services receive reimbursement at Title XIX 50/50 FFP.

This policy change is inclusive of CMS approved, time-limited supplemental payments, at a rate equal to 150 percent of the current Family PACT rates, to Family PACT providers for specific family planning services. Expenditures for these services are delineated in the Proposition 56-Women's Health Supplemental Payments policy change.

Drug rebates for Family PACT drugs are included in the Family PACT Drug Rebates policy change.

FAMILY PACT PROGRAM

REGULAR POLICY CHANGE NUMBER: 30

Reason for Change:
The change in FY 2019-20, from the prior estimate, is an increase due to a slight growth in utilization of Family PACT services and updated actual expenditure data. The change in FY 2020-21, from the prior estimate, is a decrease due to a slight reduction in projected users of Family PACT services in FY 2020-21. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease due to a projected decrease in users for FY 2020-21.

Methodology:
1. The Department used linear regressions based upon the most recent 36 months of actual data for users, units per user, and dollars per unit.

2. Family planning services and testing for sexually transmitted infections (STIs) are eligible for 90% FFP.

3. The treatment of STIs and other family planning-related services are eligible for Title XIX 50/50 FFP.

4. It is assumed that 13.95% of the Family PACT population are undocumented persons and are budgeted at 100% GF.

(Dollars in Thousands)

Service Category	FY 2019-20		FY 2020-21	
	TF	GF	TF	GF
Physicians	$63,751	$15,182	$60,900	$14,503
Other Medical	$280,878	$66,891	$278,218	$66,258
Co. & Comm. Outpatient	$1,354	$322	$1,341	$319
Pharmacy	$25,890	$6,166	$26,274	$6,257
Total	**$371,873**	**$88,562**	**$366,733**	**$87,338**

*Totals may differ due to rounding.

Funding:
(Dollars in Thousands)

FY 2019-20	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890/0001)	$11,715	$5,857	$5,857
100% GF (4260-101-0001)	$51,876	$51,876	$0
90% Family Planning / 10% GF (4260-101-0890/0001)	$308,282	$30,828	$277,454
Total	**$371,873**	**$88,562**	**$283,311**

FY 2020-21	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890/0001)	$11,553	$5,776	$5,776
100% GF (4260-101-0001)	$51,159	$51,159	$0
90% Family Planning / 10% GF (4260-101-0890/0001)	$304,021	$30,402	$273,619
Total	**$366,733**	**$87,338**	**$279,395**

*Totals may differ due to rounding.

ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

REGULAR POLICY CHANGE NUMBER:	31
IMPLEMENTATION DATE:	5/2013
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	1476

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$356,323,000	$388,005,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$356,323,000	$388,005,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$356,323,000	$388,005,000

DESCRIPTION

Purpose:
This policy change estimates the federal match to the California Department of Developmental Services (CDDS) for participant-directed Home and Community Based Services (HCBS) for persons with developmental disabilities under a 1915(i) state plan option.

Authority:
Section 6086 of the Deficit Reduction Act (DRA) of 2005, Public Law 109-171
Interagency Agreement (IA) 09-86388

Interdependent Policy Changes:
Not Applicable

Background:
State Plan Amendment (SPA) 09-023A was approved on April 25, 2013, retroactive to October 1, 2009. It authorizes CDDS to claim federal financial participation (FFP) for the provision of certain services by the state's Regional Center (RC) network of nonprofit providers to persons with developmental disabilities. RC consumers who received or currently receive certain services will continue to be eligible for these services even though their institutional level of care requirements for the HCBS waiver for persons with developmental disabilities are not met. Services covered under this SPA include but are not limited to: habilitation, respite care, personal care services, homemaker services, and home health aide services.

On September 29, 2016, SPA 16-016 was approved by the Centers for Medicare and Medicaid Services (CMS) to renew SPA 09-023A with an effective date of October 1, 2016. The SPA will expire on September 30, 2021.

AB3 X 5 (Chapter 20, Statutes of 2009), eliminated non-emergency medical transportation and various optional services for adults in September 2009. SPA 11-041 authorizes CDDS to claim reimbursement, effective October 1, 2011 for the eliminated services rendered in FY 2011-12 and forward, enabling persons with developmental disabilities access to these benefits.

ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

REGULAR POLICY CHANGE NUMBER: 31

On October 9, 2015, SPA 11-040 was approved, retroactive to October 1, 2011, which extends Medi-Cal coverage for existing infant development programs provided to Medi-Cal eligible infants and toddlers with a developmental delay. The Department and CDDS have a separate interagency agreement to draw down FFP for infant development services.

Reason for Change:
The change in FY 2019-20 and FY 2020-21, from the prior estimate, is an increase due to population growth and service utilization.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to an increase in the projected caseload for FY 2020-21.

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	FF
FY 2019-20	$712,646	$356,323	**$356,323**
FY 2020-21	$776,010	$388,005	**$388,005**

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

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER:	32
IMPLEMENTATION DATE:	7/2000
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	25

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$130,696,000	$129,016,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$130,696,000	$129,016,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$130,696,000	$129,016,000

DESCRIPTION

Purpose:
This policy change estimates the federal match provided to Local Educational Agencies (LEAs) for Medi-Cal eligible services through the LEA Medi-Cal Billing Option Program (LEA BOP), effective July 1, 2015.

Authority:
Welfare & Institutions Code 14132.06 and 14115.8

Interdependent Policy Changes:
LEA Expansion

Background:
LEAs, which consist of school districts, county offices of education, charter schools, community colleges, and university campuses, may enroll as Medi-Cal providers through the LEA BOP. Through the program, LEAs receive federal reimbursement for certified public expenditures (CPEs) incurred while providing specific eligible health services to Medi-Cal eligible students to the extent federal financial participation (FFP) is available. LEAs receive interim payments based on interim reimbursement rates, which are calculated using a Cost and Reimbursement Comparison Schedule (CRCS) that is submitted to the Department annually for the preceding fiscal year. Final payment reconciliations based on actual CPEs for a given year are completed when the Department has audited the LEAs' CRCS. If interim payments exceed the audited CPEs, the Department recovers and returns the excess federal match from the LEA to the federal government. If interim payments are less than the audited CPEs, the Department draws additional federal funds to reimburse the LEA.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is an increase due to using six months of actual paid claims data in the current year to estimate the FY 2019-20 interim payments, and no longer budgeting the reconciliation due back to the State as that recoupment is withheld from LEA payments.

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER: 32

The change in FY 2020-21, from the prior estimate, is an increase due to no longer budgeting the reconciliation due to the State.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease due to lower average of paid claims used to estimate the FY 2020-21 interim payments.

Methodology:

1. The FY 2019-20 estimate is revised based on the first six months of actual paid claims data in the current fiscal year, projected for FY 2019-20.

2. The estimate for FY 2020-21 is based on the preceding three years of actual and estimated paid claims to the LEAs.

3. State Plan Amendment 13-005 authorized the Optional Targeted Low Income Children (OTLIC) population to be Medi-Cal eligible, and allowable under the LEA Program to receive Title XXI federal financial reimbursement. Based on historical paid claims data, 81% of the adjudicated LEA payments were from Title XIX Medi-Cal population, and 19% from Title XXI OTLIC population.

(Dollars in Thousands)

FY 2019-20	TF	Title XIX FF	Title XXI FF
FY 2019-20 Interim Payments	$130,696	$105,864	$24,832
Total	**$130,696**	**$105,864**	**$24,832**

(Dollars in Thousands)

FY 2020-21	TF	Title XIX FF	Title XXI FF
FY 2020-21 Interim Payments	$129,016	$104,503	$24,513
Total	**$129,016**	**$104,503**	**$24,513**

Funding:

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

LEA EXPANSION

REGULAR POLICY CHANGE NUMBER:	33
IMPLEMENTATION DATE:	7/2020
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	2136

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$80,468,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$80,468,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$80,468,000

DESCRIPTION

Purpose:
This policy change estimates the expenditures to Local Educational Agencies (LEAs) for Medi-Cal eligible services as a result of State Plan Amendment (SPA) 15-021.

Authority:
Welfare & Institutions Code 14132.06 and 14115.8
SPA 15-021 (Pending)

Interdependent Policy Changes:
Not Applicable

Background:
LEAs, which consist of school districts, county offices of education, charter schools, community colleges, and university campuses, may enroll as Medi-Cal providers through the LEA Medi-Cal Billing Option Program. Through the program, LEAs receive reimbursement for specific eligible health services provided to Medi-Cal eligible students to the extent federal financial participation (FFP) is available. LEAs receive interim payments based on interim reimbursement rates. A Cost and Reimbursement Comparison Schedule (CRCS) is submitted to the Department annually for the preceding fiscal year. Final payment reconciliation will be completed when the Department has audited the LEAs' cost report.

SPA 15-021 will add new assessment/treatment services, new practitioner types, and lift the claiming limitation of 24 services in a 12 month period for beneficiaries without an Individualized Education Plan or Individualized Family Services Plan, effective July 1, 2015.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is a decrease due to SPA 15-021 still pending approval from CMS. As a result of the delay, the claiming has shifted to begin in FY 2020-21.

The change in FY 2020-21, from the prior estimate, is an increase due to the payments for the estimated retroactive and ongoing claims being shifted from FY 2019-20 to FY 2020-21.

LEA EXPANSION

REGULAR POLICY CHANGE NUMBER: 33

The change from FY 2019-20 to FY 2020-21, in the current estimate, is a increase due to the shift in implementation of the LEA expansion.

Methodology:

1. LEAs will be able to claim for expanded services authorized by SPA 15-021 retroactive to July 1, 2015.

2. Assume SPA 15-021 is approved in FY 2019-20 and retroactive payments will start in July 2020.

3. Retroactive claims are assumed to be 20% of the amount claimed in FY 2015-16, FY 2016-17, FY 2017-18 and FY 2018-19. The total retroactive impact is estimated to be $108,715,000 TF, of which 50% is assumed to be paid in FY 2020-21 and the remaining 50% assumed to be paid in FY 2021-22.

4. The estimated ongoing impact assumes LEA claims will increase by 20% from the total amount claimed under LEA Billing Option Program. The ongoing impact is estimated to be $26,110,000 in FY 2020-21.

5. SPA 13-005 authorized the Optional Targeted Low Income Children (OTLIC) population to be Medi-Cal eligible, and allowable under the LEA Program to receive Title XXI federal financial reimbursement. Based on historical paid claims data, 81% of the adjudicated LEA payments were from Title XIX Medi-Cal population, and 19% from Title XXI OTLIC population.

(Dollars in Thousands)

FY 2020-21	TF	Title XIX FF	Title XXI FF
SPA 15-021 Retroactive Impact	$54,358	$44,030	$10,328
SPA 15-021 Ongoing Impact	$26,110	$21,149	$4,961
Total	**$80,468**	**$65,179**	**$15,289**

Funding:

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

RESTORATION OF ADULT OPTICIAN & OPTICAL LAB SVCS

REGULAR POLICY CHANGE NUMBER:	34
IMPLEMENTATION DATE:	1/2020
ANALYST:	Autumn Recce
FISCAL REFERENCE NUMBER:	2121

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$17,740,000	$35,481,000
- STATE FUNDS	$6,285,600	$12,536,100
PAYMENT LAG	0.6840	0.9840
% REFLECTED IN BASE	5.73 %	3.40 %
APPLIED TO BASE		
TOTAL FUNDS	$11,438,900	$33,726,300
STATE FUNDS	$4,053,000	$11,916,120
FEDERAL FUNDS	$7,385,880	$21,810,140

DESCRIPTION

Purpose:
This policy change estimates the Fee-for-Service (FFS) cost of restoring optician and optical lab services for individuals age 21 and over.

Authority:
SB 97 (Chapter 52, Statute of 2017)
SB 78 (Chapter 38 Statutes of 2019)

Interdependent Policy Changes:
Not Applicable

Background:
ABX3 5 (Chapter 20, Statutes of 2009) excluded several optional benefits, including optician and optical lab services, from coverage under the Medi-Cal program for beneficiaries 21 years of age and older, effective July 1, 2009.

SB 97 restored the provision of optician services including services provided by a fabricating optical laboratory January 1, 2020, contingent upon an act from the Legislature. This allowed for the provision of eyeglasses, contact lenses, low vision devices and materials to correct visual impairments for individuals over the age of 21.

SB 78 reinstated coverage for audiology, optician and optical lab, incontinence cream and washes, podiatry, and speech therapy in the Medi-Cal program, on January 1, 2020. See the Optional Benefits Restoration policy change for the audiology, incontinence creams and washes, podiatry, and speech therapy restoration costs.

Reason for Change:
The change from the prior estimate for FY 2019-20 is a decrease due to removing the estimated costs for managed care plans as these costs are now included in the managed care base capitation rates.

RESTORATION OF ADULT OPTICIAN & OPTICAL LAB SVCS

REGULAR POLICY CHANGE NUMBER: 34

The change from the prior estimate for FY 2020-21 is a decrease due to removing the estimated costs for managed care plans as these costs are now included in the managed care base capitation rates.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to adding the estimated full year of FFS costs in FY 2020-21.

Methodology:

1. Adult optician and optical lab services were restored, effective January 1, 2020.

2. FFS annual costs are estimated at $35.4 million TF ($12.5 million GF); this includes the managed care costs for fabricating lenses which are carved-out and paid in FFS.

(Dollars in Thousands)

ANNUAL	TF	GF	FF
Total	$35,481	$12,536	$22,945

3. FFS costs are estimated beginning January 1, 2020.

4. The FY 2019-20 and FY 2020-21 FFS costs are estimated to be:

(Dollars in Thousands)

FY 2019-20	TF	GF	FF	ACA FF
Total	**$17,740**	**$6,286**	**$5,639**	**$5,815**

(Dollars in Thousands)

FY 2020-21	TF	GF	FF	ACA FF
Total	**$35,481**	**$12,536**	**$11,235**	**$11,710**

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)

MSSP SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	35
IMPLEMENTATION DATE:	7/2019
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	2142

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$4,933,000	$4,933,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,933,000	$4,933,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$4,933,000	$4,933,000

DESCRIPTION

Purpose:
This policy change estimates the cost of a one-time-only supplemental funding to the Multipurpose Senior Services Program (MSSP).

Authority:
Budget Act of 2019 (AB 74)

Interdependent Policy Changes:
Not Applicable

Background:
The MSSP provides social and health care management and purchases supplemental services to assist persons aged 65 and older who are "at risk" of needing nursing facility placement but who wish to remain in the community. The program provides services under a federal 1915(c) home and community-based services waiver for up to 11,370 participants in 9,283 participant slots in FY 2019-20 and FY 2020-21. The Coordinated Care Initiative (CCI) was previously scheduled to transition MSSP to a managed care benefit, effective January 1, 2023, however, effective January 1, 2021, MSSP will no longer be transitioned to managed care and will be carved-out of CCI. MSSP will operate as a waiver benefit in all CCI demonstration counties beginning January 1, 2021.

The Legislature approved a one-time appropriation, spread over a three-year period, to allow for a rate increase for MSSP care management and care management support services, effective July 1, 2019.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21. There is no change from FY 2019-20 to FY 2020-21 in the current estimate.

Methodology:

1. Assume the supplemental funding will be available over a three-year period.

MSSP SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 35

Funding:
50% Title XIX FF / 50% GF (4260-101-0890/0001)
Reimbursement (4260-601-0995)

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER:	36
IMPLEMENTATION DATE:	12/2008
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1228

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$28,189,000	$4,074,000
- STATE FUNDS	$6,379,000	$930,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$28,189,000	$4,074,000
STATE FUNDS	$6,379,000	$930,000
FEDERAL FUNDS	$21,810,000	$3,144,000

DESCRIPTION

Purpose:
This policy change estimates the costs of providing demonstration services to Medi-Cal eligible beneficiaries enrolled in the California Community Transitions (CCT) Demonstration Project who will transition to the community and receive qualified home and community-based services for up to 365 days following their transition.

Authority:
Federal Deficit Reduction Act (DRA) of 2005 (P.L. 109-171), Section 6071
Affordable Care Act (ACA) (P.L. 111-148), Section 2403
Medicaid Extenders Act of 2019 (P.L. 116-3), Section 2
Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16), Section 5
Sustaining Excellence in Medicaid Act of 2019 (P.L. 116-39), Section 4
Further Consolidated Appropriations Act, 2020 (P.L. 116-94), Section 205

Interdependent Policy Changes:
CCT Fund Transfer to CDSS

Background:
In January 2007, the Centers for Medicare and Medicaid Services (CMS) awarded the Department the Money Follows the Person (MFP) Rebalancing Demonstration Grant for $130 million in federal funds. The CCT demonstration is authorized under Section 6071 of the Federal DRA of 2005 and was extended by the ACA.

On April 18, 2018, the federal Medicaid Services Investment and Accountability Act of 2019 was signed into law and appropriated additional federal funding for CMS to allocate state grantees for FY 2019-20.

On January 24, 2019, the federal Medicaid Extenders Act of 2019 was passed into law and authorized MFP state grantees to continue to transition people to through December 31, 2019, using available MFP funding. The Extenders Act provided CMS with authority to allocate new funding to state grantees for FY 2019-20, to allow funding appropriated through the Extenders Act to be spent through 2023.

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 36

On August 6, 2019, the federal Sustaining Excellence in Medicaid Act of 2019 was signed into law and appropriated additional federal funds for allocation to MFP state grantees.

On December 20, 2019, the Further Consolidated Appropriations Act, 2020 amended the DRA of 2005 to extend the term of the MFP grant by five months, from January 1, 2020 to May 22, 2020. The grant requires the Department to develop and implement strategies to assist Medi-Cal eligible individuals, who have continuously resided in health care facilities for 90 days or longer, transition into qualified residences with the support of Medi-Cal HCBS.

Participants are enrolled in the demonstration for a maximum of 365-days post-transition, but also receive pre-transition services prior to leaving the inpatient facility. CCT transitions began December 1, 2008.

Currently, CCT Medi-Cal estimates are based on the average cost of services provided to the projected number of CCT enrollees and participants each fiscal year. However, the 2-year claiming period and the process to draw enhanced matching funds from CMS, which is based on the date of payment, has created an ongoing misalignment between the amounts included in the Medi-Cal estimate and actual payments every quarter. As a result, California must pay for service costs generated in previous years and draw down enhanced FFP for those costs.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a decrease based on actuals through December 2019 and estimated fewer transitions. The change from the prior estimate, for FY 2020-21, is an increase due to the extension of the grant. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to the extension of the grant.

Methodology:

1. Assume estimated costs of waiver impacted services for persons residing year-round in Nursing Facility (NF)-Bs would be $87,480 in FY 2019-20 and $86,198 in FY 2020-21. The savings from moving participants from NF-Bs to the waiver are 50% FFP and 50% GF.

2. Assume 100% of non-DD CCT participants will receive pre-transition demonstration services for up to six months at a cost of $696 per month; reimbursed at 75% MFP and 25% GF.

3. Assume 158 pre-transitions that are unsuccessful for non-DD beneficiaries in FY 2019-20 and FY 2020-21 cost $1,128 annually; reimbursed at 100% MFP.

4. Assume non-DD beneficiaries, upon transitioning into CCT, cost $18,000 annually in FY 2019-20 and FY 2020-21; reimbursed at 75% MFP and 25% GF.

5. Assume 195 non-DD beneficiaries will transition in FY 2019-20 and in FY 2020-21.

6. Assume the federal government will issue a new grant award for $22,836,000 in CY 2020, based on federal projections, which will allow CCT transitions to continue through December 31, 2020.

7. Assume the federal government will issue a new grant award for $22,836,000 in CY 2021, based on federal projections, which will allow CCT transitions to continue through December 31, 2021.

8. Assume the Department will pay the DDS invoices for 104 DD transitions, and MFP accounting memos for demonstration services in FY 2019-20.

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 36

9. Below is the overall impact of the CCT Demonstration project in FY 2019-20 and FY 2020-21.

FY 2019-20	TF	GF	FF
CCT Costs (PC 36):			
Non-DD GF costs and Total FFP	$3,857,000	$876,000	$2,981,000
Accounting Memos and DDS Invoices	$24,332,000	$5,503,000	$18,829,000
Total Costs	**$28,189,000**	**$6,379,000**	**$21,810,000**
CCT Savings:			
Total Non-DD GF savings and Total FFP	($13,414,000)	($6,707,000)	($6,707,000)
CCT Fund Transfer to CDSS (PC 45)	$175,000	$0	$175,000
CCT Outreach - Admin costs (OA 47)	$290,000	$0	$290,000
Total of CCT PCs including pass through	$15,240,000	($328,000)	$15,568,000

*The savings are included in the total, however, they are fully reflected in the base estimates.

FY 2020-21	TF	GF	FF
CCT Costs (PC 36):			
Total Non-DD GF costs and Total FFP	**$4,074,000**	**$930,000**	**$3,144,000**
CCT Savings:			
Total Non-DD GF savings and Total FFP	($14,884,000)	($7,442,000)	($7,442,000)
CCT Fund Transfer to CDSS (PC 45)	$175,000	$0	$175,000
CCT Outreach - Admin costs (OA 47)	$360,000	$0	$360,000
Total of CCT PCs including pass through	($10,275,000)	($6,512,000)	($3,763,000)

*The savings are included in the total, however, they are fully reflected in the base estimates.
**Not included in the Total of CCT PCs including pass through

Funding:
100% GF (4260-101-0001)
MFP Federal Grant (4260-106-0890)

OPTIONAL BENEFITS RESTORATION

REGULAR POLICY CHANGE NUMBER:	37
IMPLEMENTATION DATE:	1/2020
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	2150

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$8,102,000	$16,297,000
- STATE FUNDS	$2,870,600	$5,758,500
PAYMENT LAG	0.8400	0.9942
% REFLECTED IN BASE	9.18 %	5.34 %
APPLIED TO BASE		
TOTAL FUNDS	$6,180,900	$15,337,300
STATE FUNDS	$2,189,950	$5,419,380
FEDERAL FUNDS	$3,990,970	$9,917,880

DESCRIPTION

Purpose:
This policy change estimates the Fee-for-Service (FFS) costs for the optional benefits restoration for audiology, incontinence creams and washes, podiatry and speech therapy.

Authority:
AB 74 (Chapter 23, Statutes of 2019)
State Plan Amendment (SPA) 19-0046

Interdependent Policy Changes:
Not Applicable

Background:
ABX3 5 (Chapter 20, Statutes of 2009), excluded specified optional benefits from coverage under the Medi-Cal program, effective July 1, 2009.

AB 74 reinstated coverage for audiology, optician and optical lab, incontinence creams and washes, podiatry, and speech therapy in the Medi-Cal program, no sooner than January 1, 2020. The optional benefits restoration for optician and optical lab is budgeted in the Restoration of Adult Optician and Optical Lab Svcs policy change. Managed care costs are budgeted in the managed care base capitation rates.

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is a net decrease due to the following:

- Managed care costs were removed because optional benefits restoration costs are now included in the managed care base capitation rates.
- Fee-for-Service (FFS) costs increased due to updated caseload.

The change in the current estimate, from FY 2019-20 to FY 2020-21 is due to including a full year of FFS costs in FY 2020-21.

OPTIONAL BENEFITS RESTORATION

REGULAR POLICY CHANGE NUMBER: 37

Methodology:

1. The specified optional benefits were reinstated effective January 1, 2020.

2. The estimated FFS cost for the audiology, incontinence creams and washes, podiatry, and speech therapy restoration are:

(Dollars in Thousands)

Optional Benefits Restoration	TF	GF	FFP
FY 2019-20	**$8,102**	**$2,871**	**$5,231**
FY 2020-21	**$16,297**	**$5,758**	**$10,539**

Funding:

FY 2019-20	TF	GF	FFP
50% Title XIX / 50% GF (4260-101-0001/0890)	$5,151,000	$2,576,000	$2,575,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	$2,951,000	$295,000	$2,656,000
Total	**$8,102,000**	**$2,871,000**	**$5,231,000**

FY 2020-21	TF	GF	FFP
50% Title XIX / 50% GF (4260-101-0001/0890)	$10,322,000	$5,161,000	$5,161,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	$5,975,000	$597,000	$5,378,000
Total	**$16,297,000**	**$5,758,000**	**$10,539,000**

MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

REGULAR POLICY CHANGE NUMBER:	38
IMPLEMENTATION DATE:	7/2019
ANALYST:	Manvir Lallian
FISCAL REFERENCE NUMBER:	28

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$20,232,000	$20,232,000
- STATE FUNDS	$10,116,000	$10,116,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$20,232,000	$20,232,000
STATE FUNDS	$10,116,000	$10,116,000
FEDERAL FUNDS	$10,116,000	$10,116,000

DESCRIPTION

Purpose:
This policy change estimates the cost of the Multipurpose Senior Services Program (MSSP) and the General Fund (GF) reimbursement to the Department.

Authority:
Welfare & Institutions Code 9560-9568
Welfare & Institutions Code 14132.275
Welfare & Institutions Code 14186
SB 1008 (Chapter 33, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

Background:
The MSSP provides social and health care management and purchases supplemental services to assist persons aged 65 and older who are "at risk" of needing nursing facility placement but who wish to remain in the community. The program provides services under a federal 1915(c) home and community-based services waiver for up to 11,370 participants in 9,283 participant slots in FY 2019-20 and FY 2020-21. The Coordinated Care Initiative (CCI) was previously scheduled to transition MSSP to a managed care benefit effective January 1, 2023. However, as of the development of this estimate, MSSP would no longer be transitioned to Managed Care and will be carved out of CCI, effective January 1, 2021. (Subsequent to the development of this estimate, the timeline for MSSP to be carved out of CCI has been delayed. Future estimates will reflect an updated assumption.) MSSP will operate as a waiver benefit in all CCI demonstration counties, as it did prior to the implementation of CCI in 2014.

The California Legislature approved a one-time appropriation, spread over a three-year period, to allow for a supplemental payment for MSSP Care Management and Care Management Support services, effective July 1, 2019. The supplemental payment is budgeted in the MSSP Supplemental Payment policy change.

MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

REGULAR POLICY CHANGE NUMBER: 38

The total MSSP reimbursement (both for fee-for-service and managed care) is budgeted in this policy change. The reimbursement for CCI activities are budgeted in the CCI-Administrative Costs policy change. The reimbursement is estimated to be $20,232,000 TF for FY 2019-20 and FY 2020-21.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21. There is no change from FY 2019-20 to FY 2020-21 in the current estimate.

Methodology:
1. The estimates below were provided by CDA on a cash basis.

Total MSSP	FY 2019-20	FY 2020-21
Total MSSP	$39,422,000	$29,827,000
MSSP Costs in CCI	($19,190,000)	($9,595,000)
Total MSSP in this PC	**$20,232,000**	**$20,232,000**

FY 2019-20	TF	GF	FF	GF Reimb.
MSSP in this PC	$20,232,000	$10,116,000	$10,116,000	$0
Total Reimb.	$0	($19,190,000)	$0	$19,190,000
Total	**$20,232,000**	**($9,074,000)**	**$10,116,000**	**$19,190,000**

FY 2020-21	TF	GF	FF	GF Reimb.
MSSP in this PC	$20,232,000	$10,116,000	$10,116,000	$0
Total Reimb.	$0	($9,595,000)	$0	$9,595,000
Total	**$20,232,000**	**$521,000**	**$10,116,000**	**$9,595,000**

Funding:
50% Title XIX FF / 50% GF (4260-101-0890/0001)
Reimbursement (4260-610-0995)

CCS DEMONSTRATION PROJECT

REGULAR POLICY CHANGE NUMBER:	39
IMPLEMENTATION DATE:	4/2013
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1775

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$11,122,000	$6,456,000
- STATE FUNDS	$5,074,480	$3,026,080
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$11,122,000	$6,456,000
STATE FUNDS	$5,074,480	$3,026,080
FEDERAL FUNDS	$6,047,520	$3,429,920

DESCRIPTION

Purpose:
This policy change estimates the costs of implementing organized health care delivery systems for the California Children's Services (CCS) Medi-Cal beneficiaries.

Authority:
ABX4 6 (Chapter 6, Statutes of 2009)
SB 208 (Chapter 714, Statutes of 2010)
California Bridge to Reform (BTR), Section 1115(a) Medicaid Demonstration
California Medi-Cal 2020, Section 1115(a) Demonstration

Interdependent Policy Changes:
Not Applicable

Background:
The BTR, approved by the Centers for Medicare and Medicaid Services effective November 1, 2010, and the Medi-Cal 2020 extension, allows the Department to develop and implement organized health care delivery models to provide comprehensive health care services to CCS Medi-Cal eligible children. This includes both primary preventive care and services specific to the child's CCS eligible health condition.

Rady Children's Hospital – San Diego (RCHSD) demonstration project was implemented effective July 1, 2018. RCHSD acts as an Accountable Care Organization in providing services to CCS-eligible Medi-Cal beneficiaries with any one or more of the following acute conditions: cystic fibrosis, acute lymphoid leukemia, sickle cell disease, hemophilia, and diabetes. Participating members must be under the age of 21, with the exception of treatment for diabetes type 1 and 2, which holds an age requirement of 1 to 10 years old. The Department entered into a risk corridor arrangement for the first 2.5 years of the program. This program is expected to end effective January 2021, to which this sub-population of Medi-Cal recipients will transition into other Managed Care plans within San Diego county.

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is an increase due to updated

CCS DEMONSTRATION PROJECT

REGULAR POLICY CHANGE NUMBER: 39

final Bridge Period rates for RCHSD. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease due to the program ending effective January 2021.

Methodology:

1. The RCHSD demonstration project implemented in July 2018 and FY 2018-19 payments began in November 2018, retroactive back to July 1, 2018.

2. Assume one month of the FY 2018-19 RCHSD rate will pay in FY 2019-20.

3. The Department implemented a onetime 18-month rating period for the period of July 1, 2019 through December 31, 2020, which is referred to as the Bridge Period.

4. Assume 11 months of the Bridge Period RCHSD rate will pay in FY 2019-20.

5. Assume seven months of the Bridge Period RCHSD rate will pay in FY 2020-21.

6. The final Bridge Period RCHSD rate and estimated monthly enrollment on an accrual basis are expected to be:

Fiscal Year	Average Monthly Enrollment	Capitation Rate	Average Monthly Payment	RCHSD Annual Payment
FY 2019-20	380	$2,427.02	$922,300	$11,067,000
FY 2020-21 (July-Dec 2020)	380	$2,427.02	$922,300	$5,534,000

7. Assume the June 2019 capitation payment will be deferred to July 2019.

8. Assume the final capitation payment will occur in January 2021.

9. The FY 2018-19 risk corridor data is estimated to be collected on June 30, 2020, as outlined within the RCHSD contract. Final risk corridor calculations for FY 2018-19 and any associated repayments or recoupments are expected to occur in FY 2020-21. An estimate is not available at this time.

10. Bridge Period risk corridor data is estimated to be collected on December 31, 2021, as outlined in the RCHSD contract. Bridge Period risk corridor calculations and any associated repayments or recoupments are expected to occur in FY 2021-22. An estimate is not available at this time.

11. Total estimated costs for FY 2019-20 and FY 2020-21 on a cash basis are:

FY 2019-20	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$9,520,000	$4,760,000	$4,760,000
88% Title XXI / 12% GF (4260-113-0001/0890)	$539,000	$65,000	$474,000
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)	$1,063,000	$250,000	$813,000
Total	**$11,122,000**	**$5,075,000**	**$6,047,000**

CCS DEMONSTRATION PROJECT

REGULAR POLICY CHANGE NUMBER: 39

FY 2020-21	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$5,520,000	$2,760,000	$2,760,000
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)	$535,000	$126,000	$409,000
65% Title XXI / 35% GF (4260-113-0001/0890)	$401,000	$140,000	$261,000
Total	**$6,456,000**	**$3,026,000**	**$3,430,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)
65% Title XXI / 35% GF (4260-113-0001/0890)

MEDI-CAL NONMEDICAL TRANSPORTATION

REGULAR POLICY CHANGE NUMBER:	40
IMPLEMENTATION DATE:	7/2019
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	2037

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$11,080,000	$27,700,000
- STATE FUNDS	$4,219,640	$10,737,290
PAYMENT LAG	0.8150	0.8890
% REFLECTED IN BASE	77.39 %	71.74 %
APPLIED TO BASE		
TOTAL FUNDS	$2,041,700	$6,959,100
STATE FUNDS	$777,560	$2,697,540
FEDERAL FUNDS	$1,264,170	$4,261,570

DESCRIPTION

Purpose:
This policy change estimates the Fee-for-Service (FFS) costs of covering Medi-Cal nonmedical transportation (NMT) services.

Authority:
AB 2394 (Chapter 615, Statutes of 2016)

Interdependent Policy Changes:
Not Applicable

Background:
AB 2394 added Welfare and Institutions Code Section 14132(ad), which requires Medi-Cal to cover NMT for all full-scope Medi-Cal beneficiaries, subject to utilization controls and federally permissible time and distance standards. AB 2394 defines Medi-Cal NMT services to include, at a minimum, round trip transportation by passenger car, taxicab, bus passes, taxi vouchers, train tickets, any other form of public or private transportation, and mileage reimbursement if a private vehicle (not arranged by a transportation broker) is used. NMT services shall be implemented only to the extent that federal financial participation is available and not otherwise jeopardized and any necessary federal approvals have been obtained.

In Medi-Cal FFS, NMT services are available as an indirect benefit and covered administratively at the local county through transportation resources reimbursed through the County-Based Medi-Cal Administrative Activities (CMAA) and Tribal Medi-Cal Administrative Activities (TMAA) as optional programs. Under CMAA/TMAA, local governmental agencies (LGA) that choose to provide NMT participate in CMAA/TMAA to perform administrative activities that directly support access to health care for beneficiaries. Managed care costs for providing NMT services are included in base capitation rates, and currently budgeted in the following policy changes: County Organized Health Systems, Two Plan Model, Regional Model, and Geographic Managed Care.

The Department is currently implementing a uniform and statewide NMT coverage and reimbursement policy to help ensure eligible FFS beneficiaries have access to the NMT benefit. The policy will enable

MEDI-CAL NONMEDICAL TRANSPORTATION

REGULAR POLICY CHANGE NUMBER: 40

NMT providers to bill Medi-Cal and be reimbursed for providing these services, subject to utilization controls. The NMT implementation for FFS will happen in two phases:

Phase I
Effective July 1, 2018, the Department's current network of existing non-emergency medical transportation (NEMT) providers, as well as new transportation providers specializing in NMT services can bill Medi-Cal and be reimbursed for providing services, subject to utilization control.

Phase II
The Department is working towards developing a policy and process for beneficiary reimbursement by procuring a contracted vendor to arrange for transportation services and/or reimburse beneficiaries for services provided in a private vehicle. Implementation date for phase II is projected to be January 1, 2021, and costs are budgeted in the Medi-Cal Nonmedical Transportation Phase II Broker Policy Change under Other Administration.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21. The change in the current estimate, from FY 2019-20 to FY 2020-21, is due to a higher estimated utilization in FY 2020-21.

Methodology:

1. Phase I for FFS NMT services started effective July 1, 2018. As a result of the provider enrollment process, it is estimated that payments will begin starting July 1, 2019. Due to the limited number of approved NMT providers, the Department does not anticipate any retroactive NMT claims.

2. Assume approximately 400,000 full scope FFS beneficiaries are eligible to utilize NMT services. Of these, approximately 157,000 beneficiaries are pregnant women and 243,000 are the remaining beneficiaries.

3. Assume that 10% of the 400,000 FFS beneficiaries will utilize NMT services in the first year and 25% will utilize these services in FY 2020-21.

4. Assume FFS pregnant women will utilize NMT services to visit their doctors seven times per year on average. It is estimated that all other beneficiaries will visit their doctors four times annually.

5. Assume each round-trip NMT service will cost approximately $53.50.

6. Costs for NMT services on an annual basis is estimated to be $27,700,000 TF.

   - Perinatal Services: (157,000 x 25%) x 7 x $53.50 = $14,699,000 TF
   - Non-Perinatal Services: (243,000 x 25%) x 4 x $53.50 = $13,001,000 TF

7. The first year costs are estimated to be $11,080,000 TF.

   - Perinatal Services: (157,000 x 10%) x 7 x $53.50 = $5,880,000 TF
   - Non-Perinatal Services: (243,000 x 10%) x 4 x $53.50 = $5,200,000 TF

MEDI-CAL NONMEDICAL TRANSPORTATION

REGULAR POLICY CHANGE NUMBER: 40

Funding:

FY 2019-20	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$7,822,000	$3,911,000	$3,911,000
88% Title XXI FF / 12% GF (4260-113-0001/0890)	$66,000	$8,000	$58,000
76.5% Title XXI FF / 23.5% GF (4260-113-0001/0890)	$196,000	$46,000	$150,000
93% ACA Title XIX FF / 7% GF (4260-101-0001/0890)	$1,498,000	$105,000	$1,393,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	$1,498,000	$150,000	$1,348,000
Total	**$11,080,000**	**$4,220,000**	**$6,860,000**

FY 2020-21	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$19,556,000	$9,778,000	$9,778,000
65% Title XXI FF / 35% GF (4260-113-0001/0890)	$491,000	$172,000	$319,000
76.5% Title XXI FF / 23.5% GF (4260-113-0001/0890)	$164,000	$38,000	$126,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	$7,489,000	$749,000	$6,740,000
Total	**$27,700,000**	**$10,737,000**	**$16,963,000**

MEDICALLY TAILORED MEALS PILOT PROGRAM

REGULAR POLICY CHANGE NUMBER:	41
IMPLEMENTATION DATE:	4/2018
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	2046

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$2,500,000	$1,430,000
- STATE FUNDS	$2,500,000	$1,430,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,500,000	$1,430,000
STATE FUNDS	$2,500,000	$1,430,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the contract cost to provide the Medically Tailored Meals Pilot Program (Pilot).

Authority:
Welfare & Institutions Code 14042.1

Interdependent Policy Changes:
Not Applicable

Background:
The Department will identify eligible Medi-Cal participants and providers to participate in a three-year Pilot, conducted in Alameda, Los Angeles, Marin, San Diego, San Francisco, San Mateo, Santa Clara, and Sonoma counties. The Pilot will provide medically tailored meal intervention services to Medi-Cal participants with congestive heart failure. The Department may establish additional eligibility requirements based upon acuity and other selection criteria. For 12 to 24 weeks, each participating Medi-Cal beneficiary in the Pilot will receive a standard intervention of up to 21 medically tailored meals per week, designed to meet the specific nutritional needs of the beneficiary's health condition. At the conclusion of the Pilot, the Department shall evaluate the impact on hospital readmissions, decreased admissions to long-term care facilities, and emergency room utilization.

The Department will reimburse contractors or entities that provide meal intervention services.

Reason for Change:
There is no change from the prior estimate, for FY 2019-20 and FY 2020-21, to the current estimate. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease due to remaining program funds being utilized in FY 2020-21.

Methodology:
1. The Pilot began in April 2018.

MEDICALLY TAILORED MEALS PILOT PROGRAM

REGULAR POLICY CHANGE NUMBER: 41

2. Assume the cost for **FY 2019-20** is **$2,500,000 TF** and **$1,430,000 TF** for **FY 2020-21**.

Funding:
100% GF (4260-101-0001)

YOUTH REGIONAL TREATMENT CENTERS

REGULAR POLICY CHANGE NUMBER:	42
IMPLEMENTATION DATE:	1/2014
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1772

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$2,061,000	$2,203,000
- STATE FUNDS	$16,000	$19,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,061,000	$2,203,000
STATE FUNDS	$16,000	$19,000
FEDERAL FUNDS	$2,045,000	$2,184,000

DESCRIPTION

Purpose:
This policy change budgets the federal financial participation (FFP) for Youth Regional Treatment Centers (YRTCs).

Authority:
Public Law 102-573 (Title 25, U.S.C. 1665c)
Public Law 93-638

Interdependent Policy Changes:
Not Applicable

Background:
The Department implemented the enrollment and reimbursement of YRTCs for services rendered to American Indian youths. Indian health clinics refer these youths to YRTCs for culturally appropriate in-patient substance use disorder treatment. The Department receives 100% Federal Medical Assistance Percentage for YRTC services provided to eligible American Indian Medi-Cal members under the age of 21.

Reason for Change from Prior Estimate:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to updated future rate adjustments for CY 2020 and CY 2021.

Methodology:
1. The program was implemented January 2014 with an effective date of September 1, 2013.

2. Assume the daily rate per youth is $683 in CY 2019, $729 in CY 2020, and $780 in CY 2021.

   CY 2019: $683 daily rate x 365 days ÷ 12 months = $20,775 monthly
   CY 2020: $729 daily rate x 365 days ÷ 12 months = $22,174 monthly
   CY 2021: $780 daily rate x 365 days ÷ 12 months = $23,725 monthly

YOUTH REGIONAL TREATMENT CENTERS

REGULAR POLICY CHANGE NUMBER: 42

FY 2019-20
Monthly enrollee costs:
8 enrollees x 6 months x $20,775 = $997,000
8 enrollees x 6 months x $22,174 = $1,064,000

$997,000 + $1,064,000 = **$2,061,000 TF**

FY 2020-21
Monthly enrollee costs:
8 enrollees x 6 months x $22,174 = $1,064,000
8 enrollees x 6 months x $23,725 = $1,139,000

$1,064,000 + $1,139,000 = **$2,203,000 TF**

3. Assume the program will pay expenditures at 50% GF/50% FFP upfront and receive 100% FFP reimbursement in the following quarter.

4. $250,000 FFP from the last quarter of FY 2018-19 will be reimbursed in FY 2019-20 and $266,000 from the last quarter FY 2019-20 will be reimbursed in FY 2020-21.

FY 2019-20	TF	GF	FFP
*Apr - June 2019	$0	($250,000)	$250,000
Jul - Sep 2019	$499,000	$0	$499,000
Oct - Dec 2019	$498,000	$0	$498,000
Jan - Mar 2020	$532,000	$0	$532,000
**Apr - Jun 2020	$532,000	$266,000	$266,000
Total	**$2,061,000**	**$16,000**	**$2,045,000**

FY 2020-21	TF	GF	FFP
*Apr - June 2020	$0	($266,000)	$266,000
Jul - Sep 2020	$532,000	$0	$532,000
Oct - Dec 2020	$532,000	$0	$532,000
Jan - Mar 2021	$569,000	$0	$569,000
**Apr - Jun 2021	$570,000	$285,000	$285,000
Total	**$2,203,000**	**$19,000**	**$2,184,000**

Totals may differ due to rounding

* FFP reimbursement from previous quarter
** FFP to be reimbursed in the following fiscal year

Funding:
50% Title XIX FFP / 50% GF (4260-101-0890/0001)
100% Title XIX FFP (4260-101-0890)

PEDIATRIC PALLIATIVE CARE WAIVER

REGULAR POLICY CHANGE NUMBER:	43
IMPLEMENTATION DATE:	7/2013
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1787

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$1,033,000	$0
- STATE FUNDS	$1,033,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,033,000	$0
STATE FUNDS	$1,033,000	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates payment and reimbursement costs to participating Pediatric Palliative Care Waiver (PPCW) providers.

Authority:
AB 1745 (Chapter 330, Statutes of 2006)
Social Security Act, Section 1915(c)

Interdependent Policy Changes:
Not Applicable

Background:
AB 1745 required the Department to submit a federal waiver application through the Centers for Medicare and Medicaid Services (CMS) 1915(c) waiver option for a Pediatric Palliative Care pilot project. The PPCW makes available services comparable to those available through hospice that can be provided at the same time the child would receive curative services. The PPCW was approved from April 1, 2009, through December 26, 2017.

Due to technical constraints in the Medi-Cal automated claims payment system, all PPCW provider claims for payment of PPCW services could not be processed in the automated system. The Department began manually paying claims using the Payment Adjustment Notice (PAN) process for providers serving PPCW beneficiaries, which resulted in unpaid and partially paid claims for FY 2009-10 through FY 2014-15. The Department transferred claims processing back to the Fiscal Intermediary for claims with dates of service after July 1, 2016. All unpaid or partially paid claims from January 1, 2014, through June 30, 2016, will be paid in FY 2019-20. Any unpaid or partially paid claims past the two year claiming limit will be paid at 100% GF.

Effective July 1, 2013, the Department began reimbursing PPCW agencies $300 per member per month (PMPM) for administrative costs. The Department received approval on June 29, 2017, for a waiver amendment to include a supplemental payment for specified services to be paid no sooner than July 1, 2017. The supplemental payment is necessary to address the enhanced burden on providers

PEDIATRIC PALLIATIVE CARE WAIVER

REGULAR POLICY CHANGE NUMBER: 43

due to the implementation of new conflict of interest requirements, provider retention, enhanced training and certification for waiver providers, and to improve access.

The Department submitted a waiver renewal application on September 29, 2017, to request a new five-year waiver term. After discussions with CMS, the Department determined there were service delivery issues with the waiver and to end the PPC Waiver and transition current waiver participants to other systems of care, effective January 1, 2019. On August 6, 2016, CMS approved a temporary extension through November 11, 2018. On October 3, 2018, the new waiver term was approved for November 1, 2018, through December 31, 2018, transitional term. CMS approved a November 1, 2018, effective date based on the transition plan provided by the Department.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a decrease due to a revision in exact amount needed to be paid in FY 2019-20. There is no change for FY 2020-21 from the prior estimate. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease due to no dollars estimated for FY 2020-21 as the program has ended.

Methodology:
1. Underpaid and improperly denied claims from January 1, 2009, through December 31, 2018, equals $1,033,000 TF.

2. Total estimated PPCW costs are:

FY 2019-20	TF	GF	FF
Back Payments	$1,033,000	$1,033,000	$0
FY 2019-20 Total	**$1,033,000**	**$1,033,000**	**$0**

Funding:
100% GF (4260-101-0001)

FREE CLINIC OF SIMI VALLEY

REGULAR POLICY CHANGE NUMBER:	44
IMPLEMENTATION DATE:	10/2019
ANALYST:	Matt Wong
FISCAL REFERENCE NUMBER:	2149

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$700,000	$0
- STATE FUNDS	$700,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$700,000	$0
STATE FUNDS	$700,000	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change budgets the one-time funding allocation to the Free Clinic of Simi Valley.

Authority:
Budget Act of 2019 (AB 74)

Interdependent Policy Changes:
Not Applicable

Background:
The Department of Health Care Services (Department) will provide one-time funding of $700,000 GF to the Free Clinic of Simi Valley.

Reason for Change:
There is no change from the prior estimate for FY 2019-20. There is no change from the prior estimate for FY 2020-21. The change in the current estimate, from FY 2019-20 to FY 2020-21, is a decrease due to the one-time funding concluding in FY 2019-20.

Methodology:
1. The Department will provide one-time funding of $700,000 GF to the Free Clinic of Simi Valley in FY 2019-20.

Funding:
100% Title XIX GF (4260-101-0001)

CCT FUND TRANSFER TO CDSS

REGULAR POLICY CHANGE NUMBER:	45
IMPLEMENTATION DATE:	10/2011
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1562

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$175,000	$175,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$175,000	$175,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$175,000	$175,000

DESCRIPTION

Purpose:
This policy change estimates the enhanced federal funding associated with providing the California Department of Social Services (CDSS) additional Title XIX for waiver services provided to Medi-Cal beneficiaries who participate in the California Community Transitions (CCT) project.

Authority:
Federal Deficit Reduction Act (DRA) of 2005 (P.L. 109-171), Section 6071
Affordable Care Act (ACA) (P.L. 111-148), Section 2403)
Medicaid Extenders Act of 2019 (P.L. 116-3), Section 2
Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16), Section 5
Sustaining Excellence in Medicaid Act of 2019 (P.L. 116-39), Section 4
Further Consolidated Appropriations Act, 2020 (P.L. 116-94), Section 205
IA 10-87274 (CDSS)

Interdependent Policy Changes:
Not Applicable

Background:
In January 2007, the Centers for Medicare and Medicaid Services (CMS) awarded the Department a Money Follows the Person (MFP) Rebalancing Demonstration Grant, called the CCT. The CCT demonstration is authorized under Section 6071 of the Federal DRA of 2005 and was extended by the ACA.

On January 24, 2019, the federal Medicaid Extenders Act of 2019 was passed into law and authorized MFP state grantees to continue to transition people to through December 31, 2019, using available MFP funding. The Extenders Act provided CMS with authority to allocate new funding to state grantees for FY 2019-20, to allow funding appropriated through the Extenders Act to be spent through 2023.

On August 6, 2019, the federal Sustaining Excellence in Medicaid Act of 2019 was signed into law and appropriated additional federal funds for allocation to MFP state grantees.

CCT FUND TRANSFER TO CDSS

REGULAR POLICY CHANGE NUMBER: 45

On December 20, 2019, the Further Consolidated Appropriations Act, 2020 amended the DRA of 2005 to extend the term of the MFP grant by five months, from January 1, 2020 to May 22, 2020. The grant requires the Department to develop and implement strategies to assist Medi-Cal eligible individuals, who have continuously resided in health care facilities for 90 days or longer, transition into qualified residences with the support of Medi-Cal HCBS.

DD transitions were discontinued, effective July 1, 2018.

Reason for Change:
The change from the prior estimate for FY 2019-20 is a decrease due to slightly lower CCT enrollees than previously estimated. The change from the prior estimate for FY 2020-21 is an increase due to the extension of the grant. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to the extension of the grant.

Methodology:

1. The Department provides HCBS to CCT participants who are receiving IHSS. The Department provides federal funding to CDSS as the base federal match through HCBS policy changes.

2. CCT services are reimbursed at 75% FFP and 25% GF. The GF for CDSS is provided by CDSS and is budgeted in the Personal Care Services (Misc. Svcs.) policy change.

3. In FY 2010-11, the Department established IA 10-87274 with CDSS. The IA transfers the additional 25% FFP for HCBS provided to CCT participants who are receiving IHSS services during their 365 days of participation in the CCT demonstration.

4. It is assumed that 33% of all non-DD enrollees utilize IHSS under CCT. Assume each case costs $10,877 in FY 2019-20 and FY 2020-21. The Department will provide 25% of these costs to CDSS.

5. Assume 195 non-DD beneficiaries will transition in FY 2019-20 and in FY 2020-21.

6. Assume the federal government will issue a new grant award for $22,836,000 TF in CY 2020, based on federal projections, which will allow CCT transitions to continue through December 31, 2020.

7. Assume the federal government will issue a new grant award for $22,836,000 TF in CY 2021, based on federal projections, which will allow CCT transitions to continue through December 31, 2021.

CCT FUND TRANSFER TO CDSS

REGULAR POLICY CHANGE NUMBER: 45

FY 2019-20	TF	GF	FF
CCT Costs (PC 36):			
Non-DD GF costs and Total FFP	$3,857,000	$876,000	$2,981,000
Accounting Memos and DDS Invoices	$24,332,000	$5,503,000	$18,829,000
Total Costs	$28,189,000	$6,379,000	$21,810,000
CCT Savings:			
Total Non-DD GF savings and Total FFP	($13,414,000)	($6,707,000)	($6,707,000)
CCT Fund Transfer to CDSS (PC 45)	**$175,000**	**$0**	**$175,000**
CCT Outreach - Admin costs (OA 47)	$290,000	$0	$290,000
Total of CCT PCs including pass through	$15,240,000	($328,000)	$15,568,000

*The savings are included in the total, however, they are fully reflected in the base estimates.

FY 2020-21	TF	GF	FF
CCT Costs (PC 36):			
Total Non-DD GF costs and Total FFP	$4,074,000	$930,000	$3,144,000
CCT Savings:			
Total Non-DD GF savings and Total FFP	($14,884,000)	($7,442,000)	($7,442,000)
CCT Fund Transfer to CDSS (PC 45)	**$175,000**	**$0**	**$175,000**
CCT Outreach - Admin costs (OA 47)	$360,000	$0	$360,000
Total of CCT PCs including pass through	($10,275,000)	($6,512,000)	($3,763,000)

*The savings are included in the total, however, they are fully reflected in the base estimates.

Funding:
MFP Federal Grant (4260-106-0890)

DIABETES PREVENTION PROGRAM

REGULAR POLICY CHANGE NUMBER:	46
IMPLEMENTATION DATE:	7/2020
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	2056

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$676,000
- STATE FUNDS	$0	$239,200
PAYMENT LAG	1.0000	0.7940
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$536,700
STATE FUNDS	$0	$189,920
FEDERAL FUNDS	$0	$346,820

DESCRIPTION

Purpose:
This policy change estimates the Fee-for-Service (FFS) costs associated with developing and implementing the Diabetes Prevention Program (DPP).

Authority:
SB 97 (Chapter 52, Statutes of 2017)
AB 1810 (Chapter 34, Statutes of 2018)
Welfare & Institutions Code, Section 14149.9

Interdependent Policy Changes:
Not Applicable

Background:
AB 1810 required the Department to establish the DPP as a Medi-Cal covered benefit in FFS and managed care. The new DPP benefit was established on January 1, 2019 consistent with the Centers for Disease Control and Prevention's (CDC) guidelines. The program incorporated many components of the Centers for Medicare and Medicaid Services' (CMS) DPP in Medicare. The DPP is an evidence-based, lifestyle change program designed to prevent or delay Type 2 diabetes among people who have prediabetes and women with a previous diagnosis of gestational diabetes.

Medi-Cal providers choosing to offer DPP services must comply with CDC guidance and obtain CDC recognition in connection with the National Diabetes Prevention Recognition Program (DPRP). DPP services will be provided through trained peer coaches who use a CDC-approved curriculum. The CDC's DPP curriculum promotes realistic lifestyle changes, emphasizing weight loss through exercise, healthy eating and behavior modification.

Medi-Cal's DPP benefit consists of the following:

- Core Sessions (Months 1-6) – The Core Sessions consist of at least 16 sessions over the first six months. Payments for the core sessions are attendance and performance based.

DIABETES PREVENTION PROGRAM

REGULAR POLICY CHANGE NUMBER: 46

- Core Maintenance Sessions (Months 7-12) – The Core Maintenance Sessions include two intervals of two-monthly sessions; Payments for these sessions are performance based, depending on whether the required weight loss was achieved.
- Ongoing Maintenance Sessions (Months 13-24) – consists of up to four intervals of 3-monthly ongoing maintenance sessions offered during months 13 through 24 of the DPP services period.

Managed care costs for DPP are included in base capitation rates, and currently budgeted in the following policy changes: County Organized Health Systems, Two Plan Model, Regional Model, and Geographic Managed Care.

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is a decrease due to no expected payments until July 2020 due to provider enrollment delays, and no Ongoing Maintenance costs incurring in FY 2020-21.

The change in the current estimate, from FY 2019-20 to FY 2020-21, is due to no costs incurring in FY 2019-20 as a result of implementation delays.

Methodology:
1. Assume DPP payments will start July 1, 2020.

2. Total annual cost for the Core Sessions is estimated to be $907,000 TF.

Core Sessions – Attendance:	$634,000 TF
Core Sessions – Performance:	$273,000 TF

3. Assume a six-month phase-in for beneficiary participation in the Core Sessions beginning July 1, 2020. Assume Performance payments will be phased-in over a six-month period and will be paid at the end of Core Sessions, beginning January 1, 2021, on a six-month phase in basis.

4. Total annual cost for the Core Maintenance Sessions is estimated to be $323,000 TF.

5. Assume Core Maintenance Sessions will start January 1, 2021, and will be phased-in over a six-month period.

6. Total annual cost for the Ongoing Maintenance Sessions is estimated to be $170,000 TF.

7. Assume Ongoing Maintenance Sessions will start July 1, 2021, and will be phased-in over a six-month period.

8. Total estimated payments are:

DPP	Annual	FY 2020-21
Core Sessions – Attendance	$634,000	$502,000
Core Sessions – Performance	$273,000	$80,000
Core Maintenance	$323,000	$94,000
Ongoing Maintenance	$170,000	$0
Total	**$1,400,000**	**$676,000**

DIABETES PREVENTION PROGRAM

REGULAR POLICY CHANGE NUMBER: 46

Funding:

DPP	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$429,000	$214,000	$215,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	$247,000	$25,000	$222,000
Total	**$676,000**	**$239,000**	**$437,000**

ASTHMA MITIGATION PROJECT

REGULAR POLICY CHANGE NUMBER:	47
IMPLEMENTATION DATE:	2/2020
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	2148

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$15,000,000	$0
- STATE FUNDS	$15,000,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$15,000,000	$0
STATE FUNDS	$15,000,000	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the costs for the asthma mitigation project.

Authority:
AB 74 (Chapter 23, Statutes of 2019)

Interdependent Policy Changes:
Not Applicable

Background:
AB 74 allocates $15 million General Fund (GF) to establish a project to fund local health departments or local community-based providers and organizations to offer asthma mitigation, education, and disease-management services.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 or FY 2020-21.

The change in the current estimate, from FY 2019-20 to FY 2020-21, is due to the completion in FY 2019-20.

Methodology:
1. Payment for the asthma mitigation project was completed in February 2020.

(Dollars in Thousands)

FY 2019-20	TF	GF
Asthma Mitigation Project	$15,000	$15,000

Funding:
100% General Fund (4260-101-0001)

EXPANSION TO SCREENING FOR ADDITIONAL SUBSTANCES

REGULAR POLICY CHANGE NUMBER: 48
IMPLEMENTATION DATE: 7/2020
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2158

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$1,559,000
- STATE FUNDS	$0	$562,300
PAYMENT LAG	1.0000	0.8300
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$1,294,000
STATE FUNDS	$0	$466,710
FEDERAL FUNDS	$0	$827,260

DESCRIPTION

Purpose:
This policy change estimates the cost to provide screenings for additional substances in primary care settings to beneficiaries over 21 years of age.

Authority:
SB 78 (Chapter 38, Statutes of 2019)

Interdependent Policy Changes:
Not Applicable

Background:
The Department currently screens Medi-Cal beneficiaries for alcohol misuse per the United States Preventive Services Task Force (USPSTF) recommendation. The Department is adding screening for additional substances (i.e., drug use and abuse) as a Medi-Cal benefit for beneficiaries over age 21. Medi-Cal children, ages 0-21 years old, are screened for alcohol and drug use under the American Academy of Pediatrics (AAP) Bright Futures Health tobacco, alcohol, and drug use assessments.

SB 78 requires the Department to expand the Medi-Cal benefit for adult Alcohol Misuse Screening and Behavioral Counseling Interventions in Primary Care to include screening for additional substances (i.e., opioids and other drugs). In addition, in June 2020, the USPSTF assigned a “B” rating to” Unhealthy Drug Use Screening” for adults ages 18 and older, making it a mandatory benefit under the Preventive Services component (Item 13(c)) of the Department’s approved Medicaid State Plan. Adding this benefit will identify, reduce, and prevent problematic use, abuse, and dependence on drugs.

Managed care costs for the screenings are included in base capitation rates, and currently budgeted in the following policy changes: County Organized Health Systems, Two Plan Model, Regional Model, and Geographic Managed Care.

EXPANSION TO SCREENING FOR ADDITIONAL SUBSTANCES

REGULAR POLICY CHANGE NUMBER: 48

Reason for Change:
The change from the prior estimate, for FY 2020-21, is a decrease due to removing managed care costs because screening costs for additional substances are now included in the managed care base capitation rates.

The change in the current estimate, from FY 2019-20 to FY 2020-21, is due to no costs incurring in FY 2019-20.

Methodology:
1. Assume expansion to screening for additional substances will be implemented July 1, 2020.

2. Total estimated payments for the screenings are:

FY 2020-21	TF	GF	Title XIX
Additional Substances Screening	$1,559,000	$562,000	$997,000

Funding:

FY 2020-21	TF	GF	FFP
50% Title XIX / 50% GF (4260-101-0001/0890)	$1,016,000	$508,000	$508,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	$543,000	$54,000	$489,000
Total	**$1,559,000**	**$562,000**	**$997,000**

MEDICAL INTERPRETERS PILOT PROJECT

REGULAR POLICY CHANGE NUMBER:	49
IMPLEMENTATION DATE:	6/2020
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1989

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$5,000,000	$0
- STATE FUNDS	$5,000,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$5,000,000	$0
STATE FUNDS	$5,000,000	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the costs for establishing a medical interpreters pilot project.

Authority:
SB 165 (Chapter 365, Statutes of 2019)

Interdependent Policy Changes:
Not Applicable

Background:
SB 165 appropriated $5 million General Fund (GF) for the support of medical interpreters pilot projects through June 30, 2024. Pilot projects will be awarded to up to four contracts to deliver language assistance services to patients/clients who are unserved or underserved because they are limited English proficient.

Per SB 165, the Department will work with the stakeholders to conduct a study to identify current requirements for medical interpretation services as well as education, training, and licensure requirements, analyze other state Medicaid programs, and make recommendations on strategies that may be employed regarding the provision of medical interpretation services for Medi-Cal beneficiaries who are limited English proficient (LEP), in compliance with applicable state and federal requirements.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 or FY 2020-21.

The change in the current estimate, from FY 2019-20 to FY 2020-21, is due to payments being allocated in FY 2019-20.

MEDICAL INTERPRETERS PILOT PROJECT

REGULAR POLICY CHANGE NUMBER: 49

Methodology:

1. Assume payments for the one-time pilot project will be completed in June 2020.

FY 2019-20	TF	GF
Medical Interpreters Pilot Project	**$5,000,000**	**$5,000,000**

Funding:

100% General Fund (4260-101-0001)

WHOLE CHILD MODEL IMPLEMENTATION

REGULAR POLICY CHANGE NUMBER:	50
IMPLEMENTATION DATE:	7/2018
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1971

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$7,323,000	$0
- STATE FUNDS	-$3,372,260	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$7,323,000	$0
STATE FUNDS	-$3,372,260	$0
FEDERAL FUNDS	-$3,950,740	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of shifting services for California Children's Services (CCS) eligible children from Fee-for-Service (FFS) to the existing managed care County Organized Health System (COHS) under the Whole-Child Model (WCM).

Authority:
Welfare & Institutions Code 14093-14094.3

Interdependent Policy Changes:
Not applicable

Background:
Building on existing successful models and delivery systems, the WCM provides an organized delivery system of care for comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals, specialty care providers, and counties. The WCM will improve care coordination and remove fragmented healthcare delivery by providing comprehensive healthcare inclusive of CCS eligible conditions and primary care for children with special healthcare needs.

The WCM incorporates CCS services into the integrated care systems of select counties in the existing managed care COHS. The implementation process occurred in phases and includes an initial readiness review and ongoing monitoring following implementation to ensure continuity of care and continued access to specialty care. These plans are required to demonstrate support from various stakeholders that may include the respective counties CCS program, local providers and hospitals, and local families of children with CCS eligible conditions or local advocacy groups representing those families.

Phase One of the implementation process began July 1, 2018, and six of the twenty-one designated COHS counties transitioned. Phase Two of the implementation process began January 1, 2019, and fourteen of the twenty-one designated COHS counties transitioned. Phase Three of the implementation process occurred on July 1, 2019, and included one remaining designated COHS County.

WHOLE CHILD MODEL IMPLEMENTATION

REGULAR POLICY CHANGE NUMBER: 50

Implementation in designated counties was dependent on a readiness review completed by the Department.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is a net decrease in savings due to a reduction in lagged claims and savings. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease due to full phase-in of transitioned eligibles.

Methodology:

1. Assume the transition will occur as follows:
    - Phase One: CCS services for the CCS Medi-Cal population incorporated into COHS Medi-Cal managed care plans starting July 1, 2018, for the following six counties: San Luis Obispo, Santa Barbara, Merced, Monterey, Santa Cruz, and San Mateo Counties,
    - Phase Two: CCS services for the CCS Medi-Cal population incorporated into COHS Medi-Cal managed care plans starting January 1, 2019, for the following fourteen counties: Del Norte, Humboldt, Lases, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo Counties, and
    - Phase Three: CCS services for the CCS Medi-Cal population in Orange County incorporated into a COHS Medi-Cal managed care plan starting July 1, 2019.

2. The payments are assumed to only include lagged FFS claims and FFS savings for Phase Three implementation counties that transferred from FFS to Managed Care.

3. Based on a lag in processing FFS claims and FFS savings, the estimated costs/(savings) are:

    FY 2019-20: ($7,323,000) TF and ($3,372,000) GF

Funding:
50% Title XIX / 50% GF (4260-101-0890/0001)
88% Title XXI / 12% GF (4260-113-0890/0001)
76.5% Title XXI / 23.5% GF (4260-113-0890/0001)

PHARMACIST-DELIVERED MEDI-CAL SERVICES

REGULAR POLICY CHANGE NUMBER:	51
IMPLEMENTATION DATE:	1/2021
ANALYST:	Autumn Recce
FISCAL REFERENCE NUMBER:	2120

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	-$949,000
- STATE FUNDS	$0	-$355,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$949,000
STATE FUNDS	$0	-$355,300
FEDERAL FUNDS	$0	-$593,700

DESCRIPTION

Purpose:
This policy change estimates the savings for the elimination of reimbursing pharmacies for certain pharmacist-delivered services under Medi-Cal.

Authority:
Proposed Trailer Bill Language

Interdependent Policy Changes:
Not Applicable

Background:
AB 1114 (Chapter 602, Statutes of 2016) required the Department to allow the following services as a pharmacy benefit under the Medi-Cal program, subject to the Centers for Medicare and Medicaid Services (CMS) approval:

- Furnish travel medications;
- Furnish naloxone hydrochloride;
- Furnish self-administered hormonal contraception;
- Administer immunizations; and,
- Provide tobacco cessation counseling and furnishing nicotine replacement therapy.

The Department reimburses pharmacies for the provision of the services listed above, allowable under Medi-Cal, and the reimbursement rate is 85% of the physician fee schedule. The Board of Pharmacy requires pharmacists to be trained and certified to provide these services. Pharmacies bill the Department for these services using three physician procedure codes.

A State Plan Amendment (SPA) for the services and the new payment methodology was approved by CMS on November 26, 2018. AB 1114 mandates the Department to adopt new regulations by July 1, 2021. The SPA and new payment methodology became effective April 1, 2019.

Effective no sooner than July 1, 2020, the Department proposes to eliminate this benefit.

-- DELETED --

PHARMACIST-DELIVERED MEDI-CAL SERVICES

REGULAR POLICY CHANGE NUMBER: 51

Reason for Change:
The change from the prior estimate for FY 2019-20 is due to the costs are fully captured in the FFS base. The change in FY 2020-21, from the prior estimate, is due to eliminating this benefit. The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to eliminating this benefit.

Methodology:
1. Assume this benefit is eliminated effective no sooner than July 1, 2020.

2. On a cash basis, the savings is estimated to be:

FY 2020-21	TF	GF	FF
50% Title XIX / 50% GF	($651,000)	($325,000)	($326,000)
90% Title XIX/ 10% GF	($298,000)	($30,000)	($268,000)
Total	**($949,000)**	**($355,000)**	**($594,000)**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)

-- DELETED --

MEDI-CAL RX - MANAGED CARE PHARMACY BENEFIT TO FFS

REGULAR POLICY CHANGE NUMBER:	52
IMPLEMENTATION DATE:	1/2021
ANALYST:	Autumn Recce
FISCAL REFERENCE NUMBER:	2165

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	-$132,951,000
- STATE FUNDS	$0	-$54,570,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$132,951,000
STATE FUNDS	$0	-$54,570,800
FEDERAL FUNDS	$0	-$78,380,200

DESCRIPTION

Purpose:
This policy change estimates the net cost for Medi-Cal Rx by transitioning the Medi-Cal pharmacy services from Managed Care (MC) to Fee-For Service (FFS) delivery system.

Authority:
Executive Order N-01-19

Interdependent Policy Changes:
Medi-Cal Rx – Additional Savings from MAIC in FFS

Background:
On January 7, 2019, the Governor issued Executive Order N-01-19, requiring that all Medi-Cal pharmacy services be transitioned from MC to FFS by January 1, 2021. Transitioning pharmacy services from MC to FFS delivery system is referred to as Medi-Cal Rx.

The Department estimates total savings from Medi-Cal Rx will be approximately $401 million GF annually. This figure takes into consideration many factors including, but not limited to the following:

- Increases in FFS Medi-Cal drug spending, based upon the FY 2018-19 MC utilization of drugs and other-related supplies provided by a pharmacy.
- New pharmacy administrative costs in FFS for claims payment and utilization management.
- Reductions in MC related administrative costs when compared to what would have been paid by the Department under existing managed care rates.
- Additional savings from implementation of a Maximum Allowable Ingredient Cost (MAIC) policy in FFS.
- Non-hospital 340B clinic savings based on data received from those facilities.
- Additional supplemental rebate savings for the MC utilization shift to FFS and existing FFS.

Medi-Cal Rx includes the following when billed by a pharmacy on a pharmacy claim:

- Covered Outpatient Drugs, including Physician Administered Drugs (PADs)
- Medical Supplies

MEDI-CAL RX - MANAGED CARE PHARMACY BENEFIT TO FFS

REGULAR POLICY CHANGE NUMBER: 52

- Enteral Nutritional Products

Related to Medi-Cal Rx, the Department is seeking the following three statutory changes via trailer bill:

- Elimination of the Medi-Cal six prescription limit,
- Elimination of the voluntary one dollar ($1.00) Medi-Cal pharmacy copayment, and
- Redefining the California definition of Best Price to include drugs outside the United States.

This policy change is part of the carve-out effort transitioning MC pharmacy services to the FFS delivery system for all MC contracts except for the Cal Medi Connect (CMC) dual contracts. The Centers for Medicare and Medicaid Services has required the CMC dual program to continue to cover this benefit for their enrolled members until the Coordinate Care Initiative ends December 31, 2022. The PCs related to Medi-Cal Rx are:

Regular

- Medi-Cal Rx – Managed Care Pharmacy Benefit to FFS
- Medi-Cal Rx – Additional Savings from MAIC in FFS
- Medical Supply Rebates

Other Admin

- Medi-Cal Rx – Administrative Costs

Reason for Change:
There is no change from the prior estimate for FY 2019-20.

The change from the prior estimate for FY 2020-21 is a decrease in savings due to removing the MC pharmacy and related administration savings for the CMC dual contracts.

The change from FY 2019-20 to FY 2020-21, in the current estimate is due to this policy change being implemented on January 1, 2021.

Methodology:

1. The Department will transition MC pharmacy costs beginning January 1, 2021.

2. The Department expects savings related to Medi-Cal Rx will be phased-in gradually, reaching approximately $401 million in General Fund savings.

3. The estimated MC pharmacy savings and the related MC administration savings is $5,822,082,000 TF annually.

4. Costs for FFS pharmacy costs are estimated to be $5,650,063,000 TF annually.

5. The Department expects saving related to non-hospital 340B clinics to be $147,000,000 TF annually.

MEDI-CAL RX - MANAGED CARE PHARMACY BENEFIT TO FFS

REGULAR POLICY CHANGE NUMBER: 52

6. The estimated annual savings is:

(Dollars in Thousands)

Annual	TF	GF	FF
Estimated Managed Care Pharmacy Savings	($5,588,605)	($1,866,063)	($3,722,542)
Managed Care Related Administrative Cost Savings	($233,477)	($77,959)	($155,518)
Net Managed Care Savings	($5,822,082)	($1,944,022)	($3,878,060)
Estimated Fee-For-Service Pharmacy Costs	$5,650,063	$1,886,584	$3,763,479
Estimated Non-Hospital 340B Savings	($147,000)	($73,500)	($73,500)
Total MC to FFS	($319,019)	($130,938)	($188,081)

7. The estimated cost for FY 2020-21 is:

(Dollars in Thousands)

FY 2020-21 (Lagged)	TF	GF	FF
Estimated Managed Care Pharmacy Savings	($2,328,585)	($777,526)	($1,551,059)
Managed Care Related Administrative Cost Savings	($97,282)	($32,483)	($64,799)
Net Managed Care Savings	($2,425,867)	($810,009)	($1,615,858)
Estimated Fee-For-Service Pharmacy Costs	$2,354,193	$786,077	$1,568,116
Estimated Non-Hospital 340B Savings	($61,277)	($30,638)	($30,639)
Total MC to FFS	**($132,951)**	**($54,570)**	**($78,381)**

Funding:

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	($100,963)	($50,482)	($50,482)
90% Title XIX / 10% GF (4260-101-0001 / 0890)	($28,426)	($2,843)	($25,583)
65% Title XXI / 35% GF(4260-113-0001 / 0890)	($3,562)	($1,247)	($2,315)
Total	**($132,951)**	**($54,571)**	**($78,380)**

MEDI-CAL DRUG REBATE FUND

REGULAR POLICY CHANGE NUMBER:	53
IMPLEMENTATION DATE:	11/2019
ANALYST:	Autumn Recce
FISCAL REFERENCE NUMBER:	2124

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the transfer of drug rebate collections from the Medi-Cal Drug Rebate Fund to the General Fund (GF).

Authority:
SB 78 (Chapter 38, Statues of 2019)

Interdependent Policy Changes:
Not Applicable

Background:
SB 78 established the Medi-Cal Drug Rebate Fund, effective July 1, 2019. The non-federal share of federal and state supplemental Medi-Cal rebate collections will be deposited into the Medi-Cal Drug Rebates Fund. Transfers will occur from the Medi-Cal Drug Rebate Fund to offset the GF.

For information on the federal share of the rebate collections, see the Federal Drug Rebates, State Supplemental Drug Rebates, Managed Care Drug Rebates, Family PACT Drug Rebates, and BCCTP Drug Rebates policy changes.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is an increase in the GF transfer based on:

- Actual rebate collection data through February 2020, which resulted in higher rebate collections projected in FY 2019-20, and
- Including an estimated reserve in FY 2019-20.

The change from the prior estimate, for FY 2020-21 is an increase in the GF transfer based on including funds from the FY 2019-20 fund reserve and the estimated FY 2020-21 rebate collections, to be transferred in FY 2020-21.

MEDI-CAL DRUG REBATE FUND

REGULAR POLICY CHANGE NUMBER: 53

The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to including higher rebate collections projected in FY 2019-20, adding to the balance available to be transferred in FY 2020-21.

Methodology:

1. In FY 2019-20, it is estimated that $1.36 billion will be transferred from the Medi-Cal Drug Rebate Fund to the GF and $1.64 billion will be transferred from the Medi-Cal Drug Rebate Fund to the GF in FY 2020-21.

2. An estimated reserve of $169.6 million will remain in the Medi-Cal Drug Rebate Fund in FY 2019-20. In FY 2020-21, due to the severe State budget shortfall related to the COVID-19 pandemic, all rebate collections will be transferred to the GF leaving no reserve in the Medi-Cal Drug Rebate Fund.

3. The summary of the non-federal share and federal share of the estimated FY 2019-20 and FY 2020-21 rebates and the estimated reserve for each respective fiscal year are:

(Dollars in Thousands)

Summary of Drug Rebates	**TF**	**Fund 3331**	**FF**
Federal Drug Rebates	($2,350,263)	($795,703)	($1,554,560)
State Supplemental Drug Rebates	($133,281)	($31,390)	($101,891)
Managed Care Drug Rebates	($2,368,863)	($701,713)	($1,667,150)
Family PACT Drug Rebates	($26,142)	($3,530)	($22,612)
BCCTP Drug Rebates	($6,555)	($2,091)	($4,464)
Subtotal Rebates	($4,885,104)	($1,534,427)	($3,350,677)
Estimated FY 2019-20 Reserve		$169,629	
Medi-Cal Drug Rebate Fund Transfer		**($1,364,798)**	

(Dollars in Thousands)

Summary of Drug Rebates	**TF**	**Fund 3331**	**FF**
Federal Drug Rebates	($2,176,494)	($737,279)	($1,439,215)
State Supplemental Drug Rebates	($155,301)	($41,201)	($114,100)
Managed Care Drug Rebates	($2,196,097)	($691,653)	($1,504,444)
Family PACT Drug Rebates	($11,542)	($1,526)	($10,016)
BCCTP Drug Rebates	($7,435)	($2,354)	($5,081)
Subtotal Rebates	($4,546,869)	($1,474,013)	($3,072,856)
Estimated FY 2019-20 Reserve Transfer		($169,629)	
Medi-Cal Drug Rebate Fund Transfer		**($1,643,642)**	

MEDI-CAL DRUG REBATE FUND

REGULAR POLICY CHANGE NUMBER: 53

4. The estimated transfers from the Medi-Cal Drug Rebate Fund to GF are:

(Dollars in Thousands)

FY 2019-20	TF	GF	SF
Drug Rebates Transfer	**$0**	**($1,364,798)**	**$1,364,798**

(Dollars in Thousands)

FY 2020-21	TF	GF	SF
Drug Rebates Transfer	**$0**	**($1,643,642)**	**$1,643,642**

Funding:

(Dollars in Thousands)

FY 2019-20	TF	GF	SF
Medi-Cal Drug Rebate Fund (4260-601-3331)	$1,364,798	$0	$1,364,798
100% GF (4260-101-0001)	($1,364,798)	($1,364,798)	$0
Total	**$0**	**($1,364,798)**	**$1,364,798**

Dollars in Thousands)

FY 2020-21	TF	GF	SF
Medi-Cal Drug Rebate Fund (4260-601-3331)	$1,643,642	$0	$1,643,642
100% GF (4260-101-0001)	($1,643,642)	($1,643,642)	$0
Total	**$0**	**($1,643,642)**	**$1,643,642**

BLOOD FACTOR REIMBURSEMENT METHODOLOGY

REGULAR POLICY CHANGE NUMBER:	54
IMPLEMENTATION DATE:	7/2020
ANALYST:	Autumn Recce
FISCAL REFERENCE NUMBER:	2164

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	-$37,797,000
- STATE FUNDS	$0	-$13,856,700
PAYMENT LAG	1.0000	0.9430
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$35,642,600
STATE FUNDS	$0	-$13,066,870
FEDERAL FUNDS	$0	-$22,575,700

DESCRIPTION

Purpose:
This policy change estimates the savings related to the proposed reimbursement methodology for blood factors.

Authority:
Federal Social Security Act 42 CFR Part 447 Part II
SPA 19-0015

Interdependent Policy Change:
Not Applicable

Background:
The Centers for Medicare and Medicaid (CMS) Final Rule for Covered Outpatient Drugs requires States to incorporate blood factor reimbursement methodology into their Medicaid State Plan and address ingredient cost, professional dispensing fees, and other associated services in the reimbursement methodology. Blood factor is used to treat hemophilia.

Currently, Medi-Cal reimburses blood factor claims at the lower of the billed amount or Average Sales Price (ASP) + 20%. The ASP + 20% cap is set in the Welfare and Institutions Code 14105.86. The new Medi-Cal methodology for reimbursement will be:

- Hemophilia Treatment Centers (HTC) = lower of acquisition cost + $.14 per unit dispensing fee or ASP + 20%.
- Non-HTC = lower of actual acquisition cost + $.04 per unit dispensing fee or ASP + 20%.

Reason for Change:
There is no change from the prior estimate for FY 2019-20.

The change from the prior estimate for FY 2020-21 is an increase in savings due to adding in savings for non-HTC.

There is no change from FY 2019-20 to FY 2020-21, in the current estimate, due to this policy change being implemented on July 1, 2020.

BLOOD FACTOR REIMBURSEMENT METHODOLOGY

REGULAR POLICY CHANGE NUMBER: 54

Methodology:

1. The Department anticipates the new reimbursement methodology will begin July 1, 2020.

2. The new blood factor reimbursement methodology is:
   - Hemophilia Treatment Centers (HTC) = lower of acquisition cost + $.14 per unit dispensing fee or ASP + 20%.
   - Non-HTC = lower of actual acquisition cost + $.04 per unit dispensing fee or ASP + 20%.

3. Acquisition Cost is the invoice price less discounts, rebates, or chargebacks.

4. Average sales price is the price reported to CMS by the manufacturer pursuant to Section 1847A of the federal Social Security Act (42 U.S.C. Sec. 1395w-3a).

5. The estimated HTC and non-HTC savings are:

Savings (TF)	Annual	FY 2020-21 (Lagged)
HTC	($10,000,000)	($9,430,000)
Non-HTC	($27,797,000)	($26,212,000)
Total	($37,797,000)	($35,642,000)

6. The estimated FY 2020-21 blood factor savings are:

FY 2020-21	TF	GF	FF
50% Title XIX / 50% GF	($24,178,000)	($12,089,000)	($12,089,000)
90% Title XIX/ 10% GF	($11,861,000)	($1,186,000)	($10,675,000)
76.5% Title XIX / 23.5% GF	($293,000)	($69,000)	($224,000)
65% Title XIX / 35% GF	($1,465,000)	($513,000)	($952,000)
Total	**($37,797,000)**	**($13,857,000)**	**($23,940,000)**

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
65% Title XXI / 35% GF (4260-113-0001/0890)
76.5% Title XXI / 23.5% GF (4260-113-0001/890)
90% Title XIX / 10% GF (4260-101-0001/890)

MEDI-CAL RX - ADDITIONAL SAVINGS FROM MAIC IN FFS

REGULAR POLICY CHANGE NUMBER:	55
IMPLEMENTATION DATE:	1/2021
ANALYST:	Autumn Recce
FISCAL REFERENCE NUMBER:	2166

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	-$57,381,000
- STATE FUNDS	$0	-$21,088,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$57,381,000
STATE FUNDS	$0	-$21,088,600
FEDERAL FUNDS	$0	-$36,292,400

DESCRIPTION

Purpose:
This policy change estimates the savings for Medi-Cal Rx from implementing a Maximum Allowable Ingredient Cost (MAIC) benchmark.

Authority:
Social Security Act Section 1927 [42 U.S.C. 1396r-8]
Welfare & Institutions Code Section 14105
Executive Order N-01-19

Interdependent Policy Change:
Medi-Cal Rx – Managed Care Pharmacy Benefit to FFS

Background:
On January 7, 2019, the Governor issued Executive Order N-01-19, requiring that all Medi-Cal pharmacy services be transitioned from managed care (MC) to Fee-for-Service (FFS) by January 1, 2021. Transitioning pharmacy services from managed care to FFS delivery system is referred to as Medi-Cal Rx.

Currently, Medi-Cal reimburses based on the lower of Actual Acquisition Cost (AAC) plus a professional dispensing fee, or usual and customary charges. AAC is determined as the lowest of:

- National Average Drug Acquisition Cost (NADAC), or Wholesale Acquisition Cost (WAC) + 0% if the NADAC is not available,
- Federal Upper Limit (FUL), or
- Maximum Allowable Ingredient Cost (MAIC).

MAICs are currently an optional benchmark for pharmacy claims. Part of the Medi-Cal Rx transition effort will include the implementation of MAICs, as calculated by the Medi-Cal Rx contractor, for drugs which have 3 or more generically equivalent options available. Utilizing the MAIC benchmark will result in savings.

MEDI-CAL RX - ADDITIONAL SAVINGS FROM MAIC IN FFS

REGULAR POLICY CHANGE NUMBER: 55

This policy change (PC) is part of the carve-out effort transitioning MC pharmacy services to FFS delivery system. The PCs related to Medi-Cal Rx are:

Regular
- Medi-Cal Rx – Managed Care Pharmacy Benefit to FFS
- Medi-Cal Rx – Additional Savings from MAIC in FFS
- Medical Supply Rebates

Other Admin
- Medi-Cal Rx – Administrative Costs

Reason for Change:
There is no change from the prior estimate.

Methodology:
1. The Department will begin reimbursing FFS pharmacy claims at the MAIC beginning January 1, 2021.

2. The estimated annual savings is $137,741,000 TF.

(Dollars in Thousands)

Annual	TF	GF	FF
Additional Savings from MAIC Implementation in FFS	($137,714)	($50,613)	($87,101)
Total	($137,714)	($50,613)	($87,101)

3. The estimated savings for FY 2020-21 is:

(Dollars in Thousands)

FY 2020-21 (Lagged)	TF	GF	FF
Additional Savings from MAIC Implementation in FFS	($57,381)	($21,089)	($36,292)
Total	($57,381)	($21,089)	($36,292)

Funding:
(Dollars in Thousands)

FY 2020-21	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	($36,710)	($18,355)	($18,355)
90% Title XIX / 10% GF (4260-101-0001/0890)	($18,005)	($1,801)	($16,204)
65% Title XXI / 35% GF (4260-113-0001/0890)	($2,666)	($933)	($1,733)
Total	**($57,381)**	**($21,089)**	**($36,292)**

BCCTP DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	56
IMPLEMENTATION DATE:	1/2010
ANALYST:	Autumn Recce
FISCAL REFERENCE NUMBER:	1433

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$4,464,000	-$5,081,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$4,464,000	-$5,081,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$4,464,000	-$5,081,000

DESCRIPTION

Purpose:
This policy change estimates the revenues collected from the Breast and Cervical Cancer Treatment Program (BCCTP) drug rebates.

Authority:
Social Security Act, section 1927 [42 U.S.C. 1396r–8]
Omnibus Budget Reconciliation Act (OBRA) of 1990, Title IV, sec. 4401(a)(3), 104 Stat.
Welfare & Institutions Code 14105.33
SB 78 (Chapter 38, Statues of 2019)

Interdependent Policy Changes:
Medi-Cal Drug Rebate Fund

Background:
Enhanced Title XIX Medicaid funds are claimed for drugs under the federal Medicaid BCCTP. The Department is required by federal law to collect drug rebates whenever there is federal participation. The Department began collecting rebates for beneficiary drug claims for the full-scope federal BCCTP in January 2010. This policy change reflects ongoing rebates collected.

SB 78 established the Medi-Cal Drug Rebate Fund (Fund 3331), effective July 1, 2019. The non-federal share of Medi-Cal federal and state supplemental drug rebates will be deposited into Fund 3331. See the Medi-Cal Drug Rebate Fund policy change for the estimated total transfers from Fund 3331 to the General Fund (GF).

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a decrease in rebate savings due to:

- Including two additional quarters of actual rebate collection data through the quarter ending December 2019, which were lower than projected in the prior estimate, and
- Updated fee-for-service (FFS) pharmacy expenditure data through January 2020.

BCCTP DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 56

The change from the prior estimate, for FY 2020-21, is a decrease in rebate savings due to lower quarterly projections based on including actual rebate collection data through December 2019.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase in rebate savings due to:

- Higher FFS BCCTP pharmacy expenditures estimated for the FY 2020-21 BCCTP drug rebate projections.

Methodology:

1. Payments began in January 2010.

2. Rebates are invoiced quarterly.

3. The estimated rebates to collect are $6,555,000 in FY 2019-20 and $7,435,000 in FY 2020-21.

4. Assume, of the total BCCTP rebates collected, the ACA offset for BCCTP is $581,000 TF in FY 2019-20 and $710,000 TF in FY 2020-21.

5. The Department estimates $2,091,000 and $2,354,000 BCCTP drug rebates to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2019-20 and FY 2020-21, respectively.

(Dollars in Thousands)

FY 2019-20	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	($3,883)	($3,883)	($2,091)
ACA Offset	($581)	($581)	$0
Total	**($4,464)**	**($4,464)**	**($2,091)**

(Dollars in Thousands)

FY 2020-21	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	($4,371)	($4,371)	($2,354)
ACA Offset	($710)	($710)	$0
Total	**($5,081)**	**($5,081)**	($2,354)

*The Fund 3331 Transfer column is for informational purposes only. See Methodology #5.

Funding:

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

FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	57
IMPLEMENTATION DATE:	12/1999
ANALYST:	Autumn Recce
FISCAL REFERENCE NUMBER:	51

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$22,612,000	-$10,016,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$22,612,000	-$10,016,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$22,612,000	-$10,016,000

DESCRIPTION

Purpose:
This policy change estimates the revenues collected from the Family Planning Access, Care and Treatment (FPACT) drug rebates.

Authority:
Social Security Act, section 1927 [42 U.S.C. 1396r–8]
Omnibus Budget Reconciliation Act (OBRA) of 1990, Title IV, sec. 4401(a)(3), 104 Stat.
Welfare & Institutions Code 14105.33
SB 78 (Chapter 38, Statues of 2019)

Interdependent Policy Changes:
Medi-Cal Drug Rebate Fund

Background:
Rebates for drugs covered through the FPACT program are obtained by the Department from the drug companies involved. Rebates are estimated by using the actual Fee-for-Service (FFS) trend data for drug expenditures, and applying a historical percentage of the actual amounts collected to the trend projection.

In October 2008, the Department discontinued the collection of rebates for drugs that are not eligible for federal financial participation (FFP), which the Centers for Medicare & Medicaid Services (CMS) determined to be 24% of the FPACT drug costs. Effective July 2009, it is assumed 13.95% of the FPACT drug costs are not eligible for rebates.

SB 78 established the Medi-Cal Drug Rebate Fund (Fund 3331), effective July 1, 2019. The non-federal share of Medi-Cal federal and state supplemental drug rebates will be deposited into Fund 3331. See the Medi-Cal Drug Rebate Fund policy change for the estimated total transfers from Fund 3331 to the General Fund (GF).

FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 57

Reason for Change:
The change from the prior estimate, for FY 2019-20, is an increase in rebate savings due to:

- Including two additional quarters of actual rebate collection data through the quarter ending December 2019, and
- Updated FFS pharmacy expenditure data through January 2020.

The change from the prior estimate, for FY 2020-21, is a decrease due to lower FY 2020-21 projections based on the historical trends.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease in rebate savings due to including actual rebate collections through December 2019, which were higher than previously estimated.

Methodology:

1. The regular Federal Medical Assistance Percentage (FMAP) percentage is applied to 8.85% of the FPACT rebates to account for the purchase of non-family planning drugs, and the family planning percentage (90% FFP) is applied to 91.15% of the FPACT rebates.

2. Assume the ACA offset is $363,000 TF for FY 2019-20 and $405,000 TF for FY 2020-21.

3. Actual data from July 2013 to December 2019 is used to project rebates.

4. The Department estimates $3,530,000 and $1,526,000 FPACT rebate collections to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2019-20 and FY 2020-21, respectively.

(Dollars in Thousands)

FY 2019-20	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	($22,249)	($22,249)	($3,530)
ACA Offset	($363)	($363)	$0
Total	**($22,612)**	**($22,612)**	($3,530)

(Dollars in Thousands)

FY 2020-21	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	($9,611)	($9,611)	($1,526)
ACA Offset	($405)	($405)	$0
Total	**($10,016)**	**($10,016)**	($1,526)

*The Fund 3331 Transfer column is for informational purposes only. See Methodology #4.

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

LITIGATION SETTLEMENTS

REGULAR POLICY CHANGE NUMBER:	58
IMPLEMENTATION DATE:	8/2009
ANALYST:	Latoya Brown
FISCAL REFERENCE NUMBER:	1449

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$302,000	$0
- STATE FUNDS	-$302,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$302,000	$0
STATE FUNDS	-$302,000	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the settlement amounts expected to be received by the Department from pharmaceutical and other companies due to illegal promotion of drugs, kickbacks and overcharges.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The Department works collaboratively with the Office of the Attorney General to pursue charges related to Qui-Tam lawsuits (civil lawsuits filed under the False Claims Act by individuals not affiliated with the government, that result in a recovery of funds due to the Department), illegal promotion of drugs, kickbacks, and overcharging of Medicaid.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is an increase in the amount the Department expects to receive based on updated expected settlement payments. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease due to an error in reporting one of the settlement amounts below.

LITIGATION SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 58

Methodology:
The following settlements are expected to be received in FY 2019-20:

Settlement Name	FY 2019-20
CareFusion	($14,000)
Avalign Technologies, Inc.; Instrumed International, Inc.	($39,000)
Avanir Pharmaceuticals Inc	($216,000)
ResMed	($33,000)
Total GF Savings	**($302,000)**

Funding:
100% GF (4260-101-0001)

MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER:	59
IMPLEMENTATION DATE:	10/2006
ANALYST:	Autumn Recce
FISCAL REFERENCE NUMBER:	1181

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$20,024,000	-$43,098,000
- STATE FUNDS	-$10,012,000	-$21,549,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$20,024,000	-$43,098,000
STATE FUNDS	-$10,012,000	-$21,549,000
FEDERAL FUNDS	-$10,012,000	-$21,549,000

DESCRIPTION

Purpose:
This policy change estimates the revenues from the medical supply rebates collected by the Department through contracts with medical supply manufacturers.

Authority:
Welfare & Institutions Code 14100.95(a) and 14105.47(c)(1)

Interdependent Policy Changes:
Not Applicable

Background:
The Department negotiates Maximum Acquisition Cost (MAC) for diabetic test strips and lancets with manufacturers to make available the best price to all providers. The Department establishes the medical supply reimbursement rates for diabetic test strips and lancets, which are based on the contracted MAC. The Department also negotiates medical supply rebates with some manufacturers to provide savings to the Department. The rebates are a percentage of the MAC per unit of services (quantity) reimbursed.

Due to system limitations in the Rebate Accounting Information System (RAIS), manually created invoices for the rebate amounts are sent to manufacturers.

The medical supply rebate contract terms are effective January 1, 2019 through December 31, 2021.

Reason for Change:
There is no change from the prior estimate for FY 2019-20.

There is no change from the prior estimate for FY 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to the implementation of Medi-Cal Rx in January 2021.

MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER: 59

Methodology:

1. Assume the average quarterly collection is $5,006,000.

2. Assume there is a one quarter lag for medical supply rebate collections.

3. The transition of pharmacy benefits from managed care to the Fee-for-Service (FFS) delivery system, or Medi-Cal Rx, will increase the FFS medical supply rebates, beginning January 1, 2021.

4. Due to one-quarter lag, assume in last quarter of FY 2020-21 (April – June), will reflect an increase in quarterly rebate collection in proportion to the increased FFS population.

5. Assume the total rebates collected are $20,024,000 in FY 2019-20 and $43,098,000 in FY 2020-21.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2019-20	($20,024)	($10,012)	($10,012)
FY 2020-21	($43,098)	($21,549)	($21,549)

Funding:

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

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	60
IMPLEMENTATION DATE:	1/1991
ANALYST:	Autumn Recce
FISCAL REFERENCE NUMBER:	54

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$101,891,000	-$114,100,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$101,891,000	-$114,100,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$101,891,000	-$114,100,000

DESCRIPTION

Purpose:
This policy change estimates the revenues collected from the State Supplemental Drug rebates.

Authority:
Welfare & Institutions Code 14105.33
SB 78 (Chapter 38, Statues of 2019)

Interdependent Policy Changes:
Medi-Cal Drug Rebate Fund

Background:
State supplemental drug rebates for drugs provided through Fee-for-Service (FFS) and County Organized Health Systems are negotiated by the Department with drug manufacturers to provide additional drug rebates over and above the federal rebate levels (see the Federal Drug Rebate policy change).

SB 78 established the Medi-Cal Drug Rebate Fund (Fund 3331) effective July 1, 2019. The non-federal share of Medi-Cal federal and state supplemental drug rebates will be deposited into Fund 3331. See the Medi-Cal Drug Rebate Fund policy change for the estimated total transfers from Fund 3331 to the General Fund (GF).

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is a decrease in rebate savings due to:

- Including two additional quarters of actual rebate collection data through the quarter ending December 2019, and
- Updated FFS pharmacy expenditure data through January 2020.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to an increase in rebate savings due to:

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 60

- Including actual rebate collections in FY 2019-20, which were lower than previously estimated.
- FY 2020-21 projections are higher based on the historical trend.

Methodology:

1. Rebates are estimated by using actual FFS trend data for drug expenditures, and applying a historical percentage of actual amounts collected to the trend projection.

2. Assume family planning drugs account for 0.19% of the regular federal drug rebates and are funded with 90% federal funds (FF) and 10% GF.

3. Assume CHIP drug rebates are estimated to be $9,254,000 TF for FY 2019-20. These rebates are funded at 88% FF and 12% GF through September 30, 2019, and 76.5% FF and 23.5% GF beginning October 1, 2019, and 65% FF / 35% GF beginning October 1, 2020. In FY 2020-21, CHIP rebate collections of $7,347,000 FF is included in this policy change.

4. The optional expansion ACA population collections are estimated to be $73,961,000 TF for FY 2019-20, of which $68,784,000 FF is budgeted in this policy change. The amount of $5,177,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund. For FY 2020-21, the ACA collections are estimated to be $86,267,000 TF, of which $77,634,000 FF is budgeted in this policy change. The amount of $8,625,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund.

5. The Department estimates to transfer $31,390,000 and $41,201,000 state supplemental rebates to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2019-20 and FY 2020-21, respectively.

FY 2019-20	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	($23,853,000)	($23,853,000)	($26,213,000)
100% Title XIX ACA	($68,784,000)	($68,784,000)	($5,177,000)
100% Title XXI FF	($9,254,000)	($9,254,000)	$0
Total	**($101,891,000)**	**($101,891,000)**	($31,390,000)

FY 2020-21	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	($29,119,000)	($29,119,000)	($32,576,000)
100% Title XIX ACA	($77,634,000)	($77,634,000)	($8,625,000)
100% Title XXI FF	($7,347,000)	($7,347,000)	$0
Total	**($114,100,000)**	**($114,100,000)**	($41,201,000)

*The Fund 3331 Transfer column is for informational purposes only. See Methodology# 5.

Funding:
100% Title XIX FF (4260-101-0890)
100% Title XXI (4260-113-0890)

FEDERAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	62
IMPLEMENTATION DATE:	7/1990
ANALYST:	Autumn Recce
FISCAL REFERENCE NUMBER:	55

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$1,554,560,000	-$1,439,215,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,554,560,000	-$1,439,215,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$1,554,560,000	-$1,439,215,000

DESCRIPTION

Purpose:
This policy change estimates the revenues collected from the Federal Drug rebates.

Authority:
Social Security Act, section 1927 [42 U.S.C. 1396r–8]
Omnibus Budget Reconciliation Act (OBRA) of 1990, Title IV, sec. 4401(a)(3), 104 Stat.
SB 78 (Chapter 38, Statues of 2019)

Interdependent Policy Changes:
Medi-Cal Drug Rebate Fund

Background:
The Medicaid Drug Rebate Program, created by OBRA 1990, allows the Department to obtain price discounts for drugs. The program helps lower Medicaid spending on outpatient prescription drugs. Drug manufacturers must enter into a national Medicaid drug rebate agreement in order to obtain Medicaid coverage for their prescription drugs. Drug manufacturers are required to pay a rebate for all outpatient drugs that are dispensed and paid for by the State's Medi-Cal program.

SB 78 established the Medi-Cal Drug Rebate Fund (Fund 3331), effective July 1, 2019. The non-federal share of Medi-Cal federal and state supplemental drug rebates will be deposited into Fund 3331. See the Medi-Cal Drug Rebate Fund policy change for the estimated total transfers from Fund 3331 to the General Fund (GF).

Reason for Change:
The change from the prior estimate, for FY 2019-20, is an increase in rebate savings due to:

- Including two additional quarters of actual rebate collection data through the quarter ending December 2019, and
- Updated Fee-for-Service (FFS) pharmacy expenditure data through January 2020.

The change from the prior estimate, for FY 2020-21 is a decrease in rebate savings due to:

FEDERAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 62

- Including two additional quarters of actual rebate collection data through the quarter ending December 2019, and
- Updated FFS pharmacy expenditure data through January 2020.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due a decrease in rebate savings due to:

- Including actual rebate collections in FY 2019-20, which were higher than previously estimated.

Methodology:

1. Rebates are estimated by using actual FFS trend data for drug expenditures, and applying a historical percentage of actual amounts collected to the trend projection.

2. Assume family planning drugs account for 0.19% of the regular federal drug rebates and are funded with 90% federal funds (FF) and 10% GF.

3. CHIP rebates are funded at 88% FF / 12% GF through September 30, 2019, 76.5% FF / 23.5% GF beginning October 1, 2019, and 65% FF / 35% GF beginning October 1, 2020. Assume CHIP drug rebate collections are $115,686,000 FF and $91,833,000 FF in FY 2019-20 and FY 2020-21, respectively.

4. The optional expansion ACA population collections are estimated to be $633,763,000 TF for FY 2019-20, of which $589,400,000 FF is budgeted in this policy change. The amount of $44,363,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund. For FY 2020-21, a total of $651,056,000 TF is estimated for the optional expansion population, of which $585,950,000 FF is budgeted in this policy change. The amount of $65,106,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund.

5. The ongoing additional FF claimed by CMS (ACA Offset) is reflected in this policy change. The additional FF is $126,358,000 TF for FY 2019-20 and $131,657,000 TF for FY 2020-21.

6. The Department estimates $795,703,000 and $737,279,000 federal drug rebates to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2019-20 and FY 2020-21, respectively.

FY 2019-20	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	($723,116,000)	($723,116,000)	($751,340,000)
100% Title XIX ACA FF	($589,400,000)	($589,400,000)	($44,363,000)
100% Title XXI FF	($115,686,000)	($115,686,000)	$0
ACA Offset	($126,358,000)	($126,358,000)	$0
Total	**($1,554,560,000)**	**($1,554,560,000)**	($795,703,000)

FEDERAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 62

FY 2020-21	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	($629,775,000)	($629,775,000)	($672,173,000)
100% Title XIX ACA FF	($585,950,000)	($585,950,000)	($65,106,000)
100% Title XXI FF	($91,833,000)	($91,833,000)	$0
ACA Offset	($131,657,000)	($131,657,000)	$0
Total	**($1,439,215,000)**	**($1,439,215,000)**	($737,279,000)

*The Fund 3331 Transfer column is for informational purposes only. See Methodology# 6.

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XXI FFP (4260-113-0890)

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

REGULAR POLICY CHANGE NUMBER:	63
IMPLEMENTATION DATE:	4/2017
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	2012

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$341,222,000	$394,701,000
- STATE FUNDS	$47,646,880	$61,474,060
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$341,222,000	$394,701,000
STATE FUNDS	$47,646,880	$61,474,060
FEDERAL FUNDS	$293,575,120	$333,226,940

DESCRIPTION

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

Authority:
Drug Medi-Cal Organized Delivery System Waiver

Interdependent Policy Changes:
Not Applicable

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

On August 13, 2015, the Department received approval from the Centers for Medicare and Medicaid Services (CMS) to implement the DMC-ODS waiver. The DMC-ODS is a pilot project authorized originally under California's Section 1115 Bridge to Reform Demonstration Waiver and continued in the Medi-Cal 2020 Waiver. The purpose of the pilot program is to test a new paradigm for organized delivery of health care services for Medicaid eligible individuals with a substance use disorder.

DMC-ODS waiver services include the existing treatment modalities (ODF, IOT, NTP, and Perinatal RTS), and additional new and expanded county optional services. Counties that opt-in to participate in the DMC-ODS waiver are required to provide a continuum of care to all eligible beneficiaries modeled after the American Society of Addiction Medicine (ASAM) Criteria. Counties will submit implementation plans and proposed interim rates for all county-covered SUD services, except for the NTP rates, which are set by the State.

Counties currently provide many of the required services (e.g. treatments covered by the current four modalities ODF, IOT, NTP, and Perinatal RTS) under the current DMC program and will continue to

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

REGULAR POLICY CHANGE NUMBER: 63

provide these when the county opts-in to the DMC-ODS waiver. The interim rate for the existing modalities, except NTP; however, will now be paid at the county-established rate instead of the State rates.

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

Required
- Non-perinatal RTS
- Withdrawal Management (Levels 1.0, 2.0, and 3.2)
- Recovery Services
- Case Management
- Physician Consultation
- Expanded Medication Assisted Treatment (MAT) (buprenorphine, naloxone, and disulfiram)

Optional
- Additional MAT (non-NTP Providers)
- Partial Hospitalization
- Withdrawal Management (Levels 3.7 and 4.0)

Funding for the existing treatment modalities (ODF, IOT, NTP, and Perinatal RTS) will remain the same. New services under the waiver, except for non-perinatal IOT and RTS expanded services, will be funded with federal funds (FF) and County Funds (CF). Consistent with prior estimates, expanded IOT and RTS services will be funded with FF and General Fund (GF).

Reason for Change:
This change from the prior estimate, for FY 2019-20, is a net decrease due to the following:
- Updated claims data – Based on FY 2018-19 claims data for 27 counties, compared to the estimated county fiscal plan, the methodology for estimating the annual cost projection was revised, and as a result, the overall annual estimate decreased.
- Updated payment lag – Based on more recent claims data, payment lags for 27 counties increased overall resulting in more payments included in FY 2020-21.

The change from the prior estimate, for FY 2020-21, is a net decrease due to the following:
- Partnership Heath Plans (PHP):
  - The prior estimate assumed eight opt-in counties would provide waiver services under PHP. In the current estimate, the number of opt-in counties was updated to seven due to Trinity county opting-out of the DMC-ODS waiver.
  - Estimated per utilizer per month (PUPM) rates for the PHP counties were revised in the current estimate resulting in a decrease in projected costs for the PHP counties.
  - Due to delays, the implementation date for the seven PHP counties shifted from February 2020 to July 2020, resulting in a decrease in FY 2020-21 cost.
- Updated approved interim county rates – The current estimate includes updated FY 2020-21 rates for 19 counties.

The change in the current estimate, from FY 2019-20 to FY 2020-21, is due to FY 2020-21 including costs for 37 opt-in counties, compared to 30 county costs in FY 2019-20. In addition, overall rates for FY 2020-21 are higher compared to FY 2019-20, due to 19 counties updating their rates for FY 2020-21.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

REGULAR POLICY CHANGE NUMBER: 63

Methodology:

1. DMC-ODS waiver services for opt-in counties began in February 2017 on a phase-in basis.
   - Four counties implemented the waiver in FY 2016-17.
   - For FY 2017-18, seven additional counties (for a total of 11 counties) began providing waiver services.
   - For FY 2018-19, 16 additional counties (for a total of 27 counties) began providing waiver services.

2. In FY 2019-20, three additional counties (for a total of 30 counties) began providing waiver services.

3. In FY 2020-21, the remaining seven opt-in counties (for a total of 37 counties) will begin providing waiver services under the PHP. Implementation for the seven PHP counties is expected to occur in July 2020.

4. A total of 21 counties have not opted-in to implement DMC-ODS waiver services.

5. The cost estimate for waiver services is developed based on county approved rates, projected caseload, and projected total units of services (UOS) to be delivered. Rates for NTP services, including MAT expansion, are based on the existing State Plan rates developed by the Department. 19 counties have revised rates for FY 2020-21 that will be implemented in July 2020. Costs for rate adjustments are included in this estimate.

6. Effective July 1, 2018, the Department added an additional MAT, a buprenorphine–naloxone combination product, to be available under the DMC-ODS waiver. This product contains buprenorphine and naloxone, and is a safer alternative to methadone since it comes with a lower chance of addiction and dependency. In comparison to buprenorphine, the naloxone component of the combination MAT limits abuse because of the potential effects of withdrawal.

<u>Net DMC-ODS Waiver Costs</u>

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

DMC-ODS Waiver Net Cost	FY 2019-20	FY 2020-21
Required Services	$35,299,000	$38,963,000
Optional Services	$927,000	$1,104,000
Existing Services	$350,707,000	$398,076,000
PHP Counties	$0	$7,335,000
Total	$386,933,000	$445,478,000

<u>Claims Payment Error</u>

8. Payments for the DMC-ODS waiver services began in April 2017. Due to a system error, payments for all new Required and Optional services for clients with Affordable Care Act (ACA) optional aid codes were paid using GF as the funding match for federal funds. Payments for these clients do not fall under the provisions of Proposition 30 and therefore, should have been paid with county funds. The Department is currently working with the counties to make corrections to those claims. The system changes for payment corrections are expected to be completed in FY 2018-19 and the funds will be recouped to repay the GF, with completion in FY 2019-20.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

REGULAR POLICY CHANGE NUMBER: 63

Claims Payment Error	GF Cost	GF Recoupment
FY 2017-18	$655,000	$0
FY 2018-19	$6,000	($560,000)
FY 2019-20	$0	($101,000)
Total	$661,000	($661,000)

9. On a cash basis, the total costs for the claims payment error and waiver services costs are estimated to be $386,933,000 TF and $445,478,000 TF in FY 2019-20 and FY 2020-21, respectively.

FY 2019-20	**TF**	**GF**	**FF Title XIX**	**FF Title XXI**	**CF**
Regular					
Current	$146,131,000	$29,278,000	$72,013,000	$1,671,000	$43,169,000
ACA Optional	$237,018,000	$18,239,000	$216,871,000	$0	$1,908,000
Perinatal					
Current	$1,066,000	$0	$533,000	$0	$533,000
ACA Optional	$2,718,000	$231,000	$2,487,000	$0	$0
Claims Error					
General Fund	$0	($101,000)	$0	$0	$101,000
Total	$386,933,000	**$47,647,000**	**$291,904,000**	**$1,671,000**	$45,711,000

FY 2020-21	**TF**	**GF**	**FF Title XIX**	**FF Title XXI**	**CF**
Regular					
Current	$165,467,000	$35,801,000	$81,542,000	$1,618,000	$46,506,000
ACA Optional	$268,378,000	$24,355,000	$241,541,000	$0	$2,482,000
Perinatal					
Current	$1,212,000	$0	$606,000	$0	$606,000
ACA Optional	$3,086,000	$309,000	$2,777,000	$0	$0
PHP Plans					
PHP Plans	$7,335,000	$1,009,000	$5,080,000	$63,000	$1,183,000
Total	$445,478,000	**$61,474,000**	**$331,546,000**	**$1,681,000**	$50,777,000

Funding:
100% GF (4260-101-0001)
100% Title XIX FF (4260-101-0890)
100% Title XXI FF (4260-113-0890)
100% ACA Title XIX FF (4260-101-0890)
93% ACA Title XIX FF / 7% GF (4260-101-0001/0890)
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)
88% Title XXI FF / 12% GF (4260-113-0001/0890)
76.5% Title XXI FF / 23.5% GF (4260-113-0001/0890)
65% Title XXI FF / 35% GF (4260-113-0001/0890)
50% Title XIX / 50% GF (4260-101-0001/0890)

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	67
IMPLEMENTATION DATE:	7/2020
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1724

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$3,865,000
- STATE FUNDS	$0	$393,440
PAYMENT LAG	1.0000	0.8455
% REFLECTED IN BASE	0.00 %	45.19 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$1,791,100
STATE FUNDS	$0	$182,320
FEDERAL FUNDS	$0	$1,608,790

DESCRIPTION

Purpose:
This policy change budgets the annual rate adjustment to the Drug Medi-Cal (DMC) rates.

Authority:
Welfare & Institutions Code 14021.51; 14021.6(b)(1); 14021.9(c); and 14105(a)
Title 22, California Code of Regulations, Section 51516.1(a)(g)

Interdependent Policy Changes:
Not Applicable

Background:
The DMC program currently covers the following Substance Use Disorder (SUD) services under the State Plan: Outpatient Drug-Free Treatment Services (ODF), Intensive Outpatient Treatment Services (IOT), Residential Treatment Services (RTS) for pregnant and postpartum women, and the Narcotic Treatment Program (NTP).

Annually, the Department adjusts the DMC rates based on the cumulative growth in the Implicit Price (CIP) Deflator for the Costs of Goods and Services to Governmental Agencies reported by the Department of Finance. The proposed DMC rates are based either on the developed rates using annual cost report settlement data, or the FY 2009-10 Budget Act rates adjusted for the CIP deflator, whichever is lower.

The following DMC rates are adjusted each year:

- NTP Dosing – Regular and Perinatal
- NTP Individual Counseling – Regular and Perinatal
- NTP Group Counseling – Regular and Perinatal
- IOT – Regular and Perinatal
- RTS – Regular and Perinatal
- ODF Individual Counseling – Regular and Perinatal
- ODF Group Counseling – Regular and Perinatal

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 67

Reason for Change:
The change from the prior estimate, for FY 2019-20, is due to FY 2019-20 rate increase costs are fully incorporated in the DMC base estimate and no longer in this policy change.

There is no change from the prior estimate for FY 2020-21.

The change in the current estimate, from FY 2019-20 to FY 2020-21, is due to no DMC rate increase costs in FY 2019-20.

Methodology:

1. The FY 2019-20 developed rates and FY 2020-21 estimated rates for regular and perinatal services are:

Regular Services	FY 2019-20 Developed Rates	FY 2020-21 Estimated Rates
NTP Methadone	$13.93	$14.38
NTP Individual Counseling	$15.74	$16.24
NTP Group Counseling	$3.36	$3.47
Intensive Outpatient Treatment	$71.78	$74.08
Residential Treatment - EPSDT	$110.42	$113.95
ODF Individual Counseling	$78.69	$81.21
ODF Group Counseling	$30.22	$31.19

Perinatal Services	FY 2019-20 Developed Rates	FY 2020-21 Estimated Rates
NTP Methadone	$15.00	$15.48
NTP Individual Counseling	$23.39	$24.14
NTP Group Counseling	$5.37	$5.54
Intensive Outpatient Treatment	$89.71	$92.58
Residential Treatment Services	$110.42	$113.95
ODF Individual Counseling	$116.97	$120.71
ODF Group Counseling	$48.36	$49.91

2. FY 2019-20 rate changes are fully incorporated in the DMC base estimate.

3. The incremental rate changes for FY 2020-21 are shown below:

Incremental Difference	FY 2020-21 Regular	FY 2020-21 Perinatal
NTP Methadone	$0.45	$0.48
NTP Individual Counseling	$0.50	$0.75
NTP Group Counseling	$0.11	$0.17
Intensive Outpatient Treatment	$2.30	$2.87
Residential Treatment Services	$3.53	$3.53
ODF Individual Counseling	$2.52	$3.74
ODF Group Counseling	$0.97	$1.55

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 67

4. The cost estimate for FY 2020-21, based on the incremental rate changes for FY 2019-20 and FY 2020-21 are:

FY 2020-21 - Regular	Total Number of Units	Incremental Difference	Rate Adj. Cost	FY 2020-21 Rate Adj.
NTP Methadone	4,052,801	$0.45	$1,824,000	$3,405,000
NTP Individual Counseling	1,791,281	$0.50	$896,000	$645,000
NTP Group Counseling	9,310	$0.11	$1000	$0
Intensive Outpatient Treatment	39,758	$2.30	$91,000	$618,000
Residential Treatment - EPSDT	219	$3.53	$1,000	$5,000
ODF Individual Counseling	35,483	$2.52	$89,000	$62,000
ODF Group Counseling	224,709	$0.97	$218,000	$67,000
Total for Regular Services				$4,802,000

FY 2020-21 - Perinatal	Total Number of Units	Incremental Difference	Total Rate Adj. Cost	FY 2020-21 Rate Adj.
NTP Methadone	14,405	$0.48	$7,000	$13,000
NTP Individual Counseling	5,701	$0.75	$4,000	$44,000
NTP Group Counseling	0	$0.17	$0	$0
Intensive Outpatient Treatment	1,904	$2.87	$5,000	$10,000
Residential Treatment Services	9,989	$3.53	$35,000	$238,000
ODF Individual Counseling	343	$3.74	$1,000	$13,000
ODF Group Counseling	1,574	$1.55	$2,000	$17,000
Total for Perinatal Services				$335,000

5. Total estimated costs for the annual rate adjustments are:

Annual Rate Adj. Cost	FY 2020-21
NTP	$4,107,000
ODF	$159,000
IOT	$628,000
RTS	$243,000
Total	**$5,137,000**

FY 2020-21	TF	GF	FFP Title XIX	FFP Title XXI	CF
Regular					
Current	$2,622,000	$168,000	$1,303,000	$11,000	$1,140,000
ACA Optional	$2,180,000	$218,000	$1,962,000	$0	$0
Perinatal					
Current	$265,000	$0	$133,000	$0	$132,000
ACA Optional	$70,000	$7,000	$63,000	$0	$0
Total	$5,137,000	**$393,000**	**$3,461,000**	**$11,000**	$1,272,000

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 67

6. Assume DMC claims are paid 75% in the same year the services occur and the remaining 25% in the following year.

Funding:
100% Title XIX FF (4260-101-0890)
100% Title XXI FF (4260-113-0890)
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)
76.5% Title XXI FF / 23.5% GF (4260-113-0001/0890)
65% Title XXI FF / 35% GF (4260-113-0001/0890)
50% Title XIX / 50% GF (4260-101-0001/0890)

DRUG MEDI-CAL MAT BENEFIT

REGULAR POLICY CHANGE NUMBER:	69
IMPLEMENTATION DATE:	7/2020
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	2169

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$682,000
- STATE FUNDS	$0	$22,000
PAYMENT LAG	1.0000	0.7500
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$511,500
STATE FUNDS	$0	$16,500
FEDERAL FUNDS	$0	$495,000

DESCRIPTION

Purpose:
This policy change estimates the cost of additional medication assisted treatment (MAT) drugs under the State Plan.

Authority:
Public Law 115-271
H.R.6, Section 1006 (2018)

Interdependent Policy Changes:
Not Applicable

Background:
Under the Medicaid State Plan, the NTP provides outpatient methadone maintenance services directed at stabilization and rehabilitation of persons with opioid dependency and substance use disorder diagnoses. The program includes daily medication dosing, a medical evaluation, treatment planning, and a minimum of fifty minutes per month of face-to-face counseling sessions. These services are provided by certified providers under contract with the counties or the State.

Beginning on October 1, 2020 and ending September 2025, Public Law 115-271, requires states to include MAT in its Medicaid State Plan. The MAT must include all drugs and biological products approved by the Food and Drug Administration (FDA) to treat opioid addiction. The FDA has approved the following four drugs and biological products to treat opioid addiction: methadone, buprenorphine, buprenorphine-naloxone combination, and naltrexone. California's State Plan currently covers MATs through NTP providers. However, the State Plan only covers the use of methadone and naltrexone in MAT. Effective July 1, 2020, under the State Plan, NTP and non-NTP certified providers will cover all drugs and biological products that the FDA has approved to treat opioid addiction, including buprenorphine and buprenorphine-naloxone combination products.

The Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver already includes NTP MAT and Additional MAT. This fiscal impact only includes the costs to State Plan counties not participating in the DMC-ODS Waiver.

DRUG MEDI-CAL MAT BENEFIT

REGULAR POLICY CHANGE NUMBER: 69

Reason for Change:
The change from the prior estimate for FY 2020-21, is an increase due to updated MAT rates and estimated caseload.

The change in the current estimate, from FY 2019-20 to FY 2020-21, is due to no costs incurring in FY 2019-20.

Methodology:
1. Assume rates for the additional MATs will be implemented in July 2020. Currently, the FDA-approved MAT drugs already in the State Plan are methadone and naltrexone. This fiscal assumes the addition of buprenorphine and buprenorphine-naloxone combination drugs to the State Plan effective July 2020.

2. The additional MATs will be available to beneficiaries in both NTP and non-NTP certified clinic settings.

3. Total estimated costs are:

FY 2020-21	TF	GF	FFP Title XIX	FFP Title XXI	CF
Regular					
Current	$521,000	$0	$259,000	$2,000	$260,000
ACA Optional	$434,000	$22,000	$390,000	$0	$22,000
Perinatal					
Current	$12,000	$0	$6,000	$0	$6,000
ACA Optional	$3,000	$0	$3,000	$0	$0
Total	$970,000	**$22,000**	**$658,000**	**$2,000**	$288,000

Funding:
100% Title XIX FF (4260-101-0890)
100% Title XXI FF (4260-113-0890)
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)

DRUG MEDI-CAL PROGRAM COST SETTLEMENT

REGULAR POLICY CHANGE NUMBER:	70
IMPLEMENTATION DATE:	9/2019
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1723

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$162,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$162,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$162,000	$0

DESCRIPTION

Purpose:
This policy change estimates the cost settlements to counties and contracted providers for payments related to Drug Medi-Cal (DMC) services.

Authority:
Welfare & Institutions Code 14124.24 (g)(1)
Title 22, California Code of Regulations 51516.1

Interdependent Policy Changes:
Not Applicable

Background:
The DMC program currently covers the following Substance Use Disorder (SUD) services under the State Plan: Outpatient Drug-Free Treatment Services (ODF), Intensive Outpatient Treatment Services (IOT), Residential Treatment Services (RTS) for pregnant and postpartum women, and Narcotic Treatment Program (NTP).

The DMC program initially pays a claim for SUD services at a provisional rate, not to exceed the State's maximum allowance. At the end of each fiscal year, providers for non-Narcotic Treatment Program services must submit actual cost information. The DMC program completes a final settlement after receipt and review of the provider's cost report. The cost settlement is based on the county's certified public expenditures (CPE). The Department has the authority to audit the cost reports within three years of the cost settlement.

Cost settlements for non-NTP services is limited to the lowest of the following costs:

- Provider's usual and customary charge to the general public for the same or similar services,
- Provider's allowable costs of providing the service, or
- DMC statewide maximum allowance for the service.

DRUG MEDI-CAL PROGRAM COST SETTLEMENT

REGULAR POLICY CHANGE NUMBER: 70

Cost settlements for NTP services is limited to the lowest of the following costs:

- Provider's usual and customary charge to the general public for the same or similar services, or
- DMC statewide maximum allowance for the service.

Starting July 1, 2014, as instructed by the Centers for Medicare & Medicaid Services (CMS), the Department changed its cost settlement process to counties for their administrative expenses through a quarterly claims and cost settlement process. Prior to that, counties were paid for their DMC expenses (services and administration) through CPE as part of an all-inclusive rate. Starting from the FY 2014-15 annual cost report settlement, all amounts for administrative cost reimbursements or recoupments will be included in the Drug Medi-Cal County Administration policy change.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is an increase in recoupments due to additional audit settlements completed for FY 2014-15 cost reports.

There is no change for FY 2020-21 from the prior estimate.

The change in the current estimate, from FY 2019-20 to FY 2020-21, is due to no cost settlement payments or recoupments included in FY 2020-21.

Methodology:

1. The annual cost settlement is based on a reconciliation of the provider's cost report against the actual expenditures paid by the Department.

2. Final cost settlements are based on comparing actual expenditures against the audited cost reports. If an audit is not conducted within three years of the interim cost settlement, the interim cost settlement becomes the final cost settlement.

3. The audit settlements for the FY 2014-15 annual cost reports will be recouped in FY 2019-20.

FY 2019-20	TF	Title XIX	Title XXI	CF
FY 2014-15 Settlements	($267,000)	**($160,000)**	**($2,000)**	($105,000)

Funding:
100% Title XIX (4260-101-0890)
100% Title XXI (4260-113-0890)

SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER:	73
IMPLEMENTATION DATE:	10/2017
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1458

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$125,573,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$125,573,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$125,573,000	$0

DESCRIPTION

Purpose:
This policy change estimates the supplemental reimbursement based on certified public expenditures for Specialty Mental Health Services (SMHS).

Authority:
ABX4 5 (Chapter 5, Statutes of 2009)
Welfare & Institution Code 14723
State Plan Amendment (SPA) 09-004

Interdependent Policy Changes:
Not Applicable

Background:
State law allows an eligible public agency receiving reimbursement for SMHS provided to Medi-Cal beneficiaries to receive supplemental reimbursement up to 100% of the allowable costs of providing the services. To receive the supplemental payments, the public agency must certify that they incurred the public expenditures.

On February 16, 2016, the Centers for Medicare and Medicaid Services (CMS) approved the supplemental payment SPA 09-004 and Certified Public Expenditure Protocol.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is due to removing payments for multiple counties for FY 2010-11 and FY 2011-12 that were previously estimated to be paid in FY 2019-20, and are currently being reviewed.

There is no change from the prior estimate for FY 2020-21.

The change from FY 2019-20 and FY 2020-21, in the current estimate, is due to no payments scheduled for FY 2020-21 at this time.

SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 73

Methodology:

1. The unreimbursed costs for county-operated providers was calculated based on the difference between the county operated provider's gross allowable cost and the gross schedule of statewide maximum allowance (SMA).

2. The amount of unreimbursed costs was increased by the ratio of county costs to total mental health plan costs to account for unreimbursed costs for contract providers.

3. Counties submit the necessary county costs through a supplemental claiming process. It is expected that this process will continue in FY 2019-20 and FY 2020-21.

4. The estimates below were developed using actual costs from claims submitted by counties. These supplemental payments will be paid in FY 2019-20.

5. The Department anticipates supplemental claims to occur in FY 2020-21, however, these costs have not been determined and are not included in the estimate.

(Dollars in Thousands)

FY 2019-20	FF
FY 2008-09	$1,002
FY 2009-10	$556
FY 2010-11	$73,229
FY 2011-12	$50,786
Total for FY 2019-20	**$125,573**

Funding:

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

MHP COSTS FOR CONTINUUM OF CARE REFORM

REGULAR POLICY CHANGE NUMBER:	74
IMPLEMENTATION DATE:	1/2017
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1957

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$24,184,000	$24,651,000
- STATE FUNDS	$12,973,500	$13,207,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$24,184,000	$24,651,000
STATE FUNDS	$12,973,500	$13,207,000
FEDERAL FUNDS	$11,210,500	$11,444,000

DESCRIPTION

Purpose:
This policy change estimates the reimbursement to counties for participating in a child and family team (CFT), providing assessments for seriously emotionally disturbed (SED) foster children, and training for mental health staff.

Authority:
AB 403 (Chapter 773, Statutes of 2015)

Interdependent Policy Changes:
Not Applicable

Background:
AB 403 is part of an effort to reform congregate care in California. AB 403 establishes a new community care licensure category that is a short-term residential therapeutic program (STRTP). STRTPs are licensed and regulated by the California Department of Social Services (CDSS). STRTPs that provide specialty mental health services (SMHS) are certified by the Department.

County mental health departments currently participate in CFTs for children receiving intensive care coordination services once the initial mental health screening has been completed by a county social worker. AB 403 requires county mental health departments to perform the following additional workload:

- Complete a mental health assessment that determines if the child or youth has a serious emotional disturbance, or meets medical necessity criteria for SMHS for eligible beneficiaries under the age of 21 (Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)). Either a CFT or an interagency placement council (IPC) must decide that a STRTP is the appropriate level of care for the child or youth.

- A CFT will be convened for all children or youth who have an open child welfare case. The county mental health department is expected to participate in all CFTs when the child needs SMHS.

MHP COSTS FOR CONTINUUM OF CARE REFORM

REGULAR POLICY CHANGE NUMBER: 74

The responsibility for SMHS for children was realigned to the counties in 2011 as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, legislation enacted after September 30, 2012, that has an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by 2011 Realignment shall apply to local agencies only to the extent that the state provides annual funding for the cost increase. The new activities began January 2017 and the current year and budget year costs are included in this policy change.

Reason for Change:
The change from the prior estimate for FY 2019-20 and FY 2020-21, is due to:

- Updating eligible child welfare cases for CFTs;
- Updating placement assessment based on CDSS estimates; and
- Updating the discounted Federal Medical Assistance Percentages (FMAP) from 59% to 55%.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to more prior year payments are estimated in FY 2020-21.

Methodology:
Participation in a Child and Family Team (CFT)

1. Assume mental health staff will work with each child with specialty mental health needs for two hours to determine whether or not a child or youth meets criteria to be placed in an STRTP.

2. This estimate assumes 42% of Medi-Cal EPSDT eligible children with an open child welfare case will need SMHS. Of the 42%, 11,736 are assumed to be open child welfare cases and currently receiving a CFT.

Caseload	42%	Less: Current Cases	CFT Cases (A)	Hours per Year (B)	CFT Case Hours (A x B)
Tier 1	1,340	680	660	12	7,920
Tier 2	2,366	1,203	1,163	10	11,630
Tier 3	8,670	4,405	4,265	8	34,120
Tier 4	9,315	4,733	4,582	4	18,328
Tier 5	1,406	715	691	4	2,764
Total	23,097	11,736	11,361	38	74,762

3. Based on filed cost reports for mental health services, the average cost for treatment planning for mental health staff to participate in the CFT is $3.40 per minute, or $204.00 per hour for FY 2017-18, and $4.25 per minute or $255.00 per hour for FY 2018-19, $4.60 per minute or $276.00 per hour for FY 2019-20, and $4.08 per minute or $244.80 per hour for FY 2020-21.

MHP COSTS FOR CONTINUUM OF CARE REFORM

REGULAR POLICY CHANGE NUMBER: 74

4. The estimated annual costs for participation in a child and family team in FY 2017-18, FY 2018-19, FY 2019-20, and FY 2020-21 are estimated as:

(Rounded)

Caseload	CFT Case Hours	FY 2017-18 Cost (Case Hours x $204.00/hr)	FY 2018-19 Cost (Case Hours x $255.00/hr)	FY 2019-20 Cost (Case Hours x $276.00/hr)	FY 2020-21 Cost (Case Hours x $244.80/hr)
Tier 1	7,920	$1,616,000	$2,020,000	$2,186,000	$1,939,000
Tier 2	11,630	$2,373,000	$2,966,000	$3,210,000	$2,847,000
Tier 3	34,120	$6,960,000	$8,701,000	$9,417,000	$8,353,000
Tier 4	18,328	$3,739,000	$4,674,000	$5,059,000	$4,487,000
Tier 5	2,764	$564,000	$705,000	$763,000	$677,000
Total	74,762	$15,252,000	$19,066,000	$20,635,000	$18,303,000

Placement Assessments

1. Based on CDSS' estimated number of children currently in a rate classification level (RCL) 10 to 12 residential group homes, assume 856 children would phase in and transition to an STRTP in FY 2017-18, 2,465 children would transition to an STRTP in FY 2018-19, 2,994 children in FY 2019-20, and 2,994 children in FY 2020-21.

2. Assume these children and youth would need to be assessed by county mental health department prior to being placed in a STRTP.

3. Assume it will take mental health staff four hours per client to complete a mental health assessment.

4. The assumed Placement Assessment costs are:

   FY 2017-18: 856 x $204.00 x 4 = $698,496
   FY 2018-19: 2,465 x $255.00 x 4 = $2,514,300
   FY 2019-20: 2,994 x $276.00 x 4 = $3,305,376
   FY 2020-21: 2,994 x $244.80 x 4 = $2,931,725

Training

1. Beginning FY 2018-19, CDSS is requesting funds through Federal Title IV-E authority to provide counties with Continuum of Care Reform (CCR) training. The total mental health staff training request is $3,000,000 to be paid at 75% FMAP, and discounted to 55% for FY 2019-20 and FY 2020-21, to account for children in foster care that are not federally eligible. The federal share will come from CDSS. The Department is requesting the General Fund (GF) match for the training.

   FY 2019-20 and FY 2020-21: Federal Share: $3,000,000 x 0.75 x 0.55 = $1,237,000 (Rounded)
   FY 2019-20 and FY 2020-21: GF Match: $3,000,000 x (1 – (0.75 x 0.55)) = $1,763,000 (Rounded)

MHP COSTS FOR CONTINUUM OF CARE REFORM

REGULAR POLICY CHANGE NUMBER: 74

Funding Summary

1. Based on Short Doyle/Medi-Cal paid claims data, on a cash basis for FY 2019-20, the Department will pay 1% of FY 2017-18 claims, and 61% of FY 2018-19 claims, and 38% of FY 2019-20 claims. On a cash basis for FY 2020-21, the Department will pay 1% of FY 2018-19 claims, 61% of FY 2019-20 claims, and 38% of FY 2020-21 claims. There is no lag in payment for training costs. The estimated costs, on a cash basis, is:

(Dollars in Thousands)

FY 2019-20	TF	CFT	Placement Assessments	Training
FY 2017-18	$160	$153	$7	$0
FY 2018-19	$13,164	$11,630	$1,534	$0
FY 2019-20	$10,860	$7,841	$1,256	$1,763
Total FY 2019-20	$24,184	$19,624	$2,797	$1,763

(Dollars in Thousands)

FY 2020-21	TF	CFT	Placement Assessments	Training
FY 2018-19	$216	$191	$25	$0
FY 2019-20	$14,603	$12,587	$2,016	$0
FY 2020-21	$9,832	$6,955	$1,114	$1,763
Total FY 2020-21	$24,651	$19,733	$3,155	$1,763

2. The FY 2019-20 and FY 2020-21 estimate is:

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
CFT	$19,624	$9,812	$9,812
Placement Assessments	$2,797	$1,398	$1,399
Training	$1,763	$1,763	$0
Total	**$24,184**	**$12,973**	**$11,211**

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
CFT	$19,733	$9,866	$9,867
Placement Assessments	$3,155	$1,577	$1,578
Training	$1,763	$1,763	$0
Total	**$24,651**	**$13,206**	**$11,445**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
100% GF (4260-101-0001)

PATHWAYS TO WELL-BEING

REGULAR POLICY CHANGE NUMBER:	75
IMPLEMENTATION DATE:	1/2013
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1718

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$448,000	$484,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$448,000	$484,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$448,000	$484,000

DESCRIPTION

Purpose:
This policy change estimates the costs for the following Specialty Mental Health Services (SMHS): Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC). Previously, this policy change captured costs related to clients that were part of the *Katie A.* class or subclass. Membership in the Katie A. class or subclass is not a requirement for receiving medically necessary services, and therefore, a child or youth need not have an open welfare case to be considered for receipt of ICC, IHBS, or TFC.

Authority:
SPA 09-004

Interdependent Policy Changes:
Not Applicable

Background:
On March 14, 2006, the U.S. Central District Court of California issued a preliminary injunction in *Katie A. v. Diana Bontá*, requiring the provision of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services (ICC, IHBS, and TFC) under the SMHS waiver to children in foster care or “at risk” of foster care placement. On appeal, the Ninth Circuit Court reversed the granting of the preliminary injunction and remanded the case to District Court in order to review each component service to determine whether they are mandated Medicaid covered services, and if so, whether the Medi-Cal program provides each service effectively. The court ordered the parties to engage in further meetings with the court appointed Special Master. On July 15, 2011, the parties agreed to a proposed settlement that was subject to court approval and on December 2, 2011, the court granted final approval of the proposed settlement. The parties met with the Special Master to develop a plan for settlement implementation.

As a result of the lawsuit, beneficiaries meeting medical necessity criteria may receive existing services in a more intensive and effective manner. In this context, these existing services are referred to as ICC, IHBS, and TFC. Reimbursement methodologies were established for ICC and IHBS effective January 1, 2013. On February 16, 2016, the reimbursement methodology was approved by

PATHWAYS TO WELL-BEING

REGULAR POLICY CHANGE NUMBER: 75

the Centers for Medicare and Medicaid Services (CMS) in State Plan Amendment (SPA) #09-004 for TFC. These services are an EPSDT benefit for all children and youth under the age of 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for these services.

The Katie A. settlement terminated in December 2014. These services and the model in which they are provided are now called “Pathways to Well-Being” services and are incorporated as SMHS.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21.

The change from FY 2019-20 and FY 2020-21, in the current estimate, is due to the addition of estimated TFC cost in FY 2020-21.

Methodology:
1. The cost estimate is based on an increase in the number of children receiving SMHS.

2. The estimated annual cost for Medi-Cal beneficiaries under the age of 21, who are eligible for full scope Medi-Cal services and meet the medical necessity criteria for IHBS and ICC is assumed to be fully reflected in the base policy change titled SMHS for Children.

3. Assume beginning July 1, 2017, the TFC services have a cost of $904,000 on an annual accrual basis. Assume the annual costs are $1.085 million in FY 2020-21. Assume costs for TFC began in FY 2018-19, due to a limited number of Medi-Cal certified TFC providers.

4. Assume 35% of current year TFC claims will be paid in the year the services occur, and 64% is paid in the second year, and 1% is paid in the third year.

5. On a cash basis for FY 2019-20, assume the Department will pay 64% of FY 2018-19 claims, and 35% of FY 2019-20 claims.

6. On a cash basis for FY 2020-21, assume the Department will pay 1% of FY 2018-19 claims, and 64% of FY 2019-20 claims, and 35% of FY 2020-21 claims.

Fiscal Year	Service	Total Accrual	Payment Lag	Cash Estimate TF (rounded)
FY 2018-19	TFC	$904,176	0.64	$579,000
FY 2019-20	TFC	$904,176	0.35	$316,000
Total FY 2019-20 Cash Estimate				$895,000

Fiscal Year	Service	Total Accrual	Payment Lag	Cash Estimate TF (rounded)
FY 2018-19	TFC	$904,176	0.01	$9,000
FY 2019-20	TFC	$904,176	0.64	$579,000
FY 2020-21	TFC	$1,085,011	0.35	$380,000
Total FY 2020-21 Cash Estimate				$968,000

PATHWAYS TO WELL-BEING

REGULAR POLICY CHANGE NUMBER: 75

(Dollars in Thousands)

Fiscal Year	TF	FF	CF
2019-20	$895	**$448**	$447
2020-21	$968	**$484**	$484

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

LATE CLAIMS FOR SMHS

REGULAR POLICY CHANGE NUMBER:	76
IMPLEMENTATION DATE:	7/2018
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1717

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$535,000	$30,000
- STATE FUNDS	$535,000	$30,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$535,000	$30,000
STATE FUNDS	$535,000	$30,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of reimbursement for Medi-Cal Specialty Mental Health Services (SMHS) claims that are submitted by county mental health plans for late eligibility determinations.

Authority:
Title 22, California Code of Regulations 50746 and 51008.5
Welfare & Institutions Code 14680-14685.1
Specialty Mental Health Services Consolidation Waiver

Interdependent Policy Changes:
Not Applicable

Background:
County mental health plans have submitted Medi-Cal SMHS claims for clients with Letters of Authorization for late eligibility determinations. Counties have 60 days to submit claims to the Department for payment when the Department of Social Services has determined eligibility for claims over one year.

Reason for Change:
The change from the prior estimate for FY 2019-20 is a decrease due to correcting the FY 2019-20 estimated payments to only reflect the federal funds (FF) portion of the payments; the prior estimate for FY 2019-20 erroneously included the county share.

The change from the prior estimate for FY 2020-21 is an increase due to including claims expected to be paid in FY 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate is a decrease due to fewer claims remaining to be adjudicated in FY 2020-21.

Methodology:
1. Late claims are based on actual claims received from the counties.

LATE CLAIMS FOR SMHS

REGULAR POLICY CHANGE NUMBER: 76

2. Assume GF will be used to pay claims in FY 2019-20 and FY 2020-21 that exceed the federal claiming limit.

Cash Basis	TF	GF
FY 2019-20	$535,000	**535,000**
FY 2020-21	$30,000	**30,000**

Funding:
100% GF (4260-101-0001)

SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT

REGULAR POLICY CHANGE NUMBER:	77
IMPLEMENTATION DATE:	1/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1660

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of federal fund (FF) repayments made to the Centers for Medicare and Medicaid Services (CMS) for improper claims for Medi-Cal services made by Siskiyou County Mental Health Plan. In addition, Siskiyou County General Fund (GF) reimbursements are also included in this policy change.

Authority:
Title 42, United States Code (USC) 1396b (d)(2)(C)

Interdependent Policy Changes:
Not Applicable

Background:
During the audit and cost settlement processes, the Department identified overpayments to the Siskiyou County Mental Health Plan from improper Medi-Cal billing practices. Pursuant to federal statute, the Department must remit the overpaid FF to CMS within a year of the discovery date. While the county acknowledged its Medi-Cal billing problems, it is unable to repay the amounts owed in a significant or timely manner. Consequently, the County will reimburse the Department $200,000 per year until it fulfills its obligation for repayment. The County repayments began August 2012. The County has submitted eight payments totaling $1,600,000.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21. There is no change in the current estimate from FY 2019-20 to FY 2020-21.

Methodology:
1. The Department began making repayments to CMS in January 2012 and repaid CMS overpayments discovered during cost settlements for FY 2006-07 through FY 2010-11 and audit settlements for FY 2005-06 through FY 2010-11.

SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT

REGULAR POLICY CHANGE NUMBER: 77

2. Siskiyou County reimburses the GF $200,000 annually. The county has submitted payments totaling $1,600,000.

3. The Department will continue to repay CMS for overpayments as overpayment amounts are determined.

Date of Overpayment Discovery	Due to DHCS	Paid to CMS	Due to CMS GF
1/11/2011	$1,754,000	$1,754,000	$0
3/2/2011	$116,000	$116,000	$0
8/4/2011	$2,189,000	$2,189,000	$0
11/15/2011	$586,000	$586,000	$0
12/21/2011	$95,000	$95,000	$0
3/26/2012	$443,000	$443,000	$0
4/15/2013	$2,917,000	$2,917,000	$0
5/30/2013	$1,131,000	$1,131,000	$0
4/9/2014	$1,369,000	$1,369,000	$0
9/9/2015	$270,000	$270,000	$0
4/4/2016	$381,000	$381,000	$0
1/18/2018	$738,000	$738,000	$0
Subtotal	$11,989,000	$11,989,000	$0
Repayments	($1,600,000)	$0	$0
Recoupments	($381,000)	$0	$0
Total	$10,008,000	$11,989,000	$0

4. The estimate for FY 2019-20 and FY 2020-21 is as follows:

Fiscal Year	TF	GF	FF	Reimbursement
FY 2019-20	**$0**	**($200,000)**	**$0**	**$200,000**
FY 2020-21	**$0**	**($200,000)**	**$0**	**$200,000**

Funding:
100% GF (4260-101-0001)
Reimbursement GF (4260-601-0995)

CHART REVIEW

REGULAR POLICY CHANGE NUMBER:	79
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1714

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$1,107,000	-$371,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,107,000	-$371,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$1,107,000	-$371,000

DESCRIPTION

Purpose:
This policy change estimates the recoupments due to the Department from disallowed claims. The disallowed claims are the result of the on-site chart reviews of inpatient and outpatient mental health providers.

Authority:
Title 9, California Code of Regulations 1810.380

Interdependent Policy Changes:
Not Applicable

Background:
Since January 2005, the Department has been conducting on-site chart reviews of mental health providers by comparing claims to the corresponding patient chart entries. The Department recoups the disallowed claims.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is immaterial; the revision was due to an actual recoupment received in May 2019. There is no change from the prior estimate for FY 2020-21.

The change from FY 2019-20 and FY 2020-21, in the current estimate, is due to a lower projection of recoupments for FY 2019-20 inpatient and outpatient reviews expected to be received in FY 2020-21. Also, the FY 2019-20 estimate is based on actual and estimated recoupments, whereas the FY 2020-21 estimate is comprised of estimated recoupments only.

Methodology:
1. The FY 2019-20 estimate includes actual and estimated recoupments from inpatient and outpatient chart reviews conducted for FY 2016-17, FY 2017-18, and FY 2018-19.

2. The FY 2020-21 estimate includes estimated recoupments from inpatient and outpatient chart reviews to be conducted for FY 2019-20.

CHART REVIEW

REGULAR POLICY CHANGE NUMBER: 79

(Dollars in Thousands)

Fiscal Year	TF	FF
FY 2019-20	($1,107)	($1,107)
FY 2020-21	($371)	($371)

Funding:
100% Title XIX (4260-101-0890)

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER:	80
IMPLEMENTATION DATE:	7/2015
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1713

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$54,623,000	-$53,739,000
- STATE FUNDS	$4,559,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$54,623,000	-$53,739,000
STATE FUNDS	$4,559,000	$0
FEDERAL FUNDS	-$59,182,000	-$53,739,000

DESCRIPTION

Purpose:
This policy change estimates the interim and final cost settlements for specialty mental health services (SMHS).

Authority:
Welfare & Institution Code 14705(c)
Title 9, California Code of Regulations 1840.105

Interdependent Policy Changes:
Not Applicable

Background:
The Department reconciles interim payments to county cost reports for mental health plans (MHPs) for children, adults, and Healthy Families SMHS. The Department completes interim settlements within two years of the end of the fiscal year. Final settlements are completed within three years of the last amended county cost report the MHPs submit to the Department.

The reconciliation process for each fiscal year may result in an overpayment or underpayment to the county and will be handled as follows:

- For counties that have been determined to be overpaid, the Department will recoup any overpayments.
- For counties that have been determined to be underpaid, the Department will make a payment equal to the difference between the counties cost report and the Medi-Cal payments.

Reason for Change:
The change from the prior estimate for FY 2019-20 is due to:

- FY 2008-09, FY 2009-10, FY 2010-11, and FY 2011-12 audit settlements were updated, resulting in decreased recoupments scheduled to be paid in FY 2019-20,
- FY 2011-12 interim cost settlements were updated and resulted in increased recoupments, and
- FY 2012-13 and FY 2013-14 interim cost settlements were updated, decreasing the recoupments scheduled to be paid in FY 2019-20.

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 80

The change from the prior estimate for FY 2020-21 is due to estimated settlements and recoupments to be paid and collected in FY 2020-21.

The change in the current estimate for FY 2019-20 to FY 2020-21 is due to assuming audit settlements for the older periods of FY 2004-05 through FY 2009-10, will be finalized in FY 2019-20, and cost settlements for FY 2013-14 were added to be recouped in FY 2020-21.

Methodology:

1. Interim cost settlements are based on the difference between each county MHP's filed cost report and the payments they received from the Department.

2. Final cost settlements are based on the difference between each county MHP's final audited cost report and the payments they received from the Department.

3. Cost settlements for services, administration, utilization review/quality assurance, and mental health Medi-Cal administrative activities are each determined separately.

4. Cost settlements prior to 2011 Realignment may consist of General Fund (GF).

The net FF and GF to be paid in FY 2019-20 is:

(Dollars in Thousands)

Interim Settlements	TF	GF	Title XIX	Title XXI
FY 2010-11	($488)	($83)	($399)	($6)
FY 2011-12	($2,290)	$0	($1,750)	($540)
FY 2012-13	($61,772)	$0	($55,600)	($6,173)
FY 2013-14	$1,506	$0	$2,240	($734)
Subtotal	($63,043)	($83)	($55,508)	($7,452)

(Dollars in Thousands)

Audit Settlements	TF	GF	Title XIX	Title XXI
FY 2004-05	$9,008	$3,463	$5,383	$162
FY 2006-07	$1,475	$407	$1,076	($8)
FY 2008-09	$1,178	$1,433	$3,282	($3,537)
FY 2009-10	$2,925	$600	$2,297	$28
FY 2010-11	($6,203)	($1,261)	($4,063)	($879)
FY 2011-12	$39	$0	($234)	$273
Subtotal	$8,421	$4,642	$7,741	($3,961)
Total FY 2019-20	**($54,623)**	**$4,559**	**($47,767)**	**($11,414)**

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 80

The net FF and GF to be paid in FY 2020-21 is:

(Dollars in Thousands)

Interim Settlements	TF	Title XIX	Title XXI
FY 2011-12	($598)	($511)	($87)
FY 2012-13	$11	$497	($486)
FY 2013-14	($54,208)	($49,321)	($4,887)
Subtotal	($54,794)	($49,335)	($5,459)

(Dollars in Thousands)

Audit Settlements	TF	Title XIX	Title XXI
FY 2010-11	$2,235	$2,242	($7)
FY 2011-12	($1,179)	($1,190)	$11
Subtotal	$1,055	$1,052	$4
Total FY 2020-21	**($53,739)**	**($48,283)**	**($5,455)**

Funding:
Title XIX FFP (4260-101-0890)
Title XXI FFP (4260-113-0890)
100% GF (4260-101-0001)

GLOBAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER:	81
IMPLEMENTATION DATE:	12/2015
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1951

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$2,477,024,000	$2,200,578,000
- STATE FUNDS	$1,238,511,000	$1,100,289,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,477,024,000	$2,200,578,000
STATE FUNDS	$1,238,511,000	$1,100,289,000
FEDERAL FUNDS	$1,238,513,000	$1,100,289,000

DESCRIPTION

Purpose:
This policy change estimates the payments to fund California's remaining uninsured population.

Authority:
California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)
SB 815 (Chapter 111, Statutes of 2016)

Interdependent Policy Changes:
ACA DSH Reduction

Background:
Since 2005, the Designated Public Hospital and Clinic systems (DPH systems) have received partial support for health expenditures made on behalf of the uninsured through a combination of California's 1115 Waivers' Safety Net Care Pool (SNCP) and Medicaid Disproportionate Share Hospital (DSH) funding. These two funding sources have been provided through a cost-based system. The Medi-Cal 2020's redesigned Global Payment Program (GPP) includes funding from the former SNCP and the State's DSH allotment (related to the DPHs), and is designed with preset reductions to the overall funding amounts in the latter demonstration years to coincide with the Medicaid DSH reductions required in the Affordable Care Act (ACA).This safety net stabilization program provides an innovative approach to financing care to California's remaining uninsured population served by DPH systems by unifying the DSH and the successor SNCP funding streams into a DPH-specific global payment system. The GPP incentive and utilization based program steers funding to those who are providing actual inpatient and/or outpatient services to uninsured Californians who are most in need. Rather than continue payments to inpatient facilities based upon the current SNCP and DSH system that provides funding based on the volume of hospitalizations, the GPP would promote the right care, at the right time, in the right setting for uninsured Californians served by the DPH systems.

Effective July 1, 2015, DPHs, except State Government-operated University of California (UC) hospitals, receive their allocation of the federal DSH payments through the Global Payment Program.

GLOBAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 81

A five-year GPP renewal is under development, of which the proposed payment methodology would remove the SNCP federal funding for future program years, beginning Program Year (PY) 2020-21.

The ACA DSH allotment reduction was previously scheduled to go into effect on October 1, 2013. HR 2 (2015) was enacted on April 16, 2015, which delayed the reduction until October 1, 2017. HR 1892 (2018) was enacted on February 9, 2018, which postponed the reduction until October 1, 2019. Subsequently, HR 4378 (2019) and HR 3055 (2019) were enacted, postponing the reduction until November 22, 2019, and December 21, 2019, respectively. On December 20, 2019, HR 1865 further delayed the ACA DSH reduction until May 23, 2020. On March 27, 2020, HR 748 (2020) was enacted which eliminated the Federal Fiscal Year (FFY) 2020 reduction and postponed the start of the FFY 2021 reduction until December 1, 2020. See the ACA DSH Reduction policy change for more information.

Reason for Change:
The change in FY 2019-20 and FY 2020-21, from the prior estimate, is due to updated allotment estimates for PY 2018-19, PY 2019-20, and PY 2020-21. In addition, FY 2020-21 now includes final reconciliation payments for PY 2017-18 and PY 2018-19.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease due to varying DSH allotments by program year, varying final reconciliation payments, and not including SNCP funding beginning PY 2020-21.

Methodology:

1. The program year for the Global Payment Program is from July 1 to June 30, to align with the state fiscal year.

2. The Medi-Cal 2020 GPP included SNCP funding of $236 million for Demonstration Year (DY) 2015-16. In May 2016, the Department submitted an independent report on uncompensated care to the Centers for Medicare and Medicaid Services (CMS). On July 14, 2016, CMS approved $236 million in SNCP funding for DY 2016-17 through DY 2019-20.

3. The total federal funding for the GPP for PY 2015-16 through PY 2020-21 is estimated at:

(Dollars in Thousands)

Program Year	DPH DSH Allotment	SNCP	Total FFP
PY 2015-16	$869,667	$236,000	$1,105,667
PY 2016-17	$903,395	$236,000	$1,139,395
PY 2017-18	$931,427	$236,000	$1,167,427
PY 2018-19	$967,116	$236,000	$1,203,116
PY 2019-20	$981,730	$236,000	$1,217,730
PY 2020-21	$1,001,704	$0	$1,001,704

4. Payments are made on a quarterly basis where three quarters are paid in the same fiscal year and the fourth quarter is paid the following fiscal year.

5. The PY 2016-17 round 6 final close out payment of $4.37 million TF was paid in FY 2019-20.

6. The PY 2017-18 final reconciliation net payment of $143 million TF was paid in FY 2019-20.

GLOBAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 81

7. The PY 2017-18 round 6 final close out recoupment of $6.41 million TF will occur in FY 2020-21.

8. The PY 2018-19 final reconciliation net payment of $98.41 million TF will occur in FY 2020-21.

9. Assume PY 2020-21 will not include SNCP funding, pending the submission and CMS approval for a five-year GPP renewal.

10. The estimated GPP payments on a cash basis are:

(Dollars in Thousands)

FY 2019-20	TF	IGT	FF
PY 2016-17	$4,375	$2,187	$2,188
PY 2017-18	$143,000	$71,500	$71,500
PY 2018-19	$500,125	$250,062	$250,063
PY 2019-20	$1,829,524	$914,762	$914,762
Total	**$2,477,024**	**$1,238,511**	**$1,238,513**

FY 2020-21	TF	IGT	FF
PY 2017-18	($6,406)	($3,203)	($3,203)
PY 2018-19	$98,416	$49,208	$49,208
PY 2019-20	$605,936	$302,968	$302,968
PY 2020-21	$1,502,632	$751,316	$751,316
Total	**$2,200,578**	**$1,100,289**	**$1,100,289**

Funding:
100% Title XIX FFP (4260-101-0890)
100% Global Payment Program Special Fund (4260-601-8108)

PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL

REGULAR POLICY CHANGE NUMBER:	82
IMPLEMENTATION DATE:	8/2016
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1950

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$1,721,309,000	$612,000,000
- STATE FUNDS	$860,654,500	$306,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,721,309,000	$612,000,000
STATE FUNDS	$860,654,500	$306,000,000
FEDERAL FUNDS	$860,654,500	$306,000,000

DESCRIPTION

Purpose:
This policy change estimates the payments to fund the delivery system transformation and alignment incentive program, known as Public Hospital Redesign and Incentives in Medi-Cal (PRIME).

Authority:
SB 815 (Chapter 111, Statutes of 2016)
AB 1568 (Chapter 42, Statutes of 2016)
California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)

Interdependent Policy Changes:
Not Applicable

Background:
California will fund public provider system projects that will change care delivery and strengthen those systems' ability to receive payment under risk-based alternative payment models. Projects will be reported on a broad range of metrics to meet quality benchmark goals. Over the course of the demonstration, payments will increasingly move towards pay for performance. To promote greater stability, 50% of all Medi-Cal managed care beneficiaries assigned to designated public hospital systems in the aggregate will receive all of or a portion of their care under a contracted alternative payment model by January 2018; 55% by January 2019; and 60% by the end of the waiver renewal period in 2020.

Funding for this pool will not exceed $7.464 billion in combined federal and state shares of expenditures over a five-year period for designated public hospital systems (DPH) and district/municipal public hospitals (DMPH) to support reforms to care delivery, provider organization and adoption of alternative payment methodologies. The demonstration will provide up to $1.4 billion annually for the DPH systems and up to $200 million annually for the DMPH systems for the first three years of the demonstration. The pool will then phase down by 10% in the fourth year of the demonstration and by an additional 15% in the fifth year of the demonstration.

PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL

REGULAR POLICY CHANGE NUMBER: 82

Reason for Change:
The change in FY 2019-20, from the prior estimate, is due to the inclusion of recalculated funds for DY 2016-17, and remaining DY 2018-19 and DY 2017-18 supplemental and high performance pool fund payments.

There is no change in FY 2020-21, from the prior estimate.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to no supplemental payments estimated in FY 2020-21 and only the DY 2019-20 annual payment estimated in FY 2020-21.

Methodology:

1. Assumes two semi-annual reports are due: the first report will be due in March for the July to December period and the second report is due in September for the January to June period.

2. Starting in DY 2016-17, if an entity does not meet the project metric target by the annual report due date, then the entity will not be able to claim the full allocation. The entity will have the opportunity to claim up to 90% of the unearned funds for up to two consecutive years by over-performing in other project metrics through the supplemental payment. The remaining 10% of the unearned funds will go to a high performance pool in the subsequent DY and can be claimed through the supplemental payment for the subsequent DY.

3. Starting in DY 2017-18, for both DMPHs and DPHs, based on the current hospitals' plans, assume the first semi-annual payment will be 50% of the annual DY allotment. The annual payment will include the remaining 50% of the annual DY allotment plus any unclaimed allotment funds from the first semi-annual payment period, if all metrics are achieved.

4. The DY 2017-18 and remaining DY 2018-19 supplemental payments, which include high performance pool fund payments from prior year allocations, are estimated to be paid in FY 2019-20.

5. In DY 2018-19, the annual allocation to DMPHs and DPHs will be phased down by 10%. In FY 2018-19, the first semi-annual payment for DY 2018-19 is estimated based on the 10% phased down allocation. In FY 2019-20, the annual payment for DY 2018-19 is estimated based on the 10% phased down allocation.

6. In DY 2019-20, the annual allocation to DMPHs and DPHs will be phased down by an additional 15%. In FY 2019-20, the first semi-annual payment for DY 2019-20 is estimated based on the additional 15% phased down allocation. In FY 2020-21, the annual payment for DY 2019-20 is estimated based on the additional 15% phased down allocation.

PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL

REGULAR POLICY CHANGE NUMBER: 82

(Dollars in Thousands)

FY 2019-20	TF	IGT	FF
DY 2016-17			
DPH	$1,760	$880	$880
DMPH	$0	$0	$0
Total	$1,760	$880	$880
DY 2017-18			
DPH	$86,883	$43,441	$43,442
DMPH	$31,154	$15,577	$15,577
Total	$118,037	$59,018	$59,019
DY 2018-19			
DPH	$833,025	$416,512	$416,513
DMPH	$156,487	$78,244	$78,243
Total	$989,512	$494,756	$494,756
DY 2019-20			
DPH	$535,500	$267,750	$267,750
DMPH	$76,500	$38,250	$38,250
Total	$612,000	$306,000	$306,000
Total FY 2019-20	**$1,721,309**	**$860,654**	**$860,655**

(Dollars in Thousands)

FY 2020-21	TF	IGT	FF
DY 2019-20			
DPH	$535,500	$267,750	$267,750
DMPH	$76,500	$38,250	$38,250
Total	$612,000	$306,000	$306,000
Total FY 2020-21	**$612,000**	**$306,000**	**$306,000**

Funding:
50% Title XIX FF (4260-101-0890)
50% Public Hospital Investment, Improvement, and Incentive Fund (4260-601-3172)

MEDI-CAL 2020 WHOLE PERSON CARE PILOTS

REGULAR POLICY CHANGE NUMBER:	83
IMPLEMENTATION DATE:	7/2016
ANALYST:	Latoya Brown
FISCAL REFERENCE NUMBER:	1953

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$936,711,000	$671,201,000
- STATE FUNDS	$468,356,000	$335,600,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$936,711,000	$671,201,000
STATE FUNDS	$468,356,000	$335,600,000
FEDERAL FUNDS	$468,355,000	$335,601,000

DESCRIPTION

Purpose:
This policy change estimates the costs related to Medi-Cal 2020 Waiver Whole Person Care (WPC) Pilots.

Authority:
Welfare & Institutions Code Section 14184.60
California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)

Interdependent Policy Changes:
Not Applicable

Background:
Under the Medi-Cal 2020 Waiver, the Centers for Medicare and Medicaid Services (CMS) approved funding for WPC Pilot programs for a five-year period beginning January 1, 2016.

The WPC Pilots allow the following to act as a Lead Entity serving a county, or a region consisting of more than one county, to integrate services for their high-risk, high-utilizing beneficiaries to promote an integrated health system that is designed to maximize health care value and is sustainable over the long-term:

- City
- County
- City and county
- Health or hospital authority
- Consortium of any of the above entities
- Federally Recognized Tribe
- Tribal Health Program

Pilots allow city, county, state, tribal, and federal entities as well as Medi-Cal managed care plans, hospitals, and provider organizations to align communication and integrate services to prevent

MEDI-CAL 2020 WHOLE PERSON CARE PILOTS

REGULAR POLICY CHANGE NUMBER: 83

fragmentation of the delivery system that can result in duplicative or inappropriate care for Medi-Cal beneficiaries.

Proposals for WPC Pilots include specific strategies to:

- Increase and strengthen care coordination and integration for high-risk, high-utilizing beneficiaries, and develop an infrastructure that will ensure local collaboration among the entities participating in the WPC Pilots over the long term.
- Increase coordination and appropriate access to care for the most vulnerable Medi-Cal beneficiaries and reduce inappropriate emergency department utilization.
- Improve data collection and sharing among local entities to support ongoing case management, monitoring, and strategic program improvements.

WPC Pilots may also focus on Housing & Supportive Services which include (but are not limited to):

- Access to housing
- Tenancy-based care management services
- County Housing Pools

The Department approved a total of 25 local Whole Person Care Pilot programs that included 23 individual counties, one consortium of two counties, and one city.

Reason for Change:
The change from prior estimate for FY 2019-20 is an increase due to available rollover funding amounts from Program Year (PY) 3 despite a county withdrawing from Whole Person Care in June 2018.

The change from the prior estimate for FY 2020-21 is a decrease due to a county withdrawing from Whole Person Care in June 2018. FY 2020-21 did not receive significant rollover funding to cover the loss of a county.

The change from FY 2019-20 to FY 2020-21 is a decrease due to the fact that the FY 2019-20 budget received a larger rollover amount than the FY 2020-21 budget; therefore, FY 2019-20 budget did not experience a decrease by the loss of a county the way that FY 2020-21 did.

Methodology:

1. First Round Lead Entities submitted applications with annual budgets in June 2016. The Department determined the program awards in the second quarter of FY 2016-17 for approved participating entities. The payments began in FY 2016-17 and are assumed to continue through FY 2020-21.

2. Second Round Lead Entities submitted applications with annual budgets in March 2017. The Department determined the program awards in the fourth quarter of FY 2016-17 for entities approved to participate in the second round. The payments for second round entities began in FY 2017-18 and are assumed to continue through FY 2020-21.

MEDI-CAL 2020 WHOLE PERSON CARE PILOTS

REGULAR POLICY CHANGE NUMBER: 83

3. Payments are made through an Intergovernmental Transfer (IGT) process.

4. For First Round Lead Entities, PYs correspond to calendar years. PY 1 began January 1, 2016.

5. For Second Round Lead Entities, PY 1 was January – June 2017, and PY 2 is July 2017 – December 2017. The remaining program years, PY 3 – PY 5, are then aligned with First Round Lead Entities and correspond to calendar years. PY 3 began January 2018.

6. PY 3 payments were made in October 2018 and May 2019.

7. PY 4 payments were made in October 2019 and will be made in June 2020.

8. PY 5 payments will be made in November 2020 and June 2021.

9. Lead entities may roll over unused funds from the prior PY. The rollover process impacts actual expenditures in current year and projected expenditures in budget year. PY4 budget rollover process was finalized after July 2019; therefore, the total funding for FY 2019-20 and FY 2020-21 has slightly changed.

(Dollars in Thousands)

Fiscal Year	TF	IGT*	FF
FY 2019-20	**$936,711**	$468,356	$468,355
FY 2020-21	**$671,201**	$335,600	$336,601

Funding:
100% FFP Title XIX (4260-101-0890)
*Whole Person Care Pilot Special Fund (4260-601-8107)

BTR - LIHP - MCE

REGULAR POLICY CHANGE NUMBER:	84
IMPLEMENTATION DATE:	7/2011
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1578

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$189,824,000	$0
- STATE FUNDS	$17,438,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$189,824,000	$0
STATE FUNDS	$17,438,000	$0
FEDERAL FUNDS	$172,386,000	$0

DESCRIPTION

Purpose:
This policy change estimates the federal funds for the Medicaid Coverage Expansion (MCE) component of the Low Income Health Program (LIHP) under the California Bridge to Reform (BTR) Demonstration.

Authority:
AB 342 (Chapter 723, Statutes of 2010)
AB 1066 (Chapter 86, Statutes of 2011)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) (Waiver 11-W-00193/0)

Interdependent Policy Changes:
Not Applicable

Background:
The LIHP was effective November 1, 2010, through December 31, 2013, under the BTR and consisted of two components, the MCE and the Health Care Coverage Initiative (HCCI). The MCE covered eligible individuals with family incomes at or below 133% of Federal Poverty Level. The MCE program is not subject to a federal funding cap. The HCCI covered those eligible individuals with family incomes above 133% through 200% of Federal Poverty Level. These are statewide county-based elective programs. The LIHP HCCI replaced the Coverage Initiative (CI) under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration. AB 342 and AB 1066 authorize the local LIHPs to provide health care services to eligible individuals.

The local LIHPs use the following methodologies to obtain federal funding:

- Certified Public Expenditures (CPEs), and
- IGTs for county-owned Federally Qualified Health Centers (IGT-FQHCs).

BTR - LIHP - MCE

REGULAR POLICY CHANGE NUMBER: 84

The Department has used the CI cost claiming protocol for the Medi-Cal Hospital/Uninsured Care Demonstration (MH/UCD) as the basis for payments made on claims for dates of service from November 1, 2010, through September 30, 2011. This protocol is permitted by the Special Terms and Conditions of the Section 1115(a) Bridge to Reform Medicaid Demonstration for those local LIHPs which were legacy counties under the CI.

On August 13, 2012, the Centers for Medicare & Medicaid Services (CMS) approved the new cost claiming protocol for claims based on CPEs retroactive to October 1, 2011. CMS also approved the new cost claiming protocol for claims based on IGT-FQHC on February 5, 2013, retroactive to November 1, 2010.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is due to updated final reconciliation data, which also includes payments and recoupments for services provided by FQHCs.

There is no change in FY 2020-21, from the prior estimate.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to the completion of the final reconciliations in FY 2019-20.

Methodology:
1. The remaining DY 2010-11 through DY 2013-14 final reconciliations are complete and payments will occur in FY 2019-20. Final reconciliations for each DY reflect the CPE and IGT nonfederal share of the payment methodologies used.

The estimated MCE payments on a cash basis are:

FY 2019-20	TF	IGT	FF
2010-11 (CPE)	$66,001,000	$0	$66,001,000
2011-12 (CPE)	$10,031,000	$0	$10,031,000
2011-12 (IGT)	($22,520,000)	$22,520,000	($45,040,000)
2012-13 (CPE)	($760,000)	$0	($760,000)
2012-13 (IGT)	$2,126,000	($2,126,000)	$4,252,000
2013-14 (CPE)	$131,990,000	$0	$131,990,000
2013-14 (IGT)	$2,956,000	($2,956,000)	$5,912,000
Total FY 2019-20	**$189,824,000**	**$17,438,000**	**$172,386,000**

Funding:
Title XIX (4260-101-0890)
LIHP IGT Fund (4260-607-8502)

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

REGULAR POLICY CHANGE NUMBER:	85
IMPLEMENTATION DATE:	1/2017
ANALYST:	Matt Wong
FISCAL REFERENCE NUMBER:	1954

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$196,179,000	$174,230,000
- STATE FUNDS	$98,089,500	$87,115,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$196,179,000	$174,230,000
STATE FUNDS	$98,089,500	$87,115,000
FEDERAL FUNDS	$98,089,500	$87,115,000

DESCRIPTION

Purpose:
This policy change estimates the dental-related costs for the Medi-Cal 2020 Waiver. These costs include the estimated incentive payments for the provision of preventive services, caries risk assessment and disease management, continuity of care, and funding for the Local Dental Pilot Projects (LDPPs).

Authority:
California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)

Interdependent Policy Changes:
Not Applicable

Background:
Through the Medi-Cal 2020 Waiver, the Department is implementing and overseeing four dental efforts (domains), which are collectively referred to as the Dental Transformation Initiative (DTI) program.

The four domains of the DTI program are as follows:

(1) Increase Preventive Services Utilization for Children,
(2) Caries Risk Assessment and Disease Management,
(3) Increase the Continuity of Care, and
(4) LDPPs

The Increase Preventive Services Utilization for Children domain aims to increase the statewide proportion of children ages one through twenty enrolled in Medi-Cal who receive a preventive dental service in a given year. The Department offers incentive payments to dental provider service office locations that provide preventive services to an increased number of Medi-Cal children, as determined by the Department. A reassessment of this Domain and the applicable benchmarks will take place between years two and three in order to evaluate program effectiveness.

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

REGULAR POLICY CHANGE NUMBER: 85

The Caries Risk Assessment and Disease Management domain enables eligible Medi-Cal Dental program enrolled dentists to receive incentive payments for performing caries risk assessments and for each service performed under a pre-identified treatment plan for children ages six and under, based upon the beneficiary's risk level as determined by the dentist via the caries risk assessment. The key elements of this program are to formally assess and manage caries risk, and to emphasize the provision of preventive services in lieu of more invasive and costly procedures. This domain has been implemented on a pilot basis in select counties based on the percentage of restorative to preventive services, representative sampling across the state, and likelihood of provider participation. Of the eleven pilot counties selected, the Department has only seen payment activity in five counties. As of January 1, 2019 this domain has expanded to eighteen additional counties. The attributes considered when selecting these counties for expansion were ratio of restorative to preventative services (greater than 45%), provider populations, and robust eligible beneficiary count.

The Increase the Continuity of Care domain aims to encourage the continuity of care among Medi-Cal beneficiaries age 20 and under. This domain has been implemented on a pilot basis in select counties based on the ratio of service office locations to beneficiaries, current levels of continuity of care at, above and below the statewide continuity of care baseline, and representation throughout the state. As of January 1, 2019 this domain has expanded to include 19 counties and a rate increase of $60. The Department hopes to increase utilization and participation with the expansion efforts.

The Department requires the selected LDPPs to have broad-based provider and community support and collaboration, including Tribes and Indian health programs, with incentives related to goals and metrics that contribute to the overall goals of any one of the three abovementioned programs. The Department issued payments to pilot providers (i.e. the entity or entities providing the pilot proposal application) only on the basis of an approved application. Fifteen LDPPs were approved; however, two LDPP were unable to execute their contracts.

The Medi-Cal 2020 Waiver was scheduled to sunset at the end of calendar year 2020, but the Department is working with Centers for Medicare & Medicaid Services (CMS) on an extension.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a net increase due to an updated increase Domain 1 payments, an increase in Domain 2 estimate due to updated check write data, updated beneficiary data for Domain 3 costing model and payment shifts in Domain 4 into FY 2019-20. The change from the prior estimate, for FY 2020-21, is a net decrease due to updated beneficiary data for Domain 3 costing model and payment shifts in Domain 4 into FY 2019-20. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a net decrease due to the phase out of Domain 2 payments, the decrease in overall payments amounts in Domain 3 and the payments shifted into FY 2019-20 from FY 2020-21 for Domain 4.

Methodology:
<u>Domain 1: Increase Preventive Services Utilization for Children</u>

1. The implementation date for Domain 1 was July 1, 2016; however, claims data from January 1, 2016, through June 30, 2016, count towards the domains performance metrics and incentive payments. Incentive payments are paid on a semi-annual basis. The timing of the payments assumes the incentives will be completed by the first payment of the following fiscal year. Therefore, FY 2019-20 includes incentive payments for CY 2019 and the remainder of CY 2018 and FY 2020-21 includes incentive payments for CY 2020 and the remainder of CY 2019.

2. Service Office Locations are reimbursed for services in accordance with the Schedule of Maximum Allowances (SMA). In addition, qualified service office locations may receive incentive payments for

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

REGULAR POLICY CHANGE NUMBER: 85

preventive services equating to a payment of 37.5% of the SMA for every qualifying preventive service provider to users above the 1% benchmark and 75% of the SMA for every qualifying preventive service provided to users above a 2% benchmark set by the Department.

3. A factor to account for changes in statewide Medi-cal eligibles has been applied based on caseload trends.

4. The Department has re-baselined providers who have participated for two program years and has trended the expenditures to account for providers who will not make their future benchmarks.

Total Domain 1 costs are estimated to be:

Fiscal Year	TF	GF	FF
FY 2019-20	$57,731,000	$28,865,000	$28,866,000
FY 2020-21	$57,386,000	$28,693,000	$28,693,000

Domain 2: Caries Risk Assessment and Disease Management

5. This four year incentive program was implemented on January 1, 2017. The Department uses the most recent complete calendar year (CY) for Caries Risk Assessment CDT code data to determine the utilization.

6. Domain 2 has three levels of risk assessment; Low, Moderate and High Risk. Low Risk children are able to obtain these services twice a year, Moderate Risk three times per year, and High Risk four times per year. High Risk children also have the option of receiving an interim caries arresting medication twice per year. The participation is projected using the last six months of data along with a factor based on caseload trends to account for changes in statewide Medi-cal eligibles.

7. Payments are made on a monthly basis. Therefore, FY 2019-20 includes incentive payments for the second six months of CY 2019 and first six months of CY 2020 while FY 2020-21 will include incentive payments for the second six months of CY 2020 and the first six months of CY 2021.

Total Domain 2 costs are estimated to be:

Fiscal Year	TF	GF	FF
FY 2019-20	$81,436,000	$40,718,000	$40,718,000
FY 2020-21	$60,108,000	$30,054,000	$30,054,000

Domain 3: Increase the Continuity of Care

8. The implementation date for Domain 3 was July 1, 2016; however, claims data from January 1, 2016, through June 30, 2016, count towards the domain's performance metrics and incentive payments as compared to prior year's data. Payments are made once a year starting in July 2017. Therefore, FY 2019-20 will include incentive payments for CY 2018 and runout for CY 2017, while FY 2020-21 includes incentive payments for FY 2019 and runout for FY 2018.

9. This incentive program is available to service office locations that provide examinations to an enrolled Medi-Cal beneficiary for two, three, four, five, and six year continuous periods.

10. A factor to account for changes in statewide Medi-Cal eligibles has been applied based on caseload trends.

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

REGULAR POLICY CHANGE NUMBER: 85

11. This five year incentive program is only available for services performed on child beneficiary participants age 20 and under. The Department assumes that the beneficiaries from the baseline year for the selected pilot county will return to the same provider at the same rate from year one through year five.

12. There will be a projected 2.25% increase in exams utilization each year for newly entering Domain 3 participants.

13. Incentive payment amounts are made available in tiers based on the length of time a beneficiary maintains continuity of care with the same service office location. In each subsequent year of continuity, the dollar amount of the incentive payment for an exam of the same child within that period is increased.

    Total Domain 3 costs are estimated to be:

Fiscal Year	TF	GF	FF
FY 2019-20	$13,254,000	$6,627,000	$6,627,000
FY 2020-21	$30,796,000	$15,398,000	$15,398,000

Domain 4: Local Dental Pilot Projects

14. The implementation for this domain was April 15, 2017. Payments are invoiced quarterly beginning FY 2017-18.

15. Fifteen LDPPs were approved; however, two LDPPs have been withdrawn.

16. Assume financing for LDPPs is contingent upon the structure and design of approved proposals. The LDPPs domain's annual funding shall not exceed twenty-five percent of the DTI annual funding limits. The incentive funding available for payments within this domain will not exceed the amount apportioned from the DTI pool to this domain for the applicable DY, except as provided for in the Medi-Cal Waiver Special Terms and Conditions (STCs).

    Total Domain 4 costs are estimated to be:

Fiscal Year	TF	GF	FF
FY 2019-20	$43,758,000	$21,879,000	$21,879,000
FY 2020-21	$25,940,000	$12,970,000	$12,970,000

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

REGULAR POLICY CHANGE NUMBER: 85

17. On a cash basis, the FY 2019-20 and FY 2020-21 total demonstration costs are:

FY 2019-20	TF	GF	FF
Domain 1	$57,731,000	$28,865,000	$28,866,000
Domain 2	$81,436,000	$40,718,000	$40,718,000
Domain 3	$13,254,000	$6,627,000	$6,627,000
Domain 4	$43,758,000	$21,879,000	$21,879,000
Total	**$196,179,000**	**$98,089,000**	**$98,090,000**

FY 2020-21	TF	GF	FF
Domain 1	$57,386,000	$28,693,000	$28,693,000
Domain 2	$60,108,000	$30,054,000	$30,054,000
Domain 3	$30,796,000	$15,398,000	$15,398,000
Domain 4	$25,940,000	$12,970,000	$12,970,000
Total	**$174,230,000**	**$87,115,000**	**$87,115,000**

*Totals may not add due to rounding

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

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER:	86
IMPLEMENTATION DATE:	7/2006
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1153

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$117,101,000	$0
- STATE FUNDS	$117,101,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$117,101,000	$0
STATE FUNDS	$117,101,000	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of stabilization funding under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions (W&I) Code 14166.75
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration
AB 1467 (Chapter 23, Statutes of 2012), Welfare & Institutions Code 14166.14 and 14166.19

Interdependent Policy Changes:
Not Applicable

Background:
Stabilization funding is calculated as follows:

- Non-designated public hospitals (NDPHs) will receive total funds payments equal to the difference between:
  a. The NDPHs' aggregate payment increase, and
  b. The sum of $0.544 million and 0.64% of total stabilization funding.

- Private Hospitals will receive total funds payment equal to the difference between:
  a. The Private Hospitals' aggregate payment increase, and
  b. The sum of $42.228 million and an additional amount, based on the formulas specified in W&I Code 14166.20.

- Distressed Hospitals will receive total funds payments equal to the lesser of $23.5 million or 10% of total stabilization funding, with a minimum of $15.3 million.

- DPHs will receive General Fund (GF) payments to the extent that the state-funded programs' certified public expenditures (CPEs) are used for federal financial participation (FFP) from the Safety Net Care Pool (SNCP) and the corresponding GF savings exceed what is needed for the stabilization funding to the NDPHs, Private Hospitals, and Distressed Hospitals.

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER: 86

Stabilization for NDPHs and private hospitals is calculated; however, pursuant to AB 1467, the Department redirected the stabilization funding available to the NDPHs and private hospitals that was not paid for FY 2005-06 through FY 2009-10 to the GF. This policy change budgets the stabilization payments available for DPHs and Distressed Hospitals payments.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is due to updated final reconciliation data for DY 2008-09 and DY 2009-10, and the inclusion of the DY 2006-07 and DY 2007-08 final reconciliations.

There is no change in FY 2020-21, from the prior estimate.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to the completion of the final reconciliations in FY 2019-20.

Methodology:

1. Stabilization funding is calculated after the final reconciliation of the DPH interim payments is completed.

2. Until the final reconciliation of the SNCP payments is complete, the final stabilization payments to the NDPHs, Private Hospitals, Distressed Hospitals, and DPHs are not known.

3. Stabilization funding to NDPHs, Private Hospitals, and Distressed Hospitals is comprised of GF made available from the federalizing of four state-only programs and applicable FFP. Any payments made from the stabilization funding to DPHs will consist only of the GF portion budgeted, as DPHs are not allowed to draw additional FFP from any stabilization funding. Currently, all GF is matched with FFP until the final stabilization payments are calculated.

4. The MH/UCD was extended for 60 days to October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) effective November 1, 2010. Stabilization funding is not applicable under the BTR. Funding for the 60-day extension of the prior MH/UCD SNCP is included in the BTR.

5. The MH/UCD final reconciliation calculation takes into account claiming for Designated State Health Programs as well as payments to DPHs and Distressed Hospitals.

6. AB 1467 authorizes the Department to continue to exercise the authority to finalize the payments rendered under the responsibilities transferred to it with the dissolution of California Medical Assistance Commission (CMAC) under section 14165(b) of the W&I Code.

7. Final reconciliations will result in updated stabilization amounts for NDPH and Private Hospitals. These updated stabilization amounts will not be paid out.

8. Distressed Hospital payments are calculated as part of the MH/UCD waiver final reconciliation. These payments were previously distributed based on negotiations with the Office of the Selective Provider Contracting Program, formerly CMAC. The Department will now distribute these payments. Distressed Hospital payments for 2005-06 and 2006-07 were paid prior to FY 2013-14. Until the distribution methodology for Distressed Hospital payments is finalized, Distressed Hospital payments for DY 2007-08 through DY 2009-10 will not be paid out.

9. The DY 2006-07, DY 2007-08, DY 2008-09, and DY 2009-10 final reconciliations for DPHs and Distressed Hospitals will be completed in FY 2019-20.

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER: 86

The estimated stabilization payments are:

FY 2019-20	TF	GF	FF
DY 2006-07 DPHs	$30,457,000	$30,457,000	$0
DY 2007-08 DPHs	$54,821,000	$54,821,000	$0
DY 2008-09 DPHs	$31,655,000	$31,655,000	$0
DY 2009-10 DPHs	$168,000	$168,000	$0
Total	**$117,101,000**	**$117,101,000**	**$0**

Funding:
100% GF (4260-101-0001)

WHOLE PERSON CARE HOUSING SERVICES

REGULAR POLICY CHANGE NUMBER:	87
IMPLEMENTATION DATE:	11/2019
ANALYST:	Latoya Brown
FISCAL REFERENCE NUMBER:	2131

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$100,000,000	$0
- STATE FUNDS	$100,000,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$100,000,000	$0
STATE FUNDS	$100,000,000	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the Whole Person Care (WPC) one-time General Fund (GF) augmentation for housing services.

Authority:
Welfare & Institutions Code Section 14184.60
Proposed Budget Bill Language

Interdependent Policy Changes:
None

Background:
Medi-Cal's current WPC pilots coordinate physical health, behavioral health, and social services, including housing transition and tenancy sustaining services for high-risk, high-utilizing beneficiaries who continue to have poor outcomes. The one-time GF augmentation will allow WPC pilots to invest in long-term and short-term housing, as well as capital investments for housing projects for Medi-Cal beneficiaries who are mentally ill and are experiencing homelessness, or at the risk of homelessness. The $100 million will be available for expenditure until June 30, 2025.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 or 2020-21. The decrease from FY2019-20 to FY 2020-21 is due to this one-time augmentation occurring in FY 2019-20.

Methodology:
1. As specified in the Governor's Budget Proposal, the allocation methodology takes into account prevalence of homelessness, cost of living, and pilot performance.

   a) Prevalence of homelessness: 50 percent of the funding is allocated in proportion to the total number of people experiencing homelessness in the county as compared to the total for all WPC counties. The county's number of homeless people is from the federal Housing and Urban Development (HUD) Point in Time count numbers from 2017.

WHOLE PERSON CARE HOUSING SERVICES

REGULAR POLICY CHANGE NUMBER: 87

b) Cost of living: 25 percent of the funding is allocated in proportion to the cost of living in the pilot county. The department used the federal HUD Fair Market Rent Efficiency (i.e. studio apartment) amounts for each pilot area to assess cost of living, or more specifically the average cost of basic housing in the pilot county.

c) Prevalence of individuals who are mentally ill and are experiencing homelessness: 25 percent of the funding is allocated in proportion to the total number of individuals who are mentally ill and are experiencing homelessness in the county as compared to the total for all WPC counties.

d) Performance: The Department will not accept applications from pilots that have unacceptable performance regarding their pilot housing supportive services for the homeless target population.

2. Funding was made to WPC pilots in November 2019.

Fiscal Year	Total Expenditures
FY 2019-20	$100,000,000

Funding:
General Fund (4260-101-0001)

MH/UCD—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER:	88
IMPLEMENTATION DATE:	9/2005
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1072

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$73,784,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$73,784,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$73,784,000	$0

DESCRIPTION

Purpose:
This policy change estimates the federal funds for Safety Net Care Pool (SNCP) payments to Designated Public Hospitals (DPHs) under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.7
MH/UCD

Interdependent Policy Changes:
Not Applicable

Background:
Effective for dates of service on or after July 1, 2005, based on the Special Terms and Conditions of the MH/UCD, a SNCP was established to support the provision of services to the uninsured. The SNCP makes available $586 million in federal funds each of the five Demonstration Years (DYs) for baseline and stabilization funding and an additional $180 million per DY for implementing a health care coverage initiative during the last three years of the MH/UCD (Health Care Coverage Initiative). The SNCP is to be distributed through the certified public expenditures (CPEs) of DPHs for uncompensated care to the uninsured and the federalizing of four state-funded health care programs. The four state-funded health care programs are the Genetically Handicapped Persons Program (GHPP), California Children Services (CCS), Medically Indigent Adult Long-Term Care (MIA LTC), and Breast and Cervical Cancer Treatment Program (BCCTP). SNCP funding for the Health Care Coverage Initiative and for state-only programs are included in other policy changes.

In 2007, SB 474 (Chapter 518, Statutes of 2007) allocated an annual $100,000,000 of the SNCP federal financial participation (FFP) for the South Los Angeles Medical Services Preservation (SLAMSP) Fund for the last three years of the MH/UCD. These funds were claimed using the CPEs of the County of Los Angeles or its DPHs.

MH/UCD—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 88

If the DPHs require more of the SNCP funds than what is available after the Department utilizes the CPEs from the four state-funded programs to draw down FFP, the DPHs will be paid GF which will be budgeted in the Stabilization policy change. The FFP paid to the DPHs and SLAMSP, and drawn down by the state-funded programs cannot exceed $586 million.

SB 1100 authorized the establishment of the Health Care Support Fund (HCSF), Item 4260-601-7503. Funds that pass through the HCSF are to be paid in the following order:

- Meeting the baseline of the DPHs.
- Federalizing the four state-only programs, and
- Providing stabilization funding.

The reconciliation process for each DY may result in an overpayment or underpayment to a DPH, which will be handled as follows:

- For DPHs that have been determined to be overpaid, the Department will recoup any overpayments.
- For DPHs that have been determined to be underpaid, the Department will make a payment equal to the difference between the SNCP payments that the DPHs have received and the SNCP payments estimated in the interim reconciliation process.

The MH/UCD was extended for two months, until October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) effective November 1, 2010. Funding for the two-month extension of the prior MH/UCD SNCP is included in the BTR demonstration. A modified SNCP was continued in the BTR demonstration.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is due to updated final reconciliation data for DY 2007-08, DY 2008-09, and DY 2009-10, and the inclusion of the DY 2006-07 final reconciliation.

There is no change in FY 2020-21, from the prior estimate.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to the completion of the final reconciliations in FY 2019-20.

Methodology:

1. The final reconciliations for DY 2006-07, DY 2007-08, DY 2008-09, and DY 2009-10 will occur in FY 2019-20.

The estimated DPH payments/recoupments on a cash basis are:

(Dollars in Thousands)

FY 2019-20	FF
DY 2006-07	$2,243
DY 2007-08	$4,686
DY 2008-09	($3,426)
DY 2009-10	$70,281
Total	**$73,784**

MH/UCD—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 88

Funding:
100% Health Care Support Fund (4260-601-7503)

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER:	89
IMPLEMENTATION DATE:	7/2013
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1769

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$531,000	$263,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$531,000	$263,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$531,000	$263,000

DESCRIPTION

Purpose:
This policy change estimates the federal fund payments for uncompensated care services provided by Indian Health Service (IHS) tribal health facilities.

Authority:
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)

Interdependent Policy Changes:
Not Applicable

Background:
The Centers for Medicare & Medicaid Services (CMS) approved a waiver amendment to make uncompensated care payments through the Safety Net Care Pool (SNCP) – Uncompensated Care to IHS facilities.

Pursuant to the Special Terms and Conditions (STCs) of the BTR waiver, for the period covering April through December of 2013, IHS facilities may claim for services provided to uninsured individuals and optional benefits eliminated from the California Medicaid State Plan as required by ABX3 5 (Chapter 20, Statutes of 2009).

On December 24, 2013, CMS approved the extension of IHS payments for the period covering January through December 2014. On December 30, 2014, CMS approved the extension of IHS payments for the period covering January through October 2015. Under the extensions, IHS facilities may claim for eliminated optional Medi-Cal benefits, but not for services provided to uninsured individuals.

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER: 89

The BTR was extended for two months, until December 31, 2015. Effective January 1, 2016, CMS approved the Medi-Cal 2020 Demonstration that allows the State to continue to claim federal financial participation for eliminated optional Medi-Cal benefits provided by Indian Health Service tribal health facilities.

Covered Services for Uninsured Individuals (April 5, 2013 to December 31, 2013)
Until December 31, 2013, IHS facilities were eligible to receive payments for the provision of California Medicaid State Plan primary care services and optional benefit services eliminated from the California Medicaid State Plan as required by ABX3 5 to individuals:

- with income up to 133% of the Federal Poverty Level (FPL),
- who were not enrolled in a Low Income Health Program (LIHP) or Medi-Cal, and
- have no source of third party coverage for the services they receive under this demonstration.

Covered Services for Medi-Cal Enrollees (April 5, 2013 to December 31, 2020)
For Medi-Cal enrolled individuals, IHS facilities may receive payments for the provision of optional benefit services eliminated from the California Medicaid State Plan as required by ABX3 5.

FFP Claiming Methodology
Claims for allowable services will be paid at the IHS encounter rate. Claiming for Federal Financial Participation (FFP) will be based on certified public expenditures under this demonstration. For services provided to IHS eligible individuals, claims will be reimbursed with 100% FFP. For the period covering April through December of 2013, services provided to non-IHS eligible individuals are also eligible for payment under the demonstration, if the individual receiving the services otherwise meets the demonstration requirements. For services provided to non-IHS eligible individuals, claims will be reimbursed at California's Federal Medical Assistance Percentage (FMAP) rate.

Optional services eliminated from the State Plan in 2009 include:

- Acupuncture[3]
- Audiology[5]
- Chiropractic
- Dental[1,4]
- Incontinence creams and washes[5]
- Optician/optical lab[5]
- Podiatry[5]
- Psychology[2]
- Speech therapy[5]

[1]AB 82 (Chapter 23, Statutes of 2013) restored certain adult dental benefits, effective May 1, 2014. The adult dental benefit restoration did not affect calendar year 2013. For calendar year (CY) 2014, eliminated dental services were claimable for the time period from January 1, 2014 to April 30, 2014. Beginning May 1, 2014, some adult dental benefits were restored and are no longer claimable under this program.

[2]SBX1 1 (Chapter 4, Statutes of 2013) restored psychology services, effective January 1, 2014.

[3]SB 833 (Chapter 30, Statutes of 2016) restored acupuncture services, effective July 1, 2016.

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER: 89

[4]SB 97 (Chapter 52, Statutes of 2017) restored full adult dental benefits, effective January 1, 2018.

[5]SB 78 (Chapter 38, Statutes of 2019) restored coverage for audiology, optician and optical lab, incontinence creams and washes, podiatry, and speech therapy in the Medi-Cal program, effective January 1, 2020.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is a decrease due to removing CY 2014, CY 2015, and CY 2016 dental recoupments as these recoupments occurred in FY 2018-19, and decreased CY 2019 encounter data.

There is no change in FY 2020-21, from the prior estimate.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to remaining CY 2018 payments in FY 2019-20, the restoration of additional benefits effective January 1, 2020, and the conclusion of the program on December 31, 2020.

Methodology:

1. The fourth quarter and outstanding payment for CY 2018 in the amount of $111,000 will be paid in FY 2019-20.

2. Assume 757 encounters for CY 2019 will be paid over four quarters in FY 2019-20, and the outstanding CY 2019 payments will be paid in FY 2020-21.

3. Assume 165 encounters for the first quarter of CY 2020 will be paid in FY 2019-20, and the outstanding CY 2020 payments will be paid in FY 2020-21.

4. The IHS global encounter rate is updated on the Federal Register for each CY. For CY 2019, the rate is $455. Assume the rate is $455 for CY 2020.

5. IHS claims are paid for each encounter. Assume the encounters are 808 for CY 2019, and 692 for CY 2020.

Calendar Year 2019	808 encounters x	$455 =	$367,640 FF
Calendar Year 2020	692 encounters x	$455 =	$314,860 FF

6. Assume IHS payments will be made as follows on a cash basis:

FY 2019-20	TF	FF
Calendar Year 2018	$111,000	$111,000
Calendar Year 2019	$345,000	$345,000
Calendar Year 2020	$75,000	$75,000
Total	**$531,000**	**$531,000**

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER: 89

FY 2020-21	TF	FF
Calendar Year 2019	$23,000	$23,000
Calendar Year 2020	$240,000	$240,000
Total	**$263,000**	**$263,000**

Funding:
100% Health Care Support Fund (4260-601-7503)

MH/UCD—HEALTH CARE COVERAGE INITIATIVE

REGULAR POLICY CHANGE NUMBER:	90
IMPLEMENTATION DATE:	9/2007
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1154

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$1,003,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,003,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,003,000	$0

DESCRIPTION

Purpose:
This policy change estimates the federal funds for the Health Care Coverage Initiative (HCCI) under the Medi-Cal Hospital/Uninsured Care Demonstration (MH/UCD).

Authority:
SB 1448 (Chapter 76, Statutes of 2006)
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration

Interdependent Policy Changes:
Not Applicable

Background:
Under the MH/UCD, $180 million in federal funds was available annually under the Safety Net Care Pool (SNCP) to expand health care coverage to eligible low-income, uninsured persons for Demonstration Year (DY) 2007-08 through DY 2009-10.

The federal funds available will reimburse the HCCI counties at an amount equal to the applicable Federal Medical Assistance Percentage of their certified public expenditures (CPEs) for health care services provided to eligible low-income uninsured persons. The HCCI counties will submit their CPEs to the Department for verification and submission for federal financial participation (FFP). The Special Terms and Conditions (STC) of the MH/UCD waiver allowed the Department to reallocate unspent Coverage Initiative (CI) funding to counties who have additional expenditures.

The Demonstration, which would have ended on August 31, 2010, was extended until October 31, 2010. The California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) became effective November 1, 2010. The federal funds for the extension period (September and October 2010) are provided through the new BTR funding for the first year of the BTR ending June 30, 2011. The HCCI has been replaced by a modified program under the BTR which is reflected in the Low Income Health Program policy changes.

MH/UCD—HEALTH CARE COVERAGE INITIATIVE

REGULAR POLICY CHANGE NUMBER: 90

Reason for Change:
The change in FY 2019-20, from the prior estimate, is due to completed final reconciliation data.

There is no change in FY 2020-21, from the prior estimate.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to the completion of the final reconciliations in FY 2019-20.

Methodology:
1. Enrollment began on September 1, 2007. The funding allocations were awarded as follows:

(Dollars in Thousands)

County/Agency	Annual Allocations
Alameda County Health Care Services Agency	$8,204
Contra Costa County/Contra Costa Health Services	$15,250
County of Orange	$16,872
County of San Diego, Health and Human Services Agency	$13,040
County of Kern, Kern Medical Center	$10,000
Los Angeles County Department of Health Services	$54,000
San Francisco Department of Public Health	$24,370
San Mateo County	$7,564
County of Santa Clara, DBA Santa Clara Valley Health and Hospital System	$20,700
Ventura County Health Care Agency	$10,000
Total	$180,000

2. Assume all the DY 2007-08 through DY 2009-10 final reconciliations for the counties that submitted invoices and cost reports for payment will occur in FY 2019-20.

The estimated HCCI reconciliation payments on a cash basis are:

(Dollars in Thousands)

FY 2019-20	TF	FF
DY 2007-08	$3,741	$3,741
DY 2008-09	($1,096)	($1,096)
DY 2009-10	($1,642)	($1,642)
Total FY 2019-20	**$1,003**	**$1,003**

Funding:
Health Care Support Fund (4260-601-7503)

BTR - LOW INCOME HEALTH PROGRAM - HCCI

REGULAR POLICY CHANGE NUMBER:	91
IMPLEMENTATION DATE:	11/2010
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1572

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$51,369,000	$0
- STATE FUNDS	$4,390,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$51,369,000	$0
STATE FUNDS	$4,390,000	$0
FEDERAL FUNDS	-$55,759,000	$0

DESCRIPTION

Purpose:
This policy change estimates the federal funds for the Health Care Coverage Initiative (HCCI) of the Low Income Health Program (LIHP) under the California Bridge to Reform (BTR) Demonstration.

Authority:
AB 342 (Chapter 723, Statutes of 2010)
AB 1066 (Chapter 86, Statutes of 2011)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) (Waiver 11-W-00193/0)

Interdependent Policy Changes:
Not Applicable

Background:
The LIHP, effective November 1, 2010, through December 31, 2013, consisted of two components, the Medicaid Coverage Expansion (MCE) and the HCCI. The MCE covered eligible individuals with family incomes at or below 133% of the Federal Poverty Level (FPL). The HCCI covered those eligible individuals with family incomes above 133% through 200% of the FPL. Both were statewide county elective programs. The LIHP HCCI replaced the Coverage Initiative (CI) under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration which was extended until October 31, 2010. AB 342 and AB 1066 authorize the local LIHPs to provide health care services to eligible individuals.

The local LIHPs use two methodologies to obtain federal funding:

- Certified Public Expenditures (CPEs)
- IGTs for county-owned Federally Qualified Health Centers (FQHCs)

BTR - LOW INCOME HEALTH PROGRAM - HCCI

REGULAR POLICY CHANGE NUMBER: 91

The Department has used the CI cost claiming protocol for the MH/UCD as the basis for payments made on claims for dates of service from November 1, 2010, through September 30, 2011. This protocol is permitted by the Special Terms and Conditions of the section 1115(a) Bridge to Reform Medicaid Demonstration for those local LIHPs which were legacy counties under the CI.

The Centers for Medicare & Medicaid Services (CMS) approved the new cost claiming protocol for claims based on CPEs on August 13, 2012. CMS approved this change retroactive to October 1, 2011. CMS also approved the new cost claiming protocol for claims based on IGTs for health care services provided by county-owned FQHCs on February 5, 2013, retroactive to November 1, 2010.

The MCE program is not subject to a federal funding cap while HCCI funding is capped at $360 million total computable (TC) annually for Demonstration Years (DYs) 2010-11, 2011-12, and 2012-13 and $180 million TC for DY 2013-14. Federal funding will be provided through the Health Care Support Fund (HCSF).

However, local spending under the HCCI has not reached $360 million. The Department obtained CMS approval through two amendments to the BTR Medicaid Demonstration waiver to reallocate the unused HCCI funds from DY 2010-11 through DY 2013-14 to the Safety Net Care Pool (SNCP) uncompensated care component. The total reallocation amount for DY 2010-11 through DY 2013-14 is $222 million in federal funds.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is due to updated final reconciliation data, which also includes payments and recoupments for services provided by FQHCs.

There is no change in FY 2020-21, from the prior estimate.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to the completion of final reconciliations in FY 2019-20.

Methodology:
1. The remaining DY 2010-11 through DY 2013-14 final reconciliations are complete and payments will occur in FY 2019-20. Final reconciliations for each DY reflect the CPE and IGT nonfederal share of the payment methodologies used.

The estimated HCCI payments on a cash basis are:

FY 2019-20	TF	IGT	FF
DY 2010-11 (CPE)	($40,021,000)	$0	($40,021,000)
DY 2011-12 (CPE)	($4,490,000)	$0	($4,490,000)
DY 2011-12 (IGT)	($5,967,000)	$5,968,000	($11,935,000)
DY 2012-13 (CPE)	($1,160,000)	$0	($1,160,000)
DY 2012-13 (IGT)	$2,121,000	($2,121,000)	$4,242,000
DY 2013-14 (CPE)	($1,309,000)	$0	($1,309,000)
DY 2013-14 (IGT)	($543,000)	$543,000	($1,086,000)
Total FY 2019-20	**($51,369,000)**	**$4,390,000**	**($55,759,000)**

BTR - LOW INCOME HEALTH PROGRAM - HCCI

REGULAR POLICY CHANGE NUMBER: 91

Funding:
Title XIX FFP (4260-101-0890)
Health Care Support Fund (4260-601-7503)
LIHP IGT Fund (4260-607-8502)

CCI-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER:	95
IMPLEMENTATION DATE:	4/2014
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	1766

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$8,071,755,000	$8,539,346,000
- STATE FUNDS	$4,035,877,500	$4,269,673,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	67.04 %	65.40 %
APPLIED TO BASE		
TOTAL FUNDS	$2,660,450,400	$2,954,613,700
STATE FUNDS	$1,330,225,220	$1,477,306,860
FEDERAL FUNDS	$1,330,225,220	$1,477,306,860

DESCRIPTION

Purpose:
This policy change estimates the capitation payments for dual eligible (beneficiaries on Medi-Cal and Medicare) and Medi-Cal only beneficiaries transitioning from fee-for-service into Medi-Cal managed care health plans for their Medi-Cal Long Term Care (LTC) institutional and community-based services and supports benefits.

Authority:
SB 1008 (Chapter 33, Statutes of 2012)
SB 1036 (Chapter 45, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

Background:
In coordination with Federal and State Government, the Coordinated Care Initiative (CCI) provides the benefits of coordinated care models to persons eligible for Medi-Cal. By enrolling these eligibles into coordinated care delivery models, the CCI aligns financial incentives, streamlines beneficiary-centered care delivery, and rebalances the current health care system away from avoidable institutionalized services.

The CCI mandatorily enrolls dual and Medi-Cal only eligibles into managed care for their Medi-Cal benefits. Those benefits include LTC institutional services, Community-Based Adult Services (CBAS), Multi-Purpose Senior Services Program (MSSP) services, and other Home and Community-Based Services (HCBS). Savings are generated from a reduction in inpatient and LTC institutional services.

The CCI has been implemented in seven pilot counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

The 2017 Budget Act discontinued the CCI program effective January 1, 2018. Based on lessons learned from the CCI demonstration project, the 2017 Budget extended the Cal MediConnect program and the mandatory enrollment of dual eligibles and integration of long-term services and support,

CCI-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 95

except In-Home Supportive Services (IHSS), into managed care. IHSS has been removed from capitation rate payments as of January 1, 2018.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a slight decrease due to updated rate payment timing, an increase in Institutional eligibles, and an overall decrease in CY 2019 Full Dual rates. The change from the prior estimate, for FY 2020-21, is a slight increase due to updated rate payment timing, an increase in Institutional eligibles, and updated CY 2020 budget rates. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to updated budget rates, plus a growth factor resulting in an increase in rates from CY to BY.

Methodology:
1. All dual eligibles have phased in to the CCI as of July 2016.

2. Medi-Cal only eligibles and individuals receiving partial Medicare coverage had their LTC and community-based services included in Medi-Cal managed care no later than July 1, 2014, except for Orange County. Orange County began July 1, 2015.

3. Paid rates vary throughout the fiscal year depending on the most recently available approved rates. CY 2018, FY 2018-19, CY 2019, and FY 2019-20 rates will be paid in FY 2019-20, while FY 2019-20, CY 2020, and CY 2021 rates will be paid in FY 2020-21.

4. Estimated below is the overall impact of the CCI demonstration in FY 2019-20 and FY 2020-21.

(Dollars in Thousands)

FY 2019-20	TF	GF	FFP	Reimb	HTF
CCI-Managed Care Payments:					
Base managed care payments	$8,073,907	$4,035,878	$4,036,954	$0	$1,076
Prop 56 - ICF/DD Supplemental Payments	($2,151)		($1,076)		($1,076)
Total Managed Care Payments	**$8,071,755**	**$4,035,878**	**$4,035,878**	**$0**	**$0**
CCI-Savings and Deferral :					
Total Savings (In the Base)	($8,113,397)	($4,056,699)	($4,056,699)	$0	
CCI-Admin Costs, HCO Costs	$12,223	$6,112	$6,112	$0	
Retro MC Rate Adjustments	$82,845	$41,422	$41,422	$0	$0
CCI-Quality Withhold Repayments	$8,260	$4,130	$4,130	$0	
Health Insurer Fee	$0	$0	$0	$0	
Total of CCI PCs including pass through	$61,686	$30,843	$30,843	$0	

*Totals may differ due to rounding.

CCI-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 95

(Dollars in Thousands)

FY 2020-21	TF	GF	FFP	Reimb	HTF
CCI-Managed Care Payments:					
Base managed care payments	$8,541,186	$4,269,673	$4,270,593	$0	$920
Prop 56 - ICF/DD Supplemental Payments	($1,841)		($920)		($920)
Total Managed Care Payments	**$8,539,346**	**$4,269,673**	**$4,269,673**	**$0**	**$0**
CCI-Savings and Deferral :					
Total Savings (In the Base)	($8,586,075)	($4,293,038)	($4,293,038)	$0	
CCI-Admin Costs	$12,223	$6,112	$6,112	$0	
Retro MC Rate Adjustments	$107,075	$52,974	$54,101	$0	
CCI-Quality Withhold Repayments	$16,822	$8,411	$8,411	$0	
Health Insurer Fee	$924	$462	$462	$0	
Total of CCI PCs including pass through	$90,314	$46,386	$43,929	$0	$0

*Totals may differ due to rounding.

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
Healthcare Treatment Fund Prop. 56 (4260-101-3305)

MANAGED CARE HEALTH CARE FINANCING PROGRAM

REGULAR POLICY CHANGE NUMBER:	96
IMPLEMENTATION DATE:	4/2020
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	2061

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$1,821,706,000	$1,917,686,000
- STATE FUNDS	$585,232,940	$653,666,820
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,821,706,000	$1,917,686,000
STATE FUNDS	$585,232,940	$653,666,820
FEDERAL FUNDS	$1,236,473,060	$1,264,019,180

DESCRIPTION

Purpose:
This policy change estimates increased payments to managed care plans (MCPs) designed to provide additional support for counties and/or public entities serving Medi-Cal beneficiaries.

Authority:
Welfare & Institutions Code 14087.3

Interdependent Policy Changes:
Not Applicable

Background:
Effective July 1, 2018, the Department implemented a new voluntary Managed Care Health Care Financing Program which increases payments to counties and/or public entities servicing Medi-Cal beneficiaries. Participation is voluntary and the increased payment levels will be evaluated annually.

Reason for Change:
There is no change from the prior estimate for FY 2019-20. The change from the prior estimate, for FY 2020-21, is an increase due to updated program participation levels. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to updated participation levels for the first twelve months of the 18-month Bridge Period (July 2019 through December 2020) in FY 2020-21.

Methodology:
1. The Managed Care Health Care Financing Program begins with the FY 2018-19 rating period.

2. Based on final participation levels for the FY 2018-19 rating period, it is estimated total payments of $1,821,706,000 TF are occurring in FY 2019-20.

3. Based on preliminary participation levels for the first twelve months of the 18-month Bridge Period (July 2019 through December 2020), it is estimated total payments will be $1,917,686,000 TF, and are anticipated to occur in FY 2020-21.

MANAGED CARE HEALTH CARE FINANCING PROGRAM

REGULAR POLICY CHANGE NUMBER: 96

4. Anticipated costs on a cash basis are:

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
FY 2018-19 Title XIX	$1,060,624	$530,312	$530,312
FY 2018-19 Title XXI 88/12	$99,102	$11,893	$87,209
FY 2018-19 ACA 94/6	$330,990	$19,859	$311,131
FY 2018-19 ACA 93/7	$330,990	$23,169	$307,821
Total for FY 2019-20	**$1,821,706**	**$585,233**	**$1,236,473**

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
Bridge Period Title XIX	$1,148,620	$574,310	$574,310
Bridge Period Title XXI 88/12	$28,838	$3,461	$25,377
Bridge Period Title XXI 76.5/23.5	$86,510	$20,330	$66,180
Bridge Period ACA 93/7	$326,859	$22,880	$303,979
Bridge Period ACA 90/10	$326,859	$32,686	$294,173
Total for FY 2020-21	**$1,917,686**	**$653,667**	**$1,264,019**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
94% Title XIX ACA FF / 6% GF (4260-101-0001/0890)
93% Title XIX ACA FF / 7% GF (4260-101-0001/0890)
90% Title XIX ACA FF / 10% GF (4260-101-0001/0890)
88% Title XXI FF / 12% GF (4260-113-0001/0890)
76.5% Title XXI FF / 23.5% GF (4260-113-0001/0890)

MANAGED CARE PUBLIC HOSPITAL EPP

REGULAR POLICY CHANGE NUMBER:	97
IMPLEMENTATION DATE:	9/2019
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	2060

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$1,476,865,000	$1,541,109,000
- STATE FUNDS	$337,837,010	$361,561,850
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,476,865,000	$1,541,109,000
STATE FUNDS	$337,837,010	$361,561,850
FEDERAL FUNDS	$1,139,027,990	$1,179,547,150

DESCRIPTION

Purpose:
This policy change estimates Managed Care Enhanced Payment Program (EPP) Directed Payments for Designated Public Hospitals (DPHs) including University of California Health Systems (UCs).

Authority:
SB 171 (Chapter 768, Statutes of 2017)
AB 205 (Chapter 738, Statutes of 2017)
Code of Federal Regulations (CFR) Section 438.6 9 (c)

Interdependent Policy Changes:
Managed Care Reimbursements to the General Fund

Background:
The Centers for Medicare & Medicaid Services (CMS) instituted the final rule which modernized Medicaid managed care regulations. The result is changes in the usage of managed care delivery systems, CFR section 438.6 (c) provides State's flexibility to implement delivery system and provider payment initiatives under Medicaid managed care plans (MCPs) contracts based on allowable directed payments that focus on delivery system reform.

Effective July 1, 2017, with the FY 2017-18 rating period, the Department directed MCPs to reimburse California's 21 DPHs for network contracted services delivered by DPH systems. The total funding available for the enhanced network contracted payments is limited to a predetermined amount (pool). The EPP Directed Payment Program is divided into two primary sub-pools:

- Capitated sub-pool value is based on a pre-determined pool amount. Actual enhanced payments will be increased by a uniform percentage based on actual monthly DPH member assignment for network contracted services.

- Fee-For-Service (FFS) sub-pool value is based on a pre-determined pool amount. Actual enhanced payments will be increased by a uniform dollar amount based on actual utilization of network contracted services.

MANAGED CARE PUBLIC HOSPITAL EPP

REGULAR POLICY CHANGE NUMBER: 97

Prior to implementation of a directed payment program, CMS requires states seek pre-approval of any requested directed payment program through the standard CMS “pre-print” form. This “pre-print” is typically submitted on an annual basis.

On December 17, 2018, the Department received CMS pre-print approval to continue the EPP Directed Payment program for FY 2018-19 rating period. On June 30, 2019, the Department submitted a pre-print requesting program continuation and approval for the July 1, 2019 through December 31, 2020 rating period.

Reason for Change:
The change from the prior estimate for both FY 2019-20 and FY 2020-21 are updated funding levels to incorporate actual payment data; however the total fund values remain unchanged. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to updated EPP pool amounts for the FY 2018-19 rating period.

Methodology:

1. The value of the entire public hospital EPP pool is $1,476,865,000 TF for rating period FY 2017-18 on an accrual basis.

2. The value of the entire public hospital EPP pool is $1,541,109,000 TF for rating period FY 2018-19 on an accrual basis.

3. The FY 2017-18 Capitated sub-pool payments were made in September 2019.

4. The FY 2017-18 FFS sub-pool payments were issued in two separate payment periods; September 2019 and March 2020.

5. The FY 2018-19 Capitated sub-pool payments are anticipated to be made in September 2020.

6. The FY 2018-19 FFS sub-pool payments will be issued in two separate payment periods; September 2020 and March 2021.

7. On a cash basis, the estimated payments are:

(Dollars in Thousands)

FY 2019-20	TF	GF	FF	ACA
FY 2017-18 Title XIX	$570,710	$285,355	$285,355	$0
FY 2017-18 ACA 2017 95/5	$434,189	$21,709	$0	$412,480
FY 2017-18 ACA 2018 94/6	$431,056	$25,864	$0	$405,192
FY 2017-18 Title XXI 88/12	$40,910	$4,909	$36,001	$0
Total FY 2019-20	**$1,476,865**	**$337,837**	**$321,356**	**$817,672**

MANAGED CARE PUBLIC HOSPITAL EPP

REGULAR POLICY CHANGE NUMBER: 97

(Dollars in Thousands)

FY 2020-21	TF	GF	FF	ACA
FY 2018-19 Title XIX	$595,536	$297,768	$297,768	$0
FY 2018-19 ACA 2018 94/6	$453,076	$27,184	$0	$425,892
FY 2018-19 ACA 2018 93/7	$449,807	$31,487	$0	$418,320
FY 2018-19 Title XXI 88/12	$42,690	$5,123	$37,567	$0
Total FY 2020-21	**$1,541,109**	**$361,562**	**$335,335**	**$844,212**

*Difference due to rounding.

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
95% Title XIX ACA FF / 5% GF (4260-101-0001/0890)
94% Title XIX ACA FF / 6% GF (4260-101-0001/0890)
93% Title XIX ACA FF / 7% GF (4260-101-0001/0890)
88% Title XXI FF / 12% GF (4260-113-0001/0890)

MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER:	100
IMPLEMENTATION DATE:	9/2019
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	2062

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$640,000,000	$667,840,000
- STATE FUNDS	$144,674,650	$154,921,040
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$640,000,000	$667,840,000
STATE FUNDS	$144,674,650	$154,921,040
FEDERAL FUNDS	$495,325,350	$512,918,960

DESCRIPTION

Purpose:
This policy change estimates managed care directed payments to fund Quality Incentive Pool (QIP) payments by managed care plans (MCPs) to Designated Public Hospitals (DPHs) including the University of California Health Systems (UCs), based on their performance on designated performance metrics.

Authority:
SB 171 (Chapter 768, Statutes of 2017)
AB 205 (Chapter 768, Statutes of 2017)

Interdependent Policy Changes:
Managed Care Reimbursements to the General Fund

Background:
The Centers for Medicare & Medicaid Services (CMS) instituted the final rule which modernized Medicaid managed care regulations. The result is changes in the usage of managed care delivery systems, CFR section 438.6 (c) provides State's flexibility to implement delivery system and provider payment initiatives under MCPs contracts based on allowable directed payments that focus on delivery system reform.

Effective July 1, 2017, for the FY 2017-18 rating period, the Department has directed MCPs to make QIP payments tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization to DPHs. The QIP payments are linked to delivery of services under the MCP contracts and increase the amount of funding tied to quality outcomes. To receive QIP payments the DPHs must achieve specified improvement targets, which grow more difficult through year-over-year improvement or sustained high performance requirements. The total funding available for the QIP payments are limited to a predetermined amount (pool).

MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 100

Prior to implementation of a directed payment program, CMS requires states seek pre-approval of any requested directed payment program through the standard CMS “pre-print” form. This “pre-print” is typically submitted on an annual basis.

On December 17, 2018, the Department received CMS pre-print approval to continue the QIP Directed Payment program through the FY 2020-21 rating period.

The Department requested CMS pre-print approval to implement two new QIP program for DPHs and District Municipal Public Hospital (DMPHs) for the period of July 1, 2020, through December 31, 2020. The new programs will be separate and distinct from the existing Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program. The goal of the new programs is to enable hospitals to continue quality improvement efforts that have been underway after PRIME expires on June 30, 2020. Due to the timing of quality data reporting for this period, payments are not expected to be issued until FY 2021-22.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to a growth in total pool size.

Methodology:
1. The value of the FY 2017-18 QIP is $640 million total fund.

2. The value of the FY 2018-19 QIP is $667.8 million total fund.

3. FY 2017-18 and FY 2018-19 QIP payments are evaluated based on defined QIP reported requirements. Assume the entire QIP FY 2017-18 payments will occur in FY 2019-20 and the entire QIP FY 2018-19 payments will occur in FY 2020-21.

4. On a cash basis, the estimated FY 2017-18 and FY 2018-19 QIP payments are:

(Dollars in Thousands)

FY 2019-20	TF	GF	FF	ACA
FY 2017-18 Title XIX	$243,404	$121,702	$121,702	$0
FY 2017-18 ACA 2017 95/5	$189,373	$9,469	$0	$179,904
FY 2017-18 ACA 2018 94/6	$189,372	$11,362	$0	$178,010
FY 2017-18 Title XXI	$17,851	$2,142	$15,708	$0
Total FY 2019-20	**$640,000**	**$144,675**	***$137,411**	**$357,914**

(Dollars in Thousands)

FY 2020-21	TF	GF	FF	ACA
FY 2018-19 Title XIX	$253,993	$126,996	$126,996	$0
FY 2018-19 ACA 2018 94/6	$197,610	$11,857	$0	$185,754
FY 2018-19 ACA 2019 93/7	$197,610	$13,833	$0	$183,778
FY 2018-19 Title XXI	$18,627	$2,235	$16,392	$0
Total FY 2020-21	**$667,840**	**$154,921**	**$143,388**	***$369,531**

*Difference due to rounding.

MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 100

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
95% Title XIX ACA FF / 5% GF (4260-101-0001/0890)
94% Title XIX ACA FF / 6% GF (4260-101-0001/0890)
93% Title XIX ACA FF / 7% GF (4260-101-0001/0890)
88% Title XXI FF / 12% GF (4260-113-0001/0890)

MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES

REGULAR POLICY CHANGE NUMBER:	101
IMPLEMENTATION DATE:	4/2017
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	1961

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$187,991,000	$0
- STATE FUNDS	$58,472,830	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$187,991,000	$0
STATE FUNDS	$58,472,830	$0
FEDERAL FUNDS	$129,518,170	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of capitation rate increases that are offset by managed care organization (MCO) tax proceeds. The tax proceeds will be used for the non-federal share of capitation rate increases.

Authority:
SBx2 2 (Chapter 2, Statutes of 2016)

Interdependent Policy Changes:
MCO Enrollment Tax Mgd. Care Plans
MCO Enrollment Tax Mgd. Care Plans-Funding Adj.

Background:
SBx2 2 was signed by the Governor on March 1, 2016, and provides for a statewide tax on managed care plans based on reported enrollment into these plans during the 12-month period between October 1, 2014 and September 30, 2015. 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 was effective July 1, 2016 through June 30, 2019.

Reason for Change:
There is no change from the prior estimate for FY 2019-20. The MCO Enrollment Tax ended June 30, 2019, and costs for FY 2019-20 are for the June 2018 monthly capitation payment. There are no costs for FY 2020-21.

Methodology:
1. The MCO Enrollment Tax proceeds are required to be used to offset the capitation rate development process and payments made to the State that result directly from the imposition of the tax.

MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES

REGULAR POLICY CHANGE NUMBER: 101

2. Enrollment for managed care plans are based on the number of Medi-Cal enrollees, alternate healthcare service plans (AHCSP) enrollees, and “all-other” enrollees as defined in SBx2 2.

3. The enrollee count is multiplied by a tiered rate to determine total tax revenue.

4. Increased capitation rates due to the MCO Enrollment Tax are initially paid from the General Fund (GF). The GF is then reimbursed by MCO Enrollment Tax revenue through a funding adjustment. The reimbursement is budgeted in the MCO Enrollment Tax Mgd. Care Plans-Funding Adjustment policy change.

5. The June monthly capitation payment for all plans subject to MCO tax will be paid in July of the following fiscal year.

6. The costs of capitation rate increases related to the imposition of the MCO Enrollment Tax are:

(Dollars in Thousands)

Fiscal Year	TF	GF (MCO Tax)	FF
FY 2019-20	**$187,991**	$58,473	$129,518

Funding:
50% Title XIX / 50%GF (4260-101-0001/0890)
94% Title XIX ACA FF / 6% GF (4260-101-0001/0890)
93% Title XIX ACA FF / 7% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)

RETRO MC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER:	103
IMPLEMENTATION DATE:	1/2016
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1788

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$148,805,000	$363,335,000
- STATE FUNDS	$14,412,540	$211,153,890
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$148,805,000	$363,335,000
STATE FUNDS	$14,412,540	$211,153,890
FEDERAL FUNDS	$134,392,460	$152,181,110

DESCRIPTION

Purpose:
This policy change estimates retroactive managed care capitation rate adjustments.

Authority:
Welfare & Institutions Code, section 14087.3

Interdependent Policy Changes:
Not applicable

Background:
This policy change accounts for retroactive:

- Martin Luther King, Jr. (MLK) Pass Through rate adjustments,
- Managed Care Pass Through payments,
- Coordinated Care Initiative (CCI) full dual payments,
- State-only benefit recoupments, and
- Wire transfer plan recoupment dollars

The MLK pass-through rate adjustment and associated payments will sunset as of June 30, 2020 service period.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is an increase due to:

- Updating the CY 2019 Full Dual rates based on updated plan reported base data,
- Incorporating actual State-only benefit recoupment amounts, and
- The inclusion of net costs from wire transfer recoupments.

The change from the prior estimate, for FY 2020-21, is a net increase due to:

- Updated payment timing for the CY 2020 CCI Full Duals,
- The application of the final actuarially developed rates to pass-through payment rates,
- An increase to MLK due to the application of the final actuarially developed rates for SFY 2019-20; Future MLK pass-through payments have been eliminated beginning FY 2020-21, and

RETRO MC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 103

- Rate corrections for CY 2017 and CY 2018 CCI Full Duals.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to:

- A payment timing shift of the CY 2020 Full Duals,
- Inclusion of rate corrections for CY 2017 and CY 2018 CCI Full Duals in FY 2020-21, and
- The application of the final actuarially developed rates for FY 2019-20 MLK pass-through payments.

Methodology:

1. The Department estimates the following retroactive managed care capitation rate adjustments in FY 2019-20 and FY 2020-21:

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
MLK Pass-Through Payments (FY 2018-19)	$16,786	$5,431	$11,355
State-Only Benefit Recoupment	($110,374)	($110,374)	$0
Retro Pass-Through Payments (FY 2018-19)	$143,904	$70,110	$73,794
CCI Full Duals (CY 2019) - CMC	$10,576	$5,288	$5,288
CCI Full Duals (CY 2019) - MLTSS	$72,269	$36,135	$36,134
Prop 56 ICF-DD Retro	$96	$48	$48
Wire Transfer Plan Recoupment	$15,548	$7,774	$7,774
Total FY 2019-20	**$148,805**	**$14,412**	**$134,393**

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
MLK Pass Through Payments (Bridge Period)	$40,627	$13,208	$27,420
Retro Pass Through Payments (Bridge Period)	$215,826	$145,069	$70,757
CCI Full Duals (CY 2020, 6 mons.)			
CMC	$7,781	$3,891	$3,890
MLTSS	$98,074	$49,037	$49,037
CCI Full Duals (CY 2017)			
CMC	$7,328	$3,664	$3,664
CMC Reimb.	($411)	($411)	$0
MLTSS	($7,281)	($3,640)	($3,640)
MLTSS Reimb.	($716)	($716)	$0
CCI Full Duals (CY 2018)			
CMC	$9,529	$4,764	$4,765
MLTSS	($7,230)	($3,615)	($3,615)
Prop 56 ICF-DD Retro	($194)	($97)	($97)
Total FY 2021-21	**$363,335**	**$211,154**	**$152,181**

RETRO MC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 103

Funding:
50% Title XIX FF / 50% GF (4260-101-0001/0890)
88% Title XXI FF / 12% GF (4260-113-0001/0890)
ACA 94/6 (2018) (4260-101-0890)
ACA 93/7 (2019) (4260-101-0890)
ACA 90/10 (2019) (4260-101-0890)

HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS

REGULAR POLICY CHANGE NUMBER:	104
IMPLEMENTATION DATE:	10/2018
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1907

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$94,637,000	$203,895,000
- STATE FUNDS	$9,463,700	$22,748,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$94,637,000	$203,895,000
STATE FUNDS	$9,463,700	$22,748,700
FEDERAL FUNDS	$85,173,300	$181,146,300

DESCRIPTION

Purpose:
This policy change estimates the local assistance cost of a Health Home Program (HHP).

Authority:
AB 361 (Chapter 642, Statutes of 2013)
SB 75 (Chapter 18, Statutes of 2015)

Interdependent Policy Changes:
Not Applicable

Background:
The Medicaid Health Home State Plan Option is afforded to states under the Affordable Care Act (ACA). The ACA allows states to create Medicaid Health Homes to coordinate the full range of physical and behavioral health services, community-based long-term services and supports, and other community-based services that beneficiaries with chronic conditions require.

AB 361 authorized the Department to create a HHP for beneficiaries with chronic conditions. The HHP serves eligible Medi-Cal beneficiaries with multiple chronic conditions who are frequent utilizers and may benefit from enhanced care management and coordination. Health Homes provide six core services: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services.

SB 75 establishes the HHP Fund. The HHP Fund is used to pay for the non-federal share of HHP costs.

ACA Section 2703 allows geographic phasing of HHP services. The Department is implementing the HHP in four phases, by counties and conditions:

HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS

REGULAR POLICY CHANGE NUMBER: 104

	July 2018	January 2019	July 2019	January 2020	July 2020
Group 1	Eligible Chronic Physical Conditions	Eligible Serious Mental Illnesses (SMIs)			
Group 2		Eligible Chronic Physical Conditions	Eligible SMIs		
Group 3			Eligible Chronic Physical Conditions	Eligible SMIs	
Group 4				Eligible Chronic Physical Conditions	Eligible SMIs

- Group 1 represents San Francisco County. Medi-Cal managed care health plans (MCPs) in this group for members with eligible chronic physical conditions implemented in July 2018. MCPs in this group for members with SMIs implemented in January 2019.

- Group 2 represents the following two counties: Riverside and San Bernardino. MCPs in this group for members with eligible chronic physical conditions implemented in January 2019. MCPs in this group for members with SMIs implemented in July 2019.

- Group 3 represents eight counties: Alameda, Imperial, Kern, Los Angeles, Sacramento, San Diego, Santa Clara, and Tulare. MCPs in this group for members with eligible chronic physical conditions implemented in July 2019. MCPs in this group for members with SMIs implemented in January 2020.

- Group 4 represents Orange County. The MCP in this group for members with eligible chronic physical conditions implemented January 2020, while members with SMI implement July 2020.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a decrease due to updated member months and rates. There is no change from the prior estimate for FY 2020-21. The change in the current estimate, from FY 2019-20 to FY 2020-21, is an increase due to the implementation of Group 4 SMI population and updated member month projections for FY 2020-21.

Methodology:
1. Assume the program began July 2018. Enrollment will phase-in based on county and condition.

2. Assume approximately 20% of the Targeted Engagement List (TEL) members and 3% of eligible members not on the TEL will enroll in HHP. The TEL used to derive rates reflects a 50/50 mix with 50% SMI and 50% chronic condition only.

3. The average weighted rate across all plans and rating regions for FY 2019-20 is $485.01 per member per month. The average weighted rate across all plans and rating regions for FY 2020-21 is $397.18.

4. Assume 231,709 member months for FY 2019-20 and 558,117 member months for FY 2020-21.

HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS

REGULAR POLICY CHANGE NUMBER: 104

5. Assume the following payment lags for each HHP Group:

   - HHP Group 1 supplemental payments began February 2019.
   - HHP Group 2 supplemental payments began March 2019.
   - HHP Group 3 supplemental payments began September 2019.
   - HHP Group 4 supplemental payments began March 2020.

6. Assume the May and June 2020 capitation payments will be deferred to the following fiscal year.

7. The Department will receive 90% federal reimbursement for this program in FY 2018-19. The remaining 10% will be funded by non-GF sources. Funding adjusts to 50% non-GF and 50% Federal Fund two years after each implementation date.

8. On an accrual basis, the costs for FY 2019-20 and FY 2020-21 are expected to be:

   FY 2019-20: 231,709 x $485.01 = $112,381,000 TF
   FY 2020-21: 558,117 x $397.18 = $221,673,000 TF

9. On a cash basis, the costs for FY 2019-20 and FY 2020-21 are expected to be:

(Dollars in Thousands)

Fiscal Year	TF	FF	HHP Fund
FY 2019-20 (90/10)	**$94,637**	**$85,173**	**$9,464**

(Dollars in Thousands)

Fiscal Year	TF	FF	HHP Fund
FY 2020-21 (90/10)	$197,997	$178,197	$19,800
FY 2020-21 (50/50)	$5,898	$2,949	$2,949
Total FY 2020-21	**$203,895**	**$181,146**	**$22,749**

Funding:
90% Title XIX FF / 10% HHP Fund (4260-101-0890 / 4260-601-0942)
50% Title XIX FF / 50% HHP Fund (4260-101-0890 / 4260-601-0942)

CCI-QUALITY WITHHOLD REPAYMENTS

REGULAR POLICY CHANGE NUMBER:	107
IMPLEMENTATION DATE:	5/2017
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	2031

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$8,260,000	$16,822,000
- STATE FUNDS	$4,130,000	$8,411,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$8,260,000	$16,822,000
STATE FUNDS	$4,130,000	$8,411,000
FEDERAL FUNDS	$4,130,000	$8,411,000

DESCRIPTION

Purpose:
This policy change estimates the repayment of the quality withholds for the Coordinated Care Initiative (CCI).

Authority:
SB 1008 (Chapter 33, Statutes of 2012)
SB 1036 (Chapter 45, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable.

Background:
In coordination with Federal and State Government, the CCI provides the benefits of coordinated care models to persons eligible for Medi-Cal. By enrolling these eligibles into coordinated care delivery models, the CCI aligns financial incentives, streamlines beneficiary-centered care delivery, and rebalances the current health care system away from avoidable institutionalized services.

The CCI mandatorily enrolls dual and Medi-Cal only eligibles into managed care for their Medi-Cal benefits. Those benefits include Long Term Care (LTC) institutional services, In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), Multi-Purpose Senior Services Program (MSSP) services, and other Home and Community-Based Services (HCBS). Savings are generated from a reduction in inpatient and LTC institutional services. Beginning January 1, 2018, IHSS has not been included in CCI.

The CCI has been implemented in seven pilot counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

As part of CCI, a quality withhold will be applied to the Cal MediConnect (CMC) capitation rate. The withheld amounts will be repaid subject to plan performance consistent with established quality thresholds. The quality withhold started at 1% in CY 2014 and CY 2015, increasing to 2% in CY 2016, and 3% in CY 2017 and beyond until new contracts are established. Repayments of withholds will be

CCI-QUALITY WITHHOLD REPAYMENTS

REGULAR POLICY CHANGE NUMBER: 107

based on performance measures.

The 2017 Budget Act discontinued the CCI program effective January 1, 2018. Based on lessons learned from the CCI demonstration project, the 2017 Budget extended the CMC program and the mandatory enrollment of dual eligibles and integration of long-term services and support, except In-IHSS, into managed care. IHSS has been removed from capitation rate payments effective January 1, 2018.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21. The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to FY 2019-20 budgeting for CY 2016 repayments and FY 2020-21 budgeting for CY 2017 repayments.

Methodology:
1. Withheld amounts will be repaid subject to performance consistent with established quality thresholds. Thresholds are based on a combination of certain core quality withhold measures as well as state-specified quality measures.

2. CMS and the State will evaluate plan performance according to the specified metrics in order to determine how much of the withheld amount a plan will be repaid for a given year.

3. Quality withholds for CY 2016 will be repaid in FY 2019-20.

4. Assume quality withholds for CY 2017 will be repaid in FY 2020-21.

FY 2019-20	TF	GF	FF
Quality Withhold Repayment (CY 2016)	$8,260,000	$4,130,000	$4,130,000

FY 2020-21	TF	GF	FF
Quality Withhold Repayment (CY 2017)	$16,822,000	$8,411,000	$8,411,000

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

GENERAL FUND REIMBURSEMENTS FROM DPHS

REGULAR POLICY CHANGE NUMBER:	108
IMPLEMENTATION DATE:	3/2020
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	1605

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$4,981,000	$0
- STATE FUNDS	$4,981,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,981,000	$0
STATE FUNDS	$4,981,000	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the Intergovernmental Transfer (IGT) from Designated Public Hospitals (DPHs) to the Department that will reimburse the General Fund (GF) for the costs built into the managed care baseline capitation rates.

Authority:
SB 208 (Chapter 714, Statutes of 2010)
AB 85 (Chapter 24, Statutes of 2013)

Interdependent Policy Changes:
Not Applicable

Background:
Effective June 1, 2011, Seniors and Persons with Disabilities (SPDs) were transitioned from fee-for-service (FFS) to managed care. Additionally, SPDs that were not covered under other health care coverage were assigned as mandatory enrollees in managed care plans in Two-Plan and Geographic Managed Care (GMC) model counties. Prior to June 1, 2011, the DPHs in applicable counties utilized Certified Public Expenditures to reimburse allowable costs associated with inpatient services. In FY 2012-13, the DPHs began reimbursing the GF through an IGT for costs that are built into the managed care baseline capitation rates that would not have been incurred had the SPDs remained in FFS.

Effective January 1, 2014, the Affordable Care Act (ACA) expanded Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level. The expansion of Medicaid coverage to previously ineligible persons is referred to as the ACA optional expansion (OE).

State law requires DPHs to be reimbursed at no less than the costs of providing services to the OE population. Through an IGT, Public Providers have historically provided the non-federal share portion of the adjusted capitation rates related to the costs for this population. As of June 30, 2017, the DPH reimbursement program was discontinued.

GENERAL FUND REIMBURSEMENTS FROM DPHS

REGULAR POLICY CHANGE NUMBER: 108

Reason for Change:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21. The change from FY 2019-20 to FY 2020-21 is due to the program being discontinued. All reconciliations are expected to be completed in FY 2019-20. No dollars are expected to be budgeted in this policy change beginning FY 2020-21.

Methodology:
1. The FY 2016-17 reconciliation is expected to occur in FY 2019-20 to close out the DPH reimbursement program.

(Dollars in Thousands)

	FY 2019-20
FY 2016-17-Closeout Reconciliation	$4,981
GF	$4,981
Net Impact	**$4,981**

Funding:
100% State GF (4260-101-1001)

CAPITATED RATE ADJUSTMENT FOR FY 2020-21

REGULAR POLICY CHANGE NUMBER: 110
IMPLEMENTATION DATE: 7/2020
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1338

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
The policy change estimates the increase for the Managed Care capitation rates for fiscal year (FY) 2020-21.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
Managed care capitation rates will be rebased in Calendar Year 2021 as determined by the rate methodology based on more recent data. Adjustments will be implemented based on the rate year of the managed care model types. This policy change shows the increase in capitation rates from FY 2019-20 to FY 2020-21.

Reason for Change:
The change in capitation rates from FY 2019-20 to FY 2020-21 is a 3.17% average rate increase, including Optional Expansion rates.

Methodology:

	Rate Adjustment
Two Plan	3.02%
COHS	3.55%
GMC	2.97%
Regional	3.60%
Total	3.17%

CAPITATED RATE ADJUSTMENT FOR FY 2020-21

REGULAR POLICY CHANGE NUMBER: 110

Funding:
N/A

MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.

REGULAR POLICY CHANGE NUMBER:	111
IMPLEMENTATION DATE:	11/2016
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	1962

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the transfer of funds collected from the tax on managed care organizations (MCOs) to the General Fund (GF) to be used by the Department to fund related managed care capitation rate increases.

Authority:
SBx2 2 (Chapter 2, Statutes of 2016)

Interdependent Policy Changes:
MCO Enrollment Tax Mgd. Care Plans-Incr. Cap. Rates
MCO Enrollment Tax Managed Care Plans

Background:
SBx2 2 was signed by the Governor on March 1, 2016, and provides for a statewide tax on managed care plans based on reported enrollment into these plans during the 12-month period between October 1, 2014 and September 30, 2015. 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 was effective July 1, 2016 through June 30, 2019. This policy change estimates the offset of GF costs for the capitated rate increases.

Reason for Change:
There is no change from the prior estimate for FY 2019-20. The MCO Enrollment Tax ended June 30, 2019, and costs for FY 2019-20 are for the June 2018 monthly capitation payment. There are no costs for FY 2020-21.

Methodology:
1. Total revenues for Medi-Cal managed care plans are based on the number of Medi-Cal enrollees, alternate health care service plans (AHCSP) enrollees, and “all-other” enrollees as defined in SBx2 2.

MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.

REGULAR POLICY CHANGE NUMBER: 111

2. Only tax relating to Medi-Cal enrollees are budgeted in this PC.

3. The MCO Enrollment Tax fund transfers is based on 35% of the Medi-Cal share of tax.

4. The MCO Enrollment Tax fund transfers to the GF are:

(Dollars in Thousands)

Fiscal Year	TF	GF	MCO Tax
FY 2019-20	**$0**	($58,473)	$58,473

Funding:
MCO Tax 2016 (Non-GF) (4260-601-3293)

MCO ENROLLMENT TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER:	112
IMPLEMENTATION DATE:	11/2016
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	1960

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the transfer of funds collected from the enrollment tax on managed care organizations (MCOs) to the General Fund (GF) to be retained by the Department beginning July 1, 2016.

Authority:
SBx2 2 (Chapter 2, Statutes of 2016)

Interdependent Policy Changes:
MCO Enrollment Tax Mgd. Care Plans-Incr. Cap. Rates
MCO Enrollment Tax Mgd. Care Plans-Funding Adj.

Background:
SBx2 2 was signed by the Governor on March 1, 2016, and provides for a statewide tax on managed care plans based on reported enrollment into these plans during the 12-month period between October 1, 2014, and September 30, 2015. 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 was effective July 1, 2016, through June 30, 2019. This policy change estimates GF savings resulting from the imposition of the MCO Enrollment Tax.

Reason for Change:
There is no change from the prior estimate for FY 2019-20. The MCO Enrollment Tax ended June 30, 2019, and costs for FY 2019-20 are for the June 2018 monthly capitation payment. There are no costs for FY 2020-21.

Methodology:
1. The MCO Enrollment Tax is based on the cumulative enrollment of health plans during the 12-month period between October 1, 2014, and September 30, 2015.

MCO ENROLLMENT TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER: 112

2. Different rates are assessed to Medi-Cal and non-Medi-Cal health plans. Non-Medi-Cal health plans include Alternate Health Care Service Plans (AHCSP).

3. The following taxing tier structure was used to determine the MCO Enrollment Tax for FY 2018-19:

Medi-Cal			
Enrollees	**Rate**	**Average Enrollment/Entity**	
0-2,000,000	$45.00	39,161,294	$1,762,259,000
2,000,001-4,000,000	$21.00	21,180,988	$444,801,000
Over 4,000,000	$1.00	48,831,000	$48,831,000

Non-Medi-Cal (including AHCSP)			
Enrollees	**Rate**	**Average Enrollment/Entity**	
0-4,000,000	$8.50	25,757,753	$218,941,000
4,000,001-8,000,000	$3.50	16,832,337	$58,913,000
Over 8,000,000	$1.00	30,244,000	$30,244,000

The total FY 2018-19 Medi-Cal and Non-Medi-Cal MCO Enrollment Tax on an accrual basis was: $2,562,919,000

4. The impact of the increase in capitation payments related to the tax is included in the MCO Enrollment Tax Mgd. Care Plans-Incr. Cap. Rates policy change.

5. The MCO Enrollment Tax fund transfers to the GF are:

(Dollars in Thousands)

Fiscal Year	TF	GF	MCO Tax
FY 2019-20	**$0**	($582,257)	$582,257

Funding:
MCO Tax 2016 (Non-GF) (4260-601-3293)

MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND

REGULAR POLICY CHANGE NUMBER:	113
IMPLEMENTATION DATE:	2/2019
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	2063

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates reimbursements to the General Fund (GF) by Intergovernmental Transfer (IGT) from allowable public entities for Medi-Cal payment contributions and administration and processing fees.

Authority:
Welfare & Institution Code 14164 and 14301.4

Interdependent Policy Changes:
Not Applicable

Background:
Effective July 1, 2017 rating period, this policy change consolidates voluntary IGT reimbursements to the GF and administration and processing fees from allowable public entities servicing Medi-Cal managed care beneficiaries.

Reason for Change:
The change from the prior estimate, for both FY 2019-20 and FY 2020-21, is due to the GF reimbursement collection in this PC being updated to align with the most recent corresponding GF expenditure payments and expected GF reimbursement levels. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to updated GF expenditures and reimbursements.

Methodology:
1. Data from FY 2017-18 and FY 2018-19 are used to estimate the annual commitment from allowable public entities.

MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND

REGULAR POLICY CHANGE NUMBER: 113

2. On a cash basis, the estimated reimbursements to the General Fund are:

(Dollars in Thousands)

Reimbursement	GF
FY 2017-18	$482,512
FY 2018-19	$695,261
Total	$1,177,773
FY 2018-19 Support Cost to GF	($251)
GF	($1,177,522)
FY 2019-20 Net Impact	**$0**

(Dollars in Thousands)

Reimbursement	GF
FY 2018-19	$516,483
July 1, 2019-Dec 31, 2020 (Bridge Period)	$767,821
Total	$1,284,304
July 1, 2019-Dec 31, 2020 Support Cost to GF	($251)
GF	($1,284,053)
FY 2020-21 Net Impact	**$0**

Funding:
Reimbursement (4260-601-0995)
100% State GF (4260-101-0001)

COORDINATED CARE INITIATIVE RISK MITIGATION

REGULAR POLICY CHANGE NUMBER:	114
IMPLEMENTATION DATE:	6/2021
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	2135

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	-$111,260,000
- STATE FUNDS	$0	-$55,630,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$111,260,000
STATE FUNDS	$0	-$55,630,000
FEDERAL FUNDS	$0	-$55,630,000

DESCRIPTION

Purpose:
This policy change estimates additional payments to and recoveries from managed care plans (MCPs) participating in the Coordinated Care Initiative (CCI) related to the risk mitigation strategies applicable to Cal MediConnect (CMC) and non-CMC full benefit dual-eligible beneficiaries, partial-benefit dual eligible beneficiaries, and non-dual-eligible beneficiaries.

Authority:
Welfare and Institutions (W&I) Code section 14182.18
CMC Three-Way Contract

Interdependent Policy Changes:
Not Applicable

Background:
Risk mitigation strategies are in place for CMC and non-CMC full-benefit dual eligible beneficiaries. Risk mitigation strategies are also in place for partial-benefit dual eligible beneficiaries and non-dual-eligible beneficiaries enrolled in managed care in CCI counties.

There is a limited up-side risk corridor and a limited down-side risk corridor for CMC full-benefit dual eligible beneficiaries, as specified in the CMC Three-Way Contract, for all demonstration years (DYs) through December 31, 2017. For non-CMC full-benefit dual eligible beneficiaries, partial-benefit dual eligible beneficiaries, and non-dual-eligible beneficiaries, there are separate 24-month symmetrical down-side and up-side risk corridors, as specified in W&I Code, section 14182.18 and existing Medi-Cal MCP contracts.

Capitation payments for CMC and non-CMC full-benefit dual eligible beneficiaries are subject to an additional ongoing risk mitigation requirement. This ongoing requirement is applicable to periods for which capitation payments are based on a projected mix of members of varying acuity levels. If there is a difference between the projected member mix and the actual member mix that would result in a greater than 2.5 percent impact to the capitation rates, the Department and MCPs will equally share any increases or decreases beyond the 2.5 percent threshold (independent of the MCPs' actual gains

COORDINATED CARE INITIATIVE RISK MITIGATION

REGULAR POLICY CHANGE NUMBER: 114

or losses).

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a decrease in recoupments due to the previously budgeted recoupments shifting to FY 2020-21. The change from the prior estimate, for FY 2020-21, is an increase in recoupments due to a shift in recoupments that were previously budgeted in FY 2019-20. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase in recoupments due to a shift in recoupments previously budgeted in FY 2019-20 that are now anticipated to occur in FY 2020-21.

Methodology:
1. Assume all payments and recoupments attributable to the full dual eligibles for the 2.5 percent member mix threshold for 2014 through 2018 will occur in FY 2020-21.

2. Assume all CMC payments and recoupments for DY one (1) through three (3) will occur in FY 2020-21.

3. Assume all payments and recoupments for the first 24-month period, for the non-CMC full-benefit dual eligible, partial-benefit dual eligible, and non-dual-eligible will occur in FY 2020-21.

4. Total recoupments are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2020-21	($111,260)	($55,630)	($55,630)

*Totals may differ due to rounding.

Funding:
50/50 FFP Title XIX (4260-101-0890)

RECOUPMENT OF UNALLOWED CAPITATION PAYMENTS

REGULAR POLICY CHANGE NUMBER:	115
IMPLEMENTATION DATE:	7/2019
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	2160

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$68,245,000	$0
- STATE FUNDS	-$24,478,640	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$68,245,000	$0
STATE FUNDS	-$24,478,640	$0
FEDERAL FUNDS	-$43,766,360	$0

DESCRIPTION

Purpose:
This policy change estimates the recoupment of capitation payments from Managed Care Plans (MCPs) for beneficiaries that were not initially shown as deceased.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
An audit conducted by the Office of the Inspector General determined that the Department paid MCPs capitation payments for deceased beneficiaries and recommended that the Centers for Medicare and Medicaid be paid back for these capitation payments. The Department recouped capitation payments from MCP's dating back to July 2011, for any inappropriate payments made for beneficiaries who were not identified as deceased, and returned the associated federal funds.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is slight decrease due to a decrease in actuals. There is no change from the prior estimate for FY 2020-21. The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to the one-time recoupment having occurred in FY 2019-20. There is no recoupment in FY 2020-21.

Methodology:
1. A one-time recoupment of **$68,245,000 TF ($24,479,000 GF)** occurred in **FY 2019-20**.

RECOUPMENT OF UNALLOWED CAPITATION PAYMENTS

REGULAR POLICY CHANGE NUMBER: 115

Funding:
100% Title XIX FF (4260-101-0890)
100% State GF (4260-101-0001)
100% Title XIX ACA FF (4260-101-0001/0890)
95% Title XIX ACA FF / 5% GF (4260-101-0001/0890)
94% Title XIX ACA FF / 6% GF (4260-101-0001/0890)
93% Title XIX ACA FF / 7% GF (4260-101-0001/0890)
65% Title XXI FF / 35% GF (4260-113-0001/0890)
88% Title XXI FF / 12% GF (4260-113-0001/0890)
76.5% Title XXI FF / 23.5% GF (4260-113-0001/0890)

MANAGED CARE DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	116
IMPLEMENTATION DATE:	4/2013
ANALYST:	Autumn Recce
FISCAL REFERENCE NUMBER:	1585

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$1,667,150,000	-$1,504,444,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,667,150,000	-$1,504,444,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$1,667,150,000	-$1,504,444,000

DESCRIPTION

Purpose:
This policy change estimates the amount of monies received from the collection of Managed Care drug rebates.

Authority:
Social Security Act Section 1927(b) as amended by Section 2501(c) of the Affordable Care Act (ACA)
SB 78 (Chapter 38, Statues of 2019)

Interdependent Policy Changes:
Medi-Cal Drug Rebate Fund

Background:
The ACA, HR 3590, and the Health Care and Education Reconciliation Act of 2010 (HCERA), extend the federal drug rebate requirement to Medicaid managed care outpatient covered drugs provided by the Geographic Managed Care (GMC), Two-Plan, and Regional model plans, and the Health Plan of San Mateo (HPSM), a County Organized Health System (COHS). Previously, only COHS plans, with the exception of HPSM, were subject to the rebate requirement.

SB 78 established the Medi-Cal Drug Rebate Fund (Fund 3331) effective July 1, 2019. The non-federal share of Medi-Cal federal and state supplemental drug rebates will be deposited into Fund 3331. See the Medi-Cal Drug Rebate Fund policy change for the estimated total transfers from Fund 3331 to the General Fund (GF).

MANAGED CARE DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 116

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is an increase in rebate savings due to:

- Including two additional quarters of actual rebate collection data through the quarter ending December 2019, and
- Updated managed care eligible data used to project the estimated managed care rebate collections.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease in rebate savings due to including actual FY 2019-20 collections data, which were higher than previously estimated.

Methodology:

1. Rebates are invoiced quarterly and payments occur six months after the conclusion of each quarter.

2. Assume family planning drugs account for 0.19% of the regular federal drug rebates and are funded with 90% federal funds (FF) and 10% GF.

3. CHIP drug rebates are funded at 88% FF / 12% GF through September 30, 2019, and 76.5% FF / 23.5% GF beginning October 1, 2019, and 65% FF / 35% GF beginning October 1, 2020. Assume CHIP drug rebate collections are estimated to be $106,432,000 FF and $84,486,000 FF in FY 2019-20 and FY 2020-21, respectively.

4. Collections for the optional expansion ACA population are estimated to be $942,764,000 TF for FY 2019-20, of which $876,771,000 FF is budgeted in this policy change. The amount of $65,993,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund. For FY 2020-21, a total of $868,832,000 TF is estimated for the optional expansion population, of which $781,948,000 FF is budgeted in this policy change. The amount of $86,884,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund.

5. The ongoing additional FF claimed by CMS (ACA Offset) is fully reflected in this policy change. The additional FF is $74,361,000 TF for FY 2019-20 and $72,289,000 TF for FY 2020-21.

6. The Department estimates $701,713,000 and $691,653,000 managed care drug rebates to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2019-20 and FY 2020-21, respectively.

FY 2019-20	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	($609,586,000)	($609,586,000)	($635,720,000)
100% Title XIX ACA FF	($876,771,000)	($876,771,000)	($65,993,000)
100% Title XXI FF	($106,432,000)	($106,432,000)	$0
ACA Offset	($74,361,000)	($74,361,000)	$0
Total	**($1,667,150,000)**	**($1,667,150,000)**	($701,713,000)

MANAGED CARE DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 116

FY 2020-21	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	($565,721,000)	($565,721,000)	($604,769,000)
100% Title XIX ACA FF	($781,948,000)	($781,948,000)	($86,884,000)
100% Title XXI FF	($84,486,000)	($84,486,000)	$0
ACA Offset	($72,289,000)	($72,289,000)	$0
Total	**($1,504,444,000)**	**($1,504,444,000)**	($691,653,000)

*The Fund 3331 Transfer column is for informational purposes only. See Methodology# 6.

Funding:
100% Title XIX (4260-101-0890)
100% Title XXI (4260-113-0890)

GROUND EMERGENCY MEDICAL TRANSPORTATION QAF

REGULAR POLICY CHANGE NUMBER:	117
IMPLEMENTATION DATE:	4/2019
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	2081

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$242,858,000	$215,459,000
- STATE FUNDS	$77,515,000	$71,406,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	23.84 %	13.95 %
APPLIED TO BASE		
TOTAL FUNDS	$184,960,700	$185,402,500
STATE FUNDS	$59,035,420	$61,444,860
FEDERAL FUNDS	$125,925,230	$123,957,610

DESCRIPTION

Purpose:
This policy change estimates the Quality Assurance Fee (QAF) revenues and the cost of rate increases for certain Ground Emergency Medical Transportation (GEMT) services.

Authority:
SB 523 (Chapter 773, Statutes of 2017)
SPA 18-004
SPA 19-0020

Interdependent Policy Changes:
Not Applicable

Background:
SB 523 requires the Department to impose a GEMT QAF on all ground emergency medical transports. The QAF revenues will be used 1) to pay for DHCS staffing and administrative costs to implement the QAF program, capped at $1,003,000 for FY 2018-19, and $374,000 for each year thereafter, 2) to pay for health care coverage in each FY in the amount of 10 percent of the annual QAF collection amount, and 3) to be used, along with a federal match, to provide an add-on to the reimbursement rates for base ground emergency transport services.

The Department collects gross transport and revenue data from GEMT providers in order to calculate an annual QAF amount. The QAF is assessed on each GEMT transport for base ground emergency medical services, effective July 1, 2018. The revenue generated by the QAF collections is deposited directly into the Medi-Cal Emergency Medical Transportation Fund (MEMTF).

For fiscal year 2018-19, the Department was required to provide an add-on to the Medi-Cal FFS reimbursements for codes A0427 Advanced Life Support (ALS) Emergency, A0429 Basic Life Support (BLS) Emergency, and A0433 ALS2 using available QAF revenue, effective July 1, 2018.

The add-on increase was calculated to be $220.80 for FY 2018-19, to the extent that FFP was available. SPA 18-004 was approved on February 7, 2019, for the FY 2018-19 add-on. The add-on will

GROUND EMERGENCY MEDICAL TRANSPORTATION QAF

REGULAR POLICY CHANGE NUMBER: 117

also be provided for codes A0225 Neonatal Emergency Transport and A0434 Specialty Care Transport, for FY 2019-20, effective July 1, 2019. SPA 19-0020 was approved on September 6, 2019, for the FY 2019-20 add-on. The Department will submit SPA 20-0009 for the FY 2020-21 add-on.

Reason for Change:
The change for FY 2019-20 and FY 2020-21, from the prior estimate, is a net increase in the FFS and Managed Care annual estimates due to updated utilization data and revised GF offset estimates.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is a net decrease due to the Erroneous Payment Correction (EPC) for the FY 2018-19 FFS add-on occurring in FY 2019-20, less of the GF offset occurring in FY 2020-21, and revised estimates for FY 2020-21 estimates based on updated actual utilization data.

Methodology:

1. The effective date for the GEMT QAF is July 1, 2018.

2. Assume the GEMT QAF revenue will be $77,055,000 in FY 2019-20 and $80,177,000 in FY 2020-21.

3. For FY 2018-19, $1,003,000 will be transferred from the MEMTF to the GF for administration costs. Beginning FY 2019-20 and every year after, $374,000 will be transferred.

4. The transfer from the MEMTF to the GF for the 10 percent set aside for health care coverage is estimated to be $7,408,000 for FY 2018-19, $7,668,000 for FY 2019-20, and $7,980,000 for FY 2020-21. The FY 2018-19 and FY 2019-20 offsets are expected to occur in FY 2019-20. The FY 2020-21 offset is expected to occur in FY 2020-21.

5. From the remaining GEMT QAF revenue available, total annual GEMT add-on payments for FY 2019-20 are estimated to be $217,056,000 TF, of which $31,086,000 TF is for FFS and $185,970,000 TF is for Managed Care GEMT transport services.

6. From the remaining GEMT QAF revenue available, total annual GEMT add-on payments for FY 2020-21 are estimated to be $215,523,000 TF, of which $30,067,000 TF is for FFS and $185,456,000 TF is for Managed Care GEMT transport services.

7. FFS Payments:
   a. The FY 2018-19 FFS add-on payments were implemented on August 26, 2019. The EPC for the retroactive period of July 1, 2018, through August 25, 2019, was implemented in September 2019.
   b. The FY 2019-20 FFS add-on payments will continue to be paid in FY 2019-20.
   c. Assume the FY 2020-21 FFS add-on payments will continue to be paid in FY 2020-21, upon federal approval.

8. Managed Care Payments:
   a. The FY 2019-20 Managed Care payments are expected to be implemented with the FY 2019-20 capitation rates. Assume 11 months of the FY 2019-20 managed care payments will be paid in FY 2019-20 and 1 month will be paid in FY 2020-21.

GROUND EMERGENCY MEDICAL TRANSPORTATION QAF

REGULAR POLICY CHANGE NUMBER: 117

b. The FY 2020-21 Managed Care payments are expected to be implemented with the FY 2020-21 capitation rates. Assume 11 months of the FY 2020-21 managed care payments will be paid in FY 2020-21 and 1 month will be paid in FY 2021-22.

9. The cash basis estimate is summarized as follows:

(Dollars in Thousands)

FY 2019-20	TF	GF	MEMTF	FF
GF Offset 18-19	$0	($7,408)	$7,408	$0
GF Offset 19-20	$0	($7,668)	$7,668	$0
FFS Pmts (ongoing)	$25,905	$0	$7,876	$18,029
FFS Pmts (retro)	$32,000	$0	$9,433	$22,567
Mgd Care Pmts	$184,953	$0	$60,206	$124,747
Total	**$242,858**	**($15,076)**	**$92,591**	**$165,343**

(Dollars in Thousands)

FY 2020-21	TF	GF	MEMTF	FF
GF Offset 20-21	$0	($7,980)	$7,980	$0
FFS Pmts (ongoing)	$30,066	$0	$9,396	$20,670
Mgd Care Pmts	$185,393	$0	$62,010	$123,383
Total	**$215,459**	**($7,980)**	**$79,386**	**$144,053**

Funding:

(Dollars in Thousands)

FY 2019-20	TF	GF	SF	FF
100% GF (4260-101-0001)	($15,076)	($15,076)	$0	$0
MEMTF (4260-601-3323)	$92,591	$0	$92,591	$0
ACA Title XIX FF (4260-101-0890)	$91,883	$0	$0	$91,883
Title XIX FF (4260-101-0890)	$67,898	$0	$0	$67,898
Title XXI FF (4260-113-0890)	$5,562	$0	$0	$5,562
Total	**$242,858**	**($15,076)**	**$92,591**	**$165,343**

(Dollars in Thousands)

FY 2020-21	TF	GF	SF	FF
100% GF (4260-101-0001)	($7,980)	($7,980)	$0	$0
MEMTF (4260-601-3323)	$79,386	$0	$79,386	$0
ACA Title XIX FF (4260-101-0890)	$78,296	$0	$0	$78,296
Title XIX FF (4260-101-0890)	$60,823	$0	$0	$60,823
Title XXI FF (4260-113-0890)	$4,934	$0	$0	$4,934
Total	**$215,459**	**($7,980)**	**$79,386**	**$144,053**

RATE INCREASE FOR FQHCS/RHCS/CBRCS

REGULAR POLICY CHANGE NUMBER:	118
IMPLEMENTATION DATE:	10/2005
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	88

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$277,576,000	$282,051,000
- STATE FUNDS	$105,678,470	$108,598,300
PAYMENT LAG	0.9324	0.9340
% REFLECTED IN BASE	65.90 %	8.02 %
APPLIED TO BASE		
TOTAL FUNDS	$88,254,800	$242,308,100
STATE FUNDS	$33,600,300	$93,296,060
FEDERAL FUNDS	$54,654,540	$149,012,040

DESCRIPTION

Purpose:
This policy change estimates the rate increase for all Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) under the prospective payment system (PPS) reimbursement methodology and the rate increase for Cost-Based Reimbursement Clinics (CBRCs).

Authority:
Section 1833 of the Social Security Act
Welfare & Institutions Code, section 14170 and 14132.100

Interdependent Policy Changes:
Not Applicable

Background:
The Benefits Improvement and Protection Act of 2000 required the Department to reimburse FQHCs and RHCs based on the PPS reimbursement methodology. Clinics chose a PPS rate based on either 1) the average of the clinic's 1999 and 2000 cost-based rate or, 2) the clinic's 2000 cost-based rate. The clinic receives an annual rate adjustment based on the percentage increase in the Medicare Economic Index and is effective October 1st of each year.

The Department reimburses the CBRCs, owned or operated by Los Angeles County, at 100% of reasonable and allowable costs. The Department pays an interim rate to the clinics, which is adjusted once the audit reports are finalized. The interim rate is adjusted July 1st of each year.

Reason for Change:
There is no change from the prior estimate in FY 2019-20. The change from the prior estimate, in FY 2020-21, is an increase due to additional audited actuals which increased projections for CBRCs. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to the projected increase in rates and visits.

RATE INCREASE FOR FQHCS/RHCS/CBRCS

REGULAR POLICY CHANGE NUMBER: 118

Methodology:

1. The projected visits are based on the average percent increase of the last 3 years actual visit counts.

2. The rate increase will be used as a trend factor to calculate the estimated cost per visit rate. The rate increase percent was 4.76% for calendar year 2018, 3.68% for calendar year 2019, and 3.68% for calendar year 2020.

Rate Year	Projected Visits	Current Rate	Rate with Increase
2018	19,760,995	$160.25	$160.25 x (1+4.76%) = $167.88
2019	21,040,517	$167.88	$167.88 x (1+3.68%) = $174.05
2020	22,402,889	$174.05	$174.05 x (1+3.68%) = $180.45

3. The estimated expenditures are the increased rate multiplied by the number of projected visits. The projected annual expenditures due to the rate increase are:

(Dollars in Thousands)

Federal Rate Year	Expenditures	Exp. with Increase	Rate Increase
2018	$3,166,699	$3,317,476	$113,082
2019	$3,532,282	$3,662,102	$97,365
2020	$3,899,223	$4,042,601	$107,534

4. The FY 2019-20 CBRC rate increase of $29,435,000 is based on the FY 2015-16 audited PPS rate utilizing payment data from the Paid Claims Summary Reports for FY 2017-18. The estimated payment increase is determined by the difference between the calculated estimated payments and the total payments per the Paid Claims Summary Reports for FY 2017-18. The audited PPS rate for FY 2015-16 audits were effective July 1, 2018.

5. The FY 2020-21 CBRC rate increase of $15,262,000 is based on the FY 2016-17 audited PPS for all hospital audits. FY 2016-17 audited PPS rates utilized payment data from the Paid Claims Summary Reports for FY 2018-19. The estimated payment increase is determined by the difference between the calculated estimated payments and the total payments per the Paid Claims Summary reports for FY 2018-19. The audited PPS rate for FY 2016-17 audits were effective July 1, 2019.

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
CY 2019 Increase	$138,788	$52,240	$86,548
CY 2020 Increase	$138,788	$53,437	$85,351
FY 2019-20 Total	**$277,576**	**$105,677**	**$171,899**
FY 2020-21	**TF**	**GF**	**FF**
CY 2020 Increase	$141,026	$54,599	$86,727
CY 2021 Increase	$141,025	$54,298	$86,727
FY 2020-21 Total	**$282,051**	**$108,597**	**$173,454**

*Totals may differ due to rounding.

RATE INCREASE FOR FQHCS/RHCS/CBRCS

REGULAR POLICY CHANGE NUMBER: 118

FY 2019-20	TF	GF	FF
50% Title XIX / 50% GF	$197,794,000	$98,897,000	$98,897,000
93% Title XIX ACA / 7% GF	$39,891,000	$2,792,000	$37,099,000
90% Title XIX ACA / 10% GF	$39,891,000	$3,989,000	$35,902,000
FY 2019-20 Total	**$277,576,000**	**$105,677,000**	**$171,899,000**

FY 2020-21	TF	GF	FF
50% Title XIX / 50% GF	$200,983,000	$100,491,000	$100,492,000
90% Title XIX ACA / 10% GF	$81,068,000	$8,106,000	$72,962,000
FY 2020-21 Total	**$282,051,000**	**$108,597,000**	**$173,454,000**

*Totals may differ due to rounding.

Funding:
50% Title XIX / 50% GF (4260-101-0890/0001)
100% Title XIX ACA (4260-101-0890)
93% Title XIX ACA / 7% GF (4260-101-0890/0001)
90% Title XIX ACA / 10% GF (4260-101-0890/0001)

AB 1629 ANNUAL RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER:	119
IMPLEMENTATION DATE:	8/2014
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1508

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$185,748,000	$205,698,000
- STATE FUNDS	$92,874,000	$102,849,000
PAYMENT LAG	0.9974	1.0000
% REFLECTED IN BASE	56.51 %	53.31 %
APPLIED TO BASE		
TOTAL FUNDS	$80,571,800	$96,040,400
STATE FUNDS	$40,285,890	$48,020,200
FEDERAL FUNDS	$40,285,890	$48,020,200

DESCRIPTION

Purpose:
This policy change estimates the cost of the AB 1629 rate increases and add-ons for Freestanding Skilled Nursing Facilities, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facilities, Level-B (FSSA/NF-B).

Authority:
AB 1629 (Chapter 875, Statutes of 2004)
ABX1 19 (Chapter 4, Statutes of 2011)
AB 1489 (Chapter 631, Statutes of 2012)
AB 119 (Chapter 17, Statutes of 2015)
SB 3 (Chapter 4, Statutes of 2016)
SB 97 (Chapter 52, Statutes of 2017)
SB 219 (Chapter 482, Statutes of 2017)
SPA 17-020
SPA 18-0050

Interdependent Policy Changes:
Funding Adjust.—ACA Opt. Expansion
Funding Adjust.—OTLICP
Nursing Facility Financing Reform

Background:
AB 1629 requires the Department to implement a facility-specific rate methodology and impose a Quality Assurance Fee (QAF) on FS/NF-B, FSSA/NF-B, and Freestanding Pediatric Subacute (FS/PSA) facilities. The QAF is used to offset a portion of the General Fund (GF) costs associated with paying FS/NF-B, FSSA/NF-B, and FS/PSA reimbursement rates.

The QAF is used as a means to enhance federal financial participation (FFP) for the Medi-Cal program as well as to provide higher reimbursement to support quality improvement efforts in these facilities.

AB 1629 ANNUAL RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 119

To determine the QAF amount assessed to these facilities, the Department uses two-year old data as the base revenue and applies growth and trending adjustments to project an estimate of revenues. The QAF and other fees, including licensing and certification fees, cannot collectively exceed what is known as the federal safe harbor limit, which is currently 6%. Changes in the amount of licensing and certification fees for FS/NF-B and FSSA/NF-B facilities, assessed by the California Department of Public Health (CDPH), affect the amount of QAF that can be collected in order to remain within the federal safe harbor limit.

The rate methodology provides for facility-specific cost-based per diem payments for AB 1629 facilities based upon allowable audited costs and additional reimbursement for the projected Medi-Cal cost of complying with new state or federal mandates, referred to as “add-ons.” The AB 1629 program add-ons are negotiated on an annual basis, and reflect costs associated with new mandates that have yet to be captured within the audited cost reports used to compute facility specific per-diem rates. These new mandated costs are budgeted for separately, as it will take two years to be reflected in the regular facility specific reimbursement rates.

AB 1467 (Chapter 23, Statutes of 2012) established the Long Term Care Quality Assurance (LTCQA) Fund. Effective August 1, 2013, the revenue generated by the QAF collections will be deposited directly into the fund, rather than the state GF, and will be used to offset provider reimbursement rate expenditures. AB 1489 implemented a 3% increase to the weighted average Medi-Cal reimbursement rate for the 2013-14 and 2014-15 rate years (RYs).

SB 853 (Chapter 717, Statutes of 2010) implemented a quality and accountability supplemental payment (QASP) program for FS/NF-Bs and FSSA/NF-B facilities. The QASP is tied to demonstrated quality of care improvements and paid through the Skilled Nursing Facility Quality and Accountability Special Fund. The fund is comprised of penalties assessed on FS/NF-Bs and FSSA/NF-Bs that do not meet minimum staffing requirements, one-third of the AB 1629 facilities reimbursement rate increase for RY 2013-14 (up to a maximum of 1% of the overall rate), and the savings achieved from setting the professional liability insurance cost category at the 75th percentile.

AB 119 extends the AB 1629 facility-specific rate methodology, QAF, and QASP Program through July 31, 2020. Further, beginning RY 2015-16, the annual weighted average rate increase was set at 3.62%, and the GF appropriation for the QASP will continue at the RY 2014-15 amount of $43 million, rather than setting aside a portion of the annual rate increase. AB 119 also changes the annual weighted average rate increase from a cap to a mandatory set percentage increase. The Centers for Medicare and Medicaid Services (CMS) approved SPA 17-020, effective August 1, 2017, to clarify that the rate increase provided through July 31, 2020 is at 3.62%, which aligns with current statute, rather than up to a 3.62% increase.

The Department received approval from CMS on December 4, 2018, to implement SPA 18-0050, to revise the building construction and estimated building value used to calculate the Capital Cost category of the reimbursement rate methodology for FS/NF-B and FSSA/NF-B facilities. Overall, the change is cost neutral, but will provide a more appropriate level of reimbursement for new facility construction.

The Department proposes to extend and reform the AB 1629 program by tying a growing portion of future rate increases to quality measures. The Department proposes a bridge period that would extend the current methodology for five months, from August through December 2020, and the QASP program for an additional year. The proposal would then provide an additional rate increase in January 2021, and each January thereafter, thereby transitioning the AB 1629 RY from an August start date to a

AB 1629 ANNUAL RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 119

January start date to align with the managed care RY. The new rate methodology is proposed to begin January 2022, and is budgeted in the Nursing Facility Financing Reform Policy Change.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is an increase due to:

- Revised 2019-20 QAF rate;
- Revised 2019-20 facility rates;
- Delayed implementation for the 2019-20 rates, resulting in less months of payment and an increased RY 2019-20 retroactive payment; and
- Revised FFS days based on updated actual utilization data.

The change from the prior estimate, for FY 2020-21, is a net increase due to:

- Revised 2020-21 QAF rate;
- Revised 2020-21 facility rate estimates;
- Less add-ons due to some add-ons ending with the 2019-20 rate year; and
- Revised FFS days based on updated actual utilization data.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is a net increase due to including a full year of 2019-20 rates compared to seven months in FY 2019-20 and less retroactive payments in FY 2020-21.

Methodology:

1. The effective date for the rate increase and add-ons is August 1st.

2. Assume a 3.62% rate increase for RY 2019-20. Assume the AB 1629 methodology will be extended with no rate increase for RY 2020-21.

3. The 2019-20 rates and add-ons were implemented in March 2020. The 2019-20 retroactive rate payment will cover August 2019 through February 2020, and will be implemented in April 2020.

4. The AB 1629 extension after July 31, 2020 is estimated in the Nursing Facility Financing Reform policy change.

5. The estimated managed care rate adjustment impact for RY 2019-20 and RY 2020-21 is included in the FY 2019-20 and FY 2020-21 managed care capitation rates, respectively.

6. The add-on descriptions are listed below:

    - SB 3 Minimum Wage Increases: For employers who employ 26 or more employees.
        i. $11.00 per hour, effective January 2018
        ii. $12.00 per hour, effective January 2019
        iii. $13.00 per hour, effective January 2020
        iv. $14.00 per hour, effective January 2021

    - Standards of Participation: Effective November 28, 2016, CMS required SNFs to meet new health and safety standards in order to participate in the Medicare and Medicaid programs. These add-ons are scheduled to end with RY 2019-20.
        i. Phase I – Antimicrobial Stewardship

AB 1629 ANNUAL RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 119

ii. Phase II – Infection Control, Food and Nutrition Services
iii. Phase III – Infection Preventionist Staff

- SNF Staffing Ratio: Effective July 1, 2018, SB 97 requires SNFs to have a minimum number of direct care service hours of 3.5 per patient day. These add-ons are scheduled to end with RY 2019-20.

- Lesbian, Gay, Bisexual, and Transgender (LGBT) training: Effective August 1, 2018, SB 219 requires SNFs to implement an LGBT training program. These add-ons are scheduled to end with RY 2019-20.

7. The estimated payments on a cash basis are:

(Dollars in Thousands)

FY 2019-20	TF	GF	FFP
FFS (Rate Increase)	$114,590	$57,295	$57,295
RY 2019-20 Retro	$44,074	$22,037	$22,037
Add-Ons	$27,084	$13,542	$13,542
Managed Care	$0	$0	$0
Total	**$185,748**	**$92,874**	**$92,874**

(Dollars in Thousands)

FY 2020-21	TF	GF	FFP
FFS (Rate Increase)	$179,786	$89,893	$89,893
Add-Ons	$25,912	$12,956	$12,956
Managed Care	$0	$0	$0
Total	**$205,698**	**$102,849**	**$102,849**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in the Funding Adjust.—ACA Opt. Expansion policy change
OTLICP funding identified in the Funding Adjust.—OTLICP policy change

FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER:	120
IMPLEMENTATION DATE:	7/2008
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1329

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$92,591,000	$73,390,000
- STATE FUNDS	$35,251,520	$28,257,400
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	45.41 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$50,545,400	$73,390,000
STATE FUNDS	$19,243,800	$28,257,400
FEDERAL FUNDS	$31,301,620	$45,132,600

DESCRIPTION

Purpose:
This policy change estimates the reimbursement of participating Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) according to the prospective payment system (PPS), Indian Health Services/Memorandum of Agreement (IHS/MOA), and the reimbursement to Cost-Based Reimbursement Clinics (CBRCs).

Authority:
Welfare & Institutions Code, sections 14132 and 14170
Social Security Act, 1902 (bb)(5)

Interdependent Policy Changes:
Not Applicable

Background:
Annually, each FQHC/RHC submits a reconciliation request for full reimbursement. The Department must provide payment to the clinics equal to the difference between each clinic's final PPS rate and the expenditures already reimbursed by an interim payment and third party payors (i.e. managed care entities, Medicare, etc.) in order to calculate the final settlement with the clinic.

The Department reimburses the CBRCs, owned or operated by Los Angeles County, at 100% of reasonable and allowable costs. The Department pays an interim rate to the clinics, which is adjusted once the audit reports are finalized. The adjusted interim rate is used for subsequent fiscal year claims. The FY 2016-17 audited levels were used to update the CBRC rates as of July 1, 2019. The Department will complete the CBRC reconciliation audit for FY 2017-18 in FY 2019-20, and is scheduled to complete FY 2018-19 audit levels in FY 2020-21. Interim rates will be adjusted to the FY 2017-18 audit levels beginning in FY 2020-21.

Currently, there are 1,251 active FQHCs, 271 active RHCs, 25 active CBRCs, and 91 active IHS/MOA.

FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER: 120

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is an increase due to an increase in the total amount paid for each Erroneous Payment Corrections (EPC) and an increase in settlement recoveries from issued reconciliations for the period July 1, 2019 to December 31, 2019. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease due to the combined net effect from the total amounts paid for each EPC and the settlement recoveries based on issued reconciliations for the period of July 1, 2019 through December 31, 2019.

Methodology:

1. FY 2019-20 FQHC and RHC reconciliations are based on actual settlements from July 2019 through December 2019. For January 2020 through June 2020, the estimated months are based on a three-year average of actual settlements from July 2016 through June 2019. FY 2020-21 reconciliations are based on a three-year average of actual and estimated settlements from July 2017 through June 2020. FY 2016-17, FY 2017-18, and FY 2018-19 FQHC reconciliations include settlements for IHS. The change from the prior year is due to significant large settlement amounts recovered through the reconciliation process.

2. The estimated FQHC retroactive rate adjustment of $48,141,000 for FY 2019-20 is based on EPC actuals implemented and paid from July 2019 through December 2019 and the prior three-year average of actuals. For FY 2020-21, the amount of $32,269,000 is based on a three-year average of FY 2017-18 and FY 2018-19 EPC actuals and estimated EPCs for FY 2019-20. The change from the prior year estimate is attributed to an increase in EPC's implemented and paid. Currently, the fiscal intermediary processes EPCs quarterly.

3. The LA CBRC reconciliation for FY 2019-20 reconciliation is based on settlement of 95% of the FY 2017-18 reported settlements. The FY 2020-21 reconciliation is based on 95% of the projected FY 2018-19 settlements calculated utilizing an average percentage between the CBRC interim payments over revenues for FY 2015-16 and FY 2016-17 audited settlements, and FY 2017-18 reported settlements. The change from the prior year estimate is due to the completion of majority of the FY 2016-17 hospital audits.

Reconciliations and Adjustments	FY 2019-20	FY 2020-21
FQHCs Reconciliation	($37,294,000)	($37,652,000)
RHCs Reconciliation	$6,716,000	($1,713,000)
FQHC Retroactive Rate Adjustment	$48,141,000	$32,269,000
LA CBRCs Reconciliation	$75,028,000	$80,486,000
Total	**$92,591,000**	**$73,390,000**

FY 2019-20	TF	GF	FF
93% Title XIX ACA / 7% GF	$13,306,000	$931,000	$12,375,000
90% Title XIX ACA / 10% GF	$13,306,000	$1,331,000	$11,975,000
50% Title XIX / 50% GF	$65,979,000	$32,990,000	$32,989,000
FY 2019-20 Total	**$92,591,000**	**$35,252,000**	**$57,339,000**

FY 2020-21	TF	GF	FF
90% Title XIX ACA / 10% GF	$21,094,000	$2,109,000	$18,985,000
50% Title XIX / 50% GF	$52,296,000	$26,148,000	$26,148,000
FY 2020-21 Total	**$73,390,000**	**$28,257,000**	**$45,133,000**

FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER: 120

Funding:
50% Title XIX / 50% GF (4260-101-0890/0001)
93% Title XIX ACA / 7% GF (4260-101-0890/0001)
90% Title XIX ACA / 10% GF (4260-101-0890/0001)

PROP 56 - HOME HEALTH RATE INCREASE

REGULAR POLICY CHANGE NUMBER:	121
IMPLEMENTATION DATE:	7/2019
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	2077

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$113,501,000	$92,754,000
- STATE FUNDS	$54,378,440	$44,971,860
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	81.72 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	$20,748,000	$0
STATE FUNDS	$9,940,380	$0
FEDERAL FUNDS	$10,807,600	$0

DESCRIPTION

Purpose:
This policy change estimates the costs of a rate increase for Fee-for-Service (FFS) home health and private duty nursing (PDN) services, effective July 1, 2018.

Authority:
SB 856 (Chapter 30, Statutes of 2018)
SPA 18-0037

Interdependent Policy Changes:
Not Applicable

Background:
The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), passed by the voters in November 2016, increases the excise tax rate on cigarettes and electronic cigarettes, effective April 1, 2017, and other tobacco products effective July 1, 2017. The excise tax increased by $2 from 87 cents to $2.87 per pack of 20 cigarettes on distributors selling cigarettes in California with an equivalent excise tax rate increase on other tobacco products.

Pursuant to SB 856, the Department developed the structure and parameters for rate increases to be made for home health providers of medically necessary in-home services for children and adults in the Medi-Cal Fee-for-Service (FFS) system or through Home and Community Based Services (HCBS) waivers. Home Health and PDN services are an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.

On September 17, 2018, the Centers for Medicare and Medicaid Services approved State Plan Amendment (SPA) 18-0037 for federal approval to provide a rate increase to certain home health services.

This policy change identifies the use of the General Fund for these Proposition 56 payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

PROP 56 - HOME HEALTH RATE INCREASE

REGULAR POLICY CHANGE NUMBER: 121

Reason for Change:
The change for FY 2019-20, from the prior estimate, is an increase due to a revised estimate of the additional Erroneous Payment Correction (EPC).

There is no change in the total funds for FY 2020-21, from the prior estimate; however, the funding splits were revised based on updated actual FFS utilization data.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to the expected completion of the additional EPC in FY 2019-20.

Methodology:
1. The Department increased certain FFS and HCBS waiver home health agency and PDN services rates by 50%, effective for dates of service on and after July 1, 2018. Providers in the Medi-Cal FFS delivery systems, as well as the impacted HCBS waivers will receive these rate increases.

2. The rate adjustments were implemented on December 28, 2018. The EPC for the retroactive period from July 2018 to December 2018 occurred in April 2019. An additional EPC for claims not captured in the original EPC is expected to occur in June 2020.

3. The Medi-Cal costs in this policy change are as follows:

FY 2019-20	TF	GF	Title XIX FF	Title XXI FF	ACA FF
FFS Ongoing	$92,754,000	$44,507,000	$43,567,000	$3,026,000	$1,655,000
EPC	$20,747,000	$9,872,000	$9,745,000	$750,000	$380,000
Total 2019-20	**$113,501,000**	**$54,378,000**	**$53,312,000**	**$3,776,000**	**$2,035,000**

Fiscal Year	TF	GF	Title XIX FF	Title XXI FF	ACA FF
Total 2020-21	**$92,754,000**	**$44,972,000**	**$43,566,000**	**$2,588,000**	**$1,628,000**

Funding:

FY 2019-20	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	$106,624,000	$53,312,000	$53,312,000
94% Title XIX / 6% GF (4260-101-0001 / 0890)	$405,000	$24,000	$380,000
93% Title XIX / 7% GF (4260-101-0001 / 0890)	$904,000	$63,000	$841,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	$904,000	$91,000	$813,000
88% Title XXI / 12% GF (4260-101-0001 / 4260-113-0890)	$1,805,000	$216,000	$1,589,000
76.5% Title XXI / 23.5% GF (4260-101-0001 / 4260-113-0890)	$2,859,000	$672,000	$2,187,000
Total	**$113,501,000**	**$54,378,000**	**$59,123,000**

PROP 56 - HOME HEALTH RATE INCREASE

REGULAR POLICY CHANGE NUMBER: 121

FY 2020-21	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	$87,132,000	$43,566,000	$43,566,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	$1,809,000	$181,000	$1,628,000
76.5% Title XXI / 23.5% GF (4260-101-0001 / 4260-113-0890)	$953,000	$224,000	$729,000
65% Title XXI / 35% GF (4260-101-0001 / 4260-113-0890)	$2,860,000	$1,001,000	$1,859,000
Total	**$92,754,000**	**$44,972,000**	**$47,782,000**

DPH INTERIM RATE GROWTH

REGULAR POLICY CHANGE NUMBER:	122
IMPLEMENTATION DATE:	8/2019
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1162

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$3,884,000	$51,302,000
- STATE FUNDS	$1,942,000	$25,651,000
PAYMENT LAG	0.6820	0.6898
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,648,900	$35,388,100
STATE FUNDS	$1,324,440	$17,694,060
FEDERAL FUNDS	$1,324,440	$17,694,060

DESCRIPTION

Purpose:
This policy change estimates the cost of increases in payments to Designated Public Hospitals (DPHs) due to interim rate growth.

Authority:
SPA 05-21

Interdependent Policy Changes:
DPH Interim Rate
Funding Adjust. — ACA Opt. Expansion

Background:
As approved on April 25, 2006 through SPA 05-21, effective July 1, 2005, DPHs receive interim per diem rates based on estimated costs using the hospitals' prior Medi-Cal costs trended forward. The DPHs' interim rate receives a growth percent increase to reflect an increase in the hospitals' costs. The interim per diem rate consists of 100% federal funding.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is due to the FY 2019-20 rate growth for County Inpatient DPHs was removed from this policy change as the fee-for-service (FFS) base trends include the full impact of the rate increase.

The change in FY 2020-21, from the prior estimate, is due to a decrease in estimated users based on updated DPH actual data through January 2020.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to an increased growth rate for community-based DPHs by 0.81% and a reduced growth rate by 0.41% for county DPHs in FY 2020-21 based on updated DPH actual data through January 2020.

DPH INTERIM RATE GROWTH

REGULAR POLICY CHANGE NUMBER: 122

Methodology:

1. The DPHs received new FY 2019-20 interim rates in mid-July 2019, effective July 1, 2019. These rates were based on FY 2018-19 costs trended to FY 2019-20. Assume the FY 2020-21 interim rates will be implemented in July 2020.

2. For FY 2019-20:
   - The rate increase for County Inpatient DPHs is 100% captured in the FFS base trends.
   - An Erroneous Payment Correction (EPC) is expected to occur in March 2020 for the time period from July 1, 2019 through July 17, 2019.
   - Assume a 6.74% interim rate increase for county DPHs.
   - Assume no interim rate increase for community-based DPHs.
   - An additional cost of $3,884,000 TF is estimated for the FY 2019-20 interim rates. The lagged cost on a cash basis, not in the base, is estimated to be approximately $2,649,000 TF.

3. For FY 2020-21:
   - Assume a 6.33% interim rate increase for county DPHs.
   - Assume a 0.81% interim rate increase for community-based DPHs.
   - An additional cost of $51,302,000 TF is estimated for the FY 2020-21 interim rates. The lagged cost on a cash basis, not in the base, is estimated to be approximately $35,388,000 TF.

4. The interim payments are 100% federal funds, after the Department's adjustment. Until the adjustment is made, the payments are 50% GF/ 50% FFP and are budgeted as 50% GF / 50% FFP. The full adjustment is shown in the DPH Interim Rate policy change.

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in the Funding Adjust. — ACA Opt. Expansion policy change

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	123
IMPLEMENTATION DATE:	8/2007
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1046

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$29,997,000	$56,881,000
- STATE FUNDS	$14,998,500	$28,440,500
PAYMENT LAG	0.9904	0.9923
% REFLECTED IN BASE	27.62 %	28.63 %
APPLIED TO BASE		
TOTAL FUNDS	$21,503,400	$40,283,400
STATE FUNDS	$10,751,700	$20,141,690
FEDERAL FUNDS	$10,751,700	$20,141,690

DESCRIPTION

Purpose:
This policy change estimates the annual long-term care (LTC) rate adjustment for Nursing Facility-As (NF-A), Distinct Part (DP) Nursing Facility-Bs (DP/NF-Bs), Rural Swing Beds, DP Adult Subacute, DP Pediatric Subacute (DP/PSA), Freestanding Pediatric Subacute, Intermediate Care Facility – Developmentally Disabled (ICF/DD), Intermediate Care Facility – Habilitative (ICF/DD-H), and Intermediate Care Facility – Nursing (ICF/DD-N) facilities. Additionally, it estimates the rate increases due to the assessment of Quality Assurance (QA) fees for ICF-DDs and Freestanding Pediatric Subacute facilities (FS/PSA). It also estimates the additional reimbursement for the projected Medi-Cal costs of complying with new State or federal mandates, referred to as “add-ons.”

Authority:
ABX4 5 (Chapter 5, Statutes of 2009)
AB 97 (Chapter 3, Statutes of 2011)
ABX1 19 (Chapter 4, Statutes of 2011)
SB 239 (Chapter 657, Statutes of 2013)
AB 119 (Chapter 17, Statutes of 2015)
ABX2 1 (Chapter 3, Statutes of 2016)

Interdependent Policy Changes:
Funding Adjust. – ACA Opt. Expansion
Funding Adjust. – OTLICP

Background:
Prior to rate year 2009-10, Medi-Cal rates for LTC facilities were adjusted after completion of an annual rate study for specified provider types. ABX4 5 froze rates for rate year 2009-10 and every year thereafter at the 2008-09 levels. On February 24, 2010, in the case of *CHA v. David Maxwell-Jolly*, the court enjoined the Department from continuing to implement the freeze in reimbursement at the 2008-09 rate levels for DP/NF-Bs, Rural Swing Beds, DP Adult Subacute, and DP/PSA.

Effective June 1, 2011, AB 97 required the Department to freeze rates and reduce payments by up to 10% for the facilities enjoined from the original rate freeze, which was required by ABX4 5. In addition,

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 123

AB 97 extends this requirement to the other LTC facility types. The Department received approval from the Centers for Medicare and Medicaid Services (CMS) to implement a rate freeze on NF-As and DP/NF-Bs and to reduce the payments by 10%.

As a result of AB 97, the Department revised the reimbursement rate methodology for the ICF/DD, ICF/DD-H, and ICF/DD-N providers. Each rate year, individual provider costs are rebased using cost data applicable for the rate year. Each ICF/DD, ICF/DD-H, and ICF/DD-N provider will receive the lower of its projected costs plus 5% or the 65th percentile established in 2008-2009, with none receiving a rate no lower than 90% of the 2008-2009 65th percentile.

Effective September 1, 2013, SPA 13-034 exempted Rural Swing Beds in DP/NF-B facilities located in designated rural and frontier areas from the AB 97 rate freeze and rate reduction. All other bed types in DP/NF-B facilities were exempted October 1, 2013.

The Department also received CMS approval to exempt DP Adult Subacute and DP/PSA from the rate freeze based on access and utilization analyses.

ABX1 19 requires FS Pediatric Subacute Care facilities to pay a QA fee (QAF) beginning January 1, 2012. Effective October 1, 2011, the QA fee cap is 6% of total gross revenues. The fee is used to draw down Federal Financial Participation (FFP) and fund rate increases.

AB 119 extends the FS Pediatric Subacute Facilities QAF sunset from July 31, 2015 to July 31, 2020.

Effective August 1, 2016, ABX2 1 requires the Department to forgo the AB 97 retroactive recoupment for the rate reduction and rate freeze that would have been applied to the reimbursement for services provided by DP/NF-Bs between June 1, 2011 and September 30, 2013. ABX2 1 also required the Department to restore the AB 97 payment reduction and reimburse ICF/DD facilities at the 2008-09 levels, increased by 3.7%.

Restore AB 97	Increase 3.7%	Total
$5,791,000	$19,330,000	$25,121,000

The reimbursement rates for DP Adult Subacute and DP Pediatric Subacute types are described in the State Plan and are currently not subject to any rate reductions.

Add-ons reflect costs associated with new mandates that have yet to be captured within the audited cost reports used to compute facility specific reimbursement rates. These new mandated costs are negotiated on an annual basis and take two years to be reflected in the regular facility specific reimbursement rates, with the exception of DP Adult Subacute facilities, which take three years for add-ons to be reflected in their rates.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a net increase due to:

- Updated RY 2019-20 rates based on audited data;
- Revised FFS utilization based on updated actual utilization data;
- Updated RY 2019-20 add-ons;
- Revised estimate of retroactive payments; and
- Removing the managed care impact for the Fire Safety add-on because it will be captured in the capitation rates.

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 123

The change from the prior estimate, for FY 2020-21, is a net decrease due to:

- Updated RY 2020-21 estimates;
- Revised FFS utilization based on updated actual utilization data;
- Updated RY 2020-21 add-ons;
- Revised estimate of retroactive payments; and
- Removing the managed care impact for the Fire Safety add-on because it will be captured in the capitation rates.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is a net increase due to:

- A full year of the RY 2019-20 rate adjustments in FY 2020-21;
- Including the RY 2020-21 rate adjustments in FY 2020-21; and
- Less retroactive payments in FY 2020-21.

Methodology:

1. The effective date for the rate adjustments is August 1st of each rate year. The expected RY 2019-20 and RY 2020-21 implementation dates are as follows:

Facility	FY 2019-20	FY 2020-21
DP/NF-B	12/23/2019	11/1/2020
Rural Swing Beds (non-exempt)	2/1/2020	11/1/2020
Rural Swing Beds (exempt)	2/1/2020	11/1/2020
DP Adult Subacute	12/23/2019	11/1/2020
NF-A	12/24/2019	11/1/2020
ICF/DDs	12/23/2019	11/1/2020
DP Pediatric Subacute	1/27/2020	10/1/2020
FS Pediatric Subacute	1/29/2020	11/1/2020

2. The estimated managed care rate adjustment impacts for rate year 2019-20 and 2020-21 are included in the managed care capitation rates.

3. Assume add-ons remain in place for ongoing costs for providers' rates impacted by a rate freeze. The add-on descriptions are listed below:
   - SB 3 (Chapter 4, Statues of 2016) Minimum Wage Increases: For employers who employ 26 or more employees.
     i. $10.50 per hour, effective January 2017.
     ii. $11.00 per hour, effective January 2018.
     iii. $12.00 per hour, effective January 2019.
     iv. $13.00 per hour, effective January 2020.
     v. $14.00 per hour, effective January 2021.

   - Payroll-Based Journal: Effective July 1, 2016, CMS requires facilities to submit direct care staffing information based on payroll data.

   - Standards of Participation: Effective November 28, 2016, CMS required SNFs to meet new health and safety standards in order to participate in the Medicare and Medicaid programs.
     i. Phase I – Antimicrobal Stewardship
     ii. Phase II – Infection Control
     iii. Phase III – Infection Preventionist Staff

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 123

- Lesbian, Gay, Bisexual, and Transgender (LGBT) training: Effective August 1, 2018, SB 219 (Chapter 483, Statutes of 2017) requires SNFs to implement an LGBT training program.

- Fire Safety Add-on: Effective July 5, 2016, CMS formally adopted requirements from the 2012 Life Safety Code, which requires ICF/DD-H and N facilities to comply with amended fire safety requirements for attics by July 5, 2019.

4. Payments in FY 2019-20 include retroactive payments for 2018-19 and 2019-20. Payments for FY 2020-21 include retroactive payments for 2020-21. The costs below reflect the incremental rate adjustments and add-ons for each facility type:

Fee-for-Service	**FY 2019-20**	**FY 2020-21**
Rate Adjustment (19-20)		
DP/NF-B	$5,419,000	$10,839,000
Rural Swing Beds (non-exempt)	$1,000	$1,000
Rural Swing Beds (exempt)	$22,000	$52,000
DP Adult Subacute	$4,818,000	$9,636,000
NF-A	$13,000	$26,000
ICF/DDs	$7,801,000	$15,601,000
DP Pediatric Subacute	$277,000	$665,000
FS Pediatric Subacute	$6,000	$15,000
Rate Adjustment (20-21)		
DP/NF-B	$0	$5,275,000
Rural Swing Beds (non-exempt)	$0	$1,000
Rural Swing Beds (exempt)	$0	($1,000)
DP Adult Subacute	$0	$4,352,000
NF-A	$0	$0
ICF/DDs	$0	$6,271,000
DP Pediatric Subacute	$0	$297,000
FS Pediatric Subacute	$0	$33,000
Retro Rate Adjustments		
DP/NF-B	$3,231,000	$1,167,000
Rural Swing Beds (non-exempt)	$1,000	$1,000
Rural Swing Beds (exempt)	$24,000	$0
DP Adult Subacute	$2,873,000	$963,000
NF-A	$8,000	$0
ICF/DDs	$5,247,000	$1,650,000
DP Pediatric Subacute	$251,000	$30,000
FS Pediatric Subacute	$5,000	$7,000
Total FFS	$29,997,000	$56,881,000
Managed care	$0	$0
Total Cost	**$29,997,000**	**$56,881,000**

Funding:
50% Title XIX / 50% Title GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in the Funding Adjust.—ACA Opt. Expansion policy change
OTLICP funding identified in the Funding Adjust.—OTLICP policy change

DPH INTERIM & FINAL RECONS

REGULAR POLICY CHANGE NUMBER:	124
IMPLEMENTATION DATE:	10/2007
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1152

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$220,014,000	$159,698,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$220,014,000	$159,698,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$220,014,000	$159,698,000

DESCRIPTION

Purpose:
This policy change estimates the funds for the reconciliation of Designated Public Hospital (DPH) interim payments to their finalized hospital inpatient costs.

Authority:
SPA 05-21

Interdependent Policy Changes:
Not Applicable

Background:
As approved on April 25, 2006 through SPA 05-21, effective for dates of service on or after July 1, 2005, each DPH's fiscal year interim per diem rate, comprised of 100% federal funds, for inpatient hospital costs for Medi-Cal beneficiaries will be reconciled to its filed Medi-Cal cost report for the respective fiscal year. The reconciliations, interim and final, are based on the hospitals' Certified Public Expenditures (CPE).

This reconciliation process may result in an overpayment or underpayment to a DPH and will be handled as follows:

- For DPHs that have been determined to be overpaid, the Department will recoup any overpayments.
- For DPHs that have been determined to be underpaid, the Department will make a payment equal to the difference between the DPH's computed Medi-Cal cost, and a DPH's payments consisting of: share of cost, third party liability, other health coverage, Medicare, Medi-Cal administrative days, crossovers, and interim payments.

Final payment reconciliation will be completed when the Department has audited the hospitals' cost reports.

DPH INTERIM & FINAL RECONS

REGULAR POLICY CHANGE NUMBER: 124

Reason for Change:
The change in FY 2019-20, from the prior estimate, is due to:

- DY 2008-09 shifted from FY 2018-19 to FY 2019-20,
- DY 2009-10 increased, based on updated final reconciliation data,
- DY 2013-14 shifted to FY 2020-21, and
- DY 2014-15 shifted to a future year.

The change in FY 2020-21, from the prior estimate, is due to DY 2010-11 shifted to FY 2019-20, and DY 2013-14 shifted from FY 2019-20.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to the varying reconciliation estimates from the different reconciliation years.

Methodology:

1. DPH's final reconciliation for all years will be the difference between the Federal Medical Assistance Percentage (FMAP) rate of the audited costs and the respective payments.

2. The estimated final reconciliation payments and recoupments on a cash basis are:

(Dollars in Thousands)

FY 2019-20	TF	FF	ACA FF
2008-09 Final Reconciliation	$141,080	$141,080	$0
2009-10 Final Reconciliation	$46,851	$46,851	$0
2010-11 Final Reconciliation	$32,083	$32,083	$0
Total	**$220,014**	**$220,014**	**$0**

(Dollars in Thousands)

FY 2020-21	TF	FF	ACA FF
2011-12 Final Reconciliation	$86,302	$86,302	$0
2012-13 Final Reconciliation	$77,050	$77,050	$0
2013-14 Final Reconciliation	($3,654)	($12,463)	$8,809
Total	**$159,698**	**$150,889**	**$8,809**

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

PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE

REGULAR POLICY CHANGE NUMBER:	125
IMPLEMENTATION DATE:	1/2019
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	2098

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$15,190,000	$14,246,000
- STATE FUNDS	$7,313,780	$6,959,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	93.78 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	$944,800	$0
STATE FUNDS	$454,920	$0
FEDERAL FUNDS	$489,900	$0

DESCRIPTION

Purpose:
This policy change estimates the costs of a rate increase for Fee-for-Service (FFS) Pediatric Day Health Care (PDHC) facilities, effective July 1, 2018.

Authority:
SB 840 (Chapter 29, Statutes of 2018)
SB 856 (Chapter 30, Statutes of 2018)
SPA 18-0037

Interdependent Policy Changes:
Not Applicable

Background:
PDHC is an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service when rendered by a PDHC facility licensed by the Department. PDHC is a day program of less than 24 hours that is individualized and family-centered, with developmentally appropriate activities of play, learning, and social interaction, designed to optimize the individuals medical status and developmental functioning so that he or she can remain within the family.

The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), passed by the voters in November 2016, increases the excise tax rate on cigarettes and electronic cigarettes, effective April 1, 2017, and other tobacco products effective July 1, 2017. The excise tax increased by $2 from 87 cents to $2.87 per pack of 20 cigarettes on distributors selling cigarettes in California with an equivalent excise tax rate increase on other tobacco products.

Pursuant to SB 840 and SB 856, the Department developed the structure and parameters for a rate increase in 2018-19 for PDHC facilities. The Centers for Medicare and Medicaid Services (CMS) approved SPA 18-0037 on September 17, 2018, to increase PDHC rates, effective July 1, 2018.

This policy change identifies the use of the General Fund for these Proposition 56 payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE

REGULAR POLICY CHANGE NUMBER: 125

Reason for Change:
The change for FY 2019-20, from the prior estimate, is an increase due to a revised estimate of the additional Erroneous Payment Correction (EPC). There is no change for FY 2020-21, from the prior estimate.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to the expected completion of the EPC in FY 2019-20.

Methodology:
1. The Medi-Cal FFS reimbursement rate for PDHC services was $29.41 per hour.

2. The reimbursement rate for EPSDT PDHC support service rates was increased by 50 percent.

3. The PDHC rate increase implemented on December 28, 2018. An EPC for the retroactive period of July 2018 through December 2018 occurred in April 2019. An additional ECP for claims not captured in the original EPC is expected to occur in June 2020.

4. The Medi-Cal costs in this policy change are as follows:

FY 2019-20	TF	GF	Title XIX FF	Title XXI FF	ACA FF
Rate Increase	$14,246,000	$6,864,000	$6,689,000	$658,000	$35,000
EPC	$944,000	$450,000	$443,000	$48,000	$2,000
Total	**$15,190,000**	**$7,314,000**	**$7,133,000**	**$706,000**	**$37,000**

FY 2020-21	TF	GF	Title XIX FF	Title XXI FF	ACA FF
Rate Increase	**$14,246,000**	**$6,960,000**	**$6,690,000**	**$562,000**	**$34,000**

Funding:

FY 2019-20	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	$14,266,000	$7,133,000	$7,133,000
94% Title XIX / 6% GF (4260-101-0001 / 0890)	$3,000	$0	$2,000
93% Title XIX / 7% GF (4260-101-0001 / 0890)	$19,000	$1,000	$18,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	$19,000	$2,000	$17,000
88% Title XXI / 12% GF (4260-101-0001 / 4260-113-0890)	$262,000	$31,000	$231,000
76.5% Title XXI / 23.5% GF (4260-101-0001 / 4260-113-0890)	$621,000	$146,000	$475,000
Total	**$15,190,000**	**$7,313,000**	**$7,876,000**

PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE

REGULAR POLICY CHANGE NUMBER: 125

FY 2020-21	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	$13,380,000	$6,690,000	$6,690,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	$38,000	$4,000	$34,000
76.5% Title XXI / 23.5% GF (4260-101-0001 / 4260-113-0890)	$207,000	$49,000	$158,000
65% Title XXI / 35% GF (4260-101-0001 / 4260-113-0890)	$621,000	$217,000	$404,000
Total	**$14,246,000**	**$6,960,000**	**$7,286,000**

EMERGENCY MEDICAL AIR TRANSPORTATION ACT

REGULAR POLICY CHANGE NUMBER:	127
IMPLEMENTATION DATE:	11/2012
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1612

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$10,992,000	$10,000,000
- STATE FUNDS	$5,496,000	$5,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$10,992,000	$10,000,000
STATE FUNDS	$5,496,000	$5,000,000
FEDERAL FUNDS	$5,496,000	$5,000,000

DESCRIPTION

Purpose:
This policy change estimates the Fee-for-Service (FFS) augmentation payments and the offset of General Fund (GF) expenditures for Medi-Cal emergency medical air transportation service reimbursements.

Authority:
AB 2173 (Chapter 547, Statutes of 2010), Government Code 76000.10
AB 215 (Chapter 392, Statutes of 2011)
AB 1410 (Chapter 718, Statutes of 2017)
AB 651 (Chapter 537, Statutes of 2019)
SPA 18-0030
SPA 19-0012

Interdependent Policy Changes:
Not Applicable

Background:
AB 2173 imposed an additional penalty of $4 upon every conviction involving a vehicle violation, except certain parking offenses, effective January 1, 2011. The bill required county Treasurers to transfer the money collected each quarter, after payment of county administrative costs, to the State Controller's Emergency Medical Air Transportation Act (EMATA) Fund.

AB 215 eliminated the county's administrative costs by allowing the counties to remit their collections to the State under an existing process established in current law. The change in remittance procedures increased the frequency of county remission of funds from quarterly to monthly.

After payment of the Department's administrative costs, 20% of the appropriated funds is used to offset the State's portion of the Medi-Cal reimbursement rate for emergency medical air transportation services. The remaining 80% of the appropriated amount is matched with federal funds and used to provide augmentation payments for eligible Medi-Cal emergency medical air transportation services.

EMERGENCY MEDICAL AIR TRANSPORTATION ACT

REGULAR POLICY CHANGE NUMBER: 127

The augmentation payment amount is per transport and calculated annually; therefore, a State Plan Amendment (SPA) is required annually. On October 23, 2018, SPA 18-0030 was approved for FY 2018-19. On August 23, 2019, SPA 19-0012 was approved for FY 2019-20. The Department will submit SPA 20-0011 for the FY 2020-21 augmentation payments by September 2020.

AB 1410 renamed the EMATA Fund to the Emergency Medical Air Transportation and Children's Coverage (EMATCC) Fund, effective January 1, 2018. AB 1410 extends the $4 penalty for vehicle code violations until January 1, 2020, extends supplemental payments to June 30, 2021, and extends the EMATA sunset date to January 1, 2022.

AB 651 extends the assessment of the $4 penalty for vehicle code violations until July 1, 2020, extends supplemental payments until December 31, 2021, and extends the EMATA sunset date to July 1, 2022.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is an increase due to FY 2018-19 actual augmentation payments paid in October 2019 being higher than previously assumed. Additionally, there is an increase in the expected FY 2019-20 GF transfers based on revised estimates.

The change in FY 2020-21, from the prior estimate, is an increase due to revised augmentation payments and total GF transfer amounts based on updated estimates of the penalty revenues assessments.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease due to lower augmentation payments and GF transfer amounts expected in FY 2020-21.

Methodology:
1. Implementation date began November 2012.

2. Assume revenue collections for the penalty assessments that end July 1, 2020, will continue to be collected through June 2021.

3. The FY 2019-20 estimated payments include:
    - FFS augmentation payments for the second half of FY 2018-19, and the first half of FY 2019-20,
    - GF transfer from the second half of FY 2018-19 collections was $994,000, and
    - GF transfer from the first half of FY 2019-20 collections is expected to be $809,000.

4. The FY 2020-21 estimated payments include:
    - FFS augmentation payments for the second half of FY 2019-20, and the first half of FY 2020-21,
    - GF transfer from the second half of FY 2019-20 collections is expected to be $809,000, and
    - GF transfer from the first half of FY 2020-21 collections is expected to be $817,000.

EMERGENCY MEDICAL AIR TRANSPORTATION ACT

REGULAR POLICY CHANGE NUMBER: 127

5. Based on estimated fee collections, the estimated payments on a cash basis are:

(Dollars in Thousands)

FY 2019-20	TF	GF	EMATCC	FFP
GF Offset	$0	($1,803)	$1,803	$0
Augment Payment	$10,992	$0	$5,496	$5,496
Total	**$10,992**	**($1,803)**	**$7,299**	**$5,496**

(Dollars in Thousands)

FY 2020-21	TF	GF	EMATCC	FFP
GF Offset	$0	($1,626)	$1,626	$0
Augment Payment	$10,000	$0	$5,000	$5,000
Total	**$10,000**	**($1,626)**	**$6,626**	**$5,000**

Funding:
100% GF (4260-101-0001)
Title XIX FFP (4260-101-0890)
EMATA / EMATCC Fund (4260-101-3168)

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER:	128
IMPLEMENTATION DATE:	10/2006
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	96

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$3,757,000	$8,212,000
- STATE FUNDS	$1,878,500	$4,106,000
PAYMENT LAG	0.7958	0.9003
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,989,800	$7,393,300
STATE FUNDS	$1,494,910	$3,696,630
FEDERAL FUNDS	$1,494,910	$3,696,630

DESCRIPTION

Purpose:
This policy change estimates the annual rate increase for hospice services and hospice room and board rates.

Authority:
Sections 1902(a)(13) and 1814(i)(1)(C)(ii) of the Social Security Act
42 Code of Federal Regulations (CFR) Part 418 – CMS Final Rule

Interdependent Policy Changes:
Funding Adjust.—ACA Opt. Expansion
Funding Adjust.—OTLICP

Background:

1. **Hospice Services**
   Medi-Cal hospice service rates are established in accordance with Section 1902(a)(13), (42 USC 1396 a(a)(13)) of the federal Social Security Act. This act requires annual rate increases for hospice care services based on corresponding Medicare rates effective October 1st of each year.

   Effective January 1, 2016, the CMS final hospice rule changed the payment methodology for RHC rates to implement two rates that will result in a higher base payment for the first 60 days of hospice care and a reduced payment rate for days thereafter. Additionally, the CMS final hospice rule established a Service Intensity Add-On (SIA) payment for services provided by a registered nurse or social worker during the last seven days of a beneficiary's life for a maximum of four hours a day.

2. **Hospice Room and Board**
   The Department reimburses each hospice facility's room and board rate at 95% of the individual facility's per diem rates for Nursing Facility – Level B (NF-B), which include Distinct Part (DP) or Freestanding; Nursing Facility – Level A (NF-A); Intermediate Care Facility – Developmentally Disabled (ICF/DD), Intermediate Care Facility for the Developmentally Disabled – Nursing (ICF/DD-N), and Intermediate Care Facility for the Developmentally Disabled – Habilitative (ICF/DD-H). This

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 128

policy change assumes hospice room and board rates were increased with the adoption of AB 1629 (Chapter 875, Statutes of 2004) and its related State Plan Amendments. Annual increases are effective August 1st of each year.

Pursuant to AB 97 (Chapter 3, Statutes of 2011) rate freezes and payment reductions were implemented for NF-As and DP/NF-Bs, and Freestanding Pediatric Subacute rates, effective June 1, 2011. Subsequently, SB 239 (Chapter 657, Statutes of 2013) required the Department to remove the DP/NF-B providers from the rate freeze and payment reductions on a prospective basis.

ICF/DD, ICF/DD-H, and ICF/DD-N facilities—Effective August 1, 2016, ABX2 1 (Chapter 3, Statutes of 2016) requires the Department to restore the AB 97 payment reduction and reimburse ICF/DDs at the 2008-09 rate levels, increased by 3.7%.

Reason for Change:

The change for 2019-20, from the prior estimate, is a net decrease due to:

- Revised projected expenditures based on actual RY 2019 Hospice rates, and
- One less month of the prospective RY 2019-20 Hospice rates due to delayed implementation from January 2020 to February 2020.

The change for 2020-21, from the prior estimate, is a decrease due to revised projected expenditures based on actual RY 2019 Hospice rates.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to:

- A full year of RY 2019-20 hospice services rates occurring in FY 2020-21,
- Including the RY 2020-21 hospice services rates in FY 2020-21, and
- More retroactive hospice services payments occurring in FY 2020-21 than in FY 2019-20.

Methodology:

1. Hospice Services:
   a. The estimated weighted increase for hospice service rates, excluding RHC and SIA, is 6.67% for RY 2019-20 and 6.69% for RY 2020-21.

   b. RY 2018-19 hospice services rates were implemented on December 24, 2018. The EPC for the retroactive period of October 1, 2018, through December 23, 2018, occurred in June 2019.

   c. The RY 2019-20 hospice rates are expected to be implemented in February 2020. The retroactive payment for the period of October 2019 through January 2020 is expected to be implemented in June 2020.

   d. The RY 2020-21 hospice rates are expected to be implemented in January 2021. The retroactive payment for the period of October 2020 through December 2020 is expected to be implemented in June 2021.

   e. The new RHC tiered rates and SIA, effective January 1, 2016, were implemented on April 23, 2018. Retroactive claims for the period of January 2016 through April 2018 require providers to resubmit claims for payments. Payments for the retroactive period will continue to be paid in FY 2019-20 until all claims are reprocessed.

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 128

2. Hospice room and board rates will continue at 95% of the facility's rates, whether frozen or unfrozen. The weighted increase for hospice room and board rates for RY 2019-20 and RY 2020-21 is estimated to be 4.30%.

3. The estimated managed care rate adjustment impact for RY 2019-20 and RY 2020-21 is included in the FY 2019-20 and FY 2020-21 managed care capitation rates, respectively.

