MEDI-CAL
MAY 2018
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2017-18 *and* 2018-19

The Great Seal

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

MEDI-CAL
MAY 2018
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2017-18 and 2018-19

Fiscal Forecasting Division
State Department of Health Care Services
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May 2018 Medi-Cal Estimate

Current Year (FY 2017-18) Projected Expenditures Compared to the November 2017 Estimate

(Dollars in Millions)

Medical Care Services	Nov 2017 Estimate	May 2018 Estimate	Change	
			Amount	Percent
Total Funds	$95,163.4	$92,734.6	($2,428.8)	-2.6%
Federal Funds	$60,012.0	$56,699.3	($3,312.7)	-5.5%
General Fund	**$18,866.7**	**$18,994.8**	**$128.1**	**0.7%**
Other Non-Federal Funds	$16,284.7	$17,040.5	$755.8	4.6%

County Administration	Nov 2017 Estimate	May 2018 Estimate	Change	
			Amount	Percent
Total Funds	$4,427.5	$4,103.1	($324.4)	-7.3%
Federal Funds	$3,384.5	$2,887.3	($497.2)	-14.7%
General Fund	**$1,031.0**	**$1,204.4**	**$173.4**	**16.8%**
Other Non-Federal Funds	$12.0	$11.4	($0.6)	-5.0%

Fiscal Intermediary	Nov 2017 Estimate	May 2018 Estimate	Change	
			Amount	Percent
Total Funds	$449.2	$413.2	($36.0)	-8.0%
Federal Funds	$288.5	$267.6	($20.9)	-7.2%
General Fund	**$160.7**	**$145.5**	**($15.2)**	**-9.5%**
Other Non-Federal Funds	$0.0	($0.0)	($0.0)	n/a

Total Expenditures	Nov 2017 Estimate	May 2018 Estimate	Change	
			Amount	Percent
Total Funds	$100,040.1	$97,250.9	($2,789.2)	-2.8%
Federal Funds	$63,684.9	$59,854.2	($3,830.7)	-6.0%
General Fund	**$20,058.4**	**$20,344.7**	**$286.3**	**1.4%**
Other Non-Federal Funds	$16,296.7	$17,051.9	$755.2	4.6%

Note: Totals may not add due to rounding.

May 2018 Medi-Cal Estimate

Current Year (FY 2017-18) Projected Expenditures Compared to the Appropriation

(Dollars in Millions)

Medical Care Services	FY 2017-18 Appropriation	May 2018 Estimate	Change	
			Amount	Percent
Total Funds	$102,261.1	$92,734.6	($9,526.5)	-9.3%
Federal Funds	$65,041.9	$56,699.3	($8,342.6)	-12.8%
General Fund	**$18,399.7**	**$18,994.8**	**$595.1**	**3.2%**
Other Non-Federal Funds	$18,819.5	$17,040.5	($1,779.0)	-9.5%

County Administration	FY 2017-18 Appropriation	May 2018 Estimate	Change	
			Amount	Percent
Total Funds	$4,574.3	$4,103.1	($471.2)	-10.3%
Federal Funds	$3,601.6	$2,887.3	($714.3)	-19.8%
General Fund	**$960.6**	**$1,204.4**	**$243.8**	**25.4%**
Other Non-Federal Funds	$12.1	$11.4	($0.7)	-5.8%

Fiscal Intermediary	FY 2017-18 Appropriation	May 2018 Estimate	Change	
			Amount	Percent
Total Funds	$423.2	$413.2	($10.0)	-2.4%
Federal Funds	$268.7	$267.6	($1.1)	-0.4%
General Fund	**$154.5**	**$145.5**	**($9.0)**	**-5.8%**
Other Non-Federal Funds	$0.0	$0.0	$0.0	n/a

Total Expenditures	FY 2017-18 Appropriation	May 2018 Estimate	Change	
			Amount	Percent
Total Funds	$107,258.7	$97,250.9	($10,007.8)	-9.3%
Federal Funds	$68,912.1	$59,854.2	($9,057.9)	-13.1%
General Fund	**$19,514.8**	**$20,344.7**	**$829.9**	**4.3%**
Other Non-Federal Funds	$18,831.6	$17,051.9	($1,779.7)	-9.5%

Note: Totals may not add due to rounding.

May 2018 Medi-Cal Estimate

Budget Year (FY 2018-19) Projected Expenditures Compared to Current Year (FY 2017-18)

(Dollars in Millions)

Medical Care Services	FY 2017-18 Estimate	FY 2018-19 Estimate	Change	
			Amount	Percent
Total Funds	$92,734.6	$99,043.9	$6,309.3	6.8%
Federal Funds	$56,699.3	$63,709.4	$7,010.1	12.4%
General Fund	**$18,994.8**	**$21,605.8**	**$2,611.0**	**13.7%**
Other Non-Federal Funds	$17,040.5	$13,728.7	($3,311.8)	-19.4%

County Administration	FY 2017-18 Estimate	FY 2018-19 Estimate	Change	
			Amount	Percent
Total Funds	$4,103.1	$4,510.9	$407.8	9.9%
Federal Funds	$2,887.3	$3,285.5	$398.2	13.8%
General Fund	**$1,204.4**	**$1,220.0**	**$15.6**	**1.3%**
Other Non-Federal Funds	$11.4	$5.4	($6.0)	-52.6%

Fiscal Intermediary	FY 2017-18 Estimate	FY 2018-19 Estimate	Change	
			Amount	Percent
Total Funds	$413.2	$326.3	($86.9)	-21.0%
Federal Funds	$267.6	$213.5	($54.1)	-20.2%
General Fund	**$145.5**	**$112.8**	**($32.7)**	**-22.5%**
Other Non-Federal Funds	($0.0)	$0.0	$0.0	n/a

Total Expenditures	FY 2017-18 Estimate	FY 2018-19 Estimate	Change	
			Amount	Percent
Total Funds	$97,250.9	$103,881.1	$6,630.2	6.8%
Federal Funds	$59,854.2	$67,208.4	$7,354.2	12.3%
General Fund	**$20,344.7**	**$22,938.5**	**$2,593.8**	**12.7%**
Other Non-Federal Funds	$17,051.9	$13,734.1	($3,317.8)	-19.5%

Note: Totals may not add due to rounding.

May 2018 Medi-Cal Estimate

Budget Year (FY 2018-19) Projected Expenditures Compared to the November 2017 Estimate

(Dollars in Millions)

Medical Care Services	Nov 2017 Estimate	May 2018 Estimate	Change	
			Amount	Percent
Total Funds	$96,807.3	$99,043.9	$2,236.6	2.3%
Federal Funds	$63,651.2	$63,709.4	$58.2	0.1%
General Fund	**$20,388.7**	**$21,605.8**	**$1,217.1**	**6.0%**
Other Non-Federal Funds	$12,767.4	$13,728.7	$961.3	7.5%

County Administration	Nov 2017 Estimate	May 2018 Estimate	Change	
			Amount	Percent
Total Funds	$4,369.3	$4,510.9	$141.6	3.2%
Federal Funds	$3,280.8	$3,285.5	$4.7	0.1%
General Fund	**$1,083.6**	**$1,220.0**	**$136.4**	**12.6%**
Other Non-Federal Funds	$4.9	$5.4	$0.5	10.2%

Fiscal Intermediary	Nov 2017 Estimate	May 2018 Estimate	Change	
			Amount	Percent
Total Funds	$328.1	$326.3	($1.8)	-0.5%
Federal Funds	$211.3	$213.5	$2.2	1.0%
General Fund	**$116.7**	**$112.8**	**($3.9)**	**-3.3%**
Other Non-Federal Funds	$0.0	$0.0	($0.0)	n/a

Total Expenditures	Nov 2017 Estimate	May 2018 Estimate	Change	
			Amount	Percent
Total Funds	$101,504.7	$103,881.1	$2,376.4	2.3%
Federal Funds	$67,143.2	$67,208.4	$65.2	0.1%
General Fund	**$21,589.1**	**$22,938.5**	**$1,349.4**	**6.3%**
Other Non-Federal Funds	$12,772.3	$13,734.1	$961.8	7.5%

Note: Totals may not add due to rounding.

May 2018 Medi-Cal Estimate

Budget Year (FY 2018-19) Projected Expenditures Compared to the Appropriation

(Dollars in Millions)

Medical Care Services	FY 2017-18 Appropriation	May 2018 Estimate	Change	
			Amount	Percent
Total Funds	$102,261.1	$99,043.9	($3,217.2)	-3.1%
Federal Funds	$65,041.9	$63,709.4	($1,332.5)	-2.0%
General Fund	**$18,399.7**	**$21,605.8**	**$3,206.1**	**17.4%**
Other Non-Federal Funds	$18,819.5	$13,728.7	($5,090.8)	-27.1%

County Administration	FY 2017-18 Appropriation	May 2018 Estimate	Change	
			Amount	Percent
Total Funds	$4,574.3	$4,510.9	($63.4)	-1.4%
Federal Funds	$3,601.6	$3,285.5	($316.1)	-8.8%
General Fund	**$960.6**	**$1,220.0**	**$259.4**	**27.0%**
Other Non-Federal Funds	$12.1	$5.4	($6.7)	-55.4%

Fiscal Intermediary	FY 2017-18 Appropriation	May 2018 Estimate	Change	
			Amount	Percent
Total Funds	$423.2	$326.3	($96.9)	-22.9%
Federal Funds	$268.7	$213.5	($55.2)	-20.5%
General Fund	**$154.5**	**$112.8**	**($41.7)**	**-27.0%**
Other Non-Federal Funds	$0.0	$0.0	$0.0	n/a

Total Expenditures	FY 2017-18 Appropriation	May 2018 Estimate	Change	
			Amount	Percent
Total Funds	$107,258.7	$103,881.1	($3,377.6)	-3.1%
Federal Funds	$68,912.1	$67,208.4	($1,703.7)	-2.5%
General Fund	**$19,514.8**	**$22,938.5**	**$3,423.7**	**17.5%**
Other Non-Federal Funds	$18,831.6	$13,734.1	($5,097.5)	-27.1%

Note: Totals may not add due to rounding.

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May 2018 Medi-Cal Estimate
Management Summary

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:

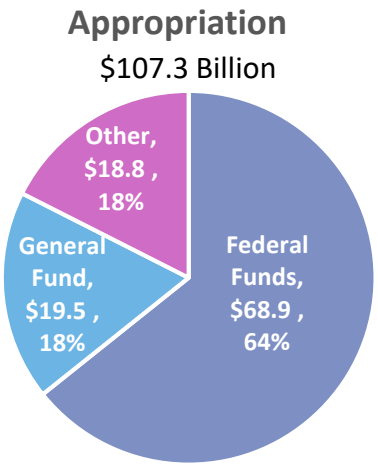
- Benefits: Expenditures for the care of Medi-Cal beneficiaries. These expenditures can be found in the following sections:
    - Fee-For-Service (FFS) Base,
    - Base Policy Changes, and
    - Regular Policy Changes.

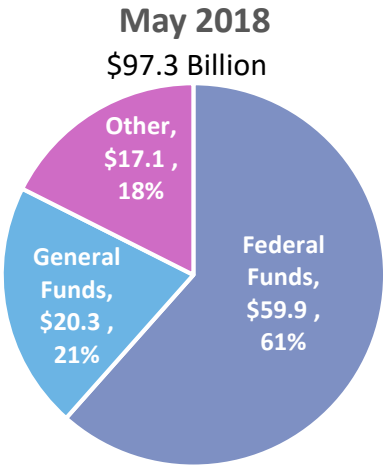
  These estimated expenditures are summarized in the Current Year and Budget Year sections.

- 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.

FY 2017-18



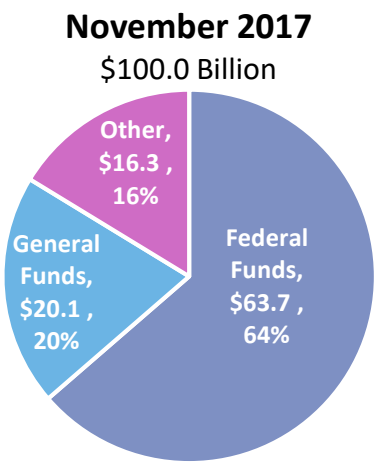


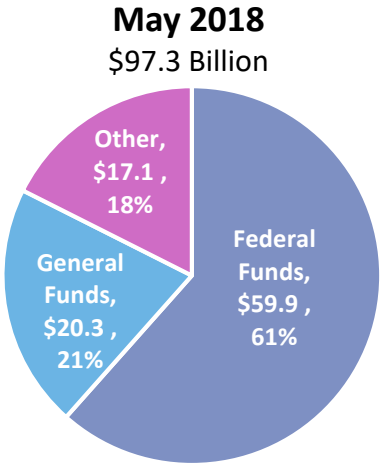
The May 2018 Estimate for FY 2017-18 projects an additional $829.9 million General Fund in expenditures than the FY 2017-18 Budget Appropriation.

FY 2017-18, General Fund

	Appropriation	May 2018	Change
Medical Care Services	$ 18,399.7	$ 18,994.8	$ 595.1
County Administration	$ 960.6	$ 1,204.4	$ 243.8
Fiscal Intermediary	$ 154.5	$ 145.5	$ -9.0
Total	$ 19,514.8	$ 20,344.7	$ 829.9

(Dollars in Millions, Rounded)

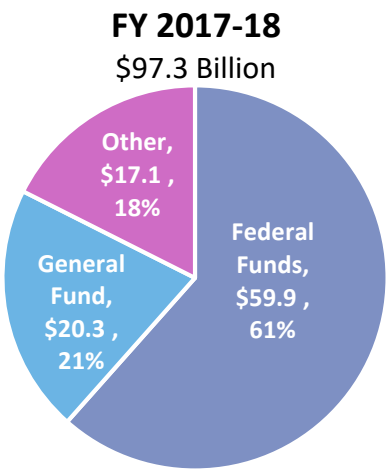


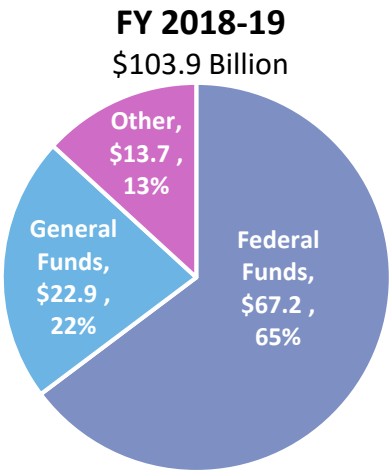


FY 2017-18, General Fund

	November 2017	May 2018	Change
Medical Care Services	$ 18,866.7	$ 18,994.8	$ 128.1
County Administration	$ 1,031.0	$ 1,204.4	$ 173.4
Fiscal Intermediary	$ 160.7	$ 145.5	$ -15.2
Total	$ 20,058.4	$ 20,344.7	$ 286.3

(Dollars in Millions, Rounded)



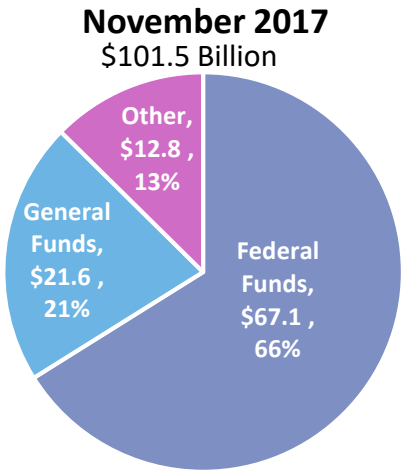


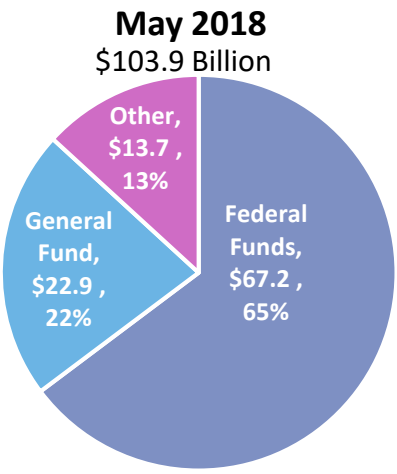
May 2018, General Fund

	FY 2017-18	FY 2018-19	Change
Medical Care Services	$ 18,994.8	$ 21,605.8	$ 2,611.0
County Administration	$ 1,204.4	$ 1,220.0	$ 15.6
Fiscal Intermediary	$ 145.5	$ 112.8	$ -32.7
Total	$ 20,344.7	$ 22,938.5	$ 2,593.8

(Dollars in Millions, Rounded)

FY 2018-19





FY 2018-19, General Fund

	November 2017	May 2018	Change
Medical Care Services	$ 20,388.7	$ 21,605.8	$ 1,217.1
County Administration	$ 1,083.6	$ 1,220.0	$ 136.4
Fiscal Intermediary	$ 116.8	$ 112.8	$ -4.0
Total	$ 21,589.1	$ 22,938.5	$ 1,349.4

(Dollars in Millions, Rounded)

Caseload

Medi-Cal Caseload for FY 2017-18 is estimated at 13,343,800 and is projected to decline slightly in FY 2018-19 at 13,328,200. The Medi-Cal caseload has been declining gradually since early 2016. This decline is mainly seen in the Families and Children categories and is believed related to California's lower unemployment and a recovering economy.

Medi-Cal's second largest eligibility group after Families and Children, the ACA Optional Expansion aid category (adults ages 19 to 64) is expected to grow slightly from FY 2017-18 to FY 2018-19 to 3.85 million eligibles.

The Medi-Cal Estimate's Seniors category has continued its historical increase and this increase is reflected in this caseload estimate. The Persons with Disabiliites' categories has leveled in recent months after a two-year decrease. Due to continued improvements in Medi-Cal's eligibility systems, primarily automation changes, dual eligibles (beneficiaires with Medicare and Medi-Cal) are no longer placed in Medi-Cal's ACA Optional Expansion aid category, which may be an indicator of the recent leveling.

Other changes in the Medi-Cal caseload include:

- Medically Indigent Adults: Adults placed in presumptive eligibility were recategorized from the Medically Indigent Children aid category to the Medically Indigent Adult aid category.
- Refugees: The Federal refugee arrivals were lower than the Federal proposed arrivals. The federal administration is, also, projecting lower future arrivals. These lower arrivals have resulted in a lower Refugee caseload.
- OBRA: The OBRA aid category consists of two aid codes with unspecified Medi-Cal linkage. These aid codes have been replaced with newer aid codes with a defined Medi-Cal linkage. The decrease in this aid category is related to eligibles being reassigned to these new aid codes and are incorporated into other Med-Cal aid categories.

SIGNIFICANT ITEMS

Dollars in Millions

		Change from November 2017		Change from FY 2017-18	
		FY 2017-18		FY 2018-19	
Name	**PC**	**TF**	**GF**	**TF**	**GF**
Non-OTLICP CHIP	9	$0.0	($282.7)	$0.0	$587.0
This policy change (PC) estimates the technical adjustment in funding for the Non-Optional Targeted Low Income Children's Program (OTLICP) population of the Children's Health Insurance Program (CHIP). This PC includes changes to the CS3-Proxy adjustment, expenditures for the Resource Disregard, Hospital Presumptive Eligibility, and Medicaid Expansion populations. A correction to previously claimed Title XXI funding is assumed in the BY. In addition, the Department did make quarterly adjustments to bring the CS3 Proxy closer to current. In late January 2017, CMS provided States with a February deadline to submit 2016 and 2017 Title XIX expenditures to be applied to the Title XXI CMS 2017 grant.					
Non-Emergency Funding Adjustment	10	$0.0	($14.2)	$0.0	($5.3)
This policy change is a technical adjustment to shift funds from Title XIX and Title XXI FFP to 100% GF because the Department cannot claim FFP on non-emergency claims for nonexempt NQI, PRUCOL, and undocumented children. The change from the prior estimate for FY 2017-18 is due to a decrease in managed care expenditures. The change from CY to BY is due to decreases in FFS and managed care Title XIX expenditures, and Title XXI managed care expenditures.					
Minimum Wage Increase – Caseload Savings	15	($0.2)	$0.0	($222.4)	($48.3)
This policy change estimates savings due to a reduction in caseload resulting from the increase in minimum wage. The change from the prior estimate for FY 2017-18 is due to caseload growth. The change from CY to BY is due to an increase in the minimum wage to $12, caseload growth, and an increase in PMPM.					
Medicare Optional Expansion Adjustment	16	$90.3	$30.2	$286.8	($152.2)
This policy change adjusts the funding from the ACA Optional Expansion funding to the Medi-Cal 50/50 funding for eligibles with Medicare coverage who are not eligible for coverage under the ACA Optional Expansion aid category. The change from the prior estimate for FY 2017-18 is due to an increase in identified eligibles.					
Health Insurer Fee	18	($410.8)	($139.8)	$215.0	$73.2
This policy change estimates the cost of capitation rate increases to fund the federally required Health Insurer Provider Fee (HIPF). The change from the prior estimate for FY 2017-18 is due to the estimated calendar 2017 HIPF payments shifting from CY to BY and the elimination of calendar year 2018 HIPF payments due to a federal moratorium. The change from CY to BY is due to the calendar year 2017 payments shifting into FY 2018-19, elimination of the calendar year 2018 HIFP, and the shifting of the estimate calendar year 2019 payments into FY 2019-20.					

Name	PC	Change from November 2017 FY 2017-18 TF	Change from November 2017 FY 2017-18 GF	Change from FY 2017-18 FY 2018-19 TF	Change from FY 2017-18 FY 2018-19 GF
Behavioral Health Treatment	27	$96.0	$46.6	$46.3	$20.7
Medi-Cal covers Behavioral Health Treatment (BHT) services for children under age 21. Beginning February 1, 2016, the Department, in collaboration with the Department of Developmental Services (DDS), transitioned responsibility for BHT services provided to existing Medi-Cal eligible DDS Regional Center clients to Medi-Cal. The current BHT estimate includes updated managed care costs based on actual payments and estimated managed care capitation rates. The increase in managed care costs is due to a higher number of supplemental capitation payments projected based on actual counts of payments seen in the data through June 2017.					
Behavioral Health Treatment - BIS DDS Transition	44	($0.9)	($0.4)	$109.2	$48.8
This policy change estimates costs for additional DDS Regional Center (RC) clients with a diagnosis other than Autism Spectrum Disorder (ASD) transitioning to Medi-Cal. The FFS transition occurred in March 2018. The managed care transition will occur in July 2018 with a phase-in for certain counties. The current estimate updates the transition population, the FY 2018-19 managed care BHT/BIS capitation rate, and managedcare phase-in.					
Full Restoration of Adult Dental Benefits	36	$78.9	$22.1	$122.3	$37.3
The policy change estimates the cost of fully restoring adult dental benefits in the Medi-Cal program. The change from the prior estimate for FY 2017-18 is due to more accurately accounting for the FFS shift to straight FFS check write payments as well as updated data regarding estimated population changes year over year. The change from CY to BY in the current estimate is due to only a partial year of straight FFS check write payments in FY 2017-18 versus a full year in FY 2018-19.					
Dental Beneficiary Outreach Efforts - Benefits	37	$51.8	$25.9	$61.6	$30.8
The policy change estimates the cost of implementing strategies to increase utilization rates. The change from the prior estimate for FY 2017-18 is due to updated user and eligible data, as well as a move to straight FFS check write payments effective February 2018. The change from CY to BY in the current estimate is due to additional utilization anticipated in FY 2018-19.					
Medi-Cal Nonmedical Transportation (NMT)	207	$0.0	$0.0	$4.2	$1.6
This policy change estimates the FFS costs of covering Medi-Cal nonmedical transportation (NMT) services. NMT is projected to begin July 1, 2018.					
Drug Rebates	48, 51, 52, 54, 55, 116	($536.1)	$275.3	$1,085.5	($354.1)
Rebate estimates were updated based on actual pharmacy drug rebate collections data through March 2018. The rebate projections include the impact of the ACA retroactive adjustments that was reported with the quarter ending December 2017.					

		Change from November 2017		Change from FY 2017-18	
		FY 2017-18		FY 2018-19	
Name	**PC**	**TF**	**GF**	**TF**	**GF**
Pharmacy Reimbursement & Dispensing Fee	49	$0.0	$0.0	($36.0)	($14.1)
This policy change estimates the savings from reimbursing pharmacy drugs based on the Actual Acquisition Cost (AAC) for Covered Outpatient Drugs and the cost associated with adopting the new Professional Dispensing Fee (PDF) methodology. Although the effective date of the new AAC and PDF reimbursement methodology is April 1, 2017, implementation is estimated to begin January 1, 2019.					
New High Cost Treatments for Specific Conditions	47	$3.3	$1.8	$44.8	$20.5
This policy change estimates the cost of new high cost treatments for specific medical conditions. Additional treatments have been added and phase-ins were updated with the latest trend data.					
Hepatitis C Revised Clinical Guidelines	225	$0.0	$0.0	$70.4	$21.8
Current Hepatitis C policy guidelines limits treatment to beneficiaries with defined fibrosis levels or with comorbid conditions. Effective July 1, 2018, the Department will revise the Hepatitis C policy guidelines to authorize treatment for all patients with the disease, regardless of stage of the disease or co-morbidity.					
Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver	56	$5.0	($0.1)	$418.8	$72.3
DMC-ODS waiver services include existing Drug Medi-Cal treatment modalities and additional new and expanded services. DMC-ODS waiver services for opt-in counties began in February 2017 on a phase-in basis. Four counties implemented the DMC-ODS waiver in FY 2016-17 with an anticipated 40 counties implementing by July 2019. This revised policy change reflects changes in the county implementation schedule, updated rates, and the addition of rates for a buprenorphine-naloxone combination drug product. Through the implemention of DMC-ODS, the Department found that some new DMC-ODS waiver services are incorrectly being paid with GF and this policy change adds GF for these payments in FY 2017-18. Reimbursement to the GF is included in FY 2018-19 when the system fix occurs.					
MHP Costs for CCR	67	($5.8)	($2.9)	$13.4	$6.7
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. The estimate has been revised with updated CDSS CFT caseload and FY 2018-19 CFT rates. In addition, payment lags were included to account for cash basis payments.					
Managed Care Regulations - MH	OA 10	($18.2)	($6.1)	$16.7	$5.6
This policy change estimates the costs to reimburse County Mental Health Plans (MHPs) for administrative activities arising from the implementation of new federal managed care regulations. The estimate has been revised to include payment lags and shifting payments from FY 2017-18 to FY 2018-19.					
Performance Outcomes Systems	OA 12	($13.8)	($6.2)	$14.3	$6.4
This policy change estimates the cost to reimburse mental health plans the cost of capturing and reporting new functional assessment data part of the Performance Outcomes System (POS) for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mental health services. The current estimate shifts payments for POS to FY 2018-19, updates IT costs, and includes payment lags to account for cash basis payments in FY 2018-19.					

		Change from November 2017		Change from FY 2017-18	
		FY 2017-18		FY 2018-19	
Name	**PC**	**TF**	**GF**	**TF**	**GF**
Managed Care Regulations – MH Parity	OA 109	$0.0	$0.0	$20.8	$3.0
The federal Parity Final Rule requires parity in access to mental health and substance use disorder services for Medicaid beneficiaries with physical health services. To comply with the parity final rule, county Mental Health Plans (MHPs) will be required to shorten times for the authorization of treatment plans for both outpatient and inpatient services. This policy change estimates the MHP costs to comply. The revised estimate updates the outpatient services requiring pre-authorizations and adds inpatient concurrent reviews.					
Interim and Final Cost Settlements – SMHS	PC 72, OA 55	$48.8	$20.3	$86.4	($17.5)
These policy changes estimate the interim and final cost settlements for specialty mental health services (SMHS).					
Audit Settlements	181	($13.9)	$0	$0	$167.0
This policy change estimates the payments for multiple audit settlements due to the Centers for Medicare and Medicaid Services (CMS). The budget year includes a repayment to CMS of $180.7 million for unallowable Federal Medicaid reimbursement for Specialty Mental Health Services (SMHS.)					
Medi-Cal 2020 Dental Transformation Initiative	76	$0.2	$0.1	$48.0	$24.0
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. The change from the prior estimate for FY 2017-18 is due to updated actuals which reflect higher incentive payments made for Domain 1. The change from CY to BY in the current estimate is due to anticipated increased participation in the DTI in FY 2018-19.					
Managed Care Base	87, 88, 89, 94	($729.3)	($256.9)	$790.9	$944.2
The four managed care base policy changes (PCs) estimate the managed care capitation costs for managed care health plans. In FY 2017-18, the California Healthcare, Research, and Prevention Tobacco Tax Act of 2016 (Proposition 56) funds a portion of the growth as compared to the 2016 Budget Act in the four PCs. In 2018-19, only growth as compared to the 2016 Budget Act in the Two Plan Model base PC will be funded with Proportion 56 revenue. The change for FY 2017-18 from the prior estimate is a net decrease due to lower ACA costs, lower Hepatitis C costs, and lower eligibles. There is a net increase from CY to BY in the current estimate due to higher anticipated monthly eligibles. Proposition 56 funding for growth decreases from $711.2 million in CY to $224.7 million in BY.					
Retro MC Rate Adjustment	117	($236.5)	$86.1	$4,357.7	($250.1)
This policy change estimates retroactive managed care capitation rate adjustments. The change from the prior estimate for FY 2017-18 is due to (1) calendar year 2016 full dual estimates being updated using final FY 2016 recast rates; (2) updated retroactive payment timing; (3) calendar year 2017 full dual estimates were updated using revised calendar year 2017 draft rates and revised payment timing; and (4) IHSS offsets with CDSS were adjusted to reimbursements. The change from CY to BY is due to updated payments and recoupments based on more recent data along with updated payment timing.					

		Change from November 2017		Change from FY 2017-18	
		FY 2017-18		FY 2018-19	
Name	**PC**	**TF**	**GF**	**TF**	**GF**
MCO Tax Managed Care Plans	110	$0.0	$114.7	$0	$300
This policy change estimates the transfer of funds collected from the tax on managed care organizations to the GF to be retained by the Department. The change from the prior estimate for FY 2017-18 is due to increased retro-period activity scheduled in FY 2017-18. The change from FY 2017-18 to FY 2018-19 is due to the timing of retro-period activity.					
MCO Enrollment Tax Managed Care Plans	115	$0.0	$230.1	$0.0	($298.4)
This policy change estimates the transfer of funds collected from the enrollment tax on managed care organizations to the GF to be retained by the Department. The change from the prior estimate for FY 2017-18 is due to an updated funding allocation based on more recent payment data. The change from FY 2017-18 to FY 2018-19 in the current estimate is due to an increase in MCO Enrollment Tax rate.					
Managed Care IGT Admin. & Processing Fee	111	$0.0	$108.5	$0.0	$33.0
This policy change estimates the savings to the General Fund due to the rate range IGTs administrative and processing fees assessed to the counties or other approved public entities. The change from the prior estimate for FY 2017-18 is due to 11 months of FY 2017-18 General Fund reimbursement dollars shifting to FY 2018-19. The change from FY 2017-18 to FY 2018-19 in the current estimate is due to the discontinuation of managed care rate range IGT assessment fees and timing of General Fund reimbursement.					
Managed Care Reimbursement to the General Fund	113	$0.0	$15.5	$0.0	($815.7)
This policy change budgets reimbursements to the GF by IGTs from allowable public entities for Medi-Cal payment contributions and administration and processing fees. The change from the prior estimate for FY 2017-18 is due to a shift in FY 2017-18 reimbursements from current year to budget year. The change from FY 2017-18 to FY 2018-19 in the current estimate is due to the delayed implementation of FY 2017-18.					
CCI Managed Care Payments	91	($79.9)	($39.9)	($2,065.8)	($1,032.9)
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 LTC institutional and community-based services and supports benefits. There is an overall net decrease from the prior estimate for FY 2017-18 due to lower eligibles in the Full Dual Opt-In and Non-Full Dual Non Institutional categories. Additionally, Non-Full Dual rates in CY decreased slightly from the prior estimate due to budgeting FY 2016-17 rates instead of projected FY 2017-18 rates, and Full Dual MLTSS rates in CY decreased from the prior estimate due to budgeting CY 2016 rates instead of CY 2017 preliminary draft rates. FY 2018-19 costs decreased from FY 2017-18 in the current estimate due to having a complete year without IHSS in FY 2018-19 as opposed to only a half year in FY 2017-18.					
Health Care Services for Reentry Programs	219	$0.0	$0.0	$9.7	$0.0
This is a new policy change that estimates the reimbursement from the California Department of Corrections and Rehabiliation (CDCR) for health care services provided to participants in the CDCR Reentry Prgoram. A total reimbursement of $9.7 million is expected in BY.					
Long Term Care Quality Assurance Fund Expenditures	133	$0.0	$98.9	$0.0	($19.2)
This policy change budgets the funding adjustment from the Long Term Care Quality Assurance Fund (LTCQAF) to 100% State General Fund. Based on transfer and collection data through February 2018, it is estimated that transfers from the LTCQAF Fund will be lower than previously estimated in FY 2017-18, and slightly higher in FY 2018-19.					

		Change from November 2017		Change from FY 2017-18	
		FY 2017-18		FY 2018-19	
Name	**PC**	**TF**	**GF**	**TF**	**GF**
Laboratory Rate Methodology Change	135	$8.2	$4.1	($16.2)	($8.1)
This policy change estimates savings from a 10% payment reduction to clinical laboratories or laboratory services, and the savings from a new reimbursement methodology for these services. Based on the revised recoupment schedule, the AB 1494 retroactive recoupment and RY 2015-16 retroactive recoupment has shifted from January 2018 to May 2018, resulting in a decrease in savings in FY 2017-18. Four months of savings has shifted to FY 2018-19, based on the delayed implementation of the recoupment.					
Reduction to Radiology Rates	136	$11.6	$5.8	($47.5)	($23.7)
This policy change estimates savings due to the implementation of a reduction to radiology reimbursement rates. There is a decrease in savings due to delayed implementation of the prospective and retroactive recoupments for the rate adjustment effective October 1, 2015, from FY 2017-18 to FY 2018-19.					
Home Health Rate Increase	204	$0.0	$0.0	$56.7	$0.0
The policy change increases home health agency and private duty nursing rates that are provided by fee-for-service (FFS) and Home and Community-Based Waiver providers by 50%, effective July 1, 2018. California Healthcare, Research, and Prevention Tobacco Tax Act of 2016 (Proposition 56) revenue will be used to fund the non-federal share of the home health agency rate increases. The current estimate updates the costs to remove the CCS-State Only costs to be budgeted in a separate policy change in the Family Health Estimate.					
Ground Emergency Medical Transportation QAF	214	$0.0	$0.0	$167.6	($6.8)
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 new 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.					
Indian Health Services Managed Care Program	222	$30.0	$2.9	($30.0)	($12.4)
This is a new policy change that estimates the costs for the direct payment of Indian Health Service clinic payments by the Managed Care Program. This results in quicker payments to the Indian Health Service clinics and also increases federal funding for Medi-Cal. The program implemented in CY at a cost; however in BY and thereafter, the Department estimates there will be a GF savings.					
Dental Services	169	($134.9)	($59.7)	($23.7)	$38.2
This policy change estimates the cost of FFS dental services. The change from the prior estimate for FY 2017-18 is primarily due to an overall decrease in average monthly eligibles and a shift in the assumed timing of HIPF payments.					

		Change from November 2017		Change from FY 2017-18	
		FY 2017-18		FY 2018-19	
Name	**PC**	**TF**	**GF**	**TF**	**GF**
Prop. 56 Supplemental Payments	141, 147, 148, 156, 160	($358.2)	$0.0	$998.7	$0.0
Effective April 2017, the California Healthcare, Research, and Prevention Tobacco Tax Act of 2016, or Proposition 56, increased taxes on cigarettes and tobacco. AB 120 appropriates a portion of Proposition 56 revenues to provide supplemental payments for specific physician, dental, women's health, HIV/AIDS and Intermediate Care Facilities for the developmentally disabled (ICF/DD) services. These policy changes estimate the expenditures related to providing supplemental payments for specific services. FY 2017-18 includes updated costs with appropriate payment lags and FY 2018-19 includes full year costs. Additionally, FY 2018-19 includes an increase of $232.8 million Prop. 56 revenue for supplemental payments and rate increases approved in the 2017 Budget Act. Of the increased amount, $163 million is for physician payments and $70 million is for dental payments.						
Prop 56- Physician Services Supplemental Payments	141	($390.1)	$0.0	$566.1	$0.0
The current estimate updates FY 2017-18 to include decreased managed care costs based on updated capitation rates and updated payment lags, and increased costs due to early implementation of supplemental payments and Erroneous Payment Correction (EPC). FY 2018-19 includes the full year costs and the additional $163 million of Prop. 56 funding for physician supplemental payments.					
Prop 56 - Supplemental Payments for Dental Services	147	$23.7	$0.0	$401.8	$0.0
The change from the prior estimate for FY 2017-18 is due to updated methodology that incorporates updated rates information and updated payment timing information. The increase from FY 2017-18 to FY 2018-19 in the current estimate is due to timing of retro payments and rates payment timing and the additional $70 million for dental supplemental payments.					
Prop 56-ICF-DD Supplemental Payments	156	$8.4	$0.0	$4.4	$0.0
The current estimate updates expenditures related to providing supplemental payments for ICF-DDs. FY 2017-18 has increased due to a revised annual FY 2017-18 estimate based on updated ICF-DD Medi-Cal days, an earlier date for the FFS EPC, and updated managed care payments. Additionally, FY 2018-19 increases due to including the full year impact of the supplemental payments for both FFS and managed care.					
Prop 56-Women's Health Supplemental Payments	148	($0.2)	$0.0	$25.1	$0.0
The change from the prior estimate for FY 2017-18 is a slight decrease due to updated actual data. The increase from FY 2017-18 to FY 2018-19 in the current estimate is due to timing of adjustments and updated actual data.					
Prop 56-AIDS Waiver Supplemental Payments	160	$0.0	$0.0	$1.3	$0.0
There is no change from the prior estimate for FY 2017-18. The increase from FY 2017-18 to FY 2018-19 in the current estimate is due to the timing of payments.					

		Change from November 2017		Change from FY 2017-18	
		FY 2017-18		FY 2018-19	
Name	**PC**	**TF**	**GF**	**TF**	**GF**
Hospital Quality Assurance Fee (HQAF) – FFS and Managed Care Payments	138, 139	$473.2	$0.0	($1,783.6)	$0.0
The HQAF program assesses a fee on applicable general acute care hospitals and matches the fee with federal financial participation (FFP) providing supplemental fee-for-service (FFS) and managed care supplemental payments to hospitals. The current estimate updates FFS and managed care payment based on the approved HQAF V payment model. For FFS, updated Affordable Care Act (ACA) FFP has been added to FY 2017-18 and FY 2018-19, and this additional ACA FFP will be used to repay CMS for provider overpayments determined from an Upper Payment Limit (UPL) review for HQAF IV. For managed care, HQAF V payments have shifted to be paid in FY 2018-19 due to the timing of the approved model.					
Hospital QAF – Children's Health Care	196	$0.0	($477.1)	$0.0	$370.2
The HQAF also provides additional funding for children's health care coverage. In the current estimate, HQAF children's health care savings have increased in FY 2017-18 and FY 2018-19 based on the approved HQAF V payment model. The increased FY 2018-19 savings are offset by the Upper Payment Limit (UPL) prior year adjustments that have shifted from FY 2017-18 to FY 2018-19 as well as fewer payment cycles.					
HQAF Withhold Transfer	223	$261.4	$130.7	$366.4	$183.2
To recover past due HQAF fees from delinquent providers, the Department currently withholds portions of the provider's FFS payments. On a cash basis, these expenditures were budgeted in the fiscal year the claim was processed; however, some withholds were not transferred into the HQAF fund in the same year the withhold occurred. This PC budgets the transfer of these carryover withhold amounts.					
DP-NF Capital Project Debt Repayment	164	$0.0	($57.2)	$0.0	$57.2
Due to a delay in the issuance of a formal disallowance, the federal fund repayments for this deferral have shifted to be paid in FY 2018-19.					
Repayment to CMS for Medi-Cal Recoveries	215	$0.0	$0.0	$0.0	$25.9
The Department will make a payment to CMS to resolve the incorrectly reported FMAPs for Medi-Cal recoveries from January 2014 to December 2016, totaling $25.9 million GF, in FY 2018-19.					
CMS Deferred Claims	84, CA 9	$0.0	$682.3	$0.0	($79.3)
The Centers for Medicare and Medicaid Services (CMS) reviews claims submitted by Medicaid agencies and may defer payment on claims requiring additional information or claims CMS interprets as not meeting all federal funding requirements. Upon receiving a deferral, the state must immediately return the federal funds to CMS. This policy change estimates the repayment of deferred amounts, issued for Federal Fiscal Year (FFY) 2015 and after, to CMS in FY 2017-18 and FY 2018-19. In addition, recoupments for expected resolved deferrals have been included in FY 2018-19. The payments for the County Administration Enhanced Federal Funding deferral is budgeted separately in a County Administration policy change (CA 9).					

		Change from November 2017		Change from FY 2017-18	
		FY 2017-18		FY 2018-19	
Name	**PC**	**TF**	**GF**	**TF**	**GF**
CMS Deferrals and Negative Balance Repayment	85	$0.0	$0.0	$0.0	$108.5
As part of the California Medi-Cal 2020 Demonstration Waiver, the Department must settle all outstanding deferrals and negative balances with the Centers for Medicare and Medicaid (CMS). The Department estimates to repay $108.5 million GF, related to negative balances, to CMS in FY 2018-19.					
School-Based Medi-Cal Administrative Activities	OA 1	($119.6)	($44.4)	$4.9	$127.5
The SMAA program reimburses Local Educational Agencies (LEAs), or school districts, for the federal share of certain costs for administering the Medi-Cal program. Under the 2014 CMS agreement, deferred SMAA claims from FY 2009-10 through FY 2014-15 (Quarters 1 and 2) are subject to backcasting, utilizing the newly established Random Moment Time Study (RMTS) methodology. Based on backcasted invoices received for FY 2009-10 and FY 2010-11, the estimate of the amount required to be repaid to the federal government has decreased for FY 2017-18. The remaining backcasting years have been estimated based on the interim settlement amounts for those fiscal years.					
Local Education Agency (LEA) Providers	30	($2.6)	($5.2)	$5.1	$0.0
On February 24, 2016, the independent federal auditor discovered that the LEA Billing Option Program paid out $5.2 million in ineligible Title XXI expenditures. The Department estimated to repay these funds to the Centers of Medicare and Medicaid Services with General Fund (GF) in FY 2017-18. The current estimate excludes the $5.2 million GF payments due to the recent final report issued by the CA State Auditor 2017-002 that overturned the Title XXI finding.					

General Information

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.

A 1% variation in total Medi-Cal expenditures would result in an $972 million TF ($203 million General Funds) change in expenditures in FY 2017-18 and $1.04 billion TF ($229 million General Funds) in FY 2018-19.

Medi-Cal Funding Summary
May 2018 Estimate Compared to November 2017 Estimate
Fiscal Year 2017 - 2018

TOTAL FUNDS

Benefits:	**Nov 2017 Estimate**	**May 2018 Estimate**	**Difference Incr./(Decr.)**
4260-101-0001/0890(3)	$68,253,118,000	$64,515,179,000	($3,737,939,000)
4260-101-0080 CLPP Funds	$725,000	$725,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$103,682,000	$103,682,000	$0
4260-101-0233 Prop 99 Physician Srvc. Acct	$33,320,000	$33,320,000	$0
4260-101-0236 Prop 99 Unallocated Account	$45,958,000	$45,958,000	$0
4260-101-3156 MCO Tax Fund MRMIB	$99,407,000	$99,407,000	$0
4260-101-3168 Emergency Air Transportation Fund	$7,890,000	$7,829,000	($61,000)
4260-101-3305 Healthcare Treatment Fund	$1,070,558,000	$963,411,000	($107,147,000)
4260-101-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$46,633,000	$46,633,000	$0
4260-102-0001/0890 Capital Debt	$75,527,000	$120,364,000	$44,837,000
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	$127,550,000	$127,550,000	$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	$11,772,000	$36,687,000	$24,915,000
4260-113-0001/0890 Healthy Families	$2,389,722,000	$3,421,761,000	$1,032,039,000
4260-601-0942142 Local Trauma Centers	$61,798,000	$55,806,000	($5,992,000)
4260-601-0942 Home Health Program Account	$0	$0	$0
4260-601-0995 Reimbursements	$3,611,335,000	$3,531,268,000	($80,067,000)
4260-601-3156 MCO Tax Fund	$329,324,000	$288,474,000	($40,850,000)
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$885,500,000	$882,864,000	($2,636,000)
4260-601-3213 LTC QA Fund	$539,842,000	$440,934,000	($98,908,000)
4260-601-3293 MCO Tax Fund 2016	$2,367,559,000	$2,361,876,000	($5,683,000)
4260-601-7502 Demonstration DSH Fund	$97,710,000	$190,400,000	$92,690,000
4260-601-7503 Health Care Support Fund	$113,067,000	$112,974,000	($93,000)
4260-601-8107 Whole Person Care Pilot Fund	$290,910,000	$176,854,000	($114,056,000)
4260-601-8108 Global Payment Program Fund	$1,044,787,000	$1,137,636,000	$92,849,000
4260-601-8113 DPH GME Special Fund	$471,791,000	$0	($471,791,000)
4260-602-0309 Perinatal Insurance Fund	$14,140,000	$17,289,000	$3,149,000
4260-603-3311 Healthcare Plan Fines and Penalties Fund	$1,392,000	$1,392,000	$0
4260-605-0001 SNF Quality & Accountability *	$48,928,000	$48,310,000	($618,000)
4260-605-3167 SNF Quality & Accountability	$43,121,000	$43,004,000	($117,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($48,928,000)	($48,310,000)	$618,000
4260-606-0834 SB 1100 DSH	$220,645,000	$130,811,000	($89,834,000)
4260-611-3158/0890 Hospital Quality Assurance	$12,802,754,000	$13,838,656,000	$1,035,902,000
4260-611-3201 LIHP MCE Out-of-Network ER Svcs.	$0	$0	$0
Total Benefits	**$95,163,437,000**	**$92,734,644,000**	**($2,428,793,000)**
County Administration:			
4260-101-0001/0890(1)	$4,383,047,000	$4,017,123,000	($365,924,000)
4260-106-0890(1) Money Follow Person Fed. Grant	$627,000	$627,000	$0
4260-113-0001/0890 Healthy Families	$19,547,000	$62,469,000	$42,922,000
4260-117-0001/0890 HIPPA	$12,275,000	$11,421,000	($854,000)
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$5,721,000	$5,721,000	$0
4260-601-0942 Home Health Program Account	$317,000	$317,000	$0
4260-601-0995 Reimbursements	$630,000	$594,000	($36,000)
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$1,419,000	$1,419,000	$0
4260-605-3167 SNF Quality & Accountability Admin.	$3,907,000	$3,407,000	($500,000)
Total County Administration	**$4,427,490,000**	**$4,103,098,000**	**($324,392,000)**
Fiscal Intermediary:			
4260-101-0001/0890(2)	$428,277,000	$393,507,000	($34,770,000)
4260-113-0001/0890 Healthy Families	$6,088,000	$5,343,000	($745,000)
4260-117-0001/0890 HIPAA	$14,827,000	$14,303,000	($524,000)
4260-601-0995 Reimbursements	$0	$0	$0
Total Fiscal Intermediar y	**$449,192,000**	**$413,153,000**	**($36,039,000)**
Grand Total - Total Funds	**$100,040,119,000**	**$97,250,895,000**	**($2,789,224,000)**

Medi-Cal Funding Summary
May 2018 Estimate Compared to November 2017 Estimate
Fiscal Year 2017 - 2018

STATE FUNDS

Benefits:	**Nov 2017 Estimate**	**May 2018 Estimate**	**Difference Incr./(Decr.)**
4260-101-0001(3) *	$18,226,737,000	$18,409,976,000	$183,239,000
4260-101-0080 CLPP Funds	$725,000	$725,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$103,682,000	$103,682,000	$0
4260-101-0233 Prop 99 Physician Srvc. Acct	$33,320,000	$33,320,000	$0
4260-101-0236 Prop 99 Unallocated Account	$45,958,000	$45,958,000	$0
4260-101-3156 MCO Tax Fund MRMIB	$99,407,000	$99,407,000	$0
4260-101-3168 Emergency Air Transportation Fund	$7,890,000	$7,829,000	($61,000)
4260-101-3305 Healthcare Treatment Fund	$1,070,558,000	$963,411,000	($107,147,000)
4260-101-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$46,633,000	$46,633,000	$0
4260-102-0001 Capital Debt *	$37,764,000	$25,634,000	($12,130,000)
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	$127,550,000	$127,550,000	$0
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-113-0001 Healthy Families *	$432,965,000	$390,556,000	($42,409,000)
4260-601-0942142 Local Trauma Centers	$61,798,000	$55,806,000	($5,992,000)
4260-601-0942 Home Health Program Account	$0	$0	$0
4260-601-0995 Reimbursements	$3,611,335,000	$3,531,268,000	($80,067,000)
4260-601-3156 MCO Tax Fund	$329,324,000	$288,474,000	($40,850,000)
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$885,500,000	$882,864,000	($2,636,000)
4260-601-3213 LTC QA Fund	$539,842,000	$440,934,000	($98,908,000)
4260-601-3293 MCO Tax Fund 2016	$2,367,559,000	$2,361,876,000	($5,683,000)
4260-601-8107 Whole Person Care Pilot Fund	$290,910,000	$176,854,000	($114,056,000)
4260-601-8108 Global Payment Program Fund	$1,044,787,000	$1,137,636,000	$92,849,000
4260-601-8113 DPH GME Special Fund	$471,791,000	$0	($471,791,000)
4260-602-0309 Perinatal Insurance Fund	$14,140,000	$17,289,000	$3,149,000
4260-603-3311 Healthcare Plan Fines and Penalties Fund	$1,392,000	$1,392,000	$0
4260-605-0001 SNF Quality & Accountability *	$48,928,000	$48,310,000	($618,000)
4260-605-3167 SNF Quality & Accountability	$43,121,000	$43,004,000	($117,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($48,928,000)	($48,310,000)	$618,000
4260-606-0834 SB 1100 DSH	$220,645,000	$130,811,000	($89,834,000)
4260-611-3158 Hospital Quality Assurance Revenue	$5,034,239,000	$6,710,509,000	$1,676,270,000
4260-611-3201 LIHP MCE Out-of-Network ER Svcs.	$0	$0	$0
Total Benefits	**$35,151,472,000**	**$36,035,298,000**	**$883,826,000**
Total Benefits General Fund *	**$18,866,694,000**	**$18,994,776,000**	**$128,082,000**
County Administration:			
4260-101-0001(1) *	$1,016,053,000	$1,196,890,000	$180,837,000
4260-113-0001 Healthy Families *	$12,740,000	$5,470,000	($7,270,000)
4260-117-0001 HIPAA *	$2,183,000	$2,022,000	($161,000)
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$5,721,000	$5,721,000	$0
4260-601-0942 Home Health Program Account	$317,000	$317,000	$0
4260-601-0995 Reimbursements	$630,000	$594,000	($36,000)
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$1,419,000	$1,419,000	$0
4260-605-3167 SNF Quality & Accountability Admin.	$3,907,000	$3,407,000	($500,000)
Total County Administration	**$1,042,970,000**	**$1,215,840,000**	**$172,870,000**
Total County Administration General Fund *	**$1,030,976,000**	**$1,204,382,000**	**$173,406,000**
Fiscal Intermediary:			
4260-101-0001(2) *	$156,302,000	$142,264,000	($14,038,000)
4260-113-0001 Healthy Families *	$1,700,000	$641,000	($1,059,000)
4260-117-0001 HIPAA *	$2,739,000	$2,608,000	($131,000)
4260-601-0995 Reimbursements	$0	$0	$0
Total Fiscal Intermediary	**$160,741,000**	**$145,513,000**	**($15,228,000)**
Total Fiscal Intermediary General Fund *	**$160,741,000**	**$145,513,000**	**($15,228,000)**
Grand Total - State Funds	**$36,355,183,000**	**$37,396,651,000**	**$1,041,468,000**
Grand Total - General Fund*	**$20,058,411,000**	**$20,344,671,000**	**$286,260,000**

Medi-Cal Funding Summary
May 2018 Estimate Compared to November 2017 Estimate
Fiscal Year 2017 - 2018

FEDERAL FUNDS

	Nov 2017 Estimate	May 2018 Estimate	Difference Incr./(Decr.)
Benefits:			
4260-101-0890(3)	$50,026,381,000	$46,105,203,000	($3,921,178,000)
4260-102-0890 Capital Debt	$37,763,000	$94,730,000	$56,967,000
4260-106-0890 Money Follows Person Federal Grant	$11,772,000	$36,687,000	$24,915,000
4260-113-0890 Health Families	$1,956,757,000	$3,031,205,000	$1,074,448,000
4260-601-7502 Demonstration DSH Fund	$97,710,000	$190,400,000	$92,690,000
4260-601-7503 Health Care Support Fund	$113,067,000	$112,974,000	($93,000)
4260-611-0890 Hospital Quality Assurance	$7,768,515,000	$7,128,147,000	($640,368,000)
Total Benefits	**$60,011,965,000**	**$56,699,346,000**	**($3,312,619,000)**
County Administration:			
4260-101-0890(1)	$3,366,994,000	$2,820,233,000	($546,761,000)
4260-106-0890(1) Money Follows Person Fed. Grant	$627,000	$627,000	$0
4260-113-0890 Healthy Families	$6,807,000	$56,999,000	$50,192,000
4260-117-0890 HIPAA	$10,092,000	$9,399,000	($693,000)
Total County Administration	**$3,384,520,000**	**$2,887,258,000**	**($497,262,000)**
Fiscal Intermediary:			
4260-101-0890(2)	$271,975,000	$251,243,000	($20,732,000)
4260-113-0890 Healthy Families	$4,388,000	$4,702,000	$314,000
4260-117-0890 HIPAA	$12,088,000	$11,695,000	($393,000)
Total Fiscal Intermediary	**$288,451,000**	**$267,640,000**	**($20,811,000)**
Grand Total - Federal Funds	**$63,684,936,000**	**$59,854,244,000**	**($3,830,692,000)**

Medi-Cal Funding Summary
May 2018 Estimate Compared to Appropriation
Fiscal Year 2017 - 2018

TOTAL FUNDS

	Total Appropriation	May 2018 Estimate	Difference Incr./(Decr.)
Benefits:			
4260-101-0001/0890(3)	$69,136,479,000	$64,515,179,000	($4,621,300,000)
4260-101-0080 CLPP Funds	$725,000	$725,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$111,400,000	$103,682,000	($7,718,000)
4260-101-0233 Prop 99 Physician Srvc. Acct	$40,220,000	$33,320,000	($6,900,000)
4260-101-0236 Prop 99 Unallocated Account	$56,904,000	$45,958,000	($10,946,000)
4260-101-3156 MCO Tax Fund MRMIB	$99,407,000	$99,407,000	$0
4260-101-3168 Emergency Air Transportation Fund	$7,890,000	$7,829,000	($61,000)
4260-101-3305 Healthcare Treatment Fund	$1,257,166,000	$963,411,000	($293,755,000)
4260-101-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$46,633,000	$46,633,000	$0
4260-102-0001/0890 Capital Debt	$165,619,000	$120,364,000	($45,255,000)
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	$127,550,000	$127,550,000	$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	$19,496,000	$36,687,000	$17,191,000
4260-113-0001/0890 Healthy Families	$3,020,483,000	$3,421,761,000	$401,278,000
4260-601-0942142 Local Trauma Centers	$44,845,000	$55,806,000	$10,961,000
4260-601-0942 Home Health Program Account	$0	$0	$0
4260-601-0995 Reimbursements	$4,947,529,000	$3,531,268,000	($1,416,261,000)
4260-601-3156 MCO Tax Fund	$328,610,000	$288,474,000	($40,136,000)
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$800,000,000	$882,864,000	$82,864,000
4260-601-3213 LTC QA Fund	$482,975,000	$440,934,000	($42,041,000)
4260-601-3293 MCO Tax Fund 2016	$2,392,507,000	$2,361,876,000	($30,631,000)
4260-601-7502 Demonstration DSH Fund	$148,011,000	$190,400,000	$42,389,000
4260-601-7503 Health Care Support Fund	$324,393,000	$112,974,000	($211,419,000)
4260-601-8107 Whole Person Care Pilot Fund	$360,000,000	$176,854,000	($183,146,000)
4260-601-8108 Global Payment Program Fund	$1,152,567,000	$1,137,636,000	($14,931,000)
4260-601-8113 DPH GME Special Fund	$0	$0	$0
4260-602-0309 Perinatal Insurance Fund	$10,997,000	$17,289,000	$6,292,000
4260-603-3311 Healthcare Plan Fines and Penalties Fund	$0	$1,392,000	$1,392,000
4260-605-0001 SNF Quality & Accountability *	$48,928,000	$48,310,000	($618,000)
4260-605-3167 SNF Quality & Accountability	$43,122,000	$43,004,000	($118,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($48,928,000)	($48,310,000)	$618,000
4260-606-0834 SB 1100 DSH	$177,411,000	$130,811,000	($46,600,000)
4260-611-3158/0890 Hospital Quality Assurance	$16,840,000,000	$13,838,656,000	($3,001,344,000)
4260-611-3201 LIHP MCE Out-of-Network ER Svcs.	$116,250,000	$0	($116,250,000)
Total Benefits	**$102,261,089,000**	**$92,734,644,000**	**($9,526,445,000)**
County Administration:			
4260-101-0001/0890(1)	$4,518,300,000	$4,017,123,000	($501,177,000)
4260-106-0890(1) Money Follow Person Fed. Grant	$688,000	$627,000	($61,000)
4260-113-0001/0890 Healthy Families	$32,587,000	$62,469,000	$29,882,000
4260-117-0001/0890 HIPPA	$10,581,000	$11,421,000	$840,000
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$5,856,000	$5,721,000	($135,000)
4260-601-0942 Home Health Program Account	$317,000	$317,000	$0
4260-601-0995 Reimbursements	$692,000	$594,000	($98,000)
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$1,419,000	$1,419,000	$0
4260-605-3167 SNF Quality & Accountability Admin.	$3,907,000	$3,407,000	($500,000)
Total County Administration	**$4,574,347,000**	**$4,103,098,000**	**($471,249,000)**
Fiscal Intermediary:			
4260-101-0001/0890(2)	$403,121,000	$393,507,000	($9,614,000)
4260-113-0001/0890 Healthy Families	$5,816,000	$5,343,000	($473,000)
4260-117-0001/0890 HIPAA	$14,293,000	$14,303,000	$10,000
4260-601-0995 Reimbursements	$0	$0	$0
Total Fiscal Intermediar y	**$423,230,000**	**$413,153,000**	**($10,077,000)**
Grand Total - Total Funds	**$107,258,666,000**	**$97,250,895,000**	**($10,007,771,000)**

Medi-Cal Funding Summary

May 2018 Estimate Compared to Appropriation

Fiscal Year 2017 - 2018

STATE FUNDS

Benefits:	**State Funds Appropriation**	**May 2018 Estimate**	**Difference Incr./(Decr.)**
4260-101-0001(3) *	$17,428,661,000	$18,409,976,000	$981,315,000
4260-101-0080 CLPP Funds	$725,000	$725,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$111,400,000	$103,682,000	($7,718,000)
4260-101-0233 Prop 99 Physician Srvc. Acct	$40,220,000	$33,320,000	($6,900,000)
4260-101-0236 Prop 99 Unallocated Account	$56,904,000	$45,958,000	($10,946,000)
4260-101-3156 MCO Tax Fund MRMIB	$99,407,000	$99,407,000	$0
4260-101-3168 Emergency Air Transportation Fund	$7,890,000	$7,829,000	($61,000)
4260-101-3305 Healthcare Treatment Fund	$1,257,166,000	$963,411,000	($293,755,000)
4260-101-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$46,633,000	$46,633,000	$0
4260-102-0001 Capital Debt *	$82,809,000	$25,634,000	($57,175,000)
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	$127,550,000	$127,550,000	$0
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-113-0001 Healthy Families *	$718,959,000	$390,556,000	($328,403,000)
4260-601-0942142 Local Trauma Centers	$44,845,000	$55,806,000	$10,961,000
4260-601-0942 Home Health Program Account	$0	$0	$0
4260-601-0995 Reimbursements	$4,947,529,000	$3,531,268,000	($1,416,261,000)
4260-601-3156 MCO Tax Fund	$328,610,000	$288,474,000	($40,136,000)
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$800,000,000	$882,864,000	$82,864,000
4260-601-3213 LTC QA Fund	$482,975,000	$440,934,000	($42,041,000)
4260-601-3293 MCO Tax Fund 2016	$2,392,507,000	$2,361,876,000	($30,631,000)
4260-601-8107 Whole Person Care Pilot Fund	$360,000,000	$176,854,000	($183,146,000)
4260-601-8108 Global Payment Program Fund	$1,152,567,000	$1,137,636,000	($14,931,000)
4260-601-8113 DPH GME Special Fund	$0	$0	$0
4260-602-0309 Perinatal Insurance Fund	$10,997,000	$17,289,000	$6,292,000
4260-603-3311 Healthcare Plan Fines and Penalties Fund	$0	$1,392,000	$1,392,000
4260-605-0001 SNF Quality & Accountability *	$48,928,000	$48,310,000	($618,000)
4260-605-3167 SNF Quality & Accountability	$43,122,000	$43,004,000	($118,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($48,928,000)	($48,310,000)	$618,000
4260-606-0834 SB 1100 DSH	$177,411,000	$130,811,000	($46,600,000)
4260-611-3158 Hospital Quality Assurance Revenue	$6,382,189,000	$6,710,509,000	$328,320,000
4260-611-3201 LIHP MCE Out-of-Network ER Svcs.	$116,250,000	$0	($116,250,000)
Total Benefits	**$37,219,226,000**	**$36,035,298,000**	**($1,183,928,000)**
Total Benefits General Fund *	**$18,399,657,000**	**$18,994,776,000**	**$595,119,000**
County Administration:			
4260-101-0001(1) *	$946,049,000	$1,196,890,000	$250,841,000
4260-113-0001 Healthy Families *	$12,804,000	$5,470,000	($7,334,000)
4260-117-0001 HIPAA *	$1,708,000	$2,022,000	$314,000
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$5,856,000	$5,721,000	($135,000)
4260-601-0942 Home Health Program Account	$317,000	$317,000	$0
4260-601-0995 Reimbursements	$692,000	$594,000	($98,000)
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$1,419,000	$1,419,000	$0
4260-605-3167 SNF Quality & Accountability Admin.	$3,907,000	$3,407,000	($500,000)
Total County Administration	**$972,752,000**	**$1,215,840,000**	**$243,088,000**
Total County Administration General Fund *	**$960,561,000**	**$1,204,382,000**	**$243,821,000**
Fiscal Intermediary:			
4260-101-0001(2) *	$150,157,000	$142,264,000	($7,893,000)
4260-113-0001 Healthy Families *	$1,701,000	$641,000	($1,060,000)
4260-117-0001 HIPAA *	$2,681,000	$2,608,000	($73,000)
4260-601-0995 Reimbursements	$0	$0	$0
Total Fiscal Intermediary	**$154,539,000**	**$145,513,000**	**($9,026,000)**
Total Fiscal Intermediary General Fund *	**$154,539,000**	**$145,513,000**	**($9,026,000)**
Grand Total - State Funds	**$38,346,517,000**	**$37,396,651,000**	**($949,866,000)**
Grand Total - General Fund*	**$19,514,757,000**	**$20,344,671,000**	**$829,914,000**

Medi-Cal Funding Summary

May 2018 Estimate Compared to Appropriation

Fiscal Year 2017 - 2018

FEDERAL FUNDS

	Federal Funds Appropriation	May 2018 Estimate	Difference Incr./(Decr.)
Benefits:			
4260-101-0890(3)	$51,707,818,000	$46,105,203,000	($5,602,615,000)
4260-102-0890 Capital Debt	$82,810,000	$94,730,000	$11,920,000
4260-106-0890 Money Follows Person Federal Grant	$19,496,000	$36,687,000	$17,191,000
4260-113-0890 Health Families	$2,301,524,000	$3,031,205,000	$729,681,000
4260-601-7502 Demonstration DSH Fund	$148,011,000	$190,400,000	$42,389,000
4260-601-7503 Health Care Support Fund	$324,393,000	$112,974,000	($211,419,000)
4260-611-0890 Hospital Quality Assurance	$10,457,811,000	$7,128,147,000	($3,329,664,000)
Total Benefits	**$65,041,863,000**	**$56,699,346,000**	**($8,342,517,000)**
County Administration:			
4260-101-0890(1)	$3,572,251,000	$2,820,233,000	($752,018,000)
4260-106-0890(1) Money Follows Person Fed. Grant	$688,000	$627,000	($61,000)
4260-113-0890 Healthy Families	$19,783,000	$56,999,000	$37,216,000
4260-117-0890 HIPAA	$8,873,000	$9,399,000	$526,000
Total County Administration	**$3,601,595,000**	**$2,887,258,000**	**($714,337,000)**
Fiscal Intermediary:			
4260-101-0890(2)	$252,964,000	$251,243,000	($1,721,000)
4260-113-0890 Healthy Families	$4,115,000	$4,702,000	$587,000
4260-117-0890 HIPAA	$11,612,000	$11,695,000	$83,000
Total Fiscal Intermediary	**$268,691,000**	**$267,640,000**	**($1,051,000)**
Grand Total - Federal Funds	**$68,912,149,000**	**$59,854,244,000**	**($9,057,905,000)**

Medi-Cal Funding Summary

May 2018 Estimate Comparison of FY 2017-18 to FY 2018-19

TOTAL FUNDS

	FY 2017-18 Estimate	FY 2018-19 Estimate	Difference Incr./(Decr.)
Benefits:			
4260-101-0001/0890(3)	$64,515,179,000	$75,253,293,000	$10,738,114,000
4260-101-0080 CLPP Funds	$725,000	$725,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$103,682,000	$73,335,000	($30,347,000)
4260-101-0233 Prop 99 Physician Srvc. Acct	$33,320,000	$22,496,000	($10,824,000)
4260-101-0236 Prop 99 Unallocated Account	$45,958,000	$31,609,000	($14,349,000)
4260-101-3156 MCO Tax Fund MRMIB	$99,407,000	$0	($99,407,000)
4260-101-3168 Emergency Air Transportation Fund	$7,829,000	$8,525,000	$696,000
4260-101-3305 Healthcare Treatment Fund	$963,411,000	$854,642,000	($108,769,000)
4260-101-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$46,633,000	$0	($46,633,000)
4260-102-0001/0890 Capital Debt	$120,364,000	$102,780,000	($17,584,000)
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	$127,550,000	$137,900,000	$10,350,000
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	$36,687,000	$10,173,000	($26,514,000)
4260-113-0001/0890 Healthy Families	$3,421,761,000	$2,752,220,000	($669,541,000)
4260-601-0942142 Local Trauma Centers	$55,806,000	$64,207,000	$8,401,000
4260-601-0942 Home Health Program Account	$0	$347,000	$347,000
4260-601-0995 Reimbursements	$3,531,268,000	$1,547,072,000	($1,984,196,000)
4260-601-3156 MCO Tax Fund	$288,474,000	$21,286,000	($267,188,000)
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$882,864,000	$762,447,000	($120,417,000)
4260-601-3213 LTC QA Fund	$440,934,000	$460,098,000	$19,164,000
4260-601-3293 MCO Tax Fund 2016	$2,361,876,000	$2,520,163,000	$158,287,000
4260-601-3323 Medi-Cal Emergency Transport Fund	$0	$60,884,000	$60,884,000
4260-601-7502 Demonstration DSH Fund	$190,400,000	$179,295,000	($11,105,000)
4260-601-7503 Health Care Support Fund	$112,974,000	$337,306,000	$224,332,000
4260-601-8107 Whole Person Care Pilot Fund	$176,854,000	$437,421,000	$260,567,000
4260-601-8108 Global Payment Program Fund	$1,137,636,000	$1,246,043,000	$108,407,000
4260-601-8113 DPH GME Special Fund	$0	$568,422,000	$568,422,000
4260-602-0309 Perinatal Insurance Fund	$17,289,000	$11,734,000	($5,555,000)
4260-603-3311 Healthcare Plan Fines and Penalties Fund	$1,392,000	$0	($1,392,000)
4260-605-0001 SNF Quality & Accountability *	$48,310,000	$48,310,000	$0
4260-605-3167 SNF Quality & Accountability	$43,004,000	$43,004,000	$0
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($48,310,000)	($48,310,000)	$0
4260-606-0834 SB 1100 DSH	$130,811,000	$151,893,000	$21,082,000
4260-611-3158/0890 Hospital Quality Assurance	$13,838,656,000	$11,382,710,000	($2,455,946,000)
4260-611-3201 LIHP MCE Out-of-Network ER Svcs.	$0	$0	$0
Total Benefits	**$92,734,644,000**	**$99,043,930,000**	**$6,309,286,000**
County Administration:			
4260-101-0001/0890(1)	$4,017,123,000	$4,432,553,000	$415,430,000
4260-106-0890(1) Money Follow Person Fed. Grant	$627,000	$682,000	$55,000
4260-113-0001/0890 Healthy Families	$62,469,000	$62,661,000	$192,000
4260-117-0001/0890 HIPPA	$11,421,000	$9,612,000	($1,809,000)
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$5,721,000	$0	($5,721,000)
4260-601-0942 Home Health Program Account	$317,000	$317,000	$0
4260-601-0995 Reimbursements	$594,000	$568,000	($26,000)
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$1,419,000	$1,063,000	($356,000)
4260-605-3167 SNF Quality & Accountability Admin.	$3,407,000	$3,407,000	$0
Total County Administration	**$4,103,098,000**	**$4,510,863,000**	**$407,765,000**
Fiscal Intermediary:			
4260-101-0001/0890(2)	$393,507,000	$307,471,000	($86,036,000)
4260-113-0001/0890 Healthy Families	$5,343,000	$4,871,000	($472,000)
4260-117-0001/0890 HIPAA	$14,303,000	$13,945,000	($358,000)
4260-601-0995 Reimbursements	$0	$0	$0
Total Fiscal Intermediary	**$413,153,000**	**$326,287,000**	**($86,866,000)**
Grand Total - Total Funds	**$97,250,895,000**	**$103,881,080,000**	**$6,630,185,000**

Medi-Cal Funding Summary

May 2018 Estimate Comparison of FY 2017-18 to FY 2018-19

STATE FUNDS

Benefits:	**FY 2017-18 Estimate**	**FY 2018-19 Estimate**	**Difference Incr./(Decr.)**
4260-101-0001(3) *	$18,409,976,000	$21,292,101,000	$2,882,125,000
4260-101-0080 CLPP Funds	$725,000	$725,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$103,682,000	$73,335,000	($30,347,000)
4260-101-0233 Prop 99 Physician Srvc. Acct	$33,320,000	$22,496,000	($10,824,000)
4260-101-0236 Prop 99 Unallocated Account	$45,958,000	$31,609,000	($14,349,000)
4260-101-3156 MCO Tax Fund MRMIB	$99,407,000	$0	($99,407,000)
4260-101-3168 Emergency Air Transportation Fund	$7,829,000	$8,525,000	$696,000
4260-101-3305 Healthcare Treatment Fund	$963,411,000	$854,642,000	($108,769,000)
4260-101-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$46,633,000	$0	($46,633,000)
4260-102-0001 Capital Debt *	$25,634,000	$36,635,000	$11,001,000
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	$127,550,000	$137,900,000	$10,350,000
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-113-0001 Healthy Families *	$390,556,000	$108,415,000	($282,141,000)
4260-601-0942142 Local Trauma Centers	$55,806,000	$64,207,000	$8,401,000
4260-601-0942 Home Health Program Account	$0	$347,000	$347,000
4260-601-0995 Reimbursements	$3,531,268,000	$1,547,072,000	($1,984,196,000)
4260-601-3156 MCO Tax Fund	$288,474,000	$21,286,000	($267,188,000)
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$882,864,000	$762,447,000	($120,417,000)
4260-601-3213 LTC QA Fund	$440,934,000	$460,098,000	$19,164,000
4260-601-3293 MCO Tax Fund 2016	$2,361,876,000	$2,520,163,000	$158,287,000
4260-601-3323 Medi-Cal Emergency Transport Fund	$0	$60,884,000	$60,884,000
4260-601-8107 Whole Person Care Pilot Fund	$176,854,000	$437,421,000	$260,567,000
4260-601-8108 Global Payment Program Fund	$1,137,636,000	$1,246,043,000	$108,407,000
4260-601-8113 DPH GME Special Fund	$0	$568,422,000	$568,422,000
4260-602-0309 Perinatal Insurance Fund	$17,289,000	$11,734,000	($5,555,000)
4260-603-3311 Healthcare Plan Fines and Penalties Fund	$1,392,000	$0	($1,392,000)
4260-605-0001 SNF Quality & Accountability *	$48,310,000	$48,310,000	$0
4260-605-3167 SNF Quality & Accountability	$43,004,000	$43,004,000	$0
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($48,310,000)	($48,310,000)	$0
4260-606-0834 SB 1100 DSH	$130,811,000	$151,893,000	$21,082,000
4260-611-3158 Hospital Quality Assurance Revenue	$6,710,509,000	$4,871,254,000	($1,839,255,000)
4260-611-3201 LIHP MCE Out-of-Network ER Svcs.	$0	$0	$0
Total Benefits	**$36,035,298,000**	**$35,334,558,000**	**($700,740,000)**
Total Benefits General Fund *	**$18,994,776,000**	**$21,605,761,000**	**$2,610,985,000**
County Administration:			
4260-101-0001(1) *	$1,196,890,000	$1,212,761,000	$15,871,000
4260-113-0001 Healthy Families *	$5,470,000	$5,507,000	$37,000
4260-117-0001 HIPAA *	$2,022,000	$1,694,000	($328,000)
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$5,721,000	$0	($5,721,000)
4260-601-0942 Home Health Program Account	$317,000	$317,000	$0
4260-601-0995 Reimbursements	$594,000	$568,000	($26,000)
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$1,419,000	$1,063,000	($356,000)
4260-605-3167 SNF Quality & Accountability Admin.	$3,407,000	$3,407,000	$0
Total County Administration	**$1,215,840,000**	**$1,225,317,000**	**$9,477,000**
Total County Administration General Fund *	**$1,204,382,000**	**$1,219,962,000**	**$15,580,000**
Fiscal Intermediary:			
4260-101-0001(2) *	$142,264,000	$109,642,000	($32,622,000)
4260-113-0001 Healthy Families *	$641,000	$585,000	($56,000)
4260-117-0001 HIPAA *	$2,608,000	$2,549,000	($59,000)
4260-601-0995 Reimbursements	$0	$0	$0
Total Fiscal Intermediary	**$145,513,000**	**$112,776,000**	**($32,737,000)**
Total Fiscal Intermediary General Fund *	**$145,513,000**	**$112,776,000**	**($32,737,000)**
Grand Total - State Funds	**$37,396,651,000**	**$36,672,651,000**	**($724,000,000)**
Grand Total - General Fund*	**$20,344,671,000**	**$22,938,499,000**	**$2,593,828,000**

Medi-Cal Funding Summary

May 2018 Estimate Comparison of FY 2017-18 to FY 2018-19

FEDERAL FUNDS

Benefits:	FY 2017-18 Estimate	FY 2018-19 Estimate	Difference Incr./(Decr.)
4260-101-0890(3)	$46,105,203,000	$53,961,192,000	$7,855,989,000
4260-102-0890 Capital Debt	$94,730,000	$66,145,000	($28,585,000)
4260-106-0890 Money Follows Person Federal Grant	$36,687,000	$10,173,000	($26,514,000)
4260-113-0890 Health Families	$3,031,205,000	$2,643,805,000	($387,400,000)
4260-601-7502 Demonstration DSH Fund	$190,400,000	$179,295,000	($11,105,000)
4260-601-7503 Health Care Support Fund	$112,974,000	$337,306,000	$224,332,000
4260-611-0890 Hospital Quality Assurance	$7,128,147,000	$6,511,456,000	($616,691,000)
Total Benefits	**$56,699,346,000**	**$63,709,372,000**	**$7,010,026,000**
County Administration:			
4260-101-0890(1)	$2,820,233,000	$3,219,792,000	$399,559,000
4260-106-0890(1) Money Follows Person Fed. Grant	$627,000	$682,000	$55,000
4260-113-0890 Healthy Families	$56,999,000	$57,154,000	$155,000
4260-117-0890 HIPAA	$9,399,000	$7,918,000	($1,481,000)
Total County Administration	**$2,887,258,000**	**$3,285,546,000**	**$398,288,000**
Fiscal Intermediary:			
4260-101-0890(2)	$251,243,000	$197,829,000	($53,414,000)
4260-113-0890 Healthy Families	$4,702,000	$4,286,000	($416,000)
4260-117-0890 HIPAA	$11,695,000	$11,396,000	($299,000)
Total Fiscal Intermediary	**$267,640,000**	**$213,511,000**	**($54,129,000)**
Grand Total - Federal Funds	**$59,854,244,000**	**$67,208,429,000**	**$7,354,185,000**

Medi-Cal Funding Summary
May 2018 Estimate Compared to November 2017 Estimate
Fiscal Year 2018 - 2019

TOTAL FUNDS

Benefits:	**Nov 2017 Estimate**	**May 2018 Estimate**	**Difference Incr./(Decr.)**
4260-101-0001/0890(3)	$74,544,924,000	$75,253,293,000	$708,369,000
4260-101-0080 CLPP Funds	$725,000	$725,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$75,580,000	$73,335,000	($2,245,000)
4260-101-0233 Prop 99 Physician Srvc. Acct	$21,732,000	$22,496,000	$764,000
4260-101-0236 Prop 99 Unallocated Account	$29,922,000	$31,609,000	$1,687,000
4260-101-3156 MCO Tax Fund MRMIB	$0	$0	$0
4260-101-3168 Emergency Air Transportation Fund	$8,525,000	$8,525,000	$0
4260-101-3305 Healthcare Treatment Fund	$850,925,000	$854,642,000	$3,717,000
4260-101-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$0	$0	$0
4260-102-0001/0890 Capital Debt	$82,166,000	$102,780,000	$20,614,000
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	$137,900,000	$137,900,000	$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	$6,379,000	$10,173,000	$3,794,000
4260-113-0001/0890 Healthy Families	$3,062,477,000	$2,752,220,000	($310,257,000)
4260-601-0942142 Local Trauma Centers	$64,207,000	$64,207,000	$0
4260-601-0942 Home Health Program Account	$1,338,000	$347,000	($991,000)
4260-601-0995 Reimbursements	$1,583,407,000	$1,547,072,000	($36,335,000)
4260-601-3156 MCO Tax Fund	$0	$21,286,000	$21,286,000
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$760,000,000	$762,447,000	$2,447,000
4260-601-3213 LTC QA Fund	$504,609,000	$460,098,000	($44,511,000)
4260-601-3293 MCO Tax Fund 2016	$2,519,214,000	$2,520,163,000	$949,000
4260-601-3323 Medi-Cal Emergency Transport Fund	$0	$60,884,000	$60,884,000
4260-601-7502 Demonstration DSH Fund	$127,794,000	$179,295,000	$51,501,000
4260-601-7503 Health Care Support Fund	$337,313,000	$337,306,000	($7,000)
4260-601-8107 Whole Person Care Pilot Fund	$323,365,000	$437,421,000	$114,056,000
4260-601-8108 Global Payment Program Fund	$1,066,905,000	$1,246,043,000	$179,138,000
4260-601-8113 DPH GME Special Fund	$393,337,000	$568,422,000	$175,085,000
4260-602-0309 Perinatal Insurance Fund	$19,553,000	$11,734,000	($7,819,000)
4260-603-3311 Healthcare Plan Fines and Penalties Fund	$0	$0	$0
4260-605-0001 SNF Quality & Accountability *	$48,928,000	$48,310,000	($618,000)
4260-605-3167 SNF Quality & Accountability	$43,121,000	$43,004,000	($117,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($48,928,000)	($48,310,000)	$618,000
4260-606-0834 SB 1100 DSH	$150,386,000	$151,893,000	$1,507,000
4260-611-3158/0890 Hospital Quality Assurance	$10,089,555,000	$11,382,710,000	$1,293,155,000
4260-611-3201 LIHP MCE Out-of-Network ER Svcs.	$0	$0	$0
Total Benefits	**$96,807,259,000**	**$99,043,930,000**	**$2,236,671,000**
County Administration:			
4260-101-0001/0890(1)	$4,296,401,000	$4,432,553,000	$136,152,000
4260-106-0890(1) Money Follow Person Fed. Grant	$682,000	$682,000	$0
4260-113-0001/0890 Healthy Families	$57,964,000	$62,661,000	$4,697,000
4260-117-0001/0890 HIPPA	$9,268,000	$9,612,000	$344,000
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$0	$0	$0
4260-601-0942 Home Health Program Account	$317,000	$317,000	$0
4260-601-0995 Reimbursements	$736,000	$568,000	($168,000)
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$0	$1,063,000	$1,063,000
4260-605-3167 SNF Quality & Accountability Admin.	$3,907,000	$3,407,000	($500,000)
Total County Administration	**$4,369,275,000**	**$4,510,863,000**	**$141,588,000**
Fiscal Intermediary:			
4260-101-0001/0890(2)	$310,500,000	$307,471,000	($3,029,000)
4260-113-0001/0890 Healthy Families	$3,700,000	$4,871,000	$1,171,000
4260-117-0001/0890 HIPAA	$13,923,000	$13,945,000	$22,000
4260-601-0995 Reimbursements	$0	$0	$0
Total Fiscal Intermediary	**$328,123,000**	**$326,287,000**	**($1,836,000)**
Grand Total - Total Funds	**$101,504,657,000**	**$103,881,080,000**	**$2,376,423,000**

Medi-Cal Funding Summary
May 2018 Estimate Compared to November 2017 Estimate
Fiscal Year 2018 - 2019

STATE FUNDS

Benefits:	**Nov 2017 Estimate**	**May 2018 Estimate**	**Difference Incr./(Decr.)**
4260-101-0001(3) *	$19,233,014,000	$21,292,101,000	$2,059,087,000
4260-101-0080 CLPP Funds	$725,000	$725,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$75,580,000	$73,335,000	($2,245,000)
4260-101-0233 Prop 99 Physician Srvc. Acct	$21,732,000	$22,496,000	$764,000
4260-101-0236 Prop 99 Unallocated Account	$29,922,000	$31,609,000	$1,687,000
4260-101-3156 MCO Tax Fund MRMIB	$0	$0	$0
4260-101-3168 Emergency Air Transportation Fund	$8,525,000	$8,525,000	$0
4260-101-3305 Healthcare Treatment Fund	$850,925,000	$854,642,000	$3,717,000
4260-101-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$0	$0	$0
4260-102-0001 Capital Debt *	$41,398,000	$36,635,000	($4,763,000)
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	$137,900,000	$137,900,000	$0
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-113-0001 Healthy Families *	$945,053,000	$108,415,000	($836,638,000)
4260-601-0942142 Local Trauma Centers	$64,207,000	$64,207,000	$0
4260-601-0942 Home Health Program Account	$1,338,000	$347,000	($991,000)
4260-601-0995 Reimbursements	$1,583,407,000	$1,547,072,000	($36,335,000)
4260-601-3156 MCO Tax Fund	$0	$21,286,000	$21,286,000
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$760,000,000	$762,447,000	$2,447,000
4260-601-3213 LTC QA Fund	$504,609,000	$460,098,000	($44,511,000)
4260-601-3293 MCO Tax Fund 2016	$2,519,214,000	$2,520,163,000	$949,000
4260-601-3323 Medi-Cal Emergency Transport Fund	$0	$60,884,000	$60,884,000
4260-601-8107 Whole Person Care Pilot Fund	$323,365,000	$437,421,000	$114,056,000
4260-601-8108 Global Payment Program Fund	$1,066,905,000	$1,246,043,000	$179,138,000
4260-601-8113 DPH GME Special Fund	$393,337,000	$568,422,000	$175,085,000
4260-602-0309 Perinatal Insurance Fund	$19,553,000	$11,734,000	($7,819,000)
4260-603-3311 Healthcare Plan Fines and Penalties Fund	$0	$0	$0
4260-605-0001 SNF Quality & Accountability *	$48,928,000	$48,310,000	($618,000)
4260-605-3167 SNF Quality & Accountability	$43,121,000	$43,004,000	($117,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($48,928,000)	($48,310,000)	$618,000
4260-606-0834 SB 1100 DSH	$150,386,000	$151,893,000	$1,507,000
4260-611-3158 Hospital Quality Assurance Revenue	$4,379,951,000	$4,871,254,000	$491,303,000
4260-611-3201 LIHP MCE Out-of-Network ER Svcs.	$0	$0	$0
Total Benefits	**$33,156,067,000**	**$35,334,558,000**	**$2,178,491,000**
Total Benefits General Fund *	**$20,388,693,000**	**$21,605,761,000**	**$1,217,068,000**
County Administration:			
4260-101-0001(1) *	$1,066,344,000	$1,212,761,000	$146,417,000
4260-113-0001 Healthy Families *	$15,549,000	$5,507,000	($10,042,000)
4260-117-0001 HIPAA *	$1,660,000	$1,694,000	$34,000
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$0	$0	$0
4260-601-0942 Home Health Program Account	$317,000	$317,000	$0
4260-601-0995 Reimbursements	$736,000	$568,000	($168,000)
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$0	$1,063,000	$1,063,000
4260-605-3167 SNF Quality & Accountability Admin.	$3,907,000	$3,407,000	($500,000)
Total County Administration	**$1,088,513,000**	**$1,225,317,000**	**$136,804,000**
Total County Administration General Fund *	**$1,083,553,000**	**$1,219,962,000**	**$136,409,000**
Fiscal Intermediary:			
4260-101-0001(2) *	$113,008,000	$109,642,000	($3,366,000)
4260-113-0001 Healthy Families *	$1,295,000	$585,000	($710,000)
4260-117-0001 HIPAA *	$2,543,000	$2,549,000	$6,000
4260-601-0995 Reimbursements	$0	$0	$0
Total Fiscal Intermediary	**$116,846,000**	**$112,776,000**	**($4,070,000)**
Total Fiscal Intermediary General Fund *	**$116,846,000**	**$112,776,000**	**($4,070,000)**
Grand Total - State Funds	**$34,361,426,000**	**$36,672,651,000**	**$2,311,225,000**
Grand Total - General Fund*	**$21,589,092,000**	**$22,938,499,000**	**$1,349,407,000**

Medi-Cal Funding Summary
May 2018 Estimate Compared to November 2017 Estimate
Fiscal Year 2018 - 2019

FEDERAL FUNDS

Benefits:	**Nov 2017 Estimate**	**May 2018 Estimate**	**Difference Incr./(Decr.)**
4260-101-0890(3)	$55,311,910,000	$53,961,192,000	($1,350,718,000)
4260-102-0890 Capital Debt	$40,768,000	$66,145,000	$25,377,000
4260-106-0890 Money Follows Person Federal Grant	$6,379,000	$10,173,000	$3,794,000
4260-113-0890 Health Families	$2,117,424,000	$2,643,805,000	$526,381,000
4260-601-7502 Demonstration DSH Fund	$127,794,000	$179,295,000	$51,501,000
4260-601-7503 Health Care Support Fund	$337,313,000	$337,306,000	($7,000)
4260-611-0890 Hospital Quality Assurance	$5,709,604,000	$6,511,456,000	$801,852,000
Total Benefits	**$63,651,192,000**	**$63,709,372,000**	**$58,180,000**
County Administration:			
4260-101-0890(1)	$3,230,057,000	$3,219,792,000	($10,265,000)
4260-106-0890(1) Money Follows Person Fed. Grant	$682,000	$682,000	$0
4260-113-0890 Healthy Families	$42,415,000	$57,154,000	$14,739,000
4260-117-0890 HIPAA	$7,608,000	$7,918,000	$310,000
Total County Administration	**$3,280,762,000**	**$3,285,546,000**	**$4,784,000**
Fiscal Intermediary:			
4260-101-0890(2)	$197,492,000	$197,829,000	$337,000
4260-113-0890 Healthy Families	$2,405,000	$4,286,000	$1,881,000
4260-117-0890 HIPAA	$11,380,000	$11,396,000	$16,000
Total Fiscal Intermediar y	**$211,277,000**	**$213,511,000**	**$2,234,000**
Grand Total - Federal Funds	**$67,143,231,000**	**$67,208,429,000**	**$65,198,000**

Medi-Cal Funding Summary
May 2018 Estimate Compared to Appropriation
Fiscal Year 2018 - 2019

TOTAL FUNDS

Benefits:	**Total Appropriation**	**May 2018 Estimate**	**Difference Incr./(Decr.)**
4260-101-0001/0890(3)	$69,136,479,000	$75,253,293,000	$6,116,814,000
4260-101-0080 CLPP Funds	$725,000	$725,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$111,400,000	$73,335,000	($38,065,000)
4260-101-0233 Prop 99 Physician Srvc. Acct	$40,220,000	$22,496,000	($17,724,000)
4260-101-0236 Prop 99 Unallocated Account	$56,904,000	$31,609,000	($25,295,000)
4260-101-3156 MCO Tax Fund MRMIB	$99,407,000	$0	($99,407,000)
4260-101-3168 Emergency Air Transportation Fund	$7,890,000	$8,525,000	$635,000
4260-101-3305 Healthcare Treatment Fund	$1,257,166,000	$854,642,000	($402,524,000)
4260-101-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$46,633,000	$0	($46,633,000)
4260-102-0001/0890 Capital Debt	$165,619,000	$102,780,000	($62,839,000)
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	$127,550,000	$137,900,000	$10,350,000
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	$19,496,000	$10,173,000	($9,323,000)
4260-113-0001/0890 Healthy Families	$3,020,483,000	$2,752,220,000	($268,263,000)
4260-601-0942142 Local Trauma Centers	$44,845,000	$64,207,000	$19,362,000
4260-601-0942 Home Health Program Account	$0	$347,000	$347,000
4260-601-0995 Reimbursements	$4,947,529,000	$1,547,072,000	($3,400,457,000)
4260-601-3156 MCO Tax Fund	$328,610,000	$21,286,000	($307,324,000)
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$800,000,000	$762,447,000	($37,553,000)
4260-601-3213 LTC QA Fund	$482,975,000	$460,098,000	($22,877,000)
4260-601-3293 MCO Tax Fund 2016	$2,392,507,000	$2,520,163,000	$127,656,000
4260-601-3323 Medi-Cal Emergency Transport Fund	$0	$60,884,000	$60,884,000
4260-601-7502 Demonstration DSH Fund	$148,011,000	$179,295,000	$31,284,000
4260-601-7503 Health Care Support Fund	$324,393,000	$337,306,000	$12,913,000
4260-601-8107 Whole Person Care Pilot Fund	$360,000,000	$437,421,000	$77,421,000
4260-601-8108 Global Payment Program Fund	$1,152,567,000	$1,246,043,000	$93,476,000
4260-601-8113 DPH GME Special Fund	$0	$568,422,000	$568,422,000
4260-602-0309 Perinatal Insurance Fund	$10,997,000	$11,734,000	$737,000
4260-603-3311 Healthcare Plan Fines and Penalties Fund	$0	$0	$0
4260-605-0001 SNF Quality & Accountability *	$48,928,000	$48,310,000	($618,000)
4260-605-3167 SNF Quality & Accountability	$43,122,000	$43,004,000	($118,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($48,928,000)	($48,310,000)	$618,000
4260-606-0834 SB 1100 DSH	$177,411,000	$151,893,000	($25,518,000)
4260-611-3158/0890 Hospital Quality Assurance	$16,840,000,000	$11,382,710,000	($5,457,290,000)
4260-611-3201 LIHP MCE Out-of-Network ER Svcs.	$116,250,000	$0	($116,250,000)
Total Benefits	**$102,261,089,000**	**$99,043,930,000**	**($3,217,159,000)**
County Administration:			
4260-101-0001/0890(1)	$4,518,300,000	$4,432,553,000	($85,747,000)
4260-106-0890(1) Money Follow Person Fed. Grant	$688,000	$682,000	($6,000)
4260-113-0001/0890 Healthy Families	$32,587,000	$62,661,000	$30,074,000
4260-117-0001/0890 HIPPA	$10,581,000	$9,612,000	($969,000)
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$5,856,000	$0	($5,856,000)
4260-601-0942 Home Health Program Account	$317,000	$317,000	$0
4260-601-0995 Reimbursements	$692,000	$568,000	($124,000)
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$1,419,000	$1,063,000	($356,000)
4260-605-3167 SNF Quality & Accountability Admin.	$3,907,000	$3,407,000	($500,000)
Total County Administration	**$4,574,347,000**	**$4,510,863,000**	**($63,484,000)**
Fiscal Intermediary:			
4260-101-0001/0890(2)	$403,121,000	$307,471,000	($95,650,000)
4260-113-0001/0890 Healthy Families	$5,816,000	$4,871,000	($945,000)
4260-117-0001/0890 HIPAA	$14,293,000	$13,945,000	($348,000)
4260-601-0995 Reimbursements	$0	$0	$0
Total Fiscal Intermediary	**$423,230,000**	**$326,287,000**	**($96,943,000)**
Grand Total - Total Funds	**$107,258,666,000**	**$103,881,080,000**	**($3,377,586,000)**

Medi-Cal Funding Summary
May 2018 Estimate Compared to Appropriation
Fiscal Year 2018 - 2019

STATE FUNDS

Benefits:	**State Funds Appropriation**	**May 2018 Estimate**	**Difference Incr./(Decr.)**
4260-101-0001(3) *	$17,428,661,000	$21,292,101,000	$3,863,440,000
4260-101-0080 CLPP Funds	$725,000	$725,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$111,400,000	$73,335,000	($38,065,000)
4260-101-0233 Prop 99 Physician Srvc. Acct	$40,220,000	$22,496,000	($17,724,000)
4260-101-0236 Prop 99 Unallocated Account	$56,904,000	$31,609,000	($25,295,000)
4260-101-3156 MCO Tax Fund MRMIB	$99,407,000	$0	($99,407,000)
4260-101-3168 Emergency Air Transportation Fund	$7,890,000	$8,525,000	$635,000
4260-101-3305 Healthcare Treatment Fund	$1,257,166,000	$854,642,000	($402,524,000)
4260-101-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$46,633,000	$0	($46,633,000)
4260-102-0001 Capital Debt *	$82,809,000	$36,635,000	($46,174,000)
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	$127,550,000	$137,900,000	$10,350,000
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-113-0001 Healthy Families *	$718,959,000	$108,415,000	($610,544,000)
4260-601-0942142 Local Trauma Centers	$44,845,000	$64,207,000	$19,362,000
4260-601-0942 Home Health Program Account	$0	$347,000	$347,000
4260-601-0995 Reimbursements	$4,947,529,000	$1,547,072,000	($3,400,457,000)
4260-601-3156 MCO Tax Fund	$328,610,000	$21,286,000	($307,324,000)
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$800,000,000	$762,447,000	($37,553,000)
4260-601-3213 LTC QA Fund	$482,975,000	$460,098,000	($22,877,000)
4260-601-3293 MCO Tax Fund 2016	$2,392,507,000	$2,520,163,000	$127,656,000
4260-601-3323 Medi-Cal Emergency Transport Fund	$0	$60,884,000	$60,884,000
4260-601-8107 Whole Person Care Pilot Fund	$360,000,000	$437,421,000	$77,421,000
4260-601-8108 Global Payment Program Fund	$1,152,567,000	$1,246,043,000	$93,476,000
4260-601-8113 DPH GME Special Fund	$0	$568,422,000	$568,422,000
4260-602-0309 Perinatal Insurance Fund	$10,997,000	$11,734,000	$737,000
4260-603-3311 Healthcare Plan Fines and Penalties Fund	$0	$0	$0
4260-605-0001 SNF Quality & Accountability *	$48,928,000	$48,310,000	($618,000)
4260-605-3167 SNF Quality & Accountability	$43,122,000	$43,004,000	($118,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($48,928,000)	($48,310,000)	$618,000
4260-606-0834 SB 1100 DSH	$177,411,000	$151,893,000	($25,518,000)
4260-611-3158 Hospital Quality Assurance Revenue	$6,382,189,000	$4,871,254,000	($1,510,935,000)
4260-611-3201 LIHP MCE Out-of-Network ER Svcs.	$116,250,000	$0	($116,250,000)
Total Benefits	**$37,219,226,000**	**$35,334,558,000**	**($1,884,668,000)**
Total Benefits General Fund *	**$18,399,657,000**	**$21,605,761,000**	**$3,206,104,000**
County Administration:			
4260-101-0001(1) *	$946,049,000	$1,212,761,000	$266,712,000
4260-113-0001 Healthy Families *	$12,804,000	$5,507,000	($7,297,000)
4260-117-0001 HIPAA *	$1,708,000	$1,694,000	($14,000)
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$5,856,000	$0	($5,856,000)
4260-601-0942 Home Health Program Account	$317,000	$317,000	$0
4260-601-0995 Reimbursements	$692,000	$568,000	($124,000)
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	$1,419,000	$1,063,000	($356,000)
4260-605-3167 SNF Quality & Accountability Admin.	$3,907,000	$3,407,000	($500,000)
Total County Administration	**$972,752,000**	**$1,225,317,000**	**$252,565,000**
Total County Administration General Fund *	**$960,561,000**	**$1,219,962,000**	**$259,401,000**
Fiscal Intermediary:			
4260-101-0001(2) *	$150,157,000	$109,642,000	($40,515,000)
4260-113-0001 Healthy Families *	$1,701,000	$585,000	($1,116,000)
4260-117-0001 HIPAA *	$2,681,000	$2,549,000	($132,000)
4260-601-0995 Reimbursements	$0	$0	$0
Total Fiscal Intermediary	**$154,539,000**	**$112,776,000**	**($41,763,000)**
Total Fiscal Intermediary General Fund *	**$154,539,000**	**$112,776,000**	**($41,763,000)**
Grand Total - State Funds	**$38,346,517,000**	**$36,672,651,000**	**($1,673,866,000)**
Grand Total - General Fund*	**$19,514,757,000**	**$22,938,499,000**	**$3,423,742,000**

Medi-Cal Funding Summary
May 2018 Estimate Compared to Appropriation
Fiscal Year 2018 - 2019

FEDERAL FUNDS

Benefits:	Federal Funds Appropriation	May 2018 Estimate	Difference Incr./(Decr.)
4260-101-0890(3)	$51,707,818,000	$53,961,192,000	$2,253,374,000
4260-102-0890 Capital Debt	$82,810,000	$66,145,000	($16,665,000)
4260-106-0890 Money Follows Person Federal Grant	$19,496,000	$10,173,000	($9,323,000)
4260-113-0890 Health Families	$2,301,524,000	$2,643,805,000	$342,281,000
4260-601-7502 Demonstration DSH Fund	$148,011,000	$179,295,000	$31,284,000
4260-601-7503 Health Care Support Fund	$324,393,000	$337,306,000	$12,913,000
4260-611-0890 Hospital Quality Assurance	$10,457,811,000	$6,511,456,000	($3,946,355,000)
Total Benefits	**$65,041,863,000**	**$63,709,372,000**	**($1,332,491,000)**
County Administration:			
4260-101-0890(1)	$3,572,251,000	$3,219,792,000	($352,459,000)
4260-106-0890(1) Money Follows Person Fed. Grant	$688,000	$682,000	($6,000)
4260-113-0890 Healthy Families	$19,783,000	$57,154,000	$37,371,000
4260-117-0890 HIPAA	$8,873,000	$7,918,000	($955,000)
Total County Administration	**$3,601,595,000**	**$3,285,546,000**	**($316,049,000)**
Fiscal Intermediary:			
4260-101-0890(2)	$252,964,000	$197,829,000	($55,135,000)
4260-113-0890 Healthy Families	$4,115,000	$4,286,000	$171,000
4260-117-0890 HIPAA	$11,612,000	$11,396,000	($216,000)
Total Fiscal Intermediary	**$268,691,000**	**$213,511,000**	**($55,180,000)**
Grand Total - Federal Funds	**$68,912,149,000**	**$67,208,429,000**	**($1,703,720,000)**

MEDI-CAL PROGRAM ESTIMATE SUMMARY
FISCAL YEAR 2017-18

	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
I. BASE ESTIMATES				
A. C/Y FFS BASE	$17,031,199,850	$8,515,599,930	$8,515,599,930	$0
B. C/Y BASE POLICY CHANGES	$46,545,158,010	$31,999,042,010	$13,710,623,000	$835,493,000
C. BASE ADJUSTMENTS	($139,010,000)	($183,300,040)	$44,290,040	$0
D. ADJUSTED BASE	**$63,437,347,860**	**$40,331,341,890**	**$22,270,512,970**	**$835,493,000**
II. REGULAR POLICY CHANGES				
A. ELIGIBILITY	($305,249,080)	($1,004,157,570)	$698,495,490	$413,000
B. AFFORDABLE CARE ACT	$3,452,198,000	$3,466,242,210	($14,044,210)	$0
C. BENEFITS	$1,490,749,840	$1,119,319,570	$360,874,270	$10,556,000
D. PHARMACY	($3,233,077,980)	($2,917,770,820)	($315,307,160)	$0
E. DRUG MEDI-CAL	$377,920,000	$301,865,240	$76,054,760	$0
F. MENTAL HEALTH	$108,320,000	$83,586,500	$24,533,500	$200,000
G. WAIVER--MH/UCD & BTR	$4,693,494,000	$2,468,445,000	$27,695,000	$2,197,354,000
H. MANAGED CARE	$5,868,256,630	$712,156,490	$255,232,150	$4,900,868,000
I. PROVIDER RATES	$615,366,590	$824,967,000	($658,363,410)	$448,763,000
J. SUPPLEMENTAL PMNTS.	$15,636,333,000	$9,389,452,300	$505,077,200	$5,741,803,500
K. OTHER	$592,985,640	$1,923,898,630	($4,235,983,990)	$2,905,071,000
L. TOTAL CHANGES	**$29,297,296,640**	**$16,368,004,550**	**($3,275,736,410)**	**$16,205,028,500**
III. TOTAL MEDI-CAL ESTIMATE	**$92,734,644,500**	**$56,699,346,450**	**$18,994,776,560**	**$17,040,521,500**

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2017-18

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	ELIGIBILITY				
1	MEDI-CAL STATE INMATE PROGRAMS	$87,912,000	$87,912,000	$0	$0
2	BREAST AND CERVICAL CANCER TREATMENT	$63,458,000	$25,430,800	$38,027,200	$0
3	MEDI-CAL COUNTY INMATE PROGRAMS	$12,760,000	$12,209,560	$550,440	$0
8	MEDI-CAL COUNTY INMATE REIMBURSEMENT	$0	$0	($413,000)	$413,000
9	NON-OTLICP CHIP	$0	$399,525,300	($399,525,300)	$0
10	NON-EMERGENCY FUNDING ADJUSTMENT	$0	($886,724,000)	$886,724,000	$0
11	SCHIP FUNDING FOR PRENATAL CARE	$0	$60,722,640	($60,722,640)	$0
12	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN	$0	($14,677,000)	$14,677,000	$0
13	PARIS-VETERANS	($8,221,250)	($4,110,620)	($4,110,620)	$0
14	OTLICP PREMIUMS	($66,265,000)	($58,313,200)	($7,951,800)	$0
15	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	($66,874,830)	($52,947,050)	($13,927,780)	$0
16	MEDICARE OPTIONAL EXPANSION ADJUSTMENT	($328,018,000)	($573,185,990)	$245,167,990	$0
	ELIGIBILITY SUBTOTAL	**($305,249,080)**	**($1,004,157,570)**	**$698,495,490**	**$413,000**
	AFFORDABLE CARE ACT				
17	COMMUNITY FIRST CHOICE OPTION	$3,355,870,000	$3,355,870,000	$0	$0
18	HEALTH INSURER FEE	$72,808,000	$48,892,370	$23,915,630	$0
19	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	$17,200,000	$17,200,000	$0	$0
20	PAYMENTS TO PRIMARY CARE PHYSICIANS	$6,320,000	$6,320,000	$0	$0
21	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	$0	$36,866,840	($36,866,840)	$0
22	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	$1,093,000	($1,093,000)	$0
23	ACA MAGI SAVINGS	$0	$0	$0	$0
	AFFORDABLE CARE ACT SUBTOTAL	**$3,452,198,000**	**$3,466,242,210**	**($14,044,210)**	**$0**
	BENEFITS				
27	BEHAVIORAL HEALTH TREATMENT	$498,218,000	$275,667,960	$222,550,040	$0
28	FAMILY PACT PROGRAM	$319,115,000	$242,692,200	$76,422,800	$0
29	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$329,907,000	$329,907,000	$0	$0
30	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$118,256,000	$118,256,000	$0	$0
31	CCS DEMONSTRATION PROJECT	$40,718,000	$22,404,920	$18,313,080	$0
32	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	$21,112,000	$10,556,000	$0	$10,556,000
33	ANNUAL CONTRACEPTIVE COVERAGE	$3,277,240	$2,538,070	$739,170	$0
34	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$36,021,000	$33,879,000	$2,142,000	$0
35	DENTAL TRANSFORMATION INITIATIVE UTILIZATION	$18,018,000	$10,817,640	$7,200,360	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2017-18

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	BENEFITS				
36	FULL RESTORATION OF ADULT DENTAL BENEFITS	$87,398,000	$61,053,040	$26,344,960	$0
37	DENTAL BENEFICIARY OUTREACH EFFORTS - BENEFITS	$12,683,530	$6,341,770	$6,341,770	$0
38	YOUTH REGIONAL TREATMENT CENTERS	$2,240,000	$2,424,000	($184,000)	$0
39	PEDIATRIC PALLIATIVE CARE WAIVER	$508,480	$241,320	$267,160	$0
40	MEDICALLY TAILORED MEALS PILOT PROGRAM	$1,000,000	$0	$1,000,000	$0
41	CCT FUND TRANSFER TO CDSS AND CDDS	$2,808,000	$2,808,000	$0	$0
43	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER	$52,000	$52,000	$0	$0
46	PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS	($582,420)	($319,350)	($263,070)	$0
	BENEFITS SUBTOTAL	**$1,490,749,840**	**$1,119,319,570**	**$360,874,270**	**$10,556,000**
	PHARMACY				
47	NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS	$27,326,020	$14,797,820	$12,528,200	$0
48	DRUG REBATES PRIOR YEAR FUNDING ADJUSTMENT	($60,286,000)	($316,889,830)	$256,603,830	$0
50	LITIGATION SETTLEMENTS	($18,133,000)	$0	($18,133,000)	$0
51	BCCTP DRUG REBATES	($10,759,000)	($7,436,800)	($3,322,200)	$0
52	FAMILY PACT DRUG REBATES	($42,415,000)	($37,259,300)	($5,155,700)	$0
53	MEDICAL SUPPLY REBATES	($24,916,000)	($12,458,000)	($12,458,000)	$0
54	STATE SUPPLEMENTAL DRUG REBATES	($146,024,000)	($48,269,730)	($97,754,270)	$0
55	FEDERAL DRUG REBATES	($2,957,871,000)	($2,510,254,980)	($447,616,020)	$0
	PHARMACY SUBTOTAL	**($3,233,077,980)**	**($2,917,770,820)**	**($315,307,160)**	**$0**
	DRUG MEDI-CAL				
56	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	$377,920,000	$301,865,240	$76,054,760	$0
	DRUG MEDI-CAL SUBTOTAL	**$377,920,000**	**$301,865,240**	**$76,054,760**	**$0**
	MENTAL HEALTH				
65	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT	$80,086,000	$80,086,000	$0	$0
66	PATHWAYS TO WELL-BEING	$11,734,000	$11,734,000	$0	$0
67	MHP COSTS FOR CONTINUUM OF CARE REFORM	$6,499,000	$2,479,500	$4,019,500	$0
69	LATE CLAIMS FOR SMHS	$4,000	$0	$4,000	$0
70	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	$0	$0	($200,000)	$200,000
71	CHART REVIEW	($1,743,000)	($1,743,000)	$0	$0
72	INTERIM AND FINAL COST SETTLEMENTS - SMHS	$11,740,000	($8,970,000)	$20,710,000	$0
	MENTAL HEALTH SUBTOTAL	**$108,320,000**	**$83,586,500**	**$24,533,500**	**$200,000**

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2017-18

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	WAIVER--MH/UCD & BTR				
73	GLOBAL PAYMENT PROGRAM	$2,275,272,000	$1,137,636,000	$0	$1,137,636,000
74	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL	$1,765,728,000	$882,864,000	$0	$882,864,000
75	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS	$353,709,000	$176,855,000	$0	$176,854,000
76	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	$107,000,000	$53,500,000	$53,500,000	$0
77	BTR - LIHP - MCE	$104,616,000	$104,616,000	$0	$0
78	MH/UCD STABILIZATION FUNDING	$55,400,000	$0	$55,400,000	$0
79	BTR - LOW INCOME HEALTH PROGRAM - HCCI	$36,060,000	$36,060,000	$0	$0
80	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$1,170,000	$1,170,000	$0	$0
81	MH/UCD HEALTH CARE COVERAGE INITIATIVE	$1,262,000	$1,262,000	$0	$0
82	MH/UCD FEDERAL FLEX. & STABILIZATION-SNCP	$0	$6,205,000	($6,205,000)	$0
83	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM	$0	$75,000,000	($75,000,000)	$0
86	MH/UCD SAFETY NET CARE POOL	($6,723,000)	($6,723,000)	$0	$0
	WAIVER--MH/UCD & BTR SUBTOTAL	**$4,693,494,000**	**$2,468,445,000**	**$27,695,000**	**$2,197,354,000**
	MANAGED CARE				
90	MANAGED CARE RATE RANGE IGTS	$1,968,917,000	$1,107,482,000	$0	$861,435,000
91	CCI-MANAGED CARE PAYMENTS	$4,853,748,630	$2,426,874,320	$2,426,874,320	$0
92	MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES	$2,505,200,000	$1,589,836,240	$915,363,760	$0
93	MANAGED CARE PUBLIC HOSPITAL IGTS	$1,713,379,000	$1,386,230,000	$0	$327,149,000
96	HQAF RATE RANGE INCREASES	$294,669,000	$162,019,000	$0	$132,650,000
99	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	$114,090,000	$26,210,000	$87,880,000	$0
101	CCI-QUALITY WITHHOLD REPAYMENTS	$3,317,000	$1,658,500	$1,658,500	$0
103	PALLIATIVE CARE SERVICES IMPLEMENTATION	$1,875,000	$999,800	$875,200	$0
109	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT	$0	$0	($87,881,000)	$87,881,000
110	MCO TAX MANAGED CARE PLANS	$0	$0	($300,000,000)	$300,000,000
111	MANAGED CARE IGT ADMIN. & PROCESSING FEE	$0	$0	($158,945,000)	$158,945,000
112	GENERAL FUND REIMBURSEMENTS FROM DPHS	$0	$0	($158,606,000)	$158,606,000
114	MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.	$0	$0	($809,823,000)	$809,823,000
115	MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	$0	($1,552,053,000)	$1,552,053,000
116	MANAGED CARE DRUG REBATES	($1,752,995,000)	($1,218,887,370)	($534,107,630)	$0
117	RETRO MC RATE ADJUSTMENTS	($3,863,906,000)	($4,797,318,000)	$421,086,000	$512,326,000
222	INDIAN HEALTH SERVICES MANAGED CARE PROGRAM	$29,962,000	$27,052,000	$2,910,000	$0
	MANAGED CARE SUBTOTAL	**$5,868,256,630**	**$712,156,490**	**$255,232,150**	**$4,900,868,000**

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2017-18

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	PROVIDER RATES				
118	DPH INTERIM & FINAL RECONS	$237,459,000	$237,459,000	$0	$0
119	DENTAL RETROACTIVE RATE CHANGES	$137,467,000	$86,627,920	$50,839,080	$0
120	FQHC/RHC/CBRC RECONCILIATION PROCESS	$160,320,000	$99,909,990	$60,410,010	$0
121	AB 1629 ANNUAL RATE ADJUSTMENTS	$70,641,170	$35,320,580	$35,320,580	$0
122	RATE INCREASE FOR FQHCS/RHCS/CBRCS	$19,452,180	$12,122,460	$7,329,710	$0
123	LTC RATE ADJUSTMENT	$4,111,120	$2,055,560	$2,055,560	$0
124	DPH INTERIM RATE GROWTH	$9,264,310	$4,632,150	$4,632,150	$0
125	HOSPICE RATE INCREASES	$3,658,350	$1,829,180	$1,829,180	$0
126	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	$435,760	$217,880	$217,880	$0
127	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	$10,868,000	$5,434,000	($2,395,000)	$7,829,000
129	ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE	$34,280	$64,500	($30,230)	$0
130	ALTERNATIVE BIRTHING CENTER REIMBURSEMENT	$7,460	$3,730	$3,730	$0
131	DP/NF-B RETROACTIVE RECOUPMENT FORGIVENESS	$0	($1,298,000)	$1,298,000	$0
133	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	$0	($440,934,000)	$440,934,000
134	DPH INTERIM RATE	$0	$359,764,050	($359,764,050)	$0
135	LABORATORY RATE METHODOLOGY CHANGE	($6,323,950)	($3,161,970)	($3,161,970)	$0
136	REDUCTION TO RADIOLOGY RATES	($8,622,210)	($4,311,110)	($4,311,110)	$0
137	10% PROVIDER PAYMENT REDUCTION	($23,405,880)	($11,702,940)	($11,702,940)	$0
	PROVIDER RATES SUBTOTAL	**$615,366,580**	**$824,966,990**	**($658,363,410)**	**$448,763,000**
	SUPPLEMENTAL PMNTS.				
138	HOSPITAL QAF - MANAGED CARE PAYMENTS	$5,093,271,000	$3,663,856,000	$0	$1,429,415,000
139	HOSPITAL QAF - FFS PAYMENTS	$7,114,270,000	$3,294,772,000	$0	$3,819,498,000
141	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	$355,918,000	$245,150,000	$0	$110,768,000
142	PRIVATE HOSPITAL DSH REPLACEMENT	$576,179,000	$288,089,500	$288,089,500	$0
143	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$442,461,000	$442,461,000	$0	$0
144	DSH PAYMENT	$400,444,000	$295,422,000	$14,939,000	$90,083,000
145	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	$319,693,000	$192,143,000	$118,400,000	$9,150,000
146	NDPH IGT SUPPLEMENTAL PAYMENTS	$124,176,000	$84,863,000	($1,415,000)	$40,728,000
147	PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES	$247,520,000	$161,313,000	$0	$86,207,000
148	PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$158,167,000	$115,627,000	$0	$42,540,000
149	DPH PHYSICIAN & NON-PHYS. COST	$83,855,000	$83,855,000	$0	$0
150	CAPITAL PROJECT DEBT REIMBURSEMENT	$154,173,000	$128,539,000	$25,634,000	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2017-18

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	SUPPLEMENTAL PMNTS.				
151	FFP FOR LOCAL TRAUMA CENTERS	$132,319,000	$76,513,000	$0	$55,806,000
152	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	$134,634,000	$86,229,300	$219,700	$48,185,000
153	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	$86,007,000	$43,003,500	$48,310,000	($5,306,500)
154	GEMT SUPPLEMENTAL PAYMENT PROGRAM	$76,182,000	$76,182,000	$0	$0
155	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	$75,732,000	$75,732,000	$0	$0
156	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS	$21,682,000	$11,689,000	$0	$9,993,000
157	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$5,000,000	$5,000,000	$0
158	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$4,000,000	$4,000,000	$0
159	IGT PAYMENTS FOR HOSPITAL SERVICES	$5,801,000	$3,801,000	$0	$2,000,000
160	PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS	$5,474,000	$2,737,000	$0	$2,737,000
161	NDPH SUPPLEMENTAL PAYMENT	$5,277,000	$3,377,000	$1,900,000	$0
162	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$5,098,000	$5,098,000	$0	$0
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$15,636,333,000**	**$9,389,452,300**	**$505,077,200**	**$5,741,803,500**
	OTHER				
84	CMS DEFERRED CLAIMS	$0	($509,238,000)	$509,238,000	$0
171	ARRA HITECH - PROVIDER PAYMENTS	$130,515,000	$130,515,000	$0	$0
174	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$102,041,000	$102,041,000	$0	$0
178	INFANT DEVELOPMENT PROGRAM	$42,313,000	$42,313,000	$0	$0
179	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$17,176,000	$9,517,000	$7,659,000	$0
180	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	$16,823,860	$8,411,930	$8,411,930	$0
181	AUDIT SETTLEMENTS	$0	($13,928,000)	$13,928,000	$0
182	OVERTIME FOR WPCS PROVIDERS	$9,961,000	$4,962,500	$4,998,500	$0
184	INDIAN HEALTH SERVICES	$3,903,000	$24,716,000	($20,813,000)	$0
185	MEDI-CAL ESTATE RECOVERIES	$5,324,560	$2,662,280	$2,662,280	$0
186	WPCS WORKERS' COMPENSATION	$3,026,000	$1,513,000	$1,513,000	$0
190	CDDS DENTAL SERVICES	$712,000	$0	$0	$712,000
191	FUNDING ADJUST. OTLICP	$122,000	$184,897,000	($184,775,000)	$0
193	HEALTH CARE SVCS. PLANS FINES AND PENALTIES FUND	$0	$0	($48,025,000)	$48,025,000
194	CLPP FUND	$0	$0	($725,000)	$725,000
195	CCI-TRANSFER OF IHSS COSTS TO DHCS	$0	$0	($1,343,703,000)	$1,343,703,000
196	HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	$0	($1,328,946,000)	$1,328,946,000
197	FUNDING ADJUST. ACA OPT. EXPANSION	$0	$1,808,695,810	($1,808,695,810)	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2017-18

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
198	COUNTY SHARE OF OTLICP-CCS COSTS	$0	$0	$0	$0
199	IMD ANCILLARY SERVICES	$0	($3,714,000)	$3,714,000	$0
200	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	$0	($182,960,000)	$182,960,000
201	INTEGRATION OF THE SF CLSB INTO THE ALW	($1,553,000)	($776,500)	($776,500)	$0
202	MEDI-CAL RECOVERIES SETTLEMENTS AND LEGAL COSTS	($391,150)	($195,580)	($195,580)	$0
211	ASSISTED LIVING WAIVER EXPANSION	($8,680)	($4,340)	($4,340)	$0
212	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER RENEWAL	$1,592,060	$796,030	$796,030	$0
223	HQAF WITHHOLD TRANSFER	$261,429,000	$130,714,500	$130,714,500	$0
	OTHER SUBTOTAL	**$592,985,640**	**$1,923,898,630**	**($4,235,983,990)**	**$2,905,071,000**
	GRAND TOTAL	**$29,297,296,640**	**$16,368,004,550**	**($3,275,736,410)**	**$16,205,028,500**

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

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
FISCAL YEAR 2017-18

SERVICE CATEGORY	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
PROFESSIONAL	$7,655,292,320	$4,653,859,600	$1,647,132,770	$1,354,299,950
PHYSICIANS	$921,265,720	$585,818,260	$287,097,290	$48,350,180
OTHER MEDICAL	$3,989,126,740	$2,469,719,760	$1,331,203,100	$188,203,880
CO. & COMM. OUTPATIENT	$2,744,899,850	$1,598,321,580	$28,832,380	$1,117,745,890
PHARMACY	$436,729,980	($604,849,760)	$977,458,570	$64,121,160
HOSPITAL INPATIENT	$14,890,099,210	$8,729,441,480	$1,641,962,990	$4,518,694,730
COUNTY INPATIENT	$3,282,575,780	$2,091,280,740	$31,729,010	$1,159,566,030
COMMUNITY INPATIENT	$11,607,523,420	$6,638,160,740	$1,610,233,980	$3,359,128,700
LONG TERM CARE	$3,252,687,930	$1,707,265,290	$1,435,147,270	$110,275,370
NURSING FACILITIES	$2,828,228,790	$1,493,774,980	$1,248,088,640	$86,365,170
ICF-DD	$424,459,140	$213,490,310	$187,058,630	$23,910,200
OTHER SERVICES	$1,148,540,600	$711,319,990	$403,038,180	$34,182,430
MEDICAL TRANSPORTATION	$157,285,700	$122,251,010	$26,042,510	$8,992,180
OTHER SERVICES	$781,056,500	$481,945,440	$276,637,480	$22,473,590
HOME HEALTH	$210,198,400	$107,123,540	$100,358,200	$2,716,660
TOTAL FEE-FOR-SERVICE	**$27,383,350,040**	**$15,197,036,600**	**$6,104,739,790**	**$6,081,573,650**
MANAGED CARE	$45,312,331,930	$27,317,575,960	$8,351,982,020	$9,642,773,940
TWO PLAN MODEL	$28,129,591,980	$16,911,598,450	$5,129,006,410	$6,088,987,120
COUNTY ORGANIZED HEALTH SYSTEMS	$10,089,828,180	$6,165,563,030	$1,750,210,010	$2,174,055,140
GEOGRAPHIC MANAGED CARE	$4,744,227,980	$2,849,685,590	$896,449,110	$998,093,290
PHP & OTHER MANAG. CARE	$977,165,730	$548,853,190	$309,840,040	$118,472,500
REGIONAL MODEL	$1,371,518,060	$841,875,710	$266,476,450	$263,165,900
DENTAL	$1,571,135,540	$1,001,409,750	$433,897,930	$135,827,860
MENTAL HEALTH	$2,928,712,500	$2,763,514,630	($61,167,010)	$226,364,880
AUDITS/ LAWSUITS	$20,613,790	($503,842,760)	$524,456,550	$0
EPSDT SCREENS	$4,998,000	$2,758,310	$1,514,690	$725,000
MEDICARE PAYMENTS	$5,328,880,000	$1,509,806,000	$3,819,074,000	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$175,445,000	$175,445,000	$0	$0
MISC. SERVICES	$9,784,704,000	$8,943,098,230	($111,650,390)	$953,256,160
RECOVERIES	($351,665,590)	($198,016,300)	($153,649,300)	$0
DRUG MEDI-CAL	$576,139,300	$490,561,020	$85,578,280	$0
GRAND TOTAL MEDI-CAL	**$92,734,644,500**	**$56,699,346,450**	**$18,994,776,560**	**$17,040,521,500**

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
MAY 2018 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2017-18

SERVICE CATEGORY	2017-18 APPROPRIATION	MAY 2018 EST. FOR 2017-18	DOLLAR DIFFERENCE	% CHANGE
PROFESSIONAL	$7,756,093,620	$7,655,292,320	($100,801,300)	-1.30%
PHYSICIANS	$1,627,897,640	$921,265,720	($706,631,920)	-43.41%
OTHER MEDICAL	$4,132,945,240	$3,989,126,740	($143,818,500)	-3.48%
CO. & COMM. OUTPATIENT	$1,995,250,730	$2,744,899,850	$749,649,120	37.57%
PHARMACY	$1,381,520,530	$436,729,980	($944,790,550)	-68.39%
HOSPITAL INPATIENT	$15,045,885,270	$14,890,099,210	($155,786,060)	-1.04%
COUNTY INPATIENT	$1,579,926,680	$3,282,575,780	$1,702,649,100	107.77%
COMMUNITY INPATIENT	$13,465,958,580	$11,607,523,420	($1,858,435,160)	-13.80%
LONG TERM CARE	$3,381,932,100	$3,252,687,930	($129,244,170)	-3.82%
NURSING FACILITIES	$2,920,489,220	$2,828,228,790	($92,260,420)	-3.16%
ICF-DD	$461,442,890	$424,459,140	($36,983,750)	-8.01%
OTHER SERVICES	$1,313,174,820	$1,148,540,600	($164,634,220)	-12.54%
MEDICAL TRANSPORTATION	$153,675,280	$157,285,700	$3,610,410	2.35%
OTHER SERVICES	$939,176,090	$781,056,500	($158,119,580)	-16.84%
HOME HEALTH	$220,323,450	$210,198,400	($10,125,050)	-4.60%
TOTAL FEE-FOR-SERVICE	**$28,878,606,340**	**$27,383,350,040**	**($1,495,256,300)**	**-5.18%**
MANAGED CARE	$54,006,785,840	$45,312,331,930	($8,694,453,910)	-16.10%
TWO PLAN MODEL	$34,465,412,840	$28,129,591,980	($6,335,820,860)	-18.38%
COUNTY ORGANIZED HEALTH SYSTEMS	$11,612,574,690	$10,089,828,180	($1,522,746,510)	-13.11%
GEOGRAPHIC MANAGED CARE	$5,417,679,970	$4,744,227,980	($673,451,980)	-12.43%
PHP & OTHER MANAG. CARE	$935,840,410	$977,165,730	$41,325,320	4.42%
REGIONAL MODEL	$1,575,277,940	$1,371,518,060	($203,759,880)	-12.93%
DENTAL	$1,655,439,050	$1,571,135,540	($84,303,510)	-5.09%
MENTAL HEALTH	$2,862,222,770	$2,928,712,500	$66,489,730	2.32%
AUDITS/ LAWSUITS	$15,925,040	$20,613,790	$4,688,750	29.44%
EPSDT SCREENS	$40,351,300	$4,998,000	($35,353,300)	-87.61%
MEDICARE PAYMENTS	$5,229,331,000	$5,328,880,000	$99,549,000	1.90%
STATE HOSP./DEVELOPMENTAL CNTRS.	$207,330,000	$175,445,000	($31,885,000)	-15.38%
MISC. SERVICES	$8,879,518,630	$9,784,704,000	$905,185,370	10.19%
RECOVERIES	($301,486,000)	($351,665,590)	($50,179,590)	16.64%
DRUG MEDI-CAL	$787,064,800	$576,139,300	($210,925,500)	-26.80%
GRAND TOTAL MEDI-CAL	**$102,261,088,760**	**$92,734,644,500**	**($9,526,444,260)**	**-9.32%**
GENERAL FUNDS	**$18,399,657,770**	**$18,994,776,560**	**$595,118,790**	**3.23%**
OTHER STATE FUNDS	**$18,819,568,500**	**$17,040,521,500**	**($1,779,047,000)**	**-9.45%**

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
MAY 2018 ESTIMATE COMPARED TO NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2017-18

SERVICE CATEGORY	NOV. 2017 EST. FOR 2017-18	MAY 2018 EST. FOR 2017-18	DOLLAR DIFFERENCE	% CHANGE
PROFESSIONAL	$7,002,470,410	$7,655,292,320	$652,821,910	9.32%
PHYSICIANS	$879,824,970	$921,265,720	$41,440,750	4.71%
OTHER MEDICAL	$4,091,818,520	$3,989,126,740	($102,691,770)	-2.51%
CO. & COMM. OUTPATIENT	$2,030,826,920	$2,744,899,850	$714,072,940	35.16%
PHARMACY	$1,089,324,180	$436,729,980	($652,594,200)	-59.91%
HOSPITAL INPATIENT	$14,493,631,550	$14,890,099,210	$396,467,650	2.74%
COUNTY INPATIENT	$3,398,608,970	$3,282,575,780	($116,033,180)	-3.41%
COMMUNITY INPATIENT	$11,095,022,590	$11,607,523,420	$512,500,840	4.62%
LONG TERM CARE	$3,073,758,440	$3,252,687,930	$178,929,490	5.82%
NURSING FACILITIES	$2,649,232,140	$2,828,228,790	$178,996,650	6.76%
ICF-DD	$424,526,300	$424,459,140	($67,160)	-0.02%
OTHER SERVICES	$1,118,144,920	$1,148,540,600	$30,395,680	2.72%
MEDICAL TRANSPORTATION	$146,746,480	$157,285,700	$10,539,220	7.18%
OTHER SERVICES	$750,174,980	$781,056,500	$30,881,530	4.12%
HOME HEALTH	$221,223,470	$210,198,400	($11,025,060)	-4.98%
TOTAL FEE-FOR-SERVICE	**$26,777,329,500**	**$27,383,350,040**	**$606,020,540**	**2.26%**
MANAGED CARE	$48,871,268,880	$45,312,331,930	($3,558,936,950)	-7.28%
TWO PLAN MODEL	$30,490,560,630	$28,129,591,980	($2,360,968,650)	-7.74%
COUNTY ORGANIZED HEALTH SYSTEMS	$10,717,645,120	$10,089,828,180	($627,816,940)	-5.86%
GEOGRAPHIC MANAGED CARE	$5,091,575,920	$4,744,227,980	($347,347,940)	-6.82%
PHP & OTHER MANAG. CARE	$1,083,938,930	$977,165,730	($106,773,210)	-9.85%
REGIONAL MODEL	$1,487,548,280	$1,371,518,060	($116,030,220)	-7.80%
DENTAL	$1,581,030,040	$1,571,135,540	($9,894,500)	-0.63%
MENTAL HEALTH	$3,016,627,380	$2,928,712,500	($87,914,890)	-2.91%
AUDITS/ LAWSUITS	$50,113,780	$20,613,790	($29,500,000)	-58.87%
EPSDT SCREENS	$29,840,690	$4,998,000	($24,842,690)	-83.25%
MEDICARE PAYMENTS	$5,362,487,000	$5,328,880,000	($33,607,000)	-0.63%
STATE HOSP./DEVELOPMENTAL CNTRS.	$207,330,000	$175,445,000	($31,885,000)	-15.38%
MISC. SERVICES	$9,054,686,410	$9,784,704,000	$730,017,590	8.06%
RECOVERIES	($370,434,160)	($351,665,590)	$18,768,570	-5.07%
DRUG MEDI-CAL	$583,156,130	$576,139,300	($7,016,840)	-1.20%
GRAND TOTAL MEDI-CAL	**$95,163,435,660**	**$92,734,644,500**	**($2,428,791,160)**	**-2.55%**
GENERAL FUNDS	**$18,866,693,190**	**$18,994,776,560**	**$128,083,360**	**0.68%**
OTHER STATE FUNDS	**$16,284,778,000**	**$17,040,521,500**	**$755,743,490**	**4.64%**

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2018 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	2017-18 APPROPRIATION TOTAL FUNDS	2017-18 APPROPRIATION GENERAL FUNDS	NOV. 2017 EST. FOR 2017-18 TOTAL FUNDS	NOV. 2017 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	DIFF. MAY TO APPROPRIATION TOTAL FUNDS	DIFF. MAY TO APPROPRIATION GENERAL FUNDS	DIFFERENCE MAY TO NOVEMBER TOTAL FUNDS	DIFFERENCE MAY TO NOVEMBER GENERAL FUNDS
		ELIGIBILITY										
1	1	MEDI-CAL STATE INMATE PROGRAMS	$117,057,000	$0	$108,677,000	$0	$87,912,000	$0	($29,145,000)	$0	($20,765,000)	$0
2	2	BREAST AND CERVICAL CANCER TREATMENT	$69,000,000	$36,800,000	$67,765,000	$36,631,600	$63,458,000	$38,027,200	($5,542,000)	$1,227,200	($4,307,000)	$1,395,600
3	3	MEDI-CAL COUNTY INMATE PROGRAMS	$301,867,000	$37,477,550	$52,316,000	$8,167,300	$12,760,000	$550,440	($289,107,000)	($36,927,110)	($39,556,000)	($7,616,860)
8	8	MEDI-CAL COUNTY INMATE REIMBURSEMENT	$0	($37,456,000)	$0	($6,125,000)	$0	($413,000)	$0	$37,043,000	$0	$5,712,000
9	9	NON-OTLICP CHIP	$401,000,000	($78,752,490)	$0	($116,863,440)	$0	($399,525,300)	($401,000,000)	($320,772,810)	$0	($282,661,860)
10	10	NON-EMERGENCY FUNDING ADJUSTMENT	$0	$899,150,000	$0	$900,963,000	$0	$886,724,000	$0	($12,426,000)	$0	($14,239,000)
11	11	SCHIP FUNDING FOR PRENATAL CARE	$0	($68,261,600)	$0	($67,868,240)	$0	($60,722,640)	$0	$7,538,960	$0	$7,145,600
12	12	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN	$0	$0	$0	$14,732,000	$0	$14,677,000	$0	$14,677,000	$0	($55,000)
13	13	PARIS-VETERANS	($24,361,990)	($16,671,840)	($19,600,290)	($9,800,150)	($19,672,760)	($9,836,380)	$4,689,230	$6,835,460	($72,470)	($36,230)
14	14	OTLICP PREMIUMS	($66,749,000)	($8,009,880)	($65,731,000)	($7,887,720)	($66,265,000)	($7,951,800)	$484,000	$58,080	($534,000)	($64,080)
15	15	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	($144,192,000)	($29,866,020)	($141,385,000)	($29,459,000)	($141,564,000)	($29,483,020)	$2,628,000	$383,000	($179,000)	($24,020)
16	16	MEDICARE OPTIONAL EXPANSION ADJUSTMENT	($515,297,000)	$225,870,970	($418,325,000)	$214,984,580	($328,018,000)	$245,167,990	$187,279,000	$19,297,020	$90,307,000	$30,183,410
7	--	STATE-ONLY BCCTP COVERAGE EXTENSION	$1,696,000	$1,696,000	$1,686,000	$1,686,000	$0	$0	($1,696,000)	($1,696,000)	($1,686,000)	($1,686,000)
		ELIGIBILITY SUBTOTAL	**$140,020,010**	**$961,976,690**	**($414,597,290)**	**$939,160,930**	**($391,389,760)**	**$677,214,490**	**($531,409,770)**	**($284,762,200)**	**$23,207,530**	**($261,946,440)**
		AFFORDABLE CARE ACT										
17	17	COMMUNITY FIRST CHOICE OPTION	$2,535,500,000	$0	$2,591,402,000	$0	$3,355,870,000	$0	$820,370,000	$0	$764,468,000	$0
18	18	HEALTH INSURER FEE	$502,274,000	$169,642,060	$483,599,000	$163,750,950	$72,808,000	$23,915,630	($429,466,000)	($145,726,430)	($410,791,000)	($139,835,320)
19	19	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	$19,463,000	$0	$18,210,000	$0	$17,200,000	$0	($2,263,000)	$0	($1,010,000)	$0
20	20	PAYMENTS TO PRIMARY CARE PHYSICIANS	$2,000,000	$0	$5,500,000	$0	$6,320,000	$0	$4,320,000	$0	$820,000	$0
21	21	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	$0	($36,365,640)	$0	($32,229,850)	$0	($36,866,840)	$0	($501,200)	$0	($4,636,990)
22	22	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	($2,026,000)	$0	($1,055,000)	$0	($1,093,000)	$0	$933,000	$0	($38,000)
23	23	ACA MAGI SAVINGS	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
24	--	TITLE XXI FEDERAL MATCH REDUCTION	($112,361,000)	$392,156,330	($114,127,000)	$295,162,910	$0	$0	$112,361,000	($392,156,330)	$114,127,000	($295,162,910)
25	--	ACA OPTIONAL EXPANSION MLR RISK CORRIDOR	$0	$0	($176,600,000)	$0	$0	$0	$0	$0	$176,600,000	$0

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2018 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	2017-18 APPROPRIATION TOTAL FUNDS	2017-18 APPROPRIATION GENERAL FUNDS	NOV. 2017 EST. FOR 2017-18 TOTAL FUNDS	NOV. 2017 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	DIFF. MAY TO APPROPRIATION TOTAL FUNDS	DIFF. MAY TO APPROPRIATION GENERAL FUNDS	DIFFERENCE MAY TO NOVEMBER TOTAL FUNDS	DIFFERENCE MAY TO NOVEMBER GENERAL FUNDS
		AFFORDABLE CARE ACT										
26	--	ACA DSH REDUCTION	($137,873,000)	($16,177,000)	($315,507,000)	($37,018,000)	$0	$0	$137,873,000	$16,177,000	$315,507,000	$37,018,000
		AFFORDABLE CARE ACT SUBTOTAL	**$2,809,003,000**	**$507,229,750**	**$2,492,477,000**	**$388,611,010**	**$3,452,198,000**	**($14,044,210)**	**$643,195,000**	**($521,273,960)**	**$959,721,000**	**($402,655,220)**
		BENEFITS										
27	27	BEHAVIORAL HEALTH TREATMENT	$213,817,000	$93,398,740	$402,206,000	$175,958,400	$498,218,000	$222,550,040	$284,401,000	$129,151,300	$96,012,000	$46,591,640
28	28	FAMILY PACT PROGRAM	$310,264,000	$74,627,800	$338,916,000	$81,598,700	$319,115,000	$76,422,800	$8,851,000	$1,795,000	($19,801,000)	($5,175,900)
29	29	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$245,649,000	$0	$321,681,000	$0	$329,907,000	$0	$84,258,000	$0	$8,226,000	$0
30	30	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$131,106,000	$0	$120,851,000	$5,213,000	$118,256,000	$0	($12,850,000)	$0	($2,595,000)	($5,213,000)
31	31	CCS DEMONSTRATION PROJECT	$36,847,000	$16,772,780	$40,718,000	$18,388,320	$40,718,000	$18,313,080	$3,871,000	$1,540,300	$0	($75,240)
32	32	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	$39,778,000	$0	$39,778,000	$0	$21,112,000	$0	($18,666,000)	$0	($18,666,000)	$0
33	33	ANNUAL CONTRACEPTIVE COVERAGE	$36,371,230	$8,203,280	$35,637,860	$8,038,130	$29,131,070	$6,570,430	($7,240,160)	($1,632,850)	($6,506,790)	($1,467,700)
34	34	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$19,680,000	$2,642,000	$12,953,000	$2,099,000	$36,021,000	$2,142,000	$16,341,000	($500,000)	$23,068,000	$43,000
35	35	DENTAL TRANSFORMATION INITIATIVE UTILIZATION	$6,490,000	$3,245,000	$9,601,000	$4,800,500	$18,018,000	$7,200,360	$11,528,000	$3,955,360	$8,417,000	$2,399,860
36	36	FULL RESTORATION OF ADULT DENTAL BENEFITS	$69,458,000	$34,729,000	$8,473,000	$4,236,500	$87,398,000	$26,344,960	$17,940,000	($8,384,040)	$78,925,000	$22,108,460
37	37	DENTAL BENEFICIARY OUTREACH EFFORTS - BENEFITS	$0	$0	$4,314,000	$2,157,000	$56,097,000	$28,048,500	$56,097,000	$28,048,500	$51,783,000	$25,891,500
38	38	YOUTH REGIONAL TREATMENT CENTERS	$5,825,000	$29,000	$3,233,000	($25,000)	$2,240,000	($184,000)	($3,585,000)	($213,000)	($993,000)	($159,000)
39	39	PEDIATRIC PALLIATIVE CARE WAIVER	$4,415,140	$2,062,140	$2,884,800	$1,320,110	$2,557,730	$1,343,850	($1,857,410)	($718,290)	($327,080)	$23,740
40	40	MEDICALLY TAILORED MEALS PILOT PROGRAM	$2,000,000	$2,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	($1,000,000)	($1,000,000)	$0	$0
41	41	CCT FUND TRANSFER TO CDSS AND CDDS	$2,458,000	$0	$918,000	$0	$2,808,000	$0	$350,000	$0	$1,890,000	$0
43	43	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER	$56,000	$0	$53,000	$0	$52,000	$0	($4,000)	$0	($1,000)	$0
46	46	PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS	($4,305,000)	($1,945,400)	($1,156,180)	($522,160)	($582,420)	($263,070)	$3,722,580	$1,682,330	$573,760	$259,090
42	--	END OF LIFE SERVICES	$659,980	$659,980	$139,230	$139,230	$0	$0	($659,980)	($659,980)	($139,230)	($139,230)
44	--	BEHAVIORAL HEALTH TREATMENT - BIS DDS TRANSITION	$11,163,000	$4,912,000	$911,000	$398,500	$0	$0	($11,163,000)	($4,912,000)	($911,000)	($398,500)

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2018 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	2017-18 APPROPRIATION TOTAL FUNDS	2017-18 APPROPRIATION GENERAL FUNDS	NOV. 2017 EST. FOR 2017-18 TOTAL FUNDS	NOV. 2017 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	DIFF. MAY TO APPROPRIATION TOTAL FUNDS	DIFF. MAY TO APPROPRIATION GENERAL FUNDS	DIFFERENCE MAY TO NOVEMBER TOTAL FUNDS	DIFFERENCE MAY TO NOVEMBER GENERAL FUNDS
		BENEFITS										
--	--	DENTAL CHILDREN'S OUTREACH AGES 0-3	$5,724,000	$2,862,000	$0	$0	$0	$0	($5,724,000)	($2,862,000)	$0	$0
--	--	MEDICAL MANAGEMENT AND TREATMENT FOR ALD	$440,000	$198,720	$0	$0	$0	$0	($440,000)	($198,720)	$0	$0
--	--	BEHAVIORAL HEALTH TREATMENT - DDS TRANSITION	$101,325,000	$44,260,260	$0	$0	$0	$0	($101,325,000)	($44,260,260)	$0	$0
--	--	SRP PRIOR AUTH. & PREVENTIVE DENTAL SERVICES	($3,201,000)	($1,600,500)	$0	$0	$0	$0	$3,201,000	$1,600,500	$0	$0
--	--	WOMEN'S HEALTH SERVICES	($7,932,000)	($1,787,500)	$0	$0	$0	$0	$7,932,000	$1,787,500	$0	$0
--	--	ALLIED DENTAL PROFESSIONALS ENROLLMENT	$763,000	$381,500	$0	$0	$0	$0	($763,000)	($381,500)	$0	$0
--	--	IMPLEMENT AAP BRIGHT FUTURES PERIODICITY FOR EPSDT	$16,372,000	$7,837,540	$0	$0	$0	$0	($16,372,000)	($7,837,540)	$0	$0
--	--	DENTAL BENEFICIARY OUTREACH AND EDUCATION PROGRAM	$725,000	$362,500	$0	$0	$0	$0	($725,000)	($362,500)	$0	$0
		BENEFITS SUBTOTAL	**$1,245,948,360**	**$293,850,840**	**$1,343,111,720**	**$304,800,240**	**$1,562,066,380**	**$389,488,950**	**$316,118,020**	**$95,638,110**	**$218,954,660**	**$84,688,720**
		PHARMACY										
47	47	NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS	$84,331,350	$38,530,210	$38,796,190	$17,518,730	$42,078,870	$19,291,950	($42,252,480)	($19,238,260)	$3,282,680	$1,773,230
48	48	DRUG REBATES PRIOR YEAR FUNDING ADJUSTMENT	$0	$0	($60,286,000)	$256,603,830	($60,286,000)	$256,603,830	($60,286,000)	$256,603,830	$0	$0
50	50	LITIGATION SETTLEMENTS	$0	$0	($2,526,000)	($2,526,000)	($18,133,000)	($18,133,000)	($18,133,000)	($18,133,000)	($15,607,000)	($15,607,000)
51	51	BCCTP DRUG REBATES	($11,263,000)	($3,545,150)	($9,172,000)	($2,884,700)	($10,759,000)	($3,322,200)	$504,000	$222,950	($1,587,000)	($437,500)
52	52	FAMILY PACT DRUG REBATES	($17,183,000)	($2,132,400)	($17,503,000)	($2,177,000)	($42,415,000)	($5,155,700)	($25,232,000)	($3,023,300)	($24,912,000)	($2,978,700)
53	53	MEDICAL SUPPLY REBATES	($24,916,000)	($12,458,000)	($24,916,000)	($12,458,000)	($24,916,000)	($12,458,000)	$0	$0	$0	$0
54	54	STATE SUPPLEMENTAL DRUG REBATES	($192,285,000)	($65,423,790)	($202,948,000)	($62,783,280)	($146,024,000)	($97,754,270)	$46,261,000	($32,330,480)	$56,924,000	($34,970,990)
55	55	FEDERAL DRUG REBATES	($2,139,644,000)	($712,018,900)	($2,254,707,000)	($725,409,460)	($2,957,871,000)	($447,616,020)	($818,227,000)	$264,402,880	($703,164,000)	$277,793,440
210	--	DRUG REBATES - RETROACTIVE ACA ADJUSTMENTS	$0	$0	$0	$46,504,000	$0	$0	$0	$0	$0	($46,504,000)
--	--	NON FFP DRUGS	$0	$69,500	$0	$0	$0	$0	$0	($69,500)	$0	$0
		PHARMACY SUBTOTAL	**($2,300,959,650)**	**($756,978,530)**	**($2,533,261,810)**	**($487,611,880)**	**($3,218,325,130)**	**($308,543,410)**	**($917,365,480)**	**$448,435,120**	**($685,063,320)**	**$179,068,480**
		DRUG MEDI-CAL										
56	56	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	$580,548,000	$124,364,740	$372,865,000	$76,171,430	$377,920,000	$76,054,760	($202,628,000)	($48,309,980)	$5,055,000	($116,670)
61	--	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	$0	$0	$3,000,000	$100,000	$0	$0	$0	$0	($3,000,000)	($100,000)

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2018 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	2017-18 APPROPRIATION TOTAL FUNDS	2017-18 APPROPRIATION GENERAL FUNDS	NOV. 2017 EST. FOR 2017-18 TOTAL FUNDS	NOV. 2017 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	DIFF. MAY TO APPROPRIATION TOTAL FUNDS	DIFF. MAY TO APPROPRIATION GENERAL FUNDS	DIFFERENCE MAY TO NOVEMBER TOTAL FUNDS	DIFFERENCE MAY TO NOVEMBER GENERAL FUNDS
		DRUG MEDI-CAL										
--	--	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	$14,189,000	$536,900	$0	$0	$0	$0	($14,189,000)	($536,900)	$0	$0
		DRUG MEDI-CAL SUBTOTAL	**$594,737,000**	**$124,901,640**	**$375,865,000**	**$76,271,430**	**$377,920,000**	**$76,054,760**	**($216,817,000)**	**($48,846,880)**	**$2,055,000**	**($216,670)**
		MENTAL HEALTH										
65	65	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT	$253,505,000	$0	$266,121,000	$0	$80,086,000	$0	($173,419,000)	$0	($186,035,000)	$0
66	66	PATHWAYS TO WELL-BEING	$17,201,000	$0	$12,982,000	$0	$11,734,000	$0	($5,467,000)	$0	($1,248,000)	$0
67	67	MHP COSTS FOR CONTINUUM OF CARE REFORM	$23,308,000	$12,423,500	$12,305,000	$6,922,000	$6,499,000	$4,019,500	($16,809,000)	($8,404,000)	($5,806,000)	($2,902,500)
69	69	LATE CLAIMS FOR SMHS	$4,000	$4,000	$4,000	$4,000	$4,000	$4,000	$0	$0	$0	$0
70	70	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	$0	($200,000)	$0	($200,000)	$0	($200,000)	$0	$0	$0	$0
71	71	CHART REVIEW	($1,485,000)	$0	($1,806,000)	$0	($1,743,000)	$0	($258,000)	$0	$63,000	$0
72	72	INTERIM AND FINAL COST SETTLEMENTS - SMHS	$20,758,000	$21,146,000	($3,972,000)	$377,000	$11,740,000	$20,710,000	($9,018,000)	($436,000)	$15,712,000	$20,333,000
68	--	TRANSITIONAL SMHS CLAIMS	$1,472,000	$1,472,000	$1,510,000	$1,510,000	$0	$0	($1,472,000)	($1,472,000)	($1,510,000)	($1,510,000)
		MENTAL HEALTH SUBTOTAL	**$314,763,000**	**$34,845,500**	**$287,144,000**	**$8,613,000**	**$108,320,000**	**$24,533,500**	**($206,443,000)**	**($10,312,000)**	**($178,824,000)**	**$15,920,500**
		WAIVER--MH/UCD & BTR										
73	73	GLOBAL PAYMENT PROGRAM	$2,388,446,000	$0	$2,279,899,000	$0	$2,275,272,000	$0	($113,174,000)	$0	($4,627,000)	$0
74	74	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL	$1,600,000,000	$0	$1,771,000,000	$0	$1,765,728,000	$0	$165,728,000	$0	($5,272,000)	$0
75	75	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS	$720,000,000	$0	$581,821,000	$0	$353,709,000	$0	($366,291,000)	$0	($228,112,000)	$0
76	76	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	$141,905,000	$70,952,500	$106,752,000	$53,376,000	$107,000,000	$53,500,000	($34,905,000)	($17,452,500)	$248,000	$124,000
77	77	BTR - LIHP - MCE	$198,363,000	$0	$104,616,000	$0	$104,616,000	$0	($93,747,000)	$0	$0	$0
78	78	MH/UCD STABILIZATION FUNDING	$55,400,000	$55,400,000	$55,400,000	$55,400,000	$55,400,000	$55,400,000	$0	$0	$0	$0
79	79	BTR - LOW INCOME HEALTH PROGRAM - HCCI	$231,547,000	$0	$36,060,000	$0	$36,060,000	$0	($195,487,000)	$0	$0	$0
80	80	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$1,060,000	$0	$1,263,000	$0	$1,170,000	$0	$110,000	$0	($93,000)	$0
81	81	MH/UCD HEALTH CARE COVERAGE INITIATIVE	$23,509,000	$0	$1,262,000	$0	$1,262,000	$0	($22,247,000)	$0	$0	$0

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2018 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	2017-18 APPROPRIATION TOTAL FUNDS	2017-18 APPROPRIATION GENERAL FUNDS	NOV. 2017 EST. FOR 2017-18 TOTAL FUNDS	NOV. 2017 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	DIFF. MAY TO APPROPRIATION TOTAL FUNDS	DIFF. MAY TO APPROPRIATION GENERAL FUNDS	DIFFERENCE MAY TO NOVEMBER TOTAL FUNDS	DIFFERENCE MAY TO NOVEMBER GENERAL FUNDS
		WAIVER--MH/UCD & BTR										
82	82	MH/UCD FEDERAL FLEX. & STABILIZATION-SNCP	$0	$0	$0	($6,205,000)	$0	($6,205,000)	$0	($6,205,000)	$0	$0
83	83	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM	$0	($75,000,000)	$0	($75,000,000)	$0	($75,000,000)	$0	$0	$0	$0
86	86	MH/UCD SAFETY NET CARE POOL	($6,723,000)	$0	($6,723,000)	$0	($6,723,000)	$0	$0	$0	$0	$0
--	--	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND	$232,500,000	$0	$0	$0	$0	$0	($232,500,000)	$0	$0	$0
		WAIVER--MH/UCD & BTR SUBTOTAL	**$5,586,007,000**	**$51,352,500**	**$4,931,350,000**	**$27,571,000**	**$4,693,494,000**	**$27,695,000**	**($892,513,000)**	**($23,657,500)**	**($237,856,000)**	**$124,000**
		MANAGED CARE										
90	90	MANAGED CARE RATE RANGE IGTS	$3,143,888,000	$0	$3,553,667,000	$0	$1,968,917,000	$0	($1,174,971,000)	$0	($1,584,750,000)	$0
91	91	CCI-MANAGED CARE PAYMENTS	$9,936,539,000	$4,968,269,500	$9,981,455,000	$4,990,727,500	$9,901,568,000	$4,950,784,000	($34,971,000)	($17,485,500)	($79,887,000)	($39,943,500)
92	92	MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES	$2,131,736,000	$612,223,010	$2,131,735,000	$610,312,390	$2,505,200,000	$915,363,760	$373,464,000	$303,140,750	$373,465,000	$305,051,370
93	93	MANAGED CARE PUBLIC HOSPITAL IGTS	$2,880,095,000	$0	$1,717,598,000	$0	$1,713,379,000	$0	($1,166,716,000)	$0	($4,219,000)	$0
96	96	HQAF RATE RANGE INCREASES	$232,000,000	$0	$265,300,000	$0	$294,669,000	$0	$62,669,000	$0	$29,369,000	$0
99	99	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	$21,304,000	$10,464,000	$22,018,000	$10,821,000	$114,090,000	$87,880,000	$92,786,000	$77,416,000	$92,072,000	$77,059,000
101	101	CCI-QUALITY WITHHOLD REPAYMENTS	$9,000,000	$4,500,000	$2,946,000	$1,473,000	$3,317,000	$1,658,500	($5,683,000)	($2,841,500)	$371,000	$185,500
103	103	PALLIATIVE CARE SERVICES IMPLEMENTATION	$2,977,000	$1,334,530	$2,046,000	$961,590	$1,875,000	$875,200	($1,102,000)	($459,330)	($171,000)	($86,390)
109	109	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT	$0	($13,631,000)	$0	($13,988,000)	$0	($87,881,000)	$0	($74,250,000)	$0	($73,893,000)
110	110	MCO TAX MANAGED CARE PLANS	$0	($414,386,000)	$0	($414,743,000)	$0	($300,000,000)	$0	$114,386,000	$0	$114,743,000
111	111	MANAGED CARE IGT ADMIN. & PROCESSING FEE	$0	($275,965,000)	$0	($267,419,000)	$0	($158,945,000)	$0	$117,020,000	$0	$108,474,000
112	112	GENERAL FUND REIMBURSEMENTS FROM DPHS	$0	($253,242,000)	$0	($160,090,000)	$0	($158,606,000)	$0	$94,636,000	$0	$1,484,000
114	114	MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.	$0	($612,223,000)	$0	($585,365,000)	$0	($809,823,000)	$0	($197,600,000)	$0	($224,458,000)
115	115	MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	($1,780,284,000)	$0	($1,782,194,000)	$0	($1,552,053,000)	$0	$228,231,000	$0	$230,141,000
116	116	MANAGED CARE DRUG REBATES	($1,066,751,000)	($345,951,190)	($1,889,663,000)	($616,537,360)	($1,752,995,000)	($534,107,630)	($686,244,000)	($188,156,440)	$136,668,000	$82,429,730
117	117	RETRO MC RATE ADJUSTMENTS	($4,048,269,000)	$191,374,000	($4,100,436,000)	$335,023,000	($3,863,906,000)	$421,086,000	$184,363,000	$229,712,000	$236,530,000	$86,063,000
--	222	INDIAN HEALTH SERVICES MANAGED CARE PROGRAM	$0	$0	$0	$0	$29,962,000	$2,910,000	$29,962,000	$2,910,000	$29,962,000	$2,910,000
113	--	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	$0	$0	$0	($15,517,000)	$0	$0	$0	$0	$0	$15,517,000

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2018 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	2017-18 APPROPRIATION TOTAL FUNDS	2017-18 APPROPRIATION GENERAL FUNDS	NOV. 2017 EST. FOR 2017-18 TOTAL FUNDS	NOV. 2017 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	DIFF. MAY TO APPROPRIATION TOTAL FUNDS	DIFF. MAY TO APPROPRIATION GENERAL FUNDS	DIFFERENCE MAY TO NOVEMBER TOTAL FUNDS	DIFFERENCE MAY TO NOVEMBER GENERAL FUNDS
		MANAGED CARE										
--	--	CAPITATED RATE ADJUSTMENT FOR FY 2017-18	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
--	--	MEDI-CAL NONMEDICAL TRANSPORTATION	$6,000,000	$1,725,530	$0	$0	$0	$0	($6,000,000)	($1,725,530)	$0	$0
--	--	CENCAL HEALTH PLAN-ADDITION OF CHDP	($3,329,000)	($1,664,500)	$0	$0	$0	$0	$3,329,000	$1,664,500	$0	$0
		MANAGED CARE SUBTOTAL	**$13,245,190,000**	**$2,092,543,880**	**$11,686,666,000**	**$2,093,465,120**	**$10,916,076,000**	**$2,779,141,830**	**($2,329,114,000)**	**$686,597,950**	**($770,590,000)**	**$685,676,710**
		PROVIDER RATES										
118	118	DPH INTERIM & FINAL RECONS	$137,004,000	$0	$215,065,000	$0	$237,459,000	$0	$100,455,000	$0	$22,394,000	$0
119	119	DENTAL RETROACTIVE RATE CHANGES	$23,693,000	$9,095,270	$186,708,000	$73,374,740	$137,467,000	$50,839,080	$113,774,000	$41,743,810	($49,241,000)	($22,535,660)
120	120	FQHC/RHC/CBRC RECONCILIATION PROCESS	$199,430,150	$75,718,460	$204,677,000	$77,124,800	$160,320,000	$60,410,010	($39,110,150)	($15,308,450)	($44,357,000)	($16,714,790)
121	121	AB 1629 ANNUAL RATE ADJUSTMENTS	$174,846,170	$87,423,090	$142,595,970	$71,297,980	$146,497,660	$73,248,830	($28,348,520)	($14,174,260)	$3,901,690	$1,950,850
122	122	RATE INCREASE FOR FQHCS/RHCS/CBRCS	$51,405,790	$19,517,480	$152,974,700	$57,642,270	$145,818,430	$54,945,380	$94,412,640	$35,427,900	($7,156,270)	($2,696,890)
123	123	LTC RATE ADJUSTMENT	$31,718,000	$15,859,000	$26,296,090	$13,148,050	$20,932,410	$10,466,200	($10,785,590)	($5,392,800)	($5,363,690)	($2,681,840)
124	124	DPH INTERIM RATE GROWTH	$37,920,420	$18,960,210	$20,964,600	$10,482,300	$20,000,670	$10,000,330	($17,919,750)	($8,959,870)	($963,930)	($481,970)
125	125	HOSPICE RATE INCREASES	$21,480,520	$10,740,260	$4,441,270	$2,220,640	$6,993,600	$3,496,800	($14,486,920)	($7,243,460)	$2,552,330	$1,276,170
126	126	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	$19,464,620	$9,732,310	$19,493,110	$9,746,560	$19,540,630	$9,770,310	$76,000	$38,000	$47,520	$23,760
127	127	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	$11,000,000	($2,390,000)	$10,868,000	($2,456,000)	$10,868,000	($2,395,000)	($132,000)	($5,000)	$0	$61,000
129	129	ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE	$1,551,580	($1,247,260)	$425,520	($349,470)	$34,280	($30,230)	($1,517,300)	$1,217,040	($391,240)	$319,250
130	130	ALTERNATIVE BIRTHING CENTER REIMBURSEMENT	$44,390	$22,190	$44,930	$22,470	$7,460	$3,730	($36,930)	($18,460)	($37,470)	($18,740)
131	131	DP/NF-B RETROACTIVE RECOUPMENT FORGIVENESS	$0	$0	$0	$744,000	$0	$1,298,000	$0	$1,298,000	$0	$554,000
133	133	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	($482,975,000)	$0	($539,842,000)	$0	($440,934,000)	$0	$42,041,000	$0	$98,908,000
134	134	DPH INTERIM RATE	$0	($391,438,740)	$0	($394,275,310)	$0	($359,764,050)	$0	$31,674,690	$0	$34,511,260
135	135	LABORATORY RATE METHODOLOGY CHANGE	($23,980,830)	($11,990,410)	($20,994,980)	($10,497,490)	($12,783,400)	($6,391,700)	$11,197,430	$5,598,710	$8,211,580	$4,105,790
136	136	REDUCTION TO RADIOLOGY RATES	($22,711,270)	($11,355,630)	($20,250,050)	($10,125,020)	($8,622,210)	($4,311,110)	$14,089,060	$7,044,530	$11,627,840	$5,813,920
137	137	10% PROVIDER PAYMENT REDUCTION	($205,136,000)	($102,568,000)	($203,884,000)	($101,942,000)	($203,884,000)	($101,942,000)	$1,252,000	$626,000	$0	$0
128	--	GDSP PRENATAL SCREENING FEE INCREASE	$4,088,310	$2,044,150	$4,088,320	$2,044,160	$0	$0	($4,088,310)	($2,044,150)	($4,088,320)	($2,044,160)

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FISCAL YEAR 2017-18

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		PROVIDER RATES										
--	--	MEDICARE PART B ADJUSTMENT	($160,682,000)	($88,557,500)	$0	$0	$0	$0	$160,682,000	$88,557,500	$0	$0
--	--	DISCONTINUE PHARMACY RATE REDUCTIONS	$22,531,850	$11,265,920	$0	$0	$0	$0	($22,531,850)	($11,265,920)	$0	$0
		PROVIDER RATES SUBTOTAL	**$323,668,690**	**($832,144,210)**	**$743,513,490**	**($741,639,330)**	**$680,649,510**	**($641,289,400)**	**$356,980,820**	**$190,854,800**	**($62,863,980)**	**$100,349,930**
		SUPPLEMENTAL PMNTS.										
138	138	HOSPITAL QAF - MANAGED CARE PAYMENTS	$15,569,513,000	$0	$6,869,242,000	$0	$5,093,271,000	$0	($10,476,242,000)	$0	($1,775,971,000)	$0
139	139	HOSPITAL QAF - FFS PAYMENTS	$100,398,000	$0	$4,865,095,000	$0	$7,114,270,000	$0	$7,013,872,000	$0	$2,249,175,000	$0
141	141	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	$650,000,000	$0	$746,051,000	$0	$355,918,000	$0	($294,082,000)	$0	($390,133,000)	$0
142	142	PRIVATE HOSPITAL DSH REPLACEMENT	$573,382,000	$286,691,000	$569,419,000	$284,709,500	$576,179,000	$288,089,500	$2,797,000	$1,398,500	$6,760,000	$3,380,000
143	143	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$415,351,000	$0	$433,217,000	$0	$442,461,000	$0	$27,110,000	$0	$9,244,000	$0
144	144	DSH PAYMENT	$444,414,000	$17,000,000	$469,970,000	$13,102,000	$400,444,000	$14,939,000	($43,970,000)	($2,061,000)	($69,526,000)	$1,837,000
145	145	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	$300,261,000	$118,400,000	$324,086,000	$118,400,000	$319,693,000	$118,400,000	$19,432,000	$0	($4,393,000)	$0
146	146	NDPH IGT SUPPLEMENTAL PAYMENTS	$184,924,000	($2,441,000)	$233,467,000	($8,190,000)	$124,176,000	($1,415,000)	($60,748,000)	$1,026,000	($109,291,000)	$6,775,000
147	147	PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES	$280,000,000	$0	$223,809,000	$0	$247,520,000	$0	($32,480,000)	$0	$23,711,000	$0
148	148	PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$167,000,000	$0	$158,347,000	$0	$158,167,000	$0	($8,833,000)	$0	($180,000)	$0
149	149	DPH PHYSICIAN & NON-PHYS. COST	$154,861,000	$0	$155,563,000	$0	$83,855,000	$0	($71,006,000)	$0	($71,708,000)	$0
150	150	CAPITAL PROJECT DEBT REIMBURSEMENT	$186,120,000	$82,810,000	$153,994,000	$37,764,000	$154,173,000	$25,634,000	($31,947,000)	($57,176,000)	$179,000	($12,130,000)
151	151	FFP FOR LOCAL TRAUMA CENTERS	$106,601,000	$0	$147,634,000	$0	$132,319,000	$0	$25,718,000	$0	($15,315,000)	$0
152	152	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	$125,117,000	$2,520,000	$137,213,000	$0	$134,634,000	$219,700	$9,517,000	($2,300,300)	($2,579,000)	$219,700
153	153	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	$86,243,000	$48,928,000	$86,242,000	$48,928,000	$86,007,000	$48,310,000	($236,000)	($618,000)	($235,000)	($618,000)
154	154	GEMT SUPPLEMENTAL PAYMENT PROGRAM	$76,800,000	$0	$70,105,000	$0	$76,182,000	$0	($618,000)	$0	$6,077,000	$0
155	155	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	$73,762,000	$0	$57,392,000	$0	$75,732,000	$0	$1,970,000	$0	$18,340,000	$0
156	156	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS	$54,000,000	$0	$13,257,000	$0	$21,682,000	$0	($32,318,000)	$0	$8,425,000	$0
157	157	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