4. The estimated payments on a cash basis are:

Cash Basis	FY 2019-20	FY 2020-21
Hospice Services (19-20)	$152,000	$364,000
RHC & SIA Payments (19-20)	$36,000	$88,000
Room & Board (19-20)	$3,456,000	$3,770,000
Hospice Services (19-20) retro	$22,000	
RHC & SIA Payments (19-20) retro	$91,000	
Hospice Services (20-21)		$185,000
RHC & SIA Payments (20-21)		$47,000
Room & Board (20-21)		$3,604,000
Hospice Services Retro (20-21) retro		$123,000
RHC & SIA Payments (20-21) retro		$31,000
TOTAL	**$3,757,000**	**$8,212,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in the Funding Adjust.—ACA Opt. Expansion policy change
OTLICP funding identified in the Funding Adjust.—OTLICP policy change

DPH INTERIM RATE

REGULAR POLICY CHANGE NUMBER:	129
IMPLEMENTATION DATE:	7/2005
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1161

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$362,258,460	-$401,766,100
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$362,258,460	-$401,766,100
FEDERAL FUNDS	$362,258,460	$401,766,100

DESCRIPTION

Purpose:
This policy change estimates the technical adjustment in funding to reimburse Designated Public Hospitals (DPHs) at 100% federal financial participation (FFP).

Authority:
SPA 05-21

Interdependent Policy Changes:
DPH Interim Rate Growth

Background:
As approved on April 25, 2006 through SPA 05-21, effective July 1, 2005, DPHs receive interim per diem rates based on estimated costs using the hospitals' two years prior Medi-Cal costs trended forward. These interim payments are 100% federal funds based on the hospitals' certified public expenditures (CPEs), resulting in 50% FFP and 50% CPE.

The Medi-Cal Estimate FFS base expenditures are calculated at 50% FFP and 50% GF. Since the DPH interim rate receives a 100% FFP, an adjustment to shift from 50% GF to 100% FFP is made.

In addition, the Medi-Cal Estimate makes funding adjustments to inpatient services for the applicable Federal Medical Assistance Percentage (FMAP) for the Affordable Care Act (ACA) optional population. As a result, this policy change will also make adjustments for the ACA optional population to shift from 5% GF / 95% FFP to 100% FFP beginning January 2017 through December 2017, 6% GF / 94% FFP to 100% FFP beginning January 2018 through December 2018, 7% GF / 93% FFP to 100% FFP beginning January 2019, and 10% GF / 90% FFP to 100% FFP beginning January 2020.

DPH INTERIM RATE

REGULAR POLICY CHANGE NUMBER: 129

Reason for Change:
The change in FY 2019-20, from the prior estimate, is due to updated DPH actual data through January 2020.

The change in FY 2020-21, from the prior estimate, is due to decreased estimated users based on updated DPH actual data through January 2020.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to the increased growth rate for community-based DPHs by 0.81%, and a decreased growth rate by 0.41% for county DPHs in FY 2020-21 based on updated DPH actual data through January 2020.

Methodology:
1. The funding adjustment is estimated at:

(Dollars in Thousands)

	Expenditures	GF to FF Shift
FY 2019-20	**$1,180,631**	**$362,258**
FY 2020-21	**$1,284,973**	**$401,766**

Funding:
(Dollars in Thousands)

FY 2019-20	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890 / 0001)	($631,096)	($315,548)	($315,548)
100% Title XIX FF (4260-101-0890)	$1,180,631	$0	$1,180,631
93% Title XIX ACA / 7% GF (4260-101-0890 / 0001)	($274,767)	($19,233)	($255,534)
90% Title XIX ACA / 10% GF (4260-101-0890 / 0001)	($274,768)	($27,477)	($247,291)
Total Funds	**$0**	**($362,258)**	**$362,258**

FY 2020-21	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890 / 0001)	($683,172)	($341,586)	($341,586)
100% Title XIX FF (4260-101-0890)	$1,284,973	$0	$1,284,973
90% Title XIX ACA / 10% GF (4260-101-0890 / 0001)	($601,801)	($60,180)	($541,621)
Total Funds	**$0**	**($401,766)**	**$401,766**

*Totals may differ due to rounding.

LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES

REGULAR POLICY CHANGE NUMBER:	130
IMPLEMENTATION DATE:	8/2013
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1784

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change budgets the funding adjustment from the Long Term Care Quality Assurance Fund (LTCQAF) to the State General Fund (GF) to partially offset GF costs associated with providing Long Term Care Services.

Authority:
AB 1467 (Chapter 23, Statutes of 2012)
AB 119 (Chapter 17, Statutes of 2015)
SB 833 (Chapter 30, Statutes of 2016)

Interdependent Policy Changes:
Not Applicable

Background:
AB 1762 (Chapter 230, Statutes of 2003) imposed a Quality Assurance (QA) fee for certain Long Term Care (LTC) provider types. AB 1629 (Chapter 875, Statutes of 2004) and ABX1 19 (Chapter 4, Statutes of 2011) imposed a QA fee, in conjunction with a facility specific reimbursement program, for additional LTC providers. The revenue generated from the fee is used to draw down a federal match to partially offset LTC rate reimbursement. The following LTC providers are subject to a QA fee:

- Freestanding Nursing Facilities Level-B (FS/NF-Bs)
- Freestanding Subacute Nursing Facilities level-B (FSSA/NF-Bs)
- Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs)
- Freestanding Pediatric Subacute Care Facilities (FS-PSAs)

AB 1467 established the LTCQAF. Effective August 1, 2013, the QA fees collected by LTC and ICF-DD facilities are deposited into the fund, rather than the state GF, which are used for LTC provider reimbursement rate expenditures.

AB 119 extends the AB 1629 facility-specific rate methodology, QAF, and Quality and Accountability Supplemental Payments (QASP) Program through July 31, 2020.

LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES

REGULAR POLICY CHANGE NUMBER: 130

SB 833 established a continuous appropriation for the LTCQAF, to allow moneys from the fund to be appropriated without further legislative action.

A withhold process was developed to collect past due AB 1629 QAF assessed on specified Skilled Nursing Facilities. The withheld portion is transferred to the LTCQAF, and subsequently to the GF. The withheld QAF payments are budgeted in the QAF Withhold Transfer policy change.

Reason for Change:
The change for FY 2019-20 and FY 2020-21, from the prior estimate, is a decrease in GF transfers based on updated collections and transfer data through April 2020.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is a net increase in the GF transfers due to less prior year GF transfers expected in FY 2020-21, more current year GF transfers expected in FY 2020-21, and less QAF withhold transfers expected to occur in FY 2020-21.

Methodology:
1. Based on collections and transfer data through December 2019, assume $508.69 million will be transferred to the GF in FY 2019-20, and $623.98 million in FY 2020-21.

2. The estimated withhold transfers for the AB 1629 QAF and QAF assessed on ICF-DDs are expected to occur is $6.77 million in FY 2019-20 and $136.00 million in FY 2020-21.

3. The estimated fund adjustment from the LTCQAF to the GF is:

(Dollars in Thousands)

FY 2019-20	TF	GF	LTCQAF
FY 2018-19	$0	($155,566)	$155,566
FY 2019-20	$0	($346,354)	$346,354
SubTotal	$0	($501,920)	$501,920
Withhold Transfers	$0	($6,773)	$6,773
Total	**$0**	**($508,693)**	**$508,693**

(Dollars in Thousands)

FY 2020-21	TF	GF	LTCQAF
FY 2019-20	$0	($112,612)	$112,612
FY 2020-21	$0	($375,372)	$375,372
SubTotal	$0	($487,984)	$487,984
Withhold Transfers	$0	($136,000)	$136,000
Total	**$0**	**($623,984)**	**$623,984**

Funding:
Long Term Care Quality Assurance Fund (4260-601-3213)
100% GF (4260-101-0001)

AB 97-RELATED ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	131
IMPLEMENTATION DATE:	3/2020
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	2172

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$40,508,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$40,508,000	$0
FEDERAL FUNDS	-$40,508,000	$0

DESCRIPTION

Purpose:
This policy change estimates the repayment of over-claimed federal financial participation (FFP) for AB 97-related supplemental payments.

Authority:
AB 97 (Chapter 3, Statutes of 2011)
SPA 17-006

Interdependent Policy Changes:
Not Applicable

Background:
The Centers for Medicare and Medicaid Services (CMS) approved SPA 17-006, authorizing a one-time supplemental payment to providers subject to AB 97 payment reductions.

Pursuant to SPA 17-006, providers shall be eligible for the one-time supplemental payment if they are (1) enrolled in Medi-Cal and submitted a FFS claim during the Eligibility Period and (2) enrolled in Medi-Cal and submitted a FFS claim during the supplemental payment period (January 2017 – June 2017). The following services and respective Eligibility Periods are:

- Physicians services for ages 21 and up (6/1/11 to 1/8/14),
- Clinic services for ages 21 and up (6/1/11 to 1/8/14),
- Medical transportation (6/1/11 to 9/4/13),
- Intermediate Care Facilities for the Developmental Disabled (ICF/DD) (8/1/12 to 5/26/14),
- Non-exempt pharmacy services (6/1/11 to 3/30/12), and
- Dental services (6/1/11 to 9/4/13).

Some providers did not meet the requirements for the supplemental payment received. The Department is required to repay CMS for the federal funds paid to providers that were ineligible for the one-time supplemental payment.

AB 97-RELATED ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 131

Reason for Change:
The change in FY 2019-20, from the prior estimate, is due to an updated estimate for the Medical Transportation service category based on revised federal funding adjustments.

There is no change from the prior estimate for FY 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to expecting the adjustment to occur in FY 2019-20.

Methodology:

1. Assume the adjustment will occur in FY 2019-20.

Service Category	TF	GF	FF
Physicians	$0	$19,036,000	($19,036,000)
Medical Transportation	$0	$4,891,000	($4,891,000)
Clinics	$0	$3,685,000	($3,685,000)
ICF/DD	$0	$489,000	($489,000)
Pharmacy	$0	$12,407,000	($12,407,000)
Total	$0	**$40,508,000**	**($40,508,000)**

Funding:
100% GF (4260-101-0001)
100% Title XIX (4260-101-0890)

DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	132
IMPLEMENTATION DATE:	4/2020
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	2161

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$356,000	-$2,564,000
- STATE FUNDS	-$163,780	-$1,180,490
PAYMENT LAG	0.9840	0.9230
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$350,300	-$2,366,600
STATE FUNDS	-$161,160	-$1,089,590
FEDERAL FUNDS	-$189,140	-$1,276,980

DESCRIPTION

Purpose:
This policy change estimates the costs to adjust Medi-Cal Fee-for-Service (FFS) Durable Medical Equipment (DME) reimbursement rates.

Authority:
Welfare and Institutions Code 14105.48

Interdependent Policy Changes:
Not Applicable

Background:
Pursuant to W&I Code 14105.48, the Department is required to set Medi-Cal FFS DME reimbursement rates at no more than 80% of the corresponding Medicare rural rate, except for wheelchairs, wheelchair accessories, and speech-generating devices and related accessories, which shall be reimbursed at no more than 100% of Medicare's rural rate.

The Centers for Medicare and Medicaid Services (CMS) approved SPA 19-0005 to adjust Medi-Cal FFS DME reimbursement rates based on Medicare rural rates, effective January 1, 2019. On March 26, 2020, the Department submitted SPA 20-0005 to seek federal approval to adjust Medi-Cal FFS DME reimbursement rates based on Medicare rural rates, effective January 1, 2020.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is a net decrease in savings due to:

- A decrease in the 2019 prospective rate adjustment based on a revised annual estimate;
- Less months of prospective savings due to a delay in implementation of the 2019 rate adjustment from January 2020 to April 2020; and
- A shift in the 2019 retroactive recoupment implementation from April 2020 to September 2020.

DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 132

The change in FY 2020-21, from the prior estimate, is a net decrease in savings due to:

- A decrease in the 2020 prospective rate adjustment based on a revised annual estimate;
- An increase in the retroactive recoupment months based on the shift of the 2019 retroactive recoupment from FY 2019-20 to FY 2020-21; and
- An increase in the 2019 retroactive recoupment amount resulting from the delayed rate implementation.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase in savings due to:

- A full year of the prospective savings rate adjustment in FY 2020-21; and
- More months of retroactive recoupments occurring in FY 2020-21.

Methodology:

1. This policy is effective January 1, 2019, through December 31, 2021.

2. System implementation for the January 2019 updated rates is expected in April 2020. The FFS annual savings is estimated to be $1.425 million. A retroactive recoupment for the period of January 2019 through March 2020 is expected to occur over 12 months beginning in September 2020.

3. System implementation for the January 2020 updated rates is expected in October 2020. The FFS annual savings is estimated to be $1.338 million. A retroactive recoupment for the period of January 2020 through September 2020 is expected to occur over 12 months beginning in January 2021.

4. The FFS savings are estimated to be:

Cash Basis	TF	GF	FF
FY 2019-20	**($356,000)**	**($164,000)**	**($192,000)**
FY 2020-21	**($2,564,000)**	**($1,180,000)**	**($1,384,000)**

Funding:

FY 2019-20	TF	GF	FFP
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	($310,000)	($155,000)	($155,000)
90%Title XIX FF / 10% GF (4260-101-0001 / 0890)	($15,000)	($2,000)	($13,000)
76.5% Title XXI FF / 23.5% GF (4260-113-0001 / 0890)	($31,000)	($7,000)	($24,000)
Total	**($356,000)**	**($164,000)**	**($192,000)**

DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 132

FY 2020-21	TF	GF	FFP
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	($2,234,000)	($1,117,000)	($1,117,000)
93%Title XIX FF / 7% GF (4260-101-0001 / 0890)	($44,000)	($3,000)	($41,000)
90%Title XIX FF / 10% GF (4260-101-0001 / 0890)	($64,000)	($6,000)	($58,000)
88% Title XXI FF / 12% GF (4260-113-0001 /0890)	($71,000)	($8,000)	($62,000)
76.5% Title XXI FF / 23.5% GF (4260-113-0001 /0890)	($64,000)	($16,000)	($49,000)
65% Title XXI FF / 35% GF (4260-113-0001 / 0890)	($87,000)	($30,000)	($57,000)
Total	**($2,564,000)**	**($1,180,000)**	**($1,384,000)**

LABORATORY RATE METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER:	133
IMPLEMENTATION DATE:	2/2016
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1703

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$8,696,000	-$22,124,000
- STATE FUNDS	-$4,348,000	-$11,062,000
PAYMENT LAG	0.9853	0.8825
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$8,568,200	-$19,524,400
STATE FUNDS	-$4,284,080	-$9,762,220
FEDERAL FUNDS	-$4,284,080	-$9,762,220

DESCRIPTION

Purpose:
This policy change estimates savings from clinical laboratories or laboratory services expenditures resulting from a 10% payment reduction for a retroactive period, savings from a weighted reimbursement methodology conducted every three years, and savings from an annual rate adjustment to reduce Fee-for-Service Medi-Cal rates to no more than 80% of corresponding Medicare rates.

Authority:
AB 1467 (Chapter 23, Statutes of 2012)
AB 1494 (Chapter 28, Statutes of 2012)
AB 1124 (Chapter 8, Statutes of 2014)
AB 659 (Chapter 346, Statutes of 2017)
Welfare and Institutions (W&I) Code 14105.22
SPA 15-015

Interdependent Policy Changes:
Funding Adjust.—ACA Opt. Expansion
Funding Adjust.—OTLICP

Background:
AB 1494 required the Department to develop a new rate methodology for clinical laboratories or laboratory services, as part of the overall reimbursement methodology. In addition to 10% payment reductions pursuant to AB 97 (Chapter 3, Statutes of 2011), AB 1494 allowed for payments to be reduced by 10% for clinical laboratories or laboratory services for dates of service on and after July 1, 2012, through June 30, 2015. The Family Planning, Access, Care, and Treatment Program (FPACT) and outpatient hospital services were exempt from the 10% provider payment reductions per AB 1494.

Effective July 1, 2015, the new reimbursement methodology is applicable to certain clinical laboratory or laboratory service codes, which may include FPACT and outpatient hospital services. AB 659 changed the frequency of data collection and rate development from once a year to once every three years, with the new rates being effective July 1, 2020.

LABORATORY RATE METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER: 133

Annual Rate Adjustment to 80% Medicare

The Centers for Medicare & Medicaid Services (CMS) approved SPA 19-0011 to adjust the reimbursement rates in accordance with W&I Code 14105.22, effective April 1, 2019, which provides that reimbursement for clinical laboratory or laboratory services may not exceed 80% of the lowest maximum allowance established by the federal Medicare program for the same or similar services.

The Department submitted SPA 20-0003 on March 30, 2020, to seek federal approval to adjust clinical laboratory or laboratory services reimbursement rates exceeding 80% of the corresponding Medicare rates, effective January 1, 2020.

Triennial Rate Adjustment

Every three years, rates for certain services will be adjusted using a weighted reimbursement methodology that is based on an average of the lowest prices other third-party payers are paying for similar services.

The Department will submit SPA 20-0010 to seek federal approval to adjust clinical laboratory or laboratory services reimbursement rates based on the triennial reimbursement methodology, effective July 1, 2020. AB 1494 requires that the Department requests input from beneficiaries, providers, and other interested stakeholders concerning the proposed SPA 20-0010.

Reason for Change:

The change for FY 2019-20, from the prior estimate, is a net increase in savings due to:

- A shift in implementation of the 2019 annual rate adjustment from December 2019 to April 2019, resulting in less savings in FY 2019-20;
- Increased recoupment amounts expected for the AB 1494 and July 2015 triennial rate adjustments based on updated actual recoupment data;
- A shift in the implementation of the 2019 rate adjustment recoupment from March 2020 to August 2020, resulting in less retro recoupment months in FY 2019-20.

The change for FY 2020-21, from the prior estimate, is a net increase in savings due to:

- Revised estimate of the 2020 annual rate adjustment, resulting in increased annual savings and the retro recoupment amount;
- Increased recoupment amounts expected for the AB 1494 and July 2015 triennial rate adjustments based on updated actual recoupment data;
- More months of the 2019 rate adjustment retro recoupment based on the shift in rate implementation.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase in savings due to a full year of prospective savings and more months of recoupments occuring in FY 2020-21.

Methodology:

1. Assume savings will begin upon California Medicaid Management Information System (CA-MMIS) system implementation.

2. The AB 97 10% payment reduction will be assessed after the AB 1494 10% payment reduction and new laboratory rate methodology reduction.

3. The retroactive AB 1494 10% savings from July 1, 2012 to June 30, 2015, was implemented in May 2018 and is expected to continue throughout FY 2019-20 and FY 2020-21.

LABORATORY RATE METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER: 133

4. **Annual rate adjustment:** The annual Medi-Cal rate adjustments will apply to clinical laboratory or laboratory services reimbursement rates exceeding 80% of corresponding Medicare rates.
   a. The savings for the 2019 rate adjustment is estimated to be $1,343,000 TF and is expected to be implemented in April 2020. The retroactive recoupment from January 2019 through March 2020 is expected to be implemented in August 2020.

   b. The savings for the 2020 rate adjustment is estimated to be $9,679,000 TF and is expected to be implemented in September 2020. The retroactive recoupment from January 2020 through August 2020 is expected to be implemented in January 2021.

5. **Triennial rate adjustment:** The Centers for Medicare and Medicaid Services (CMS) approved the new laboratory rate methodology in July 2015.
   a. The 2015-16 rate year change was implemented in February 2016. The recoupment of retroactive savings from July 2015 through January 2016 is expected to continue throughout FY 2019-20 and FY 2020-21.

   b. The savings resulting from the July 2020 rate adjustment is estimated to be $600,000 TF and is expected to be implemented November 2020. The retroactive recoupment from July 2020 through October 2020 is expected to be implemented in March 2021.

6. The expected savings in FY 2019-20 and FY 2020-21 are as follows:

FY 2019-20	**TF**	**GF**	**FF**
Prospective Savings			
2019 Annual Rate Adjustment	($336,000)	($168,000)	($168,000)
Retroactive Recoupments			
AB 1494	($1,346,000)	($673,000)	($673,000)
2015 New Rate Methodology	($7,014,000)	($3,507,000)	($3,507,000)
Total savings	**($8,696,000)**	**($4,348,000)**	**($4,348,000)**

FY 2020-21	**TF**	**GF**	**FF**
Prospective Savings			
2020 New Rate Methodology	($400,000)	($200,000)	($200,000)
2019 Annual Rate Adjustment	($1,344,000)	($672,000)	($672,000)
2020 Annual Rate Adjustment	($8,066,000)	($4,033,000)	($4,033,000)
Retroactive Recoupments			
AB 1494	($2,834,000)	($1,417,000)	($1,417,000)
2015 New Rate Methodology	($4,822,000)	($2,411,000)	($2,411,000)
2020 New Rate Methodology	($200,000)	($100,000)	($100,000)
80% Medicare Rate Adjustment	($1,232,000)	($616,000)	($616,000)
80% Medicare Rate Adjustment	($3,226,000)	($1,613,000)	($1,613,000)
Total savings	**($22,124,000)**	**($11,062,000)**	**($11,062,000)**

LABORATORY RATE METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER: 133

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in the Funding Adjust.—ACA Opt. Expansion policy change
OTLICP funding identified in the Funding Adjust.—OTLICP policy change

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER:	134
IMPLEMENTATION DATE:	12/2011
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1580

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$171,841,000	-$171,841,000
- STATE FUNDS	-$85,920,500	-$85,920,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	91.89 %	91.89 %
APPLIED TO BASE		
TOTAL FUNDS	-$13,936,300	-$13,936,300
STATE FUNDS	-$6,968,150	-$6,968,150
FEDERAL FUNDS	-$6,968,150	-$6,968,150

DESCRIPTION

Purpose:
This policy change estimates savings due to the implementation of the provider payment reduction pursuant to AB 97 (Chapter 3, Statutes of 2011).

Authority:
AB 1183 (Chapter 758, Statutes of 2008)
AB 97 (Chapter 3, Statutes of 2011)
SB 75 (Chapter 18, Statutes of 2015)

Interdependent Policy Changes:
Funding Adjust.—OTLICP

Background:
AB 97 requires the Department to implement up to a 10% provider payment reduction, which will affect all services except:

- Hospital inpatient and outpatient services, critical access hospitals, federal rural referral centers,
- Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs),
- Services provided through the Breast and Cervical Cancer Treatment and Family Planning, Access, Care and Treatment (Family PACT) programs,
- Hospice services,
- Payments to facilities owned or operated by the State Department of State Hospitals or the State Department of Developmental Services, and
- Payments funded by certified public expenditures and intergovernmental transfers.

Effective March 1, 2009, as required by AB 1183, Pharmacy and Long-Term Care (LTC) provider payments were reduced by 5%. Other fee-for-service (FFS) provider payments were reduced by 1%. Managed care provider payments were reduced by an actuarially equivalent amount. Subsequent court actions enjoined the Department from continuing to implement the payment reductions to specified providers. A court decision vacated the preliminary injunctions clearing the way for the Department to implement the payment reductions.
The actuarial equivalent of FFS payment reductions to specified managed care providers was

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 134

scheduled to be implemented on July 1, 2011; however, because of the delay in implementation, the rates for retroactive periods cannot be certified as actuarially sound. The impact of AB 97 for managed care will be determined on a prospective basis.

Reason for Change:
There is no change for FY 2019-20 and FY 2020-21, from the prior estimate. There is no change from FY 2019-20 to FY 2020-21, in the current estimate.

Methodology:

1. **Managed Care:** There are no retroactive savings for managed care payments recouped and the implementation of the managed care reductions began October 1, 2013. The impact of AB 97 for managed care is budgeted in the managed care related policy changes and will take place on a prospective basis. The following services are not subject to a reduction:
   - Pharmacy, and
   - Specialty physician services.

2. **FFS**: The Department implements the FFS payment reductions in three phases.

   - **Phase I**: Phase I includes all subject providers except for the previously enjoined providers and the Child Health and Disability Prevention (CHDP) program.
     - PDHC program was first exempted on October 25, 2012, from the 10% payment reduction, effective April 1, 2012. PDHC providers were refunded in July 2013 for the payment reduction for services provided after April 1, 2012. In October 2014, PDHC providers were exempted further for the period of June 1, 2011 to March 31, 2012 and refunded any payment reductions applied for this period.
     - The Department received CMS approval on August 28, 2013 to exempt audiology services provided by Type C Communication Disorder Center that are located in the California counties of Alameda, San Benito, Santa Clara, Santa Cruz, San Francisco, and Sonoma from the 10% payment reduction, effective October 19, 2012. The Department stopped the 10% payment reduction in November 2013 and refunded the payment reduction for the period October 19, 2012 through October 31, 2013 in September 2014.
     - Residential Care Facilities for the Elderly and Care Coordinator Agencies are not subject to the 10% payment reduction. The Department stopped the 10% payment reduction in August 2013 and refunded the payment reduction for the period June 1, 2011 through August 31, 2013 in May 2014.
     - Genetic disease screening program, administered by California Department of Public Health, is not subject to the 10% payment reduction. The Department stopped the 10% payment reduction in December 2013 and refunded the payment reduction for the period June 1, 2011 through November 30, 2013 in August 2014.

   - **Phase II**: Phase II includes all the previously enjoined providers.
     - DME/Medical Supplies payment reduction recoupment for dates of service from June 1, 2011 to October 24, 2013.
     - Nonprofit dental pediatric surgery centers that provide at least 99% of their services under general anesthesia to children with severe dental disease under age of 21 are exempt from the 10% payment reduction effective August 31, 2013.
     - For-profit dental pediatric surgery centers that provide services to at least 95% of their Medi-Cal beneficiaries under the age of 21 are exempt from the 10% payment reduction effective December 1, 2013.

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 134

- Certain prescription drugs (or categories of drugs) that are generally high-cost drugs used to treat extremely serious conditions are exempt from the 10% payment reduction effective March 31, 2012.
- The 10% payment reduction for dental providers was implemented September 2013. Effective July 1, 2015, SB 75 (Chapter 18, Statutes of 2015) exempts dental providers from the 10% payment reductions.
- Per Welfare and Institutions (W&I) Code, Section 14105.45(i), FFS prospective pharmacy provider reductions for drug products with dates of services on and after April 1, 2017 were discontinued as a result of the Department moving to an actual acquisition cost (AAC) and dispensing fee reimbursement methodology. Non-drug pharmacy products, not exempt from AB 97, will continue to be reduced by 10%.

- **Phase III**: Phase III includes the CHDP program providers.

3. The Department forgoes the retroactive recoupments prior to the corresponding implementation date for the following providers: Physicians, medical transportation, dental, clinics, certain high-cost drugs, and CHDP.

Provider Type	Payment Reduction Effective Date	Payment Reduction Implementation Date	Total Months of Retroactive Period	Recoupment Start Date	Total Months to Recoup
Phase I	6/1/2011	12/20/2011	7	6/29/2012	24
Phase II					
Physicians	1/10/2014	1/10/2014	N/A	N/A	N/A
Medical Transportation	9/5/2013	9/5/2013	N/A	N/A	N/A
DME/Medical Supplies	6/1/2011	10/24/2013	29	9/1/2017	63
Clinics	1/10/2014	1/10/2014	N/A	N/A	N/A
Pharmacy	6/1/2011	2/7/2014	32	3/1/2016	64
Phase III (CHDP)	10/1/2014	10/1/2014	N/A	N/A	N/A

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 134

4. The estimated savings (TF) from AB 97 payment reduction are:
(Dollars in Thousands)

Provider Type		FY 2019-20	FY 2020-21	Annual
Phase I	FFS	($46,823)	($46,823)	($46,823)
	FFS Retro	$0	$0	$0
	Phase I Total	($46,823)	($46,823)	($46,823)
Phase II				
Physicians	FFS	($49,746)	($49,746)	($49,746)
	FFS Retro	$0	$0	$0
Medical Transportation	FFS	($14,461)	($14,461)	($14,461)
	FFS Retro	$0	$0	$0
DME/Medical Supplies	FFS	($17,394)	($17,394)	($17,394)
	FFS Retro	($7,510)	($7,510)	($7,510)
Dental	FFS	$0	$0	$0
	FFS Retro	$0	$0	$0
Clinics	FFS	($18,512)	($18,512)	($18,512)
	FFS Retro	$0	$0	$0
Pharmacy	FFS	($8,551)	($8,551)	($8,551)
	FFS Retro	($6,430)	($6,430)	($6,430)
	FFS	($108,664)	($108,664)	($108,664)
	FFS Retro	($13,940)	($13,940)	($13,940)
	Phase II Total	($122,604)	($122,604)	($122,604)
Phase III (CHDP)	FFS	($2,414)	($2,414)	($2,414)
	FFS Retro	$0	$0	$0
	Phase III Total	($2,414)	($2,414)	($2,414)
	FFS	($157,901)	($157,901)	($157,901)
	FFS Retro	($13,940)	($13,940)	($13,940)
	Managed Care	$0	$0	$0
Grand Total	**Grand Total**	**($171,841)**	**($171,841)**	($171,841)

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
OTLICP funding identified in the Funding Adjust.—OTLICP policy change

DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER:	135
IMPLEMENTATION DATE:	7/2019
ANALYST:	Matt Wong
FISCAL REFERENCE NUMBER:	1185

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$11,368,000	$0
- STATE FUNDS	-$4,335,140	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$11,368,000	$0
STATE FUNDS	-$4,335,140	$0
FEDERAL FUNDS	-$7,032,860	$0

DESCRIPTION

Purpose:
This policy change budgets the retroactive adjustments to scheduled Dental Managed Care (DMC) rates in prior years.

Authority:
Welfare & Institutions Code 14301(a)

Interdependent Policy Changes:
Not Applicable

Background:
The W&I code authorizes the Department to determine the annual rate of payment for services provided for Medi-Cal beneficiaries enrolled in the Medi-Cal dental services program to implement the new annual rates through an amendment or change order to the contract.

In the event there is any delay in a determination of rate changes, the amendment or change order may not be processed in time to permit payment of new rates commencing July 1, the payment to contractors shall continue at the current rates. Those continued payments shall constitute interim payments only. Upon final approval of the revised rates, the Department shall make retroactive adjustments for those months for which interim payments were made.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is an increase due to a reduction in recoupment retroactive payments. There is no change, from the prior estimate, for FY 2020-21. The change in the current estimate, from FY 2019-20 to FY 2020-21, is due to the retroactive payments being completed in FY 2019-20.

DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER: 135

Methodology:

1. Assume the DMC retroactive rate adjustment to be made in FY 2019-20 for FY 2016-17, FY 2017-18, and FY 2018-19 is -$11,368,366 TF.

Funding:

FY 2019-20	TF	GF	FF
Regular FMAP T19	($8,320,000)	($4,160,000)	($4,160,000)
ACA 100% FFP (2014-2016)	($609,000)	$0	($609,000)
ACA 95% FFP/ 5% GF (2017)	($529,000)	($26,000)	($503,000)
ACA 94% FFP/ 6% GF (2018)	($696,000)	($42,000)	($654,000)
ACA 93% FFP/7% GF (2019)	($775,000)	($54,000)	($721,000)
Title 21 88% FFP/12% GF	($439,000)	($53,000)	($386,000)
Total	**($11,368,000)**	**($4,335,000)**	**($7,033,000)**

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER:	136
IMPLEMENTATION DATE:	8/2015
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1505

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$54,303,000	-$9,163,000
- STATE FUNDS	-$27,151,500	-$4,581,500
PAYMENT LAG	1.0000	0.9999
% REFLECTED IN BASE	0.94 %	5.17 %
APPLIED TO BASE		
TOTAL FUNDS	-$53,792,600	-$8,688,400
STATE FUNDS	-$26,896,280	-$4,344,200
FEDERAL FUNDS	-$26,896,280	-$4,344,200

DESCRIPTION

Purpose:
This policy change estimates savings resulting from adjustments made to certain radiology reimbursement rates.

Authority:
SB 853 (Chapter 717, Statutes of 2010)
SPA 17-014
SPA 19-0003

Interdependent Policy Changes:
Funding Adjust.—ACA Opt. Expansion
Funding Adjust.—OTLICP

Background:
SB 853 mandates that Medi-Cal rates for radiology services not exceed 80% of Medicare rates for dates of service on or after October 1, 2010. In light of the AB 97 (Chapter 3, Statutes of 2011) 10% payment reduction, and that a lengthy retroactive recoupment would likely create access to care issues for radiology services, the effective date for retroactive savings shifted from October 1, 2010, to October 1, 2012.

The Centers for Medicare and Medicaid Services (CMS) requires SPA approval for all rate reductions. CMS approved SPA 17-014 to adjust radiology rates exceeding 80% of Medicare rates, effective April 1, 2017. SPA 19-0003 was approved on June 4, 2019, to adjust radiology rates exceeding 80% of Medicare's rates, effective January 1, 2019, in order to remain compliant with state statutory requirements. SPA 20-0004 was approved on April 20, 2020, for rate adjustments effective January 1, 2020.

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER: 136

Reason for Change:
The change in FY 2019-20, from the prior estimate, is a decrease in savings due to:

- A net decrease in prospective savings due to:
  - An increased estimate of the 2017 recoupment, and
  - A decrease in the 2019 and 2020 rate adjustments based on a shift in implementation dates to FY 2020-21.
- A shift of the 2017 retro recoupment to FY 2020-21, and
- An increase in the 2019 retro recoupment amount based on the shift in prospective implementation.

The change in FY 2020-21, from the prior estimate, is an increase in savings due to:

- A net decrease in prospective savings due to:
  - An increased estimate of the 2017 and 2019 rate adjustments, and
  - A decreased estimate of the 2020 rate adjustment.
- A net increase in retroactive savings due to
  - Including more months of the 2017 retro recoupment based on the shift in implementation to FY 2020-21;
  - An increased estimate of the 2019 retro recoupment based on the shift in implementation, and
  - A decrease in the estimated 2020 retro amount.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is a net decrease due to

- Including a full year of prospective rate adjustments in FY 2020-21,
- The shift of the 2017 and 2020 recoupments from FY 2019-20 to FY 2020-21, and
- The completion of the 2019 recoupments in FY 2020-21.

Methodology:

1. The Medi-Cal rate reductions will apply to radiology services reimbursement rates exceeding 80% of Medicare rates.

2. Any managed care impact would be captured through the current rate setting process and included in the applicable base policy changes in future years.

3. The total recoupment of retroactive savings from October 1, 2015, through April 22, 2018, is estimated to be $58,435,000 TF and was implemented on May 16, 2019, and will be processed over 12 months.

4. The rate adjustments effective April 1, 2017, reflect an annual FFS savings of $805,000 TF. These rates were implemented on July 22, 2019.

   The total recoupment of retroactive savings from April 1, 2017, through July 21, 2019, is estimated to be $1,877,000 TF and is expected to be implemented in July 2020 over 12 months.

5. The rate adjustments effective January 1, 2019, reflect an annual FFS savings of $3,218,000 TF. These rates are expected to be implemented in July 2020.

   The total recoupment of retroactive savings from January 1, 2019, through June 30, 2020, is estimated to be $4,826,000 TF and is expected to be implemented in December 2020 over 12 months.

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER: 136

6. The rate adjustments effective January 1, 2020, reflect an annual FFS savings of $577,000 TF. These rates are expected to be implemented in November 2020.

   The total recoupment of retroactive savings from January 1, 2020, through October 30, 2020, is estimated to be $190,000 TF and is expected to be implemented in March 2021 over 12 months.

7. The estimated savings for the reduction to radiology reimbursement rates are:

FY 2019-20	TF	GF	FF
Prospective Savings	($738,000)	($369,000)	($369,000)
Recoupment of Retro Savings	($53,565,000)	($26,783,000)	($26,782,000)
Total	**($54,303,000)**	**($27,152,000)**	**($27,151,000)**

FY 2020-21	TF	GF	FF
Prospective Savings	($4,407,000)	($2,204,000)	($2,203,000)
Recoupment of Retro Savings	($4,756,000)	($2,378,000)	($2,378,000)
Total	**($9,163,000)**	**($4,582,000)**	**($4,581,000)**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in the Funding Adjust.—ACA Opt. Expansion policy change
OTLICP funding identified in the Funding Adjust.—OTLICP policy change

HOSPITAL QAF - FFS PAYMENTS

REGULAR POLICY CHANGE NUMBER:	137
IMPLEMENTATION DATE:	7/2017
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1475

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$4,045,622,000	$4,989,101,000
- STATE FUNDS	$1,808,916,000	$2,620,056,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,045,622,000	$4,989,101,000
STATE FUNDS	$1,808,916,000	$2,620,056,000
FEDERAL FUNDS	$2,236,706,000	$2,369,045,000

DESCRIPTION

Purpose:
This policy change estimates the fee-for-service (FFS) payments that hospitals will receive from the hospital quality assurance fee (QAF) program.

Refer to the Hospital QAF – Managed Care Payments policy change for the managed care hospital QAF payments.

Authority:
AB 1383 (Chapter 627, Statutes of 2009)
AB 188 (Chapter 645, Statutes of 2009)
AB 1653 (Chapter 218, Statutes of 2010)
SB 90 (Chapter 19, Statutes of 2011)
SB 335 (Chapter 286, Statutes of 2011)
AB 1467 (Chapter 23, Statutes of 2012)
SB 920 (Chapter 452, Statutes of 2012)
SB 239 (Chapter 657, Statutes of 2013)
Proposition 52 (2016)

Interdependent Policy Changes:
Not Applicable

Background:
AB 1383 authorized the implementation of a QAF on applicable general acute care hospitals for the period of April 1, 2009, through December 31, 2010. This QAF program period is referred to as QAF I.

SB 90 extended the Hospital QAF program for the period January 1, 2011, through June 30, 2011, based on a modified amount of payments to hospitals and an increased amount for children's health care coverage. This QAF program period is referred to as QAF II.

HOSPITAL QAF - FFS PAYMENTS

REGULAR POLICY CHANGE NUMBER: 137

SB 335 extended the Hospital QAF program from July 1, 2011, through December 31, 2013. This QAF program period is referred to as QAF III.

SB 239 extended the Hospital QAF program from January 1, 2014, through December 31, 2016. This QAF program period is referred to as QAF IV. SB 239 also provided instructions for implementation of future program periods and requires the Department to increase capitation payments for the actuarial equivalent of AB 113 (Chapter 20, Statutes of 2011) payments to non-designated public hospitals (NDPH).

Proposition 52, approved by California voters on November 8, 2016, permanently extended the Hospital QAF program. The program period from January 1, 2017, to June 30, 2019, is referred to as QAF V.

The Department received federal approval for the QAF VI program period (July 1, 2019 through December 31, 2021) in February 2020. This QAF program period is referred to as QAF VI.

Reason for Change:
The change for FY 2019-20, from the prior estimate, is due to:

- A change in the methodology used to develop the HQAF VI children's health coverage estimate. The prior estimate projected payments based on a mock-up model while the current estimate is based on the actual approved HQAF VI model, which was developed using updated Upper Payment Limit demonstrations, and
- A delay in federal approval for QAF VI resulting in two quarters of QAF VI FFS payments instead of three quarters.

The change for FY 2020-21, from the prior estimate, is due to:

- Including the QAF V FY 2018-19 UPL overage payments in FY 2020-21,
- Updated quarterly payments estimated based on the change in the QAF VI FFS payment methodology, and
- Five quarters of QAF VI FFS payments instead of four.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is a increase due to:

- Including the QAF V FY 2018-19 UPL overage payments in FY 2020-21,
- Three additional quarters of QAF VI FFS payments in FY 2020-21,
- No prior year reconciliation payments estimated in FY 2020-21, and
- Lower ACA payments in FY 2020-21.

Methodology:
<u>QAF IV-QAF VI</u>

1. SB 239 extended the QAF for 36-months from January 1, 2014, through December 31, 2016 (QAF IV). Subsequently, AB 1607 extended the program for a one-year period from January 1, 2017, to December 31, 2017. However, this was superseded by the passage of Proposition 52, which permanently extended the Hospital QAF program. The Hospital QAF V program period covers the 30-month period from January 1, 2017, through June 30, 2019 (QAF V).

2. Assume the Hospital QAF VI program periods covers a 30-month period from July 1, 2019, through December 31, 2021.

3. The first QAF IV FFS payment was made in March 2015. This includes Designated Public Hospital and NDPH grant amounts.

HOSPITAL QAF - FFS PAYMENTS

REGULAR POLICY CHANGE NUMBER: 137

4. Payments associated with QAF V were approved by CMS in December 2017.

5. Due to implementation delays, QAF V FFS payments began in February 2018.

6. The ACA claiming methodology for the FFS supplemental payments was approved in FY 2017-18. In FY 2019-20, FFS ACA payments for FY 2018-19 will be claimed. In FY 2020-21, FFS ACA payments for FY 2019-20 will be claimed. The Hospital Quality Assurance Revenue Fund will be reimbursed for the SF portion (non-federal share) and an adjustment will be made for the federal share processed at the regular 50% FMAP.

7. QAF V reconciliations for FY 2017-18 are planned in FY 2019-20. The updated methodology assumes that all eligible hospitals can be paid up to the amounts modeled in the HQAF Fee & Payment Model in lieu of the preliminary calculation that relied on the percentage of fees collected.

8. The QAF V UPL overage payback for FY 2018-19 will take place in FY 2020-21. This was calculated in accordance with State Medicaid Director Letter (SMDL) #13-003.

9. QAF VI payments are based on the QAF VI model that was approved by CMS in February 2020. Exact payment timings are still being considered and are subject to change.

10. On a cash basis, the estimated QAF V- QAF VI payments are:

(Dollars in Thousands)

FY 2019-20	**TF**	**SF(HQARF)**	**FF**	**ACA FF**	*Return to Fund 3158
QAF V					
FY 2017-18 Reconciliation	$604,907	$309,915	$294,992	$0	$0
FY 2018-19	$1,113,693	$571,322	$542,371	$0	$0
FY 2018-19 ACA	$547,014	$0	($628,838)	$1,175,852	$547,014
QAF VI					
FY 2019-20	$1,780,008	$927,679	$852,329	$0	$0
Total FY 2019-20	**$4,045,622**	**$1,808,916**	**$1,060,854**	**$1,175,852**	$547,014

HOSPITAL QAF - FFS PAYMENTS

REGULAR POLICY CHANGE NUMBER: 137

(Dollars in Thousands)

FY 2020-21	TF	SF(HQARF)	FF	ACA FF	*Return to Fund 3158
QAF V					
FY 2018-19 UPL Overage	$0	$217,158	($134,022)	($83,136)	$0
QAF VI					
FY 2019-20	$1,780,008	$927,679	$852,329	$0	$0
FY 2019-20 ACA	$371,680	$0	($432,186)	$803,866	$371,680
FY 2020-21	$2,837,413	$1,475,219	$1,362,194	$0	$0
Total FY 2020-21	**$4,989,101**	**$2,620,056**	**$1,648,315**	**$720,730**	$371,680

*The Return to Fund 3158 column is for display purposes only (see QAF V-QAF VI Methodology #6).

Funding:
Hospital Quality Assurance Revenue Fund (4260-611-3158)
Title XIX FFP (4260-611-0890)

MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS

REGULAR POLICY CHANGE NUMBER:	138
IMPLEMENTATION DATE:	9/2019
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	2055

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$2,100,000,000	$2,326,556,000
- STATE FUNDS	$701,192,000	$784,650,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,100,000,000	$2,326,556,000
STATE FUNDS	$701,192,000	$784,650,000
FEDERAL FUNDS	$1,398,808,000	$1,541,906,000

DESCRIPTION

Purpose:
This policy change estimates the managed care Private Hospital Directed Payments (PHDP) to private hospitals through enhanced capitation payments to managed care plans (MCPs).

Authority:
Proposition 52 (2016)
Title 42, Code of Federal Regulations (CFR) 438.6(c)

Interdependent Policy Changes:
Not Applicable

Background:
The Centers for Medicare & Medicaid Services (CMS) instituted the final rule which modernized Medicaid managed care regulations. The result is changes in the usage of managed care delivery systems. 42 CFR 438.6(c) provides State's flexibility to implement delivery system and provider payment initiatives under Medicaid MCPs contracts based on allowable directed payments that focus on delivery system reform.

Effective July 1, 2017, for the FY 2017-18 rating period, the Department will direct MCPs to reimburse private hospitals as defined in WIC 14169.51 for PHDP based on actual utilization of contracted services. The payments will be enhanced by a uniform dollar increment (uniform unit cost add on) and is contingent upon hospitals providing adequate access to service, including primary, specialty, and inpatient (both tertiary and quaternary) care.

The total funding available for the enhanced contracted payments will be limited to a predetermined amount (pool). Upon determination of actual utilization, the Department will direct the MCPs to make enhanced payments to private hospitals for contracted services. Following the issuance of all enhanced payments, the Department will adjust per-member-per-month increments for actual utilization.

MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS

REGULAR POLICY CHANGE NUMBER: 138

On December 17, 2018, the Department received CMS pre-print approval to continue the PHDP for the FY 2018-19 rating period. Prior to implementation of a directed payment program, CMS requires states to seek pre-approval of any requested directed payment program through the standard CMS "pre-print" form. This "pre-print" is typically submitted on an annual basis. On June 30, 2019, the Department submitted a preprint requesting program continuation and approval for the July 1, 2019 through December 31, 2020 rating period.

Reason for Change:
There is no change in the estimated total fund for FY 2019-20 from the prior estimate. The funding splits and Affordable Care Act (ACA) funding have been revised based on actual FY 2017-18 enrollment and payment data.

There is no change in the estimated total fund for FY 2020-21 from the prior estimate. The funding splits and Affordable Care Act (ACA) funding have been revised based on updated enrollment projection data for FY 2018-19.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to a growth in the total pool size.

Methodology:

1. The total value of the funding for the private hospital directed payment pool is $2.1 billion total fund and $2.3 billion total fund for the FY 2017-18 and FY 2018-19 rating periods, respectively.

2. The non-federal share will be supported by the Hospital Quality Assurance Revenue Fund (HQARF).

3. Enhanced payments will be issued to MCPs based on actual private hospital utilization for contracted services.

4. The payments will be issued in two separate periods for each rating year, based on service date.

5. Payments are anticipated to occur in September and March of each fiscal year.

6. The FY 2017-18 rating period payments occurred in September 2019 and March 2020.

7. The FY 2018-19 rating period payments are anticipated to occur in September 2020 and March 2021.

8. On a cash basis, the estimated payments are:

(Dollars in Thousands)

FY 2019-20	TF	SF (HQARF)	FF (Title 19)	FF (Title 21)	ACA FF
FY 2017-18	$2,100,000	$701,192	$651,339	$81,243	$666,226
Total FY 2019-20	**$2,100,000**	**$701,192**	**$651,339**	**$81,243**	**$666,226**

(Dollars in Thousands)

FY 2020-21	TF	SF (HQARF)	FF (Title 19)	FF (Title 21)	ACA FF
FY 2018-19	$2,326,556	$784,650	$721,608	$90,008	$730,290
Total FY 2020-21	**$2,326,556**	**$784,650**	**$721,608**	**$90,008**	**$730,290**

MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS

REGULAR POLICY CHANGE NUMBER: 138

Funding:
Hospital Quality Assurance Revenue Fund (4260-611-3158)
Title XIX FFP (4260-611-0890)
Title XXI FFP (4260-611-0890)

HOSPITAL QAF - MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER:	139
IMPLEMENTATION DATE:	3/2015
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1761

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$1,897,400,000	$2,846,100,000
- STATE FUNDS	$577,008,000	$907,359,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,897,400,000	$2,846,100,000
STATE FUNDS	$577,008,000	$907,359,000
FEDERAL FUNDS	$1,320,392,000	$1,938,741,000

DESCRIPTION

Purpose:
This policy change estimates the Managed Care payments hospitals will receive from the extension of the quality assurance fee (QAF) program.

Refer to the Hospital QAF – FFS Payments policy change for the fee-for-service (FFS) hospital QAF payments.

Authority:
SB 239 (Chapter 657, Statutes of 2013)
Proposition 52 (2016)

Interdependent Policy Changes:
Not Applicable

Background:
AB 1383, as amended by AB 1653 and SB 208, established the Hospital QAF program for the period of April 1, 2009 through December 31, 2010. This QAF program period is referred to as QAF I.

SB 90 extended the Hospital QAF program from January 1, 2011 through June 30, 2011. This QAF program period is referred to as QAF II.

SB 335 extended the Hospital QAF program from July 1, 2011, through December 31, 2013. This QAF program period is referred to as QAF III.

SB 239 extended the Hospital QAF program from January 1, 2014, through December 31, 2016. This QAF program period is referred to as QAF IV. SB 239 also provided instructions for implementation of future program periods and requires the Department to increase capitation payments for the actuarial equivalent of AB 113 (Chapter 20, Statutes of 2011) payments to non-designated public hospitals (NDPH).

HOSPITAL QAF - MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 139

Proposition 52, approved by California voters on November 8, 2016, permanently extended the Hospital QAF program. The program period from January 1, 2017, to June 30, 2019, is referred to as QAF V.

The Department received federal approval for the QAF VI program period (July 1, 2019 through December 31, 2021) in February 2020. This QAF program period is referred to as QAF VI.

Reason for Change:
There is no change in the estimated total fund for FY 2019-20 from the prior estimate. The funding splits have been updated based on actual FY 2018-19 enrollment and payment data.

There is no change in the estimated total fund for FY 2020-21 from the prior estimate. The funding splits have been revised based on updated enrollment projection data for the 18-month Bridge Period (July 1, 2019 through December 31, 2020).

The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to 18 months of HQAF VI payments occurring in FY 2020-21 for the July 1, 2019 through December 31, 2020 Bridge Period.

Methodology:

1. HQAF V payments for the FY 2018-19 rating period occurred in February 2020. HQAF VI payments for the Bridge Period (July 2019 through December 2020) are anticipated to occur in FY 2020-21.

2. Increased capitation payments under Section 14165.58 are the actuarial equivalent to AB 113 (Chapter 20, Statutes of 2011) payments made to Non-Designated Public Hospitals (NDPHs). The Department will collect from NDPHs based on the IGTs in the below table.

3. The Bridge Period (July 2019 through December 2020) calculations are based on the approved fee model pending actuarially approved PMPMs and are subject to change.

4. On a cash basis, the estimated QAF payments are:

(Dollars in Thousands)

FY 2019-20	TF	SF (HQARF)	FF (TITLE 19)	FF (TITLE 21)	ACA FF
Managed Care					
FY 2018-19	$1,800,000	$547,388	$490,522	$58,421	$703,669
Total MC	$1,800,000	$547,388	$490,522	$58,421	$703,669
NDPH IGT					
FY 2018-19	$97,400	$29,620	$26,543	$3,161	$38,076
Total NDPH IGT	$97,400	$29,620	$26,543	$3,161	$38,076
Total FY 2019-20	**$1,897,400**	**$577,008**	**$517,065**	**$61,582**	**$741,745**

HOSPITAL QAF - MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 139

(Dollars in Thousands)

FY 2020-21	TF	SF (HQARF)	FF (TITLE 19)	FF (TITLE 21)	ACA FF
Managed Care					
Bridge Period – July 2019 to December 2020	$2,700,000	$860,781	$735,784	$76,179	$1,027,256
Total MC	$2,700,000	$860,781	$735,784	$76,179	$1,027,256
NDPH IGT					
Bridge Period – July 2019 to December 2020	$146,100	$46,578	$39,814	$4,122	$55,586
Total NDPH IGT	$146,100	$46,578	$39,814	$4,122	$55,586
Total FY 2020-21	**$2,846,100**	**$907,359**	**$775,598**	**$80,301**	**$1,082,842**

Funding:
Hospital Quality Assurance Revenue Fund (4260-611-3158)
Title XIX FFP (4260-611-0890)
Title XXI FFP (4260-611-0890)

GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

REGULAR POLICY CHANGE NUMBER:	140
IMPLEMENTATION DATE:	6/2020
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	2024

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$545,042,000	$1,063,771,000
- STATE FUNDS	$272,521,000	$350,107,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$545,042,000	$1,063,771,000
STATE FUNDS	$272,521,000	$350,107,000
FEDERAL FUNDS	$272,521,000	$713,664,000

DESCRIPTION

Purpose:
This policy change estimates direct and indirect graduate medical education (GME) payments to the Designated Public Hospitals (DPHs) participating in the Medi-Cal managed care program in recognition of the Medi-Cal managed care share of graduate medical education costs.

Authority:
Title 42, CFR, Section 438.60
SB 97 (Chapter 52, Statutes of 2017)
SPA 17-0009

Interdependent Policy Changes:
IGT Admin. & Processing Fee

Background:
The Medicare enactment of direct and indirect GME identified the importance of paying the extra costs of teaching hospitals to ensure seniors' ability to access the care they require. According to the Balanced Budget Act of 1997, Medicare capped the levels of funding for both direct and indirect GME costs when the number of allopathic and osteopathic medical residents exceeded the expected limit. In accordance with Title 42, CFR, Section 438.60, the Department is authorized to make new GME payments to DPH systems.

GME is the supervised, hands-on training after medical school that all physicians complete to become independent and licensed practitioners. The length of this training varies depending on specialty, but generally lasts three to five years. Residents and supervising physicians at teaching hospitals are available around the clock and are prepared to care for the nation's most critically ill or injured patients, with hospitals often absorbing the cost of training.

The Department will make new Medi-Cal GME payments to DPH systems, pending the Centers for Medicare and Medicaid Services' (CMS) approval of State Plan Amendment (SPA) 17-0009. Building from the Medicare program, the GME payments would recognize the Medi-Cal managed care share of the cost for a combination of the following:

GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

REGULAR POLICY CHANGE NUMBER: 140

- Direct GME payments for Medicaid's share of the cost of training new health care providers,
- Indirect GME payments for the additional training time and resources,
- Incentive payments that recognize the importance of training a new workforce generation to help address access to care in California.

Intergovernmental transfers (IGTs) will fund the nonfederal share of the cost. The Department will assess a 5% administrative fee on IGTs related to the GME payments to reimburse the Department for support costs associated with administering the program. The 5% administrative fee will be assessed in addition to the IGT funding the nonfederal share of the cost. The IGT savings will be budgeted in the IGT Admin. & Processing Fee policy change.

In March 2020, CMS approved SPA 17-0009 with a January 1, 2017 effective date.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is due to the FY 2018-19 payment shifted to FY 2020-21.

The change in FY 2020-21, from the prior estimate, is due to:
- FY 2018-19 payment shifted from FY 2019-20,
- Decreased payment data for FY 2017-18 through FY 2020-21, and
- Updated Affordable Care Act (ACA) payment methodology whereby ACA payments will be processed with the interim payments, and no longer as an adjustment after the close of the respective fiscal year, with the exception of FY 2016-17 and FY 2017-18 which will be processed separately as adjustments.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to the FY 2016-17 and FY 2017-18 payments are expected to occur in FY 2019-20, with the remaining retroactive payment for FY 2019-20 expected to occur in FY 2020-21.

Methodology:
1. The direct GME payments include costs incurred by DPHs due to salaries, benefits, physician oversight, and allocated overhead costs incurred for interns and residents in medicine, osteopathy, dentistry, podiatry, nursing, and allied health/paramedical programs, at an inflation-adjusted blended average cost per full-time equivalent (FTE).

2. The indirect medical education (IME) payments include costs incurred by DPHs due to teaching activities. Such indirect, inflation-adjusted costs will be determined by measuring the ratio of uncapped interns to available beds, applying the Medicare algorithm for this intern-to-bed ratio, multiplied by Medi-Cal managed care revenues.

GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

REGULAR POLICY CHANGE NUMBER: 140

3. The GME and IME annual distribution amounts are calculated based on the methodologies outlined in SPA 17-0009.
    - FY 2016-17 payments are effective January 1, 2017 and will be the total of two quarters of the estimated annual amount of $172.6 million TF.
    - FY 2017-18 payments were calculated based on FY 2017-18 cost report data and are estimated at $372.4 million TF. FY 2018-19 payments were calculated based on FY 2018-19 cost report data and are estimated at $369.7 million TF. Assume an annual increase will occur using the CPI annual adjustment for FY 2019-20, and FY 2020-21 which is estimated to provide $383 million TF for FY 2019-20, and $393.4 million TF for FY 2020-21 in annual total computable payments.
4. Payments will be made on a lump-sum quarterly basis throughout the fiscal year and will not be paid as individual increases to current reimbursement rates for specific services.
5. The IGTs referenced in this policy change are not the basis for the 5% administrative fee for GME supplemental payments. The administrative fees are reflected in the IGT Admin & Processing Fee policy change and will be 5% of the aggregate nonfederal share that is calculated at 50% FMAP of the Total Funds.
6. The ACA allows for 100% Federal Medical Assistance Percentage (FMAP) for calendar year 2016 for newly eligible Medi-Cal beneficiaries. Beginning January 1, 2017, the ACA optional population FMAP reduces to 95%, 94% beginning January 1, 2018, 93% beginning January 1, 2019, and 90% beginning January 1, 2020. The ACA reimbursement methodology is pending submission to CMS and approval is anticipated in the third quarter of FY 2019-20.
7. Assume the FY 2016-17 and FY 2017-18 ACA adjustments will occur in FY 2020-21.
8. Assume for FY 2018-19 and forward, ACA payments will begin in FY 2020-21, and are expected to be processed during quarterly interim payments.
9. Assume the two quarters of FY 2016-17 will be paid in FY 2019-20.
10. Assume all four quarters of FY 2017-18 will be paid in FY 2019-20.
11. Assume all four quarters of FY 2018-19 will be paid in FY 2020-21.
12. Assume all four quarters of FY 2019-20 will be paid in FY 2020-21.
13. Assume all four quarters of FY 2020-21 will be paid in FY 2020-21.

GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

REGULAR POLICY CHANGE NUMBER: 140

(Dollars in Thousands)

FY 2019-20	TF	IGT	FF	ACA FF
FY 2016-17 Payment	$172,566	$86,283	$86,283	$0
FY 2017-18 Payment	$372,476	$186,238	$186,238	$0
Total	**$545,042**	**$272,521**	**$272,521**	**$0**

FY 2020-21	TF	IGT	FF	ACA FF
FY 2016-17 ACA Adjustment	$24,073	$0	($26,748)	$50,821
FY 2017-18 ACA Adjustment	($106,454)	($70,282)	($148,808)	$112,636
FY 2018-19 Payment	$369,712	$133,392	$125,702	$110,618
FY 2019-20 Payment	$383,046	$140,654	$130,236	$112,156
FY 2020-21 Payment	$393,394	$146,343	$133,754	$113,297
Total	**$1,063,771**	**$350,107**	**$214,136**	**$499,528**

Funding:
Title XIX FFP (4260-101-0890)
DPH Graduate Medical Education Special Fund (4260-601-8113)
Title XIX ACA (4260-101-0890)

PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	141
IMPLEMENTATION DATE:	1/2018
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	2048

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$1,194,089,000	$1,191,399,000
- STATE FUNDS	$404,388,880	$426,106,610
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	5.52 %	5.54 %
APPLIED TO BASE		
TOTAL FUNDS	$1,128,175,300	$1,125,395,500
STATE FUNDS	$382,066,610	$402,500,300
FEDERAL FUNDS	$746,108,670	$722,895,190

DESCRIPTION

Purpose:
This policy change estimates the expenditures related to providing supplemental payments for certain physician services.

Authority:
AB 120 (Chapter 22, Statutes of 2017)
Title 42, Code of Federal Regulations (CFR) 447(f)
State Plan Amendment (SPA) 17-030
SPA 18-0033
SB 856 (Chapter 30, Statutes of 2018)
SPA 19-0021
AB 74 (Chapter 23, Statutes of 2019)

Interdependent Policy Changes:
Not Applicable

Background:
The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), passed by the voters in November 2016, increased the excise tax rate on cigarettes and electronic cigarettes, effective April 1, 2017, and other tobacco products effective July 1, 2017. The excise tax increased to $2.87 per pack of 20 cigarettes on distributors selling cigarettes in California with an equivalent excise tax rate increase on other tobacco products.

In accordance with AB 120, the Department developed the structure of the supplemental payments. AB 120 includes up to $325 million Proposition 56 funds for supplemental payments to new patient and established patient office/outpatient visits, psychiatric diagnostic evaluations, psychiatric diagnostic evaluations with medical services, and psychiatric pharmacological management services.

PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 141

SB 856 authorized supplemental payments for certain physician services in FY 2018-19. The Centers for Medicare and Medicaid Services (CMS) approved SPA 18-0033 for the FY 2018-19 Fee-for-Service (FFS) supplemental payments. Pursuant to AB 74, the CMS approved SPA 19-0021 for the extension of the supplemental payments for the period of July 1, 2019, through December 31, 2021.

The Department will provide supplemental payments for certain physician services in both Medi-Cal FFS and Medi-Cal managed care delivery systems. Providers who are eligible to provide and bill for the following Current Procedural Terminology (CPT) codes will receive the associated supplemental payment identified, in addition to any other payment they receive from the State in FFS or from the health plan as a network provider in managed care.

For the managed care delivery system, the Department has obtained approval of an allowable directed plan for the managed care supplemental payments for FY 2017-18, FY 2018-19, and July 1, 2019, through December 31, 2020 (Bridge Period). It is anticipated that the supplemental payments will continue in Calendar Year (CY) 2021 for managed care.

Managed Care Physician Directed Payments

CMS instituted the Medicaid Managed Care Final Rule in May 2016, which modernized Medicaid managed care regulations. The result is changes in the usage of managed care delivery systems, 42 CFR section 438.6(c) provides State's flexibility to implement delivery system and provider payment initiatives under Medicaid managed care plans (MCPs) contracts based on allowable directed payments.

Beginning with the July 1, 2017 rating period, the state has directed MCPs to make enhanced supplemental payments to eligible provider types for the above referenced CPT codes upon approval from CMS and receipt of funding. The enhanced supplemental payment is contingent upon the MCPs' receipt of providers' actual utilization for these codes reported through encounter data for FY 2017-18 through FY 2020-21.

Prior to implementation of a directed payment program, CMS requires states to seek pre-approval of any requested directed payment program through the standard CMS "pre-print" form. This "pre-print" is typically submitted on an annual basis. On June 30, 2019, the Department submitted pre-print requesting program continuation and approval for the July 1, 2019, through December 31, 2020, rating period. On May 5, 2020, the Department received approval from CMS.

This policy change identifies the use of the General Fund for these Proposition 56 payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

Reason for Change:

There is no change in the total funds for FY 2019-20 or FY 2020-21, from the prior estimate; however, the funding splits were revised based on updated actual FFS and managed care data.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease based on lower managed care payments expected in FY 2020-21.

Methodology:

1. Payments will be made via supplemental payments.

2. This policy is effective July 1, 2017.

PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 141

FFS Physician Supplemental Payments

3. The FY 2017-18 FFS supplemental payments were implemented on December 5, 2017. These supplemental payments were effective from July 1, 2017, through June 30, 2018.

4. The FY 2018-19 FFS supplemental payments were implemented on September 24, 2018. The EPC for the retroactive period of July 1, 2018, through September 23, 2018, was implemented on October 26, 2018.

5. Assume the FFS supplemental payments, on an accrual basis, are approximately $65,965,000 TF for FY 2018-19 dates of service and ongoing.

6. The FFS physician supplemental payments are expected to continue for dates of service from July 1, 2019, through December 31, 2021.

Managed Care Physician Directed Payments

7. Assume that the annual estimated value of enhanced capitation rate increases for MCPs to fund the supplemental rate increase, on an accrual basis, is $1,157,712,000 TF in FY 2018-19, $1,125,434,000 TF in FY 2019-20, and $1,125,434,000 TF in FY 2020-21.

8. A risked-based capitation rate will be issued to MCPs based on anticipated utilization of the 23 CPT codes.

9. One month of the FY 2018-19 capitation rate increases and 11 months of the FY 2019-20 capitation rate increases are expected to occur in FY 2019-20.

10. One month of the FY 2019-20 capitation rate increases and 11 months of the FY 2020-21 capitation rate increases are expected to occur in FY 2020-21.

11. Funds allocated for the supplemental payments are as follows:

FY 2019-20	TF	SF	Title XXI FF	Title XIX FF	ACA FF
FFS Pmts (ongoing)	$65,965,000	$25,821,000	$11,832,000	$22,176,000	$6,136,000
Mgd Care Pmts	$1,128,124,000	$378,568,000	$102,499,000	$324,513,000	$322,544,000
Total	**$1,194,089,000**	**$404,389,000**	**$114,331,000**	**$346,689,000**	**$328,680,000**

FY 2020-21	TF	SF	Title XXI FF	Title XIX FF	ACA FF
FFS Pmts (ongoing)	$65,965,000	$27,635,000	$10,118,000	$22,176,000	$6,036,000
Mgd Care Pmts	$1,125,434,000	$398,471,000	$87,597,000	$323,739,000	$315,627,000
Total	**$1,191,399,000**	**$426,106,000**	**$97,715,000**	**$345,915,000**	**$321,663,000**

PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 141

Funding:

FY 2019-20	TF	GF	FF
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	$693,378,000	$346,689,000	$346,689,000
93%Title XIX FF / 7% GF (4260-101-0001 / 0890)	$208,764,000	$14,613,000	$194,151,000
90%Title XIX FF / 10% GF (4260-101-0001 / 0890)	$149,477,000	$14,948,000	$134,529,000
88% Title XXI FF / 12% GF (4260-113-0001 / 0890)	$46,450,000	$5,574,000	$40,876,000
76.5% Title XXI FF / 23.5% GF (4260-113-0001 / 0890)	$96,020,000	$22,565,000	$73,455,000
Total	**$1,194,089,000**	**$404,389,000**	**$789,700,000**

FY 2020-21	TF	GF	FF
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	$691,830,000	$345,915,000	$345,915,000
90%Title XIX FF / 10% GF (4260-101-0001 / 0890)	$357,403,000	$35,740,000	$321,663,000
76.5% Title XXI FF / 23.5% GF (4260-113-0001 /0890)	$46,146,000	$10,844,000	$35,302,000
65% Title XXI FF / 35% GF (4260-113-0001 / 0890)	$96,020,000	$33,607,000	$62,413,000
Total	**$1,191,399,000**	**$426,106,000**	**$765,293,000**

PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER:	142
IMPLEMENTATION DATE:	7/2005
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1071

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$592,134,000	$608,335,000
- STATE FUNDS	$296,067,000	$304,167,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$592,134,000	$608,335,000
STATE FUNDS	$296,067,000	$304,167,500
FEDERAL FUNDS	$296,067,000	$304,167,500

DESCRIPTION

Purpose:
This policy change estimates the funds for the private Disproportionate Share Hospital (DSH) replacement payments.

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.11
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
SB 90 (Chapter 19, Statutes of 2011)
SB 335 (Chapter 286, Statutes of 2011)
HR 2 (2015)
SPA 05-022
SPA 16-010
HR 1892 (2018)
HR 4378 (2019)
HR 3055 (2019)
HR 1865 (2019)
HR 748 (2020)

Interdependent Policy Changes:
ACA DSH Reduction

Background:
Beginning July 1, 2005, based on SB 1100, private hospitals receive Medi-Cal DSH replacement payments under the DSH Replacement Program. These payments are determined using the same formulas and methodology that were previously in effect under the prior DSH methodology for the 2004-05 fiscal year. These payments are distributed to private hospitals along with $160.00 of the annual DSH allotment. Combined, these payments satisfy the State's payment obligations to private hospitals under the Federal DSH statute.

PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 142

The Centers for Medicare and Medicaid Services (CMS) approved SPA 16-010 in November 2017, which transfers the authority for DSH replacement payments from the BTR waiver to the California State Plan effective January 1, 2016.

The federal share of the DSH replacement payments is regular Title XIX funding and is not claimed from the federal DSH allotment. The non-federal share of these payments is State General Fund.

The Affordable Care Act (ACA) requires a reduction to the DSH allotments and was previously scheduled to go into effect on October 1, 2013. Instead, HR 2 (2015) was enacted on April 16, 2015, which postponed the reduction until October 1, 2017. HR 1892 (2018) was enacted on February 9, 2018, which further postpones the reduction until October 1, 2019. Subsequently HR 4378 (2019) and HR 3055 (2019) were enacted, postponing the reduction until November 22, 2019 and December 21, 2019, respectively. On December 20, 2019, HR 1865 was enacted which further delayed the DSH reduction until May 23, 2020. On March 27, 2020, HR 748 (2020) was enacted which eliminated the Federal Fiscal Year (FFY) 2020 reduction and postponed the start of the FFY 2021 reduction until December 1, 2020.

The private DSH replacement payments are affected by the ACA DSH reduction because, as required by SB 1100, the methodology to determine the DSH replacement payments is dependent on the DSH allotment and its associated payment methodologies. See the ACA DSH Reduction policy change for more information and the fiscal impact of the ACA DSH reduction on private DSH replacement funds.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is due to the inclusion of FY 2017-18 recoupments, and the release of the FY 2019-20 preliminary DSH allotment, which was slightly lower than estimated.

The change in FY 2020-21, from the prior estimate, is due to the release of the FY 2019-20 preliminary DSH allotment, which slightly lowered the FY 2020-21 estimated DSH allotment.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to higher FY 2020-21 payments based on the estimated FY 2020-21 DSH allotment.

Methodology:
1. The remaining balance of FY 2018-19 final payments will be paid in FY 2019-20.

2. The FY 2019-20 unreduced preliminary DSH allotment is a 1.9% increase over the FY 2018-19 preliminary allotment. The unreduced FY 2020-21 estimated DSH allotment assumes a 2% increase over the FY 2019-20 preliminary DSH allotment.

3. Assumes 11/12 of the FY 2019-20 DSH replacement payment will occur in FY 2019-20, and the remaining 1/12 will occur in FY 2020-21.

4. Assumes 11/12 of the FY 2020-21 DSH replacement payment will occur in FY 2020-21.

PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 142

It is assumed that the DSH replacement payments will be made as follows on a cash basis:

FY 2019-20	TF	GF	FF
FY 2017-18	($1,925,000)	($962,000)	($963,000)
FY 2018-19	$47,659,000	$23,829,000	$23,830,000
FY 2019-20	$546,400,000	$273,200,000	$273,200,000
Total FY 2019-20	**$592,134,000**	**$296,067,000**	**$296,067,000**

FY 2020-21	TF	GF	FF
FY 2019-20	$49,650,000	$24,825,000	$24,825,000
FY 2020-21	$558,685,000	$279,342,000	$279,343,000
Total FY 2020-21	**$608,335,000**	**$304,167,000**	**$304,168,000**

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

PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES

REGULAR POLICY CHANGE NUMBER:	143
IMPLEMENTATION DATE:	1/2018
ANALYST:	Matt Wong
FISCAL REFERENCE NUMBER:	2049

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$564,521,000	$522,826,000
- STATE FUNDS	$213,513,640	$207,292,150
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$564,521,000	$522,826,000
STATE FUNDS	$213,513,640	$207,292,150
FEDERAL FUNDS	$351,007,360	$315,533,850

DESCRIPTION

Purpose:
This policy change estimates the expenditures related to providing supplemental payments for specific dental services.

Authority:
AB 120 (Chapter 22, Section 3, Item 4260-101-3305, Budget Act of 2017)
SB 840 (Chapter 29, Section 2, Item 4260-101-3305, Budget Act of 2018)

Interdependent Policy Changes:
Eliminate Proposition 56 Supplemental Payments

Background:
Effective April 2017, the California Healthcare, Research, and Prevention Tobacco Tax Act of 2016, or Proposition 56, increased taxes imposed on distributors of cigarettes and tobacco products and allocates a specified percentage of those revenues to increase funding for existing health care programs under the Medi-Cal program. AB 120 appropriated from Proposition 56 revenues $140 million in Proposition 56 funds to provide supplemental payments for specific dental services. These supplemental payments for specific dental categories include restorative, endodontic, prosthodontic, oral and maxillofacial, adjunctive, visits and diagnostic services. For FY 2018-19 and FY 2019-20, the supplemental payment rates for the existing categories remain at a rate equal to 40 percent of the SMA. Effective July 1, 2018, SB 840 appropriated additional funds to allow for the increase in supplemental payments for specific procedures, and expanded supplemental payments for additional procedures.

This policy change identifies the use of the General Fund for these Proposition 56 payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

This policy change assumes the continuation of the Proposition 56 payments through FY 2020-21, on a cash basis. Proposition 56 funding for this supplemental payment is proposed to be eliminated in FY 2020-21. Refer to the Eliminate Proposition 56 Supplemental Payments policy change for the impact of the elimination.

PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES

REGULAR POLICY CHANGE NUMBER: 143

Reason for Change:
The change from the prior estimate, for FY 2019-20, is an increase due to updated actuals from check write data and an increase in the Prop 56 portions of the Dental Managed Care rates. The change from the prior estimate, for FY 2020-21, is a decrease due to decreased anticipated fee-for-service usage as well as lower Prop 56 portions of the Dental Managed Care rates. The change from FY 2019-20 to FY 2020-21, in the current estimate, is decrease due to the retroactive payment paying out in FY 2019-20.

Methodology:

1. Payments are made via supplemental payments.

2. This policy was effective on July 1, 2017. Beginning July 1, 2018, the Department made changes to add additional procedures and is changing the supplemental amount for specific procedures.

3. Supplemental payments are either a percentage of the Dental SMA or a flat rate.

4. Funds allocated for the supplemental payments are as follows:

FY 2019-20	TF	SF	FF
50% Title XIX / 50% GF	$377,728,000	$188,864,000	$188,864,000
ACA 94% FFP/ 6% GF (2018)	$3,166,000	$190,000	$2,976,000
ACA 93% (2019)	$56,321,000	$9,326,000	$46,995,000
ACA 90% (2020)	$53,156,000	$10,324,000	$42,832,000
Title 21 88% FFP	$19,336,000	$2,715,000	$16,621,000
Title 21 76.5% FFP	$54,814,000	$13,708,000	$41,106,000
Total	**$564,521,000**	**$225,127,000**	**$339,394,000**

FY 2020-21	TF	SF	FF
50% Title XIX / 50% GF	$348,228,000	$174,114,000	$174,114,000
ACA 90% FFP/10% GF (2020)	$103,555,000	$20,311,000	$83,244,000
Title 21 76.5% FFP/23.5% GF	$17,760,000	$4,447,000	$13,313,000
Title 21 65% FFP/35% GF	$53,283,000	$19,114,000	$34,169,000
Total	**$522,826,000**	**$217,986,000**	**$304,840,000**

5. The FY 2020-21 impact assumes the continuation of the Proposition 56 supplemental payment on a cash basis. Refer to the Eliminate Proposition 56 Supplemental Payments policy change for the impact of the elimination.

PROP 56 - MEDI-CAL FAMILY PLANNING

REGULAR POLICY CHANGE NUMBER:	144
IMPLEMENTATION DATE:	1/2020
ANALYST:	Sabrina Blank
FISCAL REFERENCE NUMBER:	2130

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$363,906,000	$394,485,000
- STATE FUNDS	$36,390,600	$39,448,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	76.55 %	71.74 %
APPLIED TO BASE		
TOTAL FUNDS	$85,336,000	$111,481,500
STATE FUNDS	$8,533,600	$11,148,150
FEDERAL FUNDS	$76,802,360	$100,333,320

DESCRIPTION

Purpose:
This policy change estimates the cost for providing supplemental payments for family planning services in both Medi-Cal fee-for-service (FFS) and Managed Care (MC).

Authority:
AB 74 (Chapter 23, Statues of 2019)
State Plan Amendment (SPA)19-0027

Interdependent Policy Changes:
Proposition 56 Funds Transfer

Background:
On November 8, 2016, California voters approved the California Healthcare, Research, and Prevention Tobacco Tax Act, Proposition 56, to increase the excise tax rate on cigarettes and tobacco products. Under Proposition 56, a specified portion of the tobacco tax revenue is allocated to the Department for use as the non-federal share of health care expenditures in accordance with the annual state budget process. SB 104, the Budget Act of 2019, appropriated Proposition 56 funds for specified Department health care expenditures during FY 2019-20.

On August 20, 2019, the Centers for Medicare & Medicaid Services (CMS) approved SPA 19-0027. SPA 19-0027 allows the Department to implement time-limited supplemental payments for specific family planning services delivered in the Medi-Cal FFS delivery system from July 1, 2019, through December 31, 2021. The FFS supplemental payment implemented in January 2020. In FY 2019-20, an Erroneous Payment Correction will deploy to retroactively apply supplemental payments to July 1, 2019.

In the Medi-Cal managed care delivery system, the Department has proposed to implement these payments as directed payments to eligible providers. Prior to implementation of a directed payment program, CMS requires states to seek pre-approval of any requested directed payment program through the standard CMS “pre-print” form. This “pre-print” is typically submitted on an annual basis. On June 30, 2019, the Department submitted the directed payment pre-print required by CMS, seeking

PROP 56 - MEDI-CAL FAMILY PLANNING

REGULAR POLICY CHANGE NUMBER: 144

to obtain managed care directed payment approval. On May 5, 2020, the Department received approval from CMS.

These supplemental payments for Medi-Cal family planning services are intended to help support the larger Medi-Cal population in accessing and using family planning services as well as the providers delivering such services in the Medi-Cal program. This policy change identifies the use of the General Fund (GF) for these Proposition 56 funded payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is a decrease due to using more recent FFS and MC data to project expenditures for FY 2019-20. The change in FY 2020-21, from the prior estimate, is a decrease due to using revised FY 2019-20 projections to estimate FFS and MC payments for FY 2020-21. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to projected full year of implementation occurring in FY 2020-21.

Methodology:
1. Assume an effective date of July 1, 2019.

2. The supplemental payments are paid in both FFS and MC for family planning office visits billed under specified procedure codes for service periods beginning July 1, 2019.

3. Expenditures are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2019-20	$363,906	$36,391	$327,515
FY 2020-21	$394,485	$39,448	$355,036

*Totals may differ due to rounding.

Funding:
90% Title XIX / 10% GF (4260-101-0890/0001)

DSH PAYMENT

REGULAR POLICY CHANGE NUMBER:	145
IMPLEMENTATION DATE:	7/2005
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1073

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$318,440,000	$495,326,000
- STATE FUNDS	$65,226,000	$187,018,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$318,440,000	$495,326,000
STATE FUNDS	$65,226,000	$187,018,000
FEDERAL FUNDS	$253,214,000	$308,308,000

DESCRIPTION

Purpose:
This policy change estimates the payments to Disproportionate Share Hospitals (DSHs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.6 and 14166.16
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
AB 1066 (Chapter 86, Statutes of 2011)
HR 2 (2015)
SPA 05-022
California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)
SB 815 (Chapter 111, Statutes of 2016)
HR 1892 (2018)
HR 4378 (2019)
HR 3055 (2019)
HR 1865 (2019)
HR 748 (2020)

Interdependent Policy Changes:
ACA DSH Reduction

Background:
Effective July 1, 2005, based on State Plan Amendment (SPA) 05-022 and as part of the MH/UCD and BTR, the federal DSH allotment is available to provide funding for uncompensated Medi-Cal and uninsured costs incurred by DSHs. Eligible hospitals are to receive funding through the DSH program in the following manner:

DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 145

- Designated Public Hospitals (DPHs) receive their allocation of federal DSH payments from the Demonstration DSH Fund based on the hospitals' certified public expenditures (CPEs), up to 100% of uncompensated Medi-Cal and uninsured costs. DPHs may also receive allocations of federal and non-federal DSH funds through intergovernmental transfer-funded payments for expenditures above 100% of costs, up to 175% of the hospitals' uncompensated Medi-Cal and uninsured costs.

  Effective July 1, 2015, DPHs, except State Government-operated University of California Hospitals, receive their allocation of the federal DSH payments through the Global Payment Program. See the Global Payment Program (GPP) policy change for more information and for the portion of DSH budgeted for the GPP. State Government-operated University of California Hospitals will continue to receive their allocation of federal DSH payments through CPE and intergovernmental transfer-funded payments for expenditures up to 175% of the hospitals' uncompensated Medi-Cal and uninsured costs in this policy change.

- Non-Designated Public Hospitals (NDPHs) receive their allocation from the federal DSH allotment and State General Fund (GF) based on hospitals' uncompensated Medi-Cal and uninsured costs up to the Omnibus Budget Reconciliation Act of 1993 (OBRA) limits. The federal reimbursement that is claimed based on the GF is drawn from the Federal Trust Fund.

- Private DSH hospitals, under the Special Terms and Conditions and SPA 05-022, are allocated a total of $160.00 from the federal DSH allotment and GF each demonstration year. All DSH eligible Private hospitals receive a pro-rata share of the $160.00.

The MH/UCD was extended to October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the BTR effective November 1, 2010, continuing the same DSH payment methodology from the MH/UCD.

AB 1066 amended Welfare & Institutions Code 14166.1 and provides the authority for the Department to implement new payment methodologies under the successor demonstration project to determine the federal DSH allotment for DPHs.

The Affordable Care Act (ACA) requires a reduction in the DSH allotments and was previously scheduled to go into effect on October 1, 2013. Instead, HR 2 (2015) was enacted on April 16, 2015, which postponed the reduction until October 1, 2017. HR 1892 (2018) was enacted on February 9, 2018, which further postpones the reduction until October 1, 2019. Subsequently, HR 4378 (2019) and HR 3055 (2019) were enacted postponing the reduction until November 22, 2019 and December 21, 2019, respectively. On December 20, 2019, HR 1865 further delayed the DSH reduction until May 23, 2020. On March 27, 2020, HR 748 (2020) was enacted which eliminated the Federal Fiscal Year (FFY) 2020 reduction and postponed the start of the FFY 2021 reduction until December 1, 2020. See the ACA DSH Reduction policy change for more information and for the estimated fiscal impact of the ACA DSH reduction on DSH payments.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is due to:

- FY 2011-12, FY 2014-15, and FY 2016-17 recoupments and payments shifted to FY 2020-21,
- Inclusion of FY 2007-08 recoupments,
- Slightly lowered unreduced preliminary DSH allotment amount,
- Higher NDPH DSH FY 2019-20 estimated allotment amount, and
- Lower DPH DSH FY 2019-20 payments based on an updated payment schedule.

DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 145

The change in FY 2020-21, from the prior estimate, is due to:

- Updated data for FY 2011-12, FY 2014-15, and FY 2016-17 which shifted from FY 2019-20,
- Higher NDPH DSH FY 2019-20 and FY 2020-21 estimated allotment amounts,
- Higher DPH DSH FY 2019-20 payments based on an updated payment schedule, and
- Lower DPH DSH FY 2020-21 payments due to an updated payment schedule.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to updated DPH DSH and NDPH DSH allotments estimated for FY 2020-21, and lower recoupments occurring in FY 2020-21.

Methodology:

1. The FY 2019-20 preliminary DSH allotment is a 1.9% increase over FY 2018-19. The FY 2020-21 estimated DSH allotment assumes a 2% increase over the FY 2019-20 preliminary DSH allotment. The FY 2019-20 preliminary unreduced DSH allotment is $1,281,952,080 and the unreduced FY 2020-21 DSH allotment is estimated to be $1,307,591,122.

2. Effective July 1, 2019, DPH UC DSH hospitals are paid on a quarterly basis where three quarters are paid in the same fiscal year and the fourth quarter is paid in the following fiscal year. Prior to July 1, 2019, 11/12 of the total annual allotment was paid in the same fiscal year and 1/12 was paid in the following fiscal year.

3. It is assumed that the DSH payments will be made as follows on a cash basis:

FY 2019-20	TF	GF**	FF	IGT*
DSH 2007-08	($40,416,000)	$0	$0	($40,416,000)
DSH 2012-13	$52,000	$26,000	$26,000	$0
DSH 2015-16	$1,384,000	$692,000	$692,000	$0
DSH 2017-18	($45,000)	($23,000)	($22,000)	$0
DSH 2018-19	$35,408,000	$1,106,000	$23,719,000	$10,583,000
DSH 2019-20	$322,057,000	$22,383,000	$228,799,000	$70,875,000
Total FY 2019-20	**$318,440,000**	**$24,184,000**	**$253,214,000**	**$41,042,000**

FY 2020-21	TF	GF**	FF	IGT*
DSH 2011-12	($5,399,000)	$0	$348,000	($5,747,000)
DSH 2012-13	$2,265,000	$0	$1,558,000	$707,000
DSH 2014-15	$62,697,000	$0	$1,967,000	$60,730,000
DSH 2016-17	$3,951,000	$0	$51,000	$3,900,000
DSH 2019-20	$96,500,000	$2,035,000	$70,840,000	$23,625,000
DSH 2020-21	$335,312,000	$22,917,000	$233,544,000	$78,851,000
Total FY 2020-21	**$495,326,000**	**$24,952,000**	**$308,308,000**	**$162,066,000**

DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 145

Funding:
100% Demonstration DSH Fund (4260-601-7502)
50% Title XIX / 50% MIPA (4260-606-0834/4260-101-0890)*
50% Title XIX / 50% GF (4260-101-0001/0890)**

PROP 56 - VALUE-BASED PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER:	146
IMPLEMENTATION DATE:	4/2020
ANALYST:	Latoya Brown
FISCAL REFERENCE NUMBER:	2128

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$310,065,000	$459,503,000
- STATE FUNDS	$102,975,940	$178,279,640
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$310,065,000	$459,503,000
STATE FUNDS	$102,975,940	$178,279,640
FEDERAL FUNDS	$207,089,060	$281,223,360

DESCRIPTION

Purpose:
This policy change estimates payments to providers made through increased capitation to Managed Care Plans (MCPs) who meet the Department requirements in the Value-Based Payment (VBP) program.

Authority:
FY 2019-20 Budget Bill
Trailer Bill Language

Interdependent Policy Changes:
None

Background:
On November 8, 2016, California voters passed the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) to increase the excise tax rate on cigarettes and tobacco products. Under Proposition 56, a portion of the tobacco tax revenue is allocated to the Department for use as the nonfederal share of health care expenditures in accordance with the annual state budget process.

The VBP program will require MCPs to make value-based enhanced payments to eligible network providers for specific events tied to performance on 17 core measures across the following four domains:

- Prenatal/postpartum care
- Early childhood preventive care
- Chronic disease management
- Behavioral health care

The VBP program is intended to incentivize Medi-Cal managed care network provider behaviors and improvements in individual providers' standards of practice related to the delivery of care in the four specified domains. This program also incentivizes improved data quality and completeness.

PROP 56 - VALUE-BASED PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 146

MCPs will be required to participate in the VBP program through a directed payment program. Prior to implementation of a directed payment program, Centers for Medicare and Medicaid Services (CMS) requires states to seek pre-approval of any requested directed payment program through the standard CMS “pre-print” form. On June 30, 2019, the Department submitted the CMS required pre-print form for the VBP program, seeking to obtain managed care directed payment approval. On May 5, 2020, the Department received approval from CMS.

To address health disparities, this arrangement will also direct MCPs to make enhanced payments for events tied to beneficiaries diagnosed with a substance use disorder or serious mental illness, or who are homeless.

The Behavioral Health Integration (BHI) Incentive program was intended to incentivize physical and behavioral health outcomes within the Medi-Cal Managed Care program and improve evidence-based medical and behavioral health integration practices.

Proposition 56 funding, along with federal funds, will be used to make these payments. This policy change identifies the use of the General Fund (GF) for these Proposition 56 funded payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21 is based on revised estimated timing of payments.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is based on payments for BHI beginning in FY 2020-21.

Methodology:
1. On a cash basis, the total directed payments are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2019-20	**$310,065**	$102,976	$207,089
FY 2020-21	**$459,503**	$178,280	$281,223

*Totals may differ due to rounding

Funding:
50% Title XIX FF / 50% SF (4260-101-0001 / 0890)
76.5% Title XXI FF / 23.5% GF (4260-113-0890/0001)
88% Title XXI FF / 12% GF (4260-113-0890/0001)
ACA 93% FFP / 7% GF (2019)
ACA 90% FFP / 10% GF (2020)

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER:	147
IMPLEMENTATION DATE:	7/2005
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1085

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$313,011,000	$312,824,000
- STATE FUNDS	$147,094,000	$148,903,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$313,011,000	$312,824,000
STATE FUNDS	$147,094,000	$148,903,000
FEDERAL FUNDS	$165,917,000	$163,921,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental payments made to private hospitals from the Private Hospital Supplemental Fund.

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code (W&I) 14166.12
AB 1467 (Chapter 23, Statutes of 2012), W&I Code 14166.14
SPA 14-008
SPA 15-003
SPA 16-014
SPA 16-022
SPA 18-010
SPA 19-0023

Interdependent Policy Changes:
Not Applicable

Background:
Effective July 1, 2005, based on the requirements of SB 1100, supplemental reimbursement will be available to private hospitals.

Private hospitals will receive payments from the Private Hospital Supplemental Fund (Item 4260-601-3097) using General Fund (GF), intergovernmental transfers (IGTs), and interest accrued in the Private Hospital Supplemental Fund as the non-federal share of payments. This funding, along with the federal reimbursement, will replace the amount of funding the private hospitals previously received under the Emergency Services and Supplemental Payments Program (SB 1255, Voluntary Governmental Transfers), the Graduate Medical Education Program (GME), and the Small and Rural Hospital Supplemental Payment Program (Fund 0688).

SB 1100 requires the transfer of $118,400,000 annually from the General Fund (GF) (Item 4260-101-0001) to the Private Hospital Supplemental Fund to be used for the non-federal share

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 147

of the supplemental payments. The distribution of the Private Hospital Supplemental Fund will be based on the requirements specified in SB 1100. Due to the inactivation of the Selective Provider Contracting Program (SPCP) for private hospitals on July 1, 2013, State Plan Amendments (SPAs) were required to continue the Private Hospital Supplemental Program and secure distributions from the Private Hospital Supplemental Fund.

The Department received SPA approvals from the Centers of Medicare and Medicaid Services (CMS) to continue the Private Hospital Supplemental Program for FY 2013-14 through FY 2018-19. On July 13, 2016, CMS approved SPA 16-014 which allows payments to be made outside of the fourth quarter for each SFY. In addition, CMS approved SPA 16-022 on December 8, 2016, which reduces the IGT payments from Alameda County to St. Rose Hospital. CMS approved SPA 18-010 on October 30, 2018 to continue the Private Hospital Supplemental Program through June 30, 2019. SPA 19-0023 was approved by CMS on July 17, 2019 and will continue the Private Hospital Supplemental Program through FY 2019-20. Another SPA will be submitted to CMS which will include a formulaic payment methodology and language to allow for the expenditure of any remaining funds for FY 2020-21 and beyond.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is due to updated Affordable Care Act (ACA) data for FY 2018-19.

The change in FY 2020-21, from the prior estimate, is due to updated FY 2019-20 ACA data, the inclusion of federal funds repayments for FY 2013-14 through FY 2015-16, and the inclusion of a FY 2015-16 repayment to the Private Hospital Supplemental Fund.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to a gradual reduction in the ACA optional expansion Federal Medical Assistance Percentage (FMAP) schedule, and the inclusion of federal funds and Private Hospital Supplemental Fund repayments.

Methodology:

1. The SF includes the annual General Fund appropriation, unspent funds from prior year, interest that has been accrued/estimated, and IGTs. Beginning in FY 2017-18, the SF item will also include ACA adjustments.

2. IGT payments will be $54 million TF in FY 2019-20 and FY 2020-21.

3. The ACA allows for 100% FMAP for calendar years 2014 through 2016. Beginning January 1, 2017, the ACA optional population FMAP is 95%, and reduces to 94% beginning January 1, 2018. Beginning January 1, 2019, the ACA optional population FMAP reduces to 93%, and further reduces to 90% beginning January 1, 2020. CMS approved the ACA claiming methodology in August 2017.

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 147

4. ACA payments will be processed nine months after the respective FY's supplemental payments have been issued in order to determine the proportion of the costs for newly eligible Medi-Cal beneficiaries. FY 2016-17 and FY 2017-18 ACA supplemental payments were claimed in FY 2018-19. FY 2018-19 ACA supplemental payments will be claimed in FY 2019-20. FY 2019-20 ACA supplemental payments will be claimed in FY 2020-21.
    - The counties will be reimbursed for the IGTs (non-federal share) and an adjustment will be made for the federal share processed at the regular 50% FMAP.
    - The Private Hospital Supplemental Fund will be reimbursed for the SF portion (non-federal share) and an adjustment will be made for the federal share processed at the regular 50% FMAP.
5. The Department over-claimed FY 2017-18 ACA FFP and is expected to repay the federal funds in FY 2019-20.
6. The Department over-claimed FY 2013-14 through FY 2015-16 ACA FFP and is expected to repay the federal funds in FY 2019-20.
7. The Department erroneously moved $5.994 million for FY 2015-16 from SF to GF, and is expected to repay the fund 3097 in FY 2020-21.
8. The ending balance shown is on a cash basis and does not necessarily mean that the remaining funds are available. Funds in the ending balance may be committed and scheduled to be expended in the following year.
9. The estimated Private Hospital Supplemental payments and ending balance for FY 2019-20 are shown below:

(Dollars in Thousands)

FY 2019-20 Private Hospital Supplemental Fund Summary	SF
FY 2018-19 Ending Balance	$68,332
Appropriation (GF)	$118,400
2019-20 IGT	$27,000
FY 2018-19 Interest Earned	$2,049
FY 2018-19 ACA FFP Adjustment to SF	$19,892
Funds Available	$235,673
Less: FY 2019-20 Cash Expenditures to Hospitals	($145,400)
Est. FY 2019-20 Remaining Balance	$90,273

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 147

(Dollars in Thousands)

FY 2019-20	TF	GF	SF	FF	ACA FF	Return to Fund 3097*	Return to Counties*
FY 2019-20 Cash Expenditures to Hospitals**	$290,800	$0	$145,400	$145,400	$0	$0	$0
FY 2018-19 ACA FF Adjustment to SF***	$19,892	$0	$0	($22,865)	$42,757	$19,892	$0
FY 2018-19 ACA FF Adjustment to Counties***	$2,319	$0	$0	($2,666)	$4,985	$0	$2,319
FY 2017-18 ACA FF Repayment	$0	$1,694	$0	$0	($1,694)	$0	$0
Total	**$313,011**	**$1,694**	**$145,400**	**$119,869**	**$46,048**	$19,892	$2,319

10. The estimated Private Hospital Supplemental payments and ending balance for FY 2020-21 are shown below:

(Dollars in Thousands)

FY 2020-21 Private Hospital Supplemental Fund Summary	SF
FY 2019-20 Ending Balance	$90,273
Appropriation (GF)	$118,400
2020-21 IGT	$27,000
Est. FY 2019-20 Interest Earned	$2,664
FY 2019-20 ACA FFP Adjustment to SF	$18,97
Funds Available	$257,315
Less: FY 2020-21 Cash Expenditures to Hospitals	($145,400)
Est. FY 2020-21 Remaining Balance	$111,915

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 147

(Dollars in Thousands)

FY 2020-21	TF	GF	SF	FF	ACA FF	Return to Fund 3097*	Return to Counties*
FY 2020-21 Cash Expenditures to Hospitals**	$290,800	$0	$145,400	$145,400	$0	$0	$0
FY 2019-20 ACA FF Adjustment to SF***	$18,977	$0	$0	($22,865)	$41,842	$18,978	$0
FY 2019-20 ACA FF Adjustment to Counties***	$3,047	$0	$0	($3,671)	$6,718	$0	$3,047
FY 2013-14 FF Repayment	$0	$0	$170	$0	($170)	$0	$0
FY 2014-15 FF Repayment	$0	$0	$1,452	$0	($1,452)	$0	$0
FY 2015-16 FF Repayment	$0	$1,881	$0	$0	($1,881)	$0	$0
FFY 2015-16 SF Repayment	$0	$5,994	($5,994)	$0	$0	$0	$0
Total	**$312,824**	**$7,875**	**$141,028**	**$118,864**	**$45,057**	$18,978	$3,047

*The Return to Fund 3097 and Return to Counties columns are for display purposes only (see Methodology #4).

Funding:
Private Hospital Supplemental Fund (less funded by GF) (4260-698-3097)
50% Title XIX / 50% Private Hospital Supplemental Fund (4260-601-3097/4260-101-0890)**
100% Title XIX ACA (4260-101-0890)***
100% Title XIX (4260-101-0890)***
100% GF (4260-105-0001)
100% GF (4260-101-0001)

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	148
IMPLEMENTATION DATE:	4/2004
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	78

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$247,723,000	$253,433,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$247,723,000	$253,433,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$247,723,000	$253,433,000

DESCRIPTION

Purpose:
This policy change estimates the outpatient supplemental payments based on certified public expenditures (CPEs) for providing outpatient hospital care to Medi-Cal beneficiaries.

Authority:
AB 915 (Chapter 747, Statutes of 2002)
State Plan Amendment (SPA) 02-018
SPA 16-019

Interdependent Policy Changes:
Not Applicable

Background:
AB 915 created a supplemental reimbursement program for publicly owned or operated hospital outpatient departments. Publicly owned or operated hospitals now receive supplemental payments based on CPEs for providing outpatient hospital care to Medi-Cal beneficiaries. The supplemental amount, when combined with the amount received from all other sources of Medi-Cal Fee for Service reimbursement, cannot exceed 100% of the costs of providing services to Medi-Cal beneficiaries. The non-federal share used to draw down federal financial participation (FFP) is paid exclusively with funds from the participating facilities.

Reason for Change:
The change in both FY 2019-20 and FY 2020-21, from the prior estimate, is a due to additional months of actual data increasing estimated FY 2018-19 payments.

The increase between FY 2019-20 and FY 2020-21 is a due to additional months of actual data.

Methodology:
1. Payments of $247,723,000 and $253,433,000 are expected to be made in FY 2019-20 and FY 2020-21 respectively. These payments are based on CPE claims and are adjusted for the changes in the FMAP.

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 148

2. The reconciliation mandated by AB 915 against audited cost reports will be addressed in a future estimate.

3. The ACA allows for 100% Federal Medical Assistance Percentage (FMAP) for calendar years 2014 through 2016, for newly eligible Medi-Cal beneficiaries. Beginning calendar year 2017, the ACA allows for the following FMAPs: 95% beginning on January 1, 2017, 94% beginning on January 1, 2018, 93% beginning on January 1, 2019, and 90% beginning on January 1, 2020.

4. Traditional and ACA claims are processed separately. Payments are based on CPE claims and ACA claims which are adjusted based on the FMAP methodology described above. FY 2017-18 ACA claims are based on actual claims received. FY 2018-19 and 2019-20 ACA claims are estimated based on FY 2017-18 actuals further adjusted by an average percent change calculated using actuals paid in in FY 2013-14 through FY 2017-18.

5. Estimated costs are as follows:

FY 2019-20	TF	FF	ACA
FY 2017-18 Payments	$1,107,000	$630,000	$477,000
FY 2018-19 Payments	$246,616,000	$118,335,000	$127,578,000
Total FY 2019-20	**$247,723,000**	**$118,965,000**	**$128,758,000**

FY 2020-21	TF	FF	ACA
FY 2018-19 Payments	$1,104,000	$596,000	$508,000
FY 2019-20 Payments	$252,329,000	$115,611,000	$136,718,000
Total FY 2020-21	**$253,433,000**	**$116,207,000**	**$137,226,000**

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

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER:	149
IMPLEMENTATION DATE:	7/1991
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	82

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$111,082,000	$94,555,000
- STATE FUNDS	$28,352,000	$26,770,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$111,082,000	$94,555,000
STATE FUNDS	$28,352,000	$26,770,000
FEDERAL FUNDS	$82,730,000	$67,785,000

DESCRIPTION

Purpose:
This policy change estimates the Medi-Cal reimbursement for debt services incurred from the financing of capital construction projects.

Authority:
SB 1732 (Chapter 1635, Statutes of 1988)
SB 2665 (Chapter 1310, Statutes of 1990)
SB 1128 (Chapter 757, Statutes of 1999)
State Plan Amendment (SPA) 88-25
SPA 13-011

Interdependent Policy Changes:
Not Applicable

Background:
SB 1732 and SB 2665 authorized Medi-Cal reimbursement of revenue and general obligation bond debt for principal and interest costs incurred in the construction, renovation and replacement of qualifying disproportionate share contract hospitals. The Selective Provider Contracting Program (SPCP) ended June 30, 2013, due to the implementation of the Diagnosis Related Group payment methodology. The Centers for Medicare and Medicaid Services (CMS) approved State Plan Amendment (SPA) 13-011 on December 11, 2013, which maintains the Federal authority for SB 1732.

SB 1128 authorized a distinct part skilled nursing facility (DP-NF) of an acute care hospital providing specified services to receive Medi-Cal reimbursement for debt service incurred for the financing of eligible capital construction projects. The DP-NF must meet other specific hospital and project conditions specified in Section 14105.26 of the Welfare and Institutions Code. The Department claims federal funds using certified public expenditures from eligible DP-NFs. CMS approved SPA 00-010 on July 17, 2001, which maintains the Federal authority for SB 1128.

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 149

Reason for Change:

The change in FY 2019-20, from the prior estimate, is due to:

For hospitals (SB 1732):

- Updated interim payment and ACA adjustment amounts based on additional months of actual data, and
- Interim reconciliation recoupments for SFY 2013-14 were delayed and are expected in FY 2019-20.

For DP-NFs (SB 1128):

- Updated interim payment amounts based on additional months of actual data.

The change in FY 2020-21, from the prior estimate, is due to:

For hospitals (SB 1732):

- Recalculated interim reconciliation amounts using final Medi-Cal Utilization Rate (MUR) data and
- Updated interim payment and ACA adjustment amounts based on additional months of actual data.

For DP-NFs (SB 1128):

- There is no change from the prior estimate.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to:

For hospitals (SB 1732):

- FY 2020-21 includes projected recoupments for retroactive interim reconciliations.

For DP-NFs (SB 1128):

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

Methodology:

1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008, through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011, through March 31, 2011, and 56.88% for April 1, 2011, through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

2. The ACA allows for 100% Federal Medical Assistance Percentage (FMAP) for calendar years (CY) 2014 through 2016, 95% FMAP for CY 2017, 94% FMAP for CY 2018, 93% for CY 2019, and 90% for CY 2020 and after, for newly eligible Medi-Cal beneficiaries.

3. For SB 1732, ACA payments will be processed one year after the respective FY's supplemental payments have been issued in order to determine the proportion of the hospital's costs for newly eligible Medi-Cal beneficiaries. FY 2017-18 ACA and FY 2018-19 ACA supplemental payments will be claimed in FY 2019-20 and FY 2020-21, respectively. The General Fund (GF) will be reimbursed for the nonfederal share, and an adjustment will be made for the federal share processed at the regular 50% FMAP.

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 149

4. For SB 1732, capital projects funded by new debt for which final plans were submitted to the Office of the Statewide Architect and the Office of Statewide Health Planning and Development after September 1, 1988 and prior to June 30, 1994 are eligible for this program.

   Once the debt service for a project is paid in full the hospital's interim supplemental payments and interim reconciliation will be reconciled using the final MUR data. If during the final reconciliation, it is determined that the eligible hospital has been overpaid, the hospital will repay the Medi-Cal program the overpayment amount. If it is determined that the eligible hospital has been underpaid, the hospital will receive an adjusted supplemental payment amount.

5. The estimated payments on a cash basis are:

FY 2019-20	TF	GF	FF	ARRA	ACA
Hospitals (SB 1732)					
Interim Payment					
FY 2017-18	$6,607,000	$2,572,000	$2,472,000	$0	$1,563,000
FY 2018-19	$51,862,000	$25,931,000	$25,931,000	$0	$0
FY 2019-20	$26,552,000	$13,276,000	$13,276,000	$0	$0
ACA Adjustment to GF					
FY 2017-18	$0	($15,182,000)	($17,118,000)	$0	$32,300,000
Interim Reconciliation					
FY 2013-14	($663,000)	($352,000)	($352,000)	$0	$41,000
FY 2014-15	$1,825,000	$555,000	$555,000	$0	$715,000
FY 2015-16	$7,698,000	$1,129,000	$1,129,000	$0	$5,440,000
Final Reconciliation					
FY 1995-96 to FY 2015-16	$1,114,000	$473,000	$335,000	-$138,000	$444,000
DP-NFs (SB 1128)					
Interim Payment					
FY 2017-18	$386,000	$0	$386,000	$0	$0
FY 2018-19	$15,701,000	$0	$15,701,000	$0	$0
Total FY 2019-20	**$111,082,000**	**$28,402,000**	**$42,315,000**	**($138,000)**	**$40,503,000**

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 149

FY 2020-21	TF	GF	FF	ACA
Hospitals (SB 1732)				
Interim Payment				
FY 2018-19	$8,462,000	$4,231,000	$4,231,000	$0
FY 2019-20	$58,418,000	$29,209,000	$29,209,000	$0
FY 2020-21	$23,054,000	$11,527,000	$11,527,000	$0
ACA Adjustment to GF				
FY 2018-19	$0	($14,042,000)	($16,169,000)	$30,211,000
Interim Reconciliation				
FY 2016-17	($12,379,000)	($4,155,000)	($4,155,000)	($4,069,000)
DP-NFs (SB 1128)				
Interim Payment				
FY 2018-19	$500,000	$0	$500,000	$0
FY 2019-20	$16,500,000	$0	$16,500,000	$0
Total FY 2020-21	**$94,555,000**	**$26,770,000**	**$41,643,000**	**$26,142,000**

Funding:
100% Title XIX (4260-101-0890)
50% Title XIX Capital Debt FFP / 50% GF (4260-102-0001/0890)
100% GF Capital Debt (4260-102-0001)
100% Title XIX Capital Debt FFP (4260-102-0890)
100% Title XIX ACA (4260-101-0890)

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER:	150
IMPLEMENTATION DATE:	2/2006
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	104

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$131,604,000	$163,862,000
- STATE FUNDS	$69,834,500	$81,884,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$131,604,000	$163,862,000
STATE FUNDS	$69,834,500	$81,884,000
FEDERAL FUNDS	$61,769,500	$81,978,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental reimbursement to specific hospitals that provide trauma care to Medi-Cal beneficiaries, through the use of Intergovernmental Transfers (IGTs).

Authority:
Welfare & Institutions Code, Sections 14164 and 14087.3
SPA 03-032

Interdependent Policy Changes:
Not Applicable

Background:
This program allows Los Angeles and Alameda counties to submit IGTs used as the non-federal share of costs to draw down Title XIX federal funds. The Department uses the IGTs matched with the federal funds to make supplemental payments to specified hospitals for the costs of trauma care center services provided to Medi-Cal beneficiaries.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is due to a rounding adjustment.

The change in FY 2020-21, from the prior estimate, is due to:
- Updated FY 2019-20 payment projections, based on updated IGT estimates from the counties, and
- Federal fund repayments for FYs 2013-14 through 2015-16 expected in FY 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to:
- Increased ACA estimates to counties and regular payments occurring in FY 2020-21, and
- Additional federal fund repayments occurring in FY 2020-21.

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER: 150

Methodology:

1. IGTs are deposited in the Special Deposit Fund (Local Trauma Centers).

2. ACA allows for 100% Federal Medical Assistance Percentage (FMAP) for calendar years 2014 through 2016, 95% FMAP for calendar year 2017, 94% FMAP for calendar year 2018 and 93% FMAP for calendar year 2019, and 90% for calendar year 2020 for newly eligible Medi-Cal beneficiaries. The ACA methodology has been approved by CMS.

3. ACA payments will be processed nine months after the respective FY's supplemental payments have been issued in order to determine the proportion of the hospital's trauma care costs for newly eligible Medi-Cal beneficiaries. For FY 2018-19, the ACA supplemental payments will be claimed in FY 2019-20. ACA payments for FY 2019-20 will be claimed in FY 2020-21. The County will be reimbursed for the nonfederal share, and an adjustment will be made for the federal share processed at the regular 50% FMAP.

4. The Department overclaimed FYs 2013-14, 2014-15, 2015-16, and 2017-18 ACA FFP and is expected to repay the federal funds in FY 2019-20 and FY 2020-21.

(Dollars in Thousands)

FY 2019-20	TF	GF	Special Deposit Fund	FF	ACA FF	*Return to Counties
FY 2018-19 ACA Adjustment to Counties	$11,239	$0	$0	($12,918)	$24,157	$11,239
FY 2018-19	$120,365	$0	$60,183	$60,182	$0	$0
Federal Funds Repayment	$0	$9,652	$0	$0	($9,652)	$0
Total FY 2019-20	**$131,604**	**$9,652**	**$60,183**	**$47,264**	**$14,505**	$11,239

(Dollars in Thousands)

FY 2020-21	TF	GF	Special Deposit Fund	FF	ACA FF	*Return to Counties
FY 2019-20 ACA Adjustment to Counties	$13,898	$0	$0	($16,746)	$30,644	$13,899
FY 2019-20	$149,964	$0	$74,982	$74,982	$0	$0
Federal Funds Repayment	$0	$0	$6,902	$0	($6,902)	$0
Total FY 2020-21	**$163,862**	**$0**	**$81,884**	**$58,236**	**$23,742**	$13,899

*The Return to Counties column is for display purposes only (see Methodology #3).

Funding:

100% GF (4260-101-0001)
50% Local Trauma Centers Fund / 50% Title XIX FF (4260-601-0942142) / (4260-101-0890)
100% Title XIX ACA (4260-101-0890)
100% Title XIX FF (4260-101-0890)

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	151
IMPLEMENTATION DATE:	11/2015
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1899

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$118,278,000	$118,812,000
- STATE FUNDS	$49,259,250	$50,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$118,278,000	$118,812,000
STATE FUNDS	$49,259,250	$50,000,000
FEDERAL FUNDS	$69,018,750	$68,812,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental payments to a new private nonprofit hospital, Martin Luther King, Jr. – Los Angeles (MLK-LA) Healthcare Corporation.

Authority:
SB 857 (Chapter 31, Statutes of 2014), Welfare & Institutions (W&I) Code 14165.50
SPA 17-023
SPA 18-0021

Interdependent Policy Changes:
Not Applicable

Background:
SB 857 requires specific funding requirements to facilitate the financial viability of a new private nonprofit hospital that will serve the population of South Los Angeles. Pursuant to W&I Code 14165.50, the cost-based reimbursement methodology for Medi-Cal FFS and managed care payments to the new MLK-LA hospital will provide compensation at a minimum of 100% of the projected costs for each fiscal year (FY), contingent upon federal approvals and availability of county funding.

Under the statute, the State General Fund (GF) is obligated to provide, beginning the fiscal year MLK-LA opens through FY 2016-17, the non-federal share of a guaranteed level (minimum payment level) of 77% of the total Medi-Cal FFS inpatient projected cost. If current Medi-Cal private hospital reimbursement methods result in funding that is less than 77% of the Medi-Cal FFS inpatient projected costs, GF appropriations are required to fund the non-federal share of the additional payments up to the 77% of costs.

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 151

Beginning FY 2017-18, and subsequent fiscal years, this GF obligation is reduced to 72% of projected Medi-Cal FFS costs. If current Medi-Cal private hospital reimbursement methods result in funding that is less than 72% of the Medi-Cal FFS inpatient projected costs, the GF will be required to fund the non-federal share of the additional payments up to 72% of the costs.

In order to enable reimbursement for the MLK-LA to reach 100% of the FFS inpatient projected costs, the remaining non-federal share amounts may be transferred by the County of Los Angeles via voluntary intergovernmental transfers (IGTs). Any public funds transferred shall be expended solely for the non-federal share of the supplemental payment. Additionally, the Department shall seek further federal approval to enable MLK-LA to receive Medi-Cal supplemental payments to the extent necessary to meet minimum funding requirements. Further reimbursement exceeding the 100% minimum funding requirement may be sought through additional supplemental programs upon federal approval.

State Plan Amendment (SPA) 17-023 capped payments at $113.4 million in FY 2017-18. SPA 18-0021, which was approved by CMS on July 19, 2018, increased the payment cap from $113.4 million to $115.2 million, effective July 1, 2018. The $115.2 million total payment represents $100 million in supplemental payments and $15.2 million in Diagnosis Related Group (DRG) add-on payments.

The reconciliation process may find an overpayment or underpayment to MLK-LA and will be handled as follows:

- For overpayments, MLK-LA will be subject to recovery of the payment for the amount exceeding the supplemental and DRG add-on payment cap and the amount of DRG add-on payments exceeding the minimum payment level based on actual costs.
- For underpayments, MLK-LA will receive an additional payment equal to the reconciled amount for DRG add-on payments needed to meet the minimum payment level, subject to the supplemental and DRG add-on payment cap.

Reason for Change:

The change in FY 2019-20, from the prior estimate, is due to:

- Updated FY 2018-19 Affordable Care Act (ACA) optional population payment data,
- Inclusion of FY 2018-19 DRG add-on interim reconciliations, and
- Inclusion of FY 2015-16 DRG add-on and supplemental final reconciliations.

The change in FY 2020-21, from the prior estimate, is due to updated FY 2019-20 ACA payment data.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to:

- Reduced ACA Federal Medical Assistance Percentage (FMAP) for FY 2019-20 in FY 2020-21,
- Inclusion of FY 2018-19 DRG add-on interim reconciliations in FY 2019-20, and
- Inclusion of FY 2015-16 DRG add-on and supplemental final reconciliations in FY 2019-20.

Methodology:

1. Medi-Cal certification approval is retroactive to the effective date of June 30, 2015.

2. DRG inpatient payments to MLK-LA were implemented beginning November 2015 for dates of service on or after July 1, 2015.

3. MLK-LA received the DRG statewide, wage adjusted, base rate.

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 151

4. Assume DRG payments and DRG add-on payments, if necessary, will be sufficient to reach the 72% minimum payment level for FY 2019-20 and FY 2020-21.

5. Expenditures for FY 2019-20 and FY 2020-21 costs up to 72% of total Medi-Cal FFS inpatient projected costs will be paid through DRG FFS payments which are incorporated in the FFS base.

6. Assume for FFS and supplemental payments, there are no Title XXI payments, based on updated MLK-LA payment data.

7. Supplemental payments are equal to the difference between MLK-LA's Medi-Cal FFS inpatient hospital charges and all amounts paid to MLK-LA by the Medi-Cal FFS inpatient hospital program per fiscal year. For FY 2019-20 and FY 2020-21, the supplemental payments and DRG add-on payments are limited by the payment cap of $115.2 million. FY 2019-20 and FY 2020-21 supplemental payments are estimated to be $100 million TF annually.

8. The ACA supplemental payments will be processed nine months after the respective FY's supplemental payments have been issued in order to determine the proportion of the costs for newly eligible Medi-Cal beneficiaries. FY 2018-19 ACA supplemental payments will be claimed in FY 2019-20. For FY 2019-20, the ACA payment will be claimed in FY 2020-21. The County will be reimbursed for the IGT (non-federal share), and an adjustment will be made for the federal share processed at the regular 50% FMAP. Beginning January 1, 2017, the ACA optional population FMAP is 95%, and reduces to 94% beginning January 1, 2018, and reduces again to 93% beginning January 1, 2019, and further reduces to 90% beginning January 1, 2020. CMS approved the ACA supplemental payment methodology in August 2017.

9. Managed care costs for MLK-LA are reflected in the Retro MC Rate Adjustment policy change.

10. On a cash basis, costs in FY 2019-20 and FY 2020-21 are expected to be:

(Dollars in Thousands)

FY 2019-20	TF	GF	IGT*	FF	ACA FF	Return to County**
Supplemental 2019-20	$100,000	$0	$50,000	$50,000	$0	$0
Supplemental ACA 2018-19	$19,719	$0	$0	($22,665)	$42,384	$19,719
DRG Add-On Interim Reconciliation 2018-19	($1,442)	($584)	$0	($561)	($297)	$0
DRG Add-On Final Reconciliation 2015-16	$1,710	$313	$0	$314	$1,083	$0
Supplemental Final Reconciliation 2015-16	($1,709)	$0	($470)	($470)	($769)	$0
Total	**$118,278**	**($271)**	**$49,530**	**$26,618**	**$42,401**	$19,719

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 151

(Dollars in Thousands)

FY 2020-21	TF	GF	IGT*	FF	ACA FF	Return to County**
Supplemental 2020-21	$100,000	$0	$50,000	$50,000	$0	$0
Supplemental ACA 2019-20	$18,812	$0	$0	($22,665)	$41,477	$18,812
Total	**$118,812**	**$0**	**$50,000**	**$27,335**	**$41,477**	$18,812

**The Return to County column is for display purposes only (see methodology #8)

Funding:
50% Title XIX / 50% Reimbursement GF (4260-601-0995/4260-101-0890)*
100% Title XIX ACA FF (4260-101-0890)
94% Title XIX ACA FF / 6% GF (4260-101-0890/0001)
93% Title XIX ACA FF / 7% GF (4260-101-0890/0001)

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	152
IMPLEMENTATION DATE:	10/2013
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1600

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$94,555,000	$83,684,000
- STATE FUNDS	$43,086,000	$43,141,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$94,555,000	$83,684,000
STATE FUNDS	$43,086,000	$43,141,000
FEDERAL FUNDS	$51,469,000	$40,543,000

DESCRIPTION

Purpose:
This policy change estimates the revenue and payments for a supplemental reimbursement program for Non-Designated Public Hospitals (NDPHs).

Authority:
AB 113 (Chapter 20, Statutes of 2011)
SPA 10-026
SPA 16-015

Interdependent Policy Changes:
Not Applicable

Background:
AB 113 established a NDPH supplemental payment program funded by intergovernmental transfers (IGTs). AB 113 authorizes the State to retain nine percent of each IGT to reimburse the administrative costs of operating the program and for the benefit of Medi-Cal children's health programs. This policy change also reflects the portion of the nine percent that is used to offset General Fund (GF) costs of Medi-Cal children's health services.

SPA 16-015 was approved by the Centers for Medicare & Medicaid Services (CMS) on July 20, 2016, to allow for an interim IGT payment in the event that an Upper Payment Limit (UPL) has not been finalized by CMS by April 30th of each State fiscal year.

Reason for Change:
There is no significant change from the prior estimate for FY 2019-20.

The overall decrease in FY 2020-21, from the prior estimate, is due to updated payment data for FY 2017-18 and FY 2018-19 based on provisional UPL for the respective fiscal year.

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 152

In the current estimate, payments are projected to be lower in FY 2020-21 than FY 2019-20 due to potential recoupments occurring in FY 2020-21 based on the decrease in the provisional FY 2017-18 and FY 2018-19 UPLs.

Methodology:

1. The NDPH IGT supplemental payments program is a formula-based program which depends on the UPL's available room. The available room is then applied to the formula to determine the supplemental payments, the administrative costs of operating the program, and the benefit of Medi-Cal's children's health programs.

2. The FY 2015-16 and FY 2016-17 UPLs were approved by CMS on June 14, 2019 at $70,124,808 and $89,869,744, respectively. FY 2017-18 and FY 2018-19 UPLs will be subsequently submitted.

3. ACA allows for 100% Federal Medical Assistance Percentage (FMAP) for calendar years 2014 through 2016, for newly eligible Medi-Cal beneficiaries. The ACA methodology has been approved. Beginning on January 1, 2017, FMAP for the ACA population decreases to 95%, 94% beginning on January 1, 2018, 93% beginning on January 1, 2019, and then 90% beginning on January 1, 2020, for all subsequent years.

4. Interim supplemental payments for FYs 2015-16 through FY 2018-19 were processed using 80 percent of the UPL room from FY 2014-15, which was the last approved UPL at the date of payment. FY 2019-20 and FY 2020-21 interim supplemental payments are estimated using 80 percent of the approved UPL room from FY 2016-17. Adjustments for FY 2017-18 and FY 2018-19 are estimated using the provisional UPL room from the respective fiscal year.

5. ACA payments will be processed nine months after the respective FY's supplemental payments have been issued in order to determine the proportion of the costs for newly eligible Medi-Cal beneficiaries. FY 2015-16 ACA supplemental payments will be claimed in FY 2019-20. FY 2016-17 through FY 2018-19 ACA supplemental payments will be claimed in FY 2020-21. Traditional overpayments (nonfederal share) will be offset with ACA payments and overpaid administrative costs. An adjustment will be made for the federal share processed at the regular 50% FMAP.

6. FY 2013-14 through FY 2016-17 Children's Services payments that were collected based on the interim payments amounts for the respective FYs will be reconciled to the respective FYs. FY 2017-18 and FY 2018-19 Children's Services payments will be reconciled upon approval of the UPLs for the respective period.

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 152

7. The estimated NDPH IGT supplemental payments are:
(Dollars in Thousands)

FY 2019-20	TF	GF*	IGT**	FF	ACA	***Return to NDPHs
FY 2013-14 Additional Payments	$11,584	$0	$5,792	$5,792	$0	$0
FY 2013-14 Children's Services (Est.)	$0	($529)	$529	$0	$0	$0
FY 2014-15 Additional Payments	$358	$0	$179	$179	$0	$0
FY 2014-15 Children's Services (Est.)	$0	$630	($630)	$0	$0	$630
FY 2015-16 Payment Finalization	$9,550	$0	$0	($11,796)	$21,346	$0
FY 2015-16 Children's Services (Est.)	$1,167	($2,316)	$3,483	$0	$0	$1,167
FY 2019-20 Interim Payment	$71,896	$0	$35,948	$35,948	$0	$0
Total FY 2019-20	**$94,555**	**($2,215)**	**$45,301**	**$30,123**	**$21,346**	$1,797

Dollars in Thousands)

FY 2020-21	TF	GF*	IGT**	FF	ACA	***Return to NDPHs
FY 2016-17 Payment Finalization	$22,079	$0	$715	($6,510)	$27,874	$0
FY 2016-17 Children's Services (Est.)	$573	($3,005)	$3,578	$0	$0	$573
FY 2017-18 Payment Finalization	($7,431)	$0	$800	($21,984)	$13,753	$0
FY 2017-18 Children's Services (Est.)	$2,095	($1,360)	$3,455	$0	$0	$2,095
FY 2018-19 Payment Finalization	($7,606)	$0	$932	($21,940)	$13,402	$0
FY 2018-19 Children's Services (Est.)	$2,078	($1,491)	$3,569	$0	$0	$2,078
FY 2020-21 Interim Payment	$71,896	$0	$35,948	$35,948	$0	$0
Total FY 2020-21	**$83,684**	**($5,856)**	**$48,997**	**($14,486)**	**$55,029**	$4,746

***The Return to NDPHs column is for display purposes only (see methodology #5).

Funding:
50% Title XIX /50% MIPA (4260-606-0834/4260-101-0890)**
100% GF (4260-101-0001)*
100% Title XIX ACA (4260-101-0890)
100% MIPA (4260-606-0834)

CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER:	153
IMPLEMENTATION DATE:	6/2002
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	86

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$82,304,000	$85,239,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$82,304,000	$85,239,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$82,304,000	$85,239,000

DESCRIPTION

Purpose:
This policy change estimates federal financial participation (FFP) payments based on Certified Public Expenditures (CPE) to nursing facilities (NF) that are distinct parts (DP) of acute care hospitals that are owned or operated by a public entity.

Authority:
AB 430 (Chapter 171, Statutes of 2001)
State Plan Amendment (SPA) 01-022
SPA 12-021

Interdependent Policy Changes:
Not Applicable

Background:
DP-NFs are allowed to claim FFP on the difference between their actual costs and the amount Medi-Cal currently pays. The acute care hospital must be owned and operated by a public entity, such as a city, city and county, or health care district. In addition, the acute care hospital must meet specified requirements and provide skilled nursing services to Medi-Cal beneficiaries.

AB 97 (Chapter 3, Statutes of 2011) authorized the Department to reimburse Medi-Cal providers at the rates established in FY 2008-09, reduced by 10%, for services DP-NFs Level B providers render on or after June 1, 2011.

The Department received CMS approval on December 20, 2013, to prospectively exempt DP-NF Level B providers from the 10% payment reduction effective September 1, 2013, for providers located in designated rural and frontier areas. The remaining DP-NF Level B providers are exempt from the 10% payment reduction effective October 1, 2013, pursuant to the provisions of SB 239 (Chapter 657, Statutes of 2013).

CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER: 153

ABX2 1 (Chapter 3, Statutes of 2016) prohibits the Department from seeking to retroactively implement certain Medi-Cal provider base payment reductions and limitations with regards to reimbursements for services provided by skilled nursing facilities that are distinct parts of general acute care hospitals for dates of service on or after June 1, 2011, and on or before September 30, 2013, and from seeking to recoup overpayments of the base rate. This prohibition does not apply to supplemental payments for skilled nursing services nor the recoupment of such supplemental funds.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is due to:

- Revised final reconciliation amounts for RY 2013-14 based on updated payment data;
- RY 2014-15 final reconciliations shifted to FY 2020-21; and
- Revised interim payment amounts for RY 2017-18, RY 2018-19, and RY 2019-20 based on updated payment data.

The change in FY 2020-21, from the prior estimate, is due to:

- Addition of delayed RY 2014-15final reconciliations;
- Revised final reconciliation amounts for RY 2015-16 based on updated payment data; and
- Revised interim payment amounts for RY 2019-20 and RY 2020-21 based on updated payment data and projected payments.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to additional retroactive final reconciliations occurring in FY 2020-21.

Methodology:

1. Expenditures may receive the applicable FMAP based on date of service, such as DP-NF payments when Medi-Cal draws the federal funds in a subsequent fiscal year.

2. The reconciliation, against audited cost reports, started in FY 2010-11. This process is mandated by the Office of Inspector General (OIG) Audit (A-09-05-00050) for fiscal years subsequent to the audit year 2003-04. Scheduled interim payments and reconciliation payments are represented below.

3. ACA allows for 100% FMAP for calendar years 2014 through 2016, for newly eligible Medi-Cal beneficiaries. Beginning calendar year 2017, FMAP for ACA population allows for the following: 95% beginning on January 1, 2017, 94% beginning on January 1, 2018, and 93% beginning January 1, 2019, and 90% beginning on January 1, 2020, and thereafter. The ACA methodology has been approved by CMS.

   Assume half of the interim ACA payments occur in the current fiscal year, and the remaining half will occur in the subsequent fiscal year.

   FY 2019-20 payments, include interim ACA payments from prior rate years, as some facilities do not have allowable uncompensated costs until their cost report for the respective service period is filed.

4. Assume half of the interim payments occur in the current fiscal year, and the remaining interim payments occur in the subsequent fiscal year. FY 2019-20 payments, include interim payments from prior rate years, as some facilities do not have allowable uncompensated costs until their cost report for the respective service period is filed.

CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER: 153

FY 2019-20	TF	FFP	ACA FFP
Final Reconciliation			
RY 2012-13	($1,602,000)	($1,602,000)	$0
RY 2013-14	$2,388,000	$2,388,000	$0
Final Reconciliation ACA			
RY 2013-14	$447,000	$0	$447,000
Interim Reconciliation			
RY 2016-17	$696,000	$696,000	$0
RY 2017-18	$8,077,000	$8,077,000	$0
Interim Reconciliation ACA			
RY 2016-17	$278,000	$0	$278,000
RY 2017-18	$2,405,000	$0	$2,405,000
Interim Payments			
RY 2016-17	$23,000	$23,000	$0
RY 2017-18	$1,980,000	$1,980,000	$0
RY 2018-19	$29,041,000	$29,041,000	$0
RY 2019-20	$23,289,000	$23,289,000	$0
Interim Payments ACA			
RY 2016-17	$3,000	$0	$3,000
RY 2017-18	$92,000	$0	$92,000
RY 2018-19	$8,495,000	$0	$8,495,000
RY 2019-20	$6,692,000	$0	$6,692,000
FY 2019-20 Total	**$82,304,000**	**$63,892,000**	**$18,412,000**

CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER: 153

FY 2020-21	TF	FFP	ACA FFP
Final Reconciliation			
RY 2014-15	$7,586,000	$7,586,000	$0
RY 2015-16	$5,809,000	$5,809,000	$0
Final Reconciliation ACA			
RY 2014-15	$1,711,000	$0	$1,711,000
RY 2015-16	$1,207,000	$0	$1,207,000
Interim Reconciliation			
RY 2018-19	$4,184,000	$4,184,000	$0
Interim Reconciliation ACA			
RY 2018-19	$1,777,000	$0	$1,777,000
Interim Payments			
RY 2019-20	$26,478,000	$26,478,000	$0
RY 2020-21	$23,289,000	$23,289,000	$0
Interim Payments ACA			
RY 2019-20	$6,687,000	$0	$6,687,000
RY 2020-21	$6,511,000	$0	$6,511,000
FY 2020-21 Total	**$85,239,000**	**$67,346,000**	**$17,893,000**

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

QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	154
IMPLEMENTATION DATE:	4/2014
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1563

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$88,000,000	$82,000,000
- STATE FUNDS	$44,000,000	$41,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$88,000,000	$82,000,000
STATE FUNDS	$44,000,000	$41,000,000
FEDERAL FUNDS	$44,000,000	$41,000,000

DESCRIPTION

Purpose:
This policy change estimates:

- Transfer from the General Fund (GF) to a Skilled Nursing Facility Quality and Accountability Special Fund (Special Fund), and
- Supplemental payments to Freestanding Skilled Nursing Facility Level-Bs (FS/NF-Bs) and Freestanding Subacute Nursing Facility Level-B (FSSA/NF-B) facilities through the Special Fund.

Authority:
SB 853 (Chapter 717, Statutes of 2010)
AB 1489 (Chapter 631, Statutes of 2012)
AB 119 (Chapter 17, Statutes of 2015)
SB 97 (Chapter 52, Statutes of 2017)
State Plan Amendment (SPA) 17-024
SPA 18-0034

Interdependent Policy Changes:
Not Applicable

Background:
SB 853 implemented a quality and accountability supplemental payments (QASP) program for FS/NF-Bs and FSSA/NF-B facilities. The supplemental payments are tied to demonstrated quality of care improvements. Supplemental payments began April 2014 and are paid through the Special Fund. The Special Fund is comprised of penalties collected from skilled nursing facilities that do not meet minimum staffing requirements, one-third of the AB 1629 facilities reimbursement rate increase for rate year (RY) 2014-15 (up to a maximum of 1% of the overall rate), and the savings achieved from setting the professional liability insurance (PLI) cost category at the 75th percentile.

AB 1489 implemented a 3% increase to the AB 1629 facilities weighted average Medi-Cal reimbursement rate for the 2013-14 and 2014-15 RYs, and also extended the quality assurance fee (QAF) and the QASP at 1% of the overall rate level until July 31, 2015.

QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 154

AB 119 extends the AB 1629 facility-specific rate methodology, QAF, and QASP program through July 31, 2020. Further, beginning in RY 2015-16, the annual weighted average rate increase was set at 3.62%, and the General Fund appropriation for the QASP program will continue at RY 2014-15 levels, rather than setting aside a portion of the annual rate increase. Additionally, beginning RY 2015-16, the Department is required to incorporate direct care staff retention as a performance measure into the QASP program.

SB 97 increases the minimum staffing requirement from 3.2 to 3.5, which is an eligibility requirement for the QASP program, beginning in 2019-20 RY. This requirement will have no fiscal impact on the QASP program.

The California Department of Aging (CDA) has direct appropriation authority of $1.9 million from the Special Fund to pay for the Ombudsman costs that are not matched with Federal Financial Participation (FFP).

The Department reimburses the California Department of Public Health (CDPH) administrative costs from the Special Fund. See the FFP for Department of Public Health Support Cost other administration policy change.

Reason for Change:
There is no change for FY 2019-20 and FY 2020-21 from the prior estimate. There is no change from FY 2019-20 to FY 2020-21, in the current estimate.

Methodology:

1. Administrative costs as well as supplemental payments are eligible for an FFP match. CDA Ombudsman costs are not eligible for FFP.

2. The estimated incoming funds for the Special Fund are:

Incoming Funds	FY 2019-20	FY 2020-21
Penalties on Nursing Facilities	$396,000	$100,000
QASP GF Appropriation	$43,236,000	$43,236,000
PLI savings	$3,743,000	$3,743,000

3. The penalties on nursing facilities will be deposited into the CDPH Skilled Nursing Facility Minimum Staffing Penalty Account and then transferred to the Special Fund. The total amount of supplemental payments may be adjusted in accordance with the amount of administrative penalties deposited into the Special Fund.

4. Estimated CDPH annual administrative costs are $7,500,000 TF ($3,750,000 Special Fund) for FY 2019-20 and $10,864,000 TF ($5,432,000 Special Fund) FY 2020-21.

5. The GF appropriated QASP funding will continue at RY 2014-15 levels, instead of setting aside a portion of the annual increase.

6. Assume the QASP program will be extended through FY 2020-21.

QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 154

7. Supplemental payments are estimated to be:

(Dollars in Thousands)

FY 2019-20	TF	GF	SF	FF
Supplemental Payments***	$88,000	$0	$44,000	$44,000
Transfer from GF* to Special Fund**	$0	$46,979	($46,979)	$0
Total	**$88,000**	**$46,979**	**($2,979)**	**$44,000**

(Dollars in Thousands)

FY 2020-21	TF	GF	SF	FF
Supplemental Payments***	$82,000	$0	$41,000	$41,000
Transfer from GF* to Special Fund**	$0	$46,979	($46,979)	$0
Total	**$82,000**	**$46,979**	**($5,979)**	**$41,000**

Funding:
100% GF (4260-605-0001)*
SNF Quality & Accountability (less funded by GF) (4260-698-3167)**
SNF Quality & Accountability (4260-605-3167)***
Title XIX FFP (4260-101-0890)***

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER:	155
IMPLEMENTATION DATE:	4/2014
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1661

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$3,272,000	$80,700,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,272,000	$80,700,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$3,272,000	$80,700,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental payments to publicly owned or operated ground emergency medical transportation (GEMT) service providers.

Authority:
AB 678 (Chapter 397, Statutes of 2011)
SB 523 (Chapter 773, Statutes of 2017)
State Plan Amendment (SPA) 09-024

Interdependent Policy Changes:
Not Applicable

Background:
A provider that delivers GEMT services to Medi-Cal beneficiaries will be eligible for supplemental payment under the GEMT Supplemental Payment Program for services if the following requirements are met:

1. The provider must be enrolled as a Medi-Cal provider for the period being claimed, and
2. The provider must be owned or operated by the state, a city, county, city and county, federally recognized Indian tribe, health care district, special district, community services district, or fire protection district.

Supplemental payments combined with other reimbursements cannot exceed 100% of actual costs.

Specified governmental entities will pay the non-federal share of the supplemental reimbursement through certified public expenditures (CPEs). The supplemental reimbursement program is retroactive to January 30, 2010. The Centers for Medicare and Medicaid Services (CMS) approved a State Plan Amendment (SPA) #09-024 on September 4, 2013. Annual payments are scheduled to be submitted on a lump-sum basis following the State fiscal year.

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 155

SPA 18-007, was submitted to CMS in FY 2018-19, proposes to update the definition of allowable costs to include shared direct costs and to revise the timeline for final settlements.

Reason for Change:
The changes in both FY 2019-20 and FY 2020-21, from the prior estimate, are due to:

- FY 2018-19 interim payments now being expected to occur in FY 2020-21, pending CMS approval of SPA 18-007, and
- The unanticipated early issuance of audit reports for FY 2015-16 and FY 2016-17 resulted in interim reconciliations being processed as final in FY 2019-20, completing both fiscal years of reconciliations and shifting the FY 2016-17 final reconciliations from FY 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to:

- Both FY 2018-19 and FY 2019-20 interim payments are expected to occur in FY 2020-21, pending CMS approval of SPA 18-007, and
- Net payments, instead of net recoupments, are estimated for the final reconciliations occurring in FY 2020-21.

Methodology:

1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008, through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011, through March 31, 2011, and 56.88% for April 1, 2011, through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

2. The ACA allows for 100% FMAP for calendar years (CY) 2014 through 2016, 95% FMAP for CY 2017, 94% FMAP for CY 2018, 93% for CY 2019, and 90% for CY 2020 and after for newly eligible Medi-Cal beneficiaries. The ACA methodology has been approved by CMS.

3. Effective July 1, 2018, SB 523 established the GEMT Provider Quality Assurance Fee (QAF) Program. GEMT QAF payments will reduce GEMT CPE reimbursements beginning in FY 2018-19.

4. Interim reconciliations are performed within two years of receipt of the as-filed cost report. Final reconciliations are based on audited cost reports, and the audit and settlement process is completed within three years of the postmark date of the approved cost report. Due to delays in receipt of cost reports, retroactive years are being reconciled in FY 2019-20 and FY 2020-21.

5. SPA 18-007, when approved, will be retroactive to dates of service beginning July 1, 2018. SPA 18-007 proposes to expand claimable costs that can be allocated to two or more departmental functions on the basis of shared benefits, for increased GEMT supplemental reimbursement.

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 155

The estimated payments on a cash basis are:

FY 2019-20	Total FFP	Regular FFP	ARRA	ACA
FY 2010-11 Final Recon.	($941,000)	($796,000)	($145,000)	$0
FY 2011-12 Final Recon.	($318,000)	($318,000)	$0	$0
FY 2012-13 Final Recon.	($341,000)	($341,000)	$0	$0
FY 2013-14 Final Recon.	($576,000)	($400,000)	$0	($176,000)
FY 2014-15 Final Recon.	($986,000)	($506,000)	$0	($480,000)
FY 2015-16 Final Recon.	($1,541,000)	($593,000)	$0	($948,000)
FY 2016-17 Final Recon.	($73,000)	($133,000)	$0	$60,000
FY 2010-11 Interim Payment	$7,761,000	$6,300,000	$1,461,000	$0
FY 2011-12 Interim Payment	$192,000	$192,000	$0	$0
FY 2012-13 Interim Payment	$12,000	$12,000	$0	$0
FY 2016-17 Interim Payment	$83,000	$26,000	$0	$57,000
Total FY 2019-20	**$3,272,000**	**$3,443,000**	**$1,316,000**	**($1,487,000)**

FY 2020-21	Total FFP	Regular FFP	ARRA	ACA
FY 2009-10 Final Recon.	$12,769,000	$10,366,000	$2,403,000	$0
FY 2017-18 Interim Recon.	$3,584,000	$1,042,000	$0	$2,542,000
FY 2018-19 Interim Payment	$31,749,000	$10,803,000	$0	$20,946,000
FY 2019-20 Interim Payment	$32,598,000	$11,092,000	$0	$21,506,000
Total FY 2020-21	**$80,700,000**	**$33,303,000**	**$2,403,000**	**$44,994,000**

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XIX ACA (4260-101-0890)

PROP 56 - DEVELOPMENTAL SCREENINGS

REGULAR POLICY CHANGE NUMBER:	156
IMPLEMENTATION DATE:	1/2020
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	2171

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$35,733,000	$49,128,000
- STATE FUNDS	$15,146,020	$22,269,910
PAYMENT LAG	0.9742	0.9982
% REFLECTED IN BASE	0.34 %	0.41 %
APPLIED TO BASE		
TOTAL FUNDS	$34,692,700	$48,838,500
STATE FUNDS	$14,705,080	$22,138,680
FEDERAL FUNDS	$19,987,650	$26,699,820

DESCRIPTION

Purpose:
This policy change estimates the cost for providing Proposition 56 funded payments for developmental screenings.

Authority:
AB 74 (Chapter 23, Statute of 2019)

Interdependent Policy Changes:
Not Applicable

Background:
On November 8, 2016, California voters passed the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) to increase the excise tax rate on cigarettes and tobacco products. Under Proposition 56, a portion of the tobacco tax revenue is allocated to the Department for use as the nonfederal share of health care expenditures in accordance with the annual state budget process.

The Department has proposed to begin providing Proposition 56 funded payments for clinically appropriate developmental screening services for children, starting January 1, 2020. In the Medi-Cal managed care delivery system, the Department has proposed to implement these payments as directed payments to eligible providers. On June 30, 2019, the Department submitted the directed payment pre-print (proposal) required by the Centers for Medicare and Medicaid Services, seeking to obtain managed care directed payment approval.

Developmental screening is the use of a standardized set of questions to see if a child's motor, language, cognitive, social, and emotional development are on track for their age. National guidelines recommend a developmental screening for all children at 9 months, 18 months, and 30 months of age. Repeated and regular screening is necessary to ensure timely identification of problems and early intervention, especially in later-developing skills such as language.

PROP 56 - DEVELOPMENTAL SCREENINGS

REGULAR POLICY CHANGE NUMBER: 156

This policy change identifies the use of the General Fund for these Proposition 56 payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is a net decrease due to updated Fee-for-Service (FFS) caseload and managed care capitation.

The change in the current estimate, from FY 2019-20 to FY 2020-21, is due to FY 2020-21 including a full year of cost.

Methodology:
1. Fee -for-Service (FFS) and managed care implementation for developmental screenings began January 1, 2020.

2. Developmental screenings are recommended at three specific times in early childhood (9 months, 18 months, and 30 months).

3. Assume, in any given year, there are approximately 25,000 children age 9 months each month, 29,000 children age 18 months each month, and 29,000 children age 30 months each month.

4. Total estimated payments in FY 2019-20 and FY 2020-21:

FY 2019-20	TF	GF	Title XIX	Title XXI
Fee-for-Service	$2,970,000	$1,428,000	$1,377,000	$165,000
Managed Care	$32,763,000	$13,718,000	$12,261,000	$6,784,000
Total	**$35,733,000**	**$15,146,000**	**$13,638,000**	**$6,949,000**

FY 2020-21	TF	GF	Title XIX	Title XXI
Fee-for-Service	$5,940,000	$2,893,000	$2,754,000	$293,000
Managed Care	$43,188,000	$19,377,000	$16,156,000	$7,655,000
Total	**$49,128,000**	**$22,270,000**	**$18,910,000**	**$7,948,000**

Funding:

FY 2019-20	TF	GF	FFP
50% Title XIX / 50% GF (4260-101-0001/0890)	$26,666,000	$13,333,000	$13,333,000
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)	$6,410,000	$1,506,000	$4,904,000
88% Title XXI / 12% GF (4260-113-0001/0890)	$2,323,000	$279,000	$2,044,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	$151,000	$15,000	$136,000
93% ACA Title XIX FF / 7% GF (4260-101-0001/0890)	$183,000	$13,000	$170,000
Total	**$35,733,000**	**$15,146,000**	**$20,587,000**

PROP 56 - DEVELOPMENTAL SCREENINGS

REGULAR POLICY CHANGE NUMBER: 156

FY 2020-21	TF	GF	FFP
50% Title XIX / 50% GF (4260-101-0001/0890)	$37,027,000	$18,514,000	$18,513,000
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)	$3,206,000	$753,000	$2,453,000
65% Title XXI / 35% GF (4260-113-0001/0890)	$8,454,000	$2,959,000	$5,495,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	$441,000	$44,000	$397,000
Total	**$49,128,000**	**$22,270,000**	**$26,858,000**

PROP 56 - CBAS SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	157
IMPLEMENTATION DATE:	3/2020
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	2145

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$30,992,000	$30,992,000
- STATE FUNDS	$15,496,000	$15,496,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$30,992,000	$30,992,000
STATE FUNDS	$15,496,000	$15,496,000
FEDERAL FUNDS	$15,496,000	$15,496,000

DESCRIPTION

Purpose:
This policy change estimates the expenditures related to providing supplemental payments for Community-Based Adult Services (CBAS).

Authority:
AB 74 (Chapter 23, Statutes 2019)

Interdependent Policy Changes:
Proposition 56 Funds Transfer

Background:
The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), passed by the voters in November 2016, increases the excise tax rate on cigarettes and electronic cigarettes, effective April 1, 2017, and other tobacco products effective July 1, 2017. The excise tax increased by $2 from 87 cents to $2.87 per pack of 20 cigarettes on distributors selling cigarettes in California with an equivalent excise tax rate increase on other tobacco products.

Pursuant to the Budget Act of 2019, the Department shall develop the structure and parameters for supplemental payments for CBAS in FY 2019-20.

This policy change identifies the use of the General Fund (GF) for these Proposition 56 payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21. There is no change from FY 2019-20 to FY 2020-21 in the current estimate.

Methodology:
1. The Budget Act of 2019 provides for supplemental payments for CBAS in FY 2019-20 and FY 2020-21.

PROP 56 - CBAS SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 157

2. Estimated supplemental payments are as follows:

Fiscal Year	TF	FF	GF
FY 2019-20	$30,992,000	$15,496,000	$15,496,000
FY 2020-21	$30,992,000	$15,496,000	$15,496,000

Funding:
100% GF (4260-101-0001)

PROP 56 - ADVERSE CHILDHOOD EXPERIENCES SCREENINGS

REGULAR POLICY CHANGE NUMBER:	158
IMPLEMENTATION DATE:	1/2020
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	2129

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$26,726,000	$37,958,000
- STATE FUNDS	$10,222,680	$15,305,880
PAYMENT LAG	0.9536	0.9904
% REFLECTED IN BASE	0.62 %	2.16 %
APPLIED TO BASE		
TOTAL FUNDS	$25,327,900	$36,781,600
STATE FUNDS	$9,687,910	$14,831,510
FEDERAL FUNDS	$15,639,990	$21,950,070

DESCRIPTION

Purpose:
This policy change estimates the cost for providing Adverse Childhood Experiences (ACEs) screenings.

Authority:
AB 74 (Chapter 23, Statute of 2019)

Interdependent Policy Changes:
Not Applicable

Background:
On November 8, 2016, California voters passed the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) to increase the excise tax rate on cigarettes and tobacco products. Under Proposition 56, a portion of the tobacco tax revenue is allocated to the Department for use as the nonfederal share of health care expenditures in accordance with the annual state budget process.

The Department has proposed to begin providing Proposition 56 funded payments for clinically appropriate ACEs services for children and adults, starting January 1, 2020. In the Medi-Cal managed care delivery system, the Department has proposed to implement these payments as directed payments to eligible providers. On June 30, 2019, the Department submitted the directed payment pre-print (proposal) required by the Centers for Medicare and Medicaid Services, seeking to obtain managed care directed payment approval.

Trauma informed care is an organizational transformation process to provide a model of care intended to promote healing and reduce risk for re-traumatization. ACEs evaluates children and adults for trauma that occurred during the first 18 years of life. Early identification of trauma and providing the appropriate treatment is a critical tool for reducing long-term health care costs for both children and adults.

PROP 56 - ADVERSE CHILDHOOD EXPERIENCES SCREENINGS

REGULAR POLICY CHANGE NUMBER: 158

The following Healthcare Common Procedure Coding System (HCPCS) codes are eligible for the Proposition 56 funded payments:

HCPCS Code	Description	Notes
G9919	Screening performed – results positive and provision of recommendations provided	Providers must bill this code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	Providers must bill this code when the patient's ACE score is between 0 and 3 (lower risk).

This policy change identifies the use of the General Fund (GF) for these Proposition 56 payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is a net increase due to updated Fee-for-Service (FFS) caseload and managed care capitation.

The change in the current estimate, from FY 2019-20 to FY 2020-21, is due to FY 2020-21 including a full year of cost.

Methodology:

1. Fee-for-Service (FFS) and managed care implementation for ACEs began January 1, 2020.

2. Assume all children and adults under age 65 will be initially screened within 3 years. One-third of both the child and adult population will receive an initial screening in each year for 3 years.

3. Providers will be able to bill for children to receive periodic rescreening as determined appropriate and applicable, not more often than once a year and no less often than every 3 years.

4. Assume that 20% of those initially screened would require a complex assessment.

5. Total estimated payments in FY 2019-20 and FY 2020-21 are:

FY 2019-20	TF	GF	Title XIX	Title XXI
Fee-for-Service	$4,000,000	$1,516,000	$2,413,000	$71,000
Managed Care	$22,726,000	$8,707,000	$10,248,000	$3,771,000
Total	**$26,726,000**	**$10,223,000**	**$12,661,000**	**$3,842,000**

FY 2020-21	TF	GF	Title XIX	Title XXI
Fee-for-Service	$8,001,000	$3,048,000	$4,827,000	$126,000
Managed Care	$29,957,000	$12,258,000	$13,444,000	$4,255,000
Total	**$37,958,000**	**$15,306,000**	**$18,271,000**	**$4,381,000**

PROP 56 - ADVERSE CHILDHOOD EXPERIENCES SCREENINGS

REGULAR POLICY CHANGE NUMBER: 158

Funding:

FY 2019-20	TF	GF	FFP
50% Title XIX / 50% GF (4260-101-0001/0890)	$17,740,000	$8,870,000	$8,870,000
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)	$3,537,000	$831,000	$2,706,000
88% Title XXI / 12% GF (4260-113-0001/0890)	$1,291,000	$155,000	$1,136,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	$2,517,000	$252,000	$2,265,000
93% ACA Title XIX FF / 7% GF (4260-101-0001/0890)	$1,641,000	$115,000	$1,526,000
Total	**$26,726,000**	**$10,223,000**	**$16,503,000**

FY 2020-21	TF	GF	FFP
50% Title XIX / 50% GF (4260-101-0001/0890)	$25,266,000	$12,633,000	$12,633,000
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)	$1,768,000	$416,000	$1,352,000
65% Title XXI / 35% GF (4260-113-0001/0890)	$4,660,000	$1,631,000	$3,029,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	$6,264,000	$626,000	$5,638,000
Total	**$37,958,000**	**$15,306,000**	**$22,652,000**

DPH PHYSICIAN & NON-PHYS. COST

REGULAR POLICY CHANGE NUMBER:	159
IMPLEMENTATION DATE:	5/2008
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1078

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$14,471,000	$224,686,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$14,471,000	$224,686,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$14,471,000	$224,686,000

DESCRIPTION

Purpose:
This policy change estimates the payments to Designated Public Hospitals (DPHs) for the uncompensated costs of their physician and non-physician practitioner professional services.

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.35
State Plan Amendment (SPA) 05-023
SPA 16-020

Interdependent Policy Changes:
Not Applicable

Background:
Effective July 1, 2005, pursuant to SPA 05-023, DPHs are to receive reimbursement based on certified public expenditures (CPEs) for their Medi-Cal uncompensated costs incurred for physician and non-physician practitioner professional services.

SPA 05-023 that authorizes federal funding for this reimbursement was approved by the Centers for Medicare & Medicaid Services (CMS) in December 2007. CMS approved the “Physician and Non-Physician Practitioner Time Study Implementation Plan” on December 15, 2008.

Due to the timing for the submission of the cost reporting and other data, there are significant lags between the date of service and the payments.

The reimbursement is available only for costs associated with health care services rendered to Medi-Cal beneficiaries who are patients of the hospital or its affiliated hospital and non-hospital settings. Each DPH’s physician and non-physician costs will be reconciled to the Medi-Cal cost report for the respective fiscal year end. Payments resulting from the interim or final reconciliation will be based on the hospitals’ CPEs and comprised of 100% federal funds.

DPH PHYSICIAN & NON-PHYS. COST

REGULAR POLICY CHANGE NUMBER: 159

SPA 16-020 was approved by CMS on December 6, 2016, which updates the language to reflect the current names of the hospital participants and to account for any future hospital name changes.

Reason for Change:
There is no change in FY 2019-20, from the prior estimate.

The change in FY 2020-21, from the prior estimate, is due to:

- FY 2017-18 interim reconciliation and Affordable Care Act (ACA) payments shifted to a future year,
- Updated interim reconciliation and ACA payment data for FY 2018-19, and
- Updated interim payment data for FY 2019-20 and FY 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to prior year interim reconciliations, final reconciliations, and ACA payments are expected to occur in FY 2020-21, and non-LA County hospital interim payments are expected to begin in FY 2020-21.

Methodology:

1. FY 2019-20 interim payments occur over two years. The interim payment will be made to LA County DPHs in FY 2019-20, and the interim payment to non-LA County DPHs will be made in FY 2020-21. For FY 2020-21, one annual interim payment is expected to occur for all DPHs in FY 2020-21.

2. Interim reconciliations of program years are anticipated to be completed upon receipt of the Physician/Non-Physician Practitioner time studies and the filed cost report information which are required components of the reconciliation process.

3. The ACA optional population supplemental payment methodology is pending CMS approval which is expected to occur in FY 2020-21 and will be retroactive to January 1, 2014. The ACA allows for 100% Federal Medical Assistance Percentage (FMAP) for calendar years 2014 through 2016, for newly eligible Medi-Cal beneficiaries. Beginning January 1, 2017 through December 31, 2017, the ACA optional population FMAP will be 95%, reduces to 94% beginning January 1, 2018, and further reduces to 93% beginning January 1, 2019.

DPH PHYSICIAN & NON-PHYS. COST

REGULAR POLICY CHANGE NUMBER: 159

4. Reconciliation/final settlement of program years is anticipated to be completed upon conclusion of final audited settlements. Final reconciliations are subject to cost report audit schedules.

FY 2019-20	TF	FF
FY 2019-20 Interim Payment	$14,471,000	$14,471,000
Total	**$14,471,000**	**$14,471,000**

FY 2020-21	TF	FF
FY 2013-14 Final Reconciliation	($17,387,000)	($17,387,000)
FY 2013-14 Payment ACA	$14,786,000	$14,786,000
FY 2018-19 Interim Reconciliation	$50,605,000	$50,605,000
FY 2018-19 Payment ACA	$61,070,000	$61,070,000
FY 2019-20 Interim Payment	$50,571,000	$50,571,000
FY 2020-21 Interim Payment	$65,041,000	$65,041,000
Total	**$224,686,000**	**$224,686,000**

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

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH

REGULAR POLICY CHANGE NUMBER:	160
IMPLEMENTATION DATE:	1/2005
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1038

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$10,000,000	$10,000,000
- STATE FUNDS	$5,000,000	$5,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$10,000,000	$10,000,000
STATE FUNDS	$5,000,000	$5,000,000
FEDERAL FUNDS	$5,000,000	$5,000,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental reimbursement to hospitals providing a disproportionate share of outpatient services.

Authority:
SB 2563 (Chapter 976, Statutes of 1988)

Interdependent Policy Changes:
Not Applicable

Background:
SB 2563 established a supplemental program for hospitals providing a disproportionate share of outpatient services. The Department calculates payments on a calendar year (CY) basis and reimburses eligible providers on a quarterly basis through a payment action notice (PAN). Each payment represents one quarter of the total annual amount due to each eligible hospital. Due to the payment being made at the end of a quarter, the last quarter of each calendar year will be paid the following calendar year.

Reason for Change:
There is no change, from the prior estimate for FY 2019-20 and FY 2020-21, and from FY 2019-20 to FY 2020-21 within the current estimate.

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH

REGULAR POLICY CHANGE NUMBER: 160

Methodology:

1. Assume annual reimbursements for disproportionate share of outpatient services are $10,000,000 TF ($5,000,000 GF).

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
CY 2019	$7,500	$3,750	$3,750
CY 2020	$2,500	$1,250	$1,250
Total	**$10,000**	**$5,000**	**$5,000**

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
CY 2020	$7,500	$3,750	$3,750
CY 2021	$2,500	$1,250	$1,250
Total	**$10,000**	**$5,000**	**$5,000**

Funding:

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

PROP 56 - NEMT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	161
IMPLEMENTATION DATE:	3/2020
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	2139

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$7,925,000	$7,937,000
- STATE FUNDS	$3,214,220	$3,260,460
PAYMENT LAG	0.8150	0.9998
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$6,458,900	$7,935,400
STATE FUNDS	$2,619,580	$3,259,810
FEDERAL FUNDS	$3,839,290	$4,675,600

DESCRIPTION

Purpose:
This policy change estimates the expenditures related to providing supplemental payments for non-emergency medical transportation (NEMT) services.

Authority:
AB 74 (Chapter 23, Statutes of 2019)
SPA 19-0044

Interdependent Policy Changes:
Not Applicable

Background:
The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), passed by the voters in November 2016, increases the excise tax rate on cigarettes and electronic cigarettes, effective April 1, 2017, and other tobacco products effective July 1, 2017. The excise tax increased by $2 from 87 cents to $2.87 per pack of 20 cigarettes on distributors selling cigarettes in California with an equivalent excise tax rate increase on other tobacco products.

Pursuant to AB 74, the Department shall develop the structure and parameters for supplemental payments for NEMT providers in FY 2019-20. On November 19, 2019, the Department received federal approval for SPA 19-0044 to establish a time-limited supplemental payment program for NEMT services, effective July 1, 2019, through December 31, 2021. The Department will submit SPA 20-0007 in March 2020 to clarify the services eligible for the NEMT supplemental payment.

The supplemental payment amounts will be fixed amounts. In addition to the base rates for each eligible NEMT service, the supplemental payment amounts will be distributed on a per claim basis. The supplemental payment amounts will be equivalent to a 10% increase of the current rates for Medi-Cal Fee-for-Service (FFS) NEMT services, except for codes A0130 and A0380, which will receive the equivalent of a 25% increase. Ground Medical Transportation and Air Medical Transportation providers will be eligible for the supplemental payments.

PROP 56 - NEMT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 161

This policy change identifies the use of the General Fund (GF) for these Proposition 56 payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is a decrease due to revising the supplemental payment annual estimate for payments effective July 2019 based on updated data on the NEMT services, and delayed implementation of the rate from January 2020 to March 2020.

The change in FY 2020-21, from the prior estimate, is a net decrease due to a lower estimated annual impact of the supplemental payments effective July 2019, and including additional codes eligible for supplemental payments effective January 2020.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to including additional codes eligible for supplemental payments effective January 2020 and the retroactive payments for January 2020 occurring in FY 2020-21.

Methodology:
1. The FFS supplemental payments will be provided for services beginning July 1, 2019, through December 31, 2021. No managed care impact is assumed.

2. The FFS supplemental payments for 17 codes were implemented in March 2020. The retroactive payment for July 2019 through February 2020, is expected to occur in May 2020.

3. The FFS supplemental payments for 3 additional codes will be provided for services beginning January 1, 2020, through December 31, 2021. These payments are expected to be implemented in July 2020. The retroactive payment for January 1, 2020, through June 30, 2020, is expected to occur in November 2020.

4. Funds allocated for the supplemental payments are as follows:

Fiscal Year	TF	GF	FFP
FY 2019-20	**$7,925,000**	**$3,214,000**	**$4,711,000**
FY 2020-21	**$7,937,000**	**$3,260,000**	**$4,677,000**

Funding:

FY 2019-20	TF	GF	FFP
50% Title XIX/ 50% GF	$6,102,000	$3,051,000	$3,051,000
93% Title XIX / 7% GF ACA	$984,000	$69,000	$915,000
90% Title XIX / 10% GF ACA	$737,000	$73,000	$664,000
88% Title XXI / 12% GF	$29,000	$4,000	$25,000
76.5% Title XXI / 23.5% GF	$73,000	$17,000	$56,000
Total	**$7,925,000**	**$3,214,000**	**$4,711,000**

PROP 56 - NEMT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 161

FY 2020-21	TF	GF	FFP
50% Title XIX/ 50% GF	$6,110,000	$3,055,000	$3,055,000
90% Title XIX / 10% GF ACA	$1,724,000	$172,000	$1,552,000
76.5% Title XXI / 23.5% GF	$26,000	$6,000	$20,000
65% Title XXI / 35% GF	$77,000	$27,000	$50,000
Total	**$7,937,000**	**$3,260,000**	**$4,677,000**

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	162
IMPLEMENTATION DATE:	12/2010
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1616

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$5,331,000	$8,271,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$5,331,000	$8,271,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$5,331,000	$8,271,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental payments to state veterans' homes.

Authority:
AB 959 (Chapter 162, Statutes of 2006)
State Plan Amendment 16-017

Interdependent Policy Changes:
Not Applicable

Background:
Under this program, state veterans' homes that are enrolled as Medi-Cal providers and are owned and operated by the State are eligible to receive supplemental payments. Eligible state veterans' homes may claim federal financial participation (FFP) on the difference between their projected costs and the amount Medi-Cal currently pays under the existing program. The non-federal match to draw down FFP will be paid from the public funds of the eligible state veterans' homes.

Supplemental payments to state veterans' homes were effective retroactively beginning with the rate year August 1, 2006. The Department certifies expenditures reported in facilities' cost report before claiming FFP.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is due to:

Interim Payments
- One provider is no longer expected to submit claims for FY 2019-20 Q1 and Q2.
- FY 2018-19 Q3 initial reconciliation payments processed earlier than expected and have shifted to interim payments for the same payment year.

Initial Reconciliation Payments
- Actual expenditures and payments for FY 2017-18 were less than previously estimated.
- FY 2018-19 payments were adjusted to reflect 4th Quarter traditional payments first time ACA payments.

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 162

The change in FY 2020-21, from the prior estimate, is due to:

- Projected FY 2019-20 initial reconciliation payments were updated to reflect the removal of Q1 and Q2 expenditures for one provider.

The change from FY 2019-20 to FY 2020-21 in the current estimate is due to:

- One year of final reconciliations is FY 2020-21 as compared to three years in FY 2019-20.
- FY 2020-21 includes two quarters of expenditures for one additional provider in both FY 2019-20 and FY 2020-21 interim payments.

Methodology:
Supplemental payments for state veterans' homes began in FY 2010-11 and payments are estimated based on actual historical reported certified expenditures.

The estimate is based on:

1. Interim payments,
2. Initial reconciliation payments
   a. First time (interim) ACA payments occur during initial reconciliations using as filed cost report data to calculate payments, and
3. A final reconciliation payment, if necessary.

Program payment amounts are estimated to be:

FY 2019-20	TF	Regular FF	ACA FF
Interim Payments			
FY 2018-19	$1,688,000	$1,688,000	$0
FY 2019-20	$2,599,000	$2,599,000	$0
Initial Reconciliation			
FY 2017-18	$337,000	$289,000	$48,000
FY 2018-19	$2,027,000	$1,633,000	$394,000
Final Reconciliation			
FY 2013-14	($389,000)	($389,000)	$0
FY 2014-15	($312,000)	($374,000)	$62,000
FY 2015-16	($619,000)	($663,000)	$44,000
FY 2019-20 Total	**$5,331,000**	**$4,783,000**	**$548,000**

FY 2020-21	TF	Regular FF	ACA FF
Interim Payments			
FY 2019-20	$3,149,000	$3,149,000	$0
FY 2020-21	$3,149,000	$3,149,000	$0
Initial Reconciliation			
FY 2019-20	$2,355,000	$1,633,000	$722,000
Final Reconciliation			
FY 2016-17	($382,000)	($382,000)	$0
FY 2020-21 Total	**$8,271,000**	**$7,549,000**	**$722,000**

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

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH

REGULAR POLICY CHANGE NUMBER:	163
IMPLEMENTATION DATE:	1/2005
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1039

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$8,000,000	$8,000,000
- STATE FUNDS	$4,000,000	$4,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$8,000,000	$8,000,000
STATE FUNDS	$4,000,000	$4,000,000
FEDERAL FUNDS	$4,000,000	$4,000,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental reimbursement to Small and Rural Hospitals (SRHs) that provide outpatient services.

Authority:
AB 2617 (Chapter 158, Statutes of 2000)

Interdependent Policy Changes:
Not Applicable

Background:
This program provides eligible SRHs with supplemental reimbursement for outpatient services. The Department calculates payments on a calendar year (CY) basis and reimburses eligible providers on a quarterly basis through a payment action notice (PAN). Each payment represents one quarter of the total annual amount due to each eligible hospital. Due to the payment being made at the end of a quarter, the last quarter of each calendar year will be paid the following calendar year.

Reason for Change:
There is no change, for FY 2019-20 and FY 2020-21 from the prior estimate, and from FY 2019-20 to FY 2020-21 within the current estimate.

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH

REGULAR POLICY CHANGE NUMBER: 163

Methodology:

1. Assume annual reimbursements to SRHs providing outpatient services are $8,000,000 TF ($4,000,000 GF).

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
CY 2019	$6,000	$3,000	$3,000
CY 2020	$2,000	$1,000	$1,000
Total	**$8,000**	**$4,000**	**$4,000**

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
CY 2020	$6,000	$3,000	$3,000
CY 2021	$2,000	$1,000	$1,000
Total	**$8,000**	**$4,000**	**$4,000**

Funding:

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

PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	164
IMPLEMENTATION DATE:	4/2018
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	2045

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$32,713,000	$31,394,000
- STATE FUNDS	$15,278,100	$14,799,530
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	77.35 %	80.60 %
APPLIED TO BASE		
TOTAL FUNDS	$7,409,500	$6,090,400
STATE FUNDS	$3,460,490	$2,871,110
FEDERAL FUNDS	$3,949,000	$3,219,330

DESCRIPTION

Purpose:
This policy change estimates the expenditures related to providing supplemental payments to Intermediate Care Facilities for the Developmentally Disabled (ICF/DD).

Authority:
AB 120 (Chapter 22, Statutes of 2017)
SB 856 (Chapter 30, Statutes of 2018)
SPA 17-028
SPA 18-0029
CA-0139.R05.01 HCBA Waiver Amendment

Interdependent Policy Changes:
Not Applicable

Background:
The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), passed by the voters in November 2016, increased the excise tax rate on cigarettes and electronic cigarettes, effective April 1, 2017, and other tobacco products effective July 1, 2017. The excise tax increased by $2.00 from 87 cents to $2.87 per pack of 20 cigarettes on distributors selling cigarettes in California with an equivalent excise tax rate increase on other tobacco products.

AB 120 allocated Proposition 56 funds for supplemental payments for ICF/DDs, ICF/DD-H facilities, ICF/DD-N facilities, and ICF-DD Continuous Nursing Care (CNC) facilities. The Centers for Medicare and Medicaid Services (CMS) approved SPA 17-028 for these supplemental payments. Additionally, CMS approved a 1915c Waiver amendment authorizing supplemental payments for ICF/DD-CNCs under the Home and Community-Based Alternatives (HCBA) Waiver.

SB 856 authorized the Department to extend the supplemental payments through FY 2018-19. The CMS approved SPA 18-0029 for the extension of the supplemental payments for the period of August 1, 2018, through July 31, 2019.

PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 164

AB 74 authorized the Department to extend supplemental payments for the period of August 1, 2019, through December 31, 2021. The CMS approved SPA 19-0022 for the extension of the supplemental payments for this period.

ICF/DDs will receive a supplemental payment based on the difference between the frozen rate at the 2008-09 65th percentile, increased by 3.7%; and the 2017-18 unfrozen rate. The resulting supplemental payment per diem amounts are as reflected by facility peer group below:

Facility Peer Group	Amount
ICF/DD (1-59 beds)	$15.47
ICF/DD (60+ beds)	$0.00
ICF/DD-H (4-6 beds)	$10.75
ICF/DD-H (7-15 beds)	$0.00
ICF/DD-N (4-6 beds)	$12.47
ICF/DD-N (7-15 beds)	$22.30

This policy change identifies the use of the General Fund for these Proposition 56 payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

Reason for Change:
The change for FY 2019-20, from the prior estimate, is an increase due to revised CCI and managed care costs based on updated expenditure estimates. The FFS Total Fund (TF) impact remained the same; however, the funding splits were updated based on revised FFS utilization data.

The change for FY 2020-21, from the prior estimate, is a decrease due to revised CCI and managed care costs based on updated expenditure estimates. The FFS Total Fund (TF) impact remained the same; however, the funding splits were updated based on revised FFS utilization data.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to more CCI payments and managed care payments expected in FY 2020-21.

Methodology:
1. Payments will be made via FFS supplemental payments and increased managed care capitation payments.

2. This policy is effective August 1, 2017, through December 31, 2021.

<u>Fee-for-Service Supplemental Payments</u>

3. The FFS supplemental payments were implemented June 25, 2018.

4. The FFS supplemental payments for ICF/DD, ICF/DD-H, and ICF-DD/N facilities are expected to be $24.886 million TF annually. The FFS supplemental payments for ICF/DD CNC facilities are expected to be $417,000 annually.

<u>Managed Care Supplemental Payments</u>

5. One month of the FY 2018-19 managed care payments will be paid in FY 2019-20.

PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 164

6. The managed care supplemental payments, including CCI, are estimated to be $7.41 million TF in FY 2019-20 and $6.09 million TF in FY 2020-21.

7. For non-CCI managed care payments:
   - Assume 11 months of the FY 2019-20 capitation rate increases are expected to occur in FY 2019-20.
   - Assume one month of the FY 2019-20 capitation rate increases and 11 months of the FY 2020-21 capitation rate increases are expected to occur in FY 2020-21.

8. For CCI managed care payments:
   - Assume payments for Calendar Year (CY) 2018 and 2019 will be paid in FY 2019-20.
   - Assume payments will continue in FY 2020-21 at the same level.

9. Funds allocated for the supplemental payments are as follows:

FY 2019-20	TF	GF	Title XXI FF	Title XIX FF	ACA FF
FFS Payments (ICF/DD, ICF/DD-H, ICF/DD-N)	$24,886,000	$12,256,000	$0	$12,218,000	$412,000
FFS Payments (ICF/DD-CNC)	$417,000	$200,000	$0	$199,000	$18,000
CCI Payments	$2,247,000	$1,124,000	$0	$1,123,000	$0
Managed Care Pmts	$5,163,000	$1,698,000	$122,000	$1,517,000	$1,826,000
Total	**$32,713,000**	**$15,278,000**	**$122,000**	**$15,057,000**	**$2,256,000**

FY 2020-21	TF	GF	Title XXI FF	Title XIX FF	ACA FF
FFS Payments (ICF/DD, ICF/DD-H, ICF/DD-N)	$24,886,000	$12,263,000	$0	$12,218,000	$406,000
FFS Payments (ICF/DD-CNC)	$417,000	$201,000	$0	$199,000	$17,000
CCI Payments	$1,646,000	$823,000	$0	$823,000	$0
Managed Care Pmts	$4,444,000	$1,513,000	$82,000	$1,309,000	$1,540,000
Total	**$31,394,000**	**$14,800,000**	**$82,000**	**$14,549,000**	**$1,963,000**

Funding:

FY 2019-20	TF	GF	FF
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	$30,114,000	$15,057,000	$15,057,000
93%Title XIX FF / 7% GF (4260-101-0001 / 0890)	$1,386,000	$97,000	$1,289,000
90%Title XIX FF / 10% GF (4260-101-0001 / 0890)	$1,074,000	$107,000	$967,000
88% Title XXI FF / 12% GF (4260-113-0001 / 0890)	$139,000	$17,000	$122,000
Total	**$32,713,000**	**$15,278,000**	**$17,435,000**

PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 164

FY 2020-21	TF	GF	FF
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	$29,098,000	$14,549,000	$14,549,000
90%Title XIX FF / 10% GF (4260-101-0001 / 0890)	$2,181,000	$218,000	$1,963,000
76.5% Title XXI FF / 23.5% GF (4260-113-0001 / 0890)	$68,000	$16,000	$52,000
65% Title XXI FF / 35% GF (4260-113-0001 / 0890)	$47,000	$17,000	$30,000
Total	**$31,394,000**	**$14,800,000**	**$16,594,000**

NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER:	165
IMPLEMENTATION DATE:	7/2005
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1076

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$4,299,000	$4,273,000
- STATE FUNDS	$1,900,000	$1,900,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,299,000	$4,273,000
STATE FUNDS	$1,900,000	$1,900,000
FEDERAL FUNDS	$2,399,000	$2,373,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental payments made to Non-Designated Public Hospitals (NDPHs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.17
State Plan Amendment (SPA) 14-009
SPA 15-004
SPA 16-031
SPA 18-017
SPA 19-0024

Interdependent Policy Changes:
Not Applicable

Background:
Effective July 1, 2005, based on the requirements of SB 1100, supplemental reimbursements will be available to NDPHs.

Payments to the NDPHs will be from the NDPH Supplemental Fund, Item 4260-601-3096, using State General Fund (GF) and interest accrued in the NDPH Supplemental Fund as the non-federal share of costs. It is assumed that interest accrued in a fiscal year will be paid in the subsequent fiscal year. This funding along with the federal reimbursement will replace the amount of funding the NDPHs previously received under the Emergency Services and Supplemental Payments Program (SB 1255, Voluntary Governmental Transfers). Due to the inactivation of the Selective Provider Contracting Program (SPCP) for NDPHs on January 1, 2014, State Plan Amendments (SPAs) were required to continue the NDPH Supplemental Program and secure distributions from the NDPH Supplemental Fund. In September 2016, the Department received SPA approval for a two-year transitional SPA 16-031 from the Centers for Medicare and Medicaid Services (CMS) to continue the NDPH Supplemental Program for FY 2016-17 and FY 2017-18. In October 2018, CMS approved SPA 18-017 to continue the NDPH Supplemental program through June 30, 2019. In June 2019, CMS approved

NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 165

SPA 19-0024 to continue the NDPH Supplemental program through June 30, 2020. Another one-year transition SPA will be submitted to CMS for approval to continue the NDPH Supplemental program for FY 2020-21.

Reason for Change:
There is no change in FY 2019-20, from the prior estimate.

The slight change in FY 2020-21, from the prior estimate, is due to a slight rounding adjustment.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to a gradual reduction in the ACA optional expansion Federal Medical Assistance Percentage (FMAP).

Methodology:

1. The State Funds (SF) item includes the annual General Fund appropriation, any unspent appropriations from prior years, and interest that has been accrued/estimated. Beginning in FY 2017-18, the SF item will also include ACA adjustments.

2. SB 1100 requires that $1,900,000 annually be transferred from the General Fund to the NDPH Supplemental Fund to be used for the non-federal share of payments.

3. The ACA allows for 100% FMAP for calendar years 2014 through 2016 for newly eligible Medi-Cal beneficiaries. Beginning January 1, 2017, the ACA optional population FMAP is 95%, and reduces to 94% beginning January 1, 2018. Beginning January 1, 2019, the ACA optional population FMAP reduces to 93%, and further reduces to 90% beginning January 1, 2020. CMS approved the ACA claiming methodology in August 2017.

4. ACA adjustments will be processed nine months after the respective fiscal year's supplemental payments have been issued in order to determine the proportion of the costs for newly eligible Medi-Cal beneficiaries. The FY 2018-19 ACA adjustment will be claimed in FY 2019-20 and the FY 2019-20 ACA adjustment will be claimed in FY 2020-21. The ACA adjustments for the non-federal share will be transferred into the NDPH Supplemental Fund.

5. The ending balance shown is on a cash basis and does not necessarily mean that the remaining funds are available. Funds in the ending balance may be committed and scheduled to be expended in the following year.

NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 165

6. The estimated NDPH Supplemental payments and ending balance for FY 2019-20 are shown below:

FY 2019-20 NDPH Supplemental Fund Summary	SF
FY 2018-19 Ending Balance	$2,957,000
Appropriation (GF)	$1,900,000
FY 2018-19 Interest Earned	$81,000
FY 2018-19 ACA FFP Adjustment to SF	$499,000
Funds Available	$5,437,000
Less: FY 2019-20 Cash Expenditures to Hospitals	($1,900,000)
Est. FY 2019-20 Remaining Balance	$3,537,000

FY 2019-20	TF	SF	FF	ACA FF	Return to Fund 3096*
FY 2019-20 Cash Expenditures to Hospitals**	$3,800,000	$1,900,000	$1,900,000	$0	$0
FY 2018-19 ACA FF Adjustment to SF***	$499,000	$0	($573,000)	$1,072,000	$499,000
Total	**$4,299,000**	**$1,900,000**	**$1,327,000**	**$1,072,000**	$499,000

7. The estimated NDPH Supplemental payments and ending balance for FY 2020-21 are shown below:

FY 2020-21 NDPH Supplemental Fund Summary	SF
FY 2019-20 Ending Balance	$3,537,000
Appropriation (GF)	$1,900,000
Est. FY 2019-20 Interest Earned	$84,000
FY 2019-20 ACA FFP Adjustment to SF	$473,000
Funds Available	$5,994,000
Less: FY 2020-21 Cash Expenditures to Hospitals	($1,900,000)
Est. FY 2020-21 Remaining Balance	$4,094,000

NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 165

FY 2020-21	TF	SF	FF	ACA FF	Return to Fund 3096*
FY 2020-21 Cash Expenditures to Hospitals**	$3,800,000	$1,900,000	$1,900,000	$0	$0
FY 2019-20 ACA FF Adjustment to SF***	$473,000	$0	($571,000)	$1,044,000	$473,000
Total	**$4,273,000**	**$1,900,000**	**$1,329,000**	**$1,044,000**	$473,000

*The Return to Fund 3096 column is for display purposes only (see Methodology #4).

Funding:
100% GF (4260-104-0001)
NDPH Supplemental Fund (less funded by GF) (4260-698-3096)
50% Title XIX / 50% NDPH Supplemental Fund (4260-601-3096/4260-101-0890)**
100% Title XIX ACA (4260-101-0890)***
100% Title XIX (4260-101-0890)***

PROP 56 - HOSP-BASED PEDIATRIC PHYS SUPPL PYMTS

REGULAR POLICY CHANGE NUMBER:	166
IMPLEMENTATION DATE:	5/2021
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	2147

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$2,000,000
- STATE FUNDS	$0	$2,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$2,000,000
STATE FUNDS	$0	$2,000,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the expenditures related to providing supplemental payments to hospital-based pediatric physician services.

Authority:
AB 74 (Chapter 23, Statutes of 2019)

Interdependent Policy Changes:
Not Applicable

Background:
The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), passed by the voters in November 2016, increases the excise tax rate on cigarettes and electronic cigarettes, effective April 1, 2017, and other tobacco products effective July 1, 2017. The excise tax increased by $2 from 87 cents to $2.87 per pack of 20 cigarettes on distributors selling cigarettes in California with an equivalent excise tax rate increase on other tobacco products.

Pursuant to AB 74, the Department shall develop the structure and parameters for supplemental payments for hospital-based pediatric physician services in FY 2019-20.

This policy change identifies the use of the General Fund for these Proposition 56 payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to payments expected to occur in FY 2020-21.

PROP 56 - HOSP-BASED PEDIATRIC PHYS SUPPL PYMTS

REGULAR POLICY CHANGE NUMBER: 166

Methodology:

1. AB 74 provides $2,000,000 TF for supplemental payments for hospital-based pediatric physician services. Payments are expected to occur in FY 2020-21.

2. Funds allocated for the supplemental payments are as follows:

FY 2020-21	TF	GF
Supplemental Payments	**$2,000,000**	**$2,000,000**

Funding:

100% GF (4260-101-0001)

PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	167
IMPLEMENTATION DATE:	3/2019
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	2103

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$9,013,000	$9,048,000
- STATE FUNDS	$4,084,410	$4,135,980
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	80.31 %	80.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,774,700	$1,809,600
STATE FUNDS	$804,220	$827,200
FEDERAL FUNDS	$970,440	$982,400

DESCRIPTION

Purpose:
This policy change estimates the expenditures related to supplemental payments provided to Freestanding Pediatric Subacute (FS/PSA) Facilities.

Authority:
SB 856 (Chapter 30, Statutes of 2018)
SPA 18-0042
AB 74 (Chapter 23, Statutes of 2019)
SPA 19-0042

Interdependent Policy Changes:
Not Applicable

Background:
The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), passed by the voters in November 2016, increases the excise tax rate on cigarettes and electronic cigarettes, effective April 1, 2017, and other tobacco products effective July 1, 2017. The excise tax increased by $2 from 87 cents to $2.87 per pack of 20 cigarettes on distributors selling cigarettes in California with an equivalent excise tax rate increase on other tobacco products.

SB 856 authorized supplemental payments for FS/PSA facilities in FY 2018-19. On September 18, 2018, the Centers for Medicaid and Medicare Services approved SPA 18-0042 for the supplemental payments to FS/PSAs for the period of August 1, 2018, through July 31, 2019. Pursuant to the AB 74, the Centers for Medicaid and Medicare Services approved SPA 19-0042 on September 26, 2019, for the extension of the supplemental payments for the period of August 1, 2019, through December 31, 2021.

This policy change identifies the use of the General Fund for these Proposition 56 payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 167

Reason for Change:
The change for FY 2019-20 and FY 2020-21, from the prior estimate, is an increase in managed care payments based on final actuarially certified rates.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is a net decrease due to a decrease in the managed care payments for FY 2020-21 and including an additional month of managed care payments due to the managed care cash lag.

Methodology:
1. The RY 2018-19 supplemental payments were implemented on February 25, 2019. The EPC for the retroactive period of August 1, 2018, through February 24, 2019, was implemented on March 13, 2019. No managed care impact was assumed for the period of August 1, 2018, through July 31, 2019.

2. AB 74 extended supplemental payments to FS/PSAs through December 2021. Managed care impact is assumed for the period of August 1, 2019, through December 31, 2021.

3. The following payments are estimated for FY 2019-20 and FY 2020-21:

FY 2019-20	TF	GF	Title XIX FF	Title XXI FF	ACA FF
FFS Supp Pmts	$7,238,000	$3,496,000	$3,441,000	$164,000	$137,000
MC Supp Pmts	$1,775,000	$589,000	$521,000	$38,000	$627,000
Total	**$9,013,000**	**$4,085,000**	**$3,962,000**	**$202,000**	**$764,000**

FY 2020-21	TF	GF	Title XIX FF	Title XXI FF	ACA FF
FFS Supp Pmts	$7,238,000	$3,522,000	$3,441,000	$141,000	$134,000
MC Supp Pmts	$1,810,000	$614,000	$533,000	$35,000	$628,000
Total	**$9,048,000**	**$4,136,000**	**$3,974,000**	**$176,000**	**$762,000**

Funding:

FY 2019-20	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001 / 0890)	$7,924,000	$3,962,000	$3,962,000
93% Title XIX / 7% GF (4260-101-0001 / 0890)	$448,000	$31,000	$417,000
90% Title XIX / 10% GF (4260-101-0001/ 0890)	$386,000	$39,000	$347,000
88% Title XXI / 12% GF (4260-113-001 / 0890)	$65,000	$8,000	$57,000
76.5% Title XXI / 23.5% GF (4260-113-0001 / 0890)	$190,000	$45,000	$145,000
Total	**$9,013,000**	**$4,085,000**	**$4,928,000**

PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 167

FY 2020-21	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/ 0890)	$7,948,000	$3,974,000	$3,974,000
90% Title XIX / 10% GF (4260-101-0001 / 0890)	$847,000	$85,000	$762,000
76.5% Title XXI / 23.5% GF (4260-113-0001 / 0890)	$98,000	$23,000	$75,000
65% Title XXI / 35% GF (4260-113-0001 / 0890)	$155,000	$54,000	$101,000
Total	**$9,048,000**	**$4,136,000**	**$4,912,000**

PROPOSITION 56 FUNDS TRANSFER

REGULAR POLICY CHANGE NUMBER:	168
IMPLEMENTATION DATE:	7/2018
ANALYST:	Sabrina Blank
FISCAL REFERENCE NUMBER:	2102

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change budgets the transfer from the Proposition 56 fund to the appropriate General Fund.

Authority:
California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56)

Interdependent Policy Changes:
See Funding Chart Below

Background:
Effective April 2017, Proposition 56 (Prop 56) increased taxes imposed on distributors of cigarettes and tobacco products and allocates a specified percentage of those revenues to increase funding for existing health care programs under the Medi-Cal program.

Reason for Change:
The change for FY 2019-20 and FY 2020-21, from the prior estimate, is based on updated expenditure data for various policy changes. The change from FY 2019-20 to FY 2020-21, in the current estimate, is based on updated expenditure data for various policy changes.

Methodology:
1. To allow for proper cash flow timing, Prop 56 items are initially treated as General Fund costs. Subsequently, this policy change transfers the dollars from the Prop 56 fund to the General Fund.

PROPOSITION 56 FUNDS TRANSFER

REGULAR POLICY CHANGE NUMBER: 168

(Dollars in Thousands)

FY 2019-20	Total GF to Prop 56
Prop 56 - Home Health Rate Increase	($54,378)
Prop 56 - Pediatric Day Health Care Rate Increase	($7,313)
Prop 56 - Physician Services Supplemental Payments	($404,389)
Prop 56 - Supplemental Payments for Dental Services	($213,514)
Prop 56 - Medi-Cal Family Planning	($36,391)
Prop 56 - Value-Based Payment Program	($102,976)
Prop 56 - Developmental Screenings	($15,146)
Prop 56 - CBAS Supplemental Payments	($15,496)
Prop 56 - Adverse Childhood Experiences Screenings	($10,223)
Prop 56 - NEMT Supplemental Payments	($3,215)
Prop 56 - ICF/DD Supplemental Payments	($15,278)
Prop 56 - Hosp-Based Ped. Supplemental Payments	$0
Prop 56 - FS-PSA Supplemental Payments	($4,084)
Prop 56 - Women's Health Supplemental Payments	($27,305)
Prop 56 - AIDS Waiver Supplement Payments	($3,400)
Prop 56 - Provider ACEs Trainings	($8,235)
Total of GF dollars in Prop 56 PCs	($921,341)
Prop 56 Fund	$921,341
Grand Total	**$0**

PROPOSITION 56 FUNDS TRANSFER

REGULAR POLICY CHANGE NUMBER: 168

FY 2020-21	Total GF to Prop 56
Prop 56 - Home Health Rate Increase	($45,423)
Prop 56 - Pediatric Day Health Care Rate Increase	($6,960)
Prop 56 - Physician Services Supplemental Payments	($426,106)
Prop 56 - Supplemental Payments for Dental Services	($207,293)
Prop 56 - Medi-Cal Family Planning	($39,548)
Prop 56 - Value-Based Payment Program	($178,280)
Prop 56 - Developmental Screenings	($22,270)
Prop 56 - CBAS Supplemental Payments	($15,496)
Prop 56 - Adverse Childhood Experiences Screenings	($15,307)
Prop 56 - NEMT Supplemental Payments	($3,260)
Prop 56 - ICF/DD Supplemental Payments	($14,799)
Prop 56 - Hosp-Based Ped. Supplemental Payments	($2,000)
Prop 56 - FS-PSA Supplemental Payments	($4,136)
Prop 56 - Women's Health Supplemental Payments	($26,796)
Prop 56 - AIDS Waiver Supplement Payments	($3,400)
Prop 56 - Provider ACEs Trainings	($30,962)
Total of GF dollars in Prop 56 PCs	($1,042,036)
Prop 56 Fund	$1,042,036
Grand Total	**$0**

*Totals may differ due to rounding

Funding:
Healthcare Treatment Fund (4260-101-3305)
100% Title XIX GF & 100% Title XXI GF (4260-101-0001/ 4260-113-0001)

PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	169
IMPLEMENTATION DATE:	12/2017
ANALYST:	Sabrina Blank
FISCAL REFERENCE NUMBER:	2044

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$216,918,000	$211,293,000
- STATE FUNDS	$27,305,000	$26,796,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	98.08 %	97.97 %
APPLIED TO BASE		
TOTAL FUNDS	$4,164,800	$4,289,200
STATE FUNDS	$524,260	$543,960
FEDERAL FUNDS	$3,640,570	$3,745,290

DESCRIPTION

Purpose:
This policy estimates the expenditures related to time-limited supplemental reimbursements under the Family Planning, Access, Care, Treatment (Family PACT) program for the Evaluation and Management (E&M) portion of office visits and medical pregnancy termination services.

Authority:
AB 120 (Chapter 22, Statutes of 2017)
Proposition 56 (2016)
SB 856
AB 74 (Chapter 23, Budget Act of 2019)

Interdependent Policy Changes:
Proposition 56 Funds Transfer

Background:
On November 8, 2016, California voters approved the California Healthcare, Research, and Prevention Tobacco Tax Act, Proposition 56, to increase the excise tax rate on cigarettes and tobacco products. Under Proposition 56, a specified portion of the tobacco tax revenue is allocated to the Department for use as the non-federal share of health care expenditures in accordance with the annual state budget process. AB 120 amended the Budget Act of 2017 to appropriate Proposition 56 funds for specified Department health care expenditures during FY 2017-18. SB 856 extends the appropriation of Proposition 56 funds for FY 2018-19. AB 74 extends the appropriation of Proposition 56 funds for FY 2019-20 through FY 2021-22.

The Centers for Medicare & Medicaid Services (CMS) approved State Plan Amendment (SPA) 17-029 on November 30, 2017. The SPA allocated $40 million for time-limited supplemental reimbursements, at a rate equal to 150 percent of the current Family PACT rates, to Family PACT providers for E&M office visits rendered for comprehensive family planning services. The effective date for this SPA was July 1, 2017, with an end date of June 30, 2018. On September 5, 2018, CMS approved SPA 18-0031, which extended the supplemental reimbursements under Family PACT for the period of July 1, 2018,

PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 169

through June 30, 2019. On August 20, 2019, CMS approved SPA 19-0040, which extends the supplemental reimbursements under Family PACT for the period of July 1, 2019, through December 31, 2021.

A total of $50 million is appropriated; $40 million for comprehensive family planning services, and $10 million for time-limited supplemental payments for medical pregnancy termination. This policy change identifies the use of the General Fund (GF) for these Proposition 56 payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

Reason for Change:
The change for FY 2019-20 and FY 2020-21, from the prior estimate, is a slight increase due using more recent expenditure data for FY 2019-20, and due to using FY 2019-20 expenditure data to project FY 2020-21 expenditures. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a slight decrease due to projecting less clients using these services in FY 2020-21.

Methodology:
1. Payments will be made via supplemental payments.

2. This policy is effective July 1, 2017; however payments began for pregnancy termination supplemental payments in December 2017, and for E&M office visit supplemental payments in January 2018.

3. Funds allocated for the supplemental payments are as follows:

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
E&M Office Visits	$210,681	$21,068	$189,613
Medical Pregnancy Termination	$6,237	$6,237	$0
Total	**$216,918**	**$27,305**	**$189,613**

FY 2020-21	TF	GF	FF
E&M Office Visits	$204,997	$20,500	$184,497
Medical Pregnancy Termination	$6,296	$6,296	$0
Total	**$211,293**	**$26,796**	**$184,497**

*Totals may differ due to rounding.

Funding:
90% Title XIX / 10% GF (4260-101-0890/0001)

PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	170
IMPLEMENTATION DATE:	11/2017
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	2050

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$6,800,000	$6,800,000
- STATE FUNDS	$3,400,000	$3,400,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	100.00 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the expenditures related to providing supplemental payments for specific Acquired Immune Deficiency Syndrome (AIDS) Waiver services.

Authority:
AB 120 (Chapter 22, Statutes of 2017)
Proposition 56 (2016)
AB 74 (Chapter 23, Statutes of 2019)

Interdependent Policy Changes:
Not Applicable

Background:
This policy change includes the use of California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) revenue as a funding source for the AIDS Waiver Supplemental Payment Program. AB 120 appropriates up to $4 million from Proposition 56 revenues to provide supplemental payments for specific AIDS Waiver services.

Proposition 56, passed by the voters in November 2016, increases the excise tax rate on cigarettes and electronic cigarettes, effective April 1, 2017, and other tobacco products effective July 1, 2017. The excise tax increased by $2 from 87 cents to $2.87 per pack of 20 cigarettes on distributors selling cigarettes in California with an equivalent excise tax rate increase on other tobacco products.

In accordance with Chapter 22, Statutes of 2017 (AB 120), the Department of Health Care Services developed the structure of the supplemental payments and posted those parameters on its Internet Web site on July 31, 2017. The supplemental payments shall not be available until all of the following conditions have been satisfied: (1) The director of the Department of Health Care Services seeks all necessary federal approvals; and (2) All necessary federal approvals have been obtained. The supplemental payment shall be implemented only to the extent the department determines federal financial participation is available and is not otherwise jeopardized. Additionally, the supplemental payment program is available only to the extent federal Medicaid policy does not reduce federal

PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 170

financial participation as projected in the annual budget act as determined by the Department of Finance.

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.

In FY 2017-18, the Department appropriated $4,000,000 in Proposition 56 funding to provide supplemental payments for specific AIDS Waiver services. These payments were effective beginning July 1, 2017, as identified in the approved waiver amendment and will continue through the course of the waiver term unless a separate amendment is submitted to reverse. This policy change identifies the use of the General Fund (GF) for these Proposition 56 payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21. There is no change from FY 2019-20 to FY 2020-21 in the current estimate.

Methodology:
1. Payments will be made via supplemental payments.

2. This policy is effective July 1, 2017; however payments began on November 27, 2017.

3. Supplemental payments were based on CY 2015 actual expenditure data.

4. Assume rates will increase by 90%, excluding administration and care management services.

5. Assume administration rates will increase by 45% and 59% for care management services.

6. Funds allocated for the supplemental payments are as follows:

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
Healthcare Treatment Fund Prop. 56	$3,400	$3,400	$0
100% Title XIX	$3,400	$0	$3,400
Total	**$6,800**	**$3,400**	**$3,400**
FY 2020-21	**TF**	**GF**	**FF**
Healthcare Treatment Fund Prop. 56	$3,400	$3,400	$0
100% Title XIX	$3,400	$0	$3,400
Total	**$6,800**	**$3,400**	**$3,400**

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

IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER:	171
IMPLEMENTATION DATE:	6/2020
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1601

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the savings to the General Fund due to the intergovernmental transfer (IGT) administrative and processing fees assessed to the counties or other approved public entities for the Graduate Medical Education Payments (GME) to DPHs.

Authority:
SB 97 (Chapter 52, Statutes of 2017)
SPA 17-0009

Interdependent Policy Changes:
Not Applicable

Background:
In March 2020, the Centers for Medicare and Medicaid Services (CMS) approved SPA 17-0009, with an effective date of January 1, 2017, for the Department to make new Medi-Cal GME supplemental payments to Designated Public Hospitals (DPHs) participating in the Medi-Cal managed care program. The Department will budget the GME payments to the DPHs and their affiliated governmental entities; IGTs will fund the nonfederal share of the cost. A 5% administrative fee will be assessed on the IGTs in order to reimburse the Department for support costs associated with administering the program. Fees assessed in excess of the support costs will result in a savings to the General Fund.

Reason for Change:
The change in FY 2019-20 and FY 2020-21, from the prior estimate, is due to the FY 2018-19 fees shifted to FY 2020-21, and updated data for FY 2017-18 through FY 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to the FY 2016-17 and FY 2017-18 fee assessments occurring in FY 2019-20, with the remaining retroactive fee assessment year occurring in FY 2020-21.

IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER: 171

Methodology:

1. Assume beginning in FY 2019-20, the fee for GME supplemental payments will be 5% of the aggregate nonfederal share, which is calculated at 50% FMAP of the Total Funds from the Graduate Medical Education Payments to DPHs policy change.

(Dollars in Thousands)

FY 2019-20	IGT Subject to the Fee	Reimbursement to GF
FY 2016-17	$86,283	$4,314
FY 2017-18	$186,238	$9,312
Total	$272,521	$13,626

FY 2020-21	IGT Subject to the Fee	Reimbursement to GF
FY 2018-19	$184,860	$9,243
FY 2019-20	$191,520	$9,576
FY 2020-21	$196,660	$9,833
Total	$573,040	$28,652

(Dollars in Thousands)

Fiscal Year	TF	GF	GME Special Fund
FY 2019-20	**$0**	**($13,626)**	**$13,626**
FY 2020-21	**$0**	**($28,652)**	**$28,652**

Funding:

100% State GF (4260-101-0001)
DPH Graduate Medical Education Special Fund (4260-601-8113)

ELECTRONIC VISIT VERIFICATION PHASE II FED PENALTY

REGULAR POLICY CHANGE NUMBER:	172
IMPLEMENTATION DATE:	1/2021
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	2163

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	-$5,130,000
- STATE FUNDS	$0	$417,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$5,130,000
STATE FUNDS	$0	$417,000
FEDERAL FUNDS	$0	-$5,547,000

DESCRIPTION

Purpose:
This policy change estimates the cost to budget reduced federal funds and the use of general funds to supplant the reduced federal funding in several programs due to the Electronic Visit Verification (EVV) Phase II implementation delay.

Authority:
42 U.S.C. 1396b
Social Security Act (SSA) Section 1903, subsection (l)

Interdependent Policy Changes:
Not Applicable

Background:
Pursuant to the SSA section 1903, subsection (l) (42 U.S.C. 1396b), all states must implement the EVV for Medicaid-funded personal care services (PCS) by January 2020 and home health care services by January 2023. In October 2019, the Department received approval from the Centers for Medicare & Medicaid Services for a Good Faith Effort Exemption to extend the EVV implementation date without penalty for PCS to January 2021.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21. The change from FY 2019-20 to FY 2020-21 is a decrease due to reduced federal funding, beginning January 2021.

Methodology:
1) Assume the Department will receive reduced federal funding beginning January 2021.

Funding:
100% GF (4260-101-0001)
Title XIX 100% FFP (4260-101-0890)

CCI IHSS RECONCILIATION

REGULAR POLICY CHANGE NUMBER:	178
IMPLEMENTATION DATE:	6/2020
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	1942

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$142,263,000	$100,000,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$142,263,000	$100,000,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$142,263,000	$100,000,000

DESCRIPTION

Purpose:
This policy change estimates the reimbursement of In-Home Supportive Services (IHSS) overpayments and underpayments to the California Department of Social Services (CDSS) and the managed care plans.

Authority:
Welfare & Institutions Code (W&I) 14132.275

Interdependent Policy Changes:
Not Applicable

Background:
In coordination with Federal and State Government, the Coordinated Care Initiative (CCI) provides the benefits of coordinated care models to persons eligible for Medi-Cal. CCI aimed to improve service delivery for people with dual eligibility and Medi-Cal only beneficiaries who rely on long-term services and supports (LTSS) to maintain residence in their home or community. LTSS includes both home and community-based services, such as IHSS and institutional long-term care services. Services were provided through the managed care delivery system for all Medi-Cal beneficiaries who rely on such services. CDSS and the county social service offices were responsible for the administration and payment of IHSS expenditures. The cost of IHSS was built into the CCI capitated rates and paid to CDSS to reimburse IHSS providers for personal care services. The Department is responsible for the reconciliation of the IHSS category of service, which was a component of the capitated rate, to actual IHSS expenditures paid out to providers by CDSS for a specified period of time. The Department will determine the overpayments or underpayments to CDSS or the managed care plans during the reconciliation process.

The 2017 Budget Act discontinued the CCI program effective January 1, 2018. Based on lessons learned from the CCI demonstration project, the 2017 Budget extended the Cal MediConnect program and the mandatory enrollment of dual eligibles and integration of long-term services and support, except IHSS, into managed care. IHSS was removed from capitation rate payments as of January 1, 2018.

CCI IHSS RECONCILIATION

REGULAR POLICY CHANGE NUMBER: 178

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a decrease due to rate methodology updates to the calendar year (CY) 2017 duals rates and CCI FY 2017-18 non-dual rates. The updated rates were submitted to CMS in December 2019 and the Department is awaiting approval. As a result, IHSS reconciliation for CY 2017 has shifted from FY 2019-20 to FY 2020-21.

The change from the prior estimate, for FY 2020-21, in an increase due to IHSS reconciliation for CY 2017 shifting from FY 2019-20 to FY 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to reimbursement for CY 2015 and CY 2016 being completed in FY 2019-20 and reimbursement for CY 2017 being completed in FY 2020-21.

Methodology:
1. Assume the 2015 and 2016 reconciliation for CY 2015 and CY 2016 service months and reimbursement for overpayments and underpayments will be completed in FY 2019-20.

2. Assume the 2017 reconciliation for calendar year CY 2017 service months and reimbursement for overpayments and underpayments will be completed in FY 2020-21.

3. Based on CY 2015 and CY 2016 data, it is estimated the Department will reimburse CDSS $142,263,000 TF for IHSS managed care in the seven CCI counties.

4. Based on CY 2017 data, it is estimated the Department will reimburse CDSS $100,000,000 TF for IHSS managed care in the seven CCI counties.

Funding:
100% Title XIX (4260-101-0890)

QAF WITHHOLD TRANSFER

REGULAR POLICY CHANGE NUMBER:	180
IMPLEMENTATION DATE:	7/2017
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	2092

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$98,871,000	$0
- STATE FUNDS	$49,435,500	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$98,871,000	$0
STATE FUNDS	$49,435,500	$0
FEDERAL FUNDS	$49,435,500	$0

DESCRIPTION

Purpose:
This policy change budgets for withheld Fee-for-Service payments (FFS) associated with the Hospital Quality Assurance Fee (HQAF), AB 1629 Skilled Nursing Facilities (SNF) QAF, Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs) QAF, and Ground Emergency Medical Transportation (GEMT) QAF.

Authority:
Welfare & Institutions Code section 14169.52

Interdependent Policy Changes:
Long Term Care Quality Assurance Fund Expenditures

Background:
To recover past due QAF from delinquent providers, the Department currently withholds portions of the delinquent provider's FFS payments, applies those payments to the delinquent QAF debt, and transfers the withheld portion. As Medi-Cal is on a cash basis, these expenditures were originally budgeted in the fiscal year the claim was processed.

For the HQAF, the withheld portion is transferred to the Hospital Quality Assurance Revenue Fund.

For AB 1629 SNF and ICF/DD QAF, the withheld portions are transferred to the Long Term Care Quality Assurance Fund (LTCQAF), and subsequently to the General Fund (GF), providing savings once the transfer occurs. The fund adjustment from the LTCQAF to the GF is budgeted in the Long Term Care Quality Assurance Fund Expenditures policy change.

For GEMT QAF, the withheld portion is transferred to the Medi-Cal Emergency Medical Transport Fund.

QAF WITHHOLD TRANSFER

REGULAR POLICY CHANGE NUMBER: 180

Reason for Change:
The change from the prior estimate, for FY 2019-20, is due to:

- Decrease in HQAF withhold transfers occurring in FY 2019-20 due to delayed federal approval of the HQAF VI program. The HQAF withhold timing for a portion of the HQAF FY 2019-20 withholds are estimated to occur in June 2020, with the withhold transfer occurring in FY 2020-21.
- GEMT QAF withholds are scheduled to begin in March 2020.

There is no change from the prior estimate for FY 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due no fiscal impact estimated from the HQAF, LTC QAF, and GEMT QAF withholds and withhold transfers in FY 2020-21.

Methodology:
HQAF
FY 2019-20:
1. Prior year HQAF withheld payments totaling $109.15 million TF will be transferred in FY 2019-20.

2. An estimated $66.64 million TF in HQAF withholds will occur in FY 2019-20 and offsets a portion of the $109.15 million HQAF withhold transfer.

3. An estimated $66.64 million of FY 2019-20 HQAF withheld payments will be paid in FY 2020-21.

LTCQAF
FY 2019-20:
4. Prior year LTCQAF withheld payments totaling $70.41 million TF will be transferred in FY 2019-20.

5. An estimated $11.57 million in LTCQAF withholds will occur in FY 2019-20 and offsets a portion of the $70.41 million LTCQAF withhold transfer.

6. An estimated $11.57 million of FY 2019-20 LTCQAF withheld payments will be paid in FY 2020-21.

GEMT QAF
7. An estimated $2.48 million in GEMT QAF withholds will occur in FY 2019-20.

8. An estimated $2.48 million of FY 2019-20 GEMT QAF withheld payments will be paid in FY 2020-21.

QAF WITHHOLD TRANSFER

REGULAR POLICY CHANGE NUMBER: 180

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
HQAF			
HQAF Prior Year Withhold Transfers	$109,150	$54,575	$54,575
HQAF FY 2019-20 New Withholds	($66,640)	($33,320)	($33,320)
Subtotal HQAF	$42,510	$21,255	$21,255
LTC QAF			
LTC QAF Prior Year Withhold Transfers	$70,412	$35,206	$35,206
LTC QAF FY 2019-20 New Withholds	($11,574)	($5,787)	($5,787)
Subtotal LTC QAF	$58,838	$29,419	$29,419
GEMT QAF			
GEMT QAF Prior Year Withhold Transfers	$0	$0	$0
GEMT QAF FY 2019-20 New Withholds	($2,477)	($1,238)	($1,239)
Subtotal GEMT QAF	($2,477)	($1,238)	($1,239)
Total FY 2019-20	**$98,871**	**$49,436**	**$49,435**

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

ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

REGULAR POLICY CHANGE NUMBER:	181
IMPLEMENTATION DATE:	6/2011
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	1232

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$84,915,000	$95,060,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$84,915,000	$95,060,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$84,915,000	$95,060,000

DESCRIPTION

Purpose:
This policy change estimates the federal financial participation (FFP) for transportation and day care costs of Intermediate Care Facility - Developmentally Disabled (ICF-DD) beneficiaries for the California Department of Developmental Services (CDDS).

Authority:
Interagency Agreement (IA) 07-65896

Interdependent Policy Changes:
Not Applicable

Background:
Beneficiaries that reside in ICF-DDs receive active treatment services from providers located off-site from the ICF-DD. The active treatment and transportation is currently arranged for and paid by the local Regional Centers, which in turn bill the CDDS for reimbursement with 100% General Fund dollars.

On April 15, 2011, the Centers for Medicare and Medicaid Services (CMS) approved a State Plan Amendment (SPA) to obtain FFP for the transportation and day care costs of ICF-DD beneficiaries. CMS approved reimbursement for these costs retroactive to July 1, 2007.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008, through December 31, 2010. The Education, Jobs, and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011, through March 31, 2011, and 56.88% for April 1, 2011, through June 30, 2011. This policy change includes the additional FFP in FY 2018-19. Funding for services provided between October 1, 2008, through June 30, 2011, will be reimbursed at the appropriate FMAP rate.

ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

REGULAR POLICY CHANGE NUMBER: 181

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

Reason for Change:
The change in FY 2019-20, from the prior estimate, is a decrease in expected payments with ARRA funding for FY 2009-10.

The change in FY 2020-21, from the prior estimate, is an increase due to payments with ARRA funding shifting to FY 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to shifting payments with ARRA funding in FY 2019-20, as well as higher than expected prior year expenditures occurring in FY 2020-21.

Methodology:
1. FY 2019-20 includes a portion of payments for FY 2009-10, FY 2017-18, FY 2018-19, and FY 2019-20 expenditures. FY 2020-21 includes a portion of payments for FY 2009-10, FY 2018-19, FY 2019-20, and FY 2020-21 expenditures.

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	FFP Regular	FFP ARRA	Total FFP
FY 2019-20	$166,864	$81,949	$81,949	$2,966	**$84,915**
FY 2020-21	$183,086	$88,026	$88,026	$7,034	**$95,060**

Funding:
100% Title XIX (4260-101-0890)

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER:	182
IMPLEMENTATION DATE:	12/2011
ANALYST:	Manvir Lallian
FISCAL REFERENCE NUMBER:	1488

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$49,029,000	$15,268,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$49,029,000	$15,268,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$49,029,000	$15,268,000

DESCRIPTION

Purpose:
This policy change estimates the cost of Medicaid incentive payments to qualified health care providers who adopt meaningful use (MU) Electronic Health Records (EHR) in accordance with the Health Information Technology for Economic and Clinical Health (HITECH) act under the American Recovery and Reinvestment Act of 2009 (ARRA).

Authority:
ARRA of 2009
SB 945 (Chapter 433, Statutes of 2011)
AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

Background:
The HITECH act, a component of the ARRA, authorizes federal funds for Medicare and Medicaid incentive programs from 2011 through 2021. The Medi-Cal EHR Incentive Program, now known as the Promoting Interoperability Program, is scheduled to sunset in 2021, with program and audit closeouts expected to continue beyond 2021. To qualify for incentive payments, health care providers must meet MU requirements with certified EHR technology in accordance with the HITECH act. The Centers for Medicare and Medicaid Services (CMS) approved the implementation of the provider incentive program which began October 3, 2011.

The Department has implemented a State Level Registry (SLR) for incentive payment applicants, allowing for more seamless and efficient participation and payment for eligible providers and hospitals. The payments are intended to accelerate the meaningful use of EHR technology by providers serving the Medi-Cal population. Over 25,000 providers, and 330 hospitals currently participate in the program. Provider payments are funded with 100% federal financial participation.

The SLR is necessary for the Department to enroll, pay and audit providers who participate in the Medi-Cal EHR Incentive program. The Medi-Cal Fiscal Intermediary (FI) continues to develop the SLR

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER: 182

to meet updated requirements published by CMS. System costs are budgeted in the Medical FI Optional Contractual Services policy change. Administrative costs for the State's Health Information Technology program are budgeted separately in the ARRA HITECH Incentive Program policy change.

Reason for Change:
The change in FY 2019-20 and FY 2020-21, from the prior estimate, is a decrease due to:

- A decrease in projections regarding the number of participating providers from the California Technical Assistance Program (CTAP) contracts.
- Adjusting to actual invoices paid.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease due to:

- A reduction in provider participation due to the end of the CTAP.
- Completion of all remaining hospital payments before June 30, 2020, leaving no hospital payments for FY 2020-21.

Methodology:

1. Payments to the providers began in December 2011.

2. Payments to professionals are a fixed amount for the first year of eligibility and a lesser fixed amount for eligibility years two through six. Payments to hospitals are fixed at a computed amount over four years.

3. Assume professionals will receive incentive payments over a six year period. The years do not have to be consecutive. The first eligibility year incentive payment is $21,250. Incentive payments for years two through six are $8,500 per eligible year. The maximum incentive payment for a professional over the six year period is $63,750. Professionals are no longer able to initiate participation in the program as of May 23, 2017. CMS allowed an extension to July 25, 2017, for providers attesting to 2016 as their first program year who completed all requirements by May 23, 2017, but had documented technical difficulties preventing submission. There are no outstanding year-one payments for professionals as of FY 2018-19.

4. Assume the aggregate hospital incentive payment amount is computed on a $2,000,000 base amount adjusted depending on Medi-Cal discharges for the year. Hospital incentive payments will be made over a period of four years. Payments will be limited to 50% of the aggregate hospital incentive payment for the first eligibility year, 30% for the second eligibility year and 10% for the third and fourth eligibility years. Hospitals are no longer able to initiate participation in the program as of May 23, 2017. Commencing with program year 2016, hospitals must also attest in consecutive years. There are no outstanding year-one and year-two payments for hospitals as of FY 2019-20.

   For FY 2019-20 and FY 2020-21, incentive payments are adjusted based on hospitals' pending payments. For FY 2019-20, the year-three payments will average $173,625, and the year-four payments will average $176,514. For FY 2020-21, there are no remaining hospital payments.

5. The estimated payments for FY 2019-20 and FY 2020-21 are on a cash-basis.

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER: 182

FY 2019-20 Professional Incentive Payments			
Eligibility Year	**Professionals**	**Incentive Payments**	**FF**
2	309	$8,500	$2,627,000
3	774	$8,500	$6,579,000
4	968	$8,500	$8,228,000
5	755	$8,500	$6,418,000
6	535	$8,500	$4,548,000
Total FY 2019-20 Professional Payments			**$28,400,000**

FY 2019-20 Hospital Incentive Payments			
Eligibility Year	**Hospitals**	**Incentive Payments**	**FF**
2	0	$0	$0
3	8	$173,625	$1,389,000
4	109	$176,514	$19,240,000
Total FY 2019-20 Hospital Payments			**$20,629,000**

FY 2020-21 Professional Incentive Payments			
Eligibility Year	**Professionals**	**Incentive Payments**	**FF**
2	163	$8,500	$1,386,000
3	363	$8,500	$3,086,000
4	465	$8,500	$3,953,000
5	522	$8,500	$4,437,000
6	283	$8,500	$2,406,000
Total FY 2020-21 Professional Payments			**$15,268,000**

FY 2020-21 Hospital Incentive Payments			
Eligibility Year	**Hospitals**	**Incentive Payments**	**FF**
1	0	$0	$0
2	0	$0	$0
3	0	$0	$0
4	0	$0	$0
Total FY 2020-21 Hospital Payments			$0

Fiscal Year	Professional Payments	Hospital Payments	FF
FY 2019-20	$28,400,000	$20,629,000	**$49,029,000**
FY 2020-21	$15,268,000	$0	**$15,268,000**

Funding:
100% Title XIX (4260-101-0890)

PAYMENT FOR REPROCESSED CLAIMS FOR FQHC/RHC

REGULAR POLICY CHANGE NUMBER:	186
IMPLEMENTATION DATE:	10/2019
ANALYST:	Manvir Lallian
FISCAL REFERENCE NUMBER:	2157

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$7,300,000	$0
- STATE FUNDS	$3,650,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$7,300,000	$0
STATE FUNDS	$3,650,000	$0
FEDERAL FUNDS	$3,650,000	$0

DESCRIPTION

Purpose:
This policy change estimates the cost to pay Medi-Cal claims for adult dental, podiatry, and chiropractic services to 23 Federally Qualified Health Centers (FQHC) at the prospective payment system reimbursement rate for the period July 1, 2009, to September 26, 2013.

Authority:
American Indian Health and Services Corporations, et al. v. Jennifer Kent as Director, etc. et al., 24 Cal.Appl.5th 772 42 U.S.C. sections 1396a(a)(10)(A), 1396d(l)(1) and (2), 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.

Interdependent Policy Changes:
Not Applicable

Background:
Petitioners and Plaintiffs, which are FQHCs and Rural Health Clinics (RHC), 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 (2), 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. On January 11, 2016, the Court issued the final formal judgment and writ which was subsequently appealed by the Department. On June 19, 2018, the appellate court affirmed the final judgment in favor of plaintiffs and on October 17, 2018, the California Supreme Court denied the Department's request for de-publication of the appellate court's ruling. The Department issued instructions to petitioners/plaintiffs regarding the submission of claims related to this lawsuit in October 2018 for the specified time period. The

PAYMENT FOR REPROCESSED CLAIMS FOR FQHC/RHC

REGULAR POLICY CHANGE NUMBER: 186

Department has been processing and paying eligible claims for services provided subsequent to September 26, 2013. On January 31, 2019, the court denied petitioners/plaintiffs writ to extend its prior ruling to non-party providers.

Reason for Change:
The change from the prior estimate for FY 2019-20 is a decrease based on projections informed by actual claims processed. There is no change from the prior estimate for FY 2020-21. The change from FY 2019-20 to FY 2020-21 in the current estimate is due to the Department completing claims processing and payments in FY 2019-20.

Methodology:

1. The Department reimbursed 23 FQHCs and RHCs in the amount of $5,883,000. There are 868 claims in suspense. The Department estimates the total reimbursement amount, including suspended claims, will not exceed $7,300,000.

2. In FY 2019-20, the Department estimates total costs are **$7,300,000 TF ($3,650,000 GF)**.

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

INFANT DEVELOPMENT PROGRAM

REGULAR POLICY CHANGE NUMBER:	188
IMPLEMENTATION DATE:	7/2016
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	2009

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$40,739,000	$32,746,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$40,739,000	$32,746,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$40,739,000	$32,746,000

DESCRIPTION

Purpose:
This policy change estimates the federal match provided to the California Department of Developmental Services (CDDS) for Infant Development Program (IDP) services for infants and toddlers ages 0 to 3 with or at risk of developmental disabilities.

Authority:
Interagency Agreement 11-88601

Interdependent Policy Changes:
Not Applicable

Background:
On October 9, 2015, State Plan Amendment (SPA) 11-040 was approved by the Centers for Medicare and Medicaid Services to extend Medi-Cal coverage for IDP services provided to Medi-Cal eligible infants and toddlers ages 0 to 3 with or at risk of developmental delay under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, retroactive to October 1, 2011. This SPA authorizes the Department to claim federal financial participation (FFP) for the provision of IDP services by the state's Regional Center network of nonprofit providers to persons with developmental disabilities.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a decrease due to lower growth than anticipated.

The change from the prior estimate, for FY 2020-21, is a decrease due to lower than expected prior year expenditures.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease due to lower estimated prior year expenditures.

INFANT DEVELOPMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 188

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	FF
FY 2019-20	$81,478	$40,739	**$40,739**
FY 2020-21	$65,492	$32,746	**$32,746**

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

PROP 56 - PROVIDER ACES TRAININGS

REGULAR POLICY CHANGE NUMBER:	189
IMPLEMENTATION DATE:	12/2019
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	2138

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$16,470,000	$61,924,000
- STATE FUNDS	$8,235,000	$30,962,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$16,470,000	$61,924,000
STATE FUNDS	$8,235,000	$30,962,000
FEDERAL FUNDS	$8,235,000	$30,962,000

DESCRIPTION

Purpose:
This policy change estimates the cost to train providers on delivering Adverse Childhood Experiences (ACEs) screenings.

Authority:
AB 74 (Chapter 23, Statute of 2019)

Interdependent Policy Changes:
Not Applicable

Background:
The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), passed by the voters in November 2016, increases the excise tax rate on cigarettes and electronic cigarettes, effective April 1, 2017, and other tobacco products effective July 1, 2017. The excise tax increased by $2 from 87 cents to $2.87 per pack of 20 cigarettes on distributors selling cigarettes in California with an equivalent excise tax rate increase on other tobacco products.

The Department proposes to allocate Proposition 56 funds to train providers on delivering trauma screenings in a sensitive and appropriate manner. This policy change identifies the use of the General Fund (GF) for these Proposition 56 payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is due to a decrease in provider ACEs screening training activities because of reduced consultant activities.

The change from the prior estimate, for FY 2020-21, is an increase due to a shift in payments from FY 2019-20 to FY 2020-21, due to invoicing processing delays.

The change in the current estimate, from FY 2019-20 to FY 2020-21, is due to a full year of estimated costs included in FY 2020-21.

PROP 56 - PROVIDER ACES TRAININGS

REGULAR POLICY CHANGE NUMBER: 189

Methodology:

1. Payments began in December 2019.

2. The provider trainings costs are estimated to be $16,470,000 TF ($8,235,000 Prop 56) in FY 2019-20 and $61,924,000 TF ($30,962,000 GF) in FY 2020-21.

(Dollars in Thousands)

Provider ACEs Training	TF	GF	FF
FY 2019-20	**$16,470**	**$8,235**	**$8,235**
FY 2020-21	**$61,924**	**$30,962**	**$30,962**

Funding:

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

MINIMUM WAGE INCREASE FOR HCBS WAIVERS

REGULAR POLICY CHANGE NUMBER:	190
IMPLEMENTATION DATE:	1/2017
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1975

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$41,147,000	$60,915,000
- STATE FUNDS	$20,573,500	$30,457,500
PAYMENT LAG	0.8240	0.8240
% REFLECTED IN BASE	62.02 %	2.03 %
APPLIED TO BASE		
TOTAL FUNDS	$12,877,200	$49,175,000
STATE FUNDS	$6,438,580	$24,587,510
FEDERAL FUNDS	$6,438,580	$24,587,510

DESCRIPTION

Purpose:
This policy change estimates the costs of increasing the minimum wage for the Assisted Living Waiver (ALW) and the Acquired Immune Deficiency Syndrome (AIDS) Medi-Cal Waiver Program (MCWP).

Authority:
SB 3 (Chapter 4, Statutes of 2016)

Interdependent Policy Changes:
Overtime for WPCS Providers

Background:
The passage of AB 10 in 2013 set the minimum wage in California to $10 an hour after January 1, 2016. SB 3 requires a schedule for a phased increase in the minimum wage from $10.50 per hour to $15 per hour by January 1, 2022, or January 1, 2023, depending on the size of the employer and general economic conditions, and link the minimum wage to the U.S. Consumer Price Index once the minimum wage reaches $15 per hour.

The minimum wage increase will result in increased costs for multiple long term care programs. Home and Community-Based Services (HCBS) are predominantly provided by individuals working for minimum wage, and this increase will raise the overall cost of HCBS for the following programs: the ALW and the AIDS MCWP.

The AIDS MCWP is a 1915(c) HCBS Waiver for Medi-Cal beneficiaries. MCWP provides comprehensive case management and direct care services at no cost to persons with Human Immunodeficiency Virus (HIV) disease or AIDS as an alternative to nursing facility care or hospitalization.

The ALW offers Medi-Cal eligible beneficiaries the choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility. The goal of the ALW is to facilitate nursing facility transition back into homelike and community settings or prevent skilled nursing admissions for beneficiaries with an imminent need for nursing facility placement.

MINIMUM WAGE INCREASE FOR HCBS WAIVERS

REGULAR POLICY CHANGE NUMBER: 190

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is a decrease due to a lower enrollment in the ALW and AIDS Waiver attendant care users. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to projected additional users for the ALW, a 2% increase in projected enrollment in the AIDS attendant care users, and the increase in the minimum wage.

Methodology:

1. On January 1, 2019, the minimum wage increased $.50 from $11.00 to $11.50 per hour. Beginning January 1, 2020, the minimum wage will increase $.50 from $11.50 to $12.00 per hour. Beginning January 1, 2021, the minimum wage will increase $1.00 from $12.00 to $13.00 per hour.

2. Assume a 10% cost increase for employers due to required payroll taxes and other costs.

ALW

3. Assume the total amount of users is 4,556 in calendar year (CY) 2019, 5,357 in CY 2020, and 5,744 in CY 2021.

4. For FY 2019-20, assume the total care coordination and assisted living cost minimum wage increase is $41,084,000 TF. For FY 2020-21, assume the total care coordination and assisted living cost minimum wage increase is $60,824,000 TF.

AIDS MCWP

5. For CY 2019, assume there are 46 attendant care users. For CY 2020, assume there are 47 attendant care users. For CY 2021, assume there are 48 attendant care users.

6. A unit is counted as 15 minutes of time.

7. For CY 2019, assume a participant uses 876 units of attendant care services annually. For CY 2020, assume a participant uses 894 units of attendant care services annually. For CY 2021, assume a participant uses 911 units of attendant care services annually.

8. For CY 2019, assume the estimated attendant care service rate is $5.88 per unit. For CY 2020, assume the estimated attendant care service rate is $6.47 per unit. For CY 2021, assume the estimated attendant care service rate is $7.06 per unit.

9. Assume the FY 2019-20 cost for AIDS MCWP Waiver minimum wage is $63,000 TF. Assume the FY 2020-21 cost for the AIDS MCWP Waiver minimum wage increase is $91,000 TF.

FY 2019-20	TF	GF	FF
ALW	$41,084,000	$20,542,000	$20,542,000
HIV/AIDS	$63,000	$32,000	$31,000
Total	**$41,147,000**	**$20,574,000**	**$20,573,000**

FY 2020-21	TF	GF	FF
ALW	$60,824,000	$30,412,000	$30,412,000
HIV/AIDS	$91,000	$45,000	$46,000
Total	**$60,915,000**	**$30,457,000**	**$30,458,000**

MINIMUM WAGE INCREASE FOR HCBS WAIVERS

REGULAR POLICY CHANGE NUMBER: 190

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

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

REGULAR POLICY CHANGE NUMBER:	191
IMPLEMENTATION DATE:	7/2010
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	1526

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$14,316,000	$15,797,000
- STATE FUNDS	$6,440,000	$6,928,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$14,316,000	$15,797,000
STATE FUNDS	$6,440,000	$6,928,000
FEDERAL FUNDS	$7,876,000	$8,869,000

DESCRIPTION

Purpose:
This policy change estimates the costs for the increased administrative expenses related to the active treatment and transportation services provided to beneficiaries residing in Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) and the costs of the increased rates due to the Quality Assurance Fee.

Authority:
Interagency Agreement (IA) 07-65896

Interdependent Policy Changes:
Not Applicable

Background:
The California Department of Developmental Services (CDDS) makes supplemental payments to Medi-Cal providers that are licensed as ICF-DDs, ICF-DD Habilitative, or ICF-DD Nursing, for transportation and day treatment services provided to Regional Center (RC) consumers. The services and transportation are arranged for and paid by the local RCs, which will bill CDDS on behalf of the ICF-DDs. On April 15, 2011, the Centers for Medicare and Medicaid Services approved a State Plan Amendment (SPA) for CDDS to provide payment, retroactive to July 1, 2007, to the ICF-DDs so that they can reimburse the RCs for arranging the services.

On April 8, 2011, the Department entered into an interagency agreement with CDDS for the reimbursement of administrative expenses due to the addition of active treatment and transportation services to beneficiaries residing in ICF-DDs.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008, through December 31, 2010. The Education, Jobs, and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011, through March 31, 2011, and 56.88% for April 1, 2011, through June 30, 2011. This policy change includes the additional

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

REGULAR POLICY CHANGE NUMBER: 191

FFP in FY 2019-20 and FY 2020-21. Funding for services provided between October 1, 2008, through June 30, 2011, will be reimbursed at the appropriate FMAP rate.

ICF-DDs are subject to a Quality Assurance Fee (QAF) based upon their Medi-Cal revenues, with the revenue used to increase rates for the ICF-DDs.

Reason for Change:
The change for FY 2019-20, from the prior estimate, is a decrease due to revised data based on actuals.

The change for FY 2020-21, from the prior estimate, is an increase due to shifting some ARRA payments from FY 2019-20.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is a due to including ARRA payments in FY 2020-21, and higher than expected prior year expenditures occurring in FY 2020-21.

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

(Dollars in Thousands)

Fiscal Year	RC Admin Fee	QAF & ICF Fee Reimbursements	Total Funds	CDDS GF	DHCS GF	FFP	ARRA
FY 2019-20	$1,229	$6,440	$15,545	$1,229	**$6,440**	**$7,876**	**$207**
FY 2020-21	$1,321	$6,928	$17,118	$1,321	**$6,928**	**$8,869**	**$621**

Funding:
100% GF (4260-101-0001)
100% Title XIX FFP (4260-101-0890)

OVERTIME FOR WPCS PROVIDERS

REGULAR POLICY CHANGE NUMBER:	192
IMPLEMENTATION DATE:	2/2016
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1852

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$8,031,000	$8,444,000
- STATE FUNDS	$4,015,500	$4,222,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$8,031,000	$8,444,000
STATE FUNDS	$4,015,500	$4,222,000
FEDERAL FUNDS	$4,015,500	$4,222,000

DESCRIPTION

Purpose:
This policy change estimates the cost of paying overtime and travel time for Waiver Personal Care Services (WPCS) providers.

Authority:
Welfare & Institutions (W&I) Code, Section 12300.4
SB 89 (Chapter 24, Statutes of 2017)

Interdependent Policy Changes:
Not Applicable

Background:
Federal regulations require In-Home Supportive Services (IHSS) and WPCS providers to be paid overtime. The W&I Code, Section 12300.4 requires overtime and travel time to be paid at time and a half for any hours worked over 40 in a workweek for IHSS/WPCS providers. On January 3, 2016, the California Department of Social Services issued an All-County Letter 16-02 which allowed an IHSS/WPCS provider who works for one participant to work up to, but no more than, 70 hours and 45 minutes in a workweek: a 40 hour workweek and 30 hours and 45 minutes of overtime. An IHSS/WPCS provider who works for two or more participants cannot exceed 66 hours in a workweek: a 40-hour workweek and 26 hours of overtime. Travel time is defined as time spent traveling directly from a location where authorized services are provided to one recipient, to another location where authorized services are to be provided to another recipient. Paid travel time cannot exceed seven hours per week. Beginning February 1, 2016, the Department began paying for overtime.

SB 89 amends Section 12300.4 of the W&I Code to add the In-Home Operations (IHO) Waiver to the provider exemptions language set forth in subdivision (e) of Section 14132.99. This Section extends these provisions to the Home and Community-Based Alternatives Waiver (formerly known as the Nursing Facility/Acute Hospital (NF/AH) Waiver), the IHO Waiver, and their successors.

OVERTIME FOR WPCS PROVIDERS

REGULAR POLICY CHANGE NUMBER: 192

SB 89 also adds provisions to Section 14132.99 of the W&I Code to extend two types of exemptions from the 66-hour workweek limit. A waiver provider who is granted an exemption would be allowed to work overtime between IHSS and WPCS up to 12-hours a day, or 360 hours per month, on a case-by-case basis. Factors to consider when examining exemption eligibility include the following:

- The provider lives in the same home as the waiver participant, even if the provider is not a family member;
- The provider provides care to the waiver participant and has done so for two or more years continuously; and
- The waiver participant is unable to find a local caregiver who speaks the same language.

Currently, the Department only approves an exemption for a participant enrolled in the waiver on or before January 31, 2016, who meets the allowable circumstances for granting an exemption. SB 89 extends overtime exemption to new providers and providers of newly enrolled participants who meet one of the exemption eligibility criteria.

On January 1, 2019, the minimum wage increased from $11.00 to $12.00 per hour. On January 1, 2020, the minimum wage increased from $12.00 to $13.00 per hour. Beginning January 1, 2021, the minimum wage will increase from $13.00 to $14.00 per hour.

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is an increase due to an increase in the number of providers receiving exemptions and overtime. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to the minimum wage increase.

Methodology:

1) Assume 730 WPCS beneficiaries will have providers receiving overtime in FY 2019-20 and FY 2020-21.

2) Assume the annual cost for overtime without exemptions or travel time in FY 2019-20 is $440,000 and $463,000 in FY 2020-21.

3) Assume 790 WPCS providers receive overtime exemptions in FY 2019-20 and FY 2020-21.

4) Assume the annual cost for overtime for providers who received an exemption in FY 2019-20 is $7,406,000 and $7,787,000 in FY 2020-21.

5) Assume the annual travel time cost for WPCS providers in FY 2019-20 is $185,000 and $194,000 in FY 2020-21.

6) Assume $36,000 GF will be allocated from local assistance to state support costs to support activities related to the expansion of the WPCS overtime exemptions.

7) The estimated cost for overtime, including exemptions, and travel time for WPCS providers is **$8,031,000 TF ($4,016,000 GF)** in FY 2019-20 and **$8,444,000 TF ($4,222,000 GF)** in FY 2020-21.

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

INDIAN HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER:	193
IMPLEMENTATION DATE:	4/1998
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	111

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$10,584,000	$20,174,000
- STATE FUNDS	$3,545,500	$6,758,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$10,584,000	$20,174,000
STATE FUNDS	$3,545,500	$6,758,500
FEDERAL FUNDS	$7,038,500	$13,415,500

DESCRIPTION

Purpose:
This policy change estimates the annual rate change posted in the Federal Register for services in an Indian Health Clinic.

Authority:
Public Law 93-638

Interdependent Policy Changes:
Not Applicable

Background:
The Department implemented the Indian Health Services/Memorandum of Agreement 638 Clinics (IHS/MOA) between the federal IHS and the Centers for Medicare and Medicaid Services (CMS) on April 21, 1998. The agreement permits the Department to be reimbursed at 100% FFP for payments made by the State for services rendered to American Indians (AIs) through IHS tribal facilities.

Federal policy permits retroactive claiming of 100% federal financial participation (FFP) to the date of the MOA, July 11, 1996, or at whatever later date a clinic qualifies and elects to participate as an IHS facility under the MOA.

The per visit rate payable to the Indian health clinics is adjusted annually through changes posted in the Federal Register. These rates are set by IHS with the concurrence of the Federal Office of Management and Budget and are based on cost reports compiled by IHS.

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is an increase due to the inclusion of capturing services provided to non-American Indians in an Indian Health Clinic and an increase in the number of enrolled clinics. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to the rate increase from current year to budget year.

INDIAN HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 193

Methodology:

1. Currently, there are 91 Indian health clinics participating in Medi-Cal.

2. Effective CY 2019, the rate increased from $427 to $455. The annual increase of $28 per claim resulted in $7,056,000 TF.

3. It is estimated, effective CY 2020, the updated per visit rate payable to the Indian health clinics will increase by $33, from $455 to $488. The CY 2020 annual rate increase for the additional $33 is estimated at $8,745,000 TF.

4. It is estimated, effective CY 2021, the updated per visit rate payable to the Indian health clinics will increase by $36, from $488 to $524. The annual rate increase for the additional $36 is estimated at $10,017,000 TF.

5. On a cash basis, the FY 2019-20 and FY 2020-21 estimates are:

Rate Increase	FY 2019-20	FY 2020-21
CY 2019 rate increase	$7,056,000	$7,056,000
CY 2020 rate increase	$0	$8,745,000
Retro Jan – June 2019 Increase	$3,528,000	
Retro Jan – June 2020 Increase		$4,373,000
Total Rate increase	**$10,584,000**	**$20,174,000**

Fiscal Year	TF	GF	FF
FY 2019-20	**$10,584,000**	**$3,546,000**	**$7,038,000**
FY 2020-21	**$20,174,000**	**$6,758,000**	**$13,416,000**

*Totals may differ due to rounding.

Funding:

Title XIX 100% FFP (4260-101-0890)
50% Title XIX / 50% GF (4260-101-0890/0001)

WPCS WORKERS' COMPENSATION

REGULAR POLICY CHANGE NUMBER:	194
IMPLEMENTATION DATE:	11/2016
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1866

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$3,323,000	$3,324,000
- STATE FUNDS	$1,661,500	$1,662,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,323,000	$3,324,000
STATE FUNDS	$1,661,500	$1,662,000
FEDERAL FUNDS	$1,661,500	$1,662,000

DESCRIPTION

Purpose:
This policy change estimates the cost of workers' compensation coverage for Waiver Personal Care Services (WPCS) providers.

Authority:
In-Home Supportive Services v. Workers' Comp. Appeals Bd. (1984) 152 Cal.App.3d 720, 727 [199 Cal.Rptr. 697]
Interagency Agreement (IA) 16-93498
IA 19-96325

Interdependent Policy Changes:
Not Applicable

Background:
The WPCS benefit is designed to assist the waiver participant in gaining independence in his or her activities of daily living and preventing social isolation. These services assist the waiver participant in remaining in his or her residence and continuing to be part of the community. A waiver participant must be enrolled in and receiving personal care services through the federally funded State Plan Personal Care Services program in order to be eligible for WPCS benefits. There are approximately 3,700 WPCS providers that receive payment via the Case Management Information Payrolling System (CMIPS II). The California Department of Social Services (CDSS) pays for the insurance claims for the WPCS providers and the Department reimburses CDSS for the costs. The current Workers' Compensation IA was implemented effective July 1, 2019, and will remain in effect until June 30, 2021, at which point it will be renewed for a new contract term.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to a slight increase in administrative costs.

WPCS WORKERS' COMPENSATION

REGULAR POLICY CHANGE NUMBER: 194

Methodology:

1. The current workers' compensation contract, IA 16-93498, went into effect July 1, 2017, and will be in effect until June 30, 2021. The estimated costs are based on the assumption that a new or amended contract will be implemented effective July 1, 2021.

2. The Department will reimburse CDSS monthly for the costs of any WPCS program worker's compensation claims filed by eligible WPCS providers.

3. The reimbursement of CDSS will cover costs associated with monthly administrative fees for Third Party Administrator / Sub-contractor services, monthly fees required by the State Controller's Office to perform Checkwrite functions and standard activities associated with issuing worker's compensation payments, and monthly administrative costs accrued by CDSS and the Office of Risk and Insurance Management.

4. WPCS recipients represent approximately 1% of the population receiving In-Home Supportive Services so the Department will only be responsible for reimbursing CDSS for 1% of the sub-contractor administrative fees.

5. Based on data provided by the CDSS, the total cost to be paid for workers' compensation in FY 2019-20 is $3,323,000 TF and $3,324,000 TF in FY 2020-21.

Fiscal Year	TF	GF	FF
FY 2019-20	$3,323,000	$1,662,000	$1,661,000
FY 2020-21	$3,324,000	$1,662,000	$1,662,000

Funding:

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

FUNDING ADJUST.—OTLICP

REGULAR POLICY CHANGE NUMBER:	198
IMPLEMENTATION DATE:	7/2015
ANALYST:	Sabrina Blank
FISCAL REFERENCE NUMBER:	1926

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$171,066,160	-$109,194,740
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$171,066,160	-$109,194,740
FEDERAL FUNDS	$171,066,160	$109,194,740

DESCRIPTION

Purpose:
This policy change estimates the adjustment to reflect the costs that should be charged to the Children's Health Insurance Program (CHIP).

Authority:
Affordable Care Act (ACA)

Interdependent Policy Changes:
Fee-For-Service Base Expenditures
Rate Increase for FQHCs/RHCs/CBRCs
FQHC/RHC/CBRC Reconciliation Process
AB 1629 Annual Rate Adjustments
LTC Rate Adjustment
Hospice Rate Increases
10% Provider Payment Reduction
Laboratory Rate Methodology Change
Reduction to Radiology Rates

Background:
The Balanced Budget Act of 1997 added Title XXI to the Social Security Act creating CHIP to provide new coverage opportunities for children in families with incomes too high to qualify for Medicaid. States administer the CHIP program and they are jointly funded by federal and state governments.

The ACA provides enhanced federal funding to Title XXI. The California federal funding match was 65 percent through September 30, 2015. Effective October 1, 2015, the ACA extended and increased the enhanced federal matching rate for the CHIP program by 23 percent to 88 percent. Congress reauthorized the CHIP program in January, 2018, reducing the federal matching rate to 76.5 percent effective October 1, 2019, and further reducing the match rate to 65 percent effective October 1, 2020.

FUNDING ADJUST.—OTLICP

REGULAR POLICY CHANGE NUMBER: 198

Reason for Change:
There is no significant change from the prior estimate for FY 2019-20. The change for FY 2020-21, from the prior estimate, is a general fund savings increase due updates to policy changes. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a general fund savings decrease due to the changes in the Federal Medical Assistance Percentage.

Methodology:

1) The Department identified funds allocated to CHIP beneficiaries in the OTLICP aid category that were not adjusted for additional Title XXI funding in the policy change in which they originated.

2) The total amount of unadjusted CHIP funding for all policy changes in FY 2019-20 is estimated as $575,797,300 and $596,821,537 in FY 2020-21. These amounts are credited to the Title XIX fund.

3) The funds are then broken out according to reimbursement rates based on when the Department estimates the expenditure.
   a. In FY 2019-20, the Department estimates the additional CHIP funding will offset general fund spending by $171.1M.
   b. In FY 2020-21, the Department estimates the additional CHIP funding will offset general fund spending by $111.4M.

4) The amounts adjusted by policy change are as follows:

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
Fee-For-Service Base Expenditures	$0	($170,042)	$170,042
Rate Increase for FQHCs/RHCs/CBRCs	$0	($912)	$912
FQHC/RHC/CBRC Reconciliation Process	$0	($986)	$986
AB 1629 Annual Rate Adjustments	$0	($30)	$30
LTC Rate Adjustment	$0	($7)	$7
Hospice Rate Increases	$0	($41)	$41
10% Provider Payment Reduction	$0	$209	($209)
Laboratory Rate Methodology Change	$0	$141	($141)
Reduction to Radiology Rates	$0	$602	($602)
Total	**$0**	**($171,066)**	**$171,066**

FUNDING ADJUST.—OTLICP

REGULAR POLICY CHANGE NUMBER: 198

FY 2020-21	TF	GF	FF
Fee-For-Service Base Expenditures	$0	($107,259)	$107,259
Rate Increase for FQHCs/RHCs/CBRCs	$0	($1,693)	$1,693
FQHC/RHC/CBRC Reconciliation Process	$0	($528)	$528
AB 1629 Annual Rate Adjustments	$0	($33)	$33
LTC Rate Adjustment	$0	($9)	$9
Hospice Rate Increases	$0	($64)	$64
10% Provider Payment Reduction	$0	$127	($127)
Laboratory Rate Methodology Change	$0	$198	($198)
Reduction to Radiology Rates	$0	$67	($67)
Total	**$0**	**($109,194)**	**$109,194**

Funding:
50% Title XIX FF / 50% GF (4260-101-0890/0001)
88% Title XXI FF / 12% GF (4260-113-0890/0001)
76.5% Title XXI FF / 23.5% GF (4260-113-0890/0001)
65% Title XXI FF / 35% GF (4260-113-0890/0001)

PROP 56 PHYSICIANS & DENTISTS LOAN REPAYMENT PROG

REGULAR POLICY CHANGE NUMBER:	199
IMPLEMENTATION DATE:	7/2019
ANALYST:	Matt Wong
FISCAL REFERENCE NUMBER:	2097

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$1,700,000	$15,200,000
- STATE FUNDS	$1,700,000	$15,200,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,700,000	$15,200,000
STATE FUNDS	$1,700,000	$15,200,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of the Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program.

Authority:
SB 849 (Chapter 47, Statutes of 2018)
2019 Budget Act

Interdependent Policy Changes:
Not Applicable

Background:
SB 849 establishes the Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program, which will be developed by the State Department of Health Care Services to provide loan assistance payments to qualifying, recent graduate physicians and dentists that serve beneficiaries of Medi-Cal and other specified health care programs using moneys from the Healthcare Treatment Fund.

Previously, the Department planned to administer five cohorts each receiving payments over five years. The Department proposes to revert funding for planned cohorts two through five.

The Department will administer payments to one cohort of participating physicians and dentists. This cohort will receive the payments over five years.

The Department has contracted with Physicians for a Healthy California (PHC) to implement and administer the Proposition 56 funded Physicians and Dentist Loan Repayment Program pursuant to Welfare and Institutions Code section 14114(g).

Reason for Change:
There is no change from the previous estimate for FY 2019-20 and FY 2020-21. The difference from

PROP 56 PHYSICIANS & DENTISTS LOAN REPAYMENT PROG

REGULAR POLICY CHANGE NUMBER: 199

FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to the awarded loan repayments beginning payments in FY 2020-21.

Methodology:

1. The cohort is expected to receive $13.5 million each year for 5 years. Payments for the first and only cohort will begin in FY 2020-21.

2. The contract for the administrative costs is $1.7 million in FY 2019-20 and FY 2020-21.

Fiscal Years	TF	GF
FY 2019-20	$1,700,000	$1,700,000
FY 2020-21	$15,200,000	$15,200,000

Funding:

100% Prop 56 Loan Forgiveness Program (4260-102-3305)

CMS DEFERRED CLAIMS

REGULAR POLICY CHANGE NUMBER:	200
IMPLEMENTATION DATE:	4/2017
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	2034

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$52,385,000	$350,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$52,385,000	$350,000,000
FEDERAL FUNDS	-$52,385,000	-$350,000,000

DESCRIPTION

Purpose:
This policy change estimates the repayment of deferred claims to the Centers for Medicare and Medicaid Services (CMS).

Authority:
California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)
Title 42, Code of Federal Regulations (CFR), 430.40

Interdependent Policy Changes:
Not Applicable

Background:
CMS reviews claims submitted by state Medicaid agencies to ensure federal financial participation (FFP) eligibility. Claims for which CMS questions the FFP eligibility are deferred and the state Medicaid agency is issued a deferral notice. Upon receipt of the deferral notice, the state Medicaid agency has 120 days to resolve the deferred claim.

When CMS issues a deferral to the state Medicaid agency, in accordance with the timelines set forth in 42 CFR 430.40, the state Medicaid agency must immediately return the deferred FFP to the applicable Payment Management System (PMS) subaccount while the deferral is being resolved. As part of the resolution process, the state Medicaid agency submits documentation in support of the deferred claim to CMS for review. If CMS determines the deferred claim is allowed, then the deferral is released, the funds are returned to the appropriate PMS subaccount, and the state Medicaid agency is notified that the funds are available to be redrawn.

The County Administration Enhanced Funding deferral repayments and resolutions are budgeted in a separate policy change. See the County Administration CMS Deferred Claims policy change for more information. The Fiscal Intermediary and administrative deferral repayments are budgeted in a separate policy change. See the CMS Deferred Claims – Other Admin policy change for more information.

CMS DEFERRED CLAIMS

REGULAR POLICY CHANGE NUMBER: 200

Reason for Change:
The change in FY 2019-20, from the prior estimate, is due to the updated FFY 2019 Quarter 2 repayment amount based on the actual CMS deferral, and FFY 2019 Quarter 3, FFY 2019 Quarter 4, and FFY 2020 Quarter 1 estimated repayments shifted to FY 2020-21.

The change in FY 2020-21, from the prior estimate, is due to FFY 2019 Quarter 3, FFY 2019 Quarter 4, and FFY 2020 Quarter 1 estimated repayments shifted from FY 2019-20.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to reclaimed deferrals, the Targeted Case Management (TCM) claims disallowance repayment, and actual CMS deferral repayment amounts in FY 2019-20.

Methodology:
1. The Department received CMS deferrals for FFY 2015 Quarter 1 through FFY 2019 Quarter 2.

2. The Department repaid the FFY 2015 Quarters 1 and 2 deferrals in FY 2016-17, the FFY 2015 Quarters 3 and 4 and FFY 2016 Quarters 1 through 3 deferrals in FY 2017-18, and the FFY 2016 Quarter 4 through FFY 2018 Quarter 2 deferrals in FY 2018-19. The Department will repay the federal funds (FF) according to the required timelines but will continue to work on resolving the deferrals.

3. In FY 2019-20, the Department estimates to repay a net total of $52.385 million which includes $139.33 million FF for the CMS deferrals issued for FFY 2018 Quarter 3, FFY 2018 Quarter 4, FFY 2019 Quarter 1, and FFY 2019 Quarter 2, and $30.493 million FF for the disallowance of TCM claims from FFY 2003 Quarter 4 through FFY 2010 Quarter 4.

4. In FY 2019-20, the Department reclaimed $117.438 million FF for resolved deferrals which includes $10.079 million FF for Enhanced Funding for Community First Choice capitation payments, $102.214 million FF for Physician Supplemental payments and 1115 Waiver SNCP claims, and $5.145 million for Trauma Supplemental payments.

5. In FY 2020-21, the Department estimates to repay $350 million FF for projected repayments.

CMS DEFERRED CLAIMS

REGULAR POLICY CHANGE NUMBER: 200

6. The Department will repay/resolve the following estimated deferred claims:

(Dollars in Thousands)

FY 2019-20	Total Estimated Repayment
FFY 2003 Quarter 4 - FFY 2010 Quarter 4 (Jul 2003-Sep 2010)	$30,493
FFY 2018 Quarter 3 (Apr-Jun 2018)	$74,793
FFY 2018 Quarter 4 (Jul-Sep 2018)	$16,258
FFY 2019 Quarter 1 (Oct-Dec 2018)	$22,819
FFY 2019 Quarter 2 (Jan-Mar 2019)	$25,460
Subtotal Estimated Repayments	$169,823
FFY 2016 Quarter 3 (Apr-Jun 2016)	($10,079)
FFY 2018 Quarter 3 (Apr-Jun 2018)	($102,214)
FFY 2018 Quarter 4 (Jul-Sep 2018)	($5,145)
Subtotal Resolved Deferrals	($117,438)
Total FY 2019-20	**$52,385**

(Dollars in Thousands)

FY 2020-21	Total Estimated Repayment
FFY 2019 Quarter 3 (Apr-Jun 2019)	$50,000
FFY 2019 Quarter 4 (Jul-Sep 2019)	$50,000
FFY 2020 Quarter 1 (Oct-Dec 2019)	$50,000
FFY 2020 Quarter 2 (Jan-Mar 2020)	$50,000
FFY 2020 Quarter 3 (Apr-Jun 2020)	$50,000
FFY 2020 Quarter 4 (Jul-Sep 2020)	$50,000
FFY 2021 Quarter 1 (Oct-Dec 2020)	$50,000
Total FY 2020-21	**$350,000**

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XIX GF (4260-101-0001)

INDIAN HEALTH SERVICES FUNDING SHIFT

REGULAR POLICY CHANGE NUMBER:	201
IMPLEMENTATION DATE:	7/2019
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	2156

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$13,000,000	-$13,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$13,000,000	-$13,000,000
FEDERAL FUNDS	$13,000,000	$13,000,000

DESCRIPTION

Purpose:
This policy change estimates the technical adjustment in funding from Title XIX 50% federal financial participation (FFP) to Title XIX 100% FFP for services provided by Indian health clinics to American Indians (AIs) eligible for Fee-For-Service (FFS) Medi-Cal.

Authority:
Public Law 93-638

Interdependent Policy Changes:
Not Applicable

Background:
The Department implemented the Indian Health Services/Memorandum of Agreement 638 Clinics (IHS/MOA) between the federal IHS and the Centers for Medicare and Medicaid Services (CMS) on April 21, 1998. The agreement permits the Department to be reimbursed at 100% FFP for payments made by the State for services rendered to AIs through IHS tribal facilities.

Federal policy permits retroactive claiming of 100% FFP to the date of the MOA, July 11, 1996, or at whatever later date a clinic qualifies and elects to participate as an IHS facility under the MOA.

The per visit rate payable to the Indian health clinics is adjusted annually through changes posted in the Federal Register. These rates are set by IHS with the concurrence of the Federal Office of Management and Budget and are based on cost reports compiled by IHS.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21. There is no change from FY 2019-20 to FY 2020-21, in the current estimate.

Methodology:
1. Currently, there are 91 Indian health clinics participating in Medi-Cal.

INDIAN HEALTH SERVICES FUNDING SHIFT

REGULAR POLICY CHANGE NUMBER: 201

2. In FY 2018-19, the Department spent $26,000,000 TF ($13,000,000 GF) for services provided to AIs.

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
IHS FY 2018-19 Base exp. (50% GF / 50% FF)	($26,000)	($13,000)	($13,000)
IHS total expenditures (100% FF)	$26,000	$0	$26,000
FY 2019-20 Total	**$0**	**($13,000)**	**$13,000**

FY 2020-21			
IHS FY 2018-19 Base exp. (50% GF / 50% FF)	($26,000)	($13,000)	($13,000)
IHS total expenditures (100% FF)	$26,000	$0	$26,000
FY 2020-21 Total	**$0**	**($13,000)**	**$13,000**

Funding:
50% Title XIX FFP/ 50% GF (4260-101-0890/0001)
Title XIX 100% FFP (4260-101-0890)

FUNDING ADJUST.—ACA OPT. EXPANSION

REGULAR POLICY CHANGE NUMBER:	202
IMPLEMENTATION DATE:	7/2015
ANALYST:	Sabrina Blank
FISCAL REFERENCE NUMBER:	1915

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$1,816,431,580	-$1,824,254,400
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$1,816,431,580	-$1,824,254,400
FEDERAL FUNDS	$1,816,431,580	$1,824,254,400

DESCRIPTION

Purpose:
This policy change estimates the adjustment to accurately reflect the enhanced percentage of federal funding match for the Affordable Care Act (ACA) optional expansion population.

Authority:
ACA

Interdependent Policy Changes:
Fee-for-Service Base Expenditures
AB 1629 Annual Rate Adjustment
LTC Rate Adjustment
DPH Interim Rate Growth
Hospice Rate Increases
Laboratory Rate Methodology Change
Reduction to Radiology Rates

Background:
Effective January 1, 2014, the ACA expands Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138% of the federal poverty level. The expansion of Medicaid coverage to previously ineligible persons is referred to as the ACA optional expansion. Since January 2014, the Department has experienced significant growth in Medi-Cal enrollment as a result of the ACA optional expansions. The ACA provides an enhanced federal match for optional expansion adults of 100% through calendar year (CY) 2016, and then decreases the match in yearly phases to 90% by 2020.

Reason for Change:
The change for FY2019-20 and FY 2020-21, from the prior estimate, is a slight decrease in general fund savings due to updated policy changes. The change from FY 2019-20 to FY 2020-21, is a slight increase in general fund savings due to increases in savings for a majority of policy changes.

FUNDING ADJUST.—ACA OPT. EXPANSION

REGULAR POLICY CHANGE NUMBER: 202

Methodology:

1) The Department identified funds allocated to beneficiaries in the Newly aid category that were Title XIX funding with 50% federal match in the policy change in which they originated.

2) The federal match for FY 2019-20 is matched at 93% through CY 2019, and then decreases to 90% in CY 2020. The federal match for FY 2020-21 is 90%.

3) The total amount of unadjusted ACA optional expansion funding for all policy changes in FY 2019-20 is estimated as $4,367,002,272 and $4,560,635,129 in FY 2020-21. These amounts are credited to the Title XIX fund.

4) The amounts adjusted by this policy change are as follows:

(Dollars in Thousands)

FY 2019-20	**GF**	**FF**
Fee-For-Service Base Expenditures	($1,819,538)	$1,819,538
PC 119 AB 1629 Annual Rate Adjustments	($1,941)	$1,941
PC 122 DPH Interim Rate Growth	($557)	$557
PC 123 LTC Rate Adjustment	($436)	$436
PC 128 Hospice Rate Increases	($55)	$55
PC 133 Laboratory Rate Methodology Change	$1,010	($1,010)
PC 136 Reduction To Radiology Rates	$5,086	($5,086)
Total	**($1,816,431)**	**$1,816,431**

FY 2020-21	**GF**	**FF**
Fee-For-Service Base Expenditures	($1,815,926)	$1,815,926
PC 119 AB 1629 Annual Rate Adjustments	($3,008)	$3,008
PC 122 DPH Interim Rate Growth	($7,395)	$7,395
PC 123 LTC Rate Adjustment	($856)	$856
PC 128 Hospice Rate Increases	($138)	$138
PC 133 Laboratory Rate Methodology Change	$2,232	($2,232)
PC 136 Reduction To Radiology Rates	$837	($837)
Total	**($1,824,254)**	**$1,824,254**

FUNDING ADJUST.—ACA OPT. EXPANSION

REGULAR POLICY CHANGE NUMBER: 202

Funding:
(Dollars in Thousands)

FY 2019-20	TF	GF	FF
Title XIX 50/50	($4,367,002)	($2,183,501)	($2,183,501)
ACA Title XIX 93% FF	$2,321,026	$162,472	$2,158,554
ACA Title XIX 90% FF	$2,045,976	$204,598	$1,841,378
Total	**$0**	**($1,816,431)**	**$1,816,431**

FY 2020-21	TF	GF	FF
Title XIX 50/50	($4,560,636)	($2,280,318)	($2,280,318)
ACA Title XIX 93% FF	$4,560,636	$456,064	$4,104,572
Total	**$0**	**($1,824,254)**	**$1,824,254**

CLPP FUND

REGULAR POLICY CHANGE NUMBER:	203
IMPLEMENTATION DATE:	7/2005
ANALYST:	Sasha Jetton
FISCAL REFERENCE NUMBER:	1633

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the technical adjustment in funding offsetting 100% State General Fund (GF) to Childhood Lead Poisoning Prevention (CLPP) Fund.

Authority:
Health & Safety Code, Sections 105285,105295,105305 and 105310
Interagency Agreement (IA) # 19-10498

Interdependent Policy Changes:
Not Applicable

Background:
Medi-Cal provides blood lead tests to children who are at risk for lead poisoning, and who are:

- Full-scope beneficiaries under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit of the Medi-Cal Program, or
- Pre-enrolled in Medi-Cal through the Child Health and Disability Prevention (CHDP) Gateway program.

The lead testing expenditures are in Medi-Cal's Fee-for-Service (FFS) base trends and the Managed Care capitation rate.

The CLPP Fund receives revenues from a fee assessed on entities formerly or presently engaged in commerce involving lead products and collected by the Board of Equalization.

Pursuant to AB 1316, (Chapter 507, statutes of 2017), the use of the CLPP Fund for blood lead testing is prohibited. The fund is now to be utilized for monitoring and oversight of blood lead testing, to include enhanced lead prevention activities.

CLPP FUND

REGULAR POLICY CHANGE NUMBER: 203

The new IA establishes the Childhood Lead Poisoning Prevention (CLPP) program activities to be completed by the staff of the Child Health and Disability Prevention (CHDP) program. The three-year agreement provides $805,000 for annual Local Assistance costs.

Reason for Change:
The new IA is an increase of $80,000 from the prior estimate for both FY 2019-20 and 2020-21.

Methodology:
1. Funding for Medi-Cal is at 50% State Funds.

2. The CLPP Funding for FY 2019-20 and FY 2020-21 is assumed to be $916,000.

Funding:

	FY 2019-20
100% CLPP Fund (4260-111-0080)	$ 916,000
100% GF (4260-101-0001)	**$ (916,000)**
Net Impact	**$ -**

	FY 2020-21
100% CLPP Fund (4260-111-0080)	$ 916,000
100% GF (4260-101-0001)	**$ (916,000)**
Net Impact	**$ -**

HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER:	204
IMPLEMENTATION DATE:	4/2015
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1760

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the funding for health care coverage for children in the Medi-Cal program due to the extension of a quality assurance fee (QAF) for hospitals from January 1, 2014, and after.

Authority:
SB 239 (Chapter 657, Statutes of 2013)
Proposition 52 (2016)

Interdependent Policy Changes:
Not Applicable

Background:
SB 335 (Chapter 286, Statutes of 2011) established the Hospital QAF program from July 1, 2011, through December 31, 2013, which provided additional funding to hospitals and for children's health care. The fee revenue is primarily used to match federal funds to provide supplemental payments to private hospitals, increased payments to managed care plans, and direct grants to public hospitals.

SB 239 extended the Hospital QAF program from January 1, 2014, through December 31, 2016 and provided instructions for implementation of future program periods. The Department submitted State Plan Amendments (SPA) for this program on March 31, 2014 and received approval for these SPAs in December 2014.

SB 239 also requires the Department to increase capitation payments for the actuarial equivalent of AB 113 (Chapter 20, Statutes of 2011) payments to non-designated public hospitals (NDPH).

Proposition 52, approved by California voters on November 8, 2016, permanently extended the Hospital QAF program. The HQAF V program period was approved in December 2017 with a retroactive effective date of January 1, 2017, and an end date of June 30, 2019.

HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 204

The Department received federal approval for the QAF VI program period (July 1, 2019 through December 31, 2021) in February 2020. This QAF program period is referred to as HQAF VI.

Reason for Change:
The change for FY 2019-20, from the prior estimate, is due to:

- A change in the methodology used to develop the HQAF VI children's health coverage estimate. The prior estimate projected payments based on a mock-up model while the current estimate is based on the actual approved HQAF VI model, which was developed using updated Upper Payment Limit demonstrations, and
- The COVID-19 emergency, which has caused HQAF VI children's coverage payments in FY 2019-20 to be fully postponed. These children's coverage payments will be reconciled and paid in full at a later date.

The change for FY 2020-21, from the prior estimate, is due to:

- Payments estimated based on the change in the HQAF VI children's health coverage methodology, and
- The COVID-19 emergency, which has caused the HQAF VI children's coverage payments in FY 2020-21 to be reduced to ensure that fee-for-service (FFS) payments can be made in full. The children's coverage payments will be reconciled and paid in full at a later date.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease due to:

- Completion of the HQAF IV reconciliation in FY 2019-20, and
- The COVID-19 emergency. FY 2019-20 children's coverage payments will be delayed to ensure that HQAF FFS can be paid in full. FY 2020-21 children's coverage payments will be partially paid to ensure that HQAF FFS can be paid in full.

Methodology:

1. Payments for children's health care are estimated through the period ending March 30, 2021 in this policy change.

2. The HQAF IV program period is from January 1, 2014, to December 31, 2016. The HQAF V program period is from January 1, 2017, to June 30, 2019.

3. Assume the HQAF VI program period covers a 30-month period from July 1, 2019, through December 31, 2021.

4. SB 239 requires the Department to reconcile the funds for children's health care coverage based on the actual net benefit to the hospitals from the fee program.

5. Payments for HQAF V are based on the approved HQAF V Fee & Payment Model.

6. HQAF VI payments are based on the HQAF VI model that was approved by CMS on In February 2020. The payment schedule is still under development, so timings are subject to change.

7. HQAF VI children's coverage payments in FY 2019-20 and 2020-21 have been fully or partially postponed due to the COVID-19 emergency. Partial payments will be made when possible, as long as FFS payments can be made in full. The children's coverage payments will be reconciled and paid in full at a later date.

HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 204

8. On an accrual basis, annual funds for children's health care coverage are estimated to be:

(Dollars in Thousands)

Fiscal Year	Authority	HQAF IV Period (36 months)	Amount
FY 2013-14	SB 239	1/1/14 to 6/30/14	$310,000
FY 2014-15	SB 239	7/1/14 to 6/30/15	$726,400
FY 2015-16	SB 239	7/1/15 to 6/30/16	$739,500
FY 2016-17	SB 239	7/1/16 to 12/31/16	$400,500

(Dollars in Thousands)

Fiscal Year	Authority	HQAF V Period (30 months)	Amount
FY 2016-17	Proposition 52 (1/1/17 and forward)	1/1/17 to 6/30/17	$513,154
FY 2017-18	Proposition 52	7/1/17 to 6/30/18	$1,087,722
FY 2018-19	Proposition 52	7/1/18 to 6/30/19	$1,134,384

(Dollars in Thousands)

Fiscal Year	Authority	HQAF VI Period (24 of 30 months)	Amount
FY 2019-20	Proposition 52	7/1/19 to 6/30/20	$978,000
FY 2020-21	Proposition 52	7/1/20 to 6/30/21	$1,009,200

9. HQAF IV children's health care coverage savings for the FY 2014-15 through FY 2016-17 reconciliation of $107.845 million will be paid in FY 2019-20.

10. The final quarterly children's health care payment the HQAF V program period was completed in July 2019.

11. Five quarters of HQAF VI children's health care payments will be paid in FY 2020-21. The payments have been reduced in response to the COVID-19 emergency and will be reconciled at a later date.

12. On a cash basis, the payments to health care coverage for children and the funding adjustment are:

(Dollars in Thousands)

FY 2019-20	TF	GF	Hosp. QA Rev Fund
HQAF IV (FY 2014-15 through FY 2016-17)	$0	($107,845)	$107,845
FY 2018-19	$0	($283,596)	$283,596
Total FY 2019-20	**$0**	**($391,441)**	**$391,441**

HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 204

(Dollars in Thousands)

FY 2020-21	TF	GF	Hosp. QA Rev Fund
FY 2019-20	$0	($408,000)	$408,000
FY 2020-21	$0	($568,000)	$568,000
Total FY 2020-21	**$0**	**($976,000)**	**$976,000**

Funding:
100% GF (4260-101-0001)
100% Hospital Quality Assurance Revenue Fund (4260-611-3158)

AUDIT SETTLEMENTS

REGULAR POLICY CHANGE NUMBER:	205
IMPLEMENTATION DATE:	7/2016
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	110

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$77,697,000	$734,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$77,697,000	$734,000
FEDERAL FUNDS	-$77,697,000	-$734,000

DESCRIPTION

Purpose:
This policy change estimates the payments for audit settlements due to the Centers for Medicare and Medicaid Services.

Authority:
Public Law 95-452

Interdependent Policy Changes:
Not Applicable

Background:
Federal Audit A-09-13-02015: The Department identified on its adjustment reports as non-emergency services provided to qualified aliens for which it did not claim Federal Medicaid reimbursement. The Department did not correctly identify all non-reimbursable claims for non-emergency services provided to qualified aliens. The Department incorrectly claimed Federal Medicaid reimbursement. The audit period covers payments made during the period for quarters ended June 2010, September 2010, June 2011, June 2012, June 2013, and June 2014.

Federal Audit A-09-11-02016: The Department either made unallowable, or the data was insufficient to determine if allowable, Medicaid payments for items and services furnished, ordered, or prescribed by excluded providers. The audit period covers payments made for dates of service between July 1, 2009, and June 30, 2010.

Federal Audit A-09-16-30056: The Department has delegated the performance of eligibility redeterminations to county welfare agencies in subawards. This audit found that 5 out of 140 reviewed eligibility redeterminations were missing at least one type of required eligibility information. The audit period covers payments made between July 1, 2014, and June 30, 2015.

AUDIT SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 205

Federal Audit A-09-17-31846: The Department has delegated the performance of eligibility redeterminations to county welfare agencies in subawards. This audit found that 7 out of 69 reviewed eligibility redeterminations were not performed at the required interval of once every twelve months. The audit period covers payments made between July 1, 2015, and June 30, 2016.

Federal Audit A-09-18-33530: The Department has delegated the performance of eligibility redeterminations to county welfare agencies in subawards. This audit found that 26 out of 140 reviewed eligibility redeterminations did not meet full compliance for the federal award. The audit period covers payments made between July 1, 2016, and June 30, 2017.

Federal Audit A-09-19-67175: The Department has delegated the performance of eligibility redeterminations to county welfare agencies in subawards. This audit found that 35 out of 47 reviewed eligibility redeterminations did not meet full compliance for the federal award. The audit period covers payments made between July 1, 2017, and June 30, 2018.

PERM Recovery FY 2016-17 was evaluated through the Improper Payments Information Act of 2002 which requires Federal agencies to review and estimate improper payments.

The Department has an interagency agreement with the State Controller's Office (SCO) to conduct limited scope audits. Beginning in 2013, the SCO conducted seven audits on a pharmacy chain in California. The SCO audits identified overpayments totaling $133,677,299. Following these audits, from 2015 through the beginning of 2016, the SCO submitted reports to the Department detailing their findings. All of the pharmacies have either closed or were sold without the new owner assuming responsibility for previous debts. The sales and closures of the pharmacies took place between the years of 2012 and 2014. In August 2019, the Department reimbursed the federal government for the federal share of the overpayments of approximately $66,838,650. The Department will try to recoup the funds owed.

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is a shift of PERM payments from FY 2019-20 to FY 2020-21. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease due to the settlements being one-time payments.

AUDIT SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 205

Methodology:

FY 2019-20	Audit	Finding	GF
Eligibility	Review of State's Quarterly Alien Claiming Audit	The Department incorrectly claimed Federal Medicaid reimbursement	$9,873,000
Eligibility	Annual Single Audit, FY 2014-15, FY 2015-16, and FY 2016-17	The Department failed to make, or failed to retain records to show, that eligibility redetermination were done as required	$146,000
CA-MMIS	CA Unallowable Medicaid Payments for Services Claimed by Excluded Providers	The Department incorrectly made Medicaid payments for items and services furnished, ordered, or prescribed by excluded providers	$140,000
Medi-Cal Dental	CA Unallowable Medicaid Payments for Services Claimed by Excluded Providers	The Department paid for additional items or services that may have been furnished, ordered, or prescribed by excluded providers, and therefore may have been unallowable	$699,000
SCO Audit	Overpayments		$66,839,000
		FY 2019-20 Total	**$77,697,000**

FY 2020-21	Audit	Finding	GF
PERM Recovery 2016	California Medicaid Error Rates for FFY 2016-17	Identified and estimated amount of improper payments for Medicaid	$84,000
PERM Recovery 2020	California Medicaid Error Rates for FY 2018-19	Identified and estimated amount of improper payments for Medicaid	$650,000
		FY 2020-21 Total	**$734,000**

Fiscal Year	TF	GF	FF
FY 2019-20	**$0**	**$77,697,000**	**($77,697,000)**
FY 2020-21	**$0**	**$734,000**	**($734,000)**

Funding:
100% GF (4260-101-0001)
Title XIX FFP (4260-101-0890)

IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER:	206
IMPLEMENTATION DATE:	4/2017
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	35

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$9,685,000	$20,807,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$9,685,000	$20,807,000
FEDERAL FUNDS	-$9,685,000	-$20,807,000

DESCRIPTION

Purpose:
This policy change estimates the cost of federal fund (FF) repayments that the Department must make to the Centers for Medicare and Medicaid Services (CMS) for inappropriately claimed ancillary services for Medi-Cal beneficiaries residing in Institutions for Mental Diseases (IMDs), both through Fee-For-Service (FFS) and Managed Care (MC) delivery systems.

Authority:
Title 42, Code of Federal Regulations 435.1009
Welfare & Institutions Code 14053.3

Interdependent Policy Changes:
Not Applicable

Background:
Ancillary services provided to Medi-Cal beneficiaries who are ages 21 through 64 residing in IMDs are not eligible for federal reimbursement. Identifiers are currently not available in the Medi-Cal Eligibility Data System (MEDS) to indicate whether a Medi-Cal beneficiary is residing in an IMD. Consequently, the Department's Fiscal Intermediary (FI) may not deny any claims that are ineligible for reimbursement. The Department uses data from the mental health Client and Services Information (CSI) system to retrospectively identify the dates individuals were residents of an IMD for repayment of the FF, as required by CMS. This information is not known at the time the claims were processed and paid by the FI. The Department matches the data from the CSI system to the claims data to determine which claims were inappropriately reimbursed while the individual was a resident of an IMD.

While the Department intends to develop eligibility and claiming processes to stop inappropriate claiming and reimbursement for ancillary services, the current inappropriately paid services must be repaid to CMS.

Due to the Court of Appeals' decision for the County of Colusa case on July 9, 2014, the counties will not reimburse the State for IMD ancillary costs. The State is now financially responsible for ancillary outpatient services provided to eligible individuals who are residing in an IMD.

IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER: 206

For managed care, a base claims file of Client Identification Numbers (CIN) was utilized to identify capitation that was paid when a Medi-Cal beneficiary was admitted and stayed in an IMD.

CMS has estimated IMD deferrals of $3 million federal funds per quarter. According to 42 CFR 430.40, when CMS issues a deferral of claims for federal financial participation (FFP), the state must immediately return the deferred FFP to the applicable Payment Management System (PMS) subaccount while the deferral is being resolved.

Reason for Change:
The change from the prior estimate for FY 2019-20 is a decrease due to shifting one quarter of FY 2018-19 FFS repayments and two quarters of FY 2019-20 FFS and MC repayments to FY 2020-21.

The change from the prior estimate for FY 2020-21 is and increase due to the shifted repayments from FY 2019-20 to FY 2020-21 to align with the estimated repayment schedule.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to more quarters of repayments estimated in FY 2020-21.

Methodology:
1. The costs for ancillary services provided to beneficiaries in IMDs are in the Medi-Cal base estimate.

2. For FY 2019-20, the Department estimates to repay FFS deferrals from April 2018 through March 2019 and managed care deferrals from FY 2018-19 to March 2019.

3. For FY 2020-21, the Department estimates to repay FFS deferrals from April 2019 through December 2020 and managed care deferrals from July 2019 through December 2020.

4. The estimated IMD repayments are:

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
Fee-For-Service (FFS)			
FY 2017-18 Q4 (Apr to Jun 2018)	$0	$2,320	($2,320)
Subtotal FY 2017-18		$2,320	($2,320)
FY 2018-19 Q1 (Jul to Sep 2018)	$0	$1,705	($1,705)
FY 2018-19 Q2 (Oct to Dec 2018)	$0	$1,927	($1,927)
FY 2018-19 Q3 (Jan-Mar 2019)	$0	$2,153	($2,153)
Subtotal FY 2018-19	$0	$5,785	($5,785)
Subtotal FFS	$0	$8,105	($8,105)
Managed Care			
FY 2018-19	$0	$1,580	($1,580)
Subtotal Managed Care	$0	$1,580	($1,580)
Total FY 2019-20	**$0**	**$9,685**	**($9,685)**

IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER: 206

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
Fee-For-Service (FFS)			
FY 2018-19 Q4 (Apr-Jun 2019)	$0	$2,315	($2,315)
Subtotal FY 2018-19	$0	$2,315	($2,315)
FY 2019-20 Q1 (Jul-Sep 2019)	$0	$1,705	($1,705)
FY 2019-20 Q2 (Oct-Dec 2019)	$0	$1,927	($1,927)
FY 2019-20 Q3 (Jan-Mar 2020)	$0	$2,153	($2,153)
FY 2019-20 Q4 (Apr-Jun 2020)	$0	$2,315	($2,315)
Subtotal FY 2019-20	$0	$8,100	($8,100)
FY 2020-21 Q1 (Jul-Sep 2020)	$0	$3,000	($3,000)
FY 2020-21 Q2 (Oct-Dec 2020)	$0	$3,000	($3,000)
Subtotal FY 2020-21	$0	$6,000	($6,000)
Subtotal FFS	$0	$16,415	($16,415)
Managed Care			
FY 2019-20 Q1 and Q2 (Jul- Dec 2019)	$0	$1,468	($1,468)
FY 2019-20 Q3 and Q4 (Jan-Jun 2019)	$0	$1,468	($1,468)
FY 2020-21 Q1 and Q2 (Jul- Dec 2020)	$0	$1,456	($1,456)
Subtotal Managed Care	$0	$4,392	($4,392)
Total FY 2020-21	**$0**	**$20,807**	**($20,807)**

Funding:
100% General Fund (4260-101-0001)
Title XIX FFP (4260-101-0890)

CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER:	207
IMPLEMENTATION DATE:	1/2006
ANALYST:	Matt Wong
FISCAL REFERENCE NUMBER:	1087

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change reduces the General Fund and replaces those funds with Cigarette and Tobacco Products Surtax (CTPS/Proposition 99) funds from the Hospital Services, Physicians' Services and Unallocated Accounts. This funding shift is identified in the management summary funding pages.

Authority:
California Tobacco Health Protection Act of 1988 (Proposition 99)
AB 75 (Chapter 1331, Statutes of 1989)

Interdependent Policy Changes:
Not Applicable

Background:
The CTPS/Proposition 99 funds are allocated to aid in the funding of the *Orthopaedic Hospital* settlement and other outpatient payments. The *Orthopaedic Hospital* settlement increased hospital outpatient rates by a total of 43.44% between 2001 and 2004.

This policy change supports healthcare coverage for beneficiaries in the Medi-Cal program.

Reason for Change:
Dollars were revised from prior estimate to reflect updated revenues and expenditures related to Proposition 99.

CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER: 207

Methodology:

FY 2019-20	
Hospital Services Account	$130,657,000
Physicians' Services Account	$40,862,000
Unallocated Account	$60,035,000
Total CTPS/Prop. 99	**$231,554,000**
GF	**($231,554,000)**
Net Impact	**$0**

FY 2020-21	
Hospital Services Account	$92,170,000
Physicians' Services Account	$26,639,000
Unallocated Account	$41,848,000
Total CTPS/Prop. 99	**$160,657,000**
GF	**($160,657,000)**
Net Impact	**$0**

Funding:
Proposition 99 Hospital Services Account (4260-101-0232)
Proposition 99 Physician Services Account (4260-101-0233)
Proposition 99 Unallocated Account (4260-101-0236)
Title XIX GF (4260-101-0001)

HOME & COMMUNITY-BASED ALTERNATIVES WAIVER RENEWAL

REGULAR POLICY CHANGE NUMBER:	208
IMPLEMENTATION DATE:	10/2017
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	2010

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$12,731,000	-$27,215,000
- STATE FUNDS	-$6,365,500	-$13,607,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$12,731,000	-$27,215,000
STATE FUNDS	-$6,365,500	-$13,607,500
FEDERAL FUNDS	-$6,365,500	-$13,607,500

DESCRIPTION

Purpose:
This policy change estimates the cost of renewing the Home and Community-Based Alternatives (HCBA) Waiver.

Authority:
Welfare & Institutions Code, Section 14132.991

Interdependent Policy Changes:
HCBA Waiver Renewal Administrative Cost

Background:
The HCBA waiver offers services in the home or community to Medi-Cal beneficiaries who would otherwise receive care in a skilled nursing facility. Eligibility into the waiver is based on skilled nursing levels of care. The level of care is determined by the Medi-Cal beneficiary's medical need. The waiver is held to the principle of federal cost neutrality; thus, services are arranged so that the overall total costs for the waiver and Medi-Cal State Plan services cannot exceed the costs of facilities offering equivalent levels of care. The Department received approval for an amendment to the NF/AH waiver in November 2016, retroactive to February 1, 2016. The primary change enacted through this amendment was to allow a shift to the calculation of cost neutrality in the aggregate, based upon medical necessity. The Department received approval of the waiver renewal application on May 16, 2017, retroactive to January 1, 2017. As part of the approved renewal application, the waiver was renamed to the HCBA Waiver.

Under the NF/AH Waiver renewal, the Department received approval to:

- Increase the number of waiver slots with long-term savings by expanding capacity of the HCBA waiver, which would eliminate the waitlist and allow Medi-Cal beneficiaries to remain in their home or community and mitigate the risk of institutionalization while incentivizing increased long-term skilled nursing facility transition;

HOME & COMMUNITY-BASED ALTERNATIVES WAIVER RENEWAL

REGULAR POLICY CHANGE NUMBER: 208

- Localize care management to comply with person-centered care planning and provide local care coordination that will increase access to medically necessary services for beneficiaries while reducing inpatient, emergency room, and skilled nursing facility admissions and readmissions. The primary model for the administration and operation of the Waiver is through contracted Waiver Agencies. The Waiver Agencies are responsible for local Waiver Administration functions and for the delivery of the Comprehensive Care Management Waiver services. The reimbursement structure for Waiver Administration services will be a per member per month rate. The reimbursement structure for Comprehensive Care Management will be a tiered per member per month based on acuity. The combination of transitions to Comprehensive Care Management and changing the role of state staff to oversight and monitoring will result in a reduction in health care costs over time through a significantly strengthened care management model;

- Shift to aggregate cost neutrality, based upon medically necessary waiver services, which was approved in the waiver amendment; and

- Gradual integration of the In-Home Operations (IHO) Waiver by transitioning IHO waiver beneficiaries into the HCBA waiver at the point of annual reassessment.

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is an increase in savings due to additional actuals from July 2019 through December 2019, which were higher than previously estimated, and an update to the unmet need cost from $74 to $600. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase in savings due to the additional enrollment from institutional facilities to the HCBA Waiver.

Methodology:

1. Beginning February 1, 2016, for FY 2019-20 and FY 2020-21, assume 538 and 670 respectively, current participants are over their waiver cap and their monthly cost for unmet need is $600.

2. The renewed waiver was approved on May 16, 2017, with an effective date of January 1, 2017.

3. There are currently 4,291 waiver participants. Assume 2,223 new participants will be enrolled in FY 2019-20 and 1,200 FY 2020-21.

4. From the newly enrolled participants, assume 60% will be from long-term skilled nursing facilities and the Early Periodic Screening and Diagnostic Treatment (EPSDT) Program and 40% participants will be from the community.

5. Assume the average monthly cost for comprehensive care management is $275 and that care management costs will begin in August 2018 to allow time to implement the Waiver Agency model.

6. Assume 95% of all current and new waiver participants will enroll with a Waiver Agency and receive comprehensive care management.

7. Assume the monthly cost for waiver services from the community is $3,040.

8. Assume the monthly cost for wavier services transitioning from institutions and EPSDT is $4,698.

HOME & COMMUNITY-BASED ALTERNATIVES WAIVER RENEWAL

REGULAR POLICY CHANGE NUMBER: 208

9. Assume the average monthly cost in a skilled nursing facility is $10,736.

FY 2019-20	TF	GF	FF
Care Management	$14,393,000	$7,197,000	$7,196,000
Waiver Svcs. - Community	$28,062,000	$14,031,000	$14,031,000
Waiver Svcs. - EPSDT	$10,841,000	$5,420,000	$5,421,000
Waiver Svcs. – Institutional Tran.	$54,206,000	$27,103,000	$27,103,000
Unmet Need	$3,636,000	$1,818,000	$1,818,000
Institutional Transitions Savings	($123,869,000)	($61,935,000)	($61,934,000)
Total	**($12,731,000)**	**($6,366,000)**	**($6,365,000)**
FY 2020-21	**TF**	**GF**	**FF**
Care Management	$18,155,000	$9,078,000	$9,077,000
Waiver Svcs. - Community	$45,573,000	$22,786,000	$22,787,000
Waiver Svcs. - EPSDT	$17,606,000	$8,803,000	$8,803,000
Waiver Svcs. – Institutional Tran.	$88,031,000	$44,016,000	$44,015,000
Unmet Need	$4,586,000	$2,293,000	$2,293,000
Institutional Transitions Savings	($201,167,000)	($100,584,000)	($100,583,000)
Total	**($27,215,000)**	**($13,608,000)**	**($13,607,000)**

*Totals may differ due to rounding.

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

COUNTY SHARE OF OTLICP-CCS COSTS

REGULAR POLICY CHANGE NUMBER:	210
IMPLEMENTATION DATE:	7/2014
ANALYST:	Sabrina Blank
FISCAL REFERENCE NUMBER:	1906

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$14,917,000	-$22,660,000
- STATE FUNDS	-$14,917,000	-$22,660,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$14,917,000	-$22,660,000
STATE FUNDS	-$14,917,000	-$22,660,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the reimbursement of county funds for the Optional Targeted Low Income Children's Program (OTLICP).

Authority:
AB 1494 (Chapter 28, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

Background:
AB 1494 authorized the transition of all Healthy Family Program (HFP) subscribers into the Medi-Cal OTLICP. Effective January 1, 2013, HFP subscribers transitioned into OTLICP through a phase-in methodology.

Of the subscribers, an estimated 23,381 California Children Services (CCS) – HFP eligibles shifted to CCS-OTLICP in FY 2013-14. CCS-HFP was funded with 65% FFP, 17.5% GF, and 17.5% county funds through September 30, 2015. From October 1, 2015, to September 30, 2019, CCS-HFP is funded with 88% FFP, 6% GF, and 6% county funds. Effective October 1, 2019, to September 30, 2020, CCS-HFP will be funded with 76.5% FFP, 11.75% GF, and 11.75% county funds. Effective October 1, 2020 CCS-HFP will be funded with 65% FFP, 17.5% GF, and 17.5% county funds. It is assumed that the county share will continue under OTLICP.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 or FY 2020-21. The change from FY 2019-20 to FY 2020-21 in the current estimate, is an increase due to Federal Medi-Cal Assistance Percentage changes and updated monthly expenditures.

Methodology:
1. The county share reimbursement for CCS-OTLICP in FY 2019-20, at 6% for quarter 1 and 11.75% for quarters 2 through 4, is estimated to be $14,917,000.

COUNTY SHARE OF OTLICP-CCS COSTS

REGULAR POLICY CHANGE NUMBER: 210

2. The county share reimbursement for CCS-OTLICP in FY 2020-21, at 11.75% for quarter 1 and 17.5% for quarters 2 through 4, is estimated to be $22,660,000.

3. The county share of CCS-OTLICP costs is estimated in the table below:

Fiscal Year	TF	GF	CF*
FY 2019-20	**($14,917,000)**	**($14,917,000)**	$14,917,000
FY 2020-21	**($22,660,000)**	**($22,660,000)**	$22,660,000

* County Funds are not included in the Total Fund.

Funding:
100% Title XXI State GF (4260-113-0001)

ASSISTED LIVING WAIVER EXPANSION

REGULAR POLICY CHANGE NUMBER:	211
IMPLEMENTATION DATE:	10/2018
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	2054

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$31,106,000	-$56,144,000
- STATE FUNDS	-$15,553,000	-$28,072,000
PAYMENT LAG	0.9970	1.0000
% REFLECTED IN BASE	75.80 %	44.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$7,505,100	-$31,440,600
STATE FUNDS	-$3,752,530	-$15,720,320
FEDERAL FUNDS	-$3,752,540	-$15,720,320

DESCRIPTION

Purpose:
This policy change estimates the cost to increase the capacity of the Assisted Living Waiver (ALW).

Authority:
SB 840 (Chapter 29, Statutes of 2018)

Interdependent Policy Changes:
Not Applicable

Background:
The ALW offers services in an assisted living or public subsidized housing setting to Medi-Cal members who would likely otherwise receive care in a skilled nursing facility. Eligibility into the ALW is based on a qualifying skilled nursing level of care which is captured through the assessment tool used by the Care Coordination Agencies to assess potential participants.

The Department received approval from the Centers for Medicare and Medicaid Services to expand the ALW by 2,000 waiver slots from 3,744 slots to 5,744 slots for FY 2017-18, FY 2018-19, FY 2019-20, and FY 2020-21 to accommodate current and anticipated need. A reserve capacity is set for new enrollments which will require that 60% of all new enrollments be reserved for individuals transitioning from institutional settings.

Reason for Change:
The change in FY 2019-20 and FY 2020-21, in the current estimate, is a decrease in savings due to lower estimated enrollment based on actuals through October 2019. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase in savings due to additional participants transitioning into the ALW.

Methodology:
1. Assume 2,000 new participants will be phased in by FY 2020-21.

ASSISTED LIVING WAIVER EXPANSION

REGULAR POLICY CHANGE NUMBER: 211

2. Of the new 2,000 participants, assume 1,200 will be from an institution and 800 will be from the community.

3. Assume the average annual cost for waiver services is $16,477.

4. Assume the average annual cost in a skilled nursing facility is $77,280.

FY 2019-20	**TF**	**GF**	**FF**
Total Cost from Waiver Services	$20,221,000	$10,111,000	$10,110,000
Total Savings from SNF Transitions	($51,327,000)	($25,664,000)	($25,663,000)
Net Impact Savings	**($31,106,000)**	**($15,553,000)**	**($15,553,000)**
FY 2020-21	**TF**	**GF**	**FF**
Total Cost from Waiver Services	$36,497,000	$18,249,000	$18,248,000
Total Savings from SNF Transitions	($92,641,000)	($46,321,000)	($46,320,000)
Net Impact Savings	**($56,144,000)**	**($28,072,000)**	**($28,072,000)**

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

PURE PREMIUM FUND CLOSEOUT

REGULAR POLICY CHANGE NUMBER:	213
IMPLEMENTATION DATE:	8/2019
ANALYST:	Matt Wong
FISCAL REFERENCE NUMBER:	2154

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$501,725,000	$0
- STATE FUNDS	-$142,907,390	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$501,725,000	$0
STATE FUNDS	-$142,907,390	$0
FEDERAL FUNDS	-$358,817,610	$0

DESCRIPTION

Purpose:
The policy change estimates the cost of pure premium fund closeout as a result of the final audit.

Authority:
Social Security Act, Title XIX
AB 82 (2013, Chapter 23), Section 14131.10 of the Welfare & Institutions Code

Interdependent Policy Changes:
N/A

Background:
Under the 2004 Delta Dental Contract, the contractor was required to have an annual independent audit which included the determination of any underwriting gain or loss. The audit for the period ending January 31, 2018 resulted in an underwriting gain for the Department. The final audit was completed and the general fund has been returned to the Department.

Reason for Change:
There is no change from the prior estimate for FY 2019-20. There is no change from the prior estimate for FY 2020-21. The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to the completion of the reimbursement in FY 2019-20.

Methodology:
1. The final audit of the Pure Premium Fund showed a reconciliation of $501,724,808 returning to the Department.

PURE PREMIUM FUND CLOSEOUT

REGULAR POLICY CHANGE NUMBER: 213

Funding:

(Dollars in Thousands)

FY 2019-20*	TF	GF	FF
50% Title XIX / 50% GF	($291,780)	($145,890)	($145,890)
100% FFP	($21,424)	$0	($21,424)
95% Title XIX ACA FF / 5% GF	($142,896)	($7,145)	($135,751)
94% Title XIX ACA FF / 6% GF	($9,122)	($547)	($8,575)
65% Title XIX / 35% GF	($237)	($83)	($154)
88% Title XXI / 12% GF	($53,436)	($6,412)	($47,024)
100% GF	$17,170	$17,170	$0
Total FY 2019-20	**($501,725)**	($142,907)	($358,818)

MEDICARE PART B DISREGARD

REGULAR POLICY CHANGE NUMBER:	216
IMPLEMENTATION DATE:	4/2021
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	2175

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$478,000
- STATE FUNDS	$0	$478,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$478,000
STATE FUNDS	$0	$478,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the cost for eligibles in the Aged, Blind, and Disabled (ABD) program to remain eligible for the program regardless of the state's payment of their Medicare Part B premiums, as long as they meet all other Medi-Cal eligibility requirements.

Authority:
AB 1088 (Chapter 450, Statutes of 2019)

Interdependent Policy Changes:
Not Applicable

Background:
The Department provides Medi-Cal coverage to low-income individuals, seniors and persons with a disability, at no cost through the ABD program. Applicants for the ABD program are entitled to certain deductions from their income when qualifying for Medi Cal, including the deduction for health insurance and/or Medicare premiums self−paid by the individual or their family. This health insurance premium deduction reduces the net countable income. For some applicants and beneficiaries, this deduction can reduce the net countable income to at or below the income threshold for these programs and results in eligibility for no cost Medi-Cal.

The Department operates a state Medicare Buy-in program (state Buy-in program) for full scope Medi-Cal beneficiaries who are eligible for Medicare. Through this state Buy-in program, the Department begins paying the Medicare Part B premium for recipients who qualify for no cost Medi-Cal, and the beneficiary no longer has to pay the premium. As long as the beneficiary is self-paying their Part B premiums, they will receive this health insurance premium deduction. Once the beneficiary qualifies for no cost Medi-Cal and the state begins to pay their Medicare premium (state Buy-in), they no longer receive the deduction, and their countable income for program eligibility purposes increases accordingly. For some beneficiaries, this can result in moving from no cost Medi-Cal to share of cost (SOC) Medi−Cal, solely because of the state Buy-in.

MEDICARE PART B DISREGARD

REGULAR POLICY CHANGE NUMBER: 216

AB 1088 allows for an ABD beneficiary whose Part B premiums are being paid by the Department to continue to receive Medi-Cal benefits without a SOC, as long as they meet all eligibility requirements.

Reason for Change:
There is no change from the prior estimate for FY 2019-20. The change from the prior estimate, for FY 2020-21, is an increase due to projected increases in eligibles and the SOC loss. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to the program implementing in FY 2020-21.

Methodology:

1. The Department must obtain federal approval prior to implementing this policy. Formal policy instructions will be provided to the counties through an All County Welfare Directors Letter (ACWDL). Statewide Automated Welfare Systems changes will be programed after the publication of the ACWDL. Assume this policy will implement no sooner than FY 2020-21.

2. Assume an annual impact for beneficiaries who have a monthly SOC of at least $672.

3. Assume the Department will continue to pay Part B premiums for this population.

4. Assume an estimated cost of **$478,000 General Fund** in **FY 2020-21**.

Funding:
100% GF (4260-101-0001)

RESTORATION OF DENTAL FFS IN SAC AND LA COUNTIES

REGULAR POLICY CHANGE NUMBER:	217
IMPLEMENTATION DATE:	1/2021
ANALYST:	Matt Wong
FISCAL REFERENCE NUMBER:	2028

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	-$22,253,000
- STATE FUNDS	$0	-$8,897,060
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$22,253,000
STATE FUNDS	$0	-$8,897,060
FEDERAL FUNDS	$0	-$13,355,940

DESCRIPTION

Purpose:
This policy estimates the fiscal impact of eliminating Dental Managed Care and restoring the Dental Fee-For-Service (FFS) delivery system in both Sacramento and Los Angeles counties.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The Department of Health Care Services (DHCS) is responsible for providing dental services to eligible Medi-Cal beneficiaries, and offers services through two delivery systems, FFS and Dental Managed Care (DMC). FFS was the exclusive and original delivery system offered in California's 58 counties. In 1995, DHCS implemented DMC in Sacramento and Los Angeles Counties, to explore the effectiveness of DMC as a delivery system of dental services. DHCS maintains six DMC contracts with three separate contractors. In Sacramento, enrollment is mandatory, with few exceptions. In Los Angeles, a beneficiary must opt-in to participate in DMC.

DHCS seeks to restore the delivery of Medi-Cal dental services in both Sacramento and Los Angeles counties to a FFS system. DHCS believes that this restoration will result in increased beneficiary utilization of Medi-Cal dental services. This transition will be effective no sooner than January 1, 2021.

The estimated increase in fee-for-service administrative costs are budgeted in the Restoration of Dental Fee-For-Service in Sacramento and Los Angeles Counties Admin policy change.

-- DELETED --

RESTORATION OF DENTAL FFS IN SAC AND LA COUNTIES

REGULAR POLICY CHANGE NUMBER: 217

Reason for Change:
There is no change from the prior estimate for FY 2019-20. The change from the prior estimate, for FY 2020-21, is a decrease due to a change in Dental Managed Care rates, which affect the amounts estimated to be transitioning between delivery systems. The change in the current estimate, from FY 2019-20 to FY 2020-21, is due to the transition to FFS delivery system starting January 1, 2021.

Methodology:

1. DMC savings are based on the estimated capitated payments for January 2021 and forward. The capitated payments includes costs for administration.

2. The FFS benefit costs are assumed to be equal to the DMC benefit with the appropriate payment lags applied.

3. Costs below include Proposition 56 related dollars.

FY 2020-21	TF	GF	FF
DMC	($67,923,000)	($27,151,000)	($40,772,000)
FFS	$45,670,000	$18,254,000	$27,416,000
Total	**($22,253,000)**	**($8,897,000)**	**($13,356,000)**

Funding:
65% Title XIX / 35% GF (4260-101-0001/0890)
76.5% Title XIX / 23.5% GF (4260-101-0001/0890)
50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX ACA FF / 10% GF (4260-101-0001/0890)

-- DELETED --

2020 MCO ENROLLMENT TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER:	218
IMPLEMENTATION DATE:	8/2020
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	2176

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the transfer of funds collected from the enrollment tax on managed care organizations (MCOs) to the General Fund (GF) to be retained by the Department beginning January 1, 2020.

Authority:
AB 115 (Chapter 348, Statutes of 2019)

Interdependent Policy Changes:
2020 MCO Enrollment Tax Mgd. Care Plans-Incr. Cap. Rates
2020 MCO Enrollment Tax Mgd. Care Plans-Funding Adj.

Background:
Effective January 1, 2020, the department implemented an MCO provider tax that provides for a statewide tax on managed care plans based on reported enrollment into these plans during the 12-month period between January 1, 2018, and December 31, 2018. The tax is tiered based on whether the enrollee is a Medi-Cal enrollee, alternate health care service plan enrollee, or other enrollee.

The MCO Enrollment Tax is effective for the three year period of January 1, 2020, through December 31, 2022. This policy change estimates GF savings resulting from the imposition of the MCO Enrollment Tax.

Reason for Change:
This is a new policy change.

Methodology:
1. The MCO Enrollment Tax is based on the cumulative enrollment of health plans during the 12-month period between January 1, 2018, and December 31, 2018.

2. Different rates are assessed to Medi-Cal and non-Medi-Cal health plans.

2020 MCO ENROLLMENT TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER: 218

3. The following taxing tier structures are used to determine the MCO Enrollment Tax per state fiscal year:

FY 2019-20 Medi-Cal	
Enrollees	**Rate**
0-675,000	$0.00
675,001-4,000,000	$40.00
Over 4,000,000	$0.00

FY 2019-20 Non-Medi-Cal	
Enrollees	**Rate**
0-675,000	$0.00
675,001-4,000,000	$1.00
Over 4,000,000	$0.00

FY 2020-21 Medi-Cal	
Enrollees	**Rate**
0-675,000	$0.00
675,001-4,000,000	$45.00
Over 4,000,000	$0.00

FY 2020-21 Non-Medi-Cal	
Enrollees	**Rate**
0-675,000	$0.00
675,001-4,000,000	$1.00
Over 4,000,000	$0.00

The total Medi-Cal and Non-Medi-Cal MCO Enrollment Tax on an accrual basis is:

FY 2019-20: $1,031,357,000
FY 2020-21: $2,317,734,000

4. The impact of the increase in capitation payments related to the tax is included in the 2020 MCO Enrollment Tax Mgd. Care Plans-Incr. Cap. Rates policy change.

5. The MCO Enrollment Tax fund transfers to the GF are expected to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	MCO Tax
FY 2019-20	**$0**	($0)	$0
FY 2020-21	**$0**	($1,686,645)	$1,686,645

Funding:
3334 MCO Tax

2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ

REGULAR POLICY CHANGE NUMBER:	219
IMPLEMENTATION DATE:	8/2020
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	2177

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the transfer of funds collected from the tax on managed care organizations (MCOs) to the General Fund (GF) to be used by the Department to fund related managed care capitation rate increases.

Authority:
AB 115 (Chapter 348, Statutes of 2019)

Interdependent Policy Changes:
2020 MCO Enrollment Tax Mgd. Care Plans-Incr. Cap. Rates
2020 MCO Enrollment Tax Managed Care Plans

Background:
Effective January 1, 2020, the department implemented an MCO provider tax that provides for a statewide tax on managed care plans based on reported enrollment into these plans during the 12-month period between January 1, 2018, and December 31, 2018. The tax is tiered based on whether the enrollee is a Medi-Cal enrollee, alternate health care service plan enrollee, or other enrollee.

The MCO Enrollment Tax is effective for the three year period of January 1, 2020, through December 31, 2022. This policy change estimates the offset of GF costs for the capitated rate increases.

Reason for Change:
This is a new policy change.

Methodology:
1. Total revenues for Medi-Cal managed care plans are based on the number of Medi-Cal enrollees and “all-other” enrollees as defined in AB 115.

2. Only tax relating to Medi-Cal enrollees are budgeted in this PC.

2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ

REGULAR POLICY CHANGE NUMBER: 219

3. The MCO Enrollment Tax fund transfers to the GF are expected to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	MCO Tax
FY 2019-20	**$0**	($0)	$0
FY 2020-21	**$0**	($1,083,013)	$1,083,013

Funding:
3334 MCO Tax

2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.

REGULAR POLICY CHANGE NUMBER:	220
IMPLEMENTATION DATE:	9/2020
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	2178

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$3,177,119,000
- STATE FUNDS	$0	$1,083,012,760
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$3,177,119,000
STATE FUNDS	$0	$1,083,012,760
FEDERAL FUNDS	$0	$2,094,106,240

DESCRIPTION

Purpose:
This policy change estimates the cost of capitation rate increases that are offset by managed care organization (MCO) tax proceeds. The tax proceeds will be used for the non-federal share of capitation rate increases.

Authority:
AB 115 (Chapter 348, Statutes of 2019)

Interdependent Policy Changes:
2020 MCO Enrollment Tax Mgd. Care Plans
2020 MCO Enrollment Tax Mgd. Care Plans-Funding Adj.

Background:
Effective January 1, 2020, the department implemented an MCO provider tax that provides for a statewide tax on managed care plans based on reported enrollment into these plans during the 12-month period between January 1, 2018, and December 31, 2018. The tax is tiered based on whether the enrollee is a Medi-Cal enrollee, alternate health care service plan enrollee, or other enrollee.

The MCO Enrollment Tax is effective for the three year period of January 1, 2020, through December 31, 2022.

Reason for Change:
This is a new policy change.

Methodology:
1. The MCO Enrollment Tax proceeds are required to be used to offset the capitation rate development process and payments made to the State that result directly from the imposition of the tax.

2. Enrollment for managed care plans are based on the number of Medi-Cal enrollees and “all-other” enrollees as defined in AB 115.

2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.

REGULAR POLICY CHANGE NUMBER: 220

3. The enrollee count is multiplied by a tiered rate to determine total tax revenue.

4. Increased capitation rates due to the MCO Enrollment Tax are initially paid from the General Fund (GF). The GF is then reimbursed by MCO Enrollment Tax revenue through a funding adjustment. The reimbursement is budgeted in the MCO Enrollment Tax Mgd. Care Plans-Funding Adjustment policy change.

5. Assume the January 2020 to June 2020 (FY 2019-20) estimated payments will occur in FY 2020-21.

6. Starting FY 2020-21, assume a one month payment lag for all plans subject to MCO tax.

7. The costs of capitation rate increases related to the imposition of the MCO Enrollment Tax are expected to be:

(Dollars in Thousands)

Fiscal Year	TF	GF (MCO Tax)	FF
FY 2019-20	**$0**	$0	$0
FY 2020-21	**$3,177,119**	$1,083,013	$2,094,106

Funding:
50% Title XIX / 50%GF (4260-101-0001/0890)
90% Title XIX ACA FF / 10% GF (4260-101-0001/0890)
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)
65% Title XXI / 35% GF (4260-113-0001/0890)

IGT PAYMENTS FOR HOSPITAL SERVICES

REGULAR POLICY CHANGE NUMBER:	221
IMPLEMENTATION DATE:	5/2020
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1158

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$118,000	$1,510,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$118,000	$1,510,000
FEDERAL FUNDS	-$118,000	-$1,510,000

DESCRIPTION

Purpose:
This policy change estimates the Intergovernmental Transfers (IGTs) used to draw down federal financial participation (FFP) paid to select private hospitals.

Authority:
Welfare & Institutions Code 14164

Interdependent Policy Changes
Not Applicable

Background:
The Welfare & Institutions Code provides general authority for the Department to accept IGTs from any county, other political subdivision of the state, or governmental entity in the state in support of the Medi-Cal program.

This policy change provides authority to accept the IGTs from counties or health care districts, match them with federal funds, and distribute the funds to hospitals designated by the counties or health care districts for the purpose of supporting hospitals serving Medi-Cal beneficiaries.

This policy change is a placeholder for possible IGT requests. The IGTs are not subject to the conditions stated under the Welfare & Institutions Code, section 14166.12.

The Selective Provider Contracting Program ended in June 2013. As part of the Private Hospital Supplemental Fund, the Centers for Medicare and Medicaid (CMS) approved State Plan Amendment (SPA) 14-008 on October 24, 2014 to authorize IGT distributions to eligible private hospitals. The Department obtained CMS approval of SPA 15-003 to continue IGT distributions to eligible private hospitals through FY 2017-18. Subsequent SPAs include 16-014 which made a technical change to the timing of payments and was approved by CMS on July 19, 2016, and 16-022 which reduced the total supplemental payment to St. Rose Hospital and was approved by CMS on December 8, 2016.

This program sunset on June 30, 2018, because Los Angeles County has elected to discontinue the

IGT PAYMENTS FOR HOSPITAL SERVICES

REGULAR POLICY CHANGE NUMBER: 221

IGTs used to fund the non-federal share of the supplemental payments. The final supplemental payment from this program was made in the 4th quarter of FY 2017-18 but, per the ACA methodology, the final ACA payment to Los Angeles County was not made until FY 2018-19.

Reason for Change:
There is no change from the prior estimate for FY 2019-20.

The change in FY 2020-21, from the prior estimate, is due to the federal funds and special fund repayment expected to occur in FY 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate is due to additional federal funds and a special fund repayment expected to occur in FY 2020-21.

Methodology:

1. FY 2017-18 is the last year in which IGT payments were made. This program and its payments were terminated effective June 30, 2018, as Los Angeles County declined to contribute any IGTs beyond FY 2017-18.

2. Federal approval of the ACA payment methodology was received in FY 2017-18 and payments began in December 2017. Payments are based on a ratio of the ACA optional expansion aid codes to total Medi-Cal aid codes, deriving an ACA percentage for each hospital. The ratio is then applied to each hospital's total supplemental payment in order to determine the actual amount of ACA reimbursement.

3. The ACA allows for 100% Federal Medical Assistance Percentage (FMAP) for calendar years 2014 through 2016, for newly eligible Medi-Cal beneficiaries. Beginning on January 1, 2017, FMAP for the ACA population decreases to 95%, then to 94% on January 1, 2018.

4. ACA payments were processed 9 months after the respective FY's supplemental payments have been issued in order to determine the proportion of the costs for newly eligible Medi-Cal beneficiaries. The County was reimbursed for the IGT (nonfederal share), and an adjustment was made for the federal share processed at the regular 50% FMAP.

5. The Department overclaimed FY 2017-18 ACA FFP and is expected to repay the federal funds in FY 2019-20.

6. The Department overclaimed FY 2013-14 through FY 2015-16 ACA FFP and is expected to repay the federal funds in FY 2020-21.

7. It was determined that $8.5 million was erroneously moved from Special Fund 3097 to the general fund as a result of the ACA adjustments for FY 2013-14 through FY 2015-16 dates of service. The funds are expected to be returned to the special fund in FY 2020-21.

FY 2019-20	TF	GF	ACA FF
Federal Funds Repayment	$0	$118,000	($118,000)

FY 2020-21	TF	GF	SF	ACA FF
Federal Funds Repayment	$0	$10,077,000	($8,567,000)	($1,510,000)

IGT PAYMENTS FOR HOSPITAL SERVICES

REGULAR POLICY CHANGE NUMBER: 221

Funding:

100% Title XIX GF (4260-101-0001)
100% Title XIX ACA FF (4260-101-0890)
100% Private Hospital Supplemental Fund (4260-601-3097)

NURSING FACILITY FINANCING REFORM

REGULAR POLICY CHANGE NUMBER:	223
IMPLEMENTATION DATE:	11/2020
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	2181

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$90,884,000
- STATE FUNDS	$0	$43,701,200
PAYMENT LAG	1.0000	0.7721
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$70,171,500
STATE FUNDS	$0	$33,741,700
FEDERAL FUNDS	$0	$36,429,840

DESCRIPTION

Purpose:
This policy change estimates the Fee-for-Service (FFS) costs of extending and modifying the skilled nursing facility rate methodology and Quality Assurance Fee (QAF).

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
AB 1629 (Chapter 875, Statutes of 2004), extended by AB 119 (Chapter 17, Statutes of 2015), requires the Department to implement a facility-specific rate methodology on Freestanding Skilled Nursing Facilities, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facilities, Level-B (FSSA/NF-B). Currently, the annual weighted increase across these facilities, not including add-ons, is capped at 3.62%. The methodology also imposes a Quality Assurance Fee (QAF) equivalent to 6% of all facility revenue, which is used to increase rates and offset a portion of the General Fund cost for the rate increases. SB 853 (Chapter 717, Statutes of 2010), extended by AB 119, further implemented a quality and accountability supplemental payment (QASP) program to incentivize quality of care improvements by providing supplemental payments for facilities that achieve various quality metrics.

The Department proposes to extend and reform this framework by tying a growing portion of future rate increases to quality measures. The Department proposes a bridge period that would extend the current methodology for five months, from August 2020 through December 2020 and the QASP program for another year. The proposal would then provide an additional rate increase in January 2021 and every January thereafter thereby transitioning the AB 1629 rate year from an August start date to a January start date to align with the managed care rate year. The new rate methodology is proposed to begin January 2022.

The rate methodology provides for facility-specific cost-based per diem payments for AB 1629 facilities based upon allowable audited costs and additional reimbursement for the projected Medi-Cal cost of

NURSING FACILITY FINANCING REFORM

REGULAR POLICY CHANGE NUMBER: 223

complying with new state or federal mandates, referred to as “add-ons.” The AB 1629 program add-ons are negotiated on an annual basis, and reflect costs associated with new mandates that have yet to be captured within the audited cost reports used to compute facility specific per-diem rates. These new mandated costs are budgeted for separately, as it will take two years to be reflected in the regular facility specific reimbursement rates.

Reason for Change:
The change for FY 2020-21, from the prior estimate, is a net decrease due to:

- Increased costs from revising the CY 2021 rate increase from 1.5% to 3.5%. This resulted in an overall increased estimate of FFS and managed care costs; and
- Decreased costs due to removing the managed care cash impact from this policy change. Managed care costs for CY 2021 will now be built into the managed care base capitation rates.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is a due to costs beginning in FY 2020-21.

Methodology:

1. Assume a 3.62% rate increase for August 2020 through December 2020. The 3.62% rate increase is expected to be implemented in November 2020. The retroactive rate payment will cover August 2020 through October 2020 and will occur in February 2021.

2. Assume a 3.5% rate increase for January 2021 December 2021. The 3.5% rate increase is expected to be implemented in April 2021. The retroactive rate payment will cover January 2021 through March 2021 and will occur in May 2021.

3. The RY 2020-21 add-on descriptions are listed below:

    - SB 3 Minimum Wage Increases: For employers who employ 26 or more employees.
        i. $12.00 per hour, effective January 2019
        ii. $13.00 per hour, effective January 2020
        iii. $14.00 per hour, effective January 2021

NURSING FACILITY FINANCING REFORM

REGULAR POLICY CHANGE NUMBER: 223

4. The estimated FFS and managed care costs are as follows:

FY 2020-21	TF	GF	FF
3.62% Increase			
FFS - prospective	$19,153,000	$9,209,000	$9,944,000
FFS - retro	$12,769,000	$6,140,000	$6,629,000
MC - prospective	$42,176,000	$20,280,000	$21,896,000
3.5% Increase			
FFS - prospective	$38,342,000	$18,437,000	$19,905,000
FFS - retro	$38,342,000	$18,437,000	$19,905,000
MC - prospective	$42,215,000	$20,299,000	$21,916,000
Total Rate Increase	$192,997,000	$92,802,000	$100,195,000
Add-Ons			
FFS - prospective	($12,889,000)	($6,198,000)	($6,691,000)
FFS - retro	($4,833,000)	($2,324,000)	($2,509,000)
Total Rate Increase	($17,722,000)	($8,522,000)	($9,200,000)
Total	$175,275,000	$84,280,000	$90,995,000

5. Due to managed care costs for CY 2021 being built into the managed care base capitation rates, the managed care cash impact for January 2021 through June 2021 will be removed from this policy change. The estimated cash impact in this policy change are as follows:

FY 2020-21	TF	GF	FF
3.62% Increase			
FFS - prospective	$19,153,000	$9,209,000	$9,944,000
FFS - retro	$12,769,000	$6,140,000	$6,629,000
MC - prospective	$0	$0	$0
3.5% Increase			
FFS - prospective	$38,342,000	$18,437,000	$19,905,000
FFS - retro	$38,342,000	$18,437,000	$19,905,000
MC - prospective	$0	$0	$0
Total Rate Increase	$108,606,000	$52,223,000	$56,383,000
Add-Ons			
FFS - prospective	($12,889,000)	($6,198,000)	($6,691,000)
FFS - retro	($4,833,000)	($2,324,000)	($2,509,000)
Total Rate Increase	($17,722,000)	($8,522,000)	($9,200,000)
Total	**$90,884,000**	**$43,701,000**	**$47,183,000**

NURSING FACILITY FINANCING REFORM

REGULAR POLICY CHANGE NUMBER: 223

6. The estimated FFS payments on a cash basis are:

QAF Extension	TF	GF	FFP
RY 2020-21 FFS	$57,495,000	$27,646,000	$29,849,000
RY 2020-21 FFS Retro	$46,278,000	$22,253,000	$24,025,000
RY 2020-21 Add-Ons	($12,889,000)	($6,198,000)	($6,691,000)
RY 2020-21 Managed Care	$0	$0	$0
Total	**$90,884,000**	**$43,701,000**	**$47,183,000**

Funding:

FFS - prospective	TF	GF	FF
50% Title XIX / 50% GF (4260-101-001/ 0890)	$86,532,000	$43,266,000	$43,266,000
90% Title XIX / 10% GF (4260-101-001/ 0890)	$4,352,000	$435,000	$3,917,000
Total	**$90,884,000**	**$43,701,000**	**$47,183,000**

GDSP NEWBORN SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER:	226
IMPLEMENTATION DATE:	7/2020
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	2184

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$8,564,000
- STATE FUNDS	$0	$4,282,000
PAYMENT LAG	1.0000	0.8160
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$6,988,200
STATE FUNDS	$0	$3,494,110
FEDERAL FUNDS	$0	$3,494,110

DESCRIPTION

Purpose:
This policy change estimates the costs associated with a fee increase for newborn screening provided to Medi-Cal beneficiaries under the California Department of Public Health (CDPH) Genetic Disease Screening Program (GDSP).