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		SUPPLEMENTAL PMNTS.										
158	158	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
159	159	IGT PAYMENTS FOR HOSPITAL SERVICES	$5,613,000	$0	$5,902,000	$0	$5,801,000	$0	$188,000	$0	($101,000)	$0
160	160	PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS	$8,000,000	$0	$5,474,000	$0	$5,474,000	$0	($2,526,000)	$0	$0	$0
161	161	NDPH SUPPLEMENTAL PAYMENT	$4,950,000	$1,900,000	$5,410,000	$1,900,000	$5,277,000	$1,900,000	$327,000	$0	($133,000)	$0
162	162	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$4,631,000	$0	$4,664,000	$0	$5,098,000	$0	$467,000	$0	$434,000	$0
140	--	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	$1,187,500,000	$0	$1,207,941,000	$0	$0	$0	($1,187,500,000)	$0	($1,207,941,000)	$0
164	--	DP-NF CAPITAL PROJECT DEBT REPAYMENT	$0	$57,224,000	$0	$57,224,000	$0	$0	$0	($57,224,000)	$0	($57,224,000)
--	--	FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS	$465,948,000	$0	$0	$0	$0	$0	($465,948,000)	$0	$0	$0
		SUPPLEMENTAL PMNTS. SUBTOTAL	**$21,243,389,000**	**$622,032,000**	**$16,961,494,000**	**$562,837,500**	**$15,636,333,000**	**$505,077,200**	**($5,607,056,000)**	**($116,954,800)**	**($1,325,161,000)**	**($57,760,300)**
		OTHER										
84	84	CMS DEFERRED CLAIMS	$0	$12,378,000	$0	$71,690,000	$0	$509,238,000	$0	$496,860,000	$0	$437,548,000
171	171	ARRA HITECH - PROVIDER PAYMENTS	$175,130,000	$0	$319,499,000	$0	$130,515,000	$0	($44,615,000)	$0	($188,984,000)	$0
174	174	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$110,533,000	$0	$117,532,000	$0	$102,041,000	$0	($8,492,000)	$0	($15,491,000)	$0
178	178	INFANT DEVELOPMENT PROGRAM	$26,305,000	$0	$42,024,000	$0	$42,313,000	$0	$16,008,000	$0	$289,000	$0
179	179	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$19,921,000	$8,339,000	$19,472,000	$8,512,000	$17,176,000	$7,659,000	($2,745,000)	($680,000)	($2,296,000)	($853,000)
180	180	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	$15,297,260	$7,648,630	$16,823,860	$8,411,930	$16,823,860	$8,411,930	$1,526,590	$763,300	$0	$0
181	181	AUDIT SETTLEMENTS	$13,928,000	$13,928,000	$13,928,000	$13,928,000	$0	$13,928,000	($13,928,000)	$0	($13,928,000)	$0
182	182	OVERTIME FOR WPCS PROVIDERS	$14,686,000	$7,343,000	$9,934,000	$4,967,000	$9,961,000	$4,998,500	($4,725,000)	($2,344,500)	$27,000	$31,500
184	184	INDIAN HEALTH SERVICES	$6,239,000	($20,795,000)	$4,104,000	($21,891,000)	$3,903,000	($20,813,000)	($2,336,000)	($18,000)	($201,000)	$1,078,000
185	185	MEDI-CAL ESTATE RECOVERIES	$64,707,000	$32,353,500	$3,041,000	$1,520,500	$17,176,000	$8,588,000	($47,531,000)	($23,765,500)	$14,135,000	$7,067,500
186	186	WPCS WORKERS' COMPENSATION	$3,019,000	$1,509,500	$3,026,000	$1,513,000	$3,026,000	$1,513,000	$7,000	$3,500	$0	$0
190	190	CDDS DENTAL SERVICES	$984,000	$0	$549,000	$0	$712,000	$0	($272,000)	$0	$163,000	$0
191	191	FUNDING ADJUST. OTLICP	$154,000	($176,826,160)	$132,000	($179,393,440)	$122,000	($184,775,000)	($32,000)	($7,948,840)	($10,000)	($5,381,560)
193	193	HEALTH CARE SVCS. PLANS FINES AND PENALTIES FUND	$0	($46,633,000)	$0	($48,025,000)	$0	($48,025,000)	$0	($1,392,000)	$0	$0
194	194	CLPP FUND	$0	($725,000)	$0	($725,000)	$0	($725,000)	$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 2018 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	2017-18 APPROPRIATION TOTAL FUNDS	2017-18 APPROPRIATION GENERAL FUNDS	NOV. 2017 EST. FOR 2017-18 TOTAL FUNDS	NOV. 2017 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	DIFF. MAY TO APPROPRIATION TOTAL FUNDS	DIFF. MAY TO APPROPRIATION GENERAL FUNDS	DIFFERENCE MAY TO NOVEMBER TOTAL FUNDS	DIFFERENCE MAY TO NOVEMBER GENERAL FUNDS
		OTHER										
195	195	CCI-TRANSFER OF IHSS COSTS TO DHCS	$0	($1,247,758,000)	$0	($1,305,870,000)	$0	($1,343,703,000)	$0	($95,945,000)	$0	($37,833,000)
196	196	HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	($1,020,525,000)	$0	($851,825,000)	$0	($1,328,946,000)	$0	($308,421,000)	$0	($477,121,000)
197	197	FUNDING ADJUST. ACA OPT. EXPANSION	$0	($1,764,846,210)	$0	($1,756,837,450)	$0	($1,808,695,810)	$0	($43,849,600)	$0	($51,858,360)
198	198	COUNTY SHARE OF OTLICP-CCS COSTS	$0	($8,217,000)	$0	($8,764,000)	$0	$0	$0	$8,217,000	$0	$8,764,000
199	199	IMD ANCILLARY SERVICES	$0	$29,565,000	$0	$23,022,000	$0	$3,714,000	$0	($25,851,000)	$0	($19,308,000)
200	200	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	($208,524,000)	$0	($182,960,000)	$0	($182,960,000)	$0	$25,564,000	$0	$0
201	201	INTEGRATION OF THE SF CLSB INTO THE ALW	($746,330)	($373,170)	($1,501,910)	($750,960)	($1,553,000)	($776,500)	($806,670)	($403,340)	($51,090)	($25,550)
202	202	MEDI-CAL RECOVERIES SETTLEMENTS AND LEGAL COSTS	($1,730,000)	($865,000)	($1,730,000)	($865,000)	($1,730,000)	($865,000)	$0	$0	$0	$0
211	211	ASSISTED LIVING WAIVER EXPANSION	$0	$0	($8,680)	($4,340)	($8,680)	($4,340)	($8,680)	($4,340)	$0	$0
212	212	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER RENEWAL	$6,749,700	$3,374,850	$1,757,460	$878,730	$1,592,060	$796,030	($5,157,640)	($2,578,820)	($165,390)	($82,700)
--	223	HQAF WITHHOLD TRANSFER	$0	$0	$0	$0	$261,429,000	$130,714,500	$261,429,000	$130,714,500	$261,429,000	$130,714,500
170	--	CCI IHSS RECONCILIATION	$0	$0	$339,270,000	$0	$0	$0	$0	$0	($339,270,000)	$0
--	--	MEDI-CAL RECOVERIES FIFTY PERCENT RULE	($12,160,000)	($12,160,000)	$0	$0	$0	$0	$12,160,000	$12,160,000	$0	$0
--	--	MEDICARE BUY-IN QUALITY REVIEW PROJECT RECOVERIES	($2,000,000)	($1,000,000)	$0	$0	$0	$0	$2,000,000	$1,000,000	$0	$0
--	--	CCI-FFS SAVINGS FOR ADDITIONAL ENROLLMENT	($332,853,000)	($166,426,500)	$0	$0	$0	$0	$332,853,000	$166,426,500	$0	$0
		OTHER SUBTOTAL	**$108,163,630**	**($4,559,234,560)**	**$887,851,720**	**($4,223,468,030)**	**$603,498,240**	**($4,230,727,690)**	**$495,334,610**	**$328,506,860**	**($284,353,480)**	**($7,259,660)**
		GRAND TOTAL	**$43,309,930,040**	**($1,459,624,490)**	**$36,761,613,820**	**($1,051,389,020)**	**$34,420,840,240**	**($715,398,980)**	**($8,889,089,800)**	**$744,225,520**	**($2,340,773,580)**	**$335,990,040**

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

FISCAL YEAR 2017-18 COST PER ELIGIBLE BASED ON MAY 2018 ESTIMATE

SERVICE CATEGORY	PA-OAS	NEWLY	PA-ATD	PA-AFDC	LT-OAS	H-PE
PHYSICIANS	$10,557,730	$134,417,720	$96,070,730	$48,841,980	$2,579,340	$40,813,800
OTHER MEDICAL	$71,948,540	$1,018,304,040	$389,420,890	$303,645,960	$5,369,180	$40,489,660
CO. & COMM. OUTPATIENT	$5,126,150	$135,370,520	$117,662,220	$27,749,710	$797,290	$48,387,180
PHARMACY	$967,400	$140,084,130	$181,811,600	$18,399,640	$592,750	$19,609,070
COUNTY INPATIENT	$4,632,890	$543,585,740	$38,490,810	$25,108,720	$1,879,680	$52,437,410
COMMUNITY INPATIENT	$62,908,950	$1,184,085,620	$653,473,510	$277,763,160	$15,499,390	$228,297,950
NURSING FACILITIES	$209,620,590	$141,980,050	$523,392,470	$3,406,960	$1,179,813,680	$1,624,420
ICF-DD	$991,400	$5,752,740	$178,998,780	$247,590	$41,780,090	$0
MEDICAL TRANSPORTATION	$4,782,610	$14,956,940	$16,270,160	$2,597,740	$2,356,650	$3,016,120
OTHER SERVICES	$83,878,010	$30,512,100	$279,324,850	$36,252,760	$59,938,060	$1,218,500
HOME HEALTH	$1,586,070	$1,764,090	$120,471,890	$4,605,680	$8,640	$105,960
FFS SUBTOTAL	**$457,000,340**	**$3,350,813,680**	**$2,595,387,920**	**$748,619,900**	**$1,310,614,760**	**$436,000,060**
DENTAL	$45,103,350	$390,895,660	$120,275,590	$150,344,490	$15,034,450	$0
MENTAL HEALTH	$9,103,390	$270,800,260	$1,045,174,590	$716,010,440	$744,190	$0
TWO PLAN MODEL	$2,025,271,790	$8,361,195,900	$5,831,958,380	$1,219,356,720	$0	$0
COUNTY ORGANIZED HEALTH SYSTEMS	$297,231,780	$3,266,184,560	$1,315,611,450	$279,106,280	$722,038,870	$0
GEOGRAPHIC MANAGED CARE	$234,462,050	$1,528,934,750	$1,035,556,830	$195,923,730	$0	$0
PHP & OTHER MANAG. CARE	$223,841,370	$32,818,270	$146,901,090	$20,760,130	$9,723,020	$0
EPSDT SCREENS	$0	$0	$0	$867,710	$0	$0
MEDICARE PAYMENTS	$1,706,620,610	$0	$1,600,884,280	$2,836,270	$161,242,020	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$9,862,370	$0	$22,206,710	$27,394,230	$950,780	$0
MISC. SERVICES	$731,909,750	$0	$5,232,521,900	$7,199,110	$0	$0
DRUG MEDI-CAL	$19,215,110	$169,707,140	$43,310,880	$54,499,930	$1,862,640	$0
REGIONAL MODEL	$10,111,610	$517,439,020	$264,253,000	$60,366,290	$0	$0
NON-FFS SUBTOTAL	**$5,312,733,180**	**$14,537,975,570**	**$16,658,654,710**	**$2,734,665,330**	**$911,595,970**	**$0**
TOTAL DOLLARS (1)	**$5,769,733,530**	**$17,888,789,250**	**$19,254,042,630**	**$3,483,285,230**	**$2,222,210,730**	**$436,000,060**
ELIGIBLES * **	**436,700**	**3,830,200**	**983,300**	**1,213,000**	**42,100**	**31,000**
ANNUAL $/ELIGIBLE	**$13,212**	**$4,670**	**$19,581**	**$2,872**	**$52,784**	**$14,065**
AVG. MO. $/ELIGIBLE	**$1,101**	**$389**	**$1,632**	**$239**	**$4,399**	**$1,172**

(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 2017-18 COST PER ELIGIBLE BASED ON MAY 2018 ESTIMATE

SERVICE CATEGORY	LT-ATD	POV 250	MN-OAS	MN-ATD	MN-AFDC	MI-C
PHYSICIANS	$2,353,610	$22,415,990	$24,663,570	$10,541,310	$159,407,220	$25,783,410
OTHER MEDICAL	$3,301,580	$182,279,290	$131,780,530	$69,208,710	$850,831,570	$78,255,160
CO. & COMM. OUTPATIENT	$652,590	$25,164,990	$16,489,290	$9,570,330	$117,886,670	$11,122,810
PHARMACY	$930,060	$7,519,940	$3,972,290	$8,816,670	$36,048,280	$9,603,800
COUNTY INPATIENT	$6,208,620	$4,094,570	$58,536,860	$19,395,280	$140,277,170	$5,957,990
COMMUNITY INPATIENT	$14,718,760	$113,331,420	$156,067,240	$46,307,430	$792,752,730	$71,539,380
NURSING FACILITIES	$238,273,610	$2,019,480	$221,233,420	$41,655,820	$23,223,870	$4,653,580
ICF-DD	$162,767,950	$8,300	$2,108,440	$9,105,930	$972,600	$2,196,530
MEDICAL TRANSPORTATION	$833,460	$618,800	$7,917,320	$6,333,190	$6,252,650	$1,132,590
OTHER SERVICES	$10,937,470	$9,493,140	$75,783,400	$54,815,020	$90,590,030	$10,789,030
HOME HEALTH	$17,460	$8,877,080	$1,012,980	$45,486,220	$8,100,930	$11,379,410
FFS SUBTOTAL	**$440,995,170**	**$375,823,000**	**$699,565,340**	**$321,235,890**	**$2,226,343,690**	**$232,413,690**
DENTAL	$15,034,450	$98,868,370	$45,103,350	$15,034,450	$435,999,010	$28,248,100
MENTAL HEALTH	$2,180,660	$66,420,160	$10,557,160	$105,030,980	$500,710,360	$75,445,400
TWO PLAN MODEL	$0	$768,518,060	$1,922,160,210	$590,422,730	$2,798,853,720	$33,924,300
COUNTY ORGANIZED HEALTH SYSTEMS	$195,962,750	$395,182,200	$427,312,670	$300,912,780	$1,048,897,450	$35,569,040
GEOGRAPHIC MANAGED CARE	$0	$155,066,260	$220,262,720	$114,448,530	$470,131,870	$4,706,960
PHP & OTHER MANAG. CARE	$327,810	$8,508,440	$226,842,020	$22,296,320	$34,168,060	$2,437,650
EPSDT SCREENS	$0	$661,390	$0	$0	$2,522,240	$119,360
MEDICARE PAYMENTS	$15,708,570	$0	$1,215,009,090	$517,535,190	$109,043,970	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$252,940	$0	$10,801,860	$3,708,270	$79,468,100	$3,757,960
MISC. SERVICES	$0	($51,141,610)	$799,846,510	$866,184,980	$20,816,270	$1,033,500
DRUG MEDI-CAL	$505,200	$40,297,260	$20,998,680	$7,033,240	$157,586,780	$7,806,910
REGIONAL MODEL	$0	$49,257,410	$29,401,600	$26,266,720	$169,926,770	$1,066,260
NON-FFS SUBTOTAL	**$229,972,380**	**$1,531,637,960**	**$4,928,295,860**	**$2,568,874,190**	**$5,828,124,580**	**$194,115,440**
TOTAL DOLLARS (1)	**$670,967,560**	**$1,907,460,960**	**$5,627,861,200**	**$2,890,110,090**	**$8,054,468,280**	**$426,529,140**
ELIGIBLES * **	**11,200**	**924,600**	**486,600**	**169,700**	**3,518,800**	**166,400**
ANNUAL $/ELIGIBLE	**$59,908**	**$2,063**	**$11,566**	**$17,031**	**$2,289**	**$2,563**
AVG. MO. $/ELIGIBLE	**$4,992**	**$172**	**$964**	**$1,419**	**$191**	**$214**

(1) Does not include Audits & Lawsuits and Recoveries.
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FISCAL YEAR 2017-18 COST PER ELIGIBLE BASED ON MAY 2018 ESTIMATE

SERVICE CATEGORY	MI-A	REFUGEE	OBRA	POV 185	POV 133	POV 100
PHYSICIANS	$688,830	$81,580	$332,700	$122,848,940	$16,109,700	$7,599,260
OTHER MEDICAL	$1,524,870	$862,320	$172,620	$228,754,810	$177,464,840	$80,264,290
CO. & COMM. OUTPATIENT	$392,980	$40,100	$80,880	$25,232,510	$13,036,790	$9,938,130
PHARMACY	$439,540	$33,240	$102,810	$2,593,430	$2,916,210	$5,780,510
COUNTY INPATIENT	$147,680	$33,390	$381,230	$68,890,070	$2,768,070	$2,005,110
COMMUNITY INPATIENT	$2,043,190	$199,160	$1,168,230	$711,767,970	$83,057,750	$36,925,640
NURSING FACILITIES	$23,261,010	$10	$7,623,220	$1,792,760	$6,381,380	$102,500
ICF-DD	$1,068,010	$0	$252,440	$229,530	$536,430	$10
MEDICAL TRANSPORTATION	$104,160	$3,110	$53,090	$2,316,630	$586,320	$214,040
OTHER SERVICES	$498,640	$9,170	$154,660	$9,983,820	$16,240,030	$9,647,570
HOME HEALTH	$920	$0	$0	$2,281,250	$3,316,420	$992,970
FFS SUBTOTAL	**$30,169,850**	**$1,262,070**	**$10,321,870**	**$1,176,691,730**	**$322,413,940**	**$153,470,040**
DENTAL	$15,034,450	$15,034,450	$15,034,450	$45,103,350	$75,172,240	$45,103,350
MENTAL HEALTH	$17,310	$51,960	$331,400	$7,046,670	$16,138,140	$27,915,920
TWO PLAN MODEL	$336,390	$690,550	$0	$178,077,870	$693,307,200	$366,613,360
COUNTY ORGANIZED HEALTH SYSTEMS	$88,310	$90,300	$32,340	$78,788,300	$281,853,780	$155,885,040
GEOGRAPHIC MANAGED CARE	$4,030	$448,560	$0	$29,860,580	$117,712,620	$64,806,560
PHP & OTHER MANAG. CARE	$1,215,490	$0	$0	$3,646,470	$6,077,460	$3,646,470
EPSDT SCREENS	$0	$0	$0	$0	$550,790	$276,510
MEDICARE PAYMENTS	$0	$0	$0	$0	$0	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$271,010	$0	$13,550	$8,042,110	$0	$8,715,110
MISC. SERVICES	$190	$0	$0	$55,690	$4,225,600	$2,064,110
DRUG MEDI-CAL	$52,720	$59,130	$0	$15,801,730	$21,871,470	$16,667,160
REGIONAL MODEL	$0	$3,700	$0	$11,533,040	$40,931,740	$19,842,240
NON-FFS SUBTOTAL	**$17,019,880**	**$16,378,650**	**$15,411,740**	**$377,955,810**	**$1,257,841,040**	**$711,535,830**
TOTAL DOLLARS (1)	**$47,189,720**	**$17,640,720**	**$25,733,610**	**$1,554,647,540**	**$1,580,254,980**	**$865,005,870**
ELIGIBLES * **	**12,000**	**900**	**600**	**356,100**	**770,000**	**385,900**
ANNUAL $/ELIGIBLE	**$3,932**	**$19,601**	**$42,889**	**$4,366**	**$2,052**	**$2,242**
AVG. MO. $/ELIGIBLE	**$328**	**$1,633**	**$3,574**	**$364**	**$171**	**$187**

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FISCAL YEAR 2017-18 COST PER ELIGIBLE BASED ON MAY 2018 ESTIMATE

SERVICE CATEGORY	TOTAL
PHYSICIANS	**$726,107,410**
OTHER MEDICAL	**$3,633,878,860**
CO. & COMM. OUTPATIENT	**$564,701,140**
PHARMACY	**$440,221,360**
COUNTY INPATIENT	**$974,831,310**
COMMUNITY INPATIENT	**$4,451,907,480**
NURSING FACILITIES	**$2,630,058,810**
ICF-DD	**$407,016,770**
MEDICAL TRANSPORTATION	**$70,345,590**
OTHER SERVICES	**$780,066,250**
HOME HEALTH	**$210,007,970**
FFS SUBTOTAL	**$14,889,142,950**
DENTAL	**$1,570,423,530**
MENTAL HEALTH	**$2,853,679,000**
TWO PLAN MODEL	**$24,790,687,180**
COUNTY ORGANIZED HEALTH SYSTEMS	**$8,800,747,900**
GEOGRAPHIC MANAGED CARE	**$4,172,326,040**
PHP & OTHER MANAG. CARE	**$743,210,070**
EPSDT SCREENS	**$4,998,000**
MEDICARE PAYMENTS	**$5,328,880,000**
STATE HOSP./DEVELOPMENTAL CNTRS.	**$175,445,000**
MISC. SERVICES	**$7,614,716,000**
DRUG MEDI-CAL	**$577,276,000**
REGIONAL MODEL	**$1,200,399,400**
NON-FFS SUBTOTAL	**$57,832,788,140**
TOTAL DOLLARS (1)	**$72,721,931,090**
ELIGIBLES * **	**13,339,100**
ANNUAL $/ELIGIBLE	**$5,452**
AVG. MO. $/ELIGIBLE	**$454**

(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 2017-18 COST PER ELIGIBLE BASED ON MAY 2018 ESTIMATE

EXCLUDED POLICY CHANGES: 77

2	BREAST AND CERVICAL CANCER TREATMENT
4	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
5	COUNTY HEALTH INITIATIVE MATCHING (CHIM)
6	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL
9	NON-OTLICP CHIP
12	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN
16	MEDICARE OPTIONAL EXPANSION ADJUSTMENT
22	1% FMAP INCREASE FOR PREVENTIVE SERVICES
23	ACA MAGI SAVINGS
28	FAMILY PACT PROGRAM
52	FAMILY PACT DRUG REBATES
61	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
65	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT
68	TRANSITIONAL SMHS CLAIMS
70	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT
73	GLOBAL PAYMENT PROGRAM
74	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL
75	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS
77	BTR - LIHP - MCE
78	MH/UCD STABILIZATION FUNDING
79	BTR - LOW INCOME HEALTH PROGRAM - HCCI
80	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG
81	MH/UCD HEALTH CARE COVERAGE INITIATIVE
82	MH/UCD FEDERAL FLEX. & STABILIZATION-SNCP
83	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM
84	CMS DEFERRED CLAIMS
85	CMS DEFERRALS & NEGATIVE BALANCE REPAYMENT
86	MH/UCD SAFETY NET CARE POOL
102	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)
103	PALLIATIVE CARE SERVICES IMPLEMENTATION
109	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT
110	MCO TAX MANAGED CARE PLANS
111	MANAGED CARE IGT ADMIN. & PROCESSING FEE
112	GENERAL FUND REIMBURSEMENTS FROM DPHS

FISCAL YEAR 2017-18 COST PER ELIGIBLE BASED ON MAY 2018 ESTIMATE

EXCLUDED POLICY CHANGES: 77

113	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND
114	MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.
115	MCO ENROLLMENT TAX MANAGED CARE PLANS
119	DENTAL RETROACTIVE RATE CHANGES
127	EMERGENCY MEDICAL AIR TRANSPORTATION ACT
131	DP/NF-B RETROACTIVE RECOUPMENT FORGIVENESS
133	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
138	HOSPITAL QAF - MANAGED CARE PAYMENTS
139	HOSPITAL QAF - FFS PAYMENTS
140	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS
141	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS
142	PRIVATE HOSPITAL DSH REPLACEMENT
143	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
144	DSH PAYMENT
145	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
146	NDPH IGT SUPPLEMENTAL PAYMENTS
148	PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS
149	DPH PHYSICIAN & NON-PHYS. COST
150	CAPITAL PROJECT DEBT REIMBURSEMENT
151	FFP FOR LOCAL TRAUMA CENTERS
153	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
154	GEMT SUPPLEMENTAL PAYMENT PROGRAM
155	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS
156	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS
157	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
158	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
159	IGT PAYMENTS FOR HOSPITAL SERVICES
160	PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS
161	NDPH SUPPLEMENTAL PAYMENT
162	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
164	DP-NF CAPITAL PROJECT DEBT REPAYMENT
171	ARRA HITECH - PROVIDER PAYMENTS
176	MEDI-CAL TCM PROGRAM
181	AUDIT SETTLEMENTS

FISCAL YEAR 2017-18 COST PER ELIGIBLE BASED ON MAY 2018 ESTIMATE

EXCLUDED POLICY CHANGES: 77

190	CDDS DENTAL SERVICES
193	HEALTH CARE SVCS. PLANS FINES AND PENALTIES FUND
194	CLPP FUND
195	CCI-TRANSFER OF IHSS COSTS TO DHCS
196	HOSPITAL QAF - CHILDREN'S HEALTH CARE
200	CIGARETTE AND TOBACCO SURTAX FUNDS
215	REPAYMENT TO CMS FOR MEDI-CAL RECOVERIES
219	HEALTH CARE SERVICES FOR REENTRY PROGRAMS
226	RECONCILIATION

MEDI-CAL PROGRAM ESTIMATE SUMMARY
FISCAL YEAR 2018-19

	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
I. BASE ESTIMATES				
A. B/Y FFS BASE	$17,738,522,780	$8,869,261,390	$8,869,261,390	$0
B. B/Y BASE POLICY CHANGES	$47,615,472,980	$32,413,251,850	$14,856,779,130	$345,442,000
C. BASE ADJUSTMENTS	($166,359,000)	($200,174,150)	$33,815,150	$0
D. ADJUSTED BASE	**$65,187,636,760**	**$41,082,339,090**	**$23,759,855,670**	**$345,442,000**
II. REGULAR POLICY CHANGES				
A. ELIGIBILITY	($163,325,810)	($1,229,219,700)	$1,065,537,890	$356,000
B. AFFORDABLE CARE ACT	$1,676,784,000	$1,617,045,850	$59,738,150	$0
C. BENEFITS	$1,810,384,540	$1,282,911,350	$516,917,190	$10,556,000
D. PHARMACY	($1,696,041,010)	($1,183,589,680)	($512,451,330)	$0
E. DRUG MEDI-CAL	$799,705,000	$651,299,310	$148,405,690	$0
F. MENTAL HEALTH	$203,501,000	$187,974,000	$15,327,000	$200,000
G. WAIVER--MH/UCD & BTR	$5,563,021,000	$2,950,569,000	$166,541,000	$2,445,911,000
H. MANAGED CARE	$7,014,654,280	$4,420,471,690	($1,360,897,210)	$3,955,079,800
I. PROVIDER RATES	$586,918,090	$742,475,840	($712,690,440)	$557,132,690
J. SUPPLEMENTAL PMNTS.	$16,282,371,000	$10,386,410,500	$568,776,000	$5,327,184,500
K. OTHER	$1,778,317,710	$2,800,683,620	($2,109,299,920)	$1,086,934,000
L. TOTAL CHANGES	**$33,856,289,810**	**$22,627,031,800**	**($2,154,095,980)**	**$13,383,353,990**
III. TOTAL MEDI-CAL ESTIMATE	**$99,043,926,570**	**$63,709,370,890**	**$21,605,759,690**	**$13,728,795,990**

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2018-19

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	ELIGIBILITY				
1	MEDI-CAL STATE INMATE PROGRAMS	$98,931,000	$98,931,000	$0	$0
2	BREAST AND CERVICAL CANCER TREATMENT	$63,914,000	$25,813,900	$38,100,100	$0
3	MEDI-CAL COUNTY INMATE PROGRAMS	$90,569,000	$90,276,390	$292,610	$0
8	MEDI-CAL COUNTY INMATE REIMBURSEMENT	$0	$0	($356,000)	$356,000
9	NON-OTLICP CHIP	$0	($187,461,280)	$187,461,280	$0
10	NON-EMERGENCY FUNDING ADJUSTMENT	$0	($881,430,000)	$881,430,000	$0
11	SCHIP FUNDING FOR PRENATAL CARE	$0	$56,906,960	($56,906,960)	$0
13	PARIS-VETERANS	($12,169,470)	($6,084,730)	($6,084,730)	$0
14	OTLICP PREMIUMS	($66,373,000)	($58,408,240)	($7,964,760)	$0
15	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	($296,984,340)	($233,545,670)	($63,438,660)	$0
16	MEDICARE OPTIONAL EXPANSION ADJUSTMENT	($41,213,000)	($134,218,020)	$93,005,020	$0
	ELIGIBILITY SUBTOTAL	**($163,325,810)**	**($1,229,219,700)**	**$1,065,537,890**	**$356,000**
	AFFORDABLE CARE ACT				
17	COMMUNITY FIRST CHOICE OPTION	$3,373,170,000	$3,373,170,000	$0	$0
18	HEALTH INSURER FEE	$287,808,000	$190,685,850	$97,122,150	$0
19	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	$15,806,000	$15,806,000	$0	$0
21	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	$0	$36,043,000	($36,043,000)	$0
22	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	$1,341,000	($1,341,000)	$0
23	ACA MAGI SAVINGS	$0	$0	$0	$0
25	ACA OPTIONAL EXPANSION MLR RISK CORRIDOR	($2,000,000,000)	($2,000,000,000)	$0	$0
	AFFORDABLE CARE ACT SUBTOTAL	**$1,676,784,000**	**$1,617,045,850**	**$59,738,150**	**$0**
	BENEFITS				
27	BEHAVIORAL HEALTH TREATMENT	$544,531,000	$301,293,700	$243,237,300	$0
28	FAMILY PACT PROGRAM	$322,281,000	$245,100,700	$77,180,300	$0
29	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$278,779,000	$278,779,000	$0	$0
30	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$123,374,000	$123,374,000	$0	$0
31	CCS DEMONSTRATION PROJECT	$70,982,000	$39,000,300	$31,981,700	$0
32	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	$21,112,000	$10,556,000	$0	$10,556,000
33	ANNUAL CONTRACEPTIVE COVERAGE	$1,620,330	$1,254,870	$365,460	$0
34	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$10,569,000	$8,890,000	$1,679,000	$0
35	DENTAL TRANSFORMATION INITIATIVE UTILIZATION	$43,770,000	$26,868,240	$16,901,760	$0
36	FULL RESTORATION OF ADULT DENTAL BENEFITS	$209,650,000	$145,981,220	$63,668,780	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2018-19

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	BENEFITS				
37	DENTAL BENEFICIARY OUTREACH EFFORTS - BENEFITS	$33,264,000	$16,632,000	$16,632,000	$0
38	YOUTH REGIONAL TREATMENT CENTERS	$5,140,000	$4,913,000	$227,000	$0
39	PEDIATRIC PALLIATIVE CARE WAIVER	$781,360	$427,870	$353,490	$0
40	MEDICALLY TAILORED MEALS PILOT PROGRAM	$1,600,000	$0	$1,600,000	$0
41	CCT FUND TRANSFER TO CDSS AND CDDS	$1,283,000	$1,283,000	$0	$0
44	BEHAVIORAL HEALTH TREATMENT - BIS DDS TRANSITION	$109,231,000	$60,438,240	$48,792,760	$0
45	DIABETES PREVENTION PROGRAM	$498,150	$349,410	$148,740	$0
46	PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS	($1,536,360)	($841,490)	($694,870)	$0
207	MEDI-CAL NONMEDICAL TRANSPORTATION	$4,220,070	$2,600,720	$1,619,350	$0
209	WHOLE CHILD MODEL IMPLEMENTATION	$29,235,000	$16,010,580	$13,224,420	$0
	BENEFITS SUBTOTAL	**$1,810,384,550**	**$1,282,911,350**	**$516,917,190**	**$10,556,000**
	PHARMACY				
47	NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS	$83,439,990	$45,226,640	$38,213,350	$0
49	PHARMACY REIMBURSEMENT & DISPENSING FEE	($36,000,000)	($21,852,270)	($14,147,730)	$0
51	BCCTP DRUG REBATES	($11,951,000)	($8,127,950)	($3,823,050)	$0
52	FAMILY PACT DRUG REBATES	($20,067,000)	($17,405,400)	($2,661,600)	$0
53	MEDICAL SUPPLY REBATES	($24,916,000)	($12,458,000)	($12,458,000)	$0
54	STATE SUPPLEMENTAL DRUG REBATES	($197,608,000)	($131,038,760)	($66,569,240)	$0
55	FEDERAL DRUG REBATES	($1,559,326,000)	($1,086,500,940)	($472,825,060)	$0
225	HEPATITIS C REVISED CLINICAL GUIDELINES	$70,387,000	$48,567,000	$21,820,000	$0
	PHARMACY SUBTOTAL	**($1,696,041,010)**	**($1,183,589,680)**	**($512,451,330)**	**$0**
	DRUG MEDI-CAL				
56	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	$796,705,000	$648,399,310	$148,305,690	$0
61	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	$3,000,000	$2,900,000	$100,000	$0
	DRUG MEDI-CAL SUBTOTAL	**$799,705,000**	**$651,299,310**	**$148,405,690**	**$0**
	MENTAL HEALTH				
65	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT	$100,548,000	$100,548,000	$0	$0
66	PATHWAYS TO WELL-BEING	$14,475,000	$14,475,000	$0	$0
67	MHP COSTS FOR CONTINUUM OF CARE REFORM	$19,894,000	$9,177,000	$10,717,000	$0
68	TRANSITIONAL SMHS CLAIMS	$544,000	$0	$544,000	$0
69	LATE CLAIMS FOR SMHS	$25,000	$0	$25,000	$0
70	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	$0	($1,055,000)	$855,000	$200,000

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2018-19

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	MENTAL HEALTH				
71	CHART REVIEW	($670,000)	($670,000)	$0	$0
72	INTERIM AND FINAL COST SETTLEMENTS - SMHS	$68,685,000	$65,499,000	$3,186,000	$0
	MENTAL HEALTH SUBTOTAL	**$203,501,000**	**$187,974,000**	**$15,327,000**	**$200,000**
	WAIVER--MH/UCD & BTR				
73	GLOBAL PAYMENT PROGRAM	$2,492,086,000	$1,246,043,000	$0	$1,246,043,000
74	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL	$1,524,894,000	$762,447,000	$0	$762,447,000
75	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS	$874,842,000	$437,421,000	$0	$437,421,000
76	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	$155,000,000	$77,500,000	$77,500,000	$0
77	BTR - LIHP - MCE	$198,363,000	$198,363,000	$0	$0
78	MH/UCD STABILIZATION FUNDING	$55,530,000	$0	$55,530,000	$0
79	BTR - LOW INCOME HEALTH PROGRAM - HCCI	$231,547,000	$231,547,000	$0	$0
80	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$369,000	$369,000	$0	$0
81	MH/UCD HEALTH CARE COVERAGE INITIATIVE	$20,678,000	$20,678,000	$0	$0
83	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM	$0	$75,000,000	($75,000,000)	$0
85	CMS DEFERRALS & NEGATIVE BALANCE REPAYMENT	$0	($108,511,000)	$108,511,000	$0
86	MH/UCD SAFETY NET CARE POOL	$9,712,000	$9,712,000	$0	$0
	WAIVER--MH/UCD & BTR SUBTOTAL	**$5,563,021,000**	**$2,950,569,000**	**$166,541,000**	**$2,445,911,000**
	MANAGED CARE				
90	MANAGED CARE RATE RANGE IGTS	$1,686,877,000	$1,192,797,000	$0	$494,080,000
91	CCI-MANAGED CARE PAYMENTS	$2,556,818,280	$1,278,409,140	$1,278,409,140	$0
92	MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES	$2,240,199,000	$1,564,844,550	$675,354,450	$0
99	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	$1,595,000	$797,500	$797,500	$0
101	CCI-QUALITY WITHHOLD REPAYMENTS	$11,412,000	$5,706,000	$5,706,000	$0
103	PALLIATIVE CARE SERVICES IMPLEMENTATION	$49,000	$9,710	$39,290	$0
105	MANAGED CARE HEALTH CARE FINANCING PROGRAM	$1,461,677,000	$1,018,200,130	$443,476,870	$0
106	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	$640,000,000	$448,576,520	$191,423,480	$0
107	CAPITATED RATE ADJUSTMENT FOR FY 2018-19	$0	$0	$0	$0
108	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS	$3,468,000	$3,121,200	$0	$346,800
109	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT	$0	$0	($21,286,000)	$21,286,000
110	MCO TAX MANAGED CARE PLANS	$0	$0	$0	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2018-19

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	MANAGED CARE				
111	MANAGED CARE IGT ADMIN. & PROCESSING FEE	$0	$0	($125,944,000)	$125,944,000
112	GENERAL FUND REIMBURSEMENTS FROM DPHS	$4,981,000	$0	$4,981,000	$0
113	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	$0	$0	($815,656,000)	$815,656,000
114	MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.	$0	$0	($669,704,000)	$669,704,000
115	MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	$0	($1,850,459,000)	$1,850,459,000
116	MANAGED CARE DRUG REBATES	($2,095,878,000)	($1,456,280,420)	($639,597,580)	$0
117	RETRO MC RATE ADJUSTMENTS	$493,754,000	$354,823,360	$171,028,640	($32,098,000)
219	HEALTH CARE SERVICES FOR REENTRY PROGRAMS	$9,702,000	$0	$0	$9,702,000
222	INDIAN HEALTH SERVICES MANAGED CARE PROGRAM	$0	$9,467,000	($9,467,000)	$0
	MANAGED CARE SUBTOTAL	**$7,014,654,280**	**$4,420,471,690**	**($1,360,897,210)**	**$3,955,079,800**
	PROVIDER RATES				
118	DPH INTERIM & FINAL RECONS	$889,000	$889,000	$0	$0
119	DENTAL RETROACTIVE RATE CHANGES	($62,840,000)	($41,277,640)	($21,562,360)	$0
120	FQHC/RHC/CBRC RECONCILIATION PROCESS	$164,723,000	$102,197,500	$62,525,500	$0
121	AB 1629 ANNUAL RATE ADJUSTMENTS	$95,893,930	$47,946,970	$47,946,970	$0
122	RATE INCREASE FOR FQHCS/RHCS/CBRCS	$119,005,430	$73,833,610	$45,171,830	$0
123	LTC RATE ADJUSTMENT	$28,065,940	$14,032,970	$14,032,970	$0
124	DPH INTERIM RATE GROWTH	$60,048,640	$30,024,320	$30,024,320	$0
125	HOSPICE RATE INCREASES	$33,363,060	$16,681,530	$16,681,530	$0
126	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	$2,058,030	$1,029,010	$1,029,010	$0
127	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	$12,138,000	$6,069,000	($2,456,000)	$8,525,000
129	ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE	$6,502,810	$12,129,940	($5,627,130)	$0
130	ALTERNATIVE BIRTHING CENTER REIMBURSEMENT	$52,420	$26,210	$26,210	$0
133	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	$0	($460,098,000)	$460,098,000
134	DPH INTERIM RATE	$0	$384,886,340	($384,886,340)	$0
135	LABORATORY RATE METHODOLOGY CHANGE	($22,295,750)	($11,147,870)	($11,147,870)	$0
136	REDUCTION TO RADIOLOGY RATES	($56,119,230)	($28,059,620)	($28,059,620)	$0
137	10% PROVIDER PAYMENT REDUCTION	($18,944,900)	($9,472,450)	($9,472,450)	$0
204	HOME HEALTH RATE INCREASE	$56,742,720	$29,117,030	$0	$27,625,690
214	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	$167,635,000	$113,570,000	($6,819,000)	$60,884,000
	PROVIDER RATES SUBTOTAL	**$586,918,090**	**$742,475,850**	**($712,690,440)**	**$557,132,690**

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2018-19

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	SUPPLEMENTAL PMNTS.				
138	HOSPITAL QAF - MANAGED CARE PAYMENTS	$5,485,404,000	$3,836,718,000	$0	$1,648,686,000
139	HOSPITAL QAF - FFS PAYMENTS	$4,938,537,000	$2,674,738,000	$0	$2,263,799,000
140	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	$1,453,448,000	$921,363,000	$0	$532,085,000
141	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	$922,014,000	$633,619,000	$0	$288,395,000
142	PRIVATE HOSPITAL DSH REPLACEMENT	$581,964,000	$290,982,000	$290,982,000	$0
143	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$414,677,000	$414,677,000	$0	$0
144	DSH PAYMENT	$401,603,000	$290,449,000	$13,504,000	$97,650,000
145	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	$297,172,000	$159,272,000	$118,400,000	$19,500,000
146	NDPH IGT SUPPLEMENTAL PAYMENTS	$130,216,000	$83,152,000	($7,179,000)	$54,243,000
147	PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES	$649,278,000	$399,840,000	$0	$249,438,000
148	PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$183,302,000	$134,258,000	$0	$49,044,000
149	DPH PHYSICIAN & NON-PHYS. COST	$205,803,000	$205,803,000	$0	$0
150	CAPITAL PROJECT DEBT REIMBURSEMENT	$123,280,000	$86,645,000	$36,635,000	$0
151	FFP FOR LOCAL TRAUMA CENTERS	$134,881,000	$70,674,000	$0	$64,207,000
152	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	$117,693,000	$67,693,000	$0	$50,000,000
153	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	$86,007,000	$43,003,500	$48,310,000	($5,306,500)
154	GEMT SUPPLEMENTAL PAYMENT PROGRAM	$37,900,000	$37,900,000	$0	$0
155	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	$59,011,000	$59,011,000	$0	$0
156	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS	$26,066,000	$14,022,000	$0	$12,044,000
157	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$5,000,000	$5,000,000	$0
158	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$4,000,000	$4,000,000	$0
159	IGT PAYMENTS FOR HOSPITAL SERVICES	$273,000	$273,000	$0	$0
160	PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS	$6,800,000	$3,400,000	$0	$3,400,000
161	NDPH SUPPLEMENTAL PAYMENT	$4,273,000	$2,373,000	$1,900,000	$0
162	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$4,769,000	$4,769,000	$0	$0
164	DP-NF CAPITAL PROJECT DEBT REPAYMENT	$0	($57,224,000)	$57,224,000	$0
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$16,282,371,000**	**$10,386,410,500**	**$568,776,000**	**$5,327,184,500**
	OTHER				
84	CMS DEFERRED CLAIMS	$0	($511,509,000)	$511,509,000	$0
170	CCI IHSS RECONCILIATION	$339,270,000	$339,270,000	$0	$0
171	ARRA HITECH - PROVIDER PAYMENTS	$231,917,000	$231,917,000	$0	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2018-19

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
174	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$82,326,000	$82,326,000	$0	$0
178	INFANT DEVELOPMENT PROGRAM	$29,676,000	$29,676,000	$0	$0
179	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$14,059,000	$7,823,000	$6,236,000	$0
180	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	$42,755,580	$21,377,790	$21,377,790	$0
181	AUDIT SETTLEMENTS	$0	($180,889,000)	$180,889,000	$0
182	OVERTIME FOR WPCS PROVIDERS	$10,119,000	$5,059,500	$5,059,500	$0
184	INDIAN HEALTH SERVICES	$8,710,000	$29,523,000	($20,813,000)	$0
185	MEDI-CAL ESTATE RECOVERIES	$22,954,540	$11,477,270	$11,477,270	$0
186	WPCS WORKERS' COMPENSATION	$3,322,000	$1,661,000	$1,661,000	$0
191	FUNDING ADJUST. OTLICP	$154,000	$192,643,640	($192,489,640)	$0
193	HEALTH CARE SVCS. PLANS FINES AND PENALTIES FUND	$0	$0	$0	$0
194	CLPP FUND	$0	$0	($725,000)	$725,000
196	HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	$0	($958,769,000)	$958,769,000
197	FUNDING ADJUST. ACA OPT. EXPANSION	$0	$1,912,496,130	($1,912,496,130)	$0
198	COUNTY SHARE OF OTLICP-CCS COSTS	$0	$0	$0	$0
199	IMD ANCILLARY SERVICES	$0	($30,340,000)	$30,340,000	$0
200	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	$0	($127,440,000)	$127,440,000
201	INTEGRATION OF THE SF CLSB INTO THE ALW	($1,592,000)	($796,000)	($796,000)	$0
202	MEDI-CAL RECOVERIES SETTLEMENTS AND LEGAL COSTS	($488,900)	($244,450)	($244,450)	$0
211	ASSISTED LIVING WAIVER EXPANSION	($12,350,520)	($6,175,260)	($6,175,260)	$0
212	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER RENEWAL	$4,730,000	$2,365,000	$2,365,000	$0
215	REPAYMENT TO CMS FOR MEDI-CAL RECOVERIES	$0	($25,856,000)	$25,856,000	$0
223	HQAF WITHHOLD TRANSFER	$627,756,000	$313,878,000	$313,878,000	$0
226	RECONCILIATION	$375,000,000	$375,000,000	$0	$0
	OTHER SUBTOTAL	**$1,778,317,710**	**$2,800,683,620**	**($2,109,299,920)**	**$1,086,934,000**
	GRAND TOTAL	**$33,856,289,810**	**$22,627,031,800**	**($2,154,095,980)**	**$13,383,353,990**

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

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
FISCAL YEAR 2018-19

SERVICE CATEGORY	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
PROFESSIONAL	$7,709,461,940	$4,828,975,180	$1,901,282,990	$979,203,770
PHYSICIANS	$1,049,995,450	$706,262,480	$295,731,590	$48,001,380
OTHER MEDICAL	$4,294,361,550	$2,623,118,310	$1,498,978,120	$172,265,130
CO. & COMM. OUTPATIENT	$2,365,104,940	$1,499,594,390	$106,573,280	$758,937,270
PHARMACY	$2,346,732,430	$1,387,288,010	$910,767,690	$48,676,720
HOSPITAL INPATIENT	$15,216,485,050	$9,337,328,540	$1,952,763,030	$3,926,393,480
COUNTY INPATIENT	$3,667,203,850	$2,276,372,690	$56,928,850	$1,333,902,310
COMMUNITY INPATIENT	$11,549,281,210	$7,060,955,850	$1,895,834,180	$2,592,491,170
LONG TERM CARE	$3,353,752,140	$1,706,324,290	$1,536,990,500	$110,437,350
NURSING FACILITIES	$2,904,859,090	$1,477,733,830	$1,342,276,270	$84,848,990
ICF-DD	$448,893,050	$228,590,460	$194,714,230	$25,588,370
OTHER SERVICES	$1,272,543,850	$752,368,620	$453,253,370	$66,921,870
MEDICAL TRANSPORTATION	$148,350,650	$103,052,790	$27,113,710	$18,184,140
OTHER SERVICES	$850,271,460	$508,113,160	$322,871,180	$19,287,130
HOME HEALTH	$273,921,740	$141,202,670	$103,268,480	$29,450,590
TOTAL FEE-FOR-SERVICE	**$29,898,975,410**	**$18,012,284,640**	**$6,755,057,570**	**$5,131,633,200**
MANAGED CARE	$47,187,809,560	$30,294,955,240	$9,553,743,920	$7,339,110,400
TWO PLAN MODEL	$28,223,234,780	$18,063,996,040	$5,622,302,770	$4,536,935,960
COUNTY ORGANIZED HEALTH SYSTEMS	$11,519,740,080	$7,503,664,230	$2,326,056,400	$1,690,019,450
GEOGRAPHIC MANAGED CARE	$5,114,826,690	$3,289,151,440	$1,053,390,370	$772,284,870
PHP & OTHER MANAG. CARE	$770,184,590	$420,183,180	$263,631,570	$86,369,840
REGIONAL MODEL	$1,559,823,430	$1,017,960,350	$288,362,810	$253,500,270
DENTAL	$2,165,069,990	$1,314,043,720	$567,607,330	$283,418,940
MENTAL HEALTH	$3,073,513,840	$2,894,604,590	($16,134,510)	$195,043,760
AUDITS/ LAWSUITS	$32,860,810	($784,490,110)	$817,350,930	$0
EPSDT SCREENS	$4,956,000	$2,501,330	$1,729,670	$725,000
MEDICARE PAYMENTS	$5,491,406,000	$1,557,716,500	$3,933,689,500	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$155,445,000	$155,445,000	$0	$0
MISC. SERVICES	$10,352,423,000	$9,624,180,300	($50,622,000)	$778,864,700
RECOVERIES	($326,854,360)	($211,014,180)	($115,840,180)	$0
DRUG MEDI-CAL	$1,008,321,320	$849,143,850	$159,177,460	$0
GRAND TOTAL MEDI-CAL	**$99,043,926,570**	**$63,709,370,890**	**$21,605,759,690**	**$13,728,795,990**

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2017-18 AND 2018-19

SERVICE CATEGORY	MAY 2018 EST. FOR 2017-18	MAY 2018 EST. FOR 2018-19	DOLLAR DIFFERENCE	% CHANGE
PROFESSIONAL	$7,655,292,320	$7,709,461,940	$54,169,620	0.71%
PHYSICIANS	$921,265,720	$1,049,995,450	$128,729,730	13.97%
OTHER MEDICAL	$3,989,126,740	$4,294,361,550	$305,234,810	7.65%
CO. & COMM. OUTPATIENT	$2,744,899,850	$2,365,104,940	($379,794,920)	-13.84%
PHARMACY	$436,729,980	$2,346,732,430	$1,910,002,450	437.34%
HOSPITAL INPATIENT	$14,890,099,210	$15,216,485,050	$326,385,850	2.19%
COUNTY INPATIENT	$3,282,575,780	$3,667,203,850	$384,628,060	11.72%
COMMUNITY INPATIENT	$11,607,523,420	$11,549,281,210	($58,242,220)	-0.50%
LONG TERM CARE	$3,252,687,930	$3,353,752,140	$101,064,210	3.11%
NURSING FACILITIES	$2,828,228,790	$2,904,859,090	$76,630,290	2.71%
ICF-DD	$424,459,140	$448,893,050	$24,433,910	5.76%
OTHER SERVICES	$1,148,540,600	$1,272,543,850	$124,003,250	10.80%
MEDICAL TRANSPORTATION	$157,285,700	$148,350,650	($8,935,050)	-5.68%
OTHER SERVICES	$781,056,500	$850,271,460	$69,214,960	8.86%
HOME HEALTH	$210,198,400	$273,921,740	$63,723,330	30.32%
TOTAL FEE-FOR-SERVICE	**$27,383,350,040**	**$29,898,975,410**	**$2,515,625,370**	**9.19%**
MANAGED CARE	$45,312,331,930	$47,187,809,560	$1,875,477,630	4.14%
TWO PLAN MODEL	$28,129,591,980	$28,223,234,780	$93,642,800	0.33%
COUNTY ORGANIZED HEALTH SYSTEMS	$10,089,828,180	$11,519,740,080	$1,429,911,900	14.17%
GEOGRAPHIC MANAGED CARE	$4,744,227,980	$5,114,826,690	$370,598,710	7.81%
PHP & OTHER MANAG. CARE	$977,165,730	$770,184,590	($206,981,140)	-21.18%
REGIONAL MODEL	$1,371,518,060	$1,559,823,430	$188,305,370	13.73%
DENTAL	$1,571,135,540	$2,165,069,990	$593,934,450	37.80%
MENTAL HEALTH	$2,928,712,500	$3,073,513,840	$144,801,340	4.94%
AUDITS/ LAWSUITS	$20,613,790	$32,860,810	$12,247,030	59.41%
EPSDT SCREENS	$4,998,000	$4,956,000	($42,000)	-0.84%
MEDICARE PAYMENTS	$5,328,880,000	$5,491,406,000	$162,526,000	3.05%
STATE HOSP./DEVELOPMENTAL CNTRS.	$175,445,000	$155,445,000	($20,000,000)	-11.40%
MISC. SERVICES	$9,784,704,000	$10,352,423,000	$567,719,000	5.80%
RECOVERIES	($351,665,590)	($326,854,360)	$24,811,240	-7.06%
DRUG MEDI-CAL	$576,139,300	$1,008,321,320	$432,182,020	75.01%
GRAND TOTAL MEDI-CAL	**$92,734,644,500**	**$99,043,926,570**	**$6,309,282,070**	**6.80%**
GENERAL FUNDS	**$18,994,776,560**	**$21,605,759,690**	**$2,610,983,140**	**13.75%**
OTHER STATE FUNDS	**$17,040,521,500**	**$13,728,795,990**	**($3,311,725,510)**	**-19.43%**

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
MAY 2018 ESTIMATE COMPARED TO NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2018-19

SERVICE CATEGORY	NOV. 2017 EST. FOR 2018-19	MAY 2018 EST. FOR 2018-19	DOLLAR DIFFERENCE	% CHANGE
PROFESSIONAL	$6,608,380,200	$7,709,461,940	$1,101,081,740	16.66%
PHYSICIANS	$834,278,430	$1,049,995,450	$215,717,020	25.86%
OTHER MEDICAL	$4,081,815,280	$4,294,361,550	$212,546,270	5.21%
CO. & COMM. OUTPATIENT	$1,692,286,490	$2,365,104,940	$672,818,450	39.76%
PHARMACY	$1,190,935,830	$2,346,732,430	$1,155,796,600	97.05%
HOSPITAL INPATIENT	$13,419,123,280	$15,216,485,050	$1,797,361,780	13.39%
COUNTY INPATIENT	$3,578,995,880	$3,667,203,850	$88,207,970	2.46%
COMMUNITY INPATIENT	$9,840,127,400	$11,549,281,210	$1,709,153,810	17.37%
LONG TERM CARE	$3,155,912,760	$3,353,752,140	$197,839,380	6.27%
NURSING FACILITIES	$2,707,904,310	$2,904,859,090	$196,954,780	7.27%
ICF-DD	$448,008,450	$448,893,050	$884,600	0.20%
OTHER SERVICES	$1,183,895,510	$1,272,543,850	$88,648,340	7.49%
MEDICAL TRANSPORTATION	$119,322,330	$148,350,650	$29,028,320	24.33%
OTHER SERVICES	$782,854,380	$850,271,460	$67,417,080	8.61%
HOME HEALTH	$281,718,800	$273,921,740	($7,797,060)	-2.77%
TOTAL FEE-FOR-SERVICE	**$25,558,247,570**	**$29,898,975,410**	**$4,340,727,840**	**16.98%**
MANAGED CARE	$49,176,558,660	$47,187,809,560	($1,988,749,100)	-4.04%
TWO PLAN MODEL	$29,881,172,190	$28,223,234,780	($1,657,937,420)	-5.55%
COUNTY ORGANIZED HEALTH SYSTEMS	$11,716,269,090	$11,519,740,080	($196,529,010)	-1.68%
GEOGRAPHIC MANAGED CARE	$5,136,186,290	$5,114,826,690	($21,359,600)	-0.42%
PHP & OTHER MANAG. CARE	$901,830,930	$770,184,590	($131,646,340)	-14.60%
REGIONAL MODEL	$1,541,100,160	$1,559,823,430	$18,723,270	1.21%
DENTAL	$2,018,956,460	$2,165,069,990	$146,113,530	7.24%
MENTAL HEALTH	$2,782,736,470	$3,073,513,840	$290,777,360	10.45%
AUDITS/ LAWSUITS	$32,856,240	$32,860,810	$4,580	0.01%
EPSDT SCREENS	$29,832,550	$4,956,000	($24,876,550)	-83.39%
MEDICARE PAYMENTS	$5,569,587,000	$5,491,406,000	($78,181,000)	-1.40%
STATE HOSP./DEVELOPMENTAL CNTRS.	$207,330,000	$155,445,000	($51,885,000)	-25.03%
MISC. SERVICES	$10,519,906,740	$10,352,423,000	($167,483,740)	-1.59%
RECOVERIES	($347,616,560)	($326,854,360)	$20,762,210	-5.97%
DRUG MEDI-CAL	$1,258,863,210	$1,008,321,320	($250,541,890)	-19.90%
GRAND TOTAL MEDI-CAL	**$96,807,258,330**	**$99,043,926,570**	**$2,236,668,240**	**2.31%**
GENERAL FUNDS	**$20,388,692,460**	**$21,605,759,690**	**$1,217,067,230**	**5.97%**
OTHER STATE FUNDS	**$12,767,374,400**	**$13,728,795,990**	**$961,421,590**	**7.53%**

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2018 ESTIMATE COMPARED TO NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2018-19

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2017 EST. FOR 2018-19		MAY 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		ELIGIBILITY						
1	1	MEDI-CAL STATE INMATE PROGRAMS	$88,722,000	$0	$98,931,000	$0	$10,209,000	$0
2	2	BREAST AND CERVICAL CANCER TREATMENT	$67,765,000	$36,631,600	$63,914,000	$38,100,100	($3,851,000)	$1,468,500
3	3	MEDI-CAL COUNTY INMATE PROGRAMS	$194,515,000	$19,057,200	$90,569,000	$292,610	($103,946,000)	($18,764,590)
8	8	MEDI-CAL COUNTY INMATE REIMBURSEMENT	$0	($16,334,000)	$0	($356,000)	$0	$15,978,000
9	9	NON-OTLICP CHIP	$0	($224,486,110)	$0	$187,461,280	$0	$411,947,390
10	10	NON-EMERGENCY FUNDING ADJUSTMENT	$0	$895,842,000	$0	$881,430,000	$0	($14,412,000)
11	11	SCHIP FUNDING FOR PRENATAL CARE	$0	($65,092,720)	$0	($56,906,960)	$0	$8,185,760
13	13	PARIS-VETERANS	($32,119,330)	($16,059,670)	($32,109,420)	($16,054,710)	$9,920	$4,960
14	14	OTLICP PREMIUMS	($65,750,000)	($7,890,000)	($66,373,000)	($7,964,760)	($623,000)	($74,760)
15	15	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	($363,381,000)	($77,661,010)	($363,996,000)	($77,752,990)	($615,000)	($91,980)
16	16	MEDICARE OPTIONAL EXPANSION ADJUSTMENT	($91,985,000)	$94,625,300	($41,213,000)	$93,005,020	$50,772,000	($1,620,280)
7	--	STATE-ONLY BCCTP COVERAGE EXTENSION	$1,686,000	$1,686,000	$0	$0	($1,686,000)	($1,686,000)
		ELIGIBILITY SUBTOTAL	**($200,547,330)**	**$640,318,590**	**($250,277,420)**	**$1,041,253,590**	**($49,730,080)**	**$400,935,000**
		AFFORDABLE CARE ACT						
17	17	COMMUNITY FIRST CHOICE OPTION	$3,814,981,000	$0	$3,373,170,000	$0	($441,811,000)	$0
18	18	HEALTH INSURER FEE	$308,165,000	$104,903,820	$287,808,000	$97,122,150	($20,357,000)	($7,781,670)
19	19	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	$14,130,000	$0	$15,806,000	$0	$1,676,000	$0
21	21	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	$0	($31,519,250)	$0	($36,043,000)	$0	($4,523,750)
22	22	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	($1,264,000)	$0	($1,341,000)	$0	($77,000)
23	23	ACA MAGI SAVINGS	$0	$0	$0	$0	$0	$0
25	25	ACA OPTIONAL EXPANSION MLR RISK CORRIDOR	($264,900,000)	$0	($2,000,000,000)	$0	($1,735,100,000)	$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 2018 ESTIMATE COMPARED TO NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2018-19

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2017 EST. FOR 2018-19		MAY 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		AFFORDABLE CARE ACT						
24	--	TITLE XXI FEDERAL MATCH REDUCTION	($155,838,000)	$590,209,670	$0	$0	$155,838,000	($590,209,670)
26	--	ACA DSH REDUCTION	($547,222,000)	($57,756,500)	$0	$0	$547,222,000	$57,756,500
		AFFORDABLE CARE ACT SUBTOTAL	**$3,169,316,000**	**$604,573,740**	**$1,676,784,000**	**$59,738,150**	**($1,492,532,000)**	**($544,835,590)**
		BENEFITS						
27	27	BEHAVIORAL HEALTH TREATMENT	$377,323,000	$165,071,480	$544,531,000	$243,237,300	$167,208,000	$78,165,820
28	28	FAMILY PACT PROGRAM	$344,391,000	$82,917,000	$322,281,000	$77,180,300	($22,110,000)	($5,736,700)
29	29	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$262,906,000	$0	$278,779,000	$0	$15,873,000	$0
30	30	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$125,020,000	$0	$123,374,000	$0	($1,646,000)	$0
31	31	CCS DEMONSTRATION PROJECT	$78,459,000	$35,490,680	$70,982,000	$31,981,700	($7,477,000)	($3,508,980)
32	32	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	$39,778,000	$0	$21,112,000	$0	($18,666,000)	$0
33	33	ANNUAL CONTRACEPTIVE COVERAGE	$35,637,860	$8,038,130	$33,827,260	$7,629,640	($1,810,600)	($408,490)
34	34	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$8,048,000	$1,860,000	$10,569,000	$1,679,000	$2,521,000	($181,000)
35	35	DENTAL TRANSFORMATION INITIATIVE UTILIZATION	$9,231,000	$4,615,500	$43,770,000	$16,901,760	$34,539,000	$12,286,260
36	36	FULL RESTORATION OF ADULT DENTAL BENEFITS	$21,224,000	$10,612,000	$209,650,000	$63,668,780	$188,426,000	$53,056,780
37	37	DENTAL BENEFICIARY OUTREACH EFFORTS - BENEFITS	$9,228,000	$4,614,000	$117,707,000	$58,853,500	$108,479,000	$54,239,500
38	38	YOUTH REGIONAL TREATMENT CENTERS	$4,853,000	$25,000	$5,140,000	$227,000	$287,000	$202,000
39	39	PEDIATRIC PALLIATIVE CARE WAIVER	$3,488,940	$1,578,210	$3,211,530	$1,452,900	($277,410)	($125,310)
40	40	MEDICALLY TAILORED MEALS PILOT PROGRAM	$2,000,000	$2,000,000	$1,600,000	$1,600,000	($400,000)	($400,000)
41	41	CCT FUND TRANSFER TO CDSS AND CDDS	$191,000	$0	$1,283,000	$0	$1,092,000	$0
44	44	BEHAVIORAL HEALTH TREATMENT - BIS DDS TRANSITION	$94,006,000	$41,125,920	$109,231,000	$48,792,760	$15,225,000	$7,666,840

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2018 ESTIMATE COMPARED TO NOVEMBER 2017 ESTIMATE
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NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2017 EST. FOR 2018-19		MAY 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		BENEFITS						
45	45	DIABETES PREVENTION PROGRAM	$315,560	$122,590	$498,150	$148,740	$182,580	$26,150
46	46	PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS	($4,751,070)	($2,149,070)	($1,536,360)	($694,870)	$3,214,710	$1,454,210
207	207	MEDI-CAL NONMEDICAL TRANSPORTATION	$4,220,070	$1,619,350	$4,220,070	$1,619,350	$0	$0
209	209	WHOLE CHILD MODEL IMPLEMENTATION	$45,369,000	$21,291,420	$29,235,000	$13,224,420	($16,134,000)	($8,067,000)
42	--	END OF LIFE SERVICES	$140,000	$140,000	$0	$0	($140,000)	($140,000)
		BENEFITS SUBTOTAL	**$1,461,078,360**	**$378,972,210**	**$1,929,464,640**	**$567,502,280**	**$468,386,280**	**$188,530,080**
		PHARMACY						
47	47	NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS	$111,136,930	$50,271,520	$86,880,460	$39,788,990	($24,256,480)	($10,482,520)
49	49	PHARMACY REIMBURSEMENT & DISPENSING FEE	($66,000,000)	($26,611,730)	($36,000,000)	($14,147,730)	$30,000,000	$12,464,000
51	51	BCCTP DRUG REBATES	($8,765,000)	($2,756,600)	($11,951,000)	($3,823,050)	($3,186,000)	($1,066,450)
52	52	FAMILY PACT DRUG REBATES	($18,073,000)	($2,247,900)	($20,067,000)	($2,661,600)	($1,994,000)	($413,700)
53	53	MEDICAL SUPPLY REBATES	($24,916,000)	($12,458,000)	($24,916,000)	($12,458,000)	$0	$0
54	54	STATE SUPPLEMENTAL DRUG REBATES	($217,046,000)	($68,240,500)	($197,608,000)	($66,569,240)	$19,438,000	$1,671,260
55	55	FEDERAL DRUG REBATES	($2,411,486,000)	($785,546,840)	($1,559,326,000)	($472,825,060)	$852,160,000	$312,721,780
--	225	HEPATITIS C REVISED CLINICAL GUIDELINES	$0	$0	$70,387,000	$21,820,000	$70,387,000	$21,820,000
		PHARMACY SUBTOTAL	**($2,635,149,070)**	**($847,590,050)**	**($1,692,600,540)**	**($510,875,690)**	**$942,548,520**	**$336,714,370**
		DRUG MEDI-CAL						
56	56	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	$1,039,568,000	$209,807,530	$796,705,000	$148,305,690	($242,863,000)	($61,501,840)
--	61	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	$0	$0	$3,000,000	$100,000	$3,000,000	$100,000
		DRUG MEDI-CAL SUBTOTAL	**$1,039,568,000**	**$209,807,530**	**$799,705,000**	**$148,405,690**	**($239,863,000)**	**($61,401,840)**

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MAY 2018 ESTIMATE COMPARED TO NOVEMBER 2017 ESTIMATE
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NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2017 EST. FOR 2018-19		MAY 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		MENTAL HEALTH						
--	65	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT	$0	$0	$100,548,000	$0	$100,548,000	$0
66	66	PATHWAYS TO WELL-BEING	$13,419,000	$0	$14,475,000	$0	$1,056,000	$0
67	67	MHP COSTS FOR CONTINUUM OF CARE REFORM	$15,616,000	$8,577,500	$19,894,000	$10,717,000	$4,278,000	$2,139,500
--	68	TRANSITIONAL SMHS CLAIMS	$0	$0	$544,000	$544,000	$544,000	$544,000
--	69	LATE CLAIMS FOR SMHS	$0	$0	$25,000	$25,000	$25,000	$25,000
70	70	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	$0	($200,000)	$0	$855,000	$0	$1,055,000
71	71	CHART REVIEW	($867,000)	$0	($670,000)	$0	$197,000	$0
--	72	INTERIM AND FINAL COST SETTLEMENTS - SMHS	$0	$0	$68,685,000	$3,186,000	$68,685,000	$3,186,000
		MENTAL HEALTH SUBTOTAL	**$28,168,000**	**$8,377,500**	**$203,501,000**	**$15,327,000**	**$175,333,000**	**$6,949,500**
		WAIVER--MH/UCD & BTR						
73	73	GLOBAL PAYMENT PROGRAM	$2,487,459,000	$0	$2,492,086,000	$0	$4,627,000	$0
74	74	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL	$1,520,000,000	$0	$1,524,894,000	$0	$4,894,000	$0
75	75	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS	$646,730,000	$0	$874,842,000	$0	$228,112,000	$0
76	76	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	$159,630,000	$79,815,000	$155,000,000	$77,500,000	($4,630,000)	($2,315,000)
77	77	BTR - LIHP - MCE	$198,363,000	$0	$198,363,000	$0	$0	$0
78	78	MH/UCD STABILIZATION FUNDING	$55,530,000	$55,530,000	$55,530,000	$55,530,000	$0	$0
79	79	BTR - LOW INCOME HEALTH PROGRAM - HCCI	$231,547,000	$0	$231,547,000	$0	$0	$0
80	80	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$376,000	$0	$369,000	$0	($7,000)	$0
81	81	MH/UCD HEALTH CARE COVERAGE INITIATIVE	$20,678,000	$0	$20,678,000	$0	$0	$0
83	83	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM	$0	($75,000,000)	$0	($75,000,000)	$0	$0

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MAY 2018 ESTIMATE COMPARED TO NOVEMBER 2017 ESTIMATE
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NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2017 EST. FOR 2018-19		MAY 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		WAIVER--MH/UCD & BTR						
85	85	CMS DEFERRALS & NEGATIVE BALANCE REPAYMENT	$0	$139,386,000	$0	$108,511,000	$0	($30,875,000)
86	86	MH/UCD SAFETY NET CARE POOL	$9,712,000	$0	$9,712,000	$0	$0	$0
		WAIVER--MH/UCD & BTR SUBTOTAL	**$5,330,025,000**	**$199,731,000**	**$5,563,021,000**	**$166,541,000**	**$232,996,000**	**($33,190,000)**
		MANAGED CARE						
90	90	MANAGED CARE RATE RANGE IGTS	$143,781,000	$0	$1,686,877,000	$0	$1,543,096,000	$0
91	91	CCI-MANAGED CARE PAYMENTS	$7,769,067,000	$3,884,533,500	$7,835,790,000	$3,917,895,000	$66,723,000	$33,361,500
92	92	MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES	$2,246,407,000	$654,341,330	$2,240,199,000	$675,354,450	($6,208,000)	$21,013,120
--	99	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	$0	$0	$1,595,000	$797,500	$1,595,000	$797,500
101	101	CCI-QUALITY WITHHOLD REPAYMENTS	$11,412,000	$5,706,000	$11,412,000	$5,706,000	$0	$0
103	103	PALLIATIVE CARE SERVICES IMPLEMENTATION	($122,000)	($46,210)	$49,000	$39,290	$171,000	$85,500
105	105	MANAGED CARE HEALTH CARE FINANCING PROGRAM	$1,515,011,000	$454,545,260	$1,461,677,000	$443,476,870	($53,334,000)	($11,068,390)
106	106	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	$640,000,000	$186,654,920	$640,000,000	$191,423,480	$0	$4,768,560
107	107	CAPITATED RATE ADJUSTMENT FOR FY 2018-19	$381,976,000	$180,904,240	$0	$0	($381,976,000)	($180,904,240)
108	108	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS	$13,384,000	$1,338,000	$3,468,000	$0	($9,916,000)	($1,338,000)
--	109	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT	$0	$0	$0	($21,286,000)	$0	($21,286,000)
--	110	MCO TAX MANAGED CARE PLANS	$0	$0	$0	$0	$0	$0
111	111	MANAGED CARE IGT ADMIN. & PROCESSING FEE	$0	($32,103,000)	$0	($125,944,000)	$0	($93,841,000)
--	112	GENERAL FUND REIMBURSEMENTS FROM DPHS	$0	$0	$4,981,000	$4,981,000	$4,981,000	$4,981,000
113	113	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	$0	($1,274,187,000)	$0	($815,656,000)	$0	$458,531,000

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NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2017 EST. FOR 2018-19		MAY 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		MANAGED CARE						
114	114	MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.	$0	($643,334,000)	$0	($669,704,000)	$0	($26,370,000)
115	115	MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	($1,875,880,000)	$0	($1,850,459,000)	$0	$25,421,000
116	116	MANAGED CARE DRUG REBATES	($1,913,660,000)	($624,990,980)	($2,095,878,000)	($639,597,580)	($182,218,000)	($14,606,600)
117	117	RETRO MC RATE ADJUSTMENTS	$87,972,000	$45,463,000	$493,754,000	$171,028,640	$405,782,000	$125,565,640
--	219	HEALTH CARE SERVICES FOR REENTRY PROGRAMS	$0	$0	$9,702,000	$0	$9,702,000	$0
--	222	INDIAN HEALTH SERVICES MANAGED CARE PROGRAM	$0	$0	$0	($9,467,000)	$0	($9,467,000)
104	--	MANAGED CARE PUBLIC HOSPITAL DIRECTED PAYMENTS	$1,569,000,000	$457,596,400	$0	$0	($1,569,000,000)	($457,596,400)
		MANAGED CARE SUBTOTAL	**$12,464,228,000**	**$1,420,541,460**	**$12,293,626,000**	**$1,278,588,650**	**($170,602,000)**	**($141,952,810)**
		PROVIDER RATES						
118	118	DPH INTERIM & FINAL RECONS	$240,730,000	$0	$889,000	$0	($239,841,000)	$0
--	119	DENTAL RETROACTIVE RATE CHANGES	$0	$0	($62,840,000)	($21,562,360)	($62,840,000)	($21,562,360)
120	120	FQHC/RHC/CBRC RECONCILIATION PROCESS	$161,794,000	$61,413,350	$164,723,000	$62,525,500	$2,929,000	$1,112,150
121	121	AB 1629 ANNUAL RATE ADJUSTMENTS	$117,343,730	$58,671,870	$95,903,520	$47,951,760	($21,440,210)	($10,720,100)
122	122	RATE INCREASE FOR FQHCS/RHCS/CBRCS	$202,003,490	$76,676,450	$156,647,930	$59,460,080	($45,355,550)	($17,216,360)
123	123	LTC RATE ADJUSTMENT	$31,325,170	$15,662,590	$28,192,810	$14,096,400	($3,132,370)	($1,566,180)
124	124	DPH INTERIM RATE GROWTH	$79,089,610	$39,544,800	$76,030,180	$38,015,090	($3,059,430)	($1,529,710)
125	125	HOSPICE RATE INCREASES	$43,790,730	$21,895,370	$36,462,360	$18,231,180	($7,328,380)	($3,664,190)
126	126	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	$7,875,440	$3,937,720	$7,918,530	$3,959,260	$43,090	$21,550
127	127	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	$12,138,000	($2,456,000)	$12,138,000	($2,456,000)	$0	$0
129	129	ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE	$4,907,410	($3,969,690)	$6,502,810	($5,627,130)	$1,595,400	($1,657,440)
130	130	ALTERNATIVE BIRTHING CENTER REIMBURSEMENT	$50,640	$25,320	$52,420	$26,210	$1,770	$890

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NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2017 EST. FOR 2018-19		MAY 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		PROVIDER RATES						
133	133	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	($504,609,000)	$0	($460,098,000)	$0	$44,511,000
134	134	DPH INTERIM RATE	$0	($408,504,510)	$0	($384,886,340)	$0	$23,618,170
135	135	LABORATORY RATE METHODOLOGY CHANGE	($22,610,000)	($11,305,000)	($28,948,000)	($14,474,000)	($6,338,000)	($3,169,000)
136	136	REDUCTION TO RADIOLOGY RATES	($50,604,900)	($25,302,450)	($56,119,230)	($28,059,620)	($5,514,340)	($2,757,170)
137	137	10% PROVIDER PAYMENT REDUCTION	($199,420,000)	($99,710,000)	($199,420,000)	($99,710,000)	$0	$0
204	204	HOME HEALTH RATE INCREASE	$64,475,000	$0	$56,742,720	$0	($7,732,280)	$0
--	214	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	$0	$0	$167,635,000	($6,819,000)	$167,635,000	($6,819,000)
128	--	GDSP PRENATAL SCREENING FEE INCREASE	$2,749,450	$1,374,730	$0	$0	($2,749,450)	($1,374,730)
		PROVIDER RATES SUBTOTAL	**$695,637,780**	**($776,654,460)**	**$462,511,040**	**($779,426,960)**	**($233,126,740)**	**($2,772,500)**
		SUPPLEMENTAL PMNTS.						
138	138	HOSPITAL QAF - MANAGED CARE PAYMENTS	$3,636,684,000	$0	$5,485,404,000	$0	$1,848,720,000	$0
139	139	HOSPITAL QAF - FFS PAYMENTS	$3,526,939,000	$0	$4,938,537,000	$0	$1,411,598,000	$0
140	140	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	$999,744,000	$0	$1,453,448,000	$0	$453,704,000	$0
141	141	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	$1,338,039,000	$0	$922,014,000	$0	($416,025,000)	$0
142	142	PRIVATE HOSPITAL DSH REPLACEMENT	$571,519,000	$285,759,500	$581,964,000	$290,982,000	$10,445,000	$5,222,500
143	143	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$379,083,000	$0	$414,677,000	$0	$35,594,000	$0
144	144	DSH PAYMENT	$425,460,000	$13,554,000	$401,603,000	$13,504,000	($23,857,000)	($50,000)
145	145	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	$297,963,000	$118,400,000	$297,172,000	$118,400,000	($791,000)	$0
146	146	NDPH IGT SUPPLEMENTAL PAYMENTS	$125,874,000	($4,643,000)	$130,216,000	($7,179,000)	$4,342,000	($2,536,000)
147	147	PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES	$461,501,000	$0	$649,278,000	$0	$187,777,000	$0

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			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		SUPPLEMENTAL PMNTS.						
148	148	PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$183,259,000	$0	$183,302,000	$0	$43,000	$0
149	149	DPH PHYSICIAN & NON-PHYS. COST	$123,573,000	$0	$205,803,000	$0	$82,230,000	$0
150	150	CAPITAL PROJECT DEBT REIMBURSEMENT	$123,280,000	$41,398,000	$123,280,000	$36,635,000	$0	($4,763,000)
151	151	FFP FOR LOCAL TRAUMA CENTERS	$135,868,000	$0	$134,881,000	$0	($987,000)	$0
152	152	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	$116,910,000	$0	$117,693,000	$0	$783,000	$0
153	153	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	$86,242,000	$48,928,000	$86,007,000	$48,310,000	($235,000)	($618,000)
154	154	GEMT SUPPLEMENTAL PAYMENT PROGRAM	$37,900,000	$0	$37,900,000	$0	$0	$0
155	155	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	$59,590,000	$0	$59,011,000	$0	($579,000)	$0
156	156	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS	$35,616,000	$0	$26,066,000	$0	($9,550,000)	$0
157	157	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$5,000,000	$10,000,000	$5,000,000	$0	$0
158	158	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$4,000,000	$8,000,000	$4,000,000	$0	$0
159	159	IGT PAYMENTS FOR HOSPITAL SERVICES	$271,000	$0	$273,000	$0	$2,000	$0
160	160	PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS	$6,800,000	$0	$6,800,000	$0	$0	$0
161	161	NDPH SUPPLEMENTAL PAYMENT	$4,315,000	$1,900,000	$4,273,000	$1,900,000	($42,000)	$0
162	162	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$4,614,000	$0	$4,769,000	$0	$155,000	$0
--	164	DP-NF CAPITAL PROJECT DEBT REPAYMENT	$0	$0	$0	$57,224,000	$0	$57,224,000
163	--	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	$2,100,000,000	$0	$0	$0	($2,100,000,000)	$0
		SUPPLEMENTAL PMNTS. SUBTOTAL	**$14,799,044,000**	**$514,296,500**	**$16,282,371,000**	**$568,776,000**	**$1,483,327,000**	**$54,479,500**

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			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
84	84	CMS DEFERRED CLAIMS	$0	$6,364,000	$0	$511,509,000	$0	$505,145,000
--	170	CCI IHSS RECONCILIATION	$0	$0	$339,270,000	$0	$339,270,000	$0
171	171	ARRA HITECH - PROVIDER PAYMENTS	$240,392,000	$0	$231,917,000	$0	($8,475,000)	$0
174	174	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$63,133,000	$0	$82,326,000	$0	$19,193,000	$0
178	178	INFANT DEVELOPMENT PROGRAM	$29,439,000	$0	$29,676,000	$0	$237,000	$0
179	179	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$11,106,000	$5,082,000	$14,059,000	$6,236,000	$2,953,000	$1,154,000
180	180	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	$42,755,580	$21,377,790	$42,755,580	$21,377,790	$0	$0
--	181	AUDIT SETTLEMENTS	$0	$0	$0	$180,889,000	$0	$180,889,000
182	182	OVERTIME FOR WPCS PROVIDERS	$10,128,000	$5,064,000	$10,119,000	$5,059,500	($9,000)	($4,500)
184	184	INDIAN HEALTH SERVICES	$5,592,000	($21,891,000)	$8,710,000	($20,813,000)	$3,118,000	$1,078,000
185	185	MEDI-CAL ESTATE RECOVERIES	$21,719,000	$10,859,500	$38,906,000	$19,453,000	$17,187,000	$8,593,500
186	186	WPCS WORKERS' COMPENSATION	$3,322,000	$1,661,000	$3,322,000	$1,661,000	$0	$0
191	191	FUNDING ADJUST. OTLICP	$133,000	($189,235,320)	$154,000	($192,489,640)	$21,000	($3,254,320)
193	193	HEALTH CARE SVCS. PLANS FINES AND PENALTIES FUND	$0	$0	$0	$0	$0	$0
194	194	CLPP FUND	$0	($725,000)	$0	($725,000)	$0	$0
196	196	HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	($884,850,000)	$0	($958,769,000)	$0	($73,919,000)
197	197	FUNDING ADJUST. ACA OPT. EXPANSION	$0	($1,777,687,280)	$0	($1,912,496,130)	$0	($134,808,850)
198	198	COUNTY SHARE OF OTLICP-CCS COSTS	$0	($9,343,000)	$0	$0	$0	$9,343,000
199	199	IMD ANCILLARY SERVICES	$0	$12,675,000	$0	$30,340,000	$0	$17,665,000
200	200	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	($127,234,000)	$0	($127,440,000)	$0	($206,000)
201	201	INTEGRATION OF THE SF CLSB INTO THE ALW	($1,527,000)	($763,500)	($1,592,000)	($796,000)	($65,000)	($32,500)
202	202	MEDI-CAL RECOVERIES SETTLEMENTS AND LEGAL COSTS	($1,730,000)	($865,000)	($1,730,000)	($865,000)	$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 2018 ESTIMATE COMPARED TO NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2018-19

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2017 EST. FOR 2018-19		MAY 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
211	211	ASSISTED LIVING WAIVER EXPANSION	($12,350,520)	($6,175,260)	($12,350,520)	($6,175,260)	$0	$0
212	212	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER RENEWAL	$986,040	$493,020	$4,730,000	$2,365,000	$3,743,960	$1,871,980
--	215	REPAYMENT TO CMS FOR MEDI-CAL RECOVERIES	$0	$0	$0	$25,856,000	$0	$25,856,000
--	223	HQAF WITHHOLD TRANSFER	$0	$0	$627,756,000	$313,878,000	$627,756,000	$313,878,000
--	226	RECONCILIATION	$0	$0	$375,000,000	$0	$375,000,000	$0
		OTHER SUBTOTAL	**$413,098,100**	**($2,955,193,050)**	**$1,793,028,070**	**($2,101,944,740)**	**$1,379,929,960**	**$853,248,310**
		GRAND TOTAL	**$36,564,466,840**	**($602,819,030)**	**$39,061,133,790**	**$453,884,990**	**$2,496,666,950**	**$1,056,704,020**

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 2017-18 AND 2018-19

NO.	POLICY CHANGE TITLE	MAY 2018 EST. FOR 2017-18		MAY 2018 EST. FOR 2018-19		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	ELIGIBILITY						
1	MEDI-CAL STATE INMATE PROGRAMS	$87,912,000	$0	$98,931,000	$0	$11,019,000	$0
2	BREAST AND CERVICAL CANCER TREATMENT	$63,458,000	$38,027,200	$63,914,000	$38,100,100	$456,000	$72,900
3	MEDI-CAL COUNTY INMATE PROGRAMS	$12,760,000	$550,440	$90,569,000	$292,610	$77,809,000	($257,830)
8	MEDI-CAL COUNTY INMATE REIMBURSEMENT	$0	($413,000)	$0	($356,000)	$0	$57,000
9	NON-OTLICP CHIP	$0	($399,525,300)	$0	$187,461,280	$0	$586,986,580
10	NON-EMERGENCY FUNDING ADJUSTMENT	$0	$886,724,000	$0	$881,430,000	$0	($5,294,000)
11	SCHIP FUNDING FOR PRENATAL CARE	$0	($60,722,640)	$0	($56,906,960)	$0	$3,815,680
12	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN	$0	$14,677,000	$0	$0	$0	($14,677,000)
13	PARIS-VETERANS	($19,672,760)	($9,836,380)	($32,109,420)	($16,054,710)	($12,436,660)	($6,218,330)
14	OTLICP PREMIUMS	($66,265,000)	($7,951,800)	($66,373,000)	($7,964,760)	($108,000)	($12,960)
15	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	($141,564,000)	($29,483,020)	($363,996,000)	($77,752,990)	($222,432,000)	($48,269,970)
16	MEDICARE OPTIONAL EXPANSION ADJUSTMENT	($328,018,000)	$245,167,990	($41,213,000)	$93,005,020	$286,805,000	($152,162,970)
	ELIGIBILITY SUBTOTAL	**($391,389,760)**	**$677,214,490**	**($250,277,420)**	**$1,041,253,590**	**$141,112,340**	**$364,039,100**
	AFFORDABLE CARE ACT						
17	COMMUNITY FIRST CHOICE OPTION	$3,355,870,000	$0	$3,373,170,000	$0	$17,300,000	$0
18	HEALTH INSURER FEE	$72,808,000	$23,915,630	$287,808,000	$97,122,150	$215,000,000	$73,206,520
19	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	$17,200,000	$0	$15,806,000	$0	($1,394,000)	$0
20	PAYMENTS TO PRIMARY CARE PHYSICIANS	$6,320,000	$0	$0	$0	($6,320,000)	$0
21	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	$0	($36,866,840)	$0	($36,043,000)	$0	$823,840
22	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	($1,093,000)	$0	($1,341,000)	$0	($248,000)
23	ACA MAGI SAVINGS	$0	$0	$0	$0	$0	$0
25	ACA OPTIONAL EXPANSION MLR RISK CORRIDOR	$0	$0	($2,000,000,000)	$0	($2,000,000,000)	$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 2017-18 AND 2018-19

NO.	POLICY CHANGE TITLE	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2018-19 TOTAL FUNDS	MAY 2018 EST. FOR 2018-19 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	AFFORDABLE CARE ACT SUBTOTAL	**$3,452,198,000**	**($14,044,210)**	**$1,676,784,000**	**$59,738,150**	**($1,775,414,000)**	**$73,782,360**
	BENEFITS						
27	BEHAVIORAL HEALTH TREATMENT	$498,218,000	$222,550,040	$544,531,000	$243,237,300	$46,313,000	$20,687,260
28	FAMILY PACT PROGRAM	$319,115,000	$76,422,800	$322,281,000	$77,180,300	$3,166,000	$757,500
29	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$329,907,000	$0	$278,779,000	$0	($51,128,000)	$0
30	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$118,256,000	$0	$123,374,000	$0	$5,118,000	$0
31	CCS DEMONSTRATION PROJECT	$40,718,000	$18,313,080	$70,982,000	$31,981,700	$30,264,000	$13,668,620
32	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	$21,112,000	$0	$21,112,000	$0	$0	$0
33	ANNUAL CONTRACEPTIVE COVERAGE	$29,131,070	$6,570,430	$33,827,260	$7,629,640	$4,696,190	$1,059,210
34	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$36,021,000	$2,142,000	$10,569,000	$1,679,000	($25,452,000)	($463,000)
35	DENTAL TRANSFORMATION INITIATIVE UTILIZATION	$18,018,000	$7,200,360	$43,770,000	$16,901,760	$25,752,000	$9,701,400
36	FULL RESTORATION OF ADULT DENTAL BENEFITS	$87,398,000	$26,344,960	$209,650,000	$63,668,780	$122,252,000	$37,323,820
37	DENTAL BENEFICIARY OUTREACH EFFORTS - BENEFITS	$56,097,000	$28,048,500	$117,707,000	$58,853,500	$61,610,000	$30,805,000
38	YOUTH REGIONAL TREATMENT CENTERS	$2,240,000	($184,000)	$5,140,000	$227,000	$2,900,000	$411,000
39	PEDIATRIC PALLIATIVE CARE WAIVER	$2,557,730	$1,343,850	$3,211,530	$1,452,900	$653,800	$109,050
40	MEDICALLY TAILORED MEALS PILOT PROGRAM	$1,000,000	$1,000,000	$1,600,000	$1,600,000	$600,000	$600,000
41	CCT FUND TRANSFER TO CDSS AND CDDS	$2,808,000	$0	$1,283,000	$0	($1,525,000)	$0
43	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER	$52,000	$0	$0	$0	($52,000)	$0
44	BEHAVIORAL HEALTH TREATMENT - BIS DDS TRANSITION	$0	$0	$109,231,000	$48,792,760	$109,231,000	$48,792,760
45	DIABETES PREVENTION PROGRAM	$0	$0	$498,150	$148,740	$498,150	$148,740

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2017-18 AND 2018-19

NO.	POLICY CHANGE TITLE	MAY 2018 EST. FOR 2017-18		MAY 2018 EST. FOR 2018-19		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	BENEFITS						
46	PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS	($582,420)	($263,070)	($1,536,360)	($694,870)	($953,940)	($431,800)
207	MEDI-CAL NONMEDICAL TRANSPORTATION	$0	$0	$4,220,070	$1,619,350	$4,220,070	$1,619,350
209	WHOLE CHILD MODEL IMPLEMENTATION	$0	$0	$29,235,000	$13,224,420	$29,235,000	$13,224,420
	BENEFITS SUBTOTAL	**$1,562,066,380**	**$389,488,950**	**$1,929,464,640**	**$567,502,280**	**$367,398,260**	**$178,013,330**
	PHARMACY						
47	NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS	$42,078,870	$19,291,950	$86,880,460	$39,788,990	$44,801,580	$20,497,040
48	DRUG REBATES PRIOR YEAR FUNDING ADJUSTMENT	($60,286,000)	$256,603,830	$0	$0	$60,286,000	($256,603,830)
49	PHARMACY REIMBURSEMENT & DISPENSING FEE	$0	$0	($36,000,000)	($14,147,730)	($36,000,000)	($14,147,730)
50	LITIGATION SETTLEMENTS	($18,133,000)	($18,133,000)	$0	$0	$18,133,000	$18,133,000
51	BCCTP DRUG REBATES	($10,759,000)	($3,322,200)	($11,951,000)	($3,823,050)	($1,192,000)	($500,850)
52	FAMILY PACT DRUG REBATES	($42,415,000)	($5,155,700)	($20,067,000)	($2,661,600)	$22,348,000	$2,494,100
53	MEDICAL SUPPLY REBATES	($24,916,000)	($12,458,000)	($24,916,000)	($12,458,000)	$0	$0
54	STATE SUPPLEMENTAL DRUG REBATES	($146,024,000)	($97,754,270)	($197,608,000)	($66,569,240)	($51,584,000)	$31,185,030
55	FEDERAL DRUG REBATES	($2,957,871,000)	($447,616,020)	($1,559,326,000)	($472,825,060)	$1,398,545,000	($25,209,040)
225	HEPATITIS C REVISED CLINICAL GUIDELINES	$0	$0	$70,387,000	$21,820,000	$70,387,000	$21,820,000
	PHARMACY SUBTOTAL	**($3,218,325,130)**	**($308,543,410)**	**($1,692,600,540)**	**($510,875,690)**	**$1,525,724,580**	**($202,332,280)**
	DRUG MEDI-CAL						
56	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	$377,920,000	$76,054,760	$796,705,000	$148,305,690	$418,785,000	$72,250,930
61	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	$0	$0	$3,000,000	$100,000	$3,000,000	$100,000
	DRUG MEDI-CAL SUBTOTAL	**$377,920,000**	**$76,054,760**	**$799,705,000**	**$148,405,690**	**$421,785,000**	**$72,350,930**

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 2017-18 AND 2018-19

NO.	POLICY CHANGE TITLE	MAY 2018 EST. FOR 2017-18		MAY 2018 EST. FOR 2018-19		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	MENTAL HEALTH						
65	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT	$80,086,000	$0	$100,548,000	$0	$20,462,000	$0
66	PATHWAYS TO WELL-BEING	$11,734,000	$0	$14,475,000	$0	$2,741,000	$0
67	MHP COSTS FOR CONTINUUM OF CARE REFORM	$6,499,000	$4,019,500	$19,894,000	$10,717,000	$13,395,000	$6,697,500
68	TRANSITIONAL SMHS CLAIMS	$0	$0	$544,000	$544,000	$544,000	$544,000
69	LATE CLAIMS FOR SMHS	$4,000	$4,000	$25,000	$25,000	$21,000	$21,000
70	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	$0	($200,000)	$0	$855,000	$0	$1,055,000
71	CHART REVIEW	($1,743,000)	$0	($670,000)	$0	$1,073,000	$0
72	INTERIM AND FINAL COST SETTLEMENTS - SMHS	$11,740,000	$20,710,000	$68,685,000	$3,186,000	$56,945,000	($17,524,000)
	MENTAL HEALTH SUBTOTAL	**$108,320,000**	**$24,533,500**	**$203,501,000**	**$15,327,000**	**$95,181,000**	**($9,206,500)**
	WAIVER--MH/UCD & BTR						
73	GLOBAL PAYMENT PROGRAM	$2,275,272,000	$0	$2,492,086,000	$0	$216,814,000	$0
74	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL	$1,765,728,000	$0	$1,524,894,000	$0	($240,834,000)	$0
75	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS	$353,709,000	$0	$874,842,000	$0	$521,133,000	$0
76	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	$107,000,000	$53,500,000	$155,000,000	$77,500,000	$48,000,000	$24,000,000
77	BTR - LIHP - MCE	$104,616,000	$0	$198,363,000	$0	$93,747,000	$0
78	MH/UCD STABILIZATION FUNDING	$55,400,000	$55,400,000	$55,530,000	$55,530,000	$130,000	$130,000
79	BTR - LOW INCOME HEALTH PROGRAM - HCCI	$36,060,000	$0	$231,547,000	$0	$195,487,000	$0
80	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$1,170,000	$0	$369,000	$0	($801,000)	$0
81	MH/UCD HEALTH CARE COVERAGE INITIATIVE	$1,262,000	$0	$20,678,000	$0	$19,416,000	$0
82	MH/UCD FEDERAL FLEX. & STABILIZATION-SNCP	$0	($6,205,000)	$0	$0	$0	$6,205,000

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2017-18 AND 2018-19

NO.	POLICY CHANGE TITLE	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2018-19 TOTAL FUNDS	MAY 2018 EST. FOR 2018-19 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	WAIVER--MH/UCD & BTR						
83	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM	$0	($75,000,000)	$0	($75,000,000)	$0	$0
85	CMS DEFERRALS & NEGATIVE BALANCE REPAYMENT	$0	$0	$0	$108,511,000	$0	$108,511,000
86	MH/UCD SAFETY NET CARE POOL	($6,723,000)	$0	$9,712,000	$0	$16,435,000	$0
	WAIVER--MH/UCD & BTR SUBTOTAL	**$4,693,494,000**	**$27,695,000**	**$5,563,021,000**	**$166,541,000**	**$869,527,000**	**$138,846,000**
	MANAGED CARE						
90	MANAGED CARE RATE RANGE IGTS	$1,968,917,000	$0	$1,686,877,000	$0	($282,040,000)	$0
91	CCI-MANAGED CARE PAYMENTS	$9,901,568,000	$4,950,784,000	$7,835,790,000	$3,917,895,000	($2,065,778,000)	($1,032,889,000)
92	MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES	$2,505,200,000	$915,363,760	$2,240,199,000	$675,354,450	($265,001,000)	($240,009,310)
93	MANAGED CARE PUBLIC HOSPITAL IGTS	$1,713,379,000	$0	$0	$0	($1,713,379,000)	$0
96	HQAF RATE RANGE INCREASES	$294,669,000	$0	$0	$0	($294,669,000)	$0
99	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	$114,090,000	$87,880,000	$1,595,000	$797,500	($112,495,000)	($87,082,500)
101	CCI-QUALITY WITHHOLD REPAYMENTS	$3,317,000	$1,658,500	$11,412,000	$5,706,000	$8,095,000	$4,047,500
103	PALLIATIVE CARE SERVICES IMPLEMENTATION	$1,875,000	$875,200	$49,000	$39,290	($1,826,000)	($835,910)
105	MANAGED CARE HEALTH CARE FINANCING PROGRAM	$0	$0	$1,461,677,000	$443,476,870	$1,461,677,000	$443,476,870
106	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	$0	$0	$640,000,000	$191,423,480	$640,000,000	$191,423,480
107	CAPITATED RATE ADJUSTMENT FOR FY 2018-19	$0	$0	$0	$0	$0	$0
108	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS	$0	$0	$3,468,000	$0	$3,468,000	$0
109	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT	$0	($87,881,000)	$0	($21,286,000)	$0	$66,595,000
110	MCO TAX MANAGED CARE PLANS	$0	($300,000,000)	$0	$0	$0	$300,000,000
111	MANAGED CARE IGT ADMIN. & PROCESSING FEE	$0	($158,945,000)	$0	($125,944,000)	$0	$33,001,000

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2017-18 AND 2018-19

NO.	POLICY CHANGE TITLE	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2018-19 TOTAL FUNDS	MAY 2018 EST. FOR 2018-19 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	MANAGED CARE						
112	GENERAL FUND REIMBURSEMENTS FROM DPHS	$0	($158,606,000)	$4,981,000	$4,981,000	$4,981,000	$163,587,000
113	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	$0	$0	$0	($815,656,000)	$0	($815,656,000)
114	MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.	$0	($809,823,000)	$0	($669,704,000)	$0	$140,119,000
115	MCO ENROLLMENT TAX MANAGED CARE PLANS	$0	($1,552,053,000)	$0	($1,850,459,000)	$0	($298,406,000)
116	MANAGED CARE DRUG REBATES	($1,752,995,000)	($534,107,630)	($2,095,878,000)	($639,597,580)	($342,883,000)	($105,489,950)
117	RETRO MC RATE ADJUSTMENTS	($3,863,906,000)	$421,086,000	$493,754,000	$171,028,640	$4,357,660,000	($250,057,360)
219	HEALTH CARE SERVICES FOR REENTRY PROGRAMS	$0	$0	$9,702,000	$0	$9,702,000	$0
222	INDIAN HEALTH SERVICES MANAGED CARE PROGRAM	$29,962,000	$2,910,000	$0	($9,467,000)	($29,962,000)	($12,377,000)
	MANAGED CARE SUBTOTAL	**$10,916,076,000**	**$2,779,141,830**	**$12,293,626,000**	**$1,278,588,650**	**$1,377,550,000**	**($1,500,553,180)**
	PROVIDER RATES						
118	DPH INTERIM & FINAL RECONS	$237,459,000	$0	$889,000	$0	($236,570,000)	$0
119	DENTAL RETROACTIVE RATE CHANGES	$137,467,000	$50,839,080	($62,840,000)	($21,562,360)	($200,307,000)	($72,401,440)
120	FQHC/RHC/CBRC RECONCILIATION PROCESS	$160,320,000	$60,410,010	$164,723,000	$62,525,500	$4,403,000	$2,115,490
121	AB 1629 ANNUAL RATE ADJUSTMENTS	$146,497,660	$73,248,830	$95,903,520	$47,951,760	($50,594,130)	($25,297,070)
122	RATE INCREASE FOR FQHCS/RHCS/CBRCS	$145,818,430	$54,945,380	$156,647,930	$59,460,080	$10,829,510	$4,514,700
123	LTC RATE ADJUSTMENT	$20,932,410	$10,466,200	$28,192,810	$14,096,400	$7,260,400	$3,630,200
124	DPH INTERIM RATE GROWTH	$20,000,670	$10,000,330	$76,030,180	$38,015,090	$56,029,510	$28,014,760
125	HOSPICE RATE INCREASES	$6,993,600	$3,496,800	$36,462,360	$18,231,180	$29,468,760	$14,734,380
126	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	$19,540,630	$9,770,310	$7,918,530	$3,959,260	($11,622,100)	($5,811,050)
127	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	$10,868,000	($2,395,000)	$12,138,000	($2,456,000)	$1,270,000	($61,000)
129	ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE	$34,280	($30,230)	$6,502,810	($5,627,130)	$6,468,540	($5,596,900)

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 2017-18 AND 2018-19

NO.	POLICY CHANGE TITLE	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2018-19 TOTAL FUNDS	MAY 2018 EST. FOR 2018-19 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	PROVIDER RATES						
130	ALTERNATIVE BIRTHING CENTER REIMBURSEMENT	$7,460	$3,730	$52,420	$26,210	$44,960	$22,480
131	DP/NF-B RETROACTIVE RECOUPMENT FORGIVENESS	$0	$1,298,000	$0	$0	$0	($1,298,000)
133	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	($440,934,000)	$0	($460,098,000)	$0	($19,164,000)
134	DPH INTERIM RATE	$0	($359,764,050)	$0	($384,886,340)	$0	($25,122,290)
135	LABORATORY RATE METHODOLOGY CHANGE	($12,783,400)	($6,391,700)	($28,948,000)	($14,474,000)	($16,164,600)	($8,082,300)
136	REDUCTION TO RADIOLOGY RATES	($8,622,210)	($4,311,110)	($56,119,230)	($28,059,620)	($47,497,020)	($23,748,510)
137	10% PROVIDER PAYMENT REDUCTION	($203,884,000)	($101,942,000)	($199,420,000)	($99,710,000)	$4,464,000	$2,232,000
204	HOME HEALTH RATE INCREASE	$0	$0	$56,742,720	$0	$56,742,720	$0
214	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	$0	$0	$167,635,000	($6,819,000)	$167,635,000	($6,819,000)
	PROVIDER RATES SUBTOTAL	**$680,649,510**	**($641,289,400)**	**$462,511,040**	**($779,426,960)**	**($218,138,470)**	**($138,137,550)**
	SUPPLEMENTAL PMNTS.						
138	HOSPITAL QAF - MANAGED CARE PAYMENTS	$5,093,271,000	$0	$5,485,404,000	$0	$392,133,000	$0
139	HOSPITAL QAF - FFS PAYMENTS	$7,114,270,000	$0	$4,938,537,000	$0	($2,175,733,000)	$0
140	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	$0	$0	$1,453,448,000	$0	$1,453,448,000	$0
141	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	$355,918,000	$0	$922,014,000	$0	$566,096,000	$0
142	PRIVATE HOSPITAL DSH REPLACEMENT	$576,179,000	$288,089,500	$581,964,000	$290,982,000	$5,785,000	$2,892,500
143	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$442,461,000	$0	$414,677,000	$0	($27,784,000)	$0
144	DSH PAYMENT	$400,444,000	$14,939,000	$401,603,000	$13,504,000	$1,159,000	($1,435,000)
145	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	$319,693,000	$118,400,000	$297,172,000	$118,400,000	($22,521,000)	$0
146	NDPH IGT SUPPLEMENTAL PAYMENTS	$124,176,000	($1,415,000)	$130,216,000	($7,179,000)	$6,040,000	($5,764,000)
147	PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES	$247,520,000	$0	$649,278,000	$0	$401,758,000	$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 2017-18 AND 2018-19

NO.	POLICY CHANGE TITLE	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2018-19 TOTAL FUNDS	MAY 2018 EST. FOR 2018-19 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	SUPPLEMENTAL PMNTS.						
148	PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	$158,167,000	$0	$183,302,000	$0	$25,135,000	$0
149	DPH PHYSICIAN & NON-PHYS. COST	$83,855,000	$0	$205,803,000	$0	$121,948,000	$0
150	CAPITAL PROJECT DEBT REIMBURSEMENT	$154,173,000	$25,634,000	$123,280,000	$36,635,000	($30,893,000)	$11,001,000
151	FFP FOR LOCAL TRAUMA CENTERS	$132,319,000	$0	$134,881,000	$0	$2,562,000	$0
152	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	$134,634,000	$219,700	$117,693,000	$0	($16,941,000)	($219,700)
153	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	$86,007,000	$48,310,000	$86,007,000	$48,310,000	$0	$0
154	GEMT SUPPLEMENTAL PAYMENT PROGRAM	$76,182,000	$0	$37,900,000	$0	($38,282,000)	$0
155	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	$75,732,000	$0	$59,011,000	$0	($16,721,000)	$0
156	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS	$21,682,000	$0	$26,066,000	$0	$4,384,000	$0
157	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$5,000,000	$10,000,000	$5,000,000	$0	$0
158	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$4,000,000	$8,000,000	$4,000,000	$0	$0
159	IGT PAYMENTS FOR HOSPITAL SERVICES	$5,801,000	$0	$273,000	$0	($5,528,000)	$0
160	PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS	$5,474,000	$0	$6,800,000	$0	$1,326,000	$0
161	NDPH SUPPLEMENTAL PAYMENT	$5,277,000	$1,900,000	$4,273,000	$1,900,000	($1,004,000)	$0
162	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$5,098,000	$0	$4,769,000	$0	($329,000)	$0
164	DP-NF CAPITAL PROJECT DEBT REPAYMENT	$0	$0	$0	$57,224,000	$0	$57,224,000
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$15,636,333,000**	**$505,077,200**	**$16,282,371,000**	**$568,776,000**	**$646,038,000**	**$63,698,800**
	OTHER						
84	CMS DEFERRED CLAIMS	$0	$509,238,000	$0	$511,509,000	$0	$2,271,000
170	CCI IHSS RECONCILIATION	$0	$0	$339,270,000	$0	$339,270,000	$0
171	ARRA HITECH - PROVIDER PAYMENTS	$130,515,000	$0	$231,917,000	$0	$101,402,000	$0

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2017-18 AND 2018-19

NO.	POLICY CHANGE TITLE	MAY 2018 EST. FOR 2017-18		MAY 2018 EST. FOR 2018-19		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER						
174	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$102,041,000	$0	$82,326,000	$0	($19,715,000)	$0
178	INFANT DEVELOPMENT PROGRAM	$42,313,000	$0	$29,676,000	$0	($12,637,000)	$0
179	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$17,176,000	$7,659,000	$14,059,000	$6,236,000	($3,117,000)	($1,423,000)
180	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	$16,823,860	$8,411,930	$42,755,580	$21,377,790	$25,931,730	$12,965,860
181	AUDIT SETTLEMENTS	$0	$13,928,000	$0	$180,889,000	$0	$166,961,000
182	OVERTIME FOR WPCS PROVIDERS	$9,961,000	$4,998,500	$10,119,000	$5,059,500	$158,000	$61,000
184	INDIAN HEALTH SERVICES	$3,903,000	($20,813,000)	$8,710,000	($20,813,000)	$4,807,000	$0
185	MEDI-CAL ESTATE RECOVERIES	$17,176,000	$8,588,000	$38,906,000	$19,453,000	$21,730,000	$10,865,000
186	WPCS WORKERS' COMPENSATION	$3,026,000	$1,513,000	$3,322,000	$1,661,000	$296,000	$148,000
190	CDDS DENTAL SERVICES	$712,000	$0	$0	$0	($712,000)	$0
191	FUNDING ADJUST. OTLICP	$122,000	($184,775,000)	$154,000	($192,489,640)	$32,000	($7,714,640)
193	HEALTH CARE SVCS. PLANS FINES AND PENALTIES FUND	$0	($48,025,000)	$0	$0	$0	$48,025,000
194	CLPP FUND	$0	($725,000)	$0	($725,000)	$0	$0
195	CCI-TRANSFER OF IHSS COSTS TO DHCS	$0	($1,343,703,000)	$0	$0	$0	$1,343,703,000
196	HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	($1,328,946,000)	$0	($958,769,000)	$0	$370,177,000
197	FUNDING ADJUST. ACA OPT. EXPANSION	$0	($1,808,695,810)	$0	($1,912,496,130)	$0	($103,800,320)
198	COUNTY SHARE OF OTLICP-CCS COSTS	$0	$0	$0	$0	$0	$0
199	IMD ANCILLARY SERVICES	$0	$3,714,000	$0	$30,340,000	$0	$26,626,000
200	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	($182,960,000)	$0	($127,440,000)	$0	$55,520,000
201	INTEGRATION OF THE SF CLSB INTO THE ALW	($1,553,000)	($776,500)	($1,592,000)	($796,000)	($39,000)	($19,500)
202	MEDI-CAL RECOVERIES SETTLEMENTS AND LEGAL COSTS	($1,730,000)	($865,000)	($1,730,000)	($865,000)	$0	$0
211	ASSISTED LIVING WAIVER EXPANSION	($8,680)	($4,340)	($12,350,520)	($6,175,260)	($12,341,840)	($6,170,920)
212	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER RENEWAL	$1,592,060	$796,030	$4,730,000	$2,365,000	$3,137,940	$1,568,970

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2017-18 AND 2018-19

NO.	POLICY CHANGE TITLE	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2018-19 TOTAL FUNDS	MAY 2018 EST. FOR 2018-19 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	OTHER						
215	REPAYMENT TO CMS FOR MEDI-CAL RECOVERIES	$0	$0	$0	$25,856,000	$0	$25,856,000
223	HQAF WITHHOLD TRANSFER	$261,429,000	$130,714,500	$627,756,000	$313,878,000	$366,327,000	$183,163,500
226	RECONCILIATION	$0	$0	$375,000,000	$0	$375,000,000	$0
	OTHER SUBTOTAL	**$603,498,240**	**($4,230,727,690)**	**$1,793,028,070**	**($2,101,944,740)**	**$1,189,529,830**	**$2,128,782,960**
	GRAND TOTAL	**$34,420,840,240**	**($715,398,980)**	**$39,061,133,790**	**$453,884,990**	**$4,640,293,550**	**$1,169,283,960**

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

FISCAL YEAR 2018-19 COST PER ELIGIBLE BASED ON MAY 2018 ESTIMATE

SERVICE CATEGORY	PA-OAS	NEWLY	PA-ATD	PA-AFDC	LT-OAS	H-PE
PHYSICIANS	$9,963,100	$132,793,470	$88,938,300	$45,888,210	$2,242,110	$40,447,260
OTHER MEDICAL	$75,109,860	$1,115,482,660	$409,629,510	$315,537,680	$5,531,970	$41,487,110
CO. & COMM. OUTPATIENT	$4,875,300	$137,747,920	$118,633,030	$28,326,220	$734,700	$47,971,170
PHARMACY	$5,901,680	$734,345,380	$936,984,100	$93,756,260	$3,352,980	$19,531,050
COUNTY INPATIENT	$4,019,580	$512,613,110	$32,052,180	$21,265,100	$2,102,280	$51,360,160
COMMUNITY INPATIENT	$65,009,850	$1,280,829,010	$725,566,890	$296,959,050	$14,423,120	$228,108,180
NURSING FACILITIES	$217,122,460	$146,248,450	$543,905,590	$3,827,390	$1,197,959,250	$1,606,950
ICF-DD	$1,081,620	$5,960,660	$185,306,320	$210,280	$45,430,850	$0
MEDICAL TRANSPORTATION	$6,468,060	$20,994,570	$22,486,730	$2,879,790	$3,266,000	$3,098,640
OTHER SERVICES	$91,332,990	$33,748,420	$305,242,300	$39,426,250	$57,711,440	$1,186,770
HOME HEALTH	$1,647,670	$2,245,130	$155,899,650	$5,669,400	$8,600	$86,200
FFS SUBTOTAL	**$482,532,190**	**$4,123,008,790**	**$3,524,644,590**	**$853,745,630**	**$1,332,763,300**	**$434,883,470**
DENTAL	$62,420,710	$540,979,450	$166,455,210	$208,069,020	$20,806,900	$0
MENTAL HEALTH	$9,551,210	$277,936,860	$1,090,670,590	$748,241,280	$780,800	$0
TWO PLAN MODEL	$1,812,053,720	$8,008,687,470	$5,348,695,010	$1,322,889,780	$0	$0
COUNTY ORGANIZED HEALTH SYSTEMS	$325,796,590	$3,446,928,250	$1,462,730,200	$356,797,960	$761,397,190	$0
GEOGRAPHIC MANAGED CARE	$241,515,460	$1,471,316,980	$1,078,802,340	$240,826,230	$0	$0
PHP & OTHER MANAG. CARE	$215,492,180	$35,166,860	$144,101,050	$21,616,900	$9,539,570	$0
EPSDT SCREENS	$0	$0	$0	$856,720	$0	$0
MEDICARE PAYMENTS	$1,758,671,280	$0	$1,649,714,250	$2,920,640	$166,160,730	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$8,905,380	$0	$19,755,100	$24,182,660	$846,500	$0
MISC. SERVICES	$799,296,260	$0	$5,463,525,640	$6,546,590	$0	$0
DRUG MEDI-CAL	$33,690,570	$294,447,430	$74,783,670	$94,093,940	$3,215,850	$0
REGIONAL MODEL	$13,664,880	$493,507,140	$343,301,120	$72,175,160	$0	$0
NON-FFS SUBTOTAL	**$5,281,058,240**	**$14,568,970,430**	**$16,842,534,180**	**$3,099,216,870**	**$962,747,550**	**$0**
TOTAL DOLLARS (1)	**$5,763,590,430**	**$18,691,979,220**	**$20,367,178,770**	**$3,952,962,500**	**$2,295,510,840**	**$434,883,470**
ELIGIBLES * **	**442,900**	**3,850,100**	**982,500**	**1,202,700**	**42,100**	**30,900**
ANNUAL $/ELIGIBLE	**$13,013**	**$4,855**	**$20,730**	**$3,287**	**$54,525**	**$14,074**
AVG. MO. $/ELIGIBLE	**$1,084**	**$405**	**$1,727**	**$274**	**$4,544**	**$1,173**

(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 2018-19 COST PER ELIGIBLE BASED ON MAY 2018 ESTIMATE

SERVICE CATEGORY	LT-ATD	POV 250	MN-OAS	MN-ATD	MN-AFDC	MI-C
PHYSICIANS	$2,047,640	$16,961,750	$24,390,440	$9,300,790	$146,833,820	$23,758,930
OTHER MEDICAL	$3,387,820	$156,293,750	$141,380,740	$72,124,720	$880,329,740	$85,711,180
CO. & COMM. OUTPATIENT	$578,810	$18,973,430	$15,419,130	$9,415,600	$115,421,210	$10,694,100
PHARMACY	$5,351,710	$41,934,500	$20,026,550	$39,022,530	$199,804,240	$47,729,380
COUNTY INPATIENT	$5,414,540	$3,154,980	$58,368,870	$17,468,650	$115,864,200	$4,751,680
COMMUNITY INPATIENT	$15,078,860	$98,890,630	$165,842,880	$46,026,980	$810,579,130	$76,966,980
NURSING FACILITIES	$236,527,460	$2,181,590	$238,885,300	$42,016,170	$23,122,760	$5,042,710
ICF-DD	$166,621,220	$23,630	$2,380,530	$8,948,800	$1,106,430	$2,363,790
MEDICAL TRANSPORTATION	$1,182,550	$735,920	$12,036,480	$8,945,290	$8,414,560	$1,461,590
OTHER SERVICES	$11,356,080	$5,897,670	$83,451,060	$60,175,580	$90,995,860	$11,015,220
HOME HEALTH	$6,740	$9,323,250	$1,063,580	$60,271,180	$10,064,050	$13,691,290
FFS SUBTOTAL	**$447,553,440**	**$354,371,120**	**$763,245,540**	**$373,716,280**	**$2,402,536,000**	**$283,186,870**
DENTAL	$20,806,900	$130,361,330	$62,420,710	$20,806,900	$603,400,150	$37,246,100
MENTAL HEALTH	$2,287,930	$68,235,920	$11,076,500	$109,758,900	$523,249,580	$77,935,360
TWO PLAN MODEL	$0	$729,714,170	$1,754,968,110	$558,147,470	$3,063,731,100	$36,765,610
COUNTY ORGANIZED HEALTH SYSTEMS	$207,394,430	$448,081,030	$481,920,720	$358,139,870	$1,346,806,490	$46,514,080
GEOGRAPHIC MANAGED CARE	$0	$163,817,940	$228,972,560	$118,878,230	$577,702,840	$5,866,800
PHP & OTHER MANAG. CARE	$322,330	$9,117,330	$219,165,740	$22,026,230	$36,512,590	$2,607,380
EPSDT SCREENS	$0	$659,680	$0	$0	$2,497,450	$116,270
MEDICARE PAYMENTS	$16,175,870	$0	$1,252,072,240	$533,320,310	$112,370,670	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$225,200	$0	$9,952,950	$3,341,780	$69,863,690	$3,239,230
MISC. SERVICES	$0	($49,247,880)	$886,927,340	$912,169,930	$18,807,060	$931,910
DRUG MEDI-CAL	$872,220	$69,588,250	$37,384,250	$12,142,870	$270,313,390	$13,376,160
REGIONAL MODEL	$0	$51,362,890	$39,412,740	$34,568,610	$204,940,000	$1,291,010
NON-FFS SUBTOTAL	**$248,084,890**	**$1,621,690,670**	**$4,984,273,850**	**$2,683,301,090**	**$6,830,195,010**	**$225,889,920**
TOTAL DOLLARS (1)	**$695,638,320**	**$1,976,061,790**	**$5,747,519,390**	**$3,057,017,370**	**$9,232,731,010**	**$509,076,790**
ELIGIBLES * **	**11,200**	**926,100**	**503,300**	**171,700**	**3,474,600**	**161,100**
ANNUAL $/ELIGIBLE	**$62,111**	**$2,134**	**$11,420**	**$17,804**	**$2,657**	**$3,160**
AVG. MO. $/ELIGIBLE	**$5,176**	**$178**	**$952**	**$1,484**	**$221**	**$263**

(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 2018-19 COST PER ELIGIBLE BASED ON MAY 2018 ESTIMATE

SERVICE CATEGORY	MI-A	REFUGEE	OBRA	POV 185	POV 133	POV 100
PHYSICIANS	$892,800	$109,660	$95,400	$120,410,280	$12,915,060	$7,483,630
OTHER MEDICAL	$2,367,840	$1,109,220	$156,040	$242,923,020	$157,029,200	$83,124,640
CO. & COMM. OUTPATIENT	$582,940	$57,470	$37,160	$27,192,650	$11,136,740	$9,896,380
PHARMACY	$3,191,640	$206,040	$445,800	$21,095,660	$17,217,580	$30,706,800
COUNTY INPATIENT	$101,070	$12,720	$133,790	$63,389,220	$2,280,750	$1,617,350
COMMUNITY INPATIENT	$3,731,820	$392,240	$203,680	$867,658,410	$74,859,760	$40,729,430
NURSING FACILITIES	$24,346,530	$20	$7,743,060	$2,277,760	$6,553,690	$52,190
ICF-DD	$1,145,970	$0	$253,100	$225,790	$569,400	$30
MEDICAL TRANSPORTATION	$180,350	$2,990	$69,750	$3,433,880	$730,590	$225,030
OTHER SERVICES	$683,000	$18,100	$11,420	$9,557,370	$15,437,200	$10,293,590
HOME HEALTH	$1,690	$0	$0	$2,554,780	$3,141,670	$1,223,170
FFS SUBTOTAL	**$37,225,650**	**$1,908,470**	**$9,149,210**	**$1,360,718,820**	**$301,871,650**	**$185,352,250**
DENTAL	$20,806,900	$20,806,900	$20,806,900	$62,420,710	$104,034,510	$62,420,710
MENTAL HEALTH	$18,160	$54,490	$348,220	$7,404,210	$16,670,750	$28,837,250
TWO PLAN MODEL	$25,880	$745,200	$0	$203,828,810	$659,078,600	$406,591,660
COUNTY ORGANIZED HEALTH SYSTEMS	$106,230	$122,530	$34,410	$98,243,270	$320,403,840	$200,870,890
GEOGRAPHIC MANAGED CARE	$6,040	$476,280	$0	$37,754,700	$126,432,840	$79,796,710
PHP & OTHER MANAG. CARE	$1,302,480	$0	$0	$3,907,440	$6,512,410	$3,907,440
EPSDT SCREENS	$0	$0	$0	$0	$548,860	$277,020
MEDICARE PAYMENTS	$0	$0	$0	$0	$0	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$307,640	$0	$8,040	$7,053,530	$0	$7,763,300
MISC. SERVICES	$180	$0	$0	$51,590	$3,803,670	$1,847,720
DRUG MEDI-CAL	$91,010	$142,410	$0	$26,621,770	$46,087,670	$28,616,510
REGIONAL MODEL	$0	$5,080	$0	$14,560,750	$42,782,620	$24,123,210
NON-FFS SUBTOTAL	**$22,664,520**	**$22,352,890**	**$21,197,570**	**$461,846,770**	**$1,326,355,780**	**$845,052,420**
TOTAL DOLLARS (1)	**$59,890,170**	**$24,261,360**	**$30,346,780**	**$1,822,565,590**	**$1,628,227,440**	**$1,030,404,670**
ELIGIBLES * **	**15,300**	**1,200**	**400**	**350,800**	**770,500**	**386,100**
ANNUAL $/ELIGIBLE	**$3,914**	**$20,218**	**$75,867**	**$5,195**	**$2,113**	**$2,669**
AVG. MO. $/ELIGIBLE	**$326**	**$1,685**	**$6,322**	**$433**	**$176**	**$222**

(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 2018-19 COST PER ELIGIBLE BASED ON MAY 2018 ESTIMATE

SERVICE CATEGORY	TOTAL
PHYSICIANS	**$685,472,660**
OTHER MEDICAL	**$3,788,716,720**
CO. & COMM. OUTPATIENT	**$557,693,970**
PHARMACY	**$2,220,603,890**
COUNTY INPATIENT	**$895,970,240**
COMMUNITY INPATIENT	**$4,811,856,930**
NURSING FACILITIES	**$2,699,419,310**
ICF-DD	**$421,628,410**
MEDICAL TRANSPORTATION	**$96,612,780**
OTHER SERVICES	**$827,540,320**
HOME HEALTH	**$266,898,050**
FFS SUBTOTAL	**$17,272,413,270**
DENTAL	**$2,165,070,000**
MENTAL HEALTH	**$2,973,058,000**
TWO PLAN MODEL	**$23,905,922,580**
COUNTY ORGANIZED HEALTH SYSTEMS	**$9,862,287,980**
GEOGRAPHIC MANAGED CARE	**$4,372,165,950**
PHP & OTHER MANAG. CARE	**$731,297,940**
EPSDT SCREENS	**$4,956,000**
MEDICARE PAYMENTS	**$5,491,406,000**
STATE HOSP./DEVELOPMENTAL CNTRS.	**$155,445,000**
MISC. SERVICES	**$8,044,660,000**
DRUG MEDI-CAL	**$1,005,468,000**
REGIONAL MODEL	**$1,335,695,220**
NON-FFS SUBTOTAL	**$60,047,432,660**
TOTAL DOLLARS (1)	**$77,319,845,930**
ELIGIBLES * **	**13,323,500**
ANNUAL $/ELIGIBLE	**$5,803**
AVG. MO. $/ELIGIBLE	**$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 2018-19 COST PER ELIGIBLE BASED ON MAY 2018 ESTIMATE

EXCLUDED POLICY CHANGES: 77

2	BREAST AND CERVICAL CANCER TREATMENT
4	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
5	COUNTY HEALTH INITIATIVE MATCHING (CHIM)
6	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL
9	NON-OTLICP CHIP
12	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN
16	MEDICARE OPTIONAL EXPANSION ADJUSTMENT
22	1% FMAP INCREASE FOR PREVENTIVE SERVICES
23	ACA MAGI SAVINGS
28	FAMILY PACT PROGRAM
52	FAMILY PACT DRUG REBATES
61	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
65	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT
68	TRANSITIONAL SMHS CLAIMS
70	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT
73	GLOBAL PAYMENT PROGRAM
74	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL
75	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS
77	BTR - LIHP - MCE
78	MH/UCD STABILIZATION FUNDING
79	BTR - LOW INCOME HEALTH PROGRAM - HCCI
80	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG
81	MH/UCD HEALTH CARE COVERAGE INITIATIVE
82	MH/UCD FEDERAL FLEX. & STABILIZATION-SNCP
83	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM
84	CMS DEFERRED CLAIMS
85	CMS DEFERRALS & NEGATIVE BALANCE REPAYMENT
86	MH/UCD SAFETY NET CARE POOL
102	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)
103	PALLIATIVE CARE SERVICES IMPLEMENTATION
109	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT
110	MCO TAX MANAGED CARE PLANS
111	MANAGED CARE IGT ADMIN. & PROCESSING FEE
112	GENERAL FUND REIMBURSEMENTS FROM DPHS

FISCAL YEAR 2018-19 COST PER ELIGIBLE BASED ON MAY 2018 ESTIMATE

EXCLUDED POLICY CHANGES: 77

113	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND
114	MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.
115	MCO ENROLLMENT TAX MANAGED CARE PLANS
119	DENTAL RETROACTIVE RATE CHANGES
127	EMERGENCY MEDICAL AIR TRANSPORTATION ACT
131	DP/NF-B RETROACTIVE RECOUPMENT FORGIVENESS
133	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
138	HOSPITAL QAF - MANAGED CARE PAYMENTS
139	HOSPITAL QAF - FFS PAYMENTS
140	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS
141	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS
142	PRIVATE HOSPITAL DSH REPLACEMENT
143	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
144	DSH PAYMENT
145	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
146	NDPH IGT SUPPLEMENTAL PAYMENTS
148	PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS
149	DPH PHYSICIAN & NON-PHYS. COST
150	CAPITAL PROJECT DEBT REIMBURSEMENT
151	FFP FOR LOCAL TRAUMA CENTERS
153	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
154	GEMT SUPPLEMENTAL PAYMENT PROGRAM
155	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS
156	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS
157	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
158	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
159	IGT PAYMENTS FOR HOSPITAL SERVICES
160	PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS
161	NDPH SUPPLEMENTAL PAYMENT
162	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
164	DP-NF CAPITAL PROJECT DEBT REPAYMENT
171	ARRA HITECH - PROVIDER PAYMENTS
176	MEDI-CAL TCM PROGRAM
181	AUDIT SETTLEMENTS

FISCAL YEAR 2018-19 COST PER ELIGIBLE BASED ON MAY 2018 ESTIMATE

EXCLUDED POLICY CHANGES: 77

190	CDDS DENTAL SERVICES
193	HEALTH CARE SVCS. PLANS FINES AND PENALTIES FUND
194	CLPP FUND
195	CCI-TRANSFER OF IHSS COSTS TO DHCS
196	HOSPITAL QAF - CHILDREN'S HEALTH CARE
200	CIGARETTE AND TOBACCO SURTAX FUNDS
215	REPAYMENT TO CMS FOR MEDI-CAL RECOVERIES
219	HEALTH CARE SERVICES FOR REENTRY PROGRAMS
226	RECONCILIATION

Estimated Average Monthly Certified Eligibles
May 2018 Estimate
Fiscal Years 2016-2017, 2017-2018 & 2018-2019

(With Estimated Impact of Eligibility Policy Changes)*

	2016-2017	2017-2018	2018-2019	16-17 To 17-18 % Change	17-18 To 18-19 % Change
Public Assistance	**2,725,100**	**2,633,000**	**2,628,100**	**-3.38%**	**-0.19%**
Seniors	435,000	436,700	442,900	0.39%	1.42%
Persons with Disabilities	996,300	983,300	982,500	-1.30%	-0.08%
Families [1]	1,293,800	1,213,000	1,202,700	-6.25%	-0.85%
Long Term	**54,500**	**53,300**	**53,300**	**-2.20%**	**0.00%**
Seniors	42,500	42,100	42,100	-0.94%	0.00%
Persons with Disabilities	12,000	11,200	11,200	-6.67%	0.00%
Medically Needy	**4,301,600**	**4,161,300**	**4,135,800**	**-3.26%**	**-0.61%**
Seniors	450,100	478,300	495,000	6.27%	3.49%
Persons with Disabilities	162,200	164,200	166,200	1.23%	1.22%
Families [1]	3,689,300	3,518,800	3,474,600	-4.62%	-1.26%
Medically Indigent	**198,500**	**178,400**	**176,400**	**-10.13%**	**-1.12%**
Children	197,000	166,400	161,100	-15.53%	-3.19%
Adults	1,500	12,000	15,300	700.00%	27.50%
Other	**6,240,700**	**6,317,800**	**6,334,600**	**1.24%**	**0.27%**
Refugees	2,100	900	1,200	-57.14%	33.33%
OBRA [2]	2,800	600	400	-78.57%	-33.33%
185% Poverty [3]	371,300	356,100	350,800	-4.09%	-1.49%
133% Poverty	748,800	770,000	770,500	2.83%	0.06%
100% Poverty	362,200	385,900	386,100	6.54%	0.05%
Opt. Targeted Low Income Children	940,600	924,600	926,100	-1.70%	0.16%
ACA Optional Expansion	3,764,200	3,830,200	3,850,100	1.75%	0.52%
Hospital PE	30,000	31,000	30,900	3.33%	-0.32%
Medi-Cal Access Program	4,400	4,700	4,700	6.82%	0.00%
QMB	14,300	13,800	13,800	-3.50%	0.00%
GRAND TOTAL [4]	**13,520,400**	**13,343,800**	**13,328,200**	**-1.31%**	**-0.12%**
Seniors and Persons with Disabilities	**2,098,100**	**2,115,800**	**2,139,900**	0.84%	1.14%
Families and Children [5]	**7,603,000**	**7,334,800**	**7,271,900**	-3.53%	-0.86%

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:

	2016-2017	2017-2018	2018-2019
Presumptive Eligibility	16,800	23,200	28,400

[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 2016-17	2017-18	2018-19
PC 1 Medi-Cal State Inmates	LT Seniors	42	1	1
	MN Seniors	22	34	34
	MN Persons with Disabilities	4	7	7
	MI Children	7	4	4
	185% Poverty	1	2	2
	ACA Optional Expansion	259	273	273
	Total	**336**	**321**	**321**
PC 4 Medi-Cal Access Program Mothers 213-322%	MCAP Mothers	3,507	3,874	3,926
	Total	**3,507**	**3,874**	**3,926**
PC 8 Medi-Cal Access Program Infants 266-322%	MCAP Infants	852	821	821
	Total	**852**	**821**	**821**
PC 13 PARIS-Veterans	PA Seniors		(1)	(1)
	PA Persons with Disabilities		(1)	(1)
	PA Families		(1)	(1)
	LT Seniors		(11)	(11)
	MN Seniors		(15)	(15)
	MN Persons with Disabilities		(12)	(12)
	MN Families		(5)	(5)
	MI Adults		(27)	(27)
	Total		**(73)**	**(73)**
PC 15 Minimum Wage Increase - Caseload Savings	MN Families		(7,173)	(31,281)
	MI Children		(483)	(2,108)
	185% Poverty		0	(7,016)
	100% Poverty		(646)	(2,818)
	ACA Optional Expansion		(17,187)	(74,950)
	Total		**(25,489)**	**(118,173)**

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 2016-17	2017-18	2018-19
Total by Aid Category	PA Seniors	0	(1)	(1)
	PA Persons with Disabilities	0	(1)	(1)
	PA Families	0	(1)	(1)
	LT Seniors	42	(10)	(10)
	LT Persons with Disabilities	0	0	0
	MN Seniors	22	19	19
	MN Persons with Disabilities	4	(5)	(5)
	MN Families	0	(7,178)	(31,285)
	MI Children	7	(479)	(2,104)
	MI Adults	0	(27)	(27)
	Undocumented Persons	0	0	0
	185% Poverty	1	2	(7,014)
	133% Poverty	0	0	0
	100% Poverty	0	(646)	(2,818)
	OTLICP	0	0	0
	ACA Optional Expansion	259	(16,914)	(74,677)
	MCAP Infants	852	821	821
	MCAP Mothers	3,507	3,874	3,926
	Refugees	0	0	0
	Total	**4,695**	**(20,546)**	**(113,178)**

Comparison of Average Monthly Certified Eligibles
May 2018 Estimate
Fiscal Year 2017-18

(With Estimated Impact of Eligibility Policy Changes)

	Appropriaton 2017-2018	Nov 2017 2017-2018	May 2018 2017-2018	Appropriation to Nov % Change	Nov to May % Change
Public Assistance	**2,742,400**	**2,663,900**	**2,633,000**	**-2.86%**	**-1.16%**
Seniors	441,500	437,400	436,700	-0.93%	-0.16%
Persons with Disabilities	995,900	985,900	983,300	-1.00%	-0.26%
Families	1,305,000	1,240,600	1,213,000	-4.93%	-2.22%
Long Term	**54,700**	**53,900**	**53,300**	**-1.46%**	**-1.11%**
Seniors	42,800	42,400	42,100	-0.93%	-0.71%
Persons with Disabilities	11,900	11,500	11,200	-3.36%	-2.61%
Medically Needy	**4,278,500**	**4,225,300**	**4,161,300**	**-1.24%**	**-1.51%**
Seniors	458,400	478,000	478,300	4.28%	0.06%
Persons with Disabilities	159,700	160,100	164,200	0.25%	2.56%
Families	3,660,400	3,587,200	3,518,800	-2.00%	-1.91%
Medically Indigent	**201,300**	**179,300**	**178,400**	**-10.93%**	**-0.50%**
Children	199,700	178,100	166,400	-10.82%	-6.57%
Adults	1,600	1,200	12,000	-25.00%	900.00%
Other	**6,411,200**	**6,347,000**	**6,317,800**	**-1.00%**	**-0.46%**
Refugees	2,500	2,100	900	-16.00%	-57.14%
OBRA	1,500	900	600	-40.00%	-33.33%
185% Poverty	378,700	359,700	356,100	-5.02%	-1.00%
133% Poverty	759,200	776,700	770,000	2.31%	-0.86%
100% Poverty	367,300	379,400	385,900	3.29%	1.71%
Opt. Targeted Low Income Children	930,900	917,300	924,600	-1.46%	0.80%
ACA Optional Expansion	3,919,600	3,863,100	3,830,200	-1.44%	-0.85%
Hospital PE	30,400	29,600	31,000	-2.63%	4.73%
Medi-Cal Access Program	5,100	4,300	4,700	-15.69%	9.30%
QMB	16,000	13,900	13,800	-13.13%	-0.72%
GRAND TOTAL	**13,688,100**	**13,469,400**	**13,343,800**	**-1.60%**	**-0.93%**
Seniors and Persons with Disabilities	2,110,200	2,115,300	2,115,800	0.24%	0.02%
Families and Children	7,601,200	7,439,000	7,334,800	-2.13%	-1.40%

Comparison of Average Monthly Certified Eligibles
May 2018 Estimate
Fiscal Year 2018-19

(With Estimated Impact of Eligibility Policy Changes)

	November 2017 2018-19	May 2018 2018-19	% Change
Public Assistance	**2,670,800**	**2,628,100**	**-1.60%**
Seniors	444,200	442,900	-0.29%
Persons with Disabilities	986,000	982,500	-0.35%
Families	1,240,600	1,202,700	-3.05%
Long Term	**53,900**	**53,300**	**-1.11%**
Seniors	42,400	42,100	-0.71%
Persons with Disabilities	11,500	11,200	-2.61%
Medically Needy	**4,217,000**	**4,135,800**	**-1.93%**
Seniors	492,900	495,000	0.43%
Persons with Disabilities	160,100	166,200	3.81%
Families	3,564,000	3,474,600	-2.51%
Medically Indigent	**177,800**	**176,400**	**-0.79%**
Children	176,600	161,100	-8.78%
Adults	1,200	15,300	1175.00%
Other	**6,356,200**	**6,334,600**	**-0.34%**
Refugees	2,400	1,200	-50.00%
OBRA	900	400	-55.56%
185% Poverty	351,000	350,800	-0.06%
133% Poverty	776,700	770,500	-0.80%
100% Poverty	377,300	386,100	2.33%
Opt. Targeted Low Income Children	917,500	926,100	0.94%
ACA Optional Expansion	3,882,200	3,850,100	-0.83%
Hospital PE	29,600	30,900	4.39%
Medi-Cal Access Program	4,700	4,700	0.00%
QMB	13,900	13,800	-0.72%
GRAND TOTAL	**13,475,700**	**13,328,200**	**-1.09%**
Seniors and Persons with Disabilities	2,137,100	2,139,900	2,800
Families and Children	7,403,700	7,271,900	(131,800)

Estimated Average Monthly Certified Eligibles
May 2018 Estimate
Fiscal Years 2016-2017, 2017-2018 & 2018-2019

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

	2016-2017	2017-2018	2018-2019	16-17 To 17-18 % Change	17-18 To 18-19 % Change
Public Assistance	**2,328,950**	**2,274,170**	**2,270,510**	**-2.35%**	**-0.16%**
Seniors	320,440	333,290	340,010	4.01%	2.02%
Persons with Disabilities	838,950	840,990	841,700	0.24%	0.08%
Families	1,169,560	1,099,890	1,088,800	-5.96%	-1.01%
Long Term	**26,600**	**29,400**	**29,370**	**10.53%**	**-0.10%**
Seniors	20,980	23,410	23,400	11.58%	-0.04%
Persons with Disabilities	5,620	5,990	5,970	6.58%	-0.33%
Medically Needy	**3,221,780**	**3,189,190**	**3,166,810**	**-1.01%**	**-0.70%**
Seniors	301,940	340,050	351,580	12.62%	3.39%
Persons with Disabilities	106,210	113,160	115,450	6.54%	2.02%
Families	2,813,630	2,735,980	2,699,780	-2.76%	-1.32%
Medically Indigent	**46,110**	**43,540**	**41,640**	**-5.57%**	**-4.36%**
Children	46,020	43,260	41,590	-6.00%	-3.86%
Adults	90	280	50	211.11%	-82.14%
Other	**5,184,990**	**5,297,560**	**5,296,550**	**2.17%**	**-0.02%**
Refugees	1,260	730	740	-42.06%	1.37%
OBRA	50	20	10	-60.00%	-50.00%
185% Poverty	199,350	200,720	193,980	0.69%	-3.36%
133% Poverty	695,810	725,190	724,690	4.22%	-0.07%
100% Poverty	341,240	369,760	370,320	8.36%	0.15%
Opt. Targeted Low Income Children	874,120	865,360	862,000	-1.00%	-0.39%
ACA Optional Expansion	3,070,340	3,132,270	3,140,250	2.02%	0.25%
Medi-Cal Access Program	2,820	3,510	4,560	24.47%	29.91%
GRAND TOTAL [1]	**10,808,430**	**10,833,860**	**10,804,880**	**0.24%**	**-0.27%**
Percent of Statewide	**79.94%**	**81.19%**	**81.07%**		
Seniors and Persons with Disabilities	1,594,140	1,656,890	1,678,110	3.94%	1.28%
Families and Children	6,139,730	6,040,160	5,981,160	-1.62%	-0.98%

***** 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 2018 Estimate
Fiscal Years 2016-2017, 2017-2018 & 2018-2019

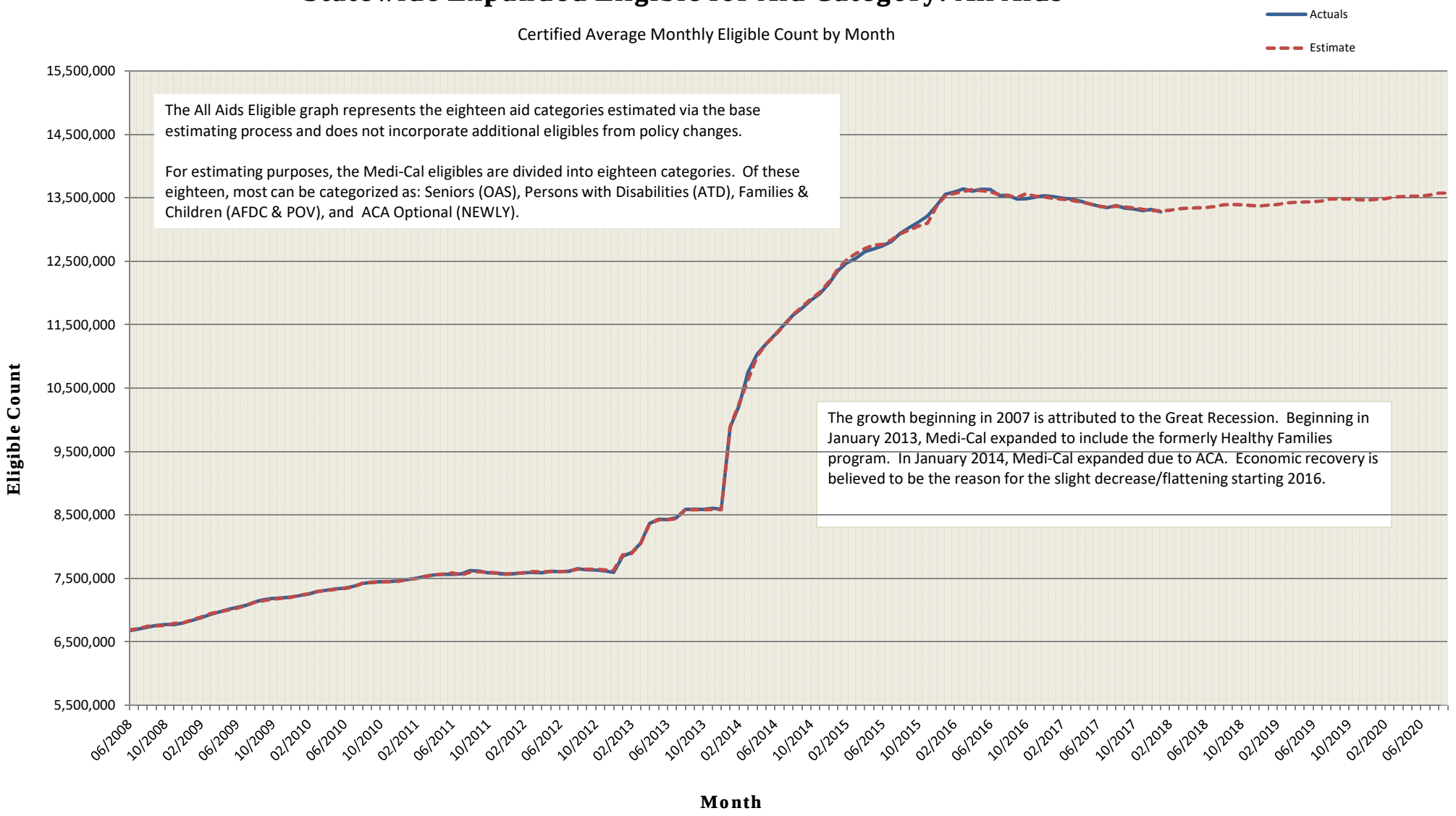
Fee-For-Service
(With Estimated Impact of Eligibility Policy Changes)*

	2016-2017	2017-2018	2018-2019	16-17 To 17-18 % Change	17-18 To 18-19 % Change
Public Assistance	**396,150**	**358,830**	**357,590**	**-9.42%**	**-0.35%**
Seniors	114,560	103,410	102,890	-9.73%	-0.50%
Persons with Disabilities	157,350	142,310	140,800	-9.56%	-1.06%
Families	124,240	113,110	113,900	-8.96%	0.70%
Long Term	**27,900**	**23,900**	**23,930**	**-14.34%**	**0.13%**
Seniors	21,520	18,690	18,700	-13.15%	0.05%
Persons with Disabilities	6,380	5,210	5,230	-18.34%	0.38%
Medically Needy	**1,079,820**	**972,110**	**968,990**	**-9.97%**	**-0.32%**
Seniors	148,160	138,250	143,420	-6.69%	3.74%
Persons with Disabilities	55,990	51,040	50,750	-8.84%	-0.57%
Families	875,670	782,820	774,820	-10.60%	-1.02%
Medically Indigent	**152,390**	**134,860**	**134,760**	**-11.50%**	**-0.07%**
Children	150,980	123,140	119,510	-18.44%	-2.95%
Adults	1,410	11,720	15,250	731.21%	30.12%
Other	**1,055,710**	**1,020,240**	**1,038,050**	**-3.36%**	**1.75%**
Refugees	840	170	460	-79.76%	170.59%
OBRA	2,750	580	390	-78.91%	-32.76%
185% Poverty	171,950	155,380	156,820	-9.64%	0.93%
133% Poverty	52,990	44,810	45,810	-15.44%	2.23%
100% Poverty	20,960	16,140	15,780	-23.00%	-2.23%
Opt. Targeted Low Income Children	66,480	59,240	64,100	-10.89%	8.20%
ACA Optional Expansion	693,860	697,930	709,850	0.59%	1.71%
Hospital PE	30,000	31,000	30,900	3.33%	-0.32%
Medi-Cal Access Program	1,580	1,190	140	-24.68%	-88.24%
QMB	14,300	13,800	13,800	-3.50%	0.00%
GRAND TOTAL	**2,711,970**	**2,509,940**	**2,523,320**	**-7.45%**	**0.53%**
Percent of Statewide	**20.06%**	**18.81%**	**18.93%**		
Seniors and Persons with Disabilities	503,960	458,910	461,790	-8.94%	0.63%
Families and Children	1,463,270	1,294,640	1,290,740	-11.52%	-0.30%

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

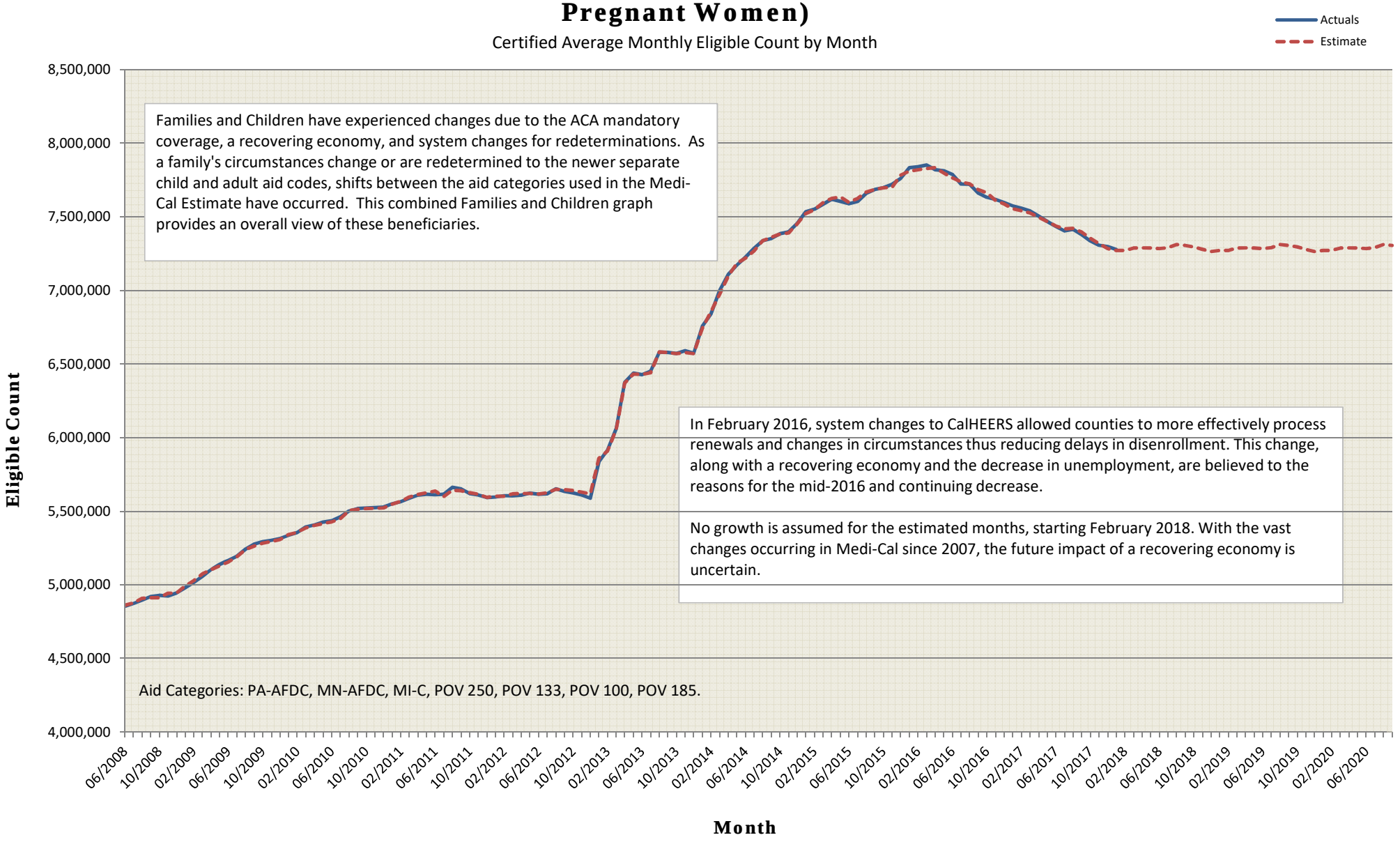
Statewide Expanded Eligible for Aid Category: All Aids

Certified Average Monthly Eligible Count by Month



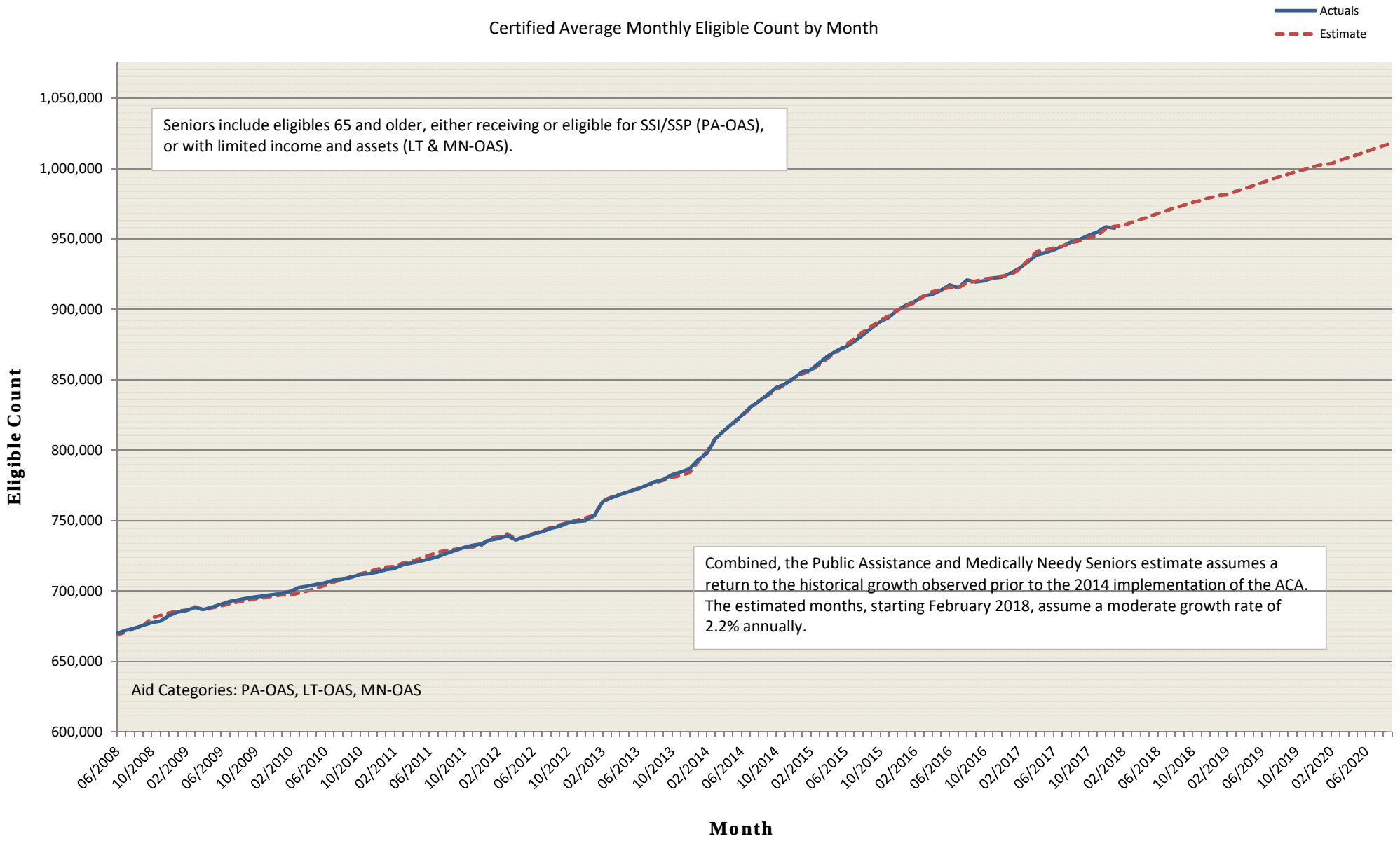
Statewide Expanded Eligible for Aid Category: Families and Children (including Pregnant Women)

Certified Average Monthly Eligible Count by Month

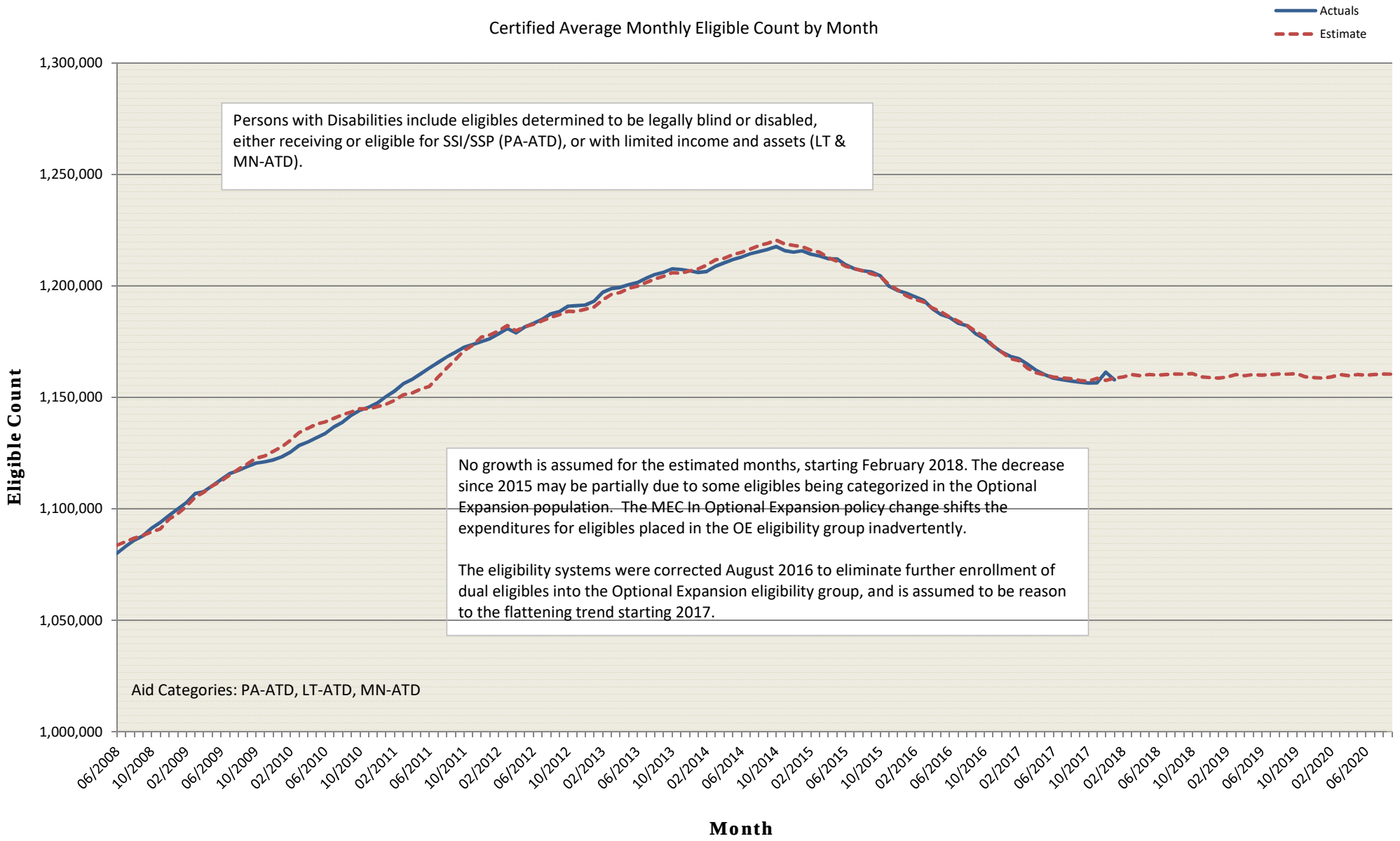


Statewide Expanded Eligible for Aid Category: Seniors

Certified Average Monthly Eligible Count by Month

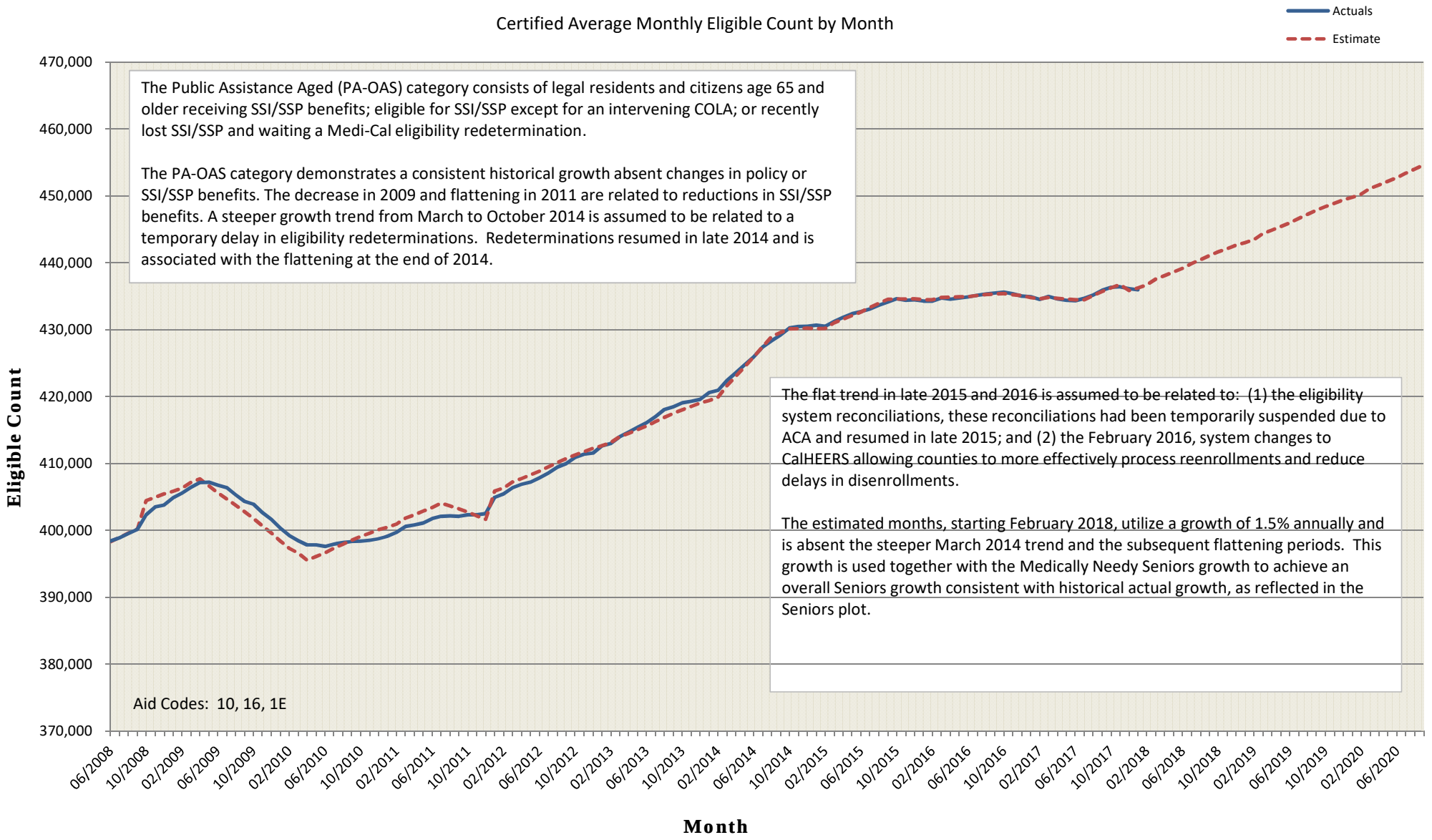


Statewide Expanded Eligible for Aid Category: Persons with Disabilities



Statewide Expanded Eligible: Public Assistance Seniors (PA-OAS)

Certified Average Monthly Eligible Count by Month



The Public Assistance Aged (PA-OAS) category consists of legal residents and citizens age 65 and older receiving SSI/SSP benefits; eligible for SSI/SSP except for an intervening COLA; or recently lost SSI/SSP and waiting a Medi-Cal eligibility redetermination.