Authority:
Health & Safety Code Section 124977
SB 1095 (Chapter 393, Statutes of 2016)

Interdependent Policy Changes:
Not Applicable

Background:
Pursuant to Health & Safety Code Section 124977, the Newborn Screening (NBS) Program fee shall be periodically adjusted to fully support GDSP.

SB 1095 requires GDSP to expand statewide newborn screening to include any disease that is detectable in blood samples as soon as practicable, but no later than two years after the disease is adopted by the federal Recommended Uniform Screening Panel (RUSP).

The RUSP adopted the Spinal Muscular Atrophy (SMA) condition on July 2, 2018. Pursuant to SB 1095, GDSP is required to add SMA to the Newborn Screening panel and begin screening for the disorder by July 2020. A fee increase of $35.00 per specimen will be implemented in July 2020 for costs associated with adding SMA to the Newborn Screening panel, increased contracted screening rates, and increased referrals for case management, coordination, and diagnostic services.

Reason for Change:
There is no change from the prior estimate for FY 2019-20. The change in FY 2020-21, from the prior estimate, is due to a decrease in projected GDSP caseload based on revised projected births. The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to costs beginning in FY 2020-21.

GDSP NEWBORN SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 226

Methodology:

1. The Department will implement a $35.00 fee increase for the GDSP NBS program in July 2020. The annual cost is estimated to be $8,564,000 TF.

2. The estimated GDSP caseload in California is 453,869 for FY 2020-21. GDSP assumes approximately 99% of newborns will be screened by the NBS Program each year.

3. Assume approximately 55% of newborns screened are from the Medi-Cal population.

4. Assume 99% of Medi-Cal claims submitted are paid.

5. The estimated cost for FY 2020-21 is:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2020-21	$8,564	$4,282	$4,282

Funding:

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

NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	227
IMPLEMENTATION DATE:	5/2021
ANALYST:	Autumn Recce
FISCAL REFERENCE NUMBER:	2185

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$52,500,000
- STATE FUNDS	$0	$26,250,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$52,500,000
STATE FUNDS	$0	$26,250,000
FEDERAL FUNDS	$0	$26,250,000

DESCRIPTION

Purpose:
This policy change estimates the cost of the Non-Hospital 340B Clinics Supplemental Payment Pool.

Authority:
Executive Order N-01-19

Interdependent Policy Change:
Not Applicable

Background:
On January 7, 2019, the Governor issued Executive Order N-01-19, requiring that all Medi-Cal pharmacy services be transitioned from managed care (MC) to fee-for-service (FFS) by January 1, 2021. Transitioning pharmacy services from managed care to Fee-For-Service (FFS) delivery system is referred to as Medi-Cal Rx.

Non-hospital 340B clinics that currently receive reimbursement from managed care plans for pharmacy services will begin billing Medi-Cal at their acquisition cost, which will result in cost savings to the State. To mitigate the revenue impact to these 340B clinics, the Department proposes to create a supplemental payment pool.

Supplemental payments will be provided to non-hospital 340B clinics.These payments will continue to support their overall safety net services that might otherwise be limited or eliminated due to the change in billing to a FFS delivery system.

NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 227

This policy change (PC) is part of the carve-out effort transitioning MC pharmacy services to FFS delivery system. The PCs related to Medi-Cal Rx are:

Regular

- Medi-Cal Rx – Managed Care Pharmacy Benefit to FFS
- Medi-Cal Rx – Additional Savings from Maximum Allowable Ingredients Cost (MAIC) to FFS
- Medical Supply Rebates

Other Admin

Medi-Cal Rx – Administrative Costs

Reason for Change:

There is no change from the prior estimate for FY 2019-20 and FY 2020-21.

The change from FY 2019-20 to FY 2020-21 in the current estimate is due to the policy change being implemented in May 2021.

Methodology:

1. The estimated Non-hospital 340B Clinic Supplemental Payment Pool annual cost is $105,000,000 TF, assuming a January 1, 2021 implementation date.

(Dollars in Thousands)

Annual	TF	GF	FF
Non-hospital 340B Clinic Supplemental Payments	$105,000	$52,500	$52,500

2. The estimated cost for FY 2020-21 is $52,500,000 TF, representing January 1, 2021 to June 30, 2021, with payments starting in May 2021.

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
Non-hospital 340B Clinic Supplemental Payments	**$52,500**	**$26,250**	**$26,250**

Funding:

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

DISABLED ADULT CHILDREN PROGRAM CLEANUP

REGULAR POLICY CHANGE NUMBER:	232
IMPLEMENTATION DATE:	4/2020
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	2191

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$2,892,000	$2,892,000
- STATE FUNDS	$5,870,000	$2,892,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,892,000	$2,892,000
STATE FUNDS	$5,870,000	$2,892,000
FEDERAL FUNDS	-$2,978,000	$0

DESCRIPTION

Purpose:
This policy change estimates the cost for Medicare Part B premium and out-of-pocket expense reimbursement for individuals who were eligible to Medi-Cal under the Disabled Adult Child(ren) (DAC) program but were granted eligibility to Medi-Cal with a share-of-cost (SOC) in error.

Authority:
Section 6 of Public Law 99-643
42 U.S.C. Section 1383(c)

Interdependent Policy Changes:
Not Applicable

Background:
Individuals who are potentially eligible to Medi-Cal under the DAC program must meet certain criteria in order to be considered a DAC. These individuals receive special income exclusions due to the DAC status, and are eligible under a zero SOC aid code. The Department discovered that an estimated 1,113 individuals with potential eligibility to the DAC program were aided in Medi-Cal with a SOC in error. As a result of these eligibility errors, some of these individuals are incorrectly paying for out-of-pocket expenses to meet their SOC and self-paying their Medicare Part B premiums. This clean-up effort will require counties to retroactively correct the eligibility for individuals who are in the incorrect Medi-Cal aid code and place them in the correct DAC zero SOC aid code.

Counties will retroactively redetermine eligibility for this population to the correct aid code to mitigate incurring additional costs in error for these eligibles. The Centers for Medicare and Medicaid Services (CMS) will reimburse Part B premiums to identified eligibles. The Department will then reimburse CMS for any Part B premiums CMS refunded to those individuals. Additionally, the Department will refund out-of-pocket expenses that identified eligibles incurred to meet their SOC.

Reason for Change:
This is a new policy change.

DISABLED ADULT CHILDREN PROGRAM CLEANUP

REGULAR POLICY CHANGE NUMBER: 232

Methodology:

1. Assume Part B repayments to CMS and out-of-pocket expense repayments to the identified beneficiaries will begin April 2020.

2. Assume the below costs for FY 2019-20 and FY 2020-21:

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
Part B Adjustment	$0	$2,978	($2,978)
Share of Cost Adjustment	$2,892	$2,892	$0
FY 2019-20 Total	**$2,892**	**$5,870**	**($2,978)**

FY 2020-21	TF	GF	FF
Share of Cost Adjustment	$2,892	$2,892	$0
FY 2020-21 Total	**$2,892**	**$2,892**	**$0**

Funding:
100%Title XIX FFP (4260-101-0890)
100% GF (4260-101-0001)

REPAYMENT TO CMS FOR CONTINGENCY FEE OFFSETS

REGULAR POLICY CHANGE NUMBER:	233
IMPLEMENTATION DATE:	7/2020
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	2192

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$10,370,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$10,370,000
FEDERAL FUNDS	$0	-$10,370,000

DESCRIPTION

Purpose:
This policy change estimates the repayment of over-claimed federal financial participation (FFP) for contingency fee offsets reported for the period October 2016 to September 2018.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The Department contracts with a safety net recovery vendor, Health Management Systems, Inc. (HMS), to pursue recovery of Medi-Cal paid claims when members have liable other health coverage. HMS is paid on a contingency fee basis, receiving 8.5% of all recovered funds. On a monthly basis, HMS submits invoices to the Department for services performed. The invoiced amounts are identified in the Medi-Cal Recovery Contracts policy change.

During the period from October 2016 to February 2019, the Department double-reported the HMS contract's contingency fee payments to the Centers for Medicare and Medicaid Services (CMS). CMS deferred contingency fee offsets from October 2018 to February 2019; see the CMS Deferred Claims policy change for information on the repayments of the deferred payments from Federal Fiscal Year (FFY) 2019 Quarters 1 and 2.

CMS has also requested the return of federal funds from October 2016 to September 2018.

REPAYMENT TO CMS FOR CONTINGENCY FEE OFFSETS

REGULAR POLICY CHANGE NUMBER: 233

Reason for Change:
This is a new policy change.

Methodology:
1. The Department will return $10,370,142 FFP that was over-claimed for the period from October 2016 to September 2018 in July 2020.

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
Repayment to CMS	$0	$10,370	($10,370)

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XIX GF (4260-101-0001)

SAN MATEO HEALTH PLAN REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER:	234
IMPLEMENTATION DATE:	7/2020
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	2193

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$30,000,000
- STATE FUNDS	$0	$30,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$30,000,000
STATE FUNDS	$0	$30,000,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates a one-time reimbursement to San Mateo Health Plan for additional costs related to a rate adjustment for Burlingame Long Term Care a Distinct Part Skilled Nursing Facility (DP-NF).

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The San Mateo County Health System currently operates two DP-NFs, Burlingame Skilled Nursing and an in hospital Skilled Nursing Facility (SNF) unit, which together provide more than 300 beds. In 2003, the Department leadership requested that San Mateo County assume responsibility for operations of the Burlingame Long Term Care nursing facility (now called Burlingame Skilled Nursing) when it would have otherwise closed following the bankruptcy of a private operator. The Department had placed the previous operator in receivership due to quality of care concerns subsequent to the unexpected deaths of two residents. As a result, San Mateo County Health's San Mateo Medical Center assumed the facility's 281 Distinct Part SNF beds on its state license, leasing the building from its owner, and began operating the unit as a department of the hospital. San Mateo Health Plan contracts with Burlingame Skilled Nursing to provide long term care services to beneficiaries.

The Department is entering into a settlement to update the DP-NF rate for rate years 2014-2018 which will substantially increase the rate for these time periods. Due to this rate adjustment and to maintain access and avoid closure of the facility, San Mateo will have significant additional costs retroactively to pay at these higher rates. As the rate change was due to the inappropriate application of a cost adjustment, the Department believes it is necessary to provide additional funding via a one-time reimbursement.

SAN MATEO HEALTH PLAN REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 234

Reason for Change:
This is a new policy change.

Methodology:

1. A one-time reimbursement of **$30,000,000 TF ($30,000,000 GF)** occurring in **FY 2020-21**.

Funding:
100% State GF (4260-101-0001)

TRIBAL FEDERALLY QUALIFIED HEALTH CENTER

REGULAR POLICY CHANGE NUMBER:	236
IMPLEMENTATION DATE:	1/2021
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	2195

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$1,576,000
- STATE FUNDS	$0	$350,550
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$1,576,000
STATE FUNDS	$0	$350,550
FEDERAL FUNDS	$0	$1,225,450

DESCRIPTION

Purpose:
This policy change estimates the cost to create a Tribal Federally Qualified Health Center (FQHC) provider type in Medi-Cal to allow for payment of services provided outside of tribal clinics.

Authority:
Not applicable

Interdependent Policy Changes:
Not applicable

Background:
The Department is pursuing the development of the Tribal FQHC provider type in Medi-Cal, effective January 1, 2021. The Centers for Medicare and Medicaid Services provided guidance to establish the provider type in Medicaid by January 2021. The Tribal FQHC provider type option will ensure that Tribal health clinics can continue to provide specific optional benefits upon expiration of the Medi-Cal 2020 Waiver's Tribal Uncompensated Care component. Optional benefits were eliminated in 2009 as reimbursable services. However, FQHCs were able to continue to bill for some of the optional benefits as the courts determined they were federally required under FQHC statute. California's Bridge to Reform and Medi-Cal 2020 Waivers included a "Tribal Uncompensated Care" component that allowed Tribal health clinics to also be reimbursed for the FQHC federally required benefits. The waivers provided a means for Tribal health clinics to continue to provide necessary services to underserved populations. The expiration of the Medi-Cal 2020 Waiver in December 2020 will discontinue this option.

Reason for Change:
This is a new policy change.

Methodology:
1. Assume the Department will reimburse Tribal FQHCs for providing optional benefits beginning January 1, 2021.

2. Assume the cost to reimburse Tribal FQHC providers is $1,576,000 TF in FY 2020-21.

TRIBAL FEDERALLY QUALIFIED HEALTH CENTER

REGULAR POLICY CHANGE NUMBER: 236

FY 2020-21	TF	GF	FF
50% Title XIX / 50% GF	$583,000	$292,000	$291,000
100% Title XIX FFP	$520,000	$0	$520,000
65% Title XXI / 35% GF	$47,000	$16,000	$31,000
90% Title XIX ACA / 10% GF	$426,000	$43,000	$383,000
FY 2020-21 Total	**$1,576,000**	**$351,000**	**$1,225,000**

*Totals may differ due to rounding.

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

PHARMACY RETROACTIVE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER:	237
IMPLEMENTATION DATE:	7/2020
ANALYST:	Autumn Recce
FISCAL REFERENCE NUMBER:	2194

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	-$189,800,000
- STATE FUNDS	$0	-$54,016,050
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$189,800,000
STATE FUNDS	$0	-$54,016,050
FEDERAL FUNDS	$0	-$135,783,950

DESCRIPTION

Purpose:
This policy change estimates the retroactive adjustments from pharmacy providers.

Authority:
CMS Final Rule (CMS-2345-FC), 42 CFR Part 447
State Plan Amendment (SPA) #17-002

Interdependent Policy Changes:
Not Applicable

Background:
The Centers for Medicare and Medicaid Services (CMS), under the provisions of the Affordable Care Act, required States to modify the reimbursement methodology for Covered Outpatient Drugs and the professional dispensing fee. CMS approved SPA 17-002 authorizing the Department to implement a new pharmacy reimbursement methodology and professional dispensing fee, effective April 1, 2017. The new reimbursement methodology requires all outpatient drugs be billed at the Actual Acquisition Cost (AAC).

Providers continued to be billed using the old Average Wholesale Price reimbursement methodology until the AAC methodology was implemented on February 23, 2019. Retroactive adjustments for the 23-month period, from April 1, 2017, to February 23, 2019 via Erroneous Payment Correction (EPC) process were to be implemented in nine iterations. The first iteration of the EPC was for one month of claims (April 2017) and was installed on May 23, 2019.

A lawsuit, *California Pharmacists Association, et al. v. Kent, et al.,* was filed in U.S. District Court on June 5, 2019, seeking an injunction preventing the Department from implementing the retroactive EPCs. The EPCs were delayed while The Department developed a process to address the plaintiff's concerns. As a result, approximately 133 out of 5100 providers have requested and been approved by the Department for an Alternative Payment Agreement (APA) which will occur over a 48-month period. All EPCs for Non-APA providers will occur over a 12-month period.

PHARMACY RETROACTIVE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 237

Reason for Change:
This is a new policy change.

Methodology:

1. Assume the retroactive adjustments for providers with a Department-approved APA and Non-APA providers will resume July 2020.

2. The total retroactive adjustments from APA providers and Non-APA providers will result in a net savings of $206.8 million TF ($71 million GF).

(Dollars in Thousands)

Total Pharmacy Retroactive Savings	TF	GF	FF
Pharmacy Non-APA Retro Savings	($177,777)	($61,049)	($116,728)
Pharmacy APA Retro Savings	($29,023)	($9,967)	($19,056)
Total	($206,800)	($71,016)	($135,784)

3. Assume the retroactive adjustments for Non-APA providers, for the remaining 22-month period, will be completed in FY 2020-21.

4. APA providers have been approved for either a 24-month, 36-month, or 48-month payment plan. Assume total retroactive adjustments from APA providers will be completed over 48 months.

5. Assume in FY 2020-21, twelve months of the retroactive adjustments will occur for APA providers.

(Dollars in Thousands)

Total APA Savings - First 12 months	TF	GF	FF
Pharmacy APA Retro Savings - First 12 months	($12,023)	($4,129)	($7,894)

6. The Department, however, will be required to immediately return the total $19 million federal funds (FF) for savings from APA providers with General Funds (GF) in FY 2020-21, resulting in a cost to the GF. As the APA repayments occur, these amounts will offset the GF costs.

7. On a cash basis, the net fiscal impact in FY 2020-21 is estimated to be:

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
Pharmacy Non-APA Retro Savings	($177,777)	($61,049)	($116,728)
Pharmacy APA Retro Savings	($12,023)	($12,023)	$0
Federal Funds Repayment	$0	$19,056	($19,056)
Total	**($189,800)**	**($54,016)**	**($135,784)**

PHARMACY RETROACTIVE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 237

Funding:
100% Title XIX GF (4260-101-0001)
100% Title XIX FF (4260-101-0890)
100% Title XXI GF (4260-113-0001)
100% Title XXI FF (4260-113-0890)
88% Title XXI FF / 12% GF (4260-113-0001/0890)
95% Title XIX/ 5% GF (4260-101-0001/0890)
94% Title XIX/ 6% GF (4260-101-0001/0890)
93% Title XIX/ 7% GF (4260-101-0001/0890)

DMC & SMHS STATE ONLY CLAIMING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	238
IMPLEMENTATION DATE:	7/2020
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	2198

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$148,514,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$148,514,000
FEDERAL FUNDS	$0	-$148,514,000

DESCRIPTION

Purpose:
This policy change estimates the reimbursement to the federal government for claiming for Specialty Mental Health Services and Drug Medi-Cal provided to eligible, nonexempt, qualified immigrants with full-scope Medi-Cal coverage.

Authority:
Welfare & Institutions Code 14021.51; 14021.6(b)(1); 14021.9(c); and 14105(a)
Welfare & Institutions Code 14680-14685.1
Title 22, California Code of Regulations, Section 51516.1(a)(g)
Drug Medi-Cal Organized Delivery System Waiver
Specialty Mental Health Consolidation Program Waiver

Interdependent Policy Changes:
Not Applicable

Background:
California provides full-scope Medi-Cal services to eligible, nonexempt, qualified immigrants; however, non-emergency services are not eligible for federal financial participation. The responsibility for SMHS and DMC was realigned to the counties in 2011 as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, state requirements enacted after September 30, 2012, that have an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by 2011 Realignment shall apply to local agencies only to the extent that the state provides annual funding for the cost increase.

The Department has discovered that it has been inappropriately claiming federal funds for ineligible beneficiaries. The Department is required to return the federal funding to the Federal Government. The Department has estimated the amount of funding that must be returned and the portion that is the responsibility of the counties and the portion that is the responsibility of the State.

Reason for Change:
This is a new policy change.

DMC & SMHS STATE ONLY CLAIMING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 238

Methodology:

1. Claims adjustments reimbursements for both DMC and SMHS will begin July 1, 2020.

2. Federal Fund (FF) reimbursements will include a one-time reimbursement for all retroactive claims and ongoing claims adjustments for FY 2019-20 and FY 2020-21.

3. For FY 2020-21, both State and counties portion of the FF reimbursement will be paid with State General Fund (GF). Counties are expected to reimburse the GF for their portion of the retroactive and ongoing claims adjustments beginning in FY 2021-22.

4. Total reimbursements for both SMHS and DMC are as follows:

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
SMHS	$0	$143,762	($143,762)
Drug Medi-Cal	$0	$4,752	($4,752)
Total	**$0**	**$148,514**	**($148,514)**

Funding:

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

SELF-DETERMINATION PROGRAM - CDDS

REGULAR POLICY CHANGE NUMBER:	242
IMPLEMENTATION DATE:	7/2020
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	2208

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$17,139,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$17,139,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$17,139,000

DESCRIPTION

Purpose:
This policy change estimates the federal match for the California Department of Developmental Services (CDDS) for the Self Determination Program Waiver.

Authority:
Interagency Agreement (IA) 19-96260

Interdependent Policy Changes:
Not Applicable

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

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

Reason for Change:
This is a new policy change.

SELF-DETERMINATION PROGRAM - CDDS

REGULAR POLICY CHANGE NUMBER: 242

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	DHCS FFP
FY 2020-21	$34,278	$17,139	**$17,139**

Funding:
100% Title XIX (4260-101-0890)

MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM

REGULAR POLICY CHANGE NUMBER: 243
IMPLEMENTATION DATE: 7/2020
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 1952

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	-$92,290,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	-$92,290,000
FEDERAL FUNDS	$0	$92,290,000

DESCRIPTION

Purpose:
This policy change estimates the additional federal financial participation (FFP) received for Certified Public Expenditures (CPEs) using state only programs under the new California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020). General Fund savings realized under this program will be used as the state share to fund the Dental Transformation Initiative (DTI).

Authority:
California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)

Interdependent Policy Changes:
Medi-Cal 2020 Dental Transformation Initiative

Background:
The Centers for Medicare & Medicaid Services (CMS) approved the State to claim FFP using the CPEs of approved Designated State Health Programs (DSHP) listed below:

State Only Medical Programs
California Children Services (CCS)
Genetically Handicapped Persons Program (GHPP)
Medically Indigent Adult Long Term Care (MIA-LTC)
Breast & Cervical Cancer Treatment Program (BCCTP)
AIDS Drug Assistance Program (ADAP)
Department of Developmental Services (DDS)
Prostate Cancer Treatment Program (PCTP)
Workforce Development Programs
Office of Statewide Health Planning & Development (OSHPD) • Song-Brown Health Care Workforce Training • Steven M. Thompson Physician Corp Loan Repayment Program (STLRP) • Mental Health Loan Assumption Program (MHLAP)

MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM

REGULAR POLICY CHANGE NUMBER: 243

The annual limit the State-Only programs may claim for Medi-Cal 2020 DSHP is $75 million in FFP each Demonstration Year (DY) for a five year total of $375 million.

Reason for Change:
This is a new policy change.

Methodology:
1. Program allocations are updated based on actual claims.

2. On a cash basis, the total DSHP payments are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2020-21	$0	($92,290)	$92,290

Funding:
100% GF (4260-101-0001)
100% Health Care Support Fund (4260-601-7503)

STATE ONLY CLAIMING ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER:	244
IMPLEMENTATION DATE:	1/2021
ANALYST:	Nikaela Ratliff
FISCAL REFERENCE NUMBER:	2210

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$817,325,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$817,325,000
FEDERAL FUNDS	$0	-$817,325,000

DESCRIPTION

Purpose:
This policy change estimates the reimbursement to the federal government for claiming for non-emergency or non-pregnancy related services provided to eligible, nonexempt, qualified immigrants with state only full scope Medi-Cal coverage.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
California provides state only full scope Medi-Cal services to eligible, nonexempt, qualified immigrants. Under the state-only Medi-Cal, for the covered populations, federal financial participation is only available for emergency and pregnancy related services and the nonemergency or non-pregnancy related services covered with state general funds. The Department is required to return the federal funding to the Federal Government that was claimed for ineligible covered benefits. The Department has estimated the amount of funding that must be returned and the portion that is the responsibility of the State.

Reason for Change:
This is a new policy change.

STATE ONLY CLAIMING ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 244

Methodology:

1. Funding adjustments are estimated for Dental Fee-for-Service (FFS), Dental Managed Care (MC), Medi-Cal Managed Care, Pharmacy Rebates, and California Department of Developmental Services (CDDS).

2. Estimates for Dental FFS and Dental Managed Care include retroactive adjustments for the prior ten years.

3. Estimates for CDDS include retroactive adjustments from July 2010 through June 2020.

4. Total adjustments are estimated to be:

(Dollars in Thousands)

FY 2020-21	TF	GF	SF (Reimb)	FF
Total	$0	$519,592	$297,733	($817,325)

Funding:

100% Title XIX GF (4260-101-0001)
100% Title XIX Federal Funds (4260-101-0890)
100% Title XXI FF (4260-113-0890)
100% Title XXI GF (4260-113-0001)
Reimbursement GF (4260-601-0995)

COVID-19 UNINSURED ELIGIBILITY GROUP

REGULAR POLICY CHANGE NUMBER:	245
IMPLEMENTATION DATE:	3/2020
ANALYST:	Kalanie Coleman
FISCAL REFERENCE NUMBER:	2211

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$17,931,000	$10,177,000
- STATE FUNDS	$9,546,000	$5,362,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$17,931,000	$10,177,000
STATE FUNDS	$9,546,000	$5,362,000
FEDERAL FUNDS	$8,385,000	$4,815,000

DESCRIPTION

Purpose:
This policy change estimates the cost to provide coronavirus disease of 2019 (COVID-19) testing and treatment services for uninsured individuals.

Authority:
Families First Coronavirus Response Act (FFCRA)
The Coronavirus Aid, Relief, and Economic Security (CARES) Act

Interdependent Policy Changes:
Not Applicable

Background:
On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing pandemic of coronavirus disease 2019 (COVID-19). A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency on January 31, 2020 and a national emergency on March 13, 2020. The public health emergency was extended on April 21, 2020 and will be effective for 90 days unless extended. These actions triggered the availability of Medicaid and Children's Health Insurance Program flexibilities, including under Section 1135 of the Social Security Act. Additionally, the President signed major federal legislation—including the FFCRA and the CARES Act—that provides increased federal funding in Medicaid and creates new options for states to address the COVID-19 pandemic.

House Resolution (H.R.) 6201 Families First Coronavirus Response Act, Section 6004, authorized State Medicaid Programs to provide access to coverage for COVID-19 diagnostic testing and testing related services no cost to the individual. Additionally, states have an ability to provide COVID-19 testing and testing-related services to uninsured individuals at no cost to the individual. Reimbursement for the COVID-19 testing and testing-related services would be at 100 percent federal funding. Additionally, California has requested, through an 1115 demonstration waiver, federal approval to provide COVID-19 treatment services at no cost to the individual and at 100 percent federal funding. The request to the federal government is still pending. Upon approval, the State General Fund costs would be replaced with federal funds.

COVID-19 UNINSURED ELIGIBILITY GROUP

REGULAR POLICY CHANGE NUMBER: 245

California implemented the Presumptive Eligibility (PE) for COVID-19 in April 2020 and is available to individuals to seek the necessary COVID-19 diagnostic testing, testing related services, and treatment services, including all medically necessary care such as the associated office, clinic, or emergency room visits related to COVID-19 at no cost to the individuals. PE COVID-19 is available to individuals with no insurance or currently have private insurance that does not cover diagnostic testing, testing related services, and treatment service, including all medically necessary care as a result of COVID-19 and are a California resident. The covered diagnostic test, testing related services, and treatment services, including all medically necessary care such as the associated office, clinic, or emergency room visit are paid up to the maximum fee-for-service (FFS) rate, in the FFS delivery system and would be provided at no cost to the individual. Individuals in this program will not be enrolled in a Medi-Cal managed care plan.

Reason for Change:
This is a new policy change

Methodology:
1. Implementation date is assumed to be no sooner than March 2020.

2. Net expenditures are expected to be:

FY 2019-20	TF	GF	FF
Uninsured COVID-19 Testing	$8,385	$0	$8,385
Uninsured COVID-19 Treatment	$9,546	$9,546	$0
Total	**$17,931**	**$9,546**	**$8,385**

FY 2020-21	TF	GF	FF
Uninsured COVID-19 Testing	$4,815	$0	$4,815
Uninsured COVID-19 Treatment	$5,362	$5,362	$0
Total	**$10,177**	**$5,362**	**$4,815**

Funding:
100% GF (4260-101-0001)
100%Title XIX FFP (4260-101-0890)

COVID-19 ADDITIONAL IMPACTS

REGULAR POLICY CHANGE NUMBER:	246
IMPLEMENTATION DATE:	3/2020
ANALYST:	Kalanie Coleman
FISCAL REFERENCE NUMBER:	2212

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$233,424,000	$286,584,000
- STATE FUNDS	$95,504,000	$126,622,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$233,424,000	$286,584,000
STATE FUNDS	$95,504,000	$126,622,000
FEDERAL FUNDS	$137,920,000	$159,962,000

DESCRIPTION

Purpose:
This policy change estimates the cost of various Medi-Cal program impacts resulting from the Coronavirus disease 2019 (COVID-19) pandemic.

Authority:
Families First Coronavirus Response Act (FFCRA)
The Coronavirus Aid, Relief, and Economic Security (CARES) Act

Interdependent Policy Changes:
Not Applicable

Background:
On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing pandemic of COVID-19. A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency on January 31, 2020, and a national emergency on March 13, 2020. The public health emergency was extended on April 21, 2020 and will be effective for 90 days unless extended. These actions triggered the availability of Medicaid and Children's Health Insurance Program flexibilities, including under Section 1135 of the Social Security Act. Additionally, the President signed major federal legislation, including the FFCRA and the CARES Act that provides increased federal funding in Medicaid and creates new options for states to address the COVID-19 pandemic.

The effects of the COVID-19 pandemic are unprecedented in modern times from a public health emergency and economic perspective. This will have fiscal impact across policy areas and beneficiary populations within the Medi-Cal program. The Department has requested federal approvals for the following program modifications through waivers and State Plan Amendment (SPA) 20-0024.

The following proposals were submitted to the Centers for Medicare and Medicaid Services (CMS) as part of the state's COVID-19 Disaster 1115 waiver submission, and are currently pending federal approval through 1115 Demonstration Authority:

COVID-19 ADDITIONAL IMPACTS

REGULAR POLICY CHANGE NUMBER: 246

- Medi-Cal Eligible Inmates: To cover expenditures on behalf of Medi-Cal eligible individuals who are inmates for services provided in public institutions, including jails and prisons. This coverage includes testing, diagnosis and treatment of COVID-19, or other State plan covered services where medically appropriate to ensure care is provided in a safe way without transporting individuals to acute care facilities.

- Institutions for Mental Diseases (IMD) Bed Capacity and Ancillary Services: To cover certain expenditures on behalf of Medi-Cal beneficiaries under 65 years of age who are patients in IMDs during the COVID-19 emergency, and to waive the 16-bed limitation and prohibition on federal financial participation for new beds created during the emergency.

- Waive Share of Cost (SOC) for COVID-19 Test and Treatment: To waive costs associated with the testing of the COVID-19 and, for those that test positive, all costs associated with the treatment of this virus for certain beneficiaries in the Medically Needy SOC program. Beneficiaries in this coverage group include children under age 21, pregnant individuals, parents and other caretaker relatives and individuals that are aged 65 or older, disabled, or blind.

Through the submission of an Appendix K amendment for the Home and Community Based Alternatives Waiver to CMS, the Department requested the following:

- Emergency Paid Sick Leave Act under FFCRA for Waiver Personal Care Services (WPCS) providers: To allow WPCS providers to receive up to 80 hours of paid emergency sick leave, in certain situations, when it is specifically related to the COVID-19 public health emergency for the period of April 2, 2020, through December 31, 2020, or the end of the COVID-19 public health emergency period if sooner.

On April 3, 2020, the Department submitted SPA 20-0024 to CMS. SPA 20-0024 is currently pending federal approval and includes, but is not limited to, the following program modifications due to the COVID-19 pandemic:

- Extend coverage to the optional uninsured coverage group (See the COVID-19 Uninsured Eligibility Group Policy Change).

- Adult Acetaminophen, Cough & Cold: To temporarily reinstate nonlegend adult acetaminophen-containing products and nonlegend cough and cold products, selected by the department, as covered benefits of the Medi-Cal program.

- Clinical Lab COVID-19 Reimbursement Rates: To pay all COVID-19 related laboratory testing and collection procedure codes at 100% of Medicare and exempt those codes from the 10% payment reduction effective for March 1, 2020, dates of service, or the date a procedure code and payment rate is established by CMS for Medicare, and through the duration of the state of emergency.

- Long Term Care (LTC) COVID-19 Reimbursement Rate: To provide a 10% per diem rate increase to fully loaded per-diem rates including add-ons and any Proposition 56 supplemental payments effective for March 1, 2020, dates of service and through the duration of the state of emergency, for the following facility types: LTC facilities, Freestanding Nursing Facilities Level-B; Nursing Facilities Level-A; Distinct Part Nursing Facilities Level-B; Freestanding Adult Subacute Facilities; Distinct Part Adult Subacute Facilities; Distinct Part Pediatric Subacute

COVID-19 ADDITIONAL IMPACTS

REGULAR POLICY CHANGE NUMBER: 246

facilities; Freestanding Pediatric Subacute facilities and ICF/DD, including ICF/DDs, ICF/DD-Habilitative, and ICF/DD-Nursing, and excluding state-owned SNFs or ICFs, including Developmental Centers and Veterans Homes and any other supplemental payments or ancillary charges.

- Hospital Presumptive Eligibility (HPE) Expansion: To expand HPE to include the aged (65 years of age and older), disabled, and blind population. This proposal also requests the expansion of current PE period limitations across all PE coverage groups to two periods within a 12-month timeframe.

- Emergency Paid Sick Leave Act under FFCRA for In Home Supportive Services (IHSS) providers: To allow IHSS providers to receive up to 80 hours of paid emergency sick leave, in certain situations, when it is specifically related to the COVID19 public health emergency for the period of April 2, 2020, through December 31, 2020, or the end of the COVID-19 public health emergency period if sooner.

Reason for Change:
This is a new policy change.

Methodology:
1. The Department estimates the impacts on the following programs and populations as a result of the COVID-19:

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
Medi-Cal Eligible Inmates	$6,281	$0	$6,281
IMD Bed Capacity and Ancillary Services	$15,702	$457	$15,245
Waive Share of Cost for COVID-19 Test and Treatment	$1,804	$902	$902
WPCS Sick Leave Benefits	$312	$137	$175
Adult Acetaminophen, Cough & Cold	($4,446)	($2,223)	($2,223)
Clinical Lab COVID-19 Reimbursement Rates	$8,138	$3,936	$4,202
LTC COVID-19 Reimbursement Rate	$144,826	$72,413	$72,413
HPE Expansion	$39,764	$19,882	$19,882
IHSS Sick Leave Benefits	$21,043	$0	$21,043
TOTAL	**$233,424**	**$95,504**	**$137,920**

COVID-19 ADDITIONAL IMPACTS

REGULAR POLICY CHANGE NUMBER: 246

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
Medi-Cal Eligible Inmates	$3,607	$0	$3,607
IMD Bed Capacity and Ancillary Services	$9,018	$263	$8,755
Waive Share of Cost for COVID-19 Test and Treatment	$1,036	$518	$518
WPCS Sick Leave Benefits	$109	$48	$61
Adult Acetaminophen, Cough & Cold	($2,554)	($1,277)	($1,277)
Clinical Lab COVID-19 Reimbursement Rates	$4,673	$2,260	$2,413
LTC COVID-19 Reimbursement Rate	$83,174	$41,587	$41,587
Base Recoveries	$90,000	$40,505	$49,495
HPE Expansion	$85,436	$42,718	$42,718
IHSS Sick Leave Benefits	$12,085	$0	$12,085
TOTAL	**$286,584**	**$126,622**	**$159,962**

Funding:

(Dollars in Thousands)

Funding	FY 2019-20	FY 2020-21
100% Title XIX FF (4260-101-0890)	$134,987	$159,941
100% Title XIX GF (4260-101-0001)	$92,571	$126,601
100% Title XXI FF (4260-113-0890)	$2,933	$21
100% Title XXI GF (4260-113-0001)	$2,933	$21
TOTAL	**$233,424**	**$286,584**

COVID-19 UTILIZATION CHANGE

REGULAR POLICY CHANGE NUMBER:	247
IMPLEMENTATION DATE:	3/2020
ANALYST:	Nikaela Ratliff
FISCAL REFERENCE NUMBER:	2213

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	-$652,397,000	-$395,693,000
- STATE FUNDS	-$229,029,000	-$146,780,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$652,397,000	-$395,693,000
STATE FUNDS	-$229,029,000	-$146,780,000
FEDERAL FUNDS	-$423,368,000	-$248,913,000

DESCRIPTION

Purpose:
This policy change estimates savings due to Medical and Dental Fee-for-Service (FFS) utilization decreases resulting from coronavirus disease of 2019 (COVID-19).

Authority:
Families First Coronavirus Response Act (FFCRA)
The Coronavirus Aid, Relief, and Economic Security (CARES) Act

Interdependent Policy Changes:
Not Applicable

Background:
On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing pandemic of coronavirus disease 2019 (COVID-19). A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency on January 31, 2020 and a national emergency on March 13, 2020. These actions triggered the availability of Medicaid and Children's Health Insurance Program flexibilities, including under Section 1135 of the Social Security Act. Additionally, the President signed major federal legislation—including the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act—that provides increased federal funding in Medicaid and creates new options for states to address the COVID-19 pandemic.

As a result of the statewide stay at home order, the Department estimates a decrease in the Medical and Dental Fee-for-Service (FFS) utilization of services.

Reason for Change:
This is a new policy change.

COVID-19 UTILIZATION CHANGE

REGULAR POLICY CHANGE NUMBER: 247

Methodology:

1. Assumed Medical Fee-for-Service (FFS) utilization will decrease by 30% from April – June 2020 for services excluding Pharmacy, Nursing Facilities, and ICF-DDs.

2. Assume Dental FFS utilization will decrease by 50% from March – June 2020.

3. Assume utilization related to the Dental Transformation Initiative will decrease by 30% for Program Year 5 (PY 5).

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
Medical FFS Reduction	($439,615)	($158,261)	($281,354)
Dental FFS Reduction	($203,518)	($66,136)	($137,382)
Dental – DTI Reduction (PY 5)	($9,264)	($4,632)	($4,632)
Total	**($652,397)**	**($229,029)**	**($423,368)**

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
Medical FFS Reduction	($364,759)	($131,313)	($233,446)
Dental FFS Reduction	$0	$0	$0
Dental – DTI Reduction (PY 5)	($30,934)	($15,467)	($15,467)
Total	**($395,693)**	**($146,780)**	**($248,913)**

Funding:
100% State GF (4260-101-0001)
100% Federal Funds (4260-101-0890)
100% FF Title XXI (4260-113-0890)
100% GF Title XXI (4260-113-0001)

COVID-19 EMERGENCY FMAP - OTHER DEPTS

REGULAR POLICY CHANGE NUMBER:	248
IMPLEMENTATION DATE:	3/2020
ANALYST:	Kalanie Coleman
FISCAL REFERENCE NUMBER:	2214

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$257,717,000	$1,296,027,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$257,717,000	$1,296,027,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$257,717,000	$1,296,027,000

DESCRIPTION

Purpose:
This policy change provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS), the California Department of Developmental Services (CDDS), and the California Department of Aging (CDA) resulting from an increase in FFP due to the coronavirus disease 2019 (COVID-19).

Authority:
Families First Coronavirus Response Act (FFCRA)
The Coronavirus Aid, Relief, and Economic Security (CARES) Act

Interdependent Policy Changes:
Not Applicable

Background:
On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing pandemic of COVID-19. A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency on January 31, 2020, and a national emergency on March 13, 2020. These actions triggered the availability of Medicaid and Children's Health Insurance Program flexibilities, including under Section 1135 of the Social Security Act. Additionally, the President signed major federal legislation, including the Families First Coronavirus Response Act (FFCRA) and the CARES Act that provide increased federal funding in Medicaid and creates new options for states to address the COVID-19 pandemic.

The Federal Medical Assistance Percentage (FMAP) increase is effective January 1, 2020, and extends through the last day of the calendar quarter of the Health and Human Services COVID-19 national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of the Health and Human Services extended the COVID-19 national public health emergency on April 21, 2020.

Reason for Change:
This is a new policy change.

COVID-19 EMERGENCY FMAP - OTHER DEPTS

REGULAR POLICY CHANGE NUMBER: 248

Methodology:

1. The FMAP increase of 6.2% is applicable on regular Medicaid 50% FMAP claiming.
2. The FMAP increase is assumed to continue to June 30, 2021.
3. The following estimates reflect a cash basis.

FY 2019-20	**TF**	**GF**	**FF**
CDSS FMAP Increase FF Only	$256,977,000	$0	$256,977,000
CDA FMAP Increase FF Only	$740,000	$0	$740,000
Total FMAP Increase FF Only	**$257,717,000**	$0	**$257,717,000**
FY 2020-21	**TF**	**GF**	**FF**
CDDS FMAP Increase FF Only	$458,012,000	$0	$458,012,000
CDSS FMAP Increase FF Only	$836,904,000	$0	$836,904,000
CDA FMAP Increase FF Only	$1,111,000	$0	$1,111,000
Total FMAP Increase FF Only	**$1,296,027,000**	$0	**$1,296,027,000**

Funding:

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

COVID-19 BEHAVIORAL HEALTH

REGULAR POLICY CHANGE NUMBER:	249
IMPLEMENTATION DATE:	3/2020
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	2215

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$135,303,000	$77,705,000
- STATE FUNDS	$13,324,000	$7,652,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$135,303,000	$77,705,000
STATE FUNDS	$13,324,000	$7,652,000
FEDERAL FUNDS	$121,979,000	$70,053,000

DESCRIPTION

Purpose:
This policy change estimates the cost of establishing interim rates for certain Behavioral Health Medi-Cal programs due to impacts resulting from the Coronavirus disease 2019 (COVID-19) pandemic.

Authority:
Families First Coronavirus Response Act (FFCRA)
The Coronavirus Aid, Relief, and Economic Security (CARES) Act

Interdependent Policy Changes:
Not Applicable

Background:
On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing COVID-19 pandemic. A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency on January 31, 2020 and a national emergency on March 13, 2020. The public health emergency was extended on April 21, 2020 and will be effective for 90 days unless extended. These actions triggered the availability of Medicaid and Children's Health Insurance Program flexibilities, including under Section 1135 of the Social Security Act. Additionally, the President signed major federal legislation including the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act that provides increased federal funding in Medicaid and creates new options for states to address the COVID-19 pandemic.

The effects of the COVID-19 pandemic are unprecedented in modern times from a public health emergency and economic perspective. This will have fiscal impact across policy areas and beneficiary populations within the Medi-Cal program.

Due to COVID-19, there's been a significant decrease in utilization with certain Specialty Mental Health (SMHS) and DMC (non-NTP) outpatient services, while costs per unit of service has increased. In order to account for the higher cost per unit of service and help counties to continue to provide necessary behavioral health services during the pandemic and to maintain their existing provider

COVID-19 BEHAVIORAL HEALTH

REGULAR POLICY CHANGE NUMBER: 249

networks so that they are prepared to provide behavioral health treatment to all Medi-Cal beneficiaries who need services when the public health emergency ends, the Department implemented the following changes to the reimbursement rates:

Specialty Mental Health Services:

For specialty mental health outpatient services delivered by county-owned providers, the current interim reimbursement methodology is the lower of the county's Certified Public Expenditure (CPE) or the county interim rate developed using the most recently filed cost report and an appropriate cost of living adjustment. Effective for March 1 dates of service until the end of the COVID-19 public health emergency, the Department would provide interim reimbursement equal to the lower of the county's CPE or the county interim rate increased by 100%.

Drug Medi-Cal:

For non-Narcotic Treatment Program (non-NTP) outpatient services in Drug Medi-Cal (DMC) State Plan counties, the current interim reimbursement methodology is the lower of the county's CPE or the Statewide Maximum Allowance (SMA) rate for the service rendered. Effective March 1, 2020, the Department would provide interim reimbursement equal to the lower of the county's CPE or the SMA rate increased by 100%. In the interim and final reconciliations, these costs would be settled to allowable cost, suspending the limitations of usual and customary charges and the SMA rate.

For non-NTP outpatient services in DMC Organized Delivery System (ODS) counties, counties are required to develop, and the Department reviews and approves, county interim rates on an annual basis. Counties are required to reimburse contract providers at these county interim rates and the Department reimburses counties the non-county share of these county interim rates. Effective March 1, 2020, the Department would provide interim reimbursement equal to the lower of the county's CPE or the county interim rates increased by 100%. In the interim and final reconciliations, these costs would be settled to allowable cost, suspending the limitation of usual and customary charges.

Additionally, Executive Order N-55-20, raises the cap on administrative costs for the program from 15% to 30%. This action is assumed to be budget neutral. While the raising of this cap would allow counties to receive more reimbursement (on a percentage basis) during the emergency period, both county and private providers are reporting lower levels of behavioral health service utilization than before COVID-19 due to various factors such as patients not engaging in services, struggling to adapt to telehealth modalities, etc. The raising of the administrative cap reflects this increase due to the counties' administrative costs remaining the same during the crisis while at the same time that lower utilization may lead to lower reimbursement for direct client services.

Reason for Change:
This is a new policy change.

Methodology:
1. Total cost for both SMHS and DMC are as follows:

FY 2019-20	TF	GF	FF
SMHS Interim Rate	$111,795,000	$10,163,000	$101,632,000
Non-NTP Interim Rate - DMC State Plan	$1,403,000	$112,000	$1,291,000
Non-NTP interim rate - DMC-ODS Waiver	$22,105,000	$3,049,000	$19,056,000
Total	**$135,303,000**	**$13,324,000**	**$121,979,000**

COVID-19 BEHAVIORAL HEALTH

REGULAR POLICY CHANGE NUMBER: 249

FY 2020-21	TF	GF	FF
SMHS Interim Rate	$64,205,000	$5,837,000	$58,368,000
Non-NTP Interim Rate - DMC State Plan	$805,000	$64,000	$741,000
Non-NTP interim rate - DMC-ODS Waiver	$12,695,000	$1,751,000	$10,944,000
Total	**$77,705,000**	**$7,652,000**	**$70,053,000**

Funding:

FY 2019-20	TF	GF	FF
100% Title XIX GF (4260-101-0001)	$12,581,000	$12,581,000	$0
100% Title XXI GF (4260-113-0001)	$743,000	$743,000	$0
100% Title XIX FFP (4260-101-0890)	$114,614,000	$0	$114,614,000
100% Title XXI FFP (4260-113-0890)	$7,365,000	$0	$7,365,000
Total	**$135,303,000**	**$13,324,000**	**$121,979,000**

FY 2020-21	TF	GF	FF
100% Title XIX GF (4260-101-0001)	$7,225,000	$7,225,000	$0
100% Title XXI GF (4260-113-0001)	$427,000	$427,000	$0
100% Title XIX FFP (4260-101-0890)	$65,823,000	$0	$65,823,000
100% Title XXI FFP (4260-113-0890)	$4,230,000	$0	$4,230,000
Total	**$77,705,000**	**$7,652,000**	**$70,053,000**

COVID-19 EMERGENCY FMAP - DHCS

REGULAR POLICY CHANGE NUMBER:	250
IMPLEMENTATION DATE:	1/2020
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	2217

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$775,000,000	-$2,554,167,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$775,000,000	-$2,554,167,000
FEDERAL FUNDS	$775,000,000	$2,554,167,000

DESCRIPTION

Purpose:
This policy change estimates the impact of the increased FMAP related to the coronavirus disease 2019 (COVID-19) for the Department.

Authority:
Families First Coronavirus Response Act (FFCRA)
The Coronavirus Aid, Relief, and Economic Security (CARES) Act

Interdependent Policy Changes:
Not Applicable

Background:
On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing pandemic of COVID-19. A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency on January 31, 2020, and a national emergency on March 13, 2020. These actions triggered the availability of Medicaid and Children's Health Insurance Program flexibilities, including under Section 1135 of the Social Security Act. Additionally, the President signed major federal legislation, including the Families First Coronavirus Response Act (FFCRA) and the CARES Act that provide increased federal funding in Medicaid and creates new options for states to address the COVID-19 pandemic.

The increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the Health and Human Services COVID-19 national public health emergency. National public head emergencies are effective for 90 days unless extended or terminated. The Secretary of the Health and Human Services extended the COVID-19 national public health emergency on April 21, 2020.

Reason for Change:
This is a new policy change.

COVID-19 EMERGENCY FMAP - DHCS

REGULAR POLICY CHANGE NUMBER: 250

Methodology:

1. The increased FMAP of 6.2% is applicable on regular Medicaid 50% FMAP expenditures.
2. A CHIP FMAP increase of 4.34% is applicable on CHIP expenditures.
3. The increased FMAP is assumed to continue to June 30, 2021.
4. The following estimates reflect a cash basis.

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
Medicaid Title XIX 6.20%	$0	($740,000)	$740,000
CHIP Title XXI 4.34%	$0	($35,000)	$35,000
Total	**$0**	**($775,000)**	**$775,000**

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
Medicaid Title XIX 6.20%	$0	($2,490,000)	$2,490,000
CHIP Title XXI 4.34%	$0	($64,167)	$64,167
Total	**$0**	**($2,554,167)**	**$2,554,167**

Funding:
Title XIX FFP/GF (4260-101-0890/0001)
Title XXI FFP/GF (4260-113-0890/0001)

COVID-19 CASELOAD IMPACT

REGULAR POLICY CHANGE NUMBER:	251
IMPLEMENTATION DATE:	4/2020
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	2218

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$898,603,000	$6,829,878,000
- STATE FUNDS	$318,951,000	$2,408,249,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$898,603,000	$6,829,878,000
STATE FUNDS	$318,951,000	$2,408,249,000
FEDERAL FUNDS	$579,652,000	$4,421,629,000

DESCRIPTION

Purpose:
This policy change estimates the expenditure increase due to an increase in caseload related to unemployment/underemployment and suspension of renewals related to the COVID-19 pandemic.

Authority:
Families First Coronavirus Response Act (FFCRA)
The Coronavirus Aid, Relief, and Economic Security (CARES) Act

Interdependent Policy Changes:
Not Applicable

Background:
On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing pandemic of COVID-19. A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency on January 31, 2020, and a national emergency on March 13, 2020. These actions triggered the availability of Medicaid and Children's Health Insurance Program flexibilities, including under Section 1135 of the Social Security Act. Additionally, the President signed major federal legislation, including the Families First Coronavirus Response Act (FFCRA) and the CARES Act that provide increased federal funding in Medicaid and creates new options for states to address the COVID-19 pandemic.

The increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the Health and Human Services COVID-19 national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of the Health and Human Services extended the COVID-19 national public health emergency on April 21, 2020.

With the stay at home order, nonessential businesses have closed and restaurants have scaled back, Medi-Cal enrollment is expected to significantly increase. A portion of these unemployed/unemployed are expected to apply and qualify for Medi-Cal.

COVID-19 CASELOAD IMPACT

REGULAR POLICY CHANGE NUMBER: 251

In addition, the FFCRA required States to halt disenrollment of Medicaid eligibles enrolled at the beginning of the enrollment period or who would have enrolled during the emergency period until the end of the month the public health emergency end as a requirement of receiving the temporary increase in the federal medical assistance percentage (FMAP). To meet this requirement, Medi-Cal is temporarily suspending the annual renewal process.

Reason for Change:
This is a new policy change.

Methodology:
1. Unemployment Impact:

    a. Assume a 1-month lag between unemployment and Medi-Cal enrollment.

    b. Assume a historical correlation between Medi-Cal enrollment and unemployment.

    c. Expenditures include the emergency FMAP.

    d. Average Monthly Eligibles due to the COVID-19 unemployment is:

Time Period	Average Monthly Eligibles
March – June 2020	1,114,200
July 2020 – June 2021	1,466,800

2. Suspension of Renewals

    a. Assume 104,000 Medi-Cal eligibles lose eligibility each month and will now continue due to the suspension of renewals.

    b. Assume 80% of the 104,000 Medi-Cal eligibles are included the Unemployment Impact take-up and 20% are included in the Suspension of Renewals.

    c. Assume the suspension of renewals begin in March 2020 and continue through June 2021.

    d. Average Monthly Eligibles due to the Suspension of Renewals is:

Time Period	Average Monthly Eligibles
March – June 2020	52,100
July 2020 – June 2021	194,700

(Dollars in Thousands)

FY 2019-20	TF	GF	Title XIX FF	Title XXI FF
Unemployment Impact	$846,435	$298,084	$526,417	$21,934
Suspension of Renewals	$52,168	$20,867	$30,049	$1,252
Total	**$898,603**	**$318,951**	**$556,466**	**$23,186**

COVID-19 CASELOAD IMPACT

REGULAR POLICY CHANGE NUMBER: 251

(Dollars in Thousands)

FY 2020-21	TF	GF	Title XIX FF	Title XXI FF
Unemployment Impact	$5,705,770	$1,935,297	$3,594,088	$149,265
Suspension of Renewals	$1,124,768	$472,952	$651,816	$26,460
Total	**$6,829,878**	**$2,408,249**	**$4,245,904**	**$175,725**

Funding:
Title XIX FFP/GF (4260-101-0890/0001)
Title XXI FFP/GF (4260-113-0890/0001)

MEDI-CAL ESTATE RECOVERIES

REGULAR POLICY CHANGE NUMBER:	253
IMPLEMENTATION DATE:	1/2021
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	1991

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	-$33,800,000
- STATE FUNDS	$0	-$16,900,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$33,800,000
STATE FUNDS	$0	-$16,900,000
FEDERAL FUNDS	$0	-$16,900,000

DESCRIPTION

Purpose:
This policy change estimates the savings due to changes in the Medi-Cal Estate Recovery (ER) program.

Authority:
Welfare and Institutions Code Section 14009.5
Title 42, United States Code, Section 1396p
Title 22, California Code of Regulations Sections 50960-50966
Proposed Trailer Bill Language

Interdependent Policy Changes:
Not Applicable

Background:
The Medi-Cal ER program is one of several controls to mitigate Medi-Cal costs for care. Upon death of a Medi-Cal beneficiary, the decedent's estate or any recipient of the decedent's estate may have to pay back the costs of services through the ER program. The program has been restored to the federal maximum. These changes increase the number of estates of deceased Medi-Cal members 55 years of age and older (and those of any age who are permanently institutionalized) who are subject to recovery.

The Department proposes to restore Medi-Cal ER to the federal maximum in FY 2020-21.

Reason for Change:
This is a new policy change.

-- DELETED --

MEDI-CAL ESTATE RECOVERIES

REGULAR POLICY CHANGE NUMBER: 253

Methodology:

1. The estimated savings for restoring ER to the federal maximum is $33.8 million TF in FY 2020-21.

(Dollars in Thousands)

Estate Recoveries	TF	GF	FF
FY 2020-21	($33,800)	($16,900)	($16,900)

Funding:

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

-- DELETED --

ELIMINATE FQHC AND RHC PPS CARVE-OUTS

REGULAR POLICY CHANGE NUMBER:	254
IMPLEMENTATION DATE:	7/2020
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	2220

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	-$100,000,000
- STATE FUNDS	$0	-$50,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$100,000,000
STATE FUNDS	$0	-$50,000,000
FEDERAL FUNDS	$0	-$50,000,000

DESCRIPTION

Purpose:
This policy change estimates the savings resulting from eliminating Prospective Payment System (PPS) carve-outs for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).

Authority:
Benefits Improvement and Protection Act of 2000, Section 702 (BIPA)
Social Security Act (SSA), section 1902(bb)
SSA, section 1905(a)(2)(C)
SSA, section 1905 (a)(2)(B)
Welfare and Institutions Code (W&I) 14132.100, (k)

Interdependent Policy Changes:
Not applicable

Background:
FQHCs and RHCs are federally designated clinics that are required to serve medically underserved populations that provide primary care services. Medi-Cal reimbursement to FQHCs and RHCs is governed by state and federal law. BIPA, the federal law establishing FQHC and RHC Medicaid reimbursement, created SSA, section 1902(bb). This section requires Medicaid programs make payments for FQHC and RHC services in an amount calculated on a per-visit basis that is equal to the reasonable cost of such services documented for a baseline period, with certain adjustments, or to use an alternative payment methodology to pay for FQHC and RHC services. These payments require annual adjustments by an amount equal to the percentage of the federal Medicare Economic Index. BIPA establishes the PPS for payment of services authorized under SSA Sections 1905(a)(2)(C) furnished by FQHCs and 1905 (a)(2)(B) for RHCs. Subsequently, California Welfare and Institutions Code (W&I) 14132.100, paragraph (k), permits FQHCs and RHCs to elect to have pharmacy or dental services to be reimbursed at the fee-for-service rate using the current fee schedule.

Currently, if an FQHC or RHC chooses to carve-out pharmacy or dental services, the costs for those services are adjusted out of the FQHC or RHC base PPS rate using the “scope-of-service change” rate adjustment methodology and then a fee-for-service reimbursement can occur. Therefore, FQHCs

-- DELETED --

ELIMINATE FQHC AND RHC PPS CARVE-OUTS

REGULAR POLICY CHANGE NUMBER: 254

and RHCs that carve out these services receive reimbursement outside of the FQHC's or RHC's PPS rate, resulting in a general fund impact beyond federal requirements. This policy will require that all covered Medi-Cal services, including but not limited to pharmacy and dental services, except for Specialty Mental Health (SMH) and Drug Medi-Cal (DMC), provided by an FQHC or RHC, be reimbursed only through the clinic's base PPS rate. This policy will align reimbursement for FQHC and RHC services with federally required reasonable costs.

Reason for Change:
This is a new policy change.

Methodology:

1. If the FQHC or RHC base PPS rate was established before pharmacy, dental or other services were carved out, with the exception of SMH and DMC services, the FQHC or RHC will be required to revert to its prior base PPS rate, subject to an increase to account for all Medicare Economic Index (MEI) increases during the intervening time.

2. If the FQHC or RHC is unable to revert to its prior base PPS rate, the costs of pharmacy, dental or other services, except for SMH and DMC, would be adjusted into the FQHC or RHC base PC via a scope of service change.

3. The required scope of service change must be submitted within 90 days of the beginning of any FQHC or RHC fiscal year occurring after the effective date of this change.

4. Assume the option to carve out pharmacy, dental or other services with the exception of SMH and DMC will be eliminated beginning January 1, 2021.

5. The estimated savings from eliminating this option is **$100,000,000 TF ($50,000,000 GF)** in FY 2020-21.

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

-- DELETED --

ADJUST MC CAP PAYMENTS FOR JULY 2019-DEC 2020

REGULAR POLICY CHANGE NUMBER:	255
IMPLEMENTATION DATE:	7/2020
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	2221

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	-$585,917,000
- STATE FUNDS	$0	-$181,978,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$585,917,000
STATE FUNDS	$0	-$181,978,300
FEDERAL FUNDS	$0	-$403,938,700

DESCRIPTION

Purpose:
This policy changes estimates the savings associated with reducing the managed care capitation rates gross medical expense (GME) for the period of July 1, 2019 through December 31, 2020 (Bridge Period).

Authority:
42 CFR §438
WIC § 14301.1

Interdependent Policy Changes:
N/A

Background:
The current managed care rates for the Bridge Period were developed prior to COVID-19, coupled with the Governor's order to postpone non-essential medical services, the Department anticipates lower costs and utilization for this period. As a result, the Department will implement a 1.5 percent GME rate reduction for the Adult, Child, Optional Expansion, and Seniors and Persons with Disabilities (SPD) rating categories per the federal authority granted in 42 CFR §438.7(c)(3).

There is uncertainty on actual managed care plan (MCP) costs and utilization during this timeframe. In an effort to mitigate upside and downside risk to the MCPs, the State, and federal government, the Department will be implementing a complementing risk corridor for this time period. The risk corridor calculations, and associated payments or recoupments, are anticipated to occur in FY 2022-23.

Reason for Change:
This is a new policy change.

Methodology:
1. Calculated the 1.5% rate reduction for Adult, Child, Optional Expansion, and SPD rating categories utilizing the GME component of the Bridge Period rates.

ADJUST MC CAP PAYMENTS FOR JULY 2019-DEC 2020

REGULAR POLICY CHANGE NUMBER: 255

2. The reduction will apply to the entire Bridge Period of July 1, 2019 through December 31, 2020.

3. On a cash basis, associated rate reduction savings are expected to be realized in FY 2020-21.

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
Bridge Period Savings	($585,917)	($181,978)	($403,939)
Total	**($585,917)**	**($181,978)**	**($403,939)**

Funding:
50% Title XIX FF / 50% SF (4260-101-0001 / 0890)
88% Title XXI FF / 12% GF (4260-113-0890/0001)
76.5% Title XXI FF / 23.5% GF (4260-113-0890/0001)
65% Title XXI / 35% GF (4260-113-0001/0890)
93%Title XIX FF / 7% GF (4260-101-0001 / 0890)
90%Title XIX FF / 10% GF (4260-101-0001 / 0890)

OPTIONAL ADULT DENTAL PARTIAL ELIMINATION

REGULAR POLICY CHANGE NUMBER:	256
IMPLEMENTATION DATE:	7/2020
ANALYST:	Matt Wong
FISCAL REFERENCE NUMBER:	2222

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	-$67,756,000
- STATE FUNDS	$0	-$22,909,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$67,756,000
STATE FUNDS	$0	-$22,909,000
FEDERAL FUNDS	$0	-$44,847,000

DESCRIPTION

Purpose:
The policy change estimates the savings of a partial elimination of optional adult dental services.

Authority:
N/A

Interdependent Policy Changes:
N/A

Background:
MediCal has been providing health and dental care benefits to Californians since 1965. Medi-Cal members access services through Medi-Cal fee-for-service (FFS) and managed care programs.

Medi-Cal is serving approximately 12.8 million Medi-Cal members in FY 2019-20. Approximately eight million are adults 21 years of age or older. With the budget ramifications of COVID19, the Department is seeking to remove full restoration of adult dental services to the levels provided for with the May 2014 partial restoration. The partial restoration of adult dental services is as follows:

- Medical and surgical services provided by a doctor of dental medicine or dental surgery, which, if provided by a physician, would be considered physician services and may be provided by either a physician or dentist.
- Emergency dental services.
- Examinations, radiographs/photographic images, prophylaxis, and fluoride treatments.
- Amalgam and composite restorations.
- Stainless steel, resin, and resin window crowns.
- Anterior root canal therapy.
- Complete dentures, including immediate dentures.
- Complete denture adjustments, repairs, and relines.

Full dental benefits remain available for children under 21 who are entitled to Early and Periodic, Screening Diagnostic and Treatment Services, pregnant women, individuals in skilled nursing facility or

-- DELETED --

OPTIONAL ADULT DENTAL PARTIAL ELIMINATION

REGULAR POLICY CHANGE NUMBER: 256

intermediate care facility settings, or when provided under a federally required qualified health center or a rural health center as part of their covered services, as applicable. These changes are subject to federal approval.

Reason for Change:
This is a new policy change.

Methodology:
1. This policy is effective no sooner than July 1, 2020.

2. The savings in FY 2020-21 for dental services is estimated at $67,756,000 TF ($22,909,000 GF).

	TF	GF	FF
FY 2020-21	($67,756,000)	($22,909,000)	($44,847,000)

Funding:
100% Title XIX GF (4260-101-0001)
100% Title XIX Federal Funds (4260-101-0890)

-- DELETED --

DISCONTINUE ADULT OPTIONAL BENEFITS

REGULAR POLICY CHANGE NUMBER:	257
IMPLEMENTATION DATE:	1/2021
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	2223

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	-$284,200,000
- STATE FUNDS	$0	-$125,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$284,200,000
STATE FUNDS	$0	-$125,500,000
FEDERAL FUNDS	$0	-$158,700,000

DESCRIPTION

Purpose:
This policy change estimates the savings as a result of discontinuing specified adult optional benefits in Medi-Cal Fee-for-Service (FFS) and managed care plans.

Authority:
Proposed Trailer Bill Language

Interdependent Policy Changes:
Not Applicable

Background:
ABX3 5 (Chapter 20, Statutes of 2009), excluded specified optional benefits from coverage under the Medi-Cal program, effective July 1, 2009.

AB 74 (Chapter 23, Statutes of 2019) reinstated coverage in both FFS and managed care for the following optional benefits, effective January 1, 2020.

- Audiology
- Optician and optical lab
- Incontinence creams and washes
- Podiatry
- Speech therapy

Costs for restoring these optional benefits in FFS are budgeted in the Optional Benefits Restoration, and Restoration of Adult Optician and Optical Lab Svcs policy changes. Managed care costs are included in the managed care base capitation rates.

-- DELETED --

DISCONTINUE ADULT OPTIONAL BENEFITS

REGULAR POLICY CHANGE NUMBER: 257

Effective no sooner than July 1, 2020, the Department proposes to discontinue the optional benefits restored in AB 74, and the following additional optional benefits:

- Acupuncture
- Community-Based Adult Services
- Optometry
- Nurse Anesthetists
- Occupational Therapy
- Physical Therapy
- Dental[1]
- Multipurpose Senior Services Program (MSSP)[2]
- Pharmacist services[3]
- Diabetes Prevention Program (DPP)[4]
- Screening and Brief Intervention for Misuse of Opioids and other Illicit Drugs[5]

These services remain available for children under 21 who are entitled to Early and Periodic, Screening Diagnostic and Treatment Services, pregnant women, individuals in skilled nursing facility or intermediate care facility settings, or when provided under a federally required qualified health center or a rural health center as part of their covered services, as applicable. These changes are subject to federal approval.

The fiscal impact for the elimination of dental, MSSP, pharmacist services, DPP, and Screening and Brief Intervention for Misuse of Opiods and other Illicit Drugs are estimated in separate policy changes noted below or removed from the estimate as noted:

1) Refer to the Optional Adult Dental Partial Elimination policy change.
2) Refer to the Multipurpose Senior Services Program –CDA policy change.
3) Refer to the Pharmacist-Delivered Medi-Cal Services policy change.
4) Refer to the Diabetes Prevention Program policy change.
5) The previous Expansion to Screening for Additional Substances policy change has been removed from the estimate.

Reason for Change:
This is a new policy change.

Methodology:

1. The specified optional benefits will be discontinued effective no sooner than July 1, 2020.

2. For optometry and nurse anesthetists, FFS savings have been estimated, and managed care savings are to be determined.

-- DELETED --

DISCONTINUE ADULT OPTIONAL BENEFITS

REGULAR POLICY CHANGE NUMBER: 257

3. The estimated savings for discontinuing the adults optional benefits are:

FY 2020-21	TF	GF	FFP
Optional Benefits Savings			
Audiology	($4,200,000)	($1,500,000)	($2,700,000)
Incontinence Creams and Washes	($9,400,000)	($3,300,000)	($6,100,000)
Speech Therapy	($700,000)	($200,000)	($500,000)
Podiatry	($5,900,000)	($2,000,000)	($3,900,000)
Optical and Optician Services	($44,200,000)	($14,500,000)	($29,700,000)
Subtotal	($64,400,000)	($21,500,000)	($42,900,000)
Optional Benefits (New) Savings			
Acupuncture	($5,600,000)	($2,100,000)	($3,500,000)
Community-Based Adult Services	($191,300,000)	($95,200,000)	($96,100,000)
Optometry	($1,400,000)	($600,000)	($800,000)
Nurse Anesthetists	($300,000)	($100,000)	($200,000)
Occupational Therapy	($1,400,000)	($400,000)	($1,000,000)
Physical Therapy	($19,800,000)	($5,600,000)	($14,200,000)
Subtotal	($219,800,000)	($104,000,000)	($115,800,000)
Grand Total	**($284,200,000)**	**($125,500,000)**	**($158,700,000)**

Funding:
100% GF (4260-101-0001)
100% Title XIX (4260-101-0890)

-- DELETED --

MANAGED CARE EFFICIENCIES

REGULAR POLICY CHANGE NUMBER:	258
IMPLEMENTATION DATE:	7/2020
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	2224

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	-$182,058,000
- STATE FUNDS	$0	-$59,253,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$182,058,000
STATE FUNDS	$0	-$59,253,000
FEDERAL FUNDS	$0	-$122,805,000

DESCRIPTION

Purpose:
This policy changes estimates the savings associated with implementing Managed Care rate adjustments and efficiencies as deemed actuarially appropriate.

Authority:
42 CFR §438
WIC § 14301.1

Interdependent Policy Changes:
N/A

Background:
The Department will implement the following Managed Care rate adjustments and efficiencies as deemed actuarially appropriate beginning in calendar year (CY) 2021 in an effort to continue to drive Managed Care rate and contracting efficiencies with the goal of preserving the prudent use of federal and State resources:

- Implement new Managed Care efficiency adjustments including but not limited to:
  - Low Acuity Non-Emergent (LANE) Services Efficiency Adjustment - The LANE efficiency adjustment focuses on identifying instances in which an emergency room visit could have been avoided had effective outreach, care coordination, and access to preventive care been available.
  - Healthcare Common Procedure Coding System (HCPCS) Efficiency Adjustment - The HCPCS efficiency adjustment identifies opportunities for Managed Care plan savings, by identifying historical contracting levels that can be reduced in future prospective periods. This efficiency adjustment promotes improved contracting with providers for clinician-administered drugs billed via HCPCS codes.

- Implement a reduced Managed Care Underwriting Gain (UG) within the final certified capitation rates. The UG would be reduced from 2 percent to 1.5 percent, resulting in a 0.5 percent reduction.

MANAGED CARE EFFICIENCIES

REGULAR POLICY CHANGE NUMBER: 258

- General rate adjustments as determined actuarially appropriate.

The applicability of these adjustments will be evaluated on an annual basis thereafter, to determine the actuarial appropriateness of continuing for future rating periods.

Reason for Change:
This is a new policy change.

Methodology:
1. Beginning January 1, 2021 service period, on a cash basis, associated Managed Care rate adjustments and efficiencies savings expected to be realized in FY 2020-21 are:

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
Total	($182,058)	($59,253)	($122,805)

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

ELIMINATE PROPOSITION 56 SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 259
IMPLEMENTATION DATE: 7/2020
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2225

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	-$2,173,364,000
- STATE FUNDS	$0	-$671,964,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$2,173,364,000
STATE FUNDS	$0	-$671,964,000
FEDERAL FUNDS	$0	-$1,501,400,000

DESCRIPTION

Purpose:
This policy change estimates the savings from eliminating certain Proposition 56 supplemental payments.

Authority:
Proposed Budget Bill Language

Interdependent Policy Changes:
Not Applicable

Background:
The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), passed by the voters in November 2016, increased the excise tax rate on cigarettes and electronic cigarettes, effective April 1, 2017, and other tobacco products effective July 1, 2017. The excise tax increased to $2.87 per pack of 20 cigarettes on distributors selling cigarettes in California with an equivalent excise tax rate increase on other tobacco products.

The elimination of certain Proposition 56 supplemental payments is estimated in FY 2020-21.

Reason for Change:
This is a new policy change.

-DELETED-

ELIMINATE PROPOSITION 56 SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 259

Methodology:

1. The savings from eliminating certain Proposition 56 supplemental payments is estimated to be:

(Dollars in Thousands)

FY 2020-21	TF	Prop 56	Title XIX FF	Title XXI FF
Prop 56 - Physician Services Supplemental Payments	($1,102,630)	($389,016)	($622,435)	($91,179)
Prop 56 - Supplemental Payments for Dental Services	($446,853)	($183,778)	($223,182)	($39,893)
Prop 56 - Medi-Cal Family Planning	($359,230)	($35,923)	($323,307)	$0
Prop 56 - Developmental Screenings	($45,139)	($20,773)	($17,328)	($7,038)
Prop 56 - CBAS Supplemental Payments	($13,422)	($6,711)	($6,711)	$0
Prop 56 - NEMT Supplemental Payments	($6,466)	($2,656)	($3,753)	($57)
Prop 56 - ICF/DD Supplemental Payments	($25,770)	($12,422)	($13,315)	($33)
Prop 56 - Hosp-Based Pediatric Phys Suppl Pymts	($2,000)	($2,000)	$0	$0
Prop 56 - Women's Health Supplemental Payments	($171,854)	($18,685)	($153,169)	$0
Total Savings	**($2,173,364)**	**($671,964)**	**($1,363,200)**	**($138,200)**

Funding:

Healthcare Treatment Fund (4260-101-3305)
100% Title XIX FF (4260-101-0890)
100% Title XXI FF (4260-113-0890)

-- DELETED --

FUND 3156 TRANSFER TO THE GENERAL FUND

REGULAR POLICY CHANGE NUMBER:	261
IMPLEMENTATION DATE:	7/2020
ANALYST:	Jerrold Anub
FISCAL REFERENCE NUMBER:	2227

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change transfers dollars from Fund 3156 to the General Fund.

Authority:
SBx2 2 (Chapter 2, Statutes of 2016)

Interdependent Policy Changes:
Not applicable

Background:
SB 78 was signed by the Governor on June 27, 2013, and provided for a statewide tax on the total operating revenue of the following Medi-Cal Managed Care plans: Two-Plan, COHS, GMC, Regional, AIDS Healthcare Centers (AHF), and Senior Care Action Network (SCAN). The tax revenue was used to increase capitation rates for health care services provided to children, seniors, persons with disabilities, and dual eligible in the Medi-Cal program.

This MCO tax was effective July 1, 2013, through June 30, 2016. A portion of the remaining funds will be transferred to the General Fund. The remaining funds are subject to final reconciliation of amounts paid by Medi-Cal Managed Care plans to amounts due. The reconciliation has been delayed due to retroactive revenue adjustments such as the ACA Optional Expansion Medical Loss Ratio Risk Corridor.

Reason for Change:
This is a new policy change.

Methodology:

1. Estimated funds to be transferred to the General Fund in FY 2020-21 is $100,000,000.

FUND 3156 TRANSFER TO THE GENERAL FUND

REGULAR POLICY CHANGE NUMBER: 261

Funding:
100% State GF (4260-101-0001)
*3156 MCO (Non-GF) (4260-601-3156)

FUND 3311 TRANSFER TO THE GENERAL FUND

REGULAR POLICY CHANGE NUMBER:	262
IMPLEMENTATION DATE:	7/2020
ANALYST:	Jerrold Anub
FISCAL REFERENCE NUMBER:	2228

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change transfers dollars from Fund 3311 to the General Fund.

Authority:

Interdependent Policy Changes:
Not applicable

Background:

The Health Care Services Plans Fines and Penalties Fund is used to deposit various fines and administrative penalties for the licensing and regulation of health care service plans by the Department of Managed Health Care (DMHC). Funds are used to support coverage for individuals remaining in the Major Risk Medical Insurance Program (MRMIP) and Medi-Cal program. Residual dollars remaining in the fund will be transferred to the State General Fund.

Reason for Change:
This is a new policy change.

Methodology:

1. Estimated funds to be transferred to the General Fund in FY 2020-21 are $36,522,000.

Funding:
Health Care Services Plans Fines and Penalties Fund (4260-601-3311)
Title XIX GF (4260-101-0001)

ELECTRONIC CIGARETTE PRODUCTS TAX

REGULAR POLICY CHANGE NUMBER:	263
IMPLEMENTATION DATE:	7/2020
ANALYST:	Jerrold Anub
FISCAL REFERENCE NUMBER:	2229

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change reduces the General Fund and replaces those funds with Electronic Cigarette Products Tax funds.

Authority:

Interdependent Policy Changes:
Not applicable

Background:
Unallocated revenues from the proposed e-cigarette tax increase will be used to support growth in the Medi-Cal program.

Reason for Change:
This is a new policy change.

Methodology:

1. Estimated funds to be transferred to the General Fund in FY 2020-21 are $9,600,000.

Funding:
Electronic Cigarette Products Tax (4260-101-3366)
Title XIX GF (4260-101-0001)

USE OF PROP 56 TO FUND MEDI-CAL GROWTH

REGULAR POLICY CHANGE NUMBER: 264
IMPLEMENTATION DATE: 7/2020
ANALYST: Jerrold Anub
FISCAL REFERENCE NUMBER: 2230

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change identifies Proposition 56 dollars that will be used to fund new caseload growth in the Medi-Cal program.

Authority:

Interdependent Policy Changes:
Not applicable

Background:

The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), passed by the voters in November 2016, increased the excise tax rate on cigarettes and electronic cigarettes, effective April 1, 2017, and other tobacco products effective July 1, 2017. The excise tax increased to $2.87 per pack of 20 cigarettes on distributors selling cigarettes in California with an equivalent excise tax rate increase on other tobacco products.

Reason for Change:
This is a new policy change.

Methodology:

1. Beginning FY 2020-21, the Department will utilize Proposition 6 dollars to fund new caseload growth in the Medi-Cal Program.

2. The amount of Proposition 56 funds is estimated to be $1,176,585,000 in FY 2020-21.

-DELETED-

USE OF PROP 56 TO FUND MEDI-CAL GROWTH

REGULAR POLICY CHANGE NUMBER: 264

Funding:
Healthcare Treatment Fund Prop 56

-- DELETED --

RECONCILIATION

REGULAR POLICY CHANGE NUMBER:	265
IMPLEMENTATION DATE:	7/2020
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	1527

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$2,491,000
- STATE FUNDS	$0	$10,681,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$2,491,000
STATE FUNDS	$0	$10,681,000
FEDERAL FUNDS	$0	-$8,190,000

DESCRIPTION

Purpose: This policy change reconciles the May 2020 Medi-Cal Estimate to the Budget Act of 2020.

This adjustment includes a 2,491,000 TF adjustment to balance to the Budget Act of 2020.

FY 2021	TF	GF	FF
Budget Reconciliation	**$2,491,000**	**$10,681,000**	**-$8,190,000**

HEARING AID COVERAGE - ADMIN

REGULAR POLICY CHANGE NUMBER:	266
IMPLEMENTATION DATE:	4/2021
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	2231

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$195,000
- STATE FUNDS	$0	$195,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$195,000
STATE FUNDS	$0	$195,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the administrative costs of providing hearing aids and associated services to non-Medi-Cal children who otherwise do not have health insurance coverage for these services and are at or below 600% Federal Poverty Level (FPL).

Authority:
Budget Bill Language

Interdependent Policy Changes:
Not Applicable

Background:
Coverage for hearing aids and associated services is proposed to be offered to non-Medi-Cal children, who otherwise do not have health insurance coverage for these services and are at or below 600% FPL, beginning no sooner than July 1, 2021. Funding for this program will be provided with 100% General Fund (GF).

Reason for Change:
This is a new PC.

Methodology:
1. Assume costs on a cash basis for FY 2020-21 will be $195,000 TF ($195,000 GF).

Funding:
100% GF (4260-101-0001)

ADDITIONAL FEDERAL FUNDING TO OTHER DEPT.

REGULAR POLICY CHANGE NUMBER: 267
IMPLEMENTATION DATE: 7/2020
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2232

	FY 2019-20	FY 2020-21
FULL YEAR COST - TOTAL FUNDS	$0	$438,643,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$438,643,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$438,643,000

DESCRIPTION

Purpose:
This policy change estimates the federal match to the California Department of Developmental Services (CDDS) and the California Department of Social Services (CDSS) for conforming changes resulting from the Budget Act of 2020.

Authority:
Budget Act of 2020

Interdependent Policy Changes:
Not Applicable

Background:
Additional federal reimbursements were included to reconcile to the Budget Act of 2020.

Reason for Change:
This is a new policy change.

Methodology:
1. The additional federal reimbursements to CDSS and CDDS in FY 2020-21 were estimated to be:

(Dollars in Thousands)

FY 2020-21	TF	FF
CDSS	$257,671	$257,671
CDDS	$180,972	$180,972
Total	**$438,643**	**$438,643**

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

TABLE OF CONTENTS

COUNTY ADMINISTRATION

The County Administration section provides a detailed overview of estimated expenditures for counties to determine Medi-Cal eligibility for both current and budget years.

SUMMARY OF CURRENT YEAR POLICY CHANGES 1

COST BREAKDOWN OF ONE-TIME AND ON-GOING CURRENT YEAR PROCEDURAL AND CASELOAD EXPENDITURES 2

SUMMARY OF BUDGET YEAR POLICY CHANGES 3

COST BREAKDOWN OF ONE-TIME AND ON-GOING BUDGET YEAR PROCEDURAL AND CASELOAD EXPENDITURES 4

COMPARISON OF FISCAL IMPACTS: CURRENT YEAR ESTIMATE COMPARISONS 5

COMPARISON OF FISCAL IMPACTS: BUDGET YEAR ESTIMATE COMPARISONS 6

COMPARISON OF FISCAL IMPACTS: CURRENT YEAR ESTIMATE COMPARED TO BUDGET YEAR ESTIMATE 7

MEDI-CAL PROGRAM COUNTY ADMINISTRATION POLICY CHANGES 8-24

SUMMARY OF COUNTY ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2019-20

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
1	COUNTY ADMINISTRATION ALLOCATION	$2,095,604,000	$1,054,167,500	$1,041,436,500	$0
2	SAWS	$133,723,000	$132,723,000	$1,000,000	$0
3	CalWORKS APPLICATIONS	$56,306,000	$28,153,000	$28,153,000	$0
4	CASE MANAGEMENT FOR OTLICP	$43,541,000	$21,770,500	$21,770,500	$0
5	LOS ANGELES COUNTY HOSPITAL INTAKES	$43,275,000	$38,514,000	$4,761,000	$0
6	ENHANCED FEDERAL FUNDING	$0	$514,216,250	($514,216,250)	$0
7	COUNTY ADMINISTRATION CMS DEFERRED CLAIMS	$0	$4,021,000	($4,021,000)	$0
8	SAVE	$0	$4,000,000	($4,000,000)	$0
	OTHER SUBTOTAL	**$2,372,449,000**	**$1,797,565,250**	**$574,883,750**	**$0**
	GRAND TOTAL	**$2,372,449,000**	**$1,797,565,250**	**$574,883,750**	**$0**

MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE COST BREAKDOWN
FISCAL YEAR 2019-20

NO.	POLICY CHANGE TITLE	ONE-TIME CHANGES		ON-GOING CHANGES		TOTAL POLICY CHANGES	GENERAL FUNDS
		PROCEDURAL	CASELOAD	PROCEDURAL	CASELOAD		
	OTHER						
1	COUNTY ADMINISTRATION ALLOCATION	$0	$0	$2,095,604,000	$0	$2,095,604,000	$1,041,436,500
2	SAWS	$133,723,000	$0	$0	$0	$133,723,000	$1,000,000
3	CalWORKS APPLICATIONS	$0	$0	$56,306,000	$0	$56,306,000	$28,153,000
4	CASE MANAGEMENT FOR OTLICP	$0	$0	$0	$43,541,000	$43,541,000	$21,770,500
5	LOS ANGELES COUNTY HOSPITAL INTAKES	$0	$0	$0	$43,275,000	$43,275,000	$4,761,000
6	ENHANCED FEDERAL FUNDING	$0	$0	$0	$0	$0	($514,216,250)
7	COUNTY ADMINISTRATION CMS DEFERRED CLAIMS	$0	$0	$0	$0	$0	($4,021,000)
8	SAVE	$0	$0	$0	$0	$0	($4,000,000)
	OTHER SUBTOTAL	**$133,723,000**	**$0**	**$2,151,910,000**	**$86,816,000**	**$2,372,449,000**	**$574,883,750**
	GRAND TOTAL	**$133,723,000**	**$0**	**$2,151,910,000**	**$86,816,000**	**$2,372,449,000**	**$574,883,750**

SUMMARY OF COUNTY ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2020-21

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
1	COUNTY ADMINISTRATION ALLOCATION	$2,150,566,000	$1,075,283,000	$1,075,283,000	$0
2	SAWS	$120,600,000	$120,600,000	$0	$0
3	CalWORKS APPLICATIONS	$56,119,000	$28,059,500	$28,059,500	$0
4	CASE MANAGEMENT FOR OTLICP	$43,498,000	$21,749,000	$21,749,000	$0
5	LOS ANGELES COUNTY HOSPITAL INTAKES	$43,275,000	$38,514,000	$4,761,000	$0
6	ENHANCED FEDERAL FUNDING	$0	$517,726,000	($517,726,000)	$0
8	SAVE	$0	$4,000,000	($4,000,000)	$0
	OTHER SUBTOTAL	**$2,414,058,000**	**$1,805,931,500**	**$608,126,500**	**$0**
	GRAND TOTAL	**$2,414,058,000**	**$1,805,931,500**	**$608,126,500**	**$0**

MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE COST BREAKDOWN
FISCAL YEAR 2020-21

NO.	POLICY CHANGE TITLE	ONE-TIME CHANGES		ON-GOING CHANGES		TOTAL POLICY CHANGES	GENERAL FUNDS
		PROCEDURAL	CASELOAD	PROCEDURAL	CASELOAD		
	OTHER						
1	COUNTY ADMINISTRATION ALLOCATION	$0	$0	$2,150,566,000	$0	$2,150,566,000	$1,075,283,000
2	SAWS	$120,600,000	$0	$0	$0	$120,600,000	$0
3	CalWORKS APPLICATIONS	$0	$0	$56,119,000	$0	$56,119,000	$28,059,500
4	CASE MANAGEMENT FOR OTLICP	$0	$0	$0	$43,498,000	$43,498,000	$21,749,000
5	LOS ANGELES COUNTY HOSPITAL INTAKES	$0	$0	$0	$43,275,000	$43,275,000	$4,761,000
6	ENHANCED FEDERAL FUNDING	$0	$0	$0	$0	$0	($517,726,000)
8	SAVE	$0	$0	$0	$0	$0	($4,000,000)
	OTHER SUBTOTAL	**$120,600,000**	**$0**	**$2,206,685,000**	**$86,773,000**	**$2,414,058,000**	**$608,126,500**
	GRAND TOTAL	**$120,600,000**	**$0**	**$2,206,685,000**	**$86,773,000**	**$2,414,058,000**	**$608,126,500**

COMPARISON OF FISCAL IMPACTS OF COUNTY ADMINISTRATION POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2019-20

NOV.	MAY		2019-20 APPROPRIATION		NOV. 2019 EST. FOR 2019-20		MAY 2020 EST. FOR 2019-20		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
NO.	NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER										
1	1	COUNTY ADMINISTRATION ALLOCATION	$2,082,873,000	$1,041,436,500	$2,082,873,000	$1,041,436,500	$2,095,604,000	$1,041,436,500	$12,731,000	$0	$12,731,000	$0
2	2	SAWS	$148,600,000	$0	$136,200,000	$1,000,000	$133,723,000	$1,000,000	($14,877,000)	$1,000,000	($2,477,000)	$0
3	3	CalWORKS APPLICATIONS	$56,306,000	$28,153,000	$56,306,000	$28,153,000	$56,306,000	$28,153,000	$0	$0	$0	$0
4	4	CASE MANAGEMENT FOR OTLICP	$43,868,000	$21,934,000	$43,868,000	$21,934,000	$43,541,000	$21,770,500	($327,000)	($163,500)	($327,000)	($163,500)
5	5	LOS ANGELES COUNTY HOSPITAL INTAKES	$42,555,000	$3,257,500	$42,555,000	$3,257,500	$43,275,000	$4,761,000	$720,000	$1,503,500	$720,000	$1,503,500
6	6	ENHANCED FEDERAL FUNDING	$0	($371,685,250)	$0	($496,705,250)	$0	($514,216,250)	$0	($142,531,000)	$0	($17,511,000)
7	7	COUNTY ADMINISTRATION CMS DEFERRED CLAIMS	$0	$0	$0	($1,881,000)	$0	($4,021,000)	$0	($4,021,000)	$0	($2,140,000)
8	8	SAVE	$0	($4,000,000)	$0	($4,000,000)	$0	($4,000,000)	$0	$0	$0	$0
		OTHER SUBTOTAL	**$2,374,202,000**	**$719,095,750**	**$2,361,802,000**	**$593,194,750**	**$2,372,449,000**	**$574,883,750**	**($1,753,000)**	**($144,212,000)**	**$10,647,000**	**($18,311,000)**
		COUNTY ADMINISTRATION GRAND TOTAL	**$2,374,202,000**	**$719,095,750**	**$2,361,802,000**	**$593,194,750**	**$2,372,449,000**	**$574,883,750**	**($1,753,000)**	**($144,212,000)**	**$10,647,000**	**($18,311,000)**

COMPARISON OF FISCAL IMPACTS OF COUNTY ADMINISTRATION POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2020-21

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2019 EST. FOR 2020-21		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
1	1	COUNTY ADMINISTRATION ALLOCATION	$2,150,566,000	$1,075,283,000	$2,150,566,000	$1,075,283,000	$0	$0
2	2	SAWS	$121,600,000	$1,000,000	$120,600,000	$0	($1,000,000)	($1,000,000)
3	3	CalWORKS APPLICATIONS	$56,119,000	$28,059,500	$56,119,000	$28,059,500	$0	$0
4	4	CASE MANAGEMENT FOR OTLICP	$43,451,000	$21,725,500	$43,498,000	$21,749,000	$47,000	$23,500
5	5	LOS ANGELES COUNTY HOSPITAL INTAKES	$42,555,000	$3,257,500	$43,275,000	$4,761,000	$720,000	$1,503,500
6	6	ENHANCED FEDERAL FUNDING	$0	($485,738,750)	$0	($517,726,000)	$0	($31,987,250)
8	8	SAVE	$0	($4,000,000)	$0	($4,000,000)	$0	$0
		OTHER SUBTOTAL	**$2,414,291,000**	**$639,586,750**	**$2,414,058,000**	**$608,126,500**	**($233,000)**	**($31,460,250)**
		COUNTY ADMINISTRATION GRAND TOTAL	**$2,414,291,000**	**$639,586,750**	**$2,414,058,000**	**$608,126,500**	**($233,000)**	**($31,460,250)**

COMPARISON OF FISCAL IMPACTS OF COUNTY ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2019-20 AND 2020-21

		MAY 2020 EST. FOR 2019-20		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER						
1	COUNTY ADMINISTRATION ALLOCATION	$2,095,604,000	$1,041,436,500	$2,150,566,000	$1,075,283,000	$54,962,000	$33,846,500
2	SAWS	$133,723,000	$1,000,000	$120,600,000	$0	($13,123,000)	($1,000,000)
3	CalWORKS APPLICATIONS	$56,306,000	$28,153,000	$56,119,000	$28,059,500	($187,000)	($93,500)
4	CASE MANAGEMENT FOR OTLICP	$43,541,000	$21,770,500	$43,498,000	$21,749,000	($43,000)	($21,500)
5	LOS ANGELES COUNTY HOSPITAL INTAKES	$43,275,000	$4,761,000	$43,275,000	$4,761,000	$0	$0
6	ENHANCED FEDERAL FUNDING	$0	($514,216,250)	$0	($517,726,000)	$0	($3,509,750)
7	COUNTY ADMINISTRATION CMS DEFERRED CLAIMS	$0	($4,021,000)	$0	$0	$0	$4,021,000
8	SAVE	$0	($4,000,000)	$0	($4,000,000)	$0	$0
	OTHER SUBTOTAL	**$2,372,449,000**	**$574,883,750**	**$2,414,058,000**	**$608,126,500**	**$41,609,000**	**$33,242,750**
	COUNTY ADMINISTRATION GRAND TOTAL	**$2,372,449,000**	**$574,883,750**	**$2,414,058,000**	**$608,126,500**	**$41,609,000**	**$33,242,750**

MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	OTHER
1	COUNTY ADMINISTRATION ALLOCATION
2	SAWS
3	CALWORKS APPLICATIONS
4	CASE MANAGEMENT FOR OTLICP
5	LOS ANGELES COUNTY HOSPITAL INTAKES
6	ENHANCED FEDERAL FUNDING
7	COUNTY ADMINISTRATION CMS DEFERRED CLAIMS
8	SAVE

COUNTY ADMINISTRATION ALLOCATION

COUNTY ADMIN. POLICY CHANGE NUMBER:	1
IMPLEMENTATION DATE:	7/2012
ANALYST:	Sabrina Blank
FISCAL REFERENCE NUMBER:	1704

	FY 2019-20		FY 2020-21	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$2,095,604,000	$0	$2,150,566,000
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$2,095,604,000	$0	$2,150,566,000
STATE FUNDS	$0	$1,041,436,500	$0	$1,075,283,000
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$0	$2,095,604,000	$0	$2,150,566,000
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$2,095,604,000	$0	$2,150,566,000
STATE FUNDS	$0	$1,041,436,500	$0	$1,075,283,000

DESCRIPTION

Purpose:
This policy change reflects the allocation funded to counties for costs associated with Medi-Cal eligibility determination activities.

Authority:
Welfare & Institutions Code 14154

Interdependent Policy Changes:
Not Applicable

Background:
The Department is responsible for determining the appropriate allocation for funding county welfare department costs associated with Medi-Cal eligibility determinations. The Department establishes and maintains a cost control plan. The plan provides for the administrative costs that the counties incur for Medi-Cal eligibility determination activities. This estimate reflects the allocation to the counties utilizing recent workload data, county expenditure data, and other county-submitted information.

Beginning in FY 2018-19, the Department includes funding for the implementation of the ACA in this policy change. The Department uses the projected California Consumer Price index (CPI) change to adjust the total dollars available and applies similar adjustments as the county eligibility systems move to a single Statewide Automated Welfare System. With this increase, counties work to place beneficiaries into the correct aid codes based on changes in circumstances, increase the percentage of completed and accurate eligibility determinations and annual redeterminations, and provide timely eligibility and enrollment data and reports to the Department.

COUNTY ADMINISTRATION ALLOCATION

COUNTY ADMIN. POLICY CHANGE NUMBER: 1

Reason for Change:
The change from the prior estimate for FY 2019-20 is a FF increase due to the $12,731,000 GF augmentation provided by Executive Order No. E 19/20 – 135 (EO 19/20 – 135). There is no change from the prior estimate for FY 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to the Department increasing the total allocation by 3.25% for the projected California CPI prior to the EO 19/20 – 135 allocation, resulting in a $68M increase.

Methodology:
1. EO 19/20 – 135 adds $12,731,000 GF to cover the impacts of COVID-19 for county administration activities in FY 2019-20. EO 19/20 – 135 GF dollars are not captured in this policy change and are budgeted elsewhere. As such, the total county administration GF allocation is approximately $1,054,168,000.

2. The total rounded estimated FY 2019-20 and FY 2020-21 county administration costs are:

(Dollars In Thousands)

Total Allocation	TF	GF	FF
FY 2019-20	$2,095,604	$1,041,437	$1,054,167
FY 2020-21	$2,150,566	$1,075,283	$1,075,283

Funding:
50% Title XIX FF / 50% GF (4260-101-0890/0001)
Medicaid Management Information Systems Enhanced Funding identified in the Enhanced Federal Funding policy change.

SAWS

COUNTY ADMIN. POLICY CHANGE NUMBER:	2
IMPLEMENTATION DATE:	7/1987
ANALYST:	Sabrina Blank
FISCAL REFERENCE NUMBER:	214

	FY 2019-20		FY 2020-21	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$133,723,000	$0	$120,600,000	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$133,723,000	$0	$120,600,000	$0
STATE FUNDS	$1,000,000	$0	$0	$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$133,723,000	$0	$120,600,000	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$133,723,000	$0	$120,600,000	$0
STATE FUNDS	$1,000,000	$0	$0	$0

DESCRIPTION

Purpose:
This policy change estimates and reimburses the California Department of Social Services (CDSS) federal financial participation (FFP) for automated Eligibility Determination and Automated Benefit Computation. This policy change also estimates the funds that the Department pays for the Los Angeles Eligibility Automated Determination Evaluation and Reporting System (LEADER) Replacement System (LRS) and the California Automated Consortium Eligibility System (CalACES).

Authority:
Welfare & Institutions Code 14154
Interagency Agreement # 04-35639
Interagency Agreement CalHEERS # 14-90510
Affordable Care Act (ACA)

Interdependent Policy Changes:
Not Applicable

Background:
The Statewide Automated Welfare Systems (SAWS) consists of three county consortium systems: LRS, Consortium-IV (C-IV), and CalWORKs Information Network (CalWIN). SAWS project management is now the responsibility of the Office of Systems Integration (OSI) within the Health and Human Services Agency. The Department provides expertise to OSI on program and technical system requirements for the Medi-Cal program and the Medi-Cal Eligibility Data System interfaces.

LRS is the automated system used in Los Angeles County and is currently in the maintenance and operations phase. The CalWIN consortium is used by 18 counties and the C-IV system is used by 39 counties. CalWIN and C-IV are currently in the maintenance and operation phase.

SAWS

COUNTY ADMIN. POLICY CHANGE NUMBER: 2

The State Strategy for Eligibility Systems and ABX1 16 (Chapter 13, Statutes of 2011) dictate the migration of the 39 C-IV counties into a system jointly designed by the C-IV counties and Los Angeles County under the LRS contract. LRS was developed using the C-IV system as the baseline. The process of migrating the C-IV counties to the LRS codebase is scheduled to begin July 2020, after modifications are made to meet C-IV county needs. The C-IV migration to a modified LRS, will result in a new consortium system called CalACES. CalACES will replace both LRS and C-IV.

The process of migrating the CalWIN counties to CalACES is scheduled to begin in 2023, after modifications are made to meet CalWIN county needs. The CalWIN migration to a modified CalACES will result in a new system called CalSAWS (California Statewide Automated Welfare Systems).

The Appeals Case Management System cost was removed from this policy change and is now located in the Department of Social Services Administrative Cost, Other Administration policy change.

Reason for Change:
The change for FY 2019-20, from the prior estimate, is a decrease due to updated expenditure data provided by CDSS. The change for FY 2020-21, from the prior estimate, is a GF decrease due to removing costs for the undocumented older Californians expansion. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease due to updated expenditure data provided by CDSS and a one-time GF cost in FY 2019-20 for the undocumented young adults full-scope expansion.

Methodology:
1) The following estimate was provided by CDSS on a cash basis.

(Dollars in Thousands)

Line Item	FY 2019-20	FY 2020-21
Statewide Project Management	$2,633	$2,520
SB 1341 Medi-Cal/SAWS	$3,085	$8,470
WCDS-CalWIN	$45,304	$43,222
State Client Index	$0	$0
Inter-County Transfer	$0	$0
CalACES	$78,867	$66,388
Shared Application Forms Revisions	$2,835	$0
Total	**$132,723**	**$120,600**

*Totals may differ due to rounding.

2) There is a $1,000,000 GF cost in FY 2019-20 for the undocumented young adult full-scope expansion.

3) Assume an estimated annual cost of $133,723,000 TF ($1,000,000 GF) in FY 2019-20 and $120,600,000 TF in FY 2020-21.

Funding:
50% Title XIX FF / 50% GF (4260-101-0890/0001)
100% Title XIX FF (4260-101-0890)
100% GF (4260-101-0001)

CalWORKS APPLICATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER:	3
IMPLEMENTATION DATE:	7/1998
ANALYST:	Sabrina Blank
FISCAL REFERENCE NUMBER:	217

	FY 2019-20		FY 2020-21	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$56,306,000	$0	$56,119,000
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$56,306,000	$0	$56,119,000
STATE FUNDS	$0	$28,153,000	$0	$28,059,500
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$0	$56,306,000	$0	$56,119,000
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$56,306,000	$0	$56,119,000
STATE FUNDS	$0	$28,153,000	$0	$28,059,500

DESCRIPTION

Purpose:
This policy change estimates the Medi-Cal portion of the shared costs for processing applications which are submitted through CalWORKS and/or CalFresh programs. These costs include staff and support costs.

Authority:
Welfare & Institutions Code 14154

Interdependent Policy Changes:
Not Applicable

Background:
Since 1998, the Department has shared in the costs for CalWORKS applications with the California Department of Social Services (CDSS). CDSS amended the claim forms and time study documents completed by the counties to allow CalWORKS application costs that are also necessary for Medi-Cal and CalFresh eligibility, to be shared between the three programs.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 or 2020-21. The change from FY 2019-20 to FY 2020-21, in the current estimate, reflects a projected decline in expenditures based on the most recent quarters of available data.

CalWORKS APPLICATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER: 3

Methodology:

1) The estimated costs for FY 2019-20 and FY 2020-21 were provided on a cash basis by CDSS.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2019-20	$56,306	$28,153	$28,153
FY 2020-21	$56,119	$28,060	$28,060

*Totals may differ due to rounding.

Funding:

50% Title XIX FF/ 50% GF (4260-101-0890/0001)
Medicaid Management Information Systems Enhanced Funding identified in the Enhanced Federal Funding policy change.

CASE MANAGEMENT FOR OTLICP

COUNTY ADMIN. POLICY CHANGE NUMBER:	4
IMPLEMENTATION DATE:	12/2012
ANALYST:	Sabrina Blank
FISCAL REFERENCE NUMBER:	1598

	FY 2019-20		FY 2020-21	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$43,541,000	$0	$43,498,000
TOTAL FUNDS	$0	$43,541,000	$0	$43,498,000
STATE FUNDS	$0	$21,770,500	$0	$21,749,000
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$43,541,000	$0	$43,498,000
TOTAL FUNDS	$0	$43,541,000	$0	$43,498,000
STATE FUNDS	$0	$21,770,500	$0	$21,749,000

DESCRIPTION

Purpose:
This policy change budgets the county administration costs associated with the ongoing costs for case management and redetermination of Optional Targeted Low Income Children's Program (OTLICP) beneficiaries.

Authority:
AB 1494 (Chapter 28, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2013, the Healthy Families Program (HFP) subscribers began transitioning into Medi-Cal through a phase-in methodology. HFP sent current subscribers' applications and information to the counties. The final group transitioned November 1, 2013. The program has since been renamed as the OTLICP.

Reason for Change:
The change from the prior estimate, for FY 2019-20 is a slight decrease due to lower projected eligibles for FY 2019-20. The change from the prior estimate, for FY 2020-21 is a slight increase due to higher projected eligibles for FY 2020-21. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a slight decrease due estimated eligible trends.

CASE MANAGEMENT FOR OTLICP

COUNTY ADMIN. POLICY CHANGE NUMBER: 4

Methodology:

1. The Department currently estimates the case management and redetermination for the former OTLICP beneficiaries at $4.00 Per Member Per Month.

2. The estimated average monthly OTLICP eligibles for FY 2019-20 is 907,111 and 906,218 for FY 2020-21.

3. The estimated costs are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2019-20	$43,541	$21,171	$21,171
FY 2020-21	$43,498	$21,749	$21,749

Funding:

50% Title XIX / 50% GF (4260-113-0890/0001)
Medicaid Management Information Systems Enhanced Funding identified in the Enhanced Federal Funding policy change

LOS ANGELES COUNTY HOSPITAL INTAKES

COUNTY ADMIN. POLICY CHANGE NUMBER:	5
IMPLEMENTATION DATE:	7/1994
ANALYST:	Sabrina Blank
FISCAL REFERENCE NUMBER:	213

	FY 2019-20		FY 2020-21	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$43,275,000	$0	$43,275,000
TOTAL FUNDS	$0	$43,275,000	$0	$43,275,000
STATE FUNDS	$0	$4,761,000	$0	$4,761,000
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$43,275,000	$0	$43,275,000
TOTAL FUNDS	$0	$43,275,000	$0	$43,275,000
STATE FUNDS	$0	$4,761,000	$0	$4,761,000

DESCRIPTION

Purpose:
The policy change estimates the costs for Patient Financial Services Workers (PFSWs) to process Medi-Cal applications taken in Los Angeles County hospitals.

Authority:
Welfare & Institutions Code (W&I) 14154

Interdependent Policy Changes:
Not Applicable

Background:
Los Angeles County uses PFSWs to collect and process Medi-Cal applications taken in Los Angeles County hospitals. Los Angeles County hospitals send applications processed by the PFSWs to the Los Angeles County Human Services Agency for final eligibility determination. W&I Section 14154 limits the reimbursement amount for PFSW intakes to the amount paid to Los Angeles County Department of Social Services (DPSS) eligibility workers for regular Medi-Cal intakes. The Department passes through the federal share for any costs not covered by the DPSS rate to the county.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is an increase due to final reconciliation being completed for FY 2017-18 in November 2019. The change from the prior estimate, for FY 2020-21, is an increase due to using higher FY 2018-19 reconciliation placeholder amounts.

There is no change from FY 2019-20 to FY 2020-21 in the current estimate.

LOS ANGELES COUNTY HOSPITAL INTAKES

COUNTY ADMIN. POLICY CHANGE NUMBER: 5

Methodology:

1. The reimbursement rate is $268 for both current year and budget year. Assume in FY 2019-20 and FY 2020-21, PFSWs will continue processing a base caseload of 2,215 per month.

   FY 2019-20: 2,215 x $268 x 12 = $7,124,000 TF ($3,562,000 GF)
   FY 2020-21: 2,215 x $268 x 12 = $7,124,000 TF ($3,562,000 GF)

2. The Department completed the FY 2017-18 reconciliation in FY 2019-20. The FY 2018-19 reconciliation amounts are placeholders.

(Dollars in Thousands)

Line Item	FY 2019-20			FY 2020-21		
	TF	GF	FF	TF	GF	FF
PFSW Base	$7,124	$3,562	$3,562	$7,124	$3,562	$3,562
FY 2017-18 Recon.	$19,874	$1,199	$18,675			
FY 2017-18 Pass.	$16,277	$0	$16,277			
FY 2018-19 Recon.				$19,874	$1,199	$18,675
FY 2018-19 Pass.				$16,277	$0	$16,277
Total	**$43,275**	**$4,761**	**$38,514**	**$43,275**	**$4,761**	**$38,514**

Funding:

(Dollars in Thousands)

FY 2019-20	Fund Number	TF	GF	FF
50% Title XIX FF/ 50% GF	4260-101-0001/0890	$7,124	$3,562	$3,562
100% Title XIX FF	4260-101-0890	$34,952	$0	$34,952
100% GF	4260-101-0001	$1,199	$1,199	$0
Total		**$43,275**	**$4,761**	**$38,514**

FY 2020-21	Fund Number	TF	GF	FF
50% Title XIX FF/ 50% GF	4260-101-0001/0890	$7,124	$3,562	$3,562
100% Title XIX FF	4260-101-0890	$34,952	$0	$34,952
100% GF	4260-101-0001	$1,199	$1,199	$0
Total		**$43,275**	**$4,761**	**$38,514**

ENHANCED FEDERAL FUNDING

COUNTY ADMIN. POLICY CHANGE NUMBER:	6
IMPLEMENTATION DATE:	1/2015
ANALYST:	Sabrina Blank
FISCAL REFERENCE NUMBER:	1835

	FY 2019-20		FY 2020-21	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$0	$0	$0
STATE FUNDS	-$514,216,250	$0	-$517,726,000	$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$0	$0	$0
STATE FUNDS	-$514,216,250	$0	-$517,726,000	$0

DESCRIPTION

Purpose:
This policy change estimates the savings from enhanced federal funding for certain eligibility determination functions.

Authority:
Not Applicable

Interdependent Policy Changes:
County Administration Allocation
CalWORKS Applications
Case Management for OTLICP

Background:
Generally, payments to counties for making Medi-Cal eligibility determinations are budgeted at 50% federal funding. However, the Centers for Medicare and Medicaid Services (CMS) published guidance that allows for federal funding at 75% for some of these activities. CMS considers certain eligibility determination-related costs to fall under Medicaid Management Information Systems (MMIS) rules for approval of enhanced funding. The enhanced 75% federal funding is available for costs of the application, on-going case maintenance, and renewal functions. Funding remains at 50% for policy, outreach, and post-eligibility functions.

There are various conditions required of a MMIS to secure the enhanced funding. There are also minimum critical success factors for accepting the new applications, making modified adjusted gross income determinations and coordination with Covered California. The Department submitted an Advanced Planning Document (APD) to secure CMS approval in January 2014, and received approval on September 29, 2014. The Department conducts an annual APD review and submits an update to

ENHANCED FEDERAL FUNDING

COUNTY ADMIN. POLICY CHANGE NUMBER: 6

CMS. CMS approved the APD for FFY 2019 on September 26, 2018.

Reason for Change:
The change for FY 2019-20, from the previous estimate, is a slight increase in General Fund (GF) due to receiving more quarters of actual, audited, and updated claimed expenditure data from the California Department of Social Services (CDSS), which is used to identify and claim enhanced federal funding.

The change for FY 2020-21, from the previous estimate, is a slight increase in GF due to updated estimated claim funding projections that utilize the expenditure trends from FY 2019-20.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase in GF due to assuming the continued expenditure trend in FY 2020-21.

Methodology:
1. The effective date for the Department's APD is September 26, 2018.

2. The Department utilizes actual, audited, and claimed expenditure data provided by CDSS to identify and claim Enhanced FFP and to estimate FFP for future quarters.

3. Beginning December 2018, the Department will receive reports from CDSS identifying actual expenditure costs eligible for enhanced funding.

4. In FY 2019-20, the Department will claim payments for FY 2018-19 quarters 3-4 and FY 2019-20 quarters 1-2. In FY 2020-21, the Department will claim payments for FY 2019-20 quarters 3-4 and FY 2020-21 quarters 1-2.

5. The savings are estimated to be:

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
Title XIX at 50% FFP	($2,056,865)	($1,028,433)	($1,028,432)
Title XIX at 75% FFP	$2,056,865	$514,216	$1,542,649
Total Difference	**$0**	**($514,216)**	**$514,216**

FY 2020-21	TF	GF	FF
Title XIX at 50% FFP	($2,070,904)	($1,035,452)	($1,035,452)
Title XIX at 75% FFP	$2,070,904	$517,726	$1,553,178
Total Difference	**$0**	**($517,726)**	**$517,726**

*Totals may differ due to rounding.

Funding:
50% Title XIX FF/ 50% GF (4260-101-0890/0001)
75% Title XIX FF/ 25% GF (4260-101-0890/0001)

COUNTY ADMINISTRATION CMS DEFERRED CLAIMS

COUNTY ADMIN. POLICY CHANGE NUMBER:	7
IMPLEMENTATION DATE:	8/2018
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	2089

	FY 2019-20		FY 2020-21	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$0	$0	$0
STATE FUNDS	-$4,021,000	$0	$0	$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$0	$0	$0
STATE FUNDS	-$4,021,000	$0	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the repayment of County Administration Enhanced Funding deferred claims to the Centers for Medicare and Medicaid Services (CMS).

Authority:
California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)
Title 42, Code of Federal Regulations (CFR), 430.40

Interdependent Policy Changes:
Not Applicable

Background:
CMS reviews claims submitted by state Medicaid agencies to ensure federal financial participation (FFP) eligibility. Claims for which CMS questions the FFP eligibility are deferred and the state Medicaid agency is issued a deferral notice. Upon receipt of the deferral notice, the state Medicaid agency has 120 days to resolve the deferred claim.

When CMS issues a deferral to the state Medicaid agency, in accordance with the timelines set forth in 42 CFR 430.40, the state Medicaid agency must immediately return the deferred FFP to the applicable Payment Management System (PMS) subaccount while the deferral is being resolved. As part of the resolution process, the state Medicaid agency submits documentation in support of the deferred claim to CMS for review. If CMS determines the deferred claim is allowed, then the deferral is released, the funds are returned to the appropriate PMS subaccount, and the state Medicaid agency is notified that the funds are available to be redrawn.

COUNTY ADMINISTRATION CMS DEFERRED CLAIMS

COUNTY ADMIN. POLICY CHANGE NUMBER: 7

Pursuant to Special Terms and Conditions paragraph 164 of the California Medi-Cal 2020 Demonstration Waiver, Medi-Cal is required to bring all deferrals current. The Department is working with CMS to resolve specific items. All deferred claims and negative PMS subaccount balances must be repaid by the end of the demonstration waiver, December 31, 2020, or within three years from CMS' approval of California's repayment schedule, whichever is longer.

The County Administration Enhanced Funding deferral repayments and resolutions are included in this policy change and are separate from the CMS Deferred Claims policy change. See the CMS Deferred Claims policy change for more information.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is due to updated reclaiming amounts available.

There is no change in FY 2020-21, from the prior estimate.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to reclaiming funds in FY 2019-20. No funds have been estimated to be reclaimed in FY 2020-21.

Methodology:
1. The Department reclaimed $4.021 million FF in August 2019.

(Dollars in Thousands)

Resolved Deferrals	TF	GF	FF
FY 2019-20	$0	($4,021)	$4,021

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XIX GF (4260-101-0001)

SAVE

COUNTY ADMIN. POLICY CHANGE NUMBER:	8
IMPLEMENTATION DATE:	10/1988
ANALYST:	Sabrina Blank
FISCAL REFERENCE NUMBER:	215

	FY 2019-20		FY 2020-21	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$0	$0	$0
STATE FUNDS	-$4,000,000	$0	-$4,000,000	$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$0	$0	$0
STATE FUNDS	-$4,000,000	$0	-$4,000,000	$0

DESCRIPTION

Purpose:
The policy change estimates the technical adjustment in funding from Title XIX 50% Federal Financial Participation (FFP) to Title XIX 100% FFP for the Systematic Alien Verification for Entitlements (SAVE) system.

Authority:
Welfare & Institutions Code 14154

Interdependent Policy Changes:
Not Applicable

Background:
The Immigration Reform and Control Act of 1986 required states to use the SAVE system to verify immigrant status for Medi-Cal applicants beginning in October 1988. The counties complete time studies for eligibility workers and supervisors based on time spent for SAVE verifications. Beginning May of 2018, counties are federally required to use the web-based SAVE system for the third step of the SAVE process.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 or 2020-21. There is no change from FY 2019-20 to FY 2020-21 in the current estimate.

SAVE

COUNTY ADMIN. POLICY CHANGE NUMBER: 8

Methodology:

1. A reconciliation is completed 18 months after the end of each fiscal year to adjust funding received by counties from 50% FFP to 100% FFP.

2. The Medi-Cal accrual costs for SAVE reported over the last three years by the counties were:

Fiscal Year	Actual	Fiscal Year	Estimated
FY 2015-16	$7,553,372	FY 2018-19	$8,000,000
FY 2016-17	$8,037,456	FY 2019-20	$8,000,000
FY 2017-18	$7,776,649	FY 2020-21	$8,000,000

3. Based on claims through June 2018, federal funds will be:

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
50% Title XIX /50% GF 4260-101-0890/0001	($8,000)	($4,000)	($4,000)
100 % Title XIX FFP 4260-101-0890	$8,000	$0	$8,000
Net Impact	**$0**	**($4,000)**	**$4,000**

FY 2020-21	TF	GF	FF
50% Title XIX /50% GF 4260-101-0890/0001	($8,000)	($4,000)	($4,000)
100% Title XIX FFP 4260-101-0890	$8,000	$0	$8,000
Net Impact	**$0**	**($4,000)**	**$4,000**

Funding:

50% Title XIX / 50% GF (4260-101-0890/0001)
100% Title XIX FFP (4260-101-0890)

TABLE OF CONTENTS

OTHER ADMINISTRATION

The Other Administration section provides a detailed overview of estimated expenditures required to administer the Medi-Cal program for both current and budget years. This section includes both Local Assistance Administrative (other than County Administration) costs and Fiscal Intermediary (FI) costs associated with processing of claims.

FUNDING SUMMARY OF ALL LOCAL ASSISTANCE ADMINISTRATION COSTS BY FUND TYPE (INCLUDES COUNTY ADMINISTRATION COSTS) ..... **COVER PAGE**

SUMMARY OF CURRENT YEAR POLICY CHANGES **1-4**

SUMMARY OF BUDGET YEAR POLICY CHANGES **5-8**

COMPARISON OF FISCAL IMPACTS: CURRENT YEAR ESTIMATE COMPARIONS **9-13**

COMPARISON OF FISCAL IMPACTS: BUDGET YEAR ESTIMATE COMPARISONS **14-18**

COMPARISON OF FISCAL IMPACTS: CURRENT YEAR ESTIMATE COMPARED TO BUDGET YEAR ESTIMATE **19-23**

MEDI-CAL OTHER ADMINISTRATION POLICY CHANGES.....**24-249**

POLICY CHANGE INDEX 24-26
DHCS-OTHER 27
DHCS-MEDICAL FI 142
DHCS-HEALTH CARE OPT 187
DHCS-DENTAL FI 193
OTHER DEPARTMENTS.....205

May 2020 Medi-Cal Estimate

OTHER ADMINISTRATION FUNDING SUMMARY

Other Administration Tab contains funding for items under both the County Administration and the Fiscal Intermediary components of the Medi-Cal Estimate (located in the Management Summary Tab). The Fiscal Intermediary Tab of the Medi-Cal Estimate has been moved to the Other Administration Tab. These items continue to be budgeted in the Medi-Cal's Fiscal Intermediary component. The policy changes related to the Fiscal Intermediary can be found under the following subsections: DHCS-MEDICAL FI, DHCS-HEALTH CARE OPTIONS, AND DHCS-DENTAL FI.

FY 2019-2020 Estimate:	Total Funds	Federal Funds	General Funds	Other State Funds
OTHER ADMINISTRATION				
County Administration	$2,082,670,000	$1,668,177,000	$409,817,000	$4,676,000
Fiscal Intermediary	$380,645,000	$254,716,000	$125,929,000	$0
Total Other Administration Tab	**$2,463,315,000**	**$1,922,893,000**	**$535,746,000**	**$4,676,000**
Management Summary:				
COUNTY ADMINISTRATION	**$4,455,119,000**	**$3,465,742,000**	**$984,701,000**	**$4,676,000**
Shown in Other Administration Tab	$2,082,670,000	$1,668,177,000	$409,817,000	$4,676,000
Shown in County Administration Tab	$2,372,449,000	$1,797,565,000	$574,884,000	$0
FISCAL INTERMEDIARY	**$380,645,000**	**$254,716,000**	**$125,929,000**	**$0**
Shown in Other Administration Tab	$380,645,000	$254,716,000	$125,929,000	$0

FY 2020-2021 Estimate:	Total Funds	Federal Funds	General Funds	Other State Funds
OTHER ADMINISTRATION				
County Administration	$2,302,385,000	$1,994,966,000	$301,046,000	$6,373,000
Fiscal Intermediary	$350,727,000	$227,187,000	$123,540,000	$0
Total Other Administration Tab	**$2,653,112,000**	**$2,222,153,000**	**$424,586,000**	**$6,373,000**
Management Summary:				
COUNTY ADMINISTRATION	**$4,716,444,000**	**$3,800,899,000**	**$909,172,000**	**$6,373,000**
Shown in Other Administration Tab	$2,302,385,000	$1,994,966,000	$301,046,000	$6,373,000
Shown in County Administration Tab	$2,414,059,000	$1,805,933,000	$608,126,000	$0
FISCAL INTERMEDIARY	**$350,727,000**	**$227,187,000**	**$123,540,000**	**$0**
Shown in Other Administration Tab	$350,727,000	$227,187,000	$123,540,000	$0

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2019-20

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DHCS-OTHER				
1	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	$135,713,000	$137,954,000	($2,241,000)	$0
2	CCS CASE MANAGEMENT	$174,215,000	$115,687,140	$58,527,860	$0
3	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$168,275,000	$168,275,000	$0	$0
4	MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS	$8,442,000	$8,442,000	$0	$0
5	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	$109,924,000	$109,424,000	$500,000	$0
6	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$42,661,000	$42,661,000	$0	$0
7	DRUG MEDI-CAL COUNTY ADMINISTRATION	$11,197,000	$10,226,000	$971,000	$0
8	ARRA HITECH INCENTIVE PROGRAM	$11,643,000	$10,930,000	$0	$713,000
9	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	$38,088,000	$27,112,990	$10,975,010	$0
10	CHDP CASE MANAGEMENT	$33,962,000	$22,005,000	$11,957,000	$0
11	SMHS COUNTY UR & QA ADMIN	$31,635,000	$30,682,000	$953,000	$0
12	HEALTH ENROLLMENT NAVIGATORS	$5,574,000	$2,787,000	$2,787,000	$0
13	SMH MAA	$47,531,000	$47,531,000	$0	$0
14	POSTAGE & PRINTING	$26,043,000	$12,893,000	$13,150,000	$0
15	MANAGED CARE REGULATIONS - MENTAL HEALTH	$981,000	$696,000	$285,000	$0
16	MANAGED CARE REGULATIONS - MH PARITY	$19,367,000	$16,600,000	$2,767,000	$0
17	PAVE SYSTEM	$9,063,000	$4,531,500	$4,531,500	$0
18	ACTUARIAL COSTS FOR RATE DEVELOPMENT	$17,056,000	$8,528,000	$8,315,500	$212,500
19	PERFORMANCE OUTCOMES SYSTEM	$5,715,000	$2,920,750	$2,794,250	$0
20	SURS AND MARS SYSTEM REPROCUREMENT	$15,212,000	$10,866,100	$4,345,900	$0
21	CA HEALTH INFORMATION EXCHANGES ONBOARDING PROGRAM	$500,000	$450,000	$50,000	$0
22	MEDI-CAL RECOVERY CONTRACTS	$7,159,000	$5,369,250	$1,789,750	$0
23	MIS/DSS CONTRACT	$12,716,000	$9,405,800	$3,310,200	$0
24	MITA	$5,675,000	$4,994,340	$680,660	$0
25	CCI-ADMINISTRATIVE COSTS	$11,213,000	$5,606,500	$5,606,500	$0
26	PASRR	$8,964,000	$6,723,000	$2,241,000	$0
27	HCBA WAIVER RENEWAL ADMINISTRATIVE COST	$9,764,000	$4,882,000	$4,882,000	$0
28	LITIGATION RELATED SERVICES	$9,980,000	$4,990,000	$4,990,000	$0
29	NEWBORN HEARING SCREENING PROGRAM	$7,580,000	$3,790,000	$3,790,000	$0

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2019-20

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DHCS-OTHER				
30	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$5,995,000	$4,252,000	$1,743,000	$0
31	HIPAA CAPMAN	$5,448,000	$4,085,410	$1,362,590	$0
32	DRUG MEDI-CAL COUNTY UR & QA ADMIN	$4,096,000	$4,096,000	$0	$0
33	PACES	$2,540,000	$2,250,360	$289,640	$0
34	CA-MMIS MEDCOMPASS SOLUTION	$2,202,000	$1,101,000	$1,101,000	$0
35	SDMC SYSTEM M&O SUPPORT	$2,325,000	$1,162,500	$1,162,500	$0
37	SSA COSTS FOR HEALTH COVERAGE INFO.	$2,040,000	$1,020,000	$1,020,000	$0
38	FAMILY PACT PROGRAM ADMIN.	$1,207,000	$1,086,300	$120,700	$0
39	LTSS ACTUARIAL STUDY	$453,000	$0	$453,000	$0
40	MMA - DSH ANNUAL INDEPENDENT AUDIT	$488,000	$244,000	$244,000	$0
41	MEDICARE BENEFICIARY IDENTIFIER	$828,000	$733,820	$94,180	$0
42	CALIFORNIA HEALTH INTERVIEW SURVEY	$933,000	$933,000	$0	$0
43	ENCRYPTION OF PHI DATA	$750,000	$375,000	$375,000	$0
44	ELECTRONIC ASSET VERIFICATION PROGRAM	$659,000	$329,500	$329,500	$0
46	T-MSIS	$311,000	$233,250	$77,750	$0
47	CCT OUTREACH - ADMINISTRATIVE COSTS	$290,000	$290,000	$0	$0
66	CMS DEFERRED CLAIMS - OTHER ADMIN	$0	($223,428,000)	$223,428,000	$0
102	COVID-19 EMERGENCY FMAP - OTHER ADMIN	$0	$1,000,000	($1,000,000)	$0
	DHCS-OTHER SUBTOTAL	**$1,016,413,000**	**$636,727,500**	**$378,760,000**	**$925,500**
	DHCS-MEDICAL FI				
49	MEDICAL FI OPERATIONS	$32,340,000	$22,458,250	$9,881,750	$0
50	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	$24,801,000	$18,600,750	$6,200,250	$0
51	MEDICAL FI BO & IT CHANGE ORDERS	$25,128,000	$18,645,250	$6,482,750	$0
52	MEDICAL FI BO & IT COST REIMBURSEMENT	$22,351,000	$15,703,300	$6,647,700	$0
53	MEDICAL FI IT INFRASTRUCTURE SERVICES	$17,763,000	$12,716,250	$5,046,750	$0
54	MEDICAL FI HOURLY REIMBURSEMENT	$43,605,000	$32,618,150	$10,986,850	$0
55	MEDICAL FI COST REIMBURSEMENT	$28,096,000	$20,230,950	$7,865,050	$0
56	MEDICAL FI BO OTHER ESTIMATED COSTS	$10,873,000	$7,677,500	$3,195,500	$0

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2019-20

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DHCS-MEDICAL FI				
57	MEDICAL FI BO TELEPHONE SERVICE CENTER	$8,161,000	$5,792,250	$2,368,750	$0
58	MEDICAL FI BUSINESS OPERATIONS	$6,868,000	$4,778,250	$2,089,750	$0
59	MEDICAL FI OTHER ESTIMATED COSTS	$5,951,000	$4,238,750	$1,712,250	$0
60	MEDICAL FI BO HOURLY REIMBURSEMENT	$5,364,000	$4,023,000	$1,341,000	$0
61	MEDICAL FI SRP RELEASE 1 HOSTING	$3,162,000	$2,702,400	$459,600	$0
62	MEDICAL FI OPTIONAL CONTRACTUAL SERVICES	$373,000	$335,700	$37,300	$0
63	MEDICAL FI MISCELLANEOUS EXPENSES	$1,349,000	$925,250	$423,750	$0
64	MEDICAL FI BO MISCELLANEOUS EXPENSES	$1,037,000	$714,750	$322,250	$0
65	MEDICAL FI CHANGE ORDERS	$246,000	$184,500	$61,500	$0
97	CMS DEFERRED CLAIMS - FI	$0	($2,235,000)	$2,235,000	$0
	DHCS-MEDICAL FI SUBTOTAL	**$237,468,000**	**$170,110,250**	**$67,357,750**	**$0**
	DHCS-HEALTH CARE OPT				
67	HCO OPERATIONS 2017 CONTRACT	$40,872,000	$21,036,420	$19,835,580	$0
68	HCO COST REIMBURSEMENT 2017 CONTRACT	$20,646,000	$10,626,150	$10,019,850	$0
69	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	$13,716,000	$7,059,570	$6,656,430	$0
	DHCS-HEALTH CARE OPT SUBTOTAL	**$75,234,000**	**$38,722,140**	**$36,511,860**	**$0**
	DHCS-DENTAL FI				
70	DENTAL ASO ADMINISTRATION 2016 CONTRACT	$37,920,000	$24,563,000	$13,357,000	$0
71	DENTAL FI ADMINISTRATION 2016 CONTRACT	$18,457,000	$13,190,750	$5,266,250	$0
72	DENTAL FI TAKEOVER 2016 CONTRACT	$7,797,000	$5,847,750	$1,949,250	$0
73	DENTAL FI CD-MMIS COSTS	$256,000	$161,250	$94,750	$0
74	DENTAL ASO TAKEOVER 2016 CONTRACT	$940,000	$705,000	$235,000	$0
	DHCS-DENTAL FI SUBTOTAL	**$65,370,000**	**$44,467,750**	**$20,902,250**	**$0**
	OTHER DEPARTMENTS				
75	HEALTH-RELATED ACTIVITIES - CDSS	$281,138,000	$281,138,000	$0	$0
76	PERSONAL CARE SERVICES	$382,761,000	$382,761,000	$0	$0
77	CALHEERS DEVELOPMENT	$143,594,000	$111,726,120	$31,867,880	$0

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2019-20

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER DEPARTMENTS				
78	MATERNAL AND CHILD HEALTH	$66,536,000	$66,536,000	$0	$0
79	CDDS ADMINISTRATIVE COSTS	$86,240,000	$86,240,000	$0	$0
80	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	$41,379,000	$41,379,000	$0	$0
81	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$26,381,000	$26,381,000	$0	$0
82	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	$18,314,000	$14,564,000	$0	$3,750,000
83	CLPP CASE MANAGEMENT SERVICES	$8,507,000	$8,507,000	$0	$0
84	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$4,454,000	$4,454,000	$0	$0
85	CALIFORNIA SMOKERS' HELPLINE	$3,000,000	$3,000,000	$0	$0
86	KIT FOR NEW PARENTS	$1,061,000	$1,061,000	$0	$0
87	VITAL RECORDS	$1,147,000	$1,141,000	$6,000	$0
88	VETERANS BENEFITS	$1,100,000	$1,100,000	$0	$0
89	MEDI-CAL INPATIENT SERVICES FOR INMATES	$996,000	$996,000	$0	$0
90	CHHS AGENCY HIPAA FUNDING	$849,000	$849,000	$0	$0
91	CDPH I&E PROGRAM AND EVALUATION	$693,000	$693,000	$0	$0
92	MERIT SYSTEM SERVICES FOR COUNTIES	$190,000	$95,000	$95,000	$0
93	PIA EYEWEAR COURIER SERVICE	$490,000	$245,000	$245,000	$0
	OTHER DEPARTMENTS SUBTOTAL	**$1,068,830,000**	**$1,032,866,120**	**$32,213,880**	**$3,750,000**
	GRAND TOTAL	**$2,463,315,000**	**$1,922,893,760**	**$535,745,740**	**$4,675,500**

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2020-21

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DHCS-OTHER				
1	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	$141,765,000	$141,765,000	$0	$0
2	CCS CASE MANAGEMENT	$172,410,000	$113,741,120	$58,668,880	$0
3	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$170,067,000	$170,067,000	$0	$0
5	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	$113,838,000	$113,838,000	$0	$0
6	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$32,100,000	$32,100,000	$0	$0
7	DRUG MEDI-CAL COUNTY ADMINISTRATION	$23,426,000	$22,532,000	$894,000	$0
8	ARRA HITECH INCENTIVE PROGRAM	$37,058,000	$36,380,000	$0	$678,000
9	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	$35,910,000	$22,521,700	$13,388,300	$0
10	CHDP CASE MANAGEMENT	$33,962,000	$22,005,000	$11,957,000	$0
11	SMHS COUNTY UR & QA ADMIN	$32,288,000	$31,335,000	$953,000	$0
12	HEALTH ENROLLMENT NAVIGATORS	$54,426,000	$27,213,000	$27,213,000	$0
13	SMH MAA	$49,860,000	$49,860,000	$0	$0
14	POSTAGE & PRINTING	$29,793,000	$14,768,000	$15,025,000	$0
15	MANAGED CARE REGULATIONS - MENTAL HEALTH	$981,000	$696,000	$285,000	$0
16	MANAGED CARE REGULATIONS - MH PARITY	$19,367,000	$16,600,000	$2,767,000	$0
17	PAVE SYSTEM	$10,353,000	$14,829,750	($4,476,750)	$0
18	ACTUARIAL COSTS FOR RATE DEVELOPMENT	$17,190,000	$8,595,000	$8,332,000	$263,000
19	PERFORMANCE OUTCOMES SYSTEM	$4,401,000	$2,263,750	$2,137,250	$0
20	SURS AND MARS SYSTEM REPROCUREMENT	$14,351,000	$16,073,250	($1,722,250)	$0
21	CA HEALTH INFORMATION EXCHANGES ONBOARDING PROGRAM	$42,620,000	$38,358,000	$4,262,000	$0
22	MEDI-CAL RECOVERY CONTRACTS	$6,837,000	$5,127,750	$1,709,250	$0
23	MIS/DSS CONTRACT	$22,943,000	$17,197,100	$5,745,900	$0
24	MITA	$11,326,000	$9,854,660	$1,471,340	$0
25	CCI-ADMINISTRATIVE COSTS	$11,213,000	$5,606,500	$5,606,500	$0
26	PASRR	$10,555,000	$7,916,250	$2,638,750	$0
27	HCBA WAIVER RENEWAL ADMINISTRATIVE COST	$12,316,000	$6,158,000	$6,158,000	$0
28	LITIGATION RELATED SERVICES	$9,980,000	$4,990,000	$4,990,000	$0
29	NEWBORN HEARING SCREENING PROGRAM	$7,580,000	$3,790,000	$3,790,000	$0
30	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$6,139,000	$4,354,250	$1,784,750	$0

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2020-21

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DHCS-OTHER				
31	HIPAA CAPMAN	$8,324,000	$6,157,460	$2,166,540	$0
32	DRUG MEDI-CAL COUNTY UR & QA ADMIN	$3,365,000	$3,365,000	$0	$0
33	PACES	$3,760,000	$3,292,300	$467,700	$0
34	CA-MMIS MEDCOMPASS SOLUTION	$3,037,000	$3,100,000	($63,000)	$0
35	SDMC SYSTEM M&O SUPPORT	$2,325,000	$1,162,500	$1,162,500	$0
37	SSA COSTS FOR HEALTH COVERAGE INFO.	$2,210,000	$1,105,000	$1,105,000	$0
38	FAMILY PACT PROGRAM ADMIN.	$1,207,000	$1,086,300	$120,700	$0
39	LTSS ACTUARIAL STUDY	$547,000	$0	$547,000	$0
40	MMA - DSH ANNUAL INDEPENDENT AUDIT	$800,000	$400,000	$400,000	$0
41	MEDICARE BENEFICIARY IDENTIFIER	$128,000	$111,640	$16,360	$0
42	CALIFORNIA HEALTH INTERVIEW SURVEY	$977,000	$977,000	$0	$0
43	ENCRYPTION OF PHI DATA	$750,000	$375,000	$375,000	$0
44	ELECTRONIC ASSET VERIFICATION PROGRAM	$3,960,000	$1,980,000	$1,980,000	$0
46	T-MSIS	$2,334,000	$2,050,500	$283,500	$0
47	CCT OUTREACH - ADMINISTRATIVE COSTS	$360,000	$360,000	$0	$0
48	MEDI-CAL RX - ADMINISTRATIVE COSTS	$39,230,000	$20,111,000	$19,119,000	$0
66	CMS DEFERRED CLAIMS - OTHER ADMIN	$0	($80,000,000)	$80,000,000	$0
102	COVID-19 EMERGENCY FMAP - OTHER ADMIN	$0	$2,000,000	($2,000,000)	$0
103	RECONCILIATION	($13,942,000)	($4,568,000)	($9,374,000)	$0
	DHCS-OTHER SUBTOTAL	**$1,194,427,000**	**$923,601,780**	**$269,884,220**	**$941,000**
	DHCS-MEDICAL FI				
50	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	$46,503,000	$34,877,250	$11,625,750	$0
51	MEDICAL FI BO & IT CHANGE ORDERS	$24,668,000	$14,081,000	$10,587,000	$0
52	MEDICAL FI BO & IT COST REIMBURSEMENT	$38,460,000	$26,743,950	$11,716,050	$0
53	MEDICAL FI IT INFRASTRUCTURE SERVICES	$30,627,000	$21,928,500	$8,698,500	$0
56	MEDICAL FI BO OTHER ESTIMATED COSTS	$21,744,000	$15,354,000	$6,390,000	$0
57	MEDICAL FI BO TELEPHONE SERVICE CENTER	$16,322,000	$11,584,500	$4,737,500	$0
58	MEDICAL FI BUSINESS OPERATIONS	$13,737,000	$9,557,000	$4,180,000	$0

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2020-21

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DHCS-MEDICAL FI				
60	MEDICAL FI BO HOURLY REIMBURSEMENT	$11,407,000	$8,555,250	$2,851,750	$0
64	MEDICAL FI BO MISCELLANEOUS EXPENSES	$2,468,000	$1,699,500	$768,500	$0
	DHCS-MEDICAL FI SUBTOTAL	**$205,936,000**	**$144,380,950**	**$61,555,050**	**$0**
	DHCS-HEALTH CARE OPT				
67	HCO OPERATIONS 2017 CONTRACT	$40,500,000	$20,611,940	$19,888,060	$0
68	HCO COST REIMBURSEMENT 2017 CONTRACT	$20,646,000	$10,507,470	$10,138,530	$0
69	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	$14,171,000	$7,212,200	$6,958,800	$0
	DHCS-HEALTH CARE OPT SUBTOTAL	**$75,317,000**	**$38,331,620**	**$36,985,380**	**$0**
	DHCS-DENTAL FI				
70	DENTAL ASO ADMINISTRATION 2016 CONTRACT	$46,692,000	$28,303,250	$18,388,750	$0
71	DENTAL FI ADMINISTRATION 2016 CONTRACT	$21,744,000	$15,582,500	$6,161,500	$0
	DHCS-DENTAL FI SUBTOTAL	**$68,436,000**	**$43,885,750**	**$24,550,250**	**$0**
	OTHER DEPARTMENTS				
75	HEALTH-RELATED ACTIVITIES - CDSS	$341,958,000	$341,958,000	$0	$0
76	PERSONAL CARE SERVICES	$392,044,000	$392,044,000	$0	$0
77	CALHEERS DEVELOPMENT	$131,197,000	$100,159,710	$31,037,290	$0
78	MATERNAL AND CHILD HEALTH	$64,269,000	$64,269,000	$0	$0
79	CDDS ADMINISTRATIVE COSTS	$70,757,000	$70,757,000	$0	$0
80	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	$41,379,000	$41,379,000	$0	$0
81	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$28,236,000	$28,236,000	$0	$0
82	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	$21,435,000	$16,003,000	$0	$5,432,000
83	CLPP CASE MANAGEMENT SERVICES	$4,200,000	$4,200,000	$0	$0
84	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$4,712,000	$4,712,000	$0	$0
85	CALIFORNIA SMOKERS' HELPLINE	$2,400,000	$2,400,000	$0	$0
86	KIT FOR NEW PARENTS	$1,061,000	$1,061,000	$0	$0
87	VITAL RECORDS	$890,000	$882,000	$8,000	$0

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2020-21

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER DEPARTMENTS				
88	VETERANS BENEFITS	$1,100,000	$1,100,000	$0	$0
89	MEDI-CAL INPATIENT SERVICES FOR INMATES	$1,036,000	$1,036,000	$0	$0
90	CHHS AGENCY HIPAA FUNDING	$1,004,000	$1,004,000	$0	$0
91	CDPH I&E PROGRAM AND EVALUATION	$187,000	$187,000	$0	$0
92	MERIT SYSTEM SERVICES FOR COUNTIES	$190,000	$95,000	$95,000	$0
93	PIA EYEWEAR COURIER SERVICE	$941,000	$470,500	$470,500	$0
	OTHER DEPARTMENTS SUBTOTAL	**$1,108,996,000**	**$1,071,953,210**	**$31,610,790**	**$5,432,000**
	GRAND TOTAL	**$2,653,112,000**	**$2,222,153,300**	**$424,585,700**	**$6,373,000**

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2019-20

NOV.	MAY		2019-20 APPROPRIATION		NOV. 2019 EST. FOR 2019-20		MAY 2020 EST. FOR 2019-20		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
NO.	NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DHCS-OTHER										
1	1	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	$179,674,000	$271,000	$176,538,000	($2,241,000)	$135,713,000	($2,241,000)	($43,961,000)	($2,512,000)	($40,825,000)	$0
2	2	CCS CASE MANAGEMENT	$174,497,000	$57,660,840	$174,158,000	$58,454,450	$174,215,000	$58,527,860	($282,000)	$867,020	$57,000	$73,410
3	3	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$144,676,000	$0	$129,399,000	$0	$168,275,000	$0	$23,599,000	$0	$38,876,000	$0
4	4	MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS	$33,353,000	$0	$119,816,000	$0	$8,442,000	$0	($24,911,000)	$0	($111,374,000)	$0
5	5	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	$112,971,000	$500,000	$114,135,000	$500,000	$109,924,000	$500,000	($3,047,000)	$0	($4,211,000)	$0
6	6	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$3,180,000	$0	$43,204,000	$0	$42,661,000	$0	$39,481,000	$0	($543,000)	$0
7	7	DRUG MEDI-CAL COUNTY ADMINISTRATION	$26,312,000	$960,000	$40,167,000	$1,295,000	$11,197,000	$971,000	($15,115,000)	$11,000	($28,970,000)	($324,000)
8	8	ARRA HITECH INCENTIVE PROGRAM	$27,288,000	$0	$36,989,000	$0	$11,643,000	$0	($15,645,000)	$0	($25,346,000)	$0
9	9	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	$28,433,000	$5,807,230	$35,952,000	$10,382,880	$38,088,000	$10,975,010	$9,655,000	$5,167,780	$2,136,000	$592,120
10	10	CHDP CASE MANAGEMENT	$33,962,000	$11,957,000	$33,962,000	$11,957,000	$33,962,000	$11,957,000	$0	$0	$0	$0
11	11	SMHS COUNTY UR & QA ADMIN	$29,858,000	$983,000	$31,213,000	$943,000	$31,635,000	$953,000	$1,777,000	($30,000)	$422,000	$10,000
12	12	HEALTH ENROLLMENT NAVIGATORS	$0	$0	$29,800,000	$14,900,000	$5,574,000	$2,787,000	$5,574,000	$2,787,000	($24,226,000)	($12,113,000)
13	13	SMH MAA	$29,139,000	$0	$28,261,000	$0	$47,531,000	$0	$18,392,000	$0	$19,270,000	$0
14	14	POSTAGE & PRINTING	$26,640,000	$13,448,500	$27,185,000	$13,721,000	$26,043,000	$13,150,000	($597,000)	($298,500)	($1,142,000)	($571,000)
15	15	MANAGED CARE REGULATIONS - MENTAL HEALTH	$23,005,000	$7,667,000	$21,162,000	$7,054,000	$981,000	$285,000	($22,024,000)	($7,382,000)	($20,181,000)	($6,769,000)
16	16	MANAGED CARE REGULATIONS - MH PARITY	$19,552,000	$2,793,000	$19,344,000	$2,763,000	$19,367,000	$2,767,000	($185,000)	($26,000)	$23,000	$4,000
17	17	PAVE SYSTEM	$19,662,000	($1,153,600)	$16,124,000	$5,610,400	$9,063,000	$4,531,500	($10,599,000)	$5,685,100	($7,061,000)	($1,078,900)
18	18	ACTUARIAL COSTS FOR RATE DEVELOPMENT	$17,055,000	$8,118,500	$17,056,000	$8,119,000	$17,056,000	$8,315,500	$1,000	$197,000	$0	$196,500
19	19	PERFORMANCE OUTCOMES SYSTEM	$15,855,000	$6,789,250	$15,989,000	$7,060,750	$5,715,000	$2,794,250	($10,140,000)	($3,995,000)	($10,274,000)	($4,266,500)
20	20	SURS AND MARS SYSTEM REPROCUREMENT	$10,835,000	$4,230,700	$15,212,000	$4,345,900	$15,212,000	$4,345,900	$4,377,000	$115,200	$0	$0
21	21	CA HEALTH INFORMATION EXCHANGES ONBOARDING PROGRAM	$0	$0	$14,760,000	$1,476,000	$500,000	$50,000	$500,000	$50,000	($14,260,000)	($1,426,000)
22	22	MEDI-CAL RECOVERY CONTRACTS	$9,372,000	$2,343,000	$10,728,000	$2,682,000	$7,159,000	$1,789,750	($2,213,000)	($553,250)	($3,569,000)	($892,250)
23	23	MIS/DSS CONTRACT	$11,507,000	$3,049,500	$12,439,000	$3,282,500	$12,716,000	$3,310,200	$1,209,000	$260,700	$277,000	$27,700
24	24	MITA	$6,084,000	$688,400	$11,256,000	$1,205,600	$5,675,000	$680,660	($409,000)	($7,740)	($5,581,000)	($524,940)
25	25	CCI-ADMINISTRATIVE COSTS	$11,213,000	$5,606,500	$11,213,000	$5,606,500	$11,213,000	$5,606,500	$0	$0	$0	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2019-20

NOV.	MAY		2019-20 APPROPRIATION		NOV. 2019 EST. FOR 2019-20		MAY 2020 EST. FOR 2019-20		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
NO.	NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DHCS-OTHER										
26	26	PASRR	$9,511,000	$2,377,750	$10,570,000	$2,642,500	$8,964,000	$2,241,000	($547,000)	($136,750)	($1,606,000)	($401,500)
27	27	HCBA WAIVER RENEWAL ADMINISTRATIVE COST	$0	$0	$10,515,000	$5,257,500	$9,764,000	$4,882,000	$9,764,000	$4,882,000	($751,000)	($375,500)
28	28	LITIGATION RELATED SERVICES	$9,980,000	$4,990,000	$9,980,000	$4,990,000	$9,980,000	$4,990,000	$0	$0	$0	$0
29	29	NEWBORN HEARING SCREENING PROGRAM	$7,700,000	$3,850,000	$7,580,000	$3,790,000	$7,580,000	$3,790,000	($120,000)	($60,000)	$0	$0
30	30	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$6,006,000	$1,739,000	$5,856,000	$1,678,750	$5,995,000	$1,743,000	($11,000)	$4,000	$139,000	$64,250
31	31	HIPAA CAPMAN	$5,295,000	$1,323,750	$5,820,000	$1,455,000	$5,448,000	$1,362,590	$153,000	$38,840	($372,000)	($92,410)
32	32	DRUG MEDI-CAL COUNTY UR & QA ADMIN	$2,029,000	$0	$4,096,000	$0	$4,096,000	$0	$2,067,000	$0	$0	$0
33	33	PACES	$2,811,000	$364,950	$3,104,000	$385,400	$2,540,000	$289,640	($271,000)	($75,320)	($564,000)	($95,760)
34	34	CA-MMIS MEDCOMPASS SOLUTION	$2,686,000	$390,200	$2,686,000	$390,200	$2,202,000	$1,101,000	($484,000)	$710,800	($484,000)	$710,800
35	35	SDMC SYSTEM M&O SUPPORT	$2,325,000	$1,162,500	$2,325,000	$1,162,500	$2,325,000	$1,162,500	$0	$0	$0	$0
37	37	SSA COSTS FOR HEALTH COVERAGE INFO.	$1,600,000	$800,000	$1,640,000	$820,000	$2,040,000	$1,020,000	$440,000	$220,000	$400,000	$200,000
38	38	FAMILY PACT PROGRAM ADMIN.	$1,207,000	$603,500	$1,207,000	$120,700	$1,207,000	$120,700	$0	($482,800)	$0	$0
39	39	LTSS ACTUARIAL STUDY	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$453,000	$453,000	($547,000)	($547,000)	($547,000)	($547,000)
40	40	MMA - DSH ANNUAL INDEPENDENT AUDIT	$1,034,000	$517,000	$890,000	$445,000	$488,000	$244,000	($546,000)	($273,000)	($402,000)	($201,000)
41	41	MEDICARE BENEFICIARY IDENTIFIER	$828,000	$82,800	$828,000	$82,800	$828,000	$94,180	$0	$11,380	$0	$11,380
42	42	CALIFORNIA HEALTH INTERVIEW SURVEY	$1,100,000	$0	$810,000	$0	$933,000	$0	($167,000)	$0	$123,000	$0
43	43	ENCRYPTION OF PHI DATA	$750,000	$375,000	$750,000	$375,000	$750,000	$375,000	$0	$0	$0	$0
44	44	ELECTRONIC ASSET VERIFICATION PROGRAM	$2,162,000	$1,081,000	$659,000	$329,500	$659,000	$329,500	($1,503,000)	($751,500)	$0	$0
46	46	T-MSIS	$260,000	$65,000	$311,000	$77,750	$311,000	$77,750	$51,000	$12,750	$0	$0
47	47	CCT OUTREACH - ADMINISTRATIVE COSTS	$0	$0	$290,000	$0	$290,000	$0	$290,000	$0	$0	$0
66	66	CMS DEFERRED CLAIMS - OTHER ADMIN	$0	$0	$0	$142,771,000	$0	$223,428,000	$0	$223,428,000	$0	$80,657,000
--	102	COVID-19 EMERGENCY FMAP - OTHER ADMIN	$0	$0	$0	$0	$0	($1,000,000)	$0	($1,000,000)	$0	($1,000,000)
--	--	VENDOR FOR AAC RATE STUDY	$332,000	$166,000	$0	$0	$0	$0	($332,000)	($166,000)	$0	$0
--	--	PROP 56 LOAN REPAYMENT ADMIN CONTRACT	$1,100,000	$0	$0	$0	$0	$0	($1,100,000)	$0	$0	$0
		DHCS-OTHER SUBTOTAL	**$1,053,839,000**	**$152,608,270**	**$1,256,979,000**	**$326,891,580**	**$1,016,413,000**	**$378,760,000**	**($37,426,000)**	**$226,151,720**	**($240,566,000)**	**$51,868,410**

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2019-20

NOV.	MAY		2019-20 APPROPRIATION		NOV. 2019 EST. FOR 2019-20		MAY 2020 EST. FOR 2019-20		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
NO.	NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DHCS-MEDICAL FI										
49	49	MEDICAL FI OPERATIONS	$37,923,000	$12,147,750	$38,065,000	$12,197,500	$32,340,000	$9,881,750	($5,583,000)	($2,266,000)	($5,725,000)	($2,315,750)
50	50	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	$21,615,000	$5,403,750	$24,801,000	$6,200,250	$24,801,000	$6,200,250	$3,186,000	$796,500	$0	$0
51	51	MEDICAL FI BO & IT CHANGE ORDERS	$16,608,000	$4,152,000	$24,195,000	$6,048,750	$25,128,000	$6,482,750	$8,520,000	$2,330,750	$933,000	$434,000
52	52	MEDICAL FI BO & IT COST REIMBURSEMENT	$15,137,000	$3,830,850	$22,351,000	$6,647,700	$22,351,000	$6,647,700	$7,214,000	$2,816,850	$0	$0
53	53	MEDICAL FI IT INFRASTRUCTURE SERVICES	$15,593,000	$3,898,250	$18,192,000	$4,548,000	$17,763,000	$5,046,750	$2,170,000	$1,148,500	($429,000)	$498,750
54	54	MEDICAL FI HOURLY REIMBURSEMENT	$13,773,000	$2,993,250	$41,221,000	$10,697,250	$43,605,000	$10,986,850	$29,832,000	$7,993,600	$2,384,000	$289,600
55	55	MEDICAL FI COST REIMBURSEMENT	$18,211,000	$4,989,550	$11,213,000	$3,374,100	$28,096,000	$7,865,050	$9,885,000	$2,875,500	$16,883,000	$4,490,950
56	56	MEDICAL FI BO OTHER ESTIMATED COSTS	$10,890,000	$3,174,250	$10,890,000	$3,174,250	$10,873,000	$3,195,500	($17,000)	$21,250	($17,000)	$21,250
57	57	MEDICAL FI BO TELEPHONE SERVICE CENTER	$8,161,000	$2,368,750	$8,161,000	$2,368,750	$8,161,000	$2,368,750	$0	$0	$0	$0
58	58	MEDICAL FI BUSINESS OPERATIONS	$7,132,000	$1,783,000	$7,132,000	$1,783,000	$6,868,000	$2,089,750	($264,000)	$306,750	($264,000)	$306,750
59	59	MEDICAL FI OTHER ESTIMATED COSTS	$5,890,000	$1,785,000	$5,890,000	$1,785,000	$5,951,000	$1,712,250	$61,000	($72,750)	$61,000	($72,750)
60	60	MEDICAL FI BO HOURLY REIMBURSEMENT	$5,364,000	$1,341,000	$5,364,000	$1,341,000	$5,364,000	$1,341,000	$0	$0	$0	$0
61	61	MEDICAL FI SRP RELEASE 1 HOSTING	$4,225,000	$614,100	$4,225,000	$614,100	$3,162,000	$459,600	($1,063,000)	($154,500)	($1,063,000)	($154,500)
62	62	MEDICAL FI OPTIONAL CONTRACTUAL SERVICES	$0	$0	$1,679,000	$167,900	$373,000	$37,300	$373,000	$37,300	($1,306,000)	($130,600)
63	63	MEDICAL FI MISCELLANEOUS EXPENSES	$1,467,000	$462,750	$1,325,000	$420,750	$1,349,000	$423,750	($118,000)	($39,000)	$24,000	$3,000
64	64	MEDICAL FI BO MISCELLANEOUS EXPENSES	$4,791,000	$1,275,000	$1,250,000	$383,250	$1,037,000	$322,250	($3,754,000)	($952,750)	($213,000)	($61,000)
65	65	MEDICAL FI CHANGE ORDERS	$243,000	$60,750	$146,000	$36,500	$246,000	$61,500	$3,000	$750	$100,000	$25,000
--	97	CMS DEFERRED CLAIMS - FI	$0	$0	$0	$0	$0	$2,235,000	$0	$2,235,000	$0	$2,235,000
		DHCS-MEDICAL FI SUBTOTAL	**$187,023,000**	**$50,280,000**	**$226,100,000**	**$61,788,050**	**$237,468,000**	**$67,357,750**	**$50,445,000**	**$17,077,750**	**$11,368,000**	**$5,569,700**
		DHCS-HEALTH CARE OPT										
67	67	HCO OPERATIONS 2017 CONTRACT	$40,873,000	$19,836,340	$40,872,000	$19,835,580	$40,872,000	$19,835,580	($1,000)	($760)	$0	$0
68	68	HCO COST REIMBURSEMENT 2017 CONTRACT	$40,619,000	$19,712,860	$20,646,000	$10,019,850	$20,646,000	$10,019,850	($19,973,000)	($9,693,020)	$0	$0
69	69	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	$13,259,000	$6,434,720	$13,716,000	$6,656,430	$13,716,000	$6,656,430	$457,000	$221,720	$0	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2019-20