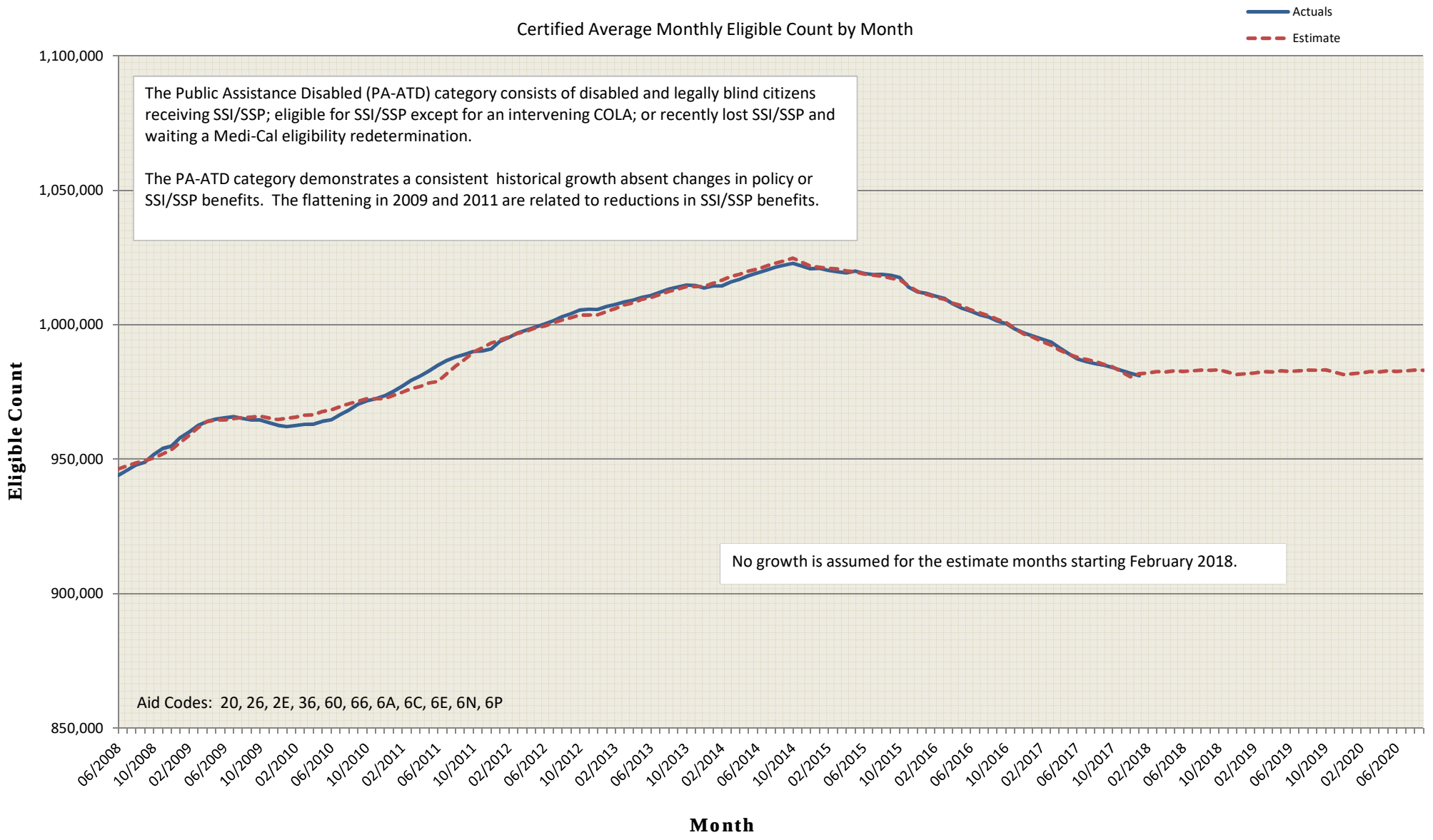
The PA-OAS category demonstrates a consistent historical growth absent changes in policy or SSI/SSP benefits. The decrease in 2009 and flattening in 2011 are related to reductions in SSI/SSP benefits. A steeper growth trend from March to October 2014 is assumed to be related to a temporary delay in eligibility redeterminations. Redeterminations resumed in late 2014 and is associated with the flattening at the end of 2014.

The flat trend in late 2015 and 2016 is assumed to be related to: (1) the eligibility system reconciliations, these reconciliations had been temporarily suspended due to ACA and resumed in late 2015; and (2) the February 2016, system changes to CalHEERS allowing counties to more effectively process reenrollments and reduce delays in disenrollments.

The estimated months, starting February 2018, utilize a growth of 1.5% annually and is absent the steeper March 2014 trend and the subsequent flattening periods. This growth is used together with the Medically Needy Seniors growth to achieve an overall Seniors growth consistent with historical actual growth, as reflected in the Seniors plot.

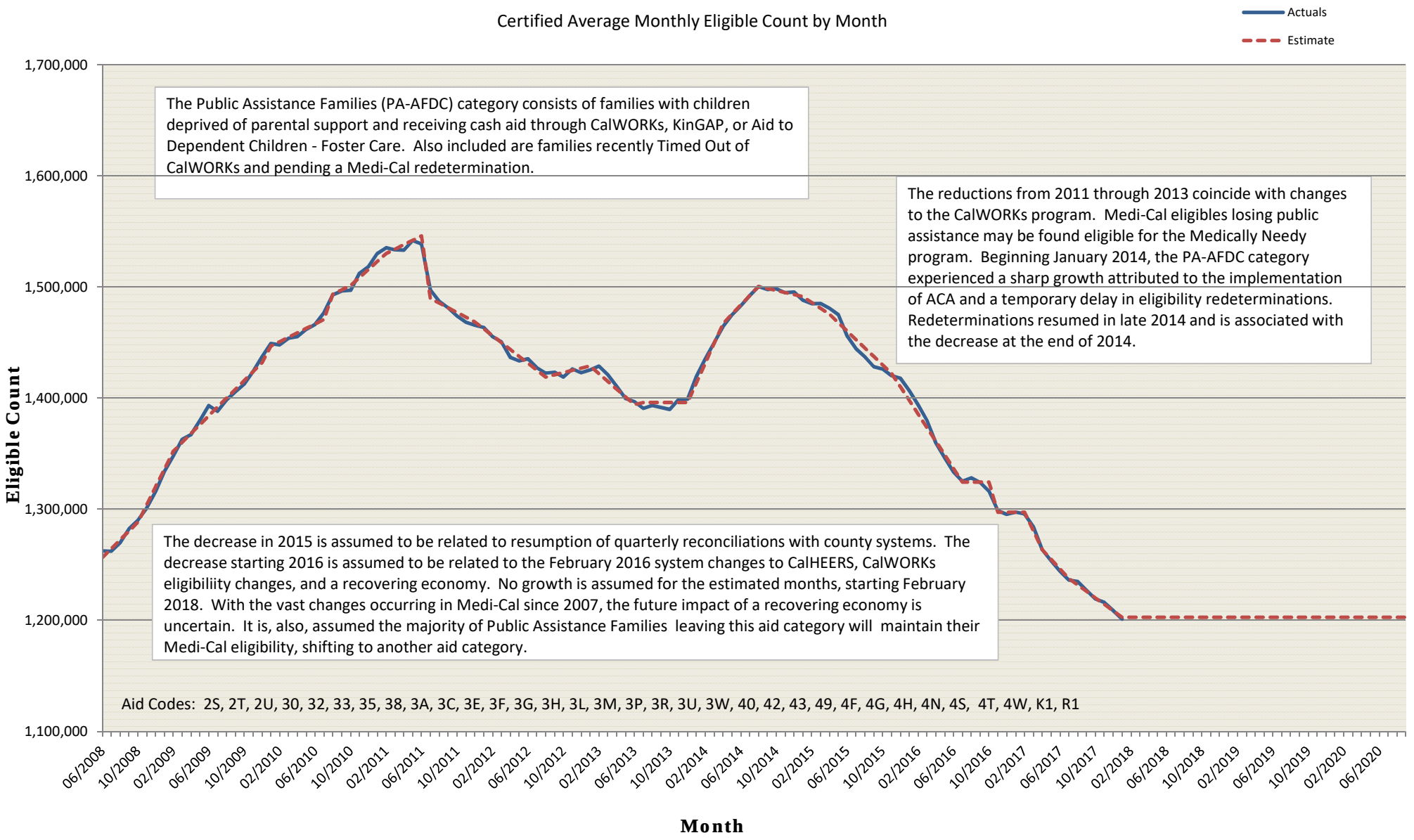
Aid Codes: 10, 16, 1E

Statewide Expanded Eligible: Public Assistance Persons with Disabilities (PA-ATD)

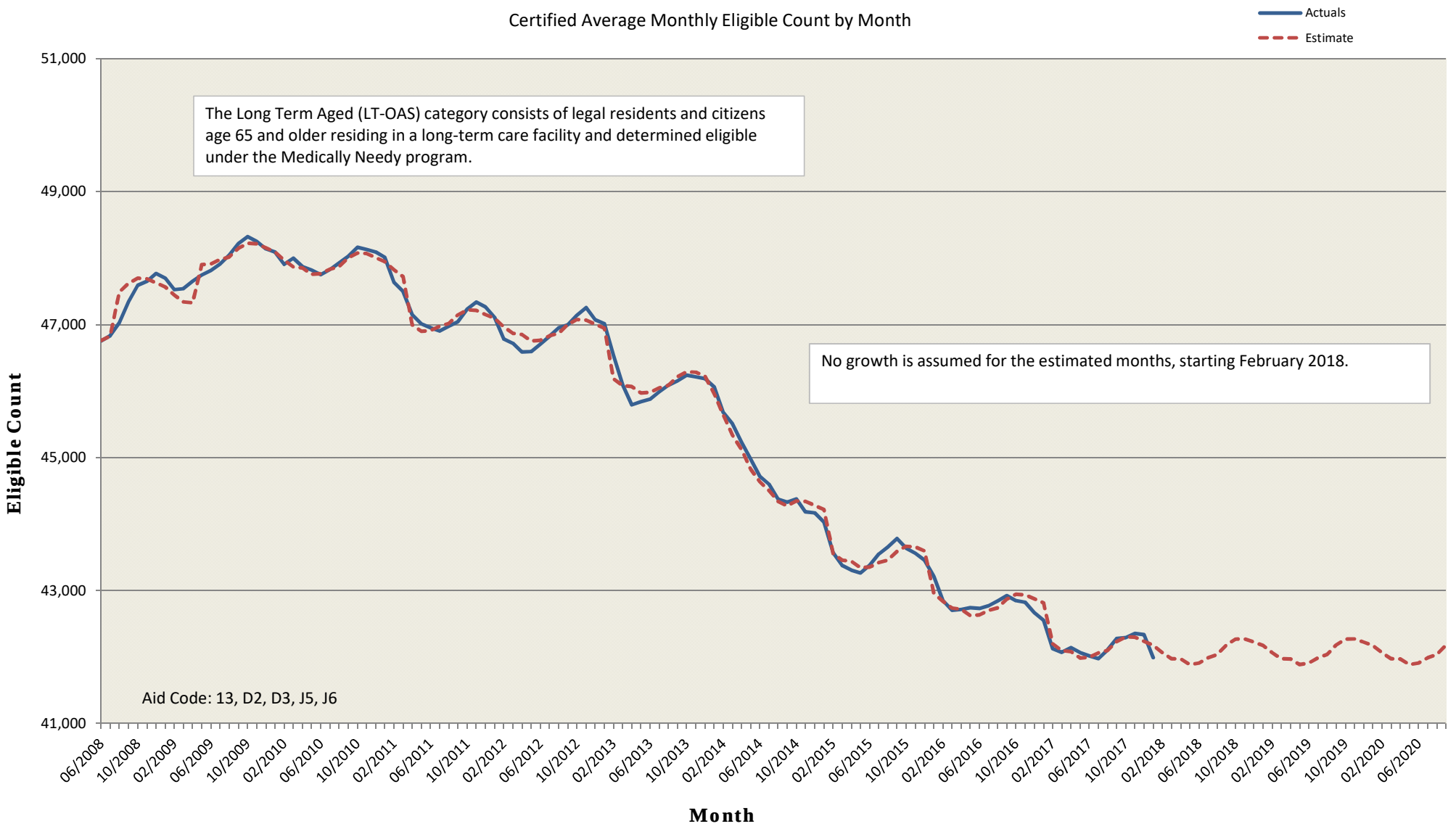


Statewide Expanded Eligible: Public Assistance Families (PA-AFDC)

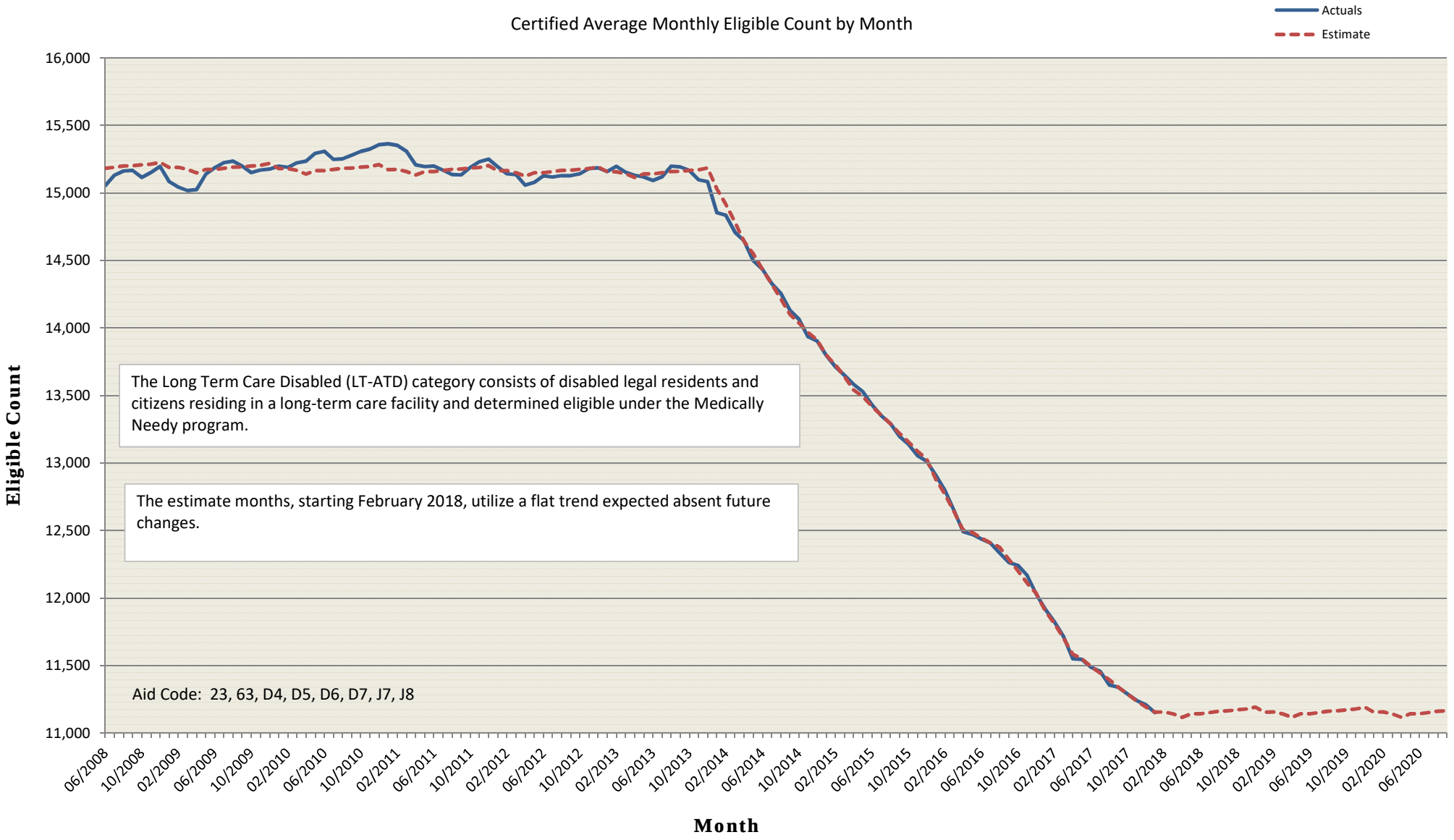
Certified Average Monthly Eligible Count by Month



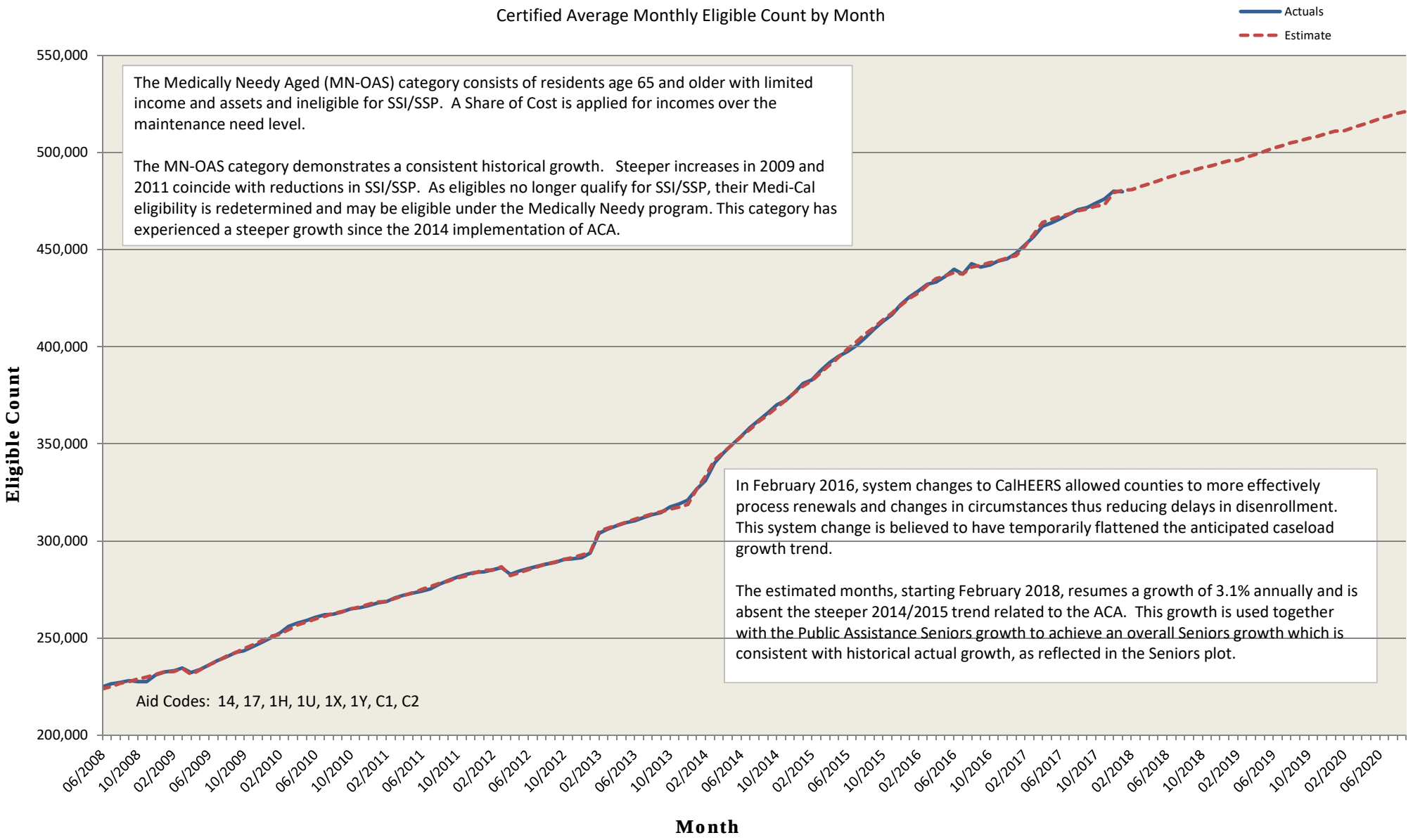
Statewide Expanded Eligible: Long Term Seniors (LT-OAS)



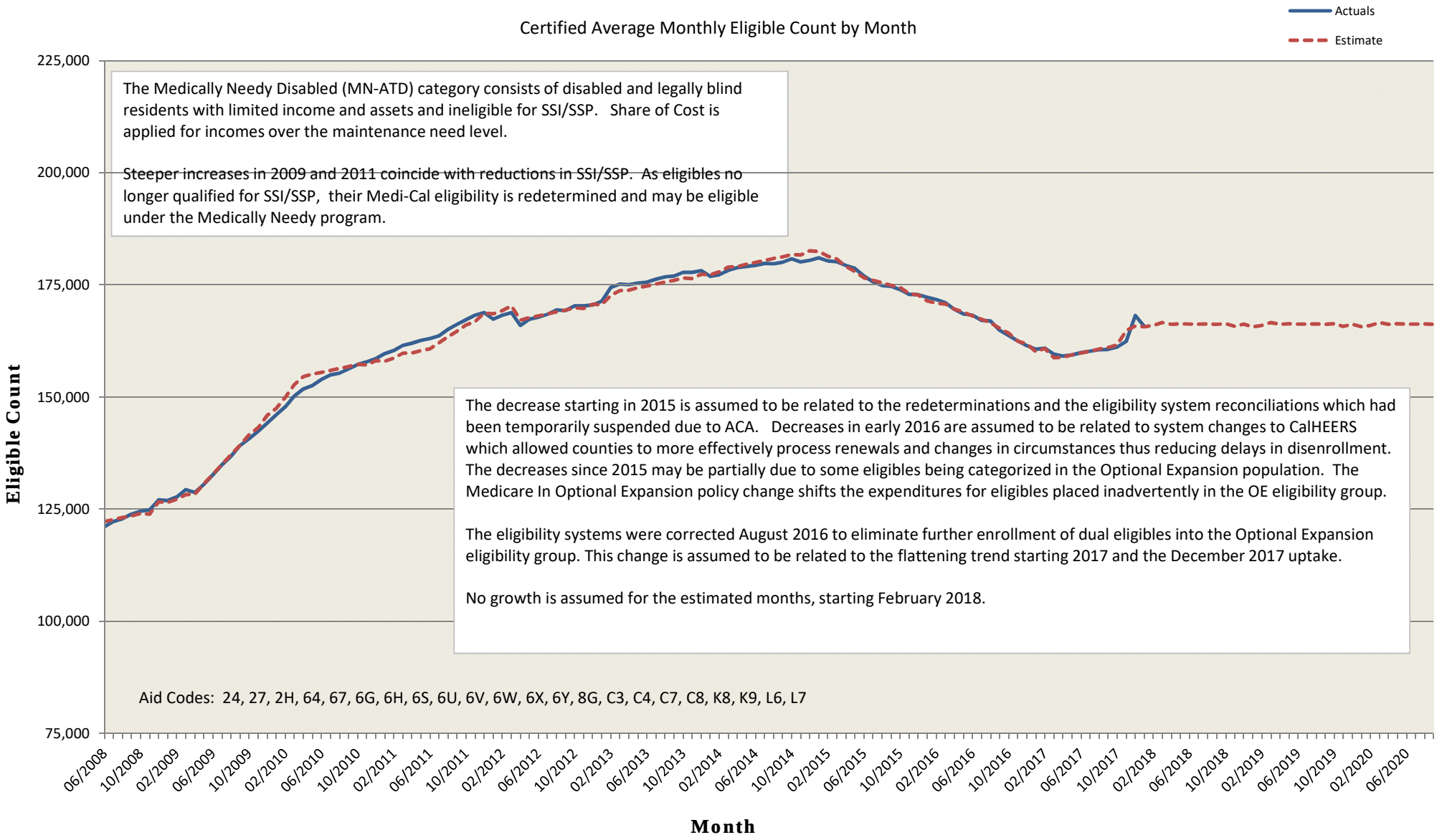
Statewide Expanded Eligible: Long Term Persons with Disabilities (LT-ATD)



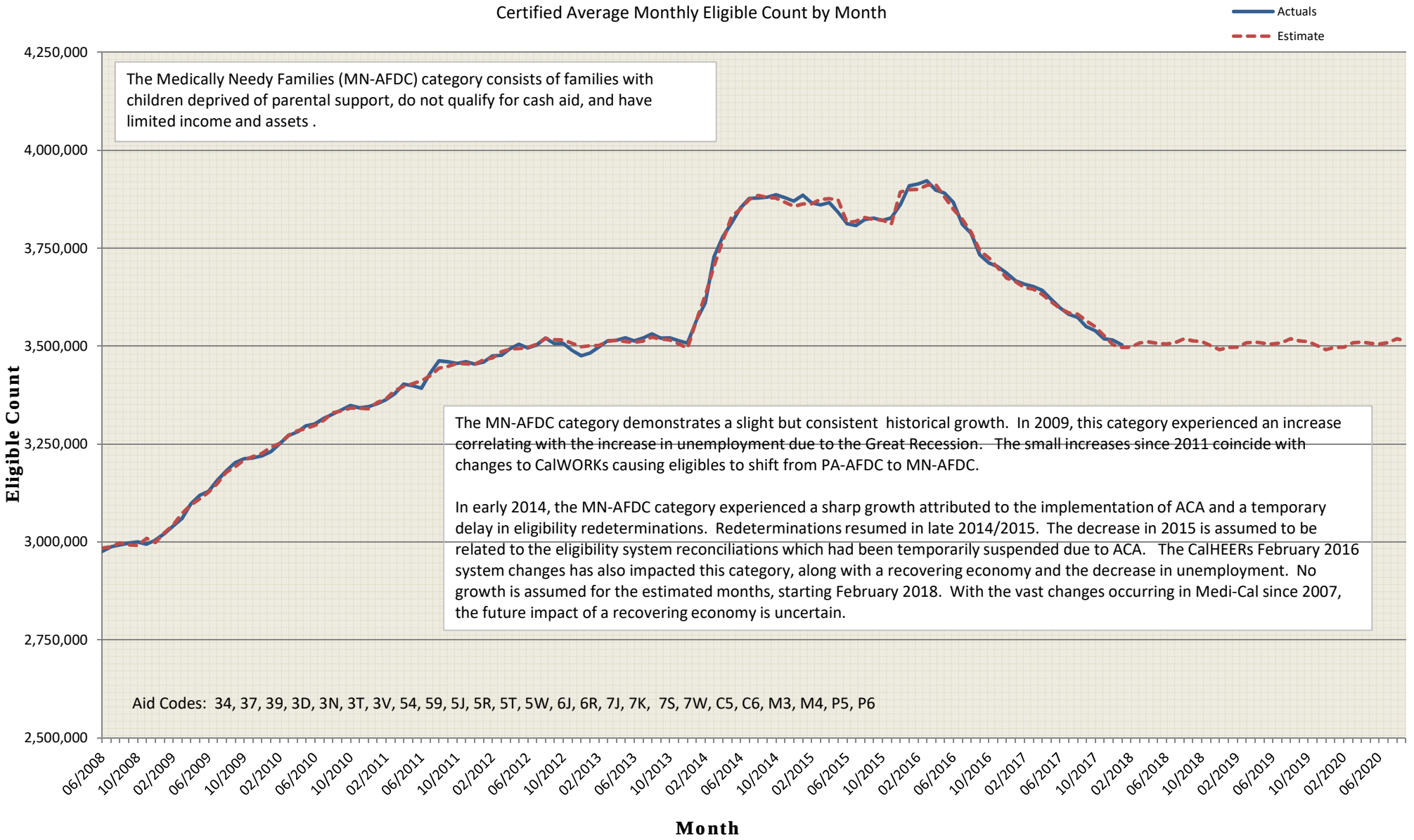
Statewide Expanded Eligible: Medically Needy Seniors (MN-OAS)



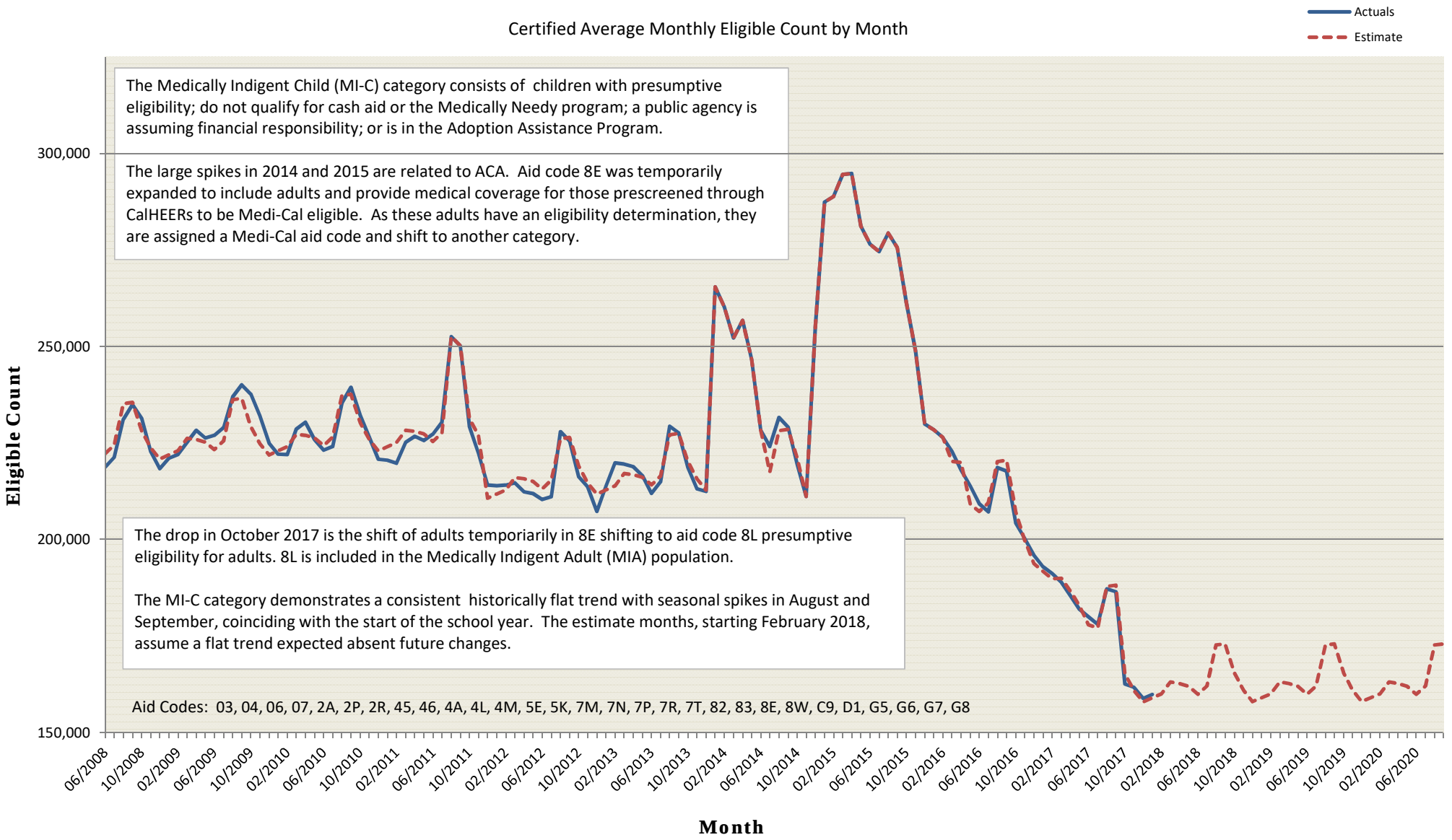
Statewide Expanded Eligible: Medically Needy Persons with Disabilities (MN-ATD)



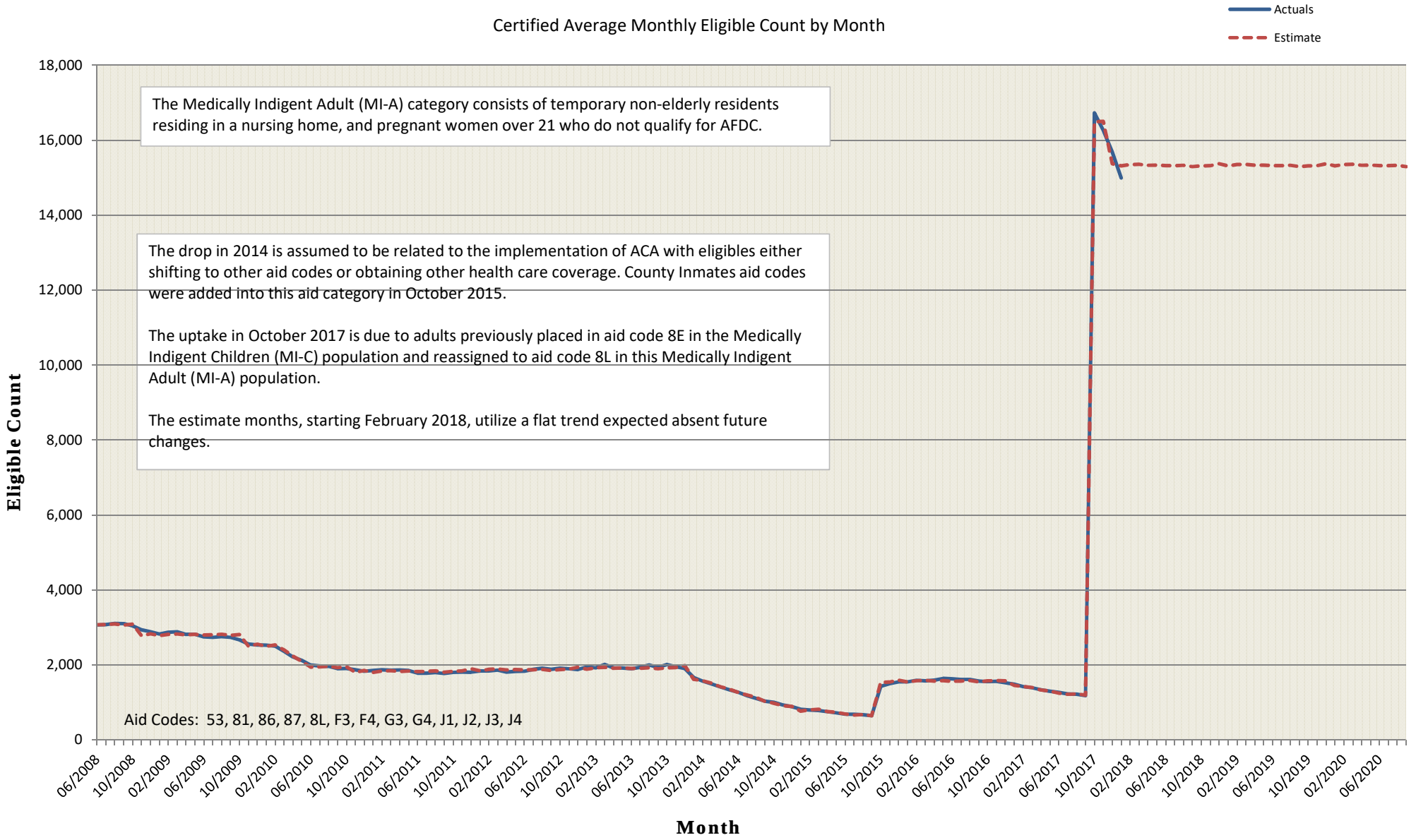
Statewide Expanded Eligible: Medically Needy Families (MN-AFDC)



Statewide Expanded Eligible: Medically Indigent Children (MI-C)

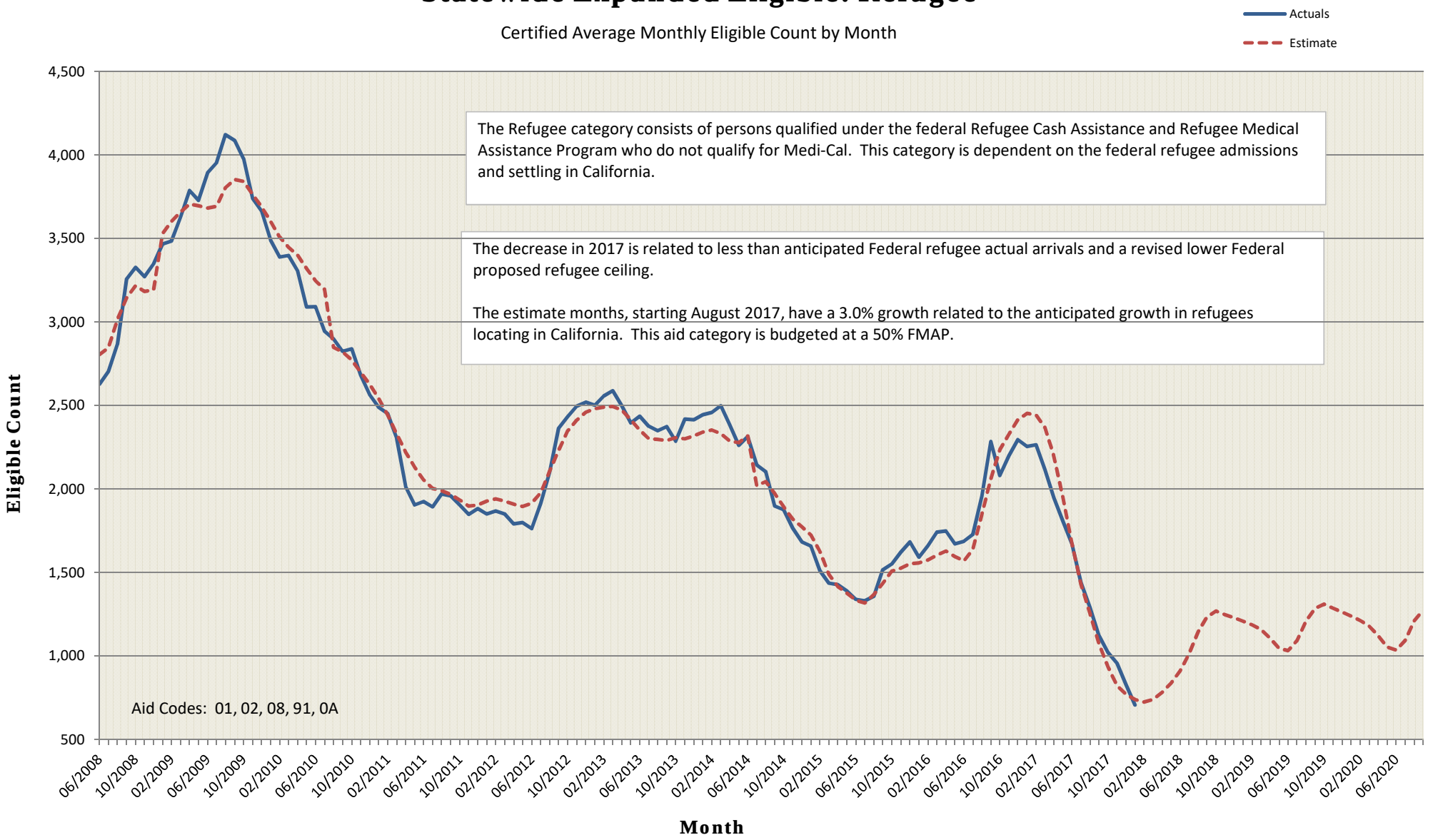


Statewide Expanded Eligible: Medically Indigent Adults (MI-A)



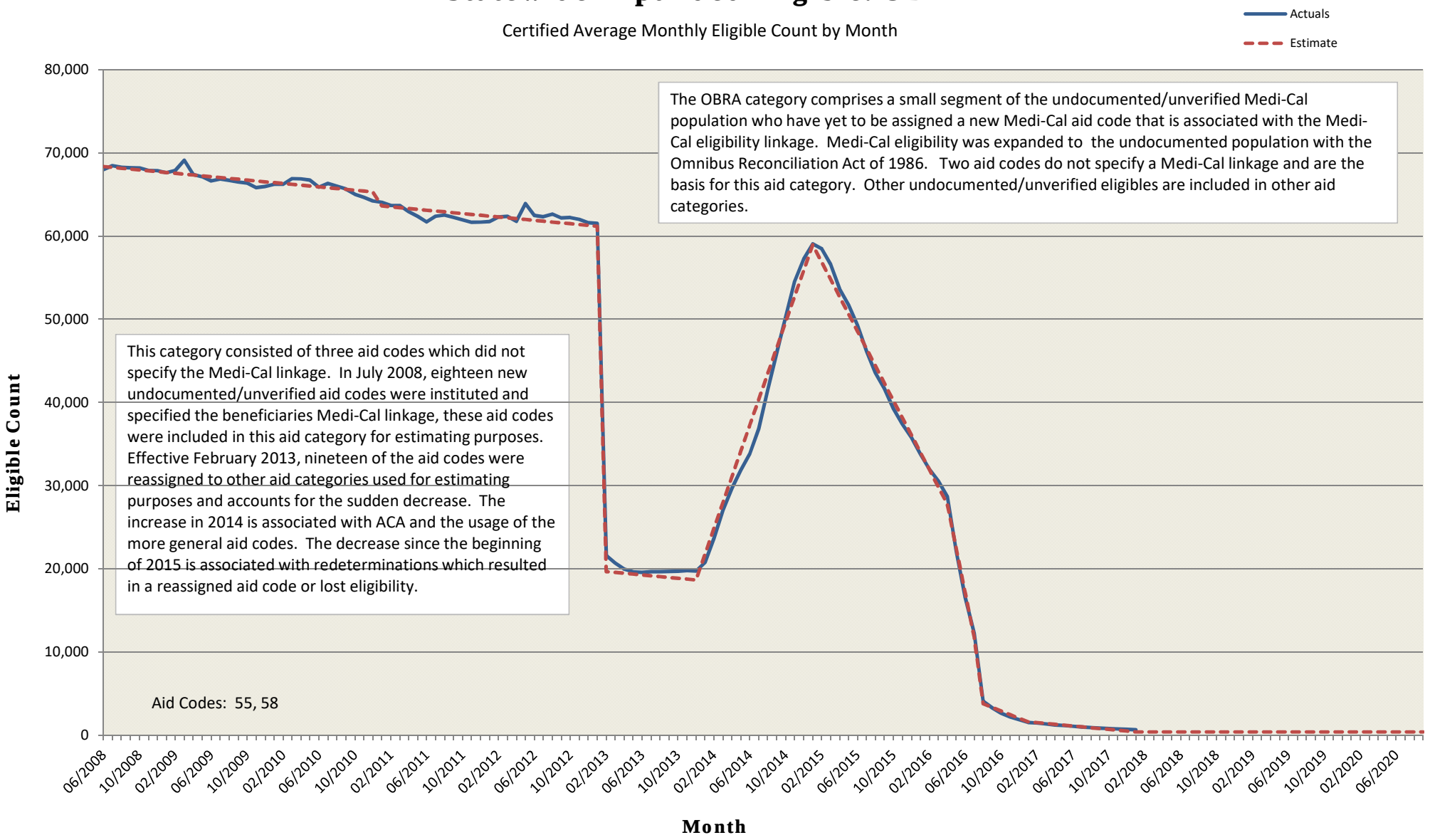
Statewide Expanded Eligible: Refugee

Certified Average Monthly Eligible Count by Month



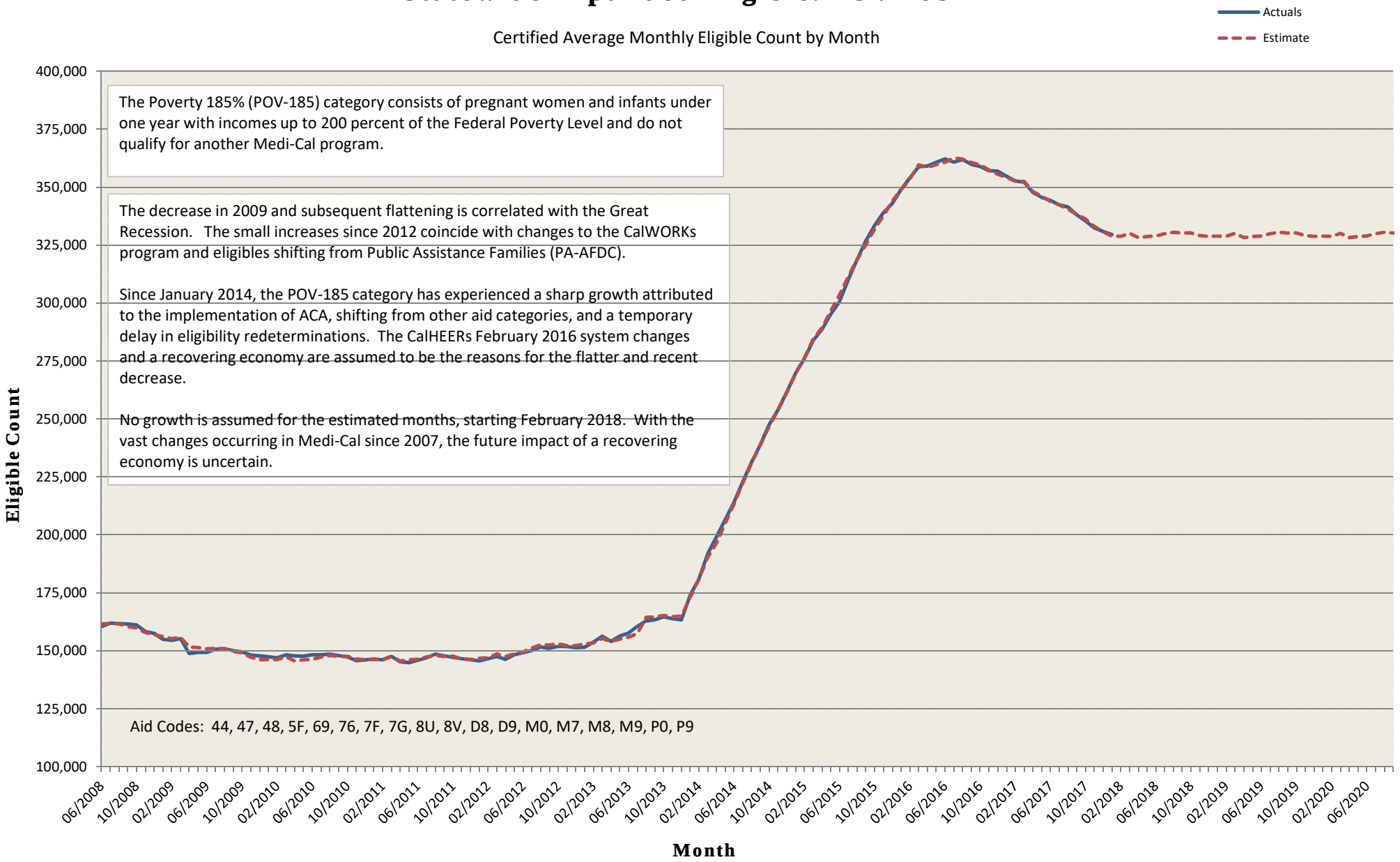
Statewide Expanded Eligible: OBRA

Certified Average Monthly Eligible Count by Month

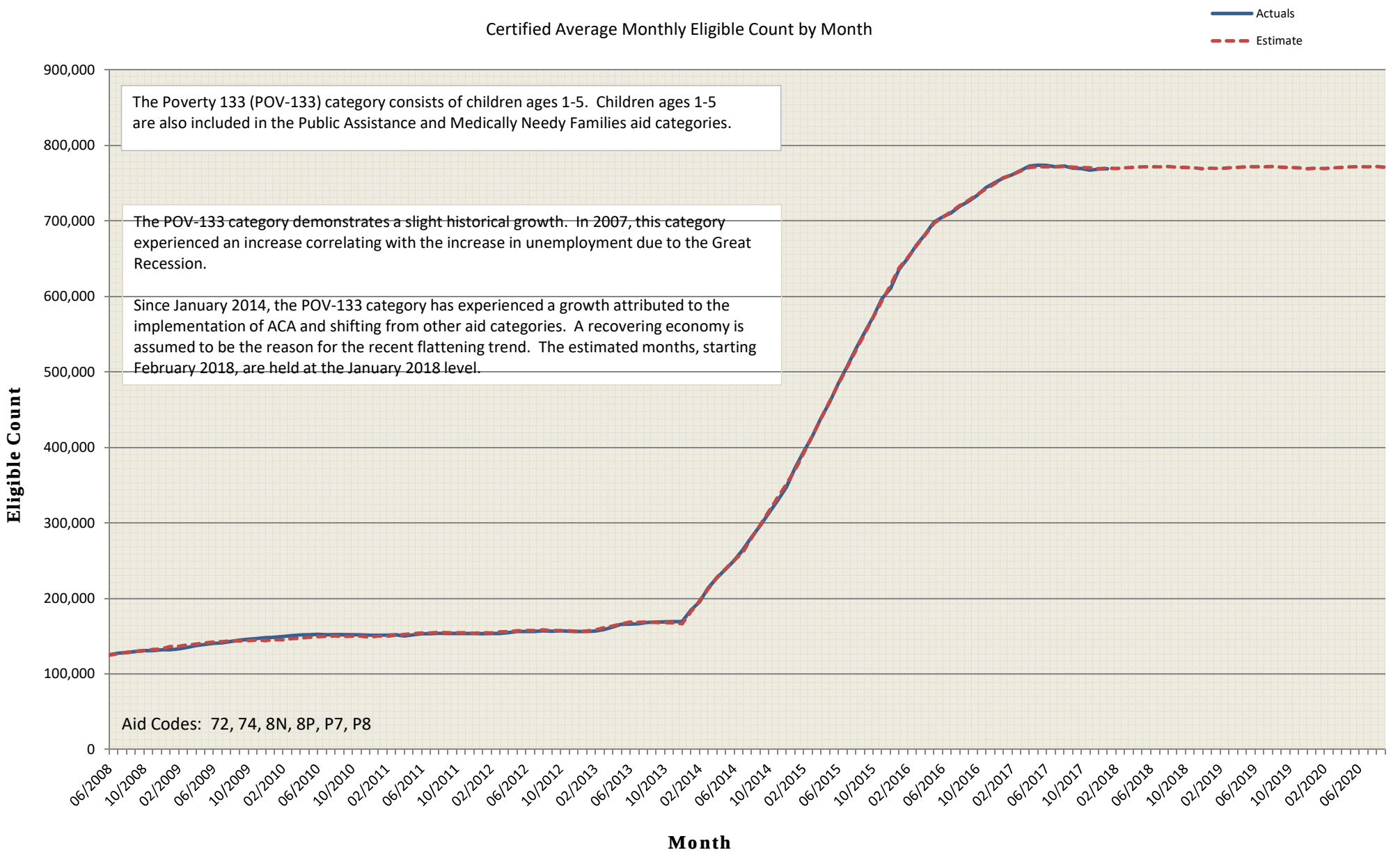


Statewide Expanded Eligible: POV-185

Certified Average Monthly Eligible Count by Month

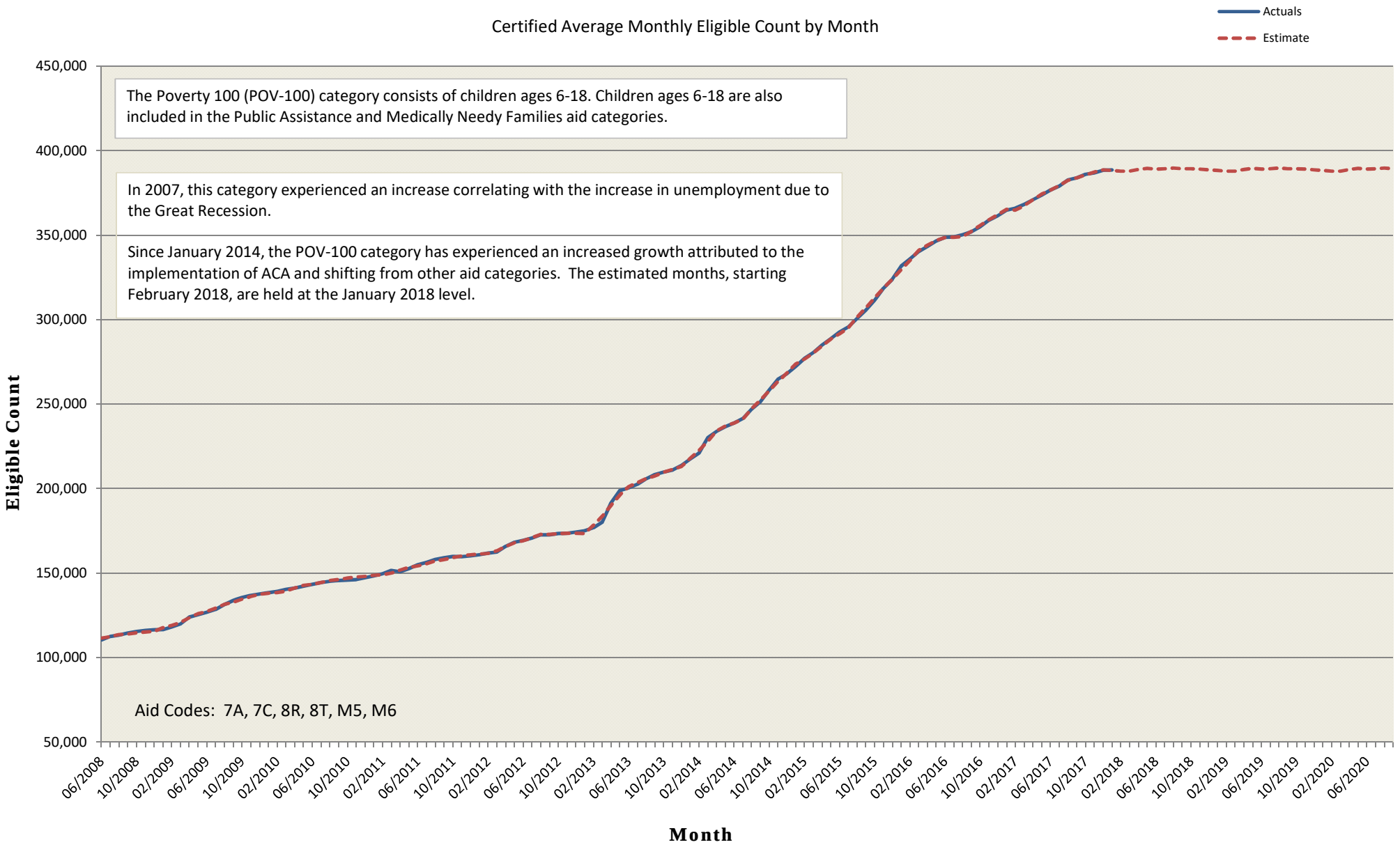


Statewide Expanded Eligible: POV-133



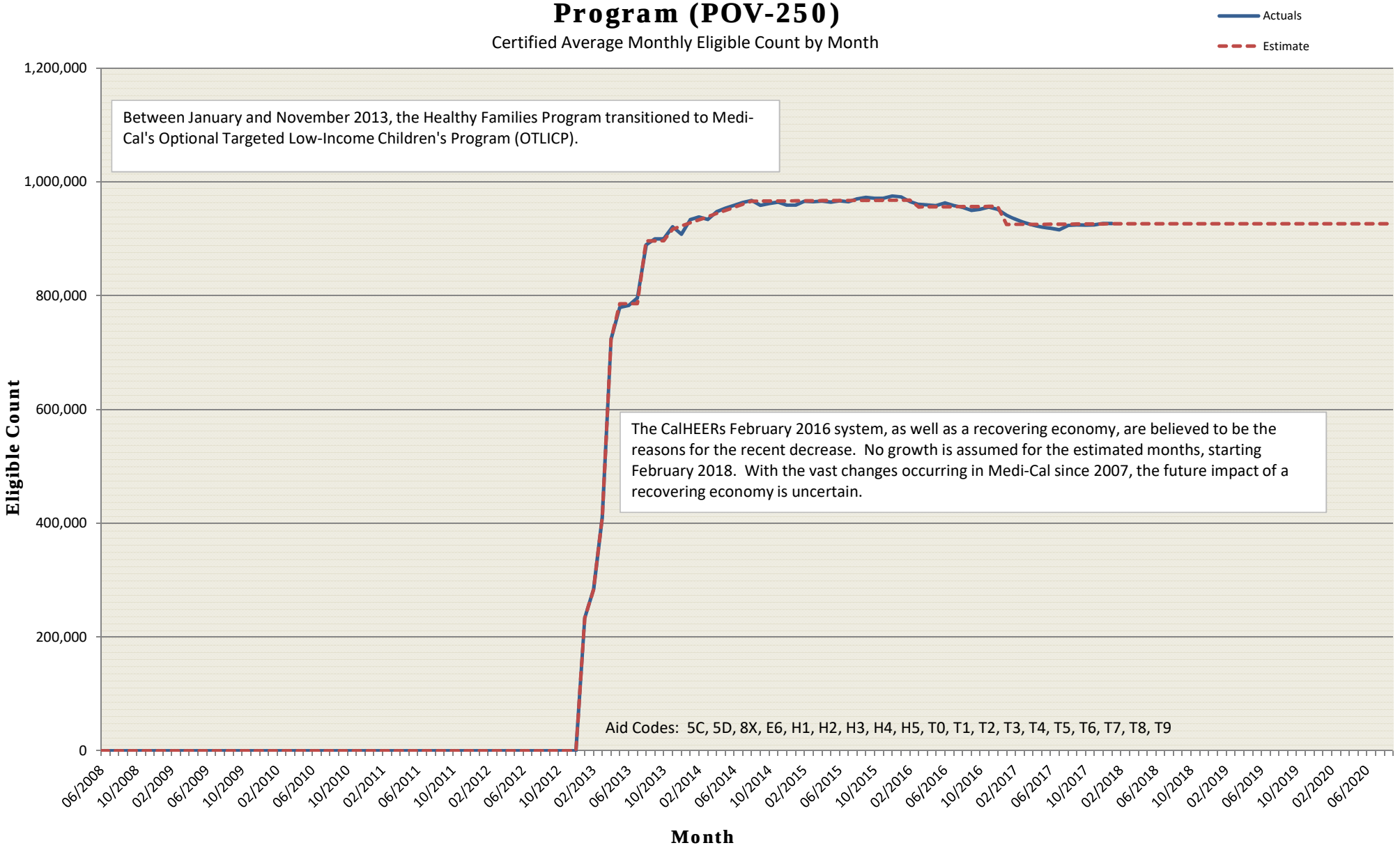
Statewide Expanded Eligible: POV-100

Certified Average Monthly Eligible Count by Month



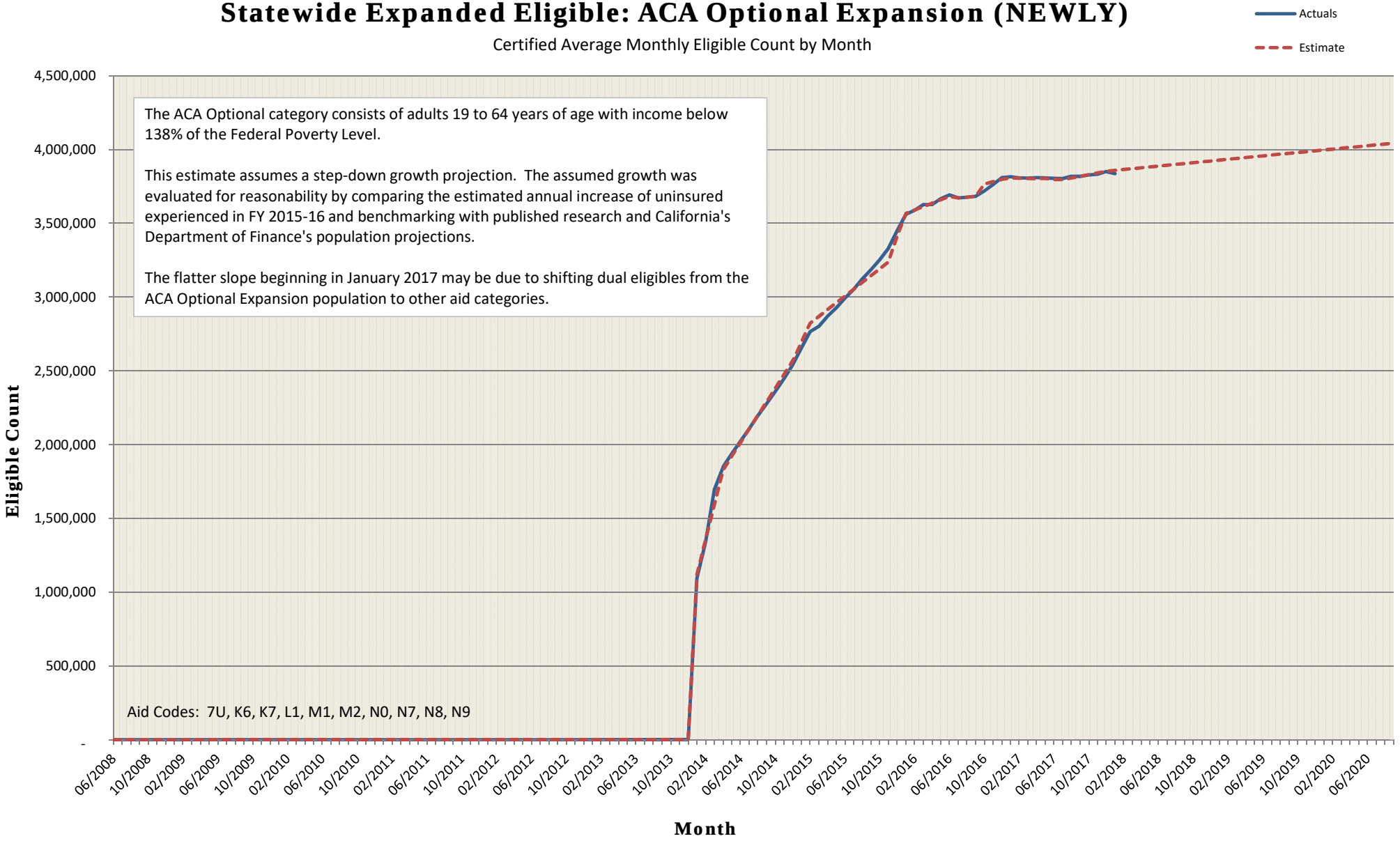
Statewide Expanded Eligible: Optional Targeted Low-Income Children's Program (POV-250)

Certified Average Monthly Eligible Count by Month

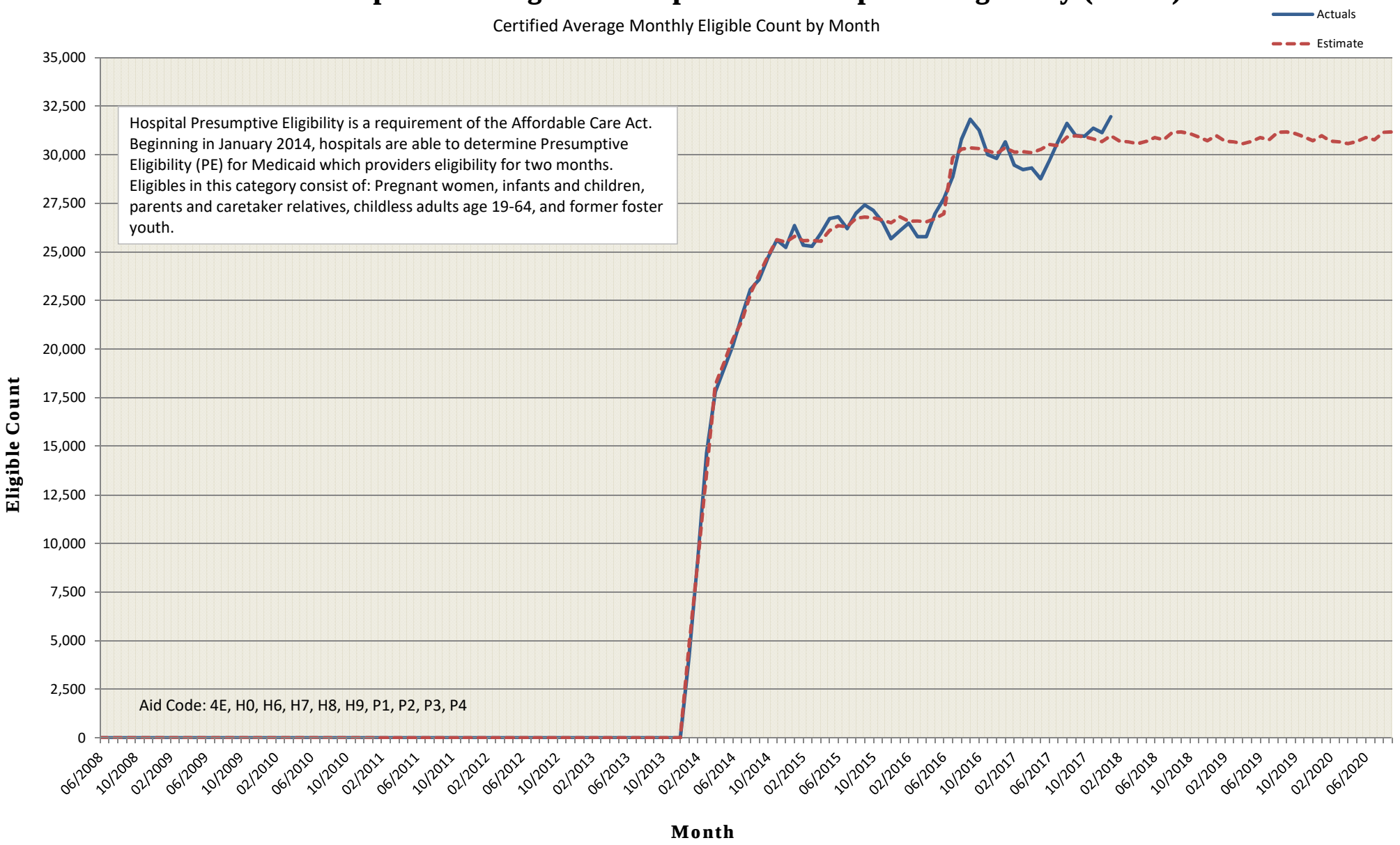


Statewide Expanded Eligible: ACA Optional Expansion (NEWLY)

Certified Average Monthly Eligible Count by Month



Statewide Expanded Eligible: Hospital Presumptive Eligibility (H-PE)



Medi-Cal Fee-For-Service Base Estimate

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

The Base Expenditure estimate consists of two main groups, (1) fee-for-service and (2) non-fee-for-service. The fee-for-service Base (FFS Base) Estimate is summarized in this section. The data used for these projections consist of 36-month claims paid through the main Medi-Cal claims processing system at the Fiscal Intermediary (FI).

The Non-Fee-for-Service (Non-FFS) Base Estimate consists of several Policy Changes and each is described and located in the Base Policy Change section.

FFS Base Estimate Service Categories

- Physicians
- Other Medical
- County & Community Outpatient*
- Pharmacy
- County Inpatient
- Community Inpatient
- Nursing Facilities
- Intermediate Care Facilities-Developmentally Disabled (ICF-DD)
- Medical Transportation
- Other Services
- Home Health

May 2018 FFS Base Estimate

Fiscal Year		May 2018 Estimate Total Expenditure	
PY	FY 2016-17	$16,699,569,100	--
CY	FY 2017-18	$17,058,966,900*	2.2%
BY	FY 2018-19	$17,738,522,300	4.0%

Fiscal Year	FFS Base Expenditure		
	November 2017 Estimate	May 2018 Estimate	% Chng
FY 2017-18	$16,975,737,600	$17,058,966,900*	0.5%
FY 2018-19	$17,382,153,100	$17,738,522,300	2.1%

* Including adjustments of $13.8 million related to Pharmacy and $14.0 million related to Other Services. See these two Service Category write-ups for additional information.

Overall, the May 2018 FFS Base is estimated at $17.1 billion and 17.7 billion, respectively, for FY 2017-18 and FY 2018-19. Compared to the November 2017 Estimate, the May 2018 FFS Base Estimate is higher by 0.5% for FY 2017-18 and 2.1% for FY 2018-19.

Several factors are contributing to these changes. The larger changes are discussed on the following page. Additional information is provided for each of the eleven (11) FFS Base service categories within this section.

Items Impacting FFS Base Estimate

Coordinated Care Initiative: With the Coordinated Care Initiative (CCI), beneficiaries moved to the Managed Care delivery system resulting in fewer Users in the FFS delivery system. The CCI was implemented in seven pilot counties with staggered implementation dates.

Overall Caseload Fluctuations: Overall caseload continues to fluctuate. The Families and Children caseload has continued to decrease since 2016, and is lower than the November 2017 Estimate. A recovering economy is assumed to be the reason for the lower caseload. The Affordable Care Act (ACA) Optional Expansion caseload continues to grow, but at a lower rate than prior year.

Crossover Claims: A crossover claim is a claim for a recipient who is eligible for both Medicare and Medi-Cal, where Medicare pays a portion of the claim and Medi-Cal is billed for any remaining deductible and/or coinsurance. Historically, both Community Inpatient and County & Community Outpatient had been impacted by changes with the crossover claims.

Processing Days: Processing days reflect the number of days Medi-Cal adjudicates and pays providers. The number of processing days sometimes varies from year to year. For the May 2018 Estimate, PY has 251 processing days, which equates to 51 checkwrite weeks, as well as CY and BY have 251 processing days equating to 51 checkwrite weeks.

FFS Claim Adjustments: Retroactive claim adjustments due to previously denied claims, payment reductions, rate changes, etc. occur often in the claims processing process. One-time retroactive claim adjustment payments temporarily change FFS users, utilization, and/or rate. FFS claim adjustments are excluded when projecting the FFS Base trends.

HIPPA Code Conversions: The Health Insurance Portability and Accountability Act (HIPAA) mandates the use of standard service/procedure code sets for transactions. The Medi-Cal program is implementing code conversions to convert its interim (local) codes to national procedure codes in compliance with the HIPPA requirements. Providers are required to discontinue use of Healthcare Common Procedure Coding System (HCPCS) Level III Local codes and utilize HCPCS Level II national HIPAA compliance codes. Several FFS Base Service categories, including Medical Transportation, Home Health, Other Medical, and Other Services have showed unusual patterns in Utilization and/or Rate attributed to the code conversions. While the code conversion is not expected to have an impact of the overall cost of services, the new codes can cause temporary changes affecting the components for estimating. The code conversion changes are assumed to be offsetting between Utilization and Rate.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2018 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
2015-16 *	1	2,033,000	3.71	$216.20	$801.98	$4,891,247,100
2015-16 *	2	1,989,130	3.41	$214.10	$729.73	$4,354,594,400
2015-16 *	3	1,916,590	3.35	$205.66	$688.47	$3,958,543,600
2015-16 *	4	1,947,110	3.35	$203.65	$682.75	$3,988,193,600
2015-16 *	TOTAL	1,971,460	3.46	$210.19	$726.73	$17,192,578,700
2016-17 *	1	2,058,050	3.54	$216.50	$766.44	$4,732,103,100
2016-17 *	2	1,931,100	3.19	$223.16	$712.32	$4,126,709,800
2016-17 *	3	1,929,790	3.29	$226.09	$744.25	$4,308,731,800
2016-17 *	4	1,793,080	2.98	$220.44	$656.60	$3,532,024,400
2016-17 *	TOTAL	1,928,000	3.26	$221.39	$721.80	$16,699,569,100
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	1,972,920	3.10	$233.45	$723.32	$4,281,143,700
2017-18 **	4	1,845,310	2.91	$231.81	$673.43	$3,728,065,000
2017-18 **	TOTAL	1,959,140	3.13	$231.68	$724.43	$17,031,199,900
2018-19 **	1	2,133,360	3.28	$242.28	$793.93	$5,081,222,100
2018-19 **	2	1,998,710	3.05	$238.44	$726.46	$4,355,939,100
2018-19 **	3	1,990,360	3.09	$240.20	$742.20	$4,431,715,100
2018-19 **	4	1,843,190	2.96	$236.73	$699.81	$3,869,646,000
2018-19 **	TOTAL	1,991,400	3.10	$239.59	$742.30	$17,738,522,300

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

Physicians Fee-for-Service Base Estimate

Analyst: Peter Bjorkman

Background: Physicians include services billed by Physicians (M.D or D.O) & Physician Group.

Fiscal Year		Users		Utilization (Claims per User)		Rate (Cost per Unit)		Total Expenditure	
PY	FY 2016-17	357,630	--	2.31	--	$73.06	--	$724,439,100	--
CY	FY 2017-18	346,690	-3.1%	2.28	-1.3%	$74.26	1.6%	$703,732,000	-2.9%
BY	FY 2018-19	346,000	-0.2%	2.29	0.4%	$73.53	-1.0%	$698,691,000	-0.7%

Users: Users are projected to decrease by 3.1% in CY due to the lower Families and Children caseload, and the Coordinated Care Initiative (CCI) enrollment shifting Seniors and Persons with Disabilities (SPDs) beneficiaries from Fee-For-Service (FFS) to Managed Care delivery system. The Families and Children caseload decrease is partially offset by an increase due to transition of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screen claims to the FFS Physicians base estimate, implemented July 2017. Users are estimated to remain relatively unchanged in BY.

Utilization: The level of Utilization experienced in PY is estimated to continue in CY and BY, around 2.3 claims per user.

Rate: The estimated CY increase is mainly due to adjustments to the primary care physician (PCP) rate increase. BY assumes a return to the level absent the PCP rate increase impact.

Total Expenditure: Total Expenditure is projected to decrease by 2.9% in CY, primarily due to the reduction in users. BY Expenditure projection is estimated to remain relatively unchanged.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	N17	M18	% Chng
FY 2017-18	$653,608,000	$703,732,000	7.7%
FY 2018-19	$650,842,700	$698,691,000	7.4%

Compared to the November 2017 Estimate, the May 2018 Estimate is higher by 7.7% and 7.4%, respectively, for FY 2017-18 and FY 2018-19. The estimated CY and BY increases are mainly due to transition of the EPSDT Screen claims to the FFS Physicians Base.

Notes:

FFS Physicians base FY 2015-16 data includes an impact of the primary care physician (PCP) incremental increase in rates. Retroactive PCP payments made in FY 2015-16, temporarily increased the number of claims processed, user count, and paid expenditures. Additional PCP payments expected after January 2018 are budgeted through the Payments to Primary Care Physicians Policy Change.

FFS Physicians base FY 2015-16 data also includes a one-time adjustment of approximately -$32 million related to the Reduction to Radiology Rate (RRR) recoupment. The processing of the adjustment occurred in FY 2015-16. The retroactive effective date then shifted to October 1, 2012. Additional RRR recoupments are budgeted in the Reduction to Radiology Rate Policy Change

FFS Physicians base for FY 2017-18 and FY 2018-19 assumes a return to the historical levels absent the PCP increase and RRR recoupment impacts.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2018 BASE ESTIMATES)

PHYSICIANS

YEAR	QUARTER	AVERAGE MONTHLY USERS	AVERAGE MONTHLY UNIT PER USER	AVERAGE MONTHLY COST PER UNIT	AVERAGE MONTHLY COST PER USER	TOTAL COST
2015-16 *	1	444,440	2.37	$73.71	$174.73	$232,970,300
2015-16 *	2	405,940	2.27	$72.70	$165.04	$200,991,100
2015-16 *	3	460,990	2.77	$70.75	$195.65	$270,573,100
2015-16 *	4	445,920	2.50	$52.56	$131.35	$175,710,700
2015-16 *	TOTAL	439,320	2.48	$67.23	$166.97	$880,245,300
2016-17 *	1	409,130	2.40	$73.04	$175.38	$215,258,300
2016-17 *	2	347,860	2.31	$74.00	$171.19	$178,654,500
2016-17 *	3	364,310	2.28	$72.76	$166.12	$181,552,000
2016-17 *	4	309,240	2.22	$72.37	$160.58	$148,974,300
2016-17 *	TOTAL	357,630	2.31	$73.06	$168.80	$724,439,100
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	362,660	2.24	$75.92	$170.16	$185,128,500
2017-18 **	4	318,940	2.17	$73.26	$159.33	$152,450,600
2017-18 **	TOTAL	346,690	2.28	$74.26	$169.15	$703,732,000
2018-19 **	1	372,400	2.39	$74.05	$177.26	$198,037,900
2018-19 **	2	331,740	2.29	$74.14	$169.60	$168,791,800
2018-19 **	3	361,320	2.24	$72.38	$162.10	$175,713,700
2018-19 **	4	318,550	2.22	$73.54	$163.39	$156,147,600
2018-19 **	TOTAL	346,000	2.29	$73.53	$168.28	$698,691,000

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

Other Medical Fee-for-Service Base Estimate

Analyst: Peter Bjorkman

Background: The Other Medical service category consists of clinics and specialist service providers. Payments to Federally Qualified Heath Care Centers and Rural Health Centers (FQHC/RHC) are approximately 83% of expenditures in this category. A full list of the provider types are listed in the Information Only Section.

Fiscal Year		Users		Utilization (Claims per User)		Rate (Cost per Claim)		Total Expenditure	
PY	FY 2016-17	1,128,010	--	1.54	--	$155.18	--	$3,240,090,800	--
CY	FY 2017-18	1,146,510	1.6%	1.54	0.0%	$160.17	3.2%	$3,393,669,900	4.7%
BY	FY 2018-19	1,156,180	0.8%	1.55	0.6%	$161.46	0.8%	$3,463,081,500	2.0%

Users: Users are estimated to increase by 1.6% in CY, primarily due to the ACA Optional Expansion caseload. Users are estimated to remain relatively unchanged in BY.

Utilization: Utilization is estimated to remain relatively unchanged in CY and BY from PY.

Rate: Rates are estimated to increase by 3.2% in CY. The CY increase is due to the partial incorporation of: (1) the FY 2017-18 rate increase for Los Angeles' Cost Based Reimbursement Clinics, implemented July 2017; (2) FY 2017-18 rate increase for Medicare Economic Index (MEI) rate increase for FQHC/RHCs, implemented October 2017; and (3) FY 2017-18 rate increase for Indian Health Services, implemented January 2018. Rates are held level in BY as future rate increases are estimated through policy changes.

Total Expenditure: CY Expenditure is estimated to increase by 4.7% due to higher Users and Rates. BY Expenditure is estimated to increase by 2.0%.

Reason for Change From Prior Estimate

Fiscal Year	Total Expenditure		
	N17	M18	% Chng
FY 2017-18	$3,432,545,800	$3,393,669,900	-1.1%
FY 2018-19	$3,396,547,200	$3,463,081,500	2.0%

Compared to the November 2017 Estimate, the May 2018 Estimate is lower by 1.1% for FY 2017-18 due to changes in caseload; and higher by 2.0% for FY 2018-19 due to incorporating the partial impact of FY 2017-18 rate increases.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2018 BASE ESTIMATES)

OTHER MEDICAL

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2015-16 *	1	1,151,530	1.61	$144.71	$233.56	$806,843,900
2015-16 *	2	1,115,460	1.56	$149.88	$233.09	$780,012,600
2015-16 *	3	1,006,930	1.50	$147.91	$221.97	$670,530,200
2015-16 *	4	1,044,530	1.52	$153.95	$234.10	$733,582,600
2015-16 *	TOTAL	1,079,610	1.55	$148.96	$230.87	$2,990,969,200
2016-17 *	1	1,195,090	1.60	$150.47	$240.03	$860,563,100
2016-17 *	2	1,133,620	1.55	$157.42	$243.50	$828,112,900
2016-17 *	3	1,133,370	1.54	$156.96	$241.78	$822,075,700
2016-17 *	4	1,049,940	1.48	$156.44	$231.55	$729,339,100
2016-17 *	TOTAL	1,128,010	1.54	$155.18	$239.37	$3,240,090,800
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	1,140,570	1.53	$164.20	$251.69	$861,210,800
2017-18 **	4	1,036,810	1.48	$160.26	$237.98	$740,233,000
2017-18 **	TOTAL	1,146,510	1.54	$160.17	$246.67	$3,393,669,900
2018-19 **	1	1,266,810	1.60	$161.01	$256.91	$976,356,200
2018-19 **	2	1,185,540	1.54	$162.92	$250.58	$891,206,200
2018-19 **	3	1,138,480	1.53	$161.44	$247.47	$845,228,600
2018-19 **	4	1,033,900	1.51	$160.36	$241.90	$750,290,600
2018-19 **	TOTAL	1,156,180	1.55	$161.46	$249.61	$3,463,081,500

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

County & Community Outpatient Fee-for-Service Base Estimate

Analyst: Alvin Bautista

Background: County and Community Outpatient providers are operated by county and community hospitals providing services that do not require an overnight stay.

Fiscal Year		Users		Utilization (Claims per User)		Rate (Cost per Claim)		Total Expenditure	
PY	FY 2016-17	222,730	--	1.52	--	$133.55	--	$542,747,600	--
CY	FY 2017-18	223,020	0.1%	1.52	0.0%	$137.73	3.1%	$561,337,400	3.4%
BY	FY 2018-19	218,490	-2.0%	1.53	0.7%	$140.36	1.9%	$562,269,900	0.2%

Users: Users are estimated to remain fairly level in CY, and decrease by 2.0% in BY.

Utilization: Utilization is projected to remain stable at approximately 1.5 claims per user.

Rate: Rate is estimated to increase by 3.1% in CY, due to the rate growth experienced in CY. Rate is estimated to increase by 1.9% in BY.

Total Expenditure: Total Expenditure is estimated to increase by 3.4% in CY due to higher Rate. BY Total Expenditure is estimated to remain consistent with CY.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	N17	M18	% Chng
FY 2017-18	$538,367,100	$561,337,400	4.3%
FY 2018-19	$531,157,700	$562,269,900	5.9%

Compared to the November 2017 Estimate, the May 2018 Estimate is higher by 4.3% and 5.9%, respectively, for FY 2017-18 and FY 2018-19. The estimated increases are due to Hospital Presumptive Eligibility and ACA Optional Expansion caseload increases and the rate growth experienced in CY.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2018 BASE ESTIMATES)

CO. & COMM. OUTPATIENT

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2015-16 *	1	266,480	1.56	$136.08	$212.03	$169,502,200
2015-16 *	2	241,980	1.50	$126.07	$189.70	$137,709,600
2015-16 *	3	221,180	1.48	$128.84	$190.13	$126,164,300
2015-16 *	4	240,520	1.51	$130.21	$196.44	$141,740,800
2015-16 *	TOTAL	242,540	1.51	$130.54	$197.60	$575,116,900
2016-17 *	1	262,450	1.57	$133.97	$210.36	$165,624,200
2016-17 *	2	218,000	1.51	$132.16	$199.50	$130,470,900
2016-17 *	3	214,040	1.52	$132.56	$201.08	$129,117,900
2016-17 *	4	196,450	1.47	$135.65	$199.43	$117,534,600
2016-17 *	TOTAL	222,730	1.52	$133.55	$203.06	$542,747,600
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	212,830	1.51	$142.25	$214.69	$137,080,700
2017-18 **	4	200,320	1.48	$135.53	$201.23	$120,934,100
2017-18 **	TOTAL	223,020	1.52	$137.73	$209.75	$561,337,400
2018-19 **	1	245,830	1.57	$145.29	$228.26	$168,337,600
2018-19 **	2	214,450	1.51	$140.21	$212.12	$136,469,800
2018-19 **	3	213,610	1.51	$138.46	$209.69	$134,378,900
2018-19 **	4	200,090	1.51	$136.24	$205.05	$123,083,600
2018-19 **	TOTAL	218,490	1.53	$140.36	$214.45	$562,269,900

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

Pharmacy Fee-for-Service Base Estimate

Analyst: Toni Richardson

Background: Pharmacy services consists of the prescribed drugs, medical supplies, and durable medical equipment (DME) billed by pharmacies.

Fiscal Year		Users		Utilization (Prescriptions per User)		Rate (Cost per Prescription)		Total Expenditure	
PY	FY 2016-17	472,910	--	2.80	--	$207.08	--	$3,292,285,500	--
CY	FY 2017-18	456,730	-3.4%	2.77	-1.1%	$235.12	13.5%	$3,584,470,000*	8.9%
BY	FY 2018-19	462,570	1.3%	2.77	0.0%	$253.01	7.6%	$3,884,808,800	8.4%

* Includes an adjustment of $13.8 million.

Users: Users are estimated to decrease by 3.4% from PY to CY, due to lower Families and Children caseload and the Coordinated Care Initiative (CCI) shifting Seniors and Persons with Disabilities (SPDs) beneficiaries from Fee-for-Services (FFS) to the Managed Care delivery system. User increases are partially offset by increase in the ACA Optional population. CY to BY estimated increase of 1.3% is due to the continual growth of the ACA Optional population.

Utilization: The level of Utilization experienced in PY is estimated to continue in CY and BY, around 2.8 prescriptions per user.

Rate: Rate is estimated to increase by 13.5% from PY to CY, related to discontinuation of FFS 10% pharmacy provider payment reductions for drug products, implemented April 2017. PY incorporates a partial year (2 months) impact of the rate restoration, while CY incorporates a full year impact of the rate restoration. In addition, BY Rate is estimated to increase by 7.6%, related to the historical growth experienced in prescription drugs.

Total Expenditure: Total expenditure is estimated to increase by 8.9% from PY to CY, due to discontinuation of FFS 10% pharmacy provider payment reductions, partially offset by lower Users; and increase by 8.4% from CY to BY primarily relate to the historical growth experienced in pharmacy rates.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditures		
	N17	M18	% Chng
FY 2017-18	$3,597,035,800	$3,584,470,000*	-0.3%
FY 2018-19	$3,825,762,300	$3,884,808,800	1.5%

* Includes an adjustment of $13.8 million.

Compared to the November 2017 Estimate, the May 2018 Estimate is relatively consistent with prior estimate for CY. The BY increase is due to increases in Users partially offset by decreases in Rates and Utilization.

Notes:

FFS Pharmacy Base FY 2015-16 data includes a one-time adjustment of -$52.7 million related to the Pharmacy recoupment of the 10% provider payment reduction. FFS Pharmacy Base FY 2017-18 data includes a one-time adjustment of -$13.8 million related to the Durable Medical Equipment/Medical Supplies (DME) recoupment of the 10% Provider Payment Reduction.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2018 BASE ESTIMATES)

PHARMACY

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2015-16 *	1	535,750	3.17	$203.18	$644.15	$1,035,306,700
2015-16 *	2	533,970	2.99	$200.93	$600.90	$962,590,900
2015-16 *	3	500,520	2.80	$210.58	$589.76	$885,557,400
2015-16 *	4	486,160	2.84	$197.19	$559.07	$815,400,700
2015-16 *	TOTAL	514,100	2.95	$202.94	$599.57	$3,698,855,600
2016-17 *	1	517,860	3.01	$196.24	$591.39	$918,761,500
2016-17 *	2	477,320	2.77	$202.80	$561.44	$803,965,300
2016-17 *	3	476,450	2.78	$209.02	$580.26	$829,394,700
2016-17 *	4	420,030	2.61	$225.38	$587.39	$740,164,000
2016-17 *	TOTAL	472,910	2.80	$207.08	$580.14	$3,292,285,500
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	469,120	2.75	$234.18	$643.36	$905,427,800
2017-18 **	4	419,440	2.59	$242.41	$627.31	$789,349,500
2017-18 **	TOTAL	456,730	2.77	$235.12	$651.50	$3,570,710,000
2018-19 **	1	497,070	2.93	$253.97	$743.87	$1,109,271,900
2018-19 **	2	470,190	2.72	$249.87	$678.89	$957,620,300
2018-19 **	3	465,990	2.74	$251.17	$688.17	$962,031,600
2018-19 **	4	417,030	2.66	$257.51	$684.11	$855,885,100
2018-19 **	TOTAL	462,570	2.77	$253.01	$699.86	$3,884,808,800

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

County Inpatient Fee-for-Service Base Estimate

Analyst: Beverly Yokoi

Background: County Inpatient includes acute inpatient services rendered by county hospitals. A county hospital is a not-for-profit public hospital operated and supported by the county. This service category consists mostly of Designated Public Hospitals (DPHs). DPHs receive annual rate increases effective July to reflect an increase in hospital costs.

Fiscal Year		Users		Utilization (Days per User)		Rate (Cost per Day)		Total Expenditure	
PY	FY 2016-17	4,850	--	5.30	--	$2,670.54	--	$822,995,000	--
CY	FY 2017-18	4,450	-8.2%	5.29	-0.2%	$2,816.00	5.4%	$795,768,800	-3.3%
BY	FY 2018-19	4,440	-0.2%	5.46	3.2%	$2,904.61	3.1%	$845,824,700	6.3%

Users: Users decrease by an estimated -8.2% in CY correlates to changes in caseload combined with the continuing Coordinated Care Initiative (CCI) enrollment shifting Seniors and Persons with Disabilities (SPDs) beneficiaries from Fee-For-Service (FFS) to Managed Care delivery system. Users are estimated to remain relatively unchanged in BY.

Utilization: Utilization or the number of days stay per user is estimated to remain stable in CY. Utilization is estimated to increase by 3.2% in BY.

Rate: Rate is estimated to increase in CY and BY, due to the partial incorporation of the FY 2017-18 DPH interim rate increase of 4.01% (for county hospitals), implemented on September 15, 2017. Rate shown above does not include the FY 2018-19 DPH interim rate increase effective July 2018. The FY 2018-19 increase is budgeted in the DPH Interim Rate Growth Regular Policy Change.

Total Expenditure: Total expenditures are estimated to decrease by 3.3% in CY due to lower Users and partially offset by an increase in Rate. Total expenditures are estimated to increase by 6.3% in BY primarily due to increases in Utilization and Rate.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	N17	M18	% Chng
FY 2017-18	$812,991,100	$795,768,800	-2.1%
FY 2018-19	$828,090,400	$845,824,700	2.1%

Compared to the November 2017 estimate, the May 2018 estimate is lower by 2.1% for FY FY 2017-18 and higher by 2.1% for FY 2018-19. The CY decrease is due to Utilization changes. The BY increase for FY 2018-19 is due to partial incorporation of the FY 2017-18 DPH interim rate increase into the FFS County Inpatient Base.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2018 BASE ESTIMATES)

COUNTY INPATIENT

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2015-16 *	1	6,630	5.39	$2,386.63	$12,855.84	$255,754,000
2015-16 *	2	5,030	5.30	$2,495.98	$13,222.41	$199,698,100
2015-16 *	3	4,670	5.52	$2,428.40	$13,410.12	$187,848,900
2015-16 *	4	5,010	5.45	$2,584.54	$14,086.37	$211,802,700
2015-16 *	TOTAL	5,340	5.41	$2,468.02	$13,352.44	$855,103,700
2016-17 *	1	5,410	5.35	$2,523.13	$13,499.51	$219,191,500
2016-17 *	2	4,960	5.12	$2,623.98	$13,430.67	$199,821,600
2016-17 *	3	4,850	5.42	$2,795.26	$15,159.56	$220,708,100
2016-17 *	4	4,170	5.29	$2,768.82	$14,638.49	$183,273,900
2016-17 *	TOTAL	4,850	5.30	$2,670.54	$14,142.27	$822,995,000
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	4,530	5.48	$2,876.31	$15,750.31	$213,909,800
2017-18 **	4	4,070	5.47	$2,908.85	$15,925.47	$194,257,200
2017-18 **	TOTAL	4,450	5.29	$2,816.00	$14,905.61	$795,768,800
2018-19 **	1	5,110	5.46	$2,845.33	$15,525.13	$238,121,000
2018-19 **	2	4,110	5.39	$2,953.09	$15,909.72	$196,253,200
2018-19 **	3	4,480	5.50	$2,928.15	$16,112.66	$216,424,000
2018-19 **	4	4,060	5.51	$2,904.61	$16,006.20	$195,026,600
2018-19 **	TOTAL	4,440	5.46	$2,904.61	$15,872.24	$845,824,700

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

Community Inpatient Fee-for-Service Base Estimate

Analyst: Beverly Yokoi

Background: Community Inpatient provides acute inpatient services rendered by community-based hospitals. This service category consists of private hospitals, Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).

Fiscal Year		Users		Utilization (Days per User)		Rate (Cost per Day)		Total Expenditure	
PY	FY 2016-17	32,250	--	4.66	--	$2,245.26	--	$4,045,885,600	--
CY	FY 2017-18	29,700	-7.9%	4.90	5.2%	$2,347.90	4.6%	$4,100,902,500	1.4%
BY	FY 2018-19	29,310	-1.3%	5.05	3.1%	$2,448.78	4.3%	$4,352,502,700	6.1%

Users: The estimated User decrease of 7.9% in CY correlates to changes in Caseload, combined with the Coordinated Care Initiative (CCI) enrollment shifting Seniors and Persons with Disabilities (SPDs) beneficiaries from Fee-For-Service (FFS) to Managed Care delivery system. Users are projected to remain relatively stable in BY.

Utilization: Utilization is estimated to increase by 5.2% in CY and 3.1% in BY.

Rate: Rate is estimated to increase in CY and BY, following historical growth trends experienced in this service category.

Total Expenditure: Total expenditures are estimated to increase by 1.4% in CY and 6.1% in BY, due to higher Utilization and Rates, partially offset by lower Users.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	N17	M18	% Chng
FY 2017-18	$4,185,741,600	$4,100,902,500	-2.0%
FY 2018-19	$4,383,029,500	$4,352,502,700	-0.7%

Compared to the November 2017 Estimate, the May 2018 Estimate is lower by 2.0% and 0.7%, respectively, for FY 2017-18 and FY 2018-19. The decreases are primarily due to the changes in caseload, combined with the CCI enrollment.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2018 BASE ESTIMATES)

COMMUNITY INPATIENT

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2015-16 *	1	41,670	4.81	$2,049.12	$9,856.47	$1,232,087,800
2015-16 *	2	36,100	4.73	$2,070.45	$9,790.17	$1,060,421,900
2015-16 *	3	31,600	4.65	$2,119.80	$9,848.83	$933,688,500
2015-16 *	4	33,450	4.54	$2,158.83	$9,799.68	$983,309,900
2015-16 *	TOTAL	35,710	4.69	$2,094.92	$9,824.72	$4,209,508,000
2016-17 *	1	38,140	4.70	$2,199.71	$10,331.18	$1,182,207,600
2016-17 *	2	31,440	4.66	$2,232.91	$10,411.74	$981,941,500
2016-17 *	3	32,970	4.78	$2,233.86	$10,686.04	$1,056,806,400
2016-17 *	4	26,450	4.43	$2,345.62	$10,395.70	$824,930,100
2016-17 *	TOTAL	32,250	4.66	$2,245.26	$10,454.73	$4,045,885,600
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	28,920	4.94	$2,358.51	$11,645.06	$1,010,183,100
2017-18 **	4	25,520	4.92	$2,412.96	$11,873.64	$908,919,800
2017-18 **	TOTAL	29,700	4.90	$2,347.90	$11,505.29	$4,100,902,500
2018-19 **	1	33,570	5.10	$2,423.34	$12,352.95	$1,244,031,000
2018-19 **	2	28,180	5.07	$2,444.84	$12,403.59	$1,048,774,500
2018-19 **	3	29,980	5.05	$2,447.16	$12,365.43	$1,112,137,600
2018-19 **	4	25,510	4.97	$2,489.48	$12,380.86	$947,559,600
2018-19 **	TOTAL	29,310	5.05	$2,448.78	$12,374.39	$4,352,502,700

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

Nursing Facilities Fee-for-Service Base Estimate

Analyst: Devon Dyer

Background: Nursing Facilities consists of Nursing Facilities A, Freestanding Nursing Facilities B (AB 1629), Distinct Part Nursing Facilities B, Adult Subacute, Pediatric Subacute, and Rural Swing Beds.

Fiscal Year		Users		Utilization (Days per User)		Rate (Cost per Day)		Total Expenditure	
PY	FY 2016-17	31,870	--	32.61	--	$216.43	--	$2,699,223,400	--
CY	FY 2017-18	28,840	-9.5%	32.43	-0.6%	$226.81	4.8%	$2,545,660,200	-5.7%
BY	FY 2018-19	28,640	-0.7%	32.74	1.0%	$225.85	-0.4%	$2,540,724,600	-0.2%

Users: Users are projected to decrease in CY from PY due to the Coordinated Care Initiative (CCI) enrollment shifting Seniors and Persons with Disabilities (SPDs) beneficiaries from Fee-For-Service (FFS) to Managed Care delivery system. Users are projected to remain relatively unchanged in BY from CY.

Utilization: Utilization is projected to remain relatively unchanged from FY 2016-17 through FY 2018-19.

Rate: The Rate is estimated to increase in CY due to the full incorporation of final 2016-17 rates and the partial incorporation of final 2017-18 rates. These increases were previously budgeted in AB 1629 Annual Rate Adjustment and LTC Rate Adjustment Policy Changes. The Rate is projected to remain relatively unchanged in BY as Policy Changes are utilized to incorporate all future rate increases into the Estimate.

Total Expenditure: Total expenditures are estimated to decrease by 5.7% in CY, due to the CCI shift of eligibles from FFS to the Managed Care delivery system, partially offset by an increase in Rates and retroactive payments for FY 2016-17 rates in CY. Projected total expenditures remain relatively unchanged in BY as policy changes incorporate future rate increases and anticipated retroactive payments into the Estimate.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	N17	M18	% Chng
FY 2017-18	$2,387,305,100	$2,545,660,200	6.6%
FY 2018-19	$2,395,476,000	$2,540,724,600	6.1%

Compared to the November 2017 Estimate, the May 2018 Estimate is higher by 6.6% and 6.1%, respectively, for FY 2017-18 and FY 2018-19. The increases are due to higher Users, the full incorporation of final 2016-17 rates, and the partial incorporation of final 2017-18 rates, and retroactive payments for FY 2016-17 rates in FY 2017-18.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2018 BASE ESTIMATES)

NURSING FACILITIES

YEAR	QUARTER	AVERAGE MONTHLY USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2015-16 *	1	35,030	35.52	$204.27	$7,255.93	$762,438,600
2015-16 *	2	33,010	33.37	$202.05	$6,742.32	$667,624,300
2015-16 *	3	31,270	29.71	$204.28	$6,069.61	$569,432,300
2015-16 *	4	31,340	31.61	$203.34	$6,428.39	$604,404,100
2015-16 *	TOTAL	32,660	32.65	$203.48	$6,643.68	$2,603,899,300
2016-17 *	1	34,840	36.25	$209.59	$7,597.23	$794,077,400
2016-17 *	2	33,520	32.22	$207.12	$6,673.61	$671,151,100
2016-17 *	3	31,940	32.63	$233.99	$7,635.67	$731,550,300
2016-17 *	4	27,190	28.39	$216.95	$6,158.99	$502,444,600
2016-17 *	TOTAL	31,870	32.61	$216.43	$7,057.24	$2,699,223,400
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	28,780	32.27	$224.73	$7,251.81	$626,157,800
2017-18 **	4	26,750	28.94	$225.71	$6,532.47	$524,248,600
2017-18 **	TOTAL	28,840	32.43	$226.81	$7,355.79	$2,545,660,200
2018-19 **	1	30,260	36.17	$228.93	$8,281.42	$751,824,800
2018-19 **	2	28,590	32.15	$223.25	$7,177.91	$615,722,000
2018-19 **	3	28,930	32.62	$224.74	$7,330.62	$636,164,600
2018-19 **	4	26,760	29.60	$225.95	$6,688.90	$537,013,200
2018-19 **	TOTAL	28,640	32.74	$225.85	$7,393.76	$2,540,724,600

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

ICF-DD Fee-for-Service Base Estimate

Analyst: Toni Richardson

Background: Intermediate Care Facilities/Developmentally Disabled (ICF/DD) are health facilities that provide 24-hour personal care, habilitation, developmental, and supportive health services and skilled nursing services for those with intermittent needs.

Fiscal Year		Users		Utilization (Days per User)		Rate (Costs per Day)		Total Expenditure	
PY	FY 2016-17	4,940	--	31.85	--	$205.45	--	$388,164,700	--
CY	FY 2017-18	4,850	-1.8%	31.57	-0.9%	$209.55	2.0%	$385,079,100	-0.8%
BY	FY 2018-19	4,860	0.2%	31.67	0.3%	$209.78	0.1%	$387,560,000	0.6%

Users: Users are estimated to decrease from PY to CY by 1.8% and remain fairly level in BY.

Utilization: Utilization is estimated to remain relatively unchanged in CY and BY from PY.

Rate: Rates are estimated to increase by 2.0% from PY to CY, due to PY incorporates a partial year impact of the FY 2016-17 ICF/DD rate increase, implemented September 2016, while CY incorporates a full year impact of this rate increase. In addition, CY includes partial impact of the FY 2017-18 ICF/DD rate update, implemented in January 2018. FY 2017-18 and FY 2018-19 ICF/DD rate increases are budgeted in the LTC Rate Adjustment policy change. BY is projected at levels consistent with CY.

Total Expenditure: Total expenditures remain relatively unchanged in CY and BY from PY.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditures		
	N17	M18	% Chng
FY 2017-18	$393,177,000	$385,079,100	-2.1%
FY 2018-19	$396,893,200	$387,560,000	-2.4%

Compared to the November 2017 Estimate, the May 2018 Estimate is lower by 2.1% and 2.4%, respectively, for FY 2017-18 and FY 2018-19 due to lower Users.

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2018 BASE ESTIMATES)

ICF-DD

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2015-16 *	1	5,170	37.70	$181.40	$6,839.47	$106,155,400
2015-16 *	2	5,100	34.13	$189.55	$6,469.25	$98,882,400
2015-16 *	3	5,080	28.96	$190.88	$5,528.37	$84,186,000
2015-16 *	4	4,900	29.37	$203.50	$5,976.33	$87,917,700
2015-16 *	TOTAL	5,060	32.59	$190.48	$6,208.60	$377,141,600
2016-17 *	1	5,060	36.77	$194.14	$7,137.89	$108,424,500
2016-17 *	2	4,970	31.46	$211.91	$6,666.82	$99,495,700
2016-17 *	3	4,940	32.08	$208.57	$6,691.68	$99,271,100
2016-17 *	4	4,790	26.82	$210.13	$5,635.68	$80,973,400
2016-17 *	TOTAL	4,940	31.85	$205.45	$6,543.90	$388,164,700
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	4,830	31.60	$209.11	$6,607.72	$95,791,700
2017-18 **	4	4,710	26.81	$210.45	$5,641.27	$79,695,400
2017-18 **	TOTAL	4,850	31.57	$209.55	$6,616.23	$385,079,100
2018-19 **	1	4,940	36.54	$209.56	$7,657.15	$113,456,100
2018-19 **	2	4,890	31.39	$210.26	$6,601.03	$96,750,100
2018-19 **	3	4,880	31.50	$209.33	$6,593.61	$96,509,300
2018-19 **	4	4,740	27.07	$210.07	$5,686.45	$80,844,400
2018-19 **	TOTAL	4,860	31.67	$209.78	$6,644.53	$387,560,000

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

Medical Transportation Fee-for-Service Base Estimate

Analyst: Felicia Oropeza

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

Fiscal Year		Users		Utilization (Claims per User)		Rate (Cost per Claim)		Total Expenditure	
PY	FY 2016-17	22,390	--	3.18	--	$79.18	--	$67,589,800	--
CY	FY 2017-18	24,880	11.1%	2.97	-6.6%	$78.45	-0.9%	$69,463,100	2.8%
BY	FY 2018-19	21,360	-14.1%	3.11	4.7%	$82.70	5.4%	$65,961,200	-5.0%

Users: Users are estimated to increase by 11.1% in CY, due to the unusually high Users in CY, related to the Healthcare Common Procedure Coding System (HCPCS) code conversion for Medical Transportation in July 2016. The CY unusually high Users is assumed related to reprocessing of denied claims due to billing requirement changes of the new HCPCS codes. BY is projected to return to a normalized User level for Families and Children and ACA Optional populations.

Utilization: Utilization is estimated to decrease by 6.6% in CY, due to the unusually low Utilization in CY, related to the HCPCS code conversion. BY is projected to return to a normalized utilization level.

Rate: Rate is estimated to remain fairly level in CY, as both PY and CY Rates reflect a lower Rate level due to the HCPCS code conversion. BY is projected to return to a normalized level.

Total Expenditure: Total expenditures are estimated to increase by 2.8%, or $1.9 million in CY and decrease by 5% or $3.5 million in BY. The CY increase mainly due to unusually high expenditures related to reprocessing of denied claims in CY. While the code conversion is not expected to have an impact of the overall cost of services, the new codes can cause temporary changes affecting the components for estimating. Overall, as calculated for estimating purposes, CY Users increased, and CY Utilization and Rate decreased attributed to the code conversion related to billing requirement changes for the new HCPCS codes. The CY changes between Users, Utilization, and Rate are assumed to be partially offsetting. BY is projected to return to a normalized expenditure level for the populations.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	N17	M18	% Chng
FY 2017-18	$65,880,900	$69,463,100	5.4%
FY 2018-19	$65,392,600	$65,961,200	0.9%

Compared to the November 2017 Estimate, the May 2018 Estimate is higher by 5.4% or $3.6 million for FY 2017-18, due to unusually high expenditures discussed above. The current estimate is fairly consistent with prior estimate for FY 2018-19, as the HCPCS code conversion is not expected to have an impact on the overall expenditure level.

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OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2018 BASE ESTIMATES)

MEDICAL TRANSPORTATION

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2015-16 *	1	30,360	2.87	$96.60	$276.99	$25,231,200
2015-16 *	2	25,960	2.87	$99.99	$286.48	$22,313,300
2015-16 *	3	22,650	2.72	$98.34	$267.64	$18,184,200
2015-16 *	4	22,900	2.73	$97.94	$267.44	$18,371,300
2015-16 *	TOTAL	25,470	2.80	$98.15	$275.18	$84,099,900
2016-17 *	1	25,120	3.07	$88.25	$270.95	$20,418,600
2016-17 *	2	23,060	3.22	$77.34	$248.90	$17,222,700
2016-17 *	3	22,020	3.34	$76.06	$253.79	$16,762,400
2016-17 *	4	19,380	3.08	$73.62	$226.82	$13,186,000
2016-17 *	TOTAL	22,390	3.18	$79.18	$251.51	$67,589,800
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	24,600	3.05	$78.01	$237.97	$17,563,800
2017-18 **	4	17,820	3.01	$81.75	$246.01	$13,152,500
2017-18 **	TOTAL	24,880	2.97	$78.45	$232.68	$69,463,100
2018-19 **	1	24,450	3.06	$83.75	$256.15	$18,787,100
2018-19 **	2	21,610	3.06	$84.97	$260.22	$16,867,600
2018-19 **	3	21,560	3.25	$79.90	$259.98	$16,813,500
2018-19 **	4	17,820	3.08	$82.09	$252.44	$13,492,900
2018-19 **	TOTAL	21,360	3.11	$82.70	$257.38	$65,961,200

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

Other Services Fee-for-Service Base Estimate

Analyst: Alvin Bautista

Background: Other Services includes Provider Types not included in other FFS service categories. Local Education Agency (LEA), Certified Hospice Services, Assistive Devices, and waiver services account for the majority of expenditures in this service category. A complete list of provider types can be found in the Information Only Section.

Fiscal Year		Users		Utilization (Claims per User)		Rate (Cost per Claim)		Total Expenditure	
PY	FY 2016-17	193,780	--	3.08	--	$92.03	--	$659,915,000	--
CY	FY 2017-18	198,180	2.3%	3.11	1.0%	$94.37	2.5%	$712,121,100*	7.9%
BY	FY 2018-19	203,540	2.7%	3.11	0.0%	$96.45	2.2%	$732,362,600	2.8%

* Includes an adjustment of $14.0 million.

Users: Users for LEA services were lower than average for several months in PY and CY, due to the Healthcare Common Procedure Coding System (HCPCS) code conversion for some LEA services. Estimated Users are expected to continue at the normalized levels for BY.

Utilization: PY Utilization was also affected by LEA services code conversion, with slightly lower claims per user for several months in PY. CY and BY are projected to return to the normalized level.

Rate: Rate is estimated to increase in CY and BY. Rate was affected by LEA services code conversion, with slightly lower cost per user for several months in PY and CY. BY are projected to return to the normalized level for LEA services.

Total Expenditure: Total expenditure is estimated to return to the normalized patterns for LEA services from the few unusually low months occurred in PY and CY.

Reason for Change from Prior Estimate:

Fiscal Year	Total Expenditure		
	N17	M18	% Chng
FY 2017-18	$687,660,600	$712,121,100*	3.6%
FY 2018-19	$686,754,800	$732,362,600	6.6%

* Includes an adjustment of $14.0 million.

Compared to the November 2017 Estimate, the May 2018 Estimate is higher by 3.6% and 6.6%, respectively, for FY 2017-18 and FY 2018-19.

Notes:

FFS Other Services Base FY 2017-18 data includes a one-time adjustment of -$14.0 million related to the Durable Medical Equipment/Medical Supplies (DME) recoupment of the 10% Provider Payment Reduction, thus reducing the CY expenditures reflected on the previous page. An adjustment of $14.0 million is added to CY Total expenditures above as noted, as this amount is recouped through the Accounts Receivable process.

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FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2018 BASE ESTIMATES)

OTHER SERVICES

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2015-16 *	1	192,780	3.81	$88.27	$336.45	$194,580,400
2015-16 *	2	199,850	2.99	$89.98	$269.23	$161,417,400
2015-16 *	3	199,610	2.89	$91.07	$263.07	$157,535,300
2015-16 *	4	207,070	3.35	$77.77	$260.19	$161,632,000
2015-16 *	TOTAL	199,830	3.26	$86.49	$281.56	$675,165,000
2016-17 *	1	204,600	3.29	$91.20	$299.94	$184,097,800
2016-17 *	2	185,410	2.47	$116.89	$288.56	$160,505,200
2016-17 *	3	188,970	3.47	$85.81	$297.39	$168,598,400
2016-17 *	4	196,140	3.08	$80.88	$249.34	$146,713,600
2016-17 *	TOTAL	193,780	3.08	$92.03	$283.79	$659,915,000
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	207,780	2.89	$98.02	$283.34	$176,617,900
2017-18 **	4	198,840	3.17	$85.13	$270.06	$161,095,800
2017-18 **	TOTAL	198,180	3.11	$94.37	$293.55	$698,114,100
2018-19 **	1	199,530	3.36	$101.83	$342.43	$204,971,300
2018-19 **	2	199,250	2.95	$100.67	$296.70	$177,349,900
2018-19 **	3	216,840	2.94	$96.67	$284.25	$184,908,100
2018-19 **	4	198,550	3.20	$86.67	$277.23	$165,133,300
2018-19 **	TOTAL	203,540	3.11	$96.45	$299.84	$732,362,600

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

Home Health Fee-for-Service Base Estimate

Analyst: Felicia Oropeza

Background: Home Health provides services to assist in supporting a beneficiary in his/her home as an alternative to care in a licensed health care facility. Home Health services require a written treatment plan approved by a physician.

Fiscal Year		Users		Utilization (Claims per User)		Rate (Cost per Claim)		Total Expenditure	
PY	FY 2016-17	4,330	--	3.41	--	$1,219.92	--	$216,232,600	--
CY	FY 2017-18	4,220	-2.5%	4.21	23.5%	$969.41	-20.5%	$206,762,700	-4.4%
BY	FY-2018-19	4,140	-1.9%	3.42	-18.8%	$1,205.64	24.4%	$204,735,200	-1.0%

Users: Users are estimated to decrease by 2.5% in CY and by 1.9% in BY.

Utilization: Utilization is estimated to increase by 23.5% in CY, due to the Healthcare Common Procedure Coding System (HCPCS) code conversion for Home Health Agencies (HHA) claims. Methodology appears to have changed on how claims are counted. BY is projected to return to a normalized utilization level. The unusually high Utilization in CY nearly offset the unusually low Rate in CY, as the code conversion is not expected to have an impact on the expenditure level.

Rate: Rate is estimated to decrease by 20.5% in CY, due to the unusually low Rate in CY, coincide with the HCPCS code conversion for HHA claims. BY is projected to return to a normalized utilization level. The unusually high Utilization in CY nearly offset the unusually low Rate in CY.

Total Expenditure: Total expenditure is estimated to decrease by 4.4% or $9 million in CY, and decrease by 1% or 2 million in BY, mainly due to the estimated lower User level.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	N17	M18	% Chng
FY 2017-18	$221,424,600	$206,762,700	-6.6%
FY 2018-19	$222,206,700	$204,735,200	-7.9%

Compared to the November 2017 Estimate, the May 2018 Estimate is lower by 6.6% and 7.9%, respectively, for FY 2017-18 and FY 2018-19. These changes are primarily due to a lower Seniors and Persons with Disabilities (SPDs) caseload changes.

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FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2018 BASE ESTIMATES)

HOME HEALTH

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2015-16 *	1	5,320	3.45	$1,278.48	$4,412.89	$70,376,700
2015-16 *	2	5,320	3.28	$1,202.92	$3,939.96	$62,933,000
2015-16 *	3	5,120	2.92	$1,223.01	$3,569.60	$54,843,400
2015-16 *	4	4,890	3.04	$1,218.45	$3,701.61	$54,321,100
2015-16 *	TOTAL	5,160	3.18	$1,232.15	$3,913.40	$242,474,100
2016-17 *	1	4,640	3.67	$1,243.75	$4,559.59	$63,478,600
2016-17 *	2	4,230	3.48	$1,252.62	$4,358.35	$55,368,400
2016-17 *	3	4,270	3.34	$1,235.80	$4,126.26	$52,894,600
2016-17 *	4	4,180	3.13	$1,134.71	$3,550.19	$44,491,000
2016-17 *	TOTAL	4,330	3.41	$1,219.92	$4,160.16	$216,232,600
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	4,460	3.83	$1,017.52	$3,892.42	$52,071,900
2017-18 **	4	3,930	3.10	$1,197.98	$3,709.03	$43,728,600
2017-18 **	TOTAL	4,220	4.21	$969.41	$4,078.28	$206,762,700
2018-19 **	1	4,340	3.66	$1,215.15	$4,451.69	$58,027,100
2018-19 **	2	4,040	3.43	$1,203.96	$4,132.11	$50,133,600
2018-19 **	3	4,240	3.36	$1,203.23	$4,040.44	$51,405,300
2018-19 **	4	3,930	3.20	$1,198.19	$3,831.21	$45,169,100
2018-19 **	TOTAL	4,140	3.42	$1,205.64	$4,121.08	$204,735,200

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND MAY 2018 BASE ESTIMATES)

PA-OAS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2015-16 *	1	73,640	4.02	$154.60	$621.01	$137,201,400
2015-16 *	2	64,510	3.87	$142.51	$551.16	$106,667,700
2015-16 *	3	83,510	4.37	$101.25	$442.38	$110,826,300
2015-16 *	4	81,180	3.92	$110.92	$434.46	$105,802,700
2015-16 *	TOTAL	75,710	4.06	$124.99	$506.87	$460,498,000
2016-17 *	1	67,560	4.09	$155.63	$635.94	$128,884,500
2016-17 *	2	63,180	3.73	$151.20	$564.33	$106,971,000
2016-17 *	3	64,940	3.66	$157.88	$578.35	$112,675,800
2016-17 *	4	58,380	3.25	$156.03	$507.72	$88,924,300
2016-17 *	TOTAL	63,520	3.70	$155.17	$573.95	$437,455,600
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	63,180	3.63	$156.83	$568.80	$107,809,500
2017-18 **	4	59,350	3.15	$163.02	$513.98	$91,515,200
2017-18 **	TOTAL	62,120	3.56	$162.74	$578.94	$431,548,200
2018-19 **	1	67,210	3.60	$174.86	$629.35	$126,903,100
2018-19 **	2	60,380	3.38	$170.05	$574.14	$104,005,100
2018-19 **	3	63,460	3.57	$160.76	$574.29	$109,331,300
2018-19 **	4	59,100	3.23	$164.95	$532.13	$94,338,900
2018-19 **	TOTAL	62,540	3.45	$167.83	$579.09	$434,578,400

* 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 2018 BASE ESTIMATES)

NEWLY

YEAR	QUARTER	AVERAGE MONTHLY USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2015-16 *	1	412,420	2.66	$282.41	$749.84	$927,755,300
2015-16 *	2	409,330	2.50	$281.96	$705.33	$866,130,400
2015-16 *	3	384,960	2.37	$285.40	$677.41	$782,313,100
2015-16 *	4	401,440	2.41	$291.08	$702.88	$846,502,200
2015-16 *	TOTAL	402,040	2.49	$285.08	$709.45	$3,422,701,000
2016-17 *	1	458,710	2.60	$276.81	$720.55	$991,562,900
2016-17 *	2	434,680	2.46	$279.09	$687.72	$896,810,400
2016-17 *	3	442,670	2.49	$293.56	$729.61	$968,916,900
2016-17 *	4	416,440	2.34	$291.22	$680.43	$850,073,100
2016-17 *	TOTAL	438,120	2.48	$284.85	$705.16	$3,707,363,300
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	459,640	2.44	$298.07	$728.27	$1,004,228,700
2017-18 **	4	447,570	2.33	$300.67	$701.39	$941,762,000
2017-18 **	TOTAL	466,930	2.47	$293.02	$723.73	$4,055,202,100
2018-19 **	1	538,530	2.60	$296.61	$771.54	$1,246,487,900
2018-19 **	2	500,180	2.45	$296.16	$726.63	$1,090,347,500
2018-19 **	3	475,100	2.39	$311.98	$747.18	$1,064,963,900
2018-19 **	4	446,770	2.35	$309.56	$728.04	$975,805,700
2018-19 **	TOTAL	490,150	2.46	$302.95	$744.27	$4,377,604,900

* 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 2018 BASE ESTIMATES)

PA-ATD

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2015-16 *	1	290,110	5.47	$249.87	$1,367.60	$1,190,281,500
2015-16 *	2	281,070	4.93	$254.48	$1,253.70	$1,057,138,400
2015-16 *	3	285,880	4.72	$235.13	$1,108.93	$951,056,300
2015-16 *	4	284,330	4.76	$224.51	$1,068.21	$911,174,800
2015-16 *	TOTAL	285,350	4.97	$241.45	$1,200.18	$4,109,651,000
2016-17 *	1	279,590	5.14	$242.14	$1,245.62	$1,044,783,700
2016-17 *	2	263,540	4.35	$257.29	$1,119.72	$885,264,100
2016-17 *	3	264,570	4.57	$254.18	$1,160.83	$921,353,800
2016-17 *	4	248,490	4.06	$258.62	$1,049.03	$782,024,300
2016-17 *	TOTAL	264,050	4.55	$252.25	$1,146.71	$3,633,426,000
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	269,610	4.23	$271.67	$1,150.09	$930,213,700
2017-18 **	4	259,740	3.89	$267.57	$1,041.13	$811,270,800
2017-18 **	TOTAL	265,260	4.33	$268.07	$1,159.85	$3,691,967,000
2018-19 **	1	285,770	4.60	$281.94	$1,297.75	$1,112,585,200
2018-19 **	2	269,220	4.10	$278.91	$1,143.94	$923,932,100
2018-19 **	3	273,860	4.19	$280.55	$1,176.27	$966,396,100
2018-19 **	4	257,920	3.99	$277.60	$1,107.16	$856,683,100
2018-19 **	TOTAL	271,700	4.23	$279.90	$1,183.80	$3,859,596,600

* 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 2018 BASE ESTIMATES)

PA-AFDC

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2015-16 *	1	184,810	2.45	$174.77	$428.15	$237,377,400
2015-16 *	2	185,930	2.33	$171.03	$398.63	$222,349,300
2015-16 *	3	171,780	2.26	$175.76	$397.44	$204,821,600
2015-16 *	4	169,860	2.33	$164.14	$382.72	$195,022,800
2015-16 *	TOTAL	178,090	2.35	$171.51	$402.21	$859,571,100
2016-17 *	1	169,940	2.38	$185.74	$442.00	$225,338,700
2016-17 *	2	160,190	2.12	$189.92	$403.33	$193,831,200
2016-17 *	3	158,630	2.28	$191.79	$436.66	$207,797,200
2016-17 *	4	145,830	2.15	$180.75	$388.35	$169,893,000
2016-17 *	TOTAL	158,650	2.24	$187.18	$418.57	$796,860,100
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	158,820	2.27	$196.30	$445.11	$212,077,600
2017-18 **	4	138,280	2.28	$186.49	$424.95	$176,288,200
2017-18 **	TOTAL	153,360	2.26	$195.90	$443.69	$816,542,200
2018-19 **	1	157,740	2.42	$210.70	$509.21	$240,969,000
2018-19 **	2	160,080	2.21	$206.01	$455.70	$218,842,500
2018-19 **	3	160,380	2.30	$201.69	$464.90	$223,678,400
2018-19 **	4	138,470	2.32	$192.94	$447.26	$185,803,600
2018-19 **	TOTAL	154,170	2.31	$203.20	$469.89	$869,293,500

* 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 2018 BASE ESTIMATES)

LT-OAS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2015-16 *	1	21,910	30.89	$178.34	$5,508.53	$362,059,300
2015-16 *	2	20,350	29.66	$173.16	$5,136.16	$313,573,100
2015-16 *	3	23,430	23.36	$171.89	$4,015.54	$282,284,600
2015-16 *	4	21,650	25.44	$178.16	$4,532.87	$294,450,700
2015-16 *	TOTAL	21,840	27.23	$175.50	$4,779.37	$1,252,367,700
2016-17 *	1	21,250	33.15	$183.31	$6,075.95	$387,354,000
2016-17 *	2	21,560	28.82	$185.27	$5,340.18	$345,328,200
2016-17 *	3	20,680	29.47	$205.53	$6,056.60	$375,708,900
2016-17 *	4	17,990	24.50	$190.65	$4,671.26	$252,070,500
2016-17 *	TOTAL	20,370	29.16	$190.88	$5,566.24	$1,360,461,600
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	18,640	28.68	$198.71	$5,699.26	$318,739,700
2017-18 **	4	17,120	25.83	$199.19	$5,144.62	$264,247,900
2017-18 **	TOTAL	18,430	28.98	$200.10	$5,798.77	$1,282,296,900
2018-19 **	1	18,890	32.66	$202.56	$6,616.07	$374,925,000
2018-19 **	2	18,230	28.91	$198.41	$5,736.09	$313,622,600
2018-19 **	3	18,740	29.05	$198.58	$5,768.45	$324,301,300
2018-19 **	4	17,120	26.38	$199.70	$5,267.47	$270,553,900
2018-19 **	TOTAL	18,240	29.32	$199.92	$5,862.24	$1,283,402,800

* 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 2018 BASE ESTIMATES)

H-PE

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2015-16 *	1	41,510	3.82	$306.35	$1,170.36	$145,742,900
2015-16 *	2	37,530	3.54	$246.77	$872.84	$98,260,400
2015-16 *	3	35,230	3.31	$249.74	$827.59	$87,470,500
2015-16 *	4	34,240	3.36	$254.72	$855.71	$87,898,700
2015-16 *	TOTAL	37,130	3.52	$267.24	$941.32	$419,372,500
2016-17 *	1	43,440	3.73	$251.58	$937.58	$122,193,400
2016-17 *	2	39,860	3.63	$241.90	$877.28	$104,900,300
2016-17 *	3	40,300	3.55	$263.45	$936.27	$113,203,000
2016-17 *	4	34,040	3.32	$229.98	$762.84	$77,891,700
2016-17 *	TOTAL	39,410	3.57	$247.78	$884.27	$418,188,400
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	42,800	3.40	$259.75	$882.49	$113,300,600
2017-18 **	4	36,810	3.23	$253.72	$818.98	$90,448,900
2017-18 **	TOTAL	41,630	3.43	$254.23	$872.87	$436,000,100
2018-19 **	1	45,430	3.54	$254.80	$903.22	$123,100,700
2018-19 **	2	40,090	3.49	$249.11	$868.46	$104,458,700
2018-19 **	3	41,980	3.43	$268.91	$922.57	$116,188,700
2018-19 **	4	36,750	3.27	$252.95	$826.54	$91,135,400
2018-19 **	TOTAL	41,060	3.44	$256.60	$882.53	$434,883,500

* 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 2018 BASE ESTIMATES)

LT-ATD

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2015-16 *	1	7,820	31.12	$198.60	$6,180.75	$145,074,600
2015-16 *	2	7,160	30.35	$197.47	$5,992.37	$128,710,000
2015-16 *	3	7,960	24.15	$192.53	$4,650.30	$111,109,600
2015-16 *	4	7,350	25.01	$199.16	$4,980.17	$109,867,600
2015-16 *	TOTAL	7,580	27.62	$197.04	$5,442.63	$494,761,900
2016-17 *	1	7,010	32.71	$206.19	$6,745.46	$141,944,700
2016-17 *	2	6,880	28.70	$211.00	$6,055.36	$125,043,300
2016-17 *	3	6,720	29.22	$224.84	$6,570.96	$132,542,800
2016-17 *	4	6,110	24.59	$213.07	$5,239.19	$96,076,200
2016-17 *	TOTAL	6,680	28.94	$213.49	$6,179.48	$495,606,900
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	5,940	28.38	$214.57	$6,089.74	$108,496,700
2017-18 **	4	5,550	24.83	$218.55	$5,426.14	$90,406,900
2017-18 **	TOTAL	5,960	28.17	$218.62	$6,157.38	$440,220,000
2018-19 **	1	6,020	31.89	$222.66	$7,101.32	$128,281,300
2018-19 **	2	5,720	28.36	$218.34	$6,191.77	$106,211,900
2018-19 **	3	5,890	28.62	$216.80	$6,203.75	$109,679,300
2018-19 **	4	5,540	25.32	$218.56	$5,534.16	$91,987,200
2018-19 **	TOTAL	5,790	28.62	$219.25	$6,273.93	$436,159,700

* 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 2018 BASE ESTIMATES)

POV 250

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2015-16 *	1	92,790	2.32	$166.01	$384.75	$107,097,800
2015-16 *	2	94,130	2.15	$169.54	$364.24	$102,860,200
2015-16 *	3	89,690	2.07	$181.26	$374.95	$100,891,000
2015-16 *	4	93,870	2.24	$168.94	$377.67	$106,351,800
2015-16 *	TOTAL	92,620	2.19	$171.13	$375.37	$417,200,800
2016-17 *	1	100,620	2.24	$187.70	$419.50	$126,631,400
2016-17 *	2	96,130	1.96	$203.56	$398.45	$114,907,800
2016-17 *	3	96,250	2.27	$178.48	$405.41	$117,065,300
2016-17 *	4	91,670	2.15	$172.51	$371.51	$102,171,000
2016-17 *	TOTAL	96,170	2.16	$185.25	$399.28	$460,775,600
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	104,810	2.13	$194.58	$415.07	$130,513,300
2017-18 **	4	97,500	2.18	$179.71	$391.04	$114,383,600
2017-18 **	TOTAL	102,030	2.16	$193.12	$417.74	$511,471,800
2018-19 **	1	107,580	2.23	$206.31	$460.42	$148,601,100
2018-19 **	2	101,580	2.12	$200.44	$425.77	$129,744,200
2018-19 **	3	104,560	2.19	$193.89	$424.84	$133,264,900
2018-19 **	4	97,500	2.21	$182.58	$403.09	$117,909,300
2018-19 **	TOTAL	102,810	2.19	$196.07	$429.22	$529,519,500

* 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 2018 BASE ESTIMATES)

MN-OAS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2015-16 *	1	72,900	4.93	$180.18	$888.05	$194,212,500
2015-16 *	2	69,390	4.66	$170.24	$793.18	$165,115,600
2015-16 *	3	76,160	4.56	$148.84	$678.19	$154,952,800
2015-16 *	4	77,890	4.38	$156.03	$683.02	$159,592,800
2015-16 *	TOTAL	74,080	4.63	$163.89	$758.01	$673,873,700
2016-17 *	1	78,290	4.67	$181.35	$847.22	$198,980,600
2016-17 *	2	72,860	4.16	$178.32	$742.18	$162,216,000
2016-17 *	3	73,400	4.05	$189.91	$768.58	$169,251,200
2016-17 *	4	68,780	3.69	$186.47	$687.76	$141,901,400
2016-17 *	TOTAL	73,330	4.16	$183.75	$764.06	$672,349,200
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	75,850	3.79	$191.60	$727.00	$165,425,300
2017-18 **	4	73,580	3.43	$193.71	$664.69	$146,726,400
2017-18 **	TOTAL	76,090	3.81	$191.78	$730.07	$666,609,900
2018-19 **	1	85,300	3.95	$199.00	$785.28	$200,958,700
2018-19 **	2	78,140	3.66	$192.90	$706.54	$165,625,400
2018-19 **	3	79,240	3.74	$192.37	$718.75	$170,870,200
2018-19 **	4	75,640	3.49	$192.11	$670.97	$152,265,300
2018-19 **	TOTAL	79,580	3.72	$194.33	$722.23	$689,719,600

* 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 2018 BASE ESTIMATES)

MN-ATD

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2015-16 *	1	49,320	5.39	$210.52	$1,134.26	$167,826,300
2015-16 *	2	45,500	4.75	$206.14	$978.22	$133,540,300
2015-16 *	3	48,480	4.70	$179.19	$842.13	$122,471,400
2015-16 *	4	47,530	4.73	$168.73	$798.09	$113,797,200
2015-16 *	TOTAL	47,710	4.90	$191.81	$939.11	$537,635,100
2016-17 *	1	44,540	4.99	$198.44	$989.56	$132,220,800
2016-17 *	2	41,240	4.19	$197.50	$828.28	$102,485,100
2016-17 *	3	41,260	4.46	$186.58	$831.94	$102,970,600
2016-17 *	4	37,800	4.04	$175.50	$708.58	$80,345,600
2016-17 *	TOTAL	41,210	4.44	$190.45	$845.33	$418,022,100
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	40,250	4.04	$183.94	$743.48	$89,782,900
2017-18 **	4	39,220	3.80	$173.89	$660.02	$77,652,000
2017-18 **	TOTAL	40,000	4.17	$179.20	$747.18	$358,647,900
2018-19 **	1	43,080	4.37	$191.00	$834.19	$107,815,500
2018-19 **	2	39,050	3.96	$183.21	$725.76	$85,024,000
2018-19 **	3	40,280	3.99	$187.28	$747.35	$90,301,500
2018-19 **	4	38,550	3.89	$177.70	$691.21	$79,942,900
2018-19 **	TOTAL	40,240	4.06	$185.19	$751.91	$363,083,900

* 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 2018 BASE ESTIMATES)

MN-AFDC

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2015-16 *	1	478,050	2.77	$189.49	$525.54	$753,704,400
2015-16 *	2	465,770	2.61	$186.29	$485.37	$678,202,200
2015-16 *	3	425,260	2.49	$190.35	$474.33	$605,146,300
2015-16 *	4	437,640	2.56	$179.75	$460.43	$604,503,700
2015-16 *	TOTAL	451,680	2.61	$186.55	$487.36	$2,641,556,600
2016-17 *	1	464,540	2.62	$189.42	$496.66	$692,158,400
2016-17 *	2	426,370	2.35	$198.82	$466.85	$597,152,600
2016-17 *	3	414,020	2.44	$192.98	$471.00	$585,001,700
2016-17 *	4	391,410	2.28	$182.65	$416.86	$489,496,800
2016-17 *	TOTAL	424,090	2.43	$191.11	$464.49	$2,363,809,500
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	422,040	2.32	$199.22	$462.02	$584,976,200
2017-18 **	4	387,420	2.15	$194.16	$417.48	$485,219,100
2017-18 **	TOTAL	419,550	2.34	$199.48	$467.39	$2,353,111,500
2018-19 **	1	450,740	2.43	$208.64	$507.56	$686,338,100
2018-19 **	2	418,010	2.35	$203.41	$478.82	$600,446,800
2018-19 **	3	416,580	2.32	$202.82	$470.34	$587,807,200
2018-19 **	4	386,910	2.19	$195.43	$428.17	$496,981,000
2018-19 **	TOTAL	418,060	2.33	$203.00	$472.74	$2,371,573,200

* 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 2018 BASE ESTIMATES)

MI-C

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2015-16 *	1	80,500	2.65	$156.59	$415.56	$100,363,200
2015-16 *	2	73,170	2.38	$159.16	$379.50	$83,307,300
2015-16 *	3	61,110	2.68	$154.63	$414.00	$75,903,800
2015-16 *	4	57,560	2.74	$137.63	$376.79	$65,064,100
2015-16 *	TOTAL	68,090	2.60	$152.56	$397.33	$324,638,300
2016-17 *	1	64,200	2.79	$149.93	$418.82	$80,670,600
2016-17 *	2	61,080	2.61	$150.78	$392.96	$72,008,800
2016-17 *	3	56,780	2.75	$153.12	$420.55	$71,631,200
2016-17 *	4	48,960	2.59	$157.54	$407.37	$59,829,400
2016-17 *	TOTAL	57,750	2.69	$152.50	$409.98	$284,140,000
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	55,540	2.70	$165.70	$447.82	$74,616,000
2017-18 **	4	48,380	2.59	$160.00	$414.79	$60,198,300
2017-18 **	TOTAL	55,720	2.66	$156.97	$417.72	$279,312,800
2018-19 **	1	59,410	2.74	$167.04	$457.51	$81,541,200
2018-19 **	2	56,900	2.58	$158.37	$409.12	$69,842,500
2018-19 **	3	54,580	2.73	$174.54	$475.97	$77,941,200
2018-19 **	4	48,180	2.64	$165.81	$438.33	$63,352,300
2018-19 **	TOTAL	54,770	2.67	$166.50	$445.32	$292,677,200

* 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 2018 BASE ESTIMATES)

MI-A

YEAR	QUARTER	AVERAGE MONTHLY USERS	AVERAGE MONTHLY UNIT PER USER	AVERAGE MONTHLY COST PER UNIT	AVERAGE MONTHLY COST PER USER	TOTAL COST
2015-16 *	1	490	19.44	$212.09	$4,122.86	$6,060,600
2015-16 *	2	440	20.89	$237.84	$4,968.60	$6,558,600
2015-16 *	3	420	22.43	$227.09	$5,094.46	$6,454,700
2015-16 *	4	440	23.57	$218.76	$5,155.40	$6,738,100
2015-16 *	TOTAL	450	21.51	$223.72	$4,812.07	$25,811,900
2016-17 *	1	470	26.15	$198.06	$5,179.71	$7,303,400
2016-17 *	2	490	23.26	$208.47	$4,848.17	$7,170,400
2016-17 *	3	460	20.75	$228.13	$4,733.51	$6,518,000
2016-17 *	4	420	21.50	$196.85	$4,231.95	$5,294,200
2016-17 *	TOTAL	460	22.97	$207.41	$4,764.56	$26,286,100
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	1,910	8.56	$178.38	$1,526.76	$8,765,800
2017-18 **	4	1,890	7.19	$184.56	$1,326.77	$7,540,600
2017-18 **	TOTAL	1,400	9.89	$189.22	$1,871.72	$31,530,700
2018-19 **	1	1,930	9.64	$181.73	$1,751.95	$10,163,300
2018-19 **	2	1,930	8.86	$176.93	$1,567.46	$9,092,400
2018-19 **	3	1,920	8.68	$180.34	$1,565.14	$8,999,400
2018-19 **	4	1,890	7.26	$186.48	$1,354.56	$7,698,600
2018-19 **	TOTAL	1,920	8.62	$181.13	$1,560.81	$35,953,800

* 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 2018 BASE ESTIMATES)

REFUGEE

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2015-16 *	1	420	2.63	$122.73	$323.21	$406,600
2015-16 *	2	550	2.89	$147.95	$428.13	$709,400
2015-16 *	3	420	2.70	$160.31	$433.50	$551,000
2015-16 *	4	470	2.54	$101.12	$257.28	$366,400
2015-16 *	TOTAL	470	2.70	$134.05	$362.45	$2,033,300
2016-17 *	1	510	2.83	$136.40	$386.60	$589,900
2016-17 *	2	550	2.72	$129.62	$352.16	$582,100
2016-17 *	3	610	2.39	$140.26	$335.43	$610,800
2016-17 *	4	520	2.39	$135.11	$322.80	$499,400
2016-17 *	TOTAL	550	2.58	$135.31	$348.60	$2,282,300
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	340	2.29	$149.68	$342.24	$353,800
2017-18 **	4	300	2.39	$128.88	$307.74	$275,000
2017-18 **	TOTAL	410	2.33	$122.02	$284.34	$1,386,900
2018-19 **	1	470	2.49	$121.41	$302.47	$425,800
2018-19 **	2	470	2.54	$153.99	$391.42	$553,200
2018-19 **	3	540	2.24	$147.98	$331.62	$536,800
2018-19 **	4	490	2.29	$121.69	$278.06	$410,000
2018-19 **	TOTAL	490	2.38	$136.62	$325.62	$1,925,800

* 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 2018 BASE ESTIMATES)

OBRA

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2015-16 *	1	8,510	4.29	$209.24	$897.48	$22,907,200
2015-16 *	2	7,260	3.82	$209.54	$800.20	$17,417,100
2015-16 *	3	5,910	3.92	$223.33	$876.28	$15,529,500
2015-16 *	4	5,140	3.98	$208.46	$828.87	$12,791,100
2015-16 *	TOTAL	6,700	4.02	$212.20	$853.33	$68,644,900
2016-17 *	1	3,190	4.11	$243.54	$1,000.14	$9,569,300
2016-17 *	2	1,150	4.10	$317.54	$1,303.18	$4,485,600
2016-17 *	3	640	6.12	$227.43	$1,392.03	$2,678,300
2016-17 *	4	450	6.20	$219.87	$1,363.92	$1,837,200
2016-17 *	TOTAL	1,360	4.52	$252.48	$1,140.62	$18,570,400
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	190	15.77	$286.98	$4,525.67	$2,610,400
2017-18 **	4	180	14.21	$258.38	$3,672.02	$1,928,600
2017-18 **	TOTAL	260	12.41	$274.46	$3,404.99	$10,719,000
2018-19 **	1	160	18.83	$263.29	$4,957.31	$2,354,300
2018-19 **	2	150	18.89	$257.70	$4,869.10	$2,213,400
2018-19 **	3	150	20.14	$270.94	$5,457.67	$2,405,600
2018-19 **	4	150	16.76	$265.71	$4,452.07	$1,962,400
2018-19 **	TOTAL	150	18.66	$264.41	$4,933.98	$8,935,700

* 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 2018 BASE ESTIMATES)

POV 185

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2015-16 *	1	131,050	3.21	$243.43	$780.53	$306,868,600
2015-16 *	2	129,740	2.92	$250.62	$730.64	$284,378,500
2015-16 *	3	121,260	2.86	$253.62	$725.30	$263,845,600
2015-16 *	4	124,360	2.82	$257.62	$727.07	$271,262,500
2015-16 *	TOTAL	126,600	2.95	$250.94	$741.40	$1,126,355,200
2016-17 *	1	140,710	2.94	$260.60	$767.11	$323,817,500
2016-17 *	2	126,600	2.84	$275.02	$780.65	$296,492,300
2016-17 *	3	126,500	2.93	$273.78	$802.80	$304,653,400
2016-17 *	4	108,620	2.67	$260.18	$695.69	$226,689,900
2016-17 *	TOTAL	125,610	2.86	$267.53	$764.07	$1,151,653,100
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	116,750	2.88	$294.49	$848.62	$297,224,900
2017-18 **	4	103,060	2.68	$297.92	$798.02	$246,726,800
2017-18 **	TOTAL	118,140	2.84	$282.51	$801.97	$1,136,913,600
2018-19 **	1	120,680	2.96	$312.87	$927.62	$335,833,500
2018-19 **	2	108,970	2.82	$316.23	$890.25	$291,021,500
2018-19 **	3	114,740	2.90	$309.31	$896.45	$308,576,700
2018-19 **	4	102,740	2.73	$304.43	$832.49	$256,599,100
2018-19 **	TOTAL	111,780	2.86	$310.89	$888.65	$1,192,030,900

* 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 2018 BASE ESTIMATES)

POV 133

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2015-16 *	1	56,590	2.09	$150.40	$314.37	$53,366,900
2015-16 *	2	65,040	1.90	$152.31	$289.22	$56,429,200
2015-16 *	3	64,000	1.86	$144.71	$269.72	$51,786,300
2015-16 *	4	68,970	1.97	$154.85	$305.47	$63,208,200
2015-16 *	TOTAL	63,650	1.95	$150.73	$294.31	$224,790,600
2016-17 *	1	76,280	1.95	$169.63	$331.48	$75,854,100
2016-17 *	2	77,570	1.77	$175.84	$311.20	$72,421,100
2016-17 *	3	83,630	1.99	$157.62	$314.26	$78,845,300
2016-17 *	4	80,440	1.91	$155.90	$297.67	$71,837,800
2016-17 *	TOTAL	79,480	1.91	$164.26	$313.45	$298,958,200
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	91,580	1.86	$171.96	$319.72	$87,834,700
2017-18 **	4	86,820	1.87	$164.94	$308.75	$80,413,300
2017-18 **	TOTAL	88,740	1.90	$170.95	$324.56	$345,617,100
2018-19 **	1	96,220	1.93	$179.44	$346.42	$99,996,100
2018-19 **	2	93,110	1.86	$176.78	$328.08	$91,647,800
2018-19 **	3	93,000	1.89	$171.21	$322.81	$90,062,100
2018-19 **	4	86,970	1.89	$168.56	$318.86	$83,198,200
2018-19 **	TOTAL	92,330	1.89	$174.15	$329.36	$364,904,200

* 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 2018 BASE ESTIMATES)

POV 100

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNIT PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2015-16 *	1	30,150	2.19	$166.64	$364.16	$32,940,800
2015-16 *	2	32,260	2.02	$170.43	$343.49	$33,246,700
2015-16 *	3	31,120	1.95	$170.81	$333.45	$31,129,200
2015-16 *	4	33,190	2.07	$163.64	$339.44	$33,798,300
2015-16 *	TOTAL	31,680	2.06	$167.76	$344.88	$131,115,100
2016-17 *	1	37,200	2.07	$182.89	$378.57	$42,245,200
2016-17 *	2	37,170	1.82	$190.65	$346.50	$38,639,300
2016-17 *	3	37,740	2.05	$161.08	$329.50	$37,307,500
2016-17 *	4	36,750	1.96	$162.61	$319.01	$35,168,700
2016-17 *	TOTAL	37,210	1.97	$173.97	$343.42	$153,360,800
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	45,030	1.79	$182.25	$326.99	$44,173,900
2017-18 **	4	42,550	1.83	$176.17	$321.69	$41,061,300
2017-18 **	TOTAL	43,120	1.89	$185.79	$351.96	$182,102,300
2018-19 **	1	48,180	1.89	$197.80	$373.20	$53,942,200
2018-19 **	2	46,490	1.78	$198.58	$353.50	$49,307,500
2018-19 **	3	45,360	1.79	$190.97	$341.04	$46,410,400
2018-19 **	4	42,470	1.84	$183.07	$337.62	$43,019,000
2018-19 **	TOTAL	45,630	1.82	$192.87	$351.91	$192,679,100

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

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 2017-18

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	ELIGIBILITY				
4	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	$69,611,000	$52,322,000	$0	$17,289,000
5	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	$7,863,000	$6,919,440	$943,560	$0
6	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL	$3,412,000	$3,002,560	$409,440	$0
	ELIGIBILITY SUBTOTAL	**$80,886,000**	**$62,244,000**	**$1,353,000**	**$17,289,000**
	DRUG MEDI-CAL				
57	NARCOTIC TREATMENT PROGRAM	$167,560,000	$160,994,830	$6,565,170	$0
58	OUTPATIENT DRUG FREE TREATMENT SERVICES	$22,178,000	$21,376,200	$801,800	$0
60	INTENSIVE OUTPATIENT TREATMENT SERVICES	$8,423,000	$7,158,710	$1,264,290	$0
62	RESIDENTIAL TREATMENT SERVICES	$1,195,000	$1,152,340	$42,660	$0
	DRUG MEDI-CAL SUBTOTAL	**$199,356,000**	**$190,682,080**	**$8,673,920**	**$0**
	MENTAL HEALTH				
63	SMHS FOR ADULTS	$1,520,088,000	$1,422,273,750	$27,881,250	$69,933,000
64	SMHS FOR CHILDREN	$1,305,357,000	$1,266,640,370	$1,611,630	$37,105,000
	MENTAL HEALTH SUBTOTAL	**$2,825,445,000**	**$2,688,914,120**	**$29,492,880**	**$107,038,000**
	MANAGED CARE				
87	TWO PLAN MODEL	$19,903,403,000	$13,743,185,720	$5,650,217,280	$510,000,000
88	COUNTY ORGANIZED HEALTH SYSTEMS	$7,769,831,000	$5,419,911,900	$2,239,919,100	$110,000,000
89	GEOGRAPHIC MANAGED CARE	$3,707,278,000	$2,600,746,640	$1,046,531,360	$60,000,000
94	REGIONAL MODEL	$1,189,296,000	$837,135,480	$349,760,520	$2,400,000
95	PACE (Other M/C)	$507,561,000	$253,780,500	$225,014,500	$28,766,000
97	DENTAL MANAGED CARE (Other M/C)	$114,161,000	$71,941,020	$42,219,980	$0
98	SENIOR CARE ACTION NETWORK (Other M/C)	$52,098,000	$26,049,000	$26,049,000	$0
100	AIDS HEALTHCARE CENTERS (Other M/C)	$17,090,000	$8,545,000	$8,545,000	$0
102	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$3,056,000	$1,528,000	$1,528,000	$0
	MANAGED CARE SUBTOTAL	**$33,263,774,000**	**$22,962,823,260**	**$9,589,784,740**	**$711,166,000**
	OTHER				
165	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$3,233,313,000	$1,509,806,000	$1,723,507,000	$0
166	MEDICARE PAYMENTS - PART D PHASED-DOWN	$2,095,567,000	$0	$2,095,567,000	$0
167	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	$1,779,095,000	$1,779,095,000	$0	$0
168	PERSONAL CARE SERVICES (Misc. Svcs.)	$1,796,201,000	$1,796,201,000	$0	$0
169	DENTAL SERVICES	$1,097,804,000	$722,614,380	$375,189,620	$0
172	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$175,445,000	$175,445,000	$0	$0

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2017-18

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
173	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$222.014.000	$222,014,000	$0	$0
175	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$40.990.000	$20,495,000	$20,495,000	$0
176	MEDI-CAL TCM PROGRAM	$45,447,000	$45,141,000	$306,000	$0
177	EPSDT SCREENS	$4,998,000	$2,596,660	$2,401,340	$0
187	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$1,485,000	$1,485,000	$0	$0
188	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$1,150,000	$575,000	$575,000	$0
203	BASE RECOVERIES	($356,599,000)	($200,483,000)	($156,116,000)	$0
208	LAWSUITS/CLAIMS	$38,787,000	$19,393,500	$19,393,500	$0
	OTHER SUBTOTAL	**$10,175,697,000**	**$6,094,378,540**	**$4,081,318,460**	**$0**
	GRAND TOTAL	**$46,545,158,000**	**$31,999,042,000**	**$13,710,623,000**	**$835,493,000**

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2018-19

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	ELIGIBILITY				
4	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	$47,497,000	$35,763,000	$0	$11,734,000
5	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	$7,401,000	$6,512,880	$888,120	$0
6	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL	$3,412,000	$3,002,560	$409,440	$0
	ELIGIBILITY SUBTOTAL	**$58,310,000**	**$45,278,440**	**$1,297,560**	**$11,734,000**
	DRUG MEDI-CAL				
57	NARCOTIC TREATMENT PROGRAM	$176,249,000	$168,129,470	$8,119,530	$0
58	OUTPATIENT DRUG FREE TREATMENT SERVICES	$22,788,000	$21,832,010	$955,990	$0
60	INTENSIVE OUTPATIENT TREATMENT SERVICES	$8,444,000	$7,132,410	$1,311,590	$0
62	RESIDENTIAL TREATMENT SERVICES	$1,282,000	$1,228,360	$53,640	$0
	DRUG MEDI-CAL SUBTOTAL	**$208,763,000**	**$198,322,250**	**$10,440,750**	**$0**
	MENTAL HEALTH				
63	SMHS FOR ADULTS	$1,560,148,000	$1,440,274,380	$49,335,620	$70,538,000
64	SMHS FOR CHILDREN	$1,310,501,000	$1,268,853,640	$3,172,360	$38,475,000
	MENTAL HEALTH SUBTOTAL	**$2,870,649,000**	**$2,709,128,020**	**$52,507,980**	**$109,013,000**
	MANAGED CARE				
87	TWO PLAN MODEL	$20,309,108,000	$13,893,166,730	$6,191,246,270	$224,695,000
88	COUNTY ORGANIZED HEALTH SYSTEMS	$8,190,098,000	$5,673,699,040	$2,516,398,960	$0
89	GEOGRAPHIC MANAGED CARE	$3,648,659,000	$2,505,303,930	$1,143,355,070	$0
94	REGIONAL MODEL	$1,212,883,000	$833,221,670	$379,661,330	$0
95	PACE (Other M/C)	$503,658,000	$251,829,000	$251,829,000	$0
97	DENTAL MANAGED CARE (Other M/C)	$123,429,000	$77,554,010	$45,874,990	$0
98	SENIOR CARE ACTION NETWORK (Other M/C)	$41,482,000	$20,741,000	$20,741,000	$0
100	AIDS HEALTHCARE CENTERS (Other M/C)	$17,325,000	$8,662,500	$8,662,500	$0
102	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$1,131,000	$565,500	$565,500	$0
	MANAGED CARE SUBTOTAL	**$34,047,773,000**	**$23,264,743,380**	**$10,558,334,620**	**$224,695,000**
	OTHER				
165	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$3,333,500,000	$1,557,716,500	$1,775,783,500	$0
166	MEDICARE PAYMENTS - PART D PHASED-DOWN	$2,157,906,000	$0	$2,157,906,000	$0
167	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	$1,836,141,000	$1,836,141,000	$0	$0
168	PERSONAL CARE SERVICES (Misc. Svcs.)	$1,895,965,000	$1,895,965,000	$0	$0
169	DENTAL SERVICES	$1,074,108,000	$660,678,750	$413,429,250	$0
172	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$155,445,000	$155,445,000	$0	$0

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2018-19

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
173	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$209.741.000	$209,741,000	$0	$0
175	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$41.299.000	$20,649,500	$20,649,500	$0
176	MEDI-CAL TCM PROGRAM	$35,254,000	$35,254,000	$0	$0
177	EPSDT SCREENS	$4,956,000	$2,574,520	$2,381,480	$0
187	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$1,028,000	$1,028,000	$0	$0
188	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$1,090,000	$545,000	$545,000	$0
203	BASE RECOVERIES	($349,320,000)	($196,391,000)	($152,929,000)	$0
208	LAWSUITS/CLAIMS	$32,865,000	$16,432,500	$16,432,500	$0
	OTHER SUBTOTAL	**$10,429,978,000**	**$6,195,779,770**	**$4,234,198,230**	**$0**
	GRAND TOTAL	**$47,615,473,000**	**$32,413,251,860**	**$14,856,779,140**	**$345,442,000**

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
MAY 2018 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	2017-18 APPROPRIATION TOTAL FUNDS	2017-18 APPROPRIATION GENERAL FUNDS	NOV. 2017 EST. FOR 2017-18 TOTAL FUNDS	NOV. 2017 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	DIFF. MAY TO APPROPRIATION TOTAL FUNDS	DIFF. MAY TO APPROPRIATION GENERAL FUNDS	DIFFERENCE MAY TO NOVEMBER TOTAL FUNDS	DIFFERENCE MAY TO NOVEMBER GENERAL FUNDS
		ELIGIBILITY										
4	4	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	$29,170,000	$0	$32,243,000	$0	$69,611,000	$0	$40,441,000	$0	$37,368,000	$0
5	5	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	$7,144,000	$857,280	$17,047,000	$2,045,640	$7,863,000	$943,560	$719,000	$86,280	($9,184,000)	($1,102,080)
6	6	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL	$2,755,000	$330,600	$3,399,000	$407,880	$3,412,000	$409,440	$657,000	$78,840	$13,000	$1,560
		ELIGIBILITY SUBTOTAL	**$39,069,000**	**$1,187,880**	**$52,689,000**	**$2,453,520**	**$80,886,000**	**$1,353,000**	**$41,817,000**	**$165,120**	**$28,197,000**	**($1,100,520)**
		DRUG MEDI-CAL										
57	57	NARCOTIC TREATMENT PROGRAM	$158,571,000	$5,326,150	$172,279,000	$5,966,460	$167,560,000	$6,565,170	$8,989,000	$1,239,020	($4,719,000)	$598,710
58	58	OUTPATIENT DRUG FREE TREATMENT SERVICES	$24,330,000	$772,510	$25,342,000	$840,740	$22,178,000	$801,800	($2,152,000)	$29,290	($3,164,000)	($38,940)
60	60	INTENSIVE OUTPATIENT TREATMENT SERVICES	$9,458,000	$1,419,370	$9,697,000	$1,404,560	$8,423,000	$1,264,290	($1,035,000)	($155,080)	($1,274,000)	($140,270)
62	62	RESIDENTIAL TREATMENT SERVICES	$1,505,000	$49,000	$1,316,000	$38,410	$1,195,000	$42,660	($310,000)	($6,340)	($121,000)	$4,250
		DRUG MEDI-CAL SUBTOTAL	**$193,864,000**	**$7,567,030**	**$208,634,000**	**$8,250,170**	**$199,356,000**	**$8,673,920**	**$5,492,000**	**$1,106,890**	**($9,278,000)**	**$423,750**
		MENTAL HEALTH										
63	63	SMHS FOR ADULTS	$1,425,027,000	$41,156,000	$1,510,777,000	$28,030,050	$1,520,088,000	$27,881,250	$95,061,000	($13,274,750)	$9,311,000	($148,800)
64	64	SMHS FOR CHILDREN	$1,127,659,000	$2,266,660	$1,224,732,000	$1,639,570	$1,305,357,000	$1,611,630	$177,698,000	($655,030)	$80,625,000	($27,940)
		MENTAL HEALTH SUBTOTAL	**$2,552,686,000**	**$43,422,660**	**$2,735,509,000**	**$29,669,620**	**$2,825,445,000**	**$29,492,880**	**$272,759,000**	**($13,929,780)**	**$89,936,000**	**($176,740)**
		MANAGED CARE										
87	87	TWO PLAN MODEL	$20,478,370,000	$5,606,509,640	$20,429,116,000	$5,852,920,190	$19,903,403,000	$5,650,217,280	($574,967,000)	$43,707,640	($525,713,000)	($202,702,910)
88	88	COUNTY ORGANIZED HEALTH SYSTEMS	$7,985,671,000	$2,275,153,800	$7,914,399,000	$2,283,870,510	$7,769,831,000	$2,239,919,100	($215,840,000)	($35,234,700)	($144,568,000)	($43,951,410)
89	89	GEOGRAPHIC MANAGED CARE	$3,798,337,000	$995,254,430	$3,760,382,000	$1,058,794,910	$3,707,278,000	$1,046,531,360	($91,059,000)	$51,276,930	($53,104,000)	($12,263,550)
94	94	REGIONAL MODEL	$1,219,782,000	$338,889,950	$1,195,203,000	$347,702,860	$1,189,296,000	$349,760,520	($30,486,000)	$10,870,570	($5,907,000)	$2,057,660
95	95	PACE (Other M/C)	$421,796,000	$182,132,000	$515,861,000	$229,164,500	$507,561,000	$225,014,500	$85,765,000	$42,882,500	($8,300,000)	($4,150,000)
97	97	DENTAL MANAGED CARE (Other M/C)	$133,170,000	$46,959,170	$118,197,000	$40,822,620	$114,161,000	$42,219,980	($19,009,000)	($4,739,190)	($4,036,000)	$1,397,360
98	98	SENIOR CARE ACTION NETWORK (Other M/C)	$65,050,000	$32,525,000	$56,327,000	$28,163,500	$52,098,000	$26,049,000	($12,952,000)	($6,476,000)	($4,229,000)	($2,114,500)
100	100	AIDS HEALTHCARE CENTERS (Other M/C)	$19,750,000	$9,875,000	$18,930,000	$9,465,000	$17,090,000	$8,545,000	($2,660,000)	($1,330,000)	($1,840,000)	($920,000)
102	102	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$3,117,000	$1,558,500	$3,051,000	$1,525,500	$3,056,000	$1,528,000	($61,000)	($30,500)	$5,000	$2,500

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
MAY 2018 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	2017-18 APPROPRIATION TOTAL FUNDS	2017-18 APPROPRIATION GENERAL FUNDS	NOV. 2017 EST. FOR 2017-18 TOTAL FUNDS	NOV. 2017 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	DIFF. MAY TO APPROPRIATION TOTAL FUNDS	DIFF. MAY TO APPROPRIATION GENERAL FUNDS	DIFFERENCE MAY TO NOVEMBER TOTAL FUNDS	DIFFERENCE MAY TO NOVEMBER GENERAL FUNDS
		MANAGED CARE SUBTOTAL	**$34,125,043,000**	**$9,488,857,490**	**$34,011,466,000**	**$9,852,429,590**	**$33,263,774,000**	**$9,589,784,740**	**($861,269,000)**	**$100,927,250**	**($747,692,000)**	**($262,644,850)**
		OTHER										
165	165	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$3,270,379,000	$1,751,636,500	$3,251,287,000	$1,732,257,000	$3,233,313,000	$1,723,507,000	($37,066,000)	($28,129,500)	($17,974,000)	($8,750,000)
166	166	MEDICARE PAYMENTS - PART D PHASED-DOWN	$2,125,280,000	$2,125,280,000	$2,111,200,000	$2,111,200,000	$2,095,567,000	$2,095,567,000	($29,713,000)	($29,713,000)	($15,633,000)	($15,633,000)
167	167	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	$1,736,805,000	$0	$1,741,895,000	$0	$1,779,095,000	$0	$42,290,000	$0	$37,200,000	$0
168	168	PERSONAL CARE SERVICES (Misc. Svcs.)	$1,464,250,000	$0	$1,353,962,000	$0	$1,796,201,000	$0	$331,951,000	$0	$442,239,000	$0
169	169	DENTAL SERVICES	$1,171,505,000	$401,821,340	$1,232,658,000	$434,901,050	$1,097,804,000	$375,189,620	($73,701,000)	($26,631,720)	($134,854,000)	($59,711,430)
172	172	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$207,330,000	$0	$207,330,000	$0	$175,445,000	$0	($31,885,000)	$0	($31,885,000)	$0
173	173	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$194,996,000	$0	$219,679,000	$0	$222,014,000	$0	$27,018,000	$0	$2,335,000	$0
175	175	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$46,068,000	$23,034,000	$45,900,000	$22,950,000	$40,990,000	$20,495,000	($5,078,000)	($2,539,000)	($4,910,000)	($2,455,000)
176	176	MEDI-CAL TCM PROGRAM	$30,063,000	$0	$41,615,000	$306,000	$45,447,000	$306,000	$15,384,000	$306,000	$3,832,000	$0
177	177	EPSDT SCREENS	$34,832,000	$16,675,000	$30,984,000	$14,921,620	$4,998,000	$2,401,340	($29,834,000)	($14,273,660)	($25,986,000)	($12,520,280)
187	187	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$1,028,000	$0	$1,485,000	$0	$1,485,000	$0	$457,000	$0	$0	$0
188	188	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$1,307,000	$653,500	$1,452,000	$726,000	$1,150,000	$575,000	($157,000)	($78,500)	($302,000)	($151,000)
203	203	BASE RECOVERIES	($352,303,000)	($169,305,000)	($371,809,000)	($173,772,000)	($356,599,000)	($156,116,000)	($4,296,000)	$13,189,000	$15,210,000	$17,656,000
208	208	LAWSUITS/CLAIMS	$0	$0	$38,760,000	$19,380,000	$38,787,000	$19,393,500	$38,787,000	$19,393,500	$27,000	$13,500
--	--	LAWSUITS/CLAIMS	$2,013,000	$1,080,500	$0	$0	$0	$0	($2,013,000)	($1,080,500)	$0	$0
		OTHER SUBTOTAL	**$9,933,553,000**	**$4,150,875,840**	**$9,906,398,000**	**$4,162,869,670**	**$10,175,697,000**	**$4,081,318,460**	**$242,144,000**	**($69,557,380)**	**$269,299,000**	**($81,551,210)**
		GRAND TOTAL	**$46,844,215,000**	**$13,691,910,900**	**$46,914,696,000**	**$14,055,672,570**	**$46,545,158,000**	**$13,710,623,000**	**($299,057,000)**	**$18,712,100**	**($369,538,000)**	**($345,049,570)**

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
MAY 2018 ESTIMATE COMPARED TO NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2018-19

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2017 EST. FOR 2018-19		MAY 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		ELIGIBILITY						
4	4	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	$46,553,000	$0	$47,497,000	$0	$944,000	$0
5	5	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	$16,872,000	$2,024,640	$7,401,000	$888,120	($9,471,000)	($1,136,520)
6	6	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL	$3,399,000	$407,880	$3,412,000	$409,440	$13,000	$1,560
		ELIGIBILITY SUBTOTAL	**$66,824,000**	**$2,432,520**	**$58,310,000**	**$1,297,560**	**($8,514,000)**	**($1,134,960)**
		DRUG MEDI-CAL						
57	57	NARCOTIC TREATMENT PROGRAM	$181,477,000	$8,216,250	$176,249,000	$8,119,530	($5,228,000)	($96,720)
58	58	OUTPATIENT DRUG FREE TREATMENT SERVICES	$26,848,000	$1,161,720	$22,788,000	$955,990	($4,060,000)	($205,730)
60	60	INTENSIVE OUTPATIENT TREATMENT SERVICES	$9,876,000	$1,502,820	$8,444,000	$1,311,590	($1,432,000)	($191,230)
62	62	RESIDENTIAL TREATMENT SERVICES	$1,397,000	$53,580	$1,282,000	$53,640	($115,000)	$60
		DRUG MEDI-CAL SUBTOTAL	**$219,598,000**	**$10,934,370**	**$208,763,000**	**$10,440,750**	**($10,835,000)**	**($493,620)**
		MENTAL HEALTH						
63	63	SMHS FOR ADULTS	$1,559,573,000	$49,449,350	$1,560,148,000	$49,335,620	$575,000	($113,730)
64	64	SMHS FOR CHILDREN	$1,196,328,000	$2,896,050	$1,310,501,000	$3,172,360	$114,173,000	$276,310
		MENTAL HEALTH SUBTOTAL	**$2,755,901,000**	**$52,345,400**	**$2,870,649,000**	**$52,507,980**	**$114,748,000**	**$162,580**
		MANAGED CARE						
87	87	TWO PLAN MODEL	$20,636,578,000	$6,295,925,240	$20,309,108,000	$6,191,246,270	($327,470,000)	($104,678,970)
88	88	COUNTY ORGANIZED HEALTH SYSTEMS	$8,048,854,000	$2,395,404,980	$8,190,098,000	$2,516,398,960	$141,244,000	$120,993,980
89	89	GEOGRAPHIC MANAGED CARE	$3,817,381,000	$1,142,332,300	$3,648,659,000	$1,143,355,070	($168,722,000)	$1,022,770
94	94	REGIONAL MODEL	$1,222,082,000	$362,275,200	$1,212,883,000	$379,661,330	($9,199,000)	$17,386,130
95	95	PACE (Other M/C)	$487,954,000	$243,977,000	$503,658,000	$251,829,000	$15,704,000	$7,852,000
97	97	DENTAL MANAGED CARE (Other M/C)	$104,176,000	$37,020,060	$123,429,000	$45,874,990	$19,253,000	$8,854,930

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
MAY 2018 ESTIMATE COMPARED TO NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2018-19

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2017 EST. FOR 2018-19		MAY 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		MANAGED CARE						
98	98	SENIOR CARE ACTION NETWORK (Other M/C)	$54,439,000	$27,219,500	$41,482,000	$20,741,000	($12,957,000)	($6,478,500)
100	100	AIDS HEALTHCARE CENTERS (Other M/C)	$19,069,000	$9,534,500	$17,325,000	$8,662,500	($1,744,000)	($872,000)
102	102	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$1,092,000	$546,000	$1,131,000	$565,500	$39,000	$19,500
		MANAGED CARE SUBTOTAL	**$34,391,625,000**	**$10,514,234,780**	**$34,047,773,000**	**$10,558,334,620**	**($343,852,000)**	**$44,099,840**
		OTHER						
165	165	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$3,347,632,000	$1,782,553,000	$3,333,500,000	$1,775,783,500	($14,132,000)	($6,769,500)
166	166	MEDICARE PAYMENTS - PART D PHASED-DOWN	$2,221,955,000	$2,221,955,000	$2,157,906,000	$2,157,906,000	($64,049,000)	($64,049,000)
167	167	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	$1,816,555,000	$0	$1,836,141,000	$0	$19,586,000	$0
168	168	PERSONAL CARE SERVICES (Misc. Svcs.)	$2,001,165,000	$0	$1,895,965,000	$0	($105,200,000)	$0
169	169	DENTAL SERVICES	$1,364,464,000	$485,090,200	$1,074,108,000	$413,429,250	($290,356,000)	($71,660,950)
172	172	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$207,330,000	$0	$155,445,000	$0	($51,885,000)	$0
173	173	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$208,970,000	$0	$209,741,000	$0	$771,000	$0
175	175	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$48,275,000	$24,137,500	$41,299,000	$20,649,500	($6,976,000)	($3,488,000)
176	176	MEDI-CAL TCM PROGRAM	$33,555,000	$0	$35,254,000	$0	$1,699,000	$0
177	177	EPSDT SCREENS	$30,857,000	$14,860,400	$4,956,000	$2,381,480	($25,901,000)	($12,478,920)
187	187	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$1,028,000	$0	$1,028,000	$0	$0	$0
188	188	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$1,448,000	$724,000	$1,090,000	$545,000	($358,000)	($179,000)
203	203	BASE RECOVERIES	($367,663,000)	($171,834,000)	($349,320,000)	($152,929,000)	$18,343,000	$18,905,000

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
MAY 2018 ESTIMATE COMPARED TO NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2018-19

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2017 EST. FOR 2018-19		MAY 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
208	208	LAWSUITS/CLAIMS	$32,865,000	$16,432,500	$32,865,000	$16,432,500	$0	$0
		OTHER SUBTOTAL	**$10,948,436,000**	**$4,373,918,600**	**$10,429,978,000**	**$4,234,198,230**	**($518,458,000)**	**($139,720,370)**
		GRAND TOTAL	**$48,382,384,000**	**$14,953,865,670**	**$47,615,473,000**	**$14,856,779,140**	**($766,911,000)**	**($97,086,530)**

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2017-18 AND 2018-19

NO.	POLICY CHANGE TITLE	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2018-19 TOTAL FUNDS	MAY 2018 EST. FOR 2018-19 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	ELIGIBILITY						
4	MEDI-CAL ACCESS PROGRAM MOTHERS 213 -322% FPL	$69,611,000	$0	$47,497,000	$0	($22,114,000)	$0
5	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	$7,863,000	$943,560	$7,401,000	$888,120	($462,000)	($55,440)
6	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL	$3,412,000	$409,440	$3,412,000	$409,440	$0	$0
	ELIGIBILITY SUBTOTAL	**$80,886,000**	**$1,353,000**	**$58,310,000**	**$1,297,560**	**($22,576,000)**	**($55,440)**
	DRUG MEDI-CAL						
57	NARCOTIC TREATMENT PROGRAM	$167,560,000	$6,565,170	$176,249,000	$8,119,530	$8,689,000	$1,554,360
58	OUTPATIENT DRUG FREE TREATMENT SERVICES	$22,178,000	$801,800	$22,788,000	$955,990	$610,000	$154,190
60	INTENSIVE OUTPATIENT TREATMENT SERVICES	$8,423,000	$1,264,290	$8,444,000	$1,311,590	$21,000	$47,300
62	RESIDENTIAL TREATMENT SERVICES	$1,195,000	$42,660	$1,282,000	$53,640	$87,000	$10,980
	DRUG MEDI-CAL SUBTOTAL	**$199,356,000**	**$8,673,920**	**$208,763,000**	**$10,440,750**	**$9,407,000**	**$1,766,830**
	MENTAL HEALTH						
63	SMHS FOR ADULTS	$1,520,088,000	$27,881,250	$1,560,148,000	$49,335,620	$40,060,000	$21,454,370
64	SMHS FOR CHILDREN	$1,305,357,000	$1,611,630	$1,310,501,000	$3,172,360	$5,144,000	$1,560,730
	MENTAL HEALTH SUBTOTAL	**$2,825,445,000**	**$29,492,880**	**$2,870,649,000**	**$52,507,980**	**$45,204,000**	**$23,015,100**
	MANAGED CARE						
87	TWO PLAN MODEL	$19,903,403,000	$5,650,217,280	$20,309,108,000	$6,191,246,270	$405,705,000	$541,028,990
88	COUNTY ORGANIZED HEALTH SYSTEMS	$7,769,831,000	$2,239,919,100	$8,190,098,000	$2,516,398,960	$420,267,000	$276,479,860
89	GEOGRAPHIC MANAGED CARE	$3,707,278,000	$1,046,531,360	$3,648,659,000	$1,143,355,070	($58,619,000)	$96,823,710
94	REGIONAL MODEL	$1,189,296,000	$349,760,520	$1,212,883,000	$379,661,330	$23,587,000	$29,900,810
95	PACE (Other M/C)	$507,561,000	$225,014,500	$503,658,000	$251,829,000	($3,903,000)	$26,814,500
97	DENTAL MANAGED CARE (Other M/C)	$114,161,000	$42,219,980	$123,429,000	$45,874,990	$9,268,000	$3,655,010
98	SENIOR CARE ACTION NETWORK (Other M/C)	$52,098,000	$26,049,000	$41,482,000	$20,741,000	($10,616,000)	($5,308,000)

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2017-18 AND 2018-19

NO.	POLICY CHANGE TITLE	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2018-19 TOTAL FUNDS	MAY 2018 EST. FOR 2018-19 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	MANAGED CARE						
100	AIDS HEALTHCARE CENTERS (Other M/C)	$17,090,000	$8,545,000	$17,325,000	$8,662,500	$235,000	$117,500
102	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$3,056,000	$1,528,000	$1,131,000	$565,500	($1,925,000)	($962,500)
	MANAGED CARE SUBTOTAL	**$33,263,774,000**	**$9,589,784,740**	**$34,047,773,000**	**$10,558,334,620**	**$783,999,000**	**$968,549,880**
	OTHER						
165	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$3,233,313,000	$1,723,507,000	$3,333,500,000	$1,775,783,500	$100,187,000	$52,276,500
166	MEDICARE PAYMENTS - PART D PHASED-DOWN	$2,095,567,000	$2,095,567,000	$2,157,906,000	$2,157,906,000	$62,339,000	$62,339,000
167	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	$1,779,095,000	$0	$1,836,141,000	$0	$57,046,000	$0
168	PERSONAL CARE SERVICES (Misc. Svcs.)	$1,796,201,000	$0	$1,895,965,000	$0	$99,764,000	$0
169	DENTAL SERVICES	$1,097,804,000	$375,189,620	$1,074,108,000	$413,429,250	($23,696,000)	$38,239,630
172	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$175,445,000	$0	$155,445,000	$0	($20,000,000)	$0
173	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$222,014,000	$0	$209,741,000	$0	($12,273,000)	$0
175	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$40,990,000	$20,495,000	$41,299,000	$20,649,500	$309,000	$154,500
176	MEDI-CAL TCM PROGRAM	$45,447,000	$306,000	$35,254,000	$0	($10,193,000)	($306,000)
177	EPSDT SCREENS	$4,998,000	$2,401,340	$4,956,000	$2,381,480	($42,000)	($19,860)
187	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$1,485,000	$0	$1,028,000	$0	($457,000)	$0
188	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$1,150,000	$575,000	$1,090,000	$545,000	($60,000)	($30,000)
203	BASE RECOVERIES	($356,599,000)	($156,116,000)	($349,320,000)	($152,929,000)	$7,279,000	$3,187,000
208	LAWSUITS/CLAIMS	$38,787,000	$19,393,500	$32,865,000	$16,432,500	($5,922,000)	($2,961,000)
	OTHER SUBTOTAL	**$10,175,697,000**	**$4,081,318,460**	**$10,429,978,000**	**$4,234,198,230**	**$254,281,000**	**$152,879,770**
	GRAND TOTAL	**$46,545,158,000**	**$13,710,623,000**	**$47,615,473,000**	**$14,856,779,140**	**$1,070,315,000**	**$1,146,156,140**

MEDI-CAL PROGRAM BASE
POLICY CHANGE INDEX

MEDI-CAL PROGRAM BASE
POLICY CHANGE INDEX

MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL

BASE POLICY CHANGE NUMBER:	4
IMPLEMENTATION DATE:	7/2014
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1837

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$69,611,000	$47,497,000
- STATE FUNDS	$17,289,000	$11,734,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$69,611,000	$47,497,000
STATE FUNDS	$17,289,000	$11,734,000
FEDERAL FUNDS	$52,322,000	$35,763,000

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)

Interdependent Policy Changes:
Not Applicable

Background:
Effective July 1, 2014, the Access for Infants and Mothers program (AIM) was transitioned and renamed MCAP. MCAP covers pregnant women in families with incomes between 213-322% of the FPL. These pregnant women are subject to premiums fixed at 1.5% of their adjusted annual income.

The Department will fully integrate MCAP into the Medi-Cal delivery model by fiscal year (FY) 2018-19. The Departmentintegratedeligibility rules for MCAP into the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) in October 2015. Previously, the Department maintained a health plan delivery system for MCAP that was separate from the Medi-Cal delivery system. The Department ended new enrollment in this delivery system on September 30, 2016 and will make final invoice payments in FY 2017-18.

Effective October 1, 2016, the Department enrolled new MCAP beneficiaries in the Fee-for-Service (FFS) delivery system. Beginning July 2017, new MCAP beneficiaries enroll into the Medi-Cal managed care (MMC) plans. Centers for Medicare and Medicaid Services (CMS) approval of a State Plan Amendment is pending for the addition of MCAP beneficiaries into the MMC plan delivery system. All MCAP beneficiaries 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 increase from the prior estimate, for FY 2017-18, is primarily due to retroactive invoice payments increasing from $3.6M to $40.2M in the current estimate. The change from FY 2017-18 to FY 2018-19, in the current estimate, resulted from no retroactive invoice payments in FY 2018-19.

Methodology:
1. Based on actual enrollment data from September 2012 through December 2017, the Department estimates the following:

FY 2017-18	Average Monthly Caseload	Average Monthly Deliveries
FFS	995	232
Medi-Cal Managed Care	2,879	319
Total	**3,874**	**552**

FY 2018-19	Average Monthly Caseload	Average Monthly Deliveries
Medi-Cal Managed Care	3,926	588
Total	**3,926**	**588**

2. The Department estimates the following Per Member Per Month (PMPM) and PMPD costs:

FY 2017-18	PMPM	PMPD
FFS	$ 491	$ -
Medi-Cal Managed Care	$ 249	$ 6,950

FY 2018-19	PMPM	PMPD
Medi-Cal Managed Care	$ 249	$ 6,950

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

4. MCAP subscribers are subject to premiums fixed at 1.5% of their adjusted annual income. Premiums are estimated to total $4,769,000 in FY 2017-18, and FY 2018-19.

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

6. The Department anticipates paying $40,240,000 in retroactive payments from FY 2015-16 and FY 2016-17 in FY 2017-18.

MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL

BASE POLICY CHANGE NUMBER: 4

FY 2017-18	TF	SF	FF
MCAP FFS	$ 3,002,000	$ 1,608,000	$ 1,394,000
Retroactive 10/15-6/17	$ 40,239,711	$ 8,419,190	$ 31,820,522
MCAP Managed Care	$ 26,369,000	$ 7,262,000	$ 19,107,000
TOTAL	**$ 69,610,711**	**$ 17,289,190**	**$ 52,321,522**

FY 2018-19	TF	SF	FF
Medi-Cal Managed Care	$ 47,497,000	$ 11,734,000	$ 35,763,000

7. The total estimated costs for MCAP mothers in FY 2017-18 and FY 2018-19 are:

(Dollars in Thousands)

FY 2017-18	TF	SF	FF
88% Title XXI FFP/12% Perinatal Insurance Fund	$ 63,749	$ 7,650	$ 56,099
100% Perinatal Insurance Fund	$ 10,631	$ 10,631	$ -
Premiums	$ (4,769)	$ (992)	$ (3,777)
TOTAL	**$ 69,611**	**$ 17,289**	**$ 52,322**

FY 2018-19	TF	SF	FF
88% Title XXI FFP/12% Perinatal Insurance Fund	$ 44,932	$ 5,392	$ 39,540
100% Perinatal Insurance Fund	$ 7,334	$ 7,334	$ -
Premiums	$ (4,769)	$ (992)	$ (3,777)
TOTAL	**$ 47,497**	**$ 11,734**	**$ 35,763**

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:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	1823

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$7,863,000	$7,401,000
- STATE FUNDS	$943,560	$888,120
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$7,863,000	$7,401,000
STATE FUNDS	$943,560	$888,120
FEDERAL FUNDS	$6,919,440	$6,512,880

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).

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) and had been funded with county local funds received via intergovernmental transfers (IGTs) and matched with Title XXI federal funding. Currently, the CHIM funds CCHIPs in two counties: San Francisco and San Mateo.

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.

CCHIP integration into the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) was completed on March 7, 2016.

COUNTY HEALTH INITIATIVE MATCHING (CHIM)

BASE POLICY CHANGE NUMBER: 5

Reason for Change:
The change from the prior estimate, for both FY 2017-18 and FY 2018-19, is a decrease due to a lower than anticipated number of enrollments following the CCHIP integration into CalHEERS and the exclusion of Santa Clara CCHIP from the CHIM fund. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to a decrease in prior year funds to be paid and an increase in caseload for FY 2018-19.

Methodology:
1. San Mateo County elected not to provide funding for the non-federal share of the IGTs beginning January 1, 2014. San Francisco County elected not to provide funding for the non-federal share of the IGTs beginning January 1, 2015.

FY 2017-18	TF	GF	FF
FY 2015-16	$519,000	$62,000	$457,000
Benefits Title XXI 88/12 GF	$467,000	$56,000	$411,000
Admin Title XXI 88/12 GF	$52,000	$6,000	$46,000
FY 2016-17	$3,297,000	$396,000	$2,901,000
Benefits Title XXI 88/12 GF	$2,967,000	$356,000	$2,611,000
Admin Title XXI 88/12 GF	$330,000	$40,000	$290,000
FY 2017-18	$4,047,000	$486,000	$3,561,000
Benefits Title XXI 88/12 GF	$3,642,000	$437,000	$3,205,000
Admin Title XXI 88/12 GF	$405,000	$49,000	$356,000
Total FY 2017-18	**$7,863,000**	**$944,000**	**$6,919,000**

FY 2018-19	TF	GF	FF
FY 2017-18	$1,568,000	$188,000	$1,380,000
Benefits Title XXI 88/12 GF	$1,411,000	$169,000	$1,242,000
Admin Title XXI 88/12 GF	$157,000	$19,000	$138,000
FY 2018-19	$5,833,000	$700,000	$5,133,000
Benefits Title XXI 88/12 GF	$5,250,000	$630,000	$4,620,000
Admin Title XXI 88/12 GF	$583,000	$70,000	$513,000
Total FY 2018-19	**$7,401,000**	**$888,000**	**$6,513,000**

*Totals may differ due to rounding.

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

MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL

BASE POLICY CHANGE NUMBER:	6
IMPLEMENTATION DATE:	11/2013
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1797

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$3,412,000	$3,412,000
- STATE FUNDS	$409,440	$409,440
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,412,000	$3,412,000
STATE FUNDS	$409,440	$409,440
FEDERAL FUNDS	$3,002,560	$3,002,560

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 Program (MCAP) 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, MCAP infants transitioned into the Medi-Cal delivery system through a phase-in methodology. MCAP infants began enrollment into Medi-Cal Managed Care in July 2014.

The Departmentintegratedeligibility rules for MCAP into the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) in October 2015. 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 MCAP are subject to premiums.

Reason for Change:
The slight change from the prior estimate, for FY 2017-18 and FY 2018-19, resulted from a higher per member per month (PMPM) rate calculated using updated claims data, that was higher, and updated eligible data, that was lower, compared to the prior estimate. There is no change from FY 2017-18 to FY 2018-19 in the current estimate.

MEDI-CAL ACCESS PROGRAM INFANTS 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 2017-18 and FY 2018-19:

Delivery System	FY 2017-18	FY 2018-19
FFS	188	188
Medi-Cal Managed Care	633	633
Total Monthly Enrollment	**821**	**821**

2. The Department estimates the weighted average PMPM cost in FY 2017-18 and FY 2018-19 is $922.81 for FFS infants and $191.79 for Medi-Cal Managed Care infants.

3. MCAP subscribers are subject to monthly premiums. Premiums are estimated to total $128,000 in FY 2017-18 and FY 2018-19.

4. The total estimated costs for MCAP infants in FY 2017-18 and FY 2018-19 are:
(Dollars in Thousands)

FY 2017-18	TF	GF	FF
Benefits	$ 3,540	$ 425	$ 3,115
Premiums	$ (128)	$ (15)	$ (113)
Net	**$ 3,412**	**$ 409**	**$ 3,002**

FY 2018-19	TF	GF	FF
Benefits	$ 3,540	$ 425	$ 3,115
Premiums	$ (128)	$ (15)	$ (113)
Net	**$ 3,412**	**$ 409**	**$ 3,002**

Funding:

88% Title XXI FFP/12% GF (4260-113-0890/0001)

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER:	57
IMPLEMENTATION DATE:	7/2012
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1728

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$167,560,000	$176,249,000
- STATE FUNDS	$6,565,170	$8,119,530
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$167,560,000	$176,249,000
STATE FUNDS	$6,565,170	$8,119,530
FEDERAL FUNDS	$160,994,830	$168,129,470

DESCRIPTION

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

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

Interdependent Policy Changes:
PC 56 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.

The responsibility for Drug Medi-Cal services 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 DMC program provides certain medically necessary substance use disorder treatment services. These services are provided by certified providers under contract with the counties or with the State. Funding for the services is 50% CF and 50% Title XIX federal funds (FF). Certain aid codes are eligible for Title XXI federal reimbursement at 88%. Funding for the ACA Optional beneficiaries is 100% FF until December 31, 2016, 95% FF / 5% GF beginning January 2017, 94% FF / 6% GF beginning January 2018, and 93% FF / 7% GF beginning January 2019.

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 57

On August 13, 2015, the Department received approval from the Centers for Medicare and Medicaid Services (CMS) 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 (SUD). DMC-ODS waiver services will include the existing treatment modalities (NTP, Intensive Outpatient Treatment (IOT), Outpatient Drug Free (ODF), and Perinatal Residential Treatment Services (RTS)), and the additional new and expanded services.

Participation in the waiver is voluntary for counties and will be implemented on a phase-in basis. NTP services costs for the phase-in counties will be offset in the Drug Medi-Cal Organized Delivery System Waiver policy change.

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is due to:

- Decreased caseload projections based on actual data through June 2017, and
- Updated Units of Service (UOS) based on updated FY 2016-17 claims data.

The change in the current estimate, from FY 2017-18 to FY 2018-19, is due to an increase in ACA Optional caseload projections for FY 2018-19.

Methodology:

1. The DMC eligible clients are categorized into two groups: Regular and Perinatal.

2. The caseload projections are based on complete caseload data from January 2010 through June 2017.

3. The UOS is based on the total approved units divided by the caseload. Complete data from July 2016 through June 2017 was used to calculate the average UOS.

4. The proposed DMC rates are based on the developed rates or the FY 2009-10 Budget Act rates adjusted for the cumulative growth in the Implicit Price (CIP) Deflator for the Cost of Goods and Services to Governmental Agencies reported by Department of Finance (DOF), whichever is lower. FY 2017-18 and FY 2018-19 budgeted amounts are based on the FY 2017-18 rates.

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 57

5. The cost estimate is developed by the following: UOS x Rates x Caseload.

			FY 2017-18		FY 2018-19	
	UOS	Rates	Caseload	Total	Caseload	Total
Regular - Current						
Dosing	283.6	$13.11	16,432	$61,094,000	16,432	$61,094,000
Individual	119.3	$15.37	16,432	$30,130,000	16,432	$30,130,000
Group	1.1	$3.43	16,432	$62,000	16,432	$62,000
Regular - EPSDT						
Dosing	119.5	$13.11	324	$508,000	324	$508,000
Individual	59.8	$15.37	324	$298,000	324	$298,000
Group	0.0	$3.43	324	$0	324	$0
Regular - ACA Optional						
Dosing	205.4	$13.11	30,775	$82,871,000	31,840	$85,739,000
Individual	91.3	$15.37	30,775	$43,186,000	31,840	$44,680,000
Group	0.6	$3.43	30,775	$63,000	31,840	$66,000
Regular Total				$218,212,000		$222,577,000
Perinatal - Current						
Dosing	131.0	$14.11	83	$153,000	83	$153,000
Individual	53.9	$16.39	83	$73,000	83	$73,000
Group	1.0	$4.28	83	$0	83	$0
Perinatal - ACA Optional						
Dosing	87.3	$14.11	213	$262,000	221	$272,000
Individual	32.6	$16.39	213	$114,000	221	$118,000
Group	0.6	$4.28	213	$1,000	221	$1,000
Perinatal Total				$603,000		$617,000
Grand Total				$218,815,000		$223,194,000

6. Based on historical claims received, assume 75% of each fiscal year claims will be paid in the year the services occurred. The remaining 25% will be paid in the following year.

Fiscal Years	Accrual	FY 2017-18	FY 2018-19
Regular	$193,810,000	$48,453,000	$0
Perinatal	$564,000	$141,000	$0
Total for FY 2016-17	$194,374,000	$48,594,000	$0
Regular	$218,212,000	$163,658,000	$54,554,000
Perinatal	$603,000	$452,000	$151,000
Total for FY 2017-18	$218,815,000	$164,110,000	$54,705,000
Regular	$222,577,000	$0	$166,934,000
Perinatal	$617,000	$0	$463,000
Total for FY 2018-19	$223,194,000	$0	$167,397,000
Total		$212,704,000	$222,102,000

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 57

7. Total estimated reimbursements for NTP services are:

FY 2017-18	TF	GF	FF (Title XIX)	FF (Title XXI)	County
Regular					
Current	$90,666,000	$0	$44,939,000	$693,000	$45,034,000
ACA Optional	$121,445,000	$6,545,000	$114,900,000	$0	$0
Perinatal					
Current	$222,000	$0	$109,000	$3,000	$110,000
ACA Optional	$371,000	$20,000	$351,000	$0	$0
Total	$212,704,000	**$6,565,000**	**$160,299,000**	**$696,000**	$45,144,000

FY 2018-19	TF	GF	FF (Title XIX)	FF (Title XXI)	County
Regular					
Current	$92,094,000	$0	$45,643,000	$710,000	$45,741,000
ACA Optional	$129,394,000	$8,096,000	$121,298,000	$0	$0
Perinatal					
Current	$227,000	$0	$112,000	$3,000	$112,000
ACA Optional	$387,000	$24,000	$363,000	$0	$0
Total	$222,102,000	**$8,120,000**	**$167,416,000**	**$713,000**	$45,853,000

Funding:
100% Title XIX FF (4260-101-0890)
100% Title XXI FF (4260-113-0890)
95% ACA Title XIX FF / 5% GF (4260-101-001/0890)
94% ACA Title XIX FF / 6% GF (4260-101-001/0890)
93% ACA Title XIX FF / 7% GF (4260-101-001/0890)

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER:	58
IMPLEMENTATION DATE:	7/2012
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1727

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$22,178,000	$22,788,000
- STATE FUNDS	$801,800	$955,990
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$22,178,000	$22,788,000
STATE FUNDS	$801,800	$955,990
FEDERAL FUNDS	$21,376,200	$21,832,010

DESCRIPTION

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

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

Interdependent Policy Changes:
PC 56 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, face-to-face, 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.

The responsibility for Drug Medi-Cal services 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.

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 58

The DMC program provides certain medically necessary substance use disorder treatment services. These services are provided by certified providers under contract with the counties or with the State. Funding for the services is generally 50% CF and 50% Title XIX Federal Funds (FF). Certain aid codes are eligible for Title XXI federal reimbursement at 65% and 88%. Funding for the ACA Optional beneficiaries is 100% FF until December 31, 2016, 95% FF / 5% GF beginning January 2017, 94% FF / 6% GF beginning January 2018 and 93% FF / 7% GF beginning January 2019.

On August 13, 2015, the Department received approval from the Centers for Medicare and Medicaid Services (CMS) 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 (SUD). DMC-ODS waiver services will include the existing treatment modalities (Narcotic Treatment Program (NTP), Intensive Outpatient Treatment (IOT), ODF, and Perinatal Residential Treatment Services (RTS)), and the additional new and expanded services.

Participation in the waiver is voluntary for counties and will be implemented on a phase-in basis. ODF services costs for the phase-in counties will be offset in the Drug Medi-Cal Organized Delivery System Waiver policy change.

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is a net decrease due to:

- Overall increased caseload projections based on actual data through June 2017, and
- Decreased Units of Service (UOS) based on updated FY 2016-17 claims data.

The change in the current estimate, from FY 2017-18 to FY 2018-19, is an increase due to estimating higher prior year payments in FY 2018-19.

Methodology:

1. The DMC eligible clients are categorized into two groups: Regular and Perinatal.

2. The caseload projections are based on complete caseload data from January 2010 through June 2017.

3. The UOS is based on the total approved units divided by the caseload. Complete data from July 2016 through June 2017 was used to calculate the average UOS.

4. Separate DMC reimbursement rates apply for perinatal and non-perinatal patients.

5. The proposed DMC rates are based on the developed rates or the FY 2009-10 Budget Act rates adjusted for the cumulative Implicit Price (CIP) Deflator for the Cost of Goods and Services to Governmental Agencies reported by the Department of Finance (DOF), whichever is lower. FY 2017-18 and FY 2018-19 budgeted amounts are based on the FY 2017-18 rates.

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 58

6. The cost estimate is developed by the following: UOS x Rate x Caseload.

			FY 2017-18		FY 2018-19	
	UOS	Rates	Caseload	Total	Caseload	Total
Regular						
Current						
Individual	2.70	$76.91	6,198	$1,287,000	6,198	$1,287,000
Group	18.00	$30.89	6,198	$3,446,000	6,198	$3,446,000
EPSDT						
Individual	3.40	$76.91	6,428	$1,681,000	6,428	$1,681,000
Group	20.60	$30.89	6,428	$4,090,000	6,428	$4,090,000
Minor Consent						
Individual	3.00	$76.91	617	$142,000	617	$142,000
Group	11.70	$30.89	617	$223,000	617	$223,000
ACA Optional						
Individual	2.30	$76.91	23,480	$4,153,000	23,480	$4,153,000
Group	15.20	$30.89	23,480	$11,025,000	23,480	$11,025,000
Perinatal						
Current						
Individual	2.40	$81.93	144	$28,000	144	$28,000
Group	11.10	$38.56	144	$62,000	144	$62,000
ACA Optional						
Individual	2.00	$81.93	192	$31,000	192	$31,000
Group	11.80	$38.56	192	$87,000	192	$87,000
Total				$26,255,000		$26,255,000

7. Based on historical claims received, assume 75% of each fiscal year claims will be paid in the year the services occurred. The remaining 25% will be paid in the following year.

	Accrual	FY 2017-18	FY 2018-19
Regular			
Current	$4,405,000	$1,101,000	$0
EPSDT	$5,020,000	$1,255,000	$0
Minor Consent	$310,000	$78,000	$0
ACA Optional	$13,516,000	$3,379,000	$0
Perinatal			
Current	$121,000	$30,000	$0
ACA Optional	$156,000	$39,000	$0
FY 2016-17	$23,528,000	$5,882,000	$0

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 58

	Accrual	FY 2017-18	FY 2018-19
Regular			
Current	$4,733,000	$3,550,000	$1,183,000
EPSDT	$5,771,000	$4,328,000	$1,443,000
Minor Consent	$365,000	$274,000	$91,000
ACA Optional	$15,178,000	$11,383,000	$3,795,000
Perinatal			
Current	$90,000	$67,000	$23,000
ACA Optional	$118,000	$88,000	$30,000
FY 2017-18	$26,255,000	$19,690,000	$6,565,000
Regular			
Current	$4,733,000	$0	$3,550,000
EPSDT	$5,771,000	$0	$4,328,000
Minor Consent	$365,000	$0	$274,000
ACA Optional	$15,178,000	$0	$11,383,000
Perinatal			
Current	$90,000	$0	$67,000
ACA Optional	$118,000	$0	$88,000
FY 2018-19	$26,255,000	$0	$19,690,000
Total		$25,572,000	$26,255,000

8. Total estimated reimbursements for ODF treatment servicesare:

FY 2017-18	TF	GF	FF (Title XIX)	FF (Title XXI)	County
Regular					
Current	$10,586,000	$0	$2,326,000	$4,913,000	$3,347,000
ACA Optional	$14,762,000	$795,000	$13,967,000	$0	$0
Perinatal					
Current	$97,000	$0	$48,000	$2,000	$47,000
ACA Optional	$127,000	$7,000	$120,000	$0	$0
Total	$25,572,000	**$802,000**	**$16,461,000**	**$4,915,000**	$3,394,000

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 58

FY 2018-19	TF	GF	FF (Title XIX)	FF (Title XXI)	County
Regular					
Current	$10,869,000	$0	$2,367,000	$5,079,000	$3,423,000
ACA Optional	$15,178,000	$949,000	$14,229,000	$0	$0
Perinatal					
Current	$90,000	$0	$44,000	$2,000	$44,000
ACA Optional	$118,000	$7,000	$111,000	$0	$0
Total	$26,255,000	**$956,000**	**$16,751,000**	**$5,081,000**	$3,467,000

Funding:
100%Title XIX FF (4260-101-0890)
100% Title XXI FF (4260-113-0890)
95% ACA Title XIX FF / 5% GF (4260-101-0001/0890)
94% ACA Title XIX FF / 6% GF (4260-101-0001/0890)
93% ACA Title XIX FF / 7% GF (4260-101-0001/0890)

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER:	60
IMPLEMENTATION DATE:	7/2012
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1726

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$8,423,000	$8,444,000
- STATE FUNDS	$1,264,290	$1,311,590
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$8,423,000	$8,444,000
STATE FUNDS	$1,264,290	$1,311,590
FEDERAL FUNDS	$7,158,710	$7,132,410

DESCRIPTION

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

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

Interdependent Policy Changes:
PC 56 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.

The responsibility for Drug Medi-Cal services 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.

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 60

The DMC program provides certain medically necessary substance use disorder treatment services. These services are provided by certified providers under contract with the counties or with the State. Funding for Perinatal beneficiaries is 50% CF and 50% Title XIX Federal Funds (FF). Certain aid codes are eligible for Title XXI federal reimbursement at 88%.

With the provisions of the Affordable Care Act (ACA) starting January 1, 2014, the Drug Medi-Cal State Plan was amended to allow the Department to expand DMC outpatient counseling and rehabilitation services to all Medi-Cal beneficiaries. Funding for the expanded population is 50% FF and 50% GF. Funding for the ACA Optional beneficiaries is 100% FF until December 31, 2016, 95% FF / 5% GF beginning January 2017, 94% FF / 6% GF beginning January 2018, and 93% FF / 7% GF beginning January 2019.

On August 13, 2015, the Department received approval from the Centers for Medicare and Medicaid Services (CMS) 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 (SUD). DMC-ODS waiver services will include the existing treatment modalities (Narcotic Treatment Program (NTP), IOT, Outpatient Drug Free (ODF), and Perinatal Residential Treatment Services (RTS)), and the additional new and expanded services.

Participation in the waiver is voluntary for counties and will be implemented on a phase-in basis. IOT services costs for the phase-in counties will be offset in the Drug Medi-Cal Organized Delivery System Waiver policy change.

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is a decrease due to the following:

- Decreased caseload projections based on actuals through June 2017, and
- Updated Units of Service (UOS) based on updated FY 2016-17 claims data.

The change in the current estimate, from FY 2017-18 to FY 2018-19, is due to an increase in the IOT Regular caseload projection for FY 2018-19.

Methodology:

1. The DMC eligible clients are categorized into two groups: Regular and Perinatal.

2. The caseload projections are based on complete caseload data from January 2010 through June 2017.

3. The Units of Service (UOS) is based on the approved units divided by the caseload. Complete data from July 2016 through June 2017 was used to calculate the average UOS.

4. The proposed DMC rates are based on the developed rates or the FY 2009-10 Budget Act rates adjusted for the cumulative growth in the Implicit Price (CIP) Deflator for the Cost of Goods and Services to Governmental Agencies reported by the Department of Finance, whichever is lower. FY 2017-18 and FY 2018-19 budgeted amounts are based on the FY 2017-18 rates.

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 60

5. The cost estimate is developed by the following: UOS x Rate x Caseload.

			FY 2017-18		FY 2018-19	
	UOS	Rates	Caseload	Total	Caseload	Total
Regular						
Current	24.6	$58.53	1,080	$1,555,000	1,107	$1,594,000
EPSDT	30.8	$58.53	955	$1,723,000	955	$1,723,000
ACA Optional	24.1	$58.53	3,377	$4,764,000	3,377	$4,764,000
Subtotal			5,412	$8,042,000	5,439	$8,081,000
Perinatal						
Current	26.4	$84.43	137	$305,000	137	$305,000
ACA Optional	22.4	$84.43	115	$217,000	115	$217,000
Subtotal			252	$522,000	252	$522,000
Total				$8,564,000		$8,603,000

6. Based on historical claims received, assume 75% of each fiscal year claims will be paid in the year the services occurred. The remaining 25% will be paid in the following year.

	Accrual	FY 2017-18	FY 2018-19
Regular	$8,069,000	$2,018,000	$0
Perinatal	$519,000	$130,000	$0
Total for FY 2016-17	$8,588,000	$2,148,000	$0
Regular	$8,042,000	$6,031,000	$2,011,000
Perinatal	$522,000	$392,000	$130,000
Total for FY 2017-18	$8,564,000	$6,423,000	$2,141,000
Regular	$8,081,000	$0	$6,061,000
Perinatal	$522,000	$0	$392,000
Total for FY 2018-19	$8,603,000	$0	$6,453,000
Total		$8,571,000	$8,594,000

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 60

7. Total estimated reimbursements for IOT services are:

FY 2017-18	TF	GF	FF Title XIX	FF Title XXI	County
Regular					
Current	$3,273,000	$996,000	$794,000	$1,483,000	$0
ACA Optional	$4,776,000	$256,000	$4,520,000	$0	$0
Perinatal					
Current	$301,000	$0	$150,000	$3,000	$148,000
ACA Optional	$221,000	$12,000	$209,000	$0	$0
Total	$8,571,000	**$1,264,000**	**$5,673,000**	**$1,486,000**	$148,000

FY 2018-19	TF	GF	FF Title XIX	FF Title XXI	County
Regular					
Current	$3,308,000	$1,000,000	$792,000	$1,516,000	$0
ACA Optional	$4,764,000	$298,000	$4,466,000	$0	$0
Perinatal					
Current	$305,000	$0	$152,000	$3,000	$150,000
ACA Optional	$217,000	$14,000	$203,000	$0	$0
Total	$8,594,000	**$1,312,000**	**$5,613,000**	**$1,519,000**	$150,000

Funding:
100% Title XIX FF (4260-101-0890)
100% Title XXI FF (4260-113-0890)
95% ACA Title XIX FF / 5% GF (4260-101-0001/0890)
94% ACA Title XIX FF / 6% GF (4260-101-0001/0890)
93% ACA Title XIX FF / 7% GF (4260-101-0001/0890)
88% Title XXI FF / 12% GF (4260-113-0001/0890)
50% Title XIX / 50% GF (4260-101-0001/0890)

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER:	62
IMPLEMENTATION DATE:	7/2012
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1725

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$1,195,000	$1,282,000
- STATE FUNDS	$42,660	$53,640
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,195,000	$1,282,000
STATE FUNDS	$42,660	$53,640
FEDERAL FUNDS	$1,152,340	$1,228,360

DESCRIPTION

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

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

Interdependent Policy Changes:
PC 56 Drug Medi-Cal Organized Delivery System Waiver

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

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

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

The DMC program provides certain medically necessary substance use treatment 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. Funding for RTS perinatal service is 50% County Funds (CF) and 50% Title XIX Federal Funds (FF). Funding for the ACA Optional beneficiaries is 100% FF until

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 62

December 31, 2016, 95% FF / 5% GF beginning January 2017, 94% FF / 6% GF beginning January 2018, and 93% FF / 7% GF beginning January 2019.

The responsibility for Drug Medi-Cal services 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.

On August 13, 2015, the Department received approval from the Centers for Medicare and Medicaid Services (CMS) 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 (SUD). DMC-ODS waiver services will include the existing treatment modalities (Narcotic Treatment Program (NTP), Intensive Outpatient Treatment (IOT), Outpatient Drug Free Treatment (ODF), and Perinatal RTS), and the additional new and expanded services.

Participation in the waiver is voluntary for counties and will be implemented on a phase-in basis. RTS services costs for the phase-in counties will be offset in the Drug Medi-Cal Organized Delivery System Waiver policy change.

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is a net decrease due to:

- Decreased caseload projections for the perinatal population and increased caseload for the ACA optional population based on actuals through June 2017, and
- Decreased Units of Service (UOS) based on updated FY 2016-17 claims data.

The change in the current estimate, from FY 2017-18 to FY 2018-19, is due to an increase in the ACA Optional caseload projection in FY 2018-19.

Methodology:

1. The caseload projections are based on complete caseload data from January 2010 through June 2017.

2. The Units of Service (UOS) is based on the approved units divided by the caseload. Complete data from July 2016 through June 2017 was used to calculate the average UOS.

3. The proposed DMC rates are based on the developed rates or the FY 2009-10 Budget Act rates adjusted for the cumulative growth in the Implicit Price (CIP) Deflator for the Cost of Goods and Services to Governmental Agencies reported by the Department of Finance, whichever is lower. FY 2017-18 and FY 2018-19 budgeted amounts are based on the FY 2017-18 rates.

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 62

4. The cost estimate is developed by the following: Caseload x UOS x Rates

	Caseload	UOS	Rates	Total
Current Perinatal	128	66.0	$80.92	$685,000
ACA Optional	225	37.1	$80.92	$675,000
FY 2016-17	353			$1,360,000
Current Perinatal	142	66.0	$90.14	$844,000
ACA Optional	248	37.1	$90.14	$829,000
FY 2017-18	390			$1,673,000
Current Perinatal	142	66.0	$90.14	$844,000
ACA Optional	259	37.1	$90.14	$866,000
FY 2018-19	401			$1,710,000

5. Based on historical claims received, assume 75% of each fiscal year claims will be paid in the year the services occurred. The remaining 25% will be paid in the following year.

	Accrual	FY 2017-18	FY 2018-19
Current Perinatal	$685,000	$171,000	$0
ACA Optional	$675,000	$169,000	$0
FY 2016-17	$1,360,000	$340,000	$0
Current Perinatal	$844,000	$633,000	$211,000
ACA Optional	$829,000	$622,000	$207,000
FY 2017-18	$1,673,000	$1,255,000	$418,000
Current Perinatal	$844,000	$0	$633,000
ACA Optional	$866,000	$0	$650,000
FY 2018-19	$1,710,000	$0	$1,283,000
Total		$1,595,000	$1,701,000

6. Total estimated reimbursements for RTS are:

FY 2017-18	**TF**	**GF**	**FF Title XIX**	**FF Title XXI**	**County**
Perinatal					
Current	$804,000	$0	$397,000	$7,000	$400,000
ACA Optional	$791,000	$43,000	$748,000	$0	$0
Total	$1,595,000	**$43,000**	**$1,145,000**	**$7,000**	$400,000

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 62

FY 2018-19	TF	GF	FF Title XIX	FF Title XXI	County
Perinatal					
Current	$844,000	$0	$418,000	$7,000	$419,000
ACA Optional	$857,000	$54,000	$803,000	$0	$0
Total	$1,701,000	**$54,000**	**$1,221,000**	**$7,000**	$419,000

Funding:
100% Title XIX FF (4260-101-0890)
100% Title XXI FF (4260-113-0890)
95% ACA Title XIX FF / 5% GF (4260-101-0001/0890)
94% ACA Title XIX FF / 6% GF (4260-101-0001/0890)
93% ACA Title XIX FF / 7% GF (4260-101-0001/0890)

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER:	63
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1780

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$1,520,088,000	$1,560,148,000
- STATE FUNDS	$97,814,250	$119,873,620
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,520,088,000	$1,560,148,000
STATE FUNDS	$97,814,250	$119,873,620
FEDERAL FUNDS	$1,422,273,750	$1,440,274,380

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: 63

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 2017-18 and FY 2018-19, is a net increase due to:

- Updated estimated Affordable Care Act (ACA) utilization and costs for SD/MC and Fee-For-Service (FFS) Inpatient clients, based on additional paid claims data through December 2017, and
- Updated FFS Inpatient payment lags based on updated paid claims data.

The change between FY 2017-18 and FY 2018-19, in the current estimate, is a net increase due to an increase of SD/MC, FFS Inpatient, and ACA utilization for FY 2018-19, based on projections and resuming the historical 37% in the same year, 62% in the second year, and 1% in the third year, SD/MC payment lags.

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, 2017, with dates of service from June 2012 through September 2017. The FFS data is current as of December 31, 2017, with dates of service from July 2010 through July 2017.

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: 63

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 2017-18 Utilization	FY 2018-19 Utilization
SD/MC	227,690	228,857
SD/MC ACA	150,587	175,456
FFS	13,324	13,521
FFS ACA	15,277	17,049
Total	406,878	434,883

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 2015-16	$1,718,287	$1,486,537	$231,750
FY 2016-17	$1,912,650	$1,658,828	$253,822
FY 2017-18	$2,073,529	$1,800,872	$272,657
FY 2018-19	$2,261,720	$1,969,032	$292,688

6. On a cash basis for FY 2017-18, the Department will be paying 1% of FY 2015-16 claims, 72% of FY 2016-17 claims, and 37% of FY 2017-18 claims for SD/MC claims. For FFS Inpatient claims, the Department will be paying 1% of FY 2015-16 claims, 57% of FY 2016-17 claims, and 42% of FY 2017-18 claims. The cash amounts (rounded) for Adult's SMHS are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2015-16	$17,182	$14,864	$2,318
FY 2016-17	$1,339,035	$1,194,356	$144,679
FY 2017-18	$780,371	$666,323	$114,048
Total FY 2017-18	$2,136,588	$1,875,543	$261,045

7. On a cash basis for FY 2018-19, the Department will be paying 1% of FY 2016-17 claims, 62% of FY 2017-18 claims, and 37% of FY 2018-19 claims for SD/MC claims. For FFS Inpatient claims, the Department will be paying 1% of FY 2016-17 claims, 57% of FY 2017-18 claims, and 42% of FY 2018-19 claims. The cash amounts (rounded) for Adult's SMHS are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2016-17	$19,127	$16,588	$2,539
FY 2017-18	$1,271,956	$1,116,541	$155,415
FY 2018-19	$850,968	$728,542	$122,426
Total FY 2018-19	$2,142,051	$1,861,671	$280,380

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER: 63

8. The chart below shows the FY 2017-18 and FY 2018-19 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, and 93% FF and 7% GF until December 31, 2019, 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)

FY	TF	FF	ACA FF	ACA GF	GF Reimbursement	County
2017-18	$2,136,588	**$686,434**	**$735,840**	**$27,881**	**$69,933**	$616,500
2018-19	$2,142,051	**$652,441**	**$787,833**	**$49,336**	**$70,538**	$581,903

Funding:
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)

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER:	64
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1779

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$1,305,357,000	$1,310,501,000
- STATE FUNDS	$38,716,630	$41,647,360
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,305,357,000	$1,310,501,000
STATE FUNDS	$38,716,630	$41,647,360
FEDERAL FUNDS	$1,266,640,370	$1,268,853,640

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.

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 64

Children's SMHS are provided under the federal requirements of the Early and Periodic Screening, Diagnosis 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.

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 2017-18 and FY 2018-19, is a net increase due to:

- Updated estimated Affordable Care Act (ACA) utilization and costs for SD/MC and Fee-For-Service (FFS) Inpatient clients, based on additional paid claims data through December 2017, and
- Updated FFS Inpatient payment lags based on updated paid claims data.

The change between FY 2017-18 and FY 2018-19, in the current estimate, is a net increase due to an increase of SD/MC, FFS Inpatient, and ACA utilization for FY 2018-19 based on projections and resuming the historical 37% in the same year, 62% in the second year, and 1% in the third year, SD/MC payment lags.

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, 2017, with dates of service from June 2012 through September 2017. The FFS data is current as of December 31, 2017, with dates of service from July 2010 through July 2017.

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: 64

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 2017-18 Utilization	FY 2018-19 Utilization
SD/MC	303,348	315,608
SD/MC ACA	9,195	10,839
FFS	12,649	13,125
FFS ACA	1,589	1,809
Total	326,781	341,381

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 2015-16	$1,691,822	$1,605,025	$86,797
FY 2016-17	$1,995,616	$1,902,371	$93,245
FY 2017-18	$2,167,615	$2,068,552	$99,063
FY 2018-19	$2,297,471	$2,192,576	$104,895

5. On a cash basis for FY 2017-18, the Department will be paying 1% of FY 2015-16 claims, 72% of FY 2016-17 claims, and 37% of FY 2017-18 claims for SD/MC claims. For FFS Inpatient children's claims, the Department will be paying 1% of FY 2015-16 claims, 57% of FY 2016-17 claims, and 42% of FY 2017-18 claims. The cash amounts (rounded) for Children's SMHS are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2015-16	$16,918	$16,050	$868
FY 2016-17	$1,426,406	$1,373,096	$53,310
FY 2017-18	$797,826	$756,390	$41,436
Total FY 2017-18	$2,241,150	$2,145,536	$95,614

6. On a cash basis for FY 2018-19, the Department will be paying 1% of FY 2016-17 claims, 62% of FY 2017-18 claims, and 37% of FY 2018-19 claims for SD/MC claims. For FFS Inpatient children's claims, the Department will be paying 1% of FY 2016-17 claims, 57% of FY 2017-18 claims, and 42% of FY 2018-19 claims. The cash amounts (rounded) for Children's SMHS are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2016-17	$19,956	$19,024	$932
FY 2017-18	$1,348,112	$1,291,476	$56,636
FY 2018-19	$845,617	$801,741	$43,876
Total FY 2018-19	$2,213,685	$2,112,241	$101,444

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 64

7. The chart below shows the FY 2017-18 and FY 2018-19 estimate with the following funding adjustments:
   - Medi-Cal claims are eligible for 50% federal reimbursement,
   - MCHIP claims are eligible for 88% federal reimbursement (through September 30, 2019)
   - ACA is funded by 100% federal funds (FF) until December 31, 2016, 95% FF and 5% GF until December 31, 2017, and 94% FF, 6% GF until December 31, 2018, and 93% FF and 7% GF until December 31, 2019, 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	FF	MCHIP	ACA FF	ACA GF	GF Reimb.	County Funds
FY 2017-18	$2,241,150	**$932,877**	**$293,496**	**$40,267**	**$1,612**	**$37,105**	$935,793
FY 2018-19	$2,213,685	**$897,991**	**$320,240**	**$50,623**	**$3,172**	**$38,475**	$903,184

Funding:
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)

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER:	87
IMPLEMENTATION DATE:	7/2000
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	56

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$19,903,403,000	$20,309,108,000
- STATE FUNDS	$6,160,217,280	$6,415,941,270
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$19,903,403,000	$20,309,108,000
STATE FUNDS	$6,160,217,280	$6,415,941,270
FEDERAL FUNDS	$13,743,185,720	$13,893,166,730

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:
PC 107 Capitated Rate Adjustment for FY 2018-19

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.

In addition to the changes specified above, another change is the use of California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) revenue as a funding source for new growth in expenditures as compared to the 2016 Budget Act for this policy change. 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 increases 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.

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 87

Reason for Change:
The change from the prior estimate, for FY 2017-18, is a decrease due to:

- Lower Hepatitis C costs due to lower than previously expected utilization growth and costs, and
- Incorporating FY 2017-18 weighted final rates.

The change from the prior estimate, for FY 2018-19, is a decrease due to:

- Lower Hepatitis C costs due to lower than previously expected utilization growth and costs, and
- Incorporating FY 2018-19 weighted draft rates.

The change from FY 2017-18 to FY 2018-19, is an increase in the current estimate due to higher eligible months.

Methodology:

1. Capitation rates are rebased annually. 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. The rates are implemented based on the rate year of the managed care model types. The rebasing process includes refreshed data and adjustments to trends.

2. FY 2017-18 final weighted rates have been updated from the previous estimate. FY 2018-19 draft weighted rates are budgeted in FY 2018-19.

3. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of $299,473,000 for FY 2017-18 and $269,000,000 for FY 2018-19 were included in the rates.

4. The savings from AB 97 are included in the rates. Savings of $264,479,000 for FY 2017-18 and $241,000,000 for FY 2018-19 were included in the rates.

5. Services provided through the LA Mobile Vision Pilot Project are included in the base rates.

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

7. Indian Health Services were removed from the base rates as of January 1, 2018.

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. Capitation rate increases due to the MCO Enrollment Tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from the tax fund on a quarterly basis. The reimbursement is budgeted in the MCO Enrollment Tax Mgd. Care Plans - Funding Adjustment policy changes.

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

11. 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.

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 87

12. Of the nonfederal share for this policy change in FY 2017-18, $510.0 million in new growth as compared to the 2016 Budget Act will be funded with Proposition 56 revenue. Of the nonfederal share for this policy change in FY 2018-19, $224.7 million in new growth as compared to the 2016 Budget Act will be funded with Proposition 56 revenue.

13. Two Plan Model costs on an accrual basis are:

(Dollars in Thousands)

FY 2017-18	Eligible Months	Total
Alameda	3,930,698	$1,010,962
Contra Costa	2,534,266	$655,561
Kern	3,901,548	$824,074
Los Angeles	36,761,898	$8,636,619
Riverside	8,305,274	$1,895,512
San Bernardino	8,428,711	$1,928,526
San Francisco	1,848,784	$568,920
San Joaquin	2,901,679	$660,530
Santa Clara	3,998,928	$922,295
Stanislaus	2,445,649	$614,616
Tulare	2,506,426	$478,104
Fresno	4,933,829	$1,173,203
Kings	569,511	$115,804
Madera	669,969	$137,800
Total	83,737,169	$19,622,526
Hepatitis C Adjustment		$319,191
Total FY 2017-18		**$19,941,717**

(Dollars in Thousands)

Included in the Above Dollars	FY 2017-18
Mental Health	$299,473
AB 97	($264,479)

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 87

(Dollars in Thousands)

FY 2018-19	Eligible Months	Total
Alameda	3,921,701	$1,055,754
Contra Costa	2,539,119	$687,058
Kern	3,927,974	$876,010
Los Angeles	36,981,049	$8,881,699
Riverside	8,331,648	$1,959,373
San Bernardino	8,431,053	$1,997,729
San Francisco	1,848,245	$598,963
San Joaquin	2,901,806	$667,361
Santa Clara	3,987,181	$902,278
Stanislaus	2,457,874	$622,194
Tulare	2,510,528	$452,671
Fresno	4,958,410	$1,140,092
Kings	574,421	$117,225
Madera	672,976	$129,623
Total	84,043,987	$20,088,030
Hepatitis C Adjustment		$254,477
Total FY 2018-19		**$20,342,507**

(Dollars in Thousands)

Included in the Above Dollars	FY 2018-19
Mental Health	$269,000
AB 97	($241,000)

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 87

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

(Dollars in Thousands)

FY 2017-18	TF	GF	FF	SF
Title XIX 50/50	$10,194,370	$5,097,185	$5,097,185	$0
State GF	$32,923	$32,923	$0	$0
ACA 94/6 GF	$3,245,239	$194,714	$3,050,525	$0
ACA 95/5 GF	$4,589,152	$229,458	$4,359,694	$0
Family Planning 90/10 GF	$133,447	$13,345	$120,103	$0
Title XXI 88/12 GF	$688,272	$82,593	$605,679	$0
Healthcare Treatment Fund	$510,000	$0	$0	$510,000
Title XIX 100%	$510,000	$0	$510,000	$0
Total	**$19,903,403**	**$5,650,218**	**$13,743,186**	**$510,000**

(Dollars in Thousands)

FY 2018-19	TF	GF	FF	SF
Title XIX 50/50	$11,110,284	$5,555,142	$5,555,142	$0
State GF	$33,133	$33,133	$0	$0
ACA 93/7 GF	$3,290,013	$230,301	$3,059,712	$0
ACA 94/6 GF	$4,597,064	$275,824	$4,321,240	$0
Family Planning 90/10 GF	$133,018	$13,302	$119,716	$0
Title XXI 88/12 GF	$696,206	$83,545	$612,661	$0
Healthcare Treatment Fund	$224,695	$0	$0	$224,695
Title XIX 100%	$224,695	$0	$224,695	$0
Total	**$20,309,108**	**$6,191,247**	**$13,893,166**	**$224,695**

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER:	88
IMPLEMENTATION DATE:	12/1987
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	57

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$7,769,831,000	$8,190,098,000
- STATE FUNDS	$2,349,919,100	$2,516,398,960
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$7,769,831,000	$8,190,098,000
STATE FUNDS	$2,349,919,100	$2,516,398,960
FEDERAL FUNDS	$5,419,911,900	$5,673,699,040

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:
PC 107 Capitated Rate Adjustment for FY 2018-19

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.

In addition to the changes specified above, another change is the use of California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) revenue as a funding source for new growth in expenditures as compared to the 2016 Budget Act for this policy change. 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 increases 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.

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 88

Reason for Change:
The change from the prior estimate, for FY 2017-18, is a decrease due to the following:

- Updated FY 2017-18 weighted draft rates to FY 2017-18 weighted final rates,
- Lower Hepatitis C costs due to lower than previously estimated average monthly utilizers,
- Lower ACA costs, and
- Lower eligibles.

The change from the prior estimate, for FY 2018-19, is an increase due updating FY 2018-19 draft weighted rates.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to:

- Higher eligible months, and
- Lower AB 97 savings (included in base rates).

Methodology:

1. Capitation rates are rebased annually. 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. The rates are implemented based on the rate year of the managed care model types. The rebasing process includes refreshed data and adjustments to trends.

2. 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).

3. FY 2017-18 final weighted rates have been updated from the previous estimate. Draft FY 2018-19 weighted rates are budgeted for FY 2018-19.

4. Capitation rate increases due to the MCO Enrollment Tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from the tax fund on a quarterly basis. The reimbursement is budgeted in the MCO Enrollment Tax Mgd. Care Plans - Funding Adjustment policy change.

5. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of $157,113,000 for FY 2017-18 and $165,001,000 for FY 2018-19 were included in the rates.

6. The savings from AB 97 are included in the rates. Savings of $79,856,000 for FY 2017-18 and $67,273,000 for FY 2018-19 were included in the rates.

7. Indian Health Services were removed from the base rates as of January 1, 2018.

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

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

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 88

11. 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.

12. Of the nonfederal share for this policy change in FY 2017-18, $110.0 million in new growth as compared to the 2016 Budget Act will be funded with Proposition 56 revenue.

13. COHS dollars on an accrual basis are:

(Dollars in Thousands)

FY 2017-18	Eligible Months	Total
501- San Luis Obispo	653,670	$193,445
502- Santa Barbara	1,502,307	$439,823
503- San Mateo	1,335,162	$399,491
504- Solano	1,327,058	$449,406
505- Santa Cruz	828,384	$243,760
506-Orange	9,239,250	$2,626,863
507- Napa	343,850	$121,472
508-Monterey	1,888,522	$465,206
509- Yolo	645,954	$214,440
513- Sonoma	1,346,656	$438,546
514- Merced	1,525,293	$346,154
510 - Marin	474,411	$179,111
512 - Mendocino	462,194	$140,704
515 - Ventura	2,435,333	$674,613
523 - Del Norte	137,640	$46,102
517 - Humboldt	629,878	$210,728
511 - Lake	372,742	$121,165
518 - Lassen	89,773	$30,027
519 - Modoc	37,388	$13,971
520 - Shasta	715,193	$253,230
521 - Siskiyou	210,752	$66,208
522 - Trinity	52,366	$17,670
Total FY 2017-18	26,253,777	$7,692,135
Hepatitis C Adjustment		$123,658
Total with Adjustments		**$7,815,793**

(Dollars in Thousands)

Included in Above Dollars	FY 2017-18
Mental Health	$157,113
AB 97	($79,856)

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 88

(Dollars in Thousands)

FY 2018-19	Eligible Months	Total
501- San Luis Obispo	656,716	$189,331
502- Santa Barbara	1,510,534	$425,122
503- San Mateo	1,341,847	$425,012
504- Solano	1,329,553	$498,046
505- Santa Cruz	831,937	$245,831
506-Orange	9,311,265	$2,788,554
507- Napa	346,719	$126,311
508-Monterey	1,898,001	$464,186
509- Yolo	646,793	$239,715
513- Sonoma	1,343,646	$463,489
514- Merced	1,530,882	$378,309
510 - Marin	478,058	$187,872
512 - Mendocino	467,920	$155,764
515 - Ventura	2,434,069	$705,614
523 - Del Norte	138,812	$50,981
517 - Humboldt	639,311	$230,839
511 - Lake	378,668	$134,276
518 - Lassen	90,136	$32,719
519 - Modoc	37,703	$15,162
520 - Shasta	718,278	$275,627
521 - Siskiyou	212,771	$73,391
522 - Trinity	52,728	$19,388
Total FY 2018-19	26,396,350	$8,125,539
Hepatitis C Adjustment		$98,586
Total with Adjustments		**$8,224,125**

(Dollars in Thousands)

Included in Above Dollars	FY 2018-19
Mental Health	$165,001
AB 97	($67,273)

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 88

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

(Dollars in Thousands)

FY 2017-18	TF	GF	FF	SF
Title XIX 50/50	$4,026,164	$2,013,082	$2,013,082	$0
State GF	$10,390	$10,390	$0	$0
Family Planning 90/10 GF	$46,183	$4,619	$41,565	$0
Title XXI 88/12 GF	$363,003	$43,560	$319,443	$0
ACA Optional Expansion 94/6	$1,306,389	$78,383	$1,228,006	$0
ACA Optional Expansion 95/5	$1,797,702	$89,885	$1,707,817	$0
Healthcare Treatment Fund	$110,000	$0	$0	$110,000
Title XIX 100% FFP	$110,000	$0	$110,000	$0
Total	**$7,769,831**	**$2,239,919**	**$5,419,912**	**$110,000**

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
Title XIX 50/50	$4,493,812	$2,246,906	$2,246,906
State GF	$10,199	$10,199	$0
Family Planning 90/10 GF	$47,637	$4,764	$42,874
Title XXI 88/12 GF	$376,389	$45,166	$331,223
ACA Optional Expansion 93/7	$1,363,992	$95,479	$1,268,513
ACA Optional Expansion 94/6	$1,898,069	$113,884	$1,784,185
Total	**$8,190,098**	**$2,516,398**	**$5,673,701**

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER:	89
IMPLEMENTATION DATE:	4/1994
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	58

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$3,707,278,000	$3,648,659,000
- STATE FUNDS	$1,106,531,360	$1,143,355,070
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,707,278,000	$3,648,659,000
STATE FUNDS	$1,106,531,360	$1,143,355,070
FEDERAL FUNDS	$2,600,746,640	$2,505,303,930

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:
PC 107 Capitated Rate Adjustment for FY 2018-19

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.

In addition to the changes specified above, another change is the use of California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) revenue as a funding source for new growth in expenditures as compared to the 2016 Budget Act for this policy change. 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 increases 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.

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 89

Reason for Change:
The change from the prior estimate, for FY 2017-18, is a decrease due to:

- Updated FY 2017-18 draft weighted rates to final weighted rates,
- Lower Newly costs, and
- Lower Hepatitis C costs due to lower than previously expected utilization.

The change from the prior estimate, for FY 2018-19, is a decrease due to:

- Updated FY 2018-19 draft weighted rates,
- Lower Newly costs, and
- Lower Hepatitis C costs due to lower than previously expected utilization

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to:

- Lower Hepatitis C costs,
- Lower Newly costs, and
- Lower eligible months.

Methodology:

1. Capitation rates are rebased annually. 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 FFP. The rates are implemented based on the rate year of the managed care model types. The rebasing process includes refreshed data and adjustments to trends.

2. FY 2017-18 final weighted rates have been updated from the previous estimate. Draft FY 2018-19 weighted rates are budgeted in FY 2018-19.

3. Capitation rate increases due to MCO Enrollment Tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment. The reimbursement is budgeted in the MCO Enrollment Tax Mgd. Care Plans - Funding Adjustment policy changes.

4. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of $58,396,000 for FY 2017-18 and $52,700,000 for FY 2018-19 were included in the rates.

5. The savings from AB 97 are included in the rates. Savings of $42,229,000 for FY 2017-18 and $39,900,000 for FY 2018-19 were included in the rates.

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

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

8. Indian Health Services were removed from the rates as of January 1, 2018.

9. 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.

10. 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.

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 89

11. Of the nonfederal share for this policy change in FY 2017-18, $60.0 million in new growth as compared to the 2016 Budget Act will be funded with Proposition 56 revenue.

12. GMC dollars on an accrual basis are:

(Dollars in Thousands)

FY 2017-18	Eligible Months	Total
Sacramento	5,285,719	$1,315,370
San Diego	8,687,576	$2,349,939
Total	13,973,295	$3,665,309
Hepatitis C Adjustment		$58,753
Total FY 2017-18		**$3,724,062**

(Dollars in Thousands)

Included in Dollars Above	FY 2017-18
Mental Health	$58,396
AB 97	($42,229)

(Dollars in Thousands)

FY 2018-19	Eligible Months	Total
Sacramento	5,278,943	$1,371,435
San Diego	8,686,369	$2,222,408
Total	13,965,312	$3,593,843
Hepatitis C Adjustment		$46,841
Total FY 2018-19		**$3,640,684**

(Dollars in Thousands)

Included in Dollars Above	FY 2018-19
Mental Health	$52,700
AB 97	($39,900)

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 89

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

(Dollars in Thousands)

FY 2017-18	TF	GF	FF	SF
Title XIX 50/50	$1,873,478	$936,739	$936,739	$0
State GF	$6,131	$6,131	$0	$0
Family Planning 90/10 GF	$24,808	$2,481	$22,327	$0
Title XXI 88/12 GF	$151,597	$18,191	$133,405	$0
ACA Optional Expansion 94/6 GF	$642,572	$38,554	$604,018	$0
ACA Optional Expansion 95/5 GF	$888,692	$44,434	$844,258	$0
Healthcare Treatment Fund	$60,000	$0	$0	$60,000
Title XIX 100% FFP	$60,000	$0	$60,000	$0
Total	**$3,707,278**	**$1,046,531**	**$2,600,746**	**$60,000**

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
Title XIX 50/50	$2,052,105	$1,026,053	$1,026,053
State GF	$6,157	$6,157	$0
Family Planning 90/10 GF	$24,526	$2,453	$22,073
Title XXI 88/12 GF	$148,000	$17,760	$130,240
ACA Optional Expansion 93/7 GF	$586,071	$41,025	$545,046
ACA Optional Expansion 94/6 GF	$831,800	$49,908	$781,892
Total	**$3,648,659**	**$1,143,356**	**$2,505,304**

REGIONAL MODEL

BASE POLICY CHANGE NUMBER:	94
IMPLEMENTATION DATE:	11/2013
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1842

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$1,189,296,000	$1,212,883,000
- STATE FUNDS	$352,160,520	$379,661,330
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,189,296,000	$1,212,883,000
STATE FUNDS	$352,160,520	$379,661,330
FEDERAL FUNDS	$837,135,480	$833,221,670

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:
PC 107 Capitated Rate Adjustment for FY 2018-19

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.

In addition to the changes specified above, another change is the use of California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) revenue as a funding source for new growth in expenditures as compared to the 2016 Budget Act for this policy change. 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 increases 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.

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 94

Reason for Change:
The change from the prior estimate, for FY 2017-18, is a decrease due to:

- Lower ACA costs, and
- Decreased Hepatitis C costs due to lower than previously expected average monthly utilizers.

The change from the prior estimate, for FY 2018-19, is a decrease due to:

- Lower ACA costs, and
- Decreased Hepatitis C costs due to lower than previously expected average monthly utilizers.

The change from FY 2017-18 to FY 2018-19, is an increase in the current estimate due to:

- Higher expected eligible months,
- Updated the weighted draft rates used for FY 2018-19, and
- Updated FY 2017-18 weighted draft rates to final rates.

Methodology:

1. Capitation rates are rebased annually. 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. The rebasing process includes refreshed data and adjustments to trends.

2. Capitation rate increases due to MCO Enrollment Tax are initially paid from the GF. The GF is then reimbursed in arrears through a funding adjustment. The reimbursement is budgeted in the MCO Enrollment Tax Mgd. Care Plans - Funding Adjustment policy changes.

3. FY 2017-18 final weighted rates have been updated from the previous estimate. FY 2018-19 draft weighted rates are budgeted in FY 2018-19.

4. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of $26,687,000 for FY 2017-18 and $24,700,000 for FY 2018-19 were included in the rates.

5. The savings from AB 97 are included in the rates. Savings of $11,614,000 for FY 2017-18 and $11,600,000 for FY 2018-19 were included in the rates. Rates include the savings for application to the primary care providers effective January 1, 2015.

6. Indian Health Services were removed from the rates as of January 1, 2018.

7. 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.

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

9. 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.

10. Of the nonfederal share for this policy change in FY 2017-18, $2.4 million in new growth as compared to the 2016 Budget Act will be funded with Proposition 56 revenue.

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 94

11. Regional Model dollars on an accrual basis are:

(Dollars in Thousands)

FY 2017-18	Eligible Months	Total
Alpine	2,587	$710
Amador	77,689	$19,634
Butte	795,139	$229,926
Calaveras	113,122	$30,316
Colusa	88,330	$18,294
El Dorado	361,563	$95,700
Glenn	119,767	$28,388
Inyo	46,328	$10,977
Mariposa	45,852	$12,195
Mono	31,762	$7,625
Nevada	249,228	$65,431
Placer	554,666	$139,469
Plumas	60,750	$17,036
Sierra	7,269	$1,997
Sutter	386,751	$91,727
Tehama	246,411	$64,598
Tuolumne	128,705	$35,850
Yuba	308,664	$79,015
Imperial	921,697	$214,443
San Benito	97,285	$15,282
Total FY 2017-18	4,643,562	$1,178,613
Hepatitis C Adjustment		$18,674
Total with Adjustments		**$1,197,287**

(Dollars in Thousands)

Included in Dollars Above	FY 2017-18
Mental Health	$26,687
AB 97	($11,614)

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 94

(Dollars in Thousands)

FY 2018-19	Eligible Months	Total
Alpine	2,571	$711
Amador	77,743	$19,708
Butte	800,274	$235,746
Calaveras	113,512	$30,441
Colusa	89,466	$18,781
El Dorado	361,693	$95,923
Glenn	120,257	$29,126
Inyo	46,796	$11,067
Mariposa	46,196	$12,284
Mono	31,740	$7,521
Nevada	252,798	$66,188
Placer	556,438	$141,071
Plumas	61,246	$17,209
Sierra	7,164	$1,978
Sutter	388,783	$93,820
Tehama	246,663	$66,197
Tuolumne	127,870	$36,094
Yuba	309,679	$80,575
Imperial	930,505	$219,875
San Benito	97,457	$15,097
Total FY 2018-19	4,668,852	$1,199,412
Hepatitis C Adjustment		$14,889
Total with Adjustments		**$1,214,301**

(Dollars in Thousands)

Included in Dollars Above	FY 2018-19
Mental Health	$24,700
AB 97	($11,600)

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 94

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

(Dollars in Thousands)

FY 2017-18		TF	GF	FF	SF
Title XIX 50/50 FFP	4260-101-0001/0890	$628,780	$314,390	$314,390	$0
State GF	4260-101-0001	$1,937	$1,937	$0	$0
ACA 100% FFP	4260-101-0890	$209,513	$12,571	$196,942	$0
ACA 95/5 GF	4260-101-0890	$289,634	$14,482	$275,152	$0
Family Planning 90/10 GF	4260-101-0001/0890	$8,740	$874	$7,866	$0
OTLICP 88/12 GF	4260-113-0001/0890	$45,892	$5,506	$40,386	$0
Healthcare Treatment Fund	4260-101-3305	$2,400	$0	$0	$2,400
Title XIX 100%	4260-101-0890	$2,400	$0	$2,400	$0
Total		**$1,189,296**	**$349,760**	**$837,136**	**$2,400**

(Dollars in Thousands)

FY 2018-19		TF	GF	FF
Title XIX 50/50 FFP	4260-101-0001/0890	$681,647	$340,824	$340,824
State GF	4260-101-0001	$1,941	$1,941	$0
ACA 95/5 GF	4260-101-0890	$196,183	$13,732	$182,451
ACA 94/6 FFP	4260-101-0890	$277,323	$16,639	$260,684
Family Planning 90/10 GF	4260-101-0001/0890	$8,502	$850	$7,651
OTLICP 88/12 GF	4260-113-0001/0890	$47,287	$5,674	$41,612
Total		**$1,212,883**	**$379,660**	**$833,222**

PACE (Other M/C)

BASE POLICY CHANGE NUMBER:	95
IMPLEMENTATION DATE:	7/1992
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	62

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$507,561,000	$503,658,000
- STATE FUNDS	$253,780,500	$251,829,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$507,561,000	$503,658,000
STATE FUNDS	$253,780,500	$251,829,000
FEDERAL FUNDS	$253,780,500	$251,829,000

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
Balanced Budget Act of 1997 (BBA)
SB 870 (Chapter 40, Statutes 2014)

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 eleven contracts with PACE Organizations for risk-based capitated lifetime care for the frail elderly. PACE rates are based upon Medi-Cal fee-for-service (FFS) expenditures for comparable populations and by law must be set at no less than 95% of the FFS Upper Payment Limits (UPL), pursuant to SB 870.

The Department worked with PACE Organizations to support passage of the PACE Modernization Act through the FY 2016-17 budget, authorizing changes to current law to transition from a FFS based methodology to a PACE experience based rate methodology. The Department has engaged a rate workgroup with the PACE Organizations, the California PACE Association, and their contracted actuaries to revise the existing UPL methodology and develop the new experience-based rate methodology. The legislation requires that the effective date for implementation of the new rate

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 95

methodology will be no sooner than July 1, 2017. The Department anticipates the implementation of the new rate methodology to occur January 1, 2018. PACE rates are set on a calendar year basis to coincide with the time period of the contracts.

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	Los Angeles	February 1, 2013
CalOptima PACE	Orange	September 1, 2013
InnovAge	San Bernardino	April 1, 2014
	Riverside	April 1, 2014
Central Valley Medical Svs.	Fresno	August 1, 2014
Redwood Coast	Humboldt	September 1, 2014
San Ysidro	San Diego	April 1, 2015
Stockton PACE	San Joaquin	July 1, 2018
	Stanislaus	July 1, 2018
Gary & Marcy West	San Diego	February 1, 2019

Reason for Change:
The change from the prior estimate, for FY 2017-18, is a decrease due to the redetermination of rates using experienced-based data for rates from January through December 2018. The change from the prior estimate, for FY 2018-19, is an increase due to a 2018 rate repayment. The change from FY 2017-18 to FY 2018-19, in the current estimate, is a net decrease due to fewer repayments in FY 2018-19.

Methodology:

1. Assume the January 2017 through December 2017 rates are calculated using the existing comparable population FFS Amount That Would Have Otherwise Been Paid (AWOP) methodology.

2. Assume the January 2018 through December 2018 rates are calculated using plan specific experienced-based data to build actuarially sound prospective rates.

3. FY 2017-18 and FY 2018-19 estimated funding is based on pending CMS approval of calendar year (CY) 2017 rates and projected CY 2018 and CY 2019 rates.

4. Assume enrollment will increase based on past enrollment in PACE organizations by county and plan and the impact of the CCI demonstration as experienced to date.

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 95

5. The Department worked with PACE Organizations to support legislation authorizing changes to current law to transition from an AWOP-based methodology to an actuarially sound experienced-based methodology. The legislation requires that the effective date for implementation of the new rate methodology will be no sooner than July 1, 2017. The Department anticipates the implementation of the new rate methodology to occur retroactive to January 1, 2018, based upon CMS approval.

6. The Department received CMS approval of contract amendments implementing 2016 rates in March 2017, retroactive to January 2016. This resulted in an adjustment of $42,424,000 for the increase of Non-dual and Dual rates that were paid at 2016 PACE rates from January 2016 to September 2017. The adjustment occurred during the October 2017 capitation cycle.

7. The Department submitted CY 2017 rates to CMS on January 31, 2018 with a projected approval date by CMS in March 2018, retroactive to January 2017. This will result in an adjustment of approximately $20,863,000 to the PACE plans. The adjustment is expected to occur during the May 2018 capitation cycle.

8. The Department plans to submit CY 2018 rates to CMS in April 2018 with a projected approval date by CMS in July 2018, retroactive to January 2018. This will result in an adjustment of approximately $12,057,000 to the PACE plans. The adjustment is expected to occur during the September 2018 capitation cycle.

9. Of the non-federal share for this policy change in FY 2017-18, $28.8 million in new growth as compared to the 2016 Budget Act will be funded with Proposition 56 revenue.

FY 2017-18	TF Cost (Rounded)	Eligible Months	Avg. Monthly Enrollment
Centers for Elders' Independence (Alameda and Contra Costa)	$45,673,000	8,403	700
Sutter Senior Care	$15,979,000	3,348	279
AltaMed Senior BuenaCare	$141,853,000	28,968	2,414
OnLok (SF, Alameda and Santa Clara)	$102,088,000	17,147	1,429
St. Paul's PACE	$39,000,000	8,200	683
Los Angeles Jewish Homes	$12,254,000	2,633	219
CalOptima PACE	$15,464,000	2,921	243
InnovAge (San Bernardino and Riverside)	$26,061,000	5,196	433
Redwood Coast	$7,177,000	1,620	135
Central Valley Medical Services	$23,131,000	4,626	386
San Ysidro San Diego	$15,594,000	2,995	250
Total Capitation Payments	$444,274,000	86,057	7,171
2016 Rate Adjustment	$42,424,000		
2017 Rate Adjustment	$20,863,000		
Total FY 2017-18	**$507,561,000**		

*Totals may differ due to rounding.

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 95

FY 2018-19	TF Cost (Rounded)	Eligible Months	Avg. Monthly Enrollment
Centers for Elders' Independence (Alameda and Contra Costa)	$47,269,000	8,370	698
Sutter Senior Care	$17,126,000	3,415	285
AltaMed Senior BuenaCare	$152,048,000	30,059	2,505
OnLok (SF, Alameda and Santa Clara)	$108,411,000	17,172	1,431
St. Paul's PACE	$43,075,000	8,851	738
Los Angeles Jewish Homes	$13,318,000	2,655	221
CalOptima PACE	$21,205,000	3,755	313
InnovAge (San Bernardino and Riverside)	$27,296,000	5,131	428
Redwood Coast	$7,994,000	1,703	142
Central Valley Medical Services	$25,028,000	4,837	403
San Ysidro San Diego	$21,968,000	3,906	326
Stockton PACE (San Joaquin and Stanislaus)	$6,624,000	1,248	104
Gary & Mary West	$239,000	44	9
Total Capitation Payments	**$491,601,000**	91,146	7,603
2018 Rate Adjustment	$12,057,000		
Total FY 2018-19	**$503,658,000**		

*Totals may differ due to rounding.

Funding:

FY 2017-18: 50% Title XIX / 50% GF (4260-101-0001/0890) $450,029,000
Healthcare Treatment Fund (4260-101-3305) $ 28,766,000
Title XIX 100% FFP (4260-101-0890) $ 28,766,000

FY 2018-19: 50% Title XIX / 50% GF (4260-101-0001/0890) $503,658,000

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER:	97
IMPLEMENTATION DATE:	7/2004
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1029

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$114,161,000	$123,429,000
- STATE FUNDS	$42,219,980	$45,874,990
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$114,161,000	$123,429,000
STATE FUNDS	$42,219,980	$45,874,990
FEDERAL FUNDS	$71,941,020	$77,554,010

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

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 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

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 97

endodontic services (root canals). The impact of the restoration of adult dental benefits is included in the capitation rates. The policy change (PC 36) for Full Restoration of Adult Dental Benefits captures the estimated cost for fully restoring the adult dental benefits in the Medi-Cal Dental Program.

Reason for Change:
The change from the prior estimate for FY 2017-18 is an overall net decrease due to changes in rate payment timing, updated eligibles, and changes in HIPF payment timing. The change from the prior estimate for FY 2018-19 is an overall net increase due to updated eligibles and rates and HIPF payment timing. The change from FY 2017-18 to FY 2018-19, in the current estimate, is an overall net increase due to additional HIPF payments expected to pay in FY 2018-19.

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 are shown in the Dental Retroactive Rate Changes policy change.

3. Rates for FY 2013-14, FY 2014-15, FY 2015-16, and FY 2017-18 are all expected to pay throughout varying portions or FY 2017-18. FY 2016-17 rates will pay only as a retro and will be captured in the Dental Retroactive Rate Changes policy change.

4. Rates for FY 2017-18 and FY 2018-19 are expected to pay throughout varying portions of FY 2017-18 and FY 2018-19. Any portions of the rate attributable to Proposition 56 Supplemental Payments are captured in the Supplemental Payments for Dental Services PC.

5. The cost impact of the HIPF has been included.

6. For the Rating Periods below, certain rates indicate “w/Prop 56.” This description is for display purposes only as the actual Prop 56 portions of those rates are captured in the Supplemental Payments for Dental Services PC.

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 97

FY 2017-18	Rating Period	Cap Rate	Elig In The Period	Total Funds
GMC				
For Period Jun and Jul 2017	FY 2013-14 Rate <21	$11.30	404,896	$4,573,872
	FY 2013-14 Rate 21+	$3.23	480,928	$1,553,870
For Period Aug 2017 - Sept 2017	FY 2014-15 Rate <21	$11.45	403,671	$4,622,033
	FY 2014-15 Rate 21+	$8.42	452,945	$3,813,797
For Period Oct 2017 - Feb 2018	FY 2015-16 Rate <21	$11.86	990,491	$11,747,219
	FY 2015-16 Rate 21+	$8.71	1,118,153	$9,739,115
For Period Mar 2018 - May 2018	FY 2017-18 Rate <21 w/Prop 56	$12.74	791,647	$10,083,659
	FY 2017-18 Rate 21+ w/Prop 56	$9.02	894,620	$8,066,296
GMC Subtotal				**$54,199,861**
PHP				
For Period Jun and Jul 2017	FY 2013-14 Rate <21	$13.07	379,439	$4,957,806
	FY 2013-14 Rate 21+	$3.42	557,182	$1,903,599
For Period Aug 2017 - Sept 2017	FY 2014-15 Rate <21	$12.95	368,937	$4,777,734
	FY 2014-15 Rate 21+	$7.80	552,062	$4,306,084
For Period Oct 2017 - Feb 2018	FY 2015-16 Rate <21	$13.50	897,026	$12,109,857
	FY 2015-16 Rate 21+	$9.31	1,362,597	$12,685,780
For Period Mar 2018 - May 2018	FY 2017-18 Rate <21 w/Prop 56	$14.62	538,224	$7,868,570
	FY 2017-18 Rate 21+ w/Prop 56	$9.54	818,458	$7,805,716
PHP Subtotal				**$56,415,145**
HIPF Add-on		**Payment Date**		
First half of CY 2015		September 2017		$1,160,111
Second half of CY 2015		October 2017		$1,205,640

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 97

First half of CY 2016		March 2018		$1,181,454
HIPF Subtotal				**$3,547,205**
Total FY 2017-18				**$114,162,211**

FY 2018-19	Rating Period	Cap Rate	Elig In The Period	Total Funds
GMC				
For Period Jun 2018 (Pay July 2018)	FY 2017-18 Rate <21 w/Prop 56	$12.74	198,037	$2,522,513
	FY 2017-18 Rate 21+ w/Prop 56	$9.02	223,797	$2,017,852
For Period Jul 2018 - Jan 2019	FY 2017-18 Rate <21 w/o Prop 56	$12.74	1,389,981	$17,704,968
	FY 2017-18 Rate 21+ w/o Prop 56	$9.02	1,570,781	$14,162,865
For Period Feb 2019 - May 2019	FY 2018-19 Rate <21 w/Prop 56	$13.37	796,423	$10,651,719
	FY 2018-19 Rate 21+ w/Prop 56	$9.47	900,017	$8,520,708
GMC Subtotal				**$55,580,626**
PHP				
For Period Jun 2018 (Pay July 2018)	FY 2017-18 Rate <21 w/Prop 56	$14.62	179,560	$2,625,074
	FY 2017-18 Rate 21+ w/Prop 56	$9.54	273,050	$2,604,105
For Period Jul 2018 - Jan 2019	FY 2017-18 Rate <21 w/o Prop 56	$14.62	1,260,291	$18,424,823
	FY 2017-18 Rate 21+ w/o Prop 56	$9.54	1,916,478	$18,277,646
For Period Feb 2019 - May 2019	FY 2018-19 Rate <21 w/Prop 56	$15.35	722,115	$11,084,800
	FY 2018-19 Rate 21+ w/Prop 56	$10.01	1,098,093	$10,996,256
PHP Subtotal				**$64,012,704**
HIPF Add-on		**Payment Date**		
Second half of CY 2016		July 2018		$1,265,900
All of CY 2017		March 2019		$2,569,711
HIPF Subtotal				**$3,835,611**
Total FY 2018-19				**$123,428,941**

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 97

Funding:

FY 2017-18	TF	GF	FF
Regular FMAP T19	$80,266,000	$40,133,000	$40,133,000
ACA 95% FFP/5% GF (2017)	$15,234,000	$762,000	$14,472,000
ACA 94% FFP/6% GF (2018)	$15,234,000	$914,000	$14,320,000
Title 21 88% FFP/12% GF	$3,427,000	$411,000	$3,016,000
Total	**$114,161,000**	**$42,220,000**	**$71,941,000**

FY 2018-19	TF	GF	FF
Regular FMAP T19	$86,558,000	$43,279,000	$43,279,000
ACA 94% FFP/6% GF (2018)	$16,623,000	$997,000	$15,626,000
ACA 93% FFP/7% GF (2019)	$16,623,000	$1,164,000	$15,459,000
Title 21 88% FFP/12% GF	$3,625,000	$435,000	$3,190,000
Total	**$123,429,000**	**$45,875,000**	**$77,554,000**

*Totals may differ due to rounding.

SENIOR CARE ACTION NETWORK (Other M/C)

BASE POLICY CHANGE NUMBER:	98
IMPLEMENTATION DATE:	2/1985
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	61

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$52,098,000	$41,482,000
- STATE FUNDS	$26,049,000	$20,741,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$52,098,000	$41,482,000
STATE FUNDS	$26,049,000	$20,741,000
FEDERAL FUNDS	$26,049,000	$20,741,000

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:
PC 99 MCO Tax Mgd. Care Plans – Incr. Cap. Rates
PC 109 MCO Tax Mgd. Care Plans – Funding Adjustment
PC 110 MCO Tax Managed Care Plans

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 2017-18 and FY 2018-19, is a decrease due to rate updates and anticipated rate timing. The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to a rate recoupment for 2017 scheduled to occur in FY 2018-19.

Methodology:
1. Estimated SCAN costs are computed by multiplying the actual and estimated monthly eligible count for each county by the capitated rates for each county and beneficiary type – Aged and Disabled or Long-Term Care.

SENIOR CARE ACTION NETWORK (Other M/C)

BASE POLICY CHANGE NUMBER: 98

2. The monthly enrollment is projected to be 13,052 in FY 2017-18 and FY 2018-19 based on Medi-Cal enrollment projections submitted by SCAN.

3. The CY 2017 rates for dually eligible enrollees were determined using SCAN provided costs for Medi-Cal services rendered to this population. The Department is finalizing CY 2017 rates using SCAN actuals. CY 2018 and CY 2019 rates are projected by trending forward CY 2017 rates. Rates in development will be based on SCAN plans' actual experience.

4. The Department implemented the SCAN 2016 rates, retroactive to January 2016, in March 2018. This will result in a repayment to SCAN of approximately $1,980,000 for the increase in rates for SCAN health plan for the period of January 2016 through January 2018.

5. The Department anticipates receiving CMS approval of the contract amendment implementing the SCAN 2017 rates, retroactive to January 2017, in July 2018. The recoupment is projected to occur in September 2018 capitation cycle for an estimated $12,364,000.

6. The Department anticipates receiving CMS approval of the contract amendment implementing the SCAN 2018 rates, retroactive to January 2018, in October 2018. The repayment is projected to occur in December 2018 capitation cycle for an estimated $1,222,000.

7. The Department anticipates receiving CMS approval of the contract amendment implementing the SCAN 2019 rates, retroactive to January 2019, in March 2019. The repayment is projected to occur in May 2019 capitation cycle

FY 2017-18	Costs	Eligible Months	Avg. Monthly Enrollment
Los Angeles	$32,751,000	106,154	8,846
Riverside	$10,882,000	30,396	2,533
San Bernardino	$6,485,000	20,076	1,673
Total	$50,118,000	156,626	13,052
2016 Rate Repayment	$1,980,000		
Total FY 2017-18	**$52,098,000**		

FY 2018-19	Costs	Eligible Months	Avg. Monthly Enrollment
Los Angeles	$34,389,000	106,154	8,846
Riverside	$11,426,000	30,396	2,533
San Bernardino	$6,809,000	20,076	1,673
Total	$52,624,000	156,626	13,052
2017 Rate Recoupment	($12,364,000)		
2018 Rate Repayment	$1,222,000		
Total FY 2018-19	**$41,482,000**		

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

AIDS HEALTHCARE CENTERS (Other M/C)

BASE POLICY CHANGE NUMBER:	100
IMPLEMENTATION DATE:	5/1985
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	63

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$17,090,000	$17,325,000
- STATE FUNDS	$8,545,000	$8,662,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$17,090,000	$17,325,000
STATE FUNDS	$8,545,000	$8,662,500
FEDERAL FUNDS	$8,545,000	$8,662,500

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 and is currently the only remaining traditional Primary Care Case Management (PCCM) program. The Department has a contract with AIDS Healthcare Centers as a PCCM plan and participates in a program savings sharing agreement. On August 2, 2012, AIDS Healthcare Foundation (AHF) received full-risk licensure. However, the contract with the Department has not been changed, and shared savings are expected to be produced by the PCCM's effective case management of services for which the PCCM is not at risk. The Department determined there were no shared savings for calendar year (CY) 2009. The shared savings for CY 2010, CY 2011, CY 2012 and beyond have not yet been determined. The Department entered into a five-year contract with AHF for January 1, 2012, through December 31, 2016. Subsequently, the Department entered into two six-month contract extensions with AHF for January 1, 2017, through June 30, 2017, and July 1, 2017, through December 31, 2017. The Department has extended the contract through June 30, 2018 and is working with CMS on formal approval. The Department is currently assuming AHF will become a full-risk managed care plan as of July 1, 2018 and anticipates further contract extensions.

Capitation rate increases due to the MCO Enrollment Tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from the tax fund on a quarterly basis. The reimbursement was budgeted in the MCO Enrollment Tax Managed Care Plans – Funding Adjustment policy change.

AIDS HEALTHCARE CENTERS (Other M/C)

BASE POLICY CHANGE NUMBER: 100

Reason for Change:
The change from the prior estimate, for FY 2017-18, is a decrease due to:

- AHF moving to full-risk effective July 1, 2018, and
- Updated member months and rates.

The change from the prior estimate, for FY 2018-19, is a decrease due to updated projected member months and draft rates.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to higher budgeted rates.

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

Member Months	Dual	Medi-Cal Only
January to June 2016	2,278	2,506
FY 2016-17	4,269	4,469
FY 2017-18	4,482	4,692
FY 2018-19	4,707	4,927

2) Assume the following paid rates:

Paid Rates	Dual	Medi-Cal Only
January to June 2016	$272.23	$1,839.50
July 2016 to June 2017	$272.23	$1,839.50

3) Assume the following revised rates to be made in FY 2017-18:

Revised Rates	Dual	Medi-Cal Only
January to June 2016	$49.56	$2,598.57
FY 2016-17	$51.62	$2,732.76
FY 2017-18	$52.24	$2,698.81
FY 2018-19	$189.29	$3,417.01

4) The following amounts is estimate for this policy change based on the updated eligible months and rates:

FY 2017-18	Year	Paid Rate	Revised Rate	Rate Difference	MM	**TF**
Dual (Retro)	Jan-June 2016	$272.23	$49.56	($222.67)	2,278	($507,000)
Medi-Cal Only (Retro)	Jan-June 2016	$1,839.50	$2,598.57	$759.07	2,506	$1,902,000
Dual (Retro)	FY 2016-17	$272.23	$51.62	($220.61)	4,269	($942,000)
Medi-Cal Only (Retro)	FY 2016-17	$1,839.50	$2,732.76	$893.26	4,669	$3,992,000
*Dual	FY 2017-18	N/A	$52.24	N/A	4,109	$215,000
*Medi-Cal Only	FY 2017-18	N/A	$2,698.81	N/A	4,301	$11,609,000
Total						$17,090,000

*Assumes five months of capitation payments.
**Assumes one month of capitation (June 2016) to occur in FY 2017-18.

AIDS HEALTHCARE CENTERS (Other M/C)

BASE POLICY CHANGE NUMBER: 100

FY 2018-19	Year	Paid Rate	Budget Rate	Rate Difference	MM	TF
**Dual (Retro)	FY 2017-18	N/A	$52.24	N/A	374	$20,000
**Medi-Cal Only (Retro)	FY 2017-18	N/A	$2,698.81	N/A	391	$1,055,000
***Dual (Retro)	FY 2018-19	N/A	$189.29	N/A	4,314	$817,000
***Medi-Cal Only (Retro)	FY 2018-19	N/A	$3,417.01	N/A	4,516	$15,433,000
Total						$17,325,000

**Assumes one month of capitation payments.
***Assumes 11 months of capitation payments.

FY 2017-18	TF	GF	FF
Dual	($1,132,000)	($566,000)	($566,000)
Medi-Cal Only	$18,222,000	$9,111,000	$9,111,000
Total FY 2017-18	**$17,090,000**	**$8,545,000**	**$8,545,000**

FY 2018-19	TF	GF	FF
Dual	$837,000	$418,000	$419,000
Medi-Cal Only	$16,488,000	$8,244,000	$8,244,000
Total FY 2018-19	**$17,325,000**	**$8,662,000**	**$8,663,000**

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

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

BASE POLICY CHANGE NUMBER:	102
IMPLEMENTATION DATE:	3/2018
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	66

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$3,056,000	$1,131,000
- STATE FUNDS	$1,528,000	$565,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,056,000	$1,131,000
STATE FUNDS	$1,528,000	$565,500
FEDERAL FUNDS	$1,528,000	$565,500

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 emotionally disturbed children at risk for out-of-home placement.

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is an increase due to updated draft rates.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to scheduling retroactive payments for prior years and 11 FY 2017-18 dates of service payments in FY 2017-18. Payments scheduled to be made in FY 2018-19 consist of one FY 2017-18 dates of service payment and 11 FY 2018-19 dates of service payments.

Methodology:
1) FY 2015-16 total member months are 310 based on actuals. Assume 312 annual member months for FY 2016-17, FY 2017-18, and FY 2018-19.

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

BASE POLICY CHANGE NUMBER: 102

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

- $3,286.64 in FY 2015-16
- $3,361.41 in FY 2016-17
- $3,454.77 in FY 2017-18
- $3,627.51 in FY 2018-19

3) Payments for FY 2015-16, FY 2016-17, and 11 months of FY 2017-18 are expected to occur in FY 2017-18.

4) Payments for one month of FY 2017-18, and 11 months of FY 2018-19 are expected to occur in FY 2018-19.

5) The costs for the Family Mosaic Project are expected to be:

FY 2015-16: $3,286.64 x 310 = $1,018,858 TF

FY 2016-17: $3,361.41 x 312 = $1,048,760 TF

FY 2017-18: $3,454.77 x 312 = $1,077,888 TF

FY 2018-19: $3,627.51 x 312 = $1,131,783 TF

6) Anticipated costs on a cash basis are:

FY 2017-18	TF	GF	FF
FY 2015-16	$1,019,000	$509,000	$510,000
FY 2016-17	$1,049,000	$525,000	$524,000
FY 2017-18*	$988,000	$494,000	$494,000
Total FY 2017-18	$3,056,000	$1,528,000	$1,528,000

FY 2018-19	TF	GF	FF
FY 2017-18**	$94,000	$47,000	$47,000
FY 2018-19*	$1,037,000	$518,000	$519,000
Total FY 2018-19	$1,131,000	$565,000	$566,000

*Assumes 11 months of capitation payments.
**Assumes 1 month of capitation payments.

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

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

BASE POLICY CHANGE NUMBER:	165
IMPLEMENTATION DATE:	7/1988
ANALYST:	Humei Wang
FISCAL REFERENCE NUMBER:	76

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$3,233,313,000	$3,333,500,000
- STATE FUNDS	$1,723,507,000	$1,775,783,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,233,313,000	$3,333,500,000
STATE FUNDS	$1,723,507,000	$1,775,783,500
FEDERAL FUNDS	$1,509,806,000	$1,557,716,500

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:
The change from the prior estimate for FY 2017-18 and FY 2018-19 is lower beneficiaries than previously estimated, partially due to reconciliation adjustments with CMS. The increase from FY 2017-18 to FY 2018-19 is related to a projected increase in the Part A 2019 premium and a moderate expected growth in beneficiaries.

	2017	2018		2019	
	Actual	November 2017 Estimate	May 2018 Actual	November 2017 Estimate	May 2018 Estimate
	Premiums				
Part A	$413.00	$421.00	$422.00	$436.00	$436.00
Part B	$134.00	$134.00	$134.00	$134.00	$134.00
	Average Estimated Monthly Beneficiaries				
Part A		178,100	177,100	180,500	179,600
Part B		1,402,400	1,396,300	1,431,300	1,425,600

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

BASE POLICY CHANGE NUMBER: 165

Methodology:

1. The Centers for Medicare and Medicaid set the following rates for 2017 and 2018

Calendar Year	Part A Premium	Part B Premium
2017	$ 413.00	$ 134.00
2018	$ 422.00	$ 134.00

2. For 2019, the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance, project a 3.39% growth in the Medicare Part A premium. Applying this growth to 2018 Part A premium ($422 x 1.0339) = $ 436 (rounded)

3. For 2019, the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance, estimate no change in Medicare Part B premium from 2018 level. The Medicare Part B premium is budgeted at $134.00.

FY 2017-18	**Part A**	**Part B**
Average Monthly Eligibles	177,100	1,396,300
Rate 07/2017-12/2017	$413.00	$134.00
Rate 01/2018-06/2018	$422.00	$134.00

FY 2018-19	**Part A**	**Part B**
Average Monthly Eligibles	179,600	1,425,600
Rate 07/2018-12/2018	$422.00	$134.00
Rate 01/2019-06/2019	$436.00	$134.00

Funding:

(Dollars in Thousands)

FY 2017-18	**TF**	**GF**	**FF**
Title XIX 50/50	$2,935,792	$1,467,896	$1,467,896
State GF 100%	$255,611	$255,611	$0
Title XIX 100% FFP	$41,910	$0	$41,910
Total	**$3,233,313**	**$1,723,507**	**$1,509,806**

FY 2018-19	**TF**	**GF**	**FF**
Title XIX 50/50	$3,029,901	$1,514,951	$1,514,950
State GF 100%	$260,833	$260,833	$0
Title XIX 100% FFP	$42,766	$0	$42,766
Total	**$3,333,500**	**$1,775,784**	**$1,557,716**

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER:	166
IMPLEMENTATION DATE:	1/2006
ANALYST:	Celine Donaldson
FISCAL REFERENCE NUMBER:	1019

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$2,095,567,000	$2,157,906,000
- STATE FUNDS	$2,095,567,000	$2,157,906,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,095,567,000	$2,157,906,000
STATE FUNDS	$2,095,567,000	$2,157,906,000
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
2015	$ 98.76
2016	$110.23
2017	$123.38
2018	$124.90
2019	$127.31 (estimated)

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER: 166

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 2014-15	$1,522,511,847	1,296,510
FY 2015-16	$1,670,974,353	1,357,168
FY 2016-17	$1,991,686,565	1,390,393

Reason for Change:
The change from the prior estimate for both FY 2017-18 and FY 2018-19 is due to a decrease in recent eligible counts of approximately 8,900 average monthly eligibles and an estimated $4.80 decrease in the 2019 PMPM. The increase between FY 2017-18 and FY 2018-19 is based on the historical trend.

Methodology:

1. The 2017 growth increased 11.93% over 2016 amounts per the *Centers for Medicare & Medicaid Services*. Medi-Cal's PMPM for 2017 is $123.38.

2. The 2018 growth increased 1.22% per the *Centers for Medicare & Medicaid Services.* Medi-Cal's PMPM for 2018 is $124.90.

3. The 2019 growth is estimated to increase 1.93% over 2018 amounts based on the Part D 2018 annual percentage increase provided by the *Centers for Medicare & Medicaid Services*. Medi-Cal's estimated PMPM for 2019 is $127.31.

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 July 2011 to January 2018.

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 2017-18	12	1,409,725	$174,630,600	**$2,095,567,000**
FY 2018-19	12	1,430,483	$179,825,500	**$2,157,906,000**

Funding:
100% GF (4260-101-0001)

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

BASE POLICY CHANGE NUMBER:	167
IMPLEMENTATION DATE:	7/1990
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	23

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$1,779,095,000	$1,836,141,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,779,095,000	$1,836,141,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,779,095,000	$1,836,141,000

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 as medical assistance 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 include 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, specialized therapeutic services, and transition/set-up expenses.

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

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

BASE POLICY CHANGE NUMBER: 167

Reason for Change:
The change for FY 2017-18, from the prior estimate, is an increase due to updated expenditures and HCBS waiver caseload, and higher prior year expenditures for FY 2016-17 than previously expected.

The change for FY 2018-19, from the prior estimate, is an increase due to updated HCBS waiver caseload and an increase in FY 2017-18 expenditures that are expected in FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a net increase due to updated HCBS waiver caseload and a decrease in prior year expenditures expected in FY 2018-19.

Methodology:
The following estimates, on a cash basis, were provided by CDDS:

(Dollars in Thousands)

	TF	CDDS GF	DHCS FFP
FY 2017-18	$3,558,190	$1,779,095	**$1,779,095**
FY 2018-19	$3,672,282	$1,836,141	**$1,836,141**

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

PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	168
IMPLEMENTATION DATE:	4/1993
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	22

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$1,796,201,000	$1,895,965,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,796,201,000	$1,895,965,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,796,201,000	$1,895,965,000

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.)
Interagency Agreements:
03-75676 (PCSP)
09-86307 (IPO)
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 via interagency agreements 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. IHSS costs are currently budgeted in this policy change, but due to the transition of IHSS recipients to managed care, some IHSS costs have been paid through managed care capitation beginning April 1, 2014. 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.

PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 168

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.

The Governor's Budget estimate of the CCI projects that it 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 In-Home Supportive Services (IHSS), into managed care. IHSS would be removed from capitation rate payments effective January 1, 2018.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is an increase due to the CCI reduction reduced twice in the previous estimate and corrected in the current estimate. The change from the prior estimate, for FY 2018-19, is a decrease due to revised expenditure data. The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to revised expenditure data.

Methodology:
1) The following estimates were provided by CDSS on a cash basis.

(Dollars in Thousands)

	TF	FFP	CDSS GF/ County Share
FY 2017-18	$3,592,402	**$1,796,201**	$1,796,201
FY 2018-19	$3,791,930	**$1,895,965**	$1,895,965

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

DENTAL SERVICES

BASE POLICY CHANGE NUMBER:	169
IMPLEMENTATION DATE:	7/1988
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	135

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$1,097,804,000	$1,074,108,000
- STATE FUNDS	$375,189,620	$413,429,250
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,097,804,000	$1,074,108,000
STATE FUNDS	$375,189,620	$413,429,250
FEDERAL FUNDS	$722,614,380	$660,678,750

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:
Delta Dental (Delta) has an at-risk contract to provide dental services to most Medi-Cal beneficiaries at a prepaid capitated rate per eligible. These dental costs are for fee-for-service (FFS) Medi-Cal beneficiaries. Dental costs for beneficiaries with dental managed care plans are shown in the Dental Managed Care policy change.

The Department acquired approval for a one-year extension of the current contract with Delta for the period July 1, 2016 through September 30, 2017. The Department approved contract extensions with contract runout and closeout activities are through September 2019. The current FI anticipates the end of operations at the end of January 2018 with the new contractors assuming operational responsibility immediately thereafter.

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

DENTAL SERVICES

BASE POLICY CHANGE NUMBER: 169

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 restoration of adult dental benefits is included in the capitation rates. The policy change (PC 36) for Full Restoration of Adult Dental Benefits captures the estimated cost for fully restoring the adult dental benefits in the Medi-Cal Dental Program.

Reason for Change:
The change from the prior estimate for FY 2017-18 is primarily due to an overall decrease due to a decrease in average monthly eligibles and a shift in the assumed timing of HIPF payments. The change from the prior estimate for FY 2018-19 is due to a change in methodology to base the estimated costs on actual weekly check write experience.

Methodology:
1. The FY 2015-16 capitation rate is used for the period of July 2017 through January 2018.

2. The FY 2016-17 and FY 2017-18 capitation rate will be paid retroactively in the month of July 2018 and will be captured in the Dental Retroactive Rate Changes PC.

3. From February 2018 forward, the FFS Delivery System will be transitioning over to straight FFS; however it is expected to be a cost neutral transition.

4. The following HIPF payments will be made in FY 2017-18:
   - HIPF for the second six months of CY 2015 is $4,006,526
   - HIPF for the first six months of CY 2016 is $4,849,023
   - HIPF for July 2017 through January 2018 is $14,196,520

DENTAL SERVICES

BASE POLICY CHANGE NUMBER: 169

FY 2017-18	Rating Period	Rate	Average Eligible Months	Total Funds
Regular Capitated				
For Period July 2017 – January 2018	FY 2015-16	$8.32	10,943,327	$637,339,000
Subtotal for Regular Capitated				**$637,339,000**
Other FFS - Non Capitated Jul 2017-Jan 2018				**$3,577,000**
Straight FFS Payments				
For Period February 2018 - June 2018				**$448,032,000**
HIPF Payments		**Payment Date**		**Amount**
For Second Half of CY 2015		October 2017		$4,007,000
For First Half of CY 2016		March 2018		$4,849,000
Subtotal HIPF Payments				**$8,856,000**
Total FY 2017-18				**$1,097,804,000**

FY 2018-19	Payment Date	Total Funds
Straight FFS Payments		
For Period July 2018 - June 2018		$1,055,192,000
Subtotal FY 2018-19 Straight FFS Payments		**$1,055,192,000**
HIPF Payments		
Second half of CY 2016	July 2018	$5,331,457
CY 2017 (July 2017 – Jan 2018)	July 2018	$13,585,000
Subtotal HIPF Payments		**$18,916,457**
Total		**$1,074,108,000**

DENTAL SERVICES

BASE POLICY CHANGE NUMBER: 169

Funding (Totals may differ due to rounding):

FY 2017-18	TF	GF	FF
50% Title XIX / 50% GF	$689,233,000	$344,616,000	$344,617,000
100% GF	$196,000	$196,000	$0
95% Title XIX ACA FF / 5% GF	$193,684,000	$9,684,000	$183,999,000
94% Title XIX ACA FF / 6% GF	$84,808,000	$5,089,000	$79,719,000
88% Title XXI / 12% GF	$129,802,000	$15,576,000	$114,226,000
65% Title XIX / 35% GF	$82,000	$29,000	$53,000
Total	**$1,097,804,000**	**$375,190,000**	**$722,614,000**
FY 2018-19	**TF**	**GF**	**FF**
50% Title XIX / 50% GF	$766,695,000	$383,347,000	$383,348,000
100% GF	$461,000	$461,000	$0
95% Title XIX ACA FF / 5% GF	$61,855,000	$4,330,000	$57,525,000
94% Title XIX ACA FF / 6% GF	$62,800,000	$3,768,000	$59,032,000
93% Title XIX ACA FF / 7% GF	$5,670,000	$284,000	$5,386,000
88% Title XXI / 12% GF	$176,435,000	$21,172,000	$155,263,000
65% Title XIX / 35% GF	$192,000	$67,000	$125,000
Total	**$1,074,108,000**	**$413,429,000**	**$660,679,000**

DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

BASE POLICY CHANGE NUMBER:	172
IMPLEMENTATION DATE:	7/1997
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	77

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$175,445,000	$155,445,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$175,445,000	$155,445,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$175,445,000	$155,445,000

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 four 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:
The change for both FY 2017-18 and FY 2018-19, from the prior estimate, is due to a decrease in funds needed based on moving consumers out of the Sonoma DC in preparation for its closure scheduled to occur in December 2018.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to the completion of the phases of moving consumers out of the Sonoma DC in FY 2018-19.

DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

BASE POLICY CHANGE NUMBER: 172

Methodology:

1. The following estimates, on a cash basis, have been provided by CDDS.

(Dollars in Thousands)

Fiscal Year	Total Funds	CDDS GF	FFP Regular
FY 2017-18	$350,890	$175,445	**$175,445**
FY 2018-19	$310,890	$155,445	**$155,445**

Funding:

100% Title XIX (4260-101-0890)

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

BASE POLICY CHANGE NUMBER:	173
IMPLEMENTATION DATE:	7/1991
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	26

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$222,014,000	$209,741,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$222,014,000	$209,741,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$222,014,000	$209,741,000

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 both FY 2017-18 and FY 2018-19, from the prior estimate, is an increase due to updated expenditure and caseload data and an increase in expected prior year expenditures.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a net decrease due to an increase in expected FY 2018-19 expenditures and a decrease in expected prior year expenditures occurring in FY 2018-19.

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

BASE POLICY CHANGE NUMBER: 173

Methodology:

1. The following estimates, on a cash basis, were provided by CDDS:

(Dollars in Thousands)

	TF	CDDS GF	DHCS FFP
FY 2017-18	$444,028	$222,014	**$222,014**
FY 2018-19	$419,482	$209,741	**$209,741**

Funding:

100% Title XIX (4260-101-0890)

WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	175
IMPLEMENTATION DATE:	4/2000
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	32

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$40,990,000	$41,299,000
- STATE FUNDS	$20,495,000	$20,649,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$40,990,000	$41,299,000
STATE FUNDS	$20,495,000	$20,649,500
FEDERAL FUNDS	$20,495,000	$20,649,500

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) 03-75898

Interdependent Policy Changes:
PC 34 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 NF Level of Care 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 In-Home Operations (IHO) Waiver. These waivers provide HCBS to Medi-Cal eligible waiver participants using specific Level Of Care (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 first utilize authorized 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.

AB 10 set the minimum wage in California to $10.00 an hour after January 1, 2016. SB 3 requires the Department to create a schedule for a phased increase in the minimum wage from $10.50 per hour to $15.00 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 (CPI) once the minimum wage reaches $15.00 per hour. Beginning January 1, 2017, the minimum wage

WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 175

increased from $10.00 to $10.50 per hour for providers living in counties that pay below $10.50 per hour. Beginning January 1, 2018, the minimum wage increased from $10.50 to $11.00 per hour. Beginning January 1, 2019, the minimum wage will increase from $11.00 to $12.00 per hour.

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is a decrease based on actual expenditures from January through June 2017. The additional six months of actual data decreased the average monthly hours projected for both fiscal years. The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to anticipated minimum wage increases each year through 2022 and a slight increase in projected hours in the HCBA waiver.

Methodology:
1. Assume the number of current HCBA waiver beneficiaries using WPCS is estimated to increase by an average of four per month in FY 2017-18 and FY 2018-19.

2. Assume the number of current IHO beneficiaries using WPCS is estimated to increase by an average of one per month in FY 2017-18 and FY 2018-19.

3. The Department's CCT Demonstration Project transferred 397 beneficiaries in FY 2016-17. The CCT Demonstration Project expects to transition 498 beneficiaries out of inpatient extended health care facilities in FY 2017-18 and 219 in FY 2018-19. Based on actual data from July 2015 through June 2016, the Department assumes 3% of CCT beneficiaries will use WPCS in FY 2017-18 and assumes 5% of CCT beneficiaries will use WPCS in FY 2018-19.

4. The average cost/hour is $11.27 for FY 2017-18 and $11.49 FY 2018-19.

5. The chart below displays the estimate on an accrual basis.

FY 2017-18	Total Hours	Cost/Hour	TF	GF	FF
HCBA Waiver	3,430,770	$11.27	$38,665,000	$19,333,000	$19,332,000
IHO Waiver	142,916	$11.27	$1,611,000	$805,000	$806,000
Total			**$40,276,000**	**$20,138,000**	**$20,138,000**

FY 2018-19	Total Hours	Cost/Hour	TF	GF	FF
HCBA Waiver	3,469,159	$11.49	$39,861,000	$19,931,000	$19,930,000
IHO Waiver	142,916	$11.49	$1,642,000	$821,000	$821,000
Total			**$41,503,000**	**$20,752,000**	**$20,751,000**

6. The chart below is adjusted on a cash basis.

(Dollars in Thousands)	TF	GF	FF
FY 2017-18	**$40,990**	**$20,495**	**$20,495**
FY 2018-19	**$41,299**	**$20,650**	**$20,649**

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

MEDI-CAL TCM PROGRAM

BASE POLICY CHANGE NUMBER:	176
IMPLEMENTATION DATE:	6/1995
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	27

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$45,447,000	$35,254,000
- STATE FUNDS	$306,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$45,447,000	$35,254,000
STATE FUNDS	$306,000	$0
FEDERAL FUNDS	$45,141,000	$35,254,000

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 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).

Reason for Change:
The change in FY 2017-18, from the prior estimate, is a net increase due to:

- A slight increase in base payments,
- A decrease in ACA payments for FY 2015-16 through FY 2017-18,
- A decrease in estimated payments from LGA turnover/additions,
- An increase in reconciliation payments, and
- A shift in FY 2012-13 reconciliation recoupments from FY 2017-18 to FY 2019-20.

The change in FY 2018-19, from the prior estimate, is a net increase due to:

- A slight increase in the base payment due to incorporating FY 2018-19 LGA turnover/additions into the base,
- Updating reconciliation payments and recoupments based on actuals, and
- An increase in ACA payments for FY 2016-17 through FY 2018-19.

MEDI-CAL TCM PROGRAM

BASE POLICY CHANGE NUMBER: 176

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to higher reconciliation payments in FY 2017-18.

Methodology:

1. SPA #10-010, approved on December 19, 2013, lifted the annual capitated amount (CAP removal), effective October 16, 2010. The annual capitated amount was the maximum amount of dollars an LGA could claim for reimbursement within a target population.

2. The projected payment amount of $31,329,000 for FY 2017-18 and $33,832,000 for FY 2018-19 is based on average expenditures from FY 2014-15 through FY 2016-17.

3. In FY 2017-18, $2,594,000 will be paid for ACA optional encounters for FY 2015-16 through FY 2017-18.

4. The following reconciliations will occur in FY 2017-18:
    a) The Department will recoup $513,000 for FY 2010-11 reconciliations.
    b) The Department will pay:
        i. $174,000 for the FY 2011-12 Final Reconciliations,
        ii. $6,000 for the FY 2013-14 ACA Final Reconciliations,
        iii. $204,000 for the FY 2013-14 Non-ACA Final Reconciliations,
        iv. $452,000 for the FY 2014-15 ACA interim reconciliations,
        v. $3,773,000 for the FY 2014-15 Non-ACA interim reconciliations,
        vi. $205,000 for the FY 2015-16 ACA Interim Reconciliations, and
        vii. $4,414,000 for the FY 2015-16 Non-ACA Interim Reconciliations.

5. LGAs may choose to participate or withdraw from the program. In FY 2017-18, it is expected the net impact of these shifts will be $2,503,000 and these payments will become part of the base payment.

6. In FY 2017-18, upon approval, the Department will utilize the General Fund (GF) for additional SPA cap removal claims for FY 2010-11 and FY 2012-13, and for FY 2014-15 pending payments for a total of $306,000. These claims exceed the federal two-year claiming limitation.

7. Assume that in FY 2018-19 the Department will perform the following reconciliations:
    a) The Department will recoup:
        i. $1,057,000 to complete the FY 2010-11 Final Reconciliations,
        ii. $19,000 for the FY 2013-14 ACA Final Reconciliations,
        iii. $1,141,000 for the FY 2013-14 Non-ACA Final Reconciliations,
        iv. $56,000 for the FY 2015-16 ACA Interim Reconciliations,
        v. $473,000 for the FY 2015-16 Non-ACA Interim Reconciliations, and
        vi. $100,000 for the FY 2016-17 Interim Reconciliations.
    b) The Department will pay $835,000 for the FY 2014-15 Final Reconciliations.

8. Assume in FY 2018-19 the Department will pay ACA encounters from FY 2016-17 through FY 2018-19 in the amount of $3,433,000.

MEDI-CAL TCM PROGRAM

BASE POLICY CHANGE NUMBER: 176

FY 2017-18	TF	GF	FF
FY 2017-18 Base (Average Expenditures)	$31,329,000		$31,329,000
SPA#10-010 increase (CAP removal) and pending FY 2014-15 payments			
FY 2010-11	$270,000	$270,000	
FY 2012-13	$29,000	$29,000	
FY 2014-15	$7,000	$7,000	
ACA encounters			
FY 2015-16	$202,000		$202,000
FY 2016-17	$1,950,000		$1,950,000
FY 2017-18	$442,000		$442,000
Reconciliations			
FY 2010-11 (Final)	($513,000)		($513,000)
FY 2011-12 (Final)	$174,000		$174,000
FY 2013-14 ACA (Final)	$6,000		$6,000
FY 2013-14 Non-ACA (Final)	$204,000		$204,000
FY 2014-15 ACA (Interim)	$452,000		$452,000
FY 2014-15 Non-ACA (Interim)	$3,773,000		$3,773,000
FY 2015-16 ACA (Interim)	$205,000		$205,000
FY 2015-16 Non-ACA (Interim)	$4,414,000		$4,414,000
LGA Turnover/Additions	$2,503,000		$2,503,000
Total FY 2017-18	**$45,447,000**	**$306,000**	**$45,141,000**

FY 2018-19	TF	FF
FY 2017-18 Base (Average Expenditures)	$33,832,000	$33,832,000
ACA		
FY 2016-17	$8,000	$8,000
FY 2017-18	$2,549,000	$2,549,000
FY 2018-19	$876,000	$876,000
Reconciliation		
FY 2010-11 (Final)	($1,057,000)	($1,057,000)
FY 2013-14 ACA (Final)	($19,000)	($19,000)
FY 2013-14 Non-ACA (Final)	($1,141,000)	($1,141,000)
FY 2014-15 Final	$835,000	$835,000
FY 2015-16 ACA (Interim)	($56,000)	($56,000)
FY 2015-16 Non-ACA (Interim)	($473,000)	($473,000)
FY 2016-17 Interim	($100,000)	($100,000)
Total FY 2018-19	**$35,254,000**	**$35,254,000**

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XIX ACA (4260-101-0890)
100% GF (4260-101-0001)

EPSDT SCREENS

BASE POLICY CHANGE NUMBER:	177
IMPLEMENTATION DATE:	7/2001
ANALYST:	Sasha Jetton
FISCAL REFERENCE NUMBER:	136

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$4,998,000	$4,956,000
- STATE FUNDS	$2,401,340	$2,381,480
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,998,000	$4,956,000
STATE FUNDS	$2,401,340	$2,381,480
FEDERAL FUNDS	$2,596,660	$2,574,520

DESCRIPTION

Purpose:
This policy change estimates the screening costs for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

Authority:
Title 22, California Code of Regulations 51340(a)

Interdependent Policy Changes:
Not Applicable

Background:
The Child Health and Disability Prevention (CHDP) program is responsible for the screening component of the EPSDT benefit of the Medi-Cal program, including the health assessments, immunizations, and laboratory screening procedures for Medi-Cal children.

The Department is transitioning EPSDT claims to the standard Fee-For-Service (FFS) paid claims process to meet the Health Insurance Portability and Accountability Act (HIPPA) requirements. Claims for clinical laboratories transitioned February 1, 2017. All other claims, except school-based transitioned on July 1, 2017 and are now included in the Fee-For-Service Base expenditures.

Reason for Change:
The decrease in the number of screens and the cost per screen from the prior estimate for both FY 2017-18 (-418,205, -$0.75) and FY 2018-19 (-417,108, -$0.68) is attributed to the transition to Fee-for-Service claims. There is no significant change between FY 2017-18 and FY 2018-19 within the current estimate.

EPSDT SCREENS

BASE POLICY CHANGE NUMBER: 177

Methodology:
Costs are determined by multiplying the estimated screens by the estimated cost per screen for FY 2017-18 and FY 2018-19, based on historical trends from July 2012 to November 2017.

FY 2017-18
Screens 81,618 x $61.24 (weighted average) = **$4,998,000** (rounded)

FY 2018-19
Screens 80,870 x $61.28 (weighted average) = **$4,956,000** (rounded)

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)

CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	187
IMPLEMENTATION DATE:	7/1997
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	1083

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$1,485,000	$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	$1,485,000	$1,028,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,485,000	$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 2017-18 and FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to fewer prior year invoices in FY 2018-19.

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: 187

2. The estimates are provided by CDPH on a cash basis.

FY 2017-18	DHCS FFP	CDPH CLPP Fee Funds
FY 2016-17 Benefits Costs	$714,000	$714,000
FY 2017-18 Benefits Costs	$771,000	$771,000
Total for FY 2017-18	**$1,485,000**	$1,485,000

FY 2018-19	DHCS FFP	CDPH CLPP Fee Funds
FY 2017-18 Benefits Costs	$257,000	$257,000
FY 2018-19 Benefits Costs	$771,000	$771,000
Total for FY 2018-19	**$1,028,000**	$1,028,000

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

HIPP PREMIUM PAYOUTS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	188
IMPLEMENTATION DATE:	1/1993
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	91

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$1,150,000	$1,090,000
- STATE FUNDS	$575,000	$545,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,150,000	$1,090,000
STATE FUNDS	$575,000	$545,000
FEDERAL FUNDS	$575,000	$545,000

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 1916(e)
Title 22 California Code of Regulations 50778 (Chapter 2, Article 15)

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. The Centers for Medicare and Medicaid Services (CMS) approved a State Plan Amendment (SPA) allowing the Department to revise the methodology for determining cost effectiveness under the HIPP program. In addition to premiums, the Department also pays for 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.

Reason for Change:
The change in FY 2017-18, from the prior estimate, is a decrease due to a decrease in the enrollment of active HIPP members and a decrease in estimated premium costs.

The change in FY 2018-19, from the prior estimate, is a net decrease due to an increase in projected enrollment of active HIPP members and a decrease in estimated premium costs.

HIPP PREMIUM PAYOUTS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 188

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to previously estimating that HIPP enrollment would decrease by 5% per year based on previous enrollment trends and premium costs would increase by 5%. It is now projected that active program enrollment will remain at or around 195 members and premium costs will decrease by 5% due to a historical 3-year trend.

Methodology:

1. Premium costs are determined by the prior three year's average premium expense and include ancillary costs as incurred.

2. In FY 2017-18, based on actual data through December 2017, it is estimated that there will a decrease in premium costs and a decrease in enrollment for FY 2017-18 compared to the prior estimate.

3. The average monthly premium cost including ancillary costs is estimated to be $491 in FY 2017-18 and $466 in FY 2018-19.

4. The average monthly HIPP enrollment is estimated to be 195 in FY 2017-18 and 195 in FY 2018-19.

5. Costs for FY 2017-18 and FY 2018-19 are estimated to be:

   FY 2017-18: $491 x 195 x 12 Months = **$1,150,000 TF ($575,000 GF)**

   FY 2018-19: $466 x 195 x 12 Months = **$1,090,000 TF ($545,000 GF)**

Funding:

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

BASE RECOVERIES

BASE POLICY CHANGE NUMBER:	203
IMPLEMENTATION DATE:	7/1987
ANALYST:	Stephanie Hockman
FISCAL REFERENCE NUMBER:	127

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	-$356,599,000	-$349,320,000
- STATE FUNDS	-$156,116,000	-$152,929,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$356,599,000	-$349,320,000
STATE FUNDS	-$156,116,000	-$152,929,000
FEDERAL FUNDS	-$200,483,000	-$196,391,000

DESCRIPTION

Purpose:
This policy change estimates estate, personal injury, and other insurance recoveries and provider/beneficiary overpayment used to offset the cost of Medi-Cal services.

Authority:
- Welfare & Institutions Code 14009, 14009.5, 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 50781-50791, 51045, 51047, and 51458.1

Interdependent Policy Changes:
PC 185 Medi-Cal Estate Recoveries

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 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.

Effective May 1, 2017, the Department ceased outsourcing of the Worker's Compensation Recovery Program (WCRP). WCRP contracts contain provisions that may enable the contractors to work existing WCRP cases, but prevent contractors from accepting new WCRP cases. Therefore, the Worker's Compensation contract estimates will trend downward, and Personal Injury Collections, consisting of both personal injury and worker's compensation recoveries, will trend upward.

BASE RECOVERIES

BASE POLICY CHANGE NUMBER: 203

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 the fluctuations of settlements, judgements, and awards. Overall, FY 2017-18 and FY 2018-19 recoveries are projected to be lower than the prior estimate. Decreases in estate recoveries due to the impact of Senate Bill 833, which limited the types of estates and services included in the Department's estate recovery program; decreases in health insurance contingency contract recoveries due to lower than anticipated recoveries for Mental Health Substance Use Disorder and Local Education Agency claims; and provider overpayment collections returning to historical levels after higher than average collections during January through July 2017, lowered projections in both fiscal years. These decreases are partially offset by higher personal injury collections. The combination of changes described above result in decreases in all recovery types except personal injury collections between FY 2017-18 and FY 2018-19 in the current estimate.

(Dollars in Thousands)

Recovery Type	FY 2017-18	FY 2018-19
Personal Injury Collections	($115,005)	($117,688)
Workers' Comp. Collections	($1,084)	($1,500)
Health Insurance Contingency Contract	($109,375)	($108,405)
General Collections	($131,135)	($121,727)
TOTAL	**($356,599)**	**($349,320)**

Methodology:
1. The recoveries estimate uses the trend in monthly recoveries for July 2014 – January 2018.

2. The General Fund ratio for collections is estimated to be 43.78% in FY 2017-18 and FY 2018-19. The Federal Medical Assistance Percentages (FMAPs) for Medi-Cal recoveries includes an adjustment related to the Repayment to CMS for Medi-Cal Recoveries policy change.

Funding:
100% GF (4260-101-0001)
100% Title XIX (4260-101-0890)

LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER:	208
IMPLEMENTATION DATE:	7/2017
ANALYST:	Matt Wong
FISCAL REFERENCE NUMBER:	2080

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$38,787,000	$32,865,000
- STATE FUNDS	$19,393,500	$16,432,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$38,787,000	$32,865,000
STATE FUNDS	$19,393,500	$16,432,500
FEDERAL FUNDS	$19,393,500	$16,432,500

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 lawsuit settlements approved by the Legislature and the Governor.

Reason for Change:
The change from the prior estimate for FY 2017-18 is a decrease due to an update to a settlement owed to the Department.

There is no change from the prior estimate for FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to the timing of when lawsuit settlements or fees are expected to be paid.

Methodology:

Attorney Fees	
OAH No. 2014120903 & Superior Court Case No. 30-2015-00812467- CU-WM-CJC	$50,900
Total for FY 2017-18	**$50,900**

LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER: 208

Provider Settlements	
Downey Regional Medical Center	$1,074
Total for FY 2017-18	**$1,074**
Beneficiary Settlements	
Total for FY 2017-18	**$0**
Other Attorney Fees Payments	
DHCS v. OAHA – Ruderman & Knox, LLP – Sonora Elem School District	$22,400
Total for FY 2017-18	**$22,400**
Other Provider Settlements	
Contra Costa	$6,000,000
LA Care	$31,000,000
AHF	($624,103)
OAHA Appeal No. HA8-0905-391D-JP – Comm Hosp Long Beach	$380,797
Korean Comm Center of the East Bay v. Jennifer Kent and DHCS	$400,000
Northern Inyo Hospital District	$301,000
Brius Settlement	($192,760)
DaVita Settlement	($495,043)
Total for FY 2017-18	**$36,769,891**
LA Care	$31,000,000
Total for FY 2018-19	**$31,000,000**
Other Beneficiary Settlements	
DHCS v. OAHA – Ruderman & Knox, LLP – Sonora Elem School District	$120,000
US ex rel Alcaine v. Braden Partners d/b/a PPS	($41,400)
Singleton v. DHCS	$5,000
Total for FY 2017-18	**$83,600**

LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER: 208

FY 2017-18		
	Committed	Balance
Attorney Fees <$5,000	$ 50,000	$ -
Provider Settlements <$75,000	$ 1,074	$ 1,598,926
Beneficiary Settlements <$2,000]=	$ -	$ 10,000
Small Claims Court	$ -	$ 200,000
Other Attorney Fees	$ 70,300	
Other Provider Settlements	$ 36,769,891	
Other Beneficiary Settlements	$ 83,600	
Interest Paid	$ 3,323	
Totals (Rounded)	**$ 36,978,000**	**$ 1,809,000**

FY 2018-19	
	Budgeted
Attorney Fees<$30,000;Provider Settlements<$100,000; Beneficiary Settlements<$10,000	$ 1,865,000
Other Attorney Fees	$ -
Other Provider Settlements	$ 31,000,000
Other Beneficiary Settlements	$ -
Interest Paid	$ -
Totals (Rounded)	**$ 32,865,000**

Funding:
50% Title XIX FF / 50% GF (4260-101-0001/0890)
100% FFP (4260-101-0890)
100% GF (4260-101-0001)

MEDI-CAL PROGRAM REGULAR
POLICY CHANGE INDEX

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MEDI-CAL STATE INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 1
IMPLEMENTATION DATE: 12/2016
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 1569

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$87,912,000	$98,931,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$87,912,000	$98,931,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$87,912,000	$98,931,000

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.

PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	156
IMPLEMENTATION DATE:	4/2018
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	2045

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$21,682,000	$26,066,000
- STATE FUNDS	$9,993,000	$12,044,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$21,682,000	$26,066,000
STATE FUNDS	$9,993,000	$12,044,000
FEDERAL FUNDS	$11,689,000	$14,022,000

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)

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 supplemental payments to ICF/DDs.

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.

AB 120 (Chapter 22, Statutes of 2017) allocated up to $27,000,000 Proposition 56 funds for supplemental payments to ICF/DDs. The Centers for Medicare and Medicaid Services (CMS) approved State Plan Amendment (SPA) 17-028 for these supplemental payments.

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.

MEDI-CAL STATE INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 1

7. Total estimated Medi-Cal Inpatient Hospital Costs for all eligible (Medi-Cal and ACA) adult and juvenile inmates in FY 2017-18 and FY 2018-19, including retroactive payments are:

FY 2017-18	TF	FF
Adults - Non ACA	$15,681,000	$7,841,000
Adults - ACA	$50,681,000	$48,624,000
Medical Parole	$763,000	$381,000
Juveniles	$115,000	$57,000
Total Retroactive Payments	$35,696,000	$31,009,000
ACA	$26,321,000	$26,321,000
Non-ACA	$9,375,000	$4,688,000
Total FY 2017-18	$102,936,000	**$87,912,000**

FY 2018-19	TF	FF
Adults - Non ACA	$16,191,000	$8,096,000
Adults - ACA	$52,720,000	$49,556,000
Medical Parole	$698,000	$349,000
Juveniles	$115,000	$57,000
Total Retroactive Payments	$58,847,000	$40,873,000
ACA	$23,710,000	$23,305,000
Non-ACA	$35,137,000	$17,568,000
Total FY 2018-19	$128,571,000	**$98,931,000**

*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:	2
IMPLEMENTATION DATE:	1/2002
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	3

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$63,458,000	$63,914,000
- STATE FUNDS	$38,027,200	$38,100,100
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$63,458,000	$63,914,000
STATE FUNDS	$38,027,200	$38,100,100
FEDERAL FUNDS	$25,430,800	$25,813,900

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)

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% FFP/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.

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. The coverage term is 18 months for breast cancer and 24 months for cervical cancer. 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.

Beneficiaries are screened through Every Woman Counts and Family Planning, Access, Care, and Treatment (Family PACT) providers.

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER: 2

Reason for Change:
The change from the prior estimate, for both FY 2017-18 and FY 2018-19, is a decrease due to a decrease in eligibles. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to updated expenditure data from July 2017 through December 2017, predicting a slight increase in expenditures.

Methodology:
1. There were 4,191 FFS and 1,893 managed care eligibles as of October 2017 (total of 6,084). 2,143 of the FFS eligibles were eligible for State-Only services.
2. 149 of the FFS eligibles were in accelerated enrollment as of October 2017.
3. Assume the State will pay Medicare and other health coverage premiums for an average of 482 beneficiaries monthly in FY 2017-18 and FY 2018-19. Assume an average monthly premium cost per beneficiary of $149.61.

   FY 2017-18: 482 x $149.61 x 12 months = $865,000 TF ($865,000 GF)
   FY 2018-19: 482 x $149.61 x 12 months = $865,000 TF ($865,000 GF)

4. FFS costs are estimated as follows:
(Dollars in Thousands)

FFS Costs	FY 2017-18		FY 2018-19	
	TF	GF	TF	GF
Full Scope Costs	$39,494	$14,063	$40,094	$14,280
State-Only Services	$23,099	$23,099	$22,955	$22,955
State-Only Premiums	$865	$865	$865	$865
Total	**$63,458**	**$38,027**	**$63,914**	**$38,100**

5. Managed Care costs associated with the BCCTP are budgeted in the Two-Plan, County Organized Health Systems, Geographic Managed Care, and Regional Model policy changes.
6. AB 1795 increases State-Only BCCTP coverage necessary for the treatment of breast/cervical cancer. Beneficiaries diagnosed with a recurrence would be eligible to re-enroll for a new coverage period of 18 or 24 months if cancer is in the same or a new location, as long as the beneficiary continues to meet all eligibility requirements. These costs were budgeted in the State-Only BCCTP Coverage Extension policy change and are now fully reflected in the base estimate.

Funding:
(Dollars in Thousands)

FY 2017-18	TF	GF	FF
General Fund 4260-101-001	$ 23,964	$ 23,964	$ -
50 Title XIX FFP / 50 GF (4260-101-0001/0890)	$ 1,602	$ 801	$ 801
Title XIX 65/35 FFP4260-101-0001/0890	$ 37,892	$ 13,262	$ 24,630
Total	**$ 63,458**	**$ 38,027**	**$ 25,431**

FY 2018-19	TF	GF	FF
General Fund 4260-101-001	$ 23,820	$ 23,820	$ -
50 Title XIX FFP / 50 GF (4260-101-0001/0890)	$ 1,648	$ 824	$ 824
Title XIX 65/35 FFP4260-101-0001/0890	$ 38,446	$ 13,456	$ 24,990
Total	**$ 63,914**	**$ 38,100**	**$ 25,814**

MEDI-CAL COUNTY INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER:	3
IMPLEMENTATION DATE:	4/2017
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	1755

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$12,760,000	$90,569,000
- STATE FUNDS	$550,440	$292,610
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$12,760,000	$90,569,000
STATE FUNDS	$550,440	$292,610
FEDERAL FUNDS	$12,209,560	$90,276,390

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: 3

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 from the prior estimate, for FY 2017-18 and FY 2018-19, is a decrease due to a change in the overall methodology for estimating MCIP payments. Assumptions for ongoing costs are now based on actual Medi-Cal County Inmate Program payment data. Prior estimates used Medi-Cal State Inmate Program payment data. The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to retroactive claim amounts expected to be paid in FY 2018-19.

Methodology:

1. The adult county inmate program began in November 2010. The juvenile county inmate program began in January 2012.

2. County inmate claims with dates of services (DOS) beginning April 1, 2017, will be processed by the fiscal intermediary.

3. Claims with dates of services prior to April 1, 2017, retroactive to the beginning of the adult and juvenile programs, will be part of the retroactive claiming process that will begin in FY 2018-19. Previously, counties paid for these services. The retroactive claiming will be processed manually and the counties will be reimbursed with federal funds for non GF payment portions made for dates of services prior to April 1, 2017.

4. Assume $79,919,000 in retroactive payments will be paid in FY 2018-19.

5. Claims with dates of services starting April 1, 2017, will be processed by the fiscal intermediary and paid with GF and federal funds. 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.

MEDI-CAL COUNTY INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 3

6. 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, and 93% for calendar year 2019.

7. County inmate claims data for FY 2017-18 and FY 2018-19 is based on actual claims paid from April 1, 2017 through December 2017. FY 2017-18 also includes pending payments from FY 2016-17.

8. Total estimated costs for Medi-Cal inpatient hospital and psychiatric services for County adult and juvenile inmates in FY 2017-18 and FY 2018-19 are:

(Dollars in Thousands)	FY 2017-18			FY 2018-19		
County Adult	**TF**	**GF**	**FF**	**TF**	**GF**	**FF**
Adult County - Non ACA	$2,179	$349	$1,830	$1,830	$137	$1,693
Adult County - ACA	$10,345	$120	$10,225	$8,604	$85	$8,519
Compassionate Release	$26	$13	$13	$22	$11	$11
Compassionate Release ACA	$82	$4	$78	$86	$6	$80
Juvenile	$128	$64	$64	$108	$54	$54
Total Retroactive Payments	$0	$0	$0	$79,919	$0	$79,919
Retro ACA	$0	$0	$0	$37,529	$0	$37,529
Retro Non-ACA	$0	$0	$0	$42,390	$0	$42,390
Grand Total	**$12,760**	**$550**	**$12,210**	**$90,569**	**$293**	**$90,276**

*Difference in totals is due to rounding

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
100% Title XIX FFP (4260-101-0890)
100% Title XIX ACA FF (4260-101-0890)
95% Title XIX ACA / 5% GF (4260-101-0001/0890)
94% Title XIX ACA / 6% GF (4260-101-0001/0890)
93% Title XIX ACA / 7% GF (4260-101-0001/0890)

MEDI-CAL COUNTY INMATE REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER:	8
IMPLEMENTATION DATE:	2/2018
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	2029

	FY 2017-18	FY 2018-19
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:
PC 3 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 from the prior estimate, for FY 2017-18 and FY 2018-19, is a decrease due to a change in the overall methodology for estimating MCIP payments. Assumptions for ongoing costs are now based on actual Medi-Cal County Inmate Program payment data. Prior estimates used Medi-Cal State Inmate Program payment data. The change from FY 2017-18 to FY 2018-19, in the current estimate, is a

MEDI-CAL COUNTY INMATE REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 8

decrease due to pending FY 2016-17 payments that will be paid in FY 2017-18 and not FY 2018-19.

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.

3. The Department estimates payments of $12,760,000 TF ($12,210,000 FF) and $90,569,000 TF ($90,276,000 FF) will be paid in FY 2017-18 and FY 2018-19, respectively.

4. Assume reimbursement will occur in the second month of each quarter, beginning in February 2018 for medical costs for dates of service beginning April 1, 2017.

5. The total estimated GF reimbursement in FY 2017-18 and FY 2018-19 will be:

FY 2017-18	GF	Reimbursement
Non ACA	$262,000	$262,000
ACA	$90,000	$90,000
Juvenile	$48,000	$48,000
Compassionate Release	$10,000	$10,000
Compassionate Release ACA	$3,000	$3,000
Total	$413,000	**$413,000**

FY 2018-19	GF	Reimbursement
Non ACA	$190,000	$190,000
ACA	$94,000	$94,000
Juvenile	$56,000	$56,000
Compassionate Release	$11,000	$11,000
Compassionate Release ACA	$5,000	$5,000
Total	$356,000	**$356,000**

Funding:
100% GF (4260-101-0001)
Reimbursement GF (4260-610-0995)

NON-OTLICP CHIP

REGULAR POLICY CHANGE NUMBER:	9
IMPLEMENTATION DATE:	12/1998
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	13

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$399,525,300	$187,461,280
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$399,525,300	$187,461,280
FEDERAL FUNDS	$399,525,300	-$187,461,280

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 65% FFP or Title XXI 88% 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: 9

- 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).

- 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 and, therefore, the State cannot determine which children are only eligible for Medicaid because of the loosening of the asset test rules and would have received CHIP funding. The CS3-Proxy aims to provide the same level of CHIP funding as before this change.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is due to a onetime CS3-Proxy catchup adjustment payment for prior years, a decrease in estimated expenditures for the Resource Disregard population, and an increase in estimated expenditures for the HPE and Medicaid Expansion populations. The change from the prior estimate, for FY 2018-19, is due to an increase in estimated expenditures for the HPE and Medicaid Expansion populations and the repayment of CHIP Title XXI federal funds. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the repayment of CHIP Title XXI federal funds in FY 2018-19 and not having a onetime CS3-Proxy catchup adjustment payment in FY 2018-19.

Methodology:
1. It is assumed the estimated costs of the HPE, Medicaid Expansion, and Resource Disregard aid codes will be $549,034,000 TF in FY 2017-18 and $544,302,000 TF in FY 2018-19.

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, estimated costs are eligible for Title XXI 88/12 FMAP.

3. The Department started claiming under the CS3-Proxy in March 2016 with a two-year lag. This adjustment shifts funding from Title 19 federal funds with a 50% General Fund match to Title 21 federal funds with a 35% General Fund match for claims dated prior to October 1, 2015, and a 12% General Fund match for claims dated on or after October 1, 2015. Four quarterly adjustments will occur in FY 2017-18 and FY 2018-19 (ongoing adjustment).

4. In FY 2018-19, the Department will repay the CHIP Title XXI federal funds and corresponding General Fund (Fund 4260-113-0001).

5. Total estimated costs for FY 2017-18 and FY 2018-19 are:

(Dollars in Thousands)

FY 2017-18	TF	GF
Resource Disregard	$6,395	($2,430)
HPE	$7,987	($3,035)
Medicaid Expansion	$534,652	($203,168)
Proxy/Ongoing Adjustments	$0	($190,893)
Total Cost	**$549,034**	**($399,526)**

NON-OTLICP CHIP

REGULAR POLICY CHANGE NUMBER: 9

FY 2018-19	TF	GF
Resource Disregard	$6,147	($2,336)
HPE	$7,314	($2,779)
Medicaid Expansion	$530,841	($201,720)
Proxy/Ongoing Adjustments	$0	($85,261)
Prior Title XXI Repayments	$0	$479,557
Total Cost	**$544,302**	**$187,461**

Funding:
(Dollars in Thousands)

FY 2017-18		TF	GF	FF
50 % Title XIX /50 % GF	4260-101-0001/0890	($1,054,860)	($527,430)	($527,430)
Title XIX FF	4260-101-0890	($33,520)	$0	($33,520)
Title XIX GF	4260-101-0001	$33,520	$33,520	$0
Title XXI FF	4260-113-0890	$55,831	$0	$55,831
Title XXI GF	4260-113-0001	($55,831)	($55,831)	$0
65 % Title XXI /35 % GF	4260-113-0001/0890	$102,750	$35,963	$66,788
88 % Title XXI /12 % GF	4260-113-0001/0890	$952,110	$114,253	$837,857
Net Impact (rounded)		**$0**	**($399,526)**	**$399,526**

FY 2018-19		TF	GF	FF
50 % Title XIX /50 % GF	4260-101-0001/0890	($742,444)	($371,222)	($371,222)
Title XIX FF	4260-101-0890	($13,114)	$0	($13,114)
Title XIX GF	4260-101-0001	$685,453	$685,453	$0
Title XXI FF	4260-113-0890	($456,476)	$0	($456,476)
Title XXI GF	4260-113-0001	($215,863)	($215,863)	$0
88 % Title XXI /12 % GF	4260-113-0001/0890	$742,444	$89,093	$653,351
Net Impact (rounded)		**$0**	**$187,461**	**($187,461)**

*Difference in totals is due to rounding

NON-EMERGENCY FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	10
IMPLEMENTATION DATE:	12/1997
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	15

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$886,724,000	$881,430,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$886,724,000	$881,430,000
FEDERAL FUNDS	-$886,724,000	-$881,430,000

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: 10

Reason for Change:
The change from the prior estimate, for both FY 2017-18 and FY 2018-19, is due to a decrease in managed care expenditures. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to a decrease in Title XIX expenditures for both FFS and managed care and a decrease in managed care Title XXI expenditures.

Methodology:
1. Based on updated July 2017 through December 2017 FFS expenditure reports of non-emergency services provided to this population, the Department estimates non-emergency FFS costs will be $309,280,000 TF in FY 2017-18 and $292,584,000 in FY 2018-19.

2. Based on July 2017 through September 2017 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 $434,709,000 TF in FY 2017-18 and $438,222,000 in FY 2018-19. The repayment for this group will be 95% FFP for FY 2017-18 until January 2018, when FFP changes to 94%. For FY 2018-19, the repayment for this group will be 93% from January 2019 to December 2019.

3. Based on July 2017 through September 2017 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 $542,243,000 TF in FY 2017-18 and $527,738,000 in FY 2018-19. The repayment for this group is at 50/50 FMAP and 88/12 FMAP.

4. The implementation date for full-scope coverage for eligible undocumented children under SB 75 was May 16, 2016. As of November 30, 2016, 100% of the 120,582 undocumented children enrolled in restricted-scope Medi-Cal transitioned to full-scope Medi-Cal. As of December 4, 2017, 97,936 eligible but not enrolled undocumented children were determined newly eligible for full-scope Medi-Cal. The total number of undocumented children enrolled in full-scope Medi-Cal is 218,518.

5. 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.

6. The impact of Children's Health Insurance Program Reauthorization Act (CHIPRA) funding for full-scope Medi-Cal with FFP to eligible NQIs, who are children or pregnant women, is budgeted in the CHIPRA Medi-Cal for Children and Pregnant Women policy change.

7. The estimated FFP Repayment in FY 2017-18 and FY 2018-19:

(Dollars in Thousands)

	FY 2017-18		FY 2018-19	
FFS and MC costs	**TF**	**FF Repayment**	**TF**	**FF Repayment**
All Others (50% FF / 50% GF)	$728,338	$364,169	$668,974	$334,487
All Others (65% FF / 35% GF)	$7,763	$5,046	$7,460	$4,848
All Others (88% FF / 12% GF)	$36,376	$32,010	$39,637	$34,881
ACA	$513,755	$485,499	$542,474	$507,214
Total	$1,286,232	**$886,724**	$1,258,545	**$881,430**

NON-EMERGENCY FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 10

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)

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER:	11
IMPLEMENTATION DATE:	7/2005
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	1007

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$60,722,640	-$56,906,960
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$60,722,640	-$56,906,960
FEDERAL FUNDS	$60,722,640	$56,906,960

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 a State Plan Amendment be submitted 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 both FY 2017-18 and FY 2018-19, is a decrease due to updated expenditure reports reflecting lower prenatal costs for undocumented and legal immigrant women. The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to a decrease in estimated prenatal costs for undocumented women.

Methodology:
1. The cost of prenatal care for undocumented women is estimated to be $58,848,000 TF in FY 2017-18 and $53,579,000 TF in FY 2018-19.

2. Assume estimated prenatal costs for undocumented women beginning October 1, 2015, are eligible for Title XXI 88/12 FMAP.

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER: 11

(Dollars in Thousands)

FY 2017-18:	$58,848 TF x .88 =	**$51,786 FFP**
FY 2018-19:	$53,579 TF x .88 =	**$47,150 FFP**

3. The cost of prenatal care for legal immigrant women is estimated to be $10,155,000 TF in FY 2017-18 and $11,088,000 in FY 2018-19.

4. Assume estimated prenatal costs for legal immigrant women beginning October 1, 2015, are eligible for Title XXI 88/12 FMAP.

(Dollars in Thousands)

FY 2017-18:	$10,155 x .88 =	**$8,936 FFP**
FY 2018-19:	$11,088 x .88 =	**$9,757 FFP**

5. The federal funding received on a cash basis will be:

(Dollars in Thousands)

FY		GF Savings
FY 2017-18	$51,786 + $8,936 =	**$60,722**
FY 2018-19:	$47,150 + $9,757 =	**$56,907**

Funding:
88% Title XXI FF /12% GF (4260-113-0001/0890)
100% GF (4260-101-0001)

CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

REGULAR POLICY CHANGE NUMBER:	12
IMPLEMENTATION DATE:	12/2016
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	1371

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$14,677,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$14,677,000	$0
FEDERAL FUNDS	-$14,677,000	$0

DESCRIPTION

Purpose:
This policy change estimates the retroactive technical adjustments in funding from 100% State General Fund (GF) to claim Title XIX or Title XXI federal match for the health care expenditures of “Qualified Immigrant” children and pregnant women who have not yet met the federal five-year bar, and other specified lawfully present children and pregnant women who are eligible for full scope Medi-Cal with federal financial participation (FFP).

Authority:
Children's Health Insurance Program Reauthorization Act (CHIPRA)

Interdependent Policy Changes:
Not Applicable

Background:
The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) provides that FFP is available for immigrants designated as “Qualified Immigrants” if they have been in the United States for at least five years. California currently provides full-scope Medi-Cal to otherwise eligible qualified immigrants who have been in the US for less than five years, designated as “New Qualified Immigrants” (NQIs), and pays for non-emergency services with 100% State funds. FFP is only available for NQIs under the five-year bar for emergency and pregnancy related services.

CHIPRA includes a provision which gives states the option to provide full-scope Medi-Cal with FFP to NQIs and specified lawfully present immigrants who are children or pregnant women regardless of their date of entry into the US. System changes have been completed, therefore an ongoing adjustment is no longer needed.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is a decrease due to the identification of additional FFP that could be claimed as part of an existing placeholder, resulting in a reduction of FFP owed to the federal government for FFY 2014. There is no change from the prior estimate for FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the cost of the remaining

CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

REGULAR POLICY CHANGE NUMBER: 12

retroactive adjustments being paid in FY 2017-18 only. Adjustments are not needed for ongoing costs as the expenditure reports that originally identified this population as 100% State GF have been corrected as of June 2016.

Methodology:

1. Title XXI funding of 88/12 FFP is available for this age group effective October 1, 2015, and Title XIX funding of 50/50 FFP is available for children under the age of 21 and pregnant women.

2. Assume that the retroactive claims from July 2011 through December 2014 will be paid in FY 2017-18.

3. The Department has identified $14,677,000 that is owed to the federal government for quarters from July 2011 through December 2014 that will be repaid in FY 2017-18.

FY 2017-18	GF	FF
Total	$14,677,000	($14,677,000)

Funding:

50% Title XIX FF/ 50% GF (4260-101-0001/0890)
65% Title XIX FF/ 35% GF (4260-101-0001/0890)
88% Title XXI FF/ 12% GF (4260-113-0001/0890)

PARIS-VETERANS

REGULAR POLICY CHANGE NUMBER:	13
IMPLEMENTATION DATE:	8/2011
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	1632

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	-$20,501,000	-$33,014,000
- STATE FUNDS	-$10,250,500	-$16,507,000
PAYMENT LAG	0.9596	0.9726
% REFLECTED IN BASE	58.21 %	62.10 %
APPLIED TO BASE		
TOTAL FUNDS	-$8,221,200	-$12,169,500
STATE FUNDS	-$4,110,620	-$6,084,730
FEDERAL FUNDS	-$4,110,620	-$6,084,740

DESCRIPTION

Purpose:
This policy change estimates the savings from the Public Assistance Reporting Information System (PARIS) Veterans Match.

Authority:
Welfare & Institutions Code 14124.11
Military & Veterans Code 972.5

Interdependent Policy Changes:
Not Applicable

Background:
PARIS is an information sharing system, operated by the U.S. Department of Health and Human Services' Administration for Children and Families, which allows states and federal agencies to verify public assistance client circumstances. The PARIS system includes three different data matches: PARIS-Interstate, PARIS-Federal, and PARIS-Veterans.

The PARIS-Veterans match allows the Department to improve the identification of veterans enrolled in the Medi-Cal program. Improved veteran identification enhances the Department's potential to shift health care costs from the Medi-Cal program to the United States Department of Veterans Affairs.

As a result of the implementation of the Affordable Care Act, several million new beneficiaries enrolled in Medi-Cal over the last three years through the California Healthcare Enrollment, Eligibility and Retention System (CalHEERS). The military question was added to CalHEERS on September 25, 2017, and will allow the Department to identify and educate recently enrolled beneficiaries on VA benefits and enhancement activities.

PARIS-VETERANS

REGULAR POLICY CHANGE NUMBER: 13

Reason for Change:
The reason for change from prior estimate, for FY 2017-18 and FY 2018-19, is a slight decrease in savings due to updated managed care (MC) rates and fee-for-service (FFS) per member per month (PMPM) costs. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the inclusion of FY 2017-18 savings in FY 2018-19.

Methodology:
1. The Department currently operates PARIS-Veterans in 58 counties for the Outreach program; 58 counties utilize the High Income Cost Avoidance and Civilian Health and Medical Program of the Department of Veteran Affairs programs.

2. Savings for PARIS-Veterans is for discontinued eligibles in MC and FFS.

3. It is estimated program expenditures will be reduced for 878 veterans (582 MC and 296 FFS) in FY 2017-18 and FY 2018-19. The Department expects that savings will continue in budget year through discontinuances, share of cost modifications, and cost avoidance by identifying Other Health Coverage.

4. Estimated average PMPM savings is $296.92 in FY 2017-18 and FY 2018-19. These savings are not captured in the base trends.

5. In FY 2017-18, it is estimated that 58.21% of the MC and FFS savings is captured in the base trends. In FY 2018-19, it is estimated that 62.10% of the MC and FFS savings is captured in the base trends.

6. Total estimated savings are $20,501,000 for FY 2017-18 and $33,014,000 for FY 2018-19.

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

OTLICP PREMIUMS

REGULAR POLICY CHANGE NUMBER:	14
IMPLEMENTATION DATE:	7/2014
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	1879

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	-$66,265,000	-$66,373,000
- STATE FUNDS	-$7,951,800	-$7,964,760
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$66,265,000	-$66,373,000
STATE FUNDS	-$7,951,800	-$7,964,760
FEDERAL FUNDS	-$58,313,200	-$58,408,240

DESCRIPTION

Purpose:
This policy change estimates the premium revenue associated with the Optional Targeted Low Income Children's Program (OTLICP).

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 OTLICP, which 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 both FY 2017-18 and FY 2018-19, is an increase due to an increase in estimated average monthly eligibles. The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to an increase in estimated average monthly eligibles.

Methodology:
1. The Department estimates in FY 2017-18 there will be 924,589 average monthly OTLICP eligibles and 926,064 in FY 2018-19. Based on FY 2015-16 data, 60.85% of the OTLICP population has family incomes over 160% of the FPL.

2. In FY 2017-18, the Department estimates there are 6,751,349 member months subject to monthly premiums and 6,762,119 in FY 2018-19.
   FY 2017-18: 924,589 x 12 months x 60.85% = **6,751,349** member months
   FY 2018-19: 926,064 x 12 months x 60.85% = **6,762,119** member months

OTLICP PREMIUMS

REGULAR POLICY CHANGE NUMBER: 14

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 2017-18	FY 2018-19
Total ExemptMember Months	101,267	101,267

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 membermonths:

Loss ofPremiums	FY 2017-18	FY 2018-19
Discount Program	877,664	879,064
Delinquent Premiums	675,126	676,203
Total Loss of Premium Member Months	**1,552,790**	**1,555,267**

5. The net member months for the OTLICP premium calculation are:

Member Months	FY 2017-18	FY 2018-19
Eligible Member Months	6,751,349	6,762,119
Exempt Member Months	(101,267)	(101,267)
Loss Member Months	(1,552,789)	(1,555,267)
Net Member Months	**5,097,293**	**5,105,585**

6. Premium requirement for children with incomes between 160-266% FPL is $13 permonth.

7. Beginning October 1, 2015, assume estimated costs are eligible for Title XXI 88/12 FMAP. The total estimated premium revenue for OTLICP are:

(Dollars In Thousands)

Fiscal Year	TF	GF	FF
FY 2017-18	**$ 66,265**	**$ 7,952**	**$ 58,313**
FY 2018-19	**$ 66,373**	**$ 7,965**	**$ 58,408**

Funding:
88% Title XXI / 12% GF (4260-113-0890/0001)

MINIMUM WAGE INCREASE - CASELOAD SAVINGS

REGULAR POLICY CHANGE NUMBER:	15
IMPLEMENTATION DATE:	4/2017
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	1979

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	-$141,564,000	-$363,996,000
- STATE FUNDS	-$29,483,020	-$77,752,990
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	52.76 %	18.41 %
APPLIED TO BASE		
TOTAL FUNDS	-$66,874,800	-$296,984,300
STATE FUNDS	-$13,927,780	-$63,438,660
FEDERAL FUNDS	-$52,947,060	-$233,545,670

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 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 perhour.

The minimum wage increase for employers with 25 employees or fewer will also phase in with an effective date of January 1, 2018, with the minimum wage reaching $15 on January 1, 2023, excluding any suspensions.

MINIMUM WAGE INCREASE - CASELOAD SAVINGS

REGULAR POLICY CHANGE NUMBER: 15

Reason for Change:
The change from the prior estimate, for both FY 2017-18 and FY 2018-19, is an increase due to updated caseload. The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to an increase in incremental savings as a result of the minimum wage increase to $12 per hour, caseload growth, increase in per-member month costs, as well as the FY 2017-18 savings only impacting a 6 month period.

Methodology:
1. Minimum wage was increased to $11.00 as of January 1, 2018. The implementation date for the increase to $12.00 is January 1, 2019.

2. Assume savings will not materialize in the first quarter of 2018 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.

3. Assume that only 1/12 of the monthly savings will materialize each month to account for annual redetermination.

4. Assume 2% caseload growth and a 3% increase in per member per month costs annually.

5. Assume that 24% of the beneficiaries in each aid category are adults, and the non ACA adult population will be funded at 50% FFP. The ACA Optional Expansion population will be funded at 95% FFP for FY 2017-18 until January 2018 when FFP changes to 94%. Effective January 2019, FFP changes to 93%.

6. Assume the Fee-for-Service (FFS) population is 28% of the total Medi-Cal population and that a payment lag will be applied to this population for the first two years of implementation.

FY 2017-18	TF	GF	FF
Title XIX 50% GF / 50% FF	($48,852,000)	($24,426,000)	($24,426,000)
Title XIX ACA 95% FF / 5% GF	($50,570,000)	($2,528,500)	($48,041,500)
Title XIX ACA 94% FF / 6% GF	($42,142,000)	($2,528,500)	($39,613,500)
Total Savings	**($141,564,000)**	**($29,483,000)**	**($112,081,000)**

FY 2018-19	TF	GF	FF
Title XIX 50% GF / 50% FF	($124,564,000)	($62,282,000)	($62,282,000)
Title XIX ACA 94% FF / 6% GF	($128,925,000)	($7,735,500)	($121,189,500)
Title XIX ACA 93% FF / 7% GF	($110,507,000)	($7,735,500)	($102,771,500)
Total Savings	**($363,996,000)**	**($77,753,000)**	**($286,243,000)**

*Totals may differ due to rounding.

Funding:
50%Title XIX FF / 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 / 6% GF (4260-101-0001/0890)

MEDICARE OPTIONAL EXPANSION ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 16
IMPLEMENTATION DATE: 7/2017
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 2033

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	-$328,018,000	-$41,213,000
- STATE FUNDS	$245,167,990	$93,005,020
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$328,018,000	-$41,213,000
STATE FUNDS	$245,167,990	$93,005,020
FEDERAL FUNDS	-$573,185,990	-$134,218,020

DESCRIPTION

Purpose:
This policy change adjusts the funding from the Optional Expansion FMAP to Medi-Cal's 50/50 FMAP for eligibles with Minimum Essential Coverage (MEC) 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. This new coverage group excludes those with MEC. A small portion of Optional Expansion eligibles have Medicare Part A or Part B, which qualifies as MEC. Enrollment systems were corrected August 2016 to eliminate further enrollment of Medicare Part A or Part B eligibles into the Optional Expansion eligibility group.

Reason for Change:
The change from the prior estimate, for both FY 2017-18 and FY 2018-19, is due to updated actuals. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the timing of the recoupment and updated actuals. Recoupment will occur in the last half of FY 2017-18.

MEDICARE OPTIONAL EXPANSION ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 16

Methodology:

1. Medicare Part A 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

2. An adjustment will continue until all eligibles have been redetermined and no Medicare Part A or Part B eligibles remain in the Optional Expansion aid codes. For January 2014 – June 2016, the actual expenditures will be adjusted for in FY 2017-18. For July 2016 – June 2017, the actual expenditures will be adjusted for in FY2018-19.

3. Assume the Department will recoup the difference between the Optional Expansion managed care capitation rate and the Dual/Partial Eligible managed care capitation rate from the managed care plans. This is estimated to occur in FY 2017-18. The total recoupment is expected to be $310 million.

4. Those Medi-Cal eligibles with Part A or Part B are estimated in the Optional Expansion aid category, this policy also adjusts the funding for expenditures estimated for FY 2017-18 and FY 2018-19.

5. Assume the Department will adjust the managed care capitation rate paid to the managed care plans for these individuals with the June 2017 managed care payment which is paid in July 2017. For FY 2017-18 and FY 2018-19 payments, this policy change will reduce the expenditures estimated in the managed care policychanges.

6. Changes in the managed care capitation rates will result in changes for related supplemental payments.
    a. Hospital Quality Assurance Payments (HQAF) made at the 100% ACA FFP will need to be returned to the Department and HQAF payments will be made at the lower dual capitation rate.
    b. Rate Ranged IGT payments will need to be made for the dual capitation rate.
    c. Recoupment of General Fund Reimbursement from Designated Public Hospitals (DPHs) from the managed care plans will be needed along with the return of the Intergovernmental Transfer (IGT) to the DPHs.

7. Assume Drug Medi-Cal and Specialty Mental Health Services (SMHS) will include County Funds (CF) once the adjustment to 50% FMAP occurs. The CF are displayed for informational purposes.