NOV.	MAY		2019-20 APPROPRIATION		NOV. 2019 EST. FOR 2019-20		MAY 2020 EST. FOR 2019-20		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
NO.	NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DHCS-HEALTH CARE OPT SUBTOTAL	**$94,751,000**	**$45,983,920**	**$75,234,000**	**$36,511,860**	**$75,234,000**	**$36,511,860**	**($19,517,000)**	**($9,472,060)**	**$0**	**$0**
		DHCS-DENTAL FI										
70	70	DENTAL ASO ADMINISTRATION 2016 CONTRACT	$48,932,000	$17,221,750	$45,950,000	$16,906,000	$37,920,000	$13,357,000	($11,012,000)	($3,864,750)	($8,030,000)	($3,549,000)
71	71	DENTAL FI ADMINISTRATION 2016 CONTRACT	$22,729,000	$6,242,000	$21,456,000	$6,125,250	$18,457,000	$5,266,250	($4,272,000)	($975,750)	($2,999,000)	($859,000)
72	72	DENTAL FI TAKEOVER 2016 CONTRACT	$0	$0	$7,808,000	$1,952,000	$7,797,000	$1,949,250	$7,797,000	$1,949,250	($11,000)	($2,750)
73	73	DENTAL FI CD-MMIS COSTS	$0	$0	$2,738,000	$715,250	$256,000	$94,750	$256,000	$94,750	($2,482,000)	($620,500)
74	74	DENTAL ASO TAKEOVER 2016 CONTRACT	$0	$0	$940,000	$235,000	$940,000	$235,000	$940,000	$235,000	$0	$0
--	--	DENTAL BENEFICIARY OUTREACH & ED PROGRAM - ADMIN	$900,000	$450,000	$0	$0	$0	$0	($900,000)	($450,000)	$0	$0
		DHCS-DENTAL FI SUBTOTAL	**$72,561,000**	**$23,913,750**	**$78,892,000**	**$25,933,500**	**$65,370,000**	**$20,902,250**	**($7,191,000)**	**($3,011,500)**	**($13,522,000)**	**($5,031,250)**
		OTHER DEPARTMENTS										
75	75	HEALTH-RELATED ACTIVITIES - CDSS	$470,244,000	$0	$289,481,000	$0	$281,138,000	$0	($189,106,000)	$0	($8,343,000)	$0
76	76	PERSONAL CARE SERVICES	$374,260,000	$0	$389,761,000	$0	$382,761,000	$0	$8,501,000	$0	($7,000,000)	$0
77	77	CALHEERS DEVELOPMENT	$127,288,000	$27,884,460	$144,027,000	$31,971,000	$143,594,000	$31,867,880	$16,306,000	$3,983,420	($433,000)	($103,110)
78	78	MATERNAL AND CHILD HEALTH	$55,802,000	$0	$66,536,000	$0	$66,536,000	$0	$10,734,000	$0	$0	$0
79	79	CDDS ADMINISTRATIVE COSTS	$60,577,000	$0	$90,840,000	$0	$86,240,000	$0	$25,663,000	$0	($4,600,000)	$0
80	80	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	$41,379,000	$0	$41,379,000	$0	$41,379,000	$0	$0	$0	$0	$0
81	81	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$23,162,000	$0	$25,399,000	$0	$26,381,000	$0	$3,219,000	$0	$982,000	$0
82	82	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	$17,146,000	$0	$18,534,000	$0	$18,314,000	$0	$1,168,000	$0	($220,000)	$0
83	83	CLPP CASE MANAGEMENT SERVICES	$4,200,000	$0	$8,507,000	$0	$8,507,000	$0	$4,307,000	$0	$0	$0
84	84	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$6,542,000	$0	$4,542,000	$0	$4,454,000	$0	($2,088,000)	$0	($88,000)	$0
85	85	CALIFORNIA SMOKERS' HELPLINE	$2,400,000	$0	$3,000,000	$0	$3,000,000	$0	$600,000	$0	$0	$0
86	86	KIT FOR NEW PARENTS	$1,223,000	$0	$1,223,000	$0	$1,061,000	$0	($162,000)	$0	($162,000)	$0
87	87	VITAL RECORDS	$677,000	$11,000	$1,138,000	$8,000	$1,147,000	$6,000	$470,000	($5,000)	$9,000	($2,000)
88	88	VETERANS BENEFITS	$1,100,000	$0	$1,100,000	$0	$1,100,000	$0	$0	$0	$0	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2019-20

NOV.	MAY		2019-20 APPROPRIATION		NOV. 2019 EST. FOR 2019-20		MAY 2020 EST. FOR 2019-20		DIFF. MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
NO.	NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER DEPARTMENTS										
89	89	MEDI-CAL INPATIENT SERVICES FOR INMATES	$983,000	$0	$996,000	$0	$996,000	$0	$13,000	$0	$0	$0
90	90	CHHS AGENCY HIPAA FUNDING	$849,000	$0	$849,000	$0	$849,000	$0	$0	$0	$0	$0
91	91	CDPH I&E PROGRAM AND EVALUATION	$558,000	$0	$693,000	$0	$693,000	$0	$135,000	$0	$0	$0
92	92	MERIT SYSTEM SERVICES FOR COUNTIES	$190,000	$95,000	$190,000	$95,000	$190,000	$95,000	$0	$0	$0	$0
93	93	PIA EYEWEAR COURIER SERVICE	$394,000	$197,000	$667,000	$333,500	$490,000	$245,000	$96,000	$48,000	($177,000)	($88,500)
		OTHER DEPARTMENTS SUBTOTAL	**$1,188,974,000**	**$28,187,460**	**$1,088,862,000**	**$32,407,500**	**$1,068,830,000**	**$32,213,880**	**($120,144,000)**	**$4,026,420**	**($20,032,000)**	**($193,610)**
		OTHER ADMINISTRATION TOTAL	**$2,597,148,000**	**$300,973,400**	**$2,726,067,000**	**$483,532,480**	**$2,463,315,000**	**$535,745,740**	**($133,833,000)**	**$234,772,340**	**($262,752,000)**	**$52,213,250**
		GRAND TOTAL COUNTY AND OTHER ADMINISTRATION	**$4,971,350,000**	**$1,020,069,150**	**$5,087,869,000**	**$1,076,727,240**	**$4,835,764,000**	**$1,110,629,480**	**($135,586,000)**	**$90,560,340**	**($252,105,000)**	**$33,902,250**

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2020-21

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2019 EST. FOR 2020-21		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DHCS-OTHER						
1	1	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	$143,020,000	$0	$141,765,000	$0	($1,255,000)	$0
2	2	CCS CASE MANAGEMENT	$173,361,000	$58,959,430	$172,410,000	$58,668,880	($951,000)	($290,550)
3	3	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$130,901,000	$0	$170,067,000	$0	$39,166,000	$0
5	5	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	$123,578,000	$0	$113,838,000	$0	($9,740,000)	$0
--	6	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$0	$0	$32,100,000	$0	$32,100,000	$0
7	7	DRUG MEDI-CAL COUNTY ADMINISTRATION	$26,441,000	$1,114,000	$23,426,000	$894,000	($3,015,000)	($220,000)
8	8	ARRA HITECH INCENTIVE PROGRAM	$16,993,000	$0	$37,058,000	$0	$20,065,000	$0
9	9	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	$33,800,000	$12,621,740	$35,910,000	$13,388,300	$2,110,000	$766,560
10	10	CHDP CASE MANAGEMENT	$33,962,000	$11,957,000	$33,962,000	$11,957,000	$0	$0
11	11	SMHS COUNTY UR & QA ADMIN	$31,843,000	$943,000	$32,288,000	$953,000	$445,000	$10,000
12	12	HEALTH ENROLLMENT NAVIGATORS	$29,800,000	$14,900,000	$54,426,000	$27,213,000	$24,626,000	$12,313,000
13	13	SMH MAA	$30,335,000	$0	$49,860,000	$0	$19,525,000	$0
14	14	POSTAGE & PRINTING	$26,935,000	$13,596,000	$29,793,000	$15,025,000	$2,858,000	$1,429,000
15	15	MANAGED CARE REGULATIONS - MENTAL HEALTH	$21,162,000	$7,054,000	$981,000	$285,000	($20,181,000)	($6,769,000)
16	16	MANAGED CARE REGULATIONS - MH PARITY	$19,344,000	$2,763,000	$19,367,000	$2,767,000	$23,000	$4,000
17	17	PAVE SYSTEM	$10,625,000	($4,431,750)	$10,353,000	($4,476,750)	($272,000)	($45,000)
18	18	ACTUARIAL COSTS FOR RATE DEVELOPMENT	$17,056,000	$8,119,000	$17,190,000	$8,332,000	$134,000	$213,000
19	19	PERFORMANCE OUTCOMES SYSTEM	$15,516,000	$6,675,500	$4,401,000	$2,137,250	($11,115,000)	($4,538,250)
20	20	SURS AND MARS SYSTEM REPROCUREMENT	$8,227,000	($2,166,250)	$14,351,000	($1,722,250)	$6,124,000	$444,000
21	21	CA HEALTH INFORMATION EXCHANGES ONBOARDING PROGRAM	$35,240,000	$3,524,000	$42,620,000	$4,262,000	$7,380,000	$738,000
22	22	MEDI-CAL RECOVERY CONTRACTS	$19,568,000	$4,892,000	$6,837,000	$1,709,250	($12,731,000)	($3,182,750)

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2020-21

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2019 EST. FOR 2020-21		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DHCS-OTHER						
23	23	MIS/DSS CONTRACT	$12,388,000	$3,244,550	$22,943,000	$5,745,900	$10,555,000	$2,501,350
24	24	MITA	$13,389,000	$1,418,900	$11,326,000	$1,471,340	($2,063,000)	$52,440
25	25	CCI-ADMINISTRATIVE COSTS	$11,213,000	$5,606,500	$11,213,000	$5,606,500	$0	$0
26	26	PASRR	$10,296,000	$2,574,000	$10,555,000	$2,638,750	$259,000	$64,750
27	27	HCBA WAIVER RENEWAL ADMINISTRATIVE COST	$12,582,000	$6,291,000	$12,316,000	$6,158,000	($266,000)	($133,000)
28	28	LITIGATION RELATED SERVICES	$9,980,000	$4,990,000	$9,980,000	$4,990,000	$0	$0
29	29	NEWBORN HEARING SCREENING PROGRAM	$7,580,000	$3,790,000	$7,580,000	$3,790,000	$0	$0
30	30	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$6,008,000	$1,722,250	$6,139,000	$1,784,750	$131,000	$62,500
31	31	HIPAA CAPMAN	$5,430,000	$1,357,500	$8,324,000	$2,166,540	$2,894,000	$809,040
32	32	DRUG MEDI-CAL COUNTY UR & QA ADMIN	$3,011,000	$0	$3,365,000	$0	$354,000	$0
33	33	PACES	$2,878,000	$362,800	$3,760,000	$467,700	$882,000	$104,900
34	34	CA-MMIS MEDCOMPASS SOLUTION	$2,411,000	$350,100	$3,037,000	($63,000)	$626,000	($413,100)
35	35	SDMC SYSTEM M&O SUPPORT	$2,325,000	$1,162,500	$2,325,000	$1,162,500	$0	$0
37	37	SSA COSTS FOR HEALTH COVERAGE INFO.	$1,640,000	$820,000	$2,210,000	$1,105,000	$570,000	$285,000
38	38	FAMILY PACT PROGRAM ADMIN.	$1,207,000	$120,700	$1,207,000	$120,700	$0	$0
--	39	LTSS ACTUARIAL STUDY	$0	$0	$547,000	$547,000	$547,000	$547,000
40	40	MMA - DSH ANNUAL INDEPENDENT AUDIT	$800,000	$400,000	$800,000	$400,000	$0	$0
41	41	MEDICARE BENEFICIARY IDENTIFIER	$128,000	$12,800	$128,000	$16,360	$0	$3,560
42	42	CALIFORNIA HEALTH INTERVIEW SURVEY	$1,100,000	$0	$977,000	$0	($123,000)	$0
43	43	ENCRYPTION OF PHI DATA	$750,000	$375,000	$750,000	$375,000	$0	$0
44	44	ELECTRONIC ASSET VERIFICATION PROGRAM	$3,960,000	$1,980,000	$3,960,000	$1,980,000	$0	$0
46	46	T-MSIS	$2,834,000	$333,500	$2,334,000	$283,500	($500,000)	($50,000)
--	47	CCT OUTREACH - ADMINISTRATIVE COSTS	$0	$0	$360,000	$0	$360,000	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2020-21

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2019 EST. FOR 2020-21		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DHCS-OTHER						
48	48	MEDI-CAL RX - ADMINISTRATIVE COSTS	$39,230,000	$19,119,000	$39,230,000	$19,119,000	$0	$0
--	66	CMS DEFERRED CLAIMS - OTHER ADMIN	$0	$0	$0	$80,000,000	$0	$80,000,000
--	102	COVID-19 EMERGENCY FMAP - OTHER ADMIN	$0	$0	$0	($2,000,000)	$0	($2,000,000)
--	103	RECONCILIATION	$0	$0	($13,942,000)	($9,374,000)	($13,942,000)	($9,374,000)
		DHCS-OTHER SUBTOTAL	**$1,098,847,000**	**$196,551,770**	**$1,194,427,000**	**$269,884,220**	**$95,580,000**	**$73,332,450**
		DHCS-MEDICAL FI						
50	50	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	$41,858,000	$10,464,500	$46,503,000	$11,625,750	$4,645,000	$1,161,250
51	51	MEDICAL FI BO & IT CHANGE ORDERS	$24,196,000	$6,049,000	$24,668,000	$10,587,000	$472,000	$4,538,000
52	52	MEDICAL FI BO & IT COST REIMBURSEMENT	$38,460,000	$11,716,050	$38,460,000	$11,716,050	$0	$0
53	53	MEDICAL FI IT INFRASTRUCTURE SERVICES	$31,363,000	$7,840,750	$30,627,000	$8,698,500	($736,000)	$857,750
56	56	MEDICAL FI BO OTHER ESTIMATED COSTS	$21,780,000	$6,348,250	$21,744,000	$6,390,000	($36,000)	$41,750
57	57	MEDICAL FI BO TELEPHONE SERVICE CENTER	$16,322,000	$4,737,500	$16,322,000	$4,737,500	$0	$0
58	58	MEDICAL FI BUSINESS OPERATIONS	$14,265,000	$3,567,000	$13,737,000	$4,180,000	($528,000)	$613,000
60	60	MEDICAL FI BO HOURLY REIMBURSEMENT	$10,728,000	$2,682,000	$11,407,000	$2,851,750	$679,000	$169,750
64	64	MEDICAL FI BO MISCELLANEOUS EXPENSES	$2,505,000	$767,750	$2,468,000	$768,500	($37,000)	$750
		DHCS-MEDICAL FI SUBTOTAL	**$201,477,000**	**$54,172,800**	**$205,936,000**	**$61,555,050**	**$4,459,000**	**$7,382,250**
		DHCS-HEALTH CARE OPT						
67	67	HCO OPERATIONS 2017 CONTRACT	$40,500,000	$19,888,060	$40,500,000	$19,888,060	$0	$0
68	68	HCO COST REIMBURSEMENT 2017 CONTRACT	$20,646,000	$10,138,530	$20,646,000	$10,138,530	$0	$0
69	69	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	$14,171,000	$6,958,800	$14,171,000	$6,958,800	$0	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2020-21

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2019 EST. FOR 2020-21		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DHCS-HEALTH CARE OPT SUBTOTAL	**$75,317,000**	**$36,985,380**	**$75,317,000**	**$36,985,380**	**$0**	**$0**
		DHCS-DENTAL FI						
70	70	DENTAL ASO ADMINISTRATION 2016 CONTRACT	$44,668,000	$16,184,250	$46,692,000	$18,388,750	$2,024,000	$2,204,500
71	71	DENTAL FI ADMINISTRATION 2016 CONTRACT	$21,531,000	$6,110,500	$21,744,000	$6,161,500	$213,000	$51,000
94	--	RESTORATION OF DENTAL FFS IN SAC AND LA CO ADMIN	$1,827,000	$607,750	$0	$0	($1,827,000)	($607,750)
		DHCS-DENTAL FI SUBTOTAL	**$68,026,000**	**$22,902,500**	**$68,436,000**	**$24,550,250**	**$410,000**	**$1,647,750**
		OTHER DEPARTMENTS						
75	75	HEALTH-RELATED ACTIVITIES - CDSS	$290,737,000	$0	$341,958,000	$0	$51,221,000	$0
76	76	PERSONAL CARE SERVICES	$389,951,000	$0	$392,044,000	$0	$2,093,000	$0
77	77	CALHEERS DEVELOPMENT	$126,784,000	$29,767,620	$131,197,000	$31,037,290	$4,413,000	$1,269,670
78	78	MATERNAL AND CHILD HEALTH	$64,269,000	$0	$64,269,000	$0	$0	$0
79	79	CDDS ADMINISTRATIVE COSTS	$78,114,000	$0	$70,757,000	$0	($7,357,000)	$0
80	80	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	$41,379,000	$0	$41,379,000	$0	$0	$0
81	81	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$28,236,000	$0	$28,236,000	$0	$0	$0
82	82	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	$18,071,000	$0	$21,435,000	$0	$3,364,000	$0
83	83	CLPP CASE MANAGEMENT SERVICES	$4,200,000	$0	$4,200,000	$0	$0	$0
84	84	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$4,712,000	$0	$4,712,000	$0	$0	$0
85	85	CALIFORNIA SMOKERS' HELPLINE	$2,400,000	$0	$2,400,000	$0	$0	$0
86	86	KIT FOR NEW PARENTS	$1,223,000	$0	$1,061,000	$0	($162,000)	$0
87	87	VITAL RECORDS	$891,000	$9,000	$890,000	$8,000	($1,000)	($1,000)
88	88	VETERANS BENEFITS	$1,100,000	$0	$1,100,000	$0	$0	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2020 ESTIMATE COMPARED TO NOVEMBER 2019 ESTIMATE
FISCAL YEAR 2020-21

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2019 EST. FOR 2020-21		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER DEPARTMENTS						
89	89	MEDI-CAL INPATIENT SERVICES FOR INMATES	$1,036,000	$0	$1,036,000	$0	$0	$0
90	90	CHHS AGENCY HIPAA FUNDING	$896,000	$0	$1,004,000	$0	$108,000	$0
91	91	CDPH I&E PROGRAM AND EVALUATION	$187,000	$0	$187,000	$0	$0	$0
92	92	MERIT SYSTEM SERVICES FOR COUNTIES	$190,000	$95,000	$190,000	$95,000	$0	$0
93	93	PIA EYEWEAR COURIER SERVICE	$941,000	$470,500	$941,000	$470,500	$0	$0
		OTHER DEPARTMENTS SUBTOTAL	**$1,055,317,000**	**$30,342,120**	**$1,108,996,000**	**$31,610,790**	**$53,679,000**	**$1,268,670**
		OTHER ADMINISTRATION TOTAL	**$2,498,984,000**	**$340,954,580**	**$2,653,112,000**	**$424,585,700**	**$154,128,000**	**$83,631,120**
		GRAND TOTAL COUNTY AND OTHER ADMINISTRATION	**$4,913,275,000**	**$980,541,320**	**$5,067,170,000**	**$1,032,712,200**	**$153,895,000**	**$52,170,870**

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2019-20 AND 2020-21

		MAY 2020 EST. FOR 2019-20		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DHCS-OTHER						
1	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	$135,713,000	($2,241,000)	$141,765,000	$0	$6,052,000	$2,241,000
2	CCS CASE MANAGEMENT	$174,215,000	$58,527,860	$172,410,000	$58,668,880	($1,805,000)	$141,020
3	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$168,275,000	$0	$170,067,000	$0	$1,792,000	$0
4	MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS	$8,442,000	$0	$0	$0	($8,442,000)	$0
5	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	$109,924,000	$500,000	$113,838,000	$0	$3,914,000	($500,000)
6	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$42,661,000	$0	$32,100,000	$0	($10,561,000)	$0
7	DRUG MEDI-CAL COUNTY ADMINISTRATION	$11,197,000	$971,000	$23,426,000	$894,000	$12,229,000	($77,000)
8	ARRA HITECH INCENTIVE PROGRAM	$11,643,000	$0	$37,058,000	$0	$25,415,000	$0
9	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	$38,088,000	$10,975,010	$35,910,000	$13,388,300	($2,178,000)	$2,413,280
10	CHDP CASE MANAGEMENT	$33,962,000	$11,957,000	$33,962,000	$11,957,000	$0	$0
11	SMHS COUNTY UR & QA ADMIN	$31,635,000	$953,000	$32,288,000	$953,000	$653,000	$0
12	HEALTH ENROLLMENT NAVIGATORS	$5,574,000	$2,787,000	$54,426,000	$27,213,000	$48,852,000	$24,426,000
13	SMH MAA	$47,531,000	$0	$49,860,000	$0	$2,329,000	$0
14	POSTAGE & PRINTING	$26,043,000	$13,150,000	$29,793,000	$15,025,000	$3,750,000	$1,875,000
15	MANAGED CARE REGULATIONS - MENTAL HEALTH	$981,000	$285,000	$981,000	$285,000	$0	$0
16	MANAGED CARE REGULATIONS - MH PARITY	$19,367,000	$2,767,000	$19,367,000	$2,767,000	$0	$0
17	PAVE SYSTEM	$9,063,000	$4,531,500	$10,353,000	($4,476,750)	$1,290,000	($9,008,250)
18	ACTUARIAL COSTS FOR RATE DEVELOPMENT	$17,056,000	$8,315,500	$17,190,000	$8,332,000	$134,000	$16,500
19	PERFORMANCE OUTCOMES SYSTEM	$5,715,000	$2,794,250	$4,401,000	$2,137,250	($1,314,000)	($657,000)
20	SURS AND MARS SYSTEM REPROCUREMENT	$15,212,000	$4,345,900	$14,351,000	($1,722,250)	($861,000)	($6,068,150)
21	CA HEALTH INFORMATION EXCHANGES ONBOARDING PROGRAM	$500,000	$50,000	$42,620,000	$4,262,000	$42,120,000	$4,212,000
22	MEDI-CAL RECOVERY CONTRACTS	$7,159,000	$1,789,750	$6,837,000	$1,709,250	($322,000)	($80,500)

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2019-20 AND 2020-21

		MAY 2020 EST. FOR 2019-20		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DHCS-OTHER						
23	MIS/DSS CONTRACT	$12,716,000	$3,310,200	$22,943,000	$5,745,900	$10,227,000	$2,435,700
24	MITA	$5,675,000	$680,660	$11,326,000	$1,471,340	$5,651,000	$790,680
25	CCI-ADMINISTRATIVE COSTS	$11,213,000	$5,606,500	$11,213,000	$5,606,500	$0	$0
26	PASRR	$8,964,000	$2,241,000	$10,555,000	$2,638,750	$1,591,000	$397,750
27	HCBA WAIVER RENEWAL ADMINISTRATIVE COST	$9,764,000	$4,882,000	$12,316,000	$6,158,000	$2,552,000	$1,276,000
28	LITIGATION RELATED SERVICES	$9,980,000	$4,990,000	$9,980,000	$4,990,000	$0	$0
29	NEWBORN HEARING SCREENING PROGRAM	$7,580,000	$3,790,000	$7,580,000	$3,790,000	$0	$0
30	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$5,995,000	$1,743,000	$6,139,000	$1,784,750	$144,000	$41,750
31	HIPAA CAPMAN	$5,448,000	$1,362,590	$8,324,000	$2,166,540	$2,876,000	$803,950
32	DRUG MEDI-CAL COUNTY UR & QA ADMIN	$4,096,000	$0	$3,365,000	$0	($731,000)	$0
33	PACES	$2,540,000	$289,640	$3,760,000	$467,700	$1,220,000	$178,070
34	CA-MMIS MEDCOMPASS SOLUTION	$2,202,000	$1,101,000	$3,037,000	($63,000)	$835,000	($1,164,000)
35	SDMC SYSTEM M&O SUPPORT	$2,325,000	$1,162,500	$2,325,000	$1,162,500	$0	$0
37	SSA COSTS FOR HEALTH COVERAGE INFO.	$2,040,000	$1,020,000	$2,210,000	$1,105,000	$170,000	$85,000
38	FAMILY PACT PROGRAM ADMIN.	$1,207,000	$120,700	$1,207,000	$120,700	$0	$0
39	LTSS ACTUARIAL STUDY	$453,000	$453,000	$547,000	$547,000	$94,000	$94,000
40	MMA - DSH ANNUAL INDEPENDENT AUDIT	$488,000	$244,000	$800,000	$400,000	$312,000	$156,000
41	MEDICARE BENEFICIARY IDENTIFIER	$828,000	$94,180	$128,000	$16,360	($700,000)	($77,830)
42	CALIFORNIA HEALTH INTERVIEW SURVEY	$933,000	$0	$977,000	$0	$44,000	$0
43	ENCRYPTION OF PHI DATA	$750,000	$375,000	$750,000	$375,000	$0	$0
44	ELECTRONIC ASSET VERIFICATION PROGRAM	$659,000	$329,500	$3,960,000	$1,980,000	$3,301,000	$1,650,500
46	T-MSIS	$311,000	$77,750	$2,334,000	$283,500	$2,023,000	$205,750
47	CCT OUTREACH - ADMINISTRATIVE COSTS	$290,000	$0	$360,000	$0	$70,000	$0
48	MEDI-CAL RX - ADMINISTRATIVE COSTS	$0	$0	$39,230,000	$19,119,000	$39,230,000	$19,119,000
66	CMS DEFERRED CLAIMS - OTHER ADMIN	$0	$223,428,000	$0	$80,000,000	$0	($143,428,000)
102	COVID-19 EMERGENCY FMAP - OTHER ADMIN	$0	($1,000,000)	$0	($2,000,000)	$0	($1,000,000)

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2019-20 AND 2020-21

		MAY 2020 EST. FOR 2019-20		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DHCS-OTHER						
103	RECONCILIATION	$0	$0	($13,942,000)	($9,374,000)	($13,942,000)	($9,374,000)
	DHCS-OTHER SUBTOTAL	**$1,016,413,000**	**$378,760,000**	**$1,194,427,000**	**$269,884,220**	**$178,014,000**	**($108,875,780)**
	DHCS-MEDICAL FI						
49	MEDICAL FI OPERATIONS	$32,340,000	$9,881,750	$0	$0	($32,340,000)	($9,881,750)
50	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	$24,801,000	$6,200,250	$46,503,000	$11,625,750	$21,702,000	$5,425,500
51	MEDICAL FI BO & IT CHANGE ORDERS	$25,128,000	$6,482,750	$24,668,000	$10,587,000	($460,000)	$4,104,250
52	MEDICAL FI BO & IT COST REIMBURSEMENT	$22,351,000	$6,647,700	$38,460,000	$11,716,050	$16,109,000	$5,068,350
53	MEDICAL FI IT INFRASTRUCTURE SERVICES	$17,763,000	$5,046,750	$30,627,000	$8,698,500	$12,864,000	$3,651,750
54	MEDICAL FI HOURLY REIMBURSEMENT	$43,605,000	$10,986,850	$0	$0	($43,605,000)	($10,986,850)
55	MEDICAL FI COST REIMBURSEMENT	$28,096,000	$7,865,050	$0	$0	($28,096,000)	($7,865,050)
56	MEDICAL FI BO OTHER ESTIMATED COSTS	$10,873,000	$3,195,500	$21,744,000	$6,390,000	$10,871,000	$3,194,500
57	MEDICAL FI BO TELEPHONE SERVICE CENTER	$8,161,000	$2,368,750	$16,322,000	$4,737,500	$8,161,000	$2,368,750
58	MEDICAL FI BUSINESS OPERATIONS	$6,868,000	$2,089,750	$13,737,000	$4,180,000	$6,869,000	$2,090,250
59	MEDICAL FI OTHER ESTIMATED COSTS	$5,951,000	$1,712,250	$0	$0	($5,951,000)	($1,712,250)
60	MEDICAL FI BO HOURLY REIMBURSEMENT	$5,364,000	$1,341,000	$11,407,000	$2,851,750	$6,043,000	$1,510,750
61	MEDICAL FI SRP RELEASE 1 HOSTING	$3,162,000	$459,600	$0	$0	($3,162,000)	($459,600)
62	MEDICAL FI OPTIONAL CONTRACTUAL SERVICES	$373,000	$37,300	$0	$0	($373,000)	($37,300)
63	MEDICAL FI MISCELLANEOUS EXPENSES	$1,349,000	$423,750	$0	$0	($1,349,000)	($423,750)
64	MEDICAL FI BO MISCELLANEOUS EXPENSES	$1,037,000	$322,250	$2,468,000	$768,500	$1,431,000	$446,250
65	MEDICAL FI CHANGE ORDERS	$246,000	$61,500	$0	$0	($246,000)	($61,500)
97	CMS DEFERRED CLAIMS - FI	$0	$2,235,000	$0	$0	$0	($2,235,000)
	DHCS-MEDICAL FI SUBTOTAL	**$237,468,000**	**$67,357,750**	**$205,936,000**	**$61,555,050**	**($31,532,000)**	**($5,802,700)**

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2019-20 AND 2020-21

		MAY 2020 EST. FOR 2019-20		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	DHCS-HEALTH CARE OPT						
67	HCO OPERATIONS 2017 CONTRACT	$40,872,000	$19,835,580	$40,500,000	$19,888,060	($372,000)	$52,480
68	HCO COST REIMBURSEMENT 2017 CONTRACT	$20,646,000	$10,019,850	$20,646,000	$10,138,530	$0	$118,680
69	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	$13,716,000	$6,656,430	$14,171,000	$6,958,800	$455,000	$302,360
	DHCS-HEALTH CARE OPT SUBTOTAL	**$75,234,000**	**$36,511,860**	**$75,317,000**	**$36,985,380**	**$83,000**	**$473,530**
	DHCS-DENTAL FI						
70	DENTAL ASO ADMINISTRATION 2016 CONTRACT	$37,920,000	$13,357,000	$46,692,000	$18,388,750	$8,772,000	$5,031,750
71	DENTAL FI ADMINISTRATION 2016 CONTRACT	$18,457,000	$5,266,250	$21,744,000	$6,161,500	$3,287,000	$895,250
72	DENTAL FI TAKEOVER 2016 CONTRACT	$7,797,000	$1,949,250	$0	$0	($7,797,000)	($1,949,250)
73	DENTAL FI CD-MMIS COSTS	$256,000	$94,750	$0	$0	($256,000)	($94,750)
74	DENTAL ASO TAKEOVER 2016 CONTRACT	$940,000	$235,000	$0	$0	($940,000)	($235,000)
	DHCS-DENTAL FI SUBTOTAL	**$65,370,000**	**$20,902,250**	**$68,436,000**	**$24,550,250**	**$3,066,000**	**$3,648,000**
	OTHER DEPARTMENTS						
75	HEALTH-RELATED ACTIVITIES - CDSS	$281,138,000	$0	$341,958,000	$0	$60,820,000	$0
76	PERSONAL CARE SERVICES	$382,761,000	$0	$392,044,000	$0	$9,283,000	$0
77	CALHEERS DEVELOPMENT	$143,594,000	$31,867,880	$131,197,000	$31,037,290	($12,397,000)	($830,600)
78	MATERNAL AND CHILD HEALTH	$66,536,000	$0	$64,269,000	$0	($2,267,000)	$0
79	CDDS ADMINISTRATIVE COSTS	$86,240,000	$0	$70,757,000	$0	($15,483,000)	$0
80	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	$41,379,000	$0	$41,379,000	$0	$0	$0
81	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$26,381,000	$0	$28,236,000	$0	$1,855,000	$0
82	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	$18,314,000	$0	$21,435,000	$0	$3,121,000	$0
83	CLPP CASE MANAGEMENT SERVICES	$8,507,000	$0	$4,200,000	$0	($4,307,000)	$0
84	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$4,454,000	$0	$4,712,000	$0	$258,000	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2019-20 AND 2020-21

		MAY 2020 EST. FOR 2019-20		MAY 2020 EST. FOR 2020-21		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER DEPARTMENTS						
85	CALIFORNIA SMOKERS' HELPLINE	$3,000,000	$0	$2,400,000	$0	($600,000)	$0
86	KIT FOR NEW PARENTS	$1,061,000	$0	$1,061,000	$0	$0	$0
87	VITAL RECORDS	$1,147,000	$6,000	$890,000	$8,000	($257,000)	$2,000
88	VETERANS BENEFITS	$1,100,000	$0	$1,100,000	$0	$0	$0
89	MEDI-CAL INPATIENT SERVICES FOR INMATES	$996,000	$0	$1,036,000	$0	$40,000	$0
90	CHHS AGENCY HIPAA FUNDING	$849,000	$0	$1,004,000	$0	$155,000	$0
91	CDPH I&E PROGRAM AND EVALUATION	$693,000	$0	$187,000	$0	($506,000)	$0
92	MERIT SYSTEM SERVICES FOR COUNTIES	$190,000	$95,000	$190,000	$95,000	$0	$0
93	PIA EYEWEAR COURIER SERVICE	$490,000	$245,000	$941,000	$470,500	$451,000	$225,500
	OTHER DEPARTMENTS SUBTOTAL	**$1,068,830,000**	**$32,213,880**	**$1,108,996,000**	**$31,610,790**	**$40,166,000**	**($603,100)**
	OTHER ADMINISTRATION TOTAL	**$2,463,315,000**	**$535,745,740**	**$2,653,112,000**	**$424,585,700**	**$189,797,000**	**($111,160,040)**
	GRAND TOTAL COUNTY AND OTHER ADMINISTRATION	**$4,835,764,000**	**$1,110,629,480**	**$5,067,170,000**	**$1,032,712,200**	**$231,406,000**	**($77,917,290)**

MEDI-CAL OTHER ADMINISTRATION
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	DHCS-OTHER
1	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES
2	CCS CASE MANAGEMENT
3	COUNTY SPECIALTY MENTAL HEALTH ADMIN
4	MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS
5	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES
6	INTERIM AND FINAL COST SETTLEMENTS-SMHS
7	DRUG MEDI-CAL COUNTY ADMINISTRATION
8	ARRA HITECH INCENTIVE PROGRAM
9	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS
10	CHDP CASE MANAGEMENT
11	SMHS COUNTY UR & QA ADMIN
12	HEALTH ENROLLMENT NAVIGATORS
13	SMH MAA
14	POSTAGE & PRINTING
15	MANAGED CARE REGULATIONS - MENTAL HEALTH
16	MANAGED CARE REGULATIONS - MH PARITY
17	PAVE SYSTEM
18	ACTUARIAL COSTS FOR RATE DEVELOPMENT
19	PERFORMANCE OUTCOMES SYSTEM
20	SURS AND MARS SYSTEM REPROCUREMENT
21	CA HEALTH INFORMATION EXCHANGES ONBOARDING PROGRAM
22	MEDI-CAL RECOVERY CONTRACTS
23	MIS/DSS CONTRACT
24	MITA
25	CCI-ADMINISTRATIVE COSTS
26	PASRR
27	HCBA WAIVER RENEWAL ADMINISTRATIVE COST
28	LITIGATION RELATED SERVICES
29	NEWBORN HEARING SCREENING PROGRAM
30	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)
31	HIPAA CAPMAN
32	DRUG MEDI-CAL COUNTY UR & QA ADMIN
33	PACES
34	CA-MMIS MEDCOMPASS SOLUTION
35	SDMC SYSTEM M&O SUPPORT
37	SSA COSTS FOR HEALTH COVERAGE INFO.
38	FAMILY PACT PROGRAM ADMIN.
39	LTSS ACTUARIAL STUDY

MEDI-CAL OTHER ADMINISTRATION
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	DHCS-OTHER
40	MMA - DSH ANNUAL INDEPENDENT AUDIT
41	MEDICARE BENEFICIARY IDENTIFIER
42	CALIFORNIA HEALTH INTERVIEW SURVEY
43	ENCRYPTION OF PHI DATA
44	ELECTRONIC ASSET VERIFICATION PROGRAM
46	T-MSIS
47	CCT OUTREACH - ADMINISTRATIVE COSTS
48	MEDI-CAL RX - ADMINISTRATIVE COSTS
66	CMS DEFERRED CLAIMS - OTHER ADMIN
102	COVID-19 EMERGENCY FMAP - OTHER ADMIN
103	RECONCILIATION
	DHCS-MEDICAL FI
49	MEDICAL FI OPERATIONS
50	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES
51	MEDICAL FI BO & IT CHANGE ORDERS
52	MEDICAL FI BO & IT COST REIMBURSEMENT
53	MEDICAL FI IT INFRASTRUCTURE SERVICES
54	MEDICAL FI HOURLY REIMBURSEMENT
55	MEDICAL FI COST REIMBURSEMENT
56	MEDICAL FI BO OTHER ESTIMATED COSTS
57	MEDICAL FI BO TELEPHONE SERVICE CENTER
58	MEDICAL FI BUSINESS OPERATIONS
59	MEDICAL FI OTHER ESTIMATED COSTS
60	MEDICAL FI BO HOURLY REIMBURSEMENT
61	MEDICAL FI SRP RELEASE 1 HOSTING
62	MEDICAL FI OPTIONAL CONTRACTUAL SERVICES
63	MEDICAL FI MISCELLANEOUS EXPENSES
64	MEDICAL FI BO MISCELLANEOUS EXPENSES
65	MEDICAL FI CHANGE ORDERS
97	CMS DEFERRED CLAIMS - FI
	DHCS-HEALTH CARE OPT
67	HCO OPERATIONS 2017 CONTRACT
68	HCO COST REIMBURSEMENT 2017 CONTRACT
69	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT

MEDI-CAL OTHER ADMINISTRATION
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	DHCS-DENTAL FI
70	DENTAL ASO ADMINISTRATION 2016 CONTRACT
71	DENTAL FI ADMINISTRATION 2016 CONTRACT
72	DENTAL FI TAKEOVER 2016 CONTRACT
73	DENTAL FI CD-MMIS COSTS
74	DENTAL ASO TAKEOVER 2016 CONTRACT
	OTHER DEPARTMENTS
75	HEALTH-RELATED ACTIVITIES - CDSS
76	PERSONAL CARE SERVICES
77	CALHEERS DEVELOPMENT
78	MATERNAL AND CHILD HEALTH
79	CDDS ADMINISTRATIVE COSTS
80	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN
81	DEPARTMENT OF SOCIAL SERVICES ADMIN COST
82	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS
83	CLPP CASE MANAGEMENT SERVICES
84	DEPARTMENT OF AGING ADMINISTRATIVE COSTS
85	CALIFORNIA SMOKERS' HELPLINE
86	KIT FOR NEW PARENTS
87	VITAL RECORDS
88	VETERANS BENEFITS
89	MEDI-CAL INPATIENT SERVICES FOR INMATES
90	CHHS AGENCY HIPAA FUNDING
91	CDPH I&E PROGRAM AND EVALUATION
92	MERIT SYSTEM SERVICES FOR COUNTIES
93	PIA EYEWEAR COURIER SERVICE

SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER:	1
IMPLEMENTATION DATE:	7/1992
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	235

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$135,713,000	$141,765,000
STATE FUNDS	-$2,241,000	$0
FEDERAL FUNDS	$137,954,000	$141,765,000

DESCRIPTION

Purpose:
This policy change budgets the federal financial participation (FFP) for claims submitted on behalf of Local Governmental Agencies (LGAs), Local Educational Consortia (LECs) and Local Educational Agencies (LEAs) for costs incurred through performing Medicaid administrative activities.

Authority:
AB 2377 (Chapter 147, Statutes of 1994)
AB 2780 (Chapter 310, Statutes of 1998)

Interdependent Policy Changes:
Not Applicable

Background:
AB 2377 authorized the State to implement the Medi-Cal Administrative Activities (MAA) claiming process. The Department submits claims on behalf of LGAs, which include counties and chartered cities, to obtain FFP for certified public expenditures incurred through performing Medicaid administrative activities. These activities assist Medi-Cal eligible persons to learn about, enroll in, and access services of the Medi-Cal program. AB 2780 allowed LEAs (including school districts and County Offices of Education) the option of claiming MAA through either their LECs (one of the State's eleven administrative districts) or through their LGAs.

In June 2012, the Centers for Medicare and Medicaid Services (CMS) deferred the School-Based MAA (SMAA) program retroactively to October 2011. During the deferral period, schools continued to submit invoices that were processed as an "Early Claim" in order to meet the two-year retrospective federal claiming limitation. In October 2014, the Department and CMS came to a settlement agreement to pay deferred invoices on a tiered basis and backcast the remaining balance once the Random Moment Time Study (RMTS) process had been in place for four quarters. The RMTS was implemented effective January 2015. In March 2015, the Department complied with all the necessary parameters set forth by CMS to resolve the deferral, which was lifted in April 2015. CMS approved the SMAA program to resume standard claiming beginning with fiscal year (FY) 2014-15 Quarter 3 (Q3) claims, payable in FY 2016-17.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is a net decrease due to:

- Updated actuals data through FY 2017-18 Q4, and
- FY 2018-19 Q2 payments shifted to FY 2020-21 to standardize payment schedules going forward.

SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 1

The change in FY 2020-21, from the prior estimate, is a net decrease due to:

- FY 2018-19 Q2 payments shifted from FY 2019-20 and FY 2019-20 Q2 payments are shifting to FY 2021-22 as part of the effort to standardize payment schedules.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is a increase due to:

- Updated growth factor utilizing the Employment Cost Index (ECI), and
- No GF payments or recoupments in FY 2020-21.

Methodology:
The FY 2019-20 estimate includes:

1. The FY 2017-18 Q4 amounts are based on actual invoices received.

2. The FY 2018-19 Q1 amount is based on an average of the actual invoices received for FY 2017-18 Q2-Q4 (as per SMAA Manual). It is expected that the FY 2018-19 Q1 invoices will be paid in FY 2019-20.

3. The Department utilized GF for additional payments totaling $271,000, as these claims exceeded the federal two-year claiming limitation. This payment was made in FY 2019-20.

4. Senate Bill 840 (Chapter 29, Statutes of 2018) established a recoupment process for backcasted claims which contained remaining balances due to CMS. The majority of these recoupments were resolved through the one-time discretionary fund appropriated to LEAs. However, a number of LEAs did not have sufficient discretionary funds to resolve their entire recoupment. The Department recouped the outstanding balances of $2,512,000 in FY 2019-20.

The FY 2020-21 estimate includes:

1. The FY 2018-19 Q2 and Q4 estimates are based on FY 2017-18 Q2 and Q4 actual invoices received and an additional ECI adjustment factor of 2.76.

2. The FY 2019-20 Q1 estimate is based on an average of the FY 2018-19 Q2-Q4 estimates (per the SMAA Manual).

FY 2019-20	TF	GF	FF
FY 2017-18 Q2-Q4	$103,466,000	$0	$103,466,000
FY 2018-19 Q1	$34,488,000	$0	$34,488,000
Pending Payments	$271,000	$271,000	$0
Remaining Backcasting Recoupments	($2,512,000)	($2,512,000)	$0
Total	**$135,713,000**	**($2,241,000)**	**$137,954,000**

FY 2020-21	TF	FF
FY 2018-19 Q2-Q4	$106,324,000	$106,324,000
FY 2019-20 Q1	$35,441,000	$35,441,000
Total	**$141,765,000**	**$141,765,000**

Funding:
100% Title XIX FFP (4260-101-0890)
100% GF (4260-101-0001)

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	2
IMPLEMENTATION DATE:	7/1999
ANALYST:	Sabrina Blank
FISCAL REFERENCE NUMBER:	230

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$174,215,000	$172,410,000
STATE FUNDS	$58,527,860	$58,668,880
FEDERAL FUNDS	$115,687,140	$113,741,120

DESCRIPTION

Purpose:
This policy change estimates the California Children's Services (CCS) case management cost.

Authority:
Health & Safety Code, sections 123800-123995

Interdependent Policy Changes:
Not Applicable

Background:
CCS county staff performs case management for clients who reside in counties with populations greater than 200,000 (independent counties). Case management includes performing all phases of program eligibility determination, evaluating the medical need for specific services, and determining appropriate providers. The state shares case management activities administered by CCS state regional office employees in Sacramento, and Los Angeles for counties with populations less than 200,000 (dependent counties). The Children's Medical Services Net (CMS Net) automated system is utilized by the CCS Medi-Cal program to assure case management activities.

Starting July 1, 2018, the Department began transitioning some of the case management administrative functions from the county to the County Organized Health Systems (COHS) health plans under the Whole Child Model. The WCM transition was completed on July 1, 2019.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is a slight increase due to updated actual invoiced expenditure data and caseload amounts. The change in FY 2020-21, from the prior estimate, is a decrease due to updated estimated invoiced expenditure data, caseload amounts, and the end of the Pediatric Palliative Care (PPC) waiver in FY 2019-20. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease due to lower expenditure projections for FY 2020-21 and the end of the PPC waiver in FY 2019-20.

Methodology:
1. The county administrative estimate for the budget year is updated every May based on additional data collected.

2. For FY 2019-20, the CCS case management costs are based on budgeted county expenditures of $164,966,000.

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 2

For FY 2020-21, caseload is expected to increase 0.02% from FY 2019-20.

$164,966,000 x (1 + 0.02%) = $164,999,000

3. Assume administrative costs of $1,057,000 in both FY 2019-20 and FY 2020-21 for the Medi-Cal expansion of undocumented children which are funded at 100% GF.

4. County data processing costs associated with CMS Net for CCS Medi-Cal are estimated to be $2,504,000 in FY 2019-20 and $2,522,000 in FY 2020-21.

5. Medi-Cal Optional Targeted Low Income Children Program (OTLICP) costs are separate from other Medi-Cal costs. Total Medi-Cal OTLICP costs listed below do not include county share of cost:

	FY 2019-20	FY 2020-21
County Administration:	$31,822,000	$31,282,000
County share of cost:	($1,657,000)	($2,578,000)
Total Medi-Cal OTLICP:	$30,185,000	$29,277,000

6. County data processing costs associated with CMS Net for OTLICP are estimated to be $361,000 in FY 2019-20 and $366,000 FY 2020-21.

7. Beginning July 1, 2018, the Whole Child Model incorporated CCS services into the integrated care systems of select counties in existing managed care COHS (except Ventura County). Payments to the COHS under the Whole Child Model are applied against CCS Case Management. The expenditures using a cash basis accounting are estimated to be $24,144,000 in FY 2019-20 and $25,239,000 in FY 2020-21.

8. On July 1, 2018, Rady Children's Hospital – San Diego (Rady) started a demonstration pilot with San Diego County. Rady is paid 78% of the total San Diego County Case Management Allocation and the County of San Diego retains 22% of the Case Management Allocation. The cost to CCS case management is $353,000 in FY 2019-20 and $206,000 in FY 2020-21.

9. Enhanced, Title XIX (75% FFP), funding is available for Skilled Professional Medical Personnel (SPMP) for the Medi-Cal and OTLICP populations in FY 2019-20 and FY 2020-21.

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 2

FY 2019-20				
CCS Medi-Cal	**TF***	**GF**	**FF**	CF**
CCS Case Management	$164,966,000	$61,957,000	$103,009,000	$0
Medi-Cal Expansion	$1,057,000	$1,057,000	$0	$0
CMS Net	$2,143,000	$1,072,000	$1,072,000	$0
Subtotal	$168,166,000	$64,086,000	$104,081,000	$0
CCS Medi-Cal/OTLICP				
CCS Case Management	$30,185,000	$5,623,000	$24,561,000	$1,637,000
CMS Net	$361,000	$71,000	$289,000	$0
Subtotal	$30,546,000	$5,694,000	$24,850,000	$1,637,000
Rady Children's Hospital	($353,000)	($176,000)	($176,000)	$0
WCM Implementation	($24,144,000)	($11,079,000)	($13,065,000)	$0
Total	**$174,215,000**	**$58,527,000**	**$115,687,000**	$1,637,000

FY 2020-21				
CCS Medi-Cal	**TF***	**GF**	**FF**	CF**
CCS Case Management	$164,999,000	$61,969,000	$103,030,000	$0
Medi-Cal Expansion	$1,057,000	$1,057,000	$0	$0
CMS Net	$2,156,000	$1,078,000	$1,078,000	$0
Subtotal	$168,212,000	$64,104,000	$104,108,000	$0
CCS Medi-Cal/OTLICP				
CCS Case Management	$29,277,000	$6,538,000	$22,739,000	$2,551,000
CMS Net	$366,000	$118,000	$248,000	$0
Subtotal	$29,643,000	$6,656,000	$22,987,000	$2,551,000
Rady Children's Hospital	($206,000)	($103,000)	($103,000)	$0
WCM Implementation	($25,239,000)	($11,988,000)	($13,251,000)	$0
Total	**$172,410,000**	**$58,669,000**	**$113,741,000**	$2,551,000

* Totals may differ due to rounding
** County Funds are not included in the Total Fund

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 2

Funding:

FY 2019-20	TF*	GF	FF	CF**
50% Title XIX / 50% GF (4260-101-0890/0001)	$63,889,000	$31,944,000	$31,944,000	$0
75% Title XIX / 25% GF (4260-101-0890/0001)	$98,048,000	$24,512,000	$73,536,000	$0
88% Title XXI / 12% GF (4260-113-0890/0001)	($755,000)	($91,000)	($664,000)	$0
88% Title XXI / 6% GF / 6% CF (4260-113-0890/0001)	($2,264,000)	($532,000)	($1,732,000)	$0
76.5% Title XXI / 23.5% GF (4260-113-0890/0001)	$3,347,000	$214,000	$3,133,000	$214,000
76.5% Title XXI / 11.75% GF / 11.75% CF (4260-113-0890/0001)	$10,893,000	$1,423,000	$9,470,000	$1,423,000
100% GF (4260-101-0001)	$1,057,000	$1,057,000	$0	$0
Total	**$174,215,000**	**$58,527,000**	**$115,687,000**	$1,637,000

FY 2020-21	TF*	GF	FF	CF**
50% Title XIX / 50% GF (4260-101-0890/0001)	$63,123,000	$31,562,000	$31,562,000	$0
75% Title XIX / 25% GF (4260-101-0890/0001)	$98,067,000	$24,517,000	$73,550,000	$0
76.5% Title XXI / 23.5% GF (4260-113-0890/0001)	($792,000)	($186,000)	($606,000)	$0
76.5% Title XXI / 11.75% GF / 11.75% CF (4260-113-0890/0001)	($2,375,000)	($831,000)	($1,544,000)	$0
65% Title XXI / 35% GF (4260-113-0890/0001)	$2,941,000	$392,000	$2,549,000	$392,000
65% Title XXI / 17.5% GF / 17.5% CF (4260-113-0890/0001)	$10,389,000	$2,159,000	$8,230,000	$2,159,000
100% GF (4260-101-0001)	$1,057,000	$1,057,000	$0	$0
Total	**$172,410,000**	**$58,669,000**	**$113,741,000**	$2,551,000

* Totals may differ due to rounding
** County Funds are not included in the Total Fund

COUNTY SPECIALTY MENTAL HEALTH ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER:	3
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1721

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$168,275,000	$170,067,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$168,275,000	$170,067,000

DESCRIPTION

Purpose:
This policy change estimates the county administrative costs for the Specialty Mental Health Services (SMHS) in the Medi-Cal (MC) program and the Children's Health Insurance Program (CHIP) administered by county mental health departments.

Authority:
Welfare & Institutions Code 14711(c)

Interdependent Policy Changes:
Not Applicable

Background:
Counties may obtain federal reimbursement for costs associated with administering a county's mental health program. Counties must report their administration costs and direct facility expenditures quarterly.

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is an increase due to:

- Updated base year expenditures from FY 2016-17 to FY 2017-18, and
- Updated payment lag factors resulting in a slight shift of payments for FY 2017-18 and FY 2018-19 to FY 2019-20 and FY 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to updated payment lags.

Methodology:
1. Mental Health administration costs are based on historical claims payment data. Based on historical claims received, assume 18% of each fiscal year claims will be paid in the year the services occur, 71% is paid in the following year, and 11% in the third year. The costs on an accrual and cash basis are:

COUNTY SPECIALTY MENTAL HEALTH ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 3

(Dollars in Thousands)

Fiscal Year	Accrual	FY 2019-20	FY 2020-21
MC	$292,978	$31,037	$0
CHIP	$21,062	$2,231	$0
FY 2017-18	$314,040	$33,268	$0
MC	$298,838	$212,523	$31,657
CHIP	$21,483	$15,278	$2,276
FY 2018-19	$320,321	$227,801	$33,933
MC	$305,114	$55,805	$216,986
CHIP	$21,934	$4,012	$15,599
FY 2019-20	$327,048	$59,817	$232,585
MC	$312,436	$0	$57,145
CHIP	$22,461	$0	$4,108
FY 2020-21	$334,897	$0	$61,253
Total		$320,886	$327,771

2. Mental Health administration costs are shared between federal funds (FF) and county funds (CF). MC claims are eligible for 50% federal reimbursement. CHIP claims are eligible for federal enhanced reimbursement. Beginning October 1, 2020, enhanced CHIP funding will decrease from 76.5% to 65%.

(Dollars in Thousands)

Claim Type	FY 2019-20			FY 2020-21		
	TF	FF	CF	TF	FF	CF
MC	$299,365	$149,682	$149,683	$305,788	$152,894	$152,894
CHIP	$21,521	$18,593	$2,928	$21,983	$17,173	$4,810
Total	$320,886	**$168,275**	$152,611	$327,771	**$170,067**	$157,704

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XXI FFP (4260-113-0890)

MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	4
IMPLEMENTATION DATE:	5/2019
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1589

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$8,442,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$8,442,000	$0

DESCRIPTION

Purpose:
This policy change estimates federal funds for the administrative costs associated with the Health Care Coverage Initiative (HCCI) under the Medi-Cal/Uninsured Care Demonstration (MH/UCD) and the Low Income Health Program (LIHP) under the California Bridge to Reform (BTR) Demonstration.

Authority:
AB 342 (Chapter 723, Statutes of 2010)
AB 1066 (Chapter 86, Statutes of 2011)
California Bridge to Reform Section 1115(a) Medicaid Demonstration

Interdependent Policy Changes:
Not Applicable

Background:
Under the MH/UCD, $180 million in federal funds was available annually under the Safety Net Care Pool (SNCP) to expand health coverage to eligible low-income, uninsured persons for Demonstration Year (DY) 2007-08 through 2009-10. The federal funds available will reimburse the HCCI. The HCCI was replaced by the LIHP, effective November 1, 2010 through December 31, 2013, which consisted of two components, the Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). The MCE covered eligibles with family incomes at or below 133% of the Federal Poverty Level (FPL). The HCCI covered those with family incomes above 133% through 200% of the FPL. Both were statewide county elective programs. The LIHP HCCI replaced the Coverage Initiative (CI) under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD) which was extended until October 31, 2010. AB 342 and AB 1066 authorized local LIHPs to provide health care services to eligible individuals.

The Centers for Medicare and Medicaid Services (CMS) provided uncapped federal funds to the local LIHPs at an amount equal to the regular Federal Medical Assistance Percentage (50%) for their administrative costs associated with the start-up, implementation, and close out administration of their approved LIHPs. The Department will use Certified Public Expenditures (CPEs) of the local government administrative costs to draw down federal funds and will distribute these funds to the local governments. The Department used the HCCI administrative activities cost claiming protocol for the HCCI under the MH/UCD, as the basis for providing reimbursement for the allowable administrative costs incurred from November 1, 2010 through September 30, 2011, as permitted by the Special Terms and Conditions for the Section 1115(a) BTR Demonstration. The Department received CMS approval of the BTR-LIHP administrative cost claiming protocol and time study on December 12, 2013.

MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 4

Reason for Change:
The change in FY 2019-20, from the prior estimate, is due to completed final reconciliations.

There is no change in FY 2020-21, from the prior estimate.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to the completion of the final reconciliations in FY 2019-20.

Methodology:
1. Administrative payments were based on the CMS approved administrative cost claiming protocol and time study.

2. Administrative claiming is comprised of three payment categories.

   - Start-up costs
   - Regular program costs
   - Close-out costs

3. Start-up and close-out costs will be included in the reconciliations.

4. Estimated final reconciliations are expected to be as follows:

FY 2019-20	TF	LIHP-MCE FF
DY 2007-08	($2,377,000)	($2,377,000)
DY 2008-09	$5,898,000	$5,898,000
DY 2009-10	$4,222,000	$4,222,000
DY 2010-11	$677,000	$677,000
DY 2011-12	$1,977,000	$1,977,000
DY 2012-13	($2,147,000)	($2,147,000)
DY 2013-14	$192,000	$192,000
Total FY 2019-20	**$8,442,000**	**$8,442,000**

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

COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER:	5
IMPLEMENTATION DATE:	7/1992
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1963

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$109,924,000	$113,838,000
STATE FUNDS	$500,000	$0
FEDERAL FUNDS	$109,424,000	$113,838,000

DESCRIPTION

Purpose:
This policy change budgets the federal financial participation (FFP) for claims submitted on behalf of local government agencies (LGAs) and Native American Indian tribes for Medicaid administrative activities.

Authority:
AB 2377 (Chapter 147, Statutes of 1994)
SB 308 (Chapter 253, Statutes of 2003)

Interdependent Policy Changes:
Not Applicable

Background:
AB 2377 authorized the State to implement the Medi-Cal Administrative Activities (MAA) claiming process. The Department submits claims on behalf of LGAs, which include counties and chartered cities, to obtain FFP for certified public expenditures incurred through performing Medicaid administrative activities. These activities assist Medi-Cal eligible persons to learn about, enroll in, and access services of the Medi-Cal program.

SB 308 redefined LGAs to include Native American Indian tribes and tribal organizations, as well as subgroups of these entities. This allows tribes to participate in the MAA program. Reimbursements for non-emergency and non-medical transportation expenditures are also available for Tribal entities.

Reason for Change:
The decrease in FY 2019-20, from the prior estimate, is due to:

- Additional months of actual claims data;
- A decrease in the program growth factor for both County Medi-Cal Administrative Activities (CMAA) and Tribal Medi-Cal Administrative Activities (TMAA) from 11% to 8%,

The decrease in FY 2020-21, from the prior estimate, is due to:

- Additional months of actual claims data;
- A decrease in the program growth factor for both County Medi-Cal Administrative Activities (CMAA) and Tribal Medi-Cal Administrative Activities (TMAA) from 11% to 8%,

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to:

- No General Fund TMAA payments in FY 2020-21, and
- Increased CMAA and TMAA quarterly payments estimated in FY 2020-21 based on growth factor.

COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 5

Methodology:

County Medi-Cal Administrative Activities

1. The CMAA FY 2019-20 estimate includes the remaining FY 2017-18 claims and FY 2018-19 Q1 claims. The estimated base payments assume an 8% growth, based on CMAA growth from FY 2014-15 through FY 2017-18 actual claims data.

   Estimated CMAA FY 2018-19 Q1: $102,673,000 + 8% growth factor = $110,887,000 / 4 = $27,722,000 per quarter.

CMAA FY 2019-20 Estimated Payments	
FY 2017-18 Q1 - Q4	$81,122,000
FY 2018-19 Q1	$27,722,000
Total	$108,844,000

2. The CMAA FY 2020-21 estimate includes the remaining FY 2018-19 claims and FY 2019-20 Q1 claims. The estimated base payments assume an 8% growth, based on CMAA growth from FY 2014-15 through FY 2017-18 actual claims data.

   Estimated CMAA FY 2019-20 Q1: $110,887,000 + 8% growth factor = $119,758,000 / 4 = $29,939,000 per quarter.

CMAA FY 2020-21 Estimated Payments	
FY 2018-19 Q2 - Q4	$83,165,000
FY 2019-20 Q1	$29,939,000
Total	$113,104,000

Tribal Medi-Cal Administrative Activities

1. The TMAA FY 2019-20 estimate includes the remaining FY 2017-18 claims and FY 2018-19 Q1 claims. The estimated base payments assume an 8% growth, based on 2014-15 through FY 2017-18 TMAA actual claims data. The General Fund will be used to pay for some FY 2017-18 Q2 through FY 2018-19 Q2 (through October 2018) invoices that are ineligible for federal funding.

   Estimated TMAA FY 2018-19: $997,000 + 8% growth factor = $1,077,000 / 4= $269,000 per quarter.

TMAA FY 2019-20 Estimated Payments	
FY 2017-18 Q1 - Q4	$311,000
FY 2018-19 Q1	$269,000
FY 2017-18 Q2 to October 2018 (GF)	$500,000
Total	$1,080,000

COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 5

2. The TMAA FY 2020-21 estimate includes the remaining FY 2018-19 claims and FY 2019-20 Q1 claims. The estimated base payments assume an 8% growth, based on 2014-15 through FY 2017-18 TMAA actual claims data. The TMAA FY 2020-21 estimate excludes invoices ineligible for federal funding.

   Estimated TMAA FY 2019-20 Q1: $1,077,000 + 8% growth factor = $1,163,000 / 4 = $291,000 per quarter.

TMAA FY 2020-21 Estimated Payments	
FY 2018-19 Q2 - Q4	$534,000
FY 2019-20 Q1	$200,000
Total	$734,000

3. Total CMAA and TMAA reimbursements for FY 2019-20 and FY 2020-21 on a cash basis are:

FY 2019-20	TF	GF	FF
County MAA	$108,844,000	$0	$108,844,000
Tribal MAA	$1,080,000	$500,000	$580,000
Total	**$109,924,000**	**$500,000**	**$109,424,000**

FY 2020-21	TF	FF
County MAA	$113,104,000	$113,104,000
Tribal MAA	$734,000	$734,000
Total	**$113,838,000**	**$113,838,000**

Funding:
100% Title XIX FFP (4260-101-0890)
100% GF (4260-101-0001)

INTERIM AND FINAL COST SETTLEMENTS-SMHS

OTHER ADMIN. POLICY CHANGE NUMBER:	6
IMPLEMENTATION DATE:	7/2016
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1757

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$42,661,000	$32,100,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$42,661,000	$32,100,000

DESCRIPTION

Purpose:
This policy change estimates the federal funds (FF) for the interim and final cost settlements on Specialty Mental Health Services (SMHS) administrative expenditures.

Authority:
Welfare & Institution Code 14705(c)

Interdependent Policy Changes:
Not Applicable

Background:
The Department reconciles interim payments to county cost reports for mental health plans (MHPs) for utilization review/quality assurance (UR/QA), mental health Medi-Cal administrative activities (MH MAA), and administration. The Department completes these interim settlements within two years of the end of the fiscal year. Final settlements are completed within three years of the last amended cost report the county MHPs submit to the Department.

The reconciliation process for each fiscal year may result in an overpayment or an underpayment to the county and will be handled as follows:

- For counties that have been determined to be overpaid, the Department will recoup any overpayments.
- For counties that have been determined to be underpaid, the Department will reimburse the federal funds.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a net decrease due to:

- Updating county interim settlements for decreased repayments for FY 2012-13; and
- Updating audit cost settlements for FY 2010-11 and FY 2011-12, scheduled in FY 2019-20.

The change from the prior estimate for FY 2020-21 is due to adding estimated underpayments and recoupments scheduled for FY 2020-21.

The change in the current estimate for FY 2019-20 to FY 2020-21 is due to:

- Including additional interim settlements for FY 2013-14; and
- Including additional audit recoupments for FY 2011-12, and assumes repayment and recoupments for older fiscal years are completed for FY 2019-20.

INTERIM AND FINAL COST SETTLEMENTS-SMHS

OTHER ADMIN. POLICY CHANGE NUMBER: 6

Methodology:

1. Interim cost settlements are based on the difference between each county MHP's filed cost report and the payments they received from the Department.

2. Final cost settlements are based on the difference between each county MHP's final audited cost report and the payments they received from the Department.

3. Cost settlements for administration, UR/QA, and MH MAA are each determined separately.

4. The net FF to be reimbursed and/or recouped in FY 2019-20 and FY 2020-21 for interim settlements and audit settlements are shown below:

(Dollars in Thousands)

Interim Settlements	Total FF	Title XIX FF	Title XXI FF
FY 2010-11	$274	$272	$2
FY 2011-12	$20,462	$20,446	$16
FY 2012-13	$24,242	$24,334	($92)
FY 2013-14	$2,676	$2,680	($4)
Subtotal	$47,654	$47,730	($78)

Audit Settlements	Total FF	Title XIX FF	Title XXI FF
FY 2004-05	($1,436)	($1,439)	$3
FY 2006-07	$1	$2	($1)
FY 2007-08	$527	$519	$8
FY 2008-09	$190	$188	$2
FY 2009-10	$1,095	$1,094	$1
FY 2010-11	($5,410)	($5,408)	($2)
FY 2011-12	$39	$31	$8
Subtotal	($4,993)	($5,013)	$20
Total FY 2019-20	**$42,661**	**$42,718**	**($57)**

INTERIM AND FINAL COST SETTLEMENTS-SMHS

OTHER ADMIN. POLICY CHANGE NUMBER: 6

(Dollars in Thousands)

Interim Settlements	Total FF	Title XIX FF	Title XXI FF
FY 2011-12	$292	$288	$4
FY 2012-13	$3,111	$3,100	$11
FY 2013-14	$31,167	$31,172	($5)
Subtotal	$34,570	$34,560	$10

Audit Settlements	Total FF	Title XIX FF	Title XXI FF
FY 2010-11	$423	$431	($8)
FY 2011-12	($2,894)	($2,887)	($7)
Subtotal	($2,470)	($2,455)	($15)
Total FY 2020-21	**$32,100**	**$32,105**	**($5)**

Funding:
100% Title XIX FF (4260-101-0890)
100% Title XXI FF (4260-113-0890)

DRUG MEDI-CAL COUNTY ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER:	7
IMPLEMENTATION DATE:	7/2014
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1813

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$11,197,000	$23,426,000
STATE FUNDS	$971,000	$894,000
FEDERAL FUNDS	$10,226,000	$22,532,000

DESCRIPTION

Purpose:
This policy change estimates the administrative costs for counties who provide Drug Medi-Cal (DMC) services.

Authority:
State Plan Amendment #09-022
Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver

Interdependent Policy Changes:
Not Applicable

Background:
The DMC program provides certain medically necessary substance use disorder (SUD) treatment services. These services are provided by providers under contract with the counties or with the State. This policy change budgets administrative costs for SUD services under the state plan and the DMC-ODS waiver.

Starting July 1, 2014, as instructed by the Centers for Medicare & Medicaid Services (CMS), the Department changed its process for reimbursing counties for their administrative expenses through a quarterly claims and cost settlement process. Prior to that, counties were paid for their DMC expenses (services and administration) through certified public expenditure (CPE) as part of an all-inclusive rate.

Effective FY 2014-15, the DMC county administrative reimbursement process was changed as follows:

- Quarterly Interim Claims – Counties send their quarterly claims invoices no later than 60 days after the end of the quarter and were reimbursed federal financial participation (FFP) based on their total expenses. This process is optional for participating counties.
- Annual Cost Settlement - At the end of the fiscal year, counties are required to submit their cost report and year-end administrative expense report. Cost settlements are based on comparing actual expenditures against the audited cost reports.
- Audit Settlement – The Department has the authority to audit the cost reports within three years of the cost settlement.

Starting with the FY 2014-15 annual cost report, settlement amounts for administrative cost reimbursements will be budgeted in this policy change. Annual cost settlements for administrative costs prior to FY 2014-15 were included in the Drug Medi-Cal Program Cost Settlement policy change.

DRUG MEDI-CAL COUNTY ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 7

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a decrease due to the following:

- As a result of delays in processing county cost reports, FY 2015-16 and FY 2016-17 annual settlement claims payments will not occur in FY 2019-20.
- FY 2018-19 and FY 2019-20 interim claims decreased based on actual claims data.

The change from the prior estimate, for FY 2020-21, is a decrease due to:

- Shifting FY 2015-16 annual settlement claims from FY 2019-20 to FY 2020-21 and removing FY 2017-18 annual settlement claims from the estimate.
- Interim claims for FY 2019-20 and FY 2020-21 decreased based on actual claims data.

The change in the current estimate, from FY 2019-20 to FY 2020-21, is due to a full year's annual settlement claims included in FY 2020-21.

Methodology:

1. Interim claims for the first two quarters (Q1 – Q2) are paid in the same fiscal year. Claims for the last two quarters (Q3 – Q4) are paid the following fiscal year.

2. Annual settlements for county administration claims are paid annually:
   - FY 2014-15 annual settlement claims payments from one county was paid in FY 2019-20.
   - Due to delays in cost report processing, FY 2015-16 annual settlement claims, previously scheduled to be paid in FY 2019-20, will now be paid in FY 2020-21.

3. ODS waiver county administrative claims are included in the current estimate for counties that submit quarterly interim claims.

4. The estimated DMC county administration costs for FY 2019-20 and FY 2020-21 are:

FY 2019-20	County Admin Cost	General Fund	Title XIX	County Funds
FY 2014-15, Annual Settlement	$448,000	$0	$224,000	$224,000
FY 2018-19 Claims	$10,028,000	$539,000	$5,014,000	$4,475,000
FY 2019-20 Claims	$9,976,000	$432,000	$4,988,000	$4,556,000
Total for FY 2019-20	$20,452,000	**$971,000**	**$10,226,000**	$9,255,000

FY 2020-21	County Admin Cost	General Fund	Title XIX	County Funds
FY 2015-16, Annual Settlement	$25,111,000	$30,000	$12,556,000	$12,525,000
FY 2019-20 Claims	$9,976,000	$432,000	$4,988,000	$4,556,000
FY 2020-21 Claims	$9,976,000	$432,000	$4,988,000	$4,556,000
Total for FY 2020-21	$45,063,000	**$894,000**	**$22,532,000**	$21,637,000

Funding:
100% Title XIX FF (4260-101-0890)
100% GF (4260-101-0001)

ARRA HITECH INCENTIVE PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER:	8
IMPLEMENTATION DATE:	7/2010
ANALYST:	Manvir Lallian
FISCAL REFERENCE NUMBER:	1370

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$11,643,000	$37,058,000
STATE FUNDS	$713,000	$678,000
FEDERAL FUNDS	$10,930,000	$36,380,000

DESCRIPTION

Purpose:
This policy change estimates the administrative costs associated with the advancement of the Health Information Technology for Economic and Clinical Health (HITECH) Incentive Act under the American Recovery and Reinvestment Act (ARRA) of 2009.

Authority:
ARRA of 2009
SB 945 (Chapter 433, Statutes of 2011)
SB 870 (Chapter 40, SEC 15, Budget Act of 2014)
SB 833 (Chapter 30, Sec 14, Budget Act of 2016)
Welfare & Institutions Code, Sections 14046.1 and 14046.7

Interdependent Policy Changes:
ARRA HITECH Provider Payments

Background:
The HITECH Act, a component of ARRA, authorizes federal funds for the Promoting Interoperability Program, from 2011 through 2021. The Department expects auditing and closeout of HITECH Act programs and initiatives to continue beyond 2021.

SB 945 authorized the Department to establish and administer the ARRA HITECH incentive programs with available federal funds. SB 833 authorized $425,000 General Fund (GF) for administrative costs associated with the program. SB 870 appropriates an additional $3,750,000 from the Major Risk Medical Insurance Fund to the Health Care Services Plans Fines and Penalties Fund for HITECH projects.

The Department annually submits an Implementation Advance Planning Document Update (IAPD-U) to the Centers for Medicare and Medicaid Services (CMS) for approval of continued funding. CMS approved the Department's IAPD-U for FFY 2020 on October 8, 2019. The current IAPD-U will expire September 30, 2020.

CMS requires the Department to assess the current usage of and barriers to electronic health record (EHR) adoption and administration of the Promoting Interoperability Program. Completion of these assessments requires multiple contracts. The Department, in collaboration with a wide variety of stakeholder organizations, developed a Medi-Cal EHR Incentive Program Project Book that identifies a series of projects to facilitate the ongoing development and evaluation of the program.

CMS also requires providers to meet Meaningful Use (MU) objectives to qualify for incentive payments, including reporting to immunization registries and electronic lab reporting. The Department administers

ARRA HITECH INCENTIVE PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 8

the following projects to support MU of EHRs by eligible Medi-Cal professionals and hospitals:

- The California Provider Technical Assistance Program (CTAP) offers technical assistance to providers preparing to implement EHR systems and meet Adopt, Implement, or Upgrade (AIU) and/or MU objectives.
- California Immunization Registry (CAIR) Onboarding of Medicaid Providers facilitates immunization registry reporting, by exchanging immunization information to and receiving back, a statewide, consolidated record and recommendations from CAIR.
- California Reportable Disease Information Exchange (CalREDIE) electronic Case Reports (eCR).
- Health Information Technology for EMS (HITEMS) targets improvements on two critical components of the health care system, emergency medical services (EMS), and disaster response.
- Periodic Promoting Interoperability Program Surveys, required to refine the initial landscape assessment of EHR use, and to document activities. The Department does not plan to conduct the surveys in FY 2019-20, but may implement in 2020-21.
- California Promoting Interoperability Program Summit, held annually each state fiscal year.
- The State Health Information Guidance (SHIG) document explains when it is appropriate to exchange mental health and substance use disorder information between behavioral health providers and other providers involved in providing and coordinating patient care. The Department will work with the CA Office of Health Information Integrity to expand the SHIG to address additional use cases in order to facilitate the exchange of health and behavioral health information.
- The Department of Justice (DOJ) Controlled Substance Utilization Review and Evaluation System (CURES) project seeks to support the connectivity of Health Information Exchanges (HIE) and providers to the state Prescription Drug Monitoring Program. DOJ will be responsible for establishing a method of system integration whereby approved health care practitioners and pharmacists may use a qualified health information technology system to access information in the CURES database.

Reasons for Change:

The change in FY 2019-20, from the prior estimate, is a decrease due to:

- A decrease in CAIR Onboarding due to changes in project schedules and delays in invoicing.
- A decrease in CalREDIE eCR due to changes in project schedules, pending receipt of FY 2019-20 invoices, and a delay in filling staffing vacancies.
- A decrease in HITEMS due to a delay in getting the approved Interagency Agreement in place between the Department and the Emergency Medical Services Authority (EMSA), and a delay in the CMS approval of contracts.
- A decrease in Provider Technical Assistance is due to lesser than anticipated milestones being achieved.
- A decrease in California HIT/HIE Summit due to shifting anticipated expenses from FY 2019-20 into FY 2020-21.

The change in FY 2020-21, from the prior estimate, is an increase due to:

- An increase in CAIR Onboarding, CalREDIE eCR, and HITEMS due to invoicing delays.
- An increase in California HIT/HIE Summit due to shifting anticipated expenses from FY 2019-20 into FY 2020-21, as a result of a change in the projected Summit date.

ARRA HITECH INCENTIVE PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 8

The change from FY 2019-20 to FY 2020-21, in the current estimate, is now an increase due to delays in FY 2019-20 project schedules and invoices, and costs shifting from FY 2019-20 to FY 2020-21.

Methodology:

1. The ARRA HITECH Incentive Program is eligible for Title XIX 90% FF.

2. For the CAIR Onboarding, and CalREDIE eCR projects, the 10% non-federal share is budgeted by CDPH. This policy change budgets the Title XIX 90% FF that will be provided to CDPH per the contracts through an interagency agreement.

3. CTAP project costs are eligible for Title XIX 90% FF. The 10% non-federal share will be provided by the Health Care Services Plans Fines and Penalties Fund. The Department received approval for a two-year, no-cost contract extension for CTAP. CTAP will continue until June 30, 2020, with project reallocated to FY 2019-20, and anticipated invoices being submitted into FY 2020-2021.

4. The HITEMS project costs are eligible for Title XIX 90% FF. The 10% non-federal share is budgeted by EMSA.

5. For the California HIT/HIE Stakeholder Summit, the 10% non-federal share will be provided by outside entities.

6. In FY 2019-20, the 10% non-federal share for the other projects will be provided by outside entities.

7. The medical Fiscal Intermediary (FI) projects are eligible for ARRA HITECH funding under the FI contract.

FY 2019-20	TF	Reimburs.	SF	FF
CAIR Onboarding (90% FF/10% GF)	$1,257,000	$0	$0	$1,257,000
CalREDIE eCR (90% FF/10% GF)	$543,000	$0	$0	$543,000
HITEMS (90% FF/10% GF)	$2,721,000	$0	$0	$2,721,000
Provider Technical Assist. (90% FF/10% SF)	$5,499,000	$0	$550,000	$4,949,000
California HIT/HIE Summit (90% FF/10% GF)	$88,000	$9,000	$0	$79,000
Other projects (90% FF/10% GF)	$1,535,000	$154,000	$0	$1,381,000
Total FY 2019-20	**$11,643,000**	**$163,000**	**$550,000**	**$10,930,000**

ARRA HITECH INCENTIVE PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 8

FY 2020-21	TF	Reimburs.	SF	FF
CAIR Onboarding (90% FF/10% GF)	$3,400,000	$0	$0	$3,400,000
CalREDIE eCR (90% FF/10% GF)	$2,504,000	$0	$0	$2,504,000
HITEMS (90% FF/10% GF)	$24,377,000	$0	$0	$24,377,000
Provider Technical Assist. (90% FF/10% SF)	$4,890,000	$0	$489,000	$4,401,000
California HIT/HIE Summit (90% FF/10% GF)	$352,000	$35,000	$0	$317,000
Other projects (90% FF/10% GF)	$1,535,000	$154,000	$0	$1,381,000
Total FY 2020-21	**$37,058,000**	**$189,000**	**$489,000**	**$36,380,000**

Funding:
100% Title XIX (4260-101-0890)
100% Reimbursement (4260-601-0995)
100% Health Care Services Plans Fines and Penalties Fund (4260-602-3311)

OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	9
IMPLEMENTATION DATE:	1/2013
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1748

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$38,088,000	$35,910,000
STATE FUNDS	$10,975,010	$13,388,300
FEDERAL FUNDS	$27,112,990	$22,521,700

DESCRIPTION

Purpose:
This policy change estimates the contract costs and other administrative vendor services for the Optional Targeted Low Income Children Program (OTLICP), Medi-Cal Access Program (MCAP), and Medi-Cal special populations.

Authority:
AB 1494 (Chapter 28, Statutes of 2012)
Health Services Advisory Group, Inc. Contract 15-92200
Maximus Contract 12-89315 A06

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2013, the Managed Risk Medical Insurance Board (MRMIB) contracted with MAXIMUS for Single Point of Entry (SPE) application services and other administrative vendor services for the Healthy Families Program (HFP), Access for Infants and Mothers (AIM) and Child Health and Disability Prevention (CHDP) Gateway.

HFP subscribers began transitioning into Medi-Cal as OTLICP starting January 1, 2013. Completed applications were sent to the SPE for screening and forwarded to the county welfare departments (CWD) for a Medi-Cal eligibility determination for the children's percent programs or to the new OTLICP.

The AIM infants above 250% of the federal poverty level began transitioning into Medi-Cal Access Infants Program beginning November 1, 2013, through February 1, 2014. The AIM Program was transitioned from MRMIB to the Department as of July 1, 2014, and renamed MCAP.

The Department instructed MAXIMUS to close out SPE for HFP and CHDP Gateway effective as of January 1, 2014, and to refer applicants to the application portal and toll-free line at Covered California. Maximus completed the shutdown process in FY 2013-14.

Effective July 1, 2014, all MRMIB programs, including the MAXIMUS contract, transitioned to the Department. Since the transition, MAXIMUS has provided administrative vendor services for MCAP and OTLICP. Due to application availability in the community, Maximus forwards any HFP applications it receives to the appropriate CWDs for a determination without the benefit of screening for accelerated enrollment.

OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 9

The Department transitioned the HFP and Children's Health Insurance Program (CHIP) into the Medi-Cal program in September 2013. The Title XXI CHIP program requires the State to contract with an External Quality Review Organization (EQRO) to validate performance measures, evaluate performance improvement projects, conduct focus studies, monitor encounter data activities, conduct an annual survey, and perform other EQRO activities for the duration of the contract. In July 2014, the Department became responsible for having the EQRO conduct the annual survey and other EQRO activities under the terms of the contract.

Administrative vendor services include costs for the following services: application processing, call center rate per minute, transaction forwarding fee, processing letters and notices, printing and courier fees, and implementation costs. Effective January 2017, administrative costs include publication costs for Medi-Cal special populations. Publication costs include developing, editing, updating, and performing readability evaluation of beneficiary materials as well as translation, printing, mailing, shipping, and focus group testing services that were previously budgeted in the HCO Cost Reimbursement policy change.

Effective October 1, 2019, the Department transitioned the administrative functions for the County Children Health Initiative Program (CCHIP) to the state's administrative vendor, MAXIMUS. These administrative functions include case management and premium collection for CCHIP. The additional costs for the increased scope of work is budgeted through the current MAXIMUS contract through this policy change.

Reason for Change:
The change for FY 2019-20, from the prior estimate, is an increase due to an expected increase in overall contract costs. The change for FY 2020-21, from the prior estimate, is an increase due to an increase in CCHIP administrative costs. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease due to a decrease in OTLICP costs in FY 2020-21.

Methodology:

1. This estimate is based on an average of actual usage and processing of the applications, postage, and vendor contract rates and services.

2. Contract costs are eligible for Title XXI 88/12 FMAP, Title XXI 76.5/23.5 FMAP, Title XXI 65/35 FMAP, and Title XIX 50/50 FMAP. The EQRO contract cost is eligible for Title XIX 50/50 FMAP only.

3. Administrative vendor services costs are eligible for Title XIX 50/50 FMAP.

4. Contract costs and administrative vendor service costs by program are as follows:

(Dollars in Thousands)

Program	FY 2019-20	FY 2020-21
OTLICP	$24,445	$22,626
MCAP	$4,290	$4,097
Medi-Cal Special Populations	$4,950	$4,961
CCHIP	$4,403	$4,226

5. Contract costs and administrative vendor service costs by cost category are as follows:

OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 9

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
Contract Costs	$28,199	$6,030	$22,169
Applications Processing, Printing and Courier Services, Letters and Notices, Transaction Forwarding Fee	$835	$418	$418
Call Minute Rate per Minute	$2,104	$1,052	$1,052
Implementation Costs	$2,000	$1,000	$1,000
Special Populations Publications	$4,950	$2,475	$2,475
Total	**$38,088**	**$10,975**	**$27,114**

FY 2020-21	TF	GF	FF
Contract Costs	$26,282	$8,575	$17,707
Applications Processing, Printing and Courier Services, Letters and Notices, Transaction Forwarding Fee, Pregnancy Materials	$724	$362	$362
Call Minute Rate per Minute	$1,943	$972	$972
Implementation Costs	$2,000	$1,000	$1,000
Special Populations Publications	$4,961	$2,481	$2,481
Total	**$35,910**	**$13,389**	**$22,521**

*Totals may differ due to rounding.

Funding:

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890/0001)	$10,619	$5,310	$5,310
88% Title XXI / 12% GF (4260-113-0890/0001)	$6,867	$824	$6,043
76.5% Title XXI / 23.5% GF (4260-113-0890/0001)	$20,602	$4,841	$15,761
Total	**$38,088**	**$10,975**	**$27,114**

FY 2020-21	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890/0001)	$10,362	$5,181	$5,181
76.5% Title XXI / 23.5% GF (4260-113-0890/0001)	$6,387	$1,501	$4,886
65% Title XXI / 35% GF (4260-113-0890/0001)	$19,161	$6,706	$12,454
Total	**$35,910**	**$13,389**	**$22,521**

*Totals may differ due to rounding.

CHDP CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	10
IMPLEMENTATION DATE:	7/1996
ANALYST:	Sasha Jetton
FISCAL REFERENCE NUMBER:	229

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$33,962,000	$33,962,000
STATE FUNDS	$11,957,000	$11,957,000
FEDERAL FUNDS	$22,005,000	$22,005,000

DESCRIPTION

Purpose:
This policy change estimates the county allocation for the Child Health and Disability Prevention Program (CHDP) case management benefit.

Authority:
Health & Safety Code 124075(a), 124025-124110
Welfare & Institutions Code 10507

Interdependent Policy Changes:
Not Applicable

Background:
Medi-Cal eligible children are entitled to Title XIX EPSDT provisions, including access to case management services. Most children in MediCal receive these case management services through their MediCal managed care plan. In addition to case management services being available through managed care, children have access to case management services from Fee-for Service providers, CHDP providers, county California Children's Services (CCS) programs, county Health Care Program for Children in Foster Care programs, home and community based service wavier providers and county behavioral health programs.

The CHDP Case Management budget is allocated to individual counties and controlled on an accrual basis.

Reason for Change:
There is no change from the prior estimate for either fiscal year or between fiscal years in current estimate.

Methodology:

The allocation amount for both FY 2019-20 and FY 2020-21 is $33,962,000 ($11,957,000 GF)

CHDP CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 10

Funding:

FY 2019-20	TF	GF	FF
Title XIX (50% FF / 50% GF)	$15,081,000	$7,540,500	$7,540,500
Title XIX (75% FF / 25% GF)	$17,666,000	$4,416,500	$13,249,000
Title XIX (100% FF)	$1,215,000	$0	$1,215,000
Total	**$33,962,000**	**$11,957,000**	**$22,005,000**

FY 2020-21	TF	GF	FF
Title XIX (50% FF / 50% GF)	$15,081,000	$7,540,500	$7,540,500
Title XIX (75% FF / 25% GF)	$17,666,000	$4,416,500	$13,249,000
Title XIX (100% FF)	$1,215,000	$0	$1,215,000
Total	**$33,962,000**	**$11,957,000**	**$22,005,000**

SMHS COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER:	11
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1729

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$31,635,000	$32,288,000
STATE FUNDS	$953,000	$953,000
FEDERAL FUNDS	$30,682,000	$31,335,000

DESCRIPTION

Purpose:
This policy change estimates the county utilization review (UR) and quality assurance (QA) administrative costs for Specialty Mental Health Services (SMHS).

Authority:
Welfare & Institutions Code 14711

Interdependent Policy Changes:
Not Applicable

Background:
UR and QA activities safeguard against unnecessary and inappropriate medical care. Federal reimbursement for these costs is available at 75% for skilled professional medical personnel (SPMP) and 50% for all other personnel claims.

The responsibility for SMHS was realigned to the counties in 2011 as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, legislation enacted after September 30, 2012, that has an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by 2011 Realignment shall apply to local agencies only to the extent that the state provides annual funding for the cost increase. Local agencies are not obligated to provide programs or levels of service required by legislation, above the level for which funding has been provided. Therefore, funding for the remaining non-federal costs for counties is 100% General Funds (GF).

Reason for Change:
The change from the prior estimate for FY 2019-20, is due to updating payment lag percentages for claims paid in FY 2019-20 and FY 2020-21, resulting in more payments in the year claims were submitted.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to higher estimated growth rate for FY 2020-21 resulting in more claims to be paid in FY 2020-21.

Methodology:
1. UR and QA expenditures are shared between federal funds (FF) and county funds (CF). Pursuant to Proposition 30, GF funding is provided for levels of service that are provided above those levels mandated by the 2011 Realignment.

2. Based on historical claims received from FY 2014-15 through FY 2017-18, assume 49% of each fiscal year claims will be paid in the year the services occur. Assume 48% is paid in the following

SMHS COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 11

year and the remaining 3% is assumed to be claimed through cost settlements and not included in this policy change. Assume the same payment lags for Foster Family Agencies (FFA) and Special Terms and Conditions (STC) payments.

(Dollars in Thousands)

Fiscal Year	Accrual	FY 2019-20	FY 2020-21
2018-19	$43,004	$20,642	$0
2019-20	$43,907	$21,515	$21,076
2020-21	$44,961	$0	$22,031
Total SPMP & Other		$42,157	$43,107

3. SPMP are eligible for enhanced federal reimbursement of 75%. All other personnel are eligible for 50% federal reimbursement.

4. Based on historical claims received, assume 75% are SPMP and the remaining 25% of the total claims are other personnel costs.

5. Beginning in the FY 2018-19 accrual year, costs are included for additional work, at the county level, to collect and report data elements and post Mental Health Plan (MHP) data on the county's website as specified by the STC related to the SMHS waiver. Assume the payment lags for FFA and STC are the same as listed above.

(Dollars in Thousands)

STC	Accrual	FY 2019-20	FY 2020-21
FY 2018-19	$3,075	$1,476	$0
FY 2019-20	$3,075	$1,507	$1,476
FY 2020-21	$3,075	$0	$1,507
Total for STC		$2,983	$2,983

6. Beginning in January 2017, counties will incur costs to certify 184 FFA to provide SMHS. The estimate assumes counties will need a total of 40 hours to complete each certification. Assume staff certifying the FFAs are paid $58.12 which was calculated using a wage of $40 per hour and benefits are 45.296% of salaries and wages. The Department does not anticipate FY 2016-17 FFA costs based on claims received to date. The FFA costs, on a cash basis, are:

(Dollars in Thousands)

FFA	Rate	Accrual	FY 2019-20	FY 2020-21
FY 2018-19	$58.12	$428	$205	$0
FY 2019-20	$58.12	$428	$210	$205
FY 2020-21	$58.12	$428	$0	$210
Total for FFA			$415	$415

SMHS COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 11

7. On a cash basis, the estimated payments in FY 2019-20 and FY 2020-21 are:

(Dollars in Thousands)

Personnel	TF	GF	FF	CF
SPMP	$31,618	$0	$23,713	$7,905
Other	$10,539	$0	$5,270	$5,269
STC	$2,983	$746	$1,491	$746
FFA	$415	$207	$207	$0
FY 2019-20 Total	$45,555	**$953**	**$30,682**	$13,920

(Dollars in Thousands)

Personnel	TF	GF	FF	CF
SPMP	$32,330	$0	$24,247	$8,083
Other	$10,777	$0	$5,389	$5,388
STC	$2,983	$746	$1,491	$746
FFA	$415	$207	$207	$0
FY 2020-21 Total	$46,505	**$953**	**$31,335**	$14,217

Funding:
100% Title XIX FF (4260-101-0890)
100% GF (4260-101-0001)

HEALTH ENROLLMENT NAVIGATORS

OTHER ADMIN. POLICY CHANGE NUMBER:	12
IMPLEMENTATION DATE:	7/2019
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	2144

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$5,574,000	$54,426,000
STATE FUNDS	$2,787,000	$27,213,000
FEDERAL FUNDS	$2,787,000	$27,213,000

DESCRIPTION

Purpose:
This policy change estimates the funding provided to counties and community-based organizations (CBOs) for Medi-Cal outreach, enrollment, and retention activities provided through FY 2021-22.

Authority:
AB 74 (Chapter 23, Statutes of 2019)

Interdependent Policy Changes:
Not Applicable

Background:
CBOs play a vital role in assisting counties to reach out to marginalized populations and help eligible individuals apply and successfully complete the health coverage enrollment process, retain coverage, navigate the health care system, and gain timely access to medical care through community-based care management.

Adequate funding for outreach, enrollment, retention, and community-based assistance with utilization and care management is necessary to ensure all Medi-Cal eligible individuals are enrolled in health care coverage and have access to the care they need.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a decrease due to a shift in the implementation date. The change from the prior estimate, for FY 2020-21, is an increase based on expected payment timing for activities provided. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase based on timing of payments for activities provided.

Methodology:

1. Assume an implementation date of March 1, 2020.

2. Assume selected counties that partner with local CBOs to conduct outreach, enrollment, and retention in their applicable area shall receive supplemental funding.

3. On a cash basis, assume **$5,574,000 Total Fund ($2,787,000 General Fund)** will be paid in FY 2019-20 and **$54,426,000 Total Fund ($27,213,000 General Fund)** will be paid in FY 2020-21.

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

SMH MAA

OTHER ADMIN. POLICY CHANGE NUMBER:	13
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1722

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$47,531,000	$49,860,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$47,531,000	$49,860,000

DESCRIPTION

Purpose:
This policy change budgets the federal funds (FF) for claims submitted on behalf of specialty mental health plans (MHPs) for Medi-Cal Administrative Activities (MAA).

Authority:
Welfare & Institutions Code 14132.47
AB 2377 (Chapter 147, Statutes of 1994)

Interdependent Policy Changes:
Not Applicable

Background:
AB 2377 authorized the State to implement the Medi-Cal Administrative Activities Claiming Process. The Specialty Mental Health (SMH) waiver program submits claims on behalf of MHPs to obtain federal financial participation (FFP) for MAA necessary for the proper and efficient administration of the SMH waiver program. These activities ensure that assistance is provided to Medi-Cal eligible individuals and their families for the receipt of SMH services.

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is a net increase due to:

- Increased estimated accrual FY 2018-19 expenditures, primarily due to two counties submitting large claims;
- Updating the growth factor; and
- Updating the payment lags to assume 100% of claims will be paid in the following year services occur, based on actual FY 2017-18 claims data.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to the addition of claims to be paid in FY 2020-21 based on projected costs. The FY 2010-11 Marin County reimbursement was made in FY 2019-20.

Methodology:

1. County mental health plans submit claims for reimbursement on a quarterly basis. Claims may be submitted up to six months after the close of a fiscal year.

2. Assume total SMH MAA claims will increase by 5.08% each fiscal year starting in FY 2018-19.

SMH MAA

OTHER ADMIN. POLICY CHANGE NUMBER: 13

3. For FY 2018-19, the Department projects to receive $85,802,000 TF in SMH MAA claims on an accrual basis.

(Dollars in Thousands)

Fiscal Years	Expenditures	Growth	Increase
2018-19	$85,802	5.08%	$4,362
2019-20	$90,161	5.08%	$4,583
2020-21	$94,741		

4. Based on historical claims received, assume 100% of fiscal year claims will be paid in the following year services occur.

(Dollars in Thousands)

Fiscal Years	Accrual	FY 2019-20	FY 2020-21
2018-19	$85,802	$85,802	$0
2019-20	$90,161	$0	$90,161
2020-21	$94,741	$0	$0
Total	$270,704	$85,802	$90,161

5. Skilled professional medical personnel (SPMP) are eligible for enhanced federal reimbursement of 75%. All other personnel are eligible for 50% federal reimbursement. Based on actual claims submitted for costs incurred in FY 2018-19, assume 21.21% of costs are eligible for 75% reimbursement and the remaining 78.79% are eligible for 50% reimbursement. SMH MAA total expenditures are shared between federal funds (FF) and county funds (CF).

(Dollars in Thousands)

	FY 2019-20			FY 2020-21		
Expenditures	TF	FF	CF	TF	FF	CF
SPMP (75/25)	$18,195	$13,646	$4,549	$19,120	$14,340	$4,780
Other (50/50)	$67,607	$33,804	$33,803	$71,041	$35,520	$35,521
Total	$85,802	$47,450	$38,352	$90,161	$49,860	$40,301

6. Marin County was reimbursed for FY 2010-11 claims in FY 2019-20.

(Dollars in Thousands)

Cash Basis	FY 2019-20		
Expenditures	TF	FF	CF
SPMP (75/25)	$18	$13	$5
Other (50/50)	$136	$68	$68
Total	$154	$81	$73

SMH MAA

OTHER ADMIN. POLICY CHANGE NUMBER: 13

7. The estimated SMH MAA costs are:

(Dollars in Thousands)

	FY 2019-20			FY 2020-21		
Expenditures	**TF**	**FF**	**CF**	**TF**	**FF**	**CF**
SPMP (75/25)	$18,213	$13,659	$4,554	$19,120	$14,340	$4,780
Other (50/50)	$67,743	$33,872	$33,871	$71,041	$35,520	$35,521
Total	$85,956	**$47,531**	$38,425	$90,161	**$49,860**	$40,301

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

POSTAGE & PRINTING

OTHER ADMIN. POLICY CHANGE NUMBER:	14
IMPLEMENTATION DATE:	7/1993
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	231

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$26,043,000	$29,793,000
STATE FUNDS	$13,150,000	$15,025,000
FEDERAL FUNDS	$12,893,000	$14,768,000

DESCRIPTION

Purpose:
This policy change budgets postage and printing costs for items sent to or used by Medi-Cal beneficiaries.

Authority:
Welfare & Institutions Code 14103.6, 14124.5, and 10725
Title 42, Code of Federal Regulations (CFR), Section 435.905
Title 45, Code of Federal Regulations (CFR), Section 164.520
Title 26, Code of Federal Regulations (CFR), Section 1.6055

Interdependent Policy Changes:
Not Applicable

Background:
Costs for the mailing of various legal notices and the costs for forms used in determining eligibility and available third party resources are budgeted in the local assistance item since these costs are caseload driven. Under the federal Health Insurance Portability and Accountability Act (HIPAA), it is a legal obligation of the Medi-Cal program to send out a Notice of Privacy Practices (NPP) to each beneficiary household explaining the rights of beneficiaries regarding the protected health information created and maintained by the Medi-Cal program. The notice must be sent to all new Medi-Cal and Breast and Cervical Cancer Treatment Program (BCCTP) enrollees and to existing beneficiaries at least every 3 years. Postage and printing costs for the HIPAA NPP, Quarterly JvR ("Your Fair Hearing Rights"), Incarceration Verification Program, Earned Income Tax Credit (EITC), IRS Form 1095-B (1095-B), creation and mailing of the Notice for Requested Action (NFRA), Home Community Base Services and Waiver Personal Care Services notices, and Public Assistance Reporting Information System are included in this item. The NFRA is a letter that the Department sends to beneficiaries whose record contains inconsistent information that prevents it from being accepted by the Internal Revenue Service (IRS). This item also includes additional costs for printing, storage, and mailing of important Department publications and applications to counties and beneficiaries on request.

Medi-Cal beneficiaries receive health care services from medical or pharmacy providers enrolled in the Medi-Cal program. Providers must receive authorization from Medi-Cal in order to provide and/or be paid for some of these services. The form a provider uses to request authorization is called a Treatment Authorization Request (TAR).

Costs for the printing and postage of notices and letters for the State-funded component of the BCCTP and the printing of EITC notices are 100% general fund (GF). Costs associated with IRS Form 1095-B are 50% GF and 50% federal fund.

POSTAGE & PRINTING

OTHER ADMIN. POLICY CHANGE NUMBER: 14

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a decrease due to a decrease in estimated 1095-B mailings. The change from the prior estimate, for FY 2020-21, is an increase due to the addition of the documents services and mailing costs. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to the addition of the documents services and mailing costs in FY 2020-21.

Methodology:
1. Based on actuals, the reported population receiving 1095-B mailings for FY 2019-20 is 13,025,000.

2. Assume that the cost per mailing is $0.535.

   13,025,000 mailings x $0.535 per mailing = $6,968,000 (rounded)

3. Based on FY 2019-20 actuals, assume that 8% of 1095-B forms are resent due to beneficiary request for reprints or for corrected 1095-Bs. The cost to send a reprint/correction is $0.535 per unit.

   8% x 13,025,000 mailings = 1,042,000 returned mailings

   1,042,000 returned mailings x $0.535 per unit = $557,000 (rounded)

4. Assume that NFRAs are sent to beneficiaries for IRS reported errors found on Form 1095-B. The cost to process the Form 1095-B notices is $0.535 per unit and based on FY 2018-19 actuals, assume 164,000 mailers will be sent out to beneficiaries.

   164,000 mailings x $0.535 per mailing = $88,000 (rounded)

5. TAR postage costs for Medi-Cal are assumed to be $80,000 for FY 2019-20 and FY 2020-21.

6. The Department estimates the printing and postage costs for FY 2019-20 and FY 2020-21 are:

FY 2019-20	TF	GF	FF
Base Mass Mailing	$15,750,000	$8,003,000	$7,747,000
1095B			
1095 Mailings	$6,968,000	$3,484,000	$3,484,000
Reprinted/Corrected Form 1095-B	$557,000	$279,000	$278,000
Notice for Requested Action	$88,000	$44,000	$44,000
1095 B Subtotal	$7,613,000	$3,807,000	$3,806,000
Emergency Mailings	$2,600,000	$1,300,000	$1,300,000
TAR Postage	$80,000	$40,000	$40,000
Total	**$26,043,000**	**$13,150,000**	**$12,893,000**

POSTAGE & PRINTING

OTHER ADMIN. POLICY CHANGE NUMBER: 14

FY 2020-21	TF	GF	FF
Base Mass Mailing	$15,500,000	$7,878,000	$7,622,000
1095B			
1095 Mailings	$6,968,000	$3,484,000	$3,484,000
Reprinted/Corrected Form 1095-B	$557,000	$279,000	$278,000
Notice for Requested Action	$88,000	$44,000	$44,000
1095 B Subtotal	$7,613,000	$3,807,000	$3,806,000
Printing/Mailing Services	$4,000,000	$2,000,000	$2,000,000
Emergency Mailings	$2,600,000	$1,300,000	$1,300,000
TAR Postage	$80,000	$40,000	$40,000
Total	**$29,793,000**	**$15,025,000**	**$14,768,000**

*Totals may differ due to rounding.

Funding:
50% Title XIX FF/ 50% GF (4260-101-0890/0001)
100% GF (4260-101-0001)

MANAGED CARE REGULATIONS - MENTAL HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER:	15
IMPLEMENTATION DATE:	3/2019
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	2019

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$981,000	$981,000
STATE FUNDS	$285,000	$285,000
FEDERAL FUNDS	$696,000	$696,000

DESCRIPTION

Purpose:
This policy change estimates the costs to reimburse County Mental Health Plans (MHPs) for administrative activities arising from the implementation of federal managed care regulations (Final Rule CMS-2390-P).

Authority:
Title 42, Code of Federal Regulations Part 438

Interdependent Policy Changes:
Not Applicable

Background:
The new regulations amend and expand the requirements of Title 42, Code of Federal Regulations Part 438, pertaining to managed care. The Centers for Medicare and Medicaid Services (CMS) issued Final Rule CMS-2390-P on May 6, 2016. Final Rule 2390-P changes the Medicaid managed care regulations to reflect changes in the utilization of managed care delivery systems. It aligns the rules governing Medicaid managed care with those of other major sources of coverage; implements statutory provisions; changes actuarial payment provisions; and promotes the quality of care and strengthens efforts to reform delivery systems that serve Medicaid and Children's Health Insurance Program (CHIP) beneficiaries; strengthens beneficiary protections and policies related to program integrity; and requires states to establish comprehensive quality strategies for their Medicaid and CHIP programs regardless of how services are provided to beneficiaries.

The regulations aim to standardize requirements for managed care plan types (i.e., managed care organizations (MCOs), pre-paid inpatient health plans (PIHPs), pre-paid ambulatory health plans (PAHPs)), and they have system-wide impacts for the 56 Mental Health Plans (MHPs are considered PIHPs under the regulations). The Department is working with county partners to refine the extent and magnitude of both fiscal and administrative impacts to MHPs.

The responsibility for Specialty Mental Health Services (SMHS) was realigned to the counties in 2011 as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, state requirements enacted after September 30, 2012, that have an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by 2011 Realignment shall apply to local agencies only to the extent that the state provides annual funding for the cost increase. Federal requirements enacted after September 30, 2012 that have an overall effect on increasing the costs already borne by a local agency for programs or levels of service mandated by 2011 Realignment shall apply to local agencies only to the extent that the state provides at least fifty percent of the non-federal share of the increase in costs.

MANAGED CARE REGULATIONS - MENTAL HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER: 15

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is a reduction due to:

- Projecting cost estimates based on actual claims data for FY 2017-18 and FY 2018-19,
- Updating the categories of activities from seven to three to align with data reports,
- Assuming payments will be paid in the year claims are submitted, and
- Updating the funding splits for the activities related to Utilization Review & Quality Assurance (UR & QA).

There is no change from FY 2019-20 to FY 2020-21, in the current estimate.

Methodology:
The estimated costs of Managed Care and Parity Regulations are based on actual claims data. The data is condensed into three categories in place of the seven categories listed in the prior estimate. The Department assumes the non-federal share is funded with County Funds (CF) and General Funds (GF), consistent with the California Constitution, Article 13, Section 36 (c)(5)(A).

1. The category types and funding is assumed to be:

Category	GF	FF	CF
Manage Care Admin	25%	50%	25%
Manage Care Enhanced UR/QA	12.5%	75%	12.5%
Manage Care Regular UR/QA	25%	50%	25%

2. Activities:

   a. <u>State Monitoring:</u>
   Compile data and information from a variety of state monitoring requirements such as the quality and performance rating system and compliance reviews.

   b. <u>Quality Measurement & Improvement; External Quality Review Organization (EQRO):</u>
   MHPs will need to contract with EQRO for local quality measurement and improvement activities necessary to comply.

   c. <u>Grievances and Appeals System:</u>
   Ongoing staffing impact to comply with 72-hour authorization upon notice of reversal of adverse benefit determination.

   d. <u>Program Integrity:</u>
   MHPs will need to conduct monitoring for contractor compliance, prepare and submit data, documentation, and information to the State.

   c. <u>Network Adequacy:</u>
   Collect and submit detailed provider data to the State for federally required reporting of provider networks and provider capacity.

3. Assume on a cash basis for FY 2019-20, the Department will be paying for all of the claims submitted in FY 2019-20. For FY 2020-21, the Department will be paying for all claims submitted in FY 2020-21.

MANAGED CARE REGULATIONS - MENTAL HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER: 15

4. The estimated costs in FY 2019-20 and FY 2020-21 are:

(Dollars in Thousands)

FY 2019-20	TF	GF	FF	CF
Managed Care/Final Rule Admin	$568	$150	$269	$149
Managed Care/Enhanced UR/QA	$374	$50	$273	$51
Managed Care/Regular UR/QA	$325	$85	$154	$86
Total	$1,267	**$285**	**$696**	$286

(Dollars in Thousands)

FY 2020-21	TF	GF	FF	CF
Managed Care/Final Rule Admin	$568	$150	$269	$149
Managed Care/Enhanced UR/QA	$374	$50	$273	$51
Managed Care/Regular UR/QA	$325	$85	$154	$86
Total	$1,267	**$285**	**$696**	$286

Funding:
100% Title XIX FF (4260-101-0890)
100% Title XIX GF (4260-101-0001)

MANAGED CARE REGULATIONS - MH PARITY

OTHER ADMIN. POLICY CHANGE NUMBER:	16
IMPLEMENTATION DATE:	3/2020
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	2076

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$19,367,000	$19,367,000
STATE FUNDS	$2,767,000	$2,767,000
FEDERAL FUNDS	$16,600,000	$16,600,000

DESCRIPTION

Purpose:
This policy change estimates the County Mental Health Plans (MHP) costs for new prior authorization requirements to comply with the federal Parity Final Rule.

Authority:
CMS Final Rule (CMS-2333-F) (Parity Final Rule)

Interdependent Policy Changes:
Not Applicable

Background:
Final Rule 2390-P (Managed Care Rule) requires that all beneficiaries who receive services through managed care organizations, alternative benefit plans, or Children's Health Insurance Program (CHIP) be provided access to mental health and substance use disorder benefits that comply with parity standards, regardless of whether these services are provided through the managed care organization or another service delivery system. States are required to include contract provisions requiring compliance with parity standards in all applicable contracts for these Medicaid managed care arrangements that provide services to enrollees in managed care organizations, including prepaid inpatient health plans or prepaid ambulatory health plans.

The regulations aim to standardize requirements for managed care plan types (i.e., managed care organizations (MCOs), pre-paid inpatient health plans (PIHPs), pre-paid ambulatory health plans (PAHPs), and they have system-wide impacts for the 56 Mental Health Plans (MHPs are considered PIHPs under the regulations).

On March 30, 2017, CMS issued the Parity Final Rule, to strengthen access to mental health and substance use disorder services for Medicaid beneficiaries. The Parity Final Rule stipulates that treatment limitations and financial requirements applicable to mental health/substance use disorder Medicaid benefits cannot be more restrictive than those limitations applicable to medical/surgical Medicaid benefits. Parity applies to four benefit classifications. Inpatient, Outpatient, Emergency Care, and Pharmacy. To demonstrate compliance, the Department reviewed such treatment limitations, across the various Medi-Cal service delivery systems, which includes any managed care, mental health, substance use disorder and fee-for-service benefits available to an individual enrolled in a Managed Care Plan (MCP). The Department's Parity Compliance Plan submitted to CMS on October 2, 2017, details the required system changes to comply with the federal Parity Final Rule. The Parity Compliance Plan is also posted on the Department's website.

MANAGED CARE REGULATIONS - MH PARITY

OTHER ADMIN. POLICY CHANGE NUMBER: 16

During its assessment of authorization policies across delivery systems, the Department identified inconsistencies between the application of standards and policies for authorization of services by MHPs and MCPs. The inconsistencies identified were for authorization of outpatient and inpatient services. As a result, the Department will implement changes to authorization of Specialty Mental Health Services (SMHS) policies for compliance with the Parity Final Rule. On May 31, 2019, the Department issued Mental Health and Substance Use Disorder Services Information Notice No. 19-026, which details the new statewide policy regarding authorization of SMHS. The statewide policy changes are summarized below:

For outpatient SMHS:

- The Department will adopt new requirements for prior authorization of SMHS, including:
  - the identification of services requiring prior authorization, and
  - the timeframes for making authorization decisions within five (5) business days of the request for authorization.

For inpatient/residential SMHS:

- The Department will align the requirements for MHP authorizations of psychiatric inpatient hospital services and residential treatment services with the concurrent authorization review requirements used by MCPs for inpatient hospital services.
- Similar to MCPs, MHPs will be expected to conduct concurrent review of treatment authorizations until discharge.

These changes to authorization policies and procedures constitute a significant shift in local operations. The department continues to work with local partners to assess the extent and magnitude of impacts to operational and administrative processes. The 2011 Public Safety Realignment realigned the responsibility for SMHS to the counties. Pursuant to Proposition 30, state requirements enacted after September 30, 2012, that have an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by 2011 Realignment shall apply to local agencies only to the extent that the state provides annual funding for the cost increase. Federal requirements enacted after September 30, 2012 that have an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by 2011 Realignment shall apply to local agencies only to the extent that the state provides at least fifty percent of the non-federal share of the increase in costs.

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is a minor increase due to outpatient pre-authorization estimates, and concurrent inpatient reviews, based on total service units updated to FY 2016-17 from FY 2015-16.

There is no change from FY 2019-20 to FY 2020-21, in the current estimate.

Methodology:

1. The estimated costs of Parity Regulations, related to pre-authorizations of outpatient services and concurrent reviews of inpatient admissions, are based on the estimated number of hours county staff would spend performing these reviews.

2. Outpatient services pre-authorizations and concurrent review for SMHS inpatient admissions must be conducted by a licensed mental health professional, which assumes a 75% / 25% Federal Medical Assistance Percentage (FMAP). The non-federal share is assumed to be funded with 50% County Funds (CF) and 50% General Funds (GF) pursuant to the California Constitution,

MANAGED CARE REGULATIONS - MH PARITY

OTHER ADMIN. POLICY CHANGE NUMBER: 16

Article 13, Section 36(c)(5)(A).

3. MHPs will need to be compliant with the Parity Final Rule, beginning July 2018.

4. For outpatient reviews, assume counties will need an additional 15 minutes for 428,564 reviews at a cost of $56.67 per hour, including benefits. The total estimated annual costs for outpatient pre-authorizations are $6,071,000 TF.

5. For inpatient reviews, assume counties will need an additional 30 minutes for 625,687 reviews at a cost of $56.67 per hour, including benefits. The total estimated annual costs for concurrent inpatient reviews are $17,727,000 TF.

6. On a cash basis for FY 2019-20, the Department will be paying for 64% of FY 2018-19 claims and 29% of FY 2019-20 claims. For FY 2020-21, the Department will be paying 64% of FY 2019-20 claims and 29% of FY 2020-21 claims. Assume the remaining claims will be paid through cost settlement.

(Dollars in Thousands)

Cash Basis	**Accrual**	**FY 2019-20**	**FY 2020-21**
FY 2018-19	TF	TF	TF
Outpatient Pre-Authorizations	$6,071	$3,885	$0
Inpatient – Concurrent Review	$17,727	$11,345	$0
Total FY 2018-19	$23,798	$15,230	$0
FY 2019-20			
Outpatient Pre-Authorizations	$6,071	$1,761	$3,885
Inpatient – Concurrent Review	$17,727	$5,141	$11,345
Total FY 2019-20	$23,798	$6,902	$15,230
FY 2020-21			
Outpatient Pre-Authorizations	$6,071	$0	$1,761
Inpatient – Concurrent Review	$17,727	$0	$5,141
Total FY 2020-21	$23,798	$0	$6,902
Grand Total		$22,132	$22,132

7. The estimated cost in FY 2019-20 and FY 2020-21 are:

(Dollars in Thousands)

Treatment Plan Authorizations	**TF**	**GF**	**FF**	**CF**
Outpatient - Pre-Authorizations	$5,646	$706	$4,235	$705
Inpatient – Concurrent Review	$16,486	$2,061	$12,365	$2,060
FY 2019-20	$22,132	**$2,767**	**$16,600**	$2,765

MANAGED CARE REGULATIONS - MH PARITY

OTHER ADMIN. POLICY CHANGE NUMBER: 16

(Dollars in Thousands)

Treatment Plan Authorizations	TF	GF	FF	CF
Outpatient - Pre-Authorizations	$5,646	$706	$4,235	$705
Inpatient – Concurrent Review	$16,486	$2,061	$12,365	$2,060
FY 2020-21	$22,132	**$2,767**	**$16,600**	$2,765

Funding:
100% Title XIX FF (4260-101-0890)
100% Title XIX GF (4260-101-0001)

PAVE SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER:	17
IMPLEMENTATION DATE:	4/2016
ANALYST:	Latoya Brown
FISCAL REFERENCE NUMBER:	1932

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$9,063,000	$10,353,000
STATE FUNDS	$4,531,500	-$4,476,750
FEDERAL FUNDS	$4,531,500	$14,829,750

DESCRIPTION

Purpose:
This policy change estimates the costs for the implementation and ongoing maintenance and operations (M&O) of the Provider Application and Validation for Enrollment (PAVE) system.

Authority:
Title 42, Code of Federal Regulations 455 Subpart E – Provider Screening and Enrollment

Interdependent Policy Changes:
Not Applicable

Background:
The Department deployed an enrollment portal and associated business process application to digitize provider management activities to comply with provider integrity mandates under the Affordable Care Act. Some of the requirements are:

- Monthly database checks on enrolled providers and associated entities that manage, own, or have a controlling interest;
- Enroll all ordering, referring, or prescribing providers that bill claims to Medi-Cal;
- Periodic checks of all enrolled providers against various exclusionary databases as well as the Social Security Death Master File; and
- Revalidation of all providers every five years.

PAVE entered the M&O phase in FY 2018-19. Beginning FY 2020-21, the Department will expand the PAVE system to include enrollment activities for other provider types including Managed Care Organization (MCO) and Family Planning, Access, Care, and Treatment (FPACT).

Reason for Change:
The change from the prior estimate for FY 2019-20 and FY 2020-21 is a net decrease due to removal of all DD&I costs and updates to M&O costs. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due estimated M&O payment timing. Additionally this includes General Funds savings from the M&O post-certification recoupments in FY 2020-21.

Methodology:

1. The Department is continuing to add new provider types and benefits to PAVE on a phase-in basis with costs beginning in FY 2019-20. M&O costs continue to increase due to the inclusion of additional provider types which increases system volume and associated support activities.

2. CMS Certification Analysis costs are for June 2019 to May 2020. Payments started July 2019 for services that began June 2019.

PAVE SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 17

3. CMS certification is expected to be issued in FY 2020-21 and will allow the M&O Federal Financial Participation (FFP) to be claimed at 75% FF / 25% GF. The Department expects to receive CMS certification by July 2020 and claim enhanced federal funding for the period April 2016 to July 2020. Once the system is certified, the Department will retro-claim the additional 25% FFP which had been paid at 50% FF / 50% GF. The FFP recoupment is expected in September 2020.

4. Beginning August 2020, PAVE post-certification M&O activities are funded at the enhanced rate of 75% FFP / 25% GF.

5. The total Implementation cost is $5,993,000. This includes the actual change request cost for FPACT which is $2,310,000 and MCO which is $1,683,000. This also includes an additional $2,000,000 for unexpected changes, such as new state and federal requirements. These changes include amendments in legislative bills for adding certain provider types which require modifications in the PAVE system.

6. The FY 2019-20 and FY 2020-21 costs are as follows:

FY 2019-20	TF	GF	FF
M&O (50% Title XIX / 50% GF)	$8,813,300	$4,406,650	$4,406,650
CMS Certification Business Analysis (50% Title XIX / 50% GF)	$249,204	$124,602	$124,602
Total	**$9,063,000**	**$4,532,000**	**$4,532,000**

Totals may differ due to rounding.

FY 2020-21	TF	GF	FF
M&O Post Certification (75% Title XIX / 25% GF)	$10,353,000	$2,588,250	$7,764,750
M&O Recoupment of Funds Post Certification (100% FF / GF)	$0	($7,065,325)	$7,065,325
Total	**$10,353,000**	**($4,477,000)**	**$14,830,000**

Totals may differ due to rounding.

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
75% Title XIX / 25% GF (4260-101-0001/0890)
100% GF (4260-101-0001)
100% Title XIX FFP (4260-101-0890)

ACTUARIAL COSTS FOR RATE DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	18
IMPLEMENTATION DATE:	8/2015
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1937

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$17,056,000	$17,190,000
STATE FUNDS	$8,528,000	$8,595,000
FEDERAL FUNDS	$8,528,000	$8,595,000

DESCRIPTION

Purpose:
This policy change estimates the costs for contracted actuarial rate development services.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
Federal requirements for obtaining federal financial participation require that managed care capitation rates be actuarially sound. Actuarially sound capitation rates require:

- Rates are developed in accordance with generally accepted actuarial principles,
- Practices are appropriate for the populations to be covered,
- The services to be furnished under the contract,
- Rates have been certified by actuaries who meet the qualification standards established by the American Academy of actuaries, and
- Follow the practice standards established by the Actuarial Standards Board.

The Department entered into a contract with an actuarial services consultant to ensure development of actuarially sound capitation rates.

Reason for Change:
There is no change from the prior estimate for FY 2019-20. The change from the prior estimate, for FY 2020-21, is due to updated cost data. The prior estimate for FY 2020-21 was based on FY 2019-20 costs.

The change from FY 2019-20 to FY 2020-21 is due to payment timing.

Methodology:

1. This policy change collectively budgets for all actuarial services received for different managed care programs.

2. Per payment terms, 10% of the contractor's fees are withheld for six months pending completion of outstanding projects.

3. Per payment terms, the contractor fees overlap fiscal years due to billing for projects in the subsequent invoice month.

ACTUARIAL COSTS FOR RATE DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 18

4. Specific costs are identified for existing workloads (Coordinated Care Initiative (CCI), Affordable Care Act (ACA) Expansion, Health Homes Program, and Hospital Quality Assurance Fee (HQAF) program); however, ongoing actuarial services are needed as these, and other new programs are integrated into the overall managed care delivery system rate setting process.

5. The Health Homes Program will not apply to the CY 2021 period, due to the discontinuation of the program and have been removed from FY 2020-21.

The FY 2019-20 and FY 2020-21 amounts on an accrual basis are estimated to be:

Policy	FY 2019-20	FY 2020-21
CCI - Administrative Costs	$1,010,000	$1,010,000
ACA Expansion Admin Costs	$517,000	$517,000
Health Homes Program - Contractor Costs	$650,000	$325,000
Ongoing Actuarial Services	$15,100,000	$15,100,000
HQAF Program	$200,000	$200,000
Total	**$17,477,000**	**$17,152,000**

The FY 2019-20 and FY 2020-21 amounts on a cash basis are estimated to be:

(Dollars in Thousands)

	TF	GF	HHP Fund	HQAF	FF
FY 2019-20	**$17,056**	$8,315	$163	$50	$8,528
FY 2020-21	**$17,190**	$8,332	$163	$100	$8,595

Funding:
50% Title XIX FF / 50% GF (4260-101-0890/0001)
50% HHP Fund (4260-601-0942)
Hospital Quality Assurance Revenue Fund (4260-611-3158)

PERFORMANCE OUTCOMES SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER:	19
IMPLEMENTATION DATE:	4/2019
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1948

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$5,715,000	$4,401,000
STATE FUNDS	$2,794,250	$2,137,250
FEDERAL FUNDS	$2,920,750	$2,263,750

DESCRIPTION

Purpose:
This policy change estimates the cost to the State to reimburse mental health plans the cost they incur to capture and report new functional assessment data. County mental health plans will collect, manage, use, and report additional functional assessment data to inform performance dashboards as part of the Performance Outcomes System (POS) for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mental health services.

Authority:
Welfare & Institutions Code 14707.5

Interdependent Policy Changes:
Not Applicable

Background:
W&I Code, Section 14707.5 requires the Department to develop a performance dashboard for EPSDT mental health services that will improve outcomes at the individual and system levels and to inform fiscal decision-making related to the purchase of services.

Through implementation of these performance dashboards, California will have a coordinated method for data collection, be able to evaluate specific measures of mental health services, and establish an ongoing process for quality improvement. The implementation plan for these performance dashboards consist of the following:

- Establishing the POS methodology,
- Initial performance outcomes reporting from existing Department databases,
- Functional assessment data reporting,
- Continuous quality improvement, and
- Tracking the continuum of care for children/youth.

In order to meet the milestones for this project, mental health plans will need to modify existing data systems to capture data from the new functional assessment tools and increase staff resources or enhance current staffing levels to implement the functional assessment tools.

After a study of the functional assessment tools and a recommendation by UCLA, the Department selected the Pediatric Symptom Checklist (PSC 35) and the Child and Adolescents Needs and Strengths (CANS) to be the tools that best measure child and youth functional outcomes. Mental health plans will not incur costs to purchase these tools but will incur costs to train clinicians to administer and complete CANS, and for technical changes to county data systems to collect CANS and PSC data.

PERFORMANCE OUTCOMES SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 19

The State realigned the responsibility for Specialty Mental Health Services (SMHS) to the counties in 2011 as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, state requirements enacted after September 30, 2012, that have an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by 2011 Realignment shall apply to local agencies only to the extent that the state provides funding for the cost increase.

Reason for Change:
The change from the prior estimate for FY 2019-20 and FY 2020-21 is due to:

- Adjusting the estimate based on actual claims. The prior estimate was based on assuming more claims would be received for FY 2017-18 and FY 2018-19 to be paid in FY 2019-20,
- Adjusting the county staffing costs to be based on actual and estimated cost of assessing beneficiaries.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to a decrease in FY 2020-21 annual costs due to decreased IT costs.

Methodology:

1. Training:
   County personnel costs for training are estimated to be $173,000 for FY 2018-19, FY 2019-20 and FY 2020-21.

(Dollars in Thousands)

Training Costs - Accrual	FY 2018-19	FY 2019-20	FY 2020-21
Training (75% FF / 25% GF)	$115	$115	$115
Registration Fee (50% FF / 50% GF)	$9	$9	$9
Training Sessions (75% FF / 25% GF)	$49	$49	$49
Total Training Costs	$173	$173	$173

2. Costs for IT work:
   IT work includes costs for new hardware, software, and modifications to the Management Information System (MIS). Total costs for IT work is estimated at $5,465,000 for FY 2018-19; and $5,198,000 for FY 2019-20, and FY 2020-21. The IT work is estimated at $1,256,000 for FY 2020-21.

(Dollars in Thousands)

IT Costs - Accrual	FY 2018-19	FY 2019-20	FY 2020-21
DHCS costs to install hardware and software	$267	$0	$0
MIS modifications	$5,198	$5,198	$1,256
Total (rounded)	$5,465	$5,198	$1,256

3. Costs to staff county POS:
   - Clinical Staff will assess beneficiaries two times per year, for 30 minutes at each time. Assume the clinical staff will cost $108,000 for FY 2018-19, FY 2019-20 and FY 2020-21.

   - Data Entry Staff will key data for beneficiaries into the POS. Assume the data entry staff will cost $374,000 for FY 2018-19, FY 2019-20 and FY 2020-21.

PERFORMANCE OUTCOMES SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 19

- IT Support Staff: Assume the IT support staff will cost $108,000 for FY 2018-19, FY 2019-20, and FY 2020-21.

- Assume the IT work, training costs, and data entry staffing are eligible for reimbursement at 50%, and costs for clinical staffing is eligible for enhanced FF at 75%.

(Dollars in Thousands)

County Staffing Costs - Accrual	FY 2018-19	FY 2019-20	FY 2020-21
Clinical Staff (75% FF / 25% GF)	$108	$108	$108
Data Entry (50% FF / 50% GF)	$374	$374	$374
IT Staff (50% FF / 50% GF)	$108	$108	$108
Total	$590	$590	$590

4. The estimated total costs on an accrual basis for FY 2018-19, 2019-20, and FY 2020-21 are:

(Dollars in Thousands)

Accrual Basis	TF	Training	IT Costs	County Staffing
FY 2018-19	$6,228	$173	$5,465	$590
FY 2019-20	$5,961	$173	$5,198	$590
FY 2020-21	$2,019	$173	$1,256	$590

5. On a cash basis for FY 2019-20, the Department will pay 64% of FY 2018-19 claims, and 29% of FY 2019-20 claims. On a cash basis for FY 2020-21, the Department will pay 64% of FY 2019-20 claims, and 29% of FY 2020-21 claims. The remaining FY 2018-19 and FY 2019-20 claims are expected to be billed through the cost settlement process.

(Dollars in Thousands)

Cash Basis	TF	Training	IT Costs	County Staffing
FY 2018-19	$3,986	$111	$3,498	$378
FY 2019-20	$1,729	$50	$1,507	$171
Total FY 2019-20	$5,715	$161	$5,005	$549

(Dollars in Thousands)

Cash Basis	TF	Training	IT Costs	County Staffing
FY 2019-20	$3,815	$111	$3,327	$378
FY 2020-21	$586	$50	$364	$171
Total FY 2020-21	$4,401	$161	$3,691	$549

PERFORMANCE OUTCOMES SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 19

6. The cash basis payments in FY 2019-20 and FY 2020-21 are estimated to be:

(Dollars in Thousands)

POS Costs	TF	GF	FF
Training	$161	$42	$119
IT Costs	$5,005	$2,503	$2,503
County Staffing Costs	$549	$249	$300
Total FY 2019-20	**$5,715**	**$2,794**	**$2,922**

(Dollars in Thousands)

POS Costs	TF	GF	FF
Training	$161	$42	$119
IT Costs	$3,691	$1,846	$1,845
County Staffing Costs	$549	$249	$300
Total FY 2020-21	**$4,401**	**$2,137**	**$2,264**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
75% Title XIX / 25% GF (4260-101-0001/0890)

SURS AND MARS SYSTEM REPROCUREMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	20
IMPLEMENTATION DATE:	7/2016
ANALYST:	Latoya Brown
FISCAL REFERENCE NUMBER:	1980

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$15,212,000	$14,351,000
STATE FUNDS	$4,345,900	-$1,722,250
FEDERAL FUNDS	$10,866,100	$16,073,250

DESCRIPTION

Purpose:
The policy change estimates the Surveillance and Utilization Review Subsystem (SURS) and the Management Administration Reporting Subsystem (MARS) system replacement costs associated with the California Medicaid Management Information System (CA-MMIS).

Authority:
Contract #14-90129

Interdependent Policy Changes:
Not Applicable

Background:
System Replacement Project (SRP) constituted the contractual responsibilities required for the Contractor to replace the existing CA-MMIS, which ensures timely and accurate claims processing for Medical providers. On October 13, 2015, Xerox announced it would not fully complete the implementation of the SRP. As a result of this announcement, the Department contracted with Optum Government Solutions, Inc. (Optum) for the development of the SURS and MARS components of the original SRP. Optum was the original subcontractor under the Xerox contract. Effective July 2016, this nine-year contract with Optum includes design, development, and implementation (DD&I) and ongoing maintenance and operations (M&O) of SURS and MARS.

The SURS is a post-payment statistical-based reporting system designed to identify provider and recipient service utilization, and potential fraud. The MARS maintains the data files necessary to build a database of historic information to support the Administration, Operation, Provider Relations, and Recipient Relations reports produced by this subsystem. These subsystems provide valuable tools for conducting research as well as for performing assessments of initiatives deployed to improve quality of service, minimize expenditures, and monitor operational performance.

The system replacement for SURS was implemented on April 3, 2017. The Centers for Medicare and Medicaid Services (CMS) requires that projects be funded at 50% / 50% Federal Medical Assistance Percentage (FMAP) for projects that have been implemented but have not received CMS certification. Once CMS certification is received, the appropriate FMAP for M&O invoices will be applied retroactively. The Department evaluated the system replacement for MARS and decided to take a two-phase implementation approach. Phase I was implemented February 2019 and Phase II was implemented August 2019.

The system is currently utilized by four programs within the department: Audits and Investigations, Provider Enrollment, Integrated Systems of Care, and Accounting. Data transparency efforts have resulted in:1) Increased data publishing and release, requiring departmental support of data de-

SURS AND MARS SYSTEM REPROCUREMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 20

identification that is compliant with the Health Insurance Portability and Accountability Act; 2) Data management and reporting to the California Health and Human Services (CHHS) Open Data Portal and CHHS GeoHub; 3) Data requests to the Department of Healthcare Services (DHCS) Data and Research Committee by researchers and state and county public health authorities; 4) Data requests to respond to subpoenas, audits, and public record act requests;5) Data sharing between DHCS programs and other departments at the federal, state and local levels; and 6) The need to coordinate and maximize the use of DHCS existing data analytic tools.

In addition, reporting and analytic requirements have increased significantly over the past several years. These are reflected in Standard Terms and Conditions for the various waiver programs and in various state and federal statute. Examples of federal statute include reporting for the Transformed Medicaid Statistical Information System (T-MSIS) and Core Set Reporting of Adult and Child quality measures. The increased reporting requirements have driven needs for additional data, enhancements, and use of the Management Information System/Decision Support System.

The Department is currently working on an Operating Annual Planning Document Update (OAPDU) to seek enhanced funding from CMS for contract amendment 4. The Department estimates to submit the OAPDU to CMS for approval during the fourth quarter of State Fiscal Year 2019-2020.

Since 2017, the number of licensed users has grown to 150, an increase of 600 percent and the number of queries run within the system has gone up almost 600 percent. There have been 31 change requests requesting new tables, new algorithms/reports, and increased demand to access the new data. In addition, the increased expectations for data from CMS for T-MSIS reporting has added new requirements for additional data and improved data quality. The addition of the MARS component in 2019 has expanded the user base to include Accounting and Integrated Systems of Care, and reports associated with their programs. Due to these changes, storage needs have continued to rise due to these new additions to the system along with other changes, such as the addition of Managed Care Encounter data and data retention changing from three to six years.

Reason for Change:
There is no change in FY 2019-20, from the prior estimate.

The increase in FY 2020-21, from the prior estimate, is due to:

- The current SURS and MARS contract is being amended in FY 2020-21 (contract amendment 4) to address state and federal requirements which impact the volume and complexity of data to be stored in the warehouse. MARS and SURS has grown incrementally with the data warehouse which has greatly impacted volume and usage.

The decrease from FY 2019-20 to FY 2020-21, in the current estimate, is due to:

- Completion of DD&I costs for SURS and MARS in FY 2019-20, and
- GF savings are estimated due to the recoupment of enhanced FFP in FY 2020-21.

Methodology:

1. SURS invoices that were funded at 50% FF / 50% GF FMAP as of April 1, 2017, will receive retroactive Federal Financial Participation (FFP) once the SURS and MARS projects have been certified by CMS.

2. The Department expects CMS certification to be received by August 2020 and will claim enhanced funding (25% of M&O costs which were paid at 50% FFP) for the period April 2017 to August 2020. The recoupment of this FFP is expected to occur in October 2020.

SURS AND MARS SYSTEM REPROCUREMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 20

3. All SURS and MARS M&O activities are expected to be funded at the enhanced rate of 75% FF / 25% GF beginning September 2020.

4. The estimated breakdown of the SURS costs are:

SURS	FY 2019-20	FY 2020-21
DD&I Costs	$838,000	$0
Operational Costs	$5,693,000	$11,246,000
Total	$6,531,000	$11,246,000

5. The estimated breakdown of the MARS costs are:

MARS	FY 2019-20	FY 2020-21
DD&I Costs	$6,181,000	$0
Operational Costs	$2,500,000	$3,105,000
Total	$8,681,000	$3,105,000

6. The estimated total costs for SURS and MARS are:

SURS and MARS	**TF**	**GF**	**FF**
DD&I Costs (90% FF / 10% GF)	$7,019,000	$702,000	$6,317,000
Operational Costs (50% FF / 50% GF), (75% FF / 25% GF)	$8,193,000	$3,644,000	$4,547,000
Total FY 2019-20	**$15,212,000**	**$4,346,000**	**$10,866,000**

SURS and MARS	**TF**	**GF**	**FF**
Operational Costs (50% FF / 50% GF), (75% FF / 25% GF)	$14,351,000	$3,588,000	$10,436,000
DD&I Cost (90%FF/10%GF)	$0	$0	$0
Post-Certification FFP Recoupment	$0	($5,310,000)	$5,310,000
Total FY 2020-21	**$14,351,000**	**($1,722,000)**	**$16,073,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
75% Title XIX / 25% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)

CA HEALTH INFORMATION EXCHANGES ONBOARDING PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER:	21
IMPLEMENTATION DATE:	6/2020
ANALYST:	Manvir Lallian
FISCAL REFERENCE NUMBER:	2159

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$500,000	$42,620,000
STATE FUNDS	$50,000	$4,262,000
FEDERAL FUNDS	$450,000	$38,358,000

DESCRIPTION

Purpose:
This policy change estimates the cost to administer the California Health Information Exchanges (HIE) Onboarding Program (Cal-HOP) as part of the Medi-Cal Promoting Interoperability Program.

Authority:
ARRA of 2009

Interdependent Policy Changes:
Not Applicable

Background:
On February 29, 2016, the Department received State Medicaid Director Letter 16-003 from the Centers for Medicare and Medicaid Services which provided states updated guidance on additional opportunities to draw down enhanced federal funding to implement activities to promote HIE and encourage the adoption of certified Electronic Health Records. Under this guidance, the Department requested approval to implement the Cal-HOP program, which will support Health Information Organizations (HIOs) to work with Medi-Cal providers and hospitals to onboard to the HIOs as well as establish interfaces between HIOs and the Controlled Substance Utilization Review and Evaluation System. General fund for this program was initially appropriated in FY 2018-19 with a $5 million augmentation.

On February 25, 2020, the Department received federal approval for the federal fiscal year 2020 Implementation Advanced Planning Document Update, which provided specific approval for the Cal-HOP program.

Reason for Change:
The change for FY 2019-20, from the prior estimate, is a decrease due to obtaining federal approvals later than previously anticipated. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to a full year of program implementation occurring in FY 2020-21.

Methodology:
1. Assume the Cal-HOP program implemented in May 2020.

2. The estimated expenditures for the Cal-HOP program are:

CA HEALTH INFORMATION EXCHANGES ONBOARDING PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 21

Fiscal Year	TF	GF	FF
FY 2019-20	$500,000	$50,000	$450,000
FY 2020-21	$42,620,000	$4,262,000	$38,358,000

Funding:
100% State GF (4260-101-0001)
100% Title XIX (4260-101-0890)

MEDI-CAL RECOVERY CONTRACTS

OTHER ADMIN. POLICY CHANGE NUMBER:	22
IMPLEMENTATION DATE:	2/2008
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1551

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$7,159,000	$6,837,000
STATE FUNDS	$1,789,750	$1,709,250
FEDERAL FUNDS	$5,369,250	$5,127,750

DESCRIPTION

Purpose:
This policy change estimates the cost of third party liability contracts to identify and recover Medi-Cal expenditures from responsible health insurance (HI). The policy change also includes online database contracts to access online activity and data matches in support of recovery.

Authority:
Contracts:

Dept. of Industrial Relations – Electronic Adjudication Management System (EAMS)	17-94002
Dept. of Industrial Relations – Workers' Compensation Information System (WCIS)	19-96030
Department of Social Services	15-92000
Department of Social Services	20-10026 (Pending)
EDEX Information Systems Inc. (WC)	18-95016
Health Management Systems Inc. (HI)	18-95310
RELX Inc.	17-94636
RELX Inc.	17-94636 A01 (Pending)

Interdependent Policy Changes:
Not Applicable

Background:
Since Medi-Cal is the payer of last resort, all legally responsible third parties must first be billed before the Medi-Cal program. The above contracts provide:

- Data matches between the Department's Medi-Cal member eligibility file and the contractor's policy holder/subscriber file,
- Identification of private/group health coverage and the recovery of Medi-Cal expenditures when the private/group health coverage is the primary payer,
- Online access to research database services for public records of Medi-Cal members,
- Access to disability determinations for applicants requesting an exemption from estate recovery claims on the basis of a disability, and
- Cost avoidance activities.

MEDI-CAL RECOVERY CONTRACTS

OTHER ADMIN. POLICY CHANGE NUMBER: 22

For contingency based contracts, when such insurance is identified, the vendor retroactively bills the third party to recover Medi-Cal paid claims. Payment to the vendor is contingent upon recoveries, and may exceed the vendor's estimated recovery projections. Recoveries due to third party liability vendor activities are incorporated into the Base Recoveries policy change.

The Department awarded the Health Insurance contract (18-95310) to Health Management Systems, Inc. (HMS). This contract became effective on December 1, 2018 and will run through November 30, 2023. The contingency fee is 8.5 percent.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is due to:

- Projected decrease in recoveries for the HMS contractor based on delays in additional recovery efforts in FY 2019-20.

The change in FY 2020-21, from the prior estimate, is due to:

- Projected decrease in recoveries for the HMS contractor based on reduced paid claims volume anticipated, the postponement of managed care recoveries, and
- Projected decrease due to the removal of batch processing through the online database contracts, thus resulting in lower annual rates.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to:

- Projected decrease in recoveries in FY 2020-21 based on fewer recoverable claims,
- Projected decrease due to the removal of batch processing through the online database contracts, thus resulting in lower annual rates, and
- No further payments for the EDEX Information Systems Inc. contract in FY 2020-21.

Methodology:

1. The amounts paid to the HMS contractor for HI is contingent upon recoveries. Assume the following recoveries for each fiscal year at the contracted contingency fee percentage. The HI recovery contract's timeframe is from December 1, 2018, through November 30, 2023.

   Recoveries x Contingency Fee % = Total Contingency Fee

Contractor	FY 2019-20 Recoveries	FY 2020-21 Recoveries	Contingency Fee %	FY 2019-20 Contingency Fee	FY 2020-21 Contingency Fee
HMS 18	$83,000,000	$80,000,000	8.50%	$7,055,000	$6,800,000

2. The amounts paid to the Online Database contractors is based upon usage:

Online Database Contracts	FY 2019-20	FY 2020-21
Department of Industrial Relations - EAMS	$4,000	$4,000
Department of Industrial Relations – WCIS	$2,000	$2,000
Department of Social Services	$11,000	$3,000
RELX Inc.	$86,000	$28,000
EDEX Information Systems Inc. (WC)	$1,000	$0
Total	$104,000	$37,000

MEDI-CAL RECOVERY CONTRACTS

OTHER ADMIN. POLICY CHANGE NUMBER: 22

3. The payments shown below include recent recovery activity.

FY 2019-20	TF	GF	FF
Health Insurance	$7,055,000	$1,764,000	$5,291,000
Online Database Contracts	$104,000	$26,000	$78,000
Total	**$7,159,000**	**$1,790,000**	**$5,369,000**

FY 2020-21	TF	GF	FF
Health Insurance	$6,800,000	$1,700,000	$5,100,000
Online Database Contracts	$37,000	$9,000	$28,000
Total	**$6,837,000**	**$1,709,000**	**$5,128,000**

Funding:
75% Title XIX / 25% GF (4260-101-0001/0890)

MIS/DSS CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER:	23
IMPLEMENTATION DATE:	7/2002
ANALYST:	Latoya Brown
FISCAL REFERENCE NUMBER:	252

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$12,716,000	$22,943,000
STATE FUNDS	$3,310,200	$5,745,900
FEDERAL FUNDS	$9,405,800	$17,197,100

DESCRIPTION

Purpose:
The policy change estimates the contract costs associated with the Management Information System/Decision Support System (MIS/DSS).

Authority:
Contract #14-90129
CMS Transformed Medicaid Statistical Information System (T-MSIS) Requirements

Interdependent Policy Changes:
Not Applicable

Background:
The MIS/DSS houses a variety of Medicaid-related data and incorporates it into an integrated, business intelligence system. The system is used by more than 20 different areas within the Department (i.e. Audits & Investigations, Managed Care Operations, Pharmacy Benefits, and Provider Enrollment), several other State departments, such as the California Department of Public Health and the Department of Justice, and other approved entities. The Department uses the system in various ways, including:

- Centers for Medicaid Services (CMS) Reporting,
- The Medi-Cal Managed Care Division in its monitoring of health plan performance,
- The Third Party Liability and Recovery Division in its collection efforts, and
- The Audits and Investigations Division in its anti-fraud efforts.

Ongoing maintenance and operation of the MIS/DSS are accomplished through a multi-year contract. The Department has awarded a nine-year contract for the ongoing maintenance and operation of the MIS/DSS that began March 1, 2015. The contract requires the vendor to operate and maintain the MIS/DSS data warehouse by providing help desk support, training, and maintenance on the platform. Also, the MIS/DSS contract requires the contractor to refresh the hardware and software to help maintain peak performance and control support costs.

The existing MIS/DSS contract will expire June 2023. The current MIS/DSS contract will also be amended in FY 2020-21 (contract amendment 4) to address mandatory, mission-critical state and federal requirements which impact the volume and complexity of data to be stored in the warehouse. The increased volume and complexity of data is due to accommodating larger operational data loads, primarily to satisfy T-MSIS requirements that CMS now mandates the Department to provide including utilization and claims data, beneficiary and provider enrollment data, enhanced information about beneficiary eligibility and service utilization.

MIS/DSS CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 23

Data transparency efforts have resulted in:1) Increased data publishing and release, requiring departmental support of data de-identification that is compliant with the Health Insurance Portability and Accountability Act, 2) Data management and reporting to the California Health and Human Services (CHHS) Open Data Portal and CHHS GeoHub; 3) Data requests to the DHCS Data and Research Committee by researchers and state and county public health authorities; 4) Data requests to respond to subpoenas, audits, and public record act requests;5) Data sharing between DHCS programs and other departments at the federal, state and local levels; and 6) The need to coordinate and maximize the use of DHCS existing data analytic tools.

In addition, reporting and analytic requirements have increased significantly over the past several years. These are reflected in Standard Terms and Conditions for the various waiver programs and in various state and federal statute. Examples of federal statute include reporting for the T-MSIS and Core Set Reporting of Adult and Child quality measures. The increased reporting requirements have driven needs for additional data, enhancements, and use of the MIS/DSS.

Since 2015, the number of licensed users has increased by over 33 percent and the number of queries run within the system has gone up almost 250 percent. There have been 62 change requests requesting new data feeds or layout changes and increased demand to access the new data. Examples include Combined Provider file, Waiver Enrollment and Dental data. In addition, the increased expectations for data from CMS for T-MSIS reporting has added new requirements for additional data and improved data quality. Increased usage of the new data and the system is evenly spread across the existing user base. Due to these changes, storage needs have continued to rise. With the additional volume and data loads, usage of the data warehouse has grown incrementally and the scheduled hardware/software refresh originally scheduled for FY 2021-22 is required earlier in FY 2020-21.

The Department created an Operating Annual Planning Document Update (OAPDU) to seek enhanced funding from CMS for contract amendment 4. The Department submitted the OAPDU to CMS for approval during the fourth quarter of State Fiscal Year 2019-20.

Reason for Change:
The increase from the prior estimate for FY 2019-20 is the inclusion of costs to procure technical consulting services to develop re-procurement of artifacts (e.g. current/future environment models with references; technical/business requirements; multiple technical appendices).

The increase in FY 2020-21, from the prior estimate, is due to including additional costs to procure consulting services to develop re-procurement artifacts. Additionally, contract amendment 4 will cover the cost resulting from the increased volume and complexity of data due to accommodating larger operational data loads, primarily to satisfy T-MSIS requirements.

The increase from FY 2019-20 to FY 2020-21, in the current estimate includes additional costs to procure consulting services to develop re-procurement artifacts in FY 2020-21; and, contract amendment 4, which covers the cost resulting from the increased volume and complexity of data due to accommodating larger operational data loads, primarily to satisfy T-MSIS requirements. With the additional volume and data loads, usage of the data warehouse has grown incrementally and the scheduled hardware/software refresh originally scheduled for FY 2021-22 is required earlier in FY 2020-21.

MIS/DSS CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 23

Methodology:

1. MIS/DSS total contract amendment 4 costs will begin in July 1, 2020, and end on June 30, 2023, which is the date the original contract expires. The estimated total costs included in this amendment is $11,333,000 ($8,400,000 for FY 2020-21, $33,000 for FY 2021-22, and $2,900,000 for FY 2022-23).

2. To cover costs resulting from the Non-Medicaid Pharmacy Rebates and the re-procurement, the Department assumes a one-time cost of $1.2 million in FY 2020-21 to procure software, storage, and contractor resources. It is estimated that there will be ongoing costs of $538,000 for FY 2020-21 and $1 million annually for maintenance and operations beginning in FY 2021-22.

3. It is estimated that the contractor will be paid the following amounts:

FY 2019-20	TF	GF	FF
Fixed Costs (75% FF / 25% GF)	$8,697,000	$2,174,000	$6,523,000
Additional Fixed Costs (50% FF / 50% GF)	$691,000	$346,000	$345,000
Variable Costs (75% FF / 25% GF)	$3,051,000	$763,000	$2,288,000
Re-procurement Consulting Services (90% FF / 10% GF)	$188,000	$19,000	$169,000
CDT Statewide Technology Procurement (90% FF / 10% GF)	$89,000	$9,000	$80,000
Total	**$12,716,000**	**$3,311,000**	**$9,405,000**

FY 2020-21	TF	GF	FF
Fixed Costs (75% FF / 25% GF)	$16,225,000	$4,056,000	$12,169,000
Additional Fixed Costs (50% FF / 50% GF)	$703,000	$351,000	$352,000
Variable Costs (75% FF / 25% GF)	$4,911,000	$1,228,000	$3,683,000
Re-procurement Consulting Services (90% FF / 10% GF)	$750,000	$75,000	$675,000
CDT Statewide Technology Procurement (90% FF / 10% GF)	$354,000	$35,000	$319,000
Total	**$22,943,000**	**$5,745,000**	**$17,198,000**

Funding:

50% Title XIX / 50% GF (4260-101-0890/0001)
75% Title XIX / 25% GF (4260-101-0890/0001)
90% Title XIX / 10% GF (4260-101-0890/0001)

MITA

OTHER ADMIN. POLICY CHANGE NUMBER:	24
IMPLEMENTATION DATE:	1/2011
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1137

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$5,675,000	$11,326,000
STATE FUNDS	$680,660	$1,471,340
FEDERAL FUNDS	$4,994,340	$9,854,660

DESCRIPTION

Purpose:
This policy change estimates the costs associated with the Medicaid Information Technology Architecture (MITA) initiative sponsored by Centers for Medicare and Medicaid Services (CMS).

Authority:
42 Code of Federal Regulations 433.112(b)11
42 Code of Federal Regulations 495.332(a)(2)
45 Code of Federal Regulations 95-626(b)
Interagency Agreement (IA) 13-90390 A01

Interdependent Policy Changes:
Not Applicable

Background:
CMS is requiring the Department to move toward creating flexible systems, which support interactions between the federal government and their state partners. Through MITA, the Department will develop the ability to streamline the process to access information from various systems, which will result in cost effectiveness. CMS will not approve Advance Planning Documents (APDs) or provide enhanced federal funding to the Department without adherence to MITA.

To operate more effectively and efficiently, the Department must take steps to achieve the maturity goals of the MITA Framework and focus strategic planning, system changes, and upgrades around Department-wide business processes rather than focusing on separate program needs. These steps will prevent the Department from potentially duplicating efforts regarding hardware, software, and resources across the enterprise.

This MITA project will help mature the business processes and position the Department to be more flexible as it serves the growing number of members. Enacting the MITA Framework and associated governance will also allow the Department to more quickly and accurately react to federal and state laws. Additionally, the Department will be better prepared to use the immense amounts of Medicaid data collected daily to better manage the program.

The Department conducts an annual MITA State Self-Assessment (SS-A) required by CMS, which includes a State MITA roadmap. Recently, through enforcement of their Medicaid Certification regulations, CMS now requires the use of Enterprise Independent Verification and Validation (IV&V) resources and highly recommends a Medicaid Enterprise System Integrator (MESI) as it relates to the CMS enterprise certification process. In addition, CMS requires the enterprise IV&V contract to be held outside of the organization that owns the systems requiring certification. To ensure compliance with the federal requirement for IV&V certification services the California Department of Technology (CDT)

MITA

OTHER ADMIN. POLICY CHANGE NUMBER: 24

is holding the contract and will provide contract management services.

Also integral in the Department's MITA governance is the Clarity application, which houses MITA data/roadmap information, and overall facilitates the Department's project portfolio and governance process. An additional technical consultant resource is needed to support the Clarity application.

Pursuant to an IA with the Regents of the University of California, San Diego (UCSD), an analyst and programmer provides support for data management and analytics to assist the Department in reaching MITA maturity, beginning December 2019.

MITA planning activities to improve provider management information will occur and will assess efforts necessary for a consolidated provider data repository, improving consumer facing provider directories, and collecting provider network information from behavioral health and managed care dental plans.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a net decrease due to the withdrawn MESI contract, and adjusting MITA, CDT Contract Management Services, CDT Statewide Technology Procurement, and CDT Acquisition & IT Program Branch to actual costs. The decrease was also due to delays in obtaining the consulting services resources below:

- Business analyst and technical writer consultants
- Dental provider management pre-work consultants
- Clarity portfolio management technical consultants

The change from the prior estimate, for FY 2020-21, is a decrease due to:

- A shift in the start date of the technical consultant contracts
- The withdrawn MESI contract
- Updated UCSD data analysts costs and Enterprise IV&V costs
- A delay in approvals for the new MITA efforts (business analysts and technical writers)
- A delay in contract execution for the provider management-dental planning pre-work

The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to:

- UCSD contract delays
- Approval delays for the new MITA efforts (business analysts and technical writers)
- A delay in contract execution for the provider management-dental planning pre-work
- A start date shift for technical consultant
- Adjusted Enterprise IV&V costs to reflect actual expenditures

Methodology:

1. The FY 2019-20 and FY 2020-21 contract amounts are associated with the expansion of the MITA initiative throughout the Department in order to meet federal regulations and guidelines.

2. The MITA contract ended in December 2019 and amended to extend this agreement through June 2023.

3. Costs for an IA with UCSD to implement analytics as a service to support MITA began in December 2019.

4. FY 2019-20 and FY 2020-21 include costs to support the Enterprise IV&V, Project Management Support Services, CDT Contract Management Services, CDT Statewide Technology Procurement

MITA

OTHER ADMIN. POLICY CHANGE NUMBER: 24

Services, CDT Acquisitions and IT Program Branch, MESI, and technical consultant to help further support the MITA initiative. The technical consultant resource will support the Clarity application.

5. MESI and Provider Management Directory/Repository costs have been removed from this policy change as the Department builds the Medi-Cal Enterprise Systems (MES) Division.

6. FY 2020-21 includes costs to support additional MITA business analysts and technical writers.

7. The projected FY 2019-20 and FY 2020-21 costs are:

FY 2019-20	APD	TF	GF	FF
MITA Contract	MITA	$2,772,000	$317,000	$2,455,000
UCSD IA	MITA	$470,000	$54,000	$416,000
Enterprise IV&V	IV&V	$1,200,000	$137,000	$1,063,000
Technical Consultant*	N/A	$84,000	$42,000	$42,000
Provider Management	PROV.	$536,000	$61,000	$475,000
Contract Mgmt. Svcs.	IV&V	$177,000	$20,000	$157,000
Statewide Technology Procurement	IV&V	$274,000	$31,000	$243,000
CDT Acquisition & IT Program Branch	IV&V	$162,000	$19,000	$143,000
Total		**$5,675,000**	**$681,000**	**$4,994,000**

FY 2020-21	APD	TF	GF	FF
MITA Contract	MITA	$3,465,000	$431,000	$3,034,000
UCSD IA	MITA	$487,000	$61,000	$426,000
Enterprise IV&V	IV&V	$2,888,000	$359,000	$2,529,000
Technical Consultant*	N/A	$167,000	$83,000	$84,000
Provider Management	PROV.	$800,000	$99,000	$701,000
MITA Support	MITA	$750,000	$93,000	$657,000
Contract Mgmt. Svcs.	IV&V	$468,000	$58,000	$410,000
Project Mgmt. Support Svcs.	IV&V	$1,920,000	$239,000	$1,681,000
Statewide Technology Procurement	IV&V	$57,000	$7,000	$50,000
CDT Acquisition & IT Program Branch	IV&V	$324,000	$40,000	$284,000
Total		**$11,326,000**	**$1,471,000**	**$9,855,000**

Funding:
90% Title XIX / 10% GF (4260-101-0001/0890)
*50% Title XIX / 50% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)
65% Title XXI / 35% GF (4260-113-0001/0890)
100% State GF (4260-101-0001)

CCI-ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	25
IMPLEMENTATION DATE:	7/2012
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	1677

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$11,213,000	$11,213,000
STATE FUNDS	$5,606,500	$5,606,500
FEDERAL FUNDS	$5,606,500	$5,606,500

DESCRIPTION

Purpose:
This policy change estimates the administrative costs for the Coordinated Care Initiative (CCI).

Authority:
SB 1008 (Chapter 33, Statutes of 2012)
SB 1036 (Chapter 45, Statutes of 2012)
SB 94 (Chapter 37, Statutes of 2013)
SB 75 (Chapter 18, Statutes of 2015)
SB 97 (Chapter 52, Statutes of 2017)

Interdependent Policy Changes:
Multipurpose Senior Services Program – CDA

Background:
In coordination with Federal and State Government, the CCI provides the benefits of coordinated care models to persons eligible for Medi-Cal. CCI aims to improve service delivery for people with dual eligibility and Medi-Cal only beneficiaries who rely on long-term services and supports (LTSS) to maintain residence in their communities. LTSS includes both home and community-based services and institutional long-term care services. Services are provided through the managed care delivery system for all Medi-Cal beneficiaries who rely on such services. The Department hired contractors to do the following:

- Stakeholder and Advocate Outreach,
- Quality assurance and monitoring by an External Quality Review Organization (EQRO),
- Evaluation,
- Project Management,
- Multipurpose Senior Services Program (MSSP) Transition,
- IT Project Management, and
- Data Outcomes and Evaluation Development (Encounter Data Quality and Performance Measures).

The 2017 Budget Act discontinued the CCI program effective January 1, 2018. Based on lessons learned from the CCI demonstration project, the 2017 Budget extended the Cal MediConnect program and the mandatory enrollment of dual eligibles and integration of long-term services and support, except In-Home Supportive Services (IHSS), into managed care. IHSS has been removed from capitation rate payments effective January 1, 2018.

Under the Centers for Medicare and Medicaid Services approval to carve out MSSP from the CCI, the

CCI-ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 25

MSSP benefit will be removed effective January 1, 2021.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21. There is no change from FY 2019-20 to FY 2020-21 in the current estimate.

Methodology:
1. The CCI development, implementation and operation costs began July 2012 and will continue through FY 2020-21.

2. All costs for FY 2019-20 and FY 2020-21 will be funded at 50/50 FMAP.

FY 2019-20	TF	GF	FF
Stakeholder and Advocate Outreach	$3,248,000	$1,624,000	$1,624,000
Encounter Data Quality & Perform. Measures	$2,322,000	$1,161,000	$1,161,000
Evaluation	$2,125,000	$1,062,500	$1,062,500
Technical Project Manager (IT)	$1,034,000	$517,000	$517,000
Project Management	$484,000	$242,000	$242,000
EQRO Monitoring	$1,000,000	$500,000	$500,000
MSSP Transition	$1,000,000	$500,000	$500,000
Total	**$11,213,000**	**$5,606,500**	**$5,606,500**

FY 2020-21	TF	GF	FF
Stakeholder and Advocate Outreach	$3,248,000	$1,624,000	$1,624,000
Encounter Data Quality & Perform. Measures	$2,322,000	$1,161,000	$1,161,000
Evaluation	$2,125,000	$1,062,500	$1,062,500
Technical Project Manager (IT)	$1,034,000	$517,000	$517,000
Project Management	$484,000	$242,000	$242,000
EQRO Monitoring	$1,000,000	$500,000	$500,000
MSSP Transition	$1,000,000	$500,000	$500,000
Total	**$11,213,000**	**$5,606,500**	**$5,606,500**

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

PASRR

OTHER ADMIN. POLICY CHANGE NUMBER:	26
IMPLEMENTATION DATE:	7/2013
ANALYST:	Elena Susbilla
FISCAL REFERENCE NUMBER:	1720

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$8,964,000	$10,555,000
STATE FUNDS	$2,241,000	$2,638,750
FEDERAL FUNDS	$6,723,000	$7,916,250

DESCRIPTION

Purpose:
This policy change estimates the contractor costs for the Preadmission Screening and Resident Review (PASRR) Level II evaluations, system build-out, and ongoing Maintenance and Operations (M&O) for the automated PASRR system.

Authority:
Title 42, Code of Federal Regulations 483.100-483.136, 483.200-483.206

Interdependent Policy Changes:
Not Applicable

Background:
Federal regulations mandate that the Department have an independent contractor complete all Level II PASRR evaluations. A service contract has been executed to engage Evaluators to travel to facilities and conduct Level II Evaluations on individuals with mental illness. A Level II Evaluation consists of a face-to-face mental status examination and psychosocial assessment for individuals identified with or suspected of having a mental illness upon admission to a nursing facility (NF). The findings of this evaluation result in a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care. The contractor's licensed clinical evaluators conduct the Level II Evaluations and enter their findings into the PASRR database.

A new service contract to provide Level II Evaluations was executed in March 2018 and is effective through the end of June 2020. A new service contract to provide Level II Evaluations will be awarded in July 2020.

The Department received funding to design, test, and implement a web-based automated system to bring PASRR into compliance with federally mandated regulations. The PASRR system replaced a mainframe database with a database that meets the Department's architecture, infrastructure, and security requirements. The PASRR system:

- Allows NFs, hospitals, and evaluators to electronically submit Level I Screens and Level II Evaluations;
- Significantly reduces processing time for submissions;
- Eliminates paper submissions;
- Reduces the time a contractor takes to return completed evaluations;
- Increases efficiencies for PASRR clinicians by reducing processing time for determinations.

PASRR

OTHER ADMIN. POLICY CHANGE NUMBER: 26

The PASRR Information Technology (IT) system build-out contract is effective November 2019 through November 2020. The contract engages a business analyst and software engineers to develop and implement the following updates to the existing PASRR system:

- The Level I Screening will be updated for general acute care hospitals. The Level I Screening will also capture information requested by Centers for Medicaid and Medicare Services (CMS).
- Extend the existing functionality of the system to allow electronic exchange of PASRR information between hospitals and NFs.
- Enable evaluators to complete Level II Evaluations without requiring an internet connection. The evaluators can download the Evaluations to a laptop and then upload the information to PASRR.
- Update the existing Determination wizard and Determination Letter.
- Update the existing electronic Reconsideration process that ensures facilities and the Department have complete records for patient care plans.
- Update existing dashboards for each role.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is due to:

- A decrease in Evaluations estimate since contractor was completing backlog cases between July and December 2019, which are reimbursed at a lower rate;
- A decrease in PASRR System Build Out estimate due to contract work beginning December 2019.

The change in FY 2020-21, from the prior estimate, is due to:

- Evaluations estimate based on actual trends and start of new contract anticipated to begin July 2020;
- Increase in PASRR System Build Out estimate due to contractor beginning work later than anticipated.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to:

- New Evaluations contract anticipated start date July 2020;
- PASRR System Build Out expenditures anticipated to begin January 2020.

Methodology:

1. Expenditures for the existing Level II Evaluations contract began April 2018. Expenditures for new Evaluations contract will occur in August 2020.

2. The PASRR IT system requires ongoing M&O. The M&O contract terminated May 2019. The PASRR IT system requires annual software license renewal for M&O.

3. In FY 2019-20 and FY 2020-21, existing functionality of the PASRR system will be updated. Updates planned are a redesigned Level I Screening, the ability to allow general acute care hospitals and NFs to exchange PASRR information, and the ability for evaluators to download and upload Level II Evaluation material from and to the PASRR system.

PASRR

OTHER ADMIN. POLICY CHANGE NUMBER: 26

4. The PASRR payments on a cash basis are estimated at:

FY 2019-20	TF	GF	FF
Evaluations	$8,473,000	$2,118,000	$6,355,000
Ongoing M&O Costs	$13,000	$3,000	$10,000
System Build Out	$478,000	$120,000	$358,000
Total	**$8,964,000**	**$2,241,000**	**$6,723,000**

FY 2020-21	TF	GF	FF
Evaluations	$9,899,000	$2,475,000	$7,424,000
Ongoing M&O Costs	$3,000	$1,000	$2,000
System Build Out	$653,000	$163,000	$490,000
Total	**$10,555,000**	**$2,639,000**	**$7,916,000**

Funding:
75% Title XIX / 25% GF (4260-101-0001/0890)

HCBA WAIVER RENEWAL ADMINISTRATIVE COST

OTHER ADMIN. POLICY CHANGE NUMBER:	27
IMPLEMENTATION DATE:	7/2019
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	2152

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$9,764,000	$12,316,000
STATE FUNDS	$4,882,000	$6,158,000
FEDERAL FUNDS	$4,882,000	$6,158,000

DESCRIPTION

Purpose:
This policy change estimates the administrative cost of renewing the Home and Community-Based Alternatives (HCBA) Waiver.

Authority:
Welfare and Institutions Code, Section 14132.991

Interdependent Policy Changes:
Not Applicable

Background:
The HCBA waiver offers services in the home or community to Medi-Cal beneficiaries who would otherwise receive care in a skilled nursing facility. Eligibility into the waiver is based on skilled nursing levels of care. The level of care is determined by the Medi-Cal beneficiary's medical need. The waiver is held to the principle of federal cost neutrality; thus, services are arranged so that the overall total costs for the waiver and Medi-Cal State Plan services cannot exceed the costs of facilities offering equivalent levels of care. The Department received approval for an amendment to the NF/AH waiver in November 2016, retroactive to February 1, 2016. The primary change enacted through this amendment was to allow a shift to the calculation of cost neutrality in the aggregate, based upon medical necessity. The Department received approval of the waiver renewal application on May 16, 2017, retroactive to January 1, 2017. As part of the approved renewal application, the waiver was renamed to the HCBA Waiver.

Under the NF/AH Waiver renewal, the Department received approval to:

- Increase the number of waiver slots with long-term savings by expanding capacity of the HCBA waiver, which would eliminate the waitlist and allow Medi-Cal beneficiaries to remain in their home or community and mitigate the risk of institutionalization while incentivizing increased long-term skilled nursing facility transition;

- Localize care management to comply with person-centered care planning and provide local care coordination that will increase access to medically necessary services for beneficiaries while reducing inpatient, emergency room, and skilled nursing facility admissions and readmissions. The primary model for the administration and operation of the Waiver is through contracted Waiver Agencies. The Waiver Agencies are responsible for local Waiver Administration functions and for the delivery of the Comprehensive Care Management Waiver service. The reimbursement structure for Waiver Administration services will be a per member per month rate. The reimbursement structure for Comprehensive Care Management will be a

HCBA WAIVER RENEWAL ADMINISTRATIVE COST

OTHER ADMIN. POLICY CHANGE NUMBER: 27

tiered per member per month based on acuity. The combination of transitions to Comprehensive Care Management and changing the role of state staff to oversight and monitoring will result in a reduction in health care costs over time through a significantly strengthened care management model;

- Shift to aggregate cost neutrality, based upon medically necessary waiver services, which was approved in the waiver amendment; and

- Gradual integration of the In-Home Operations (IHO) Waiver by transitioning IHO waiver beneficiaries into the HCBA waiver at the point of annual reassessment.

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is a decrease due to a lower baseline of eligibles used in the current estimate versus the prior estimate. In the prior estimate the baseline enrollment was 4,215. In the current estimate, the baseline enrollment is 2,668. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase in costs due to the additional enrollment of beneficiaries to the HCBA Waiver.

Methodology:

1. There are currently 4,291 waiver participants. Assume 2,223 new participants will be enrolled in FY 2019-20 and 1,200 FY 2020-21.

2. The renewed waiver was approved on May 16, 2017, with an effective date of January 1, 2017.

3. Assume 95% of all current and new waiver participants will enroll with a Waiver Agency and receive administrative services.

4. Assume the monthly cost for administration is $186.56.

Fiscal Year	TF	GF	FF
FY 2019-20	$9,764,000	$4,882,000	$4,882,000
FY 2020-21	$12,316,000	$6,158,000	$6,158,000

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

LITIGATION RELATED SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 28
IMPLEMENTATION DATE: 7/2009
ANALYST: Latoya Brown
FISCAL REFERENCE NUMBER: 1381

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$9,980,000	$9,980,000
STATE FUNDS	$4,990,000	$4,990,000
FEDERAL FUNDS	$4,990,000	$4,990,000

DESCRIPTION

Purpose:
This policy change estimates the costs of litigation and actuarial consulting.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The Department continues to experience litigation cases challenging legislation implementing changes to the Medi-Cal program.

Ongoing litigation filed by managed care plans relating to capitation rates has resulted in significant time expended by actuarial staff in evaluating the cases and developing defense strategies.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21. There is no change from FY 2019-20 to FY 2020-21 in the current estimate.

Methodology:
1. Based on prior Department of Justice litigation costs and projected workload, costs are projected to be $7,880,000 for both FY 2019-20 and FY 2020-21.

2. Based on prior actuary costs and the Department's projected workload, costs will be $2,100,000 in both FY 2019-20 and FY 2020-21.

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
Litigation Representation	$7,880	$3,940	$3,940
Consulting Actuaries	$2,100	$1,050	$1,050
Total	**$9,980**	**$4,990**	**$4,990**

LITIGATION RELATED SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 28

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
Litigation Representation	$7,880	$3,940	$3,940
Consulting Actuaries	$2,100	$1,050	$1,050
Total	**$9,980**	**$4,990**	**$4,990**

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

NEWBORN HEARING SCREENING PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER:	29
IMPLEMENTATION DATE:	7/2014
ANALYST:	Sabrina Blank
FISCAL REFERENCE NUMBER:	1824

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$7,580,000	$7,580,000
STATE FUNDS	$3,790,000	$3,790,000
FEDERAL FUNDS	$3,790,000	$3,790,000

DESCRIPTION

Purpose:
This policy change estimates the Newborn Hearing Screening Program's (NHSP) contract service costs.

Authority:
AB 2780 (Chapter 310, Statutes of 1998)
Health & Safety Code Section 123975 and Sections 124115 - 124120.5
Contract 15-92041
Contract 18-95011

Interdependent Policy Changes:
Not Applicable

Background:
The NHSP contracts with Hearing Coordination Centers (HCC) to provide technical assistance and consultation to hospitals in the implementation and ongoing execution of facility hearing screening programs. The HCCs also track and monitor every infant who refers on their initial hearing screening to assure they receive necessary follow-up services.

The NHSP has had a data management contract that supported the reporting activities of the program. The data management contract provided a database that assisted the NHSP in the collection and reporting of infant hearing screening data. The information collected included screening and diagnostic services provided to newborns and infants who are deaf or hard-of-hearing.

The data management and HCC contract breakdowns are as follows:

- Data management contract
  - The California Department of Technology (CDT), on behalf of the Department, released a Request for Proposal on March 7, 2018. CDT provided a Notification of Intent to Award to the current vendor on June 25, 2018.
  - Contract # 18-95011 is effective August 1, 2018, through July 31, 2021, with two 1-year options to renew. Effective August 1, 2018, Amendment A01 reduced annual costs for data management services from $1.2 million to $1.08 million annually for Contract # 18-95011.

- HCC contract #15-92041 began July 1, 2015, and expires May 31, 2020.
  - A request for a new contract proposal is scheduled for release during the first quarter of calendar year 2020.

NEWBORN HEARING SCREENING PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 29

Reason for Change:
There is no change from the prior estimate for FY 2019-20 or 2020-21. There is no change from FY 2019-20 to FY 2020-21 in the current estimate.

Methodology:
1. Assume a new contract will be in place June 2020 and ongoing. The HCC contract for tracking and monitoring services costs for FY 2019-20 and FY 2020-21 are $6,500,000.

2. The Data Management Contract for the use of a vendor's data management system cost for FY 2019-20 and FY 2020-21 is $1,080,000.

3. The estimated costs for FY 2019-20 and FY 2020-21 are as follows:

FY 2019-20	TF	GF	FF
HCC contract	$6,500,000	$3,250,000	$3,250,000
Data Management Contract	$1,080,000	$540,000	$540,000
Total	**$7,580,000**	**$3,790,000**	**$3,790,000**

FY 2020-21	TF	GF	FF
HCC contract	$6,500,000	$3,250,000	$3,250,000
Data Management Contract	$1,080,000	$540,000	$540,000
Total	**$7,580,000**	**$3,790,000**	**$3,790,000**

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

MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)

OTHER ADMIN. POLICY CHANGE NUMBER:	30
IMPLEMENTATION DATE:	7/2009
ANALYST:	Latoya Brown
FISCAL REFERENCE NUMBER:	1441

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$5,995,000	$6,139,000
STATE FUNDS	$1,743,000	$1,784,750
FEDERAL FUNDS	$4,252,000	$4,354,250

DESCRIPTION

Purpose:
This policy change estimates the maintenance and operations (M&O) expenses resulting from legislative mandates, federal and/or state directives, and Medi-Cal program policy changes which impact the Medi-Cal Eligibility Data System (MEDS).

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The MEDS is a statewide database containing eligibility information for public assistance programs administered by the Department and other departments. MEDS provides users with the ability to perform multi-program application searches, verify program eligibility status, enroll beneficiaries in multiple programs, and validate information on application status. Funding is required for the following M&O functions:

- MEDS Master Client Index maintenance;
- Data matches from various federal and state agencies;
- Supplemental Security Income termination process support;
- Medi-Cal application alerts;
- Medicare Modernization Act Part D buy-in process improvements;
- Eligibility renewal process;
- Reconciling county eligibility data used to support the counties in Medi-Cal eligibility determination;
- Supporting eligibility and enrollment functions; and
- Enabling counties to perform online statistical analysis and MEDS-alert reporting as well as allowing them to track and report county workers' MEDS transactions.

MEDS generates Client Index Numbers (CIN) to uniquely identify Medi-Cal beneficiaries. CINs can be used to identity beneficiaries for public assistance programs, including Temporary Assistance for Needy Families, In Home Support Services, and other Health and Human Services programs such as Covered California's Advance Premium Tax Credit.

MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)

OTHER ADMIN. POLICY CHANGE NUMBER: 30

The Department implements MEDS functionality to support the Medi-Cal program related to beneficiary eligibility and interfacing with the county consortia and state and county business partners. The California Department of Technology (CDT) houses MEDS and charges the Department for all associated data storage, processing, networking, data archiving, and backup costs. CDT invoices the Department on a monthly basis for the services provided. CDT data center charges remain consistent and change based on the volume of beneficiaries enrolled within the MEDS system.

Reason for Change:
The change from the prior estimate for FY 2019-20 is a slight increase due to the MEDS database continuing to grow over time, which impacts backup sizing and overall system and processing related expenses.

The change from the prior estimate for FY 2020-21 is a slight increase due to assuming the continued cost trend from FY 2019-20.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is a slight increase due to assuming the continued cost trend in FY 2020-21.

Methodology:

1. Reporting and tracking costs include non-production support costs consisting of CDT data center charges for development, testing, quality assurance, and all system related charges not related to essential M&O functions.

2. M&O costs include, but are not limited to, the MEDS Reconciliation Process for both the counties and the State, Third Party Liability file matches related to recipients that may have other health coverage, and Medicaid related system and production support costs to cover the M&O functions described in the background section.

3. A 2.4% increase is applied to current year and budget year based on the trend of actuals that have been annualized.

4. The projected costs for FY 2019-20 and FY 2020-21 are:

FY 2019-20	TF	GF	FF
Reporting and Tracking (50% FF / 50% GF)	$977,000	$489,000	$488,000
Maintenance & Operations (75% FF / 25% GF)	$5,018,000	$1,255,000	$3,763,000
Total	**$5,995,000**	**$1,744,000**	**$4,251,000**

Totals differ due to rounding.

FY 2020-21	TF	GF	FF
Reporting and Tracking (50% FF / 50% GF)	$1,000,000	$500,000	$500,000
Maintenance & Operations (75% FF / 25% GF)	$5,139,000	$1,285,000	$3,854,000
Total	**$6,139,000**	**$1,785,000**	**$4,354,000**

Totals differ due to rounding.

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
75% Title XIX / 25% GF (4260-101-0001/0890)

HIPAA CAPMAN

OTHER ADMIN. POLICY CHANGE NUMBER:	31
IMPLEMENTATION DATE:	10/2012
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1318

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$5,448,000	$8,324,000
STATE FUNDS	$1,362,590	$2,166,540
FEDERAL FUNDS	$4,085,410	$6,157,460

DESCRIPTION

Purpose:
This policy change estimates the contract costs to make improvements, maintain, and operate the existing Health Insurance Portability and Accountability Act (HIPAA) Capitation Payment Reporting system (CAPMAN). The HIPAA imposes new transaction requirements (5010).

Authority:
45 CFR Part 162

Interdependent Policy Changes:
Not Applicable

Background:
The HIPAA imposes transaction requirements, including 5010 and Operating Rules. The CAPMAN system was implemented by the Department in July 2011. The HIPAA-compliant transaction automated and improved the capitation calculation process. CAPMAN allows detailed reporting at the beneficiary level while increasing the efficacy of monthly reconciliations and supporting research efforts to perform recoveries. In May 2019, a paperless accounting interface was implemented to interface between the Department's CAPMAN and the State Controller's Office (SCO).

Due to the Affordable Care Act (ACA) and the expansion of Medi-Cal Managed Care, the Department must implement additional functionalities in CAPMAN to accommodate the influx of new beneficiaries. Modifications to the accounting interface are being made to further enhance the system to incorporate Electronic Funds Transfer (EFT). The paperless accounting interface increases the Department's efficiency in making approximately $4 billion in payments a month. The system will have to be maintained on an ongoing basis, as new functionality is required.

The Department's administrative activities related to HIPAA CAPMAN includes the following contract and other related costs:

CAPMAN (M&O and CPO)
The CAPMAN maintenance and operations (M&O) contract provides services which include continuing enhancements and maintenance needed to keep up with current technology, new federal and state mandates, and paperless accounting interface. The contract is effective for the period April 1, 2018, through March 31, 2021.

HIPAA CAPMAN

OTHER ADMIN. POLICY CHANGE NUMBER: 31

The CAPMAN Certified Product Owner (CPO) contract is responsible for optimizing performance of system maintenance and operations services. The CPO will also ensure the CAPMAN M&O vendor team is operating efficiently and effectively by tracking and prioritizing change requests and M&O activities. The contract is effective for the period April 1, 2019, through March 31, 2021, and includes three one-year optional extensions.

CAPMAN (SSE and WSE)
The CAPMAN senior systems engineer (SSE) and web services engineer (WSE) contracts ensure performance system monitoring, address unresolved issues, and provide infrastructure support.

The SSE contract was effective for the period August 1, 2017 through July 31, 2019. The contract was extended through November 30, 2019, and will be replaced with the WSE contract, which will be effective for period December 3, 2019, through December 2, 2021, and will include three one-year optional extensions.

SCO Contract
In March 2018, an Interagency Agreement (IA) with SCO was executed for the period of December 14, 2017, through December 13, 2022, in order to submit electronic claim schedules from the paperless accounting interface to SCO, implement EFT, and issue warrants in response to submitted claim schedules. This contract also includes a testing period with SCO and allows for walkthroughs of existing and future systems within the Department.

Hardware
Additional hardware/virtual environments were purchased in FY 2019-20 to upgrade the CAPMAN system to the mandated Windows 2016 platform, as the current version will no longer be supported. This includes production, staging, development, and test servers and storage required to maintain and enhance the CAPMAN system.

In FY 2020-21, the CAPMAN system will require additional hardware/virtual environments/software to accommodate anticipated changes due to work efforts to implement EFT and upgrade and redesign the non-managed care portion of the system.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a decrease due to incorporating:

- Actual amounts paid, and
- Recently finalized contracts.

The change from the prior estimate, for FY 2020-21, is an increase due to higher contract and hardware costs to account for additional workload from EFT.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase mainly due to higher M&O contract costs from EFT.

Methodology:

1. CAPMAN M&O is estimated to cost $4,465,000 TF in FY 2019-20, and $7,306,000 TF in FY 2020-21.

2. CAPMAN CPO is estimated to cost $232,000 TF in FY 2019-20 and $229,000 TF in FY 2020-21.

3. CAPMAN SSE cost is estimated to be $78,000 TF in FY 2019-20. CAPMAN WSE cost is estimated

HIPAA CAPMAN

OTHER ADMIN. POLICY CHANGE NUMBER: 31

to be $145,000 TF in FY 2019-20 and $249,000 TF in FY 2020-21.

4. The SCO IA contract is estimated to be $29,000 TF in FY 2019-20 and $40,000 TF in FY 2020-21.

5. Additional hardware/virtual environment costs in FY 2019-20 is estimated to be $500,000 TF. There is $500,000 in hardware procurements planned in FY 2020-21.

FY 2019-20	TF	GF	FF
CAPMAN M&O	$4,465,000	$1,117,000	$3,348,000
CAPMAN CPO	$231,000	$58,000	$173,000
CAPMAN SSE	$78,000	$20,000	$58,000
CAPMAN WSE	$145,000	$36,000	$109,000
SCO IA	$29,000	$7,000	$22,000
Hardware/Virtual Environments	$500,000	$125,000	$375,000
Total	**$5,448,000**	**$1,363,000**	**$4,085,000**

FY 2020-21	TF	GF	FF
CAPMAN M&O	$7,306,000	$1,902,000	$5,404,000
CAPMAN CPO	$229,000	$60,000	$169,000
CAPMAN WSE	$249,000	$65,000	$184,000
SCO IA	$40,000	$10,000	$30,000
Hardware/Virtual Environments	$500,000	$130,000	$370,000
Total	**$8,324,000**	**$2,167,000**	**$6,157,000**

Funding:
75% HIPAA FF / 25% HIPAA Fund (4260-117-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)
65% Title XXI / 35% GF (4260-113-0001/0890)
100% State GF (4260-101-0001)

DRUG MEDI-CAL COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER:	32
IMPLEMENTATION DATE:	5/2018
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1871

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$4,096,000	$3,365,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$4,096,000	$3,365,000

DESCRIPTION

Purpose:
This policy change estimates the federal fund reimbursement for Drug Medi-Cal (DMC) Utilization Review (UR) and Quality Assurance (QA) administrative costs under the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver.

Authority:
Welfare & Institutions Code, Section 14711 and Section 14124.24(a)(6)
Drug Medi-Cal Organized Delivery System Waiver

Interdependent Policy Changes:
Not Applicable

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

On August 13, 2015, the Department received approval from the Centers for Medicare and Medicaid Services (CMS) to implement the DMC-ODS waiver. The DMC-ODS waiver is a pilot program for the organized delivery of health care services for Medicaid eligible individuals with a SUD.

DMC-ODS waiver services include the existing treatment modalities (ODF, IOT, NTP, and Perinatal RTS), and the additional new and expanded services. Participation in the waiver is voluntary for counties and implementation is estimated on a phase-in basis beginning February 2017. Counties that opt-in to participate in the DMC-ODS waiver may also opt-in to implement UR and QA activities to safeguard against unnecessary and inappropriate medical care and expenses. Federal funds (FF) reimbursement for these costs is available at 75% for skilled professional medical personnel (SPMP) and 50% for all other personnel.

Reason for Change:
There is no change from the prior estimate for FY 2019-20. The change for FY 2020-21, from the prior estimate, is due to two more counties UR and QA activities cost added to the estimate.

The change in the current estimate, from FY 2019-20 to FY 2020-21, is due to FY 2019-20 including more prior year claims for the UR and QA.

DRUG MEDI-CAL COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 32

Methodology:

1. UR and QA expenditures are shared between FF and county funds (CF). Payments began in May 2018.

2. For FY 2019-20 and FY 2020-21, for counties that will submit claims quarterly, assume claims for the first three quarters (Q1-Q3) will be paid in the same fiscal year. The last quarter claims (Q4) will be paid the following fiscal year.

3. For counties that submit claims annually, assume claims will be submitted and paid the following fiscal year.

	Accrual	FY 2019-20	FY 2020-21
FY 2017-18 Claims	$1,549,000	$543,000	$0
FY 2018-19 Claims	$4,275,000	$4,275,000	$0
FY 2019-20 Claims	$4,584,000	$1,139,000	$3,445,000
FY 2020-21 Claims	$4,584,000	$0	$1,448,000
Total		$5,957,000	$4,893,000

4. Assume 75% of the total claims are for SPMP costs and the remaining 25% are for other personnel costs.

5. UR and QA costs for SPMP will receive enhanced federal reimbursement of 75%. All other personnel will receive 50% federal reimbursement.

6. The estimated UR and QA administrative cost for FY 2019-20 and FY 2020-21 are:

FY 2019-20	TF	FFP	CF
SPMP	$4,468,000	$3,351,000	$1,117,000
Other Personnel	$1,489,000	$745,000	$744,000
Total	$5,957,000	**$4,096,000**	$1,861,000

FY 2020-21	TF	FFP	CF
SPMP	$3,670,000	$2,753,000	$917,000
Other Personnel	$1,223,000	$612,000	$611,000
Total	$4,893,000	**$3,365,000**	$1,528,000

Funding:

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

PACES

OTHER ADMIN. POLICY CHANGE NUMBER:	33
IMPLEMENTATION DATE:	9/2016
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1972

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$2,540,000	$3,760,000
STATE FUNDS	$289,640	$467,700
FEDERAL FUNDS	$2,250,360	$3,292,300

DESCRIPTION

Purpose:
This policy change estimates the costs to modify the Department's existing Post-Adjudicated Claims and Encounter System (PACES) to stay in compliance with federal law. This policy change was previously titled "Clinical Data Collection".

Authority:
Section 1903(i)(4) of the Social Security Act
Title 42 of the Code of Federal Regulations (CFR), Part 438
Title 22 of the California Code of Regulations, Section 51476

Interdependent Policy Changes:
Not Applicable

Background:
Federal law mandates the Department to collect and report on Medi-Cal claims and encounters, whether they be submitted as part of a Fee-for-Services (FFS) or a contracted managed care arrangement. PACES plays a vital role in the collection of encounter and provider network data from Medi-Cal's numerous managed care plans. PACES accepts encounter transactions from both medical and dental managed care plans and also accepts encounter-related pharmacy transactions.

PACES Clinical Data Exchange
To allow the Department to collect and review clinical information for selected Medi-Cal members admitted to acute care hospitals, the existing PACES will be modified to accept an industry standard file that will contain clinical data. The data will be accepted, validated, and made available to the Management Information System/Decision Support System Data Warehouse. These efforts will fulfill Medicaid funding requirements and enable the Department to efficiently collect and review clinical medical records

PACES Interfaces and New Data Sources
42 CFR 438.10(e)(2)(vi) requires the Department to provide Medi-Cal enrollees with provider directory information for contracted managed care entities on a regular basis. Furthermore, 42 CFR 438.68 requires the Department to enforce network adequacy standards for contracted managed care entities. In order to fulfill these federal regulations, the Department must collect provider network information from participating managed care organizations as well as managed models, such as county behavioral health systems, that are considered managed care for the purpose of regulation.

PACES

OTHER ADMIN. POLICY CHANGE NUMBER: 33

The Department is in the process of extending the use of the 274 transaction to cover dental managed care plans. In addition, the Department has completed the analysis to expand the use of the 274 transaction to the county mental health plans and the Drug Medi-Cal Organized Delivery System (DMC-ODS) counties. Extending the 274 process to behavioral health and dental will allow the Department to more closely monitor the networks within those models.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a decrease due to a shift in contract start dates. The change from the prior estimate, for FY 2020-21, is an increase due to a shift in contract start dates, as well as the addition of a Project Manager contractor and Business Analyst contractor.
The change in the current estimate, from FY 2019-20 to FY 2020-21, is an increase due to anticipated contract costs related to PACES Clinical Data Exchange and PACES Interfaces and New Data Sources.

Methodology:

1. Effective November 1, 2017, a vendor concurrently provides DD&I and M&O services. The first phase of implementation was completed in December 2018.

2. A Technical Contractor, that began services in August 2016, provided services until July 31, 2018. A separate Technical Contractor, who began services in July 2018, will provide services until September 30, 2020. A new request for offer for $500,000 is in process for a Technical Contractor to start on August 1, 2020. This will replace the current contract, and will be for $250,000 per year for two years.

3. A Change Manager contractor in support of “PACES Clinical Data Exchange” is expected to begin in May 2020 and provide services through May 2022 for an estimated total contract value of $500,000.

4. A Solution Architect contractor in support of “Extended PACES Interfaces and New Data Sources” is expected to begin in May 2020 and provide services through May 2022 for an estimated total contract value of $500,000.

5. A Software Engineer contractor in support of “Extended PACES Interfaces and New Data Sources” is expected to begin in May 2020 and provide services through May 2021 for an estimated total contract value of $250,000.

6. An additional Project Manager contractor in support of “Extended PACES Interfaces and New Data Sources” is expected to begin in July 2020 and provide services through June 2021 for an estimated total contract value of $250,000.

7. An additional Business Analyst contractor in support of “Extended PACES Interfaces and New Data Sources” is expected to begin in July 2020 and provide services through June 2021 for an estimated total contract value of $250,000.

8. One-time cloud infrastructure/software services costs at $95,000, ongoing cloud platform and services costs of approximately $250,000 annually, and HIE software costs of $105,000 are included in FY 2019-20. FY 2020-21 includes ongoing cloud services at $250,000 and annual HIE software costs at $135,000.

PACES

OTHER ADMIN. POLICY CHANGE NUMBER: 33

9. Total costs are estimated to be:

FY 2019-20	TF	GF	FF
PACES Clinical Data Exchange			
Technical Contractor	$215,000	$25,000	$190,000
DD&I Vendor	$1,375,000	$157,000	$1,218,000
M&O	$500,000	$57,000	$443,000
Cloud Services	$250,000	$29,000	$221,000
Subtotal	$2,340,000	$268,000	$2,072,000
PACES Interfaces and New Data Sources			
HIE SaaS (One-Time)	$95,000	$10,000	$85,000
HIE SaaS Subscription	$105,000	$12,000	$93,000
Subtotal	$200,000	$22,000	$178,000
Total	**$2,540,000**	**$290,000**	**$2,250,000**

FY 2020-21	TF	GF	FF
PACES Clinical Data Exchange			
Technical Contractor	$250,000	$31,000	$219,000
DD&I Vendor	$1,375,000	$171,000	$1,204,000
M&O	$500,000	$62,000	$438,000
Cloud Services	$250,000	$32,000	$218,000
Subtotal	$2,375,000	$296,000	$2,079,000
PACES Interfaces and New Data Sources			
Solution Architect	$250,000	$31,000	$219,000
Software Engineer	$250,000	$31,000	$219,000
Project Manager	$250,000	$31,000	$219,000
Business Analyst	$250,000	$31,000	$219,000
Change Manager	$250,000	$31,000	$219,000
HIE SaaS Subscription	$136,000	$17,000	$119,000
Subtotal	$1,386,000	$172,000	$1,214,000
***Total**	**$3,760,000**	**$468,000**	**$3,293,000**

*Difference due to rounding.

Funding:
90% Title XIX / 10% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)
65% Title XXI / 35% GF (4260-113-0001/0890)
100% State GF (4260-101-0001)

CA-MMIS MEDCOMPASS SOLUTION

OTHER ADMIN. POLICY CHANGE NUMBER:	34
IMPLEMENTATION DATE:	7/2017
ANALYST:	Elena Susbilla
FISCAL REFERENCE NUMBER:	1982

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$2,202,000	$3,037,000
STATE FUNDS	$1,101,000	-$63,000
FEDERAL FUNDS	$1,101,000	$3,100,000

DESCRIPTION

Purpose:
This policy change estimates contractor costs to implement the MedCompass system changes and ongoing licensing and operations costs.

Authority:
Title XIX of the Federal Social Security Act 1903(a)(3)
Contract # 16-93448

Interdependent Policy Changes:
Not Applicable

Background:
The MedCompass is a Software-as-a-Service solution that was implemented for the Integrated Systems of Care Division (ISCD) with solution provider, AssureCare. MedCompass replaced the Case Management Information System and Microsoft Access Databases that ISCD used to manage cases under the Home and Community-Based Alternatives Waiver, Early Periodic Screening, Diagnostics and Treatment, and Assisted Living Waiver Programs.

MedCompass entered Maintenance and Operations (M&O) on December 18, 2017. Once certified, MedCompass intends to recoup 25% of the funds paid at 50% FF / 50% GF that was supposed to be paid at 75% FF / 25% GF.

Reason for Change:
The change from the prior estimate for FY 2019-20 and FY 2020-21, is due to applying actuals, updating the line item breakout, and correcting the FFP.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to shifting some costs from CY to BY, updating the line item breakout, correcting the FFP, and accounting for the recoupment of funds from CMS.

Methodology:
1. The estimated costs are based upon the contract provisions.

2. All costs are currently paid at 50% FF / 50% GF. Once certified, the FMAP will be claimed at 75%. FY 2020-21 reflects both the shift in FMAP and the anticipated recoupment for M&O activities paid at 50% FF / 50% GF.

CA-MMIS MEDCOMPASS SOLUTION

OTHER ADMIN. POLICY CHANGE NUMBER: 34

FY 2019-20	TF	GF	FF
License Fee	$1,372,000	$686,000	$686,000
IaaS Managed Services Ongoing Operations Support	$830,000	$415,000	$415,000
Total FY 2019-20	**$2,202,000**	**$1,101,000**	**$1,101,000**

FY 2020-21	TF	GF	FF
License Fee	$1,372,000	$429,000	$943,000
IaaS Managed Services Ongoing Operations Support	$1,665,000	$520,000	$1,145,000
M&O Recoupment of Funds Post Certification	$0	($1,012,000)	$1,012,000
Total FY 2020-21	**$3,037,000**	**($63,000)**	**$3,100,000**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 75% Title XIX / 25% GF (4260-101-0001/0890)
100% Title XIX FFP (4260-101-0890)
100% GF (4260-101-0001)

SDMC SYSTEM M&O SUPPORT

OTHER ADMIN. POLICY CHANGE NUMBER:	35
IMPLEMENTATION DATE:	7/2013
ANALYST:	Latoya Brown
FISCAL REFERENCE NUMBER:	1732

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$2,325,000	$2,325,000
STATE FUNDS	$1,162,500	$1,162,500
FEDERAL FUNDS	$1,162,500	$1,162,500

DESCRIPTION

Purpose:
This policy change estimates the infrastructure and contractor's costs to perform the ongoing maintenance and operations (M&O) support for the Short-Doyle/Medi-Cal (SDMC) system.

Authority:
Contract OHC-11-077
Contract #18-95231

Interdependent Policy Changes:
Not Applicable

Background:
The SDMC system adjudicates Medi-Cal claims for Specialty Mental Health Services (SMHS) and Substance Use Disorder Services (SUDS). Due to the Affordable Care Act, Medi-Cal has experienced an increase in the volume of claims which has created a need for system upgrades, including application servers, reporting servers, middleware, database, and storage.

The Department secured a new two-year contract with two one-year optional extensions. The new contract began July 1, 2018 and ends June 30, 2020. Moving forward the Department is planning to utilize the two one-year optional extension from July 1, 2020 to June 30, 2022.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21.

There is no change from FY 2019-20 to FY 2020-21 in the current estimate.

Methodology:
1. The contractor cost for the new two-year contract with two one-year optional extensions, that began July 2018, is $8,000,000.

2. Projections include the contractor cost related to processing SMHS and SUDS claims payments. Software costs are related to system upgrades.

FY 2019-20	TF	GF	FF
Contractor cost	$2,000,000	$1,000,000	$1,000,000
Software	$325,000	$163,000	$162,000
Total	**$2,325,000**	**$1,163,000**	**$1,162,000**

SDMC SYSTEM M&O SUPPORT

OTHER ADMIN. POLICY CHANGE NUMBER: 35

FY 2020-21	TF	GF	FF
Contractor cost	$2,000,000	$1,000,000	$1,000,000
Software	$325,000	$163,000	$162,000
Total	**$2,325,000**	**$1,163,000**	**$1,162,000**

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

SSA COSTS FOR HEALTH COVERAGE INFO.

OTHER ADMIN. POLICY CHANGE NUMBER: 37
IMPLEMENTATION DATE: 1/1989
ANALYST: Davonna McClendon
FISCAL REFERENCE NUMBER: 237

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$2,040,000	$2,210,000
STATE FUNDS	$1,020,000	$1,105,000
FEDERAL FUNDS	$1,020,000	$1,105,000

DESCRIPTION

Purpose:
This policy change estimates the cost of obtaining Supplemental Security Income/State Supplementary Payment (SSI/SSP) recipient information from the Social Security Administration (SSA).

Authority:
Social Security Act 1634(a)

Interdependent Policy Changes:
Not Applicable

Background:
The Department uses SSI/SSP information from the SSA to defer medical costs to other payers. The SSA administers the SSI/SSP programs. The SSI program is a federally funded program, which provides income support for persons aged 65 or older and qualified blind or disabled individuals. The SSP is a state program which augments SSI. The Department receives SSI/SSP information about health coverage and assignment of rights to medical coverage from SSA. The SSA bills the Department quarterly for this activity.

Reason for Change:
The change in FY 2019-20 and FY 2020-21, from the prior estimate, is an increase due to including two quarters of actual FY 2019-20 payments and two quarters of increased projections based on the most current 10 quarters of actual billings received from the SSA.

The change from FY 2019-20 to FY 2020-21, in the current estimate is an increase due to the two quarters of FY 2019-20 actuals being lower than the quarterly projections used for the FY 2020-21 estimate.

Methodology:
1. The following projections are averaged based upon the most current actual billings from SSA.

Fiscal Year	TF	GF	FF
FY 2019-20	$2,040,000	$1,020,000	$1,020,000
FY 2020-21	$2,210,000	$1,105,000	$1,105,000

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

FAMILY PACT PROGRAM ADMIN.

OTHER ADMIN. POLICY CHANGE NUMBER:	38
IMPLEMENTATION DATE:	7/2012
ANALYST:	Sabrina Blank
FISCAL REFERENCE NUMBER:	1675

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$1,207,000	$1,207,000
STATE FUNDS	$120,700	$120,700
FEDERAL FUNDS	$1,086,300	$1,086,300

DESCRIPTION

Purpose:
This policy change estimates the cost for provider recruitment, education, and support for the Family Planning, Access, Care, and Treatment (Family PACT) program.

Authority:
Interagency Agreement 14-90487
AB 1464 (Chapter 21, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

Background:
The Family PACT program has two main objectives, to increase (1) access to services for low-income women and men, including adolescents; and (2) the number of providers who serve these clients. Education and support services are provided to the Family PACT providers and potential providers, as well as clients and potential clients. Services include, but are not limited to:

- Public education, awareness, and direct client outreach;
- Provider enrollment, recruitment, and training;
- Training and technical assistance for medical and non-medical staff;
- Education and counseling services;
- Preventive clinical services;
- Sexually transmitted infection/human immunodeficiency virus training and technical assistance services; and
- Toll-free referral number.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 or FY 2020-21. There is no change from FY 2019-20 to FY 2020-21 in the current estimate.

Methodology:
1. The administrative costs for the Family PACT program are estimated in the table below:

Fiscal Year	TF	GF	FF
FY 2019-20	$1,207,000	$120,700	$1,086,300
FY 2020-21	$1,207,000	$120,700	$1,086,300

FAMILY PACT PROGRAM ADMIN.

OTHER ADMIN. POLICY CHANGE NUMBER: 38

Funding:
90% Family Planning / 10% GF (4260-101-0890/0001)

LTSS ACTUARIAL STUDY

OTHER ADMIN. POLICY CHANGE NUMBER:	39
IMPLEMENTATION DATE:	5/2020
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	2143

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$453,000	$547,000
STATE FUNDS	$453,000	$547,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the costs for a long-term services and supports (LTSS) feasibility and actuarial study.

Authority:
Budget Act of 2019 (AB 74)

Interdependent Policy Changes:
Not Applicable

Background:
The LTSS actuarial study will analyze the potential costs of various benefits designs targeted at older adults and individuals living with disabilities. The study will be based on a baseline benefit design and the associated cost impacts as well as cost impacts related to altering various eligibility and benefit parameters.

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is due to a delay in contract approval. Some cost shifted from current year to budget year due to this reason.

The change in the current estimate, from FY 2019-20 to FY 2020-21, is an increase due to the expected completion timing of this study.

Methodology:

1. This policy change budgets for an LTSS feasibility study and actuarial analysis to be performed.

2. The cost impact is estimated to be:

Fiscal Year	TF	GF
FY 2019-20	$453,000	$453,000
FY 2020-21	$547,000	$547,000

Funding:
100% GF (4260-101-0001)

MMA - DSH ANNUAL INDEPENDENT AUDIT

OTHER ADMIN. POLICY CHANGE NUMBER:	40
IMPLEMENTATION DATE:	7/2009
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	266

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$488,000	$800,000
STATE FUNDS	$244,000	$400,000
FEDERAL FUNDS	$244,000	$400,000

DESCRIPTION

Purpose:
This policy change estimates the administrative costs of contracting for the annual independent audit of the Disproportionate Share Hospital (DSH) program.

Authority:
Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)
Title 42, Code of Federal Regulations, section 455.300 et. seq.

Interdependent Policy Changes:
Not Applicable

Background:
The MMA requires an annual independent certified audit that primarily certifies:

1. The extent to which DSH hospitals have reduced their uncompensated care costs to reflect the total amount of claimed expenditures made under section 1923 of the MMA.

2. That DSH payment calculations of hospital-specific limits include all payments to DSH hospitals, including supplemental payments.

DSH-eligible Designated Public Hospitals participating in the Global Payment Program are not subject to the DSH audit.

The audits are funded with 50% Federal Financial Participation and 50% General Fund (GF). The Centers for Medicare and Medicaid Services (CMS) released the final regulation and criteria for the annual certified audit in 2008. Each fiscal year's annual audit and report is due to CMS by December 31st.

Reason for Change:
The change in FY 2019-20, from the prior estimate, and from FY 2019-20 to FY 2020-21, in the current estimate, is due to lower actual invoice amounts than originally estimated.

There is no change in FY 2020-21, from the prior estimate.

Methodology:
1. The contract amount of $3,623,291 was effective January 1, 2016 through December 31, 2019.

MMA - DSH ANNUAL INDEPENDENT AUDIT

OTHER ADMIN. POLICY CHANGE NUMBER: 40

2. The new contract period began January 1, 2020 through June 30, 2022 for a total amount of $2,000,000, with an optional extension through December 31, 2024 for an additional $2,000,000.

3. In FY 2019-20, the Department will make payments for the FY 2015-16 and FY 2016-17 audits.

4. In FY 2020-21, the Department will make payments for the FY 2016-17 and FY 2017-18 audits.

Fiscal Year	TF	GF	FF
FY 2019-20	$488,000	$244,000	$244,000
FY 2020-21	$800,000	$400,000	$400,000

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

MEDICARE BENEFICIARY IDENTIFIER

OTHER ADMIN. POLICY CHANGE NUMBER:	41
IMPLEMENTATION DATE:	7/2017
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1997

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$828,000	$128,000
STATE FUNDS	$94,180	$16,360
FEDERAL FUNDS	$733,820	$111,640

DESCRIPTION

Purpose:
This policy change estimates the costs for removing Social Security Numbers (SSN) from Medicare cards on the Department's systems and business processes in use, and remediation efforts to accommodate a new Medicare Beneficiary Identifier (MBI) by January 2020.

Authority:
H.R.2 Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) of 2015

Interdependent Policy Changes:
Not Applicable

Background:
On April 16, 2015, President Obama signed the MACRA of 2015, which stipulates federal SSN Removal Initiative (SSNRI) efforts. To decrease Medicare beneficiaries' exposure to identify theft, the SSN-based identifier referred to as the Health Insurance Claim Number (HICN) needs to be replaced by a randomly generated MBI on all Medicare cards.

The Centers for Medicare and Medicaid Services (CMS) and its program stakeholders have been using the SSN-based HICN when processing claims or exchanging data related to Medicare beneficiaries and programs. There will likely be many impacts to Department systems and business processes as a result of the transition to the MBI, including Medi-Cal Eligibility Data System (MEDS), California Medicaid Management Information System (CA-MMIS), Management Information System/Decision Support System (MIS/DSS), and Health Care Options (HCO) that include dual Medicare-Medi-Cal eligible members.

The issuance of new Medicare cards with MBI was completed in April 2019.

The successful remediation of Department-sponsored systems and processes to accommodate the SSN removal from Medicare cards allows the Department to:

- Continue to successfully adjudicate Medicare-Medi-Cal crossover claims;
- Continue to reimburse providers on a timely basis;
- Continue to successfully exchange information about Medicare-Medi-Cal dual eligible members with the Department's partners;
- Support federal efforts to improve information security by limiting the exchange of SSNs; and
- Reduce the risk of information security breaches.

MEDICARE BENEFICIARY IDENTIFIER

OTHER ADMIN. POLICY CHANGE NUMBER: 41

Reason for Change:
There is no change for FY 2019-20 and FY 2020-21 from the prior estimate.

The change in the current estimate, from FY 2019-20 to FY 2020-21, is a decrease due to the anticipated post-implementation costs in FY 2020-21 being lower than the contract costs expected in FY 2019-20.

Methodology:
1. The state MBI project assesses the impact of SSN removal from Medicare cards on the Department's systems and business processes and modifies these systems and processes to accommodate a new MBI.

2. The estimated contract costs for FY 2019-20 and FY 2020-21 are:

Fiscal Year	TF	GF	FF
FY 2019-20	$828,000	$94,000	$734,000
FY 2020-21	$128,000	$16,000	$112,000

Funding:
90% Title XIX / 10% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)
65% Title XXI / 35% GF (4260-113-0001/0890)
100% State GF (4260-101-0001)

CALIFORNIA HEALTH INTERVIEW SURVEY

OTHER ADMIN. POLICY CHANGE NUMBER:	42
IMPLEMENTATION DATE:	7/2015
ANALYST:	Sabrina Blank
FISCAL REFERENCE NUMBER:	1902

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$933,000	$977,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$933,000	$977,000

DESCRIPTION

Purpose:
This policy change estimates the California Health Interview Survey (CHIS) contract services costs.

Authority:
Interagency Agreement (IA) 15-92271 A01

Interdependent Policy Changes:
Not Applicable

Background:
CHIS is a random-dial telephone survey that asks questions on a wide range of health topics. CHIS is conducted on a continuous basis allowing it to provide a detailed picture of the health and health care needs of California's large and diverse population. The survey provides statewide information on the overall population including many racial and ethnic groups, as well as county-level information for most counties to aid with health planning, priority setting, and to compare health outcomes in numerous ways.

The University of California, Los Angeles (UCLA) Center for Health Policy Research conducts CHIS in collaboration with the California Department of Public Health (CDPH) and the Department. The Department contracts directly with UCLA to utilize CHIS for program needs and performance. The current contract is funded by federal funds (FF); the non-federal share is paid through certified public expenditures (CPEs). The Department's current contract with UCLA is effective from July 1, 2015, and will end on June 30, 2021.

Effective July 20, 2017, the IA contract was amended to increase the maximum amount reimbursable annually from $1,000,000 to $1,100,000, to align the contract to updated salary costs and operating expenses for the CHIS contractors.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is an increase due to higher than anticipated FY 2018-19 and FY 2019-20 expenditures paying in FY 2019-20. The change in FY 2020-21, from the prior estimate, is a decrease due lower projected expenditures for the remaining contract balance for FY 2019-20, which pays in FY 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to anticipated invoices for FY 2020-21 being higher than actual invoices received in FY 2019-20.

CALIFORNIA HEALTH INTERVIEW SURVEY

OTHER ADMIN. POLICY CHANGE NUMBER: 42

Methodology:

1. Assume UCLA will submit documentation of CPEs on the CHIS survey. Expenditures will consist of funds received by UCLA from non-federal sources.

2. In July 2017, the CHIS contract was amended to increase the annual reimbursement amount retroactive to FY 2015-16.

3. On an accrual basis, beginning FY 2015-16, the maximum reimbursable amount for California Health Interview Survey is $1,100,000 FF annually.

4. On a cash basis, assume two quarters will be paid in the current fiscal year and the remaining two quarters will be paid in the subsequent fiscal year.

5. The estimated administrative costs reimbursements for FY 2019-20 and FY 2020-21, on a cash basis, are:

(Dollars in Thousands)

FY 2019-20	TF	FF
FY 2018-19 Claims	$260	$260
FY 2019-20 Claims	$672	$672
Total	**$933**	**$933**

FY 2020-21	TF	FF
FY 2019-20 Claims	$426	$426
FY 2020-21 Claims	$550	$550
Total	**$977**	**$977**

*Totals may differ due to rounding.

Funding:

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

ENCRYPTION OF PHI DATA

OTHER ADMIN. POLICY CHANGE NUMBER:	43
IMPLEMENTATION DATE:	5/2010
ANALYST:	Latoya Brown
FISCAL REFERENCE NUMBER:	1452

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$750,000	$750,000
STATE FUNDS	$375,000	$375,000
FEDERAL FUNDS	$375,000	$375,000

DESCRIPTION

Purpose:
This policy change estimates the upgrades to the infrastructure and ongoing costs of maintaining and securing electronic Protected Health Information (PHI).

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The Department has designed security and backup systems to protect, monitor and secure electronic PHI data to minimize the amount of encrypted data flowing across the Wide Area Network (WAN). These systems contain Medi-Cal beneficiary information that is considered confidential and/or PHI by federal and state mandates.

The protection of these systems will:

- Secure and protect the Department's electronic data from unauthorized disclosure;
- Protect the privacy of Medi-Cal beneficiaries;
- Avoid costs to notify millions of people if a large breach does occur; and
- Maintain the Department's public image and integrity for protecting the confidentiality and privacy of the information that it maintains on its customers.

The Department is continuing its effort in upgrading data protection and the backup and recovery methods for the current infrastructure by enhancing infrastructure components. The upgrade is necessary to take advantage of technologies, such as data de-duplication, offsite data replication, and data encryption. The maintenance and increasing amount of data involved with the migration of the Department with these technologies allows the Department to grow, support its virtualization infrastructure, and provide data protection, backup and recovery methods for this infrastructure.

The upgrade allows the Department to:

- Effectively and efficiently manage Department growth;
- Provide additional backup, recovery, and storage for the business programs; and
- Enhance data security and data protection management.

ENCRYPTION OF PHI DATA

OTHER ADMIN. POLICY CHANGE NUMBER: 43

Reason for Change:
There is no change from the prior estimate for FY 2019-20 or FY 2020-21.

There is no change from FY 2019-20 to FY 2020-21 in the current estimate.

Methodology:
1. The following amounts are based upon the latest projections of cost:

Fiscal Year	TF	GF	FF
FY 2019-20	$750,000	$375,000	$375,000
FY 2020-21	$750,000	$375,000	$375,000

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

ELECTRONIC ASSET VERIFICATION PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER:	44
IMPLEMENTATION DATE:	12/2017
ANALYST:	Sabrina Blank
FISCAL REFERENCE NUMBER:	2002

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$659,000	$3,960,000
STATE FUNDS	$329,500	$1,980,000
FEDERAL FUNDS	$329,500	$1,980,000

DESCRIPTION

Purpose:
This policy change estimates the administrative costs associated with implementing an electronic asset verification program.

Authority:
Welfare & Institutions Code (W&I), Section 14013.5
Title 42 U.S. Code, Sections 1396w and 1383(e)(1)
California Financial Code, Section 293
State Plan Amendment (SPA) 09-003

Interdependent Policy Changes:
Not Applicable

Background:
Section 1940 of the Social Security Act requires that the State implement an asset verification program for use in Non-Modified Adjusted Gross Income (Non-MAGI) eligibility determinations or redeterminations for all Aged, Blind or Disabled (ABD) applicants and beneficiaries through requests to financial institutions. The law further stipulates that the program be consistent with the approach taken by the Social Security Administration (SSA) under 42 U.S. Code Section 1383(e)(1); this includes the requirement that the program be administered electronically. The SPA 09-003, Asset Verification System, was approved on April 16, 2009, and State legislation (W&I, Section 14013.5 and Financial Code, Section 293) was enacted to implement the federal requirements.

Financial institutions provide data that could indicate assets and property not reported by the applicant or beneficiary. If information is obtained indicating unreported assets, the applicant or beneficiary must provide additional supporting documentation before an eligibility determination or redetermination is made.

The Department reimburses financial institutions when obtaining asset information for ABD beneficiaries. The reimbursement rate is based on volume with an average of $4.00 per query.

Program expenditures are reduced when supplemental asset data increases the accuracy of eligibility determinations for the ABD population or detects unreported assets that result in the discontinuance of a beneficiary.

The Department conducted a pilot of the asset verification program in order to determine the success of the program in identifying unreported assets and to assist with the development of the program. The pilot concluded in April 2017, and implementation began in December 2017. Due to changes in federal

ELECTRONIC ASSET VERIFICATION PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 44

law, the Department's objective is full implementation prior to January 1, 2021.

Reason for Change:
There is no change from the previous estimate for FY 2019-20 and FY 2020-21. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a net increase due to the program expansion to the entire ABD population and the new reimbursement rate beginning in FY 2020-21.

Methodology:

1. The policy does not apply to applicants or recipients of federal Supplemental Security Income/State Supplementary Payment, whose assets are collected and valued by SSA prior to making a determination of eligibility.

2. The Department is required to verify assets for the Non-MAGI ABD population at application, annual renewal, or whenever the Department determines an asset record is necessary.

3. Based on ABD enrollment data, assume the estimated number of asset verifications performed will be 368,163 in FY 2019-20 and 1,000,000 in FY 2020-21.

4. The reimbursement rate, based on estimated query volume, is estimated to be $109,863 per month for July 2019 to November 2019 and $15,693 for December 2019 to June 2020 for FY 2019-20. For FY 2020-21, the rate will be $330,000 per month.

5. The estimated vendor cost are:

   FY 2019-20: $109,863 x 5 months + $15,693 x 7 months = **$659,000 TF ($329,500 GF)**
   FY 2020-21: $330,000 x 12 months = **$3,960,000 TF ($1,980,000 GF)**

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

T-MSIS

OTHER ADMIN. POLICY CHANGE NUMBER:	46
IMPLEMENTATION DATE:	9/2013
ANALYST:	Latoya Brown
FISCAL REFERENCE NUMBER:	1768

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$311,000	$2,334,000
STATE FUNDS	$77,750	$283,500
FEDERAL FUNDS	$233,250	$2,050,500

DESCRIPTION

Purpose:
This policy change estimates the cost for the maintenance and operations (M&O) of the Extract, Transform, and Load (ETL) data solution used to transmit data to the Transformed Medicaid Statistical Information System (T-MSIS).

Authority:
Affordable Care Act (ACA)
Medicaid Managed Care Final Rule

Interdependent Policy Changes:
Not Applicable

Background:
The Centers for Medicare & Medicaid Services (CMS) require data in a standardized format from the states to review system projects related to the ACA. The Department implemented an enterprise-wide ETL data solution to modernize and streamline the data transmission processes from the Department to the CMS T-MSIS. The project provides modern capabilities to improve business processes by collecting comprehensive data regarding cost, quantity, and quality of health care provided for Medi-Cal beneficiaries. Data transferred to the T-MSIS includes claims, eligibility, third party liability, managed care, and provider information.

In November 2017, CMS approved an Implementation Advance Planning Document Update (IAPDU) providing enhanced funding for software support as well as ETL system and training costs through Federal Fiscal Year (FFY) 2021 (Oct. 2020 to Sept. 2021). In June 2018, the Department received approval for an Operational Advance Planning Document (OAPD) from CMS which provides funding for M&O through FFY 2019 (Oct. 2018 to Sept. 2019). In July 2019, the Department submitted an updated OAPD to CMS requesting the continuation of enhanced funding for M&O costs for FFY 2020 (Oct. 2019 to Sept. 2020). The software support renewals for Data Quality (data cleansing) and PowerCenter (data repository) are considered M&O costs.

On August 10, 2018, CMS issued a State Health Official (SHO) letter providing guidance to states regarding expectations for Medicaid and Children's Health Insurance Program data and ongoing T-MSIS implementation, and access to enhanced funding for future costs to California's Medicaid Enterprise System (MES). Enhanced funding for additional system enhancement and operational costs associated with MES is contingent upon the Department's continued ability to meet T-MSIS requirements of complete, accurate, and timely data reporting. Specifically, CMS expects that:

T-MSIS

OTHER ADMIN. POLICY CHANGE NUMBER: 46

- T-MSIS data quality should be a permanent and ongoing process of state operations;
- States commit the necessary resources to make steady progress in improving their data quality;
- States resolve data quality issues for the 12 Top Priority Items no later than six months after release of SHO letter.

The Department procured contractor services to manage the additional workload to meet the T-MSIS requirements and submitted an IAPDU in September 2019 for enhanced funding. The Department received CMS approval of the IAPDU in December 2019.

Beginning State Fiscal Year 2020-21, the contractors will support the following efforts:

- Testing, as defined in CMS' Standard Operating Procedures document, and gap analysis to ensure that there is no degradation in the accuracy, completeness, or timeliness of T-MSIS data resulting from the implementation of system, operational, or programmatic changes.
- Analyze the work required to migrate from use of the proprietary 35C file format to the Health Insurance Portability and Accountability Act (HIPAA) standard 835/837 format. The new format will help resolve many T-MSIS Data Quality issues, which result from data being modified in the transmission of the 35C files.

Reason for Change:
There is no change from the prior estimate, for FY 2019-20. The decrease from the prior estimate for FY 2020-21, is due to the delays in executing the contract. The contracts will begin October 20, 2020.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to increased software costs and contractor costs in FY 2020-21.

Methodology:

1. Support and maintenance for Data Quality was procured in March 2019 and the re-procurement was executed in February 2020. Data Quality is a module within the Informatica tool which validates system data.

2. The software maintenance renewal for PowerCenter was executed December 2019. PowerCenter is a separate module within the Informatica tool which extracts, transforms, and loads system data.

3. The IAPDU provides annual funding for training on software and industry data cleansing procedures through FFY 2021 (Oct. 2020 to Sept. 2021).

4. It is estimated that ten contractor staff will be needed to perform Quality Assurance, data analysis, and replace the 35C file format with the HIPAA standard format. The contracts will be executed in October 2020 and payments will begin in November 2020. The estimated cost for the three year~~s~~ contract is $9,000,000.

T-MSIS

OTHER ADMIN. POLICY CHANGE NUMBER: 46

FY 2019-20	TF	GF	FF
Software	$286,000	$72,000	$214,000
Training	$25,000	$6,000	$19,000
Total	**$311,000**	**$78,000**	**$233,000**

Totals may differ due to rounding.

FY 2020-21	TF	GF	FF
Software	$309,000	$77,000	$232,000
Training	$25,000	$6,000	$19,000
Contractor Costs	$2,000,000	$200,000	$1,800,000
Total	**$2,334,000**	**$283,000**	**$2,051,000**

Totals may differ due to rounding.

Funding:
75% Title XIX / 25% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)

CCT OUTREACH - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	47
IMPLEMENTATION DATE:	4/2011
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1556

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$290,000	$360,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$290,000	$360,000

DESCRIPTION

Purpose:
This policy change budgets the federal funding to cover California Community Transitions (CCT) administrative costs to increase the community-based network of service providers that serve the CCT-eligible population.

Authority:
Federal Deficit Reduction Act (DRA) of 2005 (P.L. 109-171), Section 6071
Affordable Care Act (ACA) (P.L. 111-148), Section 2403
Medicaid Extenders Act of 2019 (P.L. 116-3), Section 2
Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16), Section 5
Sustaining Excellence in Medicaid Act of 2019 (P.L. 116-39), Section 4
Further Consolidated Appropriations Act, 2020 (P.L. 116-94), Section 205

Interdependent Policy Changes:
Not Applicable

Background:
Pursuant to the ACA, on September 3, 2010, the Centers for Medicare and Medicaid Services (CMS) authorized the Department to draw down $750,000 in MFP Rebalancing Demonstration supplemental grant funding. The Department allocated the supplemental grant funding to implement an assessment tool to improve the ability of Skilled Nursing Facilities/Nursing Facilities, states, and other qualified entities to identify individuals who are interested in returning to the community. The Department is collaborating with the Aging and Disability Resources Connection (ADRC) programs, CCT lead organizations, and other community-based providers to increase the community-based network of service providers that serve the CCT-eligible population. This supplemental grant funding does not require matching funds. The costs were 100% federally funded.

CMS granted the Department an extension of the supplemental grant through December 2015 to complete the objectives set forth in the grant.

Beginning January 1, 2016, the Department will allocate MFP grant funding to continue efforts that were initiated under the supplemental grant to increase community-based network of service providers that serve the CCT-eligible population. These activities qualify as administrative marketing and outreach activities, which are 100% federally funded through the MFP grant.

CCT OUTREACH - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 47

On January 24, 2019, the federal Medicaid Extenders Act of 2019 was passed into law and authorized MFP state grantees to continue to transition people to through December 31, 2019, using available MFP funding. The Extenders Act provided CMS with authority to allocate new funding to state grantees for FY 2019-20, to allow funding appropriated through the Extenders Act to be spent through 2023.

On August 6, 2019, the federal Sustaining Excellence in Medicaid Act of 2019 was signed into law and appropriated additional federal funds for allocation to MFP state grantees.

On December 20, 2019, the Further Consolidated Appropriations Act, 2020 amended the DRA of 2005 to extend the term of the MFP grant by five months, from January 1, 2020 to May 22, 2020. These short-term extensions of the MFP grant allows the Department to continue to support the development of community-based services and supports through administrative marketing and outreach activities.

Reason for Change:
There is no change from the prior estimate for FY 2019-20. The change from the prior estimate, for FY 2020-21, is an increase due to the extension of the MFP grant. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to the extension of the MFP grant.

Methodology:
1. Assume $290,000 from the MFP grant administrative funding is expected to be paid in FY 2019-20.

2. Assume $360,000 from the MFP grant administrative funding is expected to be paid in FY 2020-21.

3. Estimated costs are based on the approved contract budget which includes proposed expenditures for the following activities:

    - ADRC planning and implementation,
    - ADRC/MFP collaborative strategic planning,
    - MDS 3.0 Section Q referrals policy development,
    - MDS/Options counseling training sessions, and
    - Home and Community-Based Advisory Workgroup Series.

FY 2019-20	TF	GF	FF
CCT Costs (PC 36):			
Total Non-DD GF costs and Total FFP	$3,857,000	$876,000	$2,981,000
Accounting Memos and DDS Invoices	$24,332,000	$5,503,000	$18,829,000
Total Costs	$28,189,000	$6,379,000	$21,810,000
CCT Savings:			
Total Non-DD GF savings and Total FFP	($13,414,000)	($6,707,000)	($6,707,000)
CCT Fund Transfer to CDSS & CDDS (PC 45)	$175,000	$0	$175,000
CCT Outreach - Admin costs (OA 47)	**$290,000**	**$0**	**$290,000**
Total of CCT PCs including pass through	$15,240,000	($328,000)	$15,568,000

*The savings are included in the total, however, they are fully reflected in the base estimates.

CCT OUTREACH - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 47

FY 2020-21	TF	GF	FF
CCT Costs (PC 36):			
Total Non-DD GF costs and Total FFP	$4,074,000	$930,000	$3,144,000
CCT Savings:			
Total Non-DD GF savings and Total FFP	($14,884,000)	($7,442,000)	($7,442,000)
CCT Fund Transfer to CDSS & CDDS (PC 45)	$175,000	$0	$175,000
CCT Outreach - Admin costs (OA 47)	**$360,000**	**$0**	**$360,000**
Total of CCT PCs including pass through	($10,275,000)	($6,512,000)	($3,763,000)

*The savings are included in the total, however, they are fully reflected in the base estimates.

Funding:
MFP Federal Grant (4260-106-0890)

MEDI-CAL RX - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	48
IMPLEMENTATION DATE:	7/2020
ANALYST:	Autumn Recce
FISCAL REFERENCE NUMBER:	2167

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$0	$39,230,000
STATE FUNDS	$0	$19,119,000
FEDERAL FUNDS	$0	$20,111,000

DESCRIPTION

Purpose:
This policy change estimates the net impact from the cost of the new administrative services vendor contract and impact on the current Fee-For-Service (FFS) pharmacy claims administrator for Medi-Cal Rx.

Authority:
Executive Order N-01-19

Interdependent Policy Changes:
Medi-Cal Rx – Managed Care Pharmacy Benefit to FFS

Background:
Executive Order N-01-19 requires the Department to transition Medi-Cal pharmacy services into a FFS benefit by January 1, 2021. This effort is known as Medi-Cal Rx. To facilitate and support the carve-out and ongoing management of the Medi-Cal pharmacy benefit, the Department will procure an external vendor to provide various administrative services for Medi-Cal Rx.

The Medi-Cal Rx vendor will modernize existing pharmacy support systems and will include, but not be limited to services related to claims administration and utilization management, pharmacy drug rebate administration, and provider and beneficiary support. The Department estimates a cost savings for the administrative services that would have been provided under the existing vendor contract for the FFS pharmacy claims administrator. Administrative costs also include contractor services and supports related to takeover of operations from the current Medi-Cal Fiscal Intermediary and managed care plans.

Effective July 1, 2020, a contractor will provide consulting and project management services to support work efforts related to Medi-Cal Rx.

The Department will be seeking necessary federal approvals for enhanced federal funding for specified periods, and standard federal funding for these administrative services, as outlined below:

Vendor
FY 2020-21:
- Five months of operations costs funded at 50% FF / 50% GF

FY 2021-22 and ongoing:
- Ongoing operations costs funded at 75% FF / 25% GF

MEDI-CAL RX - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 48

Consulting
- July 2020 through December 2020 funded at 90% FF / 10% GF
- January 2021 through June 2021 funded at 50% FF / 50% GF

This policy change (PC) is part of the carve-out effort transitioning MC pharmacy services to FFS delivery system. The PCs related to Medi-Cal Rx are:

Regular
- Medi-Cal Rx – Managed Care Pharmacy Benefit to FFS
- Medi-Cal Rx – Additional Savings from Maximum Allowable Ingredient Cost (MAIC) in FFS
- Medical Supply Rebates

Other Admin
- Medi-Cal Rx – Administrative Costs

Reason for Change:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21.

The change from FY 2019-20 to FY 2020-21 in the current estimate is due to the policy change implementing in July 2020.

Methodology:
1. Assume the FFS related administrative cost is an annual savings of $8,000,000 TF.

2. Assume the new pharmacy-related administrative cost are $87,000,000 TFannually.

(Dollars in Thousands)

Annual	TF	GF	FF
FFS Related Administrative Cost Savings	($8,000)	($2,000)	($6,000)
New Pharmacy Related Administrative Costs	$87,000	$21,750	$65,250
Net Administrative Costs	$79,000	$19,750	$59,250

3. Contractor costs are included, effective July 1, 2020 through June 30, 2021.

4. The estimated cost for FY 2020-21 is:

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
FFS Related Administrative Cost Savings	($2,000)	($500)	($1,500)
New Pharmacy Related Administrative Costs	$41,230	$19,619	$21,611
Total	**$39,230**	**$19,119**	**$20,111**

MEDI-CAL RX - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 48

Funding:
(Dollars in Thousands)

FY 2020-21	TF	GF	FF
FI 75% Title XIX / 25% GF (4260-101-0001/0890)	($2,000)	($500)	($1,500)
90% Title XIX / 10% GF (4260-101-0001/0890)	$2,490	$249	$2,241
50% Title XIX / 50% GF(4260-101-0001/0890)	$38,740	$19,370	$19,370
Total	**$39,230**	**$19,119**	**$20,111**

MEDICAL FI OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER:	49
IMPLEMENTATION DATE:	7/2015
ANALYST:	Elena Susbilla
FISCAL REFERENCE NUMBER:	1916

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$32,340,000	$0
STATE FUNDS	$9,881,750	$0
FEDERAL FUNDS	$22,458,250	$0

DESCRIPTION

Purpose:
This policy change estimates the operational costs of the Conduent Medical Fiscal Intermediary (FI) contract.

Authority:
Conduent Contract # 09-86210

Interdependent Policy Changes:
Not Applicable

Background:
The Conduent FI contract required the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The Xerox/Conduent FI contract was awarded on December 8, 2009, and became effective May 3, 2010, which began the takeover phase. The Xerox/Conduent FI contract term originally ran through March 31, 2020. However, after a settlement agreement between Xerox and the Department was reached, the new contract end date was September 30, 2019. The new FI contract vendors, DXC and IBM, assumed operations October 1, 2019.

Many functions of the Conduent Medical FI contract services were performed and paid under the Base Volume Method of Payment (BVMP) or All Volume Method of Payment (AVMP) processes. For BVMP categories, the contractor bids on fixed transaction volume ranges and a fixed rate for each range. For the AVMP categories, the contractor was paid a fixed rate per transaction. The Department received a discount when total transactions fell below the base range and paid a premium when total transactions exceeded the base range.

- The volume ranges and corresponding bid rates varied from year to year.
- The State Medi-Cal caseload also varied from year to year.

Operations constituted all contractual responsibilities required for the contractor to administer and operate the California Medicaid Management Information System (CA-MMIS). These cost categories consist of:

- General Adjudicated Claim Lines (ACLs) – Lines of service associated with a Medi-Cal claim. Payments to the FI are based on the number of ACLs processed.

MEDICAL FI OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 49

- Online Drug ACLs – Lines of service associated with a Medi-Cal online drug claim. Payments to the FI are based on the number of ACLs processed.
- Prospective Drug Use Review (DUR) – DUR is performed during adjudication of online pharmacy claims and is the process of utilization review and quality assessment of drug prescribing, dispensing, and educational intervention before and after the drug is dispensed.
- Retrospective DUR – Similar to Prospective DUR, "retrospective" reviews of claims data are done to identify patterns of improper use of drug program benefits among providers and recipients.
- Encounter Claim Lines (ECL) – Lines of service associated with encounters received from Managed Care Organizations (MCO) contracted to process Medi-Cal claims.
- California Eligibility Verification and Management Systems (CA-EVS/CMS) processing – A non-mainframe system that includes online, real-time processing of eligibility verification, share of cost, Medi-services, and pharmacy claims transaction using point of sale devices, Automated Eligibility Verification System (AEVS), Claims and Eligibility Real-Time System (CERTS), internet, or through approved user-developed/modified systems.
- Medicare Drug Discount Program – The processing of inquiries that consists of unique requests for Medicare prices for CA-EV/CMS by provider for the beneficiary for a date of service.
- Treatment Authorization Requests (TARS) – The process used by providers to request for authorization to provide specified service(s) to a beneficiary.
- Telephone Services Center (TSC) – Claim volume associated with contractor work activity and responsibility to telephone responses to provider and beneficiary inquiries received over telephone lines.

The FI bid on State-specified volume ranges for each of the above categories. The Department estimated operations costs by applying these bid rates to the actual volumes for the current year.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is due to using actual costs instead of estimates.

There is no change from the prior estimate for FY 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to the Conduent FI contract ending September 30, 2019.

Methodology:
1. Operation costs are fixed price rates based on volumes within the minimum and maximum ranges under the FI contract.
2. Costs are shared between Federal Funds (FF) and General Funds (GF).
3. Medi-Cal Administration/Operations costs are funded at 75% FF and 25% GF or 50% FF and 50% GF.

MEDICAL FI OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 49

4. Of the TSC costs, about 16.1% are funded at 50% GF and 83.9% are funded at 25% GF.

FY 2019-20	TF	GF	FF
General ACLs (75% FF/25% GF, 50% FF/50% GF, 100% GF)	$21,247,000	$6,826,000	$14,421,000
Online ACLs (75% FF/25% GF, 50% FF/50% GF, 100% GF)	$1,119,000	$359,000	$759,000
Prospective DUR (75% FF/25% GF)	$134,000	$33,000	$101,000
Retrospective DUR (50% FF/50% GF)	$39,000	$19,000	$20,000
Encounter Claim Lines (75% FF/25% GF)	$235,000	$59,000	$176,000
CA-EVS/CMS Processing (75% FF/25% GF)	$1,095,000	$274,000	$821,000
Medicare Drug Discount (100% GF)	$5,000	$5,000	$0
TARS (75% FF/25% GF)	$3,754,000	$939,000	$2,816,000
TSC (75% FF/25% GF, 50% FF/50% GF)	$4,713,000	$1,368,000	$3,345,000
Total	**$32,340,000**	**$9,882,000**	**$22,458,000**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 75% Title XIX / 25% GF (4260-101-0001/0890)
FI 100% GF (4260-101-0001)

MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER:	50
IMPLEMENTATION DATE:	11/2019
ANALYST:	Elena Susbilla
FISCAL REFERENCE NUMBER:	2119

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$24,801,000	$46,503,000
STATE FUNDS	$6,200,250	$11,625,750
FEDERAL FUNDS	$18,600,750	$34,877,250

DESCRIPTION

Purpose:
This policy change estimates the cost of the DXC Medical Fiscal Intermediary (FI) contract IT Operations and Development Services.

Authority:
DXC Contract # 18-95357

Interdependent Policy Changes:
Not Applicable

Background:
The DXC FI contracts require the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The Assumption of Operations for the FI IT Maintenance and Operations (IT M&O) contract started in October 2019. The FI contract term is five years with two one-year optional extensions.

IT Development and Operations Services of the Medical FI IT Maintenance and Operations contract are performed and paid under either an hourly rate or a fixed price where the FI provides a set cost per contract year for the services provided under that portion of the contract. IT Development and Operations Services include the following Application Maintenance and Support Services (AMSS):

- Application Development Services
- Application Maintenance and Operations Services
- Project Management Office

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is due to an increase in Systems Group hours for upcoming system change via Systems Development Notice (SDN).

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to including a full year of costs in FY 2020-21.

MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 50

Methodology:

1. Costs are paid under an hourly rate or via a fixed price negotiated during the procurement phase of the contract.

2. The costs for FY 2019-20 are for seven months of FI services which accounts for the contract effective date, payments beginning November 2019, and the shifting of costs for May and June incurred at the end of FY 2019-20 to FY 2020-21.

3. Beginning FY 2020-21 and forward, 12 months of costs are used to estimate the annual budget.

FY 2019-20	TF	GF	FF
Application Development Services	$14,710,000	$3,677,000	$11,033,000
Application Maintenance and Operations Services	$5,804,000	$1,451,000	$4,353,000
Project Management Office	$4,287,000	$1,072,000	$3,215,000
Total:	**$24,801,000**	**$6,200,000**	**$18,601,000**

FY 2020-21	TF	GF	FF
Application Development Services	$29,472,000	$7,368,000	$22,104,000
Application Maintenance and Operations Services	$9,869,000	$2,468,000	$7,401,000
Project Management Office	$7,162,000	$1,790,000	$5,372,000
Total:	**$46,503,000**	**$11,626,000**	**$34,877,000**

Funding:

FI 75% Title XIX FF/ 25% GF (4260-101-0001/0890)

MEDICAL FI BO & IT CHANGE ORDERS

OTHER ADMIN. POLICY CHANGE NUMBER:	51
IMPLEMENTATION DATE:	11/2019
ANALYST:	Elena Susbilla
FISCAL REFERENCE NUMBER:	2117

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$25,128,000	$24,668,000
STATE FUNDS	$6,482,750	$10,587,000
FEDERAL FUNDS	$18,645,250	$14,081,000

DESCRIPTION

Purpose:
This policy change estimates the cost of the DXC Medical Fiscal Intermediary (FI) contract Change Orders (i.e. Change Requests).

Authority:
DXC Contract # 18-95357
IBM Contract # 18-95302
SB 853 (Chapter 717, Statutes of 2010)
Welfare & Institutions (W&I) Code Section 14105.05

Interdependent Policy Changes:
Not Applicable

Background:
The DXC FI contracts require the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The Assumption of Operations for the Business Operations (BO) and Information Technology Maintenance and Operations (IT M&O) FI contracts started in October 2019. The DXC Business Operations FI contract term is five years with five one-year optional extensions. The IT M&O contract term is five years with two one-year optional extensions.

Modifications resulting in changes to contractor responsibilities are initiated by Change Orders (CO) and billed separately from contract operations. A CO is a documentable increase of effort identified as having a direct relation to the administration of the contract that is above the volume of the required work within the scope and above the normal costs of the contract. Either or both of the FI contractors may be required to engage in a CO project and their respective scope is determined at the initiation phase. IT Infrastructure Services estimated in this PC are comprised of work that is outside the scope of work that is estimated in the Medical FI IT Infrastructure Services policy change.

As COs are not originally known or knowable at the time the contract was procured, and require an increased level of work and effort. The Department has agreed to reimburse the FI for all documentable expenses that are a direct result of Change Order efforts. The Business Operations FI costs are determined during the analysis phase of a CO. The IT Infrastructure, Development, and Operations costs are estimated based on the preliminary pricing bids that have been submitted by the IT M&O contractor.

While change orders are generally not known at the time the contract was executed, in this case, the change orders were identified and known but detailed scope and line item costs were not finalized. There items were termed “unanticipated tasks” by DGS when they approved the contract.

MEDICAL FI BO & IT CHANGE ORDERS

OTHER ADMIN. POLICY CHANGE NUMBER: 51

Reason for Change:
The change from prior estimate, for FY 2019-20 and FY 2020-21, is due to clarification of the types and costs of COs. The Change Order Allocation line item has been broken down into several line items.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to the variation in Change Order costs estimated in FY 2019-20 and FY 2020-21.

Methodology:

1. Certain costs, such as software and travel expenses, can be paid through cost reimbursement. These costs are budgeted in the Medical FI BO & IT Cost Reimbursement policy change.

2. The contract allows for overhead and profit to be included in CO expenses (not to exceed thirty-percent). The FI itemizes the actual costs, overhead, and profit on the invoices submitted to the Department.

3. Costs are shared between Federal Funds (FF) and General Funds (GF).

FY 2019-20	TF	GF	FF
IT Infrastructure Services			
CMS 64, SIT, UAT, and PROD	$413,000	$103,000	$310,000
SMTP Server Infrastructure Support	$72,000	$18,000	$54,000
Infrastructure Software License Assessment	$624,000	$156,000	$468,000
IT Development & Operations Services			
Level 1 Help Desk	$464,000	$116,000	$348,000
COGNOS	$241,000	$60,000	$181,000
File Maintenance	$2,821,000	$906,000	$1,915,000
State Level Registry	$1,897,000	$474,000	$1,423,000
Security Encryption Services	$4,251,000	$1,062,000	$3,188,000
Testing Services	$6,765,000	$1,691,000	$5,074,000
Security Services – Certes	$220,000	$55,000	$165,000
Formulary Liaison Services	$915,000	$229,000	$686,000
EOL EOS Network	$832,000	$208,000	$624,000
Field Office Automated Groups	$964,000	$241,000	$723,000
HE Portal	$788,000	$197,000	$591,000
McWeb UAT Servers Refresh	$84,000	$21,000	$63,000
Mainframe Tape Refresh	$174,000	$43,000	$131,000
Production Environment Hardware Refresh	$483,000	$121,000	$362,000
Production Critical Servers	$49,000	$12,000	$37,000
Qradar	$1,167,000	$292,000	$875,000
Software License – Part II	$567,000	$142,000	$425,000
DXC Circuits	$1,104,000	$276,000	$828,000
TPL Liaison Services	$126,000	$31,000	$94,000
PPFS File Server and RDWEB	$51,000	$13,000	$38,000
AppDynamics Performance Monitoring	$56,000	$14,000	$42,000
Total:	**$25,128,000**	**$6,483,000**	**$18,645,000**

MEDICAL FI BO & IT CHANGE ORDERS

OTHER ADMIN. POLICY CHANGE NUMBER: 51

FY 2020-21	TF	GF	FF
IT Infrastructure Services			
CMS 64, SIT, UAT, and PROD	$93,000	$41,000	$52,000
SMTP Server Infrastructure Support	$42,000	$18,000	$24,000
Infrastructure Software License Assessment	$917,000	$401,000	$516,000
IT Development & Operations Services			
Level 1 Help Desk	$243,000	$107,000	$136,000
COGNOS	$279,000	$122,000	$157,000
File Maintenance	$1,750,000	$562,000	$1,187,000
State Level Registry	$1,793,000	$784,000	$1,009,000
Security Encryption Services	$4,475,000	$1,958,000	$2,517,000
Testing Services	$7,895,000	$3,454,000	$4,441,000
Security Services – Certes	$39,000	$17,000	$22,000
Formulary Liaison Services	$1,213,000	$531,000	$682,000
EOL EOS Network	$694,000	$303,000	$391,000
Field Office Automated Groups	1,962,000	$858,000	$1,104,000
HE Portal	$656,000	$287,000	$369,000
McWeb UAT Servers Refresh	$92,000	$40,000	$52,000
Mainframe Tape Refresh	$145,000	$63,000	$82,000
Production Environment Hardware Refresh	$402,000	$176,000	$226,000
Production Critical Servers	$41,000	$18,000	$23,000
Qradar	$972,000	$425,000	$547,000
Software License – Part II	$551,000	$241,000	$310,000
TPL Liaison Services	$253,000	$111,000	$142,000
PPFS File Server and RDWEB	$54,000	$23,000	$31,000
AppDynamics Performance Monitoring	$108,000	$47,000	$61,000
Total:	**$24,668,000**	**$10,587,000**	**$14,081,000**

Funding:
FI 75% Title XIX / 25% GF (4260-101-0001/0890)
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 100% GF (4260-101-0001)

MEDICAL FI BO & IT COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	52
IMPLEMENTATION DATE:	11/2019
ANALYST:	Elena Susbilla
FISCAL REFERENCE NUMBER:	2115

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$22,351,000	$38,460,000
STATE FUNDS	$6,647,700	$11,716,050
FEDERAL FUNDS	$15,703,300	$26,743,950

DESCRIPTION

Purpose:
This policy change estimates the total cost reimbursement of the DXC Medical Fiscal Intermediary (FI) contracts.

Authority:
DXC Contract # 16-95357
IBM Contract # 18-95302

Interdependent Policy Changes:
Not Applicable

Background:
The FI contracts require the FIs to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The Assumption of Operations for the Business Operations and Information Technology Maintenance and Operations (IT M&O) contracts started in October 2019. The FI Business Operations contract term is five years with five one-year optional extensions. The IT M&O contract term is five years with two one-year optional extensions.

Various costs incurred by the contractor while performing responsibilities under the contract are reimbursed by the Department using a Cost Reimbursement, or Direct Cost, pricing methodology. These costs are not a part of the bid price of the contract and are paid dollar for dollar, with no overhead or profit included. Any of the following costs may be cost reimbursed under the contract:

- Postage
  - Postal rates utilized to mail documents to providers, beneficiaries, the State, the federal government, or any other Medi-Cal or State program-related business. Return envelope postage is also reimbursable.

- Parcel Services and Common Carriers
  - The actual charges paid for parcel services and common carriers for the delivery of: Medi-Cal and other health program claim and Treatment Authorization Request (TAR) forms to providers; and documents, materials, and equipment to providers, beneficiaries, and State or federal offices.

MEDICAL FI BO & IT COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 52

- Equipment and Services (Personal Computers, Monitors, Printers, Related Equipment, and Software)
  - Installation and monthly charges for data lines;
  - Purchase, lease, installation, and maintenance of desktops for State staff at Field Offices and Contractor facilities; and
  - Point-of-Sale (POS) devices.

- Facilities Lease, Improvement, Modifications
  - The direct costs for the Medi-Cal Operations Center (MOC) as well as any required modifications and improvements.

- Consultant Contracts
  - Consultant contracts utilized for operational project oversight that are paid through Cost Reimbursement.

- Telecommunications and Data Center
  - Telephone Toll Charges – Actual telecommunication charges paid for by the contractor for maintaining toll-free lines available to providers and beneficiaries, telephone lines for audio text equipment, computer media claims, TAR submissions, the print and distribution center, on-line pharmacy claims processing and on-line eligibility verification, and any other beneficiary or provider use lines. Excludes all other direct or indirect costs associated with telephone toll charges.

  - Data Center Access – Actual charges incurred by the contractor for access to records contained in the Medi-Cal Eligibility Data System and the utilization of the telecommunications network, as charged by the Department of Technology Services Data Center.

- Other Cost Reimbursable Items
  - Equipment and furniture for the Field Office Automation Group (FOAG).

  - The Department has established a rate policy which applies to the contract and defines lodging, mileage, and meal expense reimbursement for travel expenses.

  - Drug Use Review (DUR) work performed on behalf of the Department to provide DUR research, articles for DUR publication, attend conferences, and submit monthly/quarterly reports/

  - Special Training which falls outside the required training scope, as defined by the contract, and directly relates to California Medicaid Management Information System (CA-MMIS) support activities.

- Sales Tax
  - The Department will reimburse the contractor only for the actual sales and/or use tax paid by the Contractor to the California Board of Equalization for the operations of this contract.

MEDICAL FI BO & IT COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 52

- Audits and Research
  - Annual audits for the Electronic Data Processing Application System shall be cost reimbursed for the direct cost of the audit as paid to the independent auditor by the contractor, excluding procurement costs or effort expended by the contractor.

- Change Order and/or Amendments
  - Certain costs associated with Contract Change Orders/Amendments can be paid through Cost Reimbursement.

Costs under these categories consist of direct costs, or subsets thereof, which can be specifically identified with the particular cost objective.

Reason for Change:
There is no change from the prior estimate, for FY 2019-20 and FY 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to including a full year of costs in FY 2020-21.

Methodology:
1. Costs for Audits & Research and Change Orders will be added to this policy change once a contractor commences scheduling that work.

2. Takeover costs are not paid with Local Assistance funds.

3. The costs for FY 2019-20 are for six months of FI services which accounts for the contract effective date, payments beginning November 2019, and the shifting of costs incurred at the end of FY 2019-20 to FY 2020-21.

4. Contract costs are shared between Federal Funds (FF) and General Funds (GF).

FY 2019-20	TF	GF	FF
Postage (50% FF / 50% GF)	$822,000	$411,000	$411,000
Parcel Services & Common Carriers (50% FF / 50% GF)	$50,000	$25,000	$25,000
Equipment & Services (75% FF / 25% GF)	$2,425,000	$607,000	$1,818,000
Facilities Improvement & Modification (50% FF / 50% GF)	$4,008,000	$2,004,000	$2,004,000
Consultant Contracts (50% FF / 50% GF, 75% FF / 25% GF, 90% FF / 10% GF)	$10,415,000	$2,577,000	$7,838,000
Telecommunications & Data Center (75% FF / 25% GF)	$489,000	$122,000	$367,000
Other Cost Reimbursable Items (50% FF / 50% GF, 90% FF / 10% GF)	$2,029,000	$359,000	$1,670,000
Sales Tax (75% FF / 25% GF)	$2,053,000	$513,000	$1,540,000
Total:	**$22,351,000**	**$6,648,000**	**$15,703,000**

MEDICAL FI BO & IT COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 52

FY 2020-21	TF	GF	FF
Postage (50% FF / 50% GF)	$1,765,000	$882,000	$883,000
Parcel Services & Common Carriers (50% FF / 50% GF)	$100,000	$50,000	$50,000
Equipment & Services (75% FF / 25% GF)	$4,218,000	$1,054,000	$3,164,000
Facilities Improvement & Modification (50% FF / 50% GF)	$7,937,000	$3,969,000	$3,968,000
Consultant Contracts (50% FF / 50% GF, 75% FF / 25% GF, 90% FF / 10% GF)	$15,299,000	$3,772,000	$11,527,000
Telecommunications & Data Center (75% FF / 25% GF)	$978,000	$244,000	$734,000
Other Cost Reimbursable Items (50% FF / 50% GF, 90% FF / 10% GF)	$4,057,000	$718,000	$3,339,000
Sales Tax (75% FF / 25% GF)	$4,106,000	$1,027,000	$3,079,000
Total:	**$38,460,000**	**$11,716,000**	**$26,744,000**

Funding:
FI 50% Title XIX/ 50% GF (4260-101-0001/0890)
FI 75% Title XIX/ 25% GF (4260-101-0001/0890)
FI 90% Title XIX/ 10% GF (4260-101-0001/0890)
FI 50% HIPAA FF/ 50% GF (4260-117-0001/0890)
FI 75% HIPAA FF/ 25% GF (4260-117-0001/0890)
FI 90% HIPAA FF/ 10% GF (4260-117-0001/0890)

MEDICAL FI IT INFRASTRUCTURE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER:	53
IMPLEMENTATION DATE:	11/2019
ANALYST:	Elena Susbilla
FISCAL REFERENCE NUMBER:	2118

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$17,763,000	$30,627,000
STATE FUNDS	$5,046,750	$8,698,500
FEDERAL FUNDS	$12,716,250	$21,928,500

DESCRIPTION

Purpose:
This policy change estimates the cost of the IBM Medical Fiscal Intermediary (FI) contract Information Technology (IT) Infrastructure Services.

Authority:
IBM Contract # 18-95302

Interdependent Policy Changes:
Not Applicable

Background:
The FI contracts require the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The Assumption of Operations for the FI IT Maintenance and Operations (IT M&O) IBM contract started in October 2019. The FI contract term is five years with two one-year optional extensions.

IT Infrastructure Services of the IBM Medical FI IT M&O contract are performed and paid under a fixed price where the FI provides a set cost per contract year for the services provided under that portion of the contract. Application Hosting and Managed Network Support Services (AH/MNS) include:

- Mainframe Data Center Operations Services
- Midrange Data Center Operations Services
- Midrange Storage Operations Services
- Managed Network Services
- Disaster Recovery
- Service Delivery Management, Asset Management, and Facilities
- Fixed Security Services
- Hardware and Refresh
- Software

Reason for Change:
There is no change from the prior estimate, for FY 2019-20 and FY 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to including a full year of costs in FY 2020-21.

MEDICAL FI IT INFRASTRUCTURE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 53

Methodology:

1. Costs are paid under an hourly rate or via a fixed price negotiated during the procurement phase of the contract.

2. Takeover costs are not paid with Local Assistance funds.

3. The costs for FY 2019-20 are for seven months of FI services which accounts for the contract effective date, payments beginning November 2019, and the shifting of costs incurred at the end of FY 2019-20 to FY 2020-21.

4. Beginning FY 2020-21 and forward, 12 months of costs are used to estimate the annual budget.

5. Contract costs are shared between Federal Funds (FF) and General Funds (GF).

FY 2019-20	TF	GF	FF
Mainframe Data Center Operations Services	$2,881,000	$926,000	$1,955,000
Midrange Data Center Operations Services	$1,887,000	$606,000	$1,281,000
Midrange Storage Operations Services	$138,000	$44,000	$94,000
Managed Network Services	$2,129,000	$684,000	$1,445,000
Disaster Recovery	$1,147,000	$287,000	$860,000
Service Delivery Mgmt, Asset Mgmt, and Facilities	$4,049,000	$1,012,000	$3,037,000
Fixed Security Services	$1,482,000	$476,000	$1,006,000
Hardware and Refresh	$353,000	$88,000	$265,000
Software	$3,697,000	$924,000	$2,773,000
Total:	**$17,763,000**	**$5,047,000**	**$12,716,000**

FY 2020-21	TF	GF	FF
Mainframe Data Center Operations Services	$4,968,000	$1,596,000	$3,372,000
Midrange Data Center Operations Services	$3,223,000	$1,035,000	$2,188,000
Midrange Storage Operations Services	$236,000	$76,000	$160,000
Managed Network Services	$3,649,000	$1,172,000	$2,477,000
Disaster Recovery	$1,967,000	$492,000	$1,475,000
Service Delivery Mgmt, Asset Mgmt, and Facilities	$6,940,000	$1,735,000	$5,205,000
Fixed Security Services	$2,534,000	$814,000	$1,720,000
Hardware and Refresh	$623,000	$156,000	$467,000
Software	$6,487,000	$1,622,000	$4,865,000
Total:	**$30,627,000**	**$8,698,000**	**$21,929,000**

Funding:

FI 75% Title XIX / 25% GF (4260-101-0001/0890)
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 100% GF (4260-101-0001)

MEDICAL FI HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	54
IMPLEMENTATION DATE:	7/2015
ANALYST:	Elena Susbilla
FISCAL REFERENCE NUMBER:	1918

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$43,605,000	$0
STATE FUNDS	$10,986,850	$0
FEDERAL FUNDS	$32,618,150	$0

DESCRIPTION

Purpose:
This policy change estimates the hourly reimbursement costs of the Conduent Medical Fiscal Intermediary (FI) contract.

Authority:
Conduent Contract # 09-86210

Interdependent Policy Changes:
Not Applicable

Background:
The Conduent FI contract required the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The Xerox/Conduent FI contract was awarded on December 8, 2009, and became effective May 3, 2010, which began the takeover phase. The Xerox/Conduent FI contract term originally ran through March 31, 2020. However, after a settlement agreement between Xerox and the Department was reached, the new contract end date was September 30, 2019. The new FI contract vendors, DXC and IBM, assumed operations October 1, 2019.

Certain activities are reimbursed on an hourly basis by the Department. The rate paid to the contractor consists of all direct and indirect costs required to support these activities, plus profit. Hourly reimbursed areas consist of the Systems Group (SG) and Field Office Automation Group (FOAG) pharmacists. The SG staff consists of technical and supervisory staff that design, develop, and implement Department required modifications and/or provide technical support to the California Medicaid Management Information Systems (CA-MMIS). FOAG pharmacists administer processes and review drug Treatment Authorization Requests (TAR) in accordance with the Department's criteria, guidelines, and policy. They provide consultation services to contractor staff consultants, physicians, nurses, and field office personnel. FOAG pharmacists independently evaluate and adjudicate TARs, and maintain currency with continuously evolving healthcare practices, equipment, and technology.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is due to using actual costs instead of estimates.

There is no change from the prior estimate for FY 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to the Conduent FI contract ending September 30, 2019.

MEDICAL FI HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 54

Methodology:

1. SG costs are based on the contract bid price for SG Hourly Reimbursements and the System Replacement Project settlement agreement.

2. Costs are shared between Federal Funds (FF) and General Funds (GF), based on the fixed price Base Volume Method of Payment (BVMP) bid rates.

FY 2019-20	TF	GF	FF
Non-HIPAA (75% FF / 25% GF, 90% FF / 10% GF, 50% FF / 50% GF, 100% GF)	$7,425,000	$1,942,000	$5,483,000
HIPAA (75% FF / 25% GF)	$36,180,000	$9,045,000	$27,135,000
Total Hourly Reimbursement	**$43,605,000**	**$10,987,000**	**$32,618,000**

Funding:

FI 50% Title XIX FF/ 50% GF (4260-101-0001/0890)
FI 75% Title XIX FF/ 25% GF (4260-101-0001/0890)
FI 90% Title XIX FF/ 10% GF (4260-101-0001/0890)
FI HIPAA 75% FF / 25% GF (4260-117-0001/0890)
FI 100% GF (4260-101-0001)

MEDICAL FI COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	55
IMPLEMENTATION DATE:	7/2015
ANALYST:	Elena Susbilla
FISCAL REFERENCE NUMBER:	1917

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$28,096,000	$0
STATE FUNDS	$7,865,050	$0
FEDERAL FUNDS	$20,230,950	$0

DESCRIPTION

Purpose:
This policy change estimates the total cost reimbursement of the Conduent Medical Fiscal Intermediary (FI) contract.

Authority:
Conduent Contract # 09-86210

Interdependent Policy Changes:
Not Applicable

Background:
The Conduent FI contract required the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The Xerox/Conduent FI contract was awarded on December 8, 2009, and became effective May 3, 2010, which began the takeover phase. The Xerox/Conduent FI contract term originally ran through March 31, 2020. However, after a settlement agreement between Xerox and the Department was reached, the new contract end date was September 30, 2019. The new FI contract vendors, DXC and IBM assumed operations October 1, 2019.

Various costs incurred by the contractor while performing responsibilities under the contract will be reimbursed by the State. These costs are not a part of the bid price of the contract and are paid dollar for dollar, with no overhead or profit included. Any of the following costs may be cost reimbursed under the contract:

- Postage - Postal rates utilized to mail documents to providers, beneficiaries, the State, the federal government, or any other Medi-Cal or State program-related business. Return envelope postage is also reimbursable.

- Parcel Services and Common Carriers - The actual charges paid for parcel services and common carriers for the delivery of: Medi-Cal and other health program claim and Treatment Authorization Request (TAR) forms to providers; and documents, materials, and equipment to providers, beneficiaries, and State or federal offices.

- Personal Computers, Monitors, Printers, Related Equipment, and Software – The installation and monthly charges for data lines; and the purchase, lease, installation, and maintenance of desktops for State staff at Field Office and Contractor facilities, or at the Direction of the Contracting Officer and Point-of-Sale (POS) devices.

MEDICAL FI COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 55

- Printing – Costs to print the forms, documents, and other State program printing requests as directed by the State.
- Telephone Toll Charges – Actual telecommunication charges paid for by the contractor for maintaining toll-free lines available to providers and beneficiaries, telephone lines for audio text equipment, computer media claims, TAR submissions, the print and distribution center, on-line pharmacy claims processing and on-line eligibility verification, and any other beneficiary or provider use lines. Excludes all other direct or indirect costs associated with telephone toll charges.
- Data Center Access – Actual charges incurred by the contractor for access to records contained in the Medi-Cal Eligibility Data System and the utilization of the telecommunications network, as charged by the Department of Technology Services Data Center.
- Special Training Sessions – Payment for training sessions that exceeds the fixed price training bid.
- Facilities Improvement and Modifications – The direct costs for modifications and improvements to facilities, for the purposes of housing State or federal on-site audit and monitoring staff.
- Audits and Research – Annual audits for the Electronic Data Processing Application System shall be cost reimbursed for the direct cost of the audit as paid to the independent auditor by the contractor, excluding procurement costs or effort expended by the contractor.
- Sales Tax – The Department will reimburse the contractor only for the actual sales and/or use tax paid by the Contractor to the California Board of Equalization for the operations of this contract.
- Change Order and/or Amendments – Certain costs associated with Contract Change Orders/Amendments can be paid through Cost Reimbursement.
- The Medi-Cal Print and Distribution Center – Contractor shall be reimbursed for the Medi-Cal Print and Distribution Center staff required to perform the functions of printing as described in the contract. The Department will also reimburse the contractor for all space, cost of equipment, fire suppressant system, cabinets, staff, printing, and distribution services.
- Drug Use Review (DUR) and Eligibility Verification Telecommunications – Real-time drug use approvals and eligibility verifications that take place via California POS.
- Field Office Automation Group (FOAG) equipment and furniture – Direct costs incurred for the purchase and maintenance of computer equipment and furniture for FOAG staff located in State offices. Excludes supplies, purchases, and maintenance for computer equipment and furniture in TAR Processing Centers.
- Consultant Contracts – Services include but are not limited to technical support for the State Level Registry, organizational change management, program integration services, data conversion consultation, and Rebate Accounting Information System (RAIS) platform maintenance are paid through Cost Reimbursement.

MEDICAL FI COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 55

Costs under these categories consist of direct costs, or subsets thereof, which can be specifically identified with the particular cost objective.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a net increase due to the prior estimate only captured five months of estimated cost while actual costs were paid over seven months and includes invoices paid on a four to six month lag. FY 2019-20 payments reflect actual invoices processed and the longer payment lag resulted in higher Consultant Contracts cost than previously estimated.

There is no change from the prior estimate for FY 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to the Conduent FI contract ending September 30, 2019.

Methodology:
1. Contract costs are shared between Federal Funds (FF) and General Funds (GF).

FY 2019-20	TF	GF	FF
Postage (50% FF / 50% GF)	$918,000	$459,000	$459,000
Parcel Services & Common Carriers (50% FF / 50% GF)	$52,000	$26,000	$26,000
Equipment/Services (75% FF / 25% GF)	$1,841,000	$460,000	$1,381,000
Print/Distribution Center (50% FF / 50% GF,75% FF / 25% GF)	$1,159,000	$464,000	$695,000
P&D Other Direct Costs (50% FF / 50% GF, 75% FF / 25% GF)	$530,000	$199,000	$331,000
Facilities Improvement & Modification (50% FF / 50% GF)	$883,000	$442,000	$441,000
Sales Tax (75% FF / 25% GF)	$2,548,000	$637,000	$1,911,000
Consultant Contracts (50% FF / 50%GF, 75% FF / 25% GF, 90% FF / 10% GF)	$16,112,000	$4,001,000	$12,111,000
Telecommunication & Data Center Access (75% FF / 25% GF)	$1,041,000	$260,000	$781,000
Other Cost Reimb. Items (50% FF / 50% GF, 75% FF / 25% GF)	$3,012,000	$917,000	$2,095,000
Total	**$28,096,000**	**$7,865,000**	**$20,231,000**

MEDICAL FI COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 55

Funding:
FI 50% Title XIX/ 50% GF (4260-101-0001/0890)
FI 75% Title XIX/ 25% GF (4260-101-0001/0890)
FI 50% HIPAA FF/ 50% GF (4260-117-0001/0890)
FI 75% HIPAA FF/ 25% GF (4260-117-0001/0890)
FI 90% HIPAA FF/ 10% GF (4260-117-0001/0890)

MEDICAL FI BO OTHER ESTIMATED COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	56
IMPLEMENTATION DATE:	11/2019
ANALYST:	Elena Susbilla
FISCAL REFERENCE NUMBER:	2112

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$10,873,000	$21,744,000
STATE FUNDS	$3,195,500	$6,390,000
FEDERAL FUNDS	$7,677,500	$15,354,000

DESCRIPTION

Purpose:
This policy change estimates the other estimated costs of the DXC Medical Fiscal Intermediary (FI) contract.

Authority:
DXC Contract # 18-95357

Interdependent Policy Changes:
Not Applicable

Background:
The DXC FI contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The Assumption of Operations for the Business Operations FI contract started in October 2019. The FI contract term is five years with five one-year optional extensions.

Some functions and services of the DXC Medical FI contract are performed and paid using a Fixed Price payment methodology. For Fixed Price categories, the Contractor is paid a fixed rate for certain annual services.

Costs under this category consist of payment to the contractor for contract services, such as:

- Process Appeals - The Contractor reviews the appeal documents and the claim history, and either rejects the appeal or approves and resubmits the claim for processing. The Contractor regularly provides information to the providers regarding claim appeal status, denial reasons, and estimated payment dates, as appropriate. All appeal information is recorded in the California Medicaid Management Information System (CA-MMIS) Appeals subsystem.

- Support Audits - The Contractor is required to plan, track, and coordinate audit support tasks, gather data or other information requested for the audit, and obtain all information necessary to present a complete and accurate audit response to the Department for review and approval.

- Process Drug Rebates – The Contractor processes drug rebates in order to create invoices submitted to manufacturers which generate revenue received by the Department in excess of $4 billion annually.

MEDICAL FI BO OTHER ESTIMATED COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 56

- Provide Litigation Support - The Contractor's litigation support includes, but is not limited to, planning, tracking, and coordinating litigation support tasks, developing responses to subpoenas and other legal requests, and providing written and oral testimony on behalf of the Department.

- Service Delivery Support – The Contractor performs broad management, administrative, and supporting services that apply to the delivery of all Business, IT, and Facilities Services while conforming to standardized process, protocols, templates, and tools as prescribed by the Department.

- Publish Provider Communications – The Contractor assists with the development and distribution of provider communications related to provider billing as well as related processes and procedures. Provider communications take many forms, such as bulletins targeted to the different provider types, forms, public content forums, Provider Manual changes, Medi-Cal website content, provider letters, news articles, system alerts, user guides, technical documents, and education and training opportunities.

- Conduct Provider Outreach and Education – The Contractor conducts centralized and regional provider outreach and education activities, and provides on-site support resources and specialists focused on small providers, and out-of-state providers to address specific provider issues.

- Print and Mail Medi-Cal Information - The Department requires the Contractor to print and mail information of any type, as approved by the Department, to audiences, identified by the Department, on a scheduled and ad hoc basis. The Contractor is also required to create, update, and manage forms, including developing and maintaining a Master Index of Forms. The Contractor prints 1099s, Departmental standard forms, ad hoc forms as requested, and reports monthly regarding these activities.

- Perform Proactive Provider Research - The Contractor conducts research and reviews provider customer services data from multiple sources to identify trends, systemic issues, needs, and concerns. The findings lead to recommendations for development of provider communication materials, provider educational materials, policy changes, and process and procedural improvements for review by the Department. The Contractor prepares position papers, problem statements, and reports for review and approval by the Department prior to taking any action. The Contractor also develops and submits content changes directly to Outreach and Training teams for inclusion in ongoing services.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to including a full year of costs in FY 2020-21.

Methodology:

1. Other Estimated Costs are paid using Fixed pricing methodology. The contract stipulates an annual rate for each of the services defined above.

2. The costs for FY 2019-20 include six months of FI services which accounts for the contract effective date, payments beginning November 2019, and the shifting of costs incurred at the end

MEDICAL FI BO OTHER ESTIMATED COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 56

of FY 2019-20 to FY 2020-21.

3. Costs are shared between Federal Funds (FF) and General Funds (GF).

FY 2019-20	TF	GF	FF
Process Appeals (75% FF/25% GF, 100% GF)	$356,000	$115,000	$241,000
Support Audits (75% FF/25% GF)	$80,000	$20,000	$60,000
Process Drug Rebates (75% FF/25% GF)	$566,000	$141,000	$425,000
Provide Litigation Support (75% FF/25% GF)	$82,000	$21,000	$61,000
Service Delivery Support (75% FF/25% GF)	$4,693,000	$1,173,000	$3,520,000
Publish Provider Communication Materials (75% FF/25% GF, 50% FF/50% GF)	$1,603,000	$681,000	$922,000
Conduct Provider Outreach and Education (75% FF/25% GF)	$2,429,000	$607,000	$1,822,000
Print and Mail Medi-Cal Information (75% FF/25% GF, 50% FF/50% GF)	$978,000	$416,000	$562,000
Perform Proactive Provider Research (75% FF/25% GF)	$85,000	$21,000	$64,000
Total:	**$10,873,000**	**$3,196,000**	**$7,677,000**

FY 2020-21	TF	GF	FF
Process Appeals (75% FF/25% GF, 100% GF)	$712,000	$229,000	$483,000
Support Audits (75% FF/25% GF)	$160,000	$40,000	$120,000
Process Drug Rebates (75% FF/25% GF)	$1,133,000	$283,000	$850,000
Provide Litigation Support (75% FF/25% GF)	$163,000	$41,000	$122,000
Service Delivery Support (75% FF/25% GF)	$9,388,000	$2,347,000	$7,041,000
Publish Provider Communication Materials (75% FF/25% GF, 50% FF/50% GF)	$3,205,000	$1,362,000	$1,843,000
Conduct Provider Outreach and Education (75% FF/25% GF)	$4,857,000	$1,214,000	$3,643,000
Print and Mail Medi-Cal Information (75% FF/25% GF, 50% FF/50% GF)	$1,956,000	$831,000	$1,125,000
Perform Proactive Provider Research (75% FF/25% GF)	$170,000	$43,000	$127,000
Total:	**$21,744,000**	**$6,390,000**	**$15,354,000**

MEDICAL FI BO OTHER ESTIMATED COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 56

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 75% Title XIX / 25% GF (4260-101-0001/0890)
FI 100% GF (4260-101-0001/0890)

MEDICAL FI BO TELEPHONE SERVICE CENTER

OTHER ADMIN. POLICY CHANGE NUMBER:	57
IMPLEMENTATION DATE:	11/2019
ANALYST:	Elena Susbilla
FISCAL REFERENCE NUMBER:	2116

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$8,161,000	$16,322,000
STATE FUNDS	$2,368,750	$4,737,500
FEDERAL FUNDS	$5,792,250	$11,584,500

DESCRIPTION

Purpose:
This policy change estimates the Telephone Service Center (TSC) costs of the DXC Medical Fiscal Intermediary (FI) contract.

Authority:
DXC Contract # 18-95357

Interdependent Policy Changes:
Not Applicable

Background:
The FI contracts require an FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The Assumption of Operations for the Business Operations FI contract was October 2019. The FI contract term is five years with five one-year optional extensions.

The TSC functions and services of the DXC Medical FI contract are paid using a Fixed Price and a Variable Pricing methodology. For Fixed Price categories, the Contractor is paid a fixed rate for certain annual services. Variable Pricing methodology is based on estimated volume-driven metrics and account for increases in actual volumes. The costs are calculated using a fixed annual rate for transactions up to a State-specified volume and a per-transaction rate for transactions which exceed that volume. Variable Pricing is also known as “Fixed Plus.”

The TSC provides telephone and chat services to providers and beneficiaries in three areas. Each TSC service area utilizes telecommunications infrastructure, Customer Relationship Management application(s), and the records repository which are implemented and maintained by the contractor.

- Provider Customer Services (Variable Pricing)
- Member Customer Services (Variable Pricing)
- Financial Services (Fixed Price)

Reason for Change:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to including a full year of cost.

MEDICAL FI BO TELEPHONE SERVICE CENTER

OTHER ADMIN. POLICY CHANGE NUMBER: 57

Methodology:

1. TSC costs are paid using Variable price rates based on volumes within a maximum threshold. The contract stipulates an annual fixed price for services up to a specified volume and a per-transaction price for services which exceed that volume.

2. Takeover costs are not paid with Local Assistance funds.

3. The costs for FY 2019-20 are for six months of FI services which accounts for the contract effective date, payments beginning November 2019, and the shifting of costs incurred at the end of FY 2019-20 to FY 2020-21.

4. Costs are shared between Federal Funds (FF) and General Funds (GF).

FY 2019-20	TF	GF	FF
TSC – Conduct Provider Customer Services (75% FF/25% GF, 50% FF/50% GF)	$4,933,000	$1,432,000	$3,501,000
TSC – Conduct Member Customer Services (75% FF/25% GF, 50% FF/50% GF)	$2,429,000	$705,000	$1,724,000
TSC – Provide Financial Services (75% FF/25% GF, 50% FF/50% GF)	$799,000	$232,000	$567,000
Total	**$8,161,000**	**$2,369,000**	**$5,792,000**

FY 2020-21	TF	GF	FF
TSC – Conduct Provider Customer Services (75% FF/25% GF, 50% FF/50% GF)	$9,866,000	$2,864,000	$7,002,000
TSC – Conduct Member Customer Services (75% FF/25% GF, 50% FF/50% GF)	$4,857,000	$1,409,000	$3,448,000
TSC – Provide Financial Services (75% FF/25% GF, 50% FF/50% GF)	$1,599,000	$464,000	$1,135,000
Total	**$16,322,000**	**$4,737,000**	**$11,585,000**

Funding:

FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 75% Title XIX / 25% GF (4260-101-0001/0890)

MEDICAL FI BUSINESS OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER:	58
IMPLEMENTATION DATE:	11/2019
ANALYST:	Elena Susbilla
FISCAL REFERENCE NUMBER:	2111

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$6,868,000	$13,737,000
STATE FUNDS	$2,089,750	$4,180,000
FEDERAL FUNDS	$4,778,250	$9,557,000

DESCRIPTION

Purpose:
This policy change estimates the operational costs of the DXC Medical Fiscal Intermediary (FI) contract.

Authority:
DXC Contract # 18-95357

Interdependent Policy Changes:
Not Applicable

Background:
The FI contracts require an FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The Assumption of Operations for the DXC Business Operations FI contract started in October 2019. The DXC Business Operations FI contract term is five years with five one-year optional extensions.

The Operations functions and services of the DXC Medical FI contract are paid using a Variable Pricing methodology. The Variable Pricing methodology is based on estimated volume-driven metrics and account for increases in actual volumes. The costs are calculated using a fixed annual rate for transactions up to a State-specified volume and a per-transaction rate for transactions which exceed that volume. Variable Pricing is also known as “Fixed Plus.”

Operations constitute contractual responsibilities required for the contractor to administer and operate the California Medicaid Management Information System (CA-MMIS). These cost categories consist of:

- Process Paper Claims – The Contractor is responsible for the manual entry of claim data into the CA-MMIS Claims system for adjudication, when those claims are received on paper (mail or fax), rather than electronically.

- Process Suspended Claims - The Contractor uses CA-MMIS subsystems and applications to manually adjudicate suspended claims and address suspended claims issues, in accordance with program policy, system validations, established rates, and State and Federal statutes and regulations.

MEDICAL FI BUSINESS OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 58

- Manage Records - The Contractor is required to provide a comprehensive Manage Records service that results in preservation, protection and maintenance of all official Medi-Cal records according to State, Federal, Contractual, or program requirements. The Contractor acts as "Custodian of Records" for the Medi-Cal program, including certifying record authenticity, managing electronic access to records, performing manual research and record retrieval, and producing "acceptable copies."

- Process Member Card Request – The Contractor is responsible for the production and distribution of Benefit Identification Cards to Medi-Cal members, and Health Access Program cards to public health providers.

- Process Paper Treatment Authorization Request (TAR) – The Contractor is responsible for the entering of TAR data into the TAR system for review and/or adjudication of TARs and TAR Appeals, including the scanning of paper TARs and attachments so that an official record is stored and made available for further use by TAR adjudicators in the Records Repository.

The FI has provided State-specified volumes for each of the above categories. The Department estimates operations costs by applying the rates established by the contract to the projected volumes for the current and budget year.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to including a full year of costs in FY 2020-21.

Methodology:
1. Operation costs are paid using Fixed Plus pricing methodology with a rate for an annual volume threshold and a rate for each transaction which exceeds that threshold.

2. Projected volumes are established by the Department using trends and counts from previous years and the FI rate established by the contract is applied to the respective volume.

3. Takeover costs are not paid with Local Assistance funds.

4. The costs for FY 2019-20 are for six months of FI services which accounts for the contract effective date, payments beginning November 2019, and the shifting of costs incurred at the end of FY 2019-20 to FY 2020-21.

5. Costs are shared between Federal Funds (FF) and General Funds (GF).

FY 2019-20	TF	GF	FF
Process Paper Claims	$3,743,000	$1,203,000	$2,540,000
Process Suspended Claims	$1,488,000	$478,000	$1,010,000
Manage Records	$625,000	$156,000	$469,000
Process Member Card Requests	$836,000	$209,000	$627,000
Process Paper TAR	$176,000	$44,000	$132,000
Total:	**$6,868,000**	**$2,090,000**	**$4,778,000**

MEDICAL FI BUSINESS OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 58

FY 2020-21	TF	GF	FF
Process Paper Claims	$7,486,000	$2,405,000	$5,081,000
Process Suspended Claims	$2,976,000	$956,000	$2,020,000
Manage Records	$1,250,000	$313,000	$937,000
Process Member Card Requests	$1,673,000	$418,000	$1,255,000
Process Paper TAR	$352,000	$88,000	$264,000
Total:	**$13,737,000**	**$4,180,000**	**$9,557,000**

Funding:
FI 75% Title XIX / 25% GF (4260-101-0001/0890)
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 100% GF (4260-101-0001)

MEDICAL FI OTHER ESTIMATED COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	59
IMPLEMENTATION DATE:	7/2015
ANALYST:	Elena Susbilla
FISCAL REFERENCE NUMBER:	1921

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$5,951,000	$0
STATE FUNDS	$1,712,250	$0
FEDERAL FUNDS	$4,238,750	$0

DESCRIPTION

Purpose:
This policy change estimates the total of other estimated costs of the Conduent Medical Fiscal Intermediary (FI) contract.

Authority:
Conduent Contract # 09-86210

Interdependent Policy Changes:
Not Applicable

Background:
The Conduent FI contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The Xerox/Conduent FI contract was awarded on December 8, 2009, and became effective May 3, 2010, which began the takeover phase. The Xerox/Conduent FI contract term originally ran through March 31, 2020. However, after a settlement agreement between Xerox and the Department was reached, the new contract end date was September 30, 2019. The new FI contract vendors, DXC and IBM assumed operations October 1, 2019.

Costs under this category consist of payment to the contractor for other contract services, such as:

- Beneficiary Identification Cards (BIC) – Plastic cards issued by the Department to each Medi-Cal recipient.
- Health Access Program Cards (HAP) – Plastic cards issued by the Department to beneficiaries participating in Family Planning, Access, Care, and Treatment (FPACT) and other special health care programs.
- Rebate Accounting and Information System (RAIS) Medi-Cal – The processing of RAIS invoices/claims in fee-for-service.
- RAIS Managed Care Organizations (MCO) – The processing of RAIS invoices/claims for MCOs.
- Cost containment – Items brought to the attention of the Department by the contractor that result in savings in Medi-Cal program expenditures and which the contractor shares a portion of the savings.
- Fixed price hourly billable Systems Group (SG) – Projects such as International Classification of Diseases and 10th Revision (ICD-10).

MEDICAL FI OTHER ESTIMATED COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 59

Reason for Change:
The change from the prior estimate for FY 2019-20 is due to using actual costs instead of estimates.

There is no change from the prior estimate for FY 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to the Conduent FI contract ending September 30, 2019.

Methodology:
1. Costs are shared between Federal Funds (FF) and General Funds (GF).

2. Payment calculated by a transaction rate multiplied by volume basis, based on contract year and General Adjudicated Claim Lines (ACL) volume.

FY 2019-20	TF	GF	FF
Beneficiary ID Cards (75% FF / 25% GF)	$250,000	$63,000	$187,000
Health Access Program Cards (75% FF / 25% GF)	$79,000	$20,000	$59,000
RAIS Medi-Cal (75% FF / 25% GF)	$361,000	$90,000	$271,000
RAIS MCO (75% FF / 25% GF)	$4,363,000	$1,091,000	$3,272,000
Cost Containment (50% FF / 50% GF)	$898,000	$449,000	$449,000
Total Costs	**$5,951,000**	**$1,713,000**	**$4,238,000**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 75% Title XIX / 25% GF (4260-101-0001/0890)

MEDICAL FI BO HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	60
IMPLEMENTATION DATE:	11/2019
ANALYST:	Elena Susbilla
FISCAL REFERENCE NUMBER:	2113

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$5,364,000	$11,407,000
STATE FUNDS	$1,341,000	$2,851,750
FEDERAL FUNDS	$4,023,000	$8,555,250

DESCRIPTION

Purpose:
This policy change estimates the hourly reimbursement costs of the DXC Medical Fiscal Intermediary (FI) contract.

Authority:
DXC Contract # 16-95357

Interdependent Policy Changes:
Not Applicable

Background:
The DXC FI contracts require the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The Assumption of Operations for the Business Operations FI contract started in October 2019. The FI contract term is five years with five one-year optional extensions.

Under the DXC Medi-Cal FI contract, certain activities are reimbursed on an hourly basis by the Department. The rate paid to the contractor consists of all direct and indirect costs required to support these activities, plus profit. Hourly reimbursed items under the contract consist of Medical Review Services and Service Changes.

- Medical Review Services - The Contractor provides drug utilization review, Formulary File analysis, medical review consultation, and Treatment Authorization Request (TAR) adjudication. An outcome of the Contractor's Medical Review Services is a reduction in excessive treatment and expense while remaining fully compliant with State and Federal requirements and Medi-Cal policy.

- Service Changes - The collection of activities performed by the Contractor's Business Services staff to ensure any changes to the California Medicaid Management Information System (CA-MMIS) Business Services either improve the efficiency of, and/or minimize the disruption to, related services.

Reason for Change:
There is no change from the prior estimate for FY 2019-20. The change from the prior estimate, for FY 2020-21 is due to an increase in systems work required for system enhancements.

MEDICAL FI BO HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 60

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to including a full year of costs in FY 2020-21.

Methodology:

1. Hourly costs are paid using hourly rates which vary depending on the service being performed and the expertise required.

2. The costs for FY 2019-20 are for six months of FI services which accounts for the contract effective date, payments beginning November 2019, and the shifting of costs in May and June incurred at the end of FY 2019-20 to FY 2020-21.

3. Costs are shared between Federal Funds (FF) and General Funds (GF).

FY 2019-20	TF	GF	FF
Perform Medical Review Services	$3,616,000	$904,000	$2,712,000
Service Changes (formerly Systems Group)	$1,748,000	$437,000	$1,311,000
Total:	**$5,364,000**	**$1,341,000**	**$4,023,000**

FY 2020-21	TF	GF	FF
Perform Medical Review Services	$7,231,000	$1,808,000	$5,423,000
Service Changes (formerly Systems Group)	$4,176,000	$1,044,000	$3,132,000
Total:	**$11,407,000**	**$2,852,000**	**$8,555,000**

Funding:

FI 75% Title XIX FF/ 25% GF (4260-101-0001/0890)

MEDICAL FI SRP RELEASE 1 HOSTING

OTHER ADMIN. POLICY CHANGE NUMBER:	61
IMPLEMENTATION DATE:	7/2015
ANALYST:	Elena Susbilla
FISCAL REFERENCE NUMBER:	1924

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$3,162,000	$0
STATE FUNDS	$459,600	$0
FEDERAL FUNDS	$2,702,400	$0

DESCRIPTION

Purpose:
This policy change estimates the California Medicaid Management Information System (CA-MMIS) replacement costs.

Authority:
Conduent Contract # 09-86210

Interdependent Policy Changes:
Not Applicable

Background:
CA-MMIS is a mission critical system, which processes timely and accurate claims payments to providers within the Medi-Cal program. The Conduent Medical Fiscal Intermediary (FI) contract required the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The Xerox/Conduent FI contract was awarded on December 8, 2009, and became effective on May 3, 2010, which began the takeover phase. The Xerox/Conduent FI contract term originally ran through March 31, 2020. However, after a settlement agreement between Xerox and the Department was reached, the new contract end date is September 30, 2019. The new FI contract vendors, DXC and IBM, assumed operations October 1, 2019.

The System Replacement Project (SRP) constituted the contractual responsibilities required for the Conduent FI to replace the existing CA-MMIS. As a result of the SRP settlement agreement, the contractual responsibilities for the SRP were removed from the Conduent FI contract with the exception of System Replacement Release I maintenance and operations (M&O). Release I, implemented in December 2014, established an online portal, single sign-on functionality, user administration functions, and related reporting. The Department compensated the FI for the continued hosting and M&O of Release I until the expiration of the Conduent FI contract.

Reason for Change:
The change from the prior estimate for FY 2019-20 is due to using actual costs instead of estimates.

There is no change from the prior estimate for FY 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to the Conduent FI contract ending September 30, 2019.

MEDICAL FI SRP RELEASE 1 HOSTING

OTHER ADMIN. POLICY CHANGE NUMBER: 61

Methodology:

1. Costs are shared between Federal Funds (FF) and General Funds (GF).

FY 2019-20	TF	GF	FF
50% Title XIX / 50% GF	$210,000	$105,000	$105,000
90% Title XIX / 10% GF	$2,886,000	$289,000	$2,597,000
100% GF	$66,000	$66,000	$0
Total	**$3,162,000**	**$460,000**	**$2,702,000**

Funding:

FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 90% Title XIX / 10% GF (4260-101-0001/0890)
FI 100% GF (4260-101-0001)

MEDICAL FI OPTIONAL CONTRACTUAL SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER:	62
IMPLEMENTATION DATE:	6/2018
ANALYST:	Elena Susbilla
FISCAL REFERENCE NUMBER:	1923

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$373,000	$0
STATE FUNDS	$37,300	$0
FEDERAL FUNDS	$335,700	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of Optional Contractual Services (OCS) of the Conduent Medical Fiscal Intermediary (FI) contract.

Authority:
Conduent Contract # 09-86210

Interdependent Policy Changes:
Not Applicable

Background:
The Conduent FI contract required the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The Xerox/Conduent FI contract was awarded on December 8, 2009, and became effective on May 3, 2010. The Xerox/Conduent FI contract term originally ran through March 31, 2020. However, after a settlement agreement between Xerox and the Department was reached, the new contract end date was September 30, 2019. The new FI contract vendors, DXC and IBM, assumed operations October 1, 2019.

OCS were contractor-proposed methods of providing services, functions, and procedures above contract requirements to improve the California Medicaid Management Information System (CA-MMIS) performance. Unlike regular operations activities, OCS were not always part of the FI budget. Costs in this category were due to the contractor proposing an OCS and the Department approving the OCS. The identified costs were for the implementation of the Medicaid Incentive program, which provided incentives to providers who adopted and used Electronic Health Records (EHR) in accordance with the Health Information Technology for Economic and Clinical Health (HITECH) Act.

Due to the American Recovery and Reinvestment Act (ARRA) HITECH State Level Registry (SLR) work ending beyond the Conduent FI contract end date, the Department took over management of the SLR application from the Conduent FI. Remaining OCS costs were paid to the Conduent FI once the System Development Notice was implemented. The final payment was issued in November 2019.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is due to using actual costs instead of estimates.

There is no change from the prior estimate for 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to the final payment being completed in FY 2019-20. There are no costs in FY 2020-21.

MEDICAL FI OPTIONAL CONTRACTUAL SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 62

Methodology:

Fiscal Year	TF	GF	FF
FY 2019-20	$373,000	$37,000	$336,000

Funding:
FI 90% Title XIX / 10% GF (4260-101-0001/0890)

MEDICAL FI MISCELLANEOUS EXPENSES

OTHER ADMIN. POLICY CHANGE NUMBER:	63
IMPLEMENTATION DATE:	7/2015
ANALYST:	Elena Susbilla
FISCAL REFERENCE NUMBER:	1922

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$1,349,000	$0
STATE FUNDS	$423,750	$0
FEDERAL FUNDS	$925,250	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of miscellaneous expenses of the Conduent Medical Fiscal Intermediary (FI) contract.

Authority:
Conduent Contract # 09-86210
Interagency Agreement (IA) # 16-93264, 15-92027, 14-90507, 15-92026 & 17-94428

Interdependent Policy Changes:
Not Applicable

Background:
The Conduent FI contract required the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The Xerox/Conduent FI contract was awarded on December 8, 2009, and became effective May 3, 2010, which began the takeover phase. The Xerox/Conduent FI contract term originally ran through March 31, 2020. However, after a settlement agreement between Xerox and the Department was reached, the new contract end date is September 30, 2019. The new FI contract vendors, DXC and IBM, assumed operations October 1, 2019.

Pursuant to an IA with the Department, the California State Controller's Office (SCO) issues warrants to Medi-Cal providers and the California State Treasurer's Office (CSTO) provides funds for warrant redemption. SCO also provides the Department various administrative and project activities as they relate to the electronic claims process for the Health Enterprise (HE) system.

Pursuant to an IA with the California Department of Consumer Affairs (CDCA), Medical Board of California, the Department purchases licensure data. This data gives the Department the ability to verify prospective providers are currently licensed prior to enrollment in the Medi-Cal program. It also enables the Department to verify the validity of the referring provider license number on Medi-Cal claims.

Pursuant to an IA with the Office of Systems Integration (OSI), the Department utilizes one OSI Technical Architect (TA) and one Project Manager (PM) staff to provide California Medicaid Management Information Systems (CA-MMIS) modernization project management, oversight, procurement, and support services. The IA was finalized in March 2018.

The administrative costs for the Family Planning, Access, Care, and Treatment Family Pact (FPACT) program, which provides services at no cost to low-income residents of reproductive age, are included.

MEDICAL FI MISCELLANEOUS EXPENSES

OTHER ADMIN. POLICY CHANGE NUMBER: 63

Reason for Change:
The change from the prior estimate, for FY 2019-20, is due to using actual costs instead of estimates.

There is no change from the prior estimate for FY 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to the Conduent FI contract ending September 30, 2019.

Methodology:
1. Costs are shared between Federal Funds (FF) and General Funds (GF).

FY 2019-20	TF	GF	FF
SCO - Warrants and RADs (75% FF / 25% GF)	$985,000	$246,000	$739,000
SCO - Postage (50% FF / 50% GF)	$326,000	$163,000	$163,000
CSTO Warrant Redemption (75% FF / 25% GF)	$18,000	$5,000	$13,000
FPACT (50% FF / 50% GF)	$20,000	$10,000	$10,000
Total	**$1,349,000**	**$424,000**	**$925,000**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 75% Title XIX / 25% GF (4260-101-0001/0890)

MEDICAL FI BO MISCELLANEOUS EXPENSES

OTHER ADMIN. POLICY CHANGE NUMBER:	64
IMPLEMENTATION DATE:	11/2019
ANALYST:	Elena Susbilla
FISCAL REFERENCE NUMBER:	2114

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$1,037,000	$2,468,000
STATE FUNDS	$322,250	$768,500
FEDERAL FUNDS	$714,750	$1,699,500

DESCRIPTION

Purpose:
This policy change estimates the cost of miscellaneous expenses of the DXC Medical Fiscal Intermediary (FI) contract.

Authority:
DXC Contract # 18-95357
Interagency Agreement (IA) # 18-95321, 18-85091, 16-93264, and 18-95090

Interdependent Policy Changes:
Not Applicable

Background:
The FI contracts require the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The Assumption of Operations for the Business Operations FI contract was October 2019. The DXC FI contract term is five years with five one-year optional extensions.

Under the Medi-Cal FI contract, services classified as Miscellaneous Expenses are paid using a Fixed pricing methodology and include IAs, Optional Contract Services (OCS), and Facilities provisioning.

Pursuant to an IA with the Department, the California State Controller's Office (SCO) issues warrants to Medi-Cal providers and the California State Treasurer's Office (CSTO) provides funds for warrant redemption.

Pursuant to an IA with the California Department of Consumer Affairs (CDCA), Medical Board of California, the Department purchases licensure data. This data gives the Department the ability to verify prospective providers are currently licensed prior to enrollment in the Medi-Cal program. It also enables the Department to verify the validity of the referring provider license number on Medi-Cal claims.

OCS are contractor-proposed methods of providing services, functions, and procedures above contract requirements to improve the California Medicaid Management Information System (CA-MMIS) performance. Unlike regular operations activities, OCS are not always part of the FI budget. Costs in this category are due to the contractor proposing an OCS and the Department approving the OCS.

The FI is required to provide and manage the Medi-Cal Operations Center (MOC) where the Department and Contractors supporting the Medi-Cal program can be co-located with adequate security to ensure protection of the sensitive information and data consumed and produced by the program.

MEDICAL FI BO MISCELLANEOUS EXPENSES

OTHER ADMIN. POLICY CHANGE NUMBER: 64

Reason for Change:
The change from the prior estimate, for FY 2019-20 and FY 2020-21, is due to an updated rate calculation.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to including a full year of cost in FY 2020-21.

Methodology:
1. Miscellaneous costs are paid using Fixed pricing methodology. The contract stipulates an annual rate for each of the services defined above.

2. Takeover costs are not paid with Local Assistance funds.

3. The costs for FY 2019-20 are for six months of FI services which accounts for the contract effective date, payments beginning November 2019, and the shifting of costs incurred at the end of FY 2019-20 to FY 2020-21.

4. Costs are shared between Federal Funds (FF) and General Funds (GF).

FY 2019-20	TF	GF	FF
Interagency Agreements (75% FF/25% GF, 50% FF/50% GF)	$1,037,000	$322,000	$715,000
Total:	**$1,037,000**	**$322,000**	**$715,000**

FY 2020-21	TF	GF	FF
Interagency Agreements (75% FF/25% GF, 50% FF/50% GF)	$2,468,000	$769,000	$1,699,000
Total:	**$2,468,000**	**$769,000**	**$1,699,000**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 75% Title XIX / 25% GF (4260-101-0001/0890)

MEDICAL FI CHANGE ORDERS

OTHER ADMIN. POLICY CHANGE NUMBER:	65
IMPLEMENTATION DATE:	7/2015
ANALYST:	Elena Susbilla
FISCAL REFERENCE NUMBER:	1919

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$246,000	$0
STATE FUNDS	$61,500	$0
FEDERAL FUNDS	$184,500	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of the Conduent Fiscal Medical Intermediary (FI) contract Change Orders (CO).

Authority:
Conduent Contract # 09-86210
SB 853 (Chapter 717, Statutes of 2010)
Welfare & Institutions (W&I) Code Section 14105.05

Interdependent Policy Changes:
Not Applicable

Background:
The Conduent FI contract required the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The Xerox/Conduent FI contract was awarded on December 8, 2009, and became effective on May 3, 2010, which began the takeover phase. The Xerox/Conduent FI contract term originally ran through March 31, 2020. However, after a settlement agreement between Xerox and the Department was reached, the new contract end date was September 30, 2019. The new FI contract vendors, DXC and IBM, assumed operations October 1, 2019.

Modifications resulting in changes to contractor responsibilities are initiated by COs and billed separately from contract operations. A CO is a documentable increase of effort identified as having a direct relation to the administration of the contract that is above the volume of the required work within the scope and above the normal fixed-price of the contract. The section below details the current CO in progress.

- Operations Code Conversion (OCC) Change Order:

  To comply with the Health Insurance Portability and Accountability Act (HIPAA), W&I Code Section 14105.05 mandates the conversion of Healthcare Common Procedure Coding System (HCPCS) Level III codes (local codes) to HCPCS Level II codes (national codes). Thus, additional staff is required to effectively support provider-related activities from the beginning of conversions through implementation. Focused attention to the provider-related activities at the appropriate level, such as outreach, communication, and training, will ensure successful conversion implementations.

MEDICAL FI CHANGE ORDERS

OTHER ADMIN. POLICY CHANGE NUMBER: 65

As COs are not originally known or knowable at the time the contract was procured, and require an increased level of work and effort, the Department has agreed to reimburse the FI for all documentable expenses that are a direct result of efforts detailed above.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is due to using actual amounts instead of estimates.

There is no change from the prior estimate, for FY 2020-21.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to the Conduent FI contract ending September 30, 2019.

Methodology:

1. Certain costs, such as software, travel expenses, etc., can be paid through cost reimbursement. These costs are budgeted in the Medical FI Cost Reimbursement policy change.

2. The contract allowed for overhead and profit to be included in CO expenses (not to exceed thirty percent).

3. The estimated costs for FY 2019-20 are:

FY 2019-20	TF	GF	FF
FI Change Order	$246,000	$62,000	$184,000

Funding:
FI 75% HIPAA FF / 25% GF (4260-117-0001/0890)

CMS DEFERRED CLAIMS - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER:	66
IMPLEMENTATION DATE:	9/2018
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	2123

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$0	$0
STATE FUNDS	$223,428,000	$80,000,000
FEDERAL FUNDS	-$223,428,000	-$80,000,000

DESCRIPTION

Purpose:
This policy change estimates the repayment of administrative deferred claims to the Centers for Medicare and Medicaid Services (CMS).

Authority:
California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)
Title 42, Code of Federal Regulations (CFR), 430.40

Interdependent Policy Changes:
Not Applicable

Background:
CMS reviews claims submitted by state Medicaid agencies to ensure federal financial participation (FFP) eligibility. Claims for which CMS questions the FFP eligibility are deferred and the state Medicaid agency is issued a deferral notice. Upon receipt of the deferral notice, the state Medicaid agency has 120 days to resolve the deferred claim.

When CMS issues a deferral to the state Medicaid agency, in accordance with the timelines set forth in 42 CFR 430.40, the state Medicaid agency must immediately return the deferred FFP to the applicable Payment Management System (PMS) subaccount while the deferral is being resolved. As part of the resolution process, the state Medicaid agency submits documentation in support of the deferred claim to CMS for review. If CMS determines the deferred claim is allowed, then the deferral is released, the funds are returned to the appropriate PMS subaccount, and the state Medicaid agency is notified that the funds are available to be redrawn.

Pursuant to Special Terms and Conditions paragraph 164 of the California Medi-Cal 2020 Demonstration Waiver, Medi-Cal is required to bring all deferrals current. The Department is working with CMS to resolve specific items. All deferred claims and negative PMS subaccount balances must be repaid by the end of the demonstration waiver, December 31, 2020, or within three years from CMS' approval of California's repayment schedule, whichever is longer.

The administrative deferred claims are included in this policy change and are separate from the CMS Deferred Claims and CMS Deferred Claims – FI policy changes. See the CMS Deferred Claims and CMS Deferred Claims – FI policy changes for more information.

CMS DEFERRED CLAIMS - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 66

Reason for Change:
The change in FY 2019-20, from the prior estimate, is due to $2.235 million shifted to the CMS Deferred Claims – FI policy change, and the inclusion of FFY 2019 Quarter 2 actual repayments.

The change in FY 2020-21, from the prior estimate, is due to the inclusion of estimated repayments for FFY 2019 Quarter 3 and FFY 2020 Quarters 1 through 4, and estimated resolved deferrals for FFY 2019 Quarters 1 through 3.

The change from FY 2019-20 to FY 2020-21, in the current estimate, is due to different repayment quarters, and FY 2019-20 includes actual repayment amounts.

Methodology:
1. In FY 2019-20, the Department will repay $223.428 million FF for the CMS deferrals issued which includes $141.389 million FF for FFY 2019 Quarter 1 and $82.039 million FF for FFY 2019 Quarter 2.

(Dollars in Thousands)

FY 2019-20	Total Estimated Repayment
FFY 2019 Quarter 1 (Oct-Dec 2018)	$141,389
FFY 2019 Quarter 2 (Jan-Mar 2019)	$82,039
Total FY 2019-20	**$223,428**

2. In FY 2020-21, the Department expects to repay a net total of $80 million FF which includes an estimated $381 million FF in repayments for FFY 2019 Quarter 3 and FFY 2020 Quarters 1 through 4, and an estimated $301 million FF reclaimed for resolved cost allocation deferrals.

(Dollars in Thousands)

FY 2020-21	Total Estimated Repayment
FFY 2019 Quarter 3 (Apr-Jun 2019)	$81,000
FFY 2020 Quarter 1 (Oct-Dec 2019)	$75,000
FFY 2020 Quarter 2 (Jan-Mar 2020)	$75,000
FFY 2020 Quarter 3 (Apr-Jun 2020)	$75,000
FFY 2020 Quarter 4 (Jul-Sep 2020)	$75,000
Subtotal Estimated Repayments	$381,000
Estimated Resolved Deferrals	($301,000)
Total FY 2020-21	**$80,000**

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XIX GF (4260-101-0001)

HCO OPERATIONS 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER:	67
IMPLEMENTATION DATE:	11/2018
ANALYST:	Latoya Brown
FISCAL REFERENCE NUMBER:	2051

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$40,872,000	$40,500,000
STATE FUNDS	$19,835,580	$19,888,060
FEDERAL FUNDS	$21,036,420	$20,611,940

DESCRIPTION

Purpose:
This policy change estimates the operational costs of the Health Care Options (HCO) program for the #17-94437 contract with Maximus.

Authority:
HCO Contract #17-94437

Interdependent Policy Changes:
Not Applicable

Background:
The enrollment broker contractor for the HCO program is responsible for enrolling Medi-Cal beneficiaries into managed care health plans within three Medi-Cal managed care health plan models including Two-Plan, Regional, and Geographic Managed Care. The broker also enrolls beneficiaries with two Dental Managed Care plan models; one in Sacramento County where enrollment is mandatory, and one in Los Angeles County, where enrollment is voluntary. The contractor assumed operations on October 1, 2018. Operations for the contractor are based on a fixed price bid.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease due to bid price adjustments.

Methodology:
1. Operations costs are fixed price rates based on volumes within minimum and maximum ranges under the HCO contract. These are based on agreed-upon contracted bid rates in the new contract.

(Dollars in Thousands)

FY 2019-20	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced Title XXI	Enhanced Title XXI
Transactions	$8,743	$4,153	$4,153	$90	$347
Packet Mailings	$6,879	$3,268	$3,268	$71	$272
BDA/Call Center	$25,250	$11,994	$11,994	$260	$1,002
Total	**$40,872**	**$19,415**	**$19,415**	**$421**	**$1,621**

HCO OPERATIONS 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 67

(Dollars in Thousands)

FY 2020-21	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced Title XXI	Enhanced Title XXI
Transactions	$7,727	$3,670	$3,670	$124	$263
Packet Mailings	$7,197	$3,419	$3,419	$115	$244
BDA/Call Center	$25,576	$12,149	$12,149	$411	$867
Total	**$40,500**	**$19,238**	**$19,238**	**$650**	**$1,374**

Funding:
FI 50%Title XIX / 50% GF (4260-101-0001/0890)
FI 88% Title XXI / 12% GF (4260-113-0001/0890)
FI 65% Title XXI / 35% GF (4260-113-0001/0890)
FI 76.5% Title XXI / 23.5% GF (4260-113-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO COST REIMBURSEMENT 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER:	68
IMPLEMENTATION DATE:	11/2018
ANALYST:	Latoya Brown
FISCAL REFERENCE NUMBER:	2052

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$20,646,000	$20,646,000
STATE FUNDS	$10,019,850	$10,138,530
FEDERAL FUNDS	$10,626,150	$10,507,470

DESCRIPTION

Purpose:
This policy change estimates the total cost reimbursement of the Health Care Options (HCO) program under the #17-94437 contract with Maximus.

Authority:
HCO Contract #17-94437

Interdependent Policy Changes:
Not Applicable

Background:
The enrollment broker contract for the HCO program is responsible for enrolling Medi-Cal beneficiaries into managed care health plans within three Medi-Cal managed care health plan models including Two-Plan, Regional, and Geographic Managed Care. The broker also enrolls beneficiaries into two Dental Managed Care plan models; one in Sacramento County, where enrollment in mandatory, and one in Los Angeles County, where enrollment is voluntary. The contractor assumed operations on October 1, 2018. Cost reimbursements are direct costs incurred by the enrollment contractor while performing responsibilities under the contract that are in addition to fixed operations costs.

Reason for change:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21. There is no change from FY 2019-20 to FY 2020-21 in the current estimate.

Methodology:
1. Contract costs are shared between federal funds (FF) and General Fund (GF).

HCO COST REIMBURSEMENT 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 68

(Dollars in Thousands)

	TF	GF	FF	GF	FF
(FY 2019-20)		**Title XIX**	**Title XIX**	**Enhanced Title XXI**	**Enhanced Title XXI**
Postage	$10,315	$4,900	$4,900	$106	$409
Printing	$3,035	$1,442	$1,442	$31	$120
Materials Maintenance and Development	$2,522	$1,198	$1,198	$26	$100
Mass Mailings	$800	$380	$380	$8	$32
Other Cost. Reimb.	$1,010	$480	$480	$10	$40
Additional Systems Group Staff	$2,505	$1,190	$1,190	$26	$99
Miscellaneous	$459	$218	$218	$5	$18
Total	**$20,646**	**$9,808**	**$9,808**	**$212**	**$818**

(Dollars in Thousands)

	TF	GF	FF	GF	FF
(FY 2020-21)		**Title XIX**	**Title XIX**	**Enhanced Title XXI**	**Enhanced Title XXI**
Postage	$10,315	$4,900	$4,900	$165	$350
Printing	$3,035	$1,442	$1,442	$49	$102
Materials Maintenance and Development	$2,522	$1,198	$1,198	$40	$86
Mass Mailings	$800	$380	$380	$13	$27
Other Cost. Reimb.	$1,010	$480	$480	$16	$34
Additional Systems Group Staff	$2,505	$1,190	$1,190	$40	$85
Miscellaneous	$459	$218	$218	$7	$16
Total	**$20,646**	**$9,808**	**$9,808**	**$330**	**$700**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 88% Title XXI / 12% GF (4260-113-0001/0890)
FI 65% Title XXI / 35% GF (4260-113-0001/0890)
FI 76.5% Title XXI / 23.5% GF (4260-113-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER:	69
IMPLEMENTATION DATE:	11/2018
ANALYST:	Latoya Brown
FISCAL REFERENCE NUMBER:	2053

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$13,716,000	$14,171,000
STATE FUNDS	$6,656,430	$6,958,800
FEDERAL FUNDS	$7,059,570	$7,212,200

DESCRIPTION

Purpose:
This policy change estimates the Enrollment Services Representative's (ESRs) hourly reimbursement for the Health Care Options (HCO) program under the #17-94437 contract with Maximus.

Authority:
HCO contract # 17-94437

Interdependent Policy Changes:
Not Applicable

Background:
The enrollment broker contractor for the HCO program is responsible for enrolling Medi-Cal beneficiaries into managed care health plans within three Medi-Cal managed care health plan models including Two-Plan, Regional, and Geographic Managed Care. The broker also enrolls beneficiaries into two Dental Managed Care plan models; one in Sacramento County, where enrollment is mandatory, and one in Los Angeles County, where enrollment is voluntary. Assumption of operations for the new contractor began October 1, 2018. An important goal of the HCO program is to provide every Medi-Cal applicant/beneficiary, who shall be required or is eligible to enroll in a medical and/or dental plan under the Medi-Cal Managed Care program, with the opportunity to receive a face-to-face presentation describing that individual's rights and enrollment choices as well as a fundamental introduction to the managed health care delivery system. The primary objective of the HCO presentation is to educate applicants/beneficiaries to make an informed plan choice. An effective educational program ultimately increases the number of potential eligible enrollees who choose a plan prior to or during the informing process, thereby avoiding auto-assignment (default assignment) to a plan. This program is conducted by the enrollment contractor with the use of ESRs in county offices statewide.

Reason for Change:
There was no change from the prior estimate for FY 2019-20 and FY 2020-21. The change from FY 2019-20 to FY 2020-21 in the current estimate is an increase due to bid price adjustments.

Methodology:
1. The hourly reimbursement costs are fixed price hourly rates for full-time equivalent ESR staff at county offices statewide.

2. The estimated costs for FY 2019-20 and FY 2020-21 are based on 210 ESRs per year.

HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 69

(Dollars in thousands)

FY 2019-20	TF	GF	FF
Title XIX (50% FF / 50% GF)	$13,030	$6,515	$6,515
Title XXI (88% FF / 12% GF)	$172	$21	$151
Title XXI (76.5% FF / 23.5% GF)	$514	$121	$393
Total	**$13,716**	**$6,657**	**$7,059**

(Dollars in thousands)

FY 2020-21	TF	GF	FF
Title XIX (50% FF / 50% GF)	$13,462	$6,731	$6,731
Title XXI (76.5% FF / 23.5% GF)	$177	$42	$135
Title XXI (65% FF / 35% GF)	$532	$186	$346
Total	**$14,171**	**$6,959**	**$7,212**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 88% Title XXI / 12% GF (4260-113-0001/0890)
FI 65% Title XXI / 35% GF (4260-113-0001/0890)
FI 76.5% Title XXI / 23.5% GF (4260-113-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

DENTAL ASO ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER:	70
IMPLEMENTATION DATE:	3/2018
ANALYST:	Matt Wong
FISCAL REFERENCE NUMBER:	2007

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$37,920,000	$46,692,000
STATE FUNDS	$13,357,000	$18,388,750
FEDERAL FUNDS	$24,563,000	$28,303,250

DESCRIPTION

Purpose:
This policy change estimates the total cost for reimbursable items and payment for operations for the 2016 Dental Administrative Services Organization (ASO).

Authority:
Contract 16-93287

Interdependent Policy Changes:
Not Applicable

Background:
Delta Dental (Delta) was awarded a multi-year contract in 2016. ASO assumption of operations began in February 2018. Delta is responsible for ASO services for the Medi-Cal Dental Program. The administrative costs consist of reimbursement for both operations costs as well as cost reimbursables.

Operations constitute all contractual obligations required for the contractor to administer and operate the ASO. Only direct costs of certain operations are eligible for cost reimbursement. All other costs are to be included in fixed price components. These cost categories consist of:

- Adjudicated Claim Service Lines (ACSL), paid on a per claim line basis and includes claims related to the Dental Transformation Initiative from Federally Qualified Health Centers.
- Treatment Authorization Requests (TAR), paid on a per document basis
- Telephone Service Center (TSC), paid on a per minute basis

A 2% withhold is being administered on operation invoices which are calculated using ACSL and TAR. The 2% withhold will be released if the ASO meets performance requirements set in the ASO contract; if the ASO does not meet performance measures, the 2% withhold will not be released.

Cost reimbursements are direct costs incurred by the enrollment contractor while performing responsibilities under the contract that are in addition to fixed operations costs. Various costs incurred by the contractor while performing responsibilities under the contract will be reimbursed by the Department. These costs are not a part of the bid price of the contract. Any of the following costs may be cost reimbursed under the contract:

1. Postage
2. Parcel Services and Common Carriers
3. Printing
4. Telephone Toll Charges

DENTAL ASO ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 70

5. Special Training Sessions
6. Conventions, Provider Enrollment Workshops, and Health Fairs
7. Facilities Improvement and Modifications
8. Personal Computers, Monitors, Printers, Related Equipment, and Software
9. Cost Reimbursed Audits and Research
10. Independent Contractor Consideration
11. Annual Risk Assessments
12. Business Analyst
13. Miscellaneous

The ASO has expanded its outreach efforts by securing a subcontractor (RSE) who specializes in marketing and education. RSE began with a beneficiary survey at end of 2017 followed by focused groups in early 2018. This enabled them to identify any gaps or barriers and create marketing strategies that best captured this population's needs, develop innovative marketing approaches, and improve the content of outreach and education materials while containing costs.

The outreach efforts are as follows:

1. SmileCalifornia.org website optimized for access by mobile phone and other devices with videos and new materials
2. Care coordination and case management
3. Brochures provided in print and electronic media to a variety of stakeholders
4. Updates to the beneficiary handbook and a beneficiary bulletin
5. Fee-For-Service communications with managed care plans regarding outreach
6. Trainings to local agencies and community organizations
7. Social media campaigns – Smile, California; First Tooth, First Birthday; Year-End Utilization
8. Quarterly newly enrolled mailings with letters and brochures
9. Promotional tour with press releases and print-ready articles

Outreach and education will help increase beneficiary awareness about dental benefits and provide assistance in locating a dentist to schedule an appointment.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a decrease due to updated projected costs based on actuals and delayed invoice payments shifting to FY 2020-21. The change from the prior estimate, for FY 2020-21, is an increase due to invoice payments originally projected to pay in FY 2019-20. The change from FY 2019-20 to FY 2020-21 in the current estimate is an increase due to updated projected costs based on actuals and the payment of held invoices in FY 2020-21.

Methodology:

1. Operations costs are fixed price rates based on volumes within minimum and maximum ranges under the ASO contract.

2. ACSL and TAR volumes are based on actual invoices with a caseload growth factor. Provider Enrollment activities account for 15% of the total ACSL/TAR costs.

    a. Provider Enrollment
        i. 69% of costs are funded at 50% FF and 50% GF
        ii. 31% of costs are funded at 75% FF and 25% GF
    b. Remaining costs are funded at 75% FF and 25% GF

3. The 2% withhold is based on actual invoices received. If performance requirements were met for

DENTAL ASO ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 70

calendar year 2018, the funds will be released in FY 2019-20.