MEDICARE OPTIONAL EXPANSION ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 16

8. A detailed account of the adjustment:

(Dollars in Thousands)	TF	FF	GF	HQAF	CF
FY 2013-14					
FFS	$0	($4,106)	$4,106		
SMHS/Drug Medi-Cal	($1,721)	($1,721)			$1,721
Dental	$0	($256)	$256		
Managed Care	$0	($8,890)	$8,890		
Recoup from Plans	($21,514)	($21,856)	$0	$341	
Subtotal FY 2013-14	($23,235)	($36,829)	$13,252	$341	$1,721
FY 2014-15					
FFS	$0	($13,985)	$13,985	$0	$0
SMHS/Drug Medi-Cal	($5,823)	($5,823)	$0	$0	$5,823
Dental	$0	($1,510)	$1,510	$0	$0
Managed Care	$0	($40,607)	$40,607	$0	$0
Recoup from Plans	($113,060)	($115,103)	$0	$2,043	$0
Subtotal FY 2014-15	($118,883)	($177,028)	$56,102	$2,043	$5,823
FY 2015-16					
FFS	$0	($12,962)	$12,962	$0	$0
SMHS/Drug Medi-Cal	($8,634)	($8,634)	$0	$0	$8,634
Dental	$0	($2,591)	$2,591	$0	$0
Managed Care	$0	($62,555)	$62,555	$0	$0
Recoup from Plans	($81,505)	($84,666)	$0	$3,161	$0
Subtotal FY 2015-16	($90,139)	($171,408)	$78,108	$3,161	$8,634
FY 2016-17					
FFS	$0	($18,730)	$18,730	$0	$0
SMHS/Drug Medi-Cal	($9,037)	($8,585)	($452)	$0	$9,037
Dental	$0	($2,701)	$2,701	$0	$0
Managed Care	$0	($66,748)	$66,748	$0	$0
Recoup from Plans	($83,062)	($82,842)	($2,174)	$1,954	$0
Subtotal FY 2016-17	($92,099)	($179,606)	$85,553	$1,954	$9,037
FY 2017-18					
FFS	$0	($18,137)	$18,137	$0	$0
SMHS/Drug Medi-Cal	($9,540)	($8,490)	($1,049)	$0	$9,540
Dental	$0	($2,587)	$2,587	$0	$0
Managed Care	$0	($33,830)	$33,830	$0	$0
Recoup from Plans	($10,786)	($10,192)	($593)	$0	$0
Reduce Managed Care Base Expenditures	($1,914)	($1,809)	($105)	$0	$0
Subtotal FY 2017-18	($22,239)	($75,045)	$52,806	$0	$9,540

MEDICARE OPTIONAL EXPANSION ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 16

(Dollars in Thousands)	TF	FF	GF	HQAF	CF
FY 2018-19					
FFS	$0	($18,275)	$18,275	$0	$0
SMHS/Drug Medi-Cal	($9,733)	($8,468)	($1,265)	$0	$9,733
Dental	$0	($2,580)	$2,580	$0	$0
Managed Care	$0	($33,600)	$33,600	$0	$0
Reduce Managed Care Base Expenditures	($12,903)	($12,064)	($839)	$0	$0
Subtotal FY 2018-19	($22,636)	($74,987)	$52,351	$0	$9,733
Total					
FFS	$0	($86,195)	$86,195	$0	$0
SMHS/Drug Medi-Cal	($44,487)	($41,721)	($2,766)	$0	$44,487
Dental	$0	($12,225)	$12,225	$0	$0
Managed Care	$0	($246,230)	$246,230	$0	$0
Recoup from Plans	($309,927)	($314,659)	($2,767)	$7,500	$0
Reduce Managed Care Base Expenditures	($14,817)	($13,873)	($944)	$0	$0
Subtotal	**($369,231)**	**($714,902)**	**$338,172**	**$7,500**	$44,487

(Dollars in Thousands)	TF	FF	GF	HQAF	CF (Display only)
FY 2017-18	**($328,018)**	**($580,685)**	**$245,167**	**$7,500**	$16,177
FY 2018-19	**($41,213)**	**($134,218)**	**$93,005**	**$0**	$28,310

Funding:

(Dollars in Thousands)

FY 2017-18	Total Funds	Federal Funds	State Funds
100% ACA Title XIX FF (4260-101-0890)	($668,197)	($668,197)	
95% ACA Title XIX FF /5% GF (4260-101-0890/0001)	($158,107)	($150,201)	($7,906)
94% ACA Title XIX FF /6% GF (4260-101-0890/0001)	($44,361)	($41,699)	($2,662)
50 % Title XIX FF / 50% GF (4260-101-0890/0001)	$511,470	$255,735	$255,735
100% Title XIX FF (4260-101-0890)	$23,677	$23,677	
HQAF Title XIX FF (4260-611-0890)	$7,500	$7,500	$0
Total	**($328,018)**	**($573,185)**	**$245,167**

(Dollars in Thousands)

FY 2018-19	Total Funds	Federal Funds	State Funds
100% ACA Title XIX FF (4260-101-0890)	($31,597)	($31,597)	
95% ACA Title XIX FF /5% GF (4260-101-0890/0001)	($64,422)	($61,201)	($3,221)
94% ACA Title XIX FF /6% GF (4260-101-0890/0001)	($111,601)	($104,905)	($6,696)
93% ACA Title XIX FF /7% GF (4260-101-0890/0001)	($78,776)	($73,262)	($5,514)
50 % Title XIX FF / 50% GF (4260-101-0890/0001)	$216,873	$108,437	$108,437
100% Title XIX FF (4260-101-0890)	$28,310	$28,310	
Total	**($41,213)**	**($134,218)**	**$93,005**

COMMUNITY FIRST CHOICE OPTION

REGULAR POLICY CHANGE NUMBER: 17
IMPLEMENTATION DATE: 12/2012
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1595

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$3,355,870,000	$3,373,170,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,355,870,000	$3,373,170,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$3,355,870,000	$3,373,170,000

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 (IPO) 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, updating 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: 17

Reason for Change:
The change from the prior estimate, for FY 2017-18, is a increase due to the CCI reduction reduced twice in the previous estimate and corrected in the current estimate. The change from the prior estimate, for FY 2018-19, is an increase due to revised expenditure data. The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to revised expenditure data.

Methodology:
1. Costs for Medi-Cal beneficiaries enrolled in CFCO are eligible for an additional enhanced Federal Medical Assistance Percentage (FMAP) rate of 6%. The CFCO policy change include 56% Federal Financial Participation (FFP).

2. The estimated costs were provided by CDSS on a cash basis.

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

HEALTH INSURER FEE

REGULAR POLICY CHANGE NUMBER:	18
IMPLEMENTATION DATE:	4/2015
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1831

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$72,808,000	$287,808,000
- STATE FUNDS	$23,915,630	$97,122,150
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$72,808,000	$287,808,000
STATE FUNDS	$23,915,630	$97,122,150
FEDERAL FUNDS	$48,892,370	$190,685,850

DESCRIPTION

Purpose:
This policy change estimates the cost of 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 places an $8 billion fee on the health insurance industry nationwide. The fee grows to $14.3 billion in 2018 and is trended based on the rate of premium growth after 2018. The fee will be 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 2017 calendar year (the tax to be paid on CY 2016 revenues). This one year moratorium precludes collection of the HIPF as required under the Affordable Care Act. The moratorium eliminated the CY 2016 HIPF payments. Subsequently, additional federal legislation was signed on January 22, 2018, that suspended the HIPF for the 2019 calendar year (the tax to be paid on CY 2018 revenues). This policy change budgets the Medi-Cal managed care anticipated HIPF expenditures.

Subsequent to the November 2017 estimate, CMS notified the Department that HIPF payments may be made retroactively.

HEALTH INSURER FEE

REGULAR POLICY CHANGE NUMBER: 18

Reason for Change:
The change from the prior estimate, for FY 2017-18, nets a decrease due to:

- Updated actuals increasing a portion of CY 2015 HIPF payments,
- CY 2017 HIPF payments shifting from FY 2017-18 to FY 2018-19 and assumed a 5% growth factor on CY 2015 HIPF payments to project for CY 2017 HIPF, and
- A federal moratorium on CY 2018 HIPF payments due to federal budget legislation.

The change from the prior estimate, for FY 2018-19, nets a decrease due to:

- CY 2017 HIPF payments shifting from FY 2017-18 to FY 2018-19 and assumed a 5% growth factor on CY 2015 HIPF payments to project for CY 2017 HIPF,
- A federal moratorium on CY 2018 HIPF payments due to federal budget legislation, and
- Shifting CY 2019 HIPF payments beyond FY2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to budgeting a partial year of HIPF payments in FY 2017-18 and budgeting a full year of HIPF payments in FY 2018-19.

Methodology:

1. This fee will apply to Medi-Cal premiums for existing Medi-Cal beneficiaries and the ACA expansion population.

2. CY 2015 fee payments were completed in FY2017-18.

3. CY 2017 estimated payments are expected to occur in FY 2018-19.

4. Payments for CY 2016 and CY 2018 have been suspended due to federal budget legislation.

5. Assume the following amounts:

(Dollars in Thousands)

	FY 2017-18	FY 2018-19
CY 2015 Payments	$72,808	$0
CY 2017 Payments	$0	$287,808
Total	**$72,808**	**$287,808**

6. The Internal Revenue Service will determine the effective rate and amount of tax on each plan. The total tax will be assessed on the plan's netpremium.

HEALTH INSURER FEE

REGULAR POLICY CHANGE NUMBER: 18

Funding:

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
50% Title XIX FF/ 50% GF (4260-101-0001/0890)	$45,879	$22,939	$22,940
100% Title XIX ACA (4260-101-0890)	$21,430	$0	$21,430
88% Title XXI FF/ 12% GF (4260-101-0001/0890)	$1,375	$165	$1,210
65% Title XXI FF / 35% GF (4260-113-0001/0890)	$4,124	$1,443	$2,681
Total*	**$72,808**	**$24,548**	**$48,260**

FY 2018-19	TF	GF	FF
50% Title XIX FF/ 50% GF (4260-101-0001/0890)	$180,493	$90,246	$90,247
95% Title XIX ACA / 5% GF (4260-101-0890)	$85,745	$4,287	$81,458
88% Title XXI FF/ 12% GF (4260-101-0001/0890)	$21,570	$2,588	$18,982
Total*	**$287,808**	**$97,122**	**$190,686**

*Difference due to rounding.

HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS

REGULAR POLICY CHANGE NUMBER: 19
IMPLEMENTATION DATE: 2/2016
ANALYST: Katy Clay
FISCAL REFERENCE NUMBER: 1967

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$17,200,000	$15,806,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$17,200,000	$15,806,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$17,200,000	$15,806,000

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 (SPA) 13-0027-MM7

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2014, the ACA requires the Department to give hospitals the option to determine HPE for Medicaid. The HPE program offers qualified individuals immediate access to temporary Medi-Cal while applying for permanent Medi-Cal coverage or other health coverage. Individuals complete the HPE application on-line with a qualified HPE provider at a participating, qualified hospital. Eligibility is determined in real-time.

Individuals granted temporary HPE must complete the Medi-Cal application process in order to enroll in a permanent Medi-Cal program.

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is due to the Department using updated estimated payment amounts based on actual data received. Additionally, for FY 2017-18, the change from the prior estimate includes the Department paying four quarters of payments, instead of five, as forecast in the prior estimate. Another factor in the change from the prior estimate, for FY 2018-19, is due to including two quarterly payments with calendar year (CY) 2017 ACA Federal

HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS

REGULAR POLICY CHANGE NUMBER: 19

Financial Participation (FFP) at 95%, and two with CY 2018 ACA FFP at 94%

The decrease from FY 2017-18 to FY 2018-19, in the current estimate, is due to two factors. First, the estimated payment amounts, based on actual data received, are lower for FY 2018-19. Second, FY 2017-18 has two quarters of payments for the CY 2016 ACA FFP at 100%, and two with CY 2017 ACA FFP at 95%, while FY 2018-19 has two quarters of payments for the CY 2017 ACA FFP at 95%, and two with CY 2018 ACA FFP at 94%.

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 $4,300,000 for FY 2017-18 and $3,952,000 for FY 2018-19.

3. The Department will also claim the enhanced Title XIX ACA FMAP for beneficiaries receiving services in DPHs and estimates to pay DPHs $17,200,000 in FY 2017-18 and $15,806,000 in FY 2018-19. The estimated pass-through costs are included in the chart below.

(Dollars in Thousands)

FY 2017-18	**TF**	**FF**
FY 2016-17 Q1	$ 4,500	$ 4,500
FY 2016-17 Q2	$ 3,300	$ 3,300
FY 2016-17 Q3	$ 5,404	$ 5,404
FY 2016-17 Q4	$ 3,996	$ 3,996
Net Impact	**$ 17,200**	**$ 17,200**

FY 2018-19	**TF**	**FF**
FY 2017-18 Q1	$ 3,996	$ 3,996
FY 2017-18 Q2	$ 3,996	$ 3,996
FY 2017-18 Q3	$ 3,907	$ 3,907
FY 2017-18 Q4	$ 3,907	$ 3,907
Net Impact	**$ 15,806**	**$ 15,806**

Funding:

HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS

REGULAR POLICY CHANGE NUMBER: 19

(Dollars in Thousands)

FY 2017-18	**TF**	**FF**
100% Title XIX ACA FF (4260-101-0001)	$ 17,200	$ 17,200
Net Impact	**$ 17,200**	**$ 17,200**

FY 2018-19	**TF**	**FF**
95% Title XIX ACA FF / 5% GF (4260-101-0890/0001)	$ 15,806	$ 15,806
Net Impact	**$ 15,806**	**$ 15,806**

PAYMENTS TO PRIMARY CARE PHYSICIANS

REGULAR POLICY CHANGE NUMBER: 20
IMPLEMENTATION DATE: 11/2013
ANALYST: Sharisse DeLeon
FISCAL REFERENCE NUMBER: 1659

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$6,320,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$6,320,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$6,320,000	$0

DESCRIPTION

Purpose:
This policy change estimates the federal financial participation (FFP) 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.

PAYMENTS TO PRIMARY CARE PHYSICIANS

REGULAR POLICY CHANGE NUMBER: 20

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 primary care specialists, regardless of whether furnished by the physician directly or under the physician's personal supervision.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is due to a revised estimate of the net reconciliation payments and recoupments occurring in FY 2017-18. The remaining payments are expected to be completed in FY 2017-18.

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. The total reconciliation payments are estimated at $31,663,000 TF. Approximately $9,500,000 TF is estimated to be in the Fee-for-Service (FFS) base, resulting in a net of $22,163,000 TF reconciliation payments.

4. Recoupments for ACA overpayments were implemented in February 2018, and are expected to be completed in FY 2017-18. Total recoupments for FY 2017-18 are estimated to be $15,843,000 TF.

(Dollars in Thousands)

FY 2017-18	TF	FF
Reconciliation Payments	$22,163	$22,163
Recoupment	($15,843)	($15,843)
Total	**$6,320**	**$6,320**

Funding:
100% Title XIX (4260-101-0890)

HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.

REGULAR POLICY CHANGE NUMBER: 21
IMPLEMENTATION DATE: 1/2014
ANALYST: Katy Clay
FISCAL REFERENCE NUMBER: 1821

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$36,866,840	-$36,043,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$36,866,840	-$36,043,000
FEDERAL FUNDS	$36,866,840	$36,043,000

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 (SPA) 13-0027-MM7

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2014, the ACA requires the Department to give hospitals the option to determine HPE for Medicaid. The HPE Program offers qualified individuals immediate access to temporary Medi-Cal while applying for permanent Medi-Cal coverage or other health coverage. Individuals complete the HPE application on-line with a qualified HPE Provider at a participating, qualified hospital. Eligibility is determined in real-time.

Individuals granted temporary HPE must complete the Medi-Cal application process in order to enroll in a permanent Medi-Cal program.

Reason for Change:
The increase in General Fund savings from the prior estimate, for FY 2017-18 and FY 2018-19, resulted from updated actual claims resulting from an 11% increase in Optional Expansion HPE enrollment from FY 2016-17 to FY 2017-18. The decrease in General Fund savings from FY 2017-18 to FY 2018-19, in the current estimate, results from the enhanced ACA FMAP decreasing from 95% in 2017 to 94% in 2018, and to 93% in2019.

HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.

REGULAR POLICY CHANGE NUMBER: 21

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 2015-16 Q2 through FY 2016-17 Q4, the estimated average quarterly adjustment for FY 2017-18 and FY 2018-19 is $20,596,000.

4. The Department estimates to adjust $82,384,000 TF claims from Title XIX 50/50 FMAP to claim the enhanced Title XIX ACA FMAP in FY 2017-18 and FY 2018-19. The estimated funding adjustment is included in the chart below.

(Dollars in Thousands)

FY 2017-18	**TF**	**GF**	**FF**
50% Title XIX FF / 50% GF	$ (82,384)	$ (41,192)	$ (41,192)
95% Title XIX FF / 5% GF	$ 61,788	$ 3,089	$ 58,699
94% Title XIX FF / 6% GF	$ 20,596	$ 1,236	$ 19,360
Net Impact	**$ -**	**$ (36,867)**	**$ 36,867**

FY 2018-19	**TF**	**GF**	**FF**
50% Title XIX FF / 50% GF	$ (82,384)	$ (41,192)	$ (41,192)
94% Title XIX FF / 6% GF	$ 61,788	$ 3,707	$ 58,081
93% Title XIX FF / 7% GF	$ 20,596	$ 1,442	$ 19,154
Net Impact	**$ -**	**$ (36,043)**	**$ 36,043**

Funding:

95% Title XIX FF (4260-101-0001)
94% Title XIX FF (4260-101-0001)
93% Title XIX FF (4260-101-0001)
50% Title XIX FF (4260-101-0890/0001)

1% FMAP INCREASE FOR PREVENTIVE SERVICES

REGULAR POLICY CHANGE NUMBER: 22
IMPLEMENTATION DATE: 1/2016
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1791

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$1,093,000	-$1,341,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$1,093,000	-$1,341,000
FEDERAL FUNDS	$1,093,000	$1,341,000

DESCRIPTION

Purpose:
This policy change estimates an additional 1% in federal medical assistance percentage (FMAP) for specified preventive services effective January 1, 2013.

Authority:
Affordable Care Act (ACA), Section 4106
AB 82 (Chapter 23, Statutes of 2013)

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).

1% FMAP INCREASE FOR PREVENTIVE SERVICES

REGULAR POLICY CHANGE NUMBER: 22

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.

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is due to an increase in FFS savings estimated for the period from January 1, 2017 through June 30, 2018, as a result of updated data that includes ACA optional expansion costs now eligible for 1% FMAP reimbursement.

The change in the current estimate, from FY 2017-18 to FY 2018-19, is primarily due to the federal fund repayments in FY 2017-18.

Methodology:
1. The 1% FMAP savings for period July 1, 2016 through June 30, 2017, for both FFS and managed care, will occur in FY 2017-18. For FY 2018-19, both FFS and managed care savings will include the period from July 1, 2017 through June 30,2018.

FY 2017-18	FFS	Managed Care	Total Savings
Total for FY 2016-17	($243,000)	($1,032,000)	($1,275,000)

FY 2018-19	FFS	Managed Care	Total Savings
Total for FY 2017-18	($309,000)	($1,032,000)	($1,341,000)

2. In FY 2017-18, the Department repaid federal funds, from the General Fund (GF), to the Centers for Medicare and Medicaid Services (CMS), for federal fund overpayments for FY 2015-16.

FY 2017-18	Actual 1% FMAP FFS Savings	Federal Funds Claimed	Federal Fund Repayments
FY 2015-16 (Jan 2016 to Jun 2016)	($110,000)	$292,000	$182,000

3. Total cost/(savings) for the 1% FMAP increase for preventive services are as follows:

FY 2017-18	**TF**	**GF**	**FF**
FFS:			
FY 2015-16 Repayments	$0	$182,000	($182,000)
FY 2016-17 Savings	$0	($243,000)	$243,000
Total FFS	$0	($61,000)	$61,000
Managed Care:			
FY 2016-17 Savings	$0	($1,032,000)	$1,032,000
Total Managed Care	$0	($1,032,000)	$1,032,000
Total FY 2017-18	**$0**	**($1,093,000)**	**$1,093,000**

1% FMAP INCREASE FOR PREVENTIVE SERVICES

REGULAR POLICY CHANGE NUMBER: 22

FY 2018-19	TF	GF	FF
FFS:			
FY 2017-18 Savings	$0	($309,000)	$309,000
Total FFS	$0	($309,000)	$309,000
Managed Care:			
FY 2017-18 Savings	$0	($1,032,000)	$1,032,000
Total Managed Care	$0	($1,032,000)	$1,032,000
Total FY 2018-19	**$0**	**($1,341,000)**	**$1,341,000**

Funding:
100% Title XIX (4260-101-0890)
100% GF (4260-101-0001)

ACA MAGI SAVINGS

REGULAR POLICY CHANGE NUMBER: 23
IMPLEMENTATION DATE: 1/2014
ANALYST: Katy Clay
FISCAL REFERENCE NUMBER: 1845

	FY 2017-18	FY 2018-19
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 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: 23

Reason for Change:
There is no change, from the previous estimate, for FY 2017-18 or FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, resulted from increased caseload projections and increased per member per month (PMPM) rates.

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:

Select Populations:	**FY 2017-18**	**FY 2018-19**
Individuals who forego applying for disability	$ (5,429,000)	$ (6,217,000)
Disabled not enrolled in Medicare but need LTSS	$ (4,258,000)	$ (4,877,000)
Medically Needy 19/20 no SOC not *Sneede v. Kizer*	$ (1,272,000)	$ (1,457,000)
Medically Needy parents with SOC	$ (22,468,000)	$ (25,733,000)
Pregnant women income 109-138% FPL	$ (1,635,000)	$ (1,698,000)
SB 87 pending disability individuals	$ (24,352,000)	$ (27,890,000)
TOTAL	**$ (59,414,000)**	**$ (67,872,000)**

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 2017-18		**TF**	**GF**
50% Title XIX FF / 50% GF	4260-101-0890/0001	$ (118,828)	$ (59,414)
95% Title XIX ACA FF / 5% GF	4260-101-0890/0001	$ 59,414	$ 2,971
94% Title XIX ACA FF / 6% GF	4260-101-0890/0001	$ 59,414	$ 3,565
Net Impact		**$ -**	**$ (52,878)**

FY 2018-19		**TF**	**GF**
50% Title XIX FF / 50% GF	4260-101-0890/0001	$ (135,744)	$ (67,872)
94% Title XIX ACA FF / 6% GF	4260-101-0890/0001	$ 67,872	$ 4,072
93% Title XIX ACA FF / 7% GF	4260-101-0890/0001	$ 67,872	$ 4,751
Net Impact		**$ -**	**$ (59,049)**

ACA OPTIONAL EXPANSION MLR RISK CORRIDOR

REGULAR POLICY CHANGE NUMBER:	25
IMPLEMENTATION DATE:	9/2018
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	2064

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	-$2,000,000,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$2,000,000,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	-$2,000,000,000

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:
PC 110 MCO Tax Managed Care Plans
PC 109 MCO Tax Mgd. Care Plans-Funding Adjustment
PC 99 MCO Tax Mgd. Care Plans-Incr. Cap. Rates.

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, and July 1, 2015, through June 30, 2016. 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 DHCS 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 DHCS 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: 25

Reason for Change:
The change from the prior estimate, for FY 2017-18, is a decrease due to a delay in CMS approval.

The change from the prior estimate, for FY 2018-19, is an increase in recoupment due to:

- A recoupment shift from FY 2017-18 because of a delay in CMS approval, and
- Anticipating the recoupment of two MLR calculation periods (30 months), instead of a partial 18-month MLR calculation period.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to recoupment timing.

Methodology:

1. MCPs will report data for the MLR corridor calculation for the following 18-month time period:
   - January 1, 2014, through June 30, 2014
   - July 1, 2014, through December 31, 2014
   - January 1, 2015, through June 30, 2015

2. The Department will calculate a single MLR calculation for this 18-month time period of (January 1, 2014, through June 30, 2015). Upon completion and review of these calculations, it is anticipated applicable recoupments and/or paybacks are expect to occur in FY 2018-19.

3. The Department will also perform a single MLR calculation for the 12-month period (July 1, 2015, through June 30, 2016). Upon completion and review of these calculations, it is anticipated applicable recoupments and/or paybacks of federal dollars are expected to occur in FY 2018-19.

4. For each MLR period, the Department will determine MCPs that do not meet the minimum MLR standard of 85 percent. Any dollar amount below this threshold will be reimbursed to the Centers for Medicare and Medicaid Services (CMS), as capitation payments for this rating period were 100% federally funded.

5. For each MLR period, the Department will determine MCPs that exceed an MLR of 95%. Total amounts exceeding this threshold will be paid to the applicable MCP(s), any repayments will be federally funded.

6. Based on preliminary estimates, it is assumed $2,000,000,000 will be recouped from the MCPs for both reporting periods.

(Dollars in Thousands)

	TF	FF	GF
FY 2018-19	**($2,000,000)**	**($2,000,000)**	**$0**

Funding:
ACA 100% FFP (2014-2016)Title XIX 100% FF

BEHAVIORAL HEALTH TREATMENT

REGULAR POLICY CHANGE NUMBER: 27
IMPLEMENTATION DATE: 10/2016
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1855

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$498,218,000	$544,531,000
- STATE FUNDS	$222,550,040	$243,237,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$498,218,000	$544,531,000
STATE FUNDS	$222,550,040	$243,237,300
FEDERAL FUNDS	$275,667,960	$301,293,700

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).

Authority:
Social Security Act Section 1905(a)(13)
SB 870 (Chapter 40, Statutes of 2014)
State Plan Amendment (SPA) 14-026
Welfare and Institutions (W&I) Code 14132.56
Interagency Agreement 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 Autism Spectrum Disorder (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: 27

The Department, in collaboration with DDS, began transitioning responsibility for BHT services starting February 1, 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.

The transition to Medi-Cal BHT services from 1915(c) and (i) waiver services occurred as follows:

- Fee-for-Service (FFS) Beneficiaries
  The transition of financial responsibility for BHT services for FFS beneficiaries receiving RC BHT services occurred on February 1, 2016. These beneficiaries continue to receive services with their current BHT provider(s) in the RC delivery system, at the existing levels of BHT service. On July 7, 2017, the Department entered into an Interagency Agreement (IA) contract with DDS to reimburse for costs incurred for BHT clients.

- Managed Care Beneficiaries
  The transition for managed care beneficiaries began on February 1, 2016, and was completed in September 2016. Transition was based on the beneficiary's birth month (or RC if residing in Los Angeles County).

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is an increase primarily due to a higher number of supplemental capitation payments projected for managed care based on updated actual data through June 2017.

The change in the current estimate, from FY 2017-18 to FY 2018-19, is due to a higher number of supplemental capitation payments projected in FY 2018-19, based on an expected increase in total member months in managed care through FY 2018-19. In addition, FY 2018-19 cost for FFS includes payments for FY 2017-18, and has a higher estimated annual cost.

Methodology:
1. Coverage for BHT began on September 15, 2014.

Fee-for-Service
2. A total of 1,683 FFS beneficiaries transitioned from DDS on February 1, 2016.

3. The IA contract between the Department and DDS was executed in July 2017, with a retroactive effective date of February 1, 2016. DDS began submitting invoices in July, 1 2017.

4. The estimate includes the rate increases to RC providers authorized by ABX2 1 (Chapter 3, Statutes of 2016), effective July 1, 2016.

5. The FFS cost reimbursement estimates were provided by DDS. The estimated annual cost, on an accrual basis, for FY 2017-18 is $9,153,000 TF, and $9,622,000 TF for FY 2018-19.

BEHAVIORAL HEALTH TREATMENT

REGULAR POLICY CHANGE NUMBER: 27

6. On a cash basis, FFS reimbursements are estimated to be paid as follows:

(Dollars in Thousands)

Fee-for-Service Claims	Accrual	FY 2017-18	FY 2018-19
FY 2017-18 claims	$9,153	$5,889	$3,264
FY 2018-19 claims	$9,622	$0	$7,160
Total	$18,775	$5,889	$10,424

Managed Care

7. Managed care payments began in October 2016 for BHT services based on a supplemental capitation payment methodology, retroactive to the implementation date.

8. Assume 21,514 members received BHT services in FY 2016-17; not all members received BHT services each month. The estimated number of supplemental capitation payments for FY 2016-17 is 146,243.

FY 2016-17: 146,243 x $2,152.77 = $314,828,000 TF

9. Assume 28,114 members receive BHT services in FY 2017-18; not all members received BHT services each month. The estimated number of supplemental capitation payments for FY 2017-18 is 196,668.

FY 2017-18: 196,668 x $2,334.04 = $459,031,000 TF

10. Assume 33,514 members receive 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 228,148.

FY 2018-19: 228,148 x $2,450.74 = $559,132,000 TF

11. Due to the supplemental capitation payment methodology, assume the following payment lags:
    - For FY 2016-17, assume 52.97% of payments was paid in the same fiscal year and 47.03% of payments will be paid in the following fiscal year, due to FY 2016-17 including eight months of capitation payments.
    - For FY 2017-18 and FY 2018-19, assume 75% of payments will be paid in the same fiscal year and 25% of payments will be paid the following fiscal year.

(Dollars in Thousands)

Rate Year	Accrual	FY 2017-18	FY 2018-19
FY 2016-17 - MC	$314,828	$148,056	$0
FY 2017-18 - FFS	$9,153	$5,889	$3,264
FY 2017-18 - MC	$459,031	$344,273	$114,758
FY 2018-19 - FFS	$9,622	$0	$7,160
FY 2018-19 - MC	$559,132	$0	$419,349
Total	$1,351,766	**$498,218**	**$544,531**

BEHAVIORAL HEALTH TREATMENT

REGULAR POLICY CHANGE NUMBER: 27

(Dollars in Thousands)

FY 2017-18	TF	GF	FF XIX	FF XXI
Fee-for-Service	$5,889	$2,631	$2,531	$727
Managed Care	$492,329	$219,919	$211,632	$60,778
Total	**$498,218**	**$222,550**	**$214,163**	**$61,505**

(Dollars in Thousands)

FY 2018-19	TF	GF	FF XIX	FF XXI
Fee-for-Service	$10,424	$4,656	$4,481	$1,287
Managed Care	$534,107	$238,581	$229,591	$65,935
Total	**$544,531**	**$243,237**	**$234,072**	**$67,222**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)

FAMILY PACT PROGRAM

REGULAR POLICY CHANGE NUMBER:	28
IMPLEMENTATION DATE:	1/1997
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$319,115,000	$322,281,000
- STATE FUNDS	$76,422,800	$77,180,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$319,115,000	$322,281,000
STATE FUNDS	$76,422,800	$77,180,300
FEDERAL FUNDS	$242,692,200	$245,100,700

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 (ACA), 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.

Drug rebates for Family PACT drugs are included in the Family PACT Drug Rebates policy change.

Reason for Change:
The decrease from the prior estimate, for FY 2017-18 and FY 2018-19, is due to decreases in claims in the Physicians and Other Medical service categories. The increase in the current estimate, from FY 2017-18 to FY 2018-19, is due to an increase in the average cost in the Physicians service category.

FAMILY PACT PROGRAM

REGULAR POLICY CHANGE NUMBER: 28

Methodology:

1. The Department used linear regressions on actual data from September 2011 to January 2018 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 2017-18		FY 2018-19	
	TF	GF	TF	GF
Physicians	$ 59,910	$ 14,347	$ 61,492	$ 14,726
Other Medical	$ 207,352	$ 49,657	$ 205,635	$ 49,246
Co. & Comm. Outpatient	$ 2,043	$ 489	$ 2,142	$ 513
Pharmacy	$ 49,810	$ 11,929	$53,012	$ 12,695
Total	**$ 319,115**	**$ 76,422**	**$ 322,281**	**$ 77,180**

Funding:

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$ 11,115	$ 5,557	$ 5,558
100% GF (4260-101-0001)	$ 44,517	$ 44,517	$ -
90% Family Planning / 10% GF (4260-101-0001/0890)	$ 263,483	$ 26,348	$ 237,135
Total	**$ 319,115**	**$ 76,422**	**$ 242,693**

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$ 11,225	$ 5,613	$ 5,612
100% GF (4260-101-0001)	$ 44,958	$ 44,958	$ -
90% Family Planning / 10% GF (4260-101-0001/0890)	$ 266,098	$ 26,610	$ 239,488
Total	**$ 322,281**	**$ 77,181**	**$ 245,100**

ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

REGULAR POLICY CHANGE NUMBER:	29
IMPLEMENTATION DATE:	5/2013
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1476

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$329,907,000	$278,779,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$329,907,000	$278,779,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$329,907,000	$278,779,000

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: 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: 29

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 for FY 2017-18, from the prior estimate, is an increase based on updated caseload and expenditure data, and prior year expenditures being higher than previously expected.

The change for FY 2018-19, from the prior estimate, is an increase based on higher expected caseload and an increase in FY 2017-18 funds that are expected to be received in FY 2018-19.

The change in the current estimate, from FY 2017-18 to FY 2018-19, is a net decrease due to updated caseload and FY 2017-18 including a higher number of prior year expenditures.

Methodology:
1. The following estimates, on a cash basis, were provided by CDDS.

(Dollars in Thousands)

	TF	CDDS GF	FF
FY 2017-18	$659,814	$329,907	**$329,907**
FY 2018-19	$557,558	$278,779	**$278,779**

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

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER: 30
IMPLEMENTATION DATE: 7/2000
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 25

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$118,256,000	$123,374,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$118,256,000	$123,374,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$118,256,000	$123,374,000

DESCRIPTION

Purpose:
This policy change estimates the federal match provided to Local Educational Agencies (LEAs) for Medi-Cal eligible services.

Authority:
Welfare & Institutions Code 14132.06 and 14115.8

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.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is a decrease due to updated reconciliations and no longer including the federal fund repayments for the MGO audit.

The change in FY 2018-19, from the prior estimate, is a decrease due to updated interim payments.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to the reconciliations in FY 2017-18.

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER: 30

Methodology:

1. The estimate is based on the analysis of historical claims submitted by LEAs.
2. The FY 2017-18 and FY 2018-19 interim payment estimates are calculated based on the average of the preceding three fiscal years.
3. Estimated adjustment for over collection of withholds due to the LEAs for FYs 2014-15 and 2015-16.
4. Estimated adjustment for under collection of withholds due from the LEA for FY 2014-15.
5. Estimated adjustment for cost report reconciliation due back to the State.
6. Estimated adjustment due to improper denials of speech therapy claims.
7. Amount adjudicated for an EPC for the FY 2017-18 and FY 2018-19 annual rate inflation. The EPCs will update the rates for LEA services based on the rate of inflation.
8. Macias, Gini, & O'Connell, LLP (MGO) audit C15-33 findings: The MGO Audit found that the LEA Billing Option Program paid $5,213,000 in Title XXI Children's Health Insurance Program (CHIP) expenditures that were not allowable in the LEA program. The Department determined that the Title XXI payments identified through the audit are eligible for payment under the LEA BOP and appealed the $5,213,000 finding. The California State Auditor Report 2017-002 final report has determined that the audit finding 2016-009 regarding the Title XXI payment finding is no longer valid for current and prior years.

FY 2017-18	TF	FF
FY 2017-18 Interim Payments	$123,197,000	$123,197,000
FY 2017-18 Rate Inflation	$1,332,000	$1,332,000
FY 2014-15 Withholds due to the LEAs	$2,254,000	$2,254,000
FY 2017-18 Speech Therapy EPCs to LEAs	$4,000,000	$4,000,000
FY 2014-15 Withholds due to State	($79,000)	($79,000)
FY 2017-18 Reconciliation due to State	($12,448,000)	($12,448,000)
FY 2017-18 Total	**$118,256,000**	**$118,256,000**

FY 2018-19	TF	FF
FY 2018-19 Interim Payments	$121,497,000	$121,497,000
FY 2018-19 Rate Inflation	$1,174,000	$1,174,000
FY 2015-16 Withholds due to the LEAs	$703,000	$703,000
FY 2018-19 Total	**$123,374,000**	**$123,374,000**

Funding:

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

CCS DEMONSTRATION PROJECT

REGULAR POLICY CHANGE NUMBER:	31
IMPLEMENTATION DATE:	4/2013
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1775

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$40,718,000	$70,982,000
- STATE FUNDS	$18,313,080	$31,981,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$40,718,000	$70,982,000
STATE FUNDS	$18,313,080	$31,981,700
FEDERAL FUNDS	$22,404,920	$39,000,300

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:
OA 2 CCS Case Management
PC 88 County Organized Health Systems (COHS)

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.

Effective April 1, 2013, the Health Plan of San Mateo (HPSM) an existing managed care organization, began operations as a demonstration project under the Department's 1115 BTR waiver model. Rady Children's Hospital – San Diego (RCHSD) demonstration project is in development and is projected to implement no sooner than July 1, 2018.

Reason for Change:
There is no change from the prior estimate for FY 2017-18.

The change from the prior estimate, for FY 2018-19, is a decrease due to a lower RCHSD capitation draft rate.

CCS DEMONSTRATION PROJECT

REGULAR POLICY CHANGE NUMBER: 31

The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to the implementation of the RCHSD demonstration project.

Methodology:

1. The CCS demonstration project transitioned CCS Medi-Cal beneficiaries residing in San Mateo County from the COHS, in which CCS services are carved out and reimbursed as fee-for-service, to the HPSM, in which primary preventive care and CCS services are reimbursed through a capitation rate.

2. The estimated HPSM capitation rate for FY 2017-18 and FY 2018-19 is $1,596.12 and $1,653.65, respectively. These rates include health care and administrative costs.

3. Average monthly enrollment has been adjusted to account for a projected increase due to the implementation of the ACA.

Fiscal Year	Average Monthly Enrollment	Capitation Rate	Monthly Payment	Annual Payment
FY 2017-18	2,000	$1,596.12	$3,192,240	$38,307,000
FY 2018-19	2,000	$1,653.65	$3,307,300	$39,688,000

4. Assume 70% of the CCS Medi-Cal administrative costs of $3,444,000 will be transferred to the HPSM. These payments are applied against the costs in the OA-2 CCS Case Management policy change.

   Annual HPSM administrative costs:
   $3,444,000 x 70% = $2,411,000 TF (monthly $201,000 TF)

5. HPSM received capitation payments beginning May 2013.

6. The estimated capitation payments for HPSM are:

Fiscal Year	HPSM TF	COHS	CCS Case Management
FY 2017-18	$40,718,000	$38,307,000	$ 2,411,000
FY 2018-19	$42,099,000	$39,688,000	$ 2,411,000

7. Assume the RCHSD demonstration project implements in July 2018.

8. The estimated RCHSD capitation rate and member months for FY 2018-19 is $7,458.75 and 400, respectively.

Fiscal Year	Average Monthly Enrollment	Capitation Rate	Monthly Payment	RCHSD Annual Payment
FY 2018-19	400	$6,017.24	$2,406,896	$28,883,000

9. Assume the June capitation payment will be deferred to the following fiscal year.

10. Assume the CCS demonstration project is budget neutral.

CCS DEMONSTRATION PROJECT

REGULAR POLICY CHANGE NUMBER: 31

11. Total estimated costs for FY 2017-18 and FY 2018-19 are:

Fiscal Year	TF	RCHSD	HPSM
FY 2017-18	$40,718,000	$0	$40,718,000
FY 2018-19	$70,982,000	$28,883,000	$42,099,000

Funding:

FY 2017-18	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$35,334,000	$17,667,000	$17,667,000
88% Title XXI / 12% GF (4260-113-0001/0890)	$5,384,000	$646,000	$4,738,000
Total	**$40,718,000**	**$18,313,000**	**$22,405,000**

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$61,747,000	$30,873,000	$34,874,000
88% Title XXI / 12% GF (4260-113-0001/0890)	$9,235 ,000	$1,108,000	$8,127,000
Total	**$70,982,000**	**$31,981,000**	**$39,001,000**

MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

REGULAR POLICY CHANGE NUMBER:	32
IMPLEMENTATION DATE:	7/1984
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	28

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$21,112,000	$21,112,000
- STATE FUNDS	$10,556,000	$10,556,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$21,112,000	$21,112,000
STATE FUNDS	$10,556,000	$10,556,000
FEDERAL FUNDS	$10,556,000	$10,556,000

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 (HCBS) waiver for up to 11,684 participants in 9,283 participant slots in FY 2017-18 and FY 2018-19.

In coordination with Federal and State government, the Coordinated Care Initiative (CCI) provides the benefits of coordinated care models to persons eligible for both Medicare and Medi-Cal (dual eligibles) and seniors and persons with disabilities (SPDs) who are eligible for Medi-Cal only. In the seven CCI demonstration counties, dual eligibles and SPDs are mandatorily enrolled into managed care for their Medi-Cal benefits. Those benefits comprise long-term supports and services (LTSS) including facility-based long-term care, In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS) and MSSP. Under CCI, managed care capitation includes MSSP services. In the seven CCI demonstration counties, participating managed care health plans will contract with the MSSP sites in their service area to deliver MSSP waiver services to their eligible health plan members. Eligible plan members will be enrolled into the MSSP waiver, subject to the availability of a waiver slot.

MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

REGULAR POLICY CHANGE NUMBER: 32

As CCI is implemented, MSSP will transition to a Medi-Cal managed care benefit in all CCI demonstration counties (San Mateo, Santa Clara, Los Angeles, Orange, San Diego, San Bernardino, and Riverside). All CCI counties expect to complete MSSP transition from a 1915(c) HCBS waiver benefit to a managed care health plan benefit by January 1, 2020. The total MSSP reimbursement (both for fee-for-service (FFS) and managed care (MC)) 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 $21,112,000 TF for FY 2017-18 and FY 2018-19.

The Governor's Budget estimate of the Coordinated Care Initiative (CCI) projects that it 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 In-Home Supportive Services (IHSS), into managed care. IHSS would be removed from capitation rate payments effective January 1, 2018.

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is a decrease due to CCI related activities will be included in the CCI-Administrative Costs policy change. There is no change from FY 2017-18 to FY 2018-19 in the current estimate.

Methodology:

1. The estimates below were provided by CDA on a cash basis.

(Dollars in Thousands)	TF	Reimbursement from CDA	FFP
FY 2017-18			
MSSP	$39,778		
CCI-Administrative Costs*	$18,666		
FY 2017-18 Total	**$21,112**	$10,556	$10,556

(Dollars in Thousands)	TF	Reimbursement from CDA	FFP
FY 2018-19			
MSSP	$39,778		
CCI-Administrative Costs*	$18,666		
FY 2018-19 Total	**$21,112**	$10,556	$10,556

*Costs are budgeted in the CCI-Administrative Costs policy change.

Funding:
Title XIX 100% FFP (4260-101-0890)
Reimbursement (4260-610-0995)

ANNUAL CONTRACEPTIVE COVERAGE

REGULAR POLICY CHANGE NUMBER: 33
IMPLEMENTATION DATE: 5/2017
ANALYST: Katy Clay
FISCAL REFERENCE NUMBER: 2016

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$36,689,000	$36,689,000
- STATE FUNDS	$8,275,100	$8,275,100
PAYMENT LAG	0.7940	0.9220
% REFLECTED IN BASE	88.75 %	95.21 %
APPLIED TO BASE		
TOTAL FUNDS	$3,277,200	$1,620,300
STATE FUNDS	$739,170	$365,460
FEDERAL FUNDS	$2,538,070	$1,254,870

DESCRIPTION

Purpose:
This policy change estimates the cost impact of expanding on existing contraceptive coverage for the Medi-Cal and Family Planning, Access, Care and Treatment (Family PACT) programs.

Authority:
SB 999 (Chapter 499, Statutes of 2016)

Interdependent Policy Changes:
Not Applicable

Background:
Title 22, California Code of Regulations (CCR), Section 51313(b) allows for drugs to be furnished as a pharmacy benefit in quantities not to exceed a 100 calendar day supply, including self-administered hormonal contraceptives. Medi-Cal pharmacy providers fall within the restriction of this regulation and therefore dispense three months of this prescription written by Medi-Cal and Family PACT providers.

340B clinics provide onsite dispensing of family planning drugs and supplies.

Effective January 1, 2017, the Department expanded on existing contraceptive coverage policy by covering up to a 12-month supply of Food and Drug Administration (FDA)-approved, self-administered hormonal contraceptives (ring, patch, and oral contraceptives) dispensed at one time by a prescriber, pharmacy, or onsite location licensed or authorized to dispense drugs or supplies.

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is a slight decrease due to a decrease in net costs based on updated actual claims data. There is no change, in the current estimate, from FY 2017-18 to FY 2018-19.

ANNUAL CONTRACEPTIVE COVERAGE

REGULAR POLICY CHANGE NUMBER: 33

Methodology:

1. Annual contraceptive coverage was implemented May 1, 2017, retroactive to January 1, 2017.

2. Assume a 10% increase in utilization due to the change in policy. This includes beneficiaries switching from one contraceptive to another.

3. Managed care costs are not included in this policy change.

340B Clinics

4. Prior to the implementation of annual contraceptive coverage, 340B clinics dispensed a 12-month supply for oral contraceptives and a 90-day supply for the hormonal patch and ring.

5. For the hormonal patch and ring, assume all clients will opt-in to receive a 12-month supply with providers billing at the maximum allowable rate.

6. The Department will increase the quantity of 12-month supply of self-administered hormonal contraceptives to account for clients on continuous cycle effective April 1, 2018.

7. Total costs for onsite dispensing at 340B clinics is estimated to be $21,098,000 TF ($4,759,000 GF).

Fee-for-Service Pharmacies

8. Pharmacies currently dispense a 90-day supply for oral contraceptives, hormonal patches, and rings. Assume all clients will opt-in for a 12-month supply with providers billing at the maximum allowable rate.

9. Total costs for onsite dispensing at pharmacies is estimated to be $44,280,000 TF ($9,987,000 GF).

10. Pharmacy dispensing fee savings as a result of clients getting annual supply of contraceptives instead of every 90 days is estimated to be $4,778,000 TF ($1,078,000 GF).

11. Pharmacy rebate savings due to utilization increase for oral contraceptives, hormonal patch, and ring are $23,911,000 TF ($5,393,000 GF).

12. The net cost impact due to the contraceptive coverage expansion is:

(Dollars in Thousands)

Annual Cost	**TF**	**GF**	**FF**
340B - Onsite Dispensing	$ 21,098	$ 4,759	$ 16,339
Pharmacy Costs	$ 44,280	$ 9,987	$ 34,293
Dispensing Fee Savings	$ (4,778)	$ (1,078)	$ (3,700)
Rebate Savings	$ (23,911)	$ (5,393)	$ (18,518)
Net Cost	**$ 36,689**	**$ 8,275**	**$ 28,414**

ANNUAL CONTRACEPTIVE COVERAGE

REGULAR POLICY CHANGE NUMBER: 33

Funding:

(Dollars in Thousands)

FY 2017-18	**TF**	**GF**	**FF**
90% Title XIX / 10% GF (4260-101-0890/0001)	$ 31,571	$ 3,157	$ 28,414
100% GF (4260-101-0001)	$ 5,118	$ 5,118	$ -
Total	**$ 36,689**	**$ 8,275**	**$ 28,414**

FY 2018-19	**TF**	**GF**	**FF**
90% Title XIX / 10% GF (4260-101-0890/0001)	$ 31,571	$ 3,157	$ 28,414
100% GF (4260-101-0001)	$ 5,118	$ 5,118	$ -
Total	**$ 36,689**	**$ 8,275**	**$ 28,414**

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER:	34
IMPLEMENTATION DATE:	12/2008
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1228

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$36,021,000	$10,569,000
- STATE FUNDS	$2,142,000	$1,679,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$36,021,000	$10,569,000
STATE FUNDS	$2,142,000	$1,679,000
FEDERAL FUNDS	$33,879,000	$8,890,000

DESCRIPTION

Purpose:
This policy change estimates the costs of transitioning beneficiaries who have continuously resided in health care facilities for 90 days or longer to federally-allowed home and community based services (HCBS). It also estimates the costs for providing demonstration services to Medi-Cal eligible beneficiaries enrolled in the California Community Transitions (CCT) Demonstration Project.

Authority:
Federal Deficit Reduction Act (DRA) of 2005, Section 6071
Affordable Care Act (ACA)

Interdependent Policy Changes:
PC 41 CCT Fund Transfer to CDSS and CDDS

Background:
In January 2007, the Centers for Medicare and Medicaid Services 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 extended by the ACA. It is effective from January 1, 2007, through September 30, 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 support of Medi-Cal HCBS.

Participants are enrolled in the demonstration for a maximum of 365-days, but also receive pre-transition services prior to leaving the inpatient facility. CCT transitions began December 1, 2008. Target transitions for the period of July 1, 2017, through June 30, 2018, are 588 individuals and 219 individuals for July 1, 2018, through June 30, 2019. The Department will discontinue processing new transitions effective January 1, 2019 to ensure sufficient time to bill the 365-day post transition period and perform grant close-out functions.

CCT participants who have developmental disabilities are provided services through the Developmentally Disabled (DD) waiver and partially funded by MFP. The number of DD beneficiaries

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 34

expected to transition into CCT is included in this policy change. The cost of transitioning, providing HCBS, and the supplemental federal funding that is associated with providing CCT services to these beneficiaries is budgeted in the CCT Fund Transfer to CDSS and CDDS policy change.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is an increase due to revised enrollment, which increased DD beneficiaries transitioning from January through June 2017. Additionally, the Department will transition an additional 159 beneficiaries in FY 2017-18. The change from the prior estimate, for FY 2018-19, is an increase due to 69 additional post-transition costs the Department will pay. The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to DD transitions ending by December 31, 2017 and non-DD transitions ending December 31, 2018.

Methodology:
1. Assume estimated costs of waiver impacted services for persons residing year-round in Nursing Facility (NF)-Bs would be $79,574 in FY 2017-18 and $79,621 in FY 2018-19. 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 $8,357 annually; reimbursed at 75% MFP and 25% GF.

3. Assume 498 pre-transitions that are unsuccessful for non-DD beneficiaries in FY 2017-18 and 219 in FY 2018-19 cost $1,128 annually; reimbursed at 100% MFP.

4. Assume non-DD beneficiaries, upon transitioning into CCT, cost $18,000 annually in FY 2017-18 and FY 2018-19; reimbursed at 75% MFP and 25% GF.

5. Assume 159 DD beneficiaries will transition through CCT in FY 2017-18. The Department will pay for pre and post-transition costs for 69 transitions and will pay for pre-transition costs for only 90 transitions.

6. Assume DD beneficiaries who participate in CCT have a one-time cost of $64,587 for pre-transition demonstration services; reimbursed at 75% MFP and 25% GF. The Department will no longer process DD transitions after December 31, 2017.

7. Assume DD beneficiaries, cost $105,000 in FY 2017-18 and FY 2018-19 upon transitioning into CCT for 1915(c) waiver services; reimbursed at 75% MFP and 25% GF. The Department will no longer provide reimbursement for 1915(c) waiver services utilized by DD beneficiaries as of January 1, 2019.

8. In FY 2017-18, the Department will pay $12,912,000 MFP funds for prior fiscal years that were delayed in processing.

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 34

9. Below is the overall impact of the CCT Demonstration project in FY 2017-18 and FY 2018-19.

FY 2017-18	TF	GF	FF
CCT Costs (PC 34):			
Total Non-DD GF costs and Total FFP	$23,109,000	$2,142,000	$20,967,000
Retroactive MFP payment**	$12,912,000	$0	$12,912,000
Total FY 2017-18 Costs:	**$36,021,000**	**$2,142,000**	**$33,879,000**
CCT Savings:			
Total Non-DD GF savings and Total FFP*	($30,868,000)	($15,434,000)	($15,434,000)
CCT Fund Transfer to CDSS & CDDS (PC 41)	$2,808,000	$0	$2,808,000
CCT Outreach - Admin costs (OA 44)	$342,000	$0	$342,000
Total of CCT PCs including pass through	($4,609,000)	($13,292,000)	$8,683,000

*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

FY 2018-19	TF	GF	FF
CCT Costs (PC 34):			
Total Non-DD GF costs and Total FFP	**$10,569,000**	**$1,679,000**	**$8,890,000**
CCT Savings:			
Total Non-DD GF savings and Total FFP*	($26,693,000)	($13,346,000)	($13,347,000)
CCT Fund Transfer to CDSS & CDDS (PC 41)	$1,283,000	$0	$1,283,000
CCT Outreach - Admin costs (OA 44)	$342,000	$0	$342,000
Total of CCT PCs including pass through	($14,499,000)	($11,667,000)	($2,832,000)

*The savings are included in the total, however, they are fully reflected in the base estimates.

Funding:
100% GF (4260-101-0001)
MFP Federal Grant (4260-106-0890)

DENTAL TRANSFORMATION INITIATIVE UTILIZATION

REGULAR POLICY CHANGE NUMBER:	35
IMPLEMENTATION DATE:	7/2016
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1976

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$18,018,000	$43,770,000
- STATE FUNDS	$7,200,360	$16,901,760
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$18,018,000	$43,770,000
STATE FUNDS	$7,200,360	$16,901,760
FEDERAL FUNDS	$10,817,640	$26,868,240

DESCRIPTION

Purpose:
This policy change estimates the amount of utilization based costs associated with all four domains of the Dental Transformation Initiative (DTI) effort.

The majority of dental services are paid through capitated rates; however, there is a small population of non-capitated FFS beneficiaries. This PC reflects the full costing of the policy; however because the majority of these costs are captured through the capitated rates, ultimately only the non-capitated FFS related costs are reflected in the final budgeted dollars for this PC.

Authority:
Not Applicable

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's goal is to increase the utilization amongst children enrolled in either the Fee-For-Services (FFS) or Dental Managed Care (DMC) delivery system or who receive dental services at a Federally Qualified Health Center (FQHC) by at least ten percentage points over a

DENTAL TRANSFORMATION INITIATIVE UTILIZATION

REGULAR POLICY CHANGE NUMBER: 35

five year period. The Department will offer payments as financial incentives for dental service office locations to increase delivery of preventive oral care to Medi-Cal children. These payments will be in the form of semi-annual 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.

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. Incentive payments are to be paid upon the billing of each of the aforementioned services. 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 will initially be 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.

The Increase the Continuity of Care domain aims to encourage the continuity of care among Medi-Cal beneficiaries age 20 and under. An incentive payment would be paid to dental provider service office locations that have maintained continuity of care through providing examinations for their enrolled child beneficiaries for two, three, four, five, and six year continuous periods. This domain will initially be 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. Incentive payments will be made annually.

The Department will require 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 will issue 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 have been approved; however one LDPP has withdrawn its application. No more than 25 percent of the annual DTI funding will be allocated to this domain.

Reason for Change:
The change from the prior estimate for FY 2017-18 and FY 2018-19 is a net increase due to updated data showing a projected increase in utilization as well as accounting for the FFS switch to a straight FFS check write. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to a full year's worth of straight FFS check write in the BY.

Methodology:
1. Domain 1: Based on the percent of the total payment by delivery system, determine a weighted average. Determine the percent of the providers that received a Domain 1 payment by delivery system. Multiply the total utilization actuals dollar figure by the two percents to determine the assumed utilization attributable to DTI.

   Total Domain 1 costs are expected to be $29,486,706 TF in FY 2017-18 and $35,710,438 TF in FY 2018-19.

2. Domain 2: Existing methodology in Domain 2 accounts for new services, as such; additional utilization is not included here.

3. Domain 3: Assume that Domain 3 incentives will assist in efforts to establish a dental home for beneficiaries at a growth rate of 2.25% per year. Assume that returning users will receive one

DENTAL TRANSFORMATION INITIATIVE UTILIZATION

REGULAR POLICY CHANGE NUMBER: 35

dental exam ($20), one prophylaxis ($30), and one fluoride treatment ($13) per year for a total per year cost per additional beneficiary of $63. The increase in returning beneficiaries will result in increased utilization costs which will not be absorbed in the DTI incentive payments.

Total Domain 3 costs are expected to be $2,879,514 TF in FY 2017-18 and $3,708,254 TF in FY 2018-19.

4. Domain 4: Assume a 5% utilization increase within the target population multiplied by the average cost per use. Total Domain 4 costs are expected to be $5,565,925TF in FY 2017-18 and $4,351,424 TF in FY 2018-19.

5. This PC budgets the costs for the non-capitated FFS population for the period of July 2017 through January 2018 since the move to the straight FFS check write did not occur until February 2018. 10% of the overall dental population falls under non-capitated FFS.

	TF	GF	FF
FY 2017-18	**$18,018,000**	**$3,605,000**	**$14,413,000**
FY 2018-19	**$43,770,000**	**$9,055,000**	**$34,715,000**

Funding:
50% Title XIX / 50% GF
88% Title XXI FF/12% GF
94% FF/6% GF
93% FF/7% GF

FULL RESTORATION OF ADULT DENTAL BENEFITS

REGULAR POLICY CHANGE NUMBER:	36
IMPLEMENTATION DATE:	1/2018
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	2043

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$87,398,000	$209,650,000
- STATE FUNDS	$26,344,960	$63,668,780
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$87,398,000	$209,650,000
STATE FUNDS	$26,344,960	$63,668,780
FEDERAL FUNDS	$61,053,040	$145,981,220

DESCRIPTION

Purpose:
The policy change estimates the cost of fully restoring adult dental benefits to the Medi-Cal Dental Program. This policy increases the benefits covered by the Medi-Cal Dental Program for the adult Medi-Cal population.

Authority:
SB 97 (Chapter 52, Statutes of 2017)

Interdependent Policy Changes:
N/A

Background:
Effective July 1, 2009, Assembly Bill X3 5 (Evans, Chapter 20, Statutes of 2009-10) added Section 14131.10 to the Welfare and Institutions Code, which eliminated specific optional benefits from the Medi-Cal program, including most dental services for adults ages 21 and older. Effective May 1, 2014, some adult dental benefits were restored in accordance with Assembly Bill 82. Those services included initial examinations, radiographs, restorations, anterior root canals, complete dentures and complete denture adjustments, repairs and relines.

Effective January 1, 2018, the full restoration of adult dental benefits included the remaining services which were not restored in 2014, such as restorative services (crowns), prosthodontic services (partial dentures), and endodontic services (root canals).

Reason for Change:
The change from the prior estimate for FY 2017-18 and FY 2018-19 is due to a change in methodology that more accurately accounts for the Fee-For-Service (FFS) shift to straight FFS check write payments as well as updated data regarding estimated population changes year over year. The change from FY 2017-18 to FY 2018-19 in the current estimate is due to only a partial year of straight FFS check write payments versus a full year in FY 2018-19.

FULL RESTORATION OF ADULT DENTAL BENEFITS

REGULAR POLICY CHANGE NUMBER: 36

Methodology:

1. This policy implemented January 1, 2018. As such only six (6) months are costed for FY 2017-18, but the full 12 months are costed for FY 2018-19.

2. Data regarding the number of incidences, number of users, and total reimbursement rates from 2008 were pulled and were specific to adult beneficiaries ages 21 and older.

3. A percentage increase was applied to account for population growth and the estimated resultant increased number of users.

4. Effective February 2018, the FFS delivery system switched from a partially capitated payment methodology to a straight FFS check write payment methodology. To account for this, the first 7 months of FY 2017-18 only budgets for the non-capitated FFS population since the costs for the capitated portion are captured in the Dental Services PC.

Fiscal Year	TF	GF	FF
FY 2017-18	$87,398,000	$26,345,000	$61,053,000
FY 2018-19	$209,650,000	$89,215,000	$120,435,000

*Slight differences due to rounding

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)

DENTAL BENEFICIARY OUTREACH EFFORTS - BENEFITS

REGULAR POLICY CHANGE NUMBER:	37
IMPLEMENTATION DATE:	7/2017
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	2074

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$56,097,000	$117,707,000
- STATE FUNDS	$28,048,500	$58,853,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	77.39 %	71.74 %
APPLIED TO BASE		
TOTAL FUNDS	$12,683,500	$33,264,000
STATE FUNDS	$6,341,770	$16,632,000
FEDERAL FUNDS	$6,341,770	$16,632,000

DESCRIPTION

Purpose:
The policy change (PC) estimates the cost of implementing strategies to increase utilization rates. This policy estimates the increase in statewide outreach activities and dental utilization.

Authority:
Welfare & Institutions Code (WIC) Section 14132.91
Contract 04-35745
Contract 16-93287

Interdependent Policy Changes:
Not Applicable

Background:
The Department has identified effective strategies that will have positive health outcomes while increasing utilization of services. In 2014, the California State Auditor (CSA) performed an audit of the Medi-Cal Dental Program. Among the findings/recommendations outlined in CSA's final report was a request that the Department require the 2004 Delta Dental of California (Delta) FI contractor to develop an annual dental outreach and education program, as required by the provisions of the 2004 FI contract and WIC Section 14132.91. Outreach activities outlined in the 2004 FI and the 2016 ASO contractors' Outreach and Education Program plan seek to increase utilization of these services, particularly in counties where utilization levels are lowest.

The outreach efforts are as follows:

- Targeted efforts to parents/guardians of children ages 0-3 that have not had an annual dental visit during the past 12 months with a mailer encouraging them to take their children to see a dental provider and a follow-up outbound auto-dialer,
- Targeted auto-dialer calls to beneficiaries who reside in the counties with lowest utilization rates,
- Telephone Service Center (TSC) live calls to targeted beneficiaries who reside in the counties with lowest utilization rates,
- Statewide mailers to newly enrolled beneficiaries,
- Statewide mailers to beneficiaries who have not utilized services in previous 12 months,

DENTAL BENEFICIARY OUTREACH EFFORTS - BENEFITS

REGULAR POLICY CHANGE NUMBER: 37

- Direct outreach to State, County, and community agencies,
- Website enhancements to the Denti-Cal website.

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 previous estimate, for FY 2017-18 and FY 2018-19, is an increase due to updated user and eligible data, as well as a move to straight FFS effective February 2018. The change from FY 2017-18 to FY 2018-19 in the current estimate, is due to additional utilization expected in FY 2018-19.

Methodology:
1. Assume the outreach efforts will result in a 2 percentage point utilization increase in FY 2017-18 and a 2 percentage point utilization increase in FY 2018-19.

(Dollars in thousands)

Fiscal Year	TF	GF	FF
FY 2017-18	$56,097	$36,712	$19,385
FY 2018-19	$117,707	$72,372	$45,335

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)
100% GF (4260-101-0001)
94% Title XIX ACA FF/6% GF (4260-101-0001/0890)
93% Title XIX ACA FF/7% GF (4260-101-0001/0890)
95% Title XIX ACA FF/5% GF (4260-101-0001/0890)
BCCTP Enhanced T19

YOUTH REGIONAL TREATMENT CENTERS

REGULAR POLICY CHANGE NUMBER:	38
IMPLEMENTATION DATE:	1/2014
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1772

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$2,240,000	$5,140,000
- STATE FUNDS	-$184,000	$227,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,240,000	$5,140,000
STATE FUNDS	-$184,000	$227,000
FEDERAL FUNDS	$2,424,000	$4,913,000

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 (FMAP) for YRTC services provided to eligible American Indian Medi-Cal members under the age of 21.

Reason for Change from Prior Estimate:
The change from the prior estimate, for FY 2017-18, is a decrease due to a slower phase-in of eligibles than was estimated in the previous estimate. That phase-in enrollment was revised from six months to twelve months to adjust for a slower enrollment. The change from the prior estimate, for FY 2018-19, is an increase due to the daily rates for CY 2018 and CY 2019. The rates increased by 5% and 7%, respectively. The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to the phase-in period for FY 2017-18 and an updated federal register rate adjustment for CY 2018 and CY 2019.

Methodology:
1. The program was implemented January 2014 with an effective date of September 1, 2013.

YOUTH REGIONAL TREATMENT CENTERS

REGULAR POLICY CHANGE NUMBER: 38

2. A new in-state YRTC opened in July 2017 with an estimated average monthly enrollment of 16 Medi-Cal beneficiaries.

3. Assume enrollment will be phased in over a 12-month period and payments began in November 2017.

4. Assume CY 2017 daily rate per youth is $782, $854 in CY 2018, and $906 in CY 2019.

   CY 2017: $782 daily rate x 365 days ÷ 12 months = $23,786 monthly
   CY 2018: $854 daily rate x 365 days ÷ 12 months = $25,976 monthly
   CY 2019: $906 daily rate x 365 days ÷ 12 months = $27,558 monthly

FY 2017-18
Phase-in enrollee costs:
July – Dec 2017: 21 enrollee months x $23,786 = $500,000
Jan – June 2018: 67 enrollee months x $25,976 = $1,740,000

$500,000 + $1,740,000 = **$2,240,000 TF**

FY 2018-19
Monthly enrollee costs:
16 enrollees x 6 months x $25,976 = $2,494,000
16 enrollees x 6 months x $27,558 = $2,646,000

$2,494,000 + $2,646,000 = **$5,140,000 TF**

5. Assume the program will pay expenditures at 50% GF/50% FFP upfront and receive 100% FFP reimbursement in the following quarter.

6. $619,000 FFP from last quarter of FY 2016-17 will be reimbursed in FY 2017-18 and $435,000 from last quarter FY 2017-18 will be reimbursed in FY 2018-19.

FY 2017-18	TF	GF	FFP
*Apr - June 2017	$0	($619,000)	$619,000
Jul - Sep 2017	$0	$0	$0
Oct - Dec 2017	$500,000	$0	$500,000
Jan - Mar 2018	$870,000	$0	$870,000
**Apr - Jun 2018	$870,000	$435,000	$435,000
Total	**$2,240,000**	**($184,000)**	**$2,424,000**

FY 2018-19	TF	GF	FFP
*Apr - June 2018	$0	($435,000)	$435,000
Jul - Sep 2018	$1,247,000	$0	$1,247,000
Oct - Dec 2018	$1,247,000	$0	$1,247,000
Jan - Mar 2019	$1,323,000	$0	$1,323,000
**Apr - Jun 2019	$1,323,000	$661,500	$661,500
Total	**$5,140,000**	**$226,500**	**$4,913,500**

*Totals may differ due to rounding

YOUTH REGIONAL TREATMENT CENTERS

REGULAR POLICY CHANGE NUMBER: 38

* FFP reimbursement from previous quarter
** FFP to be reimbursed in the following fiscal year

Funding:
50% Title XIX FFP / 50% GF (4260-101-001/0890)
100% Title XIX FFP (4260-101-0890)

PEDIATRIC PALLIATIVE CARE WAIVER

REGULAR POLICY CHANGE NUMBER:	39
IMPLEMENTATION DATE:	7/2013
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1787

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$2,995,000	$3,377,000
- STATE FUNDS	$1,573,600	$1,527,760
PAYMENT LAG	0.8540	0.9510
% REFLECTED IN BASE	80.12 %	75.67 %
APPLIED TO BASE		
TOTAL FUNDS	$508,500	$781,400
STATE FUNDS	$267,160	$353,490
FEDERAL FUNDS	$241,320	$427,870

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:
PC 46 Pediatric Palliative Care Expansion and Savings

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. On February 1, 2018, CMS approved an extension through May 15, 2018 and is expected to be renewed prior to its expiration.

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 2017-18. 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

PEDIATRIC PALLIATIVE CARE WAIVER

REGULAR POLICY CHANGE NUMBER: 39

July 1, 2017. The supplemental payment is necessary to address the enhanced burden on providers 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. The waiver renewal application requests continuance of the supplemental payment of $300 per month. The Department anticipates receiving CMS approval of the waiver renewal application by or before May 15, 2018.

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is a decrease due to less members enrolled than estimated in the prior estimate. The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to additional members that are to be enrolled by the end of FY 2018-19.

Methodology:
The following assumptions were used to estimate the program cost adjustment:

1. Assume 194 members were enrolled in PPCW for FY 2017-18 prior to caseload expansion.

   194 members x 12 months = 2,328 member months (MM) prior to caseload expansion.

2. Assume caseload expanding to 235 members incrementally by the end of FY 2017-18 and 334 members incrementally by the end of FY 2018-19.

   For FY 2017-18 caseload expansion includes an additional 261 MM.

   For FY 2018-19 caseload expansion includes an additional 554 MM.

3. For FY 2017-18, assume a $300 PMPM cost at 50% FFP for supplemental payments paid through December 30, 2017.

   2,328 MM x $300 PMPM = $698,000 TF (prior to caseload expansion)

   261 MM x $300 PMPM = $78,000 (FY 2016-17 caseload expansion)

   $698,000 + $78,000 = $777,000 TF (totals differ due to rounding)

4. For FY 2018-19, assume a $300 PMPM cost at 50% FFP for supplemental payments paid through June 30, 2019.

   2,820 MM x $300 PMPM = $846,000 TF (prior to caseload expansion)

   554 MM x $300 PMPM = $166,000 (FY 2018-19 caseload expansion)

   $846,000 + $166,000 = $1,012,000 TF (rounded)

PEDIATRIC PALLIATIVE CARE WAIVER

REGULAR POLICY CHANGE NUMBER: 39

5. Assume an average claims payment of $701 PMPM.

   For FY 2017-18: (2,328 MM + 261 MM) x $701 = $1,815,000 TF (rounded)

   For FY 2018-19: (2,589 MM + 554 MM) x $701 = $2,365,000 TF (rounded)

6. Assume $403,000 in back payments for underpaid claims from January 1, 2014, through June 30, 2016, to PPC Waiver Home Health Agency providers for administrative costs will be paid in FY 2017-18 at 100% GF.

7. Total estimated PPCW costs are:

   FY 2017-18: $2,995,000 TF ($1,574,000 GF)

   FY 2018-19: $3,377,000 TF ($1,528,000 GF)

FY 2017-18	**TF**	**GF**	**FF**
50% Title XIX / 50% GF	$2,262,000	$1,131,000	$1,131,000
88% Title XXI / 12% GF	$330,000	$40,000	$290,000
Back Payments 100% GF	$403,000	$403,000	$0
FY 2017-18 Total	**$2,995,000**	**$1,574,000**	**$1,421,000**
FY 2018-19	**TF**	**GF**	**FF**
50% Title XIX / 50% GF	$2,954,000	$1,477,000	$1,477,000
88% Title XXI / 12% GF	$423,000	$51,000	$372,000
FY 2018-19 Total	**$3,377,000**	**$1,528,000**	**$1,849,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)
100% GF (4260-101-0001)

MEDICALLY TAILORED MEALS PILOT PROGRAM

REGULAR POLICY CHANGE NUMBER:	40
IMPLEMENTATION DATE:	4/2018
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	2046

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$1,000,000	$1,600,000
- STATE FUNDS	$1,000,000	$1,600,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,000,000	$1,600,000
STATE FUNDS	$1,000,000	$1,600,000
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 (W&IC) 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 one or more of the following health conditions: congestive heart failure, cancer, diabetes, chronic obstructive pulmonary disease, or renal disease. 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 2017-18. The change in from the prior estimate, for FY 2018-19, is a decrease due to $400,000 TF being allocated to state support costs. The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to a full year of costs being captured.

Methodology:

MEDICALLY TAILORED MEALS PILOT PROGRAM

REGULAR POLICY CHANGE NUMBER: 40

1. Assume the Pilot will begin in April 2018.
2. Assume the cost for FY 2017-18 is $1,000,000 TF and $1,600,000 TF for FY 2018-19.

Funding:
100% GF (4260-101-0001)

CCT FUND TRANSFER TO CDSS AND CDDS

REGULAR POLICY CHANGE NUMBER:	41
IMPLEMENTATION DATE:	10/2011
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1562

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$2,808,000	$1,283,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,808,000	$1,283,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$2,808,000	$1,283,000

DESCRIPTION

Purpose:
This policy change estimates the enhanced federal funding associated with providing the California Department of Developmental Services (CDDS) and 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 6071
Affordable Care Act (ACA)
Interagency Agreement (IA) 09-86345 (CDDS)
IA 10-87274 (CDSS)

Interdependent Policy Changes:
Not Applicable

Background:
In January 2007, the Centers for Medicare and Medicaid Services awarded the Department a Money Follows the Person (MFP) Rebalancing Demonstration Grant, called the CCT. It was extended by the ACA, and is effective from January 1, 2007, through September 30, 2020. The grant requires the Department to develop and implement strategies to assist Medi-Cal eligible individuals who have resided continuously in health care facilities for 90 days or longer to transition into federally-qualified residences with the support of Medi-Cal Home and Community-Based Services (HCBS).

The Department will discontinue processing new transitions effective January 1, 2019, to ensure sufficient time to bill for 365-day post transition period and perform grant close-out functions.

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is an increase due to higher DD transitions. The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to DD transitions ending by December 31, 2017 and non-DD transitions ending December 31, 2018.

CCT FUND TRANSFER TO CDSS AND CDDS

REGULAR POLICY CHANGE NUMBER: 41

Methodology:

1. The Department provides HCBS to developmentally disabled CCT participants and CCT participants who are receiving IHSS. The Department provides federal funding to CDDS and CDSS as the base federal match through HCBS policy changes.

2. CCT services are reimbursed at 75% FFP and 25% GF. The GF for CDDS is budgeted in the Home & Community Based Svcs.-CDDS policy change. 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 09-86345 with CDDS and in FY 2011-12 IA 10-87274 was established with CDSS. Both IAs transfer the additional 25% FFP for HCBS provided to CCT participants who have developmental disabilities or are receiving IHSS services during their 365 days of participation in the CCT demonstration.

4. It is assumed that 24% of all non-DD enrollees utilize IHSS under CCT. Assume each case costs $10,460 in FY 2017-18 and $10,877 in FY 2018-19. The Department will provide 25% of these costs to CDSS.

5. Assume CDDS will receive an additional 25% FF for post transitional services for the DD population.

	FY 2017-18	FY 2018-19
CDSS	$248,000	$121,000
CDDS	$2,560,000	$1,162,000
Total	**$2,808,000**	**$1,283,000**

FY 2017-18	TF	GF	FF
CCT Costs (PC 34):			
Total Non-DD GF costs and Total FFP	$23,109,000	$2,142,000	$20,967,000
CCT Savings:			
Total Non-DD GF savings and Total FFP	($30,868,000)	($15,434,000)	($15,434,000)
CCT Fund Transfer to CDSS & CDDS (PC 41)	**$2,808,000**	**$0**	**$2,808,000**
CCT Outreach - Admin costs (OA 44)	$342,000	$0	$342,000
Total of CCT PCs including pass through	($4,609,000)	($13,292,000)	$8,683,000

*The savings are included in the total, however, they are fully reflected in the base estimates.

CCT FUND TRANSFER TO CDSS AND CDDS

REGULAR POLICY CHANGE NUMBER: 41

FY 2018-19	TF	GF	FF
CCT Costs (PC 34):			
Total Non-DD GF costs and Total FFP	$10,569,000	$1,679,000	$8,890,000
CCT Savings:			
Total Non-DD GF savings and Total FFP	($26,693,000)	($13,346,000)	($13,347,000)
CCT Fund Transfer to CDSS & CDDS (PC 41)	**$1,283,000**	**$0**	**$1,283,000**
CCT Outreach - Admin costs (OA 44)	$342,000	$0	$342,000
Total of CCT PCs including pass through	($14,499,000)	($11,667,000)	($2,832,000)

*The savings are included in the total, however, they are fully reflected in the base estimates.

Funding:
MFP Federal Grant (4260-106-0890)

SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER

REGULAR POLICY CHANGE NUMBER:	43
IMPLEMENTATION DATE:	8/2012
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1436

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$52,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$52,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$52,000	$0

DESCRIPTION

Purpose:
This policy change estimates the federal financial participation (FFP) provided for the City and County of San Francisco Community-Living Support Benefit (SF CLSB) Waiver.

Authority:
AB 2968 (Chapter 830, Statutes of 2006)
1915(c) Home and Community Based Services Waiver (CA.0855)

Interdependent Policy Changes:
Not Applicable

Background:
The Department is working with the San Francisco Department of Public Health, under the authority of a 1915(c) Home and Community Based Services Waiver to serve Medi-Cal beneficiaries who are:

- 21 years of age and older,
- reside in the City or County of San Francisco,
- and who would otherwise live in nursing facilities or be rendered homeless.

CMS approved the waiver for a five year period beginning July 1, 2012 through June 30, 2017.

Eligible participants have full-scope Medi-Cal eligibility or share-of-cost Medi-Cal for services to be rendered when residing in Residential Care Facilities for the Elderly, Adult Residential Facilities, or in residency units made available by the Direct Access to Housing program. Under the SF CLSB Waiver, participants are eligible for the following services:

- Community-living support benefits in licensed settings and in housing sites,
- Care coordination,
- Environmental accessibility adaptations,
- Home-delivered meals, and
- Behavior assessment and planning.

SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER

REGULAR POLICY CHANGE NUMBER: 43

The Department did not renew the SF CLSB Waiver, effective June 30, 2017, upon the expiration of the waiver term.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is a decrease due to adjusting the amount to final invoice paid. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the waiver ending June 30, 2017 and only a 4-month lagged cost from FY 2016-17 is being budgeted.

Methodology:
1. The waiver was amended in 2014 to reduce the maximum capacity to 90 over five years. These slots were continuously enrolled by backfilling available slots. Enrollment began in August 2012. Average monthly enrollment for the period of July 1, 2016 through June 30, 2017 was 24 individuals.

2. The Department utilized Certified Public Expenditures (CPE) from the City and County of San Francisco to match the federal funds for this waiver. Assume a four-month payment lag due to the utilization of CPEs. This policy change budgets the FFP only.

3. The enrollment was phased in throughout the year.

4. Total participant months reflected for FY 2017-18 were 93 from FY 2016-17.

5. The average monthly eligible cost was estimated at $1,131 for FY 2016-17.

6. The final invoice for the SF CLSB waiver was paid in July 2017 for $103,000 TF.

Funding:
100% Title XIX (4260-101-0890)

BEHAVIORAL HEALTH TREATMENT - BIS DDS TRANSITION

REGULAR POLICY CHANGE NUMBER:	44
IMPLEMENTATION DATE:	7/2018
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	2041

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$109,231,000
- STATE FUNDS	$0	$48,792,760
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$109,231,000
STATE FUNDS	$0	$48,792,760
FEDERAL FUNDS	$0	$60,438,240

DESCRIPTION

Purpose:
This policy change estimates the costs for transitioning additional Regional Center (RC) clients and providing medically necessary Behavioral Health Treatment (BHT)/ Behavioral Intervention Services (BIS) as recommended by a physician or psychologist for eligible beneficiaries under 21 years of age under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit from the Department of Developmental Services (DDS) RCs to Medi-Cal.

Authority:
Social Security Act Section 1905(a)(13)
SB 870 (Chapter 40, Statutes of 2014)
State Plan Amendment (SPA) 14-026

Interdependent Policy Changes:
Not Applicable

Background:
On July 7, 2014, the Centers for Medicare and Medicaid Services (CMS) released guidance requiring states to cover BHT services for Medicaid beneficiaries under 21 years of age with an Autism Spectrum Disorder (ASD) diagnosis. Subsequently, CMS determined that Medi-Cal must cover medically necessary BHT services for all individuals under the age of 21, regardless of 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 for beneficiaries under 21 years of age with an ASD diagnosis effective on or after September 15, 2014. The Department received approval for SPA 14-026 on January 21, 2016, to include BHT as a covered Medi-Cal benefit pursuant to Section 14132.56 of the Welfare and Institutions (W&I) Code.

BHT and other Medi-Cal related services were previously provided under the Medicaid 1915(c) and (i) waivers for individuals with developmental disabilities that meet certain eligibility criteria. These services are provided through a system of RCs contracted with DDS.

BEHAVIORAL HEALTH TREATMENT - BIS DDS TRANSITION

REGULAR POLICY CHANGE NUMBER: 44

The Department, in collaboration with DDS, transitioned responsibility for BHT services for consumers with an ASD diagnosis in 2016. Costs for the DDS transition are budgeted in the Behavioral Health Treatment policy change.

Additional RC clients, without an ASD diagnosis, have been receiving BHT/BIS through the RCs. Effective March 1, 2018, the Department began transitioning these additional RC clients to Medi-Cal for BHT/BIS. The transition is expected to be completed in September 2018.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is due to FFS cost shifting to FY 2018-19 as a result of delay in getting the Interagency Agreement (IA) contract approval. The change from the prior estimate, for FY 2018-19, is due to an increase in the projected managed care caseload. In addition, FFS cost for FY 2017-18 and FY 2018-19 increased based on updated data.

The change in the current estimate, from FY 2017-18 to FY 2018-19, is due to no BHT/BIS (managed care and FFS) costs in FY 2017-18.

Methodology:
1. An estimated 5,483 beneficiaries will transition into the Medi-Cal BHT program, of which 596 will transition into fee-for-service (FFS) and 4,887 will transition into managed care. For FY 2018-19, all beneficiaries will transition into managed care in July 2018 except for four counties. The beneficiaries from these counties will transition over a three-month period, beginning July 2018.

Fee-for-Service
2. A total of 596 beneficiaries transitioned from DDS on March 1, 2018.

3. The Department is currently in the process of amending the BHT IA contract to include BHT/BIS. The amended contract is projected to be executed in August 2018. DDS will submit claims on a monthly basis and payments are expected to begin in September 2018.

4. The estimate includes the rate increases to RC providers authorized by ABX2 1 (Chapter 3, Statutes of 2016), effective July 1, 2016.

5. The FFS cost reimbursement estimates were provided by DDS. The estimated annual cost, on an accrual basis, for FY 2017-18 is $1,985,000 TF, and $6,260,000 TF for FY 2018-19.

6. On a cash basis, FFS reimbursements are estimated to be paid as follows:

(Dollars in Thousands)

Fee-for-Service Claims	Accrual	FY 2018-19
FY 2017-18 claims	$1,985	$1,985
FY 2018-19 claims	$6,260	$5,217
Total	$8,245	$7,202

Managed Care
7. Assume 2,797 managed care beneficiaries will transition on a phase-in basis starting July 1, 2018 and 3,842 managed care beneficiaries will transition on a phase-in basis starting August 1, 2018. Assume all 4,887 managed care beneficiaries will transition by September 1, 2018.

BEHAVIORAL HEALTH TREATMENT - BIS DDS TRANSITION

REGULAR POLICY CHANGE NUMBER: 44

8. The estimated monthly capitation rate for BHT/BIS supplemental payments is $2,450.74 for FY 2018-19.

9. The estimated number of supplemental capitation payments for FY 2018-19 is 55,509.

   FY 2018-19: 55,509 x $2,450.74 = $136,038,000 TF

10. Due to the supplemental capitation payment methodology, assume 75% of managed care payments for FY 2018-19 will be paid the same year and 25% will be paid in the following fiscal year.

11. On a cash basis, FY 2018-19 managed care costs are estimated to be $102,029,000 TF.

12. Total estimated payments are:

(Dollars in Thousands)

FY 2018-19	TF	GF	Title XIX	Title XXI
Fee-for-Service	$7,202,000	$3,217,000	$3,096,000	$889,000
Managed Care	$102,029,000	$45,576,000	$43,858,000	$12,595,000
Total	**$109,231,000**	**$48,793,000**	**$46,954,000**	**$13,484,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)

DIABETES PREVENTION PROGRAM

REGULAR POLICY CHANGE NUMBER:	45
IMPLEMENTATION DATE:	1/2019
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	2056

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$723,000
- STATE FUNDS	$0	$215,880
PAYMENT LAG	1.0000	0.6890
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$498,100
STATE FUNDS	$0	$148,740
FEDERAL FUNDS	$0	$349,410

DESCRIPTION

Purpose:
This policy change estimates the cost associated with developing and implementing the Diabetes Prevention Program (DPP).

Authority:
SB 97 (Chapter 52, Statutes of 2017)
Welfare and Institutions Code, Section 14149.9

Interdependent Policy Changes:
Not Applicable

Background:
SB 97 requires the Department to establish the DPP, no sooner than July 1, 2018. The DPP is a lifestyle change program designed to prevent or delay Type 2 diabetes among people who have prediabetes and women with a previous diagnosis of gestational diabetes. The Centers for Medicare & Medicaid Services (CMS) allows for reimbursement of DPP services, as recognized by the U.S. Centers for Disease Control and Prevention (CDC). Trained peer coaches, who promote realistic lifestyle changes and emphasize weight loss through healthy eating and physical activity, lead the DPP curriculum.

The program consists of the following sets of benefits separated in three periods:

- Core Sessions (Months 1-6) – The Core Sessions consist of 16 sessions over the first six months. Payments for the core sessions are attendance and performance based.
- 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.

DIABETES PREVENTION PROGRAM

REGULAR POLICY CHANGE NUMBER: 45

Reason for Change:
The change from the prior estimate, for FY 2018-19, is due to an increase in the DPP rate for Core Sessions – Attendance based on Medicare's final rule for the 2018 Physician Fee Schedule. In addition, the Core Sessions – Performance, Core Maintenance Sessions, and Ongoing Maintenance rates were also updated based on the 2018 Physician Fee Schedule.

Methodology:
1. Assume the DPP will be implemented January 1, 2019.

2. Assume the total estimated Medi-Cal caseload for FY 2018-19 is 13,475,700. Of the total caseload, it is estimated that approximately 38.59% are under the age of 18, 3.16% are between the age of 18 and 21, 36.95% are between the ages of 21 and 50, and the remaining 21.30% are over 50 years old.

Age Group	Percent in Age Group	Total Medi-Cal Caseload
Age 0 -18	38.59%	5,200,273
Age 18 - 21	3.16%	425,832
Age 21-50	36.95%	4,979,271
Age 50 and above	21.30%	2,870,324
Total	100.00%	13,475,700

3. According to the 2015 California Health Interview Survey, approximately 2.90% of all children under the age of 21, 7.80% of adults between age 21 to 50, and 22.40% of adults over 50 years of age have prediabetes. Applying these percentages to Medi-Cal's estimated caseload, it is estimated that approximately 1,043,687 individuals enrolled in Medi-Cal, age 18 and over, have prediabetes.

Age Group	Total Medi-Cal Caseload	Percent in Age Group	Medi-Cal Individuals with Prediabetes
Age 18 - 21	425,832	2.90%	12,350
Age 21-50	4,979,271	7.80%	388,384
Age 50 and above	2,870,324	22.40%	642,953
		Total	1,043,687

4. Assume an estimated 2% of those eligible for DPP will enroll in the program each year. Therefore, of the 1,043,687 estimated Medi-Cal eligibles, 20,874 are estimated to enroll in the DPP.

1,043,687 x 2% = 20,874

DIABETES PREVENTION PROGRAM

REGULAR POLICY CHANGE NUMBER: 45

Core Sessions

5. Assume the total maximum payments per beneficiary for the Core Sessions include $132.00 for the 16 core session attendance and $128.00 performance payments for reaching the weight loss goal.

6. Assume 90% of beneficiaries eligible for DPP will complete the Core Sessions and 40% will reach the weight loss goal.

7. Total annual cost for the Core Sessions is estimated to be $3,549,000 TF.

Attendance: 20,874 x 90% x $132.00 = $2,480,000 TF
Performance: 20,874 x 40% x $128.00 = $1,069,000 TF

Core Maintenance Sessions

8. Assume the total maximum payments per beneficiary for the Core Maintenance Sessions include $96.00 ($48.00 for each interval) if a beneficiary achieves the performance goal. If the performance goal is not met, the DPP provider would then be paid $12.00 for each interval.

9. Assume 90% of the beneficiaries will complete the Core Maintenance Sessions. From those who complete the sessions, assume 40% will complete the core maintenance sessions with the required weight loss in both intervals, 40% will meet the required weight loss goal in one of the two intervals, and 20% will complete the core maintenance without meeting the required weight loss.

10. Total annual cost for the Core Maintenance Sessions is estimated to be $1,262,000 TF.

20,874 x 90% x 40% x $96.00 = $721,000 TF
20,874 x 90% x 40% x ($48.00 + $12.00) = $451,000 TF
20,874 x 90% x 20% x $24.00 = $90,000 TF

Ongoing Maintenance Sessions

11. Assume the total maximum payments for the Ongoing Maintenance Sessions include $160.00 ($40.00 for each interval) if the beneficiary maintains the required weight loss for all four intervals.

12. Assume 40% of the beneficiaries will complete the Ongoing Maintenance Sessions. From the 40% who will participate in the Ongoing Maintenance Sessions, assume 10% of beneficiaries will maintain the required weight loss goal for all four intervals, 20% will maintain the required weight loss goal for three intervals, 30% will maintain the required weight loss goal for two intervals, and the remaining 40% will maintain the weight loss goal for one interval.

13. Total annual cost for the Ongoing Maintenance Sessions is estimated to be $668,000 TF.

20,874 x 40% x 10% x $160.00 = $134,000
20,874 x 40% x 20% x $120.00 = $200,000
20,874 x 40% x 30% x $80.00 = $200,000
20,874 x 40% x 40% x $40.00 = $134,000

14. Assume a six-month phase-in for beneficiary participation in the Core Sessions beginning January 1, 2019. Based on the phase-in, assume 29% of beneficiaries will participate in Core Sessions in FY 2018-19.

DIABETES PREVENTION PROGRAM

REGULAR POLICY CHANGE NUMBER: 45

15. Performance payments for Core, Core Maintenance, and Ongoing Maintenance Sessions are expected to be paid in FY 2019-20.

16. Total estimated payments are:

DPP	Annual	FY 2018-19
Core Sessions – Attendance	$2,480,000	$723,000
Core Sessions – Performance	$1,069,000	$0
Core Maintenance	$1,262,000	$0
Ongoing Maintenance	$668,000	$0
Total	**$5,479,000**	**$723,000**

Funding:

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	$384,000	$192,000	$192,000
88% Title XXI FF / 12% GF (4260-113-0001/0890)	$3,000	$1,000	$2,000
93% ACA Title XIX FF / 7% GF (4260-101-0001/0890)	$336,000	$23,000	$313,000
Total	**$723,000**	**$216,000**	**$507,000**

PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS

REGULAR POLICY CHANGE NUMBER:	46
IMPLEMENTATION DATE:	8/2017
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1885

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	-$818,000	-$1,736,000
- STATE FUNDS	-$369,480	-$785,160
PAYMENT LAG	0.7120	0.8850
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$582,400	-$1,536,400
STATE FUNDS	-$263,070	-$694,870
FEDERAL FUNDS	-$319,350	-$841,490

DESCRIPTION

Purpose:
This policy change budgets projected savings attributed to the expansion of the Pediatric Palliative Care Waiver (PPCW).

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 beginning April 1, 2009, through December 26, 2017. On February 1, 2018, CMS approved an extension through May 15, 2018 and is expected to be renewed prior to its expiration.

AB 1745 also included an evaluation component which was conducted by the University of California, Los Angeles (UCLA), Center for Policy Research. The evaluation reflected a reduction of $3,133 per member per month (PMPM) under the Pediatric Palliative Care Pilot, predominantly resulting from a decrease in inpatient care. The projected increase in member participants by the end of FY 2017-18 is approximately 41 additional members; the current level of participants is 194 members.

The administrative costs of the PPCW are budgeted in other policy changes. Other Administration policy change California Children's Services (CCS) Case Management (OA 2) budgets for nurse liaisons and support staff. The Pediatric Palliative Care Waiver (PC 39) policy change budgets for the provider payment and reimbursement costs.

Reason for Change:

PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS

REGULAR POLICY CHANGE NUMBER: 46

The change from the prior estimate, for FY 2017-18 and FY 2018-19, is a decrease due to less members enrolled than estimated in the prior estimate. The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase in savings due to additional members that are to be enrolled by the end of FY 2018-19.

Methodology:
The following assumptions were used to estimate the caseload expansion cost and program savings:

1. Assume 235 members enroll in PPCW by the end of FY 2017-18.

2. Assume 334 members enroll in PPCW by the end of FY 2018-19.

3. Based on the number of members enrolled each year and $3,133 PMPM savings, assume a gross savings of $818,000 for FY 2017-18 and $1,736,000 for FY 2018-19.

4. When accounting for nurse liaison costs (OA 2) and provider payment and reimbursement costs (PC 39), the net savings of the PPC expansion are indicated in the table below.

FY 2017-18	**TF**	**GF**	**FF**
OA 2-CCS Case Management	$47,000	$12,000	$35,000
PC 39-PPCW	$261,000	$118,000	$143,000
Savings	**($818,000)**	**($369,000)**	**($449,000)**
Net Savings	($510,000)	($239,000)	($271,000)

FY 2018-19	**TF**	**GF**	**FF**
OA 2-CCS Case Management	$1,124,000	$281,000	$843,000
PC 39-PPCW	$899,000	$415,000	$484,000
Savings	**($1,736,000)**	**($785,000)**	**($951,000)**
Net Cost/Savings	$287,000	($89,000)	$376,000

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)

NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS

REGULAR POLICY CHANGE NUMBER: 47
IMPLEMENTATION DATE: 7/2015
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1931

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$47,975,000	$93,793,000
- STATE FUNDS	$21,995,160	$42,954,760
PAYMENT LAG	0.8771	0.9263
% REFLECTED IN BASE	35.06 %	3.96 %
APPLIED TO BASE		
TOTAL FUNDS	$27,326,000	$83,440,000
STATE FUNDS	$12,528,200	$38,213,350
FEDERAL FUNDS	$14,797,820	$45,226,640

DESCRIPTION

Purpose:
This policy change estimates the cost of new high cost treatments for specific medical conditions.

Authority:
Social Security Act, section 1927 [42 U.S.C. 1396r–8]

Interdependent Policy Changes:
Not Applicable

Background:
The Medi-Cal program provides needed health care services and treatments for low-income individuals and people with specific diseases who receive case management and care coordination from the California Children's Services (CCS) Program and the Genetically Handicapped Persons Program (GHPP). This policy change budgets new high cost services and treatments recently approved by the U.S. Food and Drug Administration (FDA) separately until the costs of these services are fully incorporated into the rates.

Recently approved FDA treatments and services covered under the Medi-Cal Program are:

- Orkambi: A lifetime treatment designed to address chloride channel abnormalities in cystic fibrosis (CF) patients.
- DEFLAZACORT: A lifetime treatment of Duchenne Muscular Dystrophy (DMD) patients.
- Exondys 51: A lifetime treatment of DMD in patients who have a confirmed mutation in the DMD.
- SPINRAZA: A lifetime treatment program for spinal muscular atrophy (SMA).
- CERLIPONASE ALFA (BRINEURA): A lifetime treatment to slow the progression of infantile ceroid lipofuscinoses, neuronal, type 2 (CLN2).
- Tisagenlecleuce (Kymriah): A one-time treatment for children and young adults up to 25

NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS
REGULAR POLICY CHANGE NUMBER: 47

years of age with B-Cell acute lymphoblastic Leukemia that is refractory or twice elapsed after treatment.

The populations included in this policy change are Medi-Cal Fee-for-Service CCS, Optional Targeted Low Income Children's Program (OTLICP), and GHPP beneficiaries.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is an overall increase due to:

- The use of paid data to estimate Medi-Cal and OTLICP phase in
- Deflazacort and Brineura experiencing substantially lower than expected utilization and Spinraza is experiencing a higher than expected utilization.
- The addition of Kymriah to the estimate

The change from the prior estimate, for FY 2018-19, is an overall decrease due to:

- The use of paid data to estimate Medi-Cal and OTLICP phase in
- Deflazacort and Brineura experiencing substantially lower than expected utilization and Spinraza is experiencing a higher than expected utilization.
- The addition of Kymriah to the estimate

The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to:

- The use of paid data to estimate Medi-Cal and OTLICP phase in, which identifies more users than FY 2017-18.
- Deflazacort and Brineura experiencing substantially lower than expected utilization and Spinraza is experiencing a higher than expected utilization.
- The addition of Kymriah to the estimate

Methodology:
1. For FY 2017-18 and FY 2018-19, Orkambi cost are estimated as follows:

- The cost of Orkambi for FY 2016-17 was $230,000 per beneficiary per year.
- Based on actuals, assume a 5% increase in Orkambi costs per beneficiary per year.

  FY 2017-18: $230,000 + 5% = $242,000 per beneficiary per year
  FY 2018-19: $242,000 + 5% = $254,000 per beneficiary per year

- Assume a 12-month phase-in of 20 new eligibles beginning May 1, 2017. (Costs for current eligibles using Orkambi are already in the base estimate.)
- Assume a 12-month phase-in of 6 CCS Medi-Cal eligibles in FY 2018-19.
- Assume a 12-month phase-in of 4 new CCS OTLICP eligibles in FY 2017-18 and assume a 12-month phase-in of 4 OTLICP eligibles in FY 2018-19 because of the WCM implementation.
- Total estimated costs (rounded) for Orkambi are:

	FY 2017-18	FY 2018-19
CCS Medi-Cal:	$3,602,000	$5,959,000
CCS OTLICP:	$604,000	$1,648,000
Total Orkambi:	$4,206,000	$7,607,000

NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS
REGULAR POLICY CHANGE NUMBER: 47

2. For FY 2017-18 and FY 2018-19, DEFLAZACORT cost are estimated as follows:

   - Assume a $7,400 per member per month (PMPM) cost for each beneficiary receiving DEFLAZACORT.
   - Assume a 24-month phase in of 150 beneficiaries beginning July 1, 2017.
   - Assume a 24-month phase-in of 16 OTLICP beneficiaries beginning July 1, 2017.
   - Total estimated costs (rounded) for DEFLAZACORT are:

	FY 2017-18	FY 2018-19
CCS Medi-Cal:	$3,641,000	$10,301,000
CCS OTLICP:	$414,000	$1,125,000
Total DEFLAZACORT:	$4,055,000	$11,426,000

3. For FY 2017-18 and FY 2018-19, Exondys 51 cost are estimated as follows:

   - Assume a $25,000 PMPM cost for each beneficiary receiving Exondys 51.
   - Assume a 24-month phase in of 34 beneficiaries beginning July 1, 2017.
   - Assume a 24-month phase in of 10 OTLICP beneficiaries beginning July 1, 2017.
   - Total estimated costs (rounded) for Exondys 51 are:

	FY 2017-18	FY 2018-19
CCS Medi-Cal:	$3,675,000	$7,800,000
CCS OTLICP:	$750,000	$2,250,000
Total Exondys 51:	$4,425,000	$10,050,000

4. For FY 2017-18 and FY 2018-19, SPINRAZA cost are estimated as follows:

   - Assume a 12-month phase-in of an additional 60 beneficiaries beginning July 1, 2017.
   - Assume a 12-month phase-in of an additional 60 beneficiaries beginning July 1, 2018.
   - Assume a 12-month phase-in of 5 new CCS OTLICP beneficiaries beginning July 1, 2017.
   - Assume a 12-month phase-in of 5 new CCS OTLICP beneficiaries beginning July 1, 2018.
   - Assume each beneficiary will receive loading doses over the first 72 days of treatment for a total one-time cost of $500,000 per beneficiary, and then one dose every four months, for life, at a cost of $125,000 per does.
   - Total estimated costs for SPINRAZA are:

	FY 2017-18	FY 2018-19
CCS Medi-Cal:	$30,000,000	$56,250,000
CCS OTLICP:	$3,000,000	$4,875,000
Total SPINRAZA:	$33,000,000	$61,125,000

5. For FY 2017-18 and FY 2018-19, Brineura costs are expected as follows:

   - Assuming treatment requires 1 kit every 2 weeks and each kit is $26,892.
   - Assume a 12-month phase in of the 4 Medi-Cal CCS eligible beneficiaries between August 1, 2017 through June 30, 2018.

NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS
REGULAR POLICY CHANGE NUMBER: 47

	FY 2017-18	FY 2018-19
CCS Medi-Cal:	$864,000	$2,160,000
Total Brineura:	$864,000	$2,160,000

6. For FY 2017-18 and FY 2018-19, Kymriah costs are expected as follows:

- Assume a 24-month phase-in of 4 medical beneficiaries beginning September 1, 2017.
- Assume a one-time cost of $475,000 per client.
- Assume a 24-month phase-in of 2 OTLICP beneficiaries beginning September 1, 2017.

	FY 2017-18	FY 2018-19
CCS Medi-Cal:	$950,000	$950,000
CCS OTLICP:	$475,000	$475,000
Total Kymriah:	$1,425,000	$1,425,000

7. County funds will be allocated in the County Share of OTLICP-CCS Costs policy change.

FY 2017-18	TF	GF	FF
CCS-Medi-Cal	$42,732,000	$21,366,000	$21,366,000
CCS OTLICP	$5,243,000	$629,000	$4,614,000
Total	**$47,975,000**	**$21,995,000**	**$25,980,000**

FY 2018-19	TF	GF	FF
CCS-Medi-Cal	$83,420,000	$41,710,000	$41,710,000
CCS OTLICP	$10,373,000	$1,245,000	$9,128,000
Total	**$93,793,000**	**$42,955,000**	**$50,838,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)
100% Title XIX FFP (4260-101-0890)

DRUG REBATES PRIOR YEAR FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	48
IMPLEMENTATION DATE:	7/2017
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	2075

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	-$60,286,000	$0
- STATE FUNDS	$256,603,830	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$60,286,000	$0
STATE FUNDS	$256,603,830	$0
FEDERAL FUNDS	-$316,889,830	$0

DESCRIPTION

Purpose:
This policy change estimates the funding adjustment for drug rebate collections from the January 2017 to March 2017 quarter.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
When drug rebates are initially received, the Federal Medical Assistance Percentage (FMAP) associated with the collections for certain populations are not known. Therefore, the Federal, State, and Managed Care drug rebate collections are received at the 50% Federal Funds (FF) / 50% General Fund (GF) Federal Medical Assistance Percentage (FMAP). Drug rebate collections for the Family Planning Access, Care, and Treatment (FPACT) program and Breast and Cervical Cancer Treatment Program (BCCTP) are received at enhanced 90% FF / 10% GF and 65% FF / 35% GF FMAPs, respectively.

The Department retroactively adjusts the funding for the Affordable Care Act (ACA) optional population, ACA Offset, and Children's Health Insurance Program (CHIP) populations once the allocations to the various FMAPs are determined.

Reason for Change:
There is no change from the prior estimate for FY 2017-18 and FY 2018-19.

DRUG REBATES PRIOR YEAR FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 48

Methodology:

1. Four quarterly funding adjustments are typically made in a fiscal year.

2. An additional quarterly adjustment from FY 2016-17 collections was made in FY 2017-18. The Department made the funding adjustment for the January 2017 to March 2017 quarter (2017Q1) collections for the Federal, State Supplemental, Managed Care, FPACT, and BCCTP drug rebates in July 2017.

3. The 2017Q1 CHIP adjustments to return the Title XIX 50% FF / 50% GF was made in FY 2016-17 but the adjustment to Title XXI 88% FF / 12% GF occurred in July 2017.

4. The cash basis impact of the prior year funding adjustment was:

(Dollars in Thousands)

FY 2017-18	TF	GF	Title XIX FF	Title XXI FF
2017Q1 Funding Adjustment	($60,286)	$256,604	($263,838)	($53,052)

Funding:

100% GF (4260-101-0001)
100% Title XIX FF (4260-101-0890)
90% Title XIX / 10% GF (4260-101-001/0890)
65% Title XIX / 35% GF (4260-101-0001/0890)
50/% Title XIX / 50% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-113-001/0890)

PHARMACY REIMBURSEMENT & DISPENSING FEE

REGULAR POLICY CHANGE NUMBER: 49
IMPLEMENTATION DATE: 1/2019
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 2070

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	-$36,000,000
- STATE FUNDS	$0	-$14,147,730
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$36,000,000
STATE FUNDS	$0	-$14,147,730
FEDERAL FUNDS	$0	-$21,852,270

DESCRIPTION

Purpose:
This policy change estimates the Fee-For-Service (FFS) net impact of the savings from reimbursing pharmacies based on the Actual Acquisition Cost (AAC) for Covered Outpatient Drugs (COD) and the cost associated with adopting the new Professional Dispensing Fee (PDF) methodology.

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) published its Final Rule on CODs on February 1, 2016 (CMS-2345-FC). This rule implements provisions of the Affordable Care Act, pertaining to Medicaid reimbursement for CODs. The Final Rule requires states to modify the reimbursement methodology for CODs and establish a professional dispensing fee. On August 25, 2017, the SPA #17-002 was approved, with an effective date of April 1, 2017.

The Department contracted with Mercer Government Human Services Consulting (Mercer) to conduct a study of outpatient pharmacy provider costs associated with purchasing and dispensing outpatient prescription drugs to Medi-Cal beneficiaries. Mercer issued their study results and implementation alternatives report in January 2017. The Department reviewed the alternatives and selected to implement the pharmacy reimbursement and PDF methodologies to comply with the provisions in the Final Rule.

PHARMACY REIMBURSEMENT & DISPENSING FEE

REGULAR POLICY CHANGE NUMBER: 49

Pharmacy Reimbursement:
The Department will implement the new pharmacy reimbursement methodology by adopting CMS' National Average Drug Acquisition Cost (NADAC) as the basis for ingredient cost reimbursement. The Wholesale Acquisition Cost (WAC) + 0% will be used as the basis for reimbursement when a NADAC is not available.

The previous methodology, based on the Estimated Acquisition Cost (EAC), is determined as the lowest of 1) Average Wholesale Price (AWP) minus 17%, 2) Federal Upper Limit (FUL), or 3) Maximum Allowable Ingredient Cost (MAIC).

Professional Dispensing Fee:
Currently, the Department is reimbursing pharmacies for PDF at $7.25 for retail and $8.00 for Long Term Care pharmacies. The Department will replace the current PDF structure with a two-tiered PDF, based on a pharmacy's total (both Medicaid and non-Medicaid) annual claim volume, as follows:

- Less than 90,000 claims per year = $13.20 (requires annual provider self- attestation), or
- 90,000 or more claims per year = $10.05

The new reimbursement methodology and PDF include reimbursements to outpatient pharmacies for drugs provided to beneficiaries under the Family Planning, Access, Care, and Treatment (FPACT) program.

Reason for Change:
The change from the prior estimate, for FY 2018-19, is due to shifting the implementation date from August 2018 to January 2019 to align with the timing of system changes.

Methodology:
1. Mercer aggregated and measured survey data of pharmacy providers' June 2016 pharmacy purchase invoices against CMS' NADAC list based on June 2016 data, Medi-Cal's current ingredient cost reimbursement methodology, and other industry benchmarks. Mercer's fiscal impact savings analysis indicated $132,000,000 ($126,000,000 from NADAC adoption and $6,000,000 from WAC) in annual projected savings to the Department.

2. To calculate the new PDF, Mercer determined a pharmacy's average cost to dispense and divided the prescription department's operational, labor, and allocated overheat costs by the total number of Medicaid and non-Medicaid prescriptions dispensed. Mercer's cost analysis of the two-tiered PDF indicated $60,000,000 in annual projected costs to the Department.

3. On an annual accrual basis, the pharmacy savings are estimated to be:

(Dollars in Thousands)

	Annual
AAC Savings	($132,000)
PDF Costs	$60,000
Net Savings	($72,000)

4. Due to required claim system changes, implementation of the new reimbursement methodology is not expected until January 2019. The Department will process an Erroneous Payment Correction (EPC) to adjust for claims payments made using the previous methodology. The EPC will rerun claims paid between the dates of April 1, 2017, through December 31, 2018. A date for the EPC has yet to be determined.

PHARMACY REIMBURSEMENT & DISPENSING FEE

REGULAR POLICY CHANGE NUMBER: 49

5. Assume CHIP drug expenditures are funded at 88% FF / 12% GF.

6. The ACA Optional population is eligible for Title XIX federal reimbursement at 93% beginning January 2019.

7. On a cash basis, the savings are estimated to be:

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
AAC Savings	($66,000)	($25,938)	($40,062)
PDF Costs	$30,000	$11,790	$18,210
Net Savings	**($36,000)**	**($14,148)**	**($21,852)**

Funding:

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	($26,896)	($13,448)	($13,448)
93% Title XIX / 7% GF (4260-101-0001/0890)	($7,855)	($550)	($7,305)
88% Title XXI/ 12% GF (4260-113-0001/0890)	($1,249)	($150)	($1,099)
Net Savings	**($36,000)**	**($14,148)**	**($21,852)**

LITIGATION SETTLEMENTS

REGULAR POLICY CHANGE NUMBER:	50
IMPLEMENTATION DATE:	8/2009
ANALYST:	Matt Wong
FISCAL REFERENCE NUMBER:	1449

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	-$18,133,000	$0
- STATE FUNDS	-$18,133,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$18,133,000	$0
STATE FUNDS	-$18,133,000	$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 2017-18, is an increase in the amount the Department is expecting to receive based on updated expected settlement payments. There is no change from the prior estimate for FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to only being able to budget for current year settlement amounts.

LITIGATION SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 50

Methodology:
The following settlements are expected to be received in FY 2017-18:

Settlement Name	FY 2017-18
Aegerion, Pharaceuticals	-$579,000
Allergan	-$56,000
Biocompatibles, Inc.	-$268,000
Brius Management Co.	-$193,000
Davita Rx	-$496,000
Forest Pharmaceuticals	-$70,000
IPC Healthcare, Inc	-$90,000
Kmart	-$399,000
Mylan, Inc	-$13,403,000
Novo Nordisk	-$36,000
Omnicare-Banigan	-$709,000
Omnicare-Corsi	-$31,000
Salix, Inc.	-$282,000
Shire Pharmaceuticals	-$1,345,000
Walgreen Company	-$176,000
Total GF Savings	**-$18,133,000**

Funding:
100% GF (4260-101-0001)

BCCTP DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	51
IMPLEMENTATION DATE:	1/2010
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1433

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	-$10,759,000	-$11,951,000
- STATE FUNDS	-$3,322,200	-$3,823,050
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$10,759,000	-$11,951,000
STATE FUNDS	-$3,322,200	-$3,823,050
FEDERAL FUNDS	-$7,436,800	-$8,127,950

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

Interdependent Policy Changes:
Not Applicable

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.

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is an increase due to the result of projecting collections based on:

- The addition of three quarters of actual BCCTP rebate collections from July 2017 through March 2018;
- Increased BCCTP drug expenditures for the applicable expenditure period; and
- Increased estimated ACA Offset funding based on actuals through March 2018.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to an estimated increase in BCCTP drug expenditures.

BCCTP DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 51

Methodology:

1. Payments began in January 2010.

2. Rebates are invoiced quarterly.

3. The estimated rebates to collect are $10,759,000 in FY 2017-18 and $11,951,000 in FY 2018-19.

4. Assume, of the total BCCTP rebates collected, the ACA offset for BCCTP is $1,267,000 in FY 2017-18 and $1,028,000 in FY 2018-19.

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
65% Title XIX / 35% GF	($9,492)	($3,322)	($6,170)
ACA Offset	($1,267)	$0	($1,267)
Total	**($10,759)**	**($3,322)**	**($7,437)**

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
65% Title XIX / 35% GF	($10,923)	($3,823)	($7,100)
ACA Offset	($1,028)	$0	($1,028)
Total	**($11,951)**	**($3,823)**	**($8,128)**

Funding:

65% Title XIX / 35% GF (4260-101-0001/0890)
100% Title XIX FF (4260-101-0890)

FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	52
IMPLEMENTATION DATE:	12/1999
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	51

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	-$42,415,000	-$20,067,000
- STATE FUNDS	-$5,155,700	-$2,661,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$42,415,000	-$20,067,000
STATE FUNDS	-$5,155,700	-$2,661,600
FEDERAL FUNDS	-$37,259,300	-$17,405,400

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

Interdependent Policy Changes:
Not Applicable

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.

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is an increase due to the revised collection projections based on:

- Increased average quarterly projections based on the addition of three quarters of actual FPACT rebate collections from July 2017 through March 2018;
- Increased estimated FPACT drug expenditures for the applicable expenditure period;
- Increased estimated ACA Offset funding based on actual data through March 2018.
- Updated non-family planning and family planning funding splits applied to the FPACT rebates.

FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 52

The change between FY 2017-18 and FY 2018-19, in the current estimate, is a decrease due to the net result of an increase to the projected FPACT pharmacy expenditures applied to FY 2018-19 and lower projected average quarterly rebates in FY 2018-19.

Methodology:

1. The regular Federal Medical Assistance Percentage (FMAP) percentage is applied to 9.5% of the FPACT rebates to account for the purchase of non-family planning drugs, and the family planning percentage (90% FFP) is applied to 90.5% of the FPACT rebates.

2. Assume the ACA offset is $1,030,000 for FY 2017-18 and $783,000 for FY 2018-19.

3. Actual data from July 2013 to March 2018 is used to project rebates.

(Dollars in Thousands)

Fiscal Year	FPACT Drug Expenditures	FPACT Rebate
FY 2017-18	$49,595	($42,415)
FY 2018-19	$50,121	($20,067)

(Dollars in Thousands)

FY 2017-18	**TF**	**GF**	**FF**
50% Title XIX /50% GF	($2,543)	($1,272)	($1,271)
90% Title XIX / 10% GF	($38,842)	($3,884)	($34,958)
ACA Offset	($1,030)	$0	($1,030)
Total	**($42,415)**	**($5,156)**	**($37,259)**

(Dollars in Thousands)

FY 2018-19	**TF**	**GF**	**FF**
50% Title XIX /50% GF	($1,833)	($917)	($916)
90% Title XIX / 10% GF	($17,451)	($1,745)	($15,706)
ACA Offset	($783)	$0	($783)
Total	**($20,067)**	**($2,662)**	**($17,405)**

Funding:

50% Title XIX /50% GF (4260-101-0001/0890)
90% Title XIX /10% GF (4260-101-0001/0890)
100% Title XIX FF (4260-101-0890)

MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER:	53
IMPLEMENTATION DATE:	10/2006
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1181

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	-$24,916,000	-$24,916,000
- STATE FUNDS	-$12,458,000	-$12,458,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$24,916,000	-$24,916,000
STATE FUNDS	-$12,458,000	-$12,458,000
FEDERAL FUNDS	-$12,458,000	-$12,458,000

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 testing supplies with manufacturers to make available the best price to all providers. The Department establishes the product reimbursement rates for diabetic testing products which are based on the contracted MAC. The Department also negotiates rebates with some diabetic testing supply 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 diabetic testing products rebate contract terms are effective January 1, 2016 through December 31, 2018. Assume a new contract will begin January 1, 2019.

Reason for Change:
There is no change from the prior estimate for FY 2017-18 and FY 2018-19. There is no change, from FY 2017-18 to FY 2018-19, in the current estimate.

MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER: 53

Methodology:

1. Assume the average quarterly collection is $6,229,000.

2. Assume the medical supply rebates collected are $24,916,000 in FY 2017-18 and FY 2018-19.

3. Based on the current contract terms, it is assumed that there will be no significant change in rebates collected for FY 2017-18 and FY 2018-19.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2017-18	($24,916)	($12,458)	($12,458)
FY 2018-19	($24,916)	($12,458)	($12,458)

Funding:

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

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	54
IMPLEMENTATION DATE:	1/1991
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	54

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	-$146,024,000	-$197,608,000
- STATE FUNDS	-$97,754,270	-$66,569,240
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$146,024,000	-$197,608,000
STATE FUNDS	-$97,754,270	-$66,569,240
FEDERAL FUNDS	-$48,269,730	-$131,038,760

DESCRIPTION

Purpose:
This policy change estimates the revenues collected from the State Supplemental Drug rebates.

Authority:
Welfare & Institutions Code 14105.33

Interdependent Policy Changes:
Not Applicable

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).

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is a net decrease due to revised collection projections based on the following:

- The addition of three quarters of actual State supplemental rebate collections from July 2017 through March 2018;
- Increased CHIP drug rebates based on data through March 2018;
- Decreased ACA optional rebates based on data through March 2018. In addition, the FY 2017-18 ACA optional estimate includes ACA retroactive funding adjustments that resulted in an overall estimated ACA optional costs in FY 2017-18;
- Increased funding split assumed for the family planning drugs; and
- Decreased FY 2017-18 fee-for-service (FFS) pharmacy expenditures related to the periods used to project the estimated rebates.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to increased pharmacy expenditures that were applied to the FY 2018-19 projections and higher projected average quarterly collections in FY 2018-19.

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 54

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 0.18% of the regular federal drug rebates and are funded with 90% federal funds (FF) and 10% General Fund (GF).

3. Assume CHIP drug rebates are estimated to be $7,456,000 TF for FY 2017-18 and $7,942,000 TF in FY 2018-19, funded at 88% FF and 12% GF.

4. The optional expansion ACA population collections are estimated to be -$61,599,000 TF for FY 2017-18, funded at 95% FF and 5% GF. For FY 2018-19, the ACA collections are estimated to be $66,200,000 TF, funded at 94% FF and 6% GF.

(Dollars in Thousands)

FY 2017-18	TF	GF	FFP
50% Title XIX / 50% GF	($199,807)	($99,904)	($99,903)
95% Title XIX/ 5% GF	$61,599	$3,080	$58,519
90% Title XIX / 10% GF	($360)	($36)	($324)
88% Title XXI / 12 % GF	($7,456)	($894)	($6,562)
Total	**($146,024)**	**($97,754)**	**($48,270)**

(Dollars in Thousands)

FY 2018-19	TF	GF	FFP
50% Title XIX / 50% GF	($123,244)	($61,622)	($61,622)
94% Title XIX/ 6% GF	($66,200)	($3,972)	($62,228)
90% Title XIX / 10% GF	($222)	($22)	($200)
88% Title XXI / 12 % GF	($7,942)	($953)	($6,989)
Total	**($197,608)**	**($66,569)**	**($131,039)**

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)
95% ACA Title XIX FF / 5% GF (4260-101-0001/0890)
94% ACA Title XIX FF / 6% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)

FEDERAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	55
IMPLEMENTATION DATE:	7/1990
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	55

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	-$2,957,871,000	-$1,559,326,000
- STATE FUNDS	-$447,616,020	-$472,825,060
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$2,957,871,000	-$1,559,326,000
STATE FUNDS	-$447,616,020	-$472,825,060
FEDERAL FUNDS	-$2,510,254,980	-$1,086,500,940

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.

Interdependent Policy Changes:
Not Applicable

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.

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2017-18, is an increase, due to the result of revised collection projections based on the net result of the following:

- The addition of three quarters of actual Federal rebate collections from July 2017 through March 2018,
- Increased CHIP rebates based on data through March 2018;
- Increased ACA optional and ACA offset rebates based on data through March 2018;
- Increased funding split assumed for the family planning drugs; and
- Decreased FY 2017-18 fee-for-service (FFS) pharmacy expenditures related to the periods used to project the estimated rebates.

FEDERAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 55

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to projecting a decrease for FY 2018-19 federal drug rebates based on recent actuals.

Methodology:

1. Rebates are estimated by using actual fee-for-service (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 0.18% of the regular federal drug rebates and are funded with 90% federal funds (FF) and 10% General Fund (GF).

3. Assume CHIP drug rebate collections are estimated to be $218,926,000 TF in FY 2017-18 and $59,950,000 TF in FY 2018-19. These rebates are funded at 88% FF / 12% GF.

4. The optional expansion ACA population collections are estimated to be $1,422,936,000 TF for FY 2017-18 at 95% FF / 5% GF and $514,656,000 TF for FY 2018-19, funded at 94% FF / 6% GF.

5. The ongoing additional FF claimed by CMS (ACA Offset) is reflected in this policy change. The additional FF is $211,321,000 TF for FY 2017-18 and $113,963,000 TF for FY 2018-19.

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
50% Title XIX / 50% GF	($1,279,918)	($639,959)	($639,959)
100% ACA Title XIX FF	($102,380)	$0	($102,380)
95% Title XIX/ 5% GF	($1,422,936)	($71,147)	($1,351,789)
90% Title XIX / 10% GF	($13,501)	($1,350)	($12,151)
ACA Offset	($211,321)	$0	($211,321)
88% Title XXI / 12 % GF	($218,926)	($26,271)	($192,655)
100% GF	$291,111	$291,111	$0
Total	**($2,957,871)**	**($447,616)**	**($2,510,255)**

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF	($869,190)	($434,595)	($434,595)
94% Title XIX/ 6% GF	($514,656)	($30,879)	($483,777)
90% Title XIX / 10% GF	($1,567)	($157)	($1,410)
ACA Offset	($113,963)	$0	($113,963)
88% Title XXI / 12 % GF	($59,950)	($7,194)	($52,756)
Total	**($1,559,326)**	**($472,825)**	**($1,086,501)**

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)
100% Title XIX FFP (4260-101-0890)
95% ACA Title XIX FF / 5% GF (4260-101-0001/0890)
94% ACA Title XIX FF / 6% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)
100% GF (4260-101-0001)

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

REGULAR POLICY CHANGE NUMBER:	56
IMPLEMENTATION DATE:	4/2017
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	2012

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$377,920,000	$796,705,000
- STATE FUNDS	$76,054,760	$148,305,690
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$377,920,000	$796,705,000
STATE FUNDS	$76,054,760	$148,305,690
FEDERAL FUNDS	$301,865,240	$648,399,310

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.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

REGULAR POLICY CHANGE NUMBER: 56

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 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 Residential Treatment Services
- 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)

Interim payments of federal financial participation (FFP) will be made to the DMC-ODS counties based on submitted certified public expenditures (CPEs). Claims will be reimbursed based on the approved interim rate for the service subject to the applicable Federal Medical Assistance Percentage (FMAP). The State will complete the final settlement process within three years of the interim settlement. If underpayments are determined, the State will make additional payments to the counties and if overpayments are determined, the State will recoup the FFP from the counties.

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

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).

Funding is generally 50% FF and 50% CF or 50% GF. Certain aid codes are eligible for Title XXI federal reimbursement at 88%. ACA Optional population is eligible for Title XIX federal reimbursement at 100% until December 2016, 95% beginning January 2017, 94% beginning January 2018, and 93% beginning January 2019.

Reason for Change:
This change from the prior estimate, for FY 2017-18 and FY 2018-19, is due to the following:
- Updated county implementation schedule – The prior estimate assumed costs for all 40 opt-in counties to be incurred in FY 2018-19. Due to implementation delays for certain counties and payment lags, costs for 10 counties will be incurred in FY 2017-18, and 32 counties costs are estimated to be incurred by FY 2018-19.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

REGULAR POLICY CHANGE NUMBER: 56

- Updated approved interim county rates – The current estimate includes approved rates for 13 additional counties, for a total of 27 counties with approved rates. In addition, rates for four additional counties currently not approved, were also incorporated into the estimate. Based on the addition the of approved and draft rates, costs for FY 2018-19 are lower as not all counties will provide all services as previously projected.
- Includes the GF costs for a claims adjudication error in FY 2017-18 and the GF reimbursement in FY 2018-19.
- Includes the impact of the buprenorphine-naloxone combination product in the NTP MAT and NTP estimate.

The change in the current estimate, from FY 2017-18 to FY 2018-19, is primarily due to additional counties implementing the optional DMC-ODS waiver services in FY 2018-19 on a phase-in basis.

Methodology:

1. DMC-ODS waiver services for opt-in counties began in February 2017 on a phase-in basis. Four counties (San Mateo, Riverside, Marin, and Santa Clara) implemented the waiver in FY 2016-17. For FY 2017-18 and FY 2018-19, county implementation is expected to phase-in as follows:
   - 7 additional counties (for a total of 11 counties) began providing services in FY 2017-18.
   - 29 additional counties (for a total of 40 counties) will begin providing services in FY 2018-19. The phase-in implementation is expected to occur through February 2019. From the 29 counties that will begin waiver services in FY 2018-19, eight counties will start the waiver under the Partnership Health Plans (PHP), and costs are not expected to be incurred in FY 2018-19.

2. A total of 18 counties have not opted-in to implement DMC-ODS waiver services.

3. 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.

4. Effective January 1, 2019, the Department will add 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. Costs for the new MAT is included in MAT Expansion and assumes the following:
   - Once the new MAT becomes available, it is assumed that all non-perinatal clients will switch over to the buprenorphine–naloxone combination product. The perinatal-clients will continue using buprenorphine.
   - It is assumed that 15% of clients who are currently on methadone, will switch over to the buprenorphine–naloxone combination product. Costs for these clients will shift from NTP to MAT Expansion.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

REGULAR POLICY CHANGE NUMBER: 56

DMC-ODS Waiver Costs

5. Costs for the new DMC-ODS waiver services are estimated to be:

New Waiver Services	FY 2017-18	FY 2018-19
Required		
Recovery Services	$27,981,000	$57,369,000
Case Mgmt.	$23,518,000	$66,582,000
Physician Consult.	$4,081,000	$7,647,000
WM 1.0, 2.0, 3.2	$10,764,000	$27,439,000
MAT Expansion	$4,402,000	$27,682,000
Subtotal	$70,746,000	$186,719,000
Optional		
Partial Hospitalization	$718,000	$1,096,000
Additional MAT	$2,423,000	$5,840,000
WM 3.7 and 4.0	$0	$0
Subtotal	$3,141,000	$6,936,000
Total	$73,887,000	$193,655,000

6. Costs for the existing modalities for the DMC-ODS waiver services are estimated to be:

Existing Modalities	**FY 2017-18**	**FY 2018-19**
IOT	$90,581,000	$154,542,000
RTS 3.1, 3.3, 3.5	$160,941,000	$341,819,000
NTP	$61,055,000	$148,563,000
ODF	$81,363,000	$174,879,000
Total	$393,940,000	$819,803,000

Base Adjustments for Existing Modalities

7. Costs for the existing modalities are already budgeted in the related base policy changes. Costs budgeted in this policy change account for rate changes and service expansion. Costs already included in base were adjusted based on county phase-in.

FY 2017-18	DMC Waiver - Cash Estimate	Less: Cost in Base	Cash Basis (Adjusted)
IOT	$90,581,000	$2,028,000	$88,553,000
RTS 3.1, 3.3, 3.5	$160,941,000	$10,000	$160,931,000
NTP	$61,055,000	$31,068,000	$29,987,000
ODF	$81,363,000	$3,358,000	$78,005,000
Total	$393,940,000	$36,464,000	$357,476,000
FY 2018-19			
IOT	$154,542,000	$3,873,000	$150,669,000
RTS 3.1, 3.3, 3.5	$341,819,000	$509,000	$341,310,000
NTP	$148,563,000	$82,094,000	$66,469,000
ODF	$174,879,000	$9,491,000	$165,388,000
Total	$819,803,000	$95,967,000	$723,836,000

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

REGULAR POLICY CHANGE NUMBER: 56

Net DMC-ODS Waiver Costs

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

DMC-ODS Waiver Net Cost	FY 2017-18	FY 2018-19
Required Services	$70,746,000	$186,719,000
Optional Services	$3,141,000	$6,936,000
Existing Services	$357,476,000	$723,836,000
Total	$431,363,000	$917,491,000

Claims Payment Error

9. 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 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. As a result, there will be GF costs for these claims in FY 2017-18. The funds will be recouped in FY 2018-19 to repay the GF.

Claims Payment Error	FY 2017-18 (GF costs)	FY 2018-19 (GF recoupment)
FY 2016-17 Claims	$13,000	($13,000)
FY 2017-18 Claims	$294,000	($294,000)
Total	$307,000	($307,000)

10. On a cash basis, the total costs for the claims payment error and waiver services costs are estimated to be $431,670,000 TF and $917,491,000 TF in FY 2017-18 and FY 2018-19, respectively.

FY 2017-18	**TF**	**GF**	**FF Title XIX**	**FF Title XXI**	**CF**
Regular					
Current	$235,148,000	$67,105,000	$116,594,000	$1,726,000	$49,723,000
ACA Optional	$190,507,000	$8,576,000	$180,123,000	$0	$1,808,000
Perinatal					
Current	$4,490,000	$0	$2,211,000	$60,000	$2,219,000
ACA Optional	$1,218,000	$67,000	$1,151,000	$0	$0
Claims Error					
General Fund	$307,000	$307,000	$0	$0	$0
Total	$431,670,000	**$76,055,000**	**$300,079,000**	**$1,786,000**	$53,750,000

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

REGULAR POLICY CHANGE NUMBER: 56

FY 2018-19	TF	GF	FF Title XIX	FF Title XXI	CF
Regular					
Current	$481,956,000	$127,870,000	$238,852,000	$3,739,000	$111,495,000
ACA Optional	$426,865,000	$20,627,000	$400,614,000	$0	$5,624,000
Perinatal					
Current	$6,770,000	$0	$3,353,000	$57,000	$3,360,000
ACA Optional	$1,900,000	$116,000	$1,784,000	$0	$0
Claims Error					
General Fund	$0	($307,000)	$0	$0	$307,000
Total	$917,491,000	**$148,306,000**	**$644,603,000**	**$3,796,000**	$120,786,000

Funding:

FY 2017-18	TF	GF	FF	CF
50% Title XIX / 50% GF (4260-101-0001/0890)	$133,940,000	$66,970,000	$66,970,000	$0
100% GF (4260-101-0001)	$307,000	$307,000	$0	$0
100% Title XIX FF (4260-101-0890)	$103,670,000	$0	$51,835,000	$51,835,000
100% Title XXI FF (4260-113-0890)	$899,000	$0	$792,000	$107,000
100% ACA Title XIX FF (4260-101-0890)	$33,111,000	$0	$31,303,000	$1,808,000
88% Title XXI FF / 12% GF (4260-113-0001/0890)	$1,129,000	$135,000	$994,000	$0
95% ACA Title XIX FF / 5% GF (4260-101-0001/0890)	$87,456,000	$4,373,000	$83,083,000	$0
94% ACA Title XIX FF / 6% GF (4260-101-0001/0890)	$71,158,000	$4,270,000	$66,888,000	$0
Total	$431,670,000	**$76,055,000**	**$301,865,000**	$53,750,000

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

REGULAR POLICY CHANGE NUMBER: 56

FY 2018-19	TF	GF	FF	CF
50% Title XIX / 50% GF (4260-101-0001/0890)	$255,194,000	$127,597,000	$127,597,000	$0
100% GF (4260-101-0001)	$0	($307,000)	$0	$307,000
100% Title XIX FF (4260-101-0890)	$229,217,000	$0	$114,609,000	$114,608,000
100% Title XXI FF (4260-113-0890)	$2,046,000	$0	$1,799,000	$247,000
88% Title XXI FF / 12% GF (4260-113-0001/0890)	$2,269,000	$272,000	$1,997,000	$0
100% ACA Title XIX FF (4260-101-0001)	$90,500,000	$0	$84,876,000	$5,624,000
95% ACA Title XIX FF / 5% GF (4260-101-0001/0890)	$62,191,000	$3,110,000	$59,081,000	$0
94% ACA Title XIX FF / 6% GF (4260-101-0001/0890)	$169,132,000	$10,148,000	$158,984,000	$0
93% ACA Title XIX FF / 7% GF (4260-101-0001/0890)	$106,942,000	$7,486,000	$99,456,000	$0
Total	$917,491,000	**$148,306,000**	**$648,399,000**	$120,786,000

DRUG MEDI-CAL PROGRAM COST SETTLEMENT

REGULAR POLICY CHANGE NUMBER: 61
IMPLEMENTATION DATE: 7/2018
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1723

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$3,000,000
- STATE FUNDS	$0	$100,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$3,000,000
STATE FUNDS	$0	$100,000
FEDERAL FUNDS	$0	$2,900,000

DESCRIPTION

Purpose:
This policy change estimates the reimbursement for 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).

Reimbursement for non-Narcotic Treatment Program 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: 61

Reimbursement for Narcotic Treatment Program 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 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. Starting from the FY 2014-15 annual cost report settlement, all amounts for administrative cost reimbursements will be included in the Drug Medi-Cal County Administration policy change.

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is due to a shift in payment date because of delays in finalizing the cost settlements. The payment for the FY 2014-15 services cost settlement shifted from FY 2017-18 to FY 2018-19.

The change in the current estimate, from FY 2017-18 to FY 2018-19, is due to no cost settlement payment in FY 2017-18.

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 FY 2014-15 annual cost settlement will be paid in FY 2018-19.

FY 2018-19	TF	GF	FF
FY 2014-15 Settlements	$3,000,000	$100,000	$2,900,000

Funding:
100% Title XIX (4260-101-0890)
100% GF (4260-101-0001)

SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER:	65
IMPLEMENTATION DATE:	10/2017
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1458

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$80,086,000	$100,548,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$80,086,000	$100,548,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$80,086,000	$100,548,000

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 2017-18 and FY 2018-19, is due to shifting FY 2010-11 and FY 2011-12 payments to be paid in FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the different supplemental payments estimated for each respective fiscal year. In addition, the FY 2010-11 and FY 2011-12 reimbursements were updated based on actual claim amounts determined from final cost reports submitted by a portion of the counties. Costs for remaining counties will shift to be paid through the cost settlement process.

SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 65

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. The FY 2008-09 and FY 2009-10 estimates were developed using the final filed cost reports received from each county mental health plan (MHP). The FY 2008-09 and FY 2009-10 supplemental payments will be paid in FY 2017-18.

4. The FY 2010-11 estimates were developed using the final filed cost reports received for 52 counties and estimated amounts for the remaining five counties will be processed through the cost settlement process. The FY 2010-11 supplemental payments will be paid in FY 2018-19.

5. The FY 2011-12 estimate was developed using the final cost reports for 22 counties and the remaining counties will be processed through the cost settlement process. The FY 2011-12 supplemental payments will be paid in FY 2018-19.

(Dollars in Thousands)

FY 2017-18	TOTAL FF	FF - REGULAR	FF - ARRA
FY 2008-09	$23,015	$23,015	$0
FY 2009-10	$57,071	$51,143	$5,928
Total for FY 2017-18	**$80,086**	**$74,158**	**$5,928**

(Dollars in Thousands)

FY 2018-19	TOTAL FF	FF - REGULAR	FF - ARRA
FY 2010-11	$87,763	$80,032	$7,731
FY 2011-12	$12,785	$12,785	$0
Total for FY 2018-19	**$100,548**	**$92,817**	**$7,731**

Funding:

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

PATHWAYS TO WELL-BEING

REGULAR POLICY CHANGE NUMBER:	66
IMPLEMENTATION DATE:	1/2013
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1718

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$11,734,000	$14,475,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$11,734,000	$14,475,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$11,734,000	$14,475,000

DESCRIPTION

Purpose:
This policy change, previously titled Katie A. V. Diana Bonta, estimates the costs for the following Specialty Mental Health Services (SMHS): Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and the Therapeutic Foster Care (TFC) service model. 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, and 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 the TFC service model) 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.

PATHWAYS TO WELL-BEING

REGULAR POLICY CHANGE NUMBER: 66

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 service model. Reimbursement methodologies were established for ICC and IHBS effective January 1, 2013. On February 16, 2016, the reimbursement methodology was approved by the Centers for Medicare and Medicaid Services (CMS) in State Plan Amendment (SPA) #09-004 for TFC. Billing for the TFC service model is expected to begin in April 2018. 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 the "Pathways to Well-Being" and incorporated as SMHS.

Reason for Change:
The change from the previous estimate, for FY 2017-18, is a net decrease due to:

- The IHBS and ICC costs were updated with FY 2016-17 claims data and was higher than previously estimated.
- The accrual TFC services rendered in FY 2016-17, to be paid in FY 2017-18, was updated and is lower than previously estimated.

The change from the previous estimate, for FY 2018-19, is due to higher annual accrual IHBS and ICC estimated costs based on updated FY 2016-17 data reports.

The change between FY 2017-18 and FY 2018-19, in the current estimate, is due to higher TFC costs expected to be paid in FY 2018-19.

Methodology:
1. The cost estimate is based on an increase in the number of children receiving SMHS.

2. Beginning in FY 2016-17, 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 $21,572,000 on an accrual basis. Assume 38% of the IHBS and ICC costs are reflected in the base policy change titled SMHS for Children.

3. Assume beginning January 1, 2017, the TFC services have a cost of $3,068,000 in FY 2016-17 and cost of $15,732,000 annually after. Assume 100% costs for TFC services rendered in FY 2016-17 will be paid in FY 2017-18.

4. On an accrual basis, the FY 2017-18 and FY 2018-19 estimated costs are:

(Dollars in Thousands)

Fiscal Year	IHBS and ICC Accrual	TFC Accrual	Total Accrual
2016-17	$21,572	$3,068	$24,640
2017-18	$21,572	$15,732	$37,304
2018-19	$21,572	$15,732	$37,304

PATHWAYS TO WELL-BEING

REGULAR POLICY CHANGE NUMBER: 66

5. Assume 72% of FY 2016-17 IHBS & ICC claims will be paid in FY 2017-18 and 1% in FY 2018-19. For TFC, assume 100% of FY 2016-17 claims will be paid in FY 2017-18.

6. Based on historical claims received, for FY 2017-18 and FY 2018-19, assume 37% of current year IHBS, ICC, and TFC claims will be paid in the year the services occur, and 62% is paid in the second year, and 1% is paid in the third year.

(Dollars in Thousands)

Fiscal Year	Service	Total Accrual	Payment Lag	Cash Estimate TF
2016-17	IHBS & ICC	$21,572	0.72	$15,532
Less: 38%	IHBS & ICC			($5,902)
Subtotal				$9,630
2017-18	IHBS & ICC	$21,572	0.37	$7,982
Less: 38%	IHBS & ICC			($3,033)
Subtotal				$4,949
2016-17	TFC	$3,068	1.00	$3,068
2017-18	TFC	$15,732	0.37	$5,821
Total 2017-18 Cash Estimate				$23,468

(Dollars in Thousands)

Fiscal Year	Service	Total Accrual	Payment Lag	Cash Estimate TF
2016-17	IHBS & ICC	$21,572	0.01	$216
Less: 38%	IHBS & ICC			($82)
Subtotal				$134
2017-18	IHBS & ICC	$21,572	0.62	$13,375
Less: 38%	IHBS & ICC			($5,083)
Subtotal				$8,292
2018-19	IHBS & ICC	$21,572	0.37	$7,982
Less: 38%	IHBS & ICC			($3,033)
Subtotal				$4,949
2017-18	TFC	$15,732	0.62	$9,754
2018-19	TFC	$15,732	0.37	$5,821
Total 2018-19 Cash Estimate				$28,950

(Dollars in Thousands)

Fiscal Year	TF	FF	CF
FY 2017-18	$23,468	**$11,734**	$11,734
FY 2018-19	$28,950	**$14,475**	$14,475

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

MHP COSTS FOR CONTINUUM OF CARE REFORM

REGULAR POLICY CHANGE NUMBER:	67
IMPLEMENTATION DATE:	1/2017
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1957

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$6,499,000	$19,894,000
- STATE FUNDS	$4,019,500	$10,717,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$6,499,000	$19,894,000
STATE FUNDS	$4,019,500	$10,717,000
FEDERAL FUNDS	$2,479,500	$9,177,000

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 Child and Family Teams (CFT) 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.

MHP COSTS FOR CONTINUUM OF CARE REFORM

REGULAR POLICY CHANGE NUMBER: 67

- A CFT will be convened for all children or youth who have an open child welfare case. The county mental health department is expected to participate in all CFTs when the child needs SMHS.

The responsibility for SMHS for children was realigned to the counties in 2011 as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, legislation enacted after September 30, 2012, that has an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by 2011 Realignment shall apply to local agencies only to the extent that the state provides annual funding for the cost increase. The new activities began January 2017 and the current year and budget year costs are included in this policy change.

Reason for Change:
The change from the prior estimate, for FY 2017-18 an FY 2018-19, is due to:

- Updated caseload figures based on data for CDSS county workload for placement assessments,
- Updated the FY 2018-19 cost per hour for CFTs from $202.77 to $204.00, and
- Updated payment lags based on paid claims data.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to:

- Increased the FY 2018-19 cost per hour for CFTs from $198.60 to $204.00, based on an estimated fixed growth from the FY 2017-18 rate, and
- Updated payment lags based on paid claims data.

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	Hours per Year
Tier 1	1,386	749	637	12
Tier 2	2,793	1,509	1,284	10
Tier 3	7,703	4,162	3,541	8
Tier 4	8,414	4,546	3,868	4
Tier 5	1,425	770	655	4
Total	21,721	11,736	9,985	38

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 $3.77 per minute, or $226.20 per hour for FY 2016-17, $3.31 per minute, or $198.60 per hour for FY 2017-18, and $3.40 per minute or $204.00 per hour for FY 2018-19.

MHP COSTS FOR CONTINUUM OF CARE REFORM

REGULAR POLICY CHANGE NUMBER: 67

4. The estimated cost for participation in a child and family team for six months in FY 2016-17 is:

(Rounded)

Caseload	CFT Cases	Cost per Hour	Hours	Cost
Tier 1	637	$226.20	6	$865,000
Tier 2	1,284	$226.20	6	$1,743,000
Tier 3	3,541	$226.20	4	$3,204,000
Tier 4	3,868	$226.20	2	$1,750,000
Tier 5	655	$226.20	2	$296,000
Total	9,985			$7,858,000

5. The estimated annual cost for participation in a child and family team in FY 2017-18:

(Rounded)

Caseload	CFT Cases	Cost per Hour	Hours	Cost
Tier 1	637	$198.60	12	$1,518,000
Tier 2	1,284	$198.60	10	$2,550,000
Tier 3	3,541	$198.60	8	$5,626,000
Tier 4	3,868	$198.60	4	$3,073,000
Tier 5	655	$198.60	4	$520,000
Total	9,985			$13,287,000

6. The estimated annual cost for participation in a child and family team in FY 2018-19:

(Rounded)

Caseload	CFT Cases	Cost per Hour	Hours	Cost
Tier 1	637	$204.00	12	$1,559,000
Tier 2	1,284	$204.00	10	$2,619,000
Tier 3	3,541	$204.00	8	$5,779,000
Tier 4	3,868	$204.00	4	$3,156,000
Tier 5	655	$204.00	4	$534,000
Total	9,985			$13,647,000

Placement Assessments

1. Based on CDSS' estimated number of children currently in a rate classification level (RCL) 10 to 12 residential group homes, assume 147 children would transition to an STRTP in FY 2017-18 and 407 children would transition in FY 2018-19 to an STRTP.

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.

MHP COSTS FOR CONTINUUM OF CARE REFORM

REGULAR POLICY CHANGE NUMBER: 67

4. The assumed Placement Assessment costs for FY 2017-18 and FY 2018-19 are:

   FY 2017-18: 147 x $198.60 x 4 = $116,777
   FY 2018-19: 407 x $204.00 x 4 = $332,112

Training

1. 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 64.9% for FY 2017-18 and FY 2018-19, 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 2017-18: Federal Share: $3,000,000 x 0.75 x 0.649 = $1,460,000 (Rounded)
   GF Match: $3,000,000 x (1 – (0.75 x 0.649)) = $1,540,000 (Rounded)

   FY 2018-19: Federal Share: $3,000,000 x 0.75 x 0.649 = $1,460,000 (Rounded)
   GF Match: $3,000,000 x (1 – (0.75 x 0.649)) = $1,540,000 (Rounded)

Funding Summary

1. Based on Short Doyle/Medi-Cal paid claims data, on a cash basis for FY 2017-18, the Department will pay 37% of FY 2017-18 claims. On a cash basis for FY 2018-19, the Department will pay 62% of FY 2016-17 claims, 62% of FY 2017-18 claims, and 37% of FY 2018-19 claims. There is no lag in payment for training costs. The estimated costs, on a cash basis, is:

(Dollars in Thousands)

FY 2017-18	TF	CFT	Placement Assessments	Training
Total FY 2017-18	$6,499	$4,916	$43	$1,540

(Dollars in Thousands)

FY 2018-19	TF	CFT	Placement Assessments	Training
FY 2016-17	$4,872	$4,872	$0	$0
FY 2017-18	$8,310	$8,238	$72	$0
FY 2018-19	$6,712	$5,049	$123	$1,540
Total FY 2018-19	$19,894	$18,159	$195	$1,540

2. The FY 2017-18 and FY 2018-19 estimate is:

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
CFT	$4,916	$2,458	$2,458
Placement Assessments	$43	$22	$21
Training	$1,540	$1,540	$0
Total	**$6,499**	**$4,020**	**$2,479**

MHP COSTS FOR CONTINUUM OF CARE REFORM

REGULAR POLICY CHANGE NUMBER: 67

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
CFT	$18,159	$9,080	$9,079
Placement Assessments	$195	$97	$98
Training	$1,540	$1,540	$0
Total	**$19,894**	**$10,717**	**$9,177**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
100% GF (4260-101-0001)

TRANSITIONAL SMHS CLAIMS

REGULAR POLICY CHANGE NUMBER:	68
IMPLEMENTATION DATE:	9/2018
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	2026

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$544,000
- STATE FUNDS	$0	$544,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$544,000
STATE FUNDS	$0	$544,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the cost to reimburse San Diego County for the cost of Medi-Cal Specialty Mental Health Services (SHMS) claims for services provided in FY 2009-10.

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

Interdependent Policy Changes:
Not Applicable

Background:
The Department contracted with San Diego County to be the Mental Health Plan (MHP) for Medi-Cal beneficiaries residing in that county. San Diego County submitted claims to the Department of Mental Health (DMH) for services rendered in FY 2009-10. When the DMH transitioned to the Department, it was discovered that the claims were not processed or paid.

The Department will reimburse the San Diego County MHP with the federal share of the cost to render SMHS to Medi-Cal beneficiaries. Because the two-year limit to claim federal reimbursement has passed, federal funding is not available.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is due to:

- A reduced amount based on the final invoiced amount for San Diego County,
- The Butte County payment was moved to the Interim and Final Cost Settlements policy change and will be paid in FY 2018-19. Additionally, the timing of the San Diego payment has shifted from FY 2017-18 to FY 2018-19.

TRANSITIONAL SMHS CLAIMS

REGULAR POLICY CHANGE NUMBER: 68

Methodology:

1. Payment to the San Diego County MHP is based on actual claims received from the county.

2. In FY 2018-19, assume General Funds (GF) will be used to pay claims.

Cash Basis	TF	GF
FY 2018-19	$544,000	**$544,000**

Funding:

100% GF (4260-101-0001)

LATE CLAIMS FOR SMHS

REGULAR POLICY CHANGE NUMBER:	69
IMPLEMENTATION DATE:	7/2016
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1717

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$4,000	$25,000
- STATE FUNDS	$4,000	$25,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,000	$25,000
STATE FUNDS	$4,000	$25,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of reimbursement for Medi-Cal Specialty Mental Health Services (SHMS) 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:
There is no change from the prior estimate for FY 2017-18. The change in the prior estimate and the change in the current estimate for FY 2018-19, is due to the addition of claims payments for Santa Clara County estimated to be paid in FY 2018-19.

Methodology:
1. Late claims are based on actual claims received from the counties.

LATE CLAIMS FOR SMHS

REGULAR POLICY CHANGE NUMBER: 69

2. Assume GF will be used to pay claims in FY 2017-18 and FY 2018-19 that exceed the federal claiming limit.

Cash Basis	TF	GF
FY 2017-18	$4,000	**$4,000**
FY 2018-19	$25,000	**$25,000**

Funding:
100% GF (4260-101-0001)

SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT

REGULAR POLICY CHANGE NUMBER:	70
IMPLEMENTATION DATE:	1/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1660

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$1,055,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$1,055,000
FEDERAL FUNDS	$0	-$1,055,000

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 in the amount of $200,000 per year until it fulfills its obligation for repayment. The County repayments began August 2012. The County has submitted five payments totaling $1,200,000.

Reason for Change:
There is no change, from the prior estimate, for FY 2017-18. The change, from the prior estimate for FY 2018-19, and the change between FY 2017-18 and FY 2018-19 in the current estimate, is due to the addition of a $1,055,000 repayment to CMS for FY 2010-11 audit findings.

SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT

REGULAR POLICY CHANGE NUMBER: 70

Methodology:

1. The Department began making repayments to CMS in January 2012 and has repaid CMS overpayments discovered during cost settlements for FY 2006-07 through FY 2010-11 and audit settlements for FY 2005-06 through FY 2010-11.

2. Siskiyou County will reimburse the GF $200,000 annually. The county has submitted payments totaling $1,200,000.

3. In FY 2016-17, a repayment amount of $381,000 was recouped from the county and repaid to CMS as a result of FY 2009-10 audit findings. In FY 2017-18, the Department completed an audit of FY 2010-11 for Siskiyou County with findings of $1,055,000 to be recouped. 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	$1,055,000	$0	$1,055,000
Subtotal	$12,306,000	$11,251,000	$0
Repayments	($1,200,000)	$0	$0
Recoupments	($381,000)	$0	$0
Total	$10,725,000	$11,251,000	$1,055,000

4. The estimate for FY 2017-18 and FY 2018-19 is as follows:

Fiscal Year	TF	GF	FF	Reimbursement
FY 2017-18	$0	**($200,000)**	**$0**	**$200,000**
FY 2018-19	$0	**$855,000**	**($1,055,000)**	**$200,000**

Funding:

100% GF (4260-101-0001)
Reimbursement GF (4260-601-0995)

CHART REVIEW

REGULAR POLICY CHANGE NUMBER: 71
IMPLEMENTATION DATE: 7/2012
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1714

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	-$1,743,000	-$670,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,743,000	-$670,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$1,743,000	-$670,000

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 2017-18 and FY 2018-19, is a decrease due to:

- Decreased recoupments from updating the estimate to reflect actual outpatient recoupments from the FY 2015-16 and FY 2016-17 chart reviews in FY 2017-18.
- Decreased recoupments from updating the estimate to reflect draft recoupments from the FY 2017-18 inpatient and outpatient chart reviews in FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to the completion of chart review recoupments for two fiscal years, FY 2015-16 and FY 2016-17 that occurred in FY 2017-18 and one year of recoupments budgeted in FY 2018-19. Also, the FY 2017-18 estimate is based on actuals recoupments, whereas the FY 2018-19 estimate is comprised of estimated recoupments only.

CHART REVIEW

REGULAR POLICY CHANGE NUMBER: 71

Methodology:

1. The FY 2017-18 estimate includes recoupments from inpatient and outpatient chart reviews conducted for FYs 2015-16 and 2016-17.

2. The FY 2018-19 estimate includes estimated recoupments from inpatient and outpatient chart reviews to be conducted for FY 2017-18.

(Dollars in Thousands)

Fiscal Year	TF	FF
FY 2017-18	($1,743)	($1,743)
FY 2018-19	($670)	($670)

Funding:

100% Title XIX (4260-101-0890)

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER:	72
IMPLEMENTATION DATE:	7/2015
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1713

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$11,740,000	$68,685,000
- STATE FUNDS	$20,710,000	$3,186,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$11,740,000	$68,685,000
STATE FUNDS	$20,710,000	$3,186,000
FEDERAL FUNDS	-$8,970,000	$65,499,000

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 2017-18 and FY 2018-19, is due to

- Cost settlements for FY 2010-11 and FY 2011-12 were updated and resulted in higher underpayment amounts. The underpayments are scheduled to be paid in FY 2018-19.
- Including the FY 2010-11 General Fund (GF) underpayment in FY 2017-18 of $20.7 million.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to lower GF underpayments but higher Federal fund underpayments scheduled to be paid in FY 2018-19.

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 72

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. The following tables show the interim and final cost settlement Federal Fund (FF) amounts for FY 2017-18.

(Dollars in Thousands)

Interim Cost Settlement (FY 2009-10)	Underpaid	Overpaid	Net FF
Children and Adults	$0	($9)	($9)
ARRA	$0	($2)	($2)
M-CHIP*	$14	$0	$14
Healthy Families*	$17	$0	$17
FY 2009-10 Total	$31	($11)	$20

(Dollars in Thousands)

Interim Cost Settlement (FY 2010-11)	Underpaid	Overpaid	Net FF
Children and Adults	$700	($5,689)	($4,989)
ARRA	$135	($1,101)	($966)
BCCTP	$3	($43)	($40)
Pregnancy	$601	$0	$601
Refugees	$0	($1)	($1)
M-CHIP*	$213	($183)	$30
Healthy Families*	$145	($283)	($138)
FY 2010-11 Total	$1,797	($7,300)	($5,503)

(Dollars in Thousands)

Interim Cost Settlement (FY 2011-12)	Underpaid	Overpaid	Net FF
Children and Adults	$0	($3,129)	($3,129)
BCCTP	$0	($38)	($38)
M-CHIP*	$0	($141)	($141)
Healthy Families*	$0	($179)	($179)
FY 2011-12 Total	$0	($3,487)	($3,487)

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 72

(Dollars in Thousands)

Subtotal FF	Underpaid	Overpaid	Net FF
Total FY 2017-18	$1,828	($10,798)	($8,970)

5. The following tables show the interim and final cost settlement Federal Fund (FF) amounts for FY 2018-19.

(Dollars in Thousands)

Interim Settlement (FY 2009-10)	Underpaid	Overpaid	Net FF
Children and Adults	$0	($38)	($38)
FY 2009-10 Total	$0	($38)	($38)

(Dollars in Thousands)

Interim Settlement (FY 2010-11)	Underpaid	Overpaid	Net FF
Children and Adults	$1,238	$0	$1,238
ARRA	$238	$0	$238
BCCTP	$1	($39)	($38)
Pregnancy	$549	$0	$549
Refugees	$1	$0	$1
M-CHIP*	$39	($3)	$36
Healthy Families*	$21	$0	$21
FY 2010-11 Total	$2,087	($42)	$2,045

(Dollars in Thousands)

Interim Settlement (FY 2011-12)	Underpaid	Overpaid	Net FF
Children and Adults	$65,907	($2,312)	$63,595
BCCTP	$1	($13)	($12)
Pregnancy	$341	$0	$341
Refugees	$1	($2)	($1)
M-CHIP*	$137	($297)	($160)
Healthy Families*	$366	($637)	($271)
FY 2011-12 Total	$66,753	($3,261)	$63,492

(Dollars in Thousands)

Subtotal FF	Underpaid	Overpaid	Net FF
Total FY 2018-19	$68,840	($3,341)	$65,499

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 72

6. Cost settlements prior to 2011 Realignment may consist of General Fund (GF).

(Dollars in Thousands)

Interim Settlement	GF Underpaid	GF Overpaid	Net GF
2010-11	$20,782	($72)	$20,710
Total FY 2017-18	$20,782	($72)	$20,710

(Dollars in Thousands)

Interim Settlement	GF Underpaid	GF Overpaid	Net GF
2006-07	$2	$0	$2
2009-10	$351	($146)	$205
2010-11	$2,979	$0	$2,979
Total FY 2018-19	$3,332	($146)	$3,186

7. The net FF and GF to be paid in FY 2017-18 and FY 2018-19 is:

(Dollars in Thousands)

FY 2017-18 Summary	**TF**	**GF**	**FF**
Children and Adults	$12,583	$20,710	($8,127)
ARRA	($968)	$0	($968)
BCCTP	($78)	$0	($78)
Pregnancy	$601	$0	$601
Refugees	($1)	$0	($1)
M-CHIP*	($97)	$0	($97)
Healthy Families*	($300)	$0	($300)
Total FY 2017-18	**$11,740**	**$20,710**	**($8,970)**

(Dollars in Thousands)

FY 2018-19 Summary	**TF**	**GF**	**FF**
Children and Adults	$67,981	$3,186	$64,795
ARRA	$238	$0	$238
BCCTP	($50)	$0	($50)
Pregnancy	$890	$0	$890
Refugees	$0	$0	$0
M-CHIP*	($124)	$0	($124)
Healthy Families*	($250)	$0	($250)
Total FY 2018-19	**$68,685**	**$3,186**	**$65,499**

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:	73
IMPLEMENTATION DATE:	12/2015
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1951

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$2,275,272,000	$2,492,086,000
- STATE FUNDS	$1,137,636,000	$1,246,043,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,275,272,000	$2,492,086,000
STATE FUNDS	$1,137,636,000	$1,246,043,000
FEDERAL FUNDS	$1,137,636,000	$1,246,043,000

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:
Not Applicable

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 will provide 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 will steer 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, will be receiving their allocation of the federal DSH payments through the Global Payment Program.

GLOBAL PAYMENT PROGRAM

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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 further postpones the reduction until October 1, 2019.

Reason for Change:
The change in FY 2017-18 and FY 2018-19, from the prior estimate, is due to updated estimated payment data for program year (PY) 2017-18.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to varying DSH allotments by program year.

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 2018-19 is estimated at:

(Dollars in Thousands)

Program Year	DPH DSH Allotment	SNCP	Total FFP
PY 2015-16	$869,015	$236,000	$1,105,015
PY 2016-17	$903,233	$236,000	$1,139,233
PY 2017-18	$936,551	$236,000	$1,172,551
PY 2018-19	$971,080	$236,000	$1,207,080

4. Assume payments are made on a quarterly basis. Three quarters are paid in the same fiscal year. The fourth quarter payment is paid the following fiscal year.

5. The PY 2015-16 final reconciliation payment of $52.183 million TF will be paid in FY 2017-18.

6. The estimated GPP payments on a cash basis are:

(Dollars in Thousands)

FY 2017-18	**TF**	**IGT**	**FF**
PY 2015-16	$52,183	$26,091	$26,092
PY 2016-17	$471,204	$235,602	$235,602
PY 2017-18	$1,751,885	$875,943	$875,942
Total	**$2,275,272**	**$1,137,636**	**$1,137,636**

GLOBAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 73

FY 2018-19	TF	IGT	FF
PY 2016-17	$88,250	$44,125	$44,125
PY 2017-18	$593,216	$296,608	$296,608
PY 2018-19	$1,810,620	$905,310	$905,310
Total	**$2,492,086**	**$1,246,043**	**$1,246,043**

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:	74
IMPLEMENTATION DATE:	8/2016
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1950

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$1,765,728,000	$1,524,894,000
- STATE FUNDS	$882,864,000	$762,447,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,765,728,000	$1,524,894,000
STATE FUNDS	$882,864,000	$762,447,000
FEDERAL FUNDS	$882,864,000	$762,447,000

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: 74

Reason for Change:
The change in FY 2017-18, from the prior estimate, is due to the reallocation of unearned funds from DY 2016-17. 90% of the unallocated funds from DY 2016-17 are expected to be reclaimed as the DY 2016-17 supplemental payment in FY 2017-18. The remaining 10% of the unearned funds will be reallocated into the DY 2017-18 high performance pool and shift to be paid in FY 2018-19.

The change in FY 2018-19, from the prior estimate, is due to the inclusion of the DY 2017-18 10% high performance pool amount of which the full allocation is expected to be achieved for the DY 2017-18 supplemental payment.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the inclusion of the first semi-annual payment for DY 2018-19 in FY 2018-19 which factors in the 10% phase down amount from the prior annual allocations.

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. The DY 2016-17 supplemental payments are estimated to be paid in FY 2017-18.

3. Starting in DY 2016-17, if an entity does not meet the project metric target by the DY 2016-17 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 DY 2017-18 and can be claimed through the DY 2017-18 supplemental payment.

4. 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.

5. Starting 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.

(Dollars in Thousands)

FY 2017-18	**TF**	**IGT**	**FF**
DY 2016-17			
DPH	$789,216	$394,608	$394,608
DMPH	$176,512	$88,256	$88,256
Total	$965,728	$482,864	$482,864
DY 2017-18			
DPH	$700,000	$350,000	$350,000
DMPH	$100,000	$50,000	$50,000
Total	$800,000	$400,000	$400,000
Total FY 2017-18	**$1,765,728**	**$882,864**	**$882,864**

PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL

REGULAR POLICY CHANGE NUMBER: 74

(Dollars in Thousands)

FY 2018-19	TF	IGT	FF
DY 2017-18			
DPH	$704,024	$352,012	$352,012
DMPH	$100,870	$50,435	$50,435
Total	$804,894	$402,447	$402,447
DY 2018-19			
DPH	$630,000	$315,000	$315,000
DMPH	$90,000	$45,000	$45,000
Total	$720,000	$360,000	$360,000
Total FY 2018-19	**$1,524,894**	**$762,447**	**$762,447**

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:	75
IMPLEMENTATION DATE:	7/2016
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1953

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$353,709,000	$874,842,000
- STATE FUNDS	$176,854,000	$437,421,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$353,709,000	$874,842,000
STATE FUNDS	$176,854,000	$437,421,000
FEDERAL FUNDS	$176,855,000	$437,421,000

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: 75

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

During FY 2016-17, the Department approved a total of 25 local Whole Person Care Pilot programs that included 23 individual counties, one consortium of three counties, and one city.

Reason for Change:
The change in FY 2017-18 from the prior estimate is due to rollover of unexpended funds from Program Year 2 to Program year 3. The change in FY 2018-19 from the prior estimate is due to the addition of the rollover funds into Program Year 3. The change from FY 2017-18 to FY 2018-19 is due to the rollover of unused funds to Program Year 3 which is captured in FY 2018-19.

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 are assumed to begin in FY 2017-18 and continue through FY 2020-21.

3. Payments are made through an Intergovernmental Transfer (IGT) process.

4. For First Round Lead Entities, program years (PY) correspond to calendar years. PY 1 began January 1, 2016.

5. For Second Round Lead Entities, PY 1 is 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

MEDI-CAL 2020 WHOLE PERSON CARE PILOTS

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and correspond to calendar years. PY 3 begins January 2018.

6. First Round Lead Entity PY 1 payments were made in December 2016 and in March/April 2017.
7. Second Round Lead Entity PY 1 payments were made in August 2017.
8. Mid-year PY 2 payments were made in November 2017.
9. PY 2 payments will also be made in May 2018.
10. PY 3 payments will be made in October/November 2018 and May 2019.
11. Lead entities may roll over unused funds from PY 2 to PY 3. This process began February 1, 2018 and will complete by April 2, 2018. The rollover process is expected to impact actual expenditures in FY 2017-18 and projected expenditures in FY 2018-19.

(Dollars in Thousands)

	TF	IGT*	FF
FY 2017-18	$353,709	$176,855	$176,855

(Dollars in Thousands)

	TF	IGT*	FF
FY 2018-19	$874,842	$437,421	$437,421

Funding:
100% FFP Title XIX (4260-101-0890)
*Whole Person Care Pilot Special Fund (4260-601-8107)

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

REGULAR POLICY CHANGE NUMBER:	76
IMPLEMENTATION DATE:	1/2017
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1954

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$107,000,000	$155,000,000
- STATE FUNDS	$53,500,000	$77,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$107,000,000	$155,000,000
STATE FUNDS	$53,500,000	$77,500,000
FEDERAL FUNDS	$53,500,000	$77,500,000

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's goal is to increase the utilization amongst children enrolled in either the Fee-For-Services (FFS) or Dental Managed Care (DMC) delivery system or who receive dental services at a Federally Qualified Health Center (FQHC) by at least ten percentage points over a five year period. The Department will offer payments as financial incentives for dental service office locations to increase delivery of preventive oral care to Medi-Cal children. These payments will be in

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

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the form of semi-annual 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.

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. Incentive payments are to be paid upon the billing of each of the aforementioned services. 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 will initially be 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.

The Increase the Continuity of Care domain aims to encourage the continuity of care among Medi-Cal beneficiaries age 20 and under. An incentive payment would be paid to dental provider service office locations that have maintained continuity of care through providing examinations for their enrolled child beneficiaries for two, three, four, five, and six year continuous periods. This domain will initially be 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. Incentive payments will be made annually.

The Department will require 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 will issue 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 have been approved; however, one LDPP has withdrawn its application. No more than 25 percent of the annual DTI funding will be allocated to this domain.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is an increase due to updated actuals which reflect higher incentive payments made for Domain 1. The change from the prior estimate, for FY 2018-19, is a decrease due to updated actuals across all domains. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to anticipated increased participation in the DTI.

Methodology:
Domain 1: Increase Preventive Services Utilization for Children

1. The Department uses the most recent complete calendar year (CY) for preventive services utilization data to determine the baseline. Incentive payments are calculated by establishing a benchmark of a 2% increase for each provider based on their respective baselines. When a provider meets or exceeds their benchmark, incentive payments are made for each service above the 2% increase over baseline.

2. Domain 1 expenditures also include incentive payments related to services performed in Domain 2 that parallel the preventive services for Domain 1. These Domain 2 related expenditures include only services over and above those covered by the Manual of Criteria (MOC).

3. 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 preventive services equating to a payment of 75% of the SMA for every qualifying preventive service provided to users above a threshold minimum set by the Department. Incentive payments are paid

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

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on a semi-annual basis.

4. Statewide Medi-Cal eligibles are expected to grow at 0.57% annually. Expenditures include incentive payments made at the 75% above SMA for the 2% increase of utilization with 0.57% population growth per year.

5. The implementation date for Domain 1 was July 1, 2016; however, claims data from January 1, 2016, through June 30, 2016, will count towards the domains performance metrics and incentive payments. Payments are made twice a year starting in January 2017. Therefore, FY 2017-18 includes incentive payments for CY 2017 and FY 2018-19 includes incentive payments for CY 2018 and the remainder of CY 2017.

6. The FQHC population is estimated as 10% of the combined FFS and DMC population.

Total Domain 1 costs are estimated to be:

Fiscal Year	TF	GF	FF
FY 2017-18	$72,000,000	$36,000,000	$36,000,000
FY 2018-19	$56,000,000	$28,000,000	$28,000,000

Domain 2: Caries Risk Assessment and Disease Management

7. This four year incentive program implemented on January 1, 2017, and will only be available for services performed on child beneficiaries six years of age and under. Assume that 20% of all eligible children six years of age and under, including the FQHC population, participate for the entire duration of the domain, with an annual eligible population growth of 0.57%. Assume a ramp-up period for the first two years of implementation as providers will gradually opt-in to the program and begin assessment and treatment.

8. Domain 2 has three levels of risk assessment; Low, Moderate and High Risk. The calculations reflect data from 2017 where 10% of children fall under the Low Risk category, 23% fall under the Moderate Risk category and 67% fall under the High Risk category. 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.

9. Dentists participating in the pilot will be authorized to perform an increased number of services per year in accordance with the pre-identified treatment plan options based on risk level, and are eligible to receive an incentive payment for each additional service not currently covered under the California State Plan and frequency limitations listed in the Manual of Criteria. This piece of the incentive is inclusive of the Domain 1 costing and payout schedule.

10. Payments will be made on a monthly basis. Therefore, FY 2017-18 will include incentive payments for the first six months of CY 2017 and FY 2018-19 will include incentive payments for the second six months of CY 2017, the remainder of the first six months of CY 2017 and the first six months of CY 2018.

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

REGULAR POLICY CHANGE NUMBER: 76

Total Domain 2 costs are estimated to be:

Fiscal Year	TF	GF	FF
FY 2017-18	$4,000,000	$2,000,000	$2,000,000
FY 2018-19	$28,000,000	$14,000,000	$14,000,000

Domain 3: Increase the Continuity of Care

11. The implementation date for Domain 3 was July 1, 2016; therefore, claims data from January 1, 2016, through June 30, 2016, will count towards the domain's performance metrics and incentive payments as compared to prior years data. Payments are made once a year starting in July 2017. Therefore, FY 2017-18 will include incentive payments for CY 2017.

12. This incentive program will be available to service office locations that provide examinations to an enrolled Medi-Cal beneficiary for two, three, four, five, and six year continuous periods.

13. Medi-Cal eligibles are expected to grow by 0.57% annually.

14. This five (5) year incentive program will only be available for services performed on child beneficiary participants age 20 and under. Assume that the returned beneficiaries from the baseline year for the selected pilot county return to the same provider at a rate of 95% from the previous year for year one, 90% of the previous year for year two, 80% of the previous year for year three, 70% of the previous year for year four and 60% of the previous year for year five.

15. There will be a projected 2.25% increase in exams utilization each year for newly entering Domain 3 participants.

16. The incentive payment will be an annual flat payment for providing continuity of care to a beneficiary. Incentive payment amounts will be 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, the dollar amount of the incentive payment for an exam of the same child within that period will be increased.

    Total Domain 3 costs are estimated to be:

Fiscal Year	TF	GF	FF
FY 2017-18	$9,000,000	$5,000,000	$5,000,000
FY 2018-19	$22,000,000	$11,000,000	$11,000,000

Domain 4: Local Dental Pilot Projects

17. The implementation for this domain was April 15, 2017. Payments will be made quarterly beginning FY 2017-18.

18. Fifteen LDPPs were approved; however, one LDPP has withdrawn its application.

19. 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

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

REGULAR POLICY CHANGE NUMBER: 76

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).

20. Assume incentive payments will be reviewed, approved, and payable to selected pilots that target an identified population of Medi-Cal eligible child beneficiaries in accordance with the requirements established jointly by the Department and CMS and deemed appropriate to fulfill specific strategies linked to one or more of the domains delineated above.

    Total Domain 4 costs are estimated to be:

Fiscal Year	TF	GF	FF
FY 2017-18	**$22,000,000**	**$11,000,000**	**$11,000,000**
FY 2018-19	**$49,000,000**	**$25,000,000**	**$25,000,000**

21. On a cash basis, the FY 2017-18 and FY 2018-19 total demonstration costs are:

(Dollars in thousands)

FY 2017-18	TF	GF	FF
Domain 1	$72,000	$36,000	$36,000
Domain 2	$4,000	$2,000	$2,000
Domain 3	$9,000	$5,000	$5,000
Domain 4	$22,000	$11,000	$11,000
Total	**$107,000**	**$54,000**	**$54,000**

(Dollars in thousands)

FY 2018-19	TF	GF	FF
Domain 1	$56,000	$28,000	$28,000
Domain 2	$28,000	$14,000	$14,000
Domain 3	$22,000	$11,000	$11,000
Domain 4	$49,000	$25,000	$25,000
Total	**$155,000**	**$78,000**	**$78,000**

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

BTR - LIHP - MCE

REGULAR POLICY CHANGE NUMBER:	77
IMPLEMENTATION DATE:	7/2011
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1578

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$104,616,000	$198,363,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$104,616,000	$198,363,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$104,616,000	$198,363,000

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: 77

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:
There is no change from the prior estimate for both FY 2017-18 and FY 2018-19.

The change from FY 2017-18 to FY 2018-19 in the current estimate is an increase due to the varying final reconciliation results for the LIHP invoice counties and the LIHP counties that used cost reports. The current estimate reflects reconciliation of LIHP invoice counties occurring in FY 2017-18, and the reconciliation of LIHP cost report counties occurring in FY 2018-19.

Methodology:
1. Assume the remaining DY 2010-11 through DY 2013-14 final reconciliations for the counties that submitted invoices for payment will occur in FY 2017-18.

2. Assume the DY 2010-11 through DY 2013-14 final reconciliations for the counties that submitted cost reports for payment will occur in FY 2018-19.

The estimated MCE payments on a cash basis are:

(Dollars in Thousands)

FY 2017-18	TF	FF
2010-11 (CPEs)	$33,850	$33,850
2011-12 (CPEs)	$29,916	$29,916
2012-13 (CPEs)	$21,387	$21,387
2013-14 (CPEs)	$19,463	$19,463
Total FY 2017-18	**$104,616**	**$104,616**

(Dollars in Thousands)

FY 2018-19	TF	FF
2010-11 (CPEs)	($3,238)	($3,238)
2011-12 (CPEs)	($15,078)	($15,078
2012-13 (CPEs)	$40,954	$40,954
2013-14 (CPEs)	$175,725	$175,725
Total FY 2018-19	**$198,363**	**$198,363**

Funding:
100% Title XIX (4260-101-0890)

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER:	78
IMPLEMENTATION DATE:	7/2006
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1153

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$55,400,000	$55,530,000
- STATE FUNDS	$55,400,000	$55,530,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$55,400,000	$55,530,000
STATE FUNDS	$55,400,000	$55,530,000
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: 78

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:
There is no change for FY 2017-18 and FY 2018-19 from the prior estimate. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the results of the final reconciliations for different demonstration years.

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 2008-09 final reconciliation for DPHs and Distressed Hospitals will be completed in FY 2017-18.

10. The DY 2009-10 final reconciliation for DPHs and Distressed Hospitals will be completed in FY 2018-19.

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER: 78

The estimated stabilization payments are:

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
DY 2008-09 DPHs	$55,400	$55,400	$0
Total	**$55,400**	**$55,400**	**$0**

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
DY 2009-10 DPHs	$55,530	$55,530	$0
Total	**$55,530**	**$55,530**	**$0**

Funding:
100% GF (4260-101-0001)

BTR - LOW INCOME HEALTH PROGRAM - HCCI

REGULAR POLICY CHANGE NUMBER:	79
IMPLEMENTATION DATE:	11/2010
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1572

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$36,060,000	$231,547,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$36,060,000	$231,547,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$36,060,000	$231,547,000

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)

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.

BTR - LOW INCOME HEALTH PROGRAM - HCCI

REGULAR POLICY CHANGE NUMBER: 79

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:
There is no change from the prior estimate for both FY 2017-18 and FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to the varying final reconciliation results for the LIHP invoice counties and the LIHP counties that used cost reports. The current estimate reflects reconciliation of LIHP invoice counties occurring in FY 2017-18, and the reconciliation of LIHP cost report counties occurring in FY 2018-19.

Methodology:
1. Assume the remaining DY 2010-11 through DY 2013-14 final reconciliations for the counties that submitted invoices for payment will occur in FY 2017-18.

2. Assume the DY 2010-11 through DY 2013-14 final reconciliations for the counties that submitted cost reports for payment will occur in FY 2018-19.

The estimated HCCI payments on a cash basis are:

(Dollars in Thousands)

FY 2017-18	TF	FF
DY 2010-11	$9,555	$9,555
DY 2011-12	$10,348	$10,348
DY 2012-13	$11,096	$11,096
DY 2013-14	$5,061	$5,061
Total FY 2017-18	**$36,060**	**$36,060**

BTR - LOW INCOME HEALTH PROGRAM - HCCI

REGULAR POLICY CHANGE NUMBER: 79

(Dollars in Thousands)

FY 2018-19	TF	FF
DY 2010-11	$22,546	$22,546
DY 2011-12	$192,933	$192,933
DY 2012-13	$10,915	$10,915
DY 2013-14	$5,153	$5,153
Total FY 2018-19	**$231,547**	**$231,547**

Funding:
Health Care Support Fund (4260-601-7503)

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER: 80
IMPLEMENTATION DATE: 7/2013
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 1769

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$1,170,000	$369,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,170,000	$369,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,170,000	$369,000

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.

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.

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER: 80

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 include:

- Acupuncture[3]
- Audiology
- Chiropractic
- Dental[1,4]
- Incontinence creams and washes
- Optician/optical lab
- Podiatry
- Psychology[2]
- Speech therapy

[1]AB 82 (Chapter 23, Statutes of 2013) restores certain adult dental benefits, effective May 1, 2014. The adult dental benefit restoration does not affect calendar year 2013. For calendar year 2014, eliminated dental services will be claimable for the time period from January 1, 2014 to April 30, 2014. Beginning May 1, 2014, some adult dental benefits were restored and will no longer be claimable under this program.

[2]SBX1 1 (Chapter 4, Statutes of 2013) restores psychology services, effective January 1, 2014.

[3]SB 833 (Chapter 30, Statutes of 2016) restores acupuncture services, effective July 1, 2016.

[4]SB 97 (Chapter 52, Statutes of 2017) restores full adult dental benefits, effective January 1, 2018.

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER: 80

Reason for Change:
The change in FY 2017-18, from the prior estimate, is due to a net decrease in actual encounters in CY 2017, a decrease in estimated encounters in CY 2018, and an increase in the CY 2018 IHS global encounter rate.

The change in FY 2018-19, from the prior estimate, is due to a net decrease in estimated encounters in CY 2018 and CY 2019, and an increase in the IHS global encounter rate.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to an additional CY 2016 claim paid in FY 2017-18, as well as the exclusion of projected dental encounters starting January 1, 2018.

Methodology:
1. An additional CY 2016 claim in the amount of $102,000 TF was paid in FY 2017-18.

2. Assume all of CY 2017 will be paid in FY 2017-18.

3. Assume the first quarter of CY 2018 will be paid in FY 2017-18.

4. Assume the remaining three quarters of CY 2018 will be paid in FY 2018-19.

5. Assume the first quarter of CY 2019 will be paid in FY 2018-19.

6. The IHS global encounter rate is updated on the Federal Register for each CY. For CY 2017, the rate is $391. For CY 2018, the rate is $427. Assume the rate is $427 for CY 2019.

7. IHS claims are paid for each encounter. Assume the encounters for CY 2017 are 2,497, CY 2018 are 864, and CY 2019 are 864.

Calendar Year 2017	2,497 encounters x	$391 =	$976,327 FF
Calendar Year 2018	864 encounters x	$427 =	$368,928 FF
Calendar Year 2019	864 encounters x	$427 =	$368,928 FF

8. Assume IHS payments will be made as follows on a cash basis:

FY 2017-18	TF	FF
Calendar Year 2016	$102,000	$102,000
Calendar Year 2017	$976,000	$976,000
Calendar Year 2018	$92,000	$92,000
Total	**$1,170,000**	**$1,170,000**

FY 2018-19	TF	FF
Calendar Year 2018	$277,000	$277,000
Calendar Year 2019	$92,000	$92,000
Total	**$369,000**	**$369,000**

Funding:
100% Health Care Support Fund (4260-601-7503)

MH/UCD—HEALTH CARE COVERAGE INITIATIVE

REGULAR POLICY CHANGE NUMBER:	81
IMPLEMENTATION DATE:	9/2007
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1154

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$1,262,000	$20,678,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,262,000	$20,678,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,262,000	$20,678,000

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: 81

Reason for Change:
There is no change from the prior estimate for both FY 2017-18 and FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to the varying final reconciliation results for the LIHP invoice counties and the LIHP counties that used cost reports. The current estimate reflects reconciliation of LIHP invoice counties occurring in FY 2017-18, and the reconciliation of LIHP cost report counties occurring in FY 2018-19.

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. Remaining reconciliation payments for DY 2007-08 under the MH/UCD HCCI for the counties that submitted invoices for payment will occur in FY 2017-18.

3. Assume DY 2007-08 through DY 2009-10 final reconciliations for the counties that submitted cost reports for payment will occur in FY 2018-19.

The estimated HCCI reconciliation payments on a cash basis are:

FY 2017-18	TF	FF
DY 2007-08	$1,262,000	$1,262,000
Total FY 2017-18	**$1,262,000**	**$1,262,000**

FY 2018-19	TF	FF
DY 2007-08	$19,272,000	$19,272,000
DY 2008-09	$698,000	$698,000
DY 2009-10	$708,000	$708,000
Total FY 2018-19	**$20,678,000**	**$20,678,000**

Funding:
Health Care Support Fund (4260-601-7503)

MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP

REGULAR POLICY CHANGE NUMBER:	82
IMPLEMENTATION DATE:	7/2010
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1459

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$6,205,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$6,205,000	$0
FEDERAL FUNDS	$6,205,000	$0

DESCRIPTION

Purpose:
This policy change estimates the impact of the federal flexibilities policies which allows the claiming of unused Safety Net Care Pool (SNCP) federal funds to offset State General Fund expenditures.

Authority:
Welfare & Institutions Code 14166.221
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)

Interdependent Policy Changes:
Not Applicable

Background:
Under the MH/UCD, $180 million in federal funds is available annually for 2005-06 through 2009-10 to expand health care coverage. In 2005-06 and 2006-07, $360 million of the funding was unused. On February 1, 2010, the Centers for Medicare & Medicaid Services (CMS) approved the proposed amendment to the MH/UCD Special Terms and Conditions, amended October 5, 2007. The amendment incorporates federal flexibilities to expand the Department's ability to claim additional state expenditures to utilize unused federal funding under the SNCP.

Reason for Change:
There is no change from the prior estimate for FY 2017-18 and FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the completion of the CMHS final reconciliation in FY 2017-18.

MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP

REGULAR POLICY CHANGE NUMBER: 82

Methodology:

1. The Department may claim these funds using the certified public expenditures from State-Only funded programs: Expanded Access to Primary Care (EAPC), County Medical Services Program (CMSP), County Mental Health Services for the Uninsured (CMHS), and AIDS Drug Assistance Program (ADAP).

2. AB 1653 (Chapter 218, Statutes of 2010) allowed the State to retain up to $420 million from the portion of the Hospital Quality Assurance Fee (QAF) fund set aside for direct grants to designated public hospitals for the State's use while the bill is in effect. In exchange, a portion of the federal flexibility funding would be allocated to the designated public hospitals and be identical in amount to the sum retained by the State from the QAF fund. The Department would claim these federal funds upon receipt of the necessary expenditure reports and certifications from the public hospitals, and would distribute those funds in conformity with the payment schedule for Hospital QAF payments. $135.083 million of the total $420 million was applied to this policy change and paid in FY 2010-11.

3. 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.

4. The MH/UCD demonstration required settled and audited cost reports in order to complete the final reconciliation for CMHS. The claimable time period for DY 2009-10 (DY 5) for CMHS is February 2010 through August 2010. This spans five months in FY 2009-10 and two months in FY 2010-11. Final reconciliation of DY 2009-10 will be completed when FY 2009-10 and FY 2010-11 mental health cost reports are settled and audited.

5. Due to delayed CMHS data, the Department is assuming completion of the CMHS reconciliation in FY 2017-18.

The General Fund savings resulting from the federal flexibilities are expected to be:

(Dollars in Thousands)

FY 2017-18	TF	GF	FF	ARRA
DY 5 CMHS Final Reconciliation	$0	($6,205)	$5,038	$1,167
Total	**$0**	**($6,205)**	**$5,038**	**$1,167**

Funding:

100% GF (4260-101-0001)
100% Health Care Support Fund (4260-601-7503)

MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM

REGULAR POLICY CHANGE NUMBER:	83
IMPLEMENTATION DATE:	10/2016
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1952

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$75,000,000	-$75,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$75,000,000	-$75,000,000
FEDERAL FUNDS	$75,000,000	$75,000,000

DESCRIPTION

Purpose:
This policy change estimates the additional federal financial participation (FFP) received for Certified Public Expenditures (CPEs) using programs in other departments 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.

Authority:
California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)

Interdependent Policy Changes:
PC 76 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: 83

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:
There is no change to the total claims for FY 2017-18 and FY 2018-19 from the prior estimate and from FY 2017-18 to FY 2018-19 in the current estimate. The DSHP claiming allocations, however, changed from the prior estimate based on actual expenditure data for each program. ADAP, DDS, PCTP, Song-Brown, STLRP, and MHLAP claiming are not needed to reach the annual claiming limit.

Methodology:
1. Assume DTI will claim the maximum $75 million FFP annually for FY 2017-18 and FY 2018-19.

2. Program allocations are updated based on actual claims.

3. For FY 2017-18 and FY 2018-19, the $75 million FFP annual claiming limit will be achieved without ADAP, DDS, PCTP, Song-Brown, STLRP, and MHLAP claims.

4. On a cash basis, the total DSHP payments are estimated to be:

FY 2017-18	TF	GF	FF
CCS	$0	($26,800,000)	$26,800,000
GHPP	$0	($41,800,000)	$41,800,000
MIA-LTC	$0	($5,800,000)	$5,800,000
BCCTP	$0	($600,000)	$600,000
Total	**$0**	**($75,000,000)**	**$75,000,000**

FY 2018-19	TF	GF	FF
CCS	$0	($26,800,000)	$26,800,000
GHPP	$0	($41,800,000)	$41,800,000
MIA-LTC	$0	($5,800,000)	$5,800,000
BCCTP	$0	($600,000)	$600,000
Total	**$0**	**($75,000,000)**	**$75,000,000**

Funding:
100% GF (4260-101-0001)
100% Health Care Support Fund (4260-601-7503)

CMS DEFERRED CLAIMS

REGULAR POLICY CHANGE NUMBER:	84
IMPLEMENTATION DATE:	4/2017
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	2034

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$509,238,000	$511,509,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$509,238,000	$511,509,000
FEDERAL FUNDS	-$509,238,000	-$511,509,000

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.

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.

CMS DEFERRED CLAIMS

REGULAR POLICY CHANGE NUMBER: 84

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.

Reason for Change:
The change in FY 2017-18, from the prior estimate, is due to:

- Federal Fiscal Year (FFY) 2016 Quarters 3 and 4 repayments shifted from FY 2018-19 to FY 2017-18,
- Inclusion of the Children's Health Insurance Program (CHIP) FFY 2018 Quarter 1 repayment, and
- Updated data based on actual deferral amounts from CMS.

The change in FY 2018-19, from the prior estimate, is due to:

- Inclusion of FFY 2017 Quarters 3 and 4 repayments,
- Inclusion of expected additional repayments,
- Inclusion of expected resolved deferrals,
- FFY 2016 Quarters 3 and 4 repayments shifted to FY 2017-18, and
- Updated estimated repayment data.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to:

- Inclusion of expected resolved deferrals in FY 2018-19, and
- Differing Federal Fiscal Quarter repayments which include varying deferral items and amounts.

In addition, the County Administration Enhanced Funding deferral repayments and resolutions are now excluded from this policy change and budgeted in a separate policy change.

Methodology:

1. The Department received CMS deferrals for FFY 2015 Quarter 1 through FFY 2016 Quarter 3. In addition, the Department received the CMS CHIP deferral for FFY 2018 Quarter 1. The Department repaid the FFY 2015 Quarters 1 and 2 deferrals in FY 2016-17. The Department will repay the federal funds (FF) according to the required timelines but will continue to work on resolving the deferrals.

2. In FY 2017-18, the Department repaid a total of $240.159 million FF for CMS deferrals issued for FFY 2015 Quarter 3 through FFY 2016 Quarter 2.

3. In FY 2017-18, the Department estimates to repay $111.886 million for the CMS deferral issued for FFY 2016 Quarter 3, $130 million FF for the FFY 2016 Quarter 4 projected CMS deferral, and $27.193 million FF for the FFY 2018 Quarter 1 CHIP deferral issued.

4. In FY 2018-19, the Department estimates to repay a net total of $511.509 million which includes $738.738 million FF for projected repayments and $227.229 million FF for projected resolved deferrals. The projected resolved deferrals include 1115 Waiver SNCP claims and Enhanced Funding for Community First Choice capitation payment deferrals.

CMS DEFERRED CLAIMS

REGULAR POLICY CHANGE NUMBER: 84

5. The Department will repay/resolve the following estimated deferred claims:

(Dollars in Thousands)

FY 2017-18	Total Estimated Repayment
FFY 2015 Quarter 3 (Apr-June 2015)	$20,357
FFY 2015 Quarter 4 (Jul-Sep 2015)	$47,553
FFY 2016 Quarter 1 (Oct-Dec 2015)	$80,411
FFY 2016 Quarter 2 (Jan-Mar 2016)	$91,838
FFY 2016 Quarter 3 (Apr-Jun 2016)	$111,886
FFY 2016 Quarter 4 (Jul-Sep 2016)	$130,000
FFY 2018 Quarter 1 (Oct-Dec 2017)	$27,193
Total FY 2017-18	**$509,238**

(Dollars in Thousands)

FY 2018-19	Total Estimated Repayment
FFY 2017 Quarter 1 (Oct-Dec 2016)	$68,733
FFY 2017 Quarter 2 (Jan-Mar 2017)	$68,733
FFY 2017 Quarter 3 (Apr-Jun 2017)	$150,318
FFY 2017 Quarter 4 (Jul-Sep 2017)	$150,318
FFY 2018 Quarter 1 (Oct-Dec 2017)	$150,318
FFY 2018 Quarter 2 (Jan-Mar 2018)	$150,318
Subtotal Estimated Repayments:	$738,738
Estimated Resolved Deferrals:	
FFY 2018 Quarter 2 (Jan-Mar 2018)	($227,229)
Total FY 2018-19	**$511,509**

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XIX GF (4260-101-0001)
100% Title XXI FFP (4260-113-0890)
100% Title XXI GF (4260-113-001)

CMS DEFERRALS & NEGATIVE BALANCE REPAYMENT

REGULAR POLICY CHANGE NUMBER:	85
IMPLEMENTATION DATE:	9/2018
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	2035

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$108,511,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$108,511,000
FEDERAL FUNDS	$0	-$108,511,000

DESCRIPTION

Purpose:
This policy change estimates the expenditure to settle the Centers for Medicare and Medicaid Services' (CMS) Federal Fiscal Year (FFY) 2013 and prior deferred claims and negative Payment Management System (PMS) subaccount balances.

Authority:
California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)

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 notice 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 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. Unpaid deferred claims and reporting issues resulted in negative PMS subaccount balances.

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 and PMS subaccounts into balance. The Department is working with CMS to resolve the specific items to reduce the General Fund (GF) liability for the remaining deferred claims and negative PMS subaccount balances.

CMS DEFERRALS & NEGATIVE BALANCE REPAYMENT

REGULAR POLICY CHANGE NUMBER: 85

While the repayment of remaining deferred claims is not subject to interest, the repayment for any remaining negative PMS subaccount balances is subject to interest. The Department must begin repayments for the negative PMS subaccount balance in regular, quarterly installments, with interest, by the end of the Medi-Cal 2020 waiver (December 31, 2020) or within three years from CMS' approval of California's repayment schedule, whichever is longer. Interest begins on the date of CMS' demand letter.

Reason for Change:
There is no change in FY 2017-18, from the prior estimate.

The change in FY 2018-19, from the prior estimate, is due to:

- A reduction in the estimated repayment total based on updated negative PMS account balances data as of February 2018, which decreased the quarterly repayment installment amounts, and
- A shift in the repayment start date by two months to September 2018.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the timing of the repayment start date which will begin in FY 2018-19.

Methodology:

1. The Department expects to begin the remaining repayments to CMS in September 2018 on a quarterly basis, for a total of 10 installments.

2. Assume four repayments will be made in FY 2018-19 totaling $108,511,000.

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
Repayments	$0	$108,511	($108,511)

3. The Department will continue to reconcile the remaining CMS deferred and disallowed claims.

Funding:
100% Title XIX FF (4260-101-0890)
100% GF (4260-101-0001)

MH/UCD—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER:	86
IMPLEMENTATION DATE:	9/2005
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1072

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	-$6,723,000	$9,712,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$6,723,000	$9,712,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$6,723,000	$9,712,000

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 healthcare 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: 86

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:
There is no change for FY 2017-18 and FY 2018-19 from the prior estimate. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the results of the final reconciliations for different demonstration years.

Methodology:
1. The final reconciliation for DY 2008-09 will occur in FY 2017-18.

2. The final reconciliation for DY 2009-10 will occur in FY 2018-19.

The estimated DPH payments/recoupments on a cash basis are:

(Dollars in Thousands)

FY 2017-18	**FF**
DY 2008-09	($6,723)
Total	**($6,723)**

FY 2018-19	**FF**
DY 2009-10	$9,712
Total	**$9,712**

Funding:
100% Health Care Support Fund (4260-601-7503)

MANAGED CARE RATE RANGE IGTS

REGULAR POLICY CHANGE NUMBER:	90
IMPLEMENTATION DATE:	7/2005
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1054

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$1,968,917,000	$1,686,877,000
- STATE FUNDS	$861,435,000	$494,080,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,968,917,000	$1,686,877,000
STATE FUNDS	$861,435,000	$494,080,000
FEDERAL FUNDS	$1,107,482,000	$1,192,797,000

DESCRIPTION

Purpose:
This policy change estimates the rate range intergovernmental transfers (IGTs) from the counties or other approved public entities to the Department for the purpose of providing capitation rate increases to the managed care plans.

Authority:
Welfare & Institutions Code 14164 and 14301.4

Interdependent Policy Changes:
PC 111 Managed Care IGT Admin. And Processing Fee

Background:
An IGT is a transfer of funds from a public entity to the State. The non-federal share is matched with federal funds and used to make payments.

The actuarially sound capitation rates are developed with lower to upper bound rates known as the rate range. Generally, the health plan rates are paid at the lower bound. IGTs are then used to enhance the health plan rates up to but not exceeding the upper bound of the range.

The Department's rate range IGT program has grown significantly as more plans and providers have decided to participate. As Medi-Cal managed care significantly expands, the Department seeks to maintain the safety net and access to care by continuing and expanding plan and public providers' ability to leverage additional federal funding through the rate range IGT program. As of June 30, 2018 rating period, the managed care rate range IGT program will be discontinued.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is a decrease due to 11 months of FY 2017-18 rate range dollars shifting to pay in FY 2018-19.

MANAGED CARE RATE RANGE IGTS

REGULAR POLICY CHANGE NUMBER: 90

The change from the prior estimate, for FY 2018-19, is an increase due to:

- 11 months of FY 2017-18 rate range dollars shifting to pay in FY 2018-19, and
- Updated FY 2017-18 rate range dollars based on more recent participation levels.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to the end of this program. FY 2018-19 consists of only FY 2017-18 payments.

Methodology:

COHS:

The initial transfer of funds began in June 2006, effective retroactively to July 2005. The County of San Mateo increased its IGT funds effective February 1, 2007, July 1, 2008, February 1, 2010, and July 1, 2010.

IGTs for Solano, Santa Barbara, Monterey, and Santa Cruz Counties were effective retroactive to July 1, 2009; Merced and Sonoma Counties were effective retroactive to October 1, 2009; and Orange, Napa, and Yolo counties were effective retroactive to July 1, 2010. The IGTs for Marin, Mendocino, and Ventura Counties were effective retroactive to July 1, 2011.

The COHS expansion counties (Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity) were effective retroactive to September 1, 2013.

Two Plan Model:

An IGT for Los Angeles County was effective October 2006.

IGTs for Alameda, Contra Costa, Kern, Riverside, San Bernardino, San Francisco, San Joaquin, and Santa Clara Counties were effective retroactive to October 1, 2008, and Fresno, Stanislaus, and Tulare Counties were effective retroactive to October 1, 2011.

Geographic Managed Care:

The IGTs for Sacramento and San Diego Counties were retroactive to January 2012.

Regional:

The Regional Model consists of three IGT programs, which are program specific counties. These programs are: (1) San Benito County, (2) Imperial County, and (3) Regional (Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Imperial, Mariposa, Mono, Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, Tuolumne, and Yuba). The programs were effective retroactive to November 1, 2013.

SB 78 (Chapter 33, Statutes of 2013) extended the gross premium tax through June 30, 2013. SB 78 also provides for a 3.9375% statewide tax on the total operating revenue of Medi-Cal Managed Care plans effective July 1, 2013, through June 30, 2016.

MANAGED CARE RATE RANGE IGTS

REGULAR POLICY CHANGE NUMBER: 90

(Dollars in Thousands)

FY 2017-18	IGT*	T19 FF	T21 FF	Family Planning FF	Total FF	TF
FY 2015-16	$391,392	$374,357	$107,731	$21,095	$503,183	$894,575
FY 2016-17	$470,043	$449,586	$129,379	$25,334	$604,299	$1,074,342
Total FY 2017-18	**$861,435**	$823,943	$237,110	$46,429	**$1,107,482**	**$1,968,917**

(Dollars in Thousands)

FY 2018-19	IGT*	T19 FF	T21 FF	Family Planning FF	Total FF	TF
FY 2017-18	$494,080	$439,031	$126,342	$24,739	$1,192,797	$1,686,877
Total 2018-19	**$494,080**	$439,031	$126,342	$24,739	**$1,192,797**	**$1,686,877**

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XXI FFP (4260-113-0890)
Reimbursement GF (4260-610-0995)*
ACA 95% FFP/5% GF (IGT) (4260-101-0890)
ACA 94% FFP/6% GF (IGT) (4260-101-0890)

CCI-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER:	91
IMPLEMENTATION DATE:	4/2014
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1766

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$9,901,568,000	$7,835,790,000
- STATE FUNDS	$4,950,784,000	$3,917,895,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	50.98 %	67.37 %
APPLIED TO BASE		
TOTAL FUNDS	$4,853,748,600	$2,556,818,300
STATE FUNDS	$2,426,874,320	$1,278,409,140
FEDERAL FUNDS	$2,426,874,320	$1,278,409,140

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:
PC 195 CCI-Transfer of IHSS Costs to DHCS

Background:
In coordination with Federal and State government, the Coordinated Care Initiative (CCI) provides the benefits of coordinated care models to persons eligible for both Medicare and Medi-Cal (dual eligibles) and for Medi-Cal only. 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, 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 will not be 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.

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

CCI-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 91

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.

Reason for Change:
There is an overall net decrease from the prior estimate for FY 2017-18 due to lower eligibles in the Full Dual Opt-In and Non-Full Dual Non Institutional categories. Additionally, Non-Full Dual rates in CY decreased slightly from the prior estimate due to budgeting FY 2016-17 rates instead of projected FY 2017-18 rates, and Full Dual MLTSS rates in CY decreased from the prior estimate due to budgeting CY 2016 rates instead of CY 2017 preliminary draft rates.

There is an overall net increase from the prior estimate for FY 2018-19 due to higher eligibles in the Opt-Out/Excluded category. Additionally, CMC rates increased from the prior estimate due to budgeting CY 2017 revised draft rates plus a growth instead of CY 2017 preliminary draft rates plus a growth. Full Dual MLTSS rates in BY increased as well for the same reason.

FY 2018-19 costs decreased from FY 2017-18 in the current estimate due to having a complete year without IHSS in FY 2018-19 as opposed to only a half year in FY 2017-18.

Methodology:
1. All dual eligibles have phased in to the CCI as of July 2016.

2. Medi-Cal only eligibles, individuals receiving partial Medicare coverage, and all CCI dual eligibles who are excluded from Cal Medi-Connect (CMC) (including those in non-CMC Dual Eligible Special Needs Plans (D-SNP)) had their LTC and community-based services included in Medi-Cal managed care no later than January 1, 2015, except for Orange County. Orange County began August 1, 2015.

3. The Department performs reconciliation of IHSS category of service to actual IHSS expenditures paid out to providers by the California Department of Social Services (CDSS) for the same quarter. The Department will determine the appropriate amount of reimbursement during reconciliation which will identify IHSS over/underpayments to CDSS or the managed care plans. Reconciliation was operationalized in the capitated payment system in January 2016.

4. The Department re-casted capitation rates for plans participating in the CCI for full-benefit dual eligible beneficiaries. Preliminary data suggests the department will recoup the difference between the paid capitation rate and the re-casted rate from plans participating in CCI. The recoupment of payments in excess of plans re-casted capitation payments is for the period of April 2014 through December 2014. The recasts will continue to occur through the CCI demonstration period.

5. Paid rates vary throughout the fiscal year depending on the most recently available approved rates. December 2016 “Go Forward” and CY 2016 Rates excluding IHSS will be paid in FY 2017-18, while CY 2017 Rates FY 2018-19 rates will be paid in FY 2018-19.

6. Estimated below is the overall impact of the CCI demonstration in FY 2017-18 and FY 2018-19.

(Dollars in Thousands)

CCI-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 91

FY 2017-18	TF	GF	FFP	Reimb.
CCI-Managed Care Payments (PC 91):				
Base managed care payments	$7,214,162	$3,607,081	$3,607,081	$0
Transfer of IHSS Costs to CDSS	$2,687,405	$1,343,703	$1,343,703	$0
Total Managed Care Payments	**$9,901,568**	**$4,950,784**	**$4,950,784**	**$0**
CCI-Savings and Deferral :				
Total Savings (In the Base)	($7,253,439)	($3,626,720)	($3,626,720)	$0
IHSS Savings (In the Base)	($1,343,703)	$0	($1,343,703)	$0
CCI-Transfer of IHSS Costs to DHCS (PC 195)	$0	($1,343,703)	$0	$1,343,703
CCI-Admin Costs, HCO Costs (OA 15, 18, 67)	$27,492	$13,746	$13,746	$0
Retro MC Rate Adjustments (PC 117)	$1,380,766	$245,778	$690,383	$444,605
CCI-Quality Withhold Repayments (PC 101)	$3,317	$1,659	$1,659	$0
Health Insurer Fee (PC 18)	$6,016	$3,008	$3,008	$0
Total of CCI PCs including pass through	$2,722,017	$244,552	$690,816	$1,343,703

(Dollars in Thousands)

FY 2018-19	TF	GF	FFP	Reimb.
CCI-Managed Care Payments (PC 91):				
Base managed care payments	$7,835,790	$3,917,895	$3,917,895	$0
Total Managed Care Payments	**$7,835,790**	**$3,917,895**	**$3,917,895**	**$0**
CCI-Savings and Deferral :				
Total Savings (In the Base)	($7,873,095)	($3,936,547)	($3,936,547)	$0
CCI-Admin Costs, HCO Costs (OA 15, 18, 67)	$17,039	$8,520	$8,520	$0
Retro MC Rate Adjustments (PC 117)	$349,866	$207,031	$174,933	($32,098)
CCI-Quality Withhold Repayments (PC 101)	$11,412	$5,706	$5,706	$0
Health Insurer Fee (PC 18)	$6,016	$3,008	$3,008	$0
Total of CCI PCs including pass through	$339,319	$200,242	$113,678	$0

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

MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES

REGULAR POLICY CHANGE NUMBER:	92
IMPLEMENTATION DATE:	4/2017
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1961

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$2,505,200,000	$2,240,199,000
- STATE FUNDS	$915,363,760	$675,354,450
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,505,200,000	$2,240,199,000
STATE FUNDS	$915,363,760	$675,354,450
FEDERAL FUNDS	$1,589,836,240	$1,564,844,550

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:
PC 115: MCO Enrollment Tax Mgd. Care Plans
PC 114: 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 is effective July 1, 2016 through July 1, 2019.

Reason for Change:
There is no Total Fund change from the prior estimate for FY 2017-18 and FY 2018-19, however, State and Federal Fund allocations have changed based on more recent payment data.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to an overall enrollment tax rate increase.

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: 92

2. Enrollment for 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.

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 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 expected to be:

(Dollars in Thousands)

	TF	GF (MCO Tax)	FF
FY 2017-18	**$2,505,200**	$915,364	$1,589,836
FY 2018-19	**$2,240,199**	$675,354	$1,564,845

Funding:
50% Title XIX / 50%GF (4260-101-0001/0890)
100% Title XIX ACA (4260-101-0890)
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 / 12% GF (4260-113-0001/0890)

MANAGED CARE PUBLIC HOSPITAL IGTS

REGULAR POLICY CHANGE NUMBER:	93
IMPLEMENTATION DATE:	5/2013
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1588

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$1,713,379,000	$0
- STATE FUNDS	$327,149,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,713,379,000	$0
STATE FUNDS	$327,149,000	$0
FEDERAL FUNDS	$1,386,230,000	$0

DESCRIPTION

Purpose:
This policy change estimates the Intergovernmental Transfer (IGT) from Designated Public Hospitals (DPHs) to the Department that will be used as the non-federal share of capitation rate increases, as well as the related federal match portion of the capitation rate increases.

Authority:
SB 208 (Chapter 714, Statutes of 2010)
AB 85 (Chapter 24, Statutes of 2013)

Interdependent Policy Changes:
PC 112 General Fund Reimbursement from DPHs

Background:
Effective June 1, 2011, Seniors and Persons with Disabilities (SPDs) who 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. As of May 2012, all mandatory enrollees had been fully transitioned into managed care.

Previously, DPHs used a Certified Public Expenditure methodology to receive the federal share of the allowable costs associated with the inpatient services provided to the fee-for-service (FFS) members receiving services at a DPH facility. The transition of FFS SPDs to managed care created a need for a solution that would permit a DPH to continue to receive net per service reimbursement for inpatient services at levels comparable to FFS, while ensuring that there are not new state General Fund (GF) expenditures.

The payment structure for prior FFS SPD members transitioning into managed care called for adjustments to the baseline SPD capitation rates. The historical Public Provider allowable costs for services are also recognized and included in the managed care capitation rates. Through IGTs, Public Providers will provide the non-federal share portion of the adjusted capitation related to the full recognition of the allowable costs (previously addressed by the FFS state plan reimbursement methodologies) for outpatient and other non-inpatient services.

MANAGED CARE PUBLIC HOSPITAL IGTS

REGULAR POLICY CHANGE NUMBER: 93

A portion of the IGT related to inpatient services will fund a portion of the unadjusted baseline capitation rates for the newly enrolled SPDs. This portion is budgeted in the General Fund Reimbursements from DPHs Policy Change.

Effective January 1, 2014, the 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 Affordable Care Act optional expansion (ACA OE).

State law requires DPHs to be reimbursed at no less than the costs of providing services to the OE population. The payment structure for the OE members in managed care may require adjustments to the baseline OE capitation rates. Through an IGT, Public Providers will provide the non-federal share portion of the adjusted capitation rates related to the costs for this population. This portion is budgeted in the General Fund Reimbursements from DPHs Policy Change.

As of the June 30, 2017, rating period, the Managed Care Public Hospital IGT program will be discontinued.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is a decrease due to the inclusion of SPD FY 2015-16 rating period unexpended amounts.

There is no change from the prior estimate for FY 2018-19.

The change from FY 2017-18 and FY 2018-19, in the current estimate, is due to the end of the Managed Care Public Hospital IGT program as of June 30, 2017.

Methodology:
DPH – SPDs

1. Calculate the historical DPH allowable cost per day and related utilization.
2. Calculate the DPH utilization and costs that are built into the baseline managed care capitation rates for transitioned members.
3. Calculate capitation rate adjustments.
4. Calculate the amount of funding (IGT) needed from DPHs for the state/local match related to the inpatient rate adjustments for inpatient services and the amount related to the non-inpatient rate adjustments for non-inpatient services.
5. Add IGTs for Inpatient hospital services and non-inpatient services to determine total IGTs from DPHs.
6. The Department collects an estimated amount of the IGT in advance. Once the capitation payments have been made, the Department can determine the actual amount owed by the Health Plans. If there is an overage, the amount is applied toward the following year.
7. Factor into the estimate the number of participants electing/not electing to enroll.
8. All out-of-network costs were included in the capitation rate increases; therefore, excess costs will not be paid for as part of the rate range IGTs as of July 1, 2014.
9. The FY 2014-15 DPH unexpended amounts of $2,725,000 will be applied against the FY 2015-16 IGT collection. This will result in an equal portion of Federal Fund match that will not be needed. This will create a TF reduction to SFY 2015-16 totaling $5,450,000.
10. The FY 2015-16 DPH unexpended amounts of $2,110,000 will be applied against the FY 2016-17 IGT collection. This will result in an equal portion of Federal Fund match that will not be needed. This will create a TF reduction to FY 2015-16 totaling $4,220,000.
11. The FY 2015-16 and FY 2016-17 payments are expected to occur in FY 2017-18.

MANAGED CARE PUBLIC HOSPITAL IGTS

REGULAR POLICY CHANGE NUMBER: 93

12. Program closeout reconciliation activities will be performed in FY 2018-19, the estimated impact of the reconciliation will be budgeted in the General Fund Reimbursement from DPHs policy change (PC 112).

DPH – OE

1. FY 2015-16 payments are expected to occur in FY 2017-18. $0 has been budgeted as the IGT amount as this rating period is funded solely by federal funds.
2. FY 2016-17 payments are expected to occur in FY 2017-18.
3. Program closeout reconciliation activities will be performed in FY 2018-19, the estimated impact of the reconciliation will be budgeted in the General Fund Reimbursement from DPHs policy change (PC 112).

(Dollars in Thousands)

FY 2017-18	TF	IGT	FF	ACA
SPD FY 2014-15	($5,450)	($2,725)	($2,725)	$0
SPD FY 2015-16	$298,040	$149,020	$149,020	$0
SPD FY 2015-16	($4,220)	($2,110)	($2,110)	$0
SPD FY 2016-17	$333,589	$166,794	$166,795	$0
ACA OE FY 2015-16	$444,646	$0	$0	$444,646
ACA OE FY 2016-17	$646,773	$16,169	$0	$630,604
***Total FY 2017-18**	**$1,713,379**	**$327,149**	**$310,980**	**$1,075,250**

*Difference due to rounding.

Funding:
100% Title XIX FFP (4260-101-0890)
Reimbursement GF (4260-610-0995)
100% Title XIX ACA (4260-101-0890)
95% Title XIX ACA FF / 5% GF (4260-101-0890)

HQAF RATE RANGE INCREASES

REGULAR POLICY CHANGE NUMBER:	96
IMPLEMENTATION DATE:	12/2015
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1895

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$294,669,000	$0
- STATE FUNDS	$132,650,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$294,669,000	$0
STATE FUNDS	$132,650,000	$0
FEDERAL FUNDS	$162,019,000	$0

DESCRIPTION

Purpose:
This policy change estimates the amount of increased rate range payments to the managed care plans as a result of the extension of the Hospital Quality Assurance Fee (QAF) program.

Authority:
SB 239 (Chapter 657, Statutes of 2013)

Interdependent Policy Changes:
Not Applicable

Background:
SB 239 extended the Hospital QAF program from January 1, 2014, through the December 31, 2016, rating period. 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. However, the Hospital QAF program rate range increases were discontinued as of the December 31, 2016, rating period.

Of the grant amounts to public hospitals, SB 239 requires the Department to withhold specified amounts and use the amount as the nonfederal share for managed care rate range increases. Managed care plans must expend 100% of the rate range increases on hospital services.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is an increase due to updating funding to incorporate more recent payment data, specifically TF and FF increased, however, GF remained the same.

There is no change from the prior estimate for FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to the completion of payments for this program.

HQAF RATE RANGE INCREASES

REGULAR POLICY CHANGE NUMBER: 96

Methodology:

1. Of the direct grant amounts to designated public hospitals, the Department shall withhold the following amounts:
   - $20,500,000 for FY 2013-14
   - $42,500,000 for FY 2014-15
   - $50,000,000 for FY 2015-16
   - $28,000,000 for FY 2016-17 (July to December 2016)

2. Of the direct grant amounts to non-designated public hospitals, the Department shall withhold the following amounts:
   - $10,000,000 for FY 2013-14
   - $20,000,000 for FY 2014-15
   - $24,000,000 for FY 2015-16
   - $14,000,000 for FY 2016-17 (July to December 2016)

3. The FY 2015-16 and FY 2016-17 (July – December 2016) rate range increases will be paid in FY 2017-18.

The rate range increases to be made in FY 2017-18 are expected to be:

(Dollars in Thousands)

FY 2017-18	TF	SF (HQARF)*	Regular FFP	Title 21 FFP	Family Planning FFP	Total FFP
FY 2015-16 Increases	$200,072	$90,650	$87,167	$17,858	$4,397	$109,422
FY 2016-17 Increases (July-Dec 2016)	$94,597	$42,000	$40,386	$10,173	$2,037	$52,597
Total	**$294,669**	**$132,650**	**$127,554**	**$28,031**	**$6,434**	**$162,019**

Funding:

*Hospital Quality Assurance Revenue Fund (4260-611-3158)
Title XIX FFP (4260-611-0890)
Title XXI FFP (4260-611-0890)

MCO TAX MGD. CARE PLANS - INCR. CAP. RATES

REGULAR POLICY CHANGE NUMBER:	99
IMPLEMENTATION DATE:	7/2017
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1781

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$114,090,000	$1,595,000
- STATE FUNDS	$87,880,000	$797,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$114,090,000	$1,595,000
STATE FUNDS	$87,880,000	$797,500
FEDERAL FUNDS	$26,210,000	$797,500

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:
SB 78 (Chapter 33, Statutes of 2013)

Interdependent Policy Changes:
PC 109 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 110 MCO Tax Managed Care Plans

Background:
SB 78 was signed by the Governor on June 27, 2013, and provides 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). Total operating revenue is exclusive of amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal beneficiaries.

The MCO tax was effective July 1, 2013, through June 30, 2016. One half of the tax revenue will be continuously appropriated for the Department solely for the purposes of funding managed care rates for health care services for children, seniors, persons with disabilities, and dual eligibles in the Medi-Cal program that reflect the cost of services and acuity of the population served. This policy change estimates the cost of the capitation rate increases.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is due to increased retro-period activity scheduled in FY 2017-18.

The change from the prior estimate, for FY 2018-19, is due to a shift of retro payments previously scheduled for FY 2017-18.

MCO TAX MGD. CARE PLANS - INCR. CAP. RATES

REGULAR POLICY CHANGE NUMBER: 99

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the timing of retro-period activity.

Methodology:

1. The MCO 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. Total premium revenue for Medi-Cal managed care plans is based upon the Medi-Cal Estimate.

3. The FY 2015-16 premium revenue was multiplied by the MCO tax amount of 3.9375% to determine total tax revenue.

4. Capitation rate increases due to the MCO tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from Fund 3156 on a quarterly basis. The reimbursement is budgeted in the MCO Tax Mgd Care Plans–Funding Adjustment policy change.

5. The costs of capitation rate increases related to the imposition of the MCO tax are expected to be:

	TF	GF (MCO Tax)	FF
FY 2017-18	**$114,090,000**	**$87,881,000**	**$26,210,000**
FY 2018-19	**$1,595,000**	**$797,000**	**$798,000**

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
100% Title XIX FFP (4260-101-0890)

CCI-QUALITY WITHHOLD REPAYMENTS

REGULAR POLICY CHANGE NUMBER:	101
IMPLEMENTATION DATE:	5/2017
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	2031

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$3,317,000	$11,412,000
- STATE FUNDS	$1,658,500	$5,706,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,317,000	$11,412,000
STATE FUNDS	$1,658,500	$5,706,000
FEDERAL FUNDS	$1,658,500	$5,706,000

DESCRIPTION

Purpose:
This policy change estimates the repayment of the quality withholds for the Coordinated Care Initiative.

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 both Medicare and Medi-Cal (dual eligibles) and for Medi-Cal only. 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, 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: 101

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 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.

Reason for Change:
For FY 2017-18, the change from the prior estimate is an increase due to updated actuals regarding repayments based on plan performance. There is no change from the prior estimate for FY 2018-19. The difference between FY 2017-18 and FY 2018-19 is due to FY 2017-18 budgeting for CY 2015 repayments and FY 2018-19 is budgeting for CY 2016 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 2015 will be repaid in December 2017.

4. Assume quality withholds for CY 2016 repaid in FY 2018-19.

FY 2017-18	TF	GF	FF
Quality Withhold Repayment (CY 2015)	$3,317,000	$1,658,500	$1,658,500

FY 2018-19	TF	GF	FF
Quality Withhold Repayment (CY 2016)	$11,412,000	$5,706,000	$5,706,000

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

PALLIATIVE CARE SERVICES IMPLEMENTATION

REGULAR POLICY CHANGE NUMBER:	103
IMPLEMENTATION DATE:	11/2017
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1947

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$1,875,000	$49,000
- STATE FUNDS	$875,200	$39,290
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,875,000	$49,000
STATE FUNDS	$875,200	$39,290
FEDERAL FUNDS	$999,800	$9,710

DESCRIPTION

Purpose:
This policy change estimates the overall net impact of the first year of implementation of Medi-Cal palliative care, as well as the Department providing technical assistance to Medi-Cal managed care plans for delivering palliative care services.

Authority:
SB 1004 (Chapter 574, Statutes of 2014)
Palliative Care Training Contract #: 17-94429
Medi-Cal Managed Care Plan Palliative Care Program Development Contracts

Interdependent Policy Changes:
Not Applicable

Background:
The Centers for Medicare and Medicaid Services (CMS) defines palliative care as “patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information and choice.” Services are available concurrently with curative care and care is provided through a coordinated interdisciplinary team.

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.
- Provide access to curative care for beneficiaries eligible for palliative care.

PALLIATIVE CARE SERVICES IMPLEMENTATION

REGULAR POLICY CHANGE NUMBER: 103

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is due to some training costs and managed care plan development costs shifting from FY 2017-18 to FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease in cost due to the implementation of a savings phase-in for this policy change.

Methodology:
1. Palliative care training began in October 2017.

2. The Department estimates initial training of providers will cost $233,000 TF in FY 2017-18 and $21,000 TF in FY 2018-19.

3. The Department estimates $1,150,000 TF in FY 2017-18 and $150,000 in FY 2018-19 for Medi-Cal managed care plans to develop their palliative care program and operational plan.

4. Assume implementation of palliative care services will begin January 2018.

5. FY 2017-18 and FY 2018-19 costs for this program are estimated to be:

FY 2017-18	TF	GF	FF	ACA FF
Title XIX	$1,735,000	$867,000	$868,000	$0
ACA 95/5	$70,000	$4,000	0	$66,000
ACA 94/6	$70,000	$4,000	0	$66,000
Total	**$1,875,000**	**$875,000**	**$868,000**	**$132,000**

FY 2018-19	TF	GF	FF	ACA FF
Title XIX	$83,000	$41,000	$42,000	$0
ACA 94/6	($17,000)	($1,000)	0	($16,000)
ACA 93/7	($17,000)	($1,000)	0	($16,000)
Total	**$49,000**	**$39,000**	**$42,000**	**($32,000)**

Funding:
Title XIX 50% FF / 50% GF (4260-101-0001/0890)
ACA 95% FF/5% GF (2017) (4260-101-0001/0890)
ACA 94% FF/6% GF (2018) (4260-101-0001/0890)
ACA 93% FF/7% GF (2019) (4260-101-0001/0890)

MANAGED CARE HEALTH CARE FINANCING PROGRAM

REGULAR POLICY CHANGE NUMBER:	105
IMPLEMENTATION DATE:	4/2019
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	2061

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$1,461,677,000
- STATE FUNDS	$0	$443,476,870
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$1,461,677,000
STATE FUNDS	$0	$443,476,870
FEDERAL FUNDS	$0	$1,018,200,130

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 will implement 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. Payments are anticipated to be made to participating entities beginning in FY 2018-19.

Reason for Change:
There is no change from the prior estimate for FY 2017-18.

The change from the prior estimate, for FY 2018-19, is a decrease due to updated payment information based on more recent participation levels.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the implementation of this program in FY 2018-19.

Methodology:
1. The Managed Care Health Care Financing Program will begin in FY 2018-19.

2. Based on preliminary estimates of participation levels for FY 2018-19, it is estimated total payments will be $1,628,684,000 TF on an accrual basis.

MANAGED CARE HEALTH CARE FINANCING PROGRAM

REGULAR POLICY CHANGE NUMBER: 105

3. Assume 11 months of payments for FY 2018-19 in non-County Organized Health Systems counties, and 10 months of payments for FY 2018-19 in COHS counties to occur in FY 2018-19.

4. Anticipated costs on a cash basis are:

(Dollars in Thousands)

FY 2018-19	TF	Enhanced MC Payment	FF
Title XIX	$790,799	$395,400	$395,400
Title XXI	$86,189	$10,343	75,846
ACA 94/6	$319,336	$19,160	300,175
ACA 93/7	$265,353	$18,575	246,779
Total*	**$1,461,677**	**$443,477**	**$1,018,200**

*Difference due to rounding.

Funding:
GF (4260-101-0001)
Title XIX FFP (4260-101-0890)
Title XXI FFP (4260-101-0890)
ACA 94% FFP/6% GF (2018)
ACA 93% FFP/7% GF (2019)

MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 106
IMPLEMENTATION DATE: 4/2019
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2062

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$640,000,000
- STATE FUNDS	$0	$191,423,480
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$640,000,000
STATE FUNDS	$0	$191,423,480
FEDERAL FUNDS	$0	$448,576,520

DESCRIPTION

Purpose:
This policy change budgets managed care directed payments to fund Quality Incentive Pool (QIP) payments by managed care plans (MCPs) to Designated Public Hospitals (DPHs) and University of California Health Systems (UCs), based on their performance on designated performance metrics.

Authority:
SB 171 (Chapter 768, Statutes of 2017)
AB 205 (Chapter 768, Statutes of 2017)

Interdependent Policy Changes:
N/A

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.

CMS is currently reviewing the Department's directed payment proposal. Once approved, the Department will implement a managed care DPH and UC QIP effective back to July 1, 2017, with the FY 2017-18 rating period. The Department will direct 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. The QIP payments will be linked to delivery of services under the MCP contracts and increase the amount of funding tied to quality outcomes. To receive QIP payments the DPH and UC systems 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 will be limited to a predetermined amount (pool).

MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 106

Reason for Change:
There is no change from the prior estimate for FY 2017-18.

There is no change from the prior estimate for FY 2018-19. Funding was updated to incorporate more recent payment data.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to program implementation in FY 2018-19.

Methodology:
1. Assume the estimated value of the total FY 2017-18 QIP pool is $640 million total fund.

2. An evaluation will be performed to determine if each DPH and UC system achieved improvement targets and corresponding incentive payments.

3. It is assumed the full amount of the FY 2017-18 QIP pool will be paid out to the MCPs in FY 2018-19.

4. On a cash basis, the estimated FY 2017-18 QIP payments are:

(Dollars in Thousands)

FY 2018-19	TF	GF	FF	ACA
FY 2017-18				
Title XIX	$347,375	$173,687	$173,687	$0
ACA 2017 95/5	$133,686	$6,684	$0	$127,001
ACA 2018 94/6	$133,686	$8,021	$0	$125,665
Title XXI	$25,254	$3,030	$22,224	$0
FY 2018-19	**$640,000**	**$191,423**	**$195,911**	**$252,666**

Funding:
100% State GF (4260-101-0001)
100% Title XIX FFP (4260-611-0890)
95% Title XIX ACA FF / 5% GF (4260-101-0890)
94% Title XIX ACA FF / 6% GF (4260-101-0890)
88% Title XXI FF / 12% GF (4260-611-0890)

CAPITATED RATE ADJUSTMENT FOR FY 2018-19

REGULAR POLICY CHANGE NUMBER:	107
IMPLEMENTATION DATE:	7/2018
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1338

	FY 2017-18	FY 2018-19
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) 2018-19.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
Managed care capitation rates will be rebased in FY 2018-19 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 2017-18 to FY 2018-19.

Reason for Change:
The change in classic capitation rates from FY 2017-18 to FY 2018-19 is a 3.41% average rate increase, excluding Optional Expansion (OE) rates.

CAPITATED RATE ADJUSTMENT FOR FY 2018-19

REGULAR POLICY CHANGE NUMBER: 107

Methodology:

(Rounded)	Rate Adjustment (without OE rates)	Rate Adjustment (with OE rates)
Two Plan	2.41%	1.47%
COHS	6.25%	4.77%
GMC	1.88%	-2.88%
Regional	5.79%	0.20%
Total	**3.41%**	**1.73%**

Funding:
Not applicable

HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS

REGULAR POLICY CHANGE NUMBER: 108
IMPLEMENTATION DATE: 9/2018
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1907

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$3,468,000
- STATE FUNDS	$0	$346,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$3,468,000
STATE FUNDS	$0	$346,800
FEDERAL FUNDS	$0	$3,121,200

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 authorizes the Department to create a HHP for beneficiaries with chronic conditions. The HHP will serve 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 will be used to pay for the non-federal share of HHP costs.

ACA Section 2703 allows geographic phasing of HHP services. The Department plans to implement the HHP in three phases, by counties and conditions:

HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS

REGULAR POLICY CHANGE NUMBER: 108

	July 2018	January 2019	July 2019	January 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 1 represents San Francisco county. Local programs in this group for members with eligible chronic physical conditions implement in July 2018. Local programs in this group for members with SMIs implement in January 2019.

- Group 2 represents the following two counties: Riverside and San Bernardino. Local programs in this group for members with eligible chronic physical conditions implement in January 2019. Local programs in this group for members with SMIs implement in July 2019.

- Group 3 represents 26 counties: Alameda, Del Norte, Humboldt, Fresno, Imperial, Kern, Lake, Lassen, Los Angeles, Marin, Mendocino, Merced, Monterey, Napa, Orange, Sacramento, San Diego, San Mateo, Santa Clara, Santa Cruz, Shasta, Solano, Sonoma, Siskiyou, Tulare, and Yolo. Local programs in this group for members with eligible chronic physical conditions implement in July 2019. Local programs in this group for members with SMIs implement in January 2020.

Reason for Change:
There is no change from the prior estimate for FY 2017-18.

The change from the prior estimate, for FY 2018-19, is due to:
- A program start date delay for counties in Group 1, and
- Updated rates.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to a program implementation date in FY 2018-19.

Methodology:
1. Assume the program begins 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 eligibles members not on the TEL will enroll in HHP

3. Capitation rates were developed and updated for FY 2018-19 and will be paid on a plan and rating region basis for both dual and non-dual members. The average weighted rate across all plans and rating regions for FY 2018-19 is $508.46 per member per month.

4. Assume 9,093 member months for FY 2018-19.

5. Assume a two month payment lag. Payments are estimated to begin in September 2018.

HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS

REGULAR POLICY CHANGE NUMBER: 108

6. Assume the June 2019 capitation payment 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 2018-19 are expected to be:

   9,093 x $508.46 = $4,623,376 TF

9. On a cash basis, the costs for FY 2018-19 are expected to be:

(Dollars in Thousands)

	TF	FF	HHP Fund*
FY 2018-19	**$3,468,000**	**$3,121,000**	**$347,000**

Funding:
90% Title XIX FF (4260-101-0890)
10% HHP Fund (4260-601-0942)*
Reimbursement (4260-610-0995)
100% State GF (4260-101-0001)

MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 109
IMPLEMENTATION DATE: 7/2016
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1782

	FY 2017-18	FY 2018-19
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:
SB 78 (Chapter 33, Statutes of 2013)

Interdependent Policy Changes:
PC 99 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 110 MCO Tax Managed Care Plans

Background:
SB 78 was signed by the Governor on June 27, 2013, and provides 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). Total operating revenue is exclusive of amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal beneficiaries.

The tax was effective July 1, 2013, through June 30, 2016. Part of the tax revenue will be retained by the Department to offset GF cost for capitated rate increases as a result of the imposition of the tax. This policy change estimates the offset of GF costs for the capitated rate increases.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is due to increased retro period activity scheduled in FY 2017-18.

The change from the prior estimate, for FY 2018-19, is due to a shift of retro payments previously scheduled for FY 2017-18.

The change from FY 2017-18 to FY 2018-19 is due to the timing of retro payments.

MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 109

Methodology:

1. Total premium revenue for Medi-Cal managed care plans is based upon the Medi-Cal Estimate.

2. The FY 2015-16 premium revenue was multiplied by the MCO tax rate of 3.9375% to determine total tax revenue. This policy change does not assume a FY 2016-17 tax.

3. The share that offsets GF cost for the Medi-Cal program is then determined.

4. Assume a three-month lag between when tax payments are paid to the Board of Equalization and when they are transferred to the Department.

5. The impact of the increase in capitation payments related to the tax is included in the MCO Tax Mgd. Care Plans – Incr. Cap. Rates policy change.

6. The MCO tax fund transfers to the GF are expected to be:

(Dollars in Thousands)

	TF	GF	MCO Tax*
FY 2017-18	**$0**	**($87,881)**	**$87,881**
FY 2018-19	**$0**	**($3,553)**	**$3,553**

Funding:

100% State GF (4260-101-0001)
*3156 MCO (Non-GF) (4260-601-3156)

MCO TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER:	110
IMPLEMENTATION DATE:	7/2013
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1783

	FY 2017-18	FY 2018-19
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 retained by the Department beginning July 1, 2013.

Authority:
SB 78 (Chapter 33, Statutes of 2013)

Interdependent Policy Changes:
PC 99 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 109 MCO Tax Mgd. Care Plans - Funding Adjustment

Background:
SB 78 was signed by the Governor on June 27, 2013, and provides 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). Total operating revenue is exclusive of amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal beneficiaries.

The MCO tax was effective July 1, 2013, through June 30, 2016. A portion of the tax revenue will be continuously appropriated to the Department solely for the purposes of funding managed care rates for health care services for children, seniors, persons with disabilities, and dual eligibles in the Medi-Cal program that reflect the cost of services and acuity of the population served. This policy change estimates GF savings resulting from the imposition of the MCO tax.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is due to retro period activity scheduled in FY 2017-18.

There is no change from the prior estimate for FY 2018-19.

MCO TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER: 110

The change from FY 2017-18 to FY 2018-19, is due to the timing of retro-period activity.

Methodology:

1. Total premium revenue for Medi-Cal managed care plans is based upon the Medi-Cal Estimate.

2. The assessable premium revenue was multiplied by the MCO tax rate of 3.9375% to determine total tax revenue. This policy change does not assume a FY 2016-17 tax.

3. The share that offsets GF cost for the Medi-Cal program is then determined.

4. Assume a three-month lag between when tax payments are paid to the Board of Equalization and when they are transferred to the Department.

5. The impact of the increase in capitation payments related to the tax is included in the MCO Tax Mgd. Care Plans – Incr. Cap. Rates policy change.

6. The MCO tax fund transfers to the GF are expected to be:

(Dollars in Thousands)

	GF	MCO*
FY 2017-18	**($300,000)**	**$300,000**

Funding:

100% State GF (4260-101-0001)
*3156 MCO Tax (Non-GF) (4260-601-3156)

MANAGED CARE IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER: 111
IMPLEMENTATION DATE: 7/2012
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1601

	FY 2017-18	FY 2018-19
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 rate range intergovernmental transfers (IGTs) administrative and processing fees assessed to the counties or other approved public entities.

Authority:
Welfare & Institutions Code section 14301.4
AB 102 (Chapter 29, Statutes of 2011)

Interdependent Policy Changes:
Not Applicable

Background:
The counties or other approved public entities transfer funds as IGTs to the Department to provide capitation rate increases to the managed care plans. These funds provide the nonfederal share of capitation rate increases, which are budgeted in the Managed Care Rate Range IGT policy change. The Department develops an actuarially sound rate range that consists of a lower and upper bound rate. The state has the option of paying plans any rate that is within the rate range. Generally, the health plan rates are paid at the lower bound. IGTs are then used to enhance the health plan rates up to but not exceeding the upper bound of the range.

Per Welfare & Institutions (W&I) Code 14301.4, beginning July 1, 2011, the Department began charging counties or other approved public entities a 20% administrative and processing fee for their IGTs. As specified in section 14301.4, the assessment fee is limited to those IGTs made by a transferring entity to provide the nonfederal share of rate range increases. These fees are not charged for certain IGTs related to designated public hospitals and IGTs authorized pursuant to W&I Code sections 14168.7, 14182.15, and 14301.5.

MANAGED CARE IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER: 111

The 20% assessment fees are collected at the same time as the rate range IGTs. As of June 30, 2018 rating period, the collection of the IGT assessment fees will discontinue.

Pending CMS approval of State Plan Amendment (SPA) 17-009, the Department will make new Medi-Cal Graduate Medical Education (GME) supplemental payments to Designated Public Hospitals (DPHs) systems participating in the Medi-Cal managed care program. The Department submitted SPA 17-009 to CMS in March 2017 of FY 2016-17 with an effective date of January 1, 2017. The Department will budget the Graduate Medical Education Payments to DPHs and their affiliated governmental entities; IGTs will fund the nonfederal share of the cost. A 5% administrative fee will be assessed to 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 from the prior estimate, for FY 2017-18, is a decrease due to 11 months of FY 2017-18 general fund reimbursement dollars shifting to FY 2018-19. FY 2017-18 reimbursement totals were updated based on more recent IGT participation. Fees from GME supplemental payments are shifted from FY 2017-18 to FY 2018-19 due to a delay in SPA approval and program implementation.

The change from the prior estimate, for FY 2018-19, is an increase due to 11 months of FY 2017-18 general fund reimbursement dollars shifting from FY 2017-18. SPA approval and program implementation for GME supplemental payments is expected in FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to the discontinuation of managed care rate range IGT assessment fees and timing of general fund reimbursement. Fees from FY 2018-19 GME supplemental payments previously budgeted for FY 2018-19 will now be budgeted for FY 2019-20.

Methodology:
1. The fee will be 20% of each IGT, unless exempt W&I Code section 14301.4 or 14301.5

2. The state support costs are budgeted under state support. This policy change only budgets for the Local Assistance Reimbursement to GF amount.

3. Assume beginning in FY 2017-18, the fee for GME supplemental payments will be 5% for each IGT.

FY 2017-18 (Non-GME)	IGT amount subject to the fee	20% Admin & Processing Fee	Support Cost Reimbursement to the GF	Local Assistance Reimbursement to the GF
FY 2015-16	$364,278,000	$72,856,000	$251,000	$72,605,000
FY 2016-17	$432,959,000	$86,592,000	$251,000	$86,340,000
Total FY 2017-18	$797,237,000	$159,447,000	$502,000	$158,945,000

MANAGED CARE IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER: 111

FY 2018-19 (Non-GME)	IGT amount subject to the fee	20% Admin & Processing Fee	Support Cost Reimbursement to the GF	Local Assistance Reimbursement to the GF
FY 2017-18	$449,289,000	$89,858,000	$251,000	$89,607,000
Total FY 2018-19	$449,289,000	$89,858,000	$251,000	$89,607,000

FY 2018-19 (GME)	IGT amount subject to the fee	5% GME Admin Fee	Local Assistance Reimbursement to the GF
FY 2016-17 GME	$237,492,000	$11,875,000	$11,875,000
FY 2017-18 GME	$489,232,000	$24,462,000	$24,462,000
Total FY 2018-19	$726,724,000	$36,337,000	$36,337,000

(Dollars in Thousands)

Fiscal Year	Local Assistance Reimbursement to the GF
FY 2017-18	**$158,945**
FY 2018-19	**$125,944**

Funding:
100% State GF (4260-101-0001)
Reimbursement (4260-601-0995)
DPH Graduate Medical Education Special Fund (4260-601-8113)

GENERAL FUND REIMBURSEMENTS FROM DPHS

REGULAR POLICY CHANGE NUMBER:	112
IMPLEMENTATION DATE:	5/2013
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1605

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$4,981,000
- STATE FUNDS	$0	$4,981,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$4,981,000
STATE FUNDS	$0	$4,981,000
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) who 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. As of May 2012, all mandatory enrollees have fully transitioned into managed care.

Previously, DPHs used a Certified Public Expenditure methodology to receive the federal share of the allowable costs associated with the inpatient services provided to fee-for-service (FFS) members receiving services at a DPH facility. The transition of FFS SPDs to managed care created a need for a solution that would permit a DPH to continue to receive net per service reimbursement for inpatient services at levels comparable to FFS, without GF expenditures.

The payment structure for prior FFS SPD members transitioning into managed care called for adjustments to the baseline SPD capitation rates. The historical Public Provider allowable costs for services are also recognized and included in the managed care capitation rates. Through an IGT, Public Providers will provide the non-federal share portion of the adjusted capitation rates related to the allowable costs of inpatient services. A portion of the IGT related to inpatient services will fund a portion of the unadjusted baseline capitation rates for the newly enrolled SPDs.

GENERAL FUND REIMBURSEMENTS FROM DPHS

REGULAR POLICY CHANGE NUMBER: 112

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 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 Affordable Care Act optional expansion (OE).

State law requires DPHs to be reimbursed at no less than the costs of providing services to the OE population. The payment structure for the OE members in managed care may require adjustments to the baseline OE capitation rates. Through an IGT, Public Providers will provide the non-federal share portion of the adjusted capitation rates related to the costs for this population. As of June 30, 2017, the existing DPH reimbursement program will be discontinued.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is an increase due to updated FY 2016-17 GF reimbursements based on actuals.

The change from the prior estimate, for FY 2018-19, is an increase due to adding a reconciliation payment for the discontinuation of the DPH reimbursement program

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the discontinuation of the DPH reimbursement program.

Methodology:
DPH – SPD

1. Determine the baseline of DPH inpatient services/costs in FFS that are subject to transition into managed care.

2. Account for managed care factors applied in the capitation rate development process.

3. Calculate the expected DPH inpatient cost per day for applicable SPDs. Divide the total costs by the total utilization, which yields the calculated historical DPH allowable cost per day and related utilization.

4. Calculate the DPH utilization and costs that have already been built into the baseline managed care capitation rate for transitioned members.

5. Calculate the amount of funding (IGT) needed from DPHs for the state/local match related to the inpatient portion of services included in the transitioned SPD members' baseline capitation rates.

6. The IGTs prior to June 30, 2014, are complete. Any unexpended amounts were applied against the subsequent year reimbursements.

7. Factor into the estimate the number of participants electing/not electing to enroll.

8. FY 2014-15 DPH unexpended amounts were applied against the FY 2015-16 IGT collection.

9. The FY 2015-16 and FY 2016-17 reimbursements are expected to occur in FY 2017-18.

GENERAL FUND REIMBURSEMENTS FROM DPHS

REGULAR POLICY CHANGE NUMBER: 112

DPH – OE

1. FY 2016-17 for the cost-based reimbursement for the OE population payments are expected to occur in FY 2017-18.

2. The FY 2016-17 reconciliation is expected to occur in FY 2018-19 to close out the DPH reimbursement program.

(Dollars in Thousands)

	FY 2017-18
SPD - FY 2014-15	($1,263)
SPD - FY 2015-16	$68,287
SPD - FY 2016-17	$81,861
ACA OE - FY 2016-17	$9,720
*Total Reimbursement	$158,606
*GF	($158,606)
Net Impact	**$0**

	FY 2018-19
FY 2016-17-Closeout Reconciliation	$4,981
GF	$4,981
Net Impact	**$4,981**

*Difference due to rounding.

Funding:
Reimbursement (4260-601-0995)
100% State GF (4260-101-1001)

MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND

REGULAR POLICY CHANGE NUMBER: 113
IMPLEMENTATION DATE: 1/2019
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2063

	FY 2017-18	FY 2018-19
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 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:
None

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 FY 2017-18, is a decrease to both expenditures and reimbursements due to a shift in FY 2017-18 reimbursements from current year to budget year.

The change from the prior estimate, for FY 2018-19, is a decrease to both expenditures and reimbursements due to incorporating more recent payment and IGT collection schedules.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to a shift in implementation date from FY 2017-18 to FY 2018-19.

Methodology:
1. Data from FY 2016-17 and FY 2017-18 are used to estimate the annual commitment from allowable public entities.

MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND

REGULAR POLICY CHANGE NUMBER: 113

2. Annual administration and processing fees are calculated based on the estimated FY 2017-18 participation.

3. On a cash basis, the estimated reimbursements to the General Fund are:

(Dollars in Thousands)

	FY 2018-19
FY 2017-18	$280,847
FY 2018-19	$535,039
FY 2018-19 Support Cost Reimb. To GF	($230)
Total Reimbursement	$815,656
GF	($815,656)
FY 2018-19 Net Impact	**$0**

Funding:
Reimbursement (4260-601-0995)
100% State GF (4260-101-0001)

MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.

REGULAR POLICY CHANGE NUMBER: 114
IMPLEMENTATION DATE: 11/2016
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1962

	FY 2017-18	FY 2018-19
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:
PC 92: MCO Enrollment Tax Mgd. Care Plans-Incr. Cap. Rates
PC 115: 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 is effective July 1, 2016 through July 1, 2019. This policy change estimates the offset of GF costs for the capitated rate increases.

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is due to an updated funding allocation based on recent payment data and incorporating the timing of CCI payments.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to an overall enrollment tax rate increase.

MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.

REGULAR POLICY CHANGE NUMBER: 114

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.

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 expected to be:

(Dollars in Thousands)

	TF	GF	MCO Tax
FY 2017-18	**$0**	($809,823)	$809,823
FY 2018-19	**$0**	($669,704)	$669,704

Funding:

MCO Tax 2016 (Non-GF) (4260-601-3293)

MCO ENROLLMENT TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER: 115
IMPLEMENTATION DATE: 11/2016
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1960

	FY 2017-18	FY 2018-19
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:
PC 92: MCO Enrollment Tax Mgd. Care Plans-Incr. Cap. Rates
PC 114: 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, alternate health care service plans, or other enrollee.

The MCO Enrollment tax is effective July 1, 2016, through July 1, 2019. This policy change estimates GF savings resulting from the imposition of the MCO enrollment tax.

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is due to an updated funding allocation based on more recent payment data.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to an increase in MCO Enrollment Tax rate from FY 2017-18 to FY 2018-19.

MCO ENROLLMENT TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER: 115

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.

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 is used to determine the MCO Enrollment Tax for FY 2017-18:

Medi-Cal			
Enrollees	**Rate**	**Average Enrollment/Entity**	
0-2,000,000	$42.50	39,161,294	$1,664,355,000
2,000,001-4,000,000	$20.25	21,180,988	$428,915,000
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	$8.00	25,706,250	$205,650,000
4,000,001-8,000,000	$3.00	16,975,333	$50,926,000
Over 8,000,000	$1.00	30,244,000	$30,244,000

The total FY 2017-18 Medi-Cal and Non-Medi-Cal MCO Enrollment Tax on an accrual basis is: $2,428,921,000

4. The following taxing tier structure is 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 is: $2,563,988,000

5. 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.

MCO ENROLLMENT TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER: 115

6. The MCO Enrollment Tax fund transfers to the GF are expected to be:

(Dollars in Thousands)

	TF	GF	MCO Tax
FY 2017-18	**$0**	($1,552,053)	$1,552,053
FY 2018-19	**$0**	($1,850,459)	$1,850,459

Funding:
MCO Tax 2016 (Non-GF) (4260-601-3293)

MANAGED CARE DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	116
IMPLEMENTATION DATE:	4/2013
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1585

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	-$1,752,995,000	-$2,095,878,000
- STATE FUNDS	-$534,107,630	-$639,597,580
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,752,995,000	-$2,095,878,000
STATE FUNDS	-$534,107,630	-$639,597,580
FEDERAL FUNDS	-$1,218,887,370	-$1,456,280,420

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).

Interdependent Policy Changes:
Not Applicable

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.

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is due to revised collection projections based on the net result of the following:

- Three additional quarters of actual Managed Care rebate collections from July 2017 through March 2018;
- Increased ACA optional based on data through March 2018;
- Increased ACA Offset rebates and Title XXI rebates based on data through March 2018;
- Increased funding split assumed for the family planning drugs; and
- Decreased Medi-Cal Managed Care eligibles data used to project the estimated rebates.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to higher projected quarterly collections in FY 2018-19.

MANAGED CARE DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 116

Methodology:

1. Rebates are invoiced quarterly and payments occur six months after the conclusion of each quarter.

2. Assume family planning drugs account for 0.18% of the regular federal drug rebates and are funded with 90% federal funds (FF) and 10% General Fund (GF).

3. Assume CHIP drug rebate collections are estimated to be $85,744,000 TF in FY 2017-18 and $91,331,000 TF in FY 2018-19. These rebates are funded at 88% FF / 12% GF.

4. Collections for the optional expansion ACA population are estimated to be $628,687,000 TF for FY 2017-18, funded with 95% FF and 5% GF and $769,056,000 TF for FY 2018-19, funded with 94% FF and 6% GF.

5. The ongoing additional FF claimed by CMS (ACA Offset) is fully reflected in this policy change. The additional FF is $52,376,000 TF for FY 2017-18 and $68,822,000 TF for FY 2018-19.

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
50% Title XIX / 50% GF	($984,413)	($492,207)	($492,206)
95% Title XIX/ 5% GF	($628,687)	($31,434)	($597,253)
90% Title XIX / 10% GF	($1,775)	($178)	($1,597)
ACA Offset	($52,376)	$0	($52,376)
88% Title XXI / 12 % GF	($85,744)	($10,289)	($75,455)
Total	**($1,752,995)**	**($534,108)**	**($1,218,887)**

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF	($1,164,569)	($582,285)	($582,284)
94% Title XIX/ 6% GF	($769,056)	($46,143)	($722,913)
90% Title XIX / 10% GF	($2,100)	($210)	($1,890)
ACA Offset	($68,822)	$0	($68,822)
88% Title XXI / 12 % GF	($91,331)	($10,960)	($80,371)
Total	**($2,095,878)**	**($639,598)**	**($1,456,280)**

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)
100% Title XIX (4260-101-0890)
95% ACA Title XIX FF / 5% GF (4260-101-0001/0890)
94% ACA Title XIX FF / 6% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)

RETRO MC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER:	117
IMPLEMENTATION DATE:	1/2016
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1788

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	-$3,863,906,000	$493,754,000
- STATE FUNDS	$933,412,000	$138,930,640
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$3,863,906,000	$493,754,000
STATE FUNDS	$933,412,000	$138,930,640
FEDERAL FUNDS	-$4,797,318,000	$354,823,360

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) rate adjustments,
- Optional Expansion recoupment,
- Coordinated Care Initiative (CCI) full dual and non-full dual payments, and
- Retro payments.

This policy change also includes the California Department of Social Services (CDSS) CCI calendar year (CY) 2014 In-Home Supportive Services (IHSS) reconciliation.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is a decrease in recoupments due to:

- Adjusted CCI retro amounts for the following reasons:
  - CY 2016 full dual estimates were updated using final CY 2016 recast rates and updated payment timing,
  - CY 2017 full dual estimates were updated using revised draft CY 2017 rates and updated payment timing, and
  - A cost-shift of FY 2015-16 non-full dual payments from FY 2017-18 to FY 2018-19.
- Updated ACA Optional recoupment totals.

RETRO MC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 117

The change from the prior estimate, for FY 2018-19, is an increase due to:

- Adjusted CCI retro amounts for the following reasons:
  - CY 2016 full dual estimates were updated using final CY 2016 recast rates and updated payment timing,
  - CY 2017 full dual estimates were updated using revised draft CY 2017 rates and updated payment timing,
  - CY 2018 full dual estimates were updated using revised draft CY 2018 rates,
  - A cost-shift of FY 2015-16 non-full dual payments from FY 2017-18 to FY 2018-19, and
  - FY 2017-18 non-full dual estimates were added using draft FY 2017-18 rates.

- A cost shift of FY 2017-18 MLK payments and additional retroactive rate payments now anticipated to occur in FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to updating payments and recoupment timeframes.

Methodology:

1. The Department estimates the following retroactive managed care capitation rate adjustments in FY 2017-18 and FY 2018-19:

(Dollars in Thousands)

FY 2017-18	TF	GF	FF	Reimbursement
MLK Payments				
MLK OE Payments (FY 2015-16)	$9,177	$0	$9,177	
MLK OE Payments (July – December 2016)	$4,637	$0	$4,637	
Retro Payments	$226,175	$175,308	$50,868	
CCI Full Duals (CY 2015)				
CMC	($181,976)	($64,286)	($90,988)	($26,702)
MLTSS	$23,498	$696	$11,749	$11,053
CCI Full Duals (CY 2016)				
CMC	($67,584)	($54,791)	($33,792)	$20,999
MLTSS	$1,021,744	$204,748	$510,872	$306,124
CCI Full Duals (CY 2017)				
CMC	$19,360	$322	$9,680	$9,358
MLTSS	$384,110	$135,630	$192,055	$56,425
CCI Non-Full Duals (FY 2016-17)				
SFY 2016-17	$181,614	$23,459	$90,807	$67,348
CDSS Reconciliation (CY 2014)	$67,721	$0	$0	$67,721
ACA Optional Recoupment				
ACA Optional Recoupment (FY 2015-16)	($3,265,880)	$0	($3,265,880)	
ACA Optional Recoupment (July-Dec 2016)	($2,286,503)	$0	($2,286,503)	
Total FY 2017-18	**($3,863,907)**	**$358,866**	**($4,735,098)**	**$512,326**

RETRO MC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 117

(Dollars in Thousands)

FY 2018-19	TF	GF	FF	Reimbursement
MLK Payments (FY 2017-18)	$21,400	$6,269	$15,131	
Retro Payments	$122,488	$61,240	$61,240	
CCI Full Duals (CY 2016)				
CMC	($37,828)	($7,509)	($26,423)	($3,896)
CCI Full Duals (CY 2017)				
CMC	$4,746	($4,488)	($2,115)	$11,349
MLTSS	$207,504	$63,776	$167,528	($23,800)
CMC Full Duals (CY 2018, 6 mos.)				
CMC	$4,430	$1,108	$3,323	
MLTSS	$226,112	$56,528	$169,584	
CCI Non Full Duals (FY 2015-16)				
SFY 2015-16	$33,212	$1,371	$17,977	$13,864
CCI Non Full Duals (FY 2017-18)				
SFY 2017-18	($88,310)	($7,270)	($51,425)	($29,615)
Total FY 2018-19	**$493,754**	**$171,025**	**$354,820**	**($32,098)**

Funding:
50% Title XIX FF / 50% GF (4260-101-0001/0890)
ACA 100% FFP (2014-2016) (4260-101-0890)
ACA 95/5 (2017) (4260-101-0890)
ACA 94/6 (2018) (4260-101-0890)
100% Title XIX Federal Share Only (4260-101-0890)
100% Reimbursement GF (4260-610-0995)

DPH INTERIM & FINAL RECONS

REGULAR POLICY CHANGE NUMBER:	118
IMPLEMENTATION DATE:	10/2007
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1152

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$237,459,000	$889,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$237,459,000	$889,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$237,459,000	$889,000

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: 118

Reason for Change:
The change in FY 2017-18, from the prior estimate, is due to the inclusion of an appeal adjustment for the Los Angeles County hospitals for FY 2007-08. In addition, FY 2008-09 final reconciliations were revised based on updated cost reports.

The change in FY 2018-19, from the prior estimate, is due to updated cost reports for FY 2009-10 and FY 2014-15, and a formula correction in the FY 2009-10 final settlement workbook.

The change from FY 2017-18 to FY 2018-19, 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:

FY 2017-18	TF	FF	ACA FF
2007-08 Final Reconciliation	$81,570,000	$81,570,000	$0
2008-09 Final Reconciliation	$160,037,000	$160,037,000	$0
2013-14 Final Reconciliation	($4,148,000)	($11,812,000)	$7,664,000
Total	**$237,459,000**	**$229,795,000**	**$7,664,000**

FY 2018-19	TF	FF	ACA FF
2009-10 Final Reconciliation	$50,842,000	$50,842,000	$0
2014-15 Final Reconciliation	($49,953,000)	($29,390,000)	($20,563,000)
Total	**$889,000**	**$21,452,000**	**($20,563,000)**

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

DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER:	119
IMPLEMENTATION DATE:	7/2014
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1185

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$137,467,000	-$62,840,000
- STATE FUNDS	$50,839,080	-$21,562,360
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$137,467,000	-$62,840,000
STATE FUNDS	$50,839,080	-$21,562,360
FEDERAL FUNDS	$86,627,920	-$41,277,640

DESCRIPTION

Purpose:
This policy change budgets the retroactive adjustments to Dental Managed Care (DMC) and Fee-for-Service (FFS) rates impacting prior fiscal 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 2017-18 is a decrease due to shifts in payment timing. The change from the prior estimate for FY 2018-19 is an increase in recoupments due to payment timing shifts accounting for retroactivity now anticipated in FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to some recoupments being budgeted in FY 2018-19 whereas FY 2017-18 only has payments.

DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER: 119

Methodology:

1. Assume there are no FFS retroactive rate adjustments to be made in FY 2017-18.

2. Assume the following FFS retroactive rate adjustments are to be made in FY 2018-19:

FY 2018-19 Delta Dental 2004 Contract Retro Adjustments	Dental Retro Rate Adjustment
Retro for FY 2016-17 Rate	($85,800,000)
Retro for FY 2017-18 w/Prop 56 Rate*	$17,075,000
Total Retro Adjustments for Delta Dental 2004 Contract	**($68,725,000)**

**Any Rates containing "w/Prop 56" in their title are named as such for display purposes only. All Prop 56 costs are captured separately in the Supplemental Payments for Dental Services PC.*

3. Assume the following DMC retroactive rate adjustments are to be made in FY 2017-18:

FY 2017-18 GMC and PHP Retro Adjustments	Dental Retro Rate Adjustment
Retro for FY 2014-15 Rate	$106,967,000
Retro for FY 2015-19 Rate	$24,403,000
Retro for FY 2017-18 w/Prop 56 Rate*	$6,097,000
Total Retro Adjustments for GMC and PHP	**$137,467,000**

**Any Rates containing "w/Prop 56" in their title are named as such for display purposes only. All Prop 56 costs are captured separately in the Supplemental Payments for Dental Services PC.*
Potential slight differences due to rounding.

4. Assume the following DMC retroactive rate adjustments are to be made in FY 2018-19:

FY 2018-19 GMC and PHP Retro Adjustments	Dental Retro Rate Adjustment
Retro for FY 2018-19 w/Prop 56 Rate*	$5,885,000
Total Retro Adjustments for GMC and PHP	**$5,885,000**

**Any Rates containing "w/Prop 56" in their title are named as such for display purposes only. All Prop 56 costs are captured separately in the Supplemental Payments for Dental Services PC.*

Funding:

FY 2017-18	TF	GF	FF
Regular FMAP T19	$96,652,000	$48,326,000	$48,326,000
ACA 95% FFP/5% GF (2017)	$18,344,000	$917,000	$17,427,000
ACA 94% FFP/6% GF (2018)	$18,344,000	$1,101,000	$17,243,000
Title 21 88% FFP/12% GF	$4,127,000	$495,000	$3,632,000
Total	**$137,467,000**	**$50,839,000**	**$86,628,000**

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF	($39,549,000)	($19,774,000)	($19,775,000)
100% GF	($14,000)	($14,000)	$0
95% Title XIX ACA FF / 5% GF	($11,073,000)	($554,000)	($10,519,000)
94% Title XIX ACA FF / 6% GF	($4,755,000)	($285,000)	($4,470,000)
ACA 93% FFP/7% GF (2019)	$793,000	$55,000	$738,000
88% Title XXI / 12% GF	($8,236,000)	($988,000)	($7,248,000)
65% Title XIX / 35% GF	($6,000)	($2,000)	($4,000)
Total	**($62,840,000)**	**($21,562,000)**	**($41,278,000)**

FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER:	120
IMPLEMENTATION DATE:	7/2008
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1329

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$160,320,000	$164,723,000
- STATE FUNDS	$60,410,010	$62,525,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$160,320,000	$164,723,000
STATE FUNDS	$60,410,010	$62,525,500
FEDERAL FUNDS	$99,909,990	$102,197,500

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 2014-15 audited levels were used to update the CBRC rates as of July 1, 2017. The Department is scheduled to complete the CBRC reconciliation audit for FY 2012-13 and FY 2015-16 in FY 2017-18, and will complete FY 2016-17 audit levels in FY 2018-19. Interim rates will be adjusted to the FY 2015-16 audit levels beginning in FY 2018-19.

Currently, there are 1061 active FQHCs, 279 active RHCs, 26 active CBRCs, and 70 active IHS/MOA.

FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER: 120

Reason for Change:
The change from the prior estimate, for FY 2017-18, is a decrease due to a decrease in the actual annual expenditures for FQHC. The change from the prior estimate, for FY 2018-19, is an increase in FY 2016-17 CBRC reported settlements. LA CBRCs rate adjustments are now budgeted in the Rate Increase for FQHCs/RHCs/CBRCs policy change. The change from FY 2017-18 to FY 2018-19, in the current estimate, is a slight net increase due to the various projected reconciliations.

Methodology:
1. FY 2017-18 FQHC and RHC reconciliations are based on a three-year average of actual settlements from July 2015 through June 2017. FY 2018-19 reconciliations are also based on a three-year average of actual and estimated settlements from July 2016 through June 2018. FY 2016-17 FQHC reconciliations include settlements for IHS.

2. The estimated FQHC retroactive rate adjustment for FY 2017-18 of $19,724,000 and $20,717,000 for FY 2018-19 is based on a three-year average of the previous year's implemented and paid Erroneous Payment Corrections (EPC). The Department calculates the three-year average by summing the number of EPCs for FY 2015-16, 2016-17, and 2017-18. 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 2017-18 is based on the settlement of 95% of FY 2012-13 audited settlements, and FY 2015-16 reported settlements, while the FY 2018-19 reconciliation is based on settlement of 95% of the FY 2016-17 reported settlements. The change from the prior year estimate is due to an increase in reported revenues and reported payments for FY 2016-17.

(Dollars in Thousands)	FY 2017-18	FY 2018-19
FQHCs Reconciliation	$40,536	$31,176
RHCs Reconciliation	$13,234	$15,529
FQHC Retroactive Rate Adjustment	$19,724	$20,717
LA CBRCs Reconciliation	$86,826	$97,301
Total	**$160,320**	**$164,723**

FY 2017-18	TF	GF	FF
50% Title XIX / 50% GF	$115,938,000	$57,969,000	$57,969,000
95% Title XIX ACA / 5% GF	$22,191,000	$1,110,000	$21,081,000
94% Title XIX ACA / 6% GF	$22,191,000	$1,331,000	$20,860,000
FY 2017-18 Total	**$160,320,000**	**$60,410,000**	**$99,910,000**

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF	$119,123,000	$59,562,000	$59,561,000
95% Title XIX ACA / 5% GF	$22,800,000	$1,368,000	$21,432,000
94% Title XIX ACA / 6% GF	$22,800,000	$1,596,000	$21,204,000
FY 2018-19 Total	**$164,723,000**	**$62,526,000**	**$102,197,000**

FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER: 120

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
95% Title XIX ACA / 5% GF (4260-101-0001/0890)
94% Title XIX ACA / 6% GF (4260-101-0001/0890)
93% Title XIX ACA / 7% GF (4260-101-0001/0890)

AB 1629 ANNUAL RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER:	121
IMPLEMENTATION DATE:	8/2014
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1508

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$147,086,000	$114,498,000
- STATE FUNDS	$73,543,000	$57,249,000
PAYMENT LAG	0.9960	0.8376
% REFLECTED IN BASE	51.78 %	0.01 %
APPLIED TO BASE		
TOTAL FUNDS	$70,641,200	$95,893,900
STATE FUNDS	$35,320,580	$47,946,970
FEDERAL FUNDS	$35,320,580	$47,946,970

DESCRIPTION

Purpose:
This policy change estimates the cost of the AB 1629 rate increases and add-ons for freestanding skilled nursing facilities (NF-Bs).

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)

Interdependent Policy Changes:
PC 197 Funding Adjust.—ACA Opt. Expansion
PC 191 Funding Adjust.—OTLICP

Background:
AB 1629 requires the Department to implement a facility-specific rate methodology and impose a Quality Assurance Fee (QAF) on freestanding nursing facilities (NF-Bs), including adult and pediatric subacute facilities. The QAF is used to offset the General Fund (GF) portion of the 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.

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 6%, effective October 1, 2011. Changes in the amount of licensing and certification fees for NF-Bs, 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.

AB 1629 ANNUAL RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 121

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 General Fund (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.

SB 853 (Chapter 717, Statutes of 2010) implemented a quality and accountability supplemental payments (QASP) program for NF-Bs. 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 NF-Bs that do not meet minimum staffing requirements, one-third of the AB 1629 facilities reimbursement rate increase for rate year 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 (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 was set at 3.62%, and the GF appropriation for the QASP will continue at FY 2014-15 levels, 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 Department will submit a SPA, effective August 1, 2017, to clarify that the rate increase provided through July 31, 2017 is at 3.62%, which aligns with current statute, rather than up to a 3.62% increase.

Reason for Change:

The change from the prior estimate, for FY 2017-18, is an increase due to:

- Revised Fee-for-Service (FFS) utilization based on data through January 2018,
- Updated RY 2016-17 add-ons, and
- A shift of the RY 2017-18 Erroneous Payment Correction (EPC) from FY 2018-19 to FY 2017-18.

The change from the prior estimate, for FY 2018-19, is a net decrease due to:

- Revised FFS utilization based on data through January 2018,
- Shifting the RY 2017-18 EPC to FY 2017-18, and
- No longer including the managed care costs for the SNF staffing ratio add-on in this policy change. This add-on is now included in the 2018-19 managed care capitation rates.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a net decrease due to:

- The RY 2016-17 and RY 2017-18 EPCs being paid in FY 2017-18,
- The 2016-17 rates being fully incorporated in the FFS base in FY 2017-18, and
- Including five months of the 2017-18 rate in FY 2017-18 and 12 months in FY 2018-19.

AB 1629 ANNUAL RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 121

Methodology:

1. The effective date for the rate increase and add-ons is August 1st.

2. Assume a 3.62% rate increase for the 2017-18 rate year, and a 3.62% rate increase for the 2018-19 rate year.

3. The 2016-17 rates and add-ons were implemented March 27, 2017. The 2016-17 retroactive rate payment will cover August 1, 2016, through March 26, 2017, and was implemented in FY 2017-18.

4. The 2017-18 rates and add-ons were implemented January 19, 2018. The 2017-18 retroactive rate payment will cover August 1, 2017, through January 18, 2018, and will be implemented in May 2018.

5. The 2018-19 rates and add-ons will be implemented in October 2018. The 2018-19 retroactive rate payment will cover August 2018, through September 2018, and will be implemented in January 2019.

6. The estimated managed care rate adjustment impact for 2017-18 and 2018-19 is included in the 2017-18 and 2018-19 managed care capitation rates, respectively.

AB 1629 ANNUAL RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 121

7. The add-on descriptions are listed below:

Add-On	FY 2017-18	FY 2018-19
FUTA – 2016-17: Effective August 1, 2016, the FUTA add-on increases annually and provides LTC facilities FUTA tax credit.	$0.05	
FUTA – 2017-18: Effective August 1, 2017, the FUTA add-on increases annually and provides LTC facilities FUTA tax credit.	$0.05	
Minimum wage: Effective July 1, 2014, AB 10 (Chapter 351, Statutes of 2013) increases the minimum wage to not less than $9.00 per hour and on and after January 1, 2016, to not less than $10.00 per hour.	$0.15	
ACA employer mandate: Effective January 1, 2015, the ACA Employer Mandate requires Skilled Nursing Facility employers to offer health care coverage to 95% of their full time employees in 2016 and beyond.	$0.19	
Minimum wage: Effective January 1, 2017, SB 3 increases the minimum wage to $10.50 per hour for any employer who employs 26 or more employees.	$0.17	$0.07
Minimum wage: Effective January 1, 2018, SB 3 increases the minimum wage to $11.00 per hour for any employer who employs 26 or more employees.	$0.80	$1.36
Minimum wage: Effective January 1, 2019, SB 3 increases the minimum wage to $12.00 per hour for any employer who employs 26 or more employees.		$1.69
Payroll-Based Journal: Effective July 1, 2016, CMS requires facilities to submit direct care staffing information based on payroll data.	$0.13	
Standards of Participation: Effective November 28, 2016, CMS requires Skilled Nursing Facilities to meet updated health and safety standards in order to participate in the Medicaid program.	$0.04	$0.04
SNF Staffing Ratio: Effective July 1, 2018, SB 97 requires Skilled Nursing Facilities to have a minimum number of direct care service hours of 3.5 per patient day.		$1.91

AB 1629 ANNUAL RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 121

8. The estimated payments on a cash basis are:

(Dollars in Thousands)

FY 2017-18	TF	GF	FFP
FFS (Rate Increase)	$98,028	$49,014	$49,014
RY 2016-17 Retro	$67,718	$33,859	$33,859
RY 2017-18 Retro	$1,904	$952	$952
Add-Ons	($20,564)	($10,282)	($10,282)
Managed Care	$0	$0	$0
Total	**$147,086**	**$73,543**	**$73,543**

FY 2018-19	TF	GF	FFP
FFS (Rate Increase)	$107,006	$53,503	$53,503
RY 2018-19 Retro	$20,126	$10,063	$10,063
Add-Ons	($12,634)	($6,317)	($6,317)
Managed Care	$0	$0	$0
Total	**$114,498**	**$57,249**	**$57,249**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in PC 197 Funding Adjust.—ACA Opt. Expansion
OTLICP funding identified in PC 191 Funding Adjust.—OTLICP

RATE INCREASE FOR FQHCS/RHCS/CBRCS

REGULAR POLICY CHANGE NUMBER:	122
IMPLEMENTATION DATE:	10/2005
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	88

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$155,159,000	$171,331,000
- STATE FUNDS	$58,464,970	$65,033,450
PAYMENT LAG	0.9398	0.9143
% REFLECTED IN BASE	86.66 %	24.03 %
APPLIED TO BASE		
TOTAL FUNDS	$19,452,200	$119,005,400
STATE FUNDS	$7,329,710	$45,171,820
FEDERAL FUNDS	$12,122,460	$73,833,610

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) their 2000 cost-based rate. The clinic receives an annual rate adjustment based on the percentage increase in the Medicare Economic Index (MEI) 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:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is a decrease due to a change in the estimated rate increase methodology, which represents a closer projection to the actual rate increases and cost. The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to a projected rate increase of 2.3% with a projected increase in visits.

RATE INCREASE FOR FQHCS/RHCS/CBRCS

REGULAR POLICY CHANGE NUMBER: 122

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 for calendar year 2016 was 3.46%, 1.22% for calendar year 2017, and 2.34% for calendar year 2018.

Rate Year	Projected Visits	Current Rate	Rate with Increase
2016	17,544,104	$150.66	$150.66 x (1+3.46%) = $155.87
2017	18,575,483	$155.87	$155.87 x (1+1.22%) = $157.77
2018	19,785,428	$157.77	$157.77 x (1+2.34%) = $161.46

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
2016	$2,643,195	$2,734,599	$91,405
2017	$2,895,360	$2,930,654	$35,293
2018	$3,121,547	$3,194,555	$73,008

4. The July 1, 2017 CBRC rate increase of $37,284,000 is based on the FY 2013-14 audited PPS rate utilizing payment data from the Paid Claims Summary Reports for FY 2015-16. 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 2015-16.

5. The July 1, 2018 CBRC rate increase of $43,998,000 is based on the FY 2014-15 audited PPS rate utilizing payment data from the Paid Claims Summary Reports for FY 2016-17. 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 2016-17.

(Dollars in Thousands)

FY 2017-18	**TF**	**GF**	**FF**
CY 2017 Increase	$77,580	$29,125	$48,455
CY 2018 Increase	$77,580	$29,340	$48,240
FY 2017-18 Total	**$155,159**	**$58,464**	**$96,695**
FY 2018-19	**TF**	**GF**	**FF**
CY 2018 Increase	$85,666	$32,399	$53,267
CY 2019 Increase	$85,666	$32,636	$53,030
FY 2018-19 Total	**$171,331**	**$65,034**	**$106,297**

*Totals may differ due to rounding.

RATE INCREASE FOR FQHCS/RHCS/CBRCS

REGULAR POLICY CHANGE NUMBER: 122

FY 2017-18	TF	GF	FF
50% Title XIX / 50% GF	$112,205,000	$56,103,000	$56,102,000
95% Title XIX ACA / 5% GF	$21,477,000	$1,074,000	$20,403,000
94% Title XIX ACA / 6% GF	$21,477,000	$1,289,000	$20,188,000
FY 2017-18 Total	**$155,159,000**	**$58,466,000**	**$96,693,000**

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF	$123,901,000	$61,951,000	$61,950,000
95% Title XIX ACA / 5% GF	$23,715,000	$1,423,000	$22,292,000
94% Title XIX ACA / 6% GF	$23,715,000	$1,660,000	$22,055,000
FY 2018-19 Total	**$171,331,000**	**$65,034,000**	**$106,297,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
100% Title XIX ACA (4260-101-0890)
95% Title XIX / 5% ACA (4260-101-0001/0890)
94% Title XIX / 6% ACA (4260-101-0001/0890)
93% Title XIX / 7% ACA (4260-101-0001/0890)

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	123
IMPLEMENTATION DATE:	8/2007
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1046

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$22,316,000	$30,903,000
- STATE FUNDS	$11,158,000	$15,451,500
PAYMENT LAG	0.9380	0.9123
% REFLECTED IN BASE	80.36 %	0.45 %
APPLIED TO BASE		
TOTAL FUNDS	$4,111,100	$28,065,900
STATE FUNDS	$2,055,560	$14,032,970
FEDERAL FUNDS	$2,055,560	$14,032,970

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, 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 (FS) Pediatric Subacute facilities. 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)
SB 3 (Chapter 4, Statues of 2016)

Interdependent Policy Changes:
PC 197 Funding Adjust. – ACA Opt. Expansion
PC 191 Funding Adjust. – OTLICP

Background:
Pursuant to the State Plan requirements, Medi-Cal rates for LTC facilities are adjusted after completion of an annual rate study.

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 Pediatric Subacute facilities.

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 123

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, 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.

CMS also approved the rate freeze on the Rural Swing Bed rate. However, due to access concerns, payments applicable to the Rural Swing Bed rates will not be reduced.

Effective September 1, 2013, Rural Swing Beds in DP/NF-B facilities located in designated rural and frontier areas are exempted from the rate freeze.

The Department also received CMS approval to exempt DP Adult Subacute and DP Pediatric Subacute facilities from the rate freeze based on access and utilization analyses.

The California Hospital Association (CHA) filed a lawsuit challenging the 10% payment reduction and rate freeze at the 2008-2009 levels, required by AB 97, with respect to DP/NF-Bs facilities. On December 28, 2011, the federal court issued a preliminary injunction.

On June 25, 2013, the United States Court of Appeals for the Ninth Circuit vacated the injunctions. As a result, the Department was to implement the AB 97 payment reductions and rate freezes retroactive to June 1, 2011. On December 20, 2013, CMS approved the Department's request to exempt:

- DP/NF-B facilities located in rural and frontier areas from the rate freeze at the 2008-09 levels and the 10% payment reduction, effective September 1, 2013, and
- Non rural and frontier DP/NF-B facilities from the rate freeze at the 2008-09 levels and 10% payment reduction, effective October 1, 2013.

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. Additionally, effective August 1, 2016, ABX2 1 requires the Department to reimburse ICF/DD facilities at the 2008-09 levels, increased by 3.7%, for which the Department obtained CMS approval on July 5, 2016.

Reason for Change:

The change from the prior estimate, for FY 2017-18, is due to:

- Revised FFS utilization based on data through January 2018,
- RY 2017-18 rates were finalized, and updated,
- Updated RY 2017-18 add-ons,
- Delays in the RY 2017-18 prospective implementation dates, and
- RY 2017-18 retroactive Erroneous Payment Correction (EPC) implementation dates for the DP Pediatric Subacute and FS Pediatric Subacute facilities, are now budgeted in FY 2018-19.

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 123

The change from the prior estimate, for FY 2018-19, is due to:

- Revised FFS utilization based on data through January 2018,
- Updated FY 2018-19 rates based on applying inflation factors in rate development,
- Updated RY 2018-19 add-ons, and
- RY 2018-19 retroactive EPC implementation dates for more LTC facilities are now budgeted in FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to including:

- A full year of the RY 2017-18 rate adjustments in FY 2018-19,
- Eight months of RY 2018-19 rate adjustments for DP/NF-Bs, Rural Swing Beds, DP Adult Subacute, NF-As, and ICF/DDs in FY 2018-19, and
- Ten months of the RY 2018-19 rate adjustments for DP Pediatric Subacute and FS Pediatric Subacute facilities.

Methodology:

1. The effective date for the rate adjustments is August 1st of each rate year. The RY 2017-18 and 2018-19 implementation dates are as follows:

Facility	Rate Year 2017-18	Rate Year 2018-19
DP/NF-B	12/26/2017	11/1/2018
Rural Swing Beds (non-exempt)	1/22/2018	11/1/2018
Rural Swing Beds (exempt)	1/22/2018	11/1/2018
DP Adult Subacute	12/26/2017	11/1/2018
NF-A	12/26/2017	11/1/2018
ICF/DDs	1/3/2018	11/1/2018
DP Pediatric Subacute	1/25/2018	9/1/2018
FS Pediatric Subacute	1/25/2018	9/1/2018

2. Payments in FY 2017-18 include retroactive payments for 2016-17 and 2017-18. Payments for FY 2018-19 include retroactive payments for 2017-18 and 2018-19.

3. 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.

4. Assume add-ons remain in place for ongoing costs for providers' rates impacted by a rate freeze.

5. **DP Adult Subacute and DP Pediatric Subacute facilities**: These two facilities will not be subject to any rate reductions. The Department completed a "Monitoring Access to Medi-Cal Covered Services" study that determined reducing or freezing reimbursement rates for these two facilities would negatively impact access to care. Therefore, the Department will be increasing reimbursement rates for these facility types under the "normal" rate setting process.

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 123

6. **DP/NF-B facilities**: 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. The repayment of federal funds for the lost savings is budgeted in the DP/NF-B Retroactive Recoupment Forgiveness policy change.

7. **Rural Swing Bed Rates**: The impact of the rate freeze and exemption for Rural Swing Beds in DP/NF-B facilities located in designated rural and frontier areas is captured in the FFS base trends.

8. **ICF/DD, ICF/DD-H, and ICF/DD-N facilities**: Effective August 1, 2016, ABX2 1 requires the Department to restore the AB 97 payment reduction and reimburse ICF/DDs at the 2008-09 rate levels, increased by 3.7%.

Restore AB 97	Increase 3.7%	Total
$5,791,000	$19,330,000	$25,121,000

9. 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.

10. AB 119 extends the FS Pediatric Subacute Facilities QAF sunset from July 31, 2015 to July 31, 2020.

11. The estimated managed care rate adjustment impacts for rate year 2017-18 and rate year 2018-19 are included in the managed care capitation rates.

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 123

12. The add-on descriptions are listed below:

Add-On	Rate Year 2017-18	Rate Year 2018-19
FUTA – 2015-16: Effective August 1, 2015, the FUTA add-on increases annually and provides LTC facilities FUTA tax credit.	$0.05 - $0.06	
FUTA – 2016-17: Effective August 1, 2016, the FUTA add-on increases annually and provides LTC facilities FUTA tax credit.	$0.05 - $0.06	
FUTA – 2017-18: Effective August 1, 2017, and ending in January 1, 2018, the FUTA add-on increases are prorated by 5 months and provides LTC facilities FUTA tax credit.	$0.05 - $0.06	
Minimum wage: Effective January 1, 2016, AB 10 (Chapter 351, Statutes of 2013) increases the minimum wage, to not less than $10.00 per hour.	$0.15 - $7.73	$0.35 - $7.73
2015 ACA employer mandate: Effective January 1, 2015, the ACA Employer Mandate requires Skilled Nursing Facility employers to offer health care coverage to 70% of their full time employees in 2015 and 95% in 2016 and beyond.	$0.11 - $0.85	$0.04 - $0.85
2016 ACA employer mandate: Effective January 1, 2016, for facilities that became Applicable Large Employers, the ACA Employer Mandate requires Skilled Nursing Facility employers to offer health care coverage to 70% of their full time employees in 2016 and 95% in 2017 and beyond.	$0.01 - $0.03	$0.01 - $0.03
Paid sick leave: Effective July 1, 2015, AB 1522 (Chapter 317, Statutes of 2014) requires employers to provide employees paid sick days of no less than one hour for every 30 hours worked. Employees are limited to using 24 hours of sick leave during each year of employment.	$1.72 - $4.17	$1.72 - $4.17
ACA reporting requirements: Effective January 1, 2015, the United States Department of Health and Human Services issued regulations pursuant to the ACA, mandating new reporting requirements for monthly tracking of employee health insurance coverage.	$0.17 - $0.54	$0.17 - $0.54
Minimum wage: Effective January 1, 2017, SB 3 (Chapter 4, Statutes of 2016) increases the minimum wage to $10.50 per hour for any employer who employs 26 or more employees.	$0.17 - $3.92	$0.07 - $3.92
Minimum wage: Effective January 1, 2018, SB 3 (Chapter 4, Statutes of 2016) increases the minimum wage to $11.00 per hour for any employer who employs 26 or more employees.	$0.66 - $1.13	$0.80 - $1.94
Minimum wage: Effective January 1, 2019, SB 3 (Chapter 4, Statutes of 2016) increases the minimum wage to $12.00 per hour for any employer who employs 26 or more employees.		$1.07 - $2.21
Payroll-Based Journal: Effective July 1, 2016, CMS requires facilities to submit direct care staffing information based on payroll data.	$0.13 - $0.26	$0.13
Standards of Participation: Effective November 28, 2016, CMS required SNFs and NF-As to meet new health and safety standards in order to participate in the Medicare and Medicaid programs.	$0.04	$0.04

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 123

13. The costs below reflect the incremental rate adjustments and add-ons for each facility type:

Fee-for-Service	FY 2017-18	FY 2018-19
Rate Adjustment (16-17)		
DP/NF-B	$15,633,000	$0
Rural Swing Beds (non-exempt)	($1,000)	$0
Rural Swing Beds (exempt)	($161,000)	$0
DP Adult Subacute	$1,089,000	$0
NF-A	($228,000)	$0
DP Pediatric Subacute	$387,000	$0
FS Pediatric Subacute	($10,000)	$0
Rate Adjustment (17-18)		
DP/NF-B	($220,000)	($441,000)
Rural Swing Beds (non-exempt)	$1,000	$2,000
Rural Swing Beds (exempt)	$104,000	$250,000
DP Adult Subacute	$2,308,000	$4,616,000
NF-A	$29,000	$57,000
ICF/DDs	$3,079,000	$6,159,000
DP Pediatric Subacute	$144,000	$345,000
FS Pediatric Subacute	$1,000	$2,000
Rate Adjustment (18-19)		
DP/NF-B	$0	$6,237,000
Rural Swing Beds (non-exempt)	$0	$3,000
Rural Swing Beds (exempt)	$0	$54,000
DP Adult Subacute	$0	$1,589,000
NF-A	$0	$98,000
ICF/DDs	$0	$3,645,000
DP Pediatric Subacute	$0	$311,000
FS Pediatric Subacute	$0	$52,000
Retro Rate Adjustments		
DP/NF-B	$0	$2,155,000
Rural Swing Beds (non-exempt)	$0	$1,000
Rural Swing Beds (exempt)	$0	$68,000
DP Adult Subacute	$0	$2,519,000
NF-A	$0	$28,000
ICF/DDs	$0	$2,943,000
DP Pediatric Subacute	$161,000	$204,000
FS Pediatric Subacute	$0	$6,000
Total FFS	$22,316,000	$30,903,000
Managed care	$0	$0
Total Cost	**$22,316,000**	**$30,903,000**

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 123

Funding:
50% Title XIX / 50% Title GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in PC 197 Funding Adjust. – ACA Opt. Expansion
OTLICP funding identified in PC 191 Funding Adjust. – OTLICP

DPH INTERIM RATE GROWTH

REGULAR POLICY CHANGE NUMBER:	124
IMPLEMENTATION DATE:	9/2017
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1162

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$27,149,000	$90,426,000
- STATE FUNDS	$13,574,500	$45,213,000
PAYMENT LAG	0.7367	0.8408
% REFLECTED IN BASE	53.68 %	21.02 %
APPLIED TO BASE		
TOTAL FUNDS	$9,264,300	$60,048,600
STATE FUNDS	$4,632,160	$30,024,320
FEDERAL FUNDS	$4,632,160	$30,024,320

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:
PC 134 DPH Interim Rate
PC 197 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 2017-18 and FY 2018-19, from the prior estimate, is due to a decrease in estimated users based on updated DPH actual data through January 2018.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due an increased growth rate for community-based DPHs by 6.14% and by 0.33% for county DPHs in FY 2018-19 based on updated DPH actual data through January 2018.

DPH INTERIM RATE GROWTH

REGULAR POLICY CHANGE NUMBER: 124

Methodology:

1. The DPHs received new FY 2017-18 interim rates as of September 2017, effective July 1, 2017. These rates were based on FY 2015-16 costs trended to FY 2017-18. Assume the FY 2018-19 interim rates will be implemented in September 2018.

2. For FY 2017-18:
   - An Erroneous Payment Correction (EPC) was issued in February 2018 for the time period July 2017 through August 2017.
   - Assume a 4.01% interim rate increase for county DPHs.
   - Assume no interim rate increase for community-based DPHs.
   - An additional cost of $27,149,000 TF is estimated for the FY 2017-18 interim rates. The lagged cost on a cash basis, not in the base, is estimated to be approximately $9,264,000 TF.

3. For FY 2018-19:
   - Assume the EPC will occur in February 2019 for the July 2018 to August 2018 time period.
   - Assume a 4.34% interim rate increase for county DPHs.
   - Assume a 6.14% interim rate increase for community-based DPHs.
   - An additional cost of $90,426,000 TF is estimated for the FY 2018-19 interim rates. The lagged cost on a cash basis, not in the base, is estimated to be approximately $60,049,000 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 PC 197 Funding Adjust. — ACA Opt. Expansion

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER:	125
IMPLEMENTATION DATE:	10/2006
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	96

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$6,995,000	$38,049,000
- STATE FUNDS	$3,497,500	$19,024,500
PAYMENT LAG	0.9998	0.9583
% REFLECTED IN BASE	47.69 %	8.50 %
APPLIED TO BASE		
TOTAL FUNDS	$3,658,400	$33,363,100
STATE FUNDS	$1,829,180	$16,681,530
FEDERAL FUNDS	$1,829,180	$16,681,530

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:
PC 197 Funding Adjust.—ACA Opt. Expansion
PC 191 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.

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 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.

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 125

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 from the prior estimate, for FY 2017-18 and FY 2018-19, is due to the net result of:

- Updated actual hospice payment data as of January 2018;
- A delay in the Rate Year (RY) 2017-18 hospice rates (except the Routine Home Care, RHC, and Service Intensity Add-On, SIA) from January 2018 to May 2018;
- A delay in the Erroneous Payment Correction (EPC) for the RY 2017-18 hospice services (except the RHC tiered rates), which shifted implementation to FY 2018-19;
- A delay in the prospective RHC tiered rates and SIA from April 2018 to May 2018; and
- Increased estimated hospice room and board rates.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to the following occurring in FY 2018-19:

- The retroactive payments for the period from January 2016 through April 2018 for the RHC tiered rates and SIA occurring in FY 2018-19;
- A full year of payments for the RY 2015-16, RY 2016-17, and RY 2017-18 RHC tiered rates;
- A full year of payments for the RY 2017-18 hospice services (except the RHC tiered rates);
- The RY 2018-19 RHC tiered rates and RY 2018-19 hospice services being implemented in January 2019; and
- The RY 2018-19 Hospice Room and Board rates being implemented in August 2018.

Methodology:

1. The estimated weighted increase for hospice service rates, excluding Routine Home Care, for RY 2017-18 and RY 2018-19 is 1.84%.

2. RY 2017-18 hospice services rates, excluding RHC, are assumed to be implemented in May 2018. The EPC for the retroactive period from October 2017 to April 2018 is estimated to occur in October 2018.

3. RY 2018-19 hospice services rates, excluding RHC, are assumed to be implemented in January 2019. The EPC for the retroactive period from October 2018 to December 2018 is estimated to occur in June 2019.

4. Effective January 1, 2016, the CMS final hospice rule changes 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.

5. The CMS final hospice rule also establishes a 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. It is assumed that the maximum SIA payments will be applied to each hospice beneficiary.

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 125

6. The RY 2015-16, RY 2016-17, and RY 2017-18 RHC tiered rates and SIA are expected to be implemented May 2018. Retroactive claims for the period January 2016 through April 2018 will require providers to resubmit claims for payments. Payments for the retroactive period are expected to be paid in FY 2018-19 as claims are reprocessed.

7. The RY 2018-19 RHC tiered rates and SIA are expected to be implemented January 2019, with the retroactive payment for the period of October 2018 through December 2019 expected to be implemented in June 2019.

8. Hospice room and board rates will continue at 95% of the facility rates, whether frozen or unfrozen. The weighted increase for hospice room and board rates for RY 2017-18 and RY 2018-19 is estimated to be 5.72%.

Cash Basis	FY 2017-18	FY 2018-19
RY 2016-17 - Hospice Services	$102,000	$102,000
RY 2017-18 RHC & SIA Payments	$2,224,000	$13,345,000
RY 2017-18 - Hospice Services	$6,000	$37,000
RY 2017-18 - Room & Board	$4,663,000	$5,087,000
RY 2017-18 Retroactive Payments		$22,000
RY 2018-19 RHC & SIA Payments		$2,079,000
RY 2018-19- Hospice Services		$18,000
RY 2018-19- Room & Board		$4,929,000
RY 2018-19 Retroactive Payments		$1,049,000
RHC & SIA Retroactive Payments		$11,381,000
TOTAL	**$6,995,000**	**$38,049,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in PC 197 Funding Adjust.—ACA Opt. Expansion
OTLICP funding identified in PC 191 Funding Adjust.—OTLICP

GDSP NEWBORN SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER:	126
IMPLEMENTATION DATE:	4/2017
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1938

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$19,798,000	$8,367,000
- STATE FUNDS	$9,899,000	$4,183,500
PAYMENT LAG	0.9870	0.9464
% REFLECTED IN BASE	97.77 %	74.01 %
APPLIED TO BASE		
TOTAL FUNDS	$435,800	$2,058,000
STATE FUNDS	$217,880	$1,029,010
FEDERAL FUNDS	$217,880	$1,029,010

DESCRIPTION

Purpose:
This policy change estimates the costs associated with fee increases 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
Health & Safety Code Section 125000
AB 395 (Chapter 461, Statutes of 2011)
AB 1559 (Chapter 565, Statutes of 2014)
Sb 1095 (Chapter 323, 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.

Effective January 1, 2012, AB 395 required GDSP to add Severe Combined Immunodeficiency (SCID) to the NBS Program, resulting in a $9.95 fee increase per specimen. The Department was not aware of this rate increase until late 2016. The $9.95 fee increase was implemented retroactively to January 2012 in FY 2016-17 and the Department will pay all retroactive payments in FY 2017-18.

AB 1559 requires GDSP to expand statewide screening of newborns to include screening for adrenoleukodystrophy (ALD). Effective July 1, 2016, GDSP added ALD to the NBS for all babies born in California. Additional testing and follow-up costs are associated with screening for ALD, increased appropriation in the contract for operational support for the maintenance and operation of the NBS computer system, the Screening Information System (SIS), and the transition of SIS from the Department data center to CDPH's data center necessitated a fee increase of $17.55 per specimen, effective July 1, 2016.

GDSP NEWBORN SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 126

SB 1095 requires GDSP to grandfather in two new disorders: Pompe disease and mucopolysaccharidosis type I. Effective August 1, 2018, GDSP is required to begin screening all babies in California for the two new disorders. The Department has accounted for start-up costs. However, increased appropriation for staff, equipment, consumables, reagents, contract costs for maintenance and operation of the NBS computer system and the SIS, DNA sequencing, follow-up activities, confirmatory testing, and increased contract costs due to inflation necessitate a fee increase of $12.00 per specimen, effective July 1, 2018.

Reason for Change:
There is no change from the prior estimate for FY 2017-18. The change from the prior estimate for FY 2018-19 is due to updated projected birth data for FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to the implementation of EPCs in FY 2017-18.

Methodology:
1. The Department implemented a $17.55 fee increase for the GDSP NBS Program in April 2017, retroactive to July 2016. The EPC for the period of July 2016 through March 2017 was implemented on November 14, 2017. The annual cost is $3,740,000 TF. The EPC is estimated at $2,805,000 TF.

2. The Department implemented a $9.95 fee increase for the GDSP NBS Program in April 2017, retroactive to January 2012. The EPC for the period of January 2012 through March 2017 was implemented on November 14, 2017. The annual cost is $2,121,000 TF. The EPC is estimated at $11,132,000 TF.

3. The estimated number of births in California is 478,419 in FY 2018-19. GDSP assumes approximately 99.00% of newborns will be screened by the NBS Program each year.

4. Assume approximately 45% of newborns screened are from the Medi-Cal population.

5. Assume 98% of claims submitted are paid.

6. CDPH projects a $12.00 fee increase for the GDSP NBS program starting July 1, 2018. The increase is expected to be implemented in July 2018 and the annual cost is projected to be $2,506,000 TF.

GDSP NEWBORN SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 126

7. The estimated costs for FY 2017-18 and FY 2018-19 are:

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
$9.95 Rate Increase	$2,121	$1,061	$1,060
$9.95 Rate Increase - Retro	$11,132	$5,566	$5,566
$17.55 Rate Increase	$3,740	$1,870	$1,870
$17.55 Rate Increase - Retro	$2,805	$1,402	$1,403
Total	**$19,798**	**$9,899**	**$9,899**

FY 2018-19	TF	GF	FF
$9.95 Rate Increase	$2,121	$1,061	$1,060
$17.55 Rate Increase	$3,740	$1,870	$1,870
$12.00 Rate Increase	$2,506	$1,253	$1,253
Total	**$8,367**	**$4,184**	**$4,183**

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

EMERGENCY MEDICAL AIR TRANSPORTATION ACT

REGULAR POLICY CHANGE NUMBER:	127
IMPLEMENTATION DATE:	11/2012
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1612

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$10,868,000	$12,138,000
- STATE FUNDS	$5,434,000	$6,069,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$10,868,000	$12,138,000
STATE FUNDS	$5,434,000	$6,069,000
FEDERAL FUNDS	$5,434,000	$6,069,000

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)
SB 326 (Chapter 797, Statutes of 2015)
SB 833 (Chapter 30, Statutes of 2016)
AB 1410 (Chapter 718, Statutes of 2017)
SPA 16-035
SPA 17-019

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 the 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. This change in remittance procedures increases the frequency of county remission of funds from quarterly to monthly.

After payment of the Department's administrative costs, 20% of the remaining EMATA funds will be used to offset the State's portion of the Medi-Cal reimbursement rate for emergency medical air transportation services. The remaining 80% of the fund will be 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. The SPA for FY 2016-17 was approved on December 1, 2016. The SPA for FY 2017-18 was approved on December 8, 2017.

SB 326 extended the sunset date for the assessment of penalties to January 1, 2018. The Department provided a report on the fiscal impact and planned reimbursement methodology resulting from the expiration of the EMATA fund as required by SB 833 (Chapter 30, Statutes of 2016).

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 EMATCC sunset date to January 1, 2022.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is due to a slight decrease in estimated GF offset amounts and updated augmentation payments.

There is no change from the prior estimate, for FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to increased augmentation payments in FY 2018-19.

Methodology:
1. Implementation date began November 2012.

2. The FY 2017-18 estimated payments include:
   - FFS augmentation payments for the second half of FY 2016-17 and the first half of FY 2017-18,
   - GF transfer from the second half of FY 2016-17 collections was $1,228,000, and
   - GF transfer from the first half of FY 2017-18 collections is expected to be $1,167,000.

3. The FY 2018-19 estimated payments include:
   - FFS augmentation payments for the second half of FY 2017-18, and the first half of FY 2018-19,
   - GF transfer from the second half of FY 2017-18 collections is expected to be $1,228,000, and
   - GF transfer from the first half of FY 2018-19 collections is expected to be $1,228,000.

4. Based on estimated fee collections, the estimated payments on a cash basis are:

(Dollars in Thousands)

FY 2017-18	TF	GF	EMATCC	FFP
GF Offset	$0	($2,395)	$2,395	$0
Augment Payment	$10,868	$0	$5,434	$5,434
Total	**$10,868**	**($2,395)**	**$7,829**	**$5,434**

EMERGENCY MEDICAL AIR TRANSPORTATION ACT

REGULAR POLICY CHANGE NUMBER: 127

(Dollars in Thousands)

FY 2018-19	TF	GF	EMATCC	FFP
GF Offset	$0	($2,456)	$2,456	$0
Augment Payment	$12,138	$0	$6,069	$6,069
Total	**$12,138**	**($2,456)**	**$8,525**	**$6,069**

Funding:
100% GF (4260-101-0001)
Title XIX FFP (4260-101-0890)
EMATA / EMATCC Fund (4260-101-3168)

ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE

REGULAR POLICY CHANGE NUMBER:	129
IMPLEMENTATION DATE:	5/2018
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1996

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$394,000	$6,778,000
- STATE FUNDS	-$347,420	-$5,865,260
PAYMENT LAG	0.0870	0.9594
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$34,300	$6,502,800
STATE FUNDS	-$30,230	-$5,627,130
FEDERAL FUNDS	$64,500	$12,129,940

DESCRIPTION

Purpose:
This policy change estimates funding adjustments to reflect inpatient hospital payments to Alameda Hospital and San Leandro Hospital based on their designation as a Designated Public Hospital (DPH) effective July 1, 2016.

Authority:
SB 815 (Chapter 111, Statutes of 2016)
AB 1568 (Chapter 42, Statutes of 2016)
State Plan Amendment (SPA) 16-032

Interdependent Policy Changes:
Not Applicable

Background:
Through SB 815, the designation of Alameda Hospital and San Leandro Hospital changed from a Non-Designated Public Hospital (NDPH) to a DPH, effective July 1, 2016. As a result, inpatient hospital payment methodologies for the two hospitals will change from a Diagnosis Related Group (DRG) methodology to a cost based payment methodology based on Certified Public Expenditures (CPEs).

The DRG payment methodology is calculated at 50% federal financial participation (FFP) and 50% General Fund (GF), while the DPHs receive 100% FFP reimbursements based on CPEs. Therefore, an adjustment to shift from 50% FFP / 50% GF to 100% FFP is made.

The Centers for Medicare & Medicaid Services approved SPA 16-032 on September 11, 2017, effective July 1, 2016, which allows for the two hospitals' designations to be changed to DPHs.

Reason for Change:
The change in FY 2017-18, from the prior estimate, is due to a four month delay in the expected implementation date from January 2018 to May 2018, and updated payment data.

ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE

REGULAR POLICY CHANGE NUMBER: 129

The change in FY 2018-19, from the prior estimate, is due to an additional four months included in the erroneous payment correction (EPC), and updated payment data.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to FY 2017-18 includes two months of payments, while FY 2018-19 includes a full year of payments and EPCs for retroactive periods.

Methodology:

1. Assume the FY 2017-18 DPH CPE interim rate will increase by 4.01% and DRG payments will increase by 4.66%.

2. Assume the FY 2018-19 DPH CPE interim rate will increase by 4.34% and DRG payments will increase by 4.66%.

3. The DRG payment methodology is paid at 50% GF and 50% FFP.

4. The cost based CPE payment methodology is paid at 50% FFP and 50% CPE.

5. Assume the net ACA optional population adjustments are included in FY 2016-17, FY 2017-18 and FY 2018-19. Funding for the ACA optional population is represented as 100% FFP for DRGs and 100% FFP for CPEs based on costs certified by the hospitals through December 2016. Beginning January 2017, the FFP reduces to 95% FFP / 5% GF, and again reduces to 94% FFP / 6% GF beginning January 2018. Beginning January 2019, the FFP further reduces to 93% FFP / 7% GF.

6. Assume the change in payment methodology from DRG to cost based CPEs will occur in May 2018. The GF savings as a result of the change in payment methodology is expected to be $347,000 in FY 2017-18. The FY 2018-19 interim rates are expected to be implemented in September 2018. The FY 2018-19 GF savings total $5,865,000, which includes a $4,358,000 EPC for the time period from July 1, 2016 through April 30, 2018 to be implemented in July 2018, and a $407,000 EPC for the time period from July 1, 2018 through August 31, 2018 to be implemented in February 2019.

7. The funding adjustment on an annual basis is estimated as follows:

FY 2017-18	TF	GF	FF	ACA FF
Alameda Hospital				
DRG	($350,000)	($141,000)	($137,000)	($72,000)
CPE	$615,000	$0	$386,000	$229,000
Alameda Hospital Total	$265,000	($141,000)	$249,000	$157,000
San Leandro Hospital				
DRG	($637,000)	($206,000)	($191,000)	($240,000)
CPE	$766,000	$0	$392,000	$374,000
San Leandro Hospital Total	$129,000	($206,000)	$201,000	$134,000
FY 2017-18 Total	**$394,000**	**($347,000)**	**$450,000**	**$291,000**

ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE

REGULAR POLICY CHANGE NUMBER: 129

FY 2018-19	TF	GF	FF	ACA FF
Alameda Hospital				
DRG	($5,964,000)	($2,393,000)	($2,331,000)	($1,240,000)
CPE	$10,512,000	$0	$6,570,000	$3,942,000
Alameda Hospital Total	$4,548,000	($2,393,000)	$4,239,000	$2,702,000
San Leandro Hospital				
DRG	($10,888,000)	($3,472,000)	($3,262,000)	($4,154,000)
CPE	$13,118,000	$0	$6,670,000	$6,448,000
San Leandro Hospital Total	$2,230,000	($3,472,000)	$3,408,000	$2,294,000
FY 2018-19 Total	**$6,778,000**	**($5,865,000)**	**$7,647,000**	**$4,996,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
100% Title XIX FFP (4260-101-0890)
100% Title XIX ACA (4260-101-0890)
95% Title XIX ACA / 5% GF (4260-101-0001/0890)
94% Title XIX ACA / 6% GF (4260-101-0001/0890)
93% Title XIX ACA / 7% GF (4260-101-0001/0890)

ALTERNATIVE BIRTHING CENTER REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER:	130
IMPLEMENTATION DATE:	3/2018
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	2000

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$11,000	$53,000
- STATE FUNDS	$5,500	$26,500
PAYMENT LAG	0.6780	0.9890
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$7,500	$52,400
STATE FUNDS	$3,730	$26,210
FEDERAL FUNDS	$3,730	$26,210

DESCRIPTION

Purpose:
This policy change estimates the cost of adjusted reimbursement rates that result from the amended rate-setting methodology for Fee-for-Service (FFS) all-inclusive delivery services provided in Alternative Birthing Centers (ABCs).

Authority:
AB 102 (Chapter 29, Statutes of 2011)
SB 97 (Chapter 52, Statutes of 2017)
State Plan Amendment 17-039

Interdependent Policy Changes:
PC 197 Funding Adjust.—ACA Opt. Expansion

Background:
Previously, the Department reimbursed ABCs for facility and service related costs. These costs reflected a statewide all-inclusive delivery service rate that does not exceed eighty percent of the average Medi-Cal reimbursement to General Acute Care (GAC) hospitals with Medi-Cal contracts. Under the former Selective Provider Contracting Program (SPCP), the California Medical Assistance Commission (CMAC) negotiated GAC hospital inpatient rates.

Pursuant to AB 102, CMAC was dissolved, effective July 1, 2012. Consequently, the rate-setting responsibilities were transferred to the Department. Additionally, AB 102 required the Department to develop and implement a payment methodology based on Diagnosis-Related Groups (DRG). Upon implementation of the DRG methodology, the prior SPCP methodology was discontinued.

The DRG inpatient methodology was implemented for private hospitals beginning July 2013 and for Non-Designated Public Hospitals beginning January 2014.

ALTERNATIVE BIRTHING CENTER REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 130

W&I Code Section 14148.8 was amended to reflect a rate-setting methodology for the Medi-Cal FFS ABCs all-inclusive delivery service rate, based on the Medi-Cal Level-1 DRG payment used for GACs, effective July 1, 2017.

Reason for Change:
The change in FY 2017-18 and FY 2018-19, from the prior estimate is due to:

- A delay in implementing the rate change from December 2017 to March 2018,
- A delay in implementing the retroactive payments from March 2018 to August 2018, and
- Lower estimated annual ABC births based on the average utilization for more recent years.

The change from FY 2017-18 to FY 2018-19, in the current estimate is due to the inclusion of:

- A full year of the rate increase in FY 2018-19, and
- Retroactive payments in FY 2018-19.

Methodology:

1. Effective July 2017, the change to the ABC reimbursement methodology for the all-inclusive delivery service rate would result in an increased rate for ABC providers. The rate increase is expected to be implemented March 2018.

2. Retroactive payments for the period of July 1, 2017 through February 28, 2018, are expected to be implemented August 2018.

3. On average, there are approximately 125 all-inclusive FFS deliveries in an ABC each year. The incremental increase for the new Medi-Cal rate is $253 per delivery.

   125 deliveries x $253 increase = $32,000 TF (rounded)

FY 2017-18	TF	GF	FF
Rate Increase	$11,000	$5,500	$5,500
Total	**$11,000**	**$5,500**	**$5,500**

FY 2018-19	TF	GF	FF
Rate Increase	$32,000	$16,000	$16,000
FY 2017-18 Retro	$21,000	$10,500	$10,500
Total	**$53,000**	**$26,500**	**$26,500**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in PC 197 Funding Adjust.—ACA Opt. Expansion

DP/NF-B RETROACTIVE RECOUPMENT FORGIVENESS

REGULAR POLICY CHANGE NUMBER:	131
IMPLEMENTATION DATE:	9/2016
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1964

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$1,298,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$1,298,000	$0
FEDERAL FUNDS	-$1,298,000	$0

DESCRIPTION

Purpose:
This policy changes estimates the General Fund (GF) costs due to the forgiveness of the AB 97 (Chapter 3, Statutes of 2011) retroactive recoupments of the rate reduction and rate freeze for services provided by Distinct Part Nursing Facility – Level Bs (DP/NF-Bs) for the period of June 2011 through September 2013.

Authority:
ABX2 1 (Chapter 3, Statutes of 2016)

Interdependent Policy Changes:
Not Applicable

Background:
Effective June 1, 2011, AB 97 required the Department to freeze rates for the facilities enjoined from the original rate freeze, which was required by ABX4 5 (Chapter 5, Statutes of 2009). The Department received approval from the Centers for Medicare and Medicaid Services (CMS) to implement a rate freeze on Nursing Facility – Level As and DP/NF-Bs.

The California Hospital Association (CHA) filed a lawsuit challenging the 10% payment reduction and rate freeze at the 2008-2009 levels, required by AB 97, with respect to DP/NF-B facilities. On December 28, 2011, the federal court issued a preliminary injunction.

On December 13, 2012, the United States Court of Appeal for the Ninth Circuit issued a decision in which it reversed the previous issued injunctions against AB 97 payment reductions and rate freezes. On January 28, 2013, the plaintiffs requested a rehearing. On May 24, 2013, the Ninth Circuit denied the plaintiff's request for rehearing. On June 25, 2013, the Ninth Circuit issued an order formally vacating the court injunctions. As a result, the Department was to implement AB 97 payment reductions and rate freezes retroactive to June 1, 2011.

DP/NF-B RETROACTIVE RECOUPMENT FORGIVENESS

REGULAR POLICY CHANGE NUMBER: 131

On December 20, 2013, CMS approved the Department's request to exempt:

- DP/NF-B providers located in rural and frontier areas from the rate freeze at 2008-09 levels and the 10% payment reduction to those rates as required by AB 97, effective September 1, 2013, and
- Non-rural and frontier DP/NF-B providers from the rate freeze at 2008-09 levels and the 10% payment reduction to those rates as required by AB 97, effective October 1, 2013.

Effective August 1, 2016, ABX2 1 requires the Department to forgo the AB 97 retroactive recoupments 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.

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.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is an increase in federal fund repayments to include ARRA FMAP repayments. In the current estimate, there are no costs estimated in FY 2018-19 due to the completion of the federal repayments in FY 2017-18.

Methodology:
1. The Department will forgo the retroactive recoupment for DP/NF-Bs, for dates of service on or after June 1, 2011 and on or before September 30, 2013.

2. The total estimated GF costs to repay the federal share of the loss of savings were determined to be $105.713 million GF. In FY 2016-17, federal fund repayments totaling $104.415 million GF were made to CMS. The remaining $1.298 million GF will be paid in FY 2017-18.

Fiscal Year	TF	GF	FF
FY 2017-18	$0	$1,298,000	($1,298,000)

Funding:
100% GF (4260-101-0001)
100% Title XIX FF (4260-101-0890)

LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES

REGULAR POLICY CHANGE NUMBER:	133
IMPLEMENTATION DATE:	8/2013
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1784

	FY 2017-18	FY 2018-19
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 100% State General Fund (GF).

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, offset LTC rate reimbursement payments and may also provide funding for LTC reimbursement rate increases. 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-PEDs)

AB 1467 established the LTCQAF. Effective August 1, 2013, the revenue generated by the LTC QA and ICF-DDs fees collected are deposited into the fund, rather than the state GF, which are used for LTC provider reimbursement rate expenditures.

LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES

REGULAR POLICY CHANGE NUMBER: 133

AB 119 extends the AB 1629 facility-specific rate methodology, QAF, and Quality and Accountability Supplemental Payments (QASP) Program through July 31, 2020. Beginning rate-year 2015-16, the annual weighted average rate increase is 3.62%. Further, the QASP will continue at FY 2014-15 levels, rather than setting aside a portion of the annual rate increase. Additionally, beginning fiscal year 2015-16, the legislation requires the Department to incorporate direct care staff retention as a performance measure to the QASP Program.

SB 833 established a continuous appropriation for the LTCQAF, to allow moneys from the fund to be appropriated without further legislative action.

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, and from FY 2017-18 to FY 2018-19, in the current estimate, is due to updated actual collections and transfer data through February 2018.

Methodology:
1. Based on LTC QA fee collection data from July 2015 through June 2017, the average annual LTC QA fee revenue on a cash basis is $487,406,000. Based on four years of FFS utilization data, the average growth rate for ICF-DDs and nursing facilities is 1.88% and 2.00%, respectively.

2. Based on collections and transfer data through Feburary 2018, assume $440.934 million will be transferred to the GF in FY 2017-18, and $460.098 million in FY 2018-19.

3. The estimated fund adjustment from the LTCQAF to the GF is:

(Dollars in Thousands)

FY 2017-18	TF	GF	LTCQAF
FY 2015-16	$0	($63,467)	$63,467
FY 2016-17	$0	($113,840)	$113,840
FY 2017-18	$0	($263,627)	$263,627
Total	**$0**	**($440,934)**	**$440,934**

(Dollars in Thousands)

FY 2018-19	TF	GF	LTCQAF
FY 2015-16	$0	($3,262)	$3,262
FY 2016-17	$0	($5,852)	$5,852
FY 2017-18	$0	($214,745)	$214,745
FY 2018-19	$0	($236,239)	$236,239
Total	**$0**	**($460,098)**	**$460,098**

Funding:
Long Term Care Quality Assurance Fund (4260-601-3213)
100% GF (4260-101-0001)

DPH INTERIM RATE

REGULAR POLICY CHANGE NUMBER:	134
IMPLEMENTATION DATE:	7/2005
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1161

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$359,764,050	-$384,886,340
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$359,764,050	-$384,886,340
FEDERAL FUNDS	$359,764,050	$384,886,340

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:
PC 124 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, and 7% GF / 93% FFP to 100% FFP beginning January 2019.

DPH INTERIM RATE

REGULAR POLICY CHANGE NUMBER: 134

Reason for Change:
The change in FY 2017-18 and FY 2018-19, from the prior estimate, is due to updated DPH actual data through January 2018.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the increased growth rate for community-based DPHs by 6.14%, and by 0.33% for county DPHs in FY 2018-19 based on updated DPH actual data through January 2018.

Methodology:
1. The funding adjustment is estimated at:

(Dollars in Thousands)

	Expenditures	GF to FF Shift
FY 2017-18	**$1,206,367**	**$359,764**
FY 2018-19	**$1,280,146**	**$384,886**

Funding:
(Dollars in Thousands)

FY 2017-18	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890 / 0001)	($659,357)	($329,679)	($329,678)
100% Title XIX FF (4260-101-0890)	$1,206,367	$0	$1,206,367
95% Title XIX ACA / 5% GF (4260-101-0890 / 0001)	($273,505)	($13,675)	($259,830)
94% Title XIX ACA / 6% GF (4260-101-0890 / 0001)	($273,505)	($16,410)	($257,095)
Total Funds	**$0**	**($359,764)**	**$359,764**

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890 / 0001)	($693,510)	($346,755)	($346,755)
100% Title XIX FF (4260-101-0890)	$1,280,146	$0	$1,280,146
94% Title XIX ACA / 6% GF (4260-101-0890 / 0001)	($293,318)	($17,599)	($275,719)
93% Title XIX ACA / 7% GF (4260-101-0890 / 0001)	($293,318)	($20,532)	($272,786)
Total Funds	**($0)**	**($384,886)**	**$384,886**

LABORATORY RATE METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER:	135
IMPLEMENTATION DATE:	2/2016
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1703

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	-$12,880,000	-$28,948,000
- STATE FUNDS	-$6,440,000	-$14,474,000
PAYMENT LAG	0.9925	1.0000
% REFLECTED IN BASE	50.53 %	22.98 %
APPLIED TO BASE		
TOTAL FUNDS	-$6,323,900	-$22,295,800
STATE FUNDS	-$3,161,970	-$11,147,880
FEDERAL FUNDS	-$3,161,970	-$11,147,880

DESCRIPTION

Purpose:
This policy change estimates savings from a 10% payment reduction to clinical laboratories or laboratory services, and the savings from a new reimbursement methodology for these services.

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)

Interdependent Policy Changes:
PC 197 Funding Adjust.—ACA Opt. Expansion
PC 191 Funding Adjust.—OTLICP

Background:
AB 1494 required the Department to develop a new rate methodology for clinical laboratories or laboratory services. In addition to 10% payment reductions pursuant to AB 97 (Chapter 3, Statutes of 2011), AB 1494 allows 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 are 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 changes 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: 135

Reason for Change:
The change from the prior estimate, for FY 2017-18, is due to an updated recoupment schedule:

- The AB 1494 retroactive recoupment is expected to begin May 2018 instead of January 2018,
- The 2015-16 rate year (RY) retroactive recoupment is expected to begin May 2018 instead of January 2018, and
- The RY 2016-17 retroactive recoupment began December 2017 instead of November 2017.

The change from the prior estimate, for FY 2018-19, is due to:

- Delayed implementation of the AB 1494 retroactive recoupment from January 2018 to May 2018, and
- Delayed implementation of the RY 2015-16 retroactive recoupment from January 2018 to May 2018, resulting in four months of savings shifting to FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to:

- Delayed implementation of the AB 1494 and RY 2015-16 retroactive recoupments from January 2018 to May 2018,
- Seven months of the RY 2016-17 retroactive recoupment being completed in FY 2017-18 compared to five months in FY 2018-19, and
- The RY 2017-18 retroactive recoupment, although delayed from December 2017 to May 2018, being completed in FY 2017-18.

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 revised total for the retroactive AB 1494 10% savings from July 1, 2012 to June 30, 2015, is estimated to be $28,098,000 TF and is expected to be recovered over 60 months beginning May 2018.

4. The Centers for Medicare and Medicaid Services (CMS) approved the new laboratory rate methodology in July 2015.

5. The 2015-16 rate year change was implemented in February 2016 and has been captured in the FFS base trends. The recoupment of retroactive savings from July 2015 through January 2016 is expected to be completed over 12 months beginning May 2018.

6. Effective July 1, 2016, the laboratory rate change savings is projected to be $6,641,000 TF for the 2016-17 rate year and was implemented in February 2017. The recoupment of retroactive savings from July 2016 through January 2017 was implemented in December 2017.

7. Effective July 1, 2017, the laboratory rate change savings is revised to be $34,000 TF for the 2017-18 rate year and was implemented on September 25, 2017. The recoupment of retroactive savings from July 2017 to September 2017 is expected to be implemented in May 2018.

LABORATORY RATE METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER: 135

Dollars in Thousands

FY 2017-18	TF	GF	FF
New Rate Methodology Savings	($6,667)	($3,334)	($3,333)
AB 1494 Retro Savings	($937)	($468)	($469)
New Rate Methodology Retro Savings	($5,276)	($2,638)	($2,638)
Total	**($12,880)**	**($6,440)**	**($6,440)**

FY 2018-19	TF	GF	FF
New Rate Methodology Savings	($6,675)	($3,337)	($3,338)
AB 1494 Retro Savings	($5,620)	($2,810)	($2,810)
New Rate Methodology Retro Savings	($16,653)	($8,327)	($8,326)
Total	**($28,948)**	**($14,474)**	**($14,474)**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in PC 197 Funding Adjust.—ACA Opt. Expansion
OTLICP funding identified in PC 191 Funding Adjust.—OTLICP

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER:	136
IMPLEMENTATION DATE:	8/2015
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1505

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	-$10,595,000	-$57,113,000
- STATE FUNDS	-$5,297,500	-$28,556,500
PAYMENT LAG	0.8138	0.9826
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$8,622,200	-$56,119,200
STATE FUNDS	-$4,311,100	-$28,059,620
FEDERAL FUNDS	-$4,311,110	-$28,059,620

DESCRIPTION

Purpose:
This policy change estimates savings due to the implementation of a reduction to radiology reimbursement rates.

Authority:
SB 853 (Chapter 717, Statutes of 2010)

Interdependent Policy Changes:
PC 197 Funding Adjust.—ACA Opt. Expansion
PC 191 Funding Adjust.—OTLICP

Background:
SB 853 mandates that Medi-Cal rates for radiology services may not exceed 80% of Medicare rates for dates of service on or after October 1, 2010. The Department submitted a State Plan Amendment (SPA) to reduce these rates below 80% of Medicare levels; however, due to a delay in federal approval, it was determined that a two-year retroactive application of this reduction could adversely impact beneficiary access to radiology services. In light of the AB 97 (Chapter 3, Statutes of 2011) 10% payment reduction, and that federal approval of a reduction with a lengthy retroactive recoupment was extremely unlikely, the effective date for retroactive savings shifted from October 1, 2010, to October 1, 2012.

On June 2, 2017, SPA 17-014 was submitted to the Centers for Medicare and Medicaid Services (CMS) to clearly identify that the reimbursement methodology for radiology services will be adjusted annually. Federal approval will allow for the continuation of the annual rate adjustments. Approval for SPA 17-014 is expected in June 2018.

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER: 136

Reason for Change:
The change from the prior estimate, for FY 2017-18, is a decrease in savings due to delayed implementation of the prospective and retroactive recoupments for the October 2015 rate adjustments.

The change from the prior estimate, for FY 2018-19, is an increase in savings due to:

- Shifting savings from the retroactive recoupment for the October 2015 rate adjustments to FY 2018-19,
- The addition of the April 2017 rate adjustments; and
- The addition of the January 2018 rate adjustments.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the delayed implementation of the October 2015 rate adjustments from FY 2017-18 to FY 2018-19 and including the April 2017 and January 2018 annual rate adjustments in FY 2018-19.

Methodology:

1. The Medi-Cal rate reductions will apply to radiology services reimbursement rates exceeding 80% of Medicare rates.

2. There is no managed care impact as a result of this reduction because managed care capitation rates are calculated using radiology rates that are at or below 80% of Medicare rates.

3. The rate adjustments effective October 1, 2012, reflect an annual FFS savings of $23,045,000 TF. These adjustments were implemented in August 2015 and are fully captured in the FFS base trends and no longer being budgeted in this policy change.

   The total recoupment of retroactive savings from October 1, 2012, through July 31, 2015, is estimated to be $36,385,000 TF and was implemented in May 2016. In order to recoup the overpayments made during this period, radiology providers are subject to a 20% withhold from their weekly check write. The recoupment process is expected to be completed by the end of FY 2017-18.

4. The rate adjustments effective October 1, 2015, reflect an annual FFS savings of $22,620,000 TF. These rates are expected to be implemented in May 2018.

   The total recoupment of retroactive savings from October 1, 2015, through April 30, 2017, is estimated to be $35,815,000 TF and is expected to be implemented in August 2018 over 12 months.

5. The rate adjustments effective April 1, 2017, reflect an annual FFS savings of $623,000 TF. These rates are expected to be implemented in December 2018.

   The total recoupment of retroactive savings from April 1, 2017, through November 30, 2018, is estimated to be $1,038,000 TF and is expected to be implemented in April 2019.

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER: 136

6. The rate adjustments effective January 1, 2018, reflect an annual FFS savings of $174,000 TF. These rates are expected to be implemented in January 2019.

   The total recoupment of retroactive savings from January 1, 2018, through December 31, 2018, is estimated to be $174,000 TF and is expected to be implemented in May 2019.

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
Prospective Savings	($3,770)	($1,885)	($1,885)
Recoupment of Retro Savings	($6,825)	($3,413)	($3,412)
Total	**($10,595)**	**($5,298)**	**($5,297)**

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
Prospective Savings	($23,070)	($11,535)	($11,535)
Recoupment of Retro Savings	($34,043)	($17,022)	($17,021)
Total	**($57,113)**	**($28,557)**	**($28,556)**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in PC 197 Funding Adjust.—ACA Opt. Expansion
OTLICP funding identified in PC 191 Funding Adjust.—OTLICP

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER:	137
IMPLEMENTATION DATE:	12/2011
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1580

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	-$203,884,000	-$199,420,000
- STATE FUNDS	-$101,942,000	-$99,710,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	88.52 %	90.50 %
APPLIED TO BASE		
TOTAL FUNDS	-$23,405,900	-$18,944,900
STATE FUNDS	-$11,702,940	-$9,472,450
FEDERAL FUNDS	-$11,702,940	-$9,472,450

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:
PC 191 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.

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 137

The actuarial equivalent of FFS payment reductions to specified managed care providers was 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 from the prior estimate, for both FY 2017-18 and FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to:

- A full year of the DME/Medical Supplies retroactive recoupments occurring in FY 2018-19, and
- Eight months of the Pharmacy retroactive recoupments due to the estimated completion of these retroactive recoupments by March 2019.

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.

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 137

- **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.
  - 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%.

Annual Prospective Pharmacy Savings	TF
Pharmacy drug products (restored effective April 2017)	($22,577,000)
Pharmacy non-drug products (prospective reductions shown in PC 137)	($8,551,000)
Total prospective Pharmacy reductions	($31,128,000)

- **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	36
Phase III (CHDP)	10/1/2014	10/1/2014	N/A	N/A	N/A

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 137

4. The estimated savings (TF) from AB 97 payment reduction are:
(Dollars in Thousands)

Provider Type		FY 2017-18	FY 2018-19	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	($6,258)	($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	($31,128)	($31,128)	($31,128)
	FFS Retro	($17,148)	($11,432)	($17,148)
	FFS	($131,241)	($131,241)	($131,241)
	FFS Retro	($23,406)	($18,942)	($24,658)
	Phase II Total	($154,647)	($150,183)	($155,899)
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	($180,478)	($180,478)	($180,478)
	FFS Retro	($23,406)	($18,942)	($24,658)
	Managed Care	$0	$0	$0
Grand Total	**Grand Total**	**($203,884)**	**($199,420)**	($205,136)

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
OTLICP funding identified in PC 191 Funding Adjust.—OTLICP

LABORATORY RATE METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER:	135
IMPLEMENTATION DATE:	2/2016
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1703

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	-$12,880,000	-$28,948,000
- STATE FUNDS	-$6,440,000	-$14,474,000
PAYMENT LAG	0.9925	1.0000
% REFLECTED IN BASE	50.53 %	22.98 %
APPLIED TO BASE		
TOTAL FUNDS	-$6,323,900	-$22,295,800
STATE FUNDS	-$3,161,970	-$11,147,880
FEDERAL FUNDS	-$3,161,970	-$11,147,880

DESCRIPTION

Purpose:
This policy change estimates savings from a 10% payment reduction to clinical laboratories or laboratory services, and the savings from a new reimbursement methodology for these services.

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)

Interdependent Policy Changes:
PC 197 Funding Adjust.—ACA Opt. Expansion
PC 191 Funding Adjust.—OTLICP

Background:
AB 1494 required the Department to develop a new rate methodology for clinical laboratories or laboratory services. In addition to 10% payment reductions pursuant to AB 97 (Chapter 3, Statutes of 2011), AB 1494 allows 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 are 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 changes 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.

HOSPITAL QAF - MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 138

Reason for Change:
The change from the prior estimate, for FY 2017-18, is a decrease due to:

- FY 2015-16 payment totals were updated based on actuals, and
- The second six months of FY 2016-17 payments (January 2017 through June 2017) will shift from FY 2017-18 to FY 2018-19.

The change from the prior estimate, for FY 2018-19, is an increase due to shifting the second six months of FY 2016-17 payments to FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to higher payment amounts for HQAF V program periods in FY 2018-19.

Methodology:

1. Per SB 239, the Hospital QAF program was extended from January 1, 2014, through December 31, 2016.

2. Proposition 52, permanently extends the Hospital QAF program. The program period from January 1, 2017, to June 30, 2019, is referred to as QAF V.

3. The first SB 239 managed care payment was made in August 2015.

4. The amounts paid towards the Managed Care rate range increases are not included in this policy change. This amount is budgeted in the HQAF Rate Range Increases policy change.

5. Increased capitation payments under Section 14165.58 are the actuarial equivalent to AB 113 (Chapter 20, Statutes of 2011) payments made to NDPHs. The Department will collect from NDPHs based on the IGTs in the below table.

6. The following calculations are based on the approved fee model pending actuarially approved PMPMs and are subject to change, for the following rating periods:
    - January 1, 2017, to June 30, 2017
    - FY 2017-18
    - FY 2018-19

7. On a cash basis, the estimated QAF payments are:

(Dollars in Thousands)

FY 2017-18	TF	SF(HQARF)	FF (TITLE 19)	FF (TITLE 21)	ACA FF
Managed Care					
FY 2015-16	$3,351,565	$941,845	$851,951	$120,901	$1,436,868
FY 2016-17	$1,597,605	$447,130	$408,116	$61,965	$680,394
Total MC	$4,949,170	$1,388,975	$1,260,067	$182,866	$2,117,262
NDPH IGT					
FY 2015-16	$95,400	$26,810	$24,250	$3,441	$40,899
FY 2016-17	$48,701	$13,630	$12,441	$1,889	$20,741
Total NDPH IGT	$144,101	$40,440	$36,691	$5,330	$61,640
Total FY 2017-18	**$5,093,271**	**$1,429,415**	**$1,296,758**	**$188,196**	**$2,178,902**

HOSPITAL QAF - MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 138

(Dollars in Thousands)

FY 2018-19	TF	SF(HQARF)	FF (TITLE 19)	FF (TITLE 21)	ACA FF
Managed Care					
FY 2016-17	$1,800,022	$540,445	$458,130	$69,558	$731,889
FY 2017-18	$1,799,999	$539,865	$453,571	$68,866	$737,697
FY 2018-19	$1,650,000	$497,615	$411,469	$62,474	$678,442
Total MC	$5,250,021	$1,577,925	$1,323,170	$200,898	$2,148,028
NDPH IGT					
FY 2016-17	$48,700	$14,622	$12,395	$1,882	$19,801
FY 2017-18	$97,400	$29,213	$24,543	$3,726	$39,918
FY 2018-19	$89,283	$26,926	$22,265	$3,381	$36,711
Total NDPH IGT	$235,383	$70,761	$59,203	$8,989	$96,430
Total FY 2018-19	**$5,485,404**	**$1,648,686**	**$1,382,373**	**$209,887**	**$2,244,458**

Funding:
Hospital Quality Assurance Revenue Fund (4260-611-3158)
Title XIX FFP (4260-611-0890)
Title XXI FFP (4260-611-0890)
Reimbursement (4260-601-0995)*

HOSPITAL QAF - FFS PAYMENTS

REGULAR POLICY CHANGE NUMBER:	139
IMPLEMENTATION DATE:	7/2017
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1475

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$7,114,270,000	$4,938,537,000
- STATE FUNDS	$3,819,498,000	$2,263,799,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$7,114,270,000	$4,938,537,000
STATE FUNDS	$3,819,498,000	$2,263,799,000
FEDERAL FUNDS	$3,294,772,000	$2,674,738,000

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)
AB 1607 (Chapter 27, Statutes of 2016)
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

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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 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).

AB 1607 extended the inoperative date of the Hospital QAF program to January 1, 2018, creating a one-year extension of the program.

Proposition 52, approved by California voters on November 8, 2016, permanently extends the Hospital QAF program. The program period from January 1, 2017, to June 30, 2019, is referred to as QAF V.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is due to:

- The approval of the HQAF V Fee & Payment Model in December 2017. The amounts in the approved model differ from the amounts provided in the draft model that was used for the prior estimate,
- The addition of the FY 2015-16 ACA and FY 2016-17 ACA payments in FY 2017-18, and
- The addition of a repayment to CMS for an Upper Payment Limit (UPL) overage. Through a UPL review, it was discovered that $1,090,226,000 was overpaid to providers.

The change from the prior estimate, for FY 2018-19, is an increase due to:

- The approval of the HQAF V Fee & Payment Model in December 2017,
- The addition of the FY 2016-17 ACA and FY 2017-18 ACA payments in FY 2018-19, and
- Partially shifting FY 2016-17 grant payments from FY 2017-18 to FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to fewer fiscal year payments and ACA payments for QAF IV-QAF V in FY 2018-19.

Methodology:
QAF I-QAF III

1. The remaining QAF I through QAF III payments are no longer assumed to be paid.

QAF IV-QAF V

2. 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, 2018. Furthermore, Proposition 52 permanently extends 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).

3. The first QAF IV FFS payment was made in March 2015. This includes Designated Public Hospital and NDPH grant amounts.

4. Payments associated with QAF V were approved by CMS in December 2017.

5. Due to implementation delays, payments for QAF V FFS began in February 2018.

HOSPITAL QAF - FFS PAYMENTS

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6. The ACA claiming methodology for the FFS supplemental payments was approved in FY 2017-18. The FFS ACA payments for FY 2013-14 and FY 2014-15 were claimed in December 2017 and deposited in Fund 3158. These funds will be used to pay back CMS for the QAF IV UPL overage for FY 2015-16 and FY 2016-17. FFS ACA payments for FY 2015-16 and the first two quarters of FY 2016-17 will be claimed in FY 2017-18. In FY 2018-19, FFS ACA payments for the remaining two quarters of FY 2016-17 and FY 2017-18 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. On a cash basis, the estimated QAF IV-QAF V payments are:

(Dollars in Thousands)

FY 2017-18	**TF**	**SF(HQARF)**	**FF**	**ACA FF**	*Return to Fund 3158
QAF IV-QAF V					
FY 2015-16 UPL Overage	$0	$524,097	($524,097)	$0	$0
FY 2016-17 UPL Overage	$0	$566,129	($566,129)	$0	$0
FY 2013-14 ACA	$244,028	$0	($244,028)	$488,056	$244,028
FY 2014-15 ACA	$440,436	$0	($440,436)	$880,872	$440,436
FY 2015-16 ACA	$578,974	$0	($578,974)	$1,157,948	$578,974
FY 2016-17 ACA	$547,463	$0	($547,463)	$1,094,926	$547,463
FY 2015-16	$30,250	$30,250	$0	$0	$0
FY 2016-17	$2,025,086	$1,035,668	$989,418	$0	$0
FY 2017-18	$3,248,033	$1,663,354	$1,584,679	$0	$0
Total FY 2017-18	**$7,114,270**	**$3,819,498**	**($327,030)**	**$3,621,802**	$1,810,901

(Dollars in Thousands)

FY 2018-19	**TF**	**SF(HQARF)**	**FF**	**ACA FF**	*Return to Fund 3158
QAF IV-QAF V					
FY 2016-17 ACA	$188,763	$0	($188,763)	$377,526	$188,763
FY 2017-18 ACA	$352,501	$0	($352,501)	$705,002	$352,501
FY 2016-17	$17,250	$17,250	$0	$0	$0
FY 2017-18	$1,082,677	$554,451	$528,226	$0	$0
FY 2018-19	$3,297,346	$1,692,098	$1,605,248	$0	$0
Total FY 2018-19	**$4,938,537**	**$2,263,799**	**$1,592,210**	**$1,082,528**	$541,264

*The Return to Fund 3158 column is for display purposes only (see QAF IV-QAF V Methodology #6).

Funding:
Hospital Quality Assurance Revenue Fund (4260-611-3158)
Title XIX FFP (4260-611-0890)

GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

REGULAR POLICY CHANGE NUMBER: 140
IMPLEMENTATION DATE: 9/2018
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 2024

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$1,453,448,000
- STATE FUNDS	$0	$532,085,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$1,453,448,000
STATE FUNDS	$0	$532,085,000
FEDERAL FUNDS	$0	$921,363,000

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 and their affiliated public medical/nursing/paramedical schools, 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)

Interdependent Policy Changes:
PC 111 Managed Care 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.

GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

REGULAR POLICY CHANGE NUMBER: 140

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) 17-009. 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:

- 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, resulting in a savings. The IGT savings will be budgeted in the Managed Care IGT Admin. & Processing Fee policy change.

The Department submitted SPA 17-009 to CMS in March 2017 with a January 1, 2017 effective date. CMS approval of SPA 17-009 is anticipated in the first quarter of FY 2018-19.

Reason for Change:
The change in FY 2017-18, from the prior estimate, is due to a delay in the expected implementation date by seven months which shifted FY 2016-17 and FY 2017-18 payments to FY 2018-19.

The change in FY 2018-19, from the prior estimate, is due to:

- FY 2016-17 and FY 2017-18 payments shifted from FY 2017-18,
- FY 2018-19 payments are no longer included in the estimate, and
- A slight increase in FY 2017-18 payments based on updated cost data and updated payment methodology calculations.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the timing of the payment start date which is expected to begin in FY 2018-19.

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.

3. The sum of GME and IME payments are estimated to provide a distribution of approximately $950.0 million total computable annually. Per SPA 17-009, beginning with FY 2017-18, the annual distribution amounts are adjusted based on the Consumer Price Index (CPI).
    - FY 2016-17 payments are effective January 1, 2017 and will be the total of two quarters of the estimated annual or $474.9 million TF.
    - Assume a 3% CPI annual increase for FY 2017-18 and FY 2018-19, which is estimated to provide $978.5 million TF for FY 2017-18, and $1.008 billion TF for FY 2018-19 in annual total computable payments.

GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

REGULAR POLICY CHANGE NUMBER: 140

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 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 is 95%, reduces to 94% beginning January 1, 2018, and reduces to 93% beginning January 1, 2019. The ACA reimbursement methodology is pending submission to CMS.

6. Assume ACA payments will begin in September 2018, and will coincide with the quarterly interim payments. The Medi-Cal Managed Care eligibility data from the most recent available cost reports will be used to determine the proportion of costs for newly eligible Medi-Cal beneficiaries.

7. Assume an effective date of January 1, 2017, pending CMS approval of SPA 17-009.

8. Assume the two quarters of FY 2016-17 will be paid in FY 2018-19.

9. Assume all four quarters of FY 2017-18 will be paid in FY 2018-19.

(Dollars in Thousands)

FY 2018-19	TF	IGT	FF	ACA FF
FY 2016-17	$474,983	$173,405	$166,283	$135,295
FY 2017-18	$978,465	$358,680	$342,545	$277,240
Total	**$1,453,448**	**$532,085**	**$508,828**	**$412,535**

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 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$355,918,000	$922,014,000
- STATE FUNDS	$110,768,000	$288,395,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$355,918,000	$922,014,000
STATE FUNDS	$110,768,000	$288,395,000
FEDERAL FUNDS	$245,150,000	$633,619,000

DESCRIPTION

Purpose:
This policy change estimates the expenditures related to providing supplemental payments for 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

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 supplemental payments for physician 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 AB 120 (Chapter 22, Statutes of 2017) the Department of Health Care Services shall develop 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.

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REGULAR POLICY CHANGE NUMBER: 141

The Department has proposed supplemental payments for physician services in both Medi-Cal fee-for-service (FFS) and Medi-Cal managed care delivery systems. Providers who are eligible to provide and bill for the following Current Procedural Terminology (CPT) codes will receive the associated supplemental payment identified, in addition to whatever other payment they receive from the State in FFS or from the health plan as a network provider in managed care:

CPT	Supplemental Payment
99201	$10.00
99202	$15.00
99203	$25.00
99204	$25.00
99205	$50.00
99211	$10.00
99212	$15.00
99213	$15.00
99214	$25.00
99215	$25.00
90791	$35.00
90792	$35.00
90863	$5.00

The Centers for Medicare and Medicaid Services (CMS) approved State Plan Amendment (SPA) 17-030 for the FFS delivery system supplemental payments. 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.

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. The Department received federal approval to implement managed care capitation rate increases to fund MCPs to make supplemental payments for 13 CPT codes for FY 2017-18.

Beginning 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 provider's actual utilization for these codes reported through encounter data for rating period FY 2017-18 and FY 2018-19.

Reason for Change:

The change from the prior estimate for FY 2017-18 and FY 2018-19 is due to:

- Decreased managed care payments based on the FY 2017-18 capitation rates;
- FFS supplemental payments were implemented one month earlier in January 2018;
- The Erroneous Payment Correction (EPC) for FY 2017-18 FFS supplemental payments began earlier and was implemented in February 2018; and

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REGULAR POLICY CHANGE NUMBER: 141

- Updating the managed care supplemental payments to account for 10 months of County Organized Health System (COHS) model payments and 11 months of Non-COHS models payments in FY 2017-18 with the remaining payments in FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to:
- Including two months of COHS model FY 2017-18 and one month of the Non-COHS models managed care directed payments in FY 2018-19, and
- Including additional FY 2018-19 supplemental payments in FY 2018-19.

Methodology:
1. Payments will be made via supplemental payments.

2. This policy is effective July 1, 2017 and payments began January 2018.

FFS Physician Supplemental Payments
3. Assume the annual FFS supplemental payments are approximately $24.2 million TF, on an accrual basis.

4. Assume the FY 2017-18 FFS supplemental payments was implemented in January 2018.

5. The Erroneous Payment Correction (EPC) for the July 2017 to January 2018 retroactive period was implemented in February 2018.

6. Assume the FFS supplemental payments continue for FY 2018-19.

Managed Care Physician Directed Payments
7. Assume that the estimated value of enhanced capitation rate increases for MCPs to fund the supplemental rate increase for FY 2017-18 and FY 2018-19 is $373.3 million TF on an accrual basis.

8. A risked-based capitation rate will be issued to MCPs based on anticipated utilization of the 13 CPT codes.

9. 10 months of the COHS model payments and 11 months of the Non-COHS model FY 2017-18 capitation rate increases are anticipated to occur in FY 2017-18. Two months of the COHS model and one month of the Non-COHS models FY 2017-18 capitation rate increases are anticipated to be made at the beginning of FY 2018-19.

10. 10 months of the COHS model payments and 11 months of the Non-COHS models FY 2018-19 capitation rate increases are anticipated to occur in FY 2018-19.

11. The amount of $162.983 million SF has been added to FY 2018-19 to allow for additional supplemental payments.

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REGULAR POLICY CHANGE NUMBER: 141

12. Funds allocated for the supplemental payments are as follows:

(Dollars in Thousands)

FY 2017-18	TF	SF	Title XXI FF	Title XIX FF	ACA FF
FFS Physician Supplemental FY 2017-18 (Lagged)	$10,079	$4,459	$252	$4,360	$1,008
Managed Care Directed Payments FY 2017-18	$335,760	$101,861	$11,021	$93,885	$128,993
Retro FFS Physician Supplemental FY 2017-18	$10,079	$4,448	$252	$4,360	$1,019
Total	**$355,918**	**$110,768**	**$11,525**	**$102,605**	**$131,020**

(Dollars in Thousands)

FY 2018-19	TF	SF	Title XXI FF	Title XIX FF	ACA FF
FFS Physician Supplemental FY 2018-19	$24,198	$10,716	$605	$10,468	$2,409
Managed Care Directed Payments FY 2017-18	$37,527	$11,470	$1,232	$10,493	$14,332
Managed Care Directed Payments FY 2018-19	$335,760	$103,226	$11,021	$93,885	$127,628
Additional FY 2018-19 Payments	$524,529	$162,983	$16,046	$148,899	$196,601
Total	**$922,014**	**$288,395**	**$28,904**	**$263,745**	**$340,970**

Funding:

(Dollars in Thousands)

FY 2017-18	TF	SF	FF
Healthcare Treatment Fund Prop. 56 (4260-101-3305)	$110,768	$110,768	$0
ACA Title XIX FF (4260-101-0890)	$131,020	$0	$131,020
Title XIX FF (4260-101-0890)	$102,605	$0	$102,605
Title XXI FF (4260-113-0890)	$11,525	$0	$11,525
Total	**$355,918**	**$110,768**	**$245,150**

(Dollars in Thousands)

FY 2018-19	TF	SF	FF
Healthcare Treatment Fund Prop. 56 (4260-101-3305)	$288,395	$288,395	$0
ACA Title XIX FF (4260-101-0890)	$340,970	$0	$340,970
Title XIX FF (4260-101-0890)	$263,745	$0	$263,745
Title XXI FF (4260-113-0890)	$28,904	$0	$28,904
Total	**$922,014**	**$288,395**	**$633,619**

PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER:	142
IMPLEMENTATION DATE:	7/2005
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1071

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$576,179,000	$581,964,000
- STATE FUNDS	$288,089,500	$290,982,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$576,179,000	$581,964,000
STATE FUNDS	$288,089,500	$290,982,000
FEDERAL FUNDS	$288,089,500	$290,982,000

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)

Interdependent Policy Changes:
Not Applicable

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.

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.

PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 142

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. The private DSH replacement payments are affected by this 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.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is due to:

- Updated payment data through January 2018,
- Revised final payment data for FY 2014-15, FY 2015-16, and FY 2016-17, and
- Additional DSH eligible hospitals have been included.

The change from the prior estimate, for FY 2018-19, is due to updated payment data, and an updated projected DSH eligible hospital list.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to:

- Updated and final payment data for FY 2014-15, FY 2015-16, and FY 2016-17 expected in FY 2017-18, and
- Higher FY 2018-19 payments based on the estimated FY 2018-19 DSH allotment.

Methodology:

1. The remaining balance of FY 2015-16 and FY 2016-17 final payments are assumed to be paid in FY 2017-18.

2. The FY 2014-15 remaining balance, which includes a $10.138 million recoupment, and a $615,000 payment, is assumed to be completed in FY 2017-18. The remaining payment, which is due to the increased FY 2014-15 published federal DSH allotment, is pending CMS approval of the good cause waiver which allows payments to be made beyond the two-year claiming limit.

3. The FY 2017-18 estimated DSH allotment assumes a 2.4% increase over the FY 2016-17 preliminary DSH allotment. The FY 2018-19 estimated DSH allotment assumes a 2% increase over the FY 2017-18 estimated DSH allotment

It is assumed that the DSH replacement payments will be made as follows on a cash basis:

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
FY 2014-15	($9,523)	($4,761)	($4,762)
FY 2015-16	$32,919	$16,459	$16,460
FY 2016-17	$26,442	$13,221	$13,221
FY 2017-18	$526,341	$263,170	$263,171
Total FY 2017-18	**$576,179**	**$288,089**	**$288,090**

PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 142

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
FY 2017-18	$44,636	$22,318	$22,318
FY 2018-19	$537,328	$268,664	$268,664
Total FY 2018-19	**$581,964**	**$290,982**	**$290,982**

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

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	143
IMPLEMENTATION DATE:	4/2004
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	78

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$442,461,000	$414,677,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$442,461,000	$414,677,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$442,461,000	$414,677,000

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)

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 FY 2017-18, from the prior estimate, is a net increase due to:

- Shifting FY 2005-06 reconciliation to FY 2018-19,
- Adding FY 2013-14 Adjusted Claims,
- Updating FY 2015-16 Est. ACA Claims amount with actual claim payment data,
- Updating FY 2016-17 Est. Payments amount with more current prior year payment data, and
- Adding FY 2016-17 Est. Calendar Year Claims.

The change in FY 2018-19, from the prior estimate, is an increase due to:

- Shifting FY 2005-06 reconciliation from FY 2017-18 to FY 2018-19,
- Revising FY 2016-17 Est. ACA Claims amount with updated claims data,
- Revising FY 2017-18 Est. ACA Claims amount with updated claims data, and

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 143

- Revising FY 2017-18 Est. Payments with more current prior year payment data.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to more ACA payments occurring in FY 2017-18.

Methodology:

1. Payments of $442,461,000 and $414,677,000 are expected to be made in FY 2017-18 and FY 2018-19, respectively. These payments are based on CPE claims and are adjusted for the changes in the FMAP.

2. The reconciliation mandated by AB 915 against audited cost reports will begin in FY 2018-19. Additional payments for Service Years 2005-06 and 2006-07 in the estimated amount of $9,385,000 are expected to be made in FY 2018-19 as a result of the reconciliation.

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, and 93% beginning on January 1, 2019.

4. Federal approval of the ACA payment methodology was received in FY 2017-18.

5. Estimated costs are as follows:

FY 2017-18	TF	FF	ACA
FY 2012-13 (Adjusted Claims)	($3,116,000)	($3,116,000)	$0
FY 2013-14 (Adjusted Claims)	($95,000)	($95,000)	$0
FY 2013-14 (Est. ACA Claims)	$58,000,000	$0	$58,000,000
FY 2014-15 (Est. ACA Claims)	$113,111,000	$0	$113,111,000
FY 2015-16 (Calendar Year Claims)	$518,000	$518,000	$0
FY 2015-16 (Est. ACA Claims)	$120,292,000	$0	$120,292,000
FY 2015-16 (Adjusted Claims)	($240,000)	($240,000)	$0
FY 2015-16 (Untimely Claims)	$903,000	$903,000	$0
FY 2016-17 (Est. Payments)	$152,760,000	$152,760,000	$0
FY 2016-17 (Calendar Year Claims)	$328,000	$328,000	$0
Total FY 2017-18	**$442,461,000**	**$151,058,000**	**$291,403,000**

FY 2018-19	TF	FF	ACA
FY 2005-06 (Final Reconciliation)	$9,385,000	$9,385,000	$0
FY 2006-07 (Final Reconciliation)	$9,385,000	$9,385,000	$0
FY 2016-17 (Est. ACA Claims)	$121,000,000	$0	$121,000,000
FY 2016-17 (Calendar Year Claims)	$328,000	$328,000	$0
FY 2017-18 (Est. ACA Claims)	$118,000,000	$0	$118,000,000
FY 2017-18 (Est. Payments)	$156,579,000	$156,579,000	$0
Total FY 2018-19	**$414,677,000**	**$175,677,000**	**$239,000,000**

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 143

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

DSH PAYMENT

REGULAR POLICY CHANGE NUMBER:	144
IMPLEMENTATION DATE:	7/2005
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1073

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$400,444,000	$401,603,000
- STATE FUNDS	$105,022,000	$111,154,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$400,444,000	$401,603,000
STATE FUNDS	$105,022,000	$111,154,000
FEDERAL FUNDS	$295,422,000	$290,449,000

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)

Interdependent Policy Changes:
Not Applicable

Background:
Effective July 1, 2005, based on State Plan Amendment (SPA) 05-022 and as part of the MH/UCD and BTR, the federal DSH allotment is available to provide funding for uncompensated Medi-Cal and uninsured costs incurred by DSHs. Eligible hospitals are to receive funding through the DSH program in the following manner:

- Designated Public Hospitals (DPHs) receive their allocation of federal DSH payments from the Demonstration DSH Fund based on the hospitals' certified public expenditures (CPEs), up to 100% of uncompensated Medi-Cal and uninsured costs. DPHs may also 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.

DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 144

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 policy change for more information. 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.

Reason for Change:
The change in FY 2017-18, from the prior estimate, is due to:
- Updated payment data for FY 2015-16, FY 2016-17, and FY 2017-18, and
- Updated DPH IGT and CPE estimated payment ratios for FY 2017-18.

The change in FY 2018-19, from the prior estimate, is due to updated DPH IGT and CPE estimated payment ratios for FY 2017-18 and FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to:
- Varying DSH payment years occurring in FY 2017-18 and FY 2018-19, and
- Increased DPH DSH allotment estimated for FY 2018-19.

Methodology:
1. The FY 2017-18 estimated DSH allotment assumes a 2.4% increase over FY 2016-17. The FY 2018-19 estimated DSH allotment assumes a 2% increase over the estimated FY 2017-18 allotment. The FY 2017-18 and FY 2018-19 DSH allotments are estimated to be $1,232,173,502, and $1,256,816,972, respectively.

DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 144

2. It is assumed that the DSH payments will be made as follows on a cash basis:

FY 2017-18	TF	GF**	FF	IGT*
DSH 2014-15	$824,000	$412,000	$412,000	$0
DSH 2015-16	$2,398,000	$1,199,000	$1,199,000	$0
DSH 2016-17	$14,511,000	($459,000)	$21,412,000	($6,442,000)
DSH 2017-18	$382,711,000	$13,787,000	$272,399,000	$96,525,000
Total FY 2017-18	**$400,444,000**	**$14,939,000**	**$295,422,000**	**$90,083,000**

FY 2018-19	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	$2,751,000	$0	$1,979,000	$772,000
DSH 2017-18	$34,543,000	$1,129,000	$24,639,000	$8,775,000
DSH 2018-19	$367,443,000	$12,375,000	$261,925,000	$93,143,000
Total FY 2018-19	**$401,603,000**	**$13,504,000**	**$290,449,000**	**$97,650,000**

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)**

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER:	145
IMPLEMENTATION DATE:	7/2005
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1085

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$319,693,000	$297,172,000
- STATE FUNDS	$127,550,000	$137,900,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$319,693,000	$297,172,000
STATE FUNDS	$127,550,000	$137,900,000
FEDERAL FUNDS	$192,143,000	$159,272,000

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

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 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

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 145

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 2017-18. 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. Another SPA will be submitted to CMS for approval to continue the Private Hospital Supplemental Program for FY 2018-19.

Reason for Change:
The change in FY 2017-18, from the prior estimate, is due to updated ACA claims data for FY 2013-14, FY 2014-15, FY 2015-16, and FY 2016-17.

The change in FY 2018-19, from the prior estimate, is due to updated ACA claims data for FY 2017-18.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to fewer ACA adjustment years in FY 2018-19. In addition, the FY 2018-19 IGT payments increased from $18.3 million in FY 2017-18 to $39 million in FY 2018-19.

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 are estimated to total $18.3 million TF in FY 2017-18 and $39 million TF in FY 2018-19, pending SPA submission to CMS for FY 2018-19.

3. SPA 16-022 was approved on December 8, 2016, and reduced the IGT payments from Alameda County to St. Rose Hospital from $16 million TF to $10 million TF in FY 2017-18. In FY 2018-19, assume the IGT payment from Alameda County to St. Rose will increase to $16 million TF, pending SPA submission.

4. Assume the IGT payments from Alameda County to Children's Hospital and Research Center Oakland will increase from $3 million TF to $20 million TF in FY 2018-19, pending SPA submission.

5. The ACA allows for 100% Federal Medical Assistance Percentage (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. CMS approved the ACA claiming methodology in August 2017.

6. 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. For FY 2013-14, FY 2014-15, FY 2015-16, and FY 2016-17, the ACA supplemental payments will be claimed in FY 2017-18. For FY 2017-18, the ACA supplemental payment will be claimed in FY 2018-19.

    - 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.

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 145

- 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.

7. The ending balance shown is on a cash basis and does not necessarily mean that the remaining funds are available. Funds in the ending balance may be committed and scheduled to be expended in the following year.

8. The estimated Private Hospital Supplemental payments and ending balance for FY 2017-18 are shown below:

FY 2017-18 Private Hospital Supplemental Fund Summary	SF
FY 2016-17 Ending Balance	$1,044,000
Appropriation (GF)	$118,400,000
2017-18 IGT	$9,150,000
Est. FY 2016-17 Interest Earned	$404,000
FY 2013-14 ACA FFP Adjustment to SF	$5,341,000
FY 2014-15 ACA FFP Adjustment to SF	$12,800,000
FY 2015-16 ACA FFP Adjustment to SF	$20,308,000
FY 2016-17 ACA FFP Adjustment to SF	$20,698,000
Funds Available	$188,145,000
Less: FY 2017-18 Cash Expenditures to Hospitals	($127,550,000)
Est. FY 2017-18 Remaining Balance	$60,595,000

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 145

FY 2017-18	TF	SF	FF	ACA FF	ACA Return to Fund 3097*	ACA Return to Counties*
FY 2017-18 Cash Expenditures to Hospitals**	$255,100,000	$127,550,000	$127,550,000	$0	$0	$0
FY 2013-14 ACA FF Adjustment to SF***	$5,340,000	$0	($5,341,000)	$10,681,000	$5,341,000	$0
FY 2013-14 ACA FF Adjustment to Counties***	$170,000	$0	($170,000)	$340,000	$0	$170,000
FY 2014-15 ACA FF Adjustment to SF***	$12,800,000	$0	($12,800,000)	$25,600,000	$12,800,000	$0
FY 2014-15 ACA FF Adjustment to Counties***	$1,452,000	$0	($1,452,000)	$2,904,000	$0	$1,452,000
FY 2015-16 ACA FF Adjustment to SF***	$20,309,000	$0	($20,308,000)	$40,617,000	$20,308,000	$0
FY 2015-16 ACA FF Adjustment to Counties***	$1,880,000	$0	($1,881,000)	$3,761,000	$0	$1,881,000
FY 2016-17 ACA FF Adjustment to SF***	$20,698,000	$0	($21,788,000)	$42,486,000	$20,698,000	$0
FY 2016-17 ACA FF Adjustment to Counties***	$1,944,000	$0	($2,046,000)	$3,990,000	$0	$1,944,000
Total	**$319,693,000**	**$127,550,000**	**$61,764,000**	**$130,379,000**	$59,147,000	$5,447,000

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 145

9. The estimated Private Hospital Supplemental payments and ending balance for FY 2018-19 are shown below:

FY 2018-19 Private Hospital Supplemental Fund Summary	SF
FY 2017-18 Ending Balance	$60,595,000
Appropriation (GF)	$118,400,000
2018-19 IGT	$19,500,000
Est. FY 2017-18 Interest Earned	$490,000
FY 2017-18 ACA FFP Adjustment to SF	$19,391,000
Funds Available	$218,376,000
Less: FY 2018-19 Cash Expenditures to Hospitals	($137,900,000)
Est. FY 2018-19 Remaining Balance	$80,476,000

FY 2018-19	TF	SF	FF	ACA FF	Return to Fund 3097*	Return to Counties*
FY 2018-19 Cash Expenditures to Hospitals**	$275,800,000	$137,900,000	$137,900,000	$0	$0	$0
FY 2017-18 ACA FF Adjustment to SF***	$19,391,000	$0	($21,788,000)	$41,179,000	$19,391,000	$0
FY 2017-18 ACA FF Adjustment to Counties***	$1,981,000	$0	($2,225,000)	$4,206,000	$0	$1,981,000
Total	**$297,172,000**	**$137,900,000**	**$113,887,000**	**$45,385,000**	$19,391,000	$1,981,000

*The Return to Fund 3097 and Return to Counties columns are for display purposes only (see Methodology #6).

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)

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	146
IMPLEMENTATION DATE:	10/2013
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1600

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$124,176,000	$130,216,000
- STATE FUNDS	$39,313,000	$47,064,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$124,176,000	$130,216,000
STATE FUNDS	$39,313,000	$47,064,000
FEDERAL FUNDS	$84,863,000	$83,152,000

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)

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:
The change in FY 2017-18, from the prior estimate, is a decrease due to:

- Shifting FY 2016-17 ACA payments, payments to NDPHs (adjustment), and Children's Services from FY 2017-18 to FY 2018-19, and
- Utilizing a lower UPL room for FY 2015-16, FY 2016-17, and FY 2017-18, which reduces the ACA payments and regular payments to NDPHs.

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 146

The change in FY 2018-19, from the prior estimate, is a net increase due to:

- Shifting FY 2016-17 ACA payments, payments to NDPHs (adjustment), and Children's Services to FY 2018-19, and
- Utilizing a lower UPL room for FY 2016-17, FY 2017-18, and FY 2018-19, which reduces the ACA payments and regular payments to NDPHs.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to fewer ACA adjustments occurring in FY 2018-19.

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 implementation of the ACA optional population, effective January 1, 2014, impacts the UPL calculation. The impact increased the estimated UPL's available room for FY 2015-16, FY 2016-17, FY 2017-18, and FY 2018-19. FY 2015-16 and FY 2016-17 are currently pending UPL methodology review with CMS. FY 2017-18 and FY 2018-19 UPLs will be subsequently submitted. It is assumed payments related to the ACA optional population will be made beginning in FY 2017-18.

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% and then to 94% on January 1, 2018.

4. The FY 2015-16 tentative UPL amount is $63,151,000 TF and the FY 2016-17 tentative UPL amount is $111,637,000 TF. The UPL room for FY 2017-18 and FY 2018-19 are estimated using 80 percent of the last approved UPL in FY 2014-15.

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. For FY 2013-14, FY 2014-15, and FY 2015-16, the ACA supplemental payments will be claimed in FY 2017-18. The FY 2016-17 and FY 2017-18 ACA supplemental payments will be claimed in FY 2018-19. The NDPHs will be reimbursed for the IGT (nonfederal share), and an adjustment will be made for the federal share processed at the regular 50% FMAP.

6. The adjustment of $1,413,000 FF to FY 2013-14 is for over collected IGTs during the initial NDPH IGT supplemental payments for non-ACA. Nine months after this FYs supplemental payments are issued, the proportion of the costs for non-ACA and newly eligible Medi-Cal beneficiaries are recalculated.

7. The adjustment of $6,774,000 FF to FY 2014-15 is for over collected IGTs during the initial NDPH IGT supplemental payments for non-ACA. Nine months after this FYs supplemental payments are issued, the proportion of the costs for non-ACA and newly eligible Medi-Cal beneficiaries are recalculated.

8. Due to the revised FY 2013-14 ACA payments, fewer IGTs were subject to the 9% retained for FY 2013-14 admin costs and Children's Services Payments. The GF will be required to reimburse the NDPHs in the amount of $101,000 GF.

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 146

9. Due to the revised FY 2014-15 ACA payments, fewer IGTs were subject to the 9% retained for FY 2014-15 Children's Services payments. The GF will be required to reimburse the IGTs to the NDPHs in the amount of $645,000 GF.

10. The FY 2015-16 Payments to NDPHs (ACA Adjustment) contains adjustments due to changes in the FY 2015-16 UPL calculation in addition to ACA adjustments.

11. FY 2015-16 and FY 2016-17 Children's Services payments have been collected based on the interim payments made for both FYs. Upon receiving approved UPLs, these amounts will be recalculated.

12. The estimated NDPH IGT supplemental payments are:

FY 2017-18	TF	GF*	IGT**	FF	ACA	***Return to NDPHs
FY 2013-14 Payments to NDPHs (ACA Population)	$27,510,000	$0	$0	$0	$27,510,000	$0
FY 2013-14 Payments to NDPHs (ACA Adjustment)	$1,413,000	$0	$0	($1,413,000)	$2,826,000	$1,413,000
FY 2013-14 Children's Services ACA Adjustment	$101,000	$101,000	$0	$0	$0	$101,000
FY 2014-15 Payments to NDPHs (ACA Population)	$6,908,000	$0	$0	$0	$6,908,000	$0
FY 2014-15 Payments to NDPHs (ACA Adjustment)	$6,774,000	$0	$0	($6,774,000)	$13,548,000	$6,774,000
FY 2014-15 Children's Services ACA Adjustment	$645,000	$645,000	$0	$0	$0	$645,000
FY 2015-16 Payments to NDPHs (ACA Adjustment)	$5,108,000	$0	$0	($14,327,000)	$19,435,000	$5,108,000
FY 2015-16 Children's Services	$1,417,000	($2,161,000)	$3,578,000	$0	$0	$1,417,000
FY 2017-18 Payments to NDPHs	$74,300,000	$0	$37,150,000	$37,150,000	$0	$0
Total FY 2017-18	**$124,176,000**	**($1,415,000)**	**$40,728,000**	**$14,636,000**	**$70,227,000**	$15,458,000

FY 2018-19	TF	GF*	IGT**	FF	ACA	***Return to NDPHs
FY 2016-17 Payments to NDPHs (ACA Population)	$22,138,000	$0	$553,000	$0	$21,585,000	$0
FY 2016-17 Payments to NDPHs (Non ACA Adjustment)	$15,198,000	$0	$7,599,000	$7,599,000	$0	$0
FY 2016-17 Children's Services	$0	($4,384,000)	$4,384,000	$0	$0	$0
FY 2017-18 Payments to NDPHs (ACA Population)	$17,797,000	$0	$979,000	$0	$16,818,000	$0
FY 2017-18 Children's Services	$783,000	($2,795,000)	$3,578,000	$0	$0	$783,000
FY 2018-19 Payments to NDPHs	$74,300,000	$0	$37,150,000	$37,150,000	$0	$0
Total FY 2018-19	**$130,216,000**	**($7,179,000)**	**$54,243,000**	**$44,749,000**	**$38,403,000**	$783,000

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 146

***The Return to NDPHs column is for display purposes only (see methodology #5-#7).

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)

PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES

REGULAR POLICY CHANGE NUMBER: 147
IMPLEMENTATION DATE: 1/2018
ANALYST: Ila Zapanta
FISCAL REFERENCE NUMBER: 2049

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$247,520,000	$649,278,000
- STATE FUNDS	$86,207,000	$249,438,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$247,520,000	$649,278,000
STATE FUNDS	$86,207,000	$249,438,000
FEDERAL FUNDS	$161,313,000	$399,840,000

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)

Interdependent Policy Changes:
Not Applicable

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 appropriates from Proposition 56 revenues $140 million in Proposition 56 funds to provide supplemental payments for specific dental services. Existing law establishes the Health Care Treatment Fund for this purpose. These supplemental payments for specific dental categories include restorative, endodontic, prosthodontic, oral and maxillofacial, adjunctive, visits and diagnostic services. The supplemental payment is at a rate equal to 40 percent of the Dental Schedule of Maximum Allowances (SMA) for the specified codes for dates of service during the period of July 1, 2017 through June 30, 2019.

Reason for Change:
The change from the prior estimate for FY 2017-18 and FY 2018-19 is an increase due to updated methodology that incorporates updated rates information and updated payment timing information. The increase from FY 2017-18 to FY 2018-19, in the current estimate, is due to timing of retro payments and rates payment timing.

PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES

REGULAR POLICY CHANGE NUMBER: 147

Methodology:

1. Payments are made via supplemental payments.

2. This policy was effective on July 1, 2017, but payments began in February 2018.

3. Supplemental payments are 40% of the Dental SMA.

4. In FY 2018-19, $94.7 million has been allocated from the Health Care Treatment Fund (Prop 56) for currently identified services to receive supplemental payments; however an additional $69.9 million has been allocated from the fund to allow for other additional supplemental payments.

5. Funds allocated for the supplemental payments are as follows:

Funding:

FY 2017-18	TF	SF	FF
50% Title XIX / 50% GF	$159,172,000	$79,586,000	$79,586,000
100% State GF	$44,000	$44,000	$0
ACA 95% FFP/5% GF (2017)	$39,112,000	$1,956,000	$37,156,000
ACA 94% FFP/6% GF (2018)	$21,421,000	$1,285,000	$20,136,000
Title 21 88% FFP/12% GF	$27,753,000	$3,330,000	$24,423,000
65% Title XIX / 35% GF	$18,000	$6,000	$12,000
Total	**$247,520,000**	**$86,207,000**	**$161,313,000**

FY 2018-19	TF	SF	FF
50% Title XIX / 50% GF	$463,172,000	$231,586,000	$231,586,000
100% State GF	$259,000	$259,000	$0
ACA 93% FFP/7% GF (2019)	$41,159,000	$2,881,000	$38,278,000
ACA 94% FFP/6% GF (2018)	$41,588,000	$2,495,000	$39,093,000
ACA 95% FFP/5% GF (2017)	$2,573,000	$129,000	$2,444,000
Title 21 88% FFP/12% GF	$100,419,000	$12,050,000	$88,369,000
65% Title XIX / 35% GF	$108,000	$38,000	$70,000
Total	**$649,278,000**	**$249,438,000**	**$399,840,000**

*Healthcare Treatment Fund Prop 56

PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 148
IMPLEMENTATION DATE: 12/2017
ANALYST: Katy Clay
FISCAL REFERENCE NUMBER: 2044

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$158,167,000	$183,302,000
- STATE FUNDS	$42,540,000	$49,044,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$158,167,000	$183,302,000
STATE FUNDS	$42,540,000	$49,044,000
FEDERAL FUNDS	$115,627,000	$134,258,000

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)

Interdependent Policy Changes:
Not Applicable

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 nonfederal share of health care expenditures in accordance with the annual state budget process. AB 120 amends the Budget Act of 2017 to appropriate proposition 56 funds for specified Department health care expenditures during the 2017-18 state fiscal year.

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 is July 1, 2017, with an end date of June 30, 2018.

A total of $50 million was appropriated for FY 2017-18; $40 million for comprehensive family planning services, and $10 million for time-limited supplemental payments for medical pregnancy termination.

Reason for Change:
The change from the previous estimate, for FY 2017-18, resulted in a slight decrease due to updated actual service category expenditures. The change from the previous estimate, for FY 2018-19 resulted

PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 148

in a slight increase due to updated medical pregnancy termination expenditures. The change from FY 2017-18 to FY 2018-19 in the current estimate is due to twelve months of implementation in FY 2018-19.

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 2017-18	**TF**	**SF**	**FF**
E&M Office Visits	$ 149,302	$ 33,675	$ 115,627
Medical Pregnancy Termination	$ 8,865	$ 8,865	$ -
Total	**$ 158,167**	**$ 42,540**	**$ 115,627**

FY 2018-19	**TF**	**SF**	**FF**
E&M Office Visits	$ 173,359	$ 39,101	$ 134,258
Medical Pregnancy Termination	$ 9,943	$ 9,943	$ -
Total	**$ 183,302**	**$ 49,044**	**$ 134,258**

Funding:
*Healthcare Treatment Fund (4260-101-3305)
100% Title XIX (4260-101-0890)

DPH PHYSICIAN & NON-PHYS. COST

REGULAR POLICY CHANGE NUMBER: 149
IMPLEMENTATION DATE: 5/2008
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 1078

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$83,855,000	$205,803,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$83,855,000	$205,803,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$83,855,000	$205,803,000

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.

For certain DPHs, the reimbursement under the SPA constitutes total payment. For other DPHs, the reimbursement is a supplemental payment for the uncompensated care costs associated with the allowable costs under the SPA. 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: 149

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:
The change in FY 2017-18, from the prior estimate, is due to:

- FY 2006-07 final reconciliation overpayments recovered in FY 2017-18,
- FY 2007-08 final reconciliation shifted to FY 2018-19,
- FY 2013-14 final reconciliation and Affordable Care Act (ACA) payments shifted to FY 2018-19,
- FY 2014-15 reconciliation and ACA payments shifted to FY 2018-19 and are now based on finalized cost reports,
- FY 2015-16 interim reconciliation due to providers shifted from FY 2018-19 to FY 2017-18,
- FY 2015-16 interim reconciliation ACA payments shifted to FY 2018-19, and
- FY 2017-18 interim payments increased based on updated data.

The change in FY 2018-19, from the prior estimate, is due to:

- Payments and reconciliations previously scheduled for FY 2017-18 shifted to FY 2018-19,
- Decreased FY 2015-16 and FY 2016-17 interim reconciliation amounts based on updated data, and
- Increased FY 2016-17 interim ACA payments and FY 2018-19 interim payments based on updated data.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to more retroactive interim and final reconciliations and retroactive ACA payments scheduled in FY 2018-19.

Methodology:

1. In FY 2017-18 and FY 2018-19, one annual interim payment will be made to DPHs for those respective years.

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 2018-19 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% and 94% beginning January 1, 2018.

4. Under ARRA, California's 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, California's FMAP returned to the 50% level. ARRA is reflected in the FY 2008-09 and FY 2009-10 reconciliation/final settlement amounts.

5. Reconciliation/final settlement of program years is anticipated to be completed upon conclusion of final audited settlements. Final reconciliations are subject to cost report audit schedules.

DPH PHYSICIAN & NON-PHYS. COST

REGULAR POLICY CHANGE NUMBER: 149

FY 2017-18	TF	FF
FY 2006-07 Final Reconciliation	($482,000)	($482,000)
FY 2015-16 Interim Reconciliation	$8,143,000	$8,143,000
FY 2017-18 Interim Payment	$76,194,000	$76,194,000
Total	**$83,855,000**	**$83,855,000**

FY 2018-19	TF	FF	ARRA
FY 2007-08 Final Reconciliation	($3,875,000)	($3,875,000)	$0
FY 2008-09 Final Reconciliation	($223,000)	($215,000)	($8,000)
FY 2009-10 Final Reconciliation	($4,204,000)	($3,413,000)	($791,000)
FY 2013-14 Final Reconciliation	($17,387,000)	($17,387,000)	$0
FY 2013-14 Payment ACA	$14,802,000	$14,802,000	$0
FY 2014-15 Final Reconciliation	$647,000	$647,000	$0
FY 2014-15 Payment ACA	$47,997,000	$47,997,000	$0
FY 2015-16 Interim Reconciliation	($18,459,000)	($18,459,000)	$0
FY 2015-16 Interim Payment ACA	$56,364,000	$56,364,000	$0
FY 2016-17 Interim Reconciliation	($1,008,000)	($1,008,000)	$0
FY 2016-17 Interim Payment ACA	$54,955,000	$54,955,000	$0
FY 2018-19 Interim Payment	$76,194,000	$76,194,000	$0
Total	**$205,803,000**	**$206,602,000**	**($799,000)**

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

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER:	150
IMPLEMENTATION DATE:	7/1991
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	82

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$154,173,000	$123,280,000
- STATE FUNDS	$25,634,000	$36,635,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$154,173,000	$123,280,000
STATE FUNDS	$25,634,000	$36,635,000
FEDERAL FUNDS	$128,539,000	$86,645,000

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)

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: 150

Reason for Change:
The change from the prior estimate, for FY 2017-18, is an increase due to projected amounts being revised with actual paid claims as well as adding a FY 2014-15 interim payment.

There is no total fund change in FY 2018-19 from the prior estimate, however, due to updated actuals, there was a change in the funding splits for the FY 2016-17 ACA adjustment and FY 2014-15 interim reconciliation.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to a higher portion of interim payments being made in FY 2017-18 for both the hospitals (SB 1732) and DP-NFs (SB 1128).

Methodology:
1. The ACA allows for 100% Federal Medical Assistance Percentage (FMAP) for calendar years 2014 through 2016, 95% FMAP for calendar year 2017 and 94% FMAP for calendar year 2018, for newly eligible Medi-Cal beneficiaries.

2. 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. For FY 2013-14, FY 2014-15, and FY 2015-16, the ACA supplemental payments will be claimed in FY 2017-18. FY 2016-17 ACA supplemental payments will be claimed in FY 2018-19. 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.

3. The estimated payments on a cash basis are:

FY 2017-18	TF	GF	FF	ACA
Hospitals (SB 1732)				
Interim Payment				
FY 2014-15	$644,000	$322,000	$322,000	$0
FY 2015-16	$3,404,000	$1,702,000	$1,702,000	$0
FY 2016-17	$77,724,000	$38,862,000	$38,862,000	$0
FY 2017-18	$34,506,000	$17,253,000	$17,253,000	$0
ACA Adjustment to GF				
FY 2013-14	$0	($9,191,000)	($9,191,000)	$18,382,000
FY 2014-15	$0	($13,229,000)	($13,230,000)	$26,459,000
FY 2015-16	$0	($11,971,000)	($11,972,000)	$23,943,000
Interim Reconciliation				
FY 2013-14	$4,086,000	$1,886,000	$1,886,000	$314,000
DP-NFs (SB 1128)				
Interim Payment				
FY 2015-16	$14,805,000	$0	$14,805,000	$0
FY 2016-17	$19,004,000	$0	$19,004,000	$0
Total FY 2017-18	**$154,173,000**	**$25,634,000**	**$59,441,000**	**$69,098,000**

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 150

FY 2018-19	TF	GF	FF	ACA
Hospitals (SB 1732)				
Interim Payment				
FY 2016-17	$2,726,000	$1,363,000	$1,363,000	$0
FY 2017-18	$63,030,000	$31,515,000	$31,515,000	$0
FY 2018-19	$31,736,000	$15,868,000	$15,868,000	$0
ACA Adjustment to GF				
FY 2016-17	$0	($14,071,000)	($15,064,000)	$29,135,000
Interim Reconciliation				
FY 2014-15	$5,288,000	$1,960,000	$1,960,000	$1,368,000
DP-NFs (SB 1128)				
Interim Payment				
FY 2017-18	$20,500,000	$0	$20,500,000	$0
Total FY 2018-19	**$123,280,000**	**$36,635,000**	**$56,142,000**	**$30,503,000**

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: 151
IMPLEMENTATION DATE: 2/2006
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 104

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$132,319,000	$134,881,000
- STATE FUNDS	$55,806,000	$64,207,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$132,319,000	$134,881,000
STATE FUNDS	$55,806,000	$64,207,000
FEDERAL FUNDS	$76,513,000	$70,674,000

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

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 2017-18, from the prior estimate, is a decrease due to:

- Changes to FY 2013-14, FY 2014-15, and FY 2015-16 Affordable Care Act (ACA) payments, based on actuals,
- A decrease to Alameda and Los Angeles County FY 2016-17 payments based on actuals, and
- A decrease to the estimated Los Angeles County initial FY 2017-18 payment.

The change in FY 2018-19, from the prior estimate, is a decrease due to the reduction in the estimated FY 2017-18 ACA payments based on updated data.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to a higher portion of regular payments occurring in FY 2018-19.

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER: 151

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 and 94% FMAP for calendar year 2018, 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 2013-14, FY 2014-15, FY 2015-16, and FY 2016-17, the ACA supplemental payments will be claimed in FY 2017-18. ACA payments for FY 2017-18 will be claimed in FY 2018-19. 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.

(Dollars in Thousands)

FY 2017-18	TF	Special Deposit Fund	FF	ACA FF	*Return to Counties
FY 2013-14 ACA Adjustment to Counties	$1,695	$0	($1,696)	$3,391	$1,695
FY 2014-15 ACA Adjustment to Counties	$5,256	$0	($5,257)	$10,513	$5,256
FY 2015-16 ACA Adjustment to Counties	$6,853	$0	($6,853)	$13,706	$6,853
FY 2016-17 ACA Adjustment to Counties	$6,903	$0	($7,266)	$14,169	$6,903
FY 2016-17	$66,894	$33,447	$33,447	$0	$0
FY 2017-18	$44,718	$22,359	$22,359	$0	$0
Total FY 2017-18	**$132,319**	**$55,806**	**$34,734**	**$41,779**	$20,707

(Dollars in Thousands)

FY 2018-19	TF	Special Deposit Fund	FF	ACA FF	*Return to Counties
FY 2017-18 ACA Adjustment to Counties	$6,467	$0	($7,266)	$13,733	$6,467
FY 2017-18	$83,696	$41,848	$41,848	$0	$0
FY 2018-19	$44,718	$22,359	$22,359	$0	$0
Total FY 2018-19	**$134,881**	**$64,207**	**$56,941**	**$13,733**	$6,467

*The Return to Counties column is for display purposes only (see Methodology #3).

Funding:

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:	152
IMPLEMENTATION DATE:	11/2015
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1899

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$134,634,000	$117,693,000
- STATE FUNDS	$48,404,700	$50,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$134,634,000	$117,693,000
STATE FUNDS	$48,404,700	$50,000,000
FEDERAL FUNDS	$86,229,300	$67,693,000

DESCRIPTION

Purpose:
This policy change estimates the inpatient Medi-Cal Fee-for-Service (FFS) and 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 15-008
SPA 16-017
SPA 17-023

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: 152

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) 15-008 was approved by the Centers for Medicare and Medicaid Services (CMS) on June 7, 2016. SPA 16-017, which updated the payment cap amount from $100 million to $108 million for payments made to MLK-LA, was approved on November 22, 2016, by CMS, effective July 1, 2016. SPA 17-023, which was approved by CMS on July 24, 2017, increased the payment cap from $108 million to $113.4 million, effective July 1, 2017. The $113.4 million total payment represents $100 million in supplemental payments and $13.4 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 2017-18, from the prior estimate, is due to the inclusion of the FY 2016-17 DRG add-on and supplemental interim reconciliation amounts and updated Affordable Care Act (ACA) optional population payment data for FY 2015-16 and FY 2016-17.

The change in FY 2018-19, from the prior estimate, is due to updated ACA payment data.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to fewer supplemental ACA payment years in FY 2018-19, and the inclusion of the FY 2016-17 interim reconciliation in FY 2017-18.

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.

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4. Assume DRG payments and DRG add-on payments, if necessary, will be sufficient to reach the 72% minimum payment level for FY 2017-18 and FY 2018-19.

5. Expenditures for FY 2017-18 and FY 2018-19 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. SPA 17-023, which was approved by CMS on July 24, 2017, specifies a $113.4 million cap for IGT payments and the DRG add-on amount, effective July 1, 2017.

8. 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 2017-18, the supplemental payments and DRG add-on payments are limited by the payment cap of $113.4 million. The estimates are as follows:

    - Per SPA 16-017, reimbursement payments are capped at $108 million in FY 2016-17 and include both supplemental and DRG add-on payments.
    - SPA 17-023 updates the payment cap to $113.4 million in FY 2017-18.
    - FY 2017-18 and FY 2018-19 supplemental payments are estimated to be $100 million TF annually.

9. FY 2016-17 interim reconciliations resulted in the following:
    - Additional DRG add-on payments of $462,000 TF ($231,000 GF, $231,000 FF)
    - ACA adjustment of -$452,000 TF (-$11,000 GF, -$441,000 FF)
    - Supplemental payment recoupment of $3.6 million TF

10. 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 2015-16 and FY 2016-17 ACA supplemental payments will be claimed in FY 2017-18. For FY 2017-18, the ACA payment will be claimed in FY 2018-19. 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. From January 1, 2014, through December 31, 2016, the FMAP is 100% for the ACA optional population. Beginning January 1, 2017, the ACA optional population FMAP is 95%, and reduces to 94% beginning January 1, 2018.

    For FY 2015-16, $40.1 million is attributable to the ACA optional population. Based on updated payment data, $37.4 million, and $37.6 million of the FY 2016-17 and FY 2017-18 supplemental payments, respectively, are attributable to the ACA optional population. CMS approved the ACA supplemental payment methodology in August 2017.

11. Managed care costs for MLK-LA are reflected in the managed care policy changes. The chart below shows the FY 2017-18 and FY 2018-19 totals with managed care for informational purposes only.
    - Retroactive payments for FY 2015-16 and FY 2016-17 will be made in FY 2017-18 in the Retro MC Rate Adjustments policy change.
    - A retroactive payment for FY 2017-18 will be made in FY 2018-19 in the Retro MC Rate Adjustments policy change.
    - The FY 2018-19 managed care payments are in the Two Plan Model.

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(Dollars in Thousands)

FY 2017-18	TF
Supplemental 2017-18	$100,000
Total (PC 152)	$100,000
Managed Care 2015-16 retro (PC 117)	$9,177
Managed Care 2016-17 retro (PC 117)	$4,637
Total Managed Care	$13,814
Total FY 2017-18	$113,814

(Dollars in Thousands)

FY 2018-19	TF
Supplemental 2018-19	$100,000
Total (PC 152)	$100,000
Managed Care 2017-18 retro (PC 117)	$21,400
Managed Care 2018-19 (PC 87)	$20,597
Total Managed Care	$41,997
Total FY 2018-19	$141,997

12. On a cash basis, costs in FY 2017-18 and FY 2018-19 are expected to be:

FY 2017-18	TF	GF	IGT*	FF	ACA FF	Return to County**
Supplemental 2017-18	$100,000,000	$0	$50,000,000	$50,000,000	$0	$0
Supplemental ACA 2015-16	$20,054,000	$0	$0	($20,054,000)	$40,108,000	$20,054,000
Supplemental ACA 2016-17	$18,200,000	$0	$0	($19,159,000)	$37,359,000	$18,200,000
DRG Add-On Interim Reconciliation 2016-17	$10,000	$220,000	$0	$231,000	($441,000)	$0
Supplemental Interim Reconciliation 2016-17	($3,630,000)	$0	($1,815,000)	($1,815,000)	$0	$0
Total	**$134,634,000**	**$220,000**	**$48,185,000**	**$9,203,000**	**$77,026,000**	$38,254,000

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FY 2018-19	TF	GF	IGT*	FF	ACA FF	Return to County**
Supplemental 2018-19	$100,000,000	$0	$50,000,000	$50,000,000	$0	$0
Supplemental ACA 2017-18	$17,693,000	$0	$0	($19,880,000)	$37,573,000	$17,693,000
Total	**$117,693,000**	**$0**	**$50,000,000**	**$30,120,000**	**$37,573,000**	$17,693,000

**The Return to County column is for display purposes only (see methodology #10)

Funding:
50% Title XIX / 50% Reimbursement GF (4260-601-0995/4260-101-0890)*
100% Title XIX ACA FF (4260-101-0890)
95% Title XIX ACA FF / 5% GF (4260-101-0001/0890)

QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	153
IMPLEMENTATION DATE:	4/2014
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1563

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$86,007,000	$86,007,000
- STATE FUNDS	$43,003,500	$43,003,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$86,007,000	$86,007,000
STATE FUNDS	$43,003,500	$43,003,500
FEDERAL FUNDS	$43,003,500	$43,003,500

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 nursing facilities (NF-Bs) 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)

Interdependent Policy Changes:
Not Applicable

Background:
SB 853 implemented a quality and accountability supplemental payments (QASP) program for NF-Bs. 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 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 rate years, 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: 153

AB 119 extends the AB 1629 facility-specific rate methodology, QAF, and QASP Program through July 31, 2020. Further, beginning in rate year 2015-16, the annual weighted average rate increase was set at 3.62%, and the General Fund appropriation for the QASP will continue at FY 2014-15 levels, rather than setting aside a portion of the annual rate increase. Additionally, beginning fiscal year 2015-16, the legislation requires the Department to incorporate direct care staff retention as a performance measure into 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:
The change in FY 2017-18 and FY 2018-19, from the prior estimate, is due to a decrease in PLI savings.

There is no change from FY 2017-18 to FY 2018-19, 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 2017-18	FY 2018-19
Penalties on Nursing Facilities	$100,000	$100,000
QASP GF Appropriation	$43,236,000	$43,236,000
PLI savings	$5,074,000	$5,074,000

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 $6,814,000 TF ($3,407,000 Special Fund) for FY 2017-18 and FY 2018-19.

5. The GF appropriated QASP funding will continue at FY 2014-15 levels, instead of setting aside a portion of the annual increase.

QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
REGULAR POLICY CHANGE NUMBER: 153

6. Supplemental payments are estimated to be:

(Dollars in Thousands)

FY 2017-18	TF	GF	SF	FF
Supplemental Payments***	$86,007	$0	$43,003	$43,004
Transfer from GF* to Special Fund**	$0	$48,310	($48,310)	$0
Total	**$86,007**	**$48,310**	**($5,307)**	**$43,004**

(Dollars in Thousands)

FY 2018-19	TF	GF	SF	FF
Supplemental Payments***	$86,007	$0	$43,003	$43,004
Transfer from GF* to Special Fund**	$0	$48,310	($48,310)	$0
Total	**$86,007**	**$48,310**	**($5,307)**	**$43,004**

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:	154
IMPLEMENTATION DATE:	4/2014
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1661

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$76,182,000	$37,900,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$76,182,000	$37,900,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$76,182,000	$37,900,000

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)

Interdependent Policy Changes:
Not Applicable

Background:
A provider that delivers GEMT services to Medi-Cal beneficiaries will be eligible for supplemental payment 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: 154

Reason for Change:
The change in FY 2017-18, from the prior estimate, is a net increase due to:

- FY 2009-10 and FY 2010-11 will be processed as final reconciliations, rather than interim reconciliations with amounts updated based on audits issued to date, and
- FY 2011-12 through FY 2015-16 data updated based on actuals.

There is no change from the prior estimate for FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to fewer years of interim payments and reconciliations in FY 2018-19.

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 2014 through 2016, 95% FMAP for calendar year 2017, and 94% FMAP for calendar year 2018, for newly eligible Medi-Cal beneficiaries. The ACA methodology has been approved by CMS.

3. Payments estimated for FY 2017-18 and FY 2018-19 are CPE based.

4. In FY 2016-17, payments for FY 2013-14 and FY 2014-15 ACA optional population were made at 50% FMAP. The initial 50% federal financial participation (FFP) will be adjusted in FY 2017-18 to draw down the ACA 100% FMAP payment.

5. Interim reconciliations are performed within two years of receipt of the as-filed cost report. Final reconciliations are based on audited cost reports, and the audit and settlement process is completed within three years of the postmark date of the approved cost report. Due to delays in receipt of cost reports, retroactive years are being reconciled in FY 2017-18 and FY 2018-19.

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 154

The estimated payments on a cash basis are:

FY 2017-18	Total FFP	Regular FFP	ARRA	ACA
FY 2011-12 Interim Recon.	$304,000	$304,000	$0	$0
FY 2012-13 Interim Recon.	$12,000	$12,000	$0	$0
FY 2013-14 Interim Recon.	$2,696,000	($3,082,000)	$0	$5,778,000
FY 2014-15 Interim Recon.	$5,167,000	($9,561,000)	$0	$14,728,000
FY 2009-10 Final Recon.	$13,300,000	$10,800,000	$2,500,000	$0
FY 2010-11 Final Recon.	$7,200,000	$5,675,000	$1,525,000	$0
FY 2011-12 Final Recon.	($1,182,000)	($1,181,000)	($1,000)	$0
FY 2012-13 Final Recon.	($785,000)	($785,000)	$0	$0
FY 2013-14 Final Recon.	($21,000)	($115,000)	$0	$94,000
FY 2015-16	$16,391,000	$248,000	$0	$16,143,000
FY 2016-17	$33,100,000	$14,300,000	$0	$18,800,000
Total FY 2017-18	**$76,182,000**	**$16,615,000**	**$4,024,000**	**$55,543,000**

FY 2018-19	Total FFP	Regular FFP	ACA
FY 2015-16 Interim Recon.	$900,000	$400,000	$500,000
FY 2014-15 Final Recon.	($2,000,000)	($900,000)	($1,100,000)
FY 2017-18	$39,000,000	$17,200,000	$21,800,000
Total FY 2018-19	**$37,900,000**	**$16,700,000**	**$21,200,000**

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XIX ACA (4260-101-0890)

CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER: 155
IMPLEMENTATION DATE: 6/2002
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 86

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$75,732,000	$59,011,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$75,732,000	$59,011,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$75,732,000	$59,011,000

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.

Authority:
AB 430 (Chapter 171, Statutes of 2001)

Interdependent Policy Changes:
Not Applicable

Background:
This program is designed to allow DP-NFs to claim FFP on the difference between their actual costs and the amount Medi-Cal currently pays under the existing program. The acute care hospital must be owned and operated by a public entity, such as a city, city and county, or health care district. In addition, the acute care hospital must meet specified requirements and provide skilled nursing services to Medi-Cal beneficiaries.

AB 97 (Chapter 3, Statutes of 2011) authorized the Department to reimburse Medi-Cal providers at the rates established in FY 2008-09, reduced by 10%, for services DP-NFs Level B providers render on or after June 1, 2011.

The Department received CMS approval on December 20, 2013, to prospectively exempt DP-NF Level B providers from the 10% payment reduction effective September 1, 2013, for providers located in designated rural and frontier areas. The remaining DP-NF Level B providers are exempt from the 10% payment reduction effective October 1, 2013, pursuant to the provisions of SB 239 (Chapter 657, Statutes of 2013).

ABX2 1 (Chapter 3, Statutes of 2016) prohibits the Department from seeking to retroactively implement certain Medi-Cal provider base payment reductions and limitations with regards to reimbursements for services provided by skilled nursing facilities that are distinct parts of 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

CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER: 155

skilled nursing services nor the recoupment of such supplemental funds.

Reason for Change:
The change in FY 2017-18, from the prior estimate, is a net increase due to:

- Removing FY 2013-14, FY 2014-15, and FY 2015-16 payments due to more updated payment data,
- Updating payments based on actuals for FY 2015-16 ACA and FY 2016-17, and
- Updating the FY 2017-18 payment with actuals as well as paying a higher portion of the estimated payment in FY 2017-18.

The change in FY 2018-19, from the prior estimate, is a decrease due to updating the payment amounts based on actuals for FY 2016-17, FY 2017-18, and FY 2018-19, as well as adjusting the timing of the partial payments for each fiscal year.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to:

- Additional ACA payments occurring in FY 2017-18, and
- Higher portion of regular payments estimated to occur in FY 2017-18.

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. The ACA methodology has been approved by CMS.

(Dollars in Thousands)

FY 2017-18	TF	FFP	ACA
FY 2016-17	$47,275	$47,275	$0
FY 2017-18	$17,086	$17,086	$0
FY 2013-14 ACA	$1,278	$0	$1,278
FY 2014-15 ACA	$4,597	$0	$4,597
FY 2015-16 ACA	$5,496	$0	$5,496
Total FY 2017-18	**$75,732**	**$64,361**	**$11,371**

(Dollars in Thousands)

FY 2018-19	TF	FFP	ACA
FY 2016-17	$5,253	$5,253	$0
FY 2017-18	$17,086	$17,086	$0
FY 2018-19	$28,520	$28,520	$0
FY 2016-17 ACA	$8,152	$0	$8,152
Total FY 2018-19	**$59,011**	**$50,859**	**$8,152**

CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS

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

PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	156
IMPLEMENTATION DATE:	4/2018
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	2045

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$21,682,000	$26,066,000
- STATE FUNDS	$9,993,000	$12,044,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$21,682,000	$26,066,000
STATE FUNDS	$9,993,000	$12,044,000
FEDERAL FUNDS	$11,689,000	$14,022,000

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)

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 supplemental payments to ICF/DDs.

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.

AB 120 (Chapter 22, Statutes of 2017) allocated up to $27,000,000 Proposition 56 funds for supplemental payments to ICF/DDs. The Centers for Medicare and Medicaid Services (CMS) approved State Plan Amendment (SPA) 17-028 for these supplemental payments.

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.

PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 156

Reason for Change:
The change for FY 2017-18 and FY 2018-19, from the prior estimate, is due to:

- Delayed system implementation of the fee-for-service (FFS) supplemental payments to April 2018,
- The Erroneous Payment Correction (EPC) for the retroactive FY 2017-18 FFS payments is expected to be implemented earlier in May 2018 instead of August 2018, and
- Updated FFS and managed care payments.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to:

- Two months of the FY 2017-18 County Organized Health Systems (COHS) and one month of the Non-COHS managed care payments will be paid in FY 2018-19;
- One month of the FY 2017-18 FFS supplemental payment and 11 months of the FY 2018-19 FFS supplemental payments occurring in FY 2018-19;
- 10 months of the COHS and 11 months of the Non-COHS FY 2018-19 managed care payments occurring in FY 2018-19.

Methodology:

1. Payments will be made via FFS supplemental payments and increased managed care capitation payments.

2. This policy is effective August 1, 2017, to July 31, 2018. Assume the supplemental payments will continue in FY 2018-19.

3. The ICF/DD supplemental payments are estimated to total $26.066 million TF, on an accrual basis. Of that total, the FFS supplemental payments are estimated to be $21.137 million TF and the managed care payments are estimated to be $4.929 million TF, respectively.

4. Assume the FY 2017-18 FFS supplemental payments will be implemented in April 2018 for 3 months in FY 2017-18. The EPC for the retroactive period from August 2017 to March 2018 is estimated to be implemented in May 2018. The July 2018 month of FFS payments occur in FY 2018-19.

5. Assume 11 months of the FY 2018-19 FFS supplemental payments will continue in FY 2018-19.

6. The managed care payments are expected to begin in April 2018:
   - Assume 10 months of the FY 2017-18 managed care payments for the County Organized Health Systems (COHS) model will be paid in FY 2017-18 and 2 months will be paid in FY 2018-19.
   - Assume 11 months of the FY 2017-18 managed care payments for Non-COHS models will be paid in FY 2017-18 and 1 month will be paid in FY 2018-19.

7. Assume 10 months of the COHS payments and 11 months of Non-COHS payments continue to be paid in FY 2018-19.

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REGULAR POLICY CHANGE NUMBER: 156

8. Funds allocated for the supplemental payments are as follows:

(Dollars in Thousands)

FY 2017-18	TF	SF	Title XXI FF	Title XIX FF	ACA FF
FFS ICF/DD Supplemental FY 2017-18 (Lagged)	$4,782	$2,382	$0	$2,381	$19
FFS ICF/DD Retro 17-18	$12,752	$6,353	$0	$6,350	$49
Managed Care Payments FY 2017-18	$4,148	$1,258	$136	$1,160	$1,594
Total	**$21,682**	**$9,993**	**$136**	**$9,891**	**$1,662**

(Dollars in Thousands)

FY 2018-19	TF	SF	Title XXI FF	Title XIX FF	ACA FF
FFS ICF/DD Supplemental FY 2017-18	$3,602	$1,794	$0	$1,794	$14
FFS ICF/DD Supplemental FY 2018-19 (Lagged)	$17,534	$8,736	$0	$8,731	$67
Managed Care Payments FY 2017-18	$782	$239	$26	$218	$299
Managed Care Payments FY 2018-19	$4,148	$1,275	$136	$1,160	$1,577
Total	**$26,066**	**$12,044**	**$162**	**$11,903**	**$1,957**

Funding:

(Dollars in Thousands)

FY 2017-18	TF	SF	FF
Healthcare Treatment Fund Prop. 56 (4260-101-3305)	$9,993	$9,993	$0
ACA Title XIX FF (4260-101-0890)	$1,662	$0	$1,662
Title XIX FF (4260-101-0890)	$9,891	$0	$9,891
Title XXI FF (4260-113-0890)	$136	$0	$136
Total	**$21,682**	**$9,993**	**$11,689**

(Dollars in Thousands)

FY 2018-19	TF	SF	FF
Healthcare Treatment Fund Prop. 56 (4260-101-3305)	$12,044	$12,044	$0
ACA Title XIX FF (4260-101-0890)	$1,957	$0	$1,957
Title XIX FF (4260-101-0890)	$11,903	$0	$11,903
Title XXI FF (4260-113-0890)	$162	$0	$162
Total	**$26,066**	**$12,044**	**$14,022**

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH

REGULAR POLICY CHANGE NUMBER: 157
IMPLEMENTATION DATE: 1/2005
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 1038

	FY 2017-18	FY 2018-19
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 2017-18 and FY 2018-19, and from FY 2017-18 to FY 2018-19 within the current estimate.

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH

REGULAR POLICY CHANGE NUMBER: 157

Methodology:

1. Assume annual reimbursements for disproportionate share of outpatient services are $10,000,000 TF ($5,000,000 GF).

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
CY 2017	$7,500	$3,750	$3,750
CY 2018	$2,500	$1,250	$1,250
Total	**$10,000**	**$5,000**	**$5,000**

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
CY 2018	$7,500	$3,750	$3,750
CY 2019	$2,500	$1,250	$1,250
Total	**$10,000**	**$5,000**	**$5,000**

Funding:

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

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH

REGULAR POLICY CHANGE NUMBER: 158
IMPLEMENTATION DATE: 1/2005
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 1039

	FY 2017-18	FY 2018-19
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 increase in reimbursement rates for outpatient services provided to Medi-Cal beneficiaries by Small and Rural Hospitals (SRHs).

Authority:
AB 2617 (Chapter 158, Statutes of 2000)

Interdependent Policy Changes:
Not Applicable

Background:
This program provides SRHs with increased reimbursement rates. 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 2017-18 and FY 2018-19 from the prior estimate, and from FY 2017-18 to FY 2018-19 within the current estimate.

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH

REGULAR POLICY CHANGE NUMBER: 158

Methodology:

1. Assume annual reimbursements to SRHs providing outpatient services are $8,000,000 TF ($4,000,000 GF).

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
CY 2017	$6,000	$3,000	$3,000
CY 2018	$2,000	$1,000	$1,000
Total	**$8,000**	**$4,000**	**$4,000**

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
CY 2018	$6,000	$3,000	$3,000
CY 2019	$2,000	$1,000	$1,000
Total	**$8,000**	**$4,000**	**$4,000**

Funding:

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

IGT PAYMENTS FOR HOSPITAL SERVICES

REGULAR POLICY CHANGE NUMBER:	159
IMPLEMENTATION DATE:	7/2006
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1158

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$5,801,000	$273,000
- STATE FUNDS	$2,000,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$5,801,000	$273,000
STATE FUNDS	$2,000,000	$0
FEDERAL FUNDS	$3,801,000	$273,000

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.

IGT PAYMENTS FOR HOSPITAL SERVICES

REGULAR POLICY CHANGE NUMBER: 159

This program will sunset on June 30, 2018, because Los Angeles County has elected to discontinue the IGTs used to fund the non-federal share of the supplemental payments. The final supplemental payment from this program will be made in the 4th quarter of SFY 2017-18 but, per the ACA methodology, the final ACA payment to Los Angeles County will not be made until SFY 2018-19.

Reason for Change:
The change in FY 2017-18, from the prior estimate, is a decrease due to updated actuals for the FY 2013-14 through FY 2015-16 ACA payments.

The change in FY 2018-189, from the prior estimate, is an increase due to updated actuals for the FY 2017-18 ACA payment.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to fewer ACA payments in FY 2018-19 as well as the final payment for the program occurring in FY 2018-19.

Methodology:
1. As outlined in SPA 15-003, the FY 2017-18 payment is on an accrual basis and is estimated to be $4,000,000. FY 2017-18 is the last year in which IGT payments will be made. This program and its payments will be terminated effective June 30, 2018, as Los Angeles County has declined to contribute any IGTs in future fiscal years.

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% and then to 94% on January 1, 2018.

4. ACA payments will be 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. For FY 2013-14, FY 2014-15 and FY 2015-16, the ACA payments were claimed in December 2017. For FY 2016-17 the ACA supplemental payments will be claimed in the fourth quarter of FY 2017-18. For FY 2017-18, the ACA payment will be made in FY 2018-19. The County will be reimbursed for the IGT (nonfederal share), and an adjustment will be made for the federal share processed at the regular 50% FMAP.

5. Cash basis payments are estimated to be:

IGT PAYMENTS FOR HOSPITAL SERVICES

REGULAR POLICY CHANGE NUMBER: 159

FY 2017-18	TF	IGT	FF	ACA FF	*Return to Counties
FY 2013-14 ACA Adjustment to Counties	$427,000	$0	($427,000)	$854,000	$427,000
FY 2014-15 ACA Adjustment to Counties	$805,000	$0	($806,000)	$1,611,000	$805,000
FY 2015-16 ACA Adjustment to Counties	$278,000	$0	($279,000)	$557,000	$278,000
FY 2016-17 ACA Adjustment to Counties	$291,000	$0	($307,000)	$598,000	$291,000
FY 2017-18	$4,000,000	$2,000,000	$2,000,000	$0	$0
Total FY 2017-18	**$5,801,000**	**$2,000,000**	**$181,000**	**$3,620,000**	**$1,801,000**

FY 2018-19	TF	IGT	FF	ACA FF	*Return to Counties
FY 2017-18 ACA Adjustment to Counties	$273,000	$0	($306,000)	$579,000	$273,000
Total FY 2018-19	**$273,000**	**$0**	**($306,000)**	**$579,000**	**$273,000**

*The Return to Counties column is for display purposes only (see Methodology #4).

Funding:
50% Reimbursement GF / 50% Title XIX (4260-601-0995 / 4260-101-0890)
100% Title XIX ACA FF (4260-101-0890)
100% Title XIX FF (4260-101-0890)

PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	160
IMPLEMENTATION DATE:	11/2017
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	2050

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$6,800,000	$6,800,000
- STATE FUNDS	$3,400,000	$3,400,000
PAYMENT LAG	0.8050	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$5,474,000	$6,800,000
STATE FUNDS	$2,737,000	$3,400,000
FEDERAL FUNDS	$2,737,000	$3,400,000

DESCRIPTION

Purpose:
This policy change estimates the expenditures related to providing supplemental payments for specific AIDS Waiver services.

Authority:
AB 120 (Chapter 22, Statutes of 2017)
Proposition 56 (2016)

Interdependent Policy Changes:
Not Applicable

Background:
AB 120 appropriates up to $4 million from Proposition 56 revenues to provide supplemental payments for specific AIDS waiver services.

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.

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

PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 160

payment program is available only to the extent federal Medicaid policy does not reduce federal 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.

Reason for Change:
There is no change from the prior estimate for FY 2017-18 and FY 2018-19. There is no change from FY 2017-18 to FY 2018-19 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 2017-18	TF	SF	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 2018-19	**TF**	**SF**	**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:
Healthcare Treatment Fund (4260-101-3305)
100% Title XIX (4260-101-0890)

NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER:	161
IMPLEMENTATION DATE:	7/2005
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1076

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$5,277,000	$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	$5,277,000	$4,273,000
STATE FUNDS	$1,900,000	$1,900,000
FEDERAL FUNDS	$3,377,000	$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

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. Another SPA will be submitted to CMS for approval to continue the NDPH Supplemental program for FY 2018-19.

NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 161

Reason for Change:
The change in FY 2017-18, from the prior estimate, is due to updated FY 2013-14, FY 2014-15, FY 2015-16, and FY 2016-17 Affordable Care Act (ACA) claims data.

The change in FY 2018-19, from the prior estimate, is due to updated FY 2017-18 ACA claims data.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to fewer ACA claiming years budgeted in FY 2018-19.

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% Federal Medical Assistance Percentage (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. 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. For FY 2013-14, FY 2014-15, FY 2015-16, and FY 2016-17, the ACA adjustments will be claimed in FY 2017-18. For FY 2017-18, the ACA adjustment will be claimed in FY 2018-19. 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: 161

6. The estimated NDPH Supplemental payments and ending balance for FY 2017-18 are shown below:

FY 2017-18 NDPH Supplemental Fund Summary	SF
FY 2016-17 Ending Balance	$461,000
Appropriation (GF)	$1,900,000
Est. FY 2016-17 Interest Earned	$11,000
FY 2013-14 ACA FFP Adjustment to SF	$116,000
FY 2014-15 ACA FFP Adjustment to SF	$324,000
FY 2015-16 ACA FFP Adjustment to SF	$544,000
FY 2016-17 ACA FFP Adjustment to SF	$493,000
Funds Available	$3,849,000
Less: FY 2017-18 Cash Expenditures to Hospitals	($1,900,000)
Est. FY 2017-18 Remaining Balance	$1,949,000

FY 2017-18	TF	SF	FF	ACA FF	Return to Fund 3096*
FY 2017-18 Cash Expenditures to Hospitals**	$3,800,000	$1,900,000	$1,900,000	$0	$0
FY 2013-14 ACA FF Adjustment to SF***	$116,000	$0	($115,000)	$231,000	$116,000
FY 2014-15 ACA FF Adjustment to SF***	$324,000	$0	($323,000)	$647,000	$324,000
FY 2015-16 ACA FF Adjustment to SF***	$544,000	$0	($544,000)	$1,088,000	$544,000
FY 2016-17 ACA FF Adjustment to SF***	$493,000	$0	($519,000)	$1,012,000	$493,000
Total	**$5,277,000**	**$1,900,000**	**$399,000**	**$2,978,000**	$1,477,000

NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 161

7. The estimated NDPH Supplemental payments and ending balance for FY 2018-19 are shown below:

FY 2018-19 NDPH Supplemental Fund Summary	SF
FY 2017-18 Ending Balance	$1,949,000
Appropriation (GF)	$1,900,000
Est. FY 2017-18 Interest Earned	$20,000
FY 2017-18 ACA FFP Adjustment to SF	$473,000
Funds Available	$4,342,000
Less: FY 2018-19 Cash Expenditures to Hospitals	($1,900,000)
Est. FY 2018-19 Remaining Balance	$2,442,000

FY 2018-19	TF	SF	FF	ACA FF	Return to Fund 3096*
FY 2018-19 Cash Expenditures to Hospitals**	$3,800,000	$1,900,000	$1,900,000	$0	$0
FY 2017-18 ACA FF Adjustment to SF***	$473,000	$0	($531,000)	$1,004,000	$473,000
Total	**$4,273,000**	**$1,900,000**	**$1,369,000**	**$1,004,000**	$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)***

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	162
IMPLEMENTATION DATE:	12/2010
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1616

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$5,098,000	$4,769,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$5,098,000	$4,769,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$5,098,000	$4,769,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental payments to state veterans' homes.

Authority:
AB 959 (Chapter 162, Statutes of 2006)

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 both FY 2017-18 and FY 2018-19, from the prior estimate, is an increase due to assuming initial ACA payments will now be fully budgeted instead of receiving an initial partial ACA payment and then a reconciliation adjustment at a later time.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to fewer ACA payments occurring in FY 2018-19.

Methodology:
Supplemental payments for state veterans' homes began in FY 2010-11 and payments are estimated based on actual historical reported certified expenditures.

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 162

The estimate is based on:

1. Interim payments,
2. Initial reconciliation payments, and
3. A final reconciliation payment, if necessary.

Program payment amounts are estimated to be:

FY 2017-18	FF
ACA Payments	
FY 2013-14	$39,000
FY 2014-15	$135,000
FY 2015-16	$219,000
FY 2016-17	$203,000
Interim Payments	
FY 2017-18	$2,279,000
Initial Reconciliation Payment	
FY 2016-17	$2,223,000
FY 2017-18 Total	**$5,098,000**

FY 2018-19	FF
ACA Payments	
FY 2017-18	$154,000
Interim Payments	
FY 2018-19	$2,336,000
Initial Reconciliation Payment	
FY 2017-18	$2,279,000
FY 2018-19 Total	**$4,769,000**

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

DP-NF CAPITAL PROJECT DEBT REPAYMENT

REGULAR POLICY CHANGE NUMBER:	164
IMPLEMENTATION DATE:	8/2018
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1936

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$57,224,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$57,224,000
FEDERAL FUNDS	$0	-$57,224,000

DESCRIPTION

Purpose:
This policy change estimates the federal financial participation repayment to the Centers for Medicare and Medicaid Services (CMS) for ineligible claims made through the distinct part skilled nursing facility (DP-NF) Capital Project Debt Reimbursement supplemental payment program.

Authority:
SB 1128 (Chapter 757, Statutes of 1999)

Interdependent Policy Changes:
Not Applicable

Background:
SB 1128 authorized a DP-NF of a public acute care hospital providing specified services and other specific conditions as specified in Section 14105.26 of the Welfare and Institutions Code, to receive Medi-Cal reimbursement for debt service incurred for the financing of eligible capital construction projects. The Department claims federal funds using certified public expenditures. To be eligible for payments, the capital projects must be completed and have been issued a certificate of occupancy.

On June 16, 2015, CMS notified the Department that it denied the “good cause” waiver request, thus disapproving total payments of $57,224,000 for payments that were made to Edgemoor Geriatric Hospital and Laguna Honda Hospital and Rehabilitation Center for costs prior to the certificate of occupancy and/or were not made within the two-year claiming limit. The repayment to CMS will occur in FY 2018-19. The Department will reach out to the affected entities regarding a repayment schedule.

Reason for Change:
The change for both FY 2017-18 and FY 2018-19 is due to shifting the repayment from FY 2017-18 to FY 2018-19. CMS’ formal disallowance is still pending.

DP-NF CAPITAL PROJECT DEBT REPAYMENT

REGULAR POLICY CHANGE NUMBER: 164

Methodology:

1. The Department is anticipated to reimburse the federal funds, totaling $57,224,000, in FY 2018-19.

(Dollars in Thousands)

Facility Name	TF	GF	FF
Edgemoor Geriatric Hospital	$0	$1,317	($1,317)
Laguna Honda Hospital and Rehabilitation Center	$0	$55,907	($55,907)
FY 2018-19	**$0**	**$57,224**	**($57,224)**

Funding:

100% GF (4260-101-0001)
100% Title XIX FF (4260-101-0890)

CCI IHSS RECONCILIATION

REGULAR POLICY CHANGE NUMBER:	170
IMPLEMENTATION DATE:	7/2018
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1942

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$339,270,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$339,270,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$339,270,000

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:
The Coordinated Care Initiative (CCI) provides models of care to persons eligible for both Medicare and 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 CDSS reimbursement to the managed care plans is reflected in the Retro MC Rate Adjustments policy change.

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 will be removed from capitation rate payments effective January 1, 2018.

CCI IHSS RECONCILIATION

REGULAR POLICY CHANGE NUMBER: 170

Reason for Change:
There is no change from the prior estimate for FY 2018-19.

Methodology:

1. Assume the 2014 reconciliation for calendar year (CY) 2014 service months and reimbursement for overpayments and underpayments will begin in December 2017 and will be completed in FY 2017-18.

2. Based on CY 2014 data, it is estimated the Department will reimburse CDSS $67,721,000 TF for IHSS fee-for-service in the seven CCI counties. This amount is budgeted in the Retro MC Rate Adjustments policy change.

3. Based on 2015 reconciliation data, which includes CY 2014 not captured in the 2014 reconciliation and CY 2015 service months, it is estimated the Department will reimburse CDSS $339,270,000 TF for IHSS managed care in seven CCI counties.

4. Assume 2015 reconciliation data and reimbursement for overpayment and underpayments through CY 2015 will begin in FY 2018-19.

Funding:
100% Title XIX (4260-101-0890)

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER:	171
IMPLEMENTATION DATE:	12/2011
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1488

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$130,515,000	$231,917,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$130,515,000	$231,917,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$130,515,000	$231,917,000

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. 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 (FFP).

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER: 171

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 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 changes from the prior estimate, for FY 2017-18 and FY 2018-19, are due to two factors. First, the Department is delaying payments due to pending audits. Second, professional participation was lower than expected due to changes in program requirements per CMS guidance.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to payments delayed from FY 2017-18 to FY 2018-19, pending audit completion.

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.

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.

   For FY 2017-18 and FY 2018-19, incentive payments are adjusted based on hospitals' pending payments. Due to the length of time the hospital attestations and approvals took, the Department estimates payments one and two for some hospitals in FY 2017-18. For FY 2017-18, the year one eligible incentive payments will average $695,000, the year two payments will average $476,000, the year three payments will average $261,000, and the year four payments will average $206,000. For FY 2018-19, the year two payments will average $900,000, the year three payments will average $1,200,000, and the year four payments will average $900,000.

5. The Department incorporated payment corrections identified through EHR incentive program post payment audits to offset against FY 2017-18 incentive payments. Additionally, the Department used updated payment guidance from CMS to update FY 2017-18 incentive payments.

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER: 171

6. The estimated payments for FY 2017-18 and FY 2018-19 are on a cash-basis.

FY 2017-18 Incentive Payments:

Eligibility Year	Professionals	Incentive Payments	FF
1	2,671	$21,250	$56,759,000
2	2,071	$8,500	$17,604,000
3	1,493	$8,500	$12,691,000
4	902	$8,500	$7,667,000
5	685	$8,500	$5,823,000
6	310	$8,500	$2,635,000
Total FY 2017-18 Professional Payments			**$103,179,000**

Eligibility Year	Hospitals	Incentive Payments	FF
1	7	$695,000	$4,865,000
2	26	$476,000	$12,376,000
3	15	$261,000	$3,915,000
4	30	$206,000	$6,180,000
Total FY 2017-18 Hospital Payments			**$27,336,000**

FY 2018-19 Incentive Payments:

Eligibility Year	Professionals	Incentive Payments	FF
2	4,570	$8,500	$38,845,000
3	4,398	$8,500	$37,383,000
4	1,652	$8,500	$14,042,000
5	793	$8,500	$6,741,000
6	483	$8,500	$4,106,000
Total FY 2018-19 Professional Payments			**$101,117,000**

Eligibility Year	Hospitals	Incentive Payments	FF
2	30	$900,000	$27,000,000
3	43	$1,200,000	$51,600,000
4	58	$900,000	$52,200,000
Total FY 2018-19 Hospital Payments			**$130,800,000**

Fiscal Year	Professional Payments	Hospital Payments	FF
FY 2017-18	$103,179,000	$27,336,000	**$130,515,000**
FY 2018-19	$101,117,000	$130,800,000	**$231,917,000**

Funding:
100% Title XIX (4260-101-0890)

ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

REGULAR POLICY CHANGE NUMBER:	174
IMPLEMENTATION DATE:	6/2011
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1232

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$102,041,000	$82,326,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$102,041,000	$82,326,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$102,041,000	$82,326,000

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 2017-18. Funding for services provided between October 1, 2008, through June 30, 2011, will be reimbursed at the appropriate FMAP rate.

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.

ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

REGULAR POLICY CHANGE NUMBER: 174

Reason for Change:
The change for FY 2017-18, from the prior estimate, is a decrease due to updated expenditure data and a shift in a portion of the expected FY 2017-18 ARRA funds from FY 2017-18 to FY 2018-19.

The change for FY 2018-19, from the prior estimate, is a net increase due to revised expenditure data and including the FY 2017-18 ARRA funds that are expected to be received in FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to lower prior year expenditures expected in FY 2018-19.

Methodology:
1. FY 2017-18 includes a portion of payments for FY 2009-10, FY 2015-16, FY 2016-17, and FY 2017-18 expenditures. FY 2018-19 includes a portion of payments for FY 2017-18 and FY 2018-19 expenditures.

2. The following estimates, on a cash basis, were provided by CDDS:

(Dollars in Thousands)

	TF	CDDS GF	FFP Regular	FFP ARRA	Total FFP
FY 2017-18	$198,263	$96,222	$96,222	$5,819	**$102,041**
FY 2018-19	$160,470	$78,144	$78,144	$4,182	**$82,326**

Funding:
100% Title XIX (4260-101-0890)

INFANT DEVELOPMENT PROGRAM

REGULAR POLICY CHANGE NUMBER:	178
IMPLEMENTATION DATE:	7/2016
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	2009

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$42,313,000	$29,676,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$42,313,000	$29,676,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$42,313,000	$29,676,000

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 CDDS 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 for FY 2017-18, from the prior estimate, is a net increase due to updated expenditure and caseload data and prior year expenditures for FY 2015-16 being lower than previously expected.

The change for FY 2018-19, from the prior estimate, is an increase due to increases in expected expenditure and caseload data.

The change in the current estimate, from FY 2017-18 to FY 2018-19, is a net decrease due to updated expenditure data and fewer prior year expenditures in FY 2018-19.

INFANT DEVELOPMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 178

Methodology:

1. The following estimates, on a cash basis, were provided by CDDS.

(Dollars in Thousands)

	TF	CDDS GF	FF
FY 2017-18	$84,625	$42,312	**$42,313**
FY 2018-19	$59,351	$29,675	**$29,676**

Funding:

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

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

REGULAR POLICY CHANGE NUMBER:	179
IMPLEMENTATION DATE:	7/2010
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1526

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$17,176,000	$14,059,000
- STATE FUNDS	$7,659,000	$6,236,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$17,176,000	$14,059,000
STATE FUNDS	$7,659,000	$6,236,000
FEDERAL FUNDS	$9,517,000	$7,823,000

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 FFP in FY 2017-18. Funding for services provided between October 1, 2008, through June 30, 2011, will be reimbursed at the appropriate FMAP rate.

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

REGULAR POLICY CHANGE NUMBER: 179

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 2017-18, from the prior estimate, is a decrease due to updated expenditures and some prior year expenditures shifting from FY 2017-18 to FY 2018-19.

The change for FY 2018-19, from the prior estimate, is a net increase due to updated expenditures and a shift prior year expenditures originally assumed to occur in FY 2017-18 now being paid in FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a net decrease due to prior year expenditures for FYs 2009-10, 2015-16, and 2016-17 being paid in FY 2017-18.

Methodology:
1. 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 2017-18	$1,443	$7,659	$18,619	$1,443	**$7,659**	**$9,103**	**$414**
FY 2018-19	$1,173	$6,236	$15,231	$1,173	**$6,236**	**$7,409**	**$414**

Funding:
100% GF (4260-101-0001)
100% FFP (4260-101-0890)

MINIMUM WAGE INCREASE FOR HCBS WAIVERS

REGULAR POLICY CHANGE NUMBER:	180
IMPLEMENTATION DATE:	1/2017
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1975

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$26,124,000	$43,495,000
- STATE FUNDS	$13,062,000	$21,747,500
PAYMENT LAG	0.6440	0.9830
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$16,823,900	$42,755,600
STATE FUNDS	$8,411,930	$21,377,790
FEDERAL FUNDS	$8,411,930	$21,377,790

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:
PC 182 – 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 (CPI) 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 a homelike and community setting 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: 180

Reason for Change:
There is no change from the prior estimate for FY 2017-18 and FY 2018-19. The change from FY 2017-18 to FY 2018-19, 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. Beginning January 1, 2017, the minimum wage will increase $.50 from $10.00 to $10.50 per hour. Beginning January 1, 2018, the minimum wage will increase $.50 from $10.50 to $11.00 per hour. Beginning January 1, 2019, the minimum wage will increase $.50 from $11.00 to $11.50 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 3,744 in CY 2017, 4,744 in CY 2018, and 5,744 in CY 2019.

4. For FY 2017-18, assume the total care coordination and assisted living cost minimum wage increase is $25,993,000 TF. For FY 2018-19, assume the total care coordination and assisted living cost minimum wage increase is $43,245,000 TF.

AIDS MCWP
5. For CY 2017, assume there are 212 attendant care users. For CY 2018, assume there are 216 attendant care users. For CY 2019, assume there are 221 attendant care users.

6. A unit is counted as 15 minutes of time.

7. For CY 2017, assume a participant uses 1,157 units of attendant care services annually. For CY 2018, assume a participant uses 1,180 units of attendant care services annually. For CY 2019, assume a participant uses 1,204 units of attendant care services annually.

8. For CY 2017, assume the estimated attendant care service rate is $5.01 per unit. For CY 2018, assume the estimated attendant care service rate is $5.30 per unit. For CY 2019, assume the estimated attendant care service rate is $5.88 per unit.

9. Assume the FY 2017-18 cost for the AIDS MCWP Waiver minimum wage increase is $131,000 TF. Assume the FY 2018-19 cost for AIDS MCWP Waiver minimum wage is $250,000 TF.

FY 2017-18	TF	GF	FF
ALW	$25,993,000	$12,997,000	$12,996,000
HIV/AIDS	$131,000	$65,000	$66,000
Total	**$26,124,000**	**$13,062,000**	**$13,062,000**

FY 2018-19	TF	GF	FF
ALW	$43,245,000	$21,623,000	$21,622,000
HIV/AIDS	$250,000	$125,000	$125,000
Total	**$43,495,000**	**$21,748,000**	**$21,747,000**

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

AUDIT SETTLEMENTS

REGULAR POLICY CHANGE NUMBER:	181
IMPLEMENTATION DATE:	7/2016
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	110

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$13,928,000	$180,889,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$13,928,000	$180,889,000
FEDERAL FUNDS	-$13,928,000	-$180,889,000

DESCRIPTION

Purpose:
This policy change estimates the payments for audit settlements due to the Centers for Medicare and Medicaid Services (CMS).

Authority:
Public Law 95-452

Interdependent Policy Changes:
Not Applicable

Background:
Federal Audit A-09-14-0230: The Department claimed federal reimbursement from Medicaid overpayments made to providers who were determined to be bankrupt or out-of-business. In an audit, the Office of Inspector General (OIG) found that the Department reclaimed the overpayments incorrectly at a higher Federal Medical Assistance Percentage (FMAP). The audit covers payments made during the period of federal fiscal years 2010 through 2013.

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.

Kaiser Sanction: In September 2016, the Department imposed a Corrective Action Plan (CAP) on Kaiser for failure to meet its regulatory and contractual obligations for reporting encounter data. The CAP further advised Kaiser that its failure to submit all retrospective encounter data by January 1, 2017, would result in the imposition of monetary sanctions under State law and the Medi-Cal managed health plan contract. Kaiser was unable to submit all of the following required encounter data by January 1, 2017 and will refund the Department.

AUDIT SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 181

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.

Draft Federal Audit A-09-15-02040: The OIG audit determined the Department claimed Federal Medicaid reimbursement for Specialty Mental Health Services (SMHS), unallowable under the Federal and State requirements for SMHS. The audit covers payments made during the period of federal fiscal year 2014. The Department will repay CMS in FY 2018-19. The responsibility for SMHS was realigned to counties as a part of 2011 Realignment. As such, these disallowances will ultimately be repaid by the counties over a period of four years.

Reason for Change:
There is no change from the prior estimate for FY 2017-18. The change from prior estimate for FY 2018-19 is from three additional audit findings that are expected to be paid in FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the different audit settlement findings that are expected to be paid in each fiscal year.

Methodology:

FY 2017-18	Audit	Finding	GF
Third Party Liability	CA Incorrectly Claimed Additional Medicaid Funding When Reclaiming Overpayments to Bankrupt or Out-of-Business Providers	Reclaimed overpayments incorrectly at a higher FMAP	$6,590,000
Eligibility	Review of State's Quarterly Alien Claiming Audit	The Department incorrectly claimed Federal Medicaid reimbursement	$9,873,000
Kaiser Sanction		The Department imposed a Corrective Action Plan on Kaiser for failure to meet its regulatory and contractual obligations for reporting encounter data	($2,535,000)
		FY 2017-18 Total	**$13,928,000**

AUDIT SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 181

FY 2018-19	**Audit**	**Finding**	**GF**
PERM Recovery FY 2016-17	California Medicaid Error Rates for FY 2016-17	Identified and estimated amount of improper payments for Medicaid	$182,000
PERM Recovery FY 2016-17	California CHIP Error Rates for FY 2016-17	Identified and estimated amount of improper payments for Medicaid	$7,000
Mental Health Services	California Claimed Hundreds of Millions of Dollars in Unallowable Federal Medicaid Reimbursement for Specialty Mental Health Services	Identified and estimated amount of improper payments for Medicaid	$180,700,000
		FY 2018-19 Total	**$180,889,000**

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2017-18	**$0**	**$13,928**	**($13,928)**
FY 2018-19	**$0**	**$180,889**	**($180,889)**

Funding:
100% GF (4260-101-0001)
Title XIX FFP (4260-101-0890)

OVERTIME FOR WPCS PROVIDERS

REGULAR POLICY CHANGE NUMBER:	182
IMPLEMENTATION DATE:	2/2016
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1852

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$9,961,000	$10,119,000
- STATE FUNDS	$4,998,500	$5,059,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$9,961,000	$10,119,000
STATE FUNDS	$4,998,500	$5,059,500
FEDERAL FUNDS	$4,962,500	$5,059,500

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.

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

OVERTIME FOR WPCS PROVIDERS

REGULAR POLICY CHANGE NUMBER: 182

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, 2017, the minimum wage increased from $10.00 to $10.50 per hour for providers living in counties that pay below $10.50 per hour. On January 1, 2018, the minimum wage will increase from $10.50 to $11.00 per hour. Beginning January 1, 2019, the minimum wage will increase from $11.00 to $11.50 per hour.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is an increase due to additional state support costs related to the expansion of the WPCS overtime exemptions. The change from the prior estimate, for FY 2018-19, is a decrease due to delayed input of WPCS applications. The change from FY 2017-18 to FY 2018-19, in the current estimate, increased due to the minimum wage increase and an estimated higher number of providers to receive an approved exemption.

Methodology:
1) Assume 1,640 WPCS beneficiaries will have providers receiving overtime in FY 2017-18 and 1,884 in FY 2018-19.

2) Assume the annual cost for overtime without exemptions or travel time in FY 2017-18 is $154,000 and $157,000 in FY 2018-19.

3) Assume 913 WPCS providers receive overtime exemptions in FY 2017-18 and 1,189 in FY 2018-19.

4) Assume the annual cost for overtime for providers who received an exemption in FY 2017-18 is $9,648,000 and $9,836,000 in FY 2018-19.

5) Assume the annual travel time cost for WPCS providers in FY 2017-18 is $123,000 and $125,000 in FY 2018-19.

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 **$9,961,000 TF ($4,999,000 GF)** in FY 2017-18 and **$10,119,000 TF ($5,060,000 GF)** in FY 2018-19.

OVERTIME FOR WPCS PROVIDERS

REGULAR POLICY CHANGE NUMBER: 182

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

INDIAN HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER:	184
IMPLEMENTATION DATE:	4/1998
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	111

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$3,903,000	$8,710,000
- STATE FUNDS	-$20,813,000	-$20,813,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,903,000	$8,710,000
STATE FUNDS	-$20,813,000	-$20,813,000
FEDERAL FUNDS	$24,716,000	$29,523,000

DESCRIPTION

Purpose:
This policy change estimates the annual rate change posted in the Federal Register and 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 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:
The change from the prior estimate, for FY 2017-18, is a decrease due to an adjustment to the base expenditures claims. Actual expenditures for FY 2016-17 were slightly lower than expected. The change from the prior estimate, for FY 2018-19, is an increase due to a higher rate increase than expected. The CY 2018 rate increase was expected at $16 but increased to $36. The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to the anticipated rate increase from current year to budget year of $36. Additionally, four new clinics were added to IHS.

INDIAN HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 184

Methodology:

1. Currently, there are 70 Indian health clinics participating in Medi-Cal.

2. In FY 2016-17, the Department spent $41,626,000 TF ($20,813,000 GF) for services provided to AIs.

3. Recent changes posted in the Federal Register, Volume 82, Number 11, January 18, 2017 updated the per visit rate payable to Indian health clinics. Effective CY 2017, the per visit rate payable to Indian health clinics increased by $23; from $368 to $391.

4. Effective CY 2018, the Federal Register, Volume 83, Number 4, January 5, 2018 updated the per visit rate payable to the Indian health clinics by $36, from $391 to $427.

5. The FY 2017-18 estimate includes an additional $1,301,000 due to the increased rate for the period of January 2017 through June 2017. The annual rate increase for the additional $23 is $2,602,000 TF.

6. The FY 2018-19 estimate includes an additional $2,036,000 TF due to the rate increase from $391 to $427 for the period of January 2018 through June 2018. The annual rate increase for the additional $36 is $4,072,000 TF.

	FY 2017-18	FY 2018-19
CY 2017 rate increase	$2,602,000	$2,602,000
CY 2018 rate increase	$0	$4,072,000
Retro Jan –June 2017 rate increase	$1,301,000	$0
Retro Jan –June 2018 rate increase	$0	$2,036,000
Total Rate increase	**$3,903,000**	**$8,710,000**
FY 2016-17 Base expenditures	$41,626,000	$41,626,000
Total expenditures	$45,529,000	$50,336,000

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
IHS FY 2016-17 Base exp. (50% GF / 50% FF)	($41,626)	($20,813)	($20,813)
IHS total expenditures (100% FF)	$45,529	$0	$45,529
FY 2017-18 Total	**$3,903**	**($20,813)**	**$24,716**

FY 2018-19			
IHS FY 2016-17 Base exp. (50% GF / 50% FF)	($41,626)	($20,813)	($20,813)
IHS total expenditures (100% FF)	$50,336	$0	$50,336
FY 2018-19 Total	**$8,710**	**($20,813)**	**$29,523**

*Totals may differ due to rounding.

Funding:

50% Title XIX FFP/ 50% GF (4260-101-0001/0890)
Title XIX 100% FFP (4260-101-0890)

MEDI-CAL ESTATE RECOVERIES

REGULAR POLICY CHANGE NUMBER:	185
IMPLEMENTATION DATE:	7/2017
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1991

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$17,176,000	$38,906,000
- STATE FUNDS	$8,588,000	$19,453,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	69.00 %	41.00 %
APPLIED TO BASE		
TOTAL FUNDS	$5,324,600	$22,954,500
STATE FUNDS	$2,662,280	$11,477,270
FEDERAL FUNDS	$2,662,280	$11,477,270

DESCRIPTION

Purpose:
This policy change estimates the cost for the changes in the Medi-Cal Estate Recovery (ER) program.

Authority:
SB 833 (Chapter 30, Statutes of 2016)
Welfare and Institutions Code Section 14009.5
Title 42, United States Code, Section 1396p
Title 22, California Code of Regulations Sections 50960-50966

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. However, as of January 1, 2017, pursuant to SB 833, the program changes limited the ER program to the probated estates of deceased Medi-Cal members 55 years of age and older, for only federally mandated services (skilled nursing care, home and community-based services, and related services), and also eliminated recovery if a Medi-Cal beneficiary is survived by a spouse/registered domestic partner. In addition, the ER program is limited to proportionate share recovery when a substantial hardship waiver criterion is identified.

Reason for Change:
The change in both FY 2017-18 and FY 2018-19, from the prior estimate, is an increase due to cases continuing to decrease at a faster rate of 4.96 percent and the correlated decrease in recoveries materializing at a quicker rate.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to continuing the trend of decreases in cases and the correlated decrease in recoveries.

MEDI-CAL ESTATE RECOVERIES

REGULAR POLICY CHANGE NUMBER: 185

Methodology:

1. The ER program changes, pursuant to SB 833, were effective January 1, 2017.

2. In FY 2016-17, ER recoveries were $69.5 million or $5.79 million monthly. During FY 2016-17, there were no recoveries from estates, in which the beneficiary died on or after January 1, 2017.

3. The total open ER cases which have accounts receivable balances decreased approximately 2.5 percent per month from January 1, 2017, to June 30, 2017. They further decreased approximately 4.96 percent per month from July 1, 2017, to January 31, 2018. Due to the lag between when a case is established and when a settlement is received, ER recoveries were stable during FY 2016-17, but began showing a decreasing trend beginning July 2017. The trend is expected to continue monthly, ongoing. As a result, recoveries are expected to decline to approximately $52.324 million in FY 2017-18, compared to FY 2016-17 recoveries. As a result, the savings loss estimated in FY 2017-18 is $17.176 million TF.

   FY 2017-18:
   $69.5 million TF - $52.324 million TF = $17.176 million TF Savings Loss

4. In FY 2018-19, ER recoveries are expected to continue the decline. As a result, recoveries are expected to decline further to approximately $30.594 million in FY 2018-19. As a result, the savings loss estimated in FY 2018-19 is $38.906 million TF.

   FY 2018-19:
   $69.5 million TF - $30.594 million TF = $38.906 million TF Savings Loss

(Dollars in Thousands)

Uncollectible Estate Recoveries	TF	GF	FF
FY 2017-18	$17,176	$8,588	$8,588
FY 2018-19	$38,906	$19,453	$19,453

Funding:

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

WPCS WORKERS' COMPENSATION

REGULAR POLICY CHANGE NUMBER:	186
IMPLEMENTATION DATE:	11/2016
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1866

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$3,026,000	$3,322,000
- STATE FUNDS	$1,513,000	$1,661,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,026,000	$3,322,000
STATE FUNDS	$1,513,000	$1,661,000
FEDERAL FUNDS	$1,513,000	$1,661,000

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

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 2,600 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 as of March 1, 2017 and will remain in effect until June 30, 2019.

Reason for Change:
There is no change from the prior estimate for FY 2017-18 and FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the rise in healthcare costs which increased the benefits by approximately 10 percent.

WPCS WORKERS' COMPENSATION

REGULAR POLICY CHANGE NUMBER: 186

Methodology:

1. The previous workers' compensation contract (14-90405) was a three-year IA that went into effect July 1, 2014 and ended June 30, 2017. The current contract, IA 16-93498, went into effect July 1, 2017 and will be in effect until June 30, 2019.

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 IHSS 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 2017-18 is $3,026,000 TF and $3,322,000 TF in FY 2018-19.

	TF	GF	FF
FY 2017-18	**$3,026,000**	**$1,513,000**	**$1,513,000**
FY 2018-19	**$3,322,000**	**$1,661,000**	**$1,661,000**

Funding:

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

CDDS DENTAL SERVICES

REGULAR POLICY CHANGE NUMBER:	190
IMPLEMENTATION DATE:	2/2012
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1629

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$712,000	$0
- STATE FUNDS	$712,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$712,000	$0
STATE FUNDS	$712,000	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the reimbursement from the California Department of Developmental Services (CDDS) to pay claims for CDDS consumers whose dental services are no longer covered by Medi-Cal.

Authority:
Interagency Agreement (IA) 16-93167

Interdependent Policy Changes:
Not Applicable

Background:
The Lanterman Act requires the CDDS to provide dental services to its clients. Because until January 1, 2018, Medi-Cal only covered partial dental services for adults 21 years of age and older, CDDS has an IA with the Department where the 2004 Medi-Cal dental Fiscal Intermediary (FI) processed and paid claims for FY 2016-17. For FY 2017-18, the 2016 Administrative Services Organization (ASO) contractor processes claims and the 2016 FI contractor adjudicates the claims for the broader scope of dental services covered by CDDS beginning the thirteenth month after the contract effective date.

The previous IA expired June 30, 2016; however, the Department secured approval on a new IA which will expire on June 30, 2021. The additional costs of claims processing and benefits will be reimbursed by CDDS. Effective May 1, 2014, some adult dental benefits were restored in accordance with Assembly Bill 82. Those services included initial examinations, radiographs, restorations, anterior root canals, complete dentures and complete denture adjustments, repairs and relines. Effective January 1, 2018, the full restoration of adult dental benefits included the remaining services which were not restored in 2014, such as restorative services (crowns), prosthodontic services (partial dentures), and endodontic services (root canals). After the implementation of the full restoration of adult dental benefits, CDSS will no longer need to cover these services.

This policy change estimates the reimbursement of benefit costs. The reimbursement of administration costs is budgeted in the Other Administration CDDS Dental Services policy change.

CDDS DENTAL SERVICES

REGULAR POLICY CHANGE NUMBER: 190

Reason for Change:
The change from the prior estimate, for FY 2017-18, is an increase due to updates based on actual paid invoices. There is no change from the prior estimate for FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to no additional costs being expected in FY 2018-19. With the implementation of full restoration of adult dental benefits on January 1, 2018, CDDS no longer reimburses DHCS for these services.

Methodology:
1. Assume the cost of processing claims is based on actual invoices and projected costs from the current average number of claims processed.

2. All costs are reimbursed by CDDS.

3. Costs to be reimbursed for FY 2017-18 are estimated to be in the amount of $712,000.

4. No costs are anticipated to be reimbursed in FY 2018-19 because with the restoration of full adult dental benefits, CDDS no longer reimburses DHCS for these services.

Funding:
100% Reimbursement GF (4260-610-0995)

FUNDING ADJUST.—OTLICP

REGULAR POLICY CHANGE NUMBER:	191
IMPLEMENTATION DATE:	7/2015
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1926

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$122,000	$154,000
- STATE FUNDS	-$184,775,000	-$192,489,640
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$122,000	$154,000
STATE FUNDS	-$184,775,000	-$192,489,640
FEDERAL FUNDS	$184,897,000	$192,643,640

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
PC 066 Pathways to Well-Being
PC 121 AB 1629 Annual Rate Adjustments
PC 122 Rate Increase for FQHCs/RHCs/CBRCs
PC 123 LTC Rate Adjustment
PC 125 Hospice Rate Increases
PC 135 Laboratory Rate Methodology Change
PC 136 Reduction to Radiology Rates
PC 137 10% Provider Payment Reduction

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, granting an extension of the enhanced match rate through September 30, 2023.

Reason for Change:

FUNDING ADJUST.—OTLICP

REGULAR POLICY CHANGE NUMBER: 191

The Department removed and added policy changes based on applicable funding sources.

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 2017-18 is estimated as $486,249,903 and $506,553,065 in FY 2018-19. 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 2017-18, the Department estimates the additional CHIP funding will offset general fund spending by $184.8M.
   b. In FY 2018-19, the Department estimates the additional CHIP funding will offset general fund spending by $192.5M.

4) The Department estimates the Total Fund after the adjustment of CHIP funding to be $122,000 in FY 2017-18 and $154,000 in FY 2018-19.

5) The amounts adjusted by policy change are as follows:

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
Fee-for-Service Base Expenditures	$ (0)	$ (185,256)	$ 185,256
PC 66 Pathways to Well-Being	$ 122	$ -	$ 122
PC 121 AB 1629 Annual Rate Adjustments	$ -	$ (23)	$ 23
PC 122 Rate Increase for FQHCs/RHCs/CBRCs	$ -	$ (40)	$ 40
PC 123 LTC Rate Adjustment	$ -	$ (2)	$ 2
PC 125 Hospice Rate Increases	$ -	$ (62)	$ 62
PC 135 Laboratory Rate Methodology Change	$ -	$ 47	$ (47)
PC 136 Reduction to Radiology Rates	$ -	$ 126	$ (126)
PC 137 10% Provider Payment Reduction	$ -	$ 435	$ (435)
Total	**$ 122**	**$ (184,775)**	**$ 184,897**

FUNDING ADJUST.—OTLICP

REGULAR POLICY CHANGE NUMBER: 191

FY 2018-19	TF	GF	FF
Fee-for-Service Base Expenditures	$ 0	$ (192,130)	$ 192,130
PC 66 Pathways to Well-Being	$ 154	$ -	$ 154
PC 121 AB 1629 Annual Rate Adjustments	$ -	$ (37)	$ 37
PC 122 Rate Increase for FQHCs/RHCs/CBRCs	$ -	$ (1,326)	$ 1,326
PC 123 LTC Rate Adjustment	$ -	$ (7)	$ 7
PC 125 Hospice Rate Increases	$ -	$ (608)	$ 608
PC 135 Laboratory Rate Methodology Change	$ -	$ 449	$ (449)
PC 136 Reduction to Radiology Rates	$ -	$ 828	$ (828)
PC 137 10% Provider Payment Reduction	$ -	$ 341	$ (341)
Total	**$ 154**	**$ (192,490)**	**$ 192,644**

Funding:
50% Title XIX FF / 50% GF (4260-101-0001/0890)
88% Title XXI FF / 12% GF (4260-113-0890/0001)

HEALTH CARE SVCS. PLANS FINES AND PENALTIES FUND

REGULAR POLICY CHANGE NUMBER:	193
IMPLEMENTATION DATE:	7/2017
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	2021

	FY 2017-18	FY 2018-19
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 revenues received from the Managed Care Administrative Fines and Penalties Fund to the Health Care Services Plans Fines and Penalties Fund for purposes of funding health care services for children, seniors, persons with disabilities, and dual eligibles in the Medi-Cal program.

Authority:
Proposed Trailer Bill Language

Interdependent Policy Changes:
Not Applicable

Background:
The Managed Care Administrative 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). In FY 2016-17, the administrative fines and penalties revenue was transferred to the Major Risk Medical Insurance Fund. The Budget abolishes the Major Risk Medical Insurance Fund, and proposes to transfer the fund balance, and ongoing administrative fines and penalties revenue, to the Health Care Services Plans Fines and Penalties Fund to support coverage for individuals remaining in the Major Risk Medical Insurance Program (MRMIP) and Medi-Cal program.

Reason for Change:
There is no change from the prior estimate for FY 2017-18.

Methodology:
1. The FY 2017-18 estimate is based on projected administrative fines and penalties assessed by DMHC.

HEALTH CARE SVCS. PLANS FINES AND PENALTIES FUND

REGULAR POLICY CHANGE NUMBER: 193

2. The FY 2017-18 estimate includes the transfer of the Major Risk Medical Insurance Fund FY 2016-17 fund balance to the Health Care Services Plans Fines and Penalties Fund.

FY 2017-18	**Cash Basis**
Health Care Services Plans Fines and Penalties Fund	$48,025,000
GF	($48,025,000)
Net Impact	**$0**

Funding:
Health Care Services Plans Fines and Penalties Fund (4260-101-3311)
Health Care Services Plans Fines and Penalties Fund (4260-603-3311)
Title XIX GF (4260-101-0001)

CLPP FUND

REGULAR POLICY CHANGE NUMBER:	194
IMPLEMENTATION DATE:	7/2005
ANALYST:	Sasha Jetton
FISCAL REFERENCE NUMBER:	1633

	FY 2017-18	FY 2018-19
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 105305 and 105310
Interagency Agreement (IA) #16-93210

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, Diagnosis, 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 state share of cost for the lead testing component is partly funded by the CLPP Fund. 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.

Reason for Change:
There is no change from the prior estimate or between fiscal years 2017-18 and 2018-19.

CLPP FUND

REGULAR POLICY CHANGE NUMBER: 194

Methodology:

1. Funding for Medi-Cal is at 50% State Funds.

2. The current IA with the Department of Public Health began July 1, 2016, and continues through June 30, 2019. The CLPP funding allocated for FY 2017-18 and FY 2018-19 is $725,000.

	FY 2017-18
100% CLPP Fund (4260-111-0080)	$ 725,000
100% GF (4260-101-0001)	**$ (725,000)**
Net Impact	**$ -**

	FY 2018-19
100% CLPP Fund (4260-111-0080)	$ 725,000
100% GF (4260-101-0001)	**$ (725,000)**
Net Impact	**$ -**

CCI-TRANSFER OF IHSS COSTS TO DHCS

REGULAR POLICY CHANGE NUMBER:	195
IMPLEMENTATION DATE:	4/2014
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1654

	FY 2017-18	FY 2018-19
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 the California Department of Social Services (CDSS) to the Department for In-Home Supportive Services (IHSS) costs related to dual eligible Medi-Cal Long-Term Care (LTC) beneficiaries.

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 both Medicare and Medi-Cal, and persons eligible for Medi-Cal only. The Department transitioned care for dual eligibles, partial dual eligibles and Medi-Cal only eligibles who receive LTC institutional services, IHSS and other Home and Community-Based Services (HCBS) to manage care health plans beginning April 1, 2014. These services have been discontinued from CCI as of January 1, 2018.

The IHSS payment process will be impacted as a result of transitioning eligible beneficiaries to managed care plans. Currently, the California Department of Social Services (CDSS) pays for IHSS services through their Case Management and Information and Payroll System (CMIPS) process. CDSS provides the matching General Fund and county funds and the Department draws down the federal financial participation (FFP). Under this proposal, managed care capitation was increased to include IHSS services to this population. This policy change reflects the transfer of General Fund and county funds to the Department to be used to increase managed care capitation rates.

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-TRANSFER OF IHSS COSTS TO DHCS

REGULAR POLICY CHANGE NUMBER: 195

except In-Home Supportive Services (IHSS), into managed care. IHSS has been removed from capitation rate payments effective January 1, 2018.

Reason for Change:
FY 2017-18 costs increased from the previous estimate due to an increase in IHSS rates for the CMC population, updates to rates payment timing, and updates to retro payments occurring in FY 2017-18. Costs decreased from FY 2017-18 to FY 2018-19 due to the exclusion of IHSS from CCI as of January 1, 2018.

Methodology:
1. Estimated below is the overall impact of the CCI demonstration in FY 2017-18.

(Dollars in Thousands)

FY 2017-18	TF	GF	FFP	Reimb.
CCI-Managed Care Payments (PC 91):				
Base managed care payments	$7,214,162	$3,607,081	$3,607,081	$0
Transfer of IHSS Costs to CDSS	$2,687,405	$1,343,703	$1,343,703	$0
Total Managed Care Payments	$9,901,568	$4,950,784	$4,950,784	$0
CCI-Savings and Deferral :				
Total Savings (In the Base)	($7,253,439)	($3,626,720)	($3,626,720)	$0
IHSS Savings (In the Base)	($1,343,703)	$0	($1,343,703)	$0
CCI-Transfer of IHSS Costs to DHCS (PC 195)	**$0**	**($1,343,703)**	**$0**	**$1,343,703**
CCI-Admin Costs, HCO Costs (OA 15, 18, 67)	$27,492	$13,746	$13,746	$0
Retro MC Rate Adjustments (PC 117)	$1,380,766	$245,778	$690,383	$0
CCI-Quality Withhold Repayments (PC 101)	$3,317	$1,659	$3,317	$0
Health Insurer Fee (PC 18)	$6,016	$3,008	$3,008	$0
Total of CCI PCs including pass through	$2,722,017	$244,552	$690,816	$1,343,703

Funding:
100% Reimbursement (4260-610-0995)
General Fund (4260-101-0001)

HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER:	196
IMPLEMENTATION DATE:	4/2015
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1760

	FY 2017-18	FY 2018-19
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)
AB 1607 (Chapter 27, Statutes of 2016)
Proposition 52 (2016)

Interdependent Policy Changes:
Not Applicable

Background:
SB 335 (Chapter 286, Statutes of 2011) establishes the Hospital QAF program from July 1, 2011, through December 31, 2013, which provides 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. The Department submitted State Plan Amendments (SPA) for this program on March 31, 2014. The Department 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).

AB 1607 extended the inoperative date of the Hospital QAF program to January 1, 2018, creating a one-year extension of the program.

Proposition 52, approved by California voters on November 8, 2016, permanently extends the Hospital QAF program.

HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 196

Reason for Change:
The change from the prior estimate for both FY 2017-18 and FY 2018-19, is due to:

- The approval of the HQAF V Fee & Payment Model by CMS in December 2017 that changed the amount for Children's Coverage, and
- The shift in the recalculated HQAF IV as a result of an annual Upper Payment Limit (UPL) Review from FY 2017-18 to FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to FY 2017-18 not including any prior year UPL adjustments as well as FY 2017-18 including more payment cycles.

Methodology:

1. Payments for children's health care are estimated through the period ending March 30, 2019 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. SB 239 requires the Department to reconcile the funds for children's health care coverage based on the actual net benefit to the hospitals from the fee program.

4. Payments associated with AB 1607 and Proposition 52 are based on the approved HQAF V Fee & Payment Model.

5. 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	AB 1607	1/1/17 to 6/30/17	$513,154
FY 2017-18	AB 1607 (through 12/31/17); Proposition 52 (1/1/18 and forward)	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

6. Two quarters of FY 2016-17 and three quarters of FY 2017-18 HQAF V payments will be paid in in FY 2017-18.

7. One quarter of FY 2017-18 and three quarters of FY 2018-19 HQAF V payments will be paid in FY 2018-19.

HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 196

8. On a cash basis, the payments to health care coverage for children are:

(Dollars in Thousands)

FY 2017-18	TF	GF	Hosp. QA Rev Fund
FY 2016-17 (HQAF V)	$0	($513,154)	$513,154
FY 2017-18	$0	($815,792)	$815,792
Total FY 2017-18	**$0**	**($1,328,946)**	**$1,328,946**

(Dollars in Thousands)

FY 2018-19	TF	GF	Hosp. QA Rev Fund
FY 2015-16	$0	$103,950	($103,950)
FY 2016-17 (HQAF IV)	$0	$60,000	($60,000)
FY 2017-18	$0	($271,931)	$271,931
FY 2018-19	$0	($850,788)	$850,788
Total FY 2018-19	**$0**	**($958,769)**	**$958,769**

Funding:
100% GF (4260-101-0001)
100% Hospital Quality Assurance Revenue Fund (4260-611-3158)

FUNDING ADJUST.—ACA OPT. EXPANSION

REGULAR POLICY CHANGE NUMBER:	197
IMPLEMENTATION DATE:	7/2015
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1915

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$1,808,695,810	-$1,912,496,130
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$1,808,695,810	-$1,912,496,130
FEDERAL FUNDS	$1,808,695,810	$1,912,496,130

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:
Affordable Care Act (ACA)

Interdependent Policy Changes:
Fee-for-Service Base Expenditures
PC 121 AB 1629 Annual Rate Adjustment
PC 123 LTC Rate Adjustment
PC 124 DPH Interim Rate Growth
PC 125 Hospice Rate Increases
PC 130 Alternative Birthing Center Reimbursement
PC 135 Laboratory Rate Methodology Change
PC 136 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 (FPL). 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 Department removed and added policy changes based on applicable funding sources.

FUNDING ADJUST.—ACA OPT. EXPANSION

REGULAR POLICY CHANGE NUMBER: 197

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 2017-18 is matched at 95% through CY 2017 and then decreases to 94% in CY 2018. The federal match for FY 2018-19 is matched at 94% through CY 2018 and then decreases to 93% in CY 2019.

3) The total amount of unadjusted ACA optional expansion funding for all policy changes in FY 2017-18 is estimated as $4,062,749,848 and $4,393,147,628 in FY 2018-19. These amounts are credited to the Title XIX fund.

4) The amounts adjusted by this policy change are as follows:

(Dollars in Thousands)

FY 2017-18	**GF**	**FF**
Fee-For-Service Base Expenditures	$ (1,805,381)	$ 1,805,381
PC 121 AB 1629 Annual Rate Adjustments	$ (1,716)	$ 1,716
PC 123 Reduction to Radiology Rates	$ 824	$ (824)
PC 124 DPH Interim Rate Growth	$ (2,469)	$ 2,469
PC 125 Alternative Birthing Center Reimbursement	$ (1)	$ 1
PC 128 Hospice Rate Increases	$ (68)	$ 68
PC 130 LTC Rate Adjustment	$ (172)	$ 172
PC 135 Laboratory Rate Methodology Change	$ 287	$ (287)
Total	**$ (1,808,696)**	**$ 1,808,696**

FY 2018-19	**GF**	**FF**
Fee-For-Service Base Expenditures	$ (1,905,738)	$ 1,905,738
PC 121 AB 1629 Annual Rate Adjustments	$ (2,844)	$ 2,844
PC 123 Reduction to Radiology Rates	$ 5,549	$ (5,549)
PC 124 DPH Interim Rate Growth	$ (11,022)	$ 11,022
PC 125 Alternative Birthing Center Reimbursement	$ (8)	$ 8
PC 128 Hospice Rate Increases	$ (757)	$ 757
PC 130 LTC Rate Adjustment	$ (565)	$ 565
PC 135 Laboratory Rate Methodology Change	$ 2,889	$ (2,889)
Total	**$ (1,912,496)**	**$ 1,912,496**

FUNDING ADJUST.—ACA OPT. EXPANSION

REGULAR POLICY CHANGE NUMBER: 197

Funding:
(Dollars in Thousands)

FY 2017-18	TF	GF	FF
Title XIX 50/50	$ (4,062,750)	$ (2,031,375)	$ (2,031,375)
ACA Title XIX 95% FF	$ 2,108,581	$ 105,429	$ 2,003,152
ACA Title XIX 94% FF	$ 1,954,169	$ 117,250	$ 1,836,919
Total	**$ -**	**$ (1,808,696)**	**$ 1,808,696**

FY 2018-19	TF	GF	FF
Title XIX 50/50	$ (4,393,148)	$ (2,196,574)	$ (2,196,574)
ACA Title XIX 94% FF	$ 2,344,249	$ 140,655	$ 2,203,594
ACA Title XIX 93% FF	$ 2,048,899	$ 143,423	$ 1,905,476
Total	**$ -**	**$ (1,912,496)**	**$ 1,912,496**

COUNTY SHARE OF OTLICP-CCS COSTS

REGULAR POLICY CHANGE NUMBER: 198
IMPLEMENTATION DATE: 7/2014
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1906

	FY 2017-18	FY 2018-19
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 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. Effective October 1, 2015 CCS-HFP funding adjusted to 88% FFP, 6% GF, and 6% county funds. It is assumed that the county share will continue under OTLICP.

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is an increase due to updated monthly expenditures from January 1, 2017, through December 31, 2017, and updated numbers from the phase-in of high cost treatments.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to an increase in projected CCS-OTLICP eligibles to receive Orkambi, DEFLAZACORT, Exondys 51, SPINRAZA, Brineura, and Kymriah in FY2018-19.

COUNTY SHARE OF OTLICP-CCS COSTS

REGULAR POLICY CHANGE NUMBER: 198

Methodology:

1. The county share reimbursement (6%) for CCS-OTLICP is estimated to be $9,052,000 in FY 2017-18 and $9,360,000 in FY 2018-19.

Fiscal Year	TF	GF	GF Reimbursement
FY 2017-18	**$0**	($9,052,000)	$9,052,000
FY 2018-19	**$0**	($9,360,000)	$9,360,000

Funding:
100% Title XXI State GF (4260-113-0001)
Reimbursement (4260-610-0995)

IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER:	199
IMPLEMENTATION DATE:	4/2017
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	35

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$3,714,000	$30,340,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$3,714,000	$30,340,000
FEDERAL FUNDS	-$3,714,000	-$30,340,000

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.

IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER: 199

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.

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 2017-18, is a decrease due to:

- Excluding the IMD FFS repayments for State Fiscal Year (SFY) 2012-13 Q3, previously assumed to be included in the deferral repayments, and
- Shifting the managed care repayments from FY 2017-18 to FY 2018-19.

The change from the prior estimate, for FY 2018-19, is an increase due to shifting the managed care repayments that were previously budgeted for FY 2017-18, to be paid in FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to:

- Resolving IMD FFS deferral repayments for service periods from October 2015 to June 2016 in FY 2017-18,
- Including IMD FFS deferral repayments for service periods from July 2016 to June 2017 in FY 2018-19, and
- Including managed care repayments from FY 2011-12 to FY 2016-17 in FY 2018-19.

Methodology:

1. The costs for ancillary services provided to beneficiaries in IMDs are in the Medi-Cal base estimate.

2. In FY 2017-18, the Department estimates to repay FFS IMD deferrals from October 2015 through June 2016.

3. For FY 2018-19, the Department estimates to repay FFS IMD deferrals from July 2016 through September 2017, and managed care repayments from FY 2011-12 through FY 2016-17.

IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER: 199

4. The estimated IMD repayments are:

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
Fee-For-Service			
FY 2015-16 Q2 (Oct to Dec 15)	$0	$1,046	($1,046)
FY 2015-16 Q3 (Jan to Mar 16)	$0	$1,232	($1,232)
FY 2015-16 Q4 (Apr to Jun 16)	$0	$1,436	($1,436)
Subtotal FY 2015-16	$0	$3,714	($3,714)
Subtotal FFS	$0	$3,714	($3,714)
Total FY 2017-18	**$0**	**$3,714**	**($3,714)**

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
Fee-For-Service			
FY 2016-17 Q1 (Jul to Sep 16)	$0	$1,652	($1,652)
FY 2016-17 Q2 (Oct to Dec 16)	$0	$1,859	($1,859)
FY 2016-17 Q3 (Jan to Mar 17)	$0	$1,734	($1,734)
FY 2016-17 Q4 (Apr to Jun 17)	$0	$2,103	($2,103)
Subtotal FY 2016-17	$0	$7,348	($7,348)
FY 2017-18 Q1 (Jul to Sep 17)	$0	$1,652	($1,652)
Subtotal FFS	$0	$9,000	($9,000)
Managed Care			
FY 2011-12 (Jul 11 to Jun 12)	$0	$3,279	($3,279)
FY 2012-13 (Jul 12 to Jun 13)	$0	$3,716	($3,716)
FY 2013-14 (Jul 13 to Jun 14)	$0	$3,969	($3,969)
FY 2014-15 (Jul 14 to Jun 15)	$0	$3,168	($3,168)
FY 2015-16 (Jul 15 to Jun 16)	$0	$3,533	($3,533)
FY 2016-17 (Jul 16 to Jun 17)	$0	$3,675	($3,675)
Subtotal Managed Care	$0	$21,340	($21,340)
Total FY 2018-19	**$0**	**$30,340**	**($30,340)**

Funding:
100% General Fund (4260-101-0001)
Title XIX FFP (4260-101-0890)

CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER: 200
IMPLEMENTATION DATE: 1/2006
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1087

	FY 2017-18	FY 2018-19
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: 200

Methodology:

FY 2016-17	
Hospital Services Account	$103,682,000
Physicians' Services Account	$33,320,000
Unallocated Account	$45,958,000
Total CTPS/Prop. 99	**$182,960,000**
GF	**($182,960,000)**
Net Impact	**$0**

FY 2017-18	
Hospital Services Account	$73,335,000
Physicians' Services Account	$22,496,000
Unallocated Account	$31,609,000
Total CTPS/Prop. 99	**$127,440,000**
GF	**($127,440,000)**
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)

INTEGRATION OF THE SF CLSB INTO THE ALW

REGULAR POLICY CHANGE NUMBER:	201
IMPLEMENTATION DATE:	3/2017
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	2014

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	-$1,611,000	-$1,592,000
- STATE FUNDS	-$805,500	-$796,000
PAYMENT LAG	0.9640	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,553,000	-$1,592,000
STATE FUNDS	-$776,500	-$796,000
FEDERAL FUNDS	-$776,500	-$796,000

DESCRIPTION

Purpose:
This policy change estimates the cost of integrating the San Francisco Community Living Support Benefit (SF CLSB) into the Assisted Living Waiver (ALW).

Authority:
Welfare & Institutions Code 14132.26

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. Currently, the ALW is offered in 15 counties. Effective March 1, 2017, ALW services expanded into San Francisco County which increased the total population by 44 participants. This allowed the 23 SF CLSB waiver participants the option to transition to the ALW. The remaining 21 slots are allocated for institutional transitions. The ALW term ends February 28, 2019.

The SF CLSB serves Medi-Cal members who are:

- 21 years of age and older,
- Reside in the City or County of San Francisco, and
- Who would otherwise live in nursing facilities or be rendered homeless.

The SF CLSB Waiver term ended June 30, 2017.

INTEGRATION OF THE SF CLSB INTO THE ALW

REGULAR POLICY CHANGE NUMBER: 201

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is an increase in savings due to only six of the an estimated 23 SF CLSB waiver beneficiaries transitioning to the ALW. The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to the increase for care management from $200 to $320 beginning January 1, 2018.

Methodology:

1. Assume the ALW will be renewed and the SF CLSB beneficiaries will have the option to transition into the ALW beginning in July 2017.

2. Currently, there are 3,744 total approved waiver slots for the ALW. Assume 21 new beneficiaries will transition from a skilled nursing facility through CCT then into the ALW in CY 2017.

3. Six of the 23 beneficiaries that were enrolled in SF CLSB transitioned into the ALW in FY 2017-18.

4. Assume the monthly cost for care management is $200 through December 31, 2017 and $320 beginning January 1, 2018.

5. Assume the average monthly cost for wavier services transitioning from institutions is $1,184.

6. Assume the average monthly cost in a skilled nursing facility and transitioning through CCT is $7,914.

FY 2017-18	**TF**	**GF**	**FF**
Total Cost from Waiver Services	$383,000	$192,000	$191,000
Total Savings from SNF Transitions	($1,994,000)	($997,000)	($997,000)
Net Impact Savings	**($1,611,000)**	**($805,000)**	**($806,000)**
FY 2018-19	**TF**	**GF**	**FF**
Total Cost from Waiver Services	$402,000	$201,000	$201,000
Total Savings from SNF Transitions	($1,994,000)	($997,000)	($997,000)
Net Impact Savings	**($1,592,000)**	**($796,000)**	**($796,000)**

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

MEDI-CAL RECOVERIES SETTLEMENTS AND LEGAL COSTS

REGULAR POLICY CHANGE NUMBER:	202
IMPLEMENTATION DATE:	7/2017
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	2036

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	-$1,730,000	-$1,730,000
- STATE FUNDS	-$865,000	-$865,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	77.39 %	71.74 %
APPLIED TO BASE		
TOTAL FUNDS	-$391,200	-$488,900
STATE FUNDS	-$195,580	-$244,450
FEDERAL FUNDS	-$195,580	-$244,450

DESCRIPTION

Purpose:
This policy change estimates the savings associated with the multiple settlements and litigation costs for Medi-Cal recoveries.

Authority:
Welfare and Institutions (W&I) Codes 14124.785, 14124.72 and 14124.74
SB 97 (Chapter 52, Statutes of 2017)

Interdependent Policy Changes:
Not Applicable

Background:
The Medi-Cal program complies with Federal and State laws relating to the legal liability of third parties for health care services provided to beneficiaries. The Department recovers Medi-Cal treatment costs from liable third parties, thereby ensuring that Medi-Cal is the payer of last resort. 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 estates, personal injury settlements, judgements or awards, special needs trusts, provider/beneficiary overpayments, and other health insurance to offset the cost of services provided to Medi-Cal beneficiaries in specified circumstances.

Multiple Settlements
Federal and State laws require Medi-Cal to review expenditures paid for treating a beneficiary's injury and file liens against any settlement, judgment, or award ("settlement") resulting from a beneficiary's claim or action against a liable third party. While most injury claims result in a single settlement, medical malpractice cases and other severe injuries often result in multiple settlements. W&I Code Section 14124.785 limited the Department's recovery to the amount derived from applying the lowest of the three statutory reductions defined in W&I Code 14124.72, 14124.76, or 14124.78.

MEDI-CAL RECOVERIES SETTLEMENTS AND LEGAL COSTS

REGULAR POLICY CHANGE NUMBER: 202

Attorneys found a way to use the provisions in prior law to deny the Department some or all recovery when there are multiple settlements. Often, attorneys only provided information on the first settlement, failing to disclose that there were multiple defendants, and the Department's recovery was limited by the statutory reductions. Later, when subsequent settlements were disclosed, the Department was not able to make additional recoveries, resulting in lost General Fund (GF) savings.

Litigation Costs

When an attorney facilitates a personal injury settlement on a Medi-Cal case, the Department's recovery of personal injury liens are reduced by the cost of attorney fees and the state's portion of litigation costs. Currently, provisions in W&I Code Section 14124.72(d) calculates the attorney fee reduction at 25% of the Department's lien and the proportionate share of litigation costs reduction is determined by multiplying the ratio of the Department's lien to the total settlement amount against the total litigation costs incurred.

In cases where the settlement is smaller than the Department's lien, this formula for the state's proportionate share of the litigation costs created situations where the Department must reduce its lien by amounts greater than the actual litigation costs incurred. In some cases the state's portion of litigation costs, as calculated under prior law, significantly eroded the Department's lien to result in zero recovery.

SB 97 has chaptered language that closes the loopholes that were limiting the Department's ability to recover on the above settlements. The below savings is a result of the implementation of SB 97.

Reason for Change:

For FY 2017-18 and FY 2018-19, there is no change from the prior estimate. In addition, there is no change from FY 2017-18 to FY 2018-19, in the current estimate.

Methodology:

1. The multiple settlements and litigation costs savings are estimated to start July 1, 2017.

2. For multiple settlements, the assumed savings are based on historical data of actual cases where liens were reduced. The total reductions for these cases are estimated to be $5.3 million TF.

3. Assume 10% of the total amount lost due to lien reductions have multiple settlements.

4. As a result, the annual savings for multiple settlements are estimated to be -$530,000 TF.

5. For litigation costs, the assumed savings are based on historical data of settled litigation costs.

6. Assume the litigation costs would show a reduction after applying an algorithm of historical data on settlements, liens, and pro rata share of litigation costs.

7. As a result, the annual savings for litigation costs are estimated to be -$1,200,000 TF.

8. The annual estimated savings for multiple settlements and litigation costs are shown below:

FY 2017-18	TF	GF	FF
Multiple Settlements	($530,000)	($265,000)	($265,000)
Litigation Costs	($1,200,000)	($600,000)	($600,000)
Total	**($1,730,000)**	**($865,000)**	**($865,000)**

MEDI-CAL RECOVERIES SETTLEMENTS AND LEGAL COSTS

REGULAR POLICY CHANGE NUMBER: 202

FY 2018-19	TF	GF	FF
Multiple Settlements	($530,000)	($265,000)	($265,000)
Litigation Costs	($1,200,000)	($600,000)	($600,000)
Total	**($1,730,000)**	**($865,000)**	**($865,000)**

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

HOME HEALTH RATE INCREASE

REGULAR POLICY CHANGE NUMBER:	204
IMPLEMENTATION DATE:	1/2019
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	2077

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$64,834,000
- STATE FUNDS	$0	$31,565,000
PAYMENT LAG	1.0000	0.8752
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$56,742,700
STATE FUNDS	$0	$27,625,690
FEDERAL FUNDS	$0	$29,117,030

DESCRIPTION

Purpose:
This policy change estimates the costs of a rate increase for fee-for-service (FFS) home health agency and private duty nursing (PDN) services, effective July 1, 2018.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
Home health services encompass a range of health care services to children and adults that can be provided in home, and are generally less expensive, more convenient, and equally effective as the care received in a hospital or skilled nursing facility (SNF). Home health services include:

- Wound care;
- IV therapy;
- Administering oral medications;
- Insertion of gastronomy and nasogastric tube feedings; and
- Monitoring serious illnesses and unstable health conditions that no longer require a higher level of care.

PDN is the care of clients by professionals who provide private care on a one-on-one basis in a client's home.

Home health and PDN services can be provided by home health agencies or individual nurse providers (INPs). Home health agencies hire health professionals such as Registered Nurses (RNs), Licensed Vocational Nurses (LVNs), and Certified Home Health Aids to provide skilled nursing services to a client in their home. INP providers are independent contractors that perform home health services to Medi-Cal beneficiaries. INPs can be RNs or LVNs.

HOME HEALTH RATE INCREASE

REGULAR POLICY CHANGE NUMBER: 204

Home health and PDN services are an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.

Section 1905(a) of the Social Security Act defines the EPSDT benefit to include a comprehensive array of preventive, diagnostic and treatment services for low-income infants, children and adolescents under 21 years of age, which includes in-home PDN services. States are required to provide any Medicaid covered service listed in Section 1905(a) of the SSA that is determined to be medically necessary to correct or ameliorate any physical or behavioral conditions.

States can also choose to make these benefits available through 1915(c) Home and Community-Based Servicers (HCBS) waivers. California has included these benefits in its Home and Community-Based Alternatives (HCBA) Waiver, In-Home Operations (IHO) Waiver, Pediatric Palliative Care (PPC) Waiver, and the HIV/AIDS Waiver.

Additionally, the Department must maintain compliance with federal requirements to ensure payments are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

Reason for Change:
The change for FY 2018-19 from the prior estimate is a decrease due to removing the estimated California Children's Services (CCS) State-Only costs from this policy change to be budgeted in the Family Health Local Assistance Estimate.

Methodology:

1. 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 home health agency rate increases.

   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.

2. The Department will increase 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.

3. The rate adjustments are estimated to be implemented in January 2019. The Erroneous Payment Correction (EPC) for the retroactive period from July 2018 to December 2018 is estimated to occur in April 2019.

4. The total annual costs are budgeted in the Medi-Cal and Family Health Estimates and are estimated to be:

Annual	TF	GF	SF	FF
Medi-Cal	$64,834,000	$0	$31,565,000	$33,269,000
CCS-State Only	$8,699,000	$8,699,000	$0	$0
Total	$73,533,000	$8,699,000	$31,565,000	$33,269,000

HOME HEALTH RATE INCREASE

REGULAR POLICY CHANGE NUMBER: 204

5. The Medi-Cal costs in this policy change are as follows:

FY 2018-19	TF	SF	Title XIX FF	Title XXI FF	ACA FF
Home Health Rate Increase	**$64,834,000**	**$31,565,000**	**$31,302,000**	**$1,900,000**	**$67,000**

Funding:

FY 2018-19	TF	SF	FF
50% Title XIX / 50% SF (4260-101-3305 / 0890)	$62,604,000	$31,302,000	$31,302,000
94% Title XIX / 6% SF (4260-101-3305 / 0890)	$36,000	$2,000	$34,000
93% Title XIX / 7% SF (4260-101-3305 / 0890)	$35,000	$2,000	$33,000
88% Title XXI / 12% SF (4260-101-3305 / 4260-113-0890)	$2,159,000	$259,000	$1,900,000
Total FY 2018-19	**$64,834,000**	**$31,565,000**	**$33,269,000**

MEDI-CAL NONMEDICAL TRANSPORTATION

REGULAR POLICY CHANGE NUMBER: 207
IMPLEMENTATION DATE: 7/2018
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2037

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$5,178,000
- STATE FUNDS	$0	$1,986,930
PAYMENT LAG	1.0000	0.8150
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$4,220,100
STATE FUNDS	$0	$1,619,350
FEDERAL FUNDS	$0	$2,600,720

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.

The Centers for Medicare and Medicaid Services (CMS) allow transportation services to be provided as either an Administrative Service under Title 42 Code of Federal Regulations (CFR) Section 431.53 or Optional Medical Service under 42 CFR 440.170. Under 42 CFR 431.53, Medicaid states must ensure necessary transportation for beneficiaries to and from providers and describe the methods that the agency will use to meet this requirement. Similarly, under 42 CFR 440.170, Medicaid states must reimburse for transportation expenses and other related travel expenses determined to be necessary to secure medical examinations and treatment for a beneficiary. Under this section, transportation is furnished only by a provider to whom a direct vendor payment can appropriately be made by the state Medicaid agency.

MEDI-CAL NONMEDICAL TRANSPORTATION

REGULAR POLICY CHANGE NUMBER: 207

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.

No sooner than July 1, 2018, the Department will implement a uniform and statewide NMT coverage and reimbursement policy to help ensure eligible FFS beneficiaries who attest that other currently available resources have been reasonably exhausted, have access to, and are aware of, the NMT benefit. The policy will also enable NMT providers to bill Medi-Cal and be reimbursed for providing these services, subject to utilization controls. In addition, the Department will be working towards developing a policy and process for beneficiary reimbursement. As a result, NMT implementation for FFS will happen in two phases:

Phase I
The Department will utilize its network of existing non-emergency medical transportation (NEMT) providers as well as new transportation providers specializing in NMT services.

Phase II
The Department anticipates procuring a contracted vendor to arrange for transportation services and/or reimburse beneficiaries for services provided in a private vehicle.

Reason for Change:
There is no change from the prior estimate for FY 2017-18 and FY 2018-19.

Methodology:
1. Assume Phase I for FFS NMT services will be implemented starting July 1, 2018. It is estimated that Phase II implementation will happen in FY 2019-20.

2. Assume approximately 400,000 full scope FFS beneficiaries will 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 on an annual basis.

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 $25.00.

6. Costs for NMT services on an annual basis is estimated to be $12,944,000 TF ($5,246,000 GF).

    - Perinatal Services: (157,000 x 25%) x 7 x $25.00 = $6,869,000 TF
    - Non-Perinatal Services: (243,000 x 25%) x 4 x $25.00 = $6,075,000 TF

MEDI-CAL NONMEDICAL TRANSPORTATION

REGULAR POLICY CHANGE NUMBER: 207

7. For FY 2018-19, the first year costs are estimated to be $5,178,000 TF ($1,987,000 GF).

- Perinatal Services: (157,000 x 10%) x 7 x $25.00 = $2,748,000 TF
- Non-Perinatal Services: (243,000 x 10%) x 4 x $25.00 = $2,430,000 TF

FY 2018-19	TF	GF	Title XIX FF	Title XXI FF
FFS Medi-Cal NMT	$5,178,000	$1,987,000	$3,080,000	$111,000

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
88% Title XXI FF / 12% GF (4260-113-0001/0890)
93% ACA Title XIX FF / 7% GF (4260-101-0001/0890)
94% ACA Title XIX FF / 6% GF (4260-101-0001/0890)

WHOLE CHILD MODEL IMPLEMENTATION

REGULAR POLICY CHANGE NUMBER:	209
IMPLEMENTATION DATE:	7/2018
ANALYST:	Matt Wong
FISCAL REFERENCE NUMBER:	1971

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$29,235,000
- STATE FUNDS	$0	$13,224,420
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$29,235,000
STATE FUNDS	$0	$13,224,420
FEDERAL FUNDS	$0	$16,010,580

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 will incorporate CCS services into the integrated care systems of select counties in the existing managed care County Organized Health System (COHS). The implementation process will happen in two phases and include an initial readiness review and ongoing monitoring following implementation to ensure continuity of care and continued access to specialty care. These plans will be 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 is scheduled to begin no sooner than July 1, 2018, in five of the twenty designated COHS counties and Phase Two is scheduled to begin no sooner than January 1, 2019, in the remaining designated COHS counties. Implementation in designated counties is dependent on a readiness review completed by the Department.

WHOLE CHILD MODEL IMPLEMENTATION

REGULAR POLICY CHANGE NUMBER: 209

Reason for Change:
The change from the prior estimate, for FY 2018-19, is decrease due to a change in percentage for calculating the administrative costs for the COHS counties.

Methodology:
1. Assume CCS services for an additional five counties of the CCS Medi-Cal population will incorporate into COHS Medi-Cal managed care plans starting July 1, 2018 (Phase One), and an additional fifteen counties starting January 1, 2019 (Phase Two).

2. The payments under capitation are assumed to be equal to the costs under FFS.

3. Based on actual FFS costs for CCS eligibles in the selected COHS counties and a lag in processing FFS claims, the estimated benefit costs are:

   FY 2018-19: $29,235,000 TF ($13,231,000 GF).

4. Total estimate costs for **FY 2018-19** are **$29,235,000 TF ($13,231,000 GF)**.

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890

ASSISTED LIVING WAIVER EXPANSION

REGULAR POLICY CHANGE NUMBER: 211
IMPLEMENTATION DATE: 6/2018
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2054

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	-$155,000	-$13,987,000
- STATE FUNDS	-$77,500	-$6,993,500
PAYMENT LAG	0.0560	0.8830
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$8,700	-$12,350,500
STATE FUNDS	-$4,340	-$6,175,260
FEDERAL FUNDS	-$4,340	-$6,175,260

DESCRIPTION

Purpose:
This policy change estimates the cost to increase the capacity of the Assisted Living Waiver (ALW).

Authority:
Not Applicable

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 seeks to expand 2,000 waiver slots from 3,744 slots to 5,744 slots for FY 2017-18, FY 2018-19, and FY 2019-20 to accommodate current and anticipated need. A reserve capacity will be set for new enrollments which will require that 60% of all new enrollments be reserved for individuals transitioning from institutional settings after residing in them for a minimum of 90 consecutive days. This change will require a waiver amendment to increase waiver slots.

Reason for Change:
There is no change from the prior estimate for FY 2017-18 and FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to a full fiscal year being captured.

Methodology:
1. Assume 2,000 new participants will be phased in by the end of FY 2018-19.

2. Of the new 2,000 participants, assume 1,200 will be from an institution and 800 will be from the community.

ASSISTED LIVING WAIVER EXPANSION

REGULAR POLICY CHANGE NUMBER: 211

3. Assume the average annual cost for waiver services is $16,477.

4. Assume the average annual cost in a skilled nursing facility is $68,046.

FY 2017-18	TF	GF	FF
Total Cost from Waiver Services	$126,000	$63,000	$63,000
Total Savings from SNF Transitions	($281,000)	($140,000)	($141,000)
Net Impact Savings	**($155,000)**	**($77,000)**	**($78,000)**
FY 2018-19	**TF**	**GF**	**FF**
Total Cost from Waiver Services	$11,326,000	$5,663,000	$5,663,000
Total Savings from SNF Transitions	($25,313,000)	($12,656,000)	($12,657,000)
Net Impact Savings	**($13,987,000)**	**($6,993,000)**	**($6,994,000)**

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

HOME & COMMUNITY-BASED ALTERNATIVES WAIVER RENEWAL

REGULAR POLICY CHANGE NUMBER:	212
IMPLEMENTATION DATE:	10/2017
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	2010

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$2,137,000	$4,749,000
- STATE FUNDS	$1,068,500	$2,374,500
PAYMENT LAG	0.7450	0.9960
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,592,100	$4,730,000
STATE FUNDS	$796,030	$2,365,000
FEDERAL FUNDS	$796,030	$2,365,000

DESCRIPTION

Purpose:
This policy change estimates the cost of renewing the Home and Community Based Alternatives (HCBA) Waiver (formerly known as the Nursing Facility / Acute Hospital (NF/AH) Waiver).

Authority:
Not Applicable

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;

HOME & COMMUNITY-BASED ALTERNATIVES WAIVER RENEWAL

REGULAR POLICY CHANGE NUMBER: 212

- 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 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 medical 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 2017-18, is a decrease due to waiver agencies costs shifting from April 2018 to July 2018, enrollment decreased from 749 to 180, resulting in less savings achieved from institutional transitions, and current enrolled waiver population was updated and corrected. The change from the prior estimate, for FY 2018-19, is an increase due to a higher coverage of Waiver Agencies that increased from 60% to 90% compared to the prior estimate. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the implementation of the Waiver Agencies beginning July 2018.

Methodology:

1. The Department received approval in November 2016 for a waiver amendment, retroactive to February 1, 2016, that removes the individual cost limit requirement for waiver participants.

2. Beginning February 1, 2016, for FY 2017-18 and FY 2018-19, assume 1,417 and 1,732 respectively, current participants are over their waiver cap and their monthly cost for unmet need is $367.

3. The renewed waiver was approved on May 16, 2017 with an effective date of January 1, 2017.

4. There are currently 3,480 waiver participants. Assume 180 new participants will be enrolled in FY 2017-18 and 2,300 in FY 2018-19.

5. 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.

6. Assume the average monthly cost for comprehensive care management is $275 and that care management costs will begin in July 2018 to allow time to implement the Waiver Agency model.

7. Assume 90% of all current and new waiver participants will enroll with a Waiver Agency and receive comprehensive care management.

8. Assume the monthly cost for administration is $186.56.

9. Assume the monthly cost for waiver services from the community is $3,040.

HOME & COMMUNITY-BASED ALTERNATIVES WAIVER RENEWAL

REGULAR POLICY CHANGE NUMBER: 212

10. Assume the monthly cost for wavier services transitioning from institutions and EPSDT is $4,698.

11. Assume the average monthly cost in a skilled nursing facility is $10,736.

FY 2017-18	**TF**	**GF**	**FF**
Waiver Svcs. - Community	$1,532,000	$766,000	$766,000
Waiver Svcs. - EPSDT	$677,000	$339,000	$338,000
Waiver Svcs. – Institutional Tran.	$2,875,000	$1,438,000	$1,438,000
Unmet Need	$3,624,000	$1,812,000	$1,812,000
Institutional Transitions Savings	($6,570,000)	($3,285,000)	($3,285,000)
Total	**$2,137,000**	**$1,069,000**	**$1,068,000**
FY 2018-19	**TF**	**GF**	**FF**
Administrative Cost	$10,610,000	$5,305,000	$5,305,000
Care Management	$15,640,000	$7,820,000	$7,820,000
Waiver Svcs. - Community	$26,063,000	$13,032,000	$13,031,000
Waiver Svcs. - EPSDT	$10,069,000	$5,034,000	$5,035,000
Waiver Svcs. – Institutional Tran.	$50,344,000	$25,172,000	$25,172,000
Unmet Need	$7,068,000	$3,534,000	$3,534,000
Institutional Transitions Savings	($115,045,000)	($57,522,000)	($57,523,000)
Total	**$4,749,000**	**$2,375,000**	**$2,374,000**

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

GROUND EMERGENCY MEDICAL TRANSPORTATION QAF

REGULAR POLICY CHANGE NUMBER:	214
IMPLEMENTATION DATE:	11/2018
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	2081

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$167,635,000
- STATE FUNDS	$0	$54,065,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$167,635,000
STATE FUNDS	$0	$54,065,000
FEDERAL FUNDS	$0	$113,570,000

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)
State Plan Amendment 18-004 (proposed)

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 will collect gross transport and revenue data from GEMT providers in order to calculate an annual QAF amount. The QAF will be assessed on each GEMT transport for base ground emergency medical services, effective July 1, 2018. The revenue generated by the QAF collections will be deposited directly into the Medi-Cal Emergency Medical Transportation Fund (MEMTF).

The Department is required to provide an add-on to the Medi-Cal FFS payment schedule 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 will be calculated by June 15, 2018, and must remain the same for later applicable FYs, to the extent that FFP is available.

GROUND EMERGENCY MEDICAL TRANSPORTATION QAF

REGULAR POLICY CHANGE NUMBER: 214

Reason for Change:
This is a new policy change.

Methodology:
1. The effective date for the add-on is July 1, 2018. Assume the GEMT QAF revenue will be $69,189,000 in FY 2018-19.

2. $1,003,000 will be transferred from the MEMTF to the GF for administration costs.

3. The transfer from the MEMTF to the GF for the 10 percent set aside for health care coverage is estimated to be $6,819,000 for FY 2018-19.

4. From the remaining GEMT QAF revenue available, total annual GEMT add-on payments for FY 2018-19 is estimated to be $189,462,000 TF, of which $29,891,000 TF is for FFS and $159,571,000 TF is for Managed Care GEMT transport services.

5. The FFS add-on payments are expected to implement in November 2018. The annual cost is expected to be $29,891,000 TF. The EPC is estimated at $9,964,000 TF and is expected to implement in FY 2018-19.

6. The Managed Care payments are expected to be implemented with the FY 2018-19 capitation rates. The annual cost is expected to be $159,571,000 TF.

    a. Assume 10 months of the FY 2018-19 managed care payments for the County Organized Health Systems (COHS) model will be paid in FY 2018-19 and 2 months will be paid in FY 2019-20.
    b. Assume 11 months of the FY 2018-19 managed care payments for the Non-COHS model will be paid in FY 2018-19 and 1 month will be paid in FY 2019-20.

7. On a cash basis, with payment lags applied, total FY 2018-19 GEMT add-on payments are estimated to be $167,635,000 TF, of which $24,530,000 TF is for FFS and $143,105,000 TF for Managed Care GEMT transport services.

8. The FY 2018-19 cash basis estimate is summarized as follows:

(Dollars in Thousands)

FY 2018-19	TF	GF	MEMTF	FF
Healthcare Coverage – GF Offset	$0	($6,819)	$6,819	$0
FFS Add-On (lagged)	$24,530	$0	$10,070	$14,460
Managed Care Add-On	$143,105	$0	$43,995	$99,110
Total	**$167,635**	**($6,819)**	**$60,884**	**$113,570**

GROUND EMERGENCY MEDICAL TRANSPORTATION QAF

REGULAR POLICY CHANGE NUMBER: 214

Funding:

(Dollars in Thousands)

FY 2018-19	TF	GF	MEMTF	FF
100% GF (4260-101-0001)	($6,819)	($6,819)	$0	$0
MEMTF (4260-601-3323)	$60,884	$0	$60,884	$0
ACA Title XIX FF (4260-101-0890)	$58,873	$0	$0	$58,873
Title XIX FF (4260-101-0890)	$49,741	$0	$0	$49,741
Title XXI FF (4260-113-0890)	$4,956	$0	$0	$4,956
Total	**$167,635**	**($6,819)**	**$60,884**	**$113,570**

REPAYMENT TO CMS FOR MEDI-CAL RECOVERIES

REGULAR POLICY CHANGE NUMBER: 215
IMPLEMENTATION DATE: 7/2018
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2082

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$25,856,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$25,856,000
FEDERAL FUNDS	$0	-$25,856,000

DESCRIPTION

Purpose:
This policy changes estimates the federal funds repayment to the Centers for Medicare and Medicaid Services (CMS) to resolve incorrectly reported Federal Medical Assistance Percentages (FMAPs) for Medi-Cal recoveries from January 2014 to December 2016.

Authority:
42 Code of Federal Regulations 433.154(b)

Interdependent Policy Changes:
Not Applicable

Background:
During the period from January 2014 to December 2016, the Department reported all recoveries at the 50% FMAP. Effective January 1, 2014, the Affordable Care Act (ACA) authorized increased FMAPs for state expenditures for low-income individuals in the newly eligible and the enhanced expansion groups. The Department did not account for the special Title XIX ACA funding or the Title XXI CHIP funding during this period. As a result, the Department will make a payment to CMS to resolve the incorrectly reported FMAPs for Medi-Cal recoveries from January 2014 to December 2016.

The repayment to CMS will put the Department in compliance with Federal law. There may be additional adjustments for ongoing recoveries however, these adjustments are expected to be of an indeterminate, but comparatively smaller amount.

Reason for Change:
This is a new policy change.

Methodology:
1. Assume that all recoveries were reported at 50% FMAP and will be corrected to their appropriate FMAP for the January 2014 to December 2016 period.

REPAYMENT TO CMS FOR MEDI-CAL RECOVERIES

REGULAR POLICY CHANGE NUMBER: 215

2. Assume the repayment will occur in July 2018.

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
Title XIX Repayment	$0	$24,715	($24,715)
Title XXI Repayment	$0	$1,141	($1,141)
Total FY 2018-19	**$0**	**$25,856**	**($25,856)**

Funding:
100% GF (4260-101-0001)
100% Title XIX ACA FF (4260-101-0890)
100% Title XXI FFP (4260-113-0890)

HEALTH CARE SERVICES FOR REENTRY PROGRAMS

REGULAR POLICY CHANGE NUMBER: 219
IMPLEMENTATION DATE: 7/2018
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2087

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$9,702,000
- STATE FUNDS	$0	$9,702,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$9,702,000
STATE FUNDS	$0	$9,702,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the reimbursement from the Department of Corrections and Rehabilitation (CDCR) for health care services for reentry program participants.

Authority:
Welfare & Institutions Code Section 14093.05

Interdependent Policy Changes:
N/A

Background:
The Department of Health Care Services partners with CDCR to provide health care to individuals eligible for the CDCR reentry program. Both departments will enter into an interagency agreement to facilitate health care through managed care plans. It is anticipated that the health program will be offered in San Diego, Los Angeles, Sacramento, San Joaquin, Kern, Butte, and Riverside counties. The health plans will generally provide the same level of care they provide in the Managed Care environment, excluding Managed Long Term Services and Support service. CDCR is responsible for coordinating all non-covered benefits “carved-out” through a separate CDCR process. This health care program will begin no sooner than July 2018.

Reason for Change:
This is a new policy change.

Methodology:
1. Capitation rates are negotiated annually by CDCR and the plans. An estimated enrollment of 1,151 enrollees is utilized in the calculations.

HEALTH CARE SERVICES FOR REENTRY PROGRAMS

REGULAR POLICY CHANGE NUMBER: 219

2. All funds will be reimbursed to DHCS, via an Interagency Agreement, by CDCR.

3. Estimated dollars for this program are:

(Dollars in Thousands)

FY 2018-19	TF	Reimb. GF
FY 2018-19	$9,702	$9,702
Total FY 2018-19	**$9,702**	**$9,702**

Funding:
Reimbursement GF (4260-610-0995)

INDIAN HEALTH SERVICES MANAGED CARE PROGRAM

REGULAR POLICY CHANGE NUMBER:	222
IMPLEMENTATION DATE:	1/2018
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	2090

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$29,962,000	$0
- STATE FUNDS	$2,910,000	-$9,467,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$29,962,000	$0
STATE FUNDS	$2,910,000	-$9,467,000
FEDERAL FUNDS	$27,052,000	$9,467,000

DESCRIPTION

Purpose:
This policy change estimates the costs for the Indian Health Services Managed Care Program.

Authority:
42 USC Section 1396u-2(h)(2)(C)(ii)
42 CFR Section 438.14(c)(2) & (3)

Interdependent Policy Changes:
Not Applicable

Background:
Under federal law, DHCS must ensure that American Indian Health Programs are paid the applicable encounter rate published annually in the Federal Register by the Indian Health Service (the Office of Management and Budget (OMB) encounter rate), and if there is any difference between the amount paid by a managed care plan (MCP) and the applicable OMB encounter rate, DHCS is required to make an additional payment to compensate for that difference.

Historically, DHCS satisfied this requirement by tracking the amounts American Indian Health Programs received from MCP's for eligible services and by making subsequent payments necessary to meet the applicable OMB encounter rate.

Since the statewide expansion of Medi-Cal managed care, Indian Health Services or Memorandum of Agreement (IHS/MOA) providers have been experiencing payment delays for services provided to Medi-Cal managed care beneficiaries within American Indian or Alaskan native health care facilities. As a result of these delays, DHCS has implemented a change in the payment methodology for IHS/MOA clinician providing services to Medi-Cal managed care beneficiaries.

Reason for Change:
This is a new policy change.

INDIAN HEALTH SERVICES MANAGED CARE PROGRAM

REGULAR POLICY CHANGE NUMBER: 222

Methodology:

1. Implementation occurred on January 1, 2018.
2. Assume managed care payments are equal to FFS expenditures under the old payment methodology.
3. Lagged FFS expenditures under the old methodology will occur in FY 2017-18 and FY 2018-19.
4. Under the old methodology, some FFS expenditures were only able to claim 50% FFP. Under the new methodology, those payments may now be eligible for 100% FFP, resulting in a GF savings.
5. Assume the following estimated costs/savings:

	TF	GF	FF
FY 2017-18	$29,962	$2,910	$27,052
FY 2018-19	$0	($9,467)	$9,467

Funding:
50% Title XIX FF / 50% GF (4260-101-0001/0890)
Title XXI 88/12 (4260-113-0001/0890)
ACA 94/6 (2018) (4260-101-0890)
ACA 93/7 (2019) (4260-101-0890)

HQAF WITHHOLD TRANSFER

REGULAR POLICY CHANGE NUMBER:	223
IMPLEMENTATION DATE:	7/2017
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	2092

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$261,429,000	$627,756,000
- STATE FUNDS	$130,714,500	$313,878,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$261,429,000	$627,756,000
STATE FUNDS	$130,714,500	$313,878,000
FEDERAL FUNDS	$130,714,500	$313,878,000

DESCRIPTION

Purpose:
This policy change budgets for withheld Fee-For-Service payments (FFS) associated with the Hospital Quality Assurance Fee (HQAF).

Background:
To recover past due HQAF fees from delinquent providers, the Department currently withholds portions of the delinquent provider's FFS payments and transfers the withheld portion to the HQAF fund on behalf of the delinquent provider. As Medi-Cal is on a cash basis, these expenditures were originally budgeted in the fiscal year the claim was processed.

Reason for Change:
This is a new policy change. The reason for change between FY 2017-18 and FY 2018-19 is due to projected withhold balances.

Methodology:
1. $404 million of withheld payments were paid in August 2017.
2. An estimated $142 million in withholds will occur in FY 2017-18 and offsets a portion of the August 2017 withheld payment.
3. The remaining $261 million was initially budgeted in a prior fiscal year when the claim was originally processed.
4. In FY 2018-19, the Department anticipates a net of $628 million withheld payments.

Fiscal Year	Total Fund	General Fund	Federal Fund
FY 2017-18			
Withheld Transferred to HQAF	403,916,000	201,593,000	201,593,000
New Withholds	(142,487,000)	(71,243,500)	(71,243,500)
Total 2017-18	**$261,429,000**	**$130,714,500**	**$130,714,500**
FY 2018-19			
Withheld to be Paid	627,756,000	313,878,000	313,878,000
Total 2018-19	**$627,756,000**	**$313,878,000**	**$313,878,000**

HEPATITIS C REVISED CLINICAL GUIDELINES

REGULAR POLICY CHANGE NUMBER: 225
IMPLEMENTATION DATE: 7/2018
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1909

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$70,387,000
- STATE FUNDS	$0	$21,820,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$70,387,000
STATE FUNDS	$0	$21,820,000
FEDERAL FUNDS	$0	$48,567,000

DESCRIPTION

Purpose:
This policy change estimates the increased costs of Hepatitis C (Hep C) drugs to include the expansion of clinical guidelines to all stages of the disease.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
Chronic Hep C is a common blood-borne infection that can lead to liver damage or liver failure. The Medi-Cal program currently treats patients with a Stage 2 diagnosis and patients with liver manifestations or post-liver transplants. The current policy also includes Hep C patients, regardless of stage, who also have:

- Diabetes,
- HIV,
- Hepatitis B,
- Debilitating fatigue,
- A desire to become pregnant, and
- Other comorbid conditions.

The Department is updating the Hep C policy to authorize treatment for all patients ages 13 and above with the disease, regardless of liver fibrosis stage or co-morbidity, except for patients with a life expectancy of less than 12 months.

Reason for Change:
This is a new policy change.

HEPATITIS C REVISED CLINICAL GUIDELINES

REGULAR POLICY CHANGE NUMBER: 225

Methodology:

1. Assume the revised Hep C policy will be effective July 1, 2018.

2. The increased costs are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2018-19	$70,387	$21,820	$48,567

Funding:

100% General Fund (4260-101-0001)
Title XIX FFP (4260-101-0890)

RECONCILIATION

REGULAR POLICY CHANGE NUMBER:	226
IMPLEMENTATION DATE:	7/2018
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	1700

	FY 2017-18	FY 2018-19
FULL YEAR COST - TOTAL FUNDS	$0	$375,000,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$375,000,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$375,000,000

DESCRIPTION

This policy change reconciles the May 2018 Medi-Cal Estimate to the proposed Budget for 2018.

	TF	GF	FFP
4260-101 (Title XIX)	$375,000,000	0	$375,000,000

SUMMARY OF COUNTY ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2017-18

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
1	COUNTY ADMINISTRATION ALLOCATION	$1,302,683,000	$651,341,500	$651,341,500	$0
2	IMPLEMENTATION OF ACA	$655,310,000	$327,655,000	$327,655,000	$0
3	SAWS	$125,500,000	$125,500,000	$0	$0
4	CalWORKS APPLICATIONS	$64,848,000	$32,424,000	$32,424,000	$0
5	CASE MANAGEMENT FOR OTLICP	$44,380,000	$22,190,000	$22,190,000	$0
6	LOS ANGELES COUNTY HOSPITAL INTAKES	$38,524,000	$35,851,500	$2,672,500	$0
7	ENHANCED FEDERAL FUNDING	$0	$255,017,000	($255,017,000)	$0
8	SAVE	$0	$4,000,000	($4,000,000)	$0
9	COUNTY ADMINISTRATION CMS DEFERRED CLAIMS	$0	($244,755,000)	$244,755,000	$0
	OTHER SUBTOTAL	**$2,231,245,000**	**$1,209,224,000**	**$1,022,021,000**	**$0**
	GRAND TOTAL	**$2,231,245,000**	**$1,209,224,000**	**$1,022,021,000**	**$0**

MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE COST BREAKDOWN
FISCAL YEAR 2017-18

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	$1,302,683,000	$0	$1,302,683,000	$651,341,500
2	IMPLEMENTATION OF ACA	$0	$655,310,000	$0	$0	$655,310,000	$327,655,000
3	SAWS	$125,500,000	$0	$0	$0	$125,500,000	$0
4	CalWORKS APPLICATIONS	$0	$0	$64,848,000	$0	$64,848,000	$32,424,000
5	CASE MANAGEMENT FOR OTLICP	$0	$0	$0	$44,380,000	$44,380,000	$22,190,000
6	LOS ANGELES COUNTY HOSPITAL INTAKES	$0	$0	$0	$38,524,000	$38,524,000	$2,672,500
7	ENHANCED FEDERAL FUNDING	$0	$0	$0	$0	$0	($255,017,000)
8	SAVE	$0	$0	$0	$0	$0	($4,000,000)
9	COUNTY ADMINISTRATION CMS DEFERRED CLAIMS	$0	$0	$0	$0	$0	$244,755,000
	OTHER SUBTOTAL	**$125,500,000**	**$655,310,000**	**$1,367,531,000**	**$82,904,000**	**$2,231,245,000**	**$1,022,021,000**
	GRAND TOTAL	**$125,500,000**	**$655,310,000**	**$1,367,531,000**	**$82,904,000**	**$2,231,245,000**	**$1,022,021,000**

SUMMARY OF COUNTY ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2018-19

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
1	COUNTY ADMINISTRATION ALLOCATION	$2,014,579,000	$1,007,289,500	$1,007,289,500	$0
3	SAWS	$155,500,000	$155,500,000	$0	$0
4	CalWORKS APPLICATIONS	$65,206,000	$32,603,000	$32,603,000	$0
5	CASE MANAGEMENT FOR OTLICP	$44,451,000	$22,225,500	$22,225,500	$0
6	LOS ANGELES COUNTY HOSPITAL INTAKES	$38,524,000	$35,851,500	$2,672,500	$0
7	ENHANCED FEDERAL FUNDING	$0	$345,130,000	($345,130,000)	$0
8	SAVE	$0	$4,000,000	($4,000,000)	$0
9	COUNTY ADMINISTRATION CMS DEFERRED CLAIMS	$0	($163,170,000)	$163,170,000	$0
	OTHER SUBTOTAL	**$2,318,260,000**	**$1,439,429,500**	**$878,830,500**	**$0**
	GRAND TOTAL	**$2,318,260,000**	**$1,439,429,500**	**$878,830,500**	**$0**

MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE COST BREAKDOWN
FISCAL YEAR 2018-19

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	$2,014,579,000	$0	$2,014,579,000	$1,007,289,500
3	SAWS	$155,500,000	$0	$0	$0	$155,500,000	$0
4	CalWORKS APPLICATIONS	$0	$0	$65,206,000	$0	$65,206,000	$32,603,000
5	CASE MANAGEMENT FOR OTLICP	$0	$0	$0	$44,451,000	$44,451,000	$22,225,500
6	LOS ANGELES COUNTY HOSPITAL INTAKES	$0	$0	$0	$38,524,000	$38,524,000	$2,672,500
7	ENHANCED FEDERAL FUNDING	$0	$0	$0	$0	$0	($345,130,000)
8	SAVE	$0	$0	$0	$0	$0	($4,000,000)
9	COUNTY ADMINISTRATION CMS DEFERRED CLAIMS	$0	$0	$0	$0	$0	$163,170,000
	OTHER SUBTOTAL	**$155,500,000**	**$0**	**$2,079,785,000**	**$82,975,000**	**$2,318,260,000**	**$878,830,500**
	GRAND TOTAL	**$155,500,000**	**$0**	**$2,079,785,000**	**$82,975,000**	**$2,318,260,000**	**$878,830,500**

COMPARISON OF FISCAL IMPACTS OF COUNTY ADMINISTRATION POLICY CHANGES
MAY 2018 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	2017-18 APPROPRIATION TOTAL FUNDS	2017-18 APPROPRIATION GENERAL FUNDS	NOV. 2017 EST. FOR 2017-18 TOTAL FUNDS	NOV. 2017 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	DIFF. MAY TO APPROPRIATION TOTAL FUNDS	DIFF. MAY TO APPROPRIATION GENERAL FUNDS	DIFFERENCE MAY TO NOVEMBER TOTAL FUNDS	DIFFERENCE MAY TO NOVEMBER GENERAL FUNDS
		OTHER										
1	1	COUNTY ADMINISTRATION ALLOCATION	$1,302,683,000	$651,341,500	$1,302,683,000	$651,341,500	$1,302,683,000	$651,341,500	$0	$0	$0	$0
2	2	IMPLEMENTATION OF ACA	$655,310,000	$327,655,000	$655,310,000	$327,655,000	$655,310,000	$327,655,000	$0	$0	$0	$0
3	3	SAWS	$175,828,000	$0	$169,153,000	$0	$125,500,000	$0	($50,328,000)	$0	($43,653,000)	$0
4	4	CalWORKS APPLICATIONS	$59,448,000	$29,724,000	$59,448,000	$29,724,000	$64,848,000	$32,424,000	$5,400,000	$2,700,000	$5,400,000	$2,700,000
5	5	CASE MANAGEMENT FOR OTLICP	$44,683,000	$22,341,500	$44,070,000	$22,035,000	$44,380,000	$22,190,000	($303,000)	($151,500)	$310,000	$155,000
6	6	LOS ANGELES COUNTY HOSPITAL INTAKES	$33,495,000	$2,382,500	$38,524,000	$2,672,500	$38,524,000	$2,672,500	$5,029,000	$290,000	$0	$0
7	7	ENHANCED FEDERAL FUNDING	$0	($266,354,000)	$0	($251,247,000)	$0	($255,017,000)	$0	$11,337,000	$0	($3,770,000)
8	8	SAVE	$0	($3,500,000)	$0	($4,000,000)	$0	($4,000,000)	$0	($500,000)	$0	$0
--	9	COUNTY ADMINISTRATION CMS DEFERRED CLAIMS	$0	$0	$0	$0	$0	$244,755,000	$0	$244,755,000	$0	$244,755,000
--	--	PRIOR YEAR RECONCILIATIONS	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
		OTHER SUBTOTAL	**$2,271,447,000**	**$763,590,500**	**$2,269,188,000**	**$778,181,000**	**$2,231,245,000**	**$1,022,021,000**	**($40,202,000)**	**$258,430,500**	**($37,943,000)**	**$243,840,000**
		COUNTY ADMINISTRATION GRAND TOTAL	**$2,271,447,000**	**$763,590,500**	**$2,269,188,000**	**$778,181,000**	**$2,231,245,000**	**$1,022,021,000**	**($40,202,000)**	**$258,430,500**	**($37,943,000)**	**$243,840,000**

COMPARISON OF FISCAL IMPACTS OF COUNTY ADMINISTRATION POLICY CHANGES
MAY 2018 ESTIMATE COMPARED TO NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2018-19

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2017 EST. FOR 2018-19		MAY 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
1	1	COUNTY ADMINISTRATION ALLOCATION	$2,012,817,000	$1,006,408,500	$2,014,579,000	$1,007,289,500	$1,762,000	$881,000
3	3	SAWS	$203,139,000	$0	$155,500,000	$0	($47,639,000)	$0
4	4	CalWORKS APPLICATIONS	$59,448,000	$29,724,000	$65,206,000	$32,603,000	$5,758,000	$2,879,000
5	5	CASE MANAGEMENT FOR OTLICP	$44,083,000	$22,041,500	$44,451,000	$22,225,500	$368,000	$184,000
6	6	LOS ANGELES COUNTY HOSPITAL INTAKES	$38,524,000	$2,672,500	$38,524,000	$2,672,500	$0	$0
7	7	ENHANCED FEDERAL FUNDING	$0	($343,907,000)	$0	($345,130,000)	$0	($1,223,000)
8	8	SAVE	$0	($4,000,000)	$0	($4,000,000)	$0	$0
--	9	COUNTY ADMINISTRATION CMS DEFERRED CLAIMS	$0	$0	$0	$163,170,000	$0	$163,170,000
		OTHER SUBTOTAL	**$2,358,011,000**	**$712,939,500**	**$2,318,260,000**	**$878,830,500**	**($39,751,000)**	**$165,891,000**
		COUNTY ADMINISTRATION GRAND TOTAL	**$2,358,011,000**	**$712,939,500**	**$2,318,260,000**	**$878,830,500**	**($39,751,000)**	**$165,891,000**

COMPARISON OF FISCAL IMPACTS OF COUNTY ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2017-18 AND 2018-19

NO.	POLICY CHANGE TITLE	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2018-19 TOTAL FUNDS	MAY 2018 EST. FOR 2018-19 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	OTHER						
1	COUNTY ADMINISTRATION ALLOCATION	$1,302,683,000	$651,341,500	$2,014,579,000	$1,007,289,500	$711,896,000	$355,948,000
2	IMPLEMENTATION OF ACA	$655,310,000	$327,655,000	$0	$0	($655,310,000)	($327,655,000)
3	SAWS	$125,500,000	$0	$155,500,000	$0	$30,000,000	$0
4	CalWORKS APPLICATIONS	$64,848,000	$32,424,000	$65,206,000	$32,603,000	$358,000	$179,000
5	CASE MANAGEMENT FOR OTLICP	$44,380,000	$22,190,000	$44,451,000	$22,225,500	$71,000	$35,500
6	LOS ANGELES COUNTY HOSPITAL INTAKES	$38,524,000	$2,672,500	$38,524,000	$2,672,500	$0	$0
7	ENHANCED FEDERAL FUNDING	$0	($255,017,000)	$0	($345,130,000)	$0	($90,113,000)
8	SAVE	$0	($4,000,000)	$0	($4,000,000)	$0	$0
9	COUNTY ADMINISTRATION CMS DEFERRED CLAIMS	$0	$244,755,000	$0	$163,170,000	$0	($81,585,000)
	OTHER SUBTOTAL	**$2,231,245,000**	**$1,022,021,000**	**$2,318,260,000**	**$878,830,500**	**$87,015,000**	**($143,190,500)**
	COUNTY ADMINISTRATION GRAND TOTAL	**$2,231,245,000**	**$1,022,021,000**	**$2,318,260,000**	**$878,830,500**	**$87,015,000**	**($143,190,500)**

MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE INDEX

COUNTY ADMINISTRATION ALLOCATION

COUNTY ADMIN. POLICY CHANGE NUMBER:	1
IMPLEMENTATION DATE:	7/2012
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1704

	FY 2017-18		FY 2018-19	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$1,302,683,000	$0	$2,014,579,000
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$1,302,683,000	$0	$2,014,579,000
STATE FUNDS	$0	$651,341,500	$0	$1,007,289,500
% 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	$1,302,683,000	$0	$2,014,579,000
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$1,302,683,000	$0	$2,014,579,000
STATE FUNDS	$0	$651,341,500	$0	$1,007,289,500

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:
PC 7 Enhanced Federal Funding

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.

The allocation estimate consists of the costs identified for three sub-categories: (1) staff costs, (2) support costs, and (3) staff development costs.

1. Staff Costs
   This amount includes the estimated costs for staff in three staff categories: eligibility workers and supervisors, clerical support staff, and administrative staff. The staff costs for each of the three categories will be allocated to individual counties to fund all Medi-Cal eligibility determination activities.

COUNTY ADMINISTRATION ALLOCATION

COUNTY ADMIN. POLICY CHANGE NUMBER: 1

2. Support Costs
   Support costs are a combination of two types of expenditures: operating support costs and electronic data processing costs. These two types of expenditures are further divided into allocated costs and direct costs.
   a. Allocated costs are those that are shared across all programs and distributed to individual programs based on a ratio developed from the total expenditures for each program.
   b. Direct costs are specific to the Medi-Cal program only.

3. Staff Development Costs
   Staff development costs are the costs of training Medi-Cal eligibility workers. The amount in this item includes:
   a. Trainers' salaries and benefits,
   b. Operating costs related to training,
   c. Trainees' salaries and benefits,
   d. Travel, per diem, supplies and tuition,
   e. Purchase of contracted training services.

Beginning in FY 2018-19, the Department will include funding for the implementation of the ACA in this policy change. Furthermore, the Department will use the projected California Price index (CPI) change to adjust the total dollars available. The Department will apply similar adjustments as the county eligibility systems move to a single Statewide Automated Welfare System (SAWS). With this increase, counties will 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. The Department will not reallocate unspent funds to counties that overspend their allocation.

Reason for Change:
There is no change, from the previous estimate, for FY 2017-18. The change, from the previous estimate, for FY 2018-19, resulted from an increase in the CPI from 2.8% to 2.89%.

The change in the current estimate, from FY 2017-18 to FY 2018-19, is due to two factors. First, the Department incorporated the cost of CA 2 Implementation of the ACA into CA 1 County Administration Allocation in FY 2018-19. Second, the Department increased the total cost of FY 2018-19 by 2.89%, the projected CPI, for an increase of $56.6M from FY 2017-18.

COUNTY ADMINISTRATION ALLOCATION

COUNTY ADMIN. POLICY CHANGE NUMBER: 1

Methodology:

1) The total rounded estimated FY 2017-18 and FY 2018-19 county administration costs are:

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
Staff Salary Costs	$909,623	$454,811	$454,812
Support Staff Costs	$373,643	$186,822	$186,821
Staff Development Costs	$19,417	$9,708	$9,709
Total Allocation	**$1,302,683**	**$651,341**	**$651,342**

FY 2018-19	TF	GF	FF
Staff Salary Costs	$1,406,718	$703,359	$703,359
Support Staff Costs	$577,833	$288,917	$288,917
Staff Development Costs	$30,028	$15,014	$15,014
Total Allocation	**$2,014,579**	**$1,007,289**	**$1,007,289**

COUNTY ADMINISTRATION ALLOCATION

COUNTY ADMIN. POLICY CHANGE NUMBER: 1

2) The funding allocation to counties for FY 2017-18 is included below.

Medi-Cal County Administration				
FY 2017-18				
County	Total Staff Salary Costs	Support Staff	Staff Development Costs	Base Allocation
Alameda	$32,542,588	$11,615,145	$1,385,854	$45,543,587
Alpine	$41,700	$0	$0	$41,700
Amador	$681,637	$366,187	$10,341	$1,058,165
Butte	$5,379,540	$2,399,702	$25,500	$7,804,742
Calaveras	$694,063	$441,347	$6,910	$1,142,320
Colusa	$635,448	$291,552	$21,716	$948,716
Contra Costa	$23,315,114	$12,617,981	$304,333	$36,237,428
Del Norte	$558,190	$259,284	$11,200	$828,674
El Dorado	$2,652,217	$1,101,127	$90,000	$3,843,344
Fresno	$28,892,408	$16,305,175	$657,347	$45,854,930
Glenn	$1,059,460	$342,764	$18,000	$1,420,224
Humboldt	$3,875,219	$1,057,846	$119,300	$5,052,365
Imperial	$5,074,973	$1,872,353	$115,220	$7,062,546
Inyo	$554,240	$212,327	$11,000	$777,567
Kern	$17,115,100	$7,278,489	$196,890	$24,590,479
Kings	$2,702,453	$955,428	$144,250	$3,802,131
Lake	$1,631,990	$568,477	$51,706	$2,252,173
Lassen	$492,642	$218,634	$23,468	$734,744
Los Angeles	$273,758,990	$119,782,655	$2,103,000	$395,644,645
Madera	$3,292,642	$1,697,142	$4,465	$4,994,249
Marin	$3,206,326	$1,600,478	$103,412	$4,910,216
Mariposa	$417,966	$539,071	$0	$957,037
Mendocino	$3,488,586	$1,469,968	$15,718	$4,974,272
Merced	$9,075,836	$1,956,051	$144,064	$11,175,951
Modoc	$387,012	$332,812	$15,000	$734,824
Mono	$207,098	$110,669	$20,000	$337,767
Monterey	$11,136,422	$5,713,668	$475,000	$17,325,090
Napa	$2,072,297	$1,160,104	$43,563	$3,275,964
Nevada	$1,527,574	$732,652	$25,631	$2,285,857
Orange	$77,886,813	$20,747,854	$2,000,674	$100,635,341
Placer	$4,215,254	$1,860,122	$91,206	$6,166,582
Plumas	$373,319	$197,689	$5,171	$576,179

COUNTY ADMINISTRATION ALLOCATION

COUNTY ADMIN. POLICY CHANGE NUMBER: 1

Medi-Cal County Administration				
FY 2017-18				
County	**Total Staff Salary Costs**	**Support Staff**	**Staff Development Costs**	**Base Allocation**
Riverside	$42,122,663	$23,700,136	$750,977	$66,573,776
Sacramento	$30,420,717	$12,121,920	$885,878	$43,428,515
San Benito	$1,150,098	$389,751	$64,103	$1,603,952
San Bernardino	$42,437,752	$17,141,455	$861,000	$60,440,207
San Diego	$54,194,098	$24,937,737	$2,311,253	$81,443,088
San Francisco	$21,609,931	$4,737,695	$206,824	$26,554,450
San Joaquin	$16,284,780	$4,472,548	$434,329	$21,191,657
San Luis Obispo	$5,329,928	$3,862,538	$149,947	$9,342,413
San Mateo	$15,595,364	$5,437,955	$551,844	$21,585,163
Santa Barbara	$14,576,928	$6,200,380	$881,375	$21,658,683
Santa Clara	$53,322,942	$15,373,238	$1,500,000	$70,196,180
Santa Cruz	$7,550,308	$3,000,456	$422,880	$10,973,644
Shasta	$4,145,591	$2,114,811	$200,000	$6,460,402
Sierra	$113,167	$173,930	$1,500	$288,597
Siskiyou	$1,013,009	$258,380	$128,037	$1,399,426
Solano	$9,405,955	$4,679,039	$500,000	$14,584,994
Sonoma	$11,267,525	$2,945,891	$237,048	$14,450,464
Stanislaus	$15,194,676	$3,970,500	$160,184	$19,325,360
Sutter	$2,950,607	$1,943,224	$50,000	$4,943,831
Tehama	$1,468,661	$679,223	$5,500	$2,153,384
Trinity	$353,544	$128,062	$11,500	$493,106
Tulare	$16,162,830	$4,855,829	$459,400	$21,478,059
Tuolumne	$1,153,800	$800,054	$8,928	$1,962,782
Ventura	$17,008,190	$8,607,859	$265,114	$25,881,163
Yolo	$3,821,963	$3,233,330	$71,160	$7,126,453
Yuba	$2,022,731	$2,072,590	$58,121	$4,153,442
Total	**$909,622,876**	**$373,643,283**	**$19,416,841**	**$1,302,683,000**

3) The funding allocation to counties for FY 2018-19 has not yet been determined, so the Department has not included a table in this policy change.

Funding:
50% Title XIX FF/ 50% GF (4260-101-0001/0890)
Medicaid Management Information Systems Enhanced Funding identified in CA 7 Enhanced Federal Funding

IMPLEMENTATION OF ACA

COUNTY ADMIN. POLICY CHANGE NUMBER:	2
IMPLEMENTATION DATE:	7/2013
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1796

	FY 2017-18		FY 2018-19	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$655,310,000	$0	$0	$0
TOTAL FUNDS	$655,310,000	$0	$0	$0
STATE FUNDS	$327,655,000	$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.	$655,310,000	$0	$0	$0
TOTAL FUNDS	$655,310,000	$0	$0	$0
STATE FUNDS	$327,655,000	$0	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the county administrative costs for implementing required provisions of the Affordable Care Act (ACA).

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2014, the 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. The ACA imposed penalty upon the uninsured will be in force through calendar year 2018. Currently eligible but not enrolled beneficiaries who enroll in Medi-Cal as 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 result of both the ACA optional and ACA mandatory expansions.

Additionally, the ACA established online health insurance exchanges. Covered California, California's online health insurance exchange, provides competitive health care coverage for individuals and small employers. As required by ACA, Covered California determines an applicant's eligibility for subsidized coverage. The ACA also requires states to use a single, streamlined application for the applicants to apply for all applicable health subsidy programs.

IMPLEMENTATION OF ACA

COUNTY ADMIN. POLICY CHANGE NUMBER: 2

Covered California offers applicants the option to file online, in person, by mail, by telephone with the exchange, or with the county welfare departments (CWD). To meet this requirement, the Department and Covered California formed a partnership to develop the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS). CalHEERS allows for the one-stop-shopping, making health insurance eligibility and purchasing easier and more understandable.

Reason for Change:
There is no change, in FY 2017-18 or FY 2018-19, from the previous estimate. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the Department incorporating CA 2 Implementation of the ACA funding into CA 1 County Administration Allocation.

Methodology:
1) Effective January 1, 2014, the ACA simplifies eligibility for several coverage groups (Children, Pregnant Women, and 1931b).

2) Since January 2014, the Medi-Cal program has experienced significant growth in Medi-Cal enrollment as result of both the ACA optional and ACA mandatory expansions.

3) The CalHEERS was developed to automate the eligibility work for a large portion of new and existing Medi-Cal beneficiaries. However, currently the system is not completely functional. This requires counties to manually process some eligibility determinations and renewals. These manual workarounds performed by the counties require additional resources.

4) The total county administrative costs estimated for implementing required provisions of the ACA in FY 2017-18 are $655,310,000 TF ($327,655,000 GF).

Funding:
50% Title XIX FF/ 50% GF (4260-101-0001/0890)
Medicaid Management Information Systems Enhanced Funding identified in CA 7 Enhanced Federal Funding

SAWS

COUNTY ADMIN. POLICY CHANGE NUMBER:	3
IMPLEMENTATION DATE:	7/1987
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	214

	FY 2017-18		FY 2018-19	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$125,500,000	$0	$155,500,000	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$125,500,000	$0	$155,500,000	$0
STATE FUNDS	$0	$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.	$125,500,000	$0	$155,500,000	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$125,500,000	$0	$155,500,000	$0
STATE FUNDS	$0	$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 (MEDS) 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: 3

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 (ACMS) 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 decrease from the prior estimate, for FY 2017-18 and FY 2018-19, is due to a couple of factors. First, the Department removed the ACMS cost from this policy change. Second, forecasted costs for all remaining line items decreased, with the exception of FY 2018-19 LRS C-IV Migration costs, that increased, resulting in a decrease in both fiscal years, overall, from the prior estimate. The change in the current estimate, from FY 2017-18 to FY 2018-19, is an increase due to the addition of CalACES and a decrease to C-IV due to costs for C-IV migrating into CalACES.

Methodology:
1) The following estimate was provided by CDSS on a cash basis.

(Dollars in Thousands)

Line Item	FY 2017-18	FY 2018-19
Statewide Project Management	$2,083	$2,247
SB 1341 Medi-Cal/SAWS	$3,178	$2,706
LRS	$39,187	$0
WCDS-CalWIN	$38,805	$40,884
C-IV	$33,044	$0
LRS C-IV – Migration	$8,620	$37,019
State Client Index	$60	$63
Inter-County Transfer	$523	$108
CalACES	$0	$72,473
Total	**$125,500**	**$155,500**

Funding:
50% Title XIX FF / 50% GF (4260-101-0001/0890)*
100% Title XIX FF (4260-101-0890)

CalWORKS APPLICATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER:	4
IMPLEMENTATION DATE:	7/1998
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	217

	FY 2017-18		FY 2018-19	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$64,848,000	$0	$65,206,000
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$64,848,000	$0	$65,206,000
STATE FUNDS	$0	$32,424,000	$0	$32,603,000
% 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	$64,848,000	$0	$65,206,000
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$64,848,000	$0	$65,206,000
STATE FUNDS	$0	$32,424,000	$0	$32,603,000

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 shares in the costs for CalWORKS applications with the California Department of Social Services (CDSS). CDSS amended the claim forms and time study documents completed by the counties to allow CalWORKS application costs that are also necessary for Medi-Cal and CalFresh eligibility, to be shared between the three programs.

Reason for Change:
The change in FY 2017-18 and FY 2018-19, from the prior estimate, is due to increased expenditures in recent quarters. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to an expected increase in expenditures.

CalWORKS APPLICATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER: 4

Methodology:
1) The estimated costs for FY 2017-18 and FY 2018-19 were provided on a cash basis by CDSS.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2017-18	$64,848	$32,424	$32,424
FY 2018-19	$65,206	$32,603	$32,603

Funding:
50% Title XIX FF/ 50% GF (4260-101-0001/0890)
Medicaid Management Information Systems Enhanced Funding identified in CA 7 Enhanced Federal Funding

CASE MANAGEMENT FOR OTLICP

COUNTY ADMIN. POLICY CHANGE NUMBER:	5
IMPLEMENTATION DATE:	12/2012
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1598

	FY 2017-18		FY 2018-19	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$44,380,000	$0	$44,451,000
TOTAL FUNDS	$0	$44,380,000	$0	$44,451,000
STATE FUNDS	$0	$22,190,000	$0	$22,225,500
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$44,380,000	$0	$44,451,000
TOTAL FUNDS	$0	$44,380,000	$0	$44,451,000
STATE FUNDS	$0	$22,190,000	$0	$22,225,500

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 2017-18 and FY 2018-19, is due to an increase of approximately 1 percent in the updated average monthly caseload data. The change in the current estimate from FY 2017-18 to FY 2018-19 is due to the expected growth trend of OTLICP eligibles.

Methodology:
1. The Department currently estimates the case management and redetermination for the former OTLICP beneficiaries at $4.00 Per Member Per Month (PMPM).

CASE MANAGEMENT FOR OTLICP

COUNTY ADMIN. POLICY CHANGE NUMBER: 5

2. The estimated average monthly OTLICP eligibles for FY 2017-18 is 924,589 and 926,064 for FY 2018-19.

3. The estimated costs are:

(Dollars In Thousands)

Fiscal Year	TF	GF	FF
FY 2017-18	$ 44,380	$ 22,190	$ 22,190
FY 2018-19	$ 44,451	$ 22,225	$ 22,226

Funding:
50% Title XIX / 50% GF (4260-113-0890/0001)
Medicaid Management Information Systems Enhanced Funding identified in CA 7 Enhanced Federal Funding

LOS ANGELES COUNTY HOSPITAL INTAKES

COUNTY ADMIN. POLICY CHANGE NUMBER:	6
IMPLEMENTATION DATE:	7/1994
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	213

	FY 2017-18		FY 2018-19	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$38,524,000	$0	$38,524,000
TOTAL FUNDS	$0	$38,524,000	$0	$38,524,000
STATE FUNDS	$0	$2,672,500	$0	$2,672,500
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$38,524,000	$0	$38,524,000
TOTAL FUNDS	$0	$38,524,000	$0	$38,524,000
STATE FUNDS	$0	$2,672,500	$0	$2,672,500

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 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. Welfare & Institutions Code 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:
There is no change from the prior estimate, for FY 2017-18 and FY 2018-19. There is no change in the current estimate, from FY 2017-18 to FY 2018-19.

LOS ANGELES COUNTY HOSPITAL INTAKES

COUNTY ADMIN. POLICY CHANGE NUMBER: 6

Methodology:

1. The reimbursement rate is $268 for both current year and budget year. Assume in FY 2017-18 and FY 2018-19, PFSWs will continue processing a base caseload of 2,215 per month.

   FY 2017-18: 2,215 x $268 x 12 = $7,123,000 TF ($3,561,500 GF)
   FY 2018-19: 2,215 x $268 x 12 = $7,123,000 TF ($3,561,500 GF)

2. The Department completed the FY 2015-16 Los Angeles County Hospital Intakes reconciliation in FY 2017-18 and will complete the FY 2016-17 reconciliation in FY 2018-19. The current FY 2016-17 reconciliation amounts are placeholders.

(Dollars in Thousands)

	FY 2017-18			FY 2018-19		
Line Item	**TF**	**GF**	**FF**	**TF**	**GF**	**FF**
PFSW Base	$7,123	$3,561	$3,562	$7,123	$3,561	$3,562
FY 2015-16 Recon.	$14,812	($889)	$15,701			
FY 2015-16 Pass.	$16,589	$0	$16,589			
FY 2016-17 Recon.				$14,812	($889)	$15,701
FY 2016-17 Pass.				$16,589	$0	$16,589
Total	**$38,524**	**$2,672**	**$35,852**	**$38,524**	**$2,672**	**$35,852**

Funding:

(Dollars in Thousands)

FY 2017-18	**Fund Number**	**TF**	**GF**	**FF**
50% Title XIX FF/ 50% GF	4260-101-0001/0890	$7,123	$3,561	$3,562
100% Title XIX FF	4260-101-0890	$32,290	$0	$32,290
100% GF	4260-101-0001	($889)	($889)	$0
Total		**$38,524**	**$2,672**	**$35,852**

FY 2018-19	**Fund Number**	**TF**	**GF**	**FF**
50% Title XIX FF/ 50% GF	4260-101-0001/0890	$7,123	$3,561	$3,562
100% Title XIX FF	4260-101-0890	$32,290	$0	$32,290
100% GF	4260-101-0001	($889)	($889)	$0
Total		**$38,524**	**$2,672**	**$35,852**

ENHANCED FEDERAL FUNDING

COUNTY ADMIN. POLICY CHANGE NUMBER:	7
IMPLEMENTATION DATE:	1/2015
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1835

	FY 2017-18		FY 2018-19	
	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	-$255,017,000	$0	-$345,130,000	$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	-$255,017,000	$0	-$345,130,000	$0

DESCRIPTION

Purpose:
This policy change estimates the savings from enhanced federal funding for certain eligibility determination functions.

Authority:
Not Applicable

Interdependent Policy Changes:
CA 1 County Administration Allocation
CA 2 Implementation of the ACA
CA 4 CalWORKS Applications
CA 5 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.

In order to secure the enhanced funding, there are various conditions required of a MMIS. Also, there are minimum critical success factors for accepting the new applications, making modified adjusted gross income determinations and coordination with Covered California. In January 2014, the Department submitted an Advanced Planning Document (APD) to secure CMS approval. CMS

ENHANCED FEDERAL FUNDING

COUNTY ADMIN. POLICY CHANGE NUMBER: 7

approved the APD on September 29, 2014. In July 2016, the Department conducted an annual review of the APD and submitted an update to CMS. The Department was granted approval for FFY 2017. In July 2017, the Department conducted an annual review of the APD and submitted an update to CMS. CMS approved the APD for FFY 2018 on September 1, 2017.

Reason for Change:
The change from the previous estimate, for FY 2017-18 and FY 2018-19, is due to several factors. First, expenditures increased for processing CalWORKS applications. Second, the actual claim amount for the first quarter of FY 2017-18 was slightly higher than forecast. Lastly, FY 2018-19 increased, from the previous estimate, due to an increase from 2.8% to 2.89% for the California Price Index (CPI). The change from FY 2017-18 to FY 2018-19, in the current estimate, is primarily due to claiming three quarters of enhanced funding in FY 2017-18 and four quarters in FY 2018-19.

Methodology:
1. The effective date for the Department's APD is September 29, 2017, with retroactivity for April-September 2017.

2. Assume that 65% of county administration forecasted expenditure costs are eligible for the enhanced funding because they are application, on-going case maintenance, and redetermination costs.

3. The savings are estimated to be:

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
Title XIX at 50% FFP	$ 1,020,067	$ 510,034	$ 510,034
Title XIX at 75% FFP	$ 1,020,067	$ 255,017	$ 765,050
Total Difference	**$ -**	**$ (255,017)**	**$ 255,017**

FY 2018-19	TF	GF	FF
Title XIX at 50% FFP	$ 1,380,521	$ 690,261	$ 690,261
Title XIX at 75% FFP	$ 1,380,521	$ 345,130	$ 1,035,391
Total Difference	**$ -**	**$ (345,130)**	**$ 345,130**

Funding:
50% Title XIX FF/ 50% GF (4260-101-0001/0890)
75% Title XIX GF/ 25% GF (4260-101-0001/0890)

SAVE

COUNTY ADMIN. POLICY CHANGE NUMBER:	8
IMPLEMENTATION DATE:	10/1988
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	215

	FY 2017-18		FY 2018-19	
	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 (IRCA) 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 will be 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 previous estimate, for FY 2017-18 or FY 2018-19. There is no change, in the current estimate, from FY 2017-18 to FY 2018-19.

SAVE

COUNTY ADMIN. POLICY CHANGE NUMBER: 8

Methodology:

1. 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 2013-14	$6,261,572	FY 2016-17	$8,000,000
FY 2014-15	$6,618,661	FY 2017-18	$8,000,000
FY 2015-16	$7,553,372	FY 2018-19	$8,000,000

3. Based on claims through June 2017, federal funds will be:
(Dollars in Thousands)

FY 2017-18	TF	GF	FF
50% Title XIX /50% GF 4260-101-0001/0890	($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 2018-19	TF	GF	FF
50% Title XIX /50% GF 4260-101-0001/0890	($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 (4260-101-0001/0890)
100% Title XIX FFP (4260-101-0890)

COUNTY ADMINISTRATION CMS DEFERRED CLAIMS

COUNTY ADMIN. POLICY CHANGE NUMBER:	9
IMPLEMENTATION DATE:	3/2018
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	2089

	FY 2017-18		FY 2018-19	
	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	$244,755,000	$0	$163,170,000	$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	$244,755,000	$0	$163,170,000	$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: 9

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:
This is a new policy change.

Methodology:
1. In FY 2017-18, the Department repaid $81.585 million FF for the CMS deferral issued for Federal Fiscal Year (FFY) 2016 Quarter 2.

2. The Department estimates to repay $163.170 million FF in FY 2018-19 for the CMS deferral issued for FFY 2016 Quarter 3.

3. In FY 2018-19, the Department estimates to repay $163.170 million FF for projected deferred claims.

4. The Department will repay the following estimated deferred claims:

(Dollars in Thousands)

FY 2017-18	Total Estimated Repayment
FFY 2016 Quarter 2 (Jan-Mar 2016)	$81,585
FFY 2016 Quarter 3 (Apr-Jun 2016)	$163,170
Total FY 2017-18	**$244,755**

(Dollars in Thousands)

FY 2018-19	Total Estimated Repayment
FFY 2017 Quarter 1 (Oct-Dec 2016)	$81,585
FFY 2017 Quarter 2 (Jan-Mar 2017)	$81,585
Total FY 2018-19	**$163,170**

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XIX GF (4260-101-0001)

May 2018 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 2017-2018 Estimate:	**Total Funds**	**Federal Funds**	**State Funds**
OTHER ADMINISTRATION			
County Administration	$1,871,853,000	$1,678,033,540	$193,819,460
Fiscal Intermediary	$413,153,000	$267,640,000	$145,513,000
Total Other Administration Tab	**$2,285,006,000**	**$1,945,673,540**	**$339,332,460**
Management Summary:			
COUNTY ADMINISTRATION	**$4,103,098,000**	**$2,887,258,000**	**$1,215,840,000**
Shown in Other Administration Tab	$1,871,853,000	$1,678,033,540	$193,819,460
Shown in County Administration Tab	$2,231,245,000	$1,209,224,460	$1,022,020,540
FISCAL INTERMEDIARY	**$413,153,000**	**$267,640,000**	**$145,513,000**
Shown in Other Administration Tab	$413,153,000	$267,640,000	$145,513,000

FY 2018-2019 Estimate:	**Total Funds**	**Federal Funds**	**State Funds**
OTHER ADMINISTRATION			
County Administration	$2,192,604,000	$1,846,116,670	$346,487,330
Fiscal Intermediary	$326,285,000	$213,511,000	$112,774,000
Total Other Administration Tab	**$2,518,889,000**	**$2,059,627,670**	**$459,261,330**
Management Summary:			
COUNTY ADMINISTRATION	**$4,510,863,000**	**$3,285,546,000**	**$1,225,317,000**
Shown in Other Administration Tab	$2,192,604,000	$1,846,116,670	$346,487,330
Shown in County Administration Tab	$2,318,259,000	$1,439,429,330	$878,829,670
FISCAL INTERMEDIARY	**$326,287,000**	**$213,511,000**	**$112,776,000**
Shown in Other Administration Tab	$326,285,000	$213,511,000	$112,774,000

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2017-18

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DHCS-OTHER				
1	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	$149,215,000	$140,348,000	$8,867,000	$0
2	CCS CASE MANAGEMENT	$194,938,000	$128,275,790	$66,662,210	$0
4	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$126,718,000	$126,718,000	$0	$0
5	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	$110,634,000	$110,623,000	$11,000	$0
6	EPSDT CASE MANAGEMENT	$33,962,000	$22,005,000	$11,957,000	$0
7	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	$26,726,000	$20,959,200	$5,766,800	$0
8	SMH MAA	$31,851,000	$31,851,000	$0	$0
9	ARRA HITECH INCENTIVE PROGRAM	$17,596,000	$15,996,000	$0	$1,600,000
10	MANAGED CARE REGULATIONS - MENTAL HEALTH	$5,801,000	$3,868,000	$1,933,000	$0
11	SMHS COUNTY UR & QA ADMIN	$25,855,000	$25,590,000	$265,000	$0
13	PAVE SYSTEM	$14,587,000	$10,713,900	$3,873,100	$0
14	POSTAGE & PRINTING	$20,586,000	$10,165,000	$10,421,000	$0
15	ACTUARIAL COSTS FOR RATE DEVELOPMENT	$16,872,000	$8,436,000	$8,119,000	$317,000
16	PASRR	$11,783,000	$8,837,250	$2,945,750	$0
17	MIS/DSS CONTRACT	$11,379,000	$8,365,250	$3,013,750	$0
18	CCI-ADMINISTRATIVE COSTS	$11,213,000	$5,606,500	$5,606,500	$0
19	SURS AND MARS SYSTEM REPLACEMENT	$10,090,000	$8,287,950	$1,802,050	$0
20	MEDI-CAL RECOVERY CONTRACTS	$9,475,000	$7,106,250	$2,368,750	$0
21	LITIGATION RELATED SERVICES	$9,980,000	$4,990,000	$4,990,000	$0
22	NEWBORN HEARING SCREENING PROGRAM	$7,700,000	$3,850,000	$3,850,000	$0
23	HIPAA CAPITATION PAYMENT REPORTING SYSTEM	$6,677,000	$5,007,750	$1,669,250	$0
24	DMC COUNTY UR & QA ADMIN	$190,000	$190,000	$0	$0
25	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$5,000,000	$3,325,500	$1,328,500	$346,000
26	CLINICAL DATA COLLECTION	$3,094,000	$2,740,800	$353,200	$0
27	DRUG MEDI-CAL COUNTY ADMINISTRATION	$6,356,000	$6,087,000	$269,000	$0
28	MEDICARE BENEFICIARY IDENTIFIER	$1,862,000	$1,675,800	$186,200	$0
29	ELECTRONIC ASSET VERIFICATION PROGRAM	$1,164,000	$582,000	$582,000	$0
30	SDMC SYSTEM M&O SUPPORT	$2,325,000	$1,162,500	$1,162,500	$0
31	CA-MMIS MEDCOMPASS SOLUTION	$2,252,000	$1,924,500	$327,500	$0

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2017-18

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DHCS-OTHER				
32	MITA	$2,772,000	$2,494,800	$277,200	$0
33	MEDS MODERNIZATION	$2,015,000	$1,748,250	$266,750	$0
34	SSA COSTS FOR HEALTH COVERAGE INFO.	$2,120,000	$1,060,000	$1,060,000	$0
35	CALIFORNIA HEALTH INTERVIEW SURVEY	$1,272,000	$1,272,000	$0	$0
36	FAMILY PACT PROGRAM ADMIN.	$1,207,000	$603,500	$603,500	$0
37	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES	$950,000	$0	$950,000	$0
38	MMA - DSH ANNUAL INDEPENDENT AUDIT	$888,000	$444,000	$444,000	$0
39	ENCRYPTION OF PHI DATA	$750,000	$375,000	$375,000	$0
40	POSTAGE AND PRINTING - THIRD PARTY LIAB.	$728,000	$364,000	$364,000	$0
41	IRS REPORTING FOR MIN. ESSENTIAL COVERAGE	$340,000	$170,000	$170,000	$0
42	T-MSIS	$418,000	$313,500	$104,500	$0
43	VENDOR FOR AAC RATE STUDY	$386,000	$193,000	$193,000	$0
44	CCT OUTREACH - ADMINISTRATIVE COSTS	$342,000	$342,000	$0	$0
45	MEDICARE BUY-IN QUALITY REVIEW PROJECT	$100,000	$50,000	$50,000	$0
46	STATE CONTROLLER'S OFFICE INTERAGENCY AGREEMENT	$4,000	$3,000	$1,000	$0
47	DENTAL PAPD PROJECT MANAGER	$161,000	$120,750	$40,250	$0
48	CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT	$100,000	$100,000	$0	$0
49	TAR POSTAGE	$32,000	$16,000	$16,000	$0
50	ENROLLMENT ASSIST FOR BHT INSTITUTIONALLY DEEMED	$43,000	$21,500	$21,500	$0
55	INTERIM AND FINAL COST SETTLEMENTS-SMHS	($2,688,000)	($2,688,000)	$0	$0
	DHCS-OTHER SUBTOTAL	**$887,821,000**	**$732,291,240**	**$153,266,760**	**$2,263,000**
	DHCS-MEDICAL FI				
56	MEDICAL FI OPERATIONS	$79,012,000	$53,610,500	$25,401,500	$0
57	MEDICAL FI COST REIMBURSEMENT	$42,390,000	$31,321,950	$11,068,050	$0
58	MEDICAL FI HOURLY REIMBURSEMENT	$27,546,000	$21,559,500	$5,986,500	$0
59	MEDICAL FI OTHER ESTIMATED COSTS	$11,080,000	$7,860,000	$3,220,000	$0
60	MEDICAL FI MISCELLANEOUS EXPENSES	$2,445,000	$1,677,750	$767,250	$0
61	MEDICAL FI CHANGE ORDERS	$536,000	$402,000	$134,000	$0

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2017-18

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DHCS-MEDICAL FI				
111	MEDICAL FI SRP RELEASE 1 HOSTING	$7,042,000	$6,018,300	$1,023,700	$0
114	MEDICAL FI TURNOVER	$600,000	$406,500	$193,500	$0
	DHCS-MEDICAL FI SUBTOTAL	**$170,651,000**	**$122,856,500**	**$47,794,500**	**$0**
	DHCS-HEALTH CARE OPT				
63	HCO COST REIMBURSEMENT	$44,189,000	$22,934,680	$21,254,320	$0
64	HCO OPERATIONS	$29,179,000	$15,142,020	$14,036,980	$0
65	HCO - ENROLLMENT CONTRACTOR COSTS	$17,990,000	$9,336,620	$8,653,380	$0
66	HCO ESR HOURLY REIMBURSEMENT	$15,580,000	$8,086,020	$7,493,980	$0
67	HCO CCI - CAL MEDICONNECT AND MLTSS	$15,269,000	$7,634,500	$7,634,500	$0
68	HCO TAKEOVER	$2,769,000	$1,384,500	$1,384,500	$0
69	HCO TURNOVER	$522,000	$261,000	$261,000	$0
	DHCS-HEALTH CARE OPT SUBTOTAL	**$125,498,000**	**$64,779,340**	**$60,718,660**	**$0**
	DHCS-DENTAL FI				
73	DENTAL FI OPERATIONS	$57,261,000	$37,348,750	$19,912,250	$0
74	DENTAL FI TAKEOVER 2016 CONTRACT	$23,424,000	$17,568,000	$5,856,000	$0
75	DENTAL ASO ADMINISTRATION 2016 CONTRACT	$12,303,000	$7,750,750	$4,552,250	$0
76	DENTAL FI HOURLY REIMBURSEMENT	$6,604,000	$4,953,000	$1,651,000	$0
77	DENTAL FI COST REIMBURSEMENT	$7,492,000	$3,842,000	$3,650,000	$0
78	DENTAL FI ADMINISTRATION 2016 CONTRACT	$6,794,000	$4,994,000	$1,800,000	$0
79	DENTAL ASO TAKEOVER 2016 CONTRACT	$3,756,000	$2,817,000	$939,000	$0
80	DENTAL FI CD-MMIS COSTS	$656,000	$492,000	$164,000	$0
81	DENTAL BENEFICIARY OUTREACH & ED PROGRAM - ADMIN	$1,893,000	$946,500	$946,500	$0
83	DENTAL FI FEDERAL RULE - REVALIDATION	$200,000	$100,000	$100,000	$0
84	DENTAL FI FEDERAL RULE - DATABASE CHECKS	$215,000	$107,500	$107,500	$0
85	DENTAL FI CONLAN, SCHWARZMER, STEVENS V. BONTA	$196,000	$98,000	$98,000	$0
86	DENTAL FI HIPAA ADDENDUM SECURITY RISK ASSESSMENT	$167,000	$125,250	$41,750	$0
	DHCS-DENTAL FI SUBTOTAL	**$120,961,000**	**$81,142,750**	**$39,818,250**	**$0**

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2017-18

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER DEPARTMENTS				
87	PERSONAL CARE SERVICES	$385,201,000	$385,201,000	$0	$0
88	HEALTH-RELATED ACTIVITIES - CDSS	$274,418,000	$274,418,000	$0	$0
89	CALHEERS DEVELOPMENT	$125,682,000	$99,673,210	$26,008,790	$0
90	CDDS ADMINISTRATIVE COSTS	$53,471,000	$53,471,000	$0	$0
91	MATERNAL AND CHILD HEALTH	$36,945,000	$36,945,000	$0	$0
92	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	$41,379,000	$41,379,000	$0	$0
93	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$19,640,000	$19,640,000	$0	$0
94	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	$14,395,000	$10,988,000	$0	$3,407,000
95	ACA OUTREACH AND ENROLLMENT COUNSELORS	$11,442,000	$5,721,000	$0	$5,721,000
96	CLPP CASE MANAGEMENT SERVICES	$5,355,000	$5,355,000	$0	$0
97	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$4,093,000	$4,093,000	$0	$0
98	VITAL RECORDS DATA	$1,632,000	$1,632,000	$0	$0
99	CALIFORNIA SMOKERS' HELPLINE	$1,373,000	$1,373,000	$0	$0
100	KIT FOR NEW PARENTS	$1,119,000	$1,119,000	$0	$0
101	VETERANS BENEFITS	$1,100,000	$1,100,000	$0	$0
102	CHHS AGENCY HIPAA FUNDING	$849,000	$849,000	$0	$0
103	MEDI-CAL INPATIENT SERVICES FOR INMATES	$813,000	$813,000	$0	$0
104	CDPH I&E PROGRAM AND EVALUATION	$566,000	$566,000	$0	$0
105	MERIT SYSTEM SERVICES FOR COUNTIES	$194,000	$97,000	$97,000	$0
106	CDDS DENTAL SERVICES - ADMIN	$67,000	$0	$0	$67,000
107	PIA EYEWEAR COURIER SERVICE	$341,000	$170,500	$170,500	$0
	OTHER DEPARTMENTS SUBTOTAL	**$980,075,000**	**$944,603,710**	**$26,276,290**	**$9,195,000**
	GRAND TOTAL	**$2,285,006,000**	**$1,945,673,540**	**$327,874,460**	**$11,458,000**

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2018-19

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DHCS-OTHER				
1	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	$154,118,000	$17,706,000	$136,412,000	$0
2	CCS CASE MANAGEMENT	$190,884,000	$127,064,880	$63,819,120	$0
3	MH/UCD & BTR -LIHP -ADMINISTRATIVE COSTS COUNTY	$119,816,000	$119,816,000	$0	$0
4	SPECIALTY MENTAL HEALTH ADMIN	$130,354,000	$130,354,000	$0	$0
5	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	$95,200,000	$94,082,000	$1,118,000	$0
6	EPSDT CASE MANAGEMENT	$33,962,000	$22,005,000	$11,957,000	$0
7	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	$32,835,000	$24,067,280	$8,767,720	$0
8	SMH MAA	$33,834,000	$33,834,000	$0	$0
9	ARRA HITECH INCENTIVE PROGRAM	$27,180,000	$25,895,000	$0	$1,285,000
10	MANAGED CARE REGULATIONS - MENTAL HEALTH	$22,507,000	$15,005,000	$7,502,000	$0
11	SMHS COUNTY UR & QA ADMIN	$28,667,000	$27,714,000	$953,000	$0
12	PERFORMANCE OUTCOMES SYSTEM	$14,321,000	$7,906,750	$6,414,250	$0
13	PAVE SYSTEM	$14,511,000	$6,835,500	$7,675,500	$0
14	POSTAGE & PRINTING	$26,786,000	$13,265,000	$13,521,000	$0
15	ACTUARIAL COSTS FOR RATE DEVELOPMENT	$16,872,000	$8,436,000	$8,119,000	$317,000
16	PASRR	$12,706,000	$9,529,500	$3,176,500	$0
17	MIS/DSS CONTRACT	$11,331,000	$8,326,250	$3,004,750	$0
18	CCI-ADMINISTRATIVE COSTS	$11,213,000	$5,606,500	$5,606,500	$0
19	SURS AND MARS SYSTEM REPLACEMENT	$9,077,000	$6,990,750	$2,086,250	$0
20	MEDI-CAL RECOVERY CONTRACTS	$9,339,000	$7,004,250	$2,334,750	$0
21	LITIGATION RELATED SERVICES	$9,980,000	$4,990,000	$4,990,000	$0
22	NEWBORN HEARING SCREENING PROGRAM	$8,225,000	$4,112,500	$4,112,500	$0
23	HIPAA CAPITATION PAYMENT REPORTING SYSTEM	$5,488,000	$4,116,000	$1,372,000	$0
24	DMC COUNTY UR & QA ADMIN	$5,811,000	$5,811,000	$0	$0
25	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$5,000,000	$3,325,500	$1,328,500	$346,000
26	CLINICAL DATA COLLECTION	$2,474,000	$2,151,600	$322,400	$0
27	DRUG MEDI-CAL COUNTY ADMINISTRATION	$27,767,000	$27,394,000	$373,000	$0
28	MEDICARE BENEFICIARY IDENTIFIER	$1,636,000	$1,472,400	$163,600	$0
29	ELECTRONIC ASSET VERIFICATION PROGRAM	$3,328,000	$1,664,000	$1,664,000	$0

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2018-19

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DHCS-OTHER				
30	SDMC SYSTEM M&O SUPPORT	$2,325,000	$1,162,500	$1,162,500	$0
31	CA-MMIS MEDCOMPASS SOLUTION	$1,576,000	$1,346,700	$229,300	$0
32	MITA	$5,274,000	$4,746,600	$527,400	$0
34	SSA COSTS FOR HEALTH COVERAGE INFO.	$1,500,000	$750,000	$750,000	$0
35	CALIFORNIA HEALTH INTERVIEW SURVEY	$1,100,000	$1,100,000	$0	$0
36	FAMILY PACT PROGRAM ADMIN.	$1,207,000	$603,500	$603,500	$0
37	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES	$950,000	$0	$950,000	$0
38	MMA - DSH ANNUAL INDEPENDENT AUDIT	$926,000	$463,000	$463,000	$0
39	ENCRYPTION OF PHI DATA	$750,000	$375,000	$375,000	$0
40	POSTAGE AND PRINTING - THIRD PARTY LIAB.	$696,000	$348,000	$348,000	$0
41	IRS REPORTING FOR MIN. ESSENTIAL COVERAGE	$684,000	$342,000	$342,000	$0
42	T-MSIS	$276,000	$207,000	$69,000	$0
43	VENDOR FOR AAC RATE STUDY	$332,000	$166,000	$166,000	$0
44	CCT OUTREACH - ADMINISTRATIVE COSTS	$342,000	$342,000	$0	$0
45	MEDICARE BUY-IN QUALITY REVIEW PROJECT	$300,000	$150,000	$150,000	$0
48	CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT	$100,000	$100,000	$0	$0
49	TAR POSTAGE	$32,000	$16,000	$16,000	$0
55	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$26,745,000	$26,745,000	$0	$0
109	MANAGED CARE REGULATIONS - MH PARITY	$20,799,000	$17,828,000	$2,971,000	$0
	DHCS-OTHER SUBTOTAL	**$1,131,136,000**	**$823,271,960**	**$305,916,040**	**$1,948,000**
	DHCS-MEDICAL FI				
56	MEDICAL FI OPERATIONS	$77,098,000	$52,366,250	$24,731,750	$0
57	MEDICAL FI COST REIMBURSEMENT	$36,151,000	$25,832,000	$10,319,000	$0
58	MEDICAL FI HOURLY REIMBURSEMENT	$27,546,000	$21,559,500	$5,986,500	$0
59	MEDICAL FI OTHER ESTIMATED COSTS	$11,080,000	$7,860,000	$3,220,000	$0
60	MEDICAL FI MISCELLANEOUS EXPENSES	$2,392,000	$1,602,000	$790,000	$0
61	MEDICAL FI CHANGE ORDERS	$544,000	$408,000	$136,000	$0
62	MEDICAL FI OPTIONAL CONTRACTUAL SERVICES	$1,679,000	$1,511,100	$167,900	$0

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2018-19

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	DHCS-MEDICAL FI				
111	MEDICAL FI SRP RELEASE 1 HOSTING	$8,450,000	$7,221,300	$1,228,700	$0
	DHCS-MEDICAL FI SUBTOTAL	**$164,940,000**	**$118,360,150**	**$46,579,850**	**$0**
	DHCS-HEALTH CARE OPT				
63	HCO COST REIMBURSEMENT	$13,582,000	$7,049,780	$6,532,220	$0
64	HCO OPERATIONS	$9,103,000	$4,723,640	$4,379,360	$0
65	HCO - ENROLLMENT CONTRACTOR COSTS	$5,638,000	$2,926,160	$2,711,840	$0
66	HCO ESR HOURLY REIMBURSEMENT	$4,824,000	$2,503,580	$2,320,420	$0
67	HCO CCI - CAL MEDICONNECT AND MLTSS	$4,816,000	$2,408,000	$2,408,000	$0
68	HCO TAKEOVER	$5,231,000	$2,615,500	$2,615,500	$0
69	HCO TURNOVER	$1,436,000	$718,000	$718,000	$0
70	HCO OPERATIONS 2017 CONTRACT	$27,935,000	$14,498,360	$13,436,640	$0
71	HCO COST REIMBURSEMENT 2017 CONTRACT	$27,040,000	$14,033,760	$13,006,240	$0
72	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	$9,304,000	$4,828,700	$4,475,300	$0
	DHCS-HEALTH CARE OPT SUBTOTAL	**$108,909,000**	**$56,305,480**	**$52,603,520**	**$0**
	DHCS-DENTAL FI				
74	DENTAL FI TAKEOVER 2016 CONTRACT	$5,856,000	$4,392,000	$1,464,000	$0
75	DENTAL ASO ADMINISTRATION 2016 CONTRACT	$38,138,000	$24,305,750	$13,832,250	$0
78	DENTAL FI ADMINISTRATION 2016 CONTRACT	$20,505,000	$15,066,000	$5,439,000	$0
79	DENTAL ASO TAKEOVER 2016 CONTRACT	$939,000	$704,250	$234,750	$0
80	DENTAL FI CD-MMIS COSTS	$1,279,000	$959,250	$319,750	$0
81	DENTAL BENEFICIARY OUTREACH & ED PROGRAM - ADMIN	$1,895,000	$947,500	$947,500	$0
	DHCS-DENTAL FI SUBTOTAL	**$68,612,000**	**$46,374,750**	**$22,237,250**	**$0**
	OTHER DEPARTMENTS				
87	PERSONAL CARE SERVICES	$393,693,000	$393,693,000	$0	$0

SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2018-19

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER DEPARTMENTS				
88	HEALTH-RELATED ACTIVITIES - CDSS	$330,365,000	$330,365,000	$0	$0
89	CALHEERS DEVELOPMENT	$126,987,000	$100,684,830	$26,302,170	$0
90	CDDS ADMINISTRATIVE COSTS	$52,686,000	$52,686,000	$0	$0
91	MATERNAL AND CHILD HEALTH	$37,555,000	$37,555,000	$0	$0
92	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	$41,379,000	$41,379,000	$0	$0
93	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$31,853,000	$31,853,000	$0	$0
94	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	$14,195,000	$10,788,000	$0	$3,407,000
96	CLPP CASE MANAGEMENT SERVICES	$4,200,000	$4,200,000	$0	$0
97	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$4,279,000	$4,279,000	$0	$0
98	VITAL RECORDS DATA	$922,000	$922,000	$0	$0
99	CALIFORNIA SMOKERS' HELPLINE	$2,200,000	$2,200,000	$0	$0
100	KIT FOR NEW PARENTS	$1,119,000	$1,119,000	$0	$0
101	VETERANS BENEFITS	$1,100,000	$1,100,000	$0	$0
102	CHHS AGENCY HIPAA FUNDING	$849,000	$849,000	$0	$0
103	MEDI-CAL INPATIENT SERVICES FOR INMATES	$813,000	$813,000	$0	$0
104	CDPH I&E PROGRAM AND EVALUATION	$562,000	$562,000	$0	$0
105	MERIT SYSTEM SERVICES FOR COUNTIES	$194,000	$97,000	$97,000	$0
107	PIA EYEWEAR COURIER SERVICE	$341,000	$170,500	$170,500	$0
	OTHER DEPARTMENTS SUBTOTAL	**$1,045,292,000**	**$1,015,315,330**	**$26,569,670**	**$3,407,000**
	GRAND TOTAL	**$2,518,889,000**	**$2,059,627,670**	**$453,906,330**	**$5,355,000**

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2018 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	2017-18 APPROPRIATION TOTAL FUNDS	2017-18 APPROPRIATION GENERAL FUNDS	NOV. 2017 EST. FOR 2017-18 TOTAL FUNDS	NOV. 2017 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	DIFF. MAY TO APPROPRIATION TOTAL FUNDS	DIFF. MAY TO APPROPRIATION GENERAL FUNDS	DIFFERENCE MAY TO NOVEMBER TOTAL FUNDS	DIFFERENCE MAY TO NOVEMBER GENERAL FUNDS
		DHCS-OTHER										
1	1	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	$495,234,000	$0	$268,836,000	$53,242,000	$149,215,000	$8,867,000	($346,019,000)	$8,867,000	($119,621,000)	($44,375,000)
2	2	CCS CASE MANAGEMENT	$196,000,000	$66,690,000	$194,938,000	$66,662,460	$194,938,000	$66,662,210	($1,062,000)	($27,790)	$0	($250)
4	4	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$115,824,000	$121,000	$103,229,000	$0	$126,718,000	$0	$10,894,000	($121,000)	$23,489,000	$0
5	5	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	$76,169,000	$0	$100,730,000	$11,000	$110,634,000	$11,000	$34,465,000	$11,000	$9,904,000	$0
6	6	EPSDT CASE MANAGEMENT	$33,962,000	$12,115,250	$33,962,000	$12,115,250	$33,962,000	$11,957,000	$0	($158,250)	$0	($158,250)
7	7	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	$33,704,000	$8,166,720	$30,197,000	$6,467,560	$26,726,000	$5,766,800	($6,978,000)	($2,399,920)	($3,471,000)	($700,760)
8	8	SMH MAA	$32,512,000	$0	$29,094,000	$0	$31,851,000	$0	($661,000)	$0	$2,757,000	$0
9	9	ARRA HITECH INCENTIVE PROGRAM	$18,729,000	$0	$25,525,000	$0	$17,596,000	$0	($1,133,000)	$0	($7,929,000)	$0
10	10	MANAGED CARE REGULATIONS - MENTAL HEALTH	$27,792,000	$9,264,000	$24,005,000	$8,000,000	$5,801,000	$1,933,000	($21,991,000)	($7,331,000)	($18,204,000)	($6,067,000)
11	11	SMHS COUNTY UR & QA ADMIN	$20,876,000	$415,000	$23,773,000	$348,000	$25,855,000	$265,000	$4,979,000	($150,000)	$2,082,000	($83,000)
13	13	PAVE SYSTEM	$18,562,000	$2,686,150	$20,588,000	$7,879,600	$14,587,000	$3,873,100	($3,975,000)	$1,186,950	($6,001,000)	($4,006,500)
14	14	POSTAGE & PRINTING	$19,820,000	$10,002,500	$20,586,000	$10,421,000	$20,586,000	$10,421,000	$766,000	$418,500	$0	$0
15	15	ACTUARIAL COSTS FOR RATE DEVELOPMENT	$16,872,000	$8,119,000	$16,872,000	$8,119,000	$16,872,000	$8,119,000	$0	$0	$0	$0
16	16	PASRR	$11,699,000	$2,924,750	$12,200,000	$3,050,000	$11,783,000	$2,945,750	$84,000	$21,000	($417,000)	($104,250)
17	17	MIS/DSS CONTRACT	$11,379,000	$3,013,750	$11,379,000	$3,013,750	$11,379,000	$3,013,750	$0	$0	$0	$0
18	18	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
19	19	SURS AND MARS SYSTEM REPLACEMENT	$10,790,000	$1,977,050	$10,790,000	$1,977,050	$10,090,000	$1,802,050	($700,000)	($175,000)	($700,000)	($175,000)
20	20	MEDI-CAL RECOVERY CONTRACTS	$10,218,000	$2,554,500	$10,187,000	$2,546,750	$9,475,000	$2,368,750	($743,000)	($185,750)	($712,000)	($178,000)
21	21	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
22	22	NEWBORN HEARING SCREENING PROGRAM	$7,800,000	$3,900,000	$8,845,000	$4,422,500	$7,700,000	$3,850,000	($100,000)	($50,000)	($1,145,000)	($572,500)
23	23	HIPAA CAPITATION PAYMENT REPORTING SYSTEM	$4,931,000	$1,232,750	$7,094,000	$1,773,500	$6,677,000	$1,669,250	$1,746,000	$436,500	($417,000)	($104,250)
24	24	DMC COUNTY UR & QA ADMIN	$6,156,000	$0	$6,278,000	$0	$190,000	$0	($5,966,000)	$0	($6,088,000)	$0
25	25	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$5,291,000	$1,389,750	$5,000,000	$1,328,500	$5,000,000	$1,328,500	($291,000)	($61,250)	$0	$0
26	26	CLINICAL DATA COLLECTION	$4,000,000	$475,000	$3,531,000	$409,350	$3,094,000	$353,200	($906,000)	($121,800)	($437,000)	($56,150)
27	27	DRUG MEDI-CAL COUNTY ADMINISTRATION	$3,310,000	$0	$3,248,000	$0	$6,356,000	$269,000	$3,046,000	$269,000	$3,108,000	$269,000
28	28	MEDICARE BENEFICIARY IDENTIFIER	$1,280,000	$128,000	$2,618,000	$261,800	$1,862,000	$186,200	$582,000	$58,200	($756,000)	($75,600)

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2018 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	2017-18 APPROPRIATION TOTAL FUNDS	2017-18 APPROPRIATION GENERAL FUNDS	NOV. 2017 EST. FOR 2017-18 TOTAL FUNDS	NOV. 2017 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	DIFF. MAY TO APPROPRIATION TOTAL FUNDS	DIFF. MAY TO APPROPRIATION GENERAL FUNDS	DIFFERENCE MAY TO NOVEMBER TOTAL FUNDS	DIFFERENCE MAY TO NOVEMBER GENERAL FUNDS
		DHCS-OTHER										
29	29	ELECTRONIC ASSET VERIFICATION PROGRAM	$2,416,000	$1,208,000	$2,416,000	$1,208,000	$1,164,000	$582,000	($1,252,000)	($626,000)	($1,252,000)	($626,000)
30	30	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
31	31	CA-MMIS MEDCOMPASS SOLUTION	$1,803,000	$262,500	$2,252,000	$327,500	$2,252,000	$327,500	$449,000	$65,000	$0	$0
32	32	MITA	$2,750,000	$275,000	$2,206,000	$220,600	$2,772,000	$277,200	$22,000	$2,200	$566,000	$56,600
33	33	MEDS MODERNIZATION	$0	$0	$2,015,000	$266,750	$2,015,000	$266,750	$2,015,000	$266,750	$0	$0
34	34	SSA COSTS FOR HEALTH COVERAGE INFO.	$1,500,000	$750,000	$1,600,000	$800,000	$2,120,000	$1,060,000	$620,000	$310,000	$520,000	$260,000
35	35	CALIFORNIA HEALTH INTERVIEW SURVEY	$1,000,000	$0	$1,272,000	$0	$1,272,000	$0	$272,000	$0	$0	$0
36	36	FAMILY PACT PROGRAM ADMIN.	$1,207,000	$603,500	$1,207,000	$603,500	$1,207,000	$603,500	$0	$0	$0	$0
37	37	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES	$950,000	$950,000	$950,000	$950,000	$950,000	$950,000	$0	$0	$0	$0
38	38	MMA - DSH ANNUAL INDEPENDENT AUDIT	$899,000	$449,500	$888,000	$444,000	$888,000	$444,000	($11,000)	($5,500)	$0	$0
39	39	ENCRYPTION OF PHI DATA	$750,000	$375,000	$750,000	$375,000	$750,000	$375,000	$0	$0	$0	$0
40	40	POSTAGE AND PRINTING - THIRD PARTY LIAB.	$740,000	$370,000	$734,000	$367,000	$728,000	$364,000	($12,000)	($6,000)	($6,000)	($3,000)
41	41	IRS REPORTING FOR MIN. ESSENTIAL COVERAGE	$1,024,000	$512,000	$592,000	$296,000	$340,000	$170,000	($684,000)	($342,000)	($252,000)	($126,000)
42	42	T-MSIS	$334,000	$83,500	$431,000	$107,750	$418,000	$104,500	$84,000	$21,000	($13,000)	($3,250)
43	43	VENDOR FOR AAC RATE STUDY	$325,000	$162,500	$390,000	$195,000	$386,000	$193,000	$61,000	$30,500	($4,000)	($2,000)
44	44	CCT OUTREACH - ADMINISTRATIVE COSTS	$348,000	$0	$342,000	$0	$342,000	$0	($6,000)	$0	$0	$0
45	45	MEDICARE BUY-IN QUALITY REVIEW PROJECT	$200,000	$100,000	$200,000	$100,000	$100,000	$50,000	($100,000)	($50,000)	($100,000)	($50,000)
46	46	STATE CONTROLLER'S OFFICE INTERAGENCY AGREEMENT	$173,000	$43,250	$173,000	$43,250	$4,000	$1,000	($169,000)	($42,250)	($169,000)	($42,250)
47	47	DENTAL PAPD PROJECT MANAGER	$125,000	$31,250	$125,000	$31,250	$161,000	$40,250	$36,000	$9,000	$36,000	$9,000
48	48	CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT	$100,000	$0	$100,000	$0	$100,000	$0	$0	$0	$0	$0
49	49	TAR POSTAGE	$54,000	$27,000	$52,000	$26,000	$32,000	$16,000	($22,000)	($11,000)	($20,000)	($10,000)
50	50	ENROLLMENT ASSIST FOR BHT INSTITUTIONALLY DEEMED	$0	$0	$43,000	$21,500	$43,000	$21,500	$43,000	$21,500	$0	$0
55	55	INTERIM AND FINAL COST SETTLEMENTS-SMHS	($25,692,000)	$0	($35,823,000)	$0	($2,688,000)	$0	$23,004,000	$0	$33,135,000	$0
3	--	MH/UCD & BTR -LIHP - ADMINISTRATIVE COSTS	$119,816,000	$0	$119,816,000	$0	$0	$0	($119,816,000)	$0	($119,816,000)	$0
12	--	PERFORMANCE OUTCOMES SYSTEM	$14,952,000	$6,190,000	$13,783,000	$6,227,000	$0	$0	($14,952,000)	($6,190,000)	($13,783,000)	($6,227,000)

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2018 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	2017-18 APPROPRIATION TOTAL FUNDS	2017-18 APPROPRIATION GENERAL FUNDS	NOV. 2017 EST. FOR 2017-18 TOTAL FUNDS	NOV. 2017 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	DIFF. MAY TO APPROPRIATION TOTAL FUNDS	DIFF. MAY TO APPROPRIATION GENERAL FUNDS	DIFFERENCE MAY TO NOVEMBER TOTAL FUNDS	DIFFERENCE MAY TO NOVEMBER GENERAL FUNDS
		DHCS-OTHER										
54	--	TITLE XXI FEDERAL MATCH REDUCTION OTHER ADMIN	($1,927,000)	$9,793,000	($3,099,000)	$9,764,570	$0	$0	$1,927,000	($9,793,000)	$3,099,000	($9,764,570)
--	--	MEDICAL INTERPRETERS	$5,205,000	$2,602,500	$0	$0	$0	$0	($5,205,000)	($2,602,500)	$0	$0
		DHCS-OTHER SUBTOTAL	**$1,335,480,000**	**$171,722,670**	**$1,110,438,000**	**$226,182,740**	**$887,821,000**	**$153,266,760**	**($447,659,000)**	**($18,455,910)**	**($222,617,000)**	**($72,915,980)**
		DHCS-MEDICAL FI										
56	56	MEDICAL FI OPERATIONS	$93,135,000	$30,236,000	$81,248,000	$26,095,250	$79,012,000	$25,401,500	($14,123,000)	($4,834,500)	($2,236,000)	($693,750)
57	57	MEDICAL FI COST REIMBURSEMENT	$35,664,000	$10,301,500	$41,090,000	$10,830,150	$42,390,000	$11,068,050	$6,726,000	$766,550	$1,300,000	$237,900
58	58	MEDICAL FI HOURLY REIMBURSEMENT	$27,546,000	$5,986,500	$27,546,000	$5,986,500	$27,546,000	$5,986,500	$0	$0	$0	$0
59	59	MEDICAL FI OTHER ESTIMATED COSTS	$11,280,000	$3,270,000	$11,280,000	$3,270,000	$11,080,000	$3,220,000	($200,000)	($50,000)	($200,000)	($50,000)
60	60	MEDICAL FI MISCELLANEOUS EXPENSES	$2,075,000	$674,750	$2,440,000	$766,000	$2,445,000	$767,250	$370,000	$92,500	$5,000	$1,250
61	61	MEDICAL FI CHANGE ORDERS	$515,000	$128,750	$464,000	$116,000	$536,000	$134,000	$21,000	$5,250	$72,000	$18,000
111	111	MEDICAL FI SRP RELEASE 1 HOSTING	$0	$0	$7,042,000	$1,023,700	$7,042,000	$1,023,700	$7,042,000	$1,023,700	$0	$0
--	114	MEDICAL FI TURNOVER	$0	$0	$0	$0	$600,000	$193,500	$600,000	$193,500	$600,000	$193,500
--	--	MEDICAL FI OPTIONAL CONTRACTUAL SERVICES	$804,000	$80,400	$0	$0	$0	$0	($804,000)	($80,400)	$0	$0
		DHCS-MEDICAL FI SUBTOTAL	**$171,019,000**	**$50,677,900**	**$171,110,000**	**$48,087,600**	**$170,651,000**	**$47,794,500**	**($368,000)**	**($2,883,400)**	**($459,000)**	**($293,100)**
		DHCS-HEALTH CARE OPT										
63	63	HCO COST REIMBURSEMENT	$44,849,000	$21,571,400	$44,189,000	$21,254,320	$44,189,000	$21,254,320	($660,000)	($317,080)	$0	$0
64	64	HCO OPERATIONS	$40,650,000	$19,553,980	$44,074,000	$21,201,380	$29,179,000	$14,036,980	($11,471,000)	($5,517,000)	($14,895,000)	($7,164,400)
65	65	HCO - ENROLLMENT CONTRACTOR COSTS	$16,518,000	$7,945,120	$17,990,000	$8,653,380	$17,990,000	$8,653,380	$1,472,000	$708,260	$0	$0
66	66	HCO ESR HOURLY REIMBURSEMENT	$14,318,000	$6,886,920	$15,580,000	$7,493,980	$15,580,000	$7,493,980	$1,262,000	$607,060	$0	$0
67	67	HCO CCI - CAL MEDICONNECT AND MLTSS	$14,200,000	$7,100,000	$15,269,000	$7,634,500	$15,269,000	$7,634,500	$1,069,000	$534,500	$0	$0
68	68	HCO TAKEOVER	$3,664,000	$1,832,000	$2,769,000	$1,384,500	$2,769,000	$1,384,500	($895,000)	($447,500)	$0	$0
69	69	HCO TURNOVER	$865,000	$432,500	$932,000	$466,000	$522,000	$261,000	($343,000)	($171,500)	($410,000)	($205,000)
		DHCS-HEALTH CARE OPT SUBTOTAL	**$135,064,000**	**$65,321,920**	**$140,803,000**	**$68,088,060**	**$125,498,000**	**$60,718,660**	**($9,566,000)**	**($4,603,260)**	**($15,305,000)**	**($7,369,400)**

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2018 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	2017-18 APPROPRIATION TOTAL FUNDS	2017-18 APPROPRIATION GENERAL FUNDS	NOV. 2017 EST. FOR 2017-18 TOTAL FUNDS	NOV. 2017 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	DIFF. MAY TO APPROPRIATION TOTAL FUNDS	DIFF. MAY TO APPROPRIATION GENERAL FUNDS	DIFFERENCE MAY TO NOVEMBER TOTAL FUNDS	DIFFERENCE MAY TO NOVEMBER GENERAL FUNDS
		DHCS-DENTAL FI										
73	73	DENTAL FI OPERATIONS	$52,000,000	$17,250,000	$68,813,000	$22,755,750	$57,261,000	$19,912,250	$5,261,000	$2,662,250	($11,552,000)	($2,843,500)
74	74	DENTAL FI TAKEOVER 2016 CONTRACT	$15,616,000	$3,904,000	$23,424,000	$5,856,000	$23,424,000	$5,856,000	$7,808,000	$1,952,000	$0	$0
75	75	DENTAL ASO ADMINISTRATION 2016 CONTRACT	$18,953,000	$6,827,500	$12,700,000	$4,642,750	$12,303,000	$4,552,250	($6,650,000)	($2,275,250)	($397,000)	($90,500)
76	76	DENTAL FI HOURLY REIMBURSEMENT	$8,004,000	$2,001,000	$8,748,000	$2,187,000	$6,604,000	$1,651,000	($1,400,000)	($350,000)	($2,144,000)	($536,000)
77	77	DENTAL FI COST REIMBURSEMENT	$5,638,000	$2,625,250	$8,016,000	$3,839,000	$7,492,000	$3,650,000	$1,854,000	$1,024,750	($524,000)	($189,000)
78	78	DENTAL FI ADMINISTRATION 2016 CONTRACT	$10,598,000	$2,977,000	$7,300,000	$2,019,500	$6,794,000	$1,800,000	($3,804,000)	($1,177,000)	($506,000)	($219,500)
79	79	DENTAL ASO TAKEOVER 2016 CONTRACT	$2,947,000	$736,750	$4,420,000	$1,105,000	$3,756,000	$939,000	$809,000	$202,250	($664,000)	($166,000)
80	80	DENTAL FI CD-MMIS COSTS	$2,196,000	$549,000	$2,331,000	$582,750	$656,000	$164,000	($1,540,000)	($385,000)	($1,675,000)	($418,750)
81	81	DENTAL BENEFICIARY OUTREACH & ED PROGRAM - ADMIN	$4,133,000	$2,066,500	$1,779,000	$889,500	$1,893,000	$946,500	($2,240,000)	($1,120,000)	$114,000	$57,000
83	83	DENTAL FI FEDERAL RULE - REVALIDATION	$210,000	$105,000	$254,000	$127,000	$200,000	$100,000	($10,000)	($5,000)	($54,000)	($27,000)
84	84	DENTAL FI FEDERAL RULE - DATABASE CHECKS	$175,000	$87,500	$227,000	$113,500	$215,000	$107,500	$40,000	$20,000	($12,000)	($6,000)
85	85	DENTAL FI CONLAN, SCHWARZMER, STEVENS V. BONTA	$134,000	$67,000	$179,000	$89,500	$196,000	$98,000	$62,000	$31,000	$17,000	$8,500
86	86	DENTAL FI HIPAA ADDENDUM SECURITY RISK ASSESSMENT	$137,000	$34,250	$174,000	$43,500	$167,000	$41,750	$30,000	$7,500	($7,000)	($1,750)
82	--	DENTAL TREATMENT AUTHORIZATION REQUEST PROCESSING	$2,044,000	$874,500	$1,629,000	$650,250	$0	$0	($2,044,000)	($874,500)	($1,629,000)	($650,250)
		DHCS-DENTAL FI SUBTOTAL	**$122,785,000**	**$40,105,250**	**$139,994,000**	**$44,901,000**	**$120,961,000**	**$39,818,250**	**($1,824,000)**	**($287,000)**	**($19,033,000)**	**($5,082,750)**
		OTHER DEPARTMENTS										
87	87	PERSONAL CARE SERVICES	$371,080,000	$0	$421,326,000	$0	$385,201,000	$0	$14,121,000	$0	($36,125,000)	$0
88	88	HEALTH-RELATED ACTIVITIES - CDSS	$277,756,000	$0	$299,589,000	$0	$274,418,000	$0	($3,338,000)	$0	($25,171,000)	$0
89	89	CALHEERS DEVELOPMENT	$120,477,000	$23,413,020	$125,682,000	$26,008,790	$125,682,000	$26,008,790	$5,205,000	$2,595,770	$0	$0
90	90	CDDS ADMINISTRATIVE COSTS	$57,301,000	$0	$52,239,000	$0	$53,471,000	$0	($3,830,000)	$0	$1,232,000	$0
91	91	MATERNAL AND CHILD HEALTH	$35,201,000	$0	$35,201,000	$0	$36,945,000	$0	$1,744,000	$0	$1,744,000	$0
92	92	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	$29,829,000	$0	$29,829,000	$0	$41,379,000	$0	$11,550,000	$0	$11,550,000	$0
93	93	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$28,553,000	$0	$37,029,000	$0	$19,640,000	$0	($8,913,000)	$0	($17,389,000)	$0
94	94	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	$14,645,000	$0	$15,145,000	$0	$14,395,000	$0	($250,000)	$0	($750,000)	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2018 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2017-18

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	2017-18 APPROPRIATION TOTAL FUNDS	2017-18 APPROPRIATION GENERAL FUNDS	NOV. 2017 EST. FOR 2017-18 TOTAL FUNDS	NOV. 2017 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	DIFF. MAY TO APPROPRIATION TOTAL FUNDS	DIFF. MAY TO APPROPRIATION GENERAL FUNDS	DIFFERENCE MAY TO NOVEMBER TOTAL FUNDS	DIFFERENCE MAY TO NOVEMBER GENERAL FUNDS
		OTHER DEPARTMENTS										
95	95	ACA OUTREACH AND ENROLLMENT COUNSELORS	$11,711,000	$0	$11,442,000	$0	$11,442,000	$0	($269,000)	$0	$0	$0
96	96	CLPP CASE MANAGEMENT SERVICES	$4,200,000	$0	$5,355,000	$0	$5,355,000	$0	$1,155,000	$0	$0	$0
97	97	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$4,116,000	$0	$4,093,000	$0	$4,093,000	$0	($23,000)	$0	$0	$0
98	98	VITAL RECORDS DATA	$961,000	$0	$1,668,000	$0	$1,632,000	$0	$671,000	$0	($36,000)	$0
99	99	CALIFORNIA SMOKERS' HELPLINE	$1,000,000	$0	$1,321,000	$0	$1,373,000	$0	$373,000	$0	$52,000	$0
100	100	KIT FOR NEW PARENTS	$1,119,000	$0	$1,119,000	$0	$1,119,000	$0	$0	$0	$0	$0
101	101	VETERANS BENEFITS	$956,000	$0	$1,100,000	$0	$1,100,000	$0	$144,000	$0	$0	$0
102	102	CHHS AGENCY HIPAA FUNDING	$849,000	$0	$849,000	$0	$849,000	$0	$0	$0	$0	$0
103	103	MEDI-CAL INPATIENT SERVICES FOR INMATES	$813,000	$0	$813,000	$0	$813,000	$0	$0	$0	$0	$0
104	104	CDPH I&E PROGRAM AND EVALUATION	$558,000	$0	$752,000	$0	$566,000	$0	$8,000	$0	($186,000)	$0
105	105	MERIT SYSTEM SERVICES FOR COUNTIES	$194,000	$97,000	$194,000	$97,000	$194,000	$97,000	$0	$0	$0	$0
106	106	CDDS DENTAL SERVICES - ADMIN	$120,000	$0	$62,000	$0	$67,000	$0	($53,000)	$0	$5,000	$0
107	107	PIA EYEWEAR COURIER SERVICE	$341,000	$170,500	$341,000	$170,500	$341,000	$170,500	$0	$0	$0	$0
		OTHER DEPARTMENTS SUBTOTAL	**$961,780,000**	**$23,680,520**	**$1,045,149,000**	**$26,276,290**	**$980,075,000**	**$26,276,290**	**$18,295,000**	**$2,595,770**	**($65,074,000)**	**$0**
		OTHER ADMINISTRATION TOTAL	**$2,726,128,000**	**$351,508,260**	**$2,607,494,000**	**$413,535,690**	**$2,285,006,000**	**$327,874,460**	**($441,122,000)**	**($23,633,800)**	**($322,488,000)**	**($85,661,230)**
		GRAND TOTAL COUNTY AND OTHER ADMINISTRATION	**$4,997,575,000**	**$1,115,098,760**	**$4,876,682,000**	**$1,191,716,690**	**$4,516,251,000**	**$1,349,895,460**	**($481,324,000)**	**$234,796,700**	**($360,431,000)**	**$158,178,770**

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2018 ESTIMATE COMPARED TO NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2018-19

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2017 EST. FOR 2018-19		MAY 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DHCS-OTHER						
1	1	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	$258,096,000	$163,399,000	$154,118,000	$136,412,000	($103,978,000)	($26,987,000)
2	2	CCS CASE MANAGEMENT	$183,544,000	$60,137,620	$190,884,000	$63,819,120	$7,340,000	$3,681,500
--	3	MH/UCD & BTR -LIHP - ADMINISTRATIVE COSTS	$0	$0	$119,816,000	$0	$119,816,000	$0
4	4	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$106,250,000	$0	$130,354,000	$0	$24,104,000	$0
5	5	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	$77,066,000	$0	$95,200,000	$1,118,000	$18,134,000	$1,118,000
6	6	EPSDT CASE MANAGEMENT	$33,962,000	$12,115,250	$33,962,000	$11,957,000	$0	($158,250)
7	7	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	$35,601,000	$9,190,840	$32,835,000	$8,767,720	($2,766,000)	($423,120)
8	8	SMH MAA	$32,293,000	$0	$33,834,000	$0	$1,541,000	$0
9	9	ARRA HITECH INCENTIVE PROGRAM	$11,276,000	$0	$27,180,000	$0	$15,904,000	$0
10	10	MANAGED CARE REGULATIONS - MENTAL HEALTH	$22,757,000	$7,584,000	$22,507,000	$7,502,000	($250,000)	($82,000)
11	11	SMHS COUNTY UR & QA ADMIN	$26,162,000	$948,000	$28,667,000	$953,000	$2,505,000	$5,000
12	12	PERFORMANCE OUTCOMES SYSTEM	$16,137,000	$6,953,250	$14,321,000	$6,414,250	($1,816,000)	($539,000)
13	13	PAVE SYSTEM	$15,988,000	$7,129,300	$14,511,000	$7,675,500	($1,477,000)	$546,200
14	14	POSTAGE & PRINTING	$21,586,000	$10,921,000	$26,786,000	$13,521,000	$5,200,000	$2,600,000
15	15	ACTUARIAL COSTS FOR RATE DEVELOPMENT	$16,872,000	$8,119,000	$16,872,000	$8,119,000	$0	$0
16	16	PASRR	$12,706,000	$3,176,500	$12,706,000	$3,176,500	$0	$0
17	17	MIS/DSS CONTRACT	$11,331,000	$3,004,750	$11,331,000	$3,004,750	$0	$0
18	18	CCI-ADMINISTRATIVE COSTS	$11,213,000	$5,606,500	$11,213,000	$5,606,500	$0	$0
19	19	SURS AND MARS SYSTEM REPLACEMENT	$9,077,000	$2,086,250	$9,077,000	$2,086,250	$0	$0
20	20	MEDI-CAL RECOVERY CONTRACTS	$9,884,000	$2,471,000	$9,339,000	$2,334,750	($545,000)	($136,250)
21	21	LITIGATION RELATED SERVICES	$9,980,000	$4,990,000	$9,980,000	$4,990,000	$0	$0
22	22	NEWBORN HEARING SCREENING PROGRAM	$7,825,000	$3,912,500	$8,225,000	$4,112,500	$400,000	$200,000

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2018 ESTIMATE COMPARED TO NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2018-19

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2017 EST. FOR 2018-19		MAY 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DHCS-OTHER						
23	23	HIPAA CAPITATION PAYMENT REPORTING SYSTEM	$5,488,000	$1,372,000	$5,488,000	$1,372,000	$0	$0
24	24	DMC COUNTY UR & QA ADMIN	$15,934,000	$0	$5,811,000	$0	($10,123,000)	$0
25	25	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$5,000,000	$1,328,500	$5,000,000	$1,328,500	$0	$0
26	26	CLINICAL DATA COLLECTION	$2,130,000	$288,000	$2,474,000	$322,400	$344,000	$34,400
27	27	DRUG MEDI-CAL COUNTY ADMINISTRATION	$3,248,000	$0	$27,767,000	$373,000	$24,519,000	$373,000
28	28	MEDICARE BENEFICIARY IDENTIFIER	$1,578,000	$157,800	$1,636,000	$163,600	$58,000	$5,800
29	29	ELECTRONIC ASSET VERIFICATION PROGRAM	$3,328,000	$1,664,000	$3,328,000	$1,664,000	$0	$0
30	30	SDMC SYSTEM M&O SUPPORT	$2,325,000	$1,162,500	$2,325,000	$1,162,500	$0	$0
31	31	CA-MMIS MEDCOMPASS SOLUTION	$1,576,000	$229,300	$1,576,000	$229,300	$0	$0
32	32	MITA	$2,733,000	$273,300	$5,274,000	$527,400	$2,541,000	$254,100
34	34	SSA COSTS FOR HEALTH COVERAGE INFO.	$1,500,000	$750,000	$1,500,000	$750,000	$0	$0
35	35	CALIFORNIA HEALTH INTERVIEW SURVEY	$1,100,000	$0	$1,100,000	$0	$0	$0
36	36	FAMILY PACT PROGRAM ADMIN.	$1,207,000	$603,500	$1,207,000	$603,500	$0	$0
37	37	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES	$950,000	$950,000	$950,000	$950,000	$0	$0
38	38	MMA - DSH ANNUAL INDEPENDENT AUDIT	$926,000	$463,000	$926,000	$463,000	$0	$0
39	39	ENCRYPTION OF PHI DATA	$750,000	$375,000	$750,000	$375,000	$0	$0
40	40	POSTAGE AND PRINTING - THIRD PARTY LIAB.	$708,000	$354,000	$696,000	$348,000	($12,000)	($6,000)
41	41	IRS REPORTING FOR MIN. ESSENTIAL COVERAGE	$432,000	$216,000	$684,000	$342,000	$252,000	$126,000
42	42	T-MSIS	$270,000	$67,500	$276,000	$69,000	$6,000	$1,500
43	43	VENDOR FOR AAC RATE STUDY	$327,000	$163,500	$332,000	$166,000	$5,000	$2,500
44	44	CCT OUTREACH - ADMINISTRATIVE COSTS	$342,000	$0	$342,000	$0	$0	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2018 ESTIMATE COMPARED TO NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2018-19

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2017 EST. FOR 2018-19		MAY 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DHCS-OTHER						
45	45	MEDICARE BUY-IN QUALITY REVIEW PROJECT	$200,000	$100,000	$300,000	$150,000	$100,000	$50,000
48	48	CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT	$100,000	$0	$100,000	$0	$0	$0
49	49	TAR POSTAGE	$52,000	$26,000	$32,000	$16,000	($20,000)	($10,000)
--	55	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$0	$0	$26,745,000	$0	$26,745,000	$0
109	109	MANAGED CARE REGULATIONS - MH PARITY	$21,284,000	$3,040,000	$20,799,000	$2,971,000	($485,000)	($69,000)
54	--	TITLE XXI FEDERAL MATCH REDUCTION OTHER ADMIN	($3,574,000)	$12,286,060	$0	$0	$3,574,000	($12,286,060)
		DHCS-OTHER SUBTOTAL	**$999,520,000**	**$337,614,720**	**$1,131,136,000**	**$305,916,040**	**$131,616,000**	**($31,698,680)**
		DHCS-MEDICAL FI						
56	56	MEDICAL FI OPERATIONS	$79,177,000	$25,369,500	$77,098,000	$24,731,750	($2,079,000)	($637,750)
57	57	MEDICAL FI COST REIMBURSEMENT	$36,004,000	$10,404,750	$36,151,000	$10,319,000	$147,000	($85,750)
58	58	MEDICAL FI HOURLY REIMBURSEMENT	$27,546,000	$5,986,500	$27,546,000	$5,986,500	$0	$0
59	59	MEDICAL FI OTHER ESTIMATED COSTS	$11,280,000	$3,270,000	$11,080,000	$3,220,000	($200,000)	($50,000)
60	60	MEDICAL FI MISCELLANEOUS EXPENSES	$2,440,000	$766,000	$2,392,000	$790,000	($48,000)	$24,000
61	61	MEDICAL FI CHANGE ORDERS	$523,000	$130,750	$544,000	$136,000	$21,000	$5,250
62	62	MEDICAL FI OPTIONAL CONTRACTUAL SERVICES	$1,679,000	$167,900	$1,679,000	$167,900	$0	$0
111	111	MEDICAL FI SRP RELEASE 1 HOSTING	$8,450,000	$1,228,700	$8,450,000	$1,228,700	$0	$0
		DHCS-MEDICAL FI SUBTOTAL	**$167,099,000**	**$47,324,100**	**$164,940,000**	**$46,579,850**	**($2,159,000)**	**($744,250)**
		DHCS-HEALTH CARE OPT						
63	63	HCO COST REIMBURSEMENT	$13,582,000	$6,532,220	$13,582,000	$6,532,220	$0	$0
64	64	HCO OPERATIONS	$13,686,000	$6,583,840	$9,103,000	$4,379,360	($4,583,000)	($2,204,480)
65	65	HCO - ENROLLMENT CONTRACTOR COSTS	$5,638,000	$2,711,840	$5,638,000	$2,711,840	$0	$0
66	66	HCO ESR HOURLY REIMBURSEMENT	$4,824,000	$2,320,420	$4,824,000	$2,320,420	$0	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2018 ESTIMATE COMPARED TO NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2018-19

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2017 EST. FOR 2018-19		MAY 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DHCS-HEALTH CARE OPT						
67	67	HCO CCI - CAL MEDICONNECT AND MLTSS	$4,816,000	$2,408,000	$4,816,000	$2,408,000	$0	$0
68	68	HCO TAKEOVER	$5,231,000	$2,615,500	$5,231,000	$2,615,500	$0	$0
69	69	HCO TURNOVER	$2,564,000	$1,282,000	$1,436,000	$718,000	($1,128,000)	($564,000)
70	70	HCO OPERATIONS 2017 CONTRACT	$27,935,000	$13,436,640	$27,935,000	$13,436,640	$0	$0
71	71	HCO COST REIMBURSEMENT 2017 CONTRACT	$27,040,000	$13,006,240	$27,040,000	$13,006,240	$0	$0
72	72	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	$9,248,000	$4,448,440	$9,304,000	$4,475,300	$56,000	$26,860
		DHCS-HEALTH CARE OPT SUBTOTAL	**$114,564,000**	**$55,345,140**	**$108,909,000**	**$52,603,520**	**($5,655,000)**	**($2,741,620)**
		DHCS-DENTAL FI						
74	74	DENTAL FI TAKEOVER 2016 CONTRACT	$5,856,000	$1,464,000	$5,856,000	$1,464,000	$0	$0
75	75	DENTAL ASO ADMINISTRATION 2016 CONTRACT	$35,620,000	$13,168,500	$38,138,000	$13,832,250	$2,518,000	$663,750
78	78	DENTAL FI ADMINISTRATION 2016 CONTRACT	$18,788,000	$4,973,500	$20,505,000	$5,439,000	$1,717,000	$465,500
79	79	DENTAL ASO TAKEOVER 2016 CONTRACT	$1,105,000	$276,250	$939,000	$234,750	($166,000)	($41,500)
--	80	DENTAL FI CD-MMIS COSTS	$0	$0	$1,279,000	$319,750	$1,279,000	$319,750
81	81	DENTAL BENEFICIARY OUTREACH & ED PROGRAM - ADMIN	$1,781,000	$890,500	$1,895,000	$947,500	$114,000	$57,000
		DHCS-DENTAL FI SUBTOTAL	**$63,150,000**	**$20,772,750**	**$68,612,000**	**$22,237,250**	**$5,462,000**	**$1,464,500**
		OTHER DEPARTMENTS						
87	87	PERSONAL CARE SERVICES	$382,359,000	$0	$393,693,000	$0	$11,334,000	$0
88	88	HEALTH-RELATED ACTIVITIES - CDSS	$299,700,000	$0	$330,365,000	$0	$30,665,000	$0
89	89	CALHEERS DEVELOPMENT	$126,267,000	$26,135,040	$126,987,000	$26,302,170	$720,000	$167,130
90	90	CDDS ADMINISTRATIVE COSTS	$51,378,000	$0	$52,686,000	$0	$1,308,000	$0
91	91	MATERNAL AND CHILD HEALTH	$37,522,000	$0	$37,555,000	$0	$33,000	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2018 ESTIMATE COMPARED TO NOVEMBER 2017 ESTIMATE
FISCAL YEAR 2018-19

NOV. NO.	MAY NO.	POLICY CHANGE TITLE	NOV. 2017 EST. FOR 2018-19		MAY 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER DEPARTMENTS						
92	92	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	$29,829,000	$0	$41,379,000	$0	$11,550,000	$0
93	93	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$36,257,000	$0	$31,853,000	$0	($4,404,000)	$0
94	94	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	$14,945,000	$0	$14,195,000	$0	($750,000)	$0
96	96	CLPP CASE MANAGEMENT SERVICES	$4,200,000	$0	$4,200,000	$0	$0	$0
97	97	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$4,279,000	$0	$4,279,000	$0	$0	$0
98	98	VITAL RECORDS DATA	$874,000	$0	$922,000	$0	$48,000	$0
99	99	CALIFORNIA SMOKERS' HELPLINE	$2,200,000	$0	$2,200,000	$0	$0	$0
100	100	KIT FOR NEW PARENTS	$1,119,000	$0	$1,119,000	$0	$0	$0
101	101	VETERANS BENEFITS	$1,100,000	$0	$1,100,000	$0	$0	$0
102	102	CHHS AGENCY HIPAA FUNDING	$849,000	$0	$849,000	$0	$0	$0
103	103	MEDI-CAL INPATIENT SERVICES FOR INMATES	$813,000	$0	$813,000	$0	$0	$0
104	104	CDPH I&E PROGRAM AND EVALUATION	$827,000	$0	$562,000	$0	($265,000)	$0
105	105	MERIT SYSTEM SERVICES FOR COUNTIES	$194,000	$97,000	$194,000	$97,000	$0	$0
107	107	PIA EYEWEAR COURIER SERVICE	$341,000	$170,500	$341,000	$170,500	$0	$0
		OTHER DEPARTMENTS SUBTOTAL	**$995,053,000**	**$26,402,540**	**$1,045,292,000**	**$26,569,670**	**$50,239,000**	**$167,130**
		OTHER ADMINISTRATION TOTAL	**$2,339,386,000**	**$487,459,250**	**$2,518,889,000**	**$453,906,330**	**$179,503,000**	**($33,552,920)**
		GRAND TOTAL COUNTY AND OTHER ADMINISTRATION	**$4,697,397,000**	**$1,200,398,750**	**$4,837,149,000**	**$1,332,736,830**	**$139,752,000**	**$132,338,080**

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2017-18 AND 2018-19

NO.	POLICY CHANGE TITLE	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2018-19 TOTAL FUNDS	MAY 2018 EST. FOR 2018-19 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	DHCS-OTHER						
1	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	$149,215,000	$8,867,000	$154,118,000	$136,412,000	$4,903,000	$127,545,000
2	CCS CASE MANAGEMENT	$194,938,000	$66,662,210	$190,884,000	$63,819,120	($4,054,000)	($2,843,090)
3	MH/UCD & BTR -LIHP -ADMINISTRATIVE COSTS	$0	$0	$119,816,000	$0	$119,816,000	$0
4	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$126,718,000	$0	$130,354,000	$0	$3,636,000	$0
5	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	$110,634,000	$11,000	$95,200,000	$1,118,000	($15,434,000)	$1,107,000
6	EPSDT CASE MANAGEMENT	$33,962,000	$11,957,000	$33,962,000	$11,957,000	$0	$0
7	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	$26,726,000	$5,766,800	$32,835,000	$8,767,720	$6,109,000	$3,000,920
8	SMH MAA	$31,851,000	$0	$33,834,000	$0	$1,983,000	$0
9	ARRA HITECH INCENTIVE PROGRAM	$17,596,000	$0	$27,180,000	$0	$9,584,000	$0
10	MANAGED CARE REGULATIONS - MENTAL HEALTH	$5,801,000	$1,933,000	$22,507,000	$7,502,000	$16,706,000	$5,569,000
11	SMHS COUNTY UR & QA ADMIN	$25,855,000	$265,000	$28,667,000	$953,000	$2,812,000	$688,000
12	PERFORMANCE OUTCOMES SYSTEM	$0	$0	$14,321,000	$6,414,250	$14,321,000	$6,414,250
13	PAVE SYSTEM	$14,587,000	$3,873,100	$14,511,000	$7,675,500	($76,000)	$3,802,400
14	POSTAGE & PRINTING	$20,586,000	$10,421,000	$26,786,000	$13,521,000	$6,200,000	$3,100,000
15	ACTUARIAL COSTS FOR RATE DEVELOPMENT	$16,872,000	$8,119,000	$16,872,000	$8,119,000	$0	$0
16	PASRR	$11,783,000	$2,945,750	$12,706,000	$3,176,500	$923,000	$230,750
17	MIS/DSS CONTRACT	$11,379,000	$3,013,750	$11,331,000	$3,004,750	($48,000)	($9,000)
18	CCI-ADMINISTRATIVE COSTS	$11,213,000	$5,606,500	$11,213,000	$5,606,500	$0	$0
19	SURS AND MARS SYSTEM REPLACEMENT	$10,090,000	$1,802,050	$9,077,000	$2,086,250	($1,013,000)	$284,200
20	MEDI-CAL RECOVERY CONTRACTS	$9,475,000	$2,368,750	$9,339,000	$2,334,750	($136,000)	($34,000)
21	LITIGATION RELATED SERVICES	$9,980,000	$4,990,000	$9,980,000	$4,990,000	$0	$0
22	NEWBORN HEARING SCREENING PROGRAM	$7,700,000	$3,850,000	$8,225,000	$4,112,500	$525,000	$262,500
23	HIPAA CAPITATION PAYMENT REPORTING SYSTEM	$6,677,000	$1,669,250	$5,488,000	$1,372,000	($1,189,000)	($297,250)

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2017-18 AND 2018-19

NO.	POLICY CHANGE TITLE	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2018-19 TOTAL FUNDS	MAY 2018 EST. FOR 2018-19 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	DHCS-OTHER						
24	DMC COUNTY UR & QA ADMIN	$190,000	$0	$5,811,000	$0	$5,621,000	$0
25	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$5,000,000	$1,328,500	$5,000,000	$1,328,500	$0	$0
26	CLINICAL DATA COLLECTION	$3,094,000	$353,200	$2,474,000	$322,400	($620,000)	($30,800)
27	DRUG MEDI-CAL COUNTY ADMINISTRATION	$6,356,000	$269,000	$27,767,000	$373,000	$21,411,000	$104,000
28	MEDICARE BENEFICIARY IDENTIFIER	$1,862,000	$186,200	$1,636,000	$163,600	($226,000)	($22,600)
29	ELECTRONIC ASSET VERIFICATION PROGRAM	$1,164,000	$582,000	$3,328,000	$1,664,000	$2,164,000	$1,082,000
30	SDMC SYSTEM M&O SUPPORT	$2,325,000	$1,162,500	$2,325,000	$1,162,500	$0	$0
31	CA-MMIS MEDCOMPASS SOLUTION	$2,252,000	$327,500	$1,576,000	$229,300	($676,000)	($98,200)
32	MITA	$2,772,000	$277,200	$5,274,000	$527,400	$2,502,000	$250,200
33	MEDS MODERNIZATION	$2,015,000	$266,750	$0	$0	($2,015,000)	($266,750)
34	SSA COSTS FOR HEALTH COVERAGE INFO.	$2,120,000	$1,060,000	$1,500,000	$750,000	($620,000)	($310,000)
35	CALIFORNIA HEALTH INTERVIEW SURVEY	$1,272,000	$0	$1,100,000	$0	($172,000)	$0
36	FAMILY PACT PROGRAM ADMIN.	$1,207,000	$603,500	$1,207,000	$603,500	$0	$0
37	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES	$950,000	$950,000	$950,000	$950,000	$0	$0
38	MMA - DSH ANNUAL INDEPENDENT AUDIT	$888,000	$444,000	$926,000	$463,000	$38,000	$19,000
39	ENCRYPTION OF PHI DATA	$750,000	$375,000	$750,000	$375,000	$0	$0
40	POSTAGE AND PRINTING - THIRD PARTY LIAB.	$728,000	$364,000	$696,000	$348,000	($32,000)	($16,000)
41	IRS REPORTING FOR MIN. ESSENTIAL COVERAGE	$340,000	$170,000	$684,000	$342,000	$344,000	$172,000
42	T-MSIS	$418,000	$104,500	$276,000	$69,000	($142,000)	($35,500)
43	VENDOR FOR AAC RATE STUDY	$386,000	$193,000	$332,000	$166,000	($54,000)	($27,000)
44	CCT OUTREACH - ADMINISTRATIVE COSTS	$342,000	$0	$342,000	$0	$0	$0
45	MEDICARE BUY-IN QUALITY REVIEW PROJECT	$100,000	$50,000	$300,000	$150,000	$200,000	$100,000
46	STATE CONTROLLER'S OFFICE INTERAGENCY AGREEMENT	$4,000	$1,000	$0	$0	($4,000)	($1,000)
47	DENTAL PAPD PROJECT MANAGER	$161,000	$40,250	$0	$0	($161,000)	($40,250)

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2017-18 AND 2018-19

NO.	POLICY CHANGE TITLE	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2018-19 TOTAL FUNDS	MAY 2018 EST. FOR 2018-19 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	DHCS-OTHER						
48	CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT	$100,000	$0	$100,000	$0	$0	$0
49	TAR POSTAGE	$32,000	$16,000	$32,000	$16,000	$0	$0
50	ENROLLMENT ASSIST FOR BHT INSTITUTIONALLY DEEMED	$43,000	$21,500	$0	$0	($43,000)	($21,500)
55	INTERIM AND FINAL COST SETTLEMENTS-SMHS	($2,688,000)	$0	$26,745,000	$0	$29,433,000	$0
109	MANAGED CARE REGULATIONS - MH PARITY	$0	$0	$20,799,000	$2,971,000	$20,799,000	$2,971,000
	DHCS-OTHER SUBTOTAL	**$887,821,000**	**$153,266,760**	**$1,131,136,000**	**$305,916,040**	**$243,315,000**	**$152,649,280**
	DHCS-MEDICAL FI						
56	MEDICAL FI OPERATIONS	$79,012,000	$25,401,500	$77,098,000	$24,731,750	($1,914,000)	($669,750)
57	MEDICAL FI COST REIMBURSEMENT	$42,390,000	$11,068,050	$36,151,000	$10,319,000	($6,239,000)	($749,050)
58	MEDICAL FI HOURLY REIMBURSEMENT	$27,546,000	$5,986,500	$27,546,000	$5,986,500	$0	$0
59	MEDICAL FI OTHER ESTIMATED COSTS	$11,080,000	$3,220,000	$11,080,000	$3,220,000	$0	$0
60	MEDICAL FI MISCELLANEOUS EXPENSES	$2,445,000	$767,250	$2,392,000	$790,000	($53,000)	$22,750
61	MEDICAL FI CHANGE ORDERS	$536,000	$134,000	$544,000	$136,000	$8,000	$2,000
62	MEDICAL FI OPTIONAL CONTRACTUAL SERVICES	$0	$0	$1,679,000	$167,900	$1,679,000	$167,900
111	MEDICAL FI SRP RELEASE 1 HOSTING	$7,042,000	$1,023,700	$8,450,000	$1,228,700	$1,408,000	$205,000
114	MEDICAL FI TURNOVER	$600,000	$193,500	$0	$0	($600,000)	($193,500)
	DHCS-MEDICAL FI SUBTOTAL	**$170,651,000**	**$47,794,500**	**$164,940,000**	**$46,579,850**	**($5,711,000)**	**($1,214,650)**
	DHCS-HEALTH CARE OPT						
63	HCO COST REIMBURSEMENT	$44,189,000	$21,254,320	$13,582,000	$6,532,220	($30,607,000)	($14,722,100)
64	HCO OPERATIONS	$29,179,000	$14,036,980	$9,103,000	$4,379,360	($20,076,000)	($9,657,620)
65	HCO - ENROLLMENT CONTRACTOR COSTS	$17,990,000	$8,653,380	$5,638,000	$2,711,840	($12,352,000)	($5,941,540)
66	HCO ESR HOURLY REIMBURSEMENT	$15,580,000	$7,493,980	$4,824,000	$2,320,420	($10,756,000)	($5,173,560)
67	HCO CCI - CAL MEDICONNECT AND MLTSS	$15,269,000	$7,634,500	$4,816,000	$2,408,000	($10,453,000)	($5,226,500)
68	HCO TAKEOVER	$2,769,000	$1,384,500	$5,231,000	$2,615,500	$2,462,000	$1,231,000

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2017-18 AND 2018-19

NO.	POLICY CHANGE TITLE	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2018-19 TOTAL FUNDS	MAY 2018 EST. FOR 2018-19 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	DHCS-HEALTH CARE OPT						
69	HCO TURNOVER	$522,000	$261,000	$1,436,000	$718,000	$914,000	$457,000
70	HCO OPERATIONS 2017 CONTRACT	$0	$0	$27,935,000	$13,436,640	$27,935,000	$13,436,640
71	HCO COST REIMBURSEMENT 2017 CONTRACT	$0	$0	$27,040,000	$13,006,240	$27,040,000	$13,006,240
72	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	$0	$0	$9,304,000	$4,475,300	$9,304,000	$4,475,300
	DHCS-HEALTH CARE OPT SUBTOTAL	**$125,498,000**	**$60,718,660**	**$108,909,000**	**$52,603,520**	**($16,589,000)**	**($8,115,140)**
	DHCS-DENTAL FI						
73	DENTAL FI OPERATIONS	$57,261,000	$19,912,250	$0	$0	($57,261,000)	($19,912,250)
74	DENTAL FI TAKEOVER 2016 CONTRACT	$23,424,000	$5,856,000	$5,856,000	$1,464,000	($17,568,000)	($4,392,000)
75	DENTAL ASO ADMINISTRATION 2016 CONTRACT	$12,303,000	$4,552,250	$38,138,000	$13,832,250	$25,835,000	$9,280,000
76	DENTAL FI HOURLY REIMBURSEMENT	$6,604,000	$1,651,000	$0	$0	($6,604,000)	($1,651,000)
77	DENTAL FI COST REIMBURSEMENT	$7,492,000	$3,650,000	$0	$0	($7,492,000)	($3,650,000)
78	DENTAL FI ADMINISTRATION 2016 CONTRACT	$6,794,000	$1,800,000	$20,505,000	$5,439,000	$13,711,000	$3,639,000
79	DENTAL ASO TAKEOVER 2016 CONTRACT	$3,756,000	$939,000	$939,000	$234,750	($2,817,000)	($704,250)
80	DENTAL FI CD-MMIS COSTS	$656,000	$164,000	$1,279,000	$319,750	$623,000	$155,750
81	DENTAL BENEFICIARY OUTREACH & ED PROGRAM - ADMIN	$1,893,000	$946,500	$1,895,000	$947,500	$2,000	$1,000
83	DENTAL FI FEDERAL RULE - REVALIDATION	$200,000	$100,000	$0	$0	($200,000)	($100,000)
84	DENTAL FI FEDERAL RULE - DATABASE CHECKS	$215,000	$107,500	$0	$0	($215,000)	($107,500)
85	DENTAL FI CONLAN, SCHWARZMER, STEVENS V. BONTA	$196,000	$98,000	$0	$0	($196,000)	($98,000)
86	DENTAL FI HIPAA ADDENDUM SECURITY RISK ASSESSMENT	$167,000	$41,750	$0	$0	($167,000)	($41,750)
	DHCS-DENTAL FI SUBTOTAL	**$120,961,000**	**$39,818,250**	**$68,612,000**	**$22,237,250**	**($52,349,000)**	**($17,581,000)**
	OTHER DEPARTMENTS						
87	PERSONAL CARE SERVICES	$385,201,000	$0	$393,693,000	$0	$8,492,000	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2017-18 AND 2018-19

NO.	POLICY CHANGE TITLE	MAY 2018 EST. FOR 2017-18 TOTAL FUNDS	MAY 2018 EST. FOR 2017-18 GENERAL FUNDS	MAY 2018 EST. FOR 2018-19 TOTAL FUNDS	MAY 2018 EST. FOR 2018-19 GENERAL FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE GENERAL FUNDS
	OTHER DEPARTMENTS						
88	HEALTH-RELATED ACTIVITIES - CDSS	$274,418,000	$0	$330,365,000	$0	$55,947,000	$0
89	CALHEERS DEVELOPMENT	$125,682,000	$26,008,790	$126,987,000	$26,302,170	$1,305,000	$293,380
90	CDDS ADMINISTRATIVE COSTS	$53,471,000	$0	$52,686,000	$0	($785,000)	$0
91	MATERNAL AND CHILD HEALTH	$36,945,000	$0	$37,555,000	$0	$610,000	$0
92	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	$41,379,000	$0	$41,379,000	$0	$0	$0
93	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$19,640,000	$0	$31,853,000	$0	$12,213,000	$0
94	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	$14,395,000	$0	$14,195,000	$0	($200,000)	$0
95	ACA OUTREACH AND ENROLLMENT COUNSELORS	$11,442,000	$0	$0	$0	($11,442,000)	$0
96	CLPP CASE MANAGEMENT SERVICES	$5,355,000	$0	$4,200,000	$0	($1,155,000)	$0
97	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$4,093,000	$0	$4,279,000	$0	$186,000	$0
98	VITAL RECORDS DATA	$1,632,000	$0	$922,000	$0	($710,000)	$0
99	CALIFORNIA SMOKERS' HELPLINE	$1,373,000	$0	$2,200,000	$0	$827,000	$0
100	KIT FOR NEW PARENTS	$1,119,000	$0	$1,119,000	$0	$0	$0
101	VETERANS BENEFITS	$1,100,000	$0	$1,100,000	$0	$0	$0
102	CHHS AGENCY HIPAA FUNDING	$849,000	$0	$849,000	$0	$0	$0
103	MEDI-CAL INPATIENT SERVICES FOR INMATES	$813,000	$0	$813,000	$0	$0	$0
104	CDPH I&E PROGRAM AND EVALUATION	$566,000	$0	$562,000	$0	($4,000)	$0
105	MERIT SYSTEM SERVICES FOR COUNTIES	$194,000	$97,000	$194,000	$97,000	$0	$0
106	CDDS DENTAL SERVICES - ADMIN	$67,000	$0	$0	$0	($67,000)	$0
107	PIA EYEWEAR COURIER SERVICE	$341,000	$170,500	$341,000	$170,500	$0	$0
	OTHER DEPARTMENTS SUBTOTAL	**$980,075,000**	**$26,276,290**	**$1,045,292,000**	**$26,569,670**	**$65,217,000**	**$293,380**

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2017-18 AND 2018-19

NO.	POLICY CHANGE TITLE	MAY 2018 EST. FOR 2017-18		MAY 2018 EST. FOR 2018-19		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER ADMINISTRATION TOTAL	**$2,285,006,000**	**$327,874,460**	**$2,518,889,000**	**$453,906,330**	**$233,883,000**	**$126,031,870**
	GRAND TOTAL COUNTY AND OTHER ADMINISTRATION	**$4,516,251,000**	**$1,349,895,460**	**$4,837,149,000**	**$1,332,736,830**	**$320,898,000**	**($17,158,630)**

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	MH/UCD & BTR -LIHP -ADMINISTRATIVE COSTS COUNTY
4	SPECIALTY MENTAL HEALTH ADMIN
5	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES
6	EPSDT CASE MANAGEMENT
7	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS
8	SMH MAA
9	ARRA HITECH INCENTIVE PROGRAM
10	MANAGED CARE REGULATIONS - MENTAL HEALTH
11	SMHS COUNTY UR & QA ADMIN
12	PERFORMANCE OUTCOMES SYSTEM
13	PAVE SYSTEM
14	POSTAGE & PRINTING
15	ACTUARIAL COSTS FOR RATE DEVELOPMENT
16	PASRR
17	MIS/DSS CONTRACT
18	CCI-ADMINISTRATIVE COSTS
19	SURS AND MARS SYSTEM REPLACEMENT
20	MEDI-CAL RECOVERY CONTRACTS
21	LITIGATION RELATED SERVICES
22	NEWBORN HEARING SCREENING PROGRAM
23	HIPAA CAPITATION PAYMENT REPORTING SYSTEM
24	DMC COUNTY UR & QA ADMIN
25	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)
26	CLINICAL DATA COLLECTION
27	DRUG MEDI-CAL COUNTY ADMINISTRATION
28	MEDICARE BENEFICIARY IDENTIFIER
29	ELECTRONIC ASSET VERIFICATION PROGRAM
30	SDMC SYSTEM M&O SUPPORT
31	CA-MMIS MEDCOMPASS SOLUTION
32	MITA
33	MEDS MODERNIZATION
34	SSA COSTS FOR HEALTH COVERAGE INFO.
35	CALIFORNIA HEALTH INTERVIEW SURVEY
36	FAMILY PACT PROGRAM ADMIN.
37	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES
38	MMA - DSH ANNUAL INDEPENDENT AUDIT

MEDI-CAL OTHER ADMINISTRATION
POLICY CHANGE INDEX

MEDI-CAL OTHER ADMINISTRATION
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	DHCS-DENTAL FI
73	DENTAL FI OPERATIONS
74	DENTAL FI TAKEOVER 2016 CONTRACT
75	DENTAL ASO ADMINISTRATION 2016 CONTRACT
76	DENTAL FI HOURLY REIMBURSEMENT
77	DENTAL FI COST REIMBURSEMENT
78	DENTAL FI ADMINISTRATION 2016 CONTRACT
79	DENTAL ASO TAKEOVER 2016 CONTRACT
80	DENTAL FI CD-MMIS COSTS
81	DENTAL BENEFICIARY OUTREACH & ED PROGRAM - ADMIN
83	DENTAL FI FEDERAL RULE - REVALIDATION
84	DENTAL FI FEDERAL RULE - DATABASE CHECKS
85	DENTAL FI CONLAN, SCHWARZMER, STEVENS V. BONTA
86	DENTAL FI HIPAA ADDENDUM SECURITY RISK ASSESSMENT
	OTHER DEPARTMENTS
87	PERSONAL CARE SERVICES
88	HEALTH-RELATED ACTIVITIES - CDSS
89	CALHEERS DEVELOPMENT
90	CDDS ADMINISTRATIVE COSTS
91	MATERNAL AND CHILD HEALTH
92	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN
93	DEPARTMENT OF SOCIAL SERVICES ADMIN COST
94	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS
95	ACA OUTREACH AND ENROLLMENT COUNSELORS
96	CLPP CASE MANAGEMENT SERVICES
97	DEPARTMENT OF AGING ADMINISTRATIVE COSTS
98	VITAL RECORDS DATA
99	CALIFORNIA SMOKERS' HELPLINE
100	KIT FOR NEW PARENTS
101	VETERANS BENEFITS
102	CHHS AGENCY HIPAA FUNDING
103	MEDI-CAL INPATIENT SERVICES FOR INMATES
104	CDPH I&E PROGRAM AND EVALUATION
105	MERIT SYSTEM SERVICES FOR COUNTIES
106	CDDS DENTAL SERVICES - ADMIN
107	PIA EYEWEAR COURIER SERVICE

SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER:	1
IMPLEMENTATION DATE:	7/1992
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	235

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$149,215,000	$154,118,000
STATE FUNDS	$8,867,000	$136,412,000
FEDERAL FUNDS	$140,348,000	$17,706,000

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).

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 Medicaid administrative activities. Many LGAs then subcontract with other organizations to perform MAA. 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 2017-18, from the prior estimate, is a decrease due to:

- Revising the FY 2015-16 estimate to be based on three quarters of actual RMTS claims received, and
- Updating FY 2009-10 and FY 2010-11 backcasting amounts with data from actual invoices received.

SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 1

The change in FY 2018-19, from the prior estimate, is a decrease due to:

- Revising FY 2016-17 projected payments to be based on three quarters of actual FY 2015-16 RMTS claims, and
- Revising FY 2011-12 through FY 2013-14 backcasting invoices to incorporate the two years of actual backcasting invoices received.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to:

- Projecting higher FY 2016-17 payments,
- The FY 2014-15 recoupment in FY 2017-18, and
- Adding the pending FY 2014-15 payments in FY 2018-19.

Methodology:

1. The FY 2017-18 estimate includes:
    - The FY 2014-15 recoupment is due to invoices for non-settlement claims that included unallowable costs that were already funded 100% from other funding; therefore, $708,000 will be recouped in FY 2017-18;
    - The FY 2015-16 quarterly invoice amounts have been revised based on actual FY 2015-16 Q1-Q3 payments;
    - Remaining unpaid deferred invoice claims for FY 2009-10 through FY 2011-12; and
    - The backcasting amounts for FY 2009-10 through FY 2010-11 are based on actual invoices received. The Department will use the General Fund (GF) to repay CMS for the outstanding amounts owed in order to satisfy the approved backcasting agreement according to the established timeline. To the extent a LEA has an outstanding balance owed to the federal government, the Department will apply one-time discretionary funding appropriated to those LEAs in the 2018-19 fiscal year toward the outstanding balance owed to the federal government to repay the state GF.
2. The FY 2018-19 estimate includes:
    - The FY 2016-17 RMTS invoice amounts which were based on FY 2011-12 invoice amounts have been revised based on actuals from FY 2015-16;
    - The backcasting RMTS invoice amounts for FY 2011-12, FY 2012-13, FY 2013-14 and FY 2014-15 Q1-Q2 which are based on the interim settlement amounts for those fiscal years after the application of the 2014 CMS settlement agreement. The Department will use GF to repay CMS for the outstanding amounts owed in order to satisfy the approved backcasting agreement according to the established timeline. To the extent a LEA has an outstanding balance owed to the federal government, the Department will apply one-time discretionary funding appropriated to those LEAs in the 2018-19 fiscal year toward the outstanding balance owed to the federal government to repay the state GF; and
    - Upon approval, the Department will utilize GF for additional pending payments for a total of $246,000. These claims exceed the federal two-year claiming limitation.

SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 1

FY 2017-18	TF	GF	FF
FY 2014-15 Recoupment	($708,000)	$0	($708,000)
FY 2015-16	$137,464,000	$0	$137,464,000
Unpaid Deferred Invoices	$12,459,000	$0	$12,459,000
Backcasting FY 2009-10	$0	$1,626,000	($1,626,000)
Backcasting FY 2010-11	$0	$7,241,000	($7,241,000)
Total	**$149,215,000**	**$8,867,000**	**$140,348,000**

FY 2018-19	TF	GF	FF
FY 2016-17	$153,872,000	$0	$153,872,000
Backcasting FY 2011-12	$0	$64,088,000	($64,088,000)
Backcasting FY 2012-13	$0	$35,703,000	($35,703,000)
Backcasting FY 2013-14	$0	$24,409,000	($24,409,000)
Backcasting FY 2014-15 Q1 and Q2	$0	$11,966,000	($11,966,000)
Pending FY 2014-15 payments	$246,000	$246,000	$0
Total	**$154,118,000**	**$136,412,000**	**$17,706,000**

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:	Matt Wong
FISCAL REFERENCE NUMBER:	230

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$194,938,000	$190,884,000
STATE FUNDS	$66,662,210	$63,819,120
FEDERAL FUNDS	$128,275,790	$127,064,880

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:
PC 46 Pediatric Palliative Care Expansion and Savings

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, San Francisco, 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.

CCS Case Management for Pediatric Palliative Care (PPC) involves enrolling new CCS clients into the Palliative Care program including indirect services, administrative support, overhead, and program training.

Starting no sooner than July 1, 2018, DHCS will transition some of the case management administrative functions from the county to the COHS health plans under the Whole-Child Model.

Reason for Change:
There is no change from the prior estimate, for FY 2017-18.

The change from the prior estimate, for FY 2018-19, is an increase due to:

- A decrease in the amount being transferred related to WCM implementation
- A change to cash basis accounting for FY 2018-19
- The start of the Rady Children's Hospital Demonstration Project

The change from FY 2017-18 to FY 2018-19, in the current estimate, is an overall decrease due to updated CMS Net amounts, PPC cost adjustments, the implementation of the Whole Child Model, and expected caseload changes.

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 2

Methodology:

1. The county administrative estimate for the budget year is updated every May based on additional data collected.

2. For FY 2017-18, the CCS case management costs are based on budgeted county expenditures of $158,651,000 in the May 2017 Estimate.

   For FY 2017-18, caseload is expected to increase 1.73% from FY 2017-18 to FY 2018-19.

   $158,651,000 x (1 + 1.73%) = $161,396,000

3. Assume administrative costs of $1,057,000 in both FY 2017-18 and FY 2018-19 for the Medi-Cal expansion of undocumented children which are funded at 100% GF.

4. For FY 2017-18, PPC Nurse Liaison costs are estimated as follows:
   - Each county has one medical professional (nurse) and one support staff (clerk) for every 25 palliative care participants.
   - The annual cost is $281,000 per one nurse and one clerk pair.
   - Of the ten participating counties, seven have 25 or less palliative care participants, two counties have 50 or less palliative care participants, and one county has 125 or less palliative care participants. One county does not have any PPCW clients and will not have a budget in FY 2017-18 or FY 2018-19.
   - PPC caseload is estimated to increase by 122 additional members in FY 2017-18.

     $281,000 x 7 (counties) = $1,967,000
     $281,000 x 2 (county) x 2 (pairs of nurse/clerk) = $1,124,000
     $281,000 x 1 (county) x 5 (pairs of nurse/clerk) = $1,405,000
     $1,967,000 + $1,124,000 + $1,405,000 = $4,496,000 costs prior to expansion
     $4,496,000 + $47,000 (expansion Nurse Liaison costs) = $4,543,000

5. For FY 2018-19, PPC Nurse Liaison costs are estimated as follows:
   - Each county has one medical professional (nurse) and one support staff (clerk) for every 25 palliative care participants.
   - The annual cost is $281,000 per one nurse and one clerk pair.
   - Of the ten counties, five have 25 or less palliative care participants, three counties has 50 or less palliative care participants, one county has 75 or less palliative care participants, and one counties has 125 or less palliative care participants. One county does not have any PPCW clients and will not have a budget in FY 2017-18 or FY 2018-19.
   - PPC caseload will add 50 additional members and two new nurse and clerk pairs within the existing counties by the end of FY 2018-19.

     $281,000 x 5 (counties) = $1,405,000
     $281,000 x 3 (county) x 2 (pairs of nurse/clerk) = $1,686,000
     $281,000 X 1 (county) X 3 (pairs of nurse/clerk) = $843,000
     $281,000 x 1 (county) x 5 (pairs of nurse/clerk) = $1,355,000
     $1,405,000 + $1,686,000 + $843,000 + $1,355,000 = $5,339,000 costs prior to expansion
     $5,339,000 + $1,124,000 (expansion Nurse Liaison costs) = $6,463,000

6. County data processing costs associated with CMS Net for CCS Medi-Cal are estimated to be $1,943,000 in FY 2017-18 and $1,930,000 in FY 2018-19.

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 2

7. 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 2017-18	FY 2018-19
County Administration:	$31,837,000	$31,837,000
County share of cost:	($966,000)	($966,000)
Total Medi-Cal OTLICP:	$30,871,000	$30,871,000

8. County data processing costs associated with CMS Net for OTLICP are estimated to be $283,000 in FY 2017-18 and $276,000 in FY 2018-19.

9. HPSM began operation in April 2013 and started receiving monthly payments beginning May 2013. Payments to HPSM are applied against CCS Case Management. All June payments are made in July. CY payments include a net 12 months of cost.

FY 2017-18: ($2,412,000) TF

10. Beginning July 1, 2018, the Whole Child Model will incorporate 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 will be applied against CCS Case Management.

The expenditures using a cash basis accounting for FY 2018-19 will include the 4th quarter invoice from FY 2017-18 and the first three quarters from FY 2018-19. The six counties implementing July 1, 2018 will include the last quarter from FY 2017-18 and the first three quarters of FY 2018-19. The 15 counties implementing January 1, 2019 will include the last quarter from FY 2017-18, two quarters from FY 2018-19 before WCM implementation and one quarter of WCM implemented.

Funding to be retained by WCM counties:

Phase One (9 months for 6 COHS counties):

$11,146,000 x 35% x 0.75 (nine months) = $2,926,000

Effective July 1, 2018 and affects 6 COHS counties.

FY 2018-19 Total: $2,926,000 TF ($325,111 for 9 months)

Phase Two (3 months for 15 COHS counties):

$23,807,000 x 35% x 0.25 (three months) = $2,083,000

Effective January 1, 2019 and affects 15 COHS counties

FY 2018-19: $2,083,000 TF (monthly $694,000 TF for 3 months)

Total WCM Implementation: $10,981,000 TF

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 2

11. On July 1, 2018, Rady Children's Hospital – San Diego (Rady) will start a demonstration pilot with San Diego County. Rady will be paid 78% of the total San Diego County Case Management Allocation and the County of San Diego will retain 22% of the Case Management Allocation for FY 2018-2019.

    Funding to be retained by San Diego County for 400 caseloads:

    $167,800 x 22% = $36,900 (monthly $3,076)

    Cost to CCS Case Management for FY 2018-19: $130,900 TF (monthly $10,900)

12. AB 1745 requires the Department to conduct a waiver pilot project to determine whether PPC should be provided as a benefit under the Medi-Cal program. These expenditures have been rolled into the CCS case management costs.

13. Enhanced, Title XIX (75% FFP), funding is available for Skilled Professional Medical Personnel (SPMP) for the Medi-Cal and OTLICP populations in FY 2017-18 and FY 2018-19.

FY 2017-18				
CCS Medi-Cal	**TF**	**GF**	**FF**	**CF***
CCS Case Management	$158,652,000	$59,768,000	$98,884,000	
Medi-Cal Expansion	$1,057,000	$1,057,000		
Pediatric Palliative Care	$4,543,000	$1,136,000	$3,407,000	
CMS Net	$1,944,000	$972,000	$972,000	
Subtotal	$166,196,000	$62,933,000	$103,263,000	
CCS Medi-Cal/OTLICP				
CCS Case Management	$30,871,000	$4,901,000	$25,970,000	$966,000
CMS Net	$283,000	$34,000	$249,000	
Subtotal	$31,154,000	$4,935,000	$26,219,000	$966,000
Health Plan of San Mateo	($2,412,000)	($1,206,000)	($1,206,000)	
Total	**$194,938,000**	**$66,662,000**	**$128,276,000**	$966,000

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 2

FY 2018-19				
CCS Medi-Cal	**TF**	**GF**	**FF**	**CF***
CCS Case Management	$161,401,000	$60,805,000	$100,596,000	
Medi-Cal Expansion	$1,057,000	$1,057,000		
Pediatric Palliative Care	$6,463,000	$1,615,000	$4,847,000	
CMS Net	$1,930,000	$965,000	$965,000	
Subtotal	$170,851,000	$64,443,000	$106,408,000	
CCS Medi-Cal/OTLICP				
CCS Case Management	$30,871,000	$4,901,000	$25,970,000	$966,000
CMS Net	$276,000	$33,000	$243,000	
Subtotal	$31,147,000	$4,934,000	$26,213,000	$965,640
Health Plan of San Mateo	($132,000)	($66,000)	($66,000)	
WCM Implementation	($10,982,000)	($5,491,000)	($5,491,000)	
Total	**$190,884,000**	**$63,820,000**	**$127,064,000**	$966,000

* County Funds are not included in the Total Fund

Funding:

FY 2017-18	**TF**	**GF**	**FF**	**CF***
50% Title XIX / 50% GF (4260-101-0001/0890)	$79,952,000	$39,976,000	$39,976,000	
75% Title XIX / 25% GF (4260-101-0001/0890)	$98,517,000	$24,629,000	$73,888,000	
88% Title XXI / 12% GF (4260-113-0001/0890)	$283,000	$34,000	$249,000	
88% Title XXI / 6% GF / 6% CF (4260-113-0001/0890)	$15,129,000	$966,000	$14,163,000	$966,000
100% GF (4260-101-0001)	$1,057,000	$1,057,000		
Total	**$194,938,000**	**$66,662,000**	**$128,276,000**	$966,000

FY 2018-19	**TF**	**GF**	**FF**	**CF***
50% Title XIX / 50% GF (4260-101-0001/0890)	$72,630,000	$36,315,000	$36,315,000	
75% Title XIX / 25% GF (4260-101-0001/0890)	$101,792,000	$25,449,000	$76,343,000	
88% Title XXI / 12% GF (4260-113-0001/0890)	$276,000	$33,000	$243,000	
88% Title XXI / 6% GF / 6% CF (4260-113-0001/0890)	$15,129,000	$966,000	$14,163,000	$966,000
100% GF (4260-101-0001)	$1,057,000	$1,057,000		
Total	**$190,884,000**	**$63,820,000**	**$127,064,000**	$966,000

* County Funds are not included in the Total Fund

MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 3
IMPLEMENTATION DATE: 7/2018
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 1589

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$0	$119,816,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$119,816,000

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: 3

Reason for Change:
The change from the prior estimate, for both FY 2017-18 and FY 2018-19, is due to delaying the final reconciliations for LIHP administrative costs to FY 2018-19 as a result of needing to first complete other LIHP final reconciliations. The change from FY 2017-18 to FY 2018-19 in the current estimate is due to payments currently not estimated to occur in FY 2017-18.

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:

(Dollars in Thousands)

FY 2018-19	TF	LIHP-MCE FF
Reconciliation		
DY 2007-08	$22,303	$22,303
DY 2008-09	$21,585	$21,585
DY 2009-10	$23,448	$23,448
DY 2010-11	$19,127	$19,127
DY 2011-12	$19,580	$19,580
DY 2012-13	$11,978	$11,978
DY 2013-14	$1,795	$1,795
Total FY 2018-19	**$119,816**	**$119,816**

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

COUNTY SPECIALTY MENTAL HEALTH ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER:	4
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1721

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$126,718,000	$130,354,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$126,718,000	$130,354,000

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.

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.

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is an increase due to:

- Updated base year expenditures from FY 2014-15 to FY 2015-16,
- Adding claims for Humboldt and Santa Clara counties and increased payments to LA County in FY 2015-16 resulting in a higher base estimate used to project estimated costs for FY 2017-18 and FY 2018-19; and
- Updated payment lag factors based on more recent historical claims.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the payment lags in FY 2018-19, and the growth trends applied for the FY 2017-18 and FY 2018-19 accrual years.

COUNTY SPECIALTY MENTAL HEALTH ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 4

Methodology:

1. Mental Health administration costs are based on historical claims payment data. Based on historical claims received, assume 21% of each fiscal year claims will be paid in the year the services occur, 73% is paid in the following year, and 6% in the third year. The costs on an accrual and cash basis are:

(Dollars in Thousands)

Fiscal Year	Accrual	FY 2017-18	FY 2018-19
MC	$225,614	$13,537	$0
CHIP	$9,939	$596	$0
FY 2015-16	$235,553	$14,133	$0
MC	$234,413	$171,122	$14,065
CHIP	$10,327	$7,539	$619
FY 2016-17	$244,740	$178,661	$14,684
MC	$240,976	$50,605	$175,913
CHIP	$10,616	$2,229	$7,750
FY 2017-18	$251,592	$52,834	$183,663
MC	$247,483	$0	$51,971
CHIP	$10,903	$0	$2,290
FY 2018-19	$258,386	$0	$54,261
Total		$245,628	$252,608

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 reimbursement of 65%. Beginning October 1, 2015, enhanced CHIP funding increased to 88%.

(Dollars in Thousands)

Claim Type	FY 2017-18			FY 2018-19		
	TF	FF	CF	TF	FF	CF
MC	$235,264	$117,632	$117,632	$241,949	$120,974	$120,975
CHIP*	$10,364	$9,086	$1,278	$10,659	$9,380	$1,279
Total	$245,628	**$126,718**	$118,910	$252,608	**$130,354**	$122,254

Funding:

100% Title XIX FFP (4260-101-0890)
100% Title XXI FFP (4260-113-0890)*

COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 5
IMPLEMENTATION DATE: 7/1992
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 1963

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$110,634,000	$95,200,000
STATE FUNDS	$11,000	$1,118,000
FEDERAL FUNDS	$110,623,000	$94,082,000

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 Medicaid administrative activities. Many LGAs then subcontract with other organizations to perform MAA. 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.

In June 2011, the Centers for Medicare and Medicaid Services (CMS) approved the Department's request to allow LGAs participating in the County Medi-Cal Administrative Activities (CMAA) program to submit interim claims for MAA reimbursements utilizing FY 2009-10 time survey data for FY 2010-11, FY 2011-12, and FY 2012-13 claims. CMS also stipulated that CMAA program interim claims would require reconciliation. On May 3, 2013, CMS approved the revised CMAA Operational Plan, which included a new statistically valid time survey methodology. The CMAA program will use FY 2013-14 time survey data to backcast for FY 2010-11, FY 2011-12, and FY 2012-13.

Reason for Change:
The change in FY 2017-18, from the prior estimate, is a net increase due to:

- Updated CMAA FY 2010-11 and FY 2011-12 backcasting payments and recoupments,
- A decrease in payments from $3,522,000 to $2,210,000 for the resubmitted multiple Medi-Cal discount percentage FY 2013-14 and FY 2014-15 CMAA invoices,
- FY 2014-15 Q2 invoices shifting to FY 2018-19,
- An increase in the FY 2015-16 estimated CMAA reimbursement amount, and

COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 5

- An increase in the program growth factor from 6.25% to 10%.

The change in FY 2018-19, from the prior estimate, is an increase due to:

- Moving remaining FY 2014-15 Q2 CMAA invoices ($1,118,000) that will be paid via the General Fund (GF) from FY 2017-18 to FY 2018-19,
- An increase in the program growth factor from 6.25% to 10%, and
- Partial shift in TMAA payments from FY 2017-18 to FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to:

- Estimating a lower amount of CMAA backcasting invoices will be paid in FY 2018-19 than in FY 2017-18, and
- Estimating a greater amount of CMAA backcasting recoupments will be received in FY 2018-19 than in FY 2017-18.

Methodology:

County Medi-Cal Administrative Activities

1. On January 9, 2018, the Department received CMS approval for the multiple Medi-Cal discount percentage methodology retroactive to July 1, 2017. All CMAA FY 2013-14 and 2014-15 invoices that were previously submitted utilizing multiple Medi-Cal discount percentages were resubmitted using a single Medi-Cal discount percentage, in accordance with the CMAA Operational Plan.

2. For the CMAA FY 2017-18 estimate:
   - It is estimated that FY 2010-11 backcasting will be completed and FY 2011-12 and FY 2012-13 backcasting will begin in FY 2017-18;
   - Payments are expected for unpaid FY 2013-14, 2014-15, and 2015-16 claims; which includes utilizing the GF for $11,000 for a FY 2014-15 Q3 invoice that exceeded the two-year claiming limit;
   - The FY 2016-17 Q1 claims are estimated to be paid in FY 2017-18;
   - The FY 2016-17 invoice base payments assume a 10% growth factor. This is based on the average CMAA growth from FY 2012-13 to FY 2015-16 as well as including the expected increase in claiming due to the approval of the multiple Medi-Cal discount methodology.

   CMAA FY 2015-16: $84,608,000

   Estimated CMAA FY 2016-17: $84,608,000 + 10% growth factor = $93,069,000

CMAA FY 2017-18 Estimated Payments	
FY 2010-11 Backcasting	$996,000
FY 2011-12 Backcasting	$4,048,000
FY 2012-13 Backcasting	$405,000
FY 2013-14	$2,304,000
FY 2014-15 Recoupment	($94,000)
FY 2014-15 (GF)	$11,000
FY 2015-16	$78,992,000
FY 2016-17 Q1	$23,267,000
Total	**$109,929,000**

COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 5

3. The CMAA FY 2018-19 estimate includes all remaining FY 2016-17, 2017-18 Q1, all remaining backcasting claims, and GF for $1,118,000 to pay FY 2014-15 Q2 invoices that were revised from a multiple Medi-Cal discount percentage to a single Medi-Cal discount percentage due to CMS approval being only retroactive to July 1, 2017. In addition, it is estimated that all remaining backcasting recoupments will be received. FY 2017-18 base payments assume a 10% growth factor based on the average CMAA growth from FY 2012-13 to FY 2015-16 as well as including the expected increase in claiming due to the approval of the multiple Medi-Cal discount methodology.

   Estimated CMAA FY 2017-18: $93,069,000 + 10% growth factor = $102,376,000

CMAA FY 2018-19 Estimated Payments	
FY 2011-12 Backcasting	($3,071,000)
FY 2012-13 Backcasting	$225,000
FY 2014-15 (GF)	$1,118,000
FY 2016-17 Q2-Q4	$69,802,000
FY 2017-18 Q1	$25,594,000
Total	**$93,668,000**

Tribal Medi-Cal Administrative Activities

4. The TMAA FY 2017-18 estimate includes the remaining unpaid FY 2015-16 claims and FY 2016-17 Q1 claims. The FY 2016-17 estimated base payments assumes a 10% growth, based on the average TMAA growth from FY 2012-13 to FY 2015-16.

   Estimated TMAA FY 2016-17: $1,072,000 + 10% growth factor = $1,179,000

TMAA FY 2017-18 Estimated Payments	
FY 2015-16	$410,000
FY 2016-17 Q1	$295,000
Total	**$705,000**

5. The TMAA FY 2018-19 estimate includes the remaining FY 2016-17 claims and FY 2017-18 Q1-Q2 claims. The estimated base payments assumes a 10% growth, based on the average TMAA growth from FY 2012-13 to FY 2015-16.

   Estimated TMAA FY 2017-18: $1,179,000 + 10% growth factor =$1,297,000

TMAA FY 2018-19 Estimated Payments	
FY 2016-17 Q2-Q4	$884,000
FY 2017-18 Q1-Q2	$648,000
Total	**$1,532,000**

6. Total CMAA and TMAA reimbursements for FY 2017-18 and FY 2018-19 on a cash basis are:

FY 2017-18	TF	GF	FF
County MAA	$109,929,000	$11,000	$109,918,000
Tribal MAA	$705,000	$0	$705,000
Total	**$110,634,000**	**$11,000**	**$110,623,000**

COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 5

FY 2018-19	TF	GF	FF
County MAA	$93,668,000	$1,118,000	$92,550,000
Tribal MAA	$1,532,000	$0	$1,532,000
Total	**$95,200,000**	**$1,118,000**	**$94,082,000**

Funding:
100% Title XIX FFP (4260-101-0890)
100% GF (4260-101-0001)

EPSDT CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	6
IMPLEMENTATION DATE:	7/1996
ANALYST:	Sasha Jetton
FISCAL REFERENCE NUMBER:	229

	FY 2017-18	FY 2018-19
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 Medi-Cal's early and periodic screening case management allocation under the Early and Periodic Screening Diagnosis and Treatment (EPSDT) benefit/requirement.

Authority:
Health & Safety Code 124075(a), 124025-124110
Welfare & Institutions Code 10507

Interdependent Policy Changes:
Not Applicable

Background:
Medi-Cal provides funding for the county administration of the Child Health and Disability Prevention (CHDP) program for those children that receive CHDP screening and immunization services that are Medi-Cal eligible. These services are required for Medi-Cal eligibles based on the Title XIX EPSDT provisions.

The EPSDT Case Management budget is allocated to individual counties and controlled on an accrual basis.

Reason for Change:
There is no change to the overall dollars in FY 2017-18 & 2018-19 from the prior estimate. The change is due to the reallocation of county administration fees previously associated with the State-Only CHDP program.

Methodology:
1. The set allocation amount is $33,962,000 ($11,957,000 GF).
2. The state-only CHDP program shifted to the Medi-Cal program with the expansion of Medi-Cal for undocumented children in FY 2015-16. The 100% GF ($244,000) previously allocated for this group has been incorporated into the Title XIX funds.

EPSDT CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 6

Funding:

FY 2017-18	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 2018-19	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**

OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	7
IMPLEMENTATION DATE:	1/2013
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1748

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$26,726,000	$32,835,000
STATE FUNDS	$5,766,800	$8,767,720
FEDERAL FUNDS	$20,959,200	$24,067,280

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. The transition ended on 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.

Also effective as of 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 applications still available in the community, Maximus forwards any HFP applications it receives to the appropriate County Welfare Department for a determination without the benefit of screening for accelerated enrollment.

OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS

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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.

Reason for Change:
The decrease from the prior estimate, for FY 2017-18 and FY 2018-19, is due to decreased application and payment processing for the OTLICP program, as well as a decrease in administrative and printing costs for MCAP. The increase from FY 2017-18 to FY 2018-19, in the current estimate, is due to a full year of costs estimated for the Special Populations publication contract in FY 2018-19.

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 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 2017-18	FY 2018-19
OTLICP	$22,364	$22,962
MCAP	$3,724	$3,767
Medi-Cal Special Populations	$638	$6,106

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: 7

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
Contract Costs	$ 20,167	$ 2,487	$ 17,680
Applications Processing, Printing and Courier Services, Letters and Notices, Transaction Forwarding Fee	$ 401	$ 201	$ 200
Call Minute Rate per Minute	$ 1,520	$ 760	$ 760
Implementation Costs	$ 4,000	$ 2,000	$ 2,000
Special Populations Publications	$ 638	$ 319	$ 319
Total	**$ 26,726**	**$ 5,767**	**$ 20,959**

FY 2018-19	TF	GF	FF
Contract Costs	$ 20,783	$ 2,742	$ 18,041
Applications Processing, Printing and Courier Services, Letters and Notices, Transaction Forwarding Fee, Pregnancy Materials	$ 428	$ 214	$ 214
Call Minute Rate per Minute	$ 1,518	$ 759	$ 759
Implementation Costs	$ 4,000	$ 2,000	$ 2,000
Special Populations Publications	$ 6,106	$ 3,053	$ 3,053
Total	**$ 32,835**	**$ 8,768**	**$ 24,067**

Funding:

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890/0001)	$ 6,736	$ 3,368	$ 3,368
88% Title XXI / 12% GF (4260-113-0890/0001)	$ 19,990	$ 2,399	$ 17,591
Total	**$ 26,726**	**$ 5,767**	**$ 20,959**

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890/0001)	$ 12,704	$ 6,352	$ 6,352
88% Title XXI / 12% GF (4260-113-0890/0001)	$ 20,131	$ 2,416	$ 17,715
Total	**$ 32,835**	**$ 8,768**	**$ 24,067**

SMH MAA

OTHER ADMIN. POLICY CHANGE NUMBER:	8
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1722

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$31,851,000	$33,834,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$31,851,000	$33,834,000

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 2017-18 and FY 2018-19, is a net increase due to:

- An increased estimated accrual FY 2016-17 expenditures,
- Shifting the Marin County reimbursement from FY 2018-19 to FY 2017-18,
- Updating the assumed percentage of skilled professional medical personnel and other personnel based on actual and estimated claims through FY 2016-17, and
- Updating the payment lags based on FY 2015-16 claims.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to assuming the partial payments to Marin County occurs in FY 2017-18 for claims from prior fiscal years and the addition of claims to be paid in FY 2018-19 based on projected costs.

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. Based on actual claims from FY 2010-11 through FY 2015-16, the average annual increase in MH MAA FFP reimbursements was 8.60%.

SMH MAA

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3. Assume total MH MAA claims will increase by 8.60% each fiscal year starting in FY 2016-17.

4. For FY 2016-17, the Department projects to receive $53,356,000 TF in MH MAA claims on an accrual basis.

(Dollars in Thousands)

Fiscal Years	Expenditures	Growth	Increase
2016-17	$53,356	8.60%	$4,589
2017-18	$57,945	8.60%	$4,983
2018-19	$62,928	8.60%	$5,412

5. Based on historical claims received, assume 2.43% of fiscal year claims will be paid in the year the services occur. The remaining 97.57% will be paid in the following year.

(Dollars in Thousands)

Fiscal Years	Accrual	FY 2017-18	FY 2018-19
2016-17	$53,356	$52,058	$0
2017-18	$57,945	$1,410	$56,535
2018-19	$62,928	$0	$1,531
Total	$174,229	$53,468	$58,066

6. 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 2016-17, assume 33.07% of costs are eligible for 75% reimbursement and the remaining 66.93% are eligible for 50% reimbursement. MH MAA total expenditures are shared between federal funds (FF) and county funds (CF).

(Dollars in Thousands)

	FY 2017-18			FY 2018-19		
Expenditures	TF	FF	CF	TF	FF	CF
Medical (75/25)	$17,682	$13,261	$4,421	$19,203	$14,402	$4,801
Other (50/50)	$35,786	$17,893	$17,893	$38,863	$19,432	$19,431
Total	$53,468	$31,154	$22,314	$58,066	$33,834	$24,232

7. Marin County will be reimbursed $1,870,000 FF for multiple years of MH MAA claims. Marin County was reimbursed $1,173,000 FF in FY 2016-17 and the remaining $697,000 FF will be paid in FY 2017-18. Marin County's claiming plan has been approved, allowing the claims to be paid.

(Dollars in Thousands)

Cash Basis Expenditures	FY 2017-18		
	TF	FF	CF
Medical (75/25)	$481	$362	$119
Other (50/50)	$670	$335	$335
Total	$1,151	$697	$454

SMH MAA

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8. The estimated MH MAA costs are:

(Dollars in Thousands)

	FY 2017-18			FY 2018-19		
Expenditures	**TF**	**FF**	**CF**	**TF**	**FF**	**CF**
Medical (75/25)	$18,163	$13,623	$4,540	$19,203	$14,402	$4,801
Other (50/50)	$36,456	$18,228	$18,228	$38,863	$19,432	$19,431
Total	$54,619	**$31,851**	$22,768	$58,066	**$33,834**	$24,232

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

ARRA HITECH INCENTIVE PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER:	9
IMPLEMENTATION DATE:	7/2010
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1370

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$17,596,000	$27,180,000
STATE FUNDS	$1,600,000	$1,285,000
FEDERAL FUNDS	$15,996,000	$25,895,000

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)
AB 1467 (Chapter 23, Statutes of 2012)
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:
OA 62 Medical FI Optional Contractual Services
PC 171 ARRA HITECH Provider Payments

Background:
The HITECH Act, a component of ARRA, authorizes federal funds for Medicare and Medicaid Incentive Programs from 2011 through 2021. To qualify, health care providers must meaningfully use (MU) certified Electronic Health Records (EHR) technology in accordance with the HITECH Act requirements. The Centers for Medicare and Medicaid Services (CMS) approved the implementation of the Provider Incentive Program which began October 3, 2011. The payments to the providers under HITECH are budgeted in the ARRA HITECH – Provider Payments policy change. The HITECH Act pays provider incentive payments at 100% federal funds (FF).

In 2011, SB 945 authorized the Department to establish and administer the ARRA HITECH Incentive Program only to the extent that FF was available and there would be no General Fund (GF) impact. In 2012, AB 1467 provided that no more than $200,000 from the GF may be used annually for state administrative costs associated with the program. In 2016, SB 833 expanded the existing annual limit from $200,000 to $425,000 GF for administrative costs associated with the program.

SB 870 appropriates $3,750,000 from the Major Risk Medical Insurance Fund (MRMIF) to the Department for purposes of an EHR provider technical assistance program in accordance with the State Medicaid Health Information Technology Plan (SMHP) as specified in Section 14046.1 of the Welfare and Institutions Code. The appropriated sum amounts to a ten percent match for the $37,500,000 allocation from CMS to procure vendors for the California Provider Technical Assistance

ARRA HITECH INCENTIVE PROGRAM

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Program (CTAP) for eligible providers. In FY 2017-18, the 10% non-federal share will be provided by the Health Care Services Plans Fines and Penalties Fund. MRMIF will be absorbed into the Health Care Services Plan Fines and Penalties Fund in FY 2017-18.

The Department received CMS approval of the SMHP and Implementation Advance Planning Document (IAPD) on September 30, 2011. The SMHP and IAPD authorized implementation of the EHR Incentive Program, which occurred on October 3, 2011. An IAPD Update (IAPD-U) was submitted for review on September 8, 2017 and approved on September 28, 2017. The IAPDU requests additional funds for ongoing Department administrative costs for Federal Fiscal Year (FFY) 2017, as well as support for MU measures including immunization registries, electronic lab reporting, and provider technical assistance.

The Department is required by CMS to assess the current usage of and barriers to EHR adoption by providers and continued administration of the Incentive Program. Multiple contracts are required in order to complete the assessments. 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.

The Medi-Cal medical Fiscal Intermediary (FI) continues to develop an enrollment and eligibility portal for Medi-Cal professionals and hospitals to meet new requirements published by CMS. SB 945 limitations did not apply to the FI projects as the funding for these projects were approved as part of the FI budget prior to the passage of SB 945. The cost of the Incentive Program application portal developed by the FI, which is eligible for FFP, is budgeted in the Medical FI Optional Contractual Services policy change. These costs include maintenance and operation and the development of additional functionalities.

The Department and the California Department of Public Health (CDPH) have partnered on a project to upgrade the California Immunization Registry (CAIR), called CAIR 2.0, and a project to upgrade the California Reportable Disease Information Exchange (CalREDIE). CAIR 2.0 transformed existing CAIR infrastructure and software to fully support MU data exchange among EHRs. Through the CalREDIE project, the Department provided technical support to implement a computer application system for the web-based disease reporting and surveillance system. Both projects ended June 30, 2017 and will have invoices paid through FY 2017-18.

Beginning in FY 2017-18, the Department and CDPH will partner again in order to establish a unified, efficient approach for on-boarding EHRs of targeted Medi-Cal providers, so that they can fulfill two public health functions: communicable disease reporting and immunization reporting. This partnership will help to achieve California specific goals towards meaningful use of electronic health records through the following two projects:

1. CAIR Onboarding of Medicaid Providers: CAIR will be working to provide immunization registry reporting, by exchanging immunization information to and receiving back, a statewide, consolidated record and recommendations from CAIR. This will include deploying onboarding procedures and tools for eligible providers to report public health measures to CDPH and promote the use of data to improve healthcare quality for Medicaid patients.
2. CalREDIE eCR: This project will work to achieve electronic case reporting, by submitting electronic initial case reports (eCR) for state reportable conditions to CalREDIE to improve public health surveillance.

The Department and the State of California Emergency Medical Services Authority (EMSA) will enter into an interagency agreement (IA) in FY 2018-19 to develop a statewide approach to implement health information exchange (HIE) for two critical components of the health care system, emergency medical

ARRA HITECH INCENTIVE PROGRAM

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services (EMS), and disaster response. The Department will submit an Implementation Advanced Planning Document Update (IAPD-U) to the Centers for Medicare and Medicaid (CMS) in February, 2018. Pending federal approval, the Department anticipates this program starting on July 1, 2018. Funding will be used to complete HIE onboarding and to modify HIE architecture. This project is called Health Information Technology for EMD (HITEMS).

The Department will continue to administer the following projects to support MU of EHRs by eligible Medi-Cal professionals and hospitals:

- The Department awarded contracts to multiple vendors who provide technical assistance to eligible providers preparing to implement EHR systems and meet AIU and/or MU objectives via the California Technical Assistance Program (CTAP).

- The Department will contract again with the University of California, San Francisco (UCSF) to conduct periodic surveys over the course of the EHR Incentive Program which is required to refine the initial landscape assessment of EHR use, and to document activities. A California Physicians' Use of EHR survey was completed in March 2014 and was used to facilitate Health Information Exchange and EHR adoption for Medi-Cal. The next periodic survey will be conducted in FY 2017-18.

- The Department has collaborated annually since 2015 with the California Health and Human Services (CHHS) and the California Office of Health Information Integrity to facilitate the California Health Information Technology (HIT)/Health Information Exchange (HIE) Stakeholder Summit (Summit). The most recent Summit was hosted by the Department, and occurred in November of 2017. The Summits provide stakeholders with an understanding of how individuals and organizations fit into HIE in California; enable stakeholders to learn about available resources for planning clinical and administrative integration; and provide a forum for stakeholders to have a voice in shaping the future of HIE in California.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is due to the following:
- CAIR 2.0 and CalREDIE invoices from FY 2016-17 are now final and the Department updated amounts paid in FY 2017-18;
- The Department changed the CAIR on-boarding, CalREDIE eCR, and California Physicians HER Survey project schedules;
- And the Department updated finalized expenses for the FY 2017-18 Summit.

The change from the prior estimate, for FY 2018-19, is due to:
- Changes the Department made to the CAIR on-boarding, CalREDIE eCR, and HITEMS project schedules.
- And the continuation of provider technical assistance in FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the following:
- The implementation of the HITEMS project in FY 2018-19;
- The completion of the CAIR 2.0 and CalREDIE programs were completed in FY 2017-18.
- And a full year of costs for CAIR Onboarding and and CalREDIE eCR in FY 2018-19.

Methodology:
1. The ARRA HITECH Incentive Program is eligible for Title XIX 90% FF.

2. For the CAIR 2.0, CAIR Onboarding, CalREDIE, and CalREDIE eCR projects, the 10% non-federal

ARRA HITECH INCENTIVE PROGRAM

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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. CAIR 2.0 and CalREDIE have received payments for their final invoices and will be closed-out as of June 30, 2017.

3. CTAP project costs are eligible for Title XIX 90% FF. In FY 2016-17, the 10% non-federal share was provided by MRMIF. In FY 2017-18, 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 no project cost after FY 2017-18.

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 2017-18 and FY 2018-19, the 10% non-federal share for the other projects will be provided by outside entities.

7. The medical FI projects are eligible for ARRA HITECH funding under the FI contract.

FY 2017-18	TF	Reimburs.	SF	FF
CAIR 2.0 (90% FF/10% GF)	$519,000	$0	$0	$519,000
CalREDIE (90% FF/10% GF)	$243,000	$0	$0	$243,000
CAIR Onboarding (90% FF/10% GF)	$580,000	$0	$0	$580,000
CalREDIE eCR (90% FF/10% GF)	$255,000	$0	$0	$255,000
HITEMS (90% FF/10% GF)	$0	$0	$0	$0
Provider Technical Assist. (90% FF/10% SF)*	$14,193,000	$0	$1,419,000	$12,774,000
California HIT/HIE Summit (90% FF/10% GF)	$221,000	$22,100	$0	$198,900
California Physician's EHR Survey (90% FF/10% GF)	$50,000	$5,000	$0	$45,000
Other projects (90% FF/10% GF)	$1,535,000	$154,000	$0	$1,381,000
Total FY 2017-18	**$17,596,000**	**$181,100**	**$1,419,000**	**$15,995,900**

ARRA HITECH INCENTIVE PROGRAM

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FY 2018-19	TF	Reimburs.	SF	FF
CAIR Onboarding (90% FF/10% GF)	$2,017,000	$0	$0	$2,017,000
CalREDIE eCR (90% FF/10% GF)	$1,644,000	$0	$0	$1,644,000
HITEMS (90% FF/10% GF)	$10,670,000	$0	$0	$10,670,000
Provider Technical Assist. (90% FF/10% SF)*	$10,635,000	$0	$1,063,500	$9,571,500
California HIT/HIE Summit (90% FF/10% GF)	$349,000	$35,000	$0	$314,000
California Physician's EHR Survey (90% FF/10% GF)	$330,000	$33,000	$0	$297,000
Other projects (90% FF/10% GF)	$1,535,000	$154,000	$0	$1,381,000
Total FY 2018-19	**$27,180,000**	**$222,000**	**$1,063,500**	**$25,894,500**

Funding:
100% Title XIX (4260-101-0890)
100% Reimbursement (4260-601-0995)
100% Health Care Services Plans Fines and Penalties Fund (4260-602-3311)*

MANAGED CARE REGULATIONS - MENTAL HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER:	10
IMPLEMENTATION DATE:	7/2017
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	2019

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$5,801,000	$22,507,000
STATE FUNDS	$1,933,000	$7,502,000
FEDERAL FUNDS	$3,868,000	$15,005,000

DESCRIPTION

Purpose:
This policy change estimates the costs to reimburse County Mental Health Plans (MHPs) for administrative activities arising from the implementation of new 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: 10

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is a due to shifting reimbursements from FY 2017-18 to FY 2018-19 by applying payment lags for payments on a cash basis and shifting partial year costs for activities related to county IT costs and county translation costs previously assumed to be paid in FY 2017-18.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to incorporating the payment lag for FY 2017-18 and adding partial payments for county IT costs and county translation costs, causing the expenditures to increase for FY 2018-19.

Methodology:
The estimated costs of Managed Care and Parity Regulations are based on the seven categories below for 56 counties and assumes the non-federal share is funded with 50% County Funds (CF) and 50% General Funds (GF), consistent with the California Constitution, Article 13, Section 36 (c)(5)(A).

1. State Monitoring:
   Compile data and information from a variety of state monitoring requirements such as the quality and performance rating system and compliance reviews.
   - Assume, on average, 1.0 analyst is needed per county at a cost of $90,299 per analyst. The total estimated costs are $5,057,000 TF.
   - Assume full year costs in FY 2017-18 and FY 2018-19.

2. Network Adequacy:
   Collect and submit detailed provider data to the State for federally required reporting of provider networks and provider capacity.
   - Assume, on average, 2.0 analysts are needed per county at a cost of $90,299 per analyst. The total estimated annual costs are $10,113,000 TF.
   - Assume six months of costs for FY 2017-18 and full year costs for FY 2018-19.

3. Quality Measurement & Improvement; External Quality Review Organization (EQRO):
   MHPs will need to contract with EQRO for local quality measurement and improvement activities necessary to comply.
   - Assume, on average, 1.0 analyst is needed per county at a cost of $90,299 per analyst. The total estimated costs are $5,057,000 TF.
   - Assume full year costs in FY 2017-18 and FY 2018-19.

4. Grievances and Appeals System:
   Ongoing staffing impact to comply with 72-hour authorization upon notice of reversal of adverse benefit determination.
   - Assume, on average, 1.0 analyst is needed per county at a cost of $90,299 per analyst. The total estimated costs are $5,057,000 TF.
   - Assume full year costs in FY 2017-18 and FY 2018-19.

5. Program Integrity:
   MHPs will need to conduct monitoring for contractor compliance, prepare and submit data, documentation, and information to the State.
   - Assume, on average, 1.0 analyst is needed per county at a cost of $90,299 per analyst. The total estimated costs are $5,057,000 TF.
   - Assume full year costs in FY 2017-18 and FY 2018-19.

MANAGED CARE REGULATIONS - MENTAL HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER: 10

6. One-Time County IT Costs:
   MHPs will need to begin collecting and reporting additional data to the State.
   - Assume, on average, each county will need to purchase 1,000 hours of time from an IT vendor at an average cost of $105 per hour. The total estimated annual costs are $5,880,000 TF.
   - Assume 50% of costs will be paid in FY 2017-18 and 50% will be paid in FY 2018-19.

7. One-Time County Translation Costs:
   MHPs will need to translate at a minimum five