4. TSC minutes are based on actual invoices with a caseload growth factor and funded at 50% FF and 50% GF.

FY 2019-20	TF	GF	FF
Administration/Operations (75% FF / 25% GF)	$19,928,000	$4,981,000	$14,947,000
Provider Enrollment (50% FF / 50% GF & 75% FF / 25% GF)	$3,517,000	$1,152,000	$2,365,000
2% Withhold	$22,000	$6,000	$16,000
Total ACSL/TAR	$23,119,000	$6,048,000	$17,071,000
TSC – Provider (50% FF / 50% GF)	$4,024,000	$2,012,000	$2,012,000
TSC – Beneficiary (50% FF / 50% GF)	$8,386,000	$4,193,000	$4,193,000
Total TSC	$12,410,000	$6,205,000	$6,205,000
Total Operations Costs	**$35,529,000**	**$12,253,000**	**$23,276,000**

FY 2020-21	TF	GF	FF
Administration/Operations (75% FF / 25% GF)	$17,155,000	$4,289,000	$12,866,000
Provider Enrollment (50% FF / 50% GF & 75% FF / 25% GF)	$3,027,000	$991,000	$2,036,000
2% Withhold (net of prior year withhold release)	$139,000	$36,000	$103,000
Total ACSL/TAR	$20,321,000	$5,316,000	$15,005,000
TSC – Provider (50% FF / 50% GF)	$9,258,000	$4,629,000	$4,629,000
TSC – Beneficiary (50% FF / 50% GF)	$14,006,000	$7,003,000	$7,003,000
Total TSC	$23,264,000	$11,632,000	$11,632,000
Total Operations Costs	**$43,585,000**	**$16,948,000**	**$26,637,000**

5. Cost reimbursements are based on actual invoices with a caseload growth factor.

FY 2019-20	TF	GF	FF
Total Cost Reimbursable	**$2,391,000**	**$1,104,000**	**$1,287,000**

FY 2020-21	TF	GF	FF
Total Cost Reimbursable	**$3,107,000**	**$1,441,000**	**$1,666,000**

*Costs for a business analyst ($300,000) for the Provider Application and Validation for Enrollment (PAVE) project were added.

6. Total Administration Cost

	TF	GF	FF
FY 2019-20*	**$37,920,000**	**$13,357,000**	**$24,563,000**
FY 2020-21*	**$46,692,000**	**$18,389,000**	**$28,303,000**

*Note: some slight variations due to rounding

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 75% Title XIX / 25% GF (4260-101-0001/0890)

DENTAL ASO ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 70

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

DENTAL FI ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER:	71
IMPLEMENTATION DATE:	11/2017
ANALYST:	Matt Wong
FISCAL REFERENCE NUMBER:	2006

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$18,457,000	$21,744,000
STATE FUNDS	$5,266,250	$6,161,500
FEDERAL FUNDS	$13,190,750	$15,582,500

DESCRIPTION

Purpose:
This policy change estimates the total cost for operations, cost reimbursable items, and hourly reimbursables for the 2016 Dental Fiscal Intermediary (FI).

Authority:
Contract 16-93286

Interdependent Policy Changes:
Not Applicable

Background:
DXC Technology Services (DXC) was awarded a multi-year contract in 2016. The 2004 Delta Dental FI contract ended operations at the end of January 2018 and DXC assumed operational responsibility immediately thereafter. DXC is responsible for the FI services of the Medi-Cal Dental Program. The administrative costs consist of reimbursement for operations, cost reimbursables, and hourly reimbursable costs.

Operations constitute all contractual responsibilities required for the contractor to administer and operate the FI. Only direct costs of certain operations are eligible for cost reimbursement. All other costs are included in fixed price components. These cost categories consist of a combined document count of claims, including Federally Qualified Health Center (FQHC) claims for the Dental Transformation Initiative program, and Treatment Authorization Requests (TAR), paid on a per document basis.

Cost reimbursements are direct costs incurred by the enrollment contractor while performing responsibilities under the contract that are in addition to fixed operations costs. Various costs incurred by the contractor while performing responsibilities under the contract will be reimbursed by the Department. These costs are not a part of the bid price of the contract. Any of the following costs may be cost reimbursed under the contract:

1. Printing
2. Postage
3. Parcel Services and Common Carriers
4. Data Center Access
5. Special Training Sessions
6. Facilities Improvement and Modifications
7. Personal Computers, Monitors, Printers, Related Equipment, and Software
8. Cost Reimbursed Audits and Research
9. Independent Contractor Consideration

DENTAL FI ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 71

10. Annual Risk Assessments
11. Miscellaneous
12. Cost Reimbursement Invoice

Certain activities are reimbursed on an hourly basis by the Department. The rate paid to the contractor consists of all direct and indirect costs required to support these activities. The hourly reimbursed area consists of the Systems Group (SG).

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a decrease due to lower invoice actuals. The change from the prior estimate, for FY 2020-21, is an increase due to updated projections based updated invoice trends. The change from FY 2019-20 to FY 2020-21 in the current estimate is an increase due to the costs for the annual risk assessments and audits.

Methodology:
1. Operations costs are fixed price rates based on scanned claim and TAR document volumes within minimum and maximum ranges under the FI contract.

2. Claim and TAR scanned document volumes are based on FY 2018-19 actual document counts and projected forward.

3. Check write expenditures are associated with the cost of sending payment to providers, based on adjudicated claims from the Dental Administrative Services Organization contractor.

FY 2019-20	TF	GF	FF
Scanned Claims/TAR	$10,298,000	$2,575,000	$7,723,000
Check Write	$248,000	$62,000	$186,000
Change Orders	$1,194,000	$597,000	$597,000
Total	**$11,740,000**	**$3,234,000**	**$8,506,000**

FY 2020-21	TF	GF	FF
Scanned Claims/TAR	$11,084,000	$2,771,000	$8,313,000
Check Write	$247,000	$62,000	$185,000
Change Orders	$772,000	$386,000	$386,000
Total	**$12,103,000**	**$3,219,000**	**$8,884,000**

4. Cost reimbursements are based on actual invoices.

FY 2019-20	TF	GF	FF
Total	**$1,704,000**	**$779,000**	**$925,000**

FY 2020-21	TF	GF	FF
Total	**$2,596,000**	**$1,182,000**	**$1,414,000**

DENTAL FI ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 71

5. Hourly Reimbursables:

System Group	TF	GF	FF
FY 2019-20	$5,013,000	$1,253,000	$3,760,000
FY 2020-21	$7,045,000	$1,761,000	$5,284,000

6. Total Administration Cost:

Fiscal Year	TF	GF	FF
FY 2019-20*	$18,457,000	$5,266,000	$13,191,000
FY 2020-21*	$21,744,000	$6,162,000	$15,582,000

*Note: some slight variations due to rounding

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 75% Title XIX / 25% GF (4260-101-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

DENTAL FI TAKEOVER 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER:	72
IMPLEMENTATION DATE:	8/2017
ANALYST:	Matt Wong
FISCAL REFERENCE NUMBER:	2004

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$7,797,000	$0
STATE FUNDS	$1,949,250	$0
FEDERAL FUNDS	$5,847,750	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of Takeover from the previous Fiscal Intermediary (FI), Delta Dental of California (Delta), to the current FI contractor, DXC Technology Services, LLC (DXC).

Authority:
Contract 16-93286

Interdependent Policy Changes:
Not Applicable

Background:
DXC was awarded the multi-year FI contract in 2016. The FI contractor is responsible for all the FI services of the Medi-Cal Dental Program including: operations of the California Dental Medicaid Management Information System (CD-MMIS), claims processing, quality management operations, System Group (SG), and system enhancements. Takeover started from the Contract Effective Date (CED), January 10, 2017, and ended at the end of January 2018.

Takeover constitutes all contractual obligations required for the FI contractor to assume responsibility for the operations of the CD-MMIS. Payment for takeover was on a fixed price basis and included costs for related expansion items and other work that may occur during takeover, as outlined in the contract.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a minor decrease of $11,000 due to a negative adjustment for work not performed for the Takeover Expansion Item “Business Rules Extraction (BRE).” There is no change from the prior estimate for FY 2020-21. The change from FY 2019-20 to FY 2020-21 in the current estimate is a decrease due to the takeover efforts concluding.

Methodology:
1. The price of takeover was $29,269,000 TF.

2. The remaining balance of $7,797,000 was paid in FY 2019-20.

Fiscal Year	TF	GF	FF
FY 2019-20	$7,797,000	$1,949,000	$5,848,000
FY 2020-21	$0	$0	$0

DENTAL FI TAKEOVER 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 72

Funding:
FI 75% Title XIX / 25% GF (4260-101-0001/0890)

DENTAL FI CD-MMIS COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	73
IMPLEMENTATION DATE:	11/2015
ANALYST:	Matt Wong
FISCAL REFERENCE NUMBER:	1890

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$256,000	$0
STATE FUNDS	$94,750	$0
FEDERAL FUNDS	$161,250	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of the base California Dental Medicaid Management Information System's (CD-MMIS) turnover services from the previous Dental Fiscal Intermediary (FI), Delta Dental of California (Delta) to the current FI contractor, DXC Technology Services, LLC (DXC) including the cost of the CD-MMIS runout services for the previous Dental FI contractor, Delta.

Authority:
Contract # 04-35745

Interdependent Policy Changes:
Not Applicable

Background:
Delta was awarded a multi-year dental FI contract in 2004. The 2004 FI contract with Delta ended in January 2018, with the new Administrative Services Organization (ASO) and FI contractors assuming operational responsibility beginning February 1, 2018. The dental FI is responsible for FI services related to the Medi-Cal Dental Program.

The dental FI operates CD-MMIS, which is the Medi-Cal dental claims processing system. It is a mission-critical system that must ensure timely and accurate claims processing for Medi-Cal dental providers.

In February 2012, there was an unsuccessful attempt to procure a new dental FI with Delta and they began takeover activities. However, the Centers for Medicare and Medicaid Services (CMS) determined the 2012 FI contract with Delta failed to meet the regulatory criteria and conditions as a MMIS. The Department received approval for a two-year Non Competitive Bid Sole Source extension of the 2004 contract, extending operations of the 2004 FI contract for the period of July 1, 2013, through June 30, 2015. The Department instructed the 2004 FI contractor to stop all turnover activities. The 2004 FI contractor filed a Notification of Claim to recoup costs already expended for turnover activities. The Department determined that the 2004 FI contractor should be reimbursed and five (5) out of the nine (9) installments were paid at that time.

The Department has instructed the 2004 FI contractor to resume turnover support services and all activities in accordance with the contract requirements. The turnover period ensures the orderly transfer of the dental FI contract from the 2004 FI contractor, Delta, to the successor contractor, DXC, in addition to supporting the Department's procurement effort by ensuring that all required data and documentation are included in the Office of Medi-Cal Procurement's data library. As a result, the turnover bid price has been renegotiated. The amendment to implement this change was approved by CMS on June 29, 2015.

DENTAL FI CD-MMIS COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 73

The schedule of payments for turnover services to the 2004 FI contractor, Delta, is contractually agreed upon. The turnover bid price is paid in nine installments and one final installment of 50% of the turnover bid price. The final payment was made upon completion of all turnover requirements.

Following the turnover phase of the 2004 FI contract was the runout phase. The runout period ensures the orderly decommissioning of systems and closeout of the 2004 FI contract.

The schedule of payments for runout services to the 2004 FI contractor, Delta, was contractually agreed upon. The runout bid price was paid in seven equal installments, and one final installment of 50% of the runout bid price. The final payment was made upon completion of all runout requirements.

In order to complete runout and closeout the 2004 FI contract, a final audit of the Pure Premium Fund (PPF) was required. During operations of the 2004 FI contract, an annual PPF audits took place 11 months following the end of each Contract period, coinciding with the state fiscal year. The audit to evaluate FY 2016-17 was previously deferred due to pending approval from CMS for Change Order 31, which impacted the rates paid for that period. The Department instructed Delta to initiate a final audit of the PPF with independent evaluator Armanino, LLC to evaluate FY 2016-17 and FY 2017-18, coinciding with the end of the final underwriting Pure Premium Period. This audit began on February 28, 2019. The Department reimbursed Delta for the cost of the final audit.

Reason for change:
The change from the prior estimate, for FY 2019-20, is a decrease due the final runout invoice being lower than runout bid. There is no change from the prior estimate for FY 2020-21. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease due to runout activities concluding and billing having been completed by the end of FY 2019-20.

Methodology:
1. The remaining costs were paid:

FY 2019-20 Final Runout Costs	$133,000
PPF Audit Costs	$123,000
FY 2019-20 Total	**$256,000**

2. Costs are shared between federal funds (FF) and general funds (GF).

	TF	GF	FF
FY 2019-20	**$256,000**	**$94,000**	**$162,000**

Funding:
FI 75% Title XIX FF / 25% GF (4260-101-0001/0890)
FI 50% Title XIX / 50% GF (4260-101-0001/0890)

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

DENTAL ASO TAKEOVER 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER:	74
IMPLEMENTATION DATE:	9/2017
ANALYST:	Matt Wong
FISCAL REFERENCE NUMBER:	2003

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$940,000	$0
STATE FUNDS	$235,000	$0
FEDERAL FUNDS	$705,000	$0

DESCRIPTION

Purpose:
This policy change estimates the total cost of Takeover from the 2004 Fiscal Intermediary, Delta Dental of California (Delta), to the current Administrative Services Organization (ASO) contractor Delta.

Authority:
Contract 16-93287

Interdependent Policy Changes:
Not Applicable

Background:
Delta was awarded the multi-year ASO contract in 2016. The ASO contractor is responsible for duties including claims processing, provider enrollment, and outreach of the Medi-Cal Dental Program. Takeover started from the Contract Effective Date (CED), January 10, 2017, and ended January 2018.

Takeover constitutes all contractual obligations required for the ASO contractor to assume administrative responsibilities. Payment for takeover was on a fixed price basis and included costs for related expansion items and other work that may occur during takeover, as outlined in the contract.

Reason for Change:
There is no change from the prior estimate, for FY 2019-20. There is no change from the prior estimate, for FY 2020-21. The change from FY 2019-20 to FY 2020-21 is a decrease due to the takeover efforts concluding.

Methodology:
1. The price of Takeover was $4,695,000 based on the revised takeover cost plan.

2. The remaining balance of $940,000 TF was paid in FY 2019-20.

Fiscal Year	TF	GF	FF
FY 2019-20	$940,000	$235,000	$705,000
FY 2020-21	$0	$0	$0

Funding:
FI 75% Title XIX / 25% GF (4260-101-0001/0890)

HEALTH-RELATED ACTIVITIES - CDSS

OTHER ADMIN. POLICY CHANGE NUMBER:	75
IMPLEMENTATION DATE:	7/1992
ANALYST:	Manvir Lallian
FISCAL REFERENCE NUMBER:	233

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$281,138,000	$341,958,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$281,138,000	$341,958,000

DESCRIPTION

Purpose:
This policy change provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS) for certain health-related activities provided by county social workers.

This policy change reflects the 100% FFP provided to CDSS.

Authority:
CWS Interagency Agreement (IA) 01-15931
CWS/CMS 06-55834
CSBG/APS 01-15931

Interdependent Policy Changes:
Not Applicable

Background:
The health-related services involve helping Medi-Cal eligibles to access covered medical services or maintain current treatment levels in these program areas: 1) Child Welfare Services (CWS); 2) Child Welfare Services/Case Management System (CWS/CMS); 3) County Services Block Grant (CSBG); 4) Adult Protective Services (APS) and; 5) Psychotropic Medications Medical Review.

Reason for Change:
There is a decrease from the prior estimate for FY 2019-20 due to updated expenditure data provided by CDSS on a cash basis, which removes costs that are no longer needed. There is an increase from the prior estimate for FY 2020-21 due to updated expenditure data provided by CDSS. The change from FY 2019-20 to FY 2020-21 in the current estimate is an increase due to updated expenditure data provided by CDSS on a cash basis.

Methodology:
The estimates, on a cash basis, were provided by CDSS.

HEALTH-RELATED ACTIVITIES - CDSS

OTHER ADMIN. POLICY CHANGE NUMBER: 75

(Dollars in Thousands)

FY 2019-20	TF	DHCS FFP	CDSS GF/ County Match
CWS	$285,332	$142,666	$142,666
CWS/CMS	$3,326	$1,663	$1,663
CSBG/APS	$273,618	$136,809	$136,809
TOTAL	$562,276	**$281,138**	$281,138

FY 2020-21	TF	DHCS FFP	CDSS GF/ County Match
CWS	$362,088	$181,044	$181,044
CWS/CMS	$5,148	$2,574	$2,574
CSBG/APS	$316,680	$158,340	$158,340
TOTAL	$683,916	**$341,958**	$341,958

*Totals may differ due to rounding.

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

PERSONAL CARE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER:	76
IMPLEMENTATION DATE:	4/1993
ANALYST:	Manvir Lallian
FISCAL REFERENCE NUMBER:	236

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$382,761,000	$392,044,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$382,761,000	$392,044,000

DESCRIPTION

Purpose:
This policy change provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS) for the county cost of administering two In-Home Supportive Services (IHSS) programs: the Personal Care Services Program (PCSP), and the IHSS Plus Option (IPO) program. Title XIX FFP is also provided to CDSS for the IHSS Case Management & Information Payrolling System (CMIPS) Legacy and CMIPS II.

Authority:
Interagency Agreement (IA) 03-75676
IA 14-90483
IA 15-92139
IA 09-86307 IPO

Interdependent Policy Changes:
Not Applicable

Background:
The IHSS programs, PCSP and IPO, enable eligible individuals to remain safely in their own homes as an alternative to out-of-home care. The PCSP and IPO program provide benefits that include domestic services, non-medical personal care services, and supportive services. The Medi-Cal program includes PCSP in its schedule of benefits.

Both the CMIPS Legacy and CMIPS II are currently used to authorize IHSS payments and provide CDSS and the counties with information such as wages, taxes, hours per case, cost per hour, caseload, and funding ratios.

Reason for Change:
The change for 2019-20, from the prior estimate, is a slight decrease due to updated expenditure data provided by CDSS. The change for FY 2020-21, from the prior estimate, is a slight increase due to updated expenditure data provided by CDSS. The change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to updated expenditure data provided by CDSS.

Methodology:
The estimates, on a cash basis, were provided by CDSS.

PERSONAL CARE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 76

(Dollars in Thousands)

FY 2019-20	TF	DHCS FFP	CDSS GF/ County Match
EW Time & Health Related	$650,004	$325,002	$325,002
CMIPS II	$83,832	$41,916	$41,916
CMIPS II EVV	$31,686	$15,843	$15,843
Total	$765,522	**$382,761**	$382,761
FY 2020-21	**TF**	**DHCS FFP**	**CDSS GF/ County Match**
EW Time & Health Related	$660,116	$330,058	$330,058
CMIPS II	$91,632	$45,816	$45,816
CMIPS II EVV	$32,340	$16,170	$16,170
Total	$784,088	**$392,044**	$392,044

*Totals may differ due to rounding.

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

CALHEERS DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	77
IMPLEMENTATION DATE:	6/2012
ANALYST:	Latoya Brown
FISCAL REFERENCE NUMBER:	1679

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$143,594,000	$131,197,000
STATE FUNDS	$31,867,880	$31,037,290
FEDERAL FUNDS	$111,726,120	$100,159,710

DESCRIPTION

Purpose:
This policy change estimates the cost for the development, implementation, ongoing maintenance, and operations of the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). This policy change also includes the cost for contractors on the Health Exchange and Medi-Cal Interface (HEMI) project to maintain the electronic interface between the Medi-Cal Eligibility Data System (MEDS) and CalHEERS.

Authority:
Affordable Care Act (ACA) of 2010
AB 1602 (Chapter 655, Statutes of 2010)
SB 900 (Chapter 659, Statues of 2010)
Interagency Agreement #12-89551
Contract # 73031236

Interdependent Policy Changes:
Not Applicable

Background:
California established Covered California to provide competitive health care coverage for individuals and small employers. CalHEERS determines an applicant's eligibility for subsidized coverage. In creating this one-stop shop experience, states are required to use a single, streamlined application for the applicants to apply for all applicable health subsidy programs. The application may be filed online, in person at a county social services agency, by mail, or by telephone. To meet this requirement, the Department and Covered California formed a partnership to acquire a Systems Integrator to design and implement the CalHEERS as the business solution that allows the required one-stop shopping, making health insurance eligibility purchasing easier and more understandable.

The Department is responsible for the coordination, clarification, and implementation of Medi-Cal regulations, policies, and procedures to ensure accurate and timely determination of Medi-Cal eligibility for applicants and beneficiaries. The Department also works with the county welfare department consortiums to develop the business rules necessary to implement eligibility policy and maintain the records of beneficiaries in the county eligibility systems and MEDS.

CalHEERS was programmed to provide Modified Adjusted Gross Income (MAGI) eligibility determinations for individuals seeking coverage through Covered California and Medi-Cal. In order to provide seamless integration with the CalHEERS system, the Department designed and implemented technology solutions for the ongoing maintenance of MEDS.

ACA offers additional enhanced federal funding for developing/upgrading Medicaid eligibility systems

CALHEERS DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 77

and for interactions of such systems with the ACA-required health benefit exchanges. The Department also receives enhanced federal funding for the requirements validation, design, development, testing, and implementation of MEDS related system changes needed to interface with the CalHEERS. Medi-Cal's associated cost for the one-time development and implementation (D&I) of CalHEERS is 90/10 Federal Financial Participation (FFP) for Title XIX. CalHEERS ongoing maintenance and operations (M&O) cost is 75/25 FFP for Title XIX. The FFP for Title XXI for both D&I and M&O was 88/12 until September 30, 2019, 76.5/23.5 from October 1, 2019 through September 30, 2020, and 65/35 beginning October 1, 2020, onward. CalHEERS' costs are shared between Covered California and Medi-Cal.

The Department requests its own enhanced federal funding from the Centers for Medicare and Medicaid Services (CMS) for the HEMI project. In December 2019, CMS approved funding through federal fiscal year (FFY) 2021. The Department will submit an IAPDU in July 2020 to seek approval for funding through subsequent fiscal years.

Reason for Change:
For the CalHEERS portion, there is no change from the prior estimate for FY 2019-20. For FY 2020-21 from the prior estimate, there is an increase due to: 1) annual salary and baseline benefit and retirement adjustments, 2) an increase to the OSI Enterprise costs allocated to the CalHEERS Project, and 3) an increase to the NWN support contract. The decrease from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease due to the reversion back to one System Integrator.

For the HEMI portion, there is a decrease from the prior estimate for FY 2019-20 due to a decrease in Contractor costs due to the delays in amending the HEMI contracts and a slight increase in HEMI OTech costs due to the MEDS/CalHEERS database continuing to grow over time which impacts backup sizing, and overall system and processing related expenses. For FY 2020-21, there is an increase from the prior estimate due to an increase in OTech costs based on the current trend for FY 2019-20.

The increase from FY 2019-20 to FY 2020-21 in the current estimate, is due to having a full team of HEMI Contractors in FY 2020-21.

Methodology:
1. Contractors began D&I work in July 2012 with payments beginning in August 2012. M&O started in January 2015.
2. CalHEERS' costs are shared between Covered California and Medi-Cal based on the Cost Allocation Plan.
    - From October 1, 2018 to September 30, 2019, the cost share was 12.38% from Covered California and 87.62% from the Department.
    - Effective October 1, 2019, the cost share is 12.59% from Covered California and 87.41% from the Department.
    - All costs directly attributable to the Department will be the responsibility of the Department.

CALHEERS DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 77

3. In FY 2019-20 and FY 2020-21, costs incurred are for CalHEERS' D&I and M&O.
   The D&I period is eligible for:
   - 86.27% at 90% federal reimbursement,
   - 13.73% at 88% federal reimbursement through September 30, 2019; 76.5% federal reimbursement from October 1, 2019 to September 30, 2020; and 65% federal reimbursement from October 1, 2020, and after.

   The M&O period is eligible for:
   - 86.27% at 75% federal reimbursement,
   - 13.73% at 88% federal reimbursement through September 30, 2019; 76.5% federal reimbursement from October 1, 2019 to September 30, 2020; and 65% federal reimbursement from October 1, 2020, and after.

4. The estimate for FY 2019-20 and FY 2020-21 are as follows:

FY 2019-20	TF	GF	FF
75% Title XIX FF / 25% GF	$100,101,000	$25,025,250	$75,075,750
76.5% Title XXI FF / 23.5% GF	$14,463,000	$3,398,805	$11,064,195
88% Title XXI FF / 12% GF	$4,832,000	$579,840	$4,252,160
90% Title XIX FF / 10% GF	$21,131,000	$2,113,100	$19,017,900
CalHEERS Subtotal	$140,527,000	$31,116,995	$109,410,005
75% Title XIX FF / 25% GF	$2,645,943	$661,486	$1,984,457
76.5 Title XXI FF / 23.5% GF	$338,176	$79,471	$258,704
88% Title XXI FF / 12% GF	$82,930	$9,952	$72,979
DHCS EITS Subtotal	$3,067,049	$750,909	$2,316,140
Total	**$143,594,049**	**$31,867,904**	**$111,726,145**

Totals may differ due to rounding.

FY 2020-21	TF	GF	FF
65% Title XXI FF / 35% GF	$21,123,000	$2,112,300	$19,010,700
75% Title XIX FF / 25% GF	$88,972,000	$22,243,000	$66,729,000
76.5% Title XXI FF / 23.5% GF	$3,311,000	$778,085	$2,532,915
90% Title XIX FF / 10% GF	$14,211,000	$4,973,850	$9,237,150
CalHEERS Subtotal	$127,617,000	$30,107,235	$97,509,765
65% Title XXI FF / 35% GF	$368,651	$129,028	$239,623
75% Title XIX FF / 25% GF	$3,088,466	$772,117	$2,316,350
76.5% Title XXI FF / 23.5% GF	$122,884	$28,878	$94,006
DHCS EITS Subtotal	$3,580,000	$930,022	$2,649,978
Total	**$131,197,000**	**$31,037,257**	**$100,159,743**

Totals may differ due to rounding.

CALHEERS DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 77

Funding:
90% Title XIX / 10% GF (4260-101-0001/0890)
75% Title XIX / 25% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)
65% Title XXI / 35% GF (4260-113-0001/0890)

MATERNAL AND CHILD HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER:	78
IMPLEMENTATION DATE:	7/1992
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	234

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$66,536,000	$64,269,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$66,536,000	$64,269,000

DESCRIPTION

Purpose:
This policy change estimates the federal match provided to the California Department of Public Health (CDPH) for the Maternal, Child and Adolescent Health (MCAH) programs.

Authority:
Interagency Agreement 07-65592
SB 852 (Chapter 25, Statutes of 2014)

Interdependent Policy Changes:
Not Applicable

Background:
The MCAH program administers the following services:

- Conducts outreach to pregnant and parenting adolescents who are potentially eligible for Medi-Cal;
- Assists Medi-Cal eligibles in accessing services;
- Recruits providers for Medi-Cal's Comprehensive Perinatal Services Program (CPSP) and provides technical assistance regarding CPSP enhanced services to Medi-Cal beneficiaries;
- Administers programs that offer prenatal care guidance for a target population, provides case management services, and conducts follow-up to improve access to early obstetrical care services for Medi-Cal eligible pregnant women;
- Administers programs for preventive and primary care services for children and youth; and
- Administers programs for family-centered, community-based, comprehensive health services to children with special health care needs.

The MCAH program includes the following services:

- Black Infant Health (BIH): Group intervention and case management services to pregnant and parenting African-American Medi-Cal eligible women in an effort to reduce the high death rate for African American infants as well as decrease health and social inequities for African-American women and infants. Effective July 1, 2014, SB 852 restored the General Fund for the Black Infant Health Program.
- Comprehensive Perinatal Services Program (CPSP): Provides a wide range of services to Medi-Cal pregnant women, from conception through 60 days postpartum, and provide case management services and conduct follow-up to improve access to early obstetrical and post-partum care (60-days following the delivery) for Medi-Cal eligible pregnant women.
- Adolescent Family Life Program (AFLP): Case management services for Medi-Cal eligible pregnant adolescents to address the social, health, educational, and economic consequences of adolescent pregnancy by providing comprehensive case management services to pregnant and

MATERNAL AND CHILD HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER: 78

parenting adolescents and their children. The AFLP emphasizes promotion of positive youth development, focusing on and building upon the adolescents' strengths and resources to work toward:

1) Improving the health of the pregnant and parenting adolescent;
2) Improving graduation rates;
3) Reducing repeat pregnancies; and
4) Improving linkages and creating networks for pregnant and parenting adolescents.

- California Home Visiting Program (CHVP) – pending Department review: This program focuses on overburdened families who are at risk for Adverse Childhood Experiences (ACEs) including child maltreatment, domestic violence, substance abuse, and mental illness. Home visiting gives parents the tools and know-how to independently raise their children.
- Perinatal Equity Initiative (PEI) – pending Department review: Expands the scope of interventions that close gaps in current programming offered through the BIH program to further improve black infant birth outcomes and reduce infant mortality.

Reason for Change:
There is no change from the prior estimate, for FY 2019-20 and FY 2020-21.

The change in the current estimate, from FY 2019-20 to FY 2020-21, is due to more prior year claims budgeted in FY 2019-20, and no CHVP and PEI costs budgeted in FY 2019-20.

Methodology:
1. The Department claims Title XIX federal funds with Certified Public Expenditures (CPE) from local agencies.

2. The following estimates have been provided on a cash basis by CDPH.

(Dollars in Thousands)

FY 2019-20	DHCS FFP	CDPH GF	County Match
BIH	$8,872	$5,406	$2,910
CPSP & PCG	$56,032	$0	$40,867
AFLP	$1,632	$0	$1,580
Total for FY 2019-20	**$66,536**	$5,406	$45,357

(Dollars in Thousands)

FY 2020-21	DHCS FFP	CDPH GF	County Match
BIH	$8,132	$6,722	$1,051
CPSP & PCG	$41,073	$0	$29,123
AFLP	$1,133	$0	$1,001
CHVP	$11,067	$8,353	$0
PEI	$2,864	$2,864	$0
Total for FY 2020-21	**$64,269**	$17,939	$31,175

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

CDDS ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	79
IMPLEMENTATION DATE:	7/1997
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	243

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$86,240,000	$70,757,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$86,240,000	$70,757,000

DESCRIPTION

Purpose:
This policy change estimates the federal match for the California Department of Developmental Services (CDDS) administrative costs.

Authority:
Interagency Agreement (IA)

Interdependent Policy Changes:
Not Applicable

Background:
CDDS administrative costs are comprised of Developmental Centers (DC)/State Operated Community Facility (SOCF) Medi-Cal Administration, Developmental Centers Medi-Cal Eligibility Contract, Home and Community Based Services (HCBS) Waiver Administration, Regional Centers (RC) Medicaid Administration, Regional Centers Nursing Home Reform (NHR), and Targeted Case Management (TCM).

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

Reason for Change:
The change for FY 2019-20, from the prior estimate, is a net decrease due to decreased DC/SOCF, HCBS Waiver, and TCM administrative costs.

The change for FY 2020-21, from the prior estimate, is a net decrease due to decreased DC/SOCF, HCBS Waiver, and RC Medicaid administrative costs.

The change from FY 2019-20 to FY 2020-21 in the current estimate, is a net decrease due to a decrease in TCM and RC Medicaid administrative costs, and an increase HCBS Waiver administrative costs.

CDDS ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 79

Methodology:
CDDS provides the following cash estimates of its administrative cost components:

FY 2019-20		DHCS FFP	CDDS GF	IA #
1	DC/SOCF Medi-Cal Admin.	$6,356,000	$6,356,000	03-75282/83
	DC/SOCF HIPAA*	$180,000	$0	03-75282/83
2	DC/SOCF Medi-Cal Elig	$525,000	$525,000	01-15378
3	HCBS Waiver Admin.	$30,761,000	$30,761,000	01-15834
4	RC Medicaid Admin.	$33,690,000	$11,230,000	03-75734
5	NHR Admin.	$212,000	$212,000	03-75285
6	TCM Headquarters Admin.	$579,000	$579,000	03-75284
	TCM RC Admin.	$13,299,000	$13,299,000	03-75284
	TCM HIPAA*	$638,000	$0	03-75284
	Total	**$86,240,000**	$62,962,000	

FY 2020-21		DHCS FFP	CDDS GF	IA #
1	DC/SOCF Medi-Cal Admin.	$6,486,000	$6,486,000	03-75282/83
	DC/SOCF HIPAA*	$180,000	$0	03-75282/83
2	DC/SOCF Medi-Cal Elig	$525,000	$525,000	01-15378
3	HCBS Waiver Admin.	$35,722,000	$35,722,000	01-15834
4	RC Medicaid Admin.	$14,553,000	$4,851,000	03-75734
5	NHR Admin.	$273,000	$273,000	03-75285
6	TCM Headquarters Admin.	$852,000	$852,000	03-75284
	TCM RC Admin.	$11,528,000	$11,528,000	03-75284
	TCM HIPAA*	$638,000	$0	03-75284
	Total	**$70,757,000**	$60,237,000	

Funding:
100% Title XIX (4260-101-0890)
100% HIPAA FFP (4260-117-0890)*

HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN

OTHER ADMIN. POLICY CHANGE NUMBER:	80
IMPLEMENTATION DATE:	7/1999
ANALYST:	Sabrina Blank
FISCAL REFERENCE NUMBER:	246

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$41,379,000	$41,379,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$41,379,000	$41,379,000

DESCRIPTION

Purpose:
This policy change budgets the Title XIX federal financial participation (FFP) for the Health Care Program for Children in Foster Care (HCPCFC). The Department of Social Services (CDSS) budgets the amounts for the non-federal share.

Authority:
Welfare & Institutions Code, Section 16501.3
AB 1111 (Chapter 147, Statutes of 1999)
SB 1013 (Chapter 35, Statutes of 2012)
SB 238 (Chapter 534, Statutes of 2015)
SB 319 (Chapter 535, Statutes of 2015)
AB 97 (Chapter 14, Statutes of 2017)
Interagency Agreement (IA) 18-95316

Interdependent Policy Change:
Not Applicable

Background:
On January 1, 2010, the Department, in collaboration with CDSS, implemented the following requirements of the federal Fostering Connections to Success and Increasing Adoptions Act of 2008:

- Connect and support relative caregivers,
- Improve the outcome for children in foster care,
- Provide for tribal foster care and adoption access,
- Improve incentives for adoption, and
- Require Title IV-B state and county agencies to develop a plan for ongoing oversight and coordination of health care services for children in foster care.

CDSS and the Department implemented the HCPCFC through the existing Child Health and Disability Prevention program so counties can employ public health nurses to help foster care children access health-related services including the review and monitoring of foster children under treatment with psychotropic medications.

The responsibility for HCPCFC was realigned to the counties in 2011 as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, legislation enacted after September 30, 2012, that has an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by 2011 Realignment shall apply to local agencies only to the extent that the state provides annual funding for the cost increase. Local agencies are not obligated to provide programs or levels of

HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN

OTHER ADMIN. POLICY CHANGE NUMBER: 80

service required by legislation, above the level for which funding has been provided. Therefore, funding for the remaining non-federal costs for counties is 100% General Funds.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 or FY 2020-21. There is no change from FY 2019-20 to FY 2020-21 in the current estimate.

Methodology:
1. CDSS provides the annual Local Revenue Fund of $13,793,000 for FY 2019-20 and FY 2020-21.

(Dollars in Thousands)

Fiscal Year	TF	CDSS GF	DHCS FFP
FY 2019-20	$55,172	$13,793	**$41,379**
FY 2020-21	$55,172	$13,793	**$41,379**

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

DEPARTMENT OF SOCIAL SERVICES ADMIN COST

OTHER ADMIN. POLICY CHANGE NUMBER:	81
IMPLEMENTATION DATE:	7/2002
ANALYST:	Manvir Lallian
FISCAL REFERENCE NUMBER:	256

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$26,381,000	$28,236,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$26,381,000	$28,236,000

DESCRIPTION

Purpose:
This policy change provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS) for administering various programs to Medi-Cal beneficiaries.

Authority:
IHSS PCSP Interagency Agreement (IA) 03-75676
IHSS Health Related IA 01-15931
CWS/CMS for Medi-Cal IA 06-55834
IHSS Plus Option Sec. 1915(j) IA 09-86307
SAWS IA 04-35639
Medi-Cal State Hearings IA 16-93214
Public Inquiry and Response IA 16-93215
Medicaid Disability Evaluation Services IA 16-93213

Interdependent Policy Changes:
Not Applicable

Background:
These costs cover the administration of the Personal Care Services Program (PCSP), the In-Home Supportive Services Plus Option (IPO) Section 1915(j), the Child Welfare Services/Case Management System (CWS/CMS), Statewide Automated Welfare System (SAWS), Community First Choice Option Program (CFCO), Coordinated Care Initiative (CCI) IA, and the California Community Transitions-Money Follows the Persons (CCT). The Department provides FFP to CDSS for services related to Medi-Cal beneficiaries. CDSS budgets the matching General Fund (GF).

Reason for Change:
The change from the prior estimate, for FY 2019-20, is an increase due to revised expenditure data provided by CDSS. The change for FY 2020-21 from the prior estimate and the change from FY 2019-20 to FY 2020-21, in the current estimate, is an increase due to updated expenditures provided by CDSS.

Methodology:
The following estimates, on a cash basis, were provided by CDSS.

DEPARTMENT OF SOCIAL SERVICES ADMIN COST

OTHER ADMIN. POLICY CHANGE NUMBER: 81

FY 2019-20	TF	DHCS FFP	CDSS GF
IHSS PCSP	$15,600,000	$7,800,000	$7,800,000
IHSS Health Related	$60,000	$30,000	$30,000
CWS/CMS for Medi-Cal	$1,864,000	$932,000	$932,000
IHSS Plus Option Sec. 1915(j)	$4,520,000	$2,260,000	$2,260,000
SAWS	$1,016,000	$508,000	$508,000
Medi-Cal State Hearings	$18,826,000	$9,413,000	$9,413,000
Public Inquiry and Response	$500,000	$250,000	$250,000
Medicaid Disability Evaluation Services	$5,902,000	$2,951,000	$2,951,000
Electronic Visit Verification	$4,474,000	$2,237,000	$2,237,000
TOTAL	$52,762,000	**$26,381,000**	$26,381,000

FY 2020-21	TF	DHCS FFP	CDSS GF
IHSS PCSP	$17,950,000	$8,975,000	$8,975,000
IHSS Health Related	$60,000	$30,000	$30,000
CWS/CMS for Medi-Cal	$2,000,000	$1,000,000	$1,000,000
IHSS Plus Option Sec. 1915(j)	$5,928,000	$2,964,000	$2,964,000
SAWS	$480,000	$240,000	$240,000
Medi-Cal State Hearings	$18,826,000	$9,413,000	$9,413,000
Public Inquiry and Response	$500,000	$250,000	$250,000
Medicaid Disability Evaluation Services	$6,328,000	$3,164,000	$3,164,000
Electronic Visit Verification	$4,400,000	$2,200,000	$2,200,000
TOTAL	$56,472,000	**$28,236,000**	$28,236,000

*Totals may differ due to rounding.

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

FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	82
IMPLEMENTATION DATE:	7/2007
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1192

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$18,314,000	$21,435,000
STATE FUNDS	$3,750,000	$5,432,000
FEDERAL FUNDS	$14,564,000	$16,003,000

DESCRIPTION

Purpose:
This policy change estimates the federal match provided to the California Department of Public Health (CDPH) for State Operations administrative costs related to services provided to Medi-Cal beneficiaries.

Authority:
Interagency Agreement (IA) 07-65592
IA 07-65642
IA 07-65689
IA 15-92271
IA 07-65693 A01
IA 10-87042 A02
IA 18-95089
AB 1559 (Chapter 565, Statutes of 2014)
SB 853 (Chapter 717, Statutes of 2010)

Interdependent Policy Changes:
PC 154 Quality and Accountability Supplemental Payments

Background:
The Department has existing IAs with CDPH to allow for the provision of Title XIX federal funds as a reimbursement to CDPH. The non-federal matching funds will be budgeted by CDPH. This policy change is for the following program support costs:

- Maternal, Child and Adolescent Health (MCAH)
- Office of AIDS
- Childhood Lead Poisoning Prevention Program (CLPP)
- Center for Health Care Quality (CHCQ)
- Skilled Nursing Facilities (SNF)

The MCAH program ensures the provision of statutorily required programs by developing systems to protect and improve the health of women of reproductive age, infants, children, adolescents, and their families through the following programs: Information & Education program, Adolescent Family Life program, and Black Infant Health program.

FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 82

The Office of AIDS operates and administers the Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS) waiver. The HIV/AIDS waiver program provides services designed to allow people with HIV or AIDS to remain in their homes, stabilize their health, improve their quality of life, and avoid costly institutional care.

The CLPP program provides targeted case management and environmental investigation services with associated administrative activities to lead-burdened children who are Medi-Cal beneficiaries and meet the case definition of lead poisoning.

The CHCQ program has the responsibility for regulatory oversight of health facilities, certified nurse assistants (CNAs), home health aides (HHAs), certified hemodialysis technicians (CHTs) and licensed nursing home administrators. The CHCQ contract estimate includes reimbursements for the following programs:

- Provider Certification Unit,
- Registered Nurse Unit,
- Nurse Aide Training and Competency Evaluation Program (NAR/NATCEP),
- Centralized Application Unit, and
- Intermediate Care Facility for the Developmentally Disabled Continuous Nursing Pilot Project Waiver.

SNF: SB 853 implemented a quality and accountability supplemental payment program (QASP) for nursing facilities (NF-Bs). The Department will reimburse CDPH's Skilled Nursing Facilities administrative costs from this Special Fund.

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a net decrease due to the FY 2018-19 claims for CLPP previously budgeted in FY 2019-20 due to invoicing delays.
-
The change in the prior estimate, for FY 2020-21, is a net increase due payments in FY 2020-21 for SNF FY 2018-19 claims.

The change in the current estimate, from FY 2019-20 to FY 2020-21, is due to more prior year claims in FY 2020-21 for SNF, and an increase in MCAH support costs in FY 2020-21.

The change in the current estimate, from FY 2019-20 to FY 2020-21, is due to more prior year claims in FY 2020-21 for SNF, and an increase in MCAH support costs in FY 2020-21.

Methodology:
1. CDPH provides the General Fund match.

2. For MCAH, the estimate includes an enhanced FMAP of 75% for Skilled Professional Medical Personnel (SPMP) costs. The estimate also includes funding for the Black Infant Health Program.

FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 82

3. CDPH provided the following estimates.

FY 2019-20 (Cash Basis)	DHCS FFP*	DHCS SF**	CDPH GF	Other Match
MCAH	$4,899,000	$0	$4,899,000	$0
Office of AIDS	$884,000	$0	$884,000	$0
CLPP	$2,644,000	$0	$0	$2,644,000
CHCQ	$2,387,000	$0	$0	$2,387,000
Skilled Nursing Facilities	$3,750,000	$3,750,000	$0	$0
Total	**$14,564,000**	**$3,750,000**	$5,783,000	$5,031,000

FY 2020-21 (Cash Basis)	DHCS FFP*	DHCS SF**	CDPH GF	Other Match
MCAH	$5,248,000	$0	$5,248,000	$0
Office of AIDS	$884,000	$0	$884,000	$0
CLPP	$2,052,000	$0	$0	$2,052,000
CHCQ	$2,387,000	$0	$0	$2,387,000
Skilled Nursing Facilities	$5,432,000	$5,432,000	$0	$0
Total	**$16,003,000**	**$5,432,000**	$6,132,000	$4,439,000

Funding:
100% Title XIX FFP (4260-101-0890)*
SNF Quality & Accountability (non-GF) (4260-605-3167)**

CLPP CASE MANAGEMENT SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER:	83
IMPLEMENTATION DATE:	7/1997
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	239

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$8,507,000	$4,200,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$8,507,000	$4,200,000

DESCRIPTION

Purpose:
This policy change estimates the federal match provided to the California Department of Public Health (CDPH) for administrative costs associated with Childhood Lead Poisoning Prevention (CLPP) Program case management services.

Authority:
Interagency Agreement 07-65689

Interdependent Policy Changes:
Not Applicable

Background:
The CLPP Program provides services to the community for the purpose of increasing awareness regarding the hazards of lead exposure, reducing lead exposure, and increasing the number of children assessed and appropriately blood tested for lead poisoning as defined by the Medi-Cal State Plan and CDPH. Specifically, the program services include the following:

- Offers home visitation, environmental home inspections, and nutritional assessments to families of children found to be severely lead-poisoned.
- Provides telephone contacts and educational materials to families of lead-poisoned and lead exposed children.
- Provides information and education to the general public, medical providers, and community-based organizations.
- Provides targeted case management and environmental investigation services with associated administrative activities to lead burdened children who are Medi-Cal beneficiaries and meet the case definition of lead poisoning.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21.

The change in the current estimate, from FY 2019-20 to FY 2020-21, is due to more prior year claims paid in FY 2019-20.

Methodology:
1. Annual expenditures on an accrual basis are $4,200,000. Cash basis expenditures vary from year-to-year based on when claims are actually paid.

CLPP CASE MANAGEMENT SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 83

2. The estimates are provided by CDPH on a cash basis.

(Dollars in Thousands)

FY 2019-20	DHCS FFP	CDPH CLPP Fee Funds
FY 2017-18 Claims	$2,207	$2,207
FY 2018-19 Claims	$3,150	$3,150
FY 2019-20 Claims	$3,150	$3,150
Total for FY 2019-20	**$8,507**	$8,507

(Dollars in Thousands)

FY 2020-21	DHCS FFP	CDPH CLPP Fee Funds
FY 2019-20 Claims	$1,050	$1,050
FY 2020-21 Claims	$3,150	$3,150
Total for FY 2020-21	**$4,200**	$4,200

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

DEPARTMENT OF AGING ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	84
IMPLEMENTATION DATE:	7/1984
ANALYST:	Manvir Lallian
FISCAL REFERENCE NUMBER:	253

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$4,454,000	$4,712,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$4,454,000	$4,712,000

DESCRIPTION

Purpose:
This policy change estimates the Title XIX federal financial participation (FFP) provided to the California Department of Aging (CDA) for administrative costs related to services provided to Medi-Cal eligibles in Community-Based Adult Services (CBAS) and the Multipurpose Senior Services Program (MSSP). Enhanced federal funding is also provided to CDA for administrative costs related to services provided to individuals utilizing Aging and Disability Resource Centers (ADRC).

Authority:
CBAS Interagency Agreements (IA) 03-76137
MSSP IA 01-15976
ADRC IA 19-96199

Interdependent Policy Changes:
Not Applicable

Background:
The CDA coordinates with the Department to obtain FFP for the administrative costs for services related to Medi-Cal beneficiaries. CDA budgets the matching General Fund (GF).

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a decrease due to updated expenditure and accounting data provided by CDA coming in lower than expected. There is no change for FY 2020-21 from the prior estimate. The change from FY 2019-20 to FY 2020-21 is an increase due to modified employer retirement contributions and employee compensation adjustments.

Methodology:
The estimates below were provided by CDA on a cash basis.

DEPARTMENT OF AGING ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 84

(Dollars in Thousands)

Program Support	FY 2019-20		FY 2020-21	
CBAS Support	**CDA GF**	**FFP**	**CDA GF**	**FFP**
FY 2018-19 DOS	$177	$200	$0	$0
FY 2019-20 DOS	$2,177	$2,537	$363	$474
FY 2020-21 DOS	$0	$0	$2,701	$2,540
Total CBAS	$2,354	$2,737	$3,064	$3,014
MSSP Support				
FY 2018-19 DOS	$123	$136	$0	$0
FY 2019-20 DOS	$1,202	$1,240	$264	$456
FY 2020-21 DOS	$0	$0	$1,499	$1,242
Total MSSP	$1,325	$1,376	$1,763	$1,698
ADRC Support*				
FY 2018-19 DOS	$0	$51	$0	$0
FY 2019-20 DOS	$0	$290	$0	$0
FY 2020-21 DOS	$0	$0	$0	$0
Total ADRC	$0	$341	$0	$0
Grand Total	$3,679	**$4,454**	$4,827	**$4,712**

Funding:
100% Title XIX (4260-101-0890)
100% MFP Federal Grant (4260-106-0890)*

CALIFORNIA SMOKERS' HELPLINE

OTHER ADMIN. POLICY CHANGE NUMBER:	85
IMPLEMENTATION DATE:	1/2014
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1680

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$3,000,000	$2,400,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$3,000,000	$2,400,000

DESCRIPTION

Purpose:
This policy change estimates the federal financial participation (FFP) provided to the California Department of Public Health (CDPH) for administrative costs related to California Smoker's Helpline (Helpline) services provided to Medi-Cal beneficiaries.

Authority:
Affordable Care Act Section 4107
Interagency Agreement (IA) 13-90417

Interdependent Policy Change:
Not Applicable

Background:
CDPH funds statewide smoker helpline services and counseling to Medi-Cal beneficiaries through the University of California, San Diego. The Helpline services follow the Centers for Medicare and Medicaid Services (CMS) guidelines and the Department policies for providing services to Medi-Cal beneficiaries. CDPH ensures the Helpline services includes specially trained counselors to provide free telephone-based counseling, education, and support to Medi-Cal beneficiaries who currently smoke or have recently quit smoking.

The Department has an existing IA with CDPH to enable the State to receive 50% FFP for Helpline services administrative costs beginning July 1, 2013.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21.

The change in the current estimate, from FY 2019-20 to FY 2020-21, is due to fewer prior year invoices paid in FY 2020-21.

Methodology:
1. The Helpline services administrative costs are based on expenditure data for services provided to Medi-Cal beneficiaries. CDPH submits invoices for 50% reimbursement of actual and allowable administrative costs.

2. Annual expenditure on an accrual basis is $2,400,000 for FY 2019-20 and FY 2020-21. Cash basis expenditures vary from year-to-year based on when claims are actually paid.

CALIFORNIA SMOKERS' HELPLINE

OTHER ADMIN. POLICY CHANGE NUMBER: 85

3. The estimated administrative cost reimbursements, for FY 2019-20 and FY 2020-21, on a cash basis are:

FY 2019-20	TF	FF
FY 2018-19 Claims	$1,000,000	$1,000,000
FY 2019-20 Claims	$2,000,000	$2,000,000
Total for FY 2019-20	**$3,000,000**	**$3,000,000**

FY 2020-21	TF	FF
FY 2019-20 Claims	$400,000	$400,000
FY 2020-21 Claims	$2,000,000	$2,000,000
Total for FY 2020-21	**$2,400,000**	**$2,400,000**

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

KIT FOR NEW PARENTS

OTHER ADMIN. POLICY CHANGE NUMBER:	86
IMPLEMENTATION DATE:	7/2001
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	249

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$1,061,000	$1,061,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,061,000	$1,061,000

DESCRIPTION

Purpose:
This policy change estimates the federal match provided to the California Children and Families Commission (CCFC) for providing the “Kit for New Parents” to parents of Medi-Cal eligible newborns.

Authority:
Interagency Agreement (IA) #03-76097

Interdependent Policy Changes:
Not Applicable

Background:
The Department entered into an IA with the CCFC to allow the Department to claim Title XIX federal funds (FF) for the "Kit for New Parents" distributed to parents of Medi-Cal eligible newborns by the CCFC (Proposition 10).

Reason for Change:
The change from the prior estimate, for FY 2019-20, is a decrease due to updating the estimated number of Medi-Cal newborns, from 50% to 43.38%, estimated to receive kits. The change in the prior estimate, for FY 2020-21, is a decrease due to fewer estimated number of kits provided to Medi-Cal newborns.

There is no change in the current estimate, from FY 2019-20 to FY 2020-21.

Methodology:
1. CCFC will distribute an estimated 313,000 kits in FY 2019-20 and FY 2020-21. Of these kits, 43.38% are expected to be distributed to Medi-Cal eligible newborns.

   313,000 kits x 43.38% = 135,779 Medi-Cal kits

2. Each kit, basic or custom, costs $15.63.

   135,779 Medi-Cal kits x $15.63 = $2,122,000 TF

KIT FOR NEW PARENTS

OTHER ADMIN. POLICY CHANGE NUMBER: 86

3. Assume 75% of expenditures will be paid in the year the kits are distributed and the remaining 25% of expenditures will be paid in the following year.

Fiscal Year	Accrual	FY 2019-20	FY 2020-21
FY 2018-19	$2,122,000	$530,000	$0
FY 2019-20	$2,122,000	$1,592,000	$530,000
FY 2020-21	$2,122,000	$0	$1,592,000
Total		$2,122,000	$2,122,000
Total FF (50%)		**$1,061,000**	**$1,061,000**

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

VITAL RECORDS

OTHER ADMIN. POLICY CHANGE NUMBER:	87
IMPLEMENTATION DATE:	5/2016
ANALYST:	Matt Wong
FISCAL REFERENCE NUMBER:	1774

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$1,147,000	$890,000
STATE FUNDS	$6,000	$8,000
FEDERAL FUNDS	$1,141,000	$882,000

DESCRIPTION

Purpose:
This policy change estimates the federal financial participation (FFP) for the California Department of Public Health (CDPH) to improve delivery of Vital Records data and to provide certified copies of birth and death records, as needed, to the Department.

Authority:
Contract 15-92272
Contract 18-95019

Interdependent Policy Changes:
Not Applicable

Background:
California birth, death, fetal death, still birth, marriage, and divorce records are maintained by the CDPH Vital Records. Information collected in these records is necessary to support core functions of the Department as represented in the Medicaid Information Technology Architecture (MITA) business functions. The MITA, a Centers for Medicare and Medicaid Services (CMS) initiative, fosters an integrated business and information technology transformation across the Medicaid enterprise in an effort to improve the administration and operation of the Medicaid program.

Historically, the Department has received Vital Records data from CDPH in a case-by-case and manual manner. In order to improve efficiency and advance MITA maturity, the Department has received CMS approval for enhanced FFP to establish automated and timely processes to receive Vital Record data from CDPH. CMS approved the contract in June 2016.

Beginning July 2018, the Department entered into a contract with CDPH to provide certified copies of vital records as required for business needs.

Reason for Change:
The change in FY 2019-20, from the prior estimate, is minor increase of $9,000 due to revised FY 2018-19 invoices for Vital Records data received in FY 2019-20 for payment. The change in FY 2020-21, from the prior estimate, is a slight decrease due to rounding. The change from FY 2019-20 to FY 2020-21, in the current estimate, is a decrease resulting from revised FY 2018-19 invoices paying in FY 2019-20.

VITAL RECORDS

OTHER ADMIN. POLICY CHANGE NUMBER: 87

Methodology:

1. The annual contract to deliver vital records data is $1,166,000 TF. The Department and CDPH receive 75% FFP for ongoing costs to deliver vital records data and 25% match from CDPH from the Health Statistics Special Fund (HSSF).

2. The annual contract to provide certified copies is $16,632 TF ($8,316 GF).

3. On a cash basis, for both contracts, assume three quarters will be paid in the current fiscal year and the remaining quarter will be paid in the subsequent fiscal year. The estimated reimbursements for FY 2019-20 and FY 2020-21 on a cash basis are:

(Totals Rounded to Thousands)

FY 2019-20	**TF**	**HSSF**	**GF**	**FF**
FY 2018-19 Records Data	$639,000	$160,000	$0	$479,000
FY 2018-19 Certified Copies	$500	$0	$250	$250
FY 2019-20 Records Data	$874,000	$218,000	$0	$657,000
FY 2019-20 Certified Copies	$12,000	$0	$6,000	$6,000
Total	**$1,526,000**	**$378,000**	**$6,000**	**$1,141,000**

FY 2020-21	**TF**	**HSSF**	**GF**	**FF**
FY 2019-20 Records Data	$291,000	$73,000	$0	$218,000
FY 2019-20 Certified Copies	$4,000	$0	$2,000	$2,000
FY 2020-21 Records Data	$874,000	$218,000	$0	$656,000
FY 2020-21 Certified Copies	$12,000	$0	$6,000	$6,000
Total	**$1,181,000**	**$291,000**	**$8,000**	**$882,000**

*Totals may differ due to rounding.

Funding:

100% Title XIX FF (4260-101-0890)
50% Title XIX FF / 50% GF (4260-101-0890/0001)

VETERANS BENEFITS

OTHER ADMIN. POLICY CHANGE NUMBER:	88
IMPLEMENTATION DATE:	12/1988
ANALYST:	Matt Wong
FISCAL REFERENCE NUMBER:	232

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$1,100,000	$1,100,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,100,000	$1,100,000

DESCRIPTION

Purpose:
This policy change estimates the Title XIX federal funding provided to the California Department of Veterans Affairs (CDVA) for distribution to County Veteran Service Officers (CVSO) for identifying veterans eligible for Veterans Affairs (VA) benefits.

Authority:
AB 1807 (Chapter 1424, Statutes of 1987)
California Military & Veterans Code 972.5
Interagency Agreement (IA) # 18-95220

Interdependent Policy Changes:
Not Applicable

Background:
AB 1807 permits the Department to make available federal Medicaid funds in order to obtain additional VA benefits for Medi-Cal beneficiaries, thereby reducing costs to Medi-Cal. An IA exists with the CDVA. CVSOs help identify additional VA benefits and refer the veteran to utilize those services instead of Medi-Cal. This process avoids costs for the Medi-Cal program. The previous IA expired on June 30, 2018, and was renewed effective July 1, 2018.

Reason for Change:
There is no change from the prior estimate for FY 2019-20. There is no change from the prior estimate for FY 2020-21. There is no change from FY 2019-20 to FY 2020-21 in the current estimate.

Methodology:
1. The contract amount is estimated to be $1,100,000 for FY 2019-20 and FY 2020-21. The non-federal match is budgeted by CDVA.

FY	FY 2019-20			FY 2020-21		
Cash Basis	**TF**	**CDVA GF**	**DHCS FF**	**TF**	**CDVA GF**	**DHCS FF**
Administrative	$724,000	$362,000	$362,000	$724,000	$362,000	$362,000
Workload Units	$1,476,000	$738,000	$738,000	$1,476,000	$738,000	$738,000
Total	$2,200,000	$1,100,000	**$1,100,000**	$2,200,000	$1,100,000	**$1,100,000**

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

MEDI-CAL INPATIENT SERVICES FOR INMATES

OTHER ADMIN. POLICY CHANGE NUMBER:	89
IMPLEMENTATION DATE:	3/2011
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1665

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$996,000	$1,036,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$996,000	$1,036,000

DESCRIPTION

Purpose:
This policy change estimates the federal match provided to the California Department of Corrections and Rehabilitation (CDCR)/California Correctional Health Care Services (CCHCS) for administrative costs related to the Inmate Eligibility Program.

Authority:
AB 1628 (Chapter 729, Statutes of 2010)
SB 1399 (Chapter 405, Statutes of 2010)
AB 396 (Chapter 394, Statutes of 2011)
Interagency Agreement #15-92398

Interdependent Policy Changes:
Not Applicable

Background:
AB 1628 (Chapter 729, Statutes of 2010) authorizes the Department and the CDCR/CCHCS to:

- Claim federal reimbursement for inpatient hospital services to Medi-Cal eligible adult inmates in State correctional facilities when these services are provided off the grounds of the facility. As part of these provisions, the CCHCS is claiming federal financial participation (FFP) for their administrative costs to operate the Inmate Eligibility Program. The federal funds provided to the CCHCS are included in the Medi-Cal inpatient hospital costs policy changes.

SB 1399 (Chapter 405, Statutes of 2010) authorizes the Board of Parole Hearings to:

- Grant medical parole to permanently medically incapacitated State inmates. State inmates granted medical parole are potentially eligible for Medi-Cal. When a State inmate is granted medical parole, the CCHCS submits a Medi-Cal application to the Department to determine eligibility. Previously these services were funded through the CDCR with 100% GF.

AB 396 (Chapter 394, Statutes of 2011) authorizes the Department, counties, and the CDCR to:

- Claim FFP for inpatient hospital services provided to Medi-Cal eligible juvenile inmates in State and county correctional facilities when these services are provided off the grounds of the facility. Previously, these services were paid 100 percent by the CDCR or the county. The County Administration Allocation Policy Change covers the county FFP associated with Medi-Cal eligibility determination activities for county inmates.

MEDI-CAL INPATIENT SERVICES FOR INMATES

OTHER ADMIN. POLICY CHANGE NUMBER: 89

Reason for Change:
There is no change from the prior estimate for both FY 2019-20 and FY 2020-21. The change from FY 2019-20 to FY 2020-21 in the current estimate is an increase due to a salary increase in FY 2020-21.

Methodology:
1. Implementation of the Inmate Eligibility Program began April 1, 2011.

2. Interagency Agreement #15-92398 expires December 31, 2020. Assume a new contract will be in place by January 2021.

3. Reimbursements for administrative costs began in March 2011.

4. The federal share of ongoing administrative costs is **$996,000** in **FY 2019-20** and **$1,036,000** in **FY 2020-21**.

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

CHHS AGENCY HIPAA FUNDING

OTHER ADMIN. POLICY CHANGE NUMBER:	90
IMPLEMENTATION DATE:	7/2001
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	257

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$849,000	$1,004,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$849,000	$1,004,000

DESCRIPTION

Purpose:
This policy change estimates and reimburses the California Health and Human Services (CHHS) Agency the federal funds for qualifying Health Insurance Portability and Accountability Act (HIPAA) activities related to Medi-Cal.

Authority:
Interagency Agreement (IA) 17-94031

Interdependent Policy Changes:
Not Applicable

Background:
A HIPAA office has been established at the CHHS Agency to coordinate HIPAA implementation and set policy requirements for state departments impacted by HIPAA that utilize Title XIX funding. This funding supports state Agency positions and contracted staff to assist in the implementation of HIPAA. These staff provide oversight and subject matter expertise on HIPAA rules.

Payments began in December 2017 for IA 17-94031, a three-year IA that became effective July 1, 2017. An IA beginning July 1, 2020 is currently pending approval.

Reason for Change:
There is no change from the prior estimate for FY 2019-20. The change in the current estimate, for FY 2020-21, is based on requested funds for increased staffing costs.

The change from FY 2019-20 to FY 2020-21 is due to projected increased contract costs in FY 2020-21.

Methodology:
The CHHS Agency prioritizes HIPAA projects so that the most critical projects are implemented first.

Cash Basis	DHCS FF	CHHS GF
FY 2019-20	**$849,000**	$849,000
FY 2020-21	**$1,004,000**	$1,004,000

Funding:
100% HIPAA (4260-117-0890)

CDPH I&E PROGRAM AND EVALUATION

OTHER ADMIN. POLICY CHANGE NUMBER:	91
IMPLEMENTATION DATE:	7/2003
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	261

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$693,000	$187,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$693,000	$187,000

DESCRIPTION

Purpose:
This policy change estimates the federal financial participation (FFP) provided to the California Department of Public Health (CDPH) for providing Information and Education (I&E) Adolescent Sexual Health and Pregnancy Prevention Program services to Medi-Cal beneficiaries.

Authority:
Interagency Agreement (IA) 07-65592
AB 1762 (Chapter 230, Statutes of 2003)

Interdependent Policy Changes:
Not Applicable

Background:
AB 1762 authorized the Department to require contractors and grantees, under the Office of Family Planning and the I&E program, to establish and implement clinical linkages to the Family Planning, Access, Care, and Treatment (FPACT) program. This linkage includes planning and development of a referral process for program participants to ensure access to family planning and other reproductive health care services, including technical assistance, training, and an evaluation component for grantees.

CDPH budgets the I&E program under the Maternal, Child and Adolescent Health (MCAH) Division. I&E projects have been a major component of MCAH programs. The local projects provide services to youth and adults throughout the state in a variety of settings and utilize various strategies appropriate to meeting the growing and diverse needs of Californians today. The program provides funding for educational programs that emphasize primary prevention to enhance knowledge, attitudes and skills of adolescents and young men and women of childbearing age to make responsible decisions relevant to sexual and reproductive behavior.

The Department has an existing IA with CDPH to receive 50% FFP for the I&E program's administrative costs.

Reason for Change:
There is no change from the prior estimate for FY 2019-20 and FY 2020-21.

The change in the current estimate, from FY 2019-20 to FY 2020-21, is due to more prior year claims paid in FY 2019-20.

CDPH I&E PROGRAM AND EVALUATION

OTHER ADMIN. POLICY CHANGE NUMBER: 91

Methodology:

1. CDPH budgets the non-federal matching funds.

2. The estimates are provided by CDPH on a cash basis.

FY 2019-20	TF	CDPH GF	DHCS FF
FY 2017-18 Claims	$468,000	$234,000	$234,000
FY 2018-19 Claims	$754,000	$377,000	$377,000
FY 2019-20 Claims	$164,000	$82,000	$82,000
Total for FY 2019-20	$1,386,000	$693,000	**$693,000**

FY 2020-21	TF	CDPH GF	DHCS FF
FY 2019-20 Claims	$210,000	$105,000	$105,000
FY 2020-21 Claims	$164,000	$82,000	$82,000
Total for FY 2020-21	$374,000	$187,000	**$187,000**

Funding:

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

MERIT SYSTEM SERVICES FOR COUNTIES

OTHER ADMIN. POLICY CHANGE NUMBER:	92
IMPLEMENTATION DATE:	7/2003
ANALYST:	Matt Wong
FISCAL REFERENCE NUMBER:	263

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$190,000	$190,000
STATE FUNDS	$95,000	$95,000
FEDERAL FUNDS	$95,000	$95,000

DESCRIPTION

Purpose:
This policy change estimates the cost for the interagency agreement (IA) with the California Department of Human Resources (CalHR).

Authority:
IA #12-89476

Interdependent Policy Changes:
Not Applicable

Background:
Federal regulations require that any government agency receiving federal funds have a civil service exam, classification, and pay process. Many counties do not have a civil service system that meets current state regulations. The Merit System Services Program was established under the State Personnel Board and is now administered by CalHR to administer personnel services for the counties that do not have a civil service system. In addition, CalHR reviews the merit systems in the remaining counties to ensure that they meet federal civil service requirements.

The Department reimburses CalHR via an IA for Merit System Services. The agreement continues indefinitely, until terminated, or until there is a change in scope of work affecting the cost.

Reason for Change:
There is no change from the prior estimate for FY 2019-20. There is no change from the prior estimate for FY 2020-21. There is no change in the current estimate from FY 2019-20 to FY 2020-21.

Methodology:
1. CalHR provided the estimates on a cash basis.

2. The estimated reimbursement is $190,000 TF ($95,000 GF) in FY 2019-20 and $190,000 TF ($95,000 GF) in FY 2020-21.

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

PIA EYEWEAR COURIER SERVICE

OTHER ADMIN. POLICY CHANGE NUMBER:	93
IMPLEMENTATION DATE:	7/2003
ANALYST:	Autumn Recce
FISCAL REFERENCE NUMBER:	1114

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$490,000	$941,000
STATE FUNDS	$245,000	$470,500
FEDERAL FUNDS	$245,000	$470,500

DESCRIPTION

Purpose:
This policy change estimates courier services costs for Prison Industry Authority (PIA) eyewear.

Authority:
Interagency Agreement (IA) #13-90175

Interdependent Policy Changes:
Not Applicable

Background:
The California PIA fabricates eyeglasses for Medi-Cal beneficiaries. Since July 2003, the Department has had an IA with PIA to reimburse them for one-half of the courier costs for the pick-up and delivery of orders to optical providers. The two-way courier service ensures that beneficiaries have continued access to and no disruption of optical services.

Reason for Change:
The changes from the prior estimate for FY 2019-20 is a decrease due to:

- Including actual expenditures paid through February 2020, and
- Including only one quarter instead of two quarters of estimated paid courier costs for the restoration of eyeglasses provided to adults over the age of 21, beginning January 1, 2020.

There is no change from the prior estimate for FY 2020-21.

The change in the current estimate, from FY 2019-20 to FY 2020-21, is due to the increased courier costs based on the number of packages estimated to be picked up and delivered, for FY 2020-21.

Methodology:

1. PIA contracts with a courier service company for the pick-up and delivery of orders to optical providers. The Department is responsible for one-half of the delivery cost of $2.13 per package, with no fuel surcharge.

2. The number of estimated packages to be paid is 165,824 in FY 2019-20. Beginning January 1, 2020, SB 78 (Chapter 38, Statutes of 2019) restored optician and optical lab services, including providing eyeglasses, to eligible individuals 21 years of age and older. Assume that 67,147 additional packages will be paid in FY 2019-20.

$2.13 x 165,824 = $353,000 TF (rounded)
$2.13 x 64,147 = $137,000 TF (rounded)

PIA EYEWEAR COURIER SERVICE

OTHER ADMIN. POLICY CHANGE NUMBER: 93

3. The number of packages, prior to the restoration of adult optical services, to be paid in FY 2020-21 are assumed to be 185,000 packages. Assume 256,587 additional packages to account for the full year of payments based on the estimated packages for eyeglasses restoration.

$2.13 x 441,587 = $941,000 TF (rounded)

Fiscal Year	TF	GF	FF
FY 2019-20	$490,000	$245,000	$245,000
FY 2020-21	$941,000	$470,000	$471,000

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

RESTORATION OF DENTAL FFS IN SAC AND LA CO ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER:	94
IMPLEMENTATION DATE:	1/2021
ANALYST:	Matt Wong
FISCAL REFERENCE NUMBER:	2179

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$0	$1,766,000
STATE FUNDS	$0	$591,750
FEDERAL FUNDS	$0	$1,174,250

DESCRIPTION

Purpose:
This policy estimates the fee-for-service administrative cost of eliminating Dental Managed Care and restoring the Dental Fee-For-Service (FFS) delivery system in both Sacramento and Los Angeles counties.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The Department of Health Care Services (DHCS) is responsible for providing dental services to eligible Medi-Cal beneficiaries, and offers services through two delivery systems, FFS and Dental Managed Care (DMC). FFS was the exclusive and original delivery system offered in California's 58 counties. In 1995, DHCS implemented DMC in Sacramento and Los Angeles Counties, to explore the effectiveness of DMC as a delivery system of dental services. DHCS maintains six DMC contracts with three separate contractors. In Sacramento, enrollment is mandatory, with few exceptions. In Los Angeles, a beneficiary must opt-in to participate in DMC.

DHCS seeks to restore the delivery of Medi-Cal dental services in both Sacramento and Los Angeles counties to a FFS system. DHCS believes that this restoration will result in increased beneficiary utilization of Medi-Cal dental services. This transition will be effective no sooner than January 1, 2021.

Reason for Change:
There is no change from the prior estimate for FY 2019-20. The change from the prior estimate, for FY 2020-21, is a decrease due to lower updated cost estimates for document processing by the Fiscal Intermediary and Administrative Services Organization. The change in the current estimate from FY 2019-20 to FY 2020-21 is due to the transition happening in FY 2020-21.

Methodology:
1. FFS administrative costs are based on the estimated cost per eligible multiplied by the number of DMC beneficiaries transitioning. Costs are for January 2021 through June 2021.

2. DMC administrative savings are captured in the Restoration of Dental FFS in Sacramento and Los Angeles Counties policy change.

-- DELETED --

RESTORATION OF DENTAL FFS IN SAC AND LA CO ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 94

Funding:

	TF	GF	FF
FY 2020-21	$1,766,000	$592,000	$1,174,000

FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 75% Title XIX / 25% GF (4260-101-0001/0890)

-- DELETED --

CMS DEFERRED CLAIMS - FI

OTHER ADMIN. POLICY CHANGE NUMBER:	97
IMPLEMENTATION DATE:	9/2019
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	2202

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$0	$0
STATE FUNDS	$2,235,000	$0
FEDERAL FUNDS	-$2,235,000	$0

DESCRIPTION

Purpose:
This policy change estimates the repayment of Fiscal Intermediary (FI) deferred claims to the Centers for Medicare and Medicaid Services (CMS).

Authority:
California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)
Title 42, Code of Federal Regulations (CFR), 430.40

Interdependent Policy Changes:
Not Applicable

Background:
CMS reviews claims submitted by state Medicaid agencies to ensure federal financial participation (FFP) eligibility. Claims for which CMS questions the FFP eligibility are deferred and the state Medicaid agency is issued a deferral notice. Upon receipt of the deferral notice, the state Medicaid agency has 120 days to resolve the deferred claim.

When CMS issues a deferral to the state Medicaid agency, in accordance with the timelines set forth in 42 CFR 430.40, the state Medicaid agency must immediately return the deferred FFP to the applicable Payment Management System (PMS) subaccount while the deferral is being resolved. As part of the resolution process, the state Medicaid agency submits documentation in support of the deferred claim to CMS for review. If CMS determines the deferred claim is allowed, then the deferral is released, the funds are returned to the appropriate PMS subaccount, and the state Medicaid agency is notified that the funds are available to be redrawn.

Pursuant to Special Terms and Conditions paragraph 164 of the California Medi-Cal 2020 Demonstration Waiver, Medi-Cal is required to bring all deferrals current. The Department is working with CMS to resolve specific items. All deferred claims and negative PMS subaccount balances must be repaid by the end of the demonstration waiver, December 31, 2020, or within three years from CMS' approval of California's repayment schedule, whichever is longer.

The FI deferred claims are included in this policy change and are separate from the CMS Deferred Claims and CMS Deferred Claims Other Admin policy changes. See the CMS Deferred Claims and CMS Deferred Claims Other Admin policy changes for more information.

CMS DEFERRED CLAIMS - FI

OTHER ADMIN. POLICY CHANGE NUMBER: 97

Reason for Change:
This is a new policy change.

Methodology:
1. In FY 2019-20, the Department will repay $2.235 million FF for the CMS deferrals issued which includes $552,000 FF for FFY 2018 Quarter 3, $278,000 FF for FFY 2018 Quarter 4, $552,000 FF for FFY 2019 Quarter 1, and $853,000 FF for FFY 2019 Quarter 2.

FY 2019-20	Total Estimated Repayment
FFY 2018 Q3 (Apr-Jun 2018)	$552,000
FFY 2018 Q4 (Jul-Sep 2018)	$278,000
FFY 2019 Q1 (Oct-Dec 2018)	$552,000
FFY 2019 Q2 (Jan-Mar 2019)	$853,000
Total FY 2019-20	**$2,235,000**

Funding:
FI 100% Title XXI FFP (4260-101-0890)
FI 100% Title XXI GF (4260-101-0001)

COVID-19 EMERGENCY FMAP - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER:	102
IMPLEMENTATION DATE:	1/2020
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	2216

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$0	$0
STATE FUNDS	-$1,000,000	-$2,000,000
FEDERAL FUNDS	$1,000,000	$2,000,000

DESCRIPTION

Purpose:
This policy change estimates the increase in the administrative Title XXI federal financial participation (FFP) related to the coronavirus disease 2019 (COVID-19) for the Department.

Authority:
Families First Coronavirus Response Act (FFCRA)
The Coronavirus Aid, Relief, and Economic Security (CARES) Act

Interdependent Policy Changes:
Not Applicable

Background:
On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing pandemic of COVID-19. A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency on January 31, 2020, and a national emergency on March 13, 2020. These actions triggered the availability of Medicaid and Children's Health Insurance Program flexibilities, including under Section 1135 of the Social Security Act. Additionally, the President signed major federal legislation, including the Families First Coronavirus Response Act (FFCRA) and the CARES Act that provide emergency federal funding in Medicaid and creates new options for states to address the COVID-19 pandemic.

The increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the Health and Human Services COVID-19 national public health emergency. National public head emergencies are effective for 90 days unless extended or terminated. The Secretary of the Health and Human Services extended the COVID-19 national public health emergency on April 21, 2020.

Reason for Change:
This is a new policy change.

Methodology:

1. A CHIP FMAP increase of 4.34% is applicable on CHIP expenditures, including CHIP Administration expenditures.

2. The emergency FMAP is assumed to continue to June 30, 2021.

3. The following estimates are on a cash basis.

COVID-19 EMERGENCY FMAP - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 102

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2019-20	$0	($1,000)	$1,000
FY 2020-21	$0	($2,000)	$2,000

Funding:
Title XXI GF (4260-113-0001)
Title XXI FF (4260-113-0890)

RECONCILIATION

OTHER ADMIN. POLICY CHANGE NUMBER:	103
IMPLEMENTATION DATE:	7/2020
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	2096

	FY 2019-20	FY 2020-21
TOTAL FUNDS	$0	-$13,942,000
STATE FUNDS	$0	-$9,374,000
FEDERAL FUNDS	$0	-$4,568,000

DESCRIPTION

Purpose: This policy change reconciles the May 2020 Medi-Cal Estimate to the Budget Act of 2020.

This adjustment includes a -$13,942,000 TF adjustment to balance to the Budget Act of 2020.

FY 2020-21	TF	GF	FF
Adjustment	$ (13,942,000)	$ (9,374,000)	$ (4,568,000)

TABLE OF CONTENTS

ADDITIONAL INFORMATION

The Additional Information section provides supplemental information in support of the Medi-Cal Local Assistance Estimate.

MEDI-CAL INFORMATION ONLY 1-57

INTRODUCTION 1
FEE-FOR-SERVICE BASE ESTIMATES 1-2
FEE-FOR-SERVICE SERVICE CATEGORIES 2-5
AFFORDABLE CARE ACT 5
HOME AND COMMUNITY BASED SERVICES 6-15
1115 WAIVER-MH/UCD, BTR, & MEDI-CAL 2020 16-17
MANAGED CARE 18-20
PROVIDER RATES 21-23

INFORMATION ONLY 24-36
REVENUES 24
ELIGIBILITY 26-28
AFFORDABLE CARE ACT 28
BENEFITS 29-30
HOME AND COMMUNITY-BASED SERVICES 30
BREAST AND CERVICAL CANCER TREATMENT 30
PHARMACY 30-32
DRUG MEDI-CAL 32-33
MENTAL HEALTH 33-34
1115 WAIVER-MH/UCD, BTR/WAIVER 2020 34-35
MANAGED CARE 35
PROVIDER RATES 35
SUPPLEMENTAL PAYMENTS 36

OTHER 37-52
AUDITS AND LAWSUITS 37-49
REIMBURSEMENTS 49-50
RECOVERIES 50-51
MISCELLANEOUS 51-52

FISCAL INTERMEDIARY 52-54
MEDICAL 52-53
HEALTH CARE OPTIONS 53
DENTAL 53-54

DISCONTINUED POLICY CHANGES 55-57
FULLY INCORPORATED INTO BASE DATA 55
TIME LIMITED/NO LONGER AVAILABLE 56
WITHDRAWN 57

MEDI-CAL INFORMATION ONLY
May 2020
FISCAL YEARS 2019-20 & 2020-21

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:

USERS	=	f(TND, S.QV, O.QV, Eligibles)
CLAIMS/USER	=	f(TND, S.QV, O.QV)
$/CLAIM	=	f(TND, S.QV, O.QV)

WHERE:

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

Following the estimation of coefficients for these variables during the period of historical data, the independent variables are extended into the projection period and multiplied by the appropriate coefficients. The monthly values for users, units/user and dollars/unit are then multiplied together to arrive at the monthly dollar estimates and summed to annual totals by service and aid category.

FEE-FOR-SERVICE SERVICE CATEGORIES

Medi-Cal categorizes providers into Provider Types. For estimating purposes, the Medi-Cal Estimate groups these provider types into 11 Service Categories. This information is provided below.

Note: The Fee-For-Service delivery system includes the cost of care for those eligibles in the FFS delivery system, it also includes costs for items excluded in the Managed Care delivery model capitation.

Physicians

- Physicians
- Physician Group

Other Medical

- Audiologist
- Certified Nurse Midwife
- Chiropractor
- Certified Pediatric/Family Nurse Practitioner
- Clinical Laboratory
- Group Pediatric/Family Nurse Practitioner
- Nurse Anesthetist
- Occupational Therapist
- Optometrist
- Optometric Group
- Physical Therapist
- Podiatrist
- Psychologist
- Certified Acupuncturist
- Rural Health Clinic & FQHC
- Employer/Employee Clinic
- Speech Therapist
- Free Clinic
- Community Clinic
- Chronic Dialysis Clinic
- Multispecialty Clinic
- Surgical Clinic
- Exempt From Licensure Clinic
- Rehabilitation Clinics
- County Clinic Not Associate With A Hospital
- Birthing Centers-Primary Care Clinic
- Clinic-Otherwise Undesignated
- Outpatient Heroin Detox Center
- Alternative Birthing Center
- Respiratory Care Practitioner
- Health Access Program (Formerly Family PACT)
- Group Respiratory Care Practitioner
- Indian Health Services (MOU)
- Licensed Midwife

County and Community Outpatient

- County Hospital Outpatient
- Community Hospital Outpatient

Pharmacy
- Pharmacies or Pharmacists

County Inpatient
- County Hospital Inpatient
- Consists of Designated Public Hospitals. The Designated Public Hospitals are paid based on an interim per diem rate utilizing Certified Public Expenditures. DPH payments are 100% federal funds and the DPH pays the State's match. More information is available at the Department's website (www.dhcs.ca.gov).

Community Inpatient
- Community Hospital Inpatient
- Consists of Non-Designated Public Hospitals, Private Hospitals, and some Designated Public Hospitals. The Non-Designated Public Hospitals and Private Hospitals are paid using a Diagnosis Related Group payment methodology. The Designated Public Hospitals are paid based on an interim per diem rate utilizing Certified Public Expenditures. DPH payments are 100% federal funds and the DPH pays the State's match. More information is available at the Department's website (www.dhcs.ca.gov).

Nursing Facilities
- Long Term Care Nursing Facility
- Long Term Care Intermediate Care Facility (NF-A)
- Pediatric Subacute Care – Long Term Care
- These three provider types include Nursing Facility - Level A (NF-A), Nursing Facility – Level B (NF-B), Distinct Part Skilled Nursing Facilities of General Acute Care Hospitals (DP/NF-Bs), Distinct Part Adult Subacute Units for General Acute Care Hospitals (DP/SA), Rural Swing Beds, Institution for Mental Diseases, Acute and Transitional Inpatient Care Administrative Days (Administrative Days Level 1)

ICF-DD
- Long Term Care Intermediate Care Facility/Developmentally Disabled

Medical Transportation
- Ground Medical Transportation
- Air Ambulance Transportation

Other Services

- Adult Day Health Care Center
- Assistive Device & Sick Room Supply Dealers
- Blood Banks
- Fabricating Optical Laboratory
- Optometric Supplies
- Hearing Aid Dispensers
- Home Health Agency -Home & Comm. Based Services
- Optometric Supplies (from Dispensing Opticians, Optometrists, Optometric Group)
- Orthotists
- Optometric Supplies
- Portable X-Ray
- Prosthetists
- Genetic Disease Testing
- Medicare Crossover Provider Only
- Certified Hospice Service
- Local Education Agency
- EPSDT Supplemental Services Provider
- HCBS Congregate Living Health Facility
- HCBS Personal Care Agency
- RVN Individual Nurse Provider
- HCBS Professional Corporation
- AIDS Waiver Provider
- Multipurpose Senior Services Program
- CCS/GHPP Non-Institutional
- Independent Diagnostic Center (Medicare Crossover Provider Only)
- ALWPP Residential Care Facility for the Elderly
- ALWPP Care Coordinator
- HCBS Private Non-Profit Proprietary Agency
- Clinical Nurse Specialist (Medicare Crossover Provider Only)

Home Health

- Home Health Agency (except Home & Community Based Services)

Effective January 1, 2014, the Affordable Care Act (ACA) establishes 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 Affordable Care Act (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 Federal Financial Participation (FFP) at the following rates:

- 100% FFP from calendar years 2014 to 2016,
- 95% FFP in 2017,
- 94% FFP in 2018,
- 93% FFP in 2019,
- 90% FFP in 2020 and beyond.

For those who are currently eligible, but not enrolled in Medi-Cal, enhanced FFP will not be available. Beginning in October 2015, the ACA increased the Children's Health Insurance Program (CHIP) Federal Medical Assistance Percentage provided to California by 23 percent, to 88 percent FFP, up from 65 percent.

In response to the federal ACA mandate and State legislative direction, the Department chose the Health and Human Services Secretary-approved plan option, which allows the Department to seek approval for the same full scope Medi-Cal benefits received by existing beneficiaries. This option requires the selection of a private market reference plan to define the Essential Health Benefits (EHB) offered in the Alternative Benefit Plan (ABP).

The Standard Blue Cross/Blue Shield PPO (FEHB) Plan was selected as the EHB reference plan, as it allows the Department to provide an ABP package that most closely reflects existing State Plan benefits and thereby avoids disparity between the benefits received by new and existing beneficiaries.

HOME AND COMMUNITY BASED SERVICES

Long-Term Care Alternatives

Medi-Cal includes various Long-Term Services and Supports (LTSS) that allow medically needy, frail 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

HOME AND COMMUNITY BASED SERVICES

1915(i) HCBS State Plan Services

The 1915(i) State Plan Services program provides home and community-based services (HCBS) to persons with developmental disabilities (DD) who are Regional Center consumers but do not meet nursing facility level of care criteria required for enrollment in the HCBS Waiver of Persons with DD. As of February 1, 2016, Behavioral Health Treatment (BHT) services for 1915(i) participants under the age of 21 is a state plan benefit and paid through the managed care delivery system or fee-for-service for members not eligible to enroll into managed care. The 1915(i) State Plan Amendment (SPA) was approved from October 1, 2011 through September 30, 2016. The Department initiated the 1915(i) renewal process by submitting a SPA renewal to **the Centers for Medicare and Medicaid Services (**CMS**)** in May 2016, which became effective on October 1, 2016.

The DD rate increase, as outlined in ABx2 1, was chaptered in October 2015. The Department and the **California Department of Developmental Services (**CDDS**)** submitted a SPA reflecting the rate changes. CMS approved the SPA on September 29, 2016 with a July 1, 2016 effective date. Rate increases include several different increase models including a 5% rate increase on services and survey based increases on wages.

The Department submitted a SPA to update the service specifications for respite care as required by CMS' companion letter to:

- Remove group-supported employment and specialized therapeutic services,
- Add housing access, family support, occupational therapy, physical therapy, and family/consumer training services, and
- Add Enhanced Behavioral Supports Home (EBSH) as a new setting for habilitation-community living arrangement services.

This amendment also established reimbursement methodologies for EBSH and incentive payments for individual supported employment providers, effective July 1, 2018.

The Department submitted a SPA to add the following:

- Community Crisis as a provider type under Behavioral Intervention Services,
- Categorically and medically needy limits, and
- The associated rate methodology.

The approved effective date was October 2, 2018.

The Department submitted a SPA to make changes to the reimbursement methodology to implement a one-year rate increase for certain services in high cost counties. ~~The SPA has an approved effective date of~~ **CMS approved the SPA, effective** May 1, 2019.

The Department will submit a SPA to increase reimbursement rates for specified service providers for the period of January 1, 2020, to December 31, 2021, as authorized under W&I Code section 4691.12. The proposed effective date of the SPA is January 1, 2020.

HOME AND COMMUNITY BASED SERVICES

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 Alternatives (HCBA), Multipurpose Senior Services Program (MSSP), HCBS Waiver for Persons with DD, and Self-Determination Program (SDP) Waiver for Persons with DD. A beneficiary may be enrolled in only one HCBS waiver at a time. If a beneficiary is eligible for services from more than one waiver, the beneficiary may choose the waiver that is best suited to his or her needs.

Assisted Living Waiver (ALW)

The ALW pays for assisted services and supports, care coordination, and community transition in 15 counties (Sacramento, San Joaquin, Los Angeles, Riverside, Sonoma, Fresno, San Bernardino, Alameda, Contra Costa, San Diego, Kern, San Mateo, San Francisco, Santa Clara and Orange). Waiver participants can elect to receive services in a Residential Care Facility for the Elderly (RCFE), an Adult Residential Facility (ARF) or through a home health agency while residing in publicly subsidized housing. Approved capacity 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 amended the ALW and authorized funding to add an additional 2,000 slots effective July 1, 2018. CMS approved a renewal of the ALW on February 28, 2019 effective from March 1, 2019 to February 28, 2024.

The Department will be assessing the ALW for integration in the HCBA Waiver.

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

HOME AND COMMUNITY BASED SERVICES

December 30, 2015, for five years. CBAS continues to be a waiver benefit under this new waiver until December 31, 2020. There is no cap on enrollment into this service.

The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), passed by the voters in November 2016, increases the excise tax rate on cigarettes and electronic cigarettes, effective April 1, 2017, and other tobacco products effective July 1, 2017. The excise tax increased by $2 from $.87 cents to $2.87 per pack of 20 cigarettes on distributors selling cigarettes in California with an equivalent excise tax rate increase on other tobacco products.

Pursuant to the Budget Act of 2019, the Department shall develop the structure and parameters for supplemental payments for CBAS in FY 2019-20.

Home and Community-Based Alternatives (HCBA) Waiver

The HCBA Waiver provides Medi-Cal members with long-term medical conditions, who meet the adult or pediatric acute hospital, subacute, or nursing facility (NF) Level of Care (LOC), with the option of returning to and/or remaining in their home or home-like setting in the community in lieu of institutionalization. The Department contracts with Waiver Agencies for the purpose of performing waiver administration functions and providing the Comprehensive Care Management waiver service. The Waiver Agencies are responsible for functions including: participant enrollment, LOC evaluations, person-centered care/service plan review and approval, waiver service authorization, utilization management, provider enrollment/network development, quality assurance activities and reporting to the Department.

The Department will maintain an active role in the waiver administration by determining all waiver participant eligibility, setting enrollment goals, and providing continuous, ongoing monitoring and oversight. The Department received approval of the HCBA Waiver on May 16, 2017 with a January 1, 2017 effective date. The Department implemented the Waiver Agency model on July 1, 2018. The HCBA Waiver will serve up to 8,964 participants by the end of the 5-year waiver term. ~~By~~ **On** October 1, 2019, the Department ~~will submit~~ **submitted** an amendment to the HCBA Waiver to CMS for approval in order to modify waiver enrollment policy prioritizing all eligible individuals under the age of 21 for intake processing and increase the number of waiver slots allocated for reserved capacity enrollment in years four and five. Reserved capacity waiver slots may only be used by specific groups of individuals, as identified in the HCBA Waiver. **CMS approved the amendment, effective January 1, 2020.** Additionally, the Department will be assessing integration of the ALW into the HCBA Waiver during the next HCBA Waiver renewal.

In-Home Operations (IHO) Waiver

The IHO waiver serve~~s~~**d** 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 HCBA Waiver, for the participant's assessed LOC. CMS approved the IHO

HOME AND COMMUNITY BASED SERVICES

waiver renewal from January 1, 2015 through December 31, 2019. The Department ~~will~~ **did** 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~~ **offered** the option of transitioning to the HCBA Waiver. All IHO Waiver participants ~~will be~~ **were** given sufficient notice of the waiver expiration and provided options to transition prior to the expiration of the IHO Waiver.

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 **for the period of January 1, 2017 to December 31, 2021**.

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. 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.

Multipurpose Senior Services Program (MSSP) Waiver

HOME AND COMMUNITY BASED SERVICES

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 sooner than January 1, 2020 in 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 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 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. CMS approved the amendment on April 27, 2017, with an effective date of July 1, 2016. The Department submitted a Waiver Renewal application on March 28, 2019. The MSSP Waiver ended on June 30, 2019, and CMS approved a 90-day Temporary Extension in order to resolve CMS questions related to the Renewal application. **The Department responded to all requests for additional information, and CMS approved and renewed the MSSP Waiver on November 1, 2019 for an additional five-year term, effective July 1, 2019.**

Under ~~the Centers for Medicare and Medicaid Services~~ **CMS** approval to carve out MSSP from the CCI, the MSSP benefit will be removed effective January 1, 2021.

In 2019, AB 74 **(Chapter 23, Statutes of 2019)** was approved, which provides a one-time-only supplemental funding for expenditure over a three-year period. The supplemental funding will fund waiver care management and care management support payments.

HOME AND COMMUNITY BASED SERVICES

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 developmentally disabled; in California, Intermediate Care Facility/Developmentally Disabled-type facilities, or a State Developmental Center. As of February 1, 2016, ~~Behavioral Health Treatment (~~BHT~~)~~ services for Waiver participants under the age of 21 is a state plan benefit paid through fee-for-service or the managed care delivery system.

The Department submitted a renewal application to CMS on December 22, 2016 and received approval on December 7, 2017. Approved capacity of unduplicated recipients for this waiver is 130,000 in 2018, 135,000 in 2019, 140,000 in 2020, 145,000 in 2021, and 150,000 in 2022. The waiver is approved from January 1, 2018 through December 31, 2022.

The DD rate increase, as outlined in ABx2 1, was chaptered in October 2015. The Department and CDDS submitted a SPA reflecting the rate changes, retroactive to July 1, 2016.

The Department submitted a Waiver Amendment to reflect a rate increase to Home Health Aide and Skilled Nursing Services to align them with increases to Medi-Cal, as authorized by the 2018 Budget Act. The appropriation in the 2018 Budget Act will be applied to increase the payment rates for certified Home Health Aides, Licensed Vocational Nurses, and Registered Nurses. This does not result in a change to the rate methodology. The Amendment was approved with an effective date of July 1, 2018.

The Department submitted a Waiver Amendment to provide time limited rate increases in specific geographic areas for providers of Community-Based Day Services, In-Home Respite Agencies, and providers of Community Living Arrangement Services under the Alternative Residential Model. This amendment also includes Community Crisis Homes as a new provider type under Behavioral Intervention Services, adds Community Based Adult Services as a new waiver service, and adds Adult Day Health Care Center as a provider type under Community Based Adult Services. The approved effective date is May 1, 2019.

The Department ~~intends to submit~~ **submitted** an additional Waiver Amendment~~. The amendment will be submitted~~ as a result of SB 81~~,~~ **(**Chapter 28, Statutes of 2019**)**, which provides the ~~Department of Developmental Services (DDS)~~ **CDDS** with time-limited funding to provide supplemental rate increases for specified services, effective January 1, 2020 through December 31, 2021. **The amendment was approved with an effective date of January 1, 2020.**

The Department submitted a Waiver Amendment to add State-Operated Mobile Crisis Team as a provider type under Behavioral Intervention Services. The amendment also adds rate methodologies for specified provider types under Behavior Intervention Services and Community Living Arrangement Services. The proposed effective date is February 1, 2020.

HOME AND COMMUNITY BASED SERVICES

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. CMS approved this waiver on June 6, 2018, with an effective date of July 1, 2018. This waiver is for a three-year period, ending June 30, 2021. The State may renew the waiver at the end of the initial three-year period by providing evidence and documentation of satisfactory performance and oversight.

As of February 1, 2016, ~~Behavioral Health Treatment (~~BHT~~)~~ services for Waiver participants under the age of 21 is a state plan benefit and paid through fee-for-service, or the managed care delivery system.

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~~ **CMS** awarded the Department a grant for the Money Follows the Person Rebalancing Demonstration Grant, called California Community Transitions. This grant is authorized under section 6071 of the federal Deficit Reduction Act of 2005, and was extended by the Patient Protection and Affordable Care Act of 2010 ~~and the Medicaid Extenders Act of 2019. Grant funds may be requested from January 1, 2007, through September 30, 2021~~. **On January 24, 2019, the Medicaid Extenders Act of 2019 was signed and authorized MFP state grantees to continue to transition eligibles through December 31, 2019, using available MFP funding. The Extenders Act provided CMS with the authority to allocate new funding to state grantees for calendar year 2019, to allow funding appropriated through the Extenders Act to be spent through 2023.**

On August 6, 2019, the Sustaining Excellence in Medicaid Act of 2019 was signed and appropriated additional federal funds for allocation to MFP state grantees.

On December 20, 2019, the Further Consolidated Appropriations Act, 2020 amended the DRA of 2005 to extended the term of the MFP grant by five months, from January 1, 2020 to May 22, 2020. 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~~ **April** 1, 2020 to ensure sufficient time to bill post transition period claims and perform grant close-out functions.

1115 WAIVER-MH/UCD, BTR, & MEDI-CAL 2020

The Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD) ended on October 31, 2010, and the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) ended on December 31, 2015. The Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020) was approved effective January 1, 2016, for five years.

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. The PRIME program, as currently approved by **the Centers for Medicare and Medicaid Services (**CMS**)** ends June 30, 2020 (PY 5). On June 30, 2019, ~~as part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative,~~ the Department requested federal approval to implement two new Managed Care Quality Incentive Directed Payment Programs for DPHs and DMPHs for the period of July 1, 2020 through December 31, 2020. The new programs will be separate and distinct from the existing PRIME program. The goal of the new programs is to enable hospitals to continue quality improvement efforts that have been underway at all 52 PRIME entities after PRIME expires on June 30, 2020. This transition will promote value-based purchasing and ties funding to quality outcomes. Additionally, the Department proposes to align PRIME entities' transition to the Quality Incentive Program with California's transition to the calendar year (CY) rating period for Medi-Cal managed care plans beginning in CY 2021.

- Global Payment Program (GPP) – 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

1115 WAIVER-MH/UCD, BTR, & MEDI-CAL 2020

uninsured through a value-based payment structure that rewards the provision of care in more appropriate settings. This new and innovative approach to restructuring these traditional hospital-focused funds allows California to better target funding for the remaining uninsured and incentivize delivery system change – focusing on the provision of primary and preventive care, and shifting away from avoidable emergency room and hospital utilization. The federal funding for GPP will be a combination of the DSH funding for participating DPHs and $236 million in federal funding for the first year from the prior **Safety Net Care Pool (**SNCP**)**. The non-DSH funding for years two through five will continue to be $236 million in federal funding.

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

- Whole Person Care (WPC) Pilots – Another innovative component of Medi-Cal 2020 will allow 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~~ **Affordable Care Act** Optional Expansion (ACA OE) COAs.

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

Risk adjustment is performed using the Medicaid RX risk adjustment 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, SPD, 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.

The State implemented a one-time 18-month rating period for medical managed care for the period of July 1, 2019 through December 31, 2020 to aid in future prospective rate development as federally required. Beginning in CY 2021, rates will be developed annually on a calendar year basis thereafter.

~~As part of the CalAIM initiative, beginning January 1, 2021, the Department proposes to shift the development of Medi-Cal managed care plan rates from a county-based model to a regional rate model. The proposal to move to regional rates has two main benefits. The first benefit is a decreased number of distinct actuarial rating cells that are required and submitted to the Centers for Medicare and Medicaid Services (CMS) for review and approval. The reduction in rating cells will simplify the presentation of rates to CMS with a goal of allowing the Department to pursue/implement financing advancements and innovations utilizing a more flexible rate~~

MANAGED CARE

~~model. The second benefit of regional rates will allow cost averaging across all plans. This will continue to incentivize plan cost efficiencies, as plan rates will be inclusive of the costs within the multi-county region. This shift will produce a larger base for averaging rather than just the experience of plans within the county. This change is fundamental to the ability of the Department to implement the other changes proposed in CalAIM.~~

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 Managed Care Organization (MCO) Enrollment Tax is effective July 1, 2016 through June 30, 2019.

Specific Federal Requirements:

Full-risk Medi-Cal managed care health plans (MCP) contracts establish a risk corridor pertaining to Medical Loss Ratio (MLR) for ~~ACA Optional Expansion (ACA OE)~~ **ACA OE** members, for the incurred periods of January 1, 2014, through June 30, 2015, and July 1, 2015, through June 30, 2016. For this period, MCPs who do not expend at least 85% of net capitation payments received for ACA OE members on allowed medical expenses for ACA OE members, for each county or region. An MCP which does not meet the minimum 85% threshold for a given county or region must return the difference between 85% of total net capitation payments and actual allowed medical expenses to the Department. If an MCP's MLR exceeds 95% of total net capitation payments, then the Department must make additional payment to the MCP equal to the difference between the MCP's allowed medical expenses and 95% of net capitation payments.

CMS would not approve the state's ACA OE FY 2016-17 and FY 2017-18 rates without the extension of the ACA OE MLR risk corridor through the FY 2016-17 and FY 2017-18 rating periods. The ACA OE MLR risk corridor for FY 2016-17 has been contractually established between the Department and MCPs. The Department is working on establishing the FY 2017-18 ACA OE MLR risk corridor contractual requirement and is working closely with CMS to determine whether future rating periods will require the extension of the ACA OE MLR risk corridor.

Coordinated Care Initiative (CCI) Program

The 2017 Budget Act discontinued the CCI program, effective January 1, 2018. Based on the lessons learned from the CCI demonstration project, the 2017 Budget extended the Cal MediConnect (CMC) program and the mandatory enrollment of dual eligible beneficiaries and the integration of long-term services and supports, except In-Home Supportive Services (IHSS), into managed care. IHSS was removed from capitation rate payments effective January 1, 2018.

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.

Extended File Correction

In 2018, the Department created and ran an extended file in the CAPMAN system to provide enrollment and disenrollment information beyond the standard 13 months of information that CAPMAN receives to run the monthly capitation process. Creating the extended file allowed for the correction of the rates and funding issues associated with Dual Beneficiaries in Adult Expansion Aid Codes and Hyde rates for service months back to January 2014. However, there was a technical issue with the file build and some beneficiaries were not accurately picked up. The Department is currently working on a new extended file to correct this issue and once completed and verified the file will be processed through the CAPMAN system. This will create the proper enrollments and disenrollments back to January 2014, and recoup or pay out the appropriate funds for the beneficiaries. Timing for completion and processing of the new extended file, as well as costs associated with the correction, are unknown at this time.

~~**CalAIM – Managed Care Benefits and Enrollment Standardization**~~

~~The California Advancing and Innovating Medi-Cal (CalAIM) initiative seeks to move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility by standardizing the benefits provided across all Plan Model types and counties as well as require mandatory managed care enrollment for all populations except those that have limited scope of benefits or those enrolled in managed care for a limited time.~~

~~Standardizing the benefits and the populations across the State will reduce the complexity by implementing administrative and financial efficiencies as well as reduce county by county differences. Further, standardizing benefits will ensure continuity of care without burdening beneficiaries with transitioning from one delivery system to another.~~

~~Standardization of benefits will occur on January 1, 2021. The Phase in/out of managed care members will occur in two phases: January 1, 2021, and January 1, 2023, depending upon Medicare status.~~

PROVIDER RATES

Reimbursement Methodology and the Quality Assurance Fee for AB 1629 Facilities

AB 1629 (Chapter 875, Statutes of 2004) requires the Department to develop a cost-based, facility-specific reimbursement rate methodology for Freestanding Nursing Facility Level-Bs (FS/NF-Bs), including Freestanding Subacute Nursing Facility, Level Bs (FSSA/NF-Bs). Rates are updated annually and are established based on the most recent audited cost report data. AB 1629 also imposed a Quality Assurance Fee (QAF) on these facilities and added requirements for discharge planning and assistance with community transitions.

The rate methodology developed by the Department computes facility-specific, cost-based per diem payments for FS/NF-Bs and FSSA/NF-Bs based on five cost categories, which are subject to limits. Limits are set based on expenditures within geographic peer groups. Also, costs specific to one category may not be shifted to another cost category.

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

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

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

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

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

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

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 (QASP) Program

SB 853 (Chapter 717, Statutes of 2010) requires the Department to implement a Quality and Accountability Supplemental Payment ~~(QASP)~~ Program for FS/NF-Bs and FSSA/NF-B facilities by August 1, 2010. The QASP Program will enable the reimbursement for these facilities to be tied to demonstrated quality of care improvements for ~~SNF~~ **skilled nursing facility** residents. AB 1489 (Chapter 631, Statutes of 2012) delayed the payments and required the Department to make the payments by April 30, 2014.

AB 119 (Chapter 17, Statutes of 2015) extends the AB 1629 facility-specific rate methodology, 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.

With the current AB 1629 program set to expire on July 31, 2020, the Budget proposes to extend and modify the current rate methodology. The proposal would continue to provide annual rate increases, but they would vary by year and the allocation of those increases will put a greater emphasis on value and quality of care over cost. The proposed methodology would extend the current QAF program and would provide the Department with additional authorities to collect delinquent QAF.

The proposal would also change the rate year from an August 1 start date to a January 1 start date beginning in January 2021 to align with the managed care rate year. Starting January 2022 would also replace the current QASP program with a new quality per diem add-on framework available to all facilities if they meet established quality metrics and benchmarks. Other features of the proposal include updating peer groups, increasing the percentile cap for direct labor from the 90th percentile to the 95th percentile, and exempting Freestanding Pediatric Subacute facilities from paying QAF.

Reimbursement Methodology for Other Long-Term Care Facilities (non-AB 1629)

The reimbursement methodology is based on a prospective flat-rate system, with facilities divided into peer groups by licensure, level of care, bed size and geographic area in some cases. Rates for each category are determined based on data obtained from each facility's annual or fiscal period closing cost report. Audits conducted by the Department result in adjustments to the cost reports on an individual or peer-group basis. Adjusted costs are segregated into four categories:

Fixed Costs (Typically 10.5 percent of total costs). Fixed costs are relatively constant from year to year, and therefore are not updated. Fixed costs include interest on loans, depreciation, leasehold improvements and rent.

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

PROVIDER RATES

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

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

Methodology by Type of LTC Facility

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

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

Intermediate Care Facilities for the Developmentally Disabled, Developmentally Disabled-Habilitative, and Developmentally Disabled-Nursing (ICF/DD, ICF/DD-H, ICF/DD-N) are peer grouped by level of care and bed size. Effective 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 65th percentile established in 2008-2009, with none receiving a rate lower than 90% of the 2008-2009 65th 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~~ **during** the 2008-09 rate year, increased by 3.7%.

The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) revenue provided a funding source for supplemental payments to ICF/DD facilities. AB 120 (Chapter 22, Statutes of 2017) appropriated said funds for supplemental payments to ICF/DDs in the 2017-18 Rate Year. The Budget Act of 2018 allows for the continuation of the Proposition 56 funding, which will extend the ICF/DD supplemental payments by one year.

Subacute Care Facilities are grouped into two statewide peer groups: hospital-based providers and freestanding nursing facility providers. Subacute care providers are reimbursed their projected costs up to the median of their peer group.

Pediatric Subacute Care Units/Facilities are grouped into two peer groups: hospital-based nursing facility providers (Distinct Part Pediatric Subacute (DP/PSA) facilities) and Freestanding Pediatric Subacute (FS/PSA) facilities. There are different rates for ventilator and non-ventilator patients. Reimbursement is based on a model since historical cost data were not previously available.

INFORMATION ONLY

REVENUES

1. Revenues

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

FY 2019-20:	~~$25,660,000~~ **$26,247,000**	ICF-DD Quality Assurance Fee
	~~$503,433,000~~ **$505,285,000**	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	~~$9,750,000~~ **$9,612,000**	ICF-DD Transportation/Day Care Quality Assurance Fee
	~~$1,219,000~~ **$1,224,000**	Freestanding Pediatric Subacute Quality Assurance Fee
	$1,031,357,000	**MCO Enrollment Tax (Item 4260-601-3334)**
	~~$4,330,352,000~~ **$4,378,368,000**	Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
	~~$5,929,000~~ **$6,682,000**	Emergency Medical Air Transportation (EMATA) Fund (Item 4260-101-3168)
	~~$75,365,000~~ **$77,055,000**	Medi-Cal Emergency Medical Transport (MEMTF) (Item 4260-601-3323)
	~~$1,355,795,000~~ **$1,534,427,000**	Medi-Cal Drug Rebates Fund (Item 4260-601-3331)
	~~$6,307,503,000~~ **$7,570,257,000**	Total
FY 2020-21:	~~$26,733,000~~ **$27,110,000**	ICF-DD Quality Assurance Fee
	~~$503,433,000~~ **$505,285,000**	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	~~$9,750,000~~ **$9,612,000**	ICF-DD Transportation/Day Care Quality Assurance Fee
	~~$1,219,000~~ **$1,224,000**	Freestanding Pediatric Subacute Quality Assurance Fee
	$2,317,734,000	**MCO Enrollment Tax (Item 4260-601-3334)**
	~~$3,633,072,000~~ **$4,574,430,000**	Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
	~~$5,188,000~~ **$5,011,000**	Emergency Medical Air Transportation (EMATA) Fund (Item 4260-101-3168)
	~~$77,348,000~~ **$80,177,000**	Medi-Cal Emergency Medical Transport (MEMTF) (Item 4260-601-3323)
	~~$1,496,885,000~~ **$1,474,013,000**	Medi-Cal Drug Rebates Fund (Item 4260-601-3331)
	~~$5,753,628,000~~ **$8,994,596,000**	Total

INFORMATION ONLY

Effective August 1, 2009, the Department expanded the amount of revenue upon which the quality assurance **(QA)** fee for AB 1629 facilities is assessed, to include Medicare.

Effective January 1, 2012, pursuant to ABX1 19 (Chapter 4, Statutes of 2011), the Department will implement a QA fee from Freestanding Pediatric Subacute Care facilities, pending ~~CMS~~ **Centers for Medicare and Medicaid Services** approval.

SBx2-2 (Chapter 2, Statutes of 2016) provides that the new tax will apply to the Medi-Cal revenue of most managed care plans in the state, with some exemptions. The new tax structure will meet federal requirements while achieving the same GF savings as the previous tax and also providing sufficient funding to restore the 7% reduction in the In-Home Supportive Services Program.

AB 1383 (Chapter 627, Statutes of 2009) authorized the implementation of a quality assurance fee on applicable general acute care hospitals. The fee is deposited into the Hospital Quality Assurance Revenue Fund (Item 4260-601-3158). This fund is used to provide supplemental payments to private and non-designated public hospitals, grants to designated public hospitals, and enhanced payments to managed health care and mental health plans. The fund is also used to pay for health care coverage for children, staff and related administrative expenses required to implement the **Quality Assurance Fee (**QAF**)** program. SB 90 (Chapter 19, Statutes of 2011) extended the hospital QAF through June 30, 2011. SB 90 also ties changes in hospital seismic safety standards to the enactment of a new hospital QAF that results in revenue for FY 2011-12 children's services of at least $320 million.

SB 335 (Chapter 286, Statues 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.

INFORMATION ONLY

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

ELIGIBILITY

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

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 uncodified language that the *Crespin* decision relied upon to make the current program available to eligible new applicants. Because the number of undocumented immigrants receiving State-only long-term care has not increased above the number in the 1999-00 base year, no fiscal impact is expected due to the spending limit.

INFORMATION ONLY

2. Refugee Resettlement Program

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

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

Under an approved State Plan Amendment, the Department may claim Federal Financial Participation (FFP) for full scope Medi-Cal services provided to eligible documented immigrants who are lawfully present in the United States if they are under 21 years of age or pregnant. This includes New Qualified Immigrants and other lawfully present immigrants as defined by the federal government. The Department has determined that some of these immigrants who are currently claimed at a 50/50 federal/state matching rate are eligible for a higher FFP matching rate (currently 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. Senate Bill 260 (Chapter 845, Statutes of 2019) – Covered California Automatic Enrollment

Senate Bill 260 (Chapter 845, Statutes of 2019) requires beginning no later than July 1, 2021, that Covered California automatically enroll individuals who transition from Medi-Cal and the State Children's Health Insurance Program into the lowest cost silver plan or their previous managed care plan before their current coverage ends. The Department is collaborating with Covered California to explore the timing of system implementation cost. The Department does not anticipate changes to the previous cost analysis.

5. **Confirm Inmate Eligibility to Federal Law**

The federal "Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act" requires the Department to implement indefinite Medi-Cal suspension for eligible incarcerated juveniles. Current federal law requires eligible juvenile inmates to no longer have time-limited suspensions of Medi-Cal benefits; therefore, California's current state law limit of one year for Medi-Cal suspensions must be changed for this population to conform to federal law. Implementation of this new policy, including system modifications, is anticipated to occur after October 1, 2020.

INFORMATION ONLY

6. **Minimum Essential Coverage - Increase in 1095-B Mailings**

Senate Bill 78 (Chapter 38, Statutes of 2019), Section (7), creates a Minimum Essential Coverage Individual Mandate which requires an individual who is a California resident to ensure that the individual, and any spouse or dependent of the individual, be enrolled in and maintain minimum essential coverage for each month beginning on and after January 1, 2020, except as specified. This bill requires the Department, which provides minimum essential coverage to individuals via Medi-Cal, to file specified returns to the Franchise Tax Board regarding that coverage, as prescribed by the Franchise Tax Board. The Department-provided Form 1095-B mailings to beneficiaries, documenting minimum essential coverage, may increase with undocumented populations based on Franchise Tax Board's definition of minimum essential coverage.

AFFORDABLE CARE ACT

1. Realignment

Under the Affordable Care Act, county costs and responsibilities for indigent care are expected to decrease as uninsured individuals obtain health coverage. The State, in turn will bear increased responsibility for providing care to these newly eligible individuals through the Medi-Cal expansion. The budget sets forth two mechanisms for determining county health care savings that, once determined, will be redirected to fund local human services programs. The 12 public hospital counties and the 12 non-public/non-County Medical Services Program counties have selected one of two mechanisms. Option 1 is a formula that measures health care costs and revenues for the public hospital county Medi-Cal and uninsured population and non-public/non-CMSP county indigent population. Option 2 is redirection of 60% of a county's health realignment allocation plus 60% of the maintenance of effort. Assembly Bill (AB) 85 (Chapter 24, Statutes of 2013) as amended by Senate Bill 98 (Chapter 358, Statutes of 2013) lays out the methodology for the formula in Option 1, and requires the department to perform the calculation. AB 85 also sets targets, and a process to meet the targets, for the number of newly eligible Medi-Cal enrollees who will be default assigned to County Public Hospital health systems as their managed care plan primary care provider. Public hospital health systems will be paid at least cost for their new Medi-Cal population.

The redirected amounts will be calculated by the Department, but will not be included in the Department's budget. Savings are estimated to be, ~~$980.7 million for FY 2015-16,~~ $897.5 million for FY 2016-17, ~~$688.8~~ **$989.7** million for FY 2017-18, $773.2 million for FY 2018-19, ~~and~~ $559.6 million for FY 2019-20, **and $589.8 million for FY 2020-21**.

INFORMATION ONLY

BENEFITS

1. Pompe Disease and ~~Hurler's Syndrome~~ **Mucopolysaccharidosis type I (MPSI)** Identified through Newborn Screening Program (NBS)

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

Children identified through the NBS Program as having, or at risk of having, ~~Hurler's Syndrome or~~ Pompe Disease **or MPS I** will require confirmatory testing/diagnostic studies, clinical/medical management, monitoring, and treatment. There could be a potential indeterminate cost impact to the program due to earlier detection and implementation of services.

2. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Child Health and Disability Prevention (CHDP) **program** administered by the state and counties ~~provide~~ **provides EPSDT** preventive health screening examinations (i.e., well child health assessments) and immunizations to **Medi-Cal eligible** children under 21 years of age ~~(EPSDT)~~ and **to** non-Medi-Cal eligible children ~~at or~~ under ~~18~~ **19** years of age whose family income was at or below 200% of the Federal Poverty Level (FPL).

In May 2016, the passage of SB 75 expanded Medi-Cal for all children, including the CHDP non-Medi-Cal population. All persons under ~~21~~ **19** years of age who were eligible for **state-only** CHDP services were shifted to full-scope Medi-Cal. For FY 2019-20, the few remaining CHDP screens are included in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy change.

3. Palliative Care Services Implementation

SB 1004 requires the Department to:

- Establish standards and provide technical assistance for Medi-Cal managed care plans to ensure delivery of palliative care services;
- Establish guidance on the medical conditions and prognoses that render a beneficiary eligible for the palliative care services;
- Develop a palliative care policy that, to the extent practicable, is cost neutral to the General Fund on an ongoing basis;
- Define palliative care services; and
- Provide access to curative care for beneficiaries eligible for palliative care.

INFORMATION ONLY

Services are available concurrently with curative care and care is provided through a coordinated interdisciplinary team.

HOME & COMMUNITY BASED-SERVICES

BREAST AND CERVICAL CANCER TREATMENT

PHARMACY

State Supplemental Drug Rebates – Managed Care

This assumption has been deleted as this has been withdrawn.

Pharmacy Reimbursement and Dispensing Fee Retroactive Adjustments

This assumption is now a policy change, Pharmacy Retroactive Adjustments

1. New High Cost Treatments for Specific Conditions

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

   Onasemnogene abeparvovec (Zolgensma) ~~is a one-time gene treatment, expected to be approved by the FDA this fiscal year as a potential curative treatment of spinal muscular atrophy type 1~~ **was approved by the Food and Drug Administration (FDA) on May 24, 2019, for children with spinal muscular atrophy aged less than two years with bi-allelic mutations in the survival motor neuron (SMN1) gene**.

   Tisagenlecleucel (Kymriah) is a one-time treatment for children and young adults up to 25 years of age with B-Cell acute lymphoblastic Leukemia that is refractory or twice elapsed after treatment. The therapy is administered in a single treatment and less expensive than some bone marrow transplants.

   Pegvaliase-pqpz (~~Palynzio~~ **Palynziq**) is a lifetime treatment, approved by the FDA on May 24, 2018 to treat Phenylketonuria adults who are unable to maintain phenylalanine levels (below 600 µmol/L) with current therapy.

   Cannabidiol (Epidiolex) is a lifetime treatment, approved by the FDA on June 25, 2018 to treat two rare forms of epilepsy, Lennox-Gastaut Syndrome and Dravet Syndrome, in patients older than 2 years of age.

   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 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

INFORMATION ONLY

complete blindness. There is no age restriction; however, there must be "viable retinal cells" remaining to treat.

2. Medi-Cal Monthly 6 Rx Limit and Fee-For-Service Drug Prescription Copays

The Department is seeking statutory changes to remove the Medi-Cal Fee-For-Service monthly six prescription limit that can be dispensed to a beneficiary without obtaining a Treatment Authorization Request to exceed the limit and eliminate the one dollar per prescription or refill copay. Specifically, the Department would sunset Welfare and Institutions (W&I) Code sections 14133.22 and 14134(a)(2) as of July 1, 2020, and would repeal them as of January 1, 2021.

3. **Non-Medi-Cal Rebates**

The Governor's Executive Order (EO) N-01-19 ordered the Department to consider additional options to maximize the State's bargaining power, including the Medi-Cal program, to reduce state's drug spending and more broadly promote access to affordable health care.

Currently the Medi-Cal program, under the federal Medicaid Drug Rebate Program, collects both federal and state supplemental drug rebates. Medi-Cal covers all drugs approved by the federal FDA, subject to medical necessity. The Department maintains the Medi-Cal Contract Drug List (CDL), which generally includes drugs for which there is a current state supplemental drug rebate agreement in place. To the extent there is no supplemental rebate agreement in place, the covered drug would be available subject to prior authorization establishing medical necessity.

Federal Centers for Medicare and Medicaid Services (CMS) policy guidance provides States an opportunity to seek Medicaid State Plan authorization to secure prescription drug benefits, rebates, or discounts for non-Medicaid populations by linking such benefits to a Medicaid prior authorization program. CMS guidance also indicates that states must demonstrate that inclusion of the targeted non-Medicaid populations further the goals and objectives of the Medicaid program, increases the efficiency and economy of the Medicaid program, and sufficiently benefits the Medicaid population as a whole.

The Department will seek CMS approval via a State Plan Amendment, or other applicable mechanism, leveraging the State's purchasing volume, to establish and administer a drug rebate program to collect rebate payments from drug manufacturers for drugs utilized by selected populations who are ineligible for full-scope Medi-Cal benefits.

INFORMATION ONLY

4. **Best Price**

The Governor's EO N-01-19 ordered the Department to consider additional options to maximize the state's bargaining power, inclusive of the Medi-Cal program, to reduce State's drug spending and more broadly promote access to affordable health care.

California Welfare and Institutions Code, section 14105.31(b) defines "Best Price" as, "the negotiated price, or the manufacturer's lowest price available to any class of trade organization or entity, including, but not limited to, wholesalers, retailers, hospitals, repackagers, providers, or governmental entities within the United States, that contracts with a manufacturer for a specified price for drugs, inclusive of cash discounts, free goods, volume discounts, rebates, and on- or off-invoice discounts or credits, shall be based upon the manufacturer's commonly used retail package sizes for the drug sold by wholesalers to retail pharmacies." Federal law has a similar definition of Best Price (Social Security Act Section 1927(c)(i)(C)), that limits prices to those within the United States. These federal and state statutory authorities guarantee California's Medi-Cal program the lowest drug price that any manufacturer offers to any entity in the US. The Department is seeking to strike the limitation to prices within the United States, thus allowing the Department to negotiate Medi-Cal drug rebate contracts based on global drug prices.

DRUG MEDI-CAL

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.

2. Residential Treatment Services (RTS) EPSDT Rates

Effective July 1, 2018, the Department added RTS rate for EPSDT clients under the Drug Medi-Cal State Plan services. RTS provides rehabilitation services to beneficiaries with substance use disorder diagnosis in a non-medical residential setting. Due to the limited number of licensed residential facilities that are certified to provide services to EPSDT beneficiaries, it is unknown if there will be utilization for these services.

3. Substance Use Disorder Managed Care Program Renewal and Policy Improvements

The Department proposes to incorporate the Drug Medi-Cal Organized Delivery System (also known as substance use disorder managed care) into a comprehensive Section 1915(b) waiver that would include the Medi-Cal managed care plans, mental health

INFORMATION ONLY

managed care plans, and substance use disorder managed care plans. The expenditure authority for residential treatment provided in an Institution for Mental Disease will continue to be authorized through Section 1115 waiver authority. The Department also intends to provide counties with another opportunity to opt-in to participate in the substance use disorder managed care program in hopes of promoting statewideness. Finally, the Department is exploring opportunities to improve the substance use disorder managed care program based on experience from the first several years of implementation. Accordingly, the Department proposes clarifying or changing policies to support the goal of improved beneficiary care and administrative efficiency.

MENTAL HEALTH

Behavioral Health (BH) Payment Reform
This assumption has been deleted as it has been withdrawn.

BH Medical Necessity
This assumption has been deleted as it has been withdrawn.

BH Admin Integration
This assumption has been deleted as it has been withdrawn.

SMI SED / IMD Waiver
This assumption has been deleted as it has been withdrawn.

BH Regional Contracting
This assumption has been deleted as it 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~~

INFORMATION ONLY

~~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

Medi-Cal 2020 Designated State Health Program
This assumption has been deleted as it is now a new policy change.

1. Waiver 2020 Negative Balance and Deferral Repayment

The Special Terms and Conditions (STC) of the California Medi-Cal 2020 Demonstration Waiver (Medi-Cal 2020) requires California's resolution of all existing negative Payment Management System (PMS) subaccount balances and deferred claims.

- Negative PMS subaccount 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 the Centers for Medicare and Medicaid Services (CMS) continue to actively work toward the resolution of these negative PMS subaccount balances. In June of 2017, due to the progress made to date, the CMS waiver team verbally declared that the STC 164 requirements had been met and that they would be sending written confirmation. Written confirmation from CMS is still pending. STC 164 requires that, for any negative PMS subaccount balances remaining after June 30, 2017, CMS will issue a demand letter and require California to return sufficient funding to bring the PMS subaccount balances to $0. California has submitted adjustments to resolve a significant portion of the negative PMS subaccount balances via Quarters 1 and 2 of the 2016 grant year. If CMS disallows adjustments or claims, California will have the right to appeal them. STC 164 further requires that, for negative PMS subaccount balances identified in CMS' demand letter, California will need to repay CMS, in regular quarterly installments, with interest, by the end of the Medi-Cal 2020 waiver (December 31, 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.

- Repayment of deferred claims: Claims for which California has drawn down federal funding but CMS has deferred on or before June 30, 2017, CMS will issue a disallowance, triggering the appeal process. However, if the appeal is unsuccessful, California will be required to reimburse the federal funding. The deferred claims reimbursement will not be subject to interest. Some deferred claims contribute to the negative PMS subaccount balances, mentioned above, and may be liquidated through the negative PMS subaccount balance resolution. California is actively

INFORMATION ONLY

working to resolve these deferrals and the total federal funding reimbursement is unknown at this time. California will begin the FFY quarterly payments when the amounts are finalized.

Ongoing deferred claims repayment: In the past, California has not returned federal funding on CMS deferred claims until after the deferred claim was officially disallowed. Pursuant to the STCs of the Medi-Cal 2020 waiver, California must begin complying with 42 Code of Federal Regulations 430.40, which requires the immediate repayment of federal funding for deferred claims while the deferral is being resolved. Upon its determination that the claim is allowable, CMS will release the funding and allow California to utilize the federal funding. CMS disallowances fluctuate quarter to quarter, resulting in an unpredictable federal fund repayment amount.

2. Bridge to Reform (BTR) Designated State Health Program Reconciliation

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

The DSHP program undergoes a reconciliation to determine expenditures for each DY. Currently DY 8, DY 9, and DY 10 are still undergoing reconciliations. Until the entire Demonstration Period is fully reconciled across all DSHP programs, the State will not be able to estimate the final reconciliation amounts; however, it is anticipated to have a fiscal impact.

MANAGED CARE

PROVIDER RATES

1. Aligning Rate Review with the Access Monitoring Review Plan

To align rate reviews with the Access Monitoring Review Plan, the Department proposes to amend Section 14079 of the Welfare and Institutions Code. The amendment would require the Department to periodically review physician and dental services reimbursement levels at least every three years, rather than annually; would clarify that the review of rates pertain only to the Medi-Cal Fee-for-Service delivery system; require the Department to revise reimbursement rates to the extent the Director deems necessary to comply with federal Medicaid requirements; specify that the rate reviews would be conducted consistent with the Department's federally approved access monitoring plan; and remove obsolete and inaccessible requirements for the rate reviews.

INFORMATION ONLY

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

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. SPA 15-021 has not been approved by CMS; however, the Department expects the SPA to be approved prior to the end of FY 2019-20.

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.~~

SPA 19-0009: The Department submitted SPA 19-0009 in March 2019, with a proposed effective date of January 1, 2019. The proposed SPA seeks to improve the health of low-income children by increasing their access to needed vision services by providing comprehensive eye exams, corrective lenses, and frames at school sites. ~~These medically necessary services will be considered as direct medical services covered by the LEA Medi-Cal Billing Option Program. As part of the SPA process, DHCS will establish a billing methodology and program policy to allow LEA providers to seek Federal Financial Participation for the new vision services. In addition, the SPA will remove references to all licensing, credentialing, and supervision requirements in the LEA BOP program.~~ **In addition, CMS has indicated that the Department has the option to restructure how**

INFORMATION ONLY

school-based services are written into the State Plan, and remove any duplicative or unnecessary State Plan language. This new approach also includes removing references to all licensing, credentialing and supervision practitioner requirements for the LEA Program in SPA 19-0009,

~~SPA 19-0010: The Department will be submitting SPA 19-0010 by March 2019, with an effective date of July 1, 2019. The proposed SPA will exempt nursing services provided by licensed practitioners on college campuses from the California Commission on Teacher Credentialing supervision requirements. SPA 19-0010 seeks to increase access of care to students on college campuses by removing a significant barrier to the delivery of medically necessary services and allow colleges to seek federal reimbursement for covered services.~~

OTHER: AUDITS AND LAWSUITS

1. ~~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.~~

- ~~*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. On May 8, 2018, the district court granted the state and federal defendants' motion to stay proceedings for six months to facilitate the Department and CMS review of access monitoring data relevant to the approved SPA at issue. The Department submitted its access analysis and findings to CMS on~~

INFORMATION ONLY

~~September 14, 2018. On November 8, 2018, CMS issued a letter concluding the Department sufficiently demonstrated compliance with the access standards. On May 31, 2019, Plaintiffs filed a notice of dismissal. This matter is now closed and will no longer be reported in these Informational Assumptions.~~

- ~~*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 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. On May 8, 2018, the district court granted the state and federal defendants' motion to stay proceedings for six months to facilitate DHCS/CMS review of access monitoring data relevant to the approved SPA at issue. The Department submitted its access analysis and findings to CMS on September 14, 2018. On November 8, 2018, CMS issued a letter concluding the Department sufficiently demonstrated compliance with the access standards. On May 31, 2019, Plaintiffs filed a notice of dismissal. This matter is now closed and will no longer be reported in these Informational Assumptions.~~

2. American Indian Health Services, Inc., et al. v. Toby Douglas, et al.

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

INFORMATION ONLY

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. The Department appealed the final judgment. Appellate briefing was completed in the fall of 2017. On June 19, 2018, the appellate court affirmed the final judgment in favor of plaintiffs. On October 17, 2018, the California Supreme Court denied the Department's request for de-publication of the appellate court's ruling. The Department issued instructions to petitioners/plaintiffs regarding the submission of claims related to this lawsuit in October 2018 ~~and continues to process eligible claims for payment.~~ On January 31, 2019, the court denied petitioners/plaintiffs writ to extend its prior ruling to non-party providers. On February 1, 2019, petitioners/plaintiffs motion for attorney's fees was denied. ~~This case has been settled and will be removed in the next estimate cycle.~~ **As of January 2020, the Department's fiscal intermediary continues to process eligible claims for payment submitted during the October 2018 period and the Department expects all related payments will be complete by the end of the 2019-20 fiscal year. This matter is now closed with associated payments displayed in the Payment for Reprocessed Claims for FQHC/RHC Policy Change, and will no longer be reported in these Informational Assumptions.**

3. Managed Care Potential Legal Damages

   Three health plans filed lawsuits against the Department challenging the Medi-Cal managed care rate-setting methodology for rate years 2002 through 2005. The cases are referred to as:

   - *Health Net of California, Inc. v. DHCS*
   - *Blue Cross of California, Inc., dba Anthem Blue Cross v. DHCS*
   - *Molina Healthcare of California, Inc., v. DHCS*

   On June 13, 2011, judgment was issued in favor of Plaintiffs in the Health Net, Blue Cross, and Molina Healthcare cases. In all of the cases, the trial court determined that the Department had breached its contract with the managed care plans for the years in question. On November 2, 2012, the Department and Health Net entered into a settlement agreement resolving the Health Net lawsuit. Similarly, the Department has entered into settlement agreements with Blue Cross and Molina in mid/late 2013. The amount of payment due is contingent on each plan's profits, and the settlement accounting is scheduled to occur as follows, subject to applicable run-out and reconciliation periods provided in the settlement terms: *Molina* (January 1, 2018); *Blue Cross* (January 1, 2019); *Health Net* (January 1, 2020).

4. Centinela Freeman Emergency Medical Associates, et al. v. Maxwell-Jolly

   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

INFORMATION ONLY

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. The Appellate Court found that the judgement was not entered properly, and therefore dismissal of petitioner's claim for attorney's fees was not supported. The matter was remanded to the trial court for further proceedings. On January 28, 2019, the trial court signed the proposed judgment prepared by Plaintiffs ~~and litigation regarding attorney's fees continues~~. **On July 9, 2019, the trial court partially granted Plaintiffs' motion for an attorneys' fee award of $840,000 in fees and costs. Through subsequent negotiation, the parties agreed to the Department paying a final amount of $775,000. This matter is now closed, and will be displayed in the Lawsuits/Claims policy change and will no longer be reported in these Informational Assumptions,**

~~Thomas, et al. v. Jennifer Kent, Director of DHCS, et al.~~

~~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;~~
- ~~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,~~

INFORMATION ONLY

~~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 Department renewed the waiver as the Home and Community Based Alternatives Waiver, in which services are approved based on medical necessity without any individual cost limits. Plaintiffs On May 30, 2019, the court awarded Plaintiffs motion for attorney's fees, while denying the Department's fee motion. The parties agreed to mediation regarding the attorney fees and costs, and reached a settlement in July 2019. This matter is now closed and will no longer be reported in these Informational Assumptions and will displayed in the Lawsuits/Claims policy change.~~

5. Rivera v. Douglas, Director of DHCS

There were a significant number of Medi-Cal applicants whose applications had not been processed within 45 days of the application date ("backlog") and that were still pending when Petitioners filed suit. Petitioners filed a writ seeking an order that this backlog is in violation of state law and that state law requires that all Medi-Cal applicants that appear to be eligible should be granted eligibility for Medi-Cal benefits while any necessary verifications are being completed; and specifically that the Department (1) give notice to all 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.

INFORMATION ONLY

The court denied without prejudice Petitioners' request that the Department be required to grant "conditional benefits" as early in the 45 day period as the county finds an applicant for whom income verification is pending is otherwise eligible. The injunction and writ were stayed by 61 days to allow the Department time to file an appeal.

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

Petitioners filed a motion to enforce the Writ claiming that the filing of the appeal did not automatically stay enforcement. This motion was heard by the court March 9, 2016 and was denied on May 9, 2016. The appellate court heard the appeal on June 11, 2019, and filed its ruling in favor of the Department on June 27, 2019, instructing the trial court to enter judgment denying the petition for writ of mandate. ~~This ruling becomes final on July 27, 2019, and petitioners must appeal by August 6, 2019.~~ **. Petitioners filed a Petition for Review with the California Supreme Court, along with a Request for Depublication of the appellate court decision. ~~The Department filed its Answer to the Petition for Review on August 26, 2019.~~ The Supreme Court granted review on October 9, 2019, and briefing remains ongoing.**

6. MALDEF, et al. Title VI Administrative Complaints**;** Analina Jimenez Perea, et al., v. Diana Dooley, et al.*; Deuschel v. Dooley et. al.*

On December 15, 2015, the Mexican American Legal Defense and Educational Fund (MALDEF), the National Health Law Program (NHeLP), and several other advocacy groups filed an administrative complaint with the U.S. Department of Health & Human Services' Office for Civil Rights (DHHS OCR) pursuant to Title VI of the 1964 Civil Rights Act. The groups allege, on behalf of several Medi-Cal beneficiaries, that inadequate Medi-Cal reimbursement rates, coupled with the Department's failure to ensure timely access to services, constitute discrimination against the Latino population. They seek a finding from DHHS OCR that the Department's reimbursement rates violate Title VI and an order requiring the Department to raise the rates. On December 22, 2015, MALDEF sent a copy of the administrative complaint to the attention of CHHS Secretary Diana Dooley and Department Director Jennifer Kent, along with a cover letter citing the Department's regulations governing Title VI complaint investigations. The letter demands immediate action from the Department to raise reimbursement rates and improve monitoring of access. There has been no DHHS OCR activity known to the Department since the administrative complaint was filed.

On July 12, 2017, five individuals and three organization filed a class action suit (*Perea, et al.*) against CHHS and DHCS in Alameda County Superior Court seeking injunctive relief against the same Medi-Cal reimbursement and access policies identified in the above described Title VI Administrative Complaints. Plaintiffs allege that the Department's failure to provide adequate access to providers disparately impacts Latinos. Plaintiffs allege that Medi-Cal is "disproportionately and majority Latino," and that while all beneficiaries receive poorer treatment than whites covered by other insurance plans (such as Medicare and employer-provided insurance), Latinos are impacted more than other non-Latino Medi-Cal beneficiaries. They also allege that administrative burdens in the Medi-Cal program hinder access to "meaningful" health care. Plaintiffs also contend that the Department fails to

INFORMATION ONLY

monitor Medi-Cal beneficiaries' access to health care services, and fails to ensure managed care plans have adequate networks of providers. Finally, plaintiffs contend that as the percentage of Latino Medi-Cal beneficiaries has increased, the Department has "disinvested" in the Medi-Cal program by reducing Medi-Cal rates relative to Medicare. All of these acts, plaintiffs contend, have disparately impacted Latinos, and constitute purposeful discrimination.

Plaintiffs allege violations of Government Code section 11135 (prohibiting discrimination in state programs), and the California Constitution, Articles I and IV (equal protection, substantive due process). Plaintiffs seek injunctive relief as taxpayers, under California Code of Civil Procedure section 526a, and seek a writ of mandate under Code of Civil Procedure section 1085. Plaintiffs contend that the Department's actions also violate federal Medicaid statutes, including 42 U.S.C. section 1396b(m)(1)(a)(i), and 42 U.S.C. section 1396a(a)(30)(A). Plaintiffs do not seek monetary relief for any of the individual plaintiffs. Rather, they are seeking an order requiring the Department to increase the rates it pays to Medi-Cal providers. On April 12, 2018, the court sustained the Department's demurrer but granted Plaintiffs leave to amend their complaint. Plaintiffs filed their first amended complaint on May 18, 2018, and the Department demurred on June 20, 2018. On September 21, 2018, the court sustained the Department's demurrer to the first amended complaint but granted Plaintiffs leave to amend. Plaintiffs filed their second amended complaint on October 29, 2018, and the Department demurred on November 30, 2018. On January 31, 2019, the court again sustained the Department's demurrer with leave to amend. On June 21, 2019, the court overruled the Department's demurrer allowing the case to continue to discovery. ~~A case management conference is set for September 11, 2019.~~ **The Department filed its answer to the third amended complaint on August 30, 2019. Discovery remains ongoing, and a case management conference was scheduled** ~~for~~ **on January 22, 2020.**

On December 11, 2017, another lawsuit (*Deuschel*) was filed by an individual plaintiff against the Department, CHHS, and the Department of Social Services making similar discrimination allegations as the class action suit, though the allegations are based on disability status. Plaintiff seeks injunctive relief and writ of mandate requiring the Department to increase Medi-Cal rates and to monitor and enforce network adequacy and timely access, as well as compensatory damages. The Department filed a demurrer on February 9, 2018. Plaintiff filed an amended complaint on September 18, 2018. The Department filed its demurrer to the amended complaint on November 9, 2018 ~~and the hearing on the demurrer is scheduled on October 1, 2019.~~ **The court has since issued multiple continuances, and the entire case stayed until January 21, 2020, with the Department's demurrer now scheduled to be heard on April 21, 2020.**

7. Blue Cross of California v. DHCS, et. al.; *California Physicians' Service DBA Blue Shield of California v. DHCS, et. al.* ***; Health Net of California, Inc. v. DHCS, et al.***

Blue Cross of California ~~and~~ Blue Shield of California, **and Health Net of California** (Plaintiffs) are real parties in interest in a pending California taxpayer action filed in Los Angeles Superior Court captioned Myers v. State Board of Equalization, et al. (Myers), which seeks a writ of mandate directing the appropriate taxing agencies to collect the annual gross premiums tax (GPT) from Plaintiffs as "insurers" under the California

INFORMATION ONLY

Constitution. The Plaintiffs seek reimbursement from the Department for managed care organization (MCO) taxes paid or that will be paid pursuant to SBx2 2 (Chapter 2, Statutes of 2016, 2nd Ex. Sess.) **and AB 115 (Chapter 348, Statutes of 2019)** in the event that Myers action results in the Plaintiffs being subject to the GPT and exempt from assessment of ~~the SBx2 2 version of~~ the MCO tax**es**. ~~Both~~ **The Blue Cross and Blue Shield** actions have **both** been formally stayed after being designated ~~a~~ related cases to Myers **, and it is expected that the Health Net action will be stayed as well**.

8. Ivory N. and James B. v. Kent et al.

Plaintiffs, through a class action, seek declaratory and injunctive relief requiring the Department to arrange for in-home skilled nursing care to meet the needs of medically fragile Medi-Cal eligible children in their home. Plaintiffs assert that DHCS has failed to arrange for medically-necessary in-home shift nursing services, resulting in institutionalization and risk of institutionalization, in violation of the Medicaid Act, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and state non-discrimination laws. Plaintiffs ask the court to order the Department to take all steps necessary to arrange for medically necessary in-home shift nursing for the class members. On February 28, 2019, the parties executed a settlement which includes specified Department obligations regarding the delivery of in-home skilled nursing care and dismissal of the case. The court preliminarily approved the **settlement** on April 4, 2019 and also certified the plaintiff class. The Department mailed notice of the settlement to the plaintiff class on May 30, 2019. ~~A further hearing regarding final approval of the settlement is scheduled for August 8, 2019. .~~ **On September 30, 2019, the court gave final approval of the settlement, including an attorneys' fee award of $435,000. DHCS is in process of implementing the settlement terms, including the release of multiple notices for public comment. This matter is now closed, and will be displayed in the Lawsuits/Claims policy change and will no longer be reported in these Informational Assumptions,**

9. Shield California Health Care Center, Inc. v. Department of Health Care Services

The lawsuit was filed in Los Angeles County Superior Court on May 22, 2018. Plaintiff seeks to enjoin the Department from recouping overpayments made to Plaintiff for medical supplies furnished to Medi-Cal patients between June 1, 2011 and October 24, 2013. The overpayments were the result of a since-lifted injunction on the ten percent Medi-Cal payment reductions made pursuant to Assembly Bill (AB) 97 (Chapter 3, Statutes 2011; codified at Welf. & Inst. Code § 14015.192). Plaintiff asserts that the Department unreasonably delayed the retroactive recoupment. Plaintiff asserts that the doctrine of laches should be applied to invalidate the Department's continuing recoupment of the AB 97 overpayments. The Department's Demurrer was denied November 1, 2018, and its Answer was filed on November 12, 2018. Discovery and settlement discussions are ongoing.

INFORMATION ONLY

10. California Pharmacists Association, et al. v. Kent, et al.

The lawsuit was filed in U.S. District Court for the Northern District on June 5, 2019 against the Department and the federal Secretary of the U.S. Department of Health and Human Services. Plaintiff pharmacies seek injunctive and declaratory relief to prevent the Department from implementing reimbursement changes approved in State Plan Amendment no. 17-002 relating to covered outpatient drug benefits in Medi-Cal, including the Department's retroactive implementation of those reimbursement changes effective for dates of service on or after April 1, 2017. Plaintiffs allege that the Department's revised outpatient pharmacy reimbursement methodologies violate the Medicaid Act and other state and federal laws, and that the Federal defendants improperly approved such changes in the Medi-Cal State Plan. A hearing on Plaintiff's motion for a preliminary injunction ~~is~~ scheduled ~~for~~ **on** August 30, 2019 **was taken off calendar, and the court will make its decision based on the parties' briefing alone**.

11. Independent Living Center of Southern California, et al. v. Kent, et al.

In 2009, Plaintiffs sued the Department challenging legislatively-mandated Medi-Cal payment reductions (AB 5 and AB 1183) in the U.S. District Court for the Central District. On February 27, 2009, the district court issued a preliminary injunction against the payment reductions. On February 22, 2012, the U.S. Supreme Court issued a ruling vacating the Ninth Circuit decision affirming the district court's injunction. In May 2014, the parties in this case and three other federal lawsuits involving AB 5 and AB 1183 reductions executed a settlement in which the Department agreed not to recoup amounts from providers for certain time periods in exchange for Plaintiffs dismissing several state court lawsuits. On April 23, 2015, the district court issued an order dismissing with prejudice Plaintiffs' suit and retaining jurisdiction, until January 1, 2016, for purposes of attorney fees and settlement enforcement. On July 6, 2015, the Department agreed to pay $180,000 to Plaintiffs' counsel Lynn Carman and the Medicaid Defense Fund to settle their claims for attorney fees. On that same date, the Court denied all other claims against the State for attorney fees, including those filed by attorney Stanley Friedman **and the law firm Hooper, Lundy, and Bookman (HLB)**. On July 24, 2015, **both** attorney Friedman **and HLB** filed a notice of appeal of the order denying fees. On November 21, 2018, the Ninth Circuit reversed and ruled that attorney fees may in fact be available under State law since plaintiffs initially filed a State law claim. The case was remanded to the district court to determine whether plaintiffs are eligible for fees, and if so, to calculate the award amount. Discovery and briefing in the district court is ongoing. A hearing was held on June 24, 2019, and ~~the court is expected to issue a final ruling shortly~~ **on August 7, 2019, the district court granted Plaintiffs' and intervenors' motions for attorneys' fees.** ~~The district court is allowing the Department to conduct discovery with regard to fees incurred by counsel for petitioners and intervenors, with a determination of the fee award amounts to come after subsequent briefing. The Department filed its oppositions to the fee motions on December 16, 2019.~~. **. Following discovery and subsequent briefing, the district court on January 24, 2020 issued its decision awarding approximately $7 million in aggregate fees, with approximately $2.7 million awarded to attorney Friedman and approximately $4.3 million awarded to intervenors HLB. On February 21, 2020, attorney Friedman filed a notice of appeal. The $4.3 million payment to intervenors HLB is displayed in the Lawsuits/Claims policy change.**

INFORMATION ONLY

12. Hinkle, et al. v. Kent, et al.

Plaintiffs (individual Medi-Cal beneficiaries and other similarly situated individuals) and Plaintiff California Council of the Blind allege that the Defendants (including the Department, Alameda County, Contra Costa County, and San Diego County) have failed to provide effective communication to blind individuals, by neglecting to identify and track people who need alternative, accessible formats and neglecting to respond appropriately to requests for alternative, accessible formats. These failures allegedly denied Plaintiffs and other putative class members' critical information about their health benefits, discriminate against them on the basis of their disabilities, and violate their due process rights under the United States Constitution. Plaintiffs seeks certification of the class action, a declaration from the court that all Defendants are in violation of Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act, the California Unruh Civil Rights Act, and other California statutes and implementing regulations. Plaintiffs also seek injunctive relief ordering Defendants to comply with the law and to: 1) provide all information provided to Medi-Cal applicants and beneficiaries to Plaintiffs and similarly situated individuals in their requested alternative format; and 2) in consultation with Plaintiffs, develop a plan that includes any policy changes necessary for a durable remedy.

Plaintiffs filed their Complaint on October 22, 2018. Initial disclosures and an answer to the Complaint were filed on February 1, 2019. Settlement discussions are ongoing and mediation **sessions were** ~~was~~ held on May 9, 2019, ~~and~~ July 12, 2019**, and January 17, 2020**.

13. AIDS Healthcare Foundation Rate Disputes Settlement

In January 2018, the Department entered into settlement with AIDS Healthcare Foundation (AHF) to resolve multiple managed care rate disputes dating back to 2007 and past fee-for-service overpayments for certain prescription drugs. The settlement requires AHF to pay the Department $624,102.99 upon approval of the settlement, amongst other terms. The settlement is currently under review with the federal Centers for Medicare and Medicaid Services (CMS). If not approved by CMS, the Department may be required to return federal financial participation associated with some or all of the past rate years at issue in the underlying litigation.

14. California Claimed Unallowable Federal Medicaid Reimbursement by Not Billing Manufacturers for Rebates for Some Physician Administered Drugs

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

INFORMATION ONLY

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.

15. 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 completed audits of hospitals reviewed by OIG to determine actual overpayment amounts based on adjudicated claims versus reliance on hospital-generated reports. Recent CMS clarification on the treatment of administrative, psychological, rehabilitation, and nursery bed days may result in revisions to the department's audit findings. 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' pending EHR incentive payments. The Department will request voluntary repayment from hospitals without pending payments, and initiate collection if necessary.

16. 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 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 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.

17. 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 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

INFORMATION ONLY

(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.

18. 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.

INFORMATION ONLY

19. 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

INFORMATION ONLY

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 payment s 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.

OTHER: RECOVERIES

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

SB 218 (Chapter 482, Statutes of 2017) added protections that prohibit certain types of recovery against Achieving a Better Life Experience Act (ABLE) accounts. ~~This will have a minimal fiscal impact on the Department's recoveries.~~ **California's "CalABLE Savings Plan" opened to the public on December 18, 2018.** ABLE accounts are tax-advantaged savings accounts that allow for individuals with disabilities to save funds for health related expenses while allowing the savings to not disqualify their eligibility for disability benefits. ~~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 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.

INFORMATION ONLY

2. Strengthening Coordination of Benefits and Post Payment Recovery

The Department is proposing trailer bill language to ensure that the data used for cost avoidance from our trading partners is provided at no cost to the Department, contains the necessary data elements to continue to cost avoid efficiently, and is received at intervals that will allow the Department to maximize its ability to defer costs. In addition, the language will allow the Department access to real-time eligibility verifications to ensure that all manual requests for changes to a member's other health coverage are accurate, increasing the Department's ability to remain the payor of last resort. The changes proposed by this language are either cost neutral or will result in savings by appropriately deflecting costs to the other health coverage first payor.

OTHER: MISCELLANEOUS

1. Certified Vital Records

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

2. Medi-Cal Program Integrity Data Analytics

~~Senate~~ **Assembly** Bill ~~840~~ **74** (Chapter ~~29~~ **23**, Budget Act of ~~2018~~ **2019**) appropriated $9 million in funding for the Department for Medi-Cal Program Integrity Data Analytics (MPIDA). An additional $1 million is available subject to meeting the requirements of provisional language below:

- 4260-001-0001 - The Department of Finance may augment the amount appropriated in Schedule (1) beginning in the 2019–20 fiscal year by up to $250,000 for a data analytics contract based upon verified satisfactory progress or completion of predetermined data analytics milestones.

- 4260-001-0890 - The Department of Finance may augment the amount appropriated in this item beginning in fiscal year 2019–20 by up to $750,000 for a data analytics contract based upon verified satisfactory progress or completion of predetermined data analytics milestones.

There is a separate policy change for recoveries of various types, which includes fraud/abuse recoveries.

3. Health Plan of San Mateo Dental Pilot Project

A dental integration pilot program in San Mateo County has been authorized. The pilot program is required to be designed to test the impact to oral care access, quality, and

INFORMATION ONLY

utilization, as well as medical cost impacts by the delivery of covered dental care services as a managed care benefit under the operation of the Health Plan of San Mateo. Implementation is ~~assumed to be January 2020~~ **scheduled for July 2021**.

4. Electronic Visit Verification

Electronic Visit Verification (EVV) must be implemented for Medicaid-funded personal care services by January 2020, and Home Health Care Services (HHCS) 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 Personal Care Services (PCS) providers and recipients.

On July 30, 2018, the President approved H.R. 6049 which extended the Federal Medical Assistance Percentage (FMAP) penalty for one year, from the initial EVV implementation deadline for PCS of January 1, 2019, to January 1, 2020. This penalty will reduce the FMAP rate for programs providing PCS by 0.25 percentage points starting in January 2020 and increasing each year by 0.25 percentage points to a maximum of one percent in 2023. There is a similar penalty for HHCS beginning January 2023 if EVV for HHCS is not implemented by January 1, 2023.

While the State is currently in the process of developing an infrastructure that will support the implementation of EVV, the process to successfully design and implement the EVV mandates outlined in The CURES Act will require extensive multi-agency planning, collaboration, and coordination. To ensure EVV is implemented in a manner that is consistent with the provisions outlined in The Olmstead decision, is least intrusive for participants, complies with federal law, and minimizes costs to the State as outlined in the MITA provisions, the State will be submitting a Good Faith Extension Request to the Centers for Medicare and Medicaid to extend the penalty period for one year. If approved, the Good Faith Extension Request will extend the FMAP penalty period for PCS until January 1, 2021 and for HHCS until January 1, 2024.

FISCAL INTERMEDIARY: MEDICAL

1. 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 contingency payment process. This would allow advanced interim payments to providers in the event there are disruptions to the Medi-Cal checkwrite process such as during any of the Modular Modernization 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 providers to receive

INFORMATION ONLY

payment for services rendered to ensure California's over 13 million Medi-Cal beneficiaries continue to receive health care services.

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL

1. Fiscal Intermediary (FI) and Administrative Services Organization (ASO) changes for Dental

   Due to the significant changes in policy since the FI and ASO contract was negotiated, the Department is aware of the following proposed change~~s~~ to the contract with Delta.

   - To meet the processing times in the contract and accommodate for increased TAR volumes, the Department is negotiating with the ASO for a rate to be applied for documents above the original range in the bid. The ASO has also requested additional staff to help adjudicate these claims.
   - ~~**CalAIM Initiative – Currently, various options are being considered regarding the dental related proposal.**~~

2. State Controller's Office Interagency Agreement

   The Department initiated an interagency agreement with the State Controller's Office (SCO) in FY 2016-17 to transition checkwrite services away from the Fiscal Intermediary (FI). Due to competing priorities, the Department put this project on hold. The Department initially planned to restart this work in FY 2017-18. However, due to lack of resources to fully support the project, a pending enterprise solution to the Federal Drawdown Reporting (FDR) system, as well as no legal mandate to transition the services at the time, the Department halted the project until the FDR could be properly implemented.

   The Department does intend to work in the future with the SCO to alter the current check write function, which the FI is currently responsible for. The FI will continue to fulfill duties related to checkwrite until a new process has been implemented between the SCO and the Department. This complex effort will require multiple phases in order to alter the current system to allow for SCO takeover of the check write function. Costs to consider in the future pertain to analyzing business processes, system testing, updating the CD-MMIS and enabling the SCO systems the ability to perform the check write function.

3. ~~Update Medi-Cal Dental Policy with Evidence Based Practices~~

   ~~The current law limits laboratory-processed crowns to only those authorized as an abutment for a cast metal partial denture. For Medi-Cal members whose tooth does not~~

INFORMATION ONLY

~~meet the criteria of an abutment for a cast partial denture, the only alternative treatment currently available is a pre-fabricated stainless steel crown.~~

~~The use of stainless steel crowns can lead to decay and possible damage to gum tissue around the tooth because the margins of the stainless steel crowns are not custom fitted to the tooth the way laboratory-processed crowns are fitted. The American Association of Pediatric Dentists and American Dental Association consider the stainless steel crown a temporary solution until a laboratory-processed crown can be produced. Laboratory-processed crowns will be authorized for Medi-Cal members and not limited to just an abutment for a cast metal partial denture.~~

DISCONTINUED POLICY CHANGES

Fully Incorporated into Base Data/Ongoing

ELIGIBILITY

AFFORDABLE CARE ACT

BENEFITS
PC 197 EPSDT Screens

HOME & COMMUNITY-BASED SERVICES

BREAST AND CERVICAL CANCER

PHARMACY

DRUG MEDI-CAL

MENTAL HEALTH

1115 WAIVER—MH/UCD & BTR

MANAGED CARE

PROVIDER RATES
PC 126 Alameda Hosp. & San Leandro Hosp. Interim Rate

SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

OTHER: RECOVERIES

OTHER: MISCELLANEOUS

FISCAL INTERMEDIARY: MEDICAL

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL

DISCONTINUED POLICY CHANGES

Time Limited/No Longer Available

ELIGIBILITY

AFFORDABLE CARE ACT

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: MISCELLANEOUS

FISCAL INTERMEDIARY: MEDICAL

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL

DISCONTINUED POLICY CHANGES

Withdrawn

ELIGIBILITY
PC 7 FPL Increase for Aged and Disabled Persons
PC 9 Provisional Postpartum Care Extension
PC 215 Undocumented Older Californians Expansion
PC 216 Medicare Part B Disregard

AFFORDABLE CARE ACT

BENEFITS
PC 48 Expansion to Screening for Additional Substances
PC 49 Medical Interpreters Pilot Project
PC 230 Hearing Aid Coverage

HOME & COMMUNITY-BASED SERVICES

BREAST AND CERVICAL CANCER

PHARMACY
PC 227 Non-Hospital 340B Clinic Supplemental Payments

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: MISCELLANEOUS

FISCAL INTERMEDIARY: MEDICAL

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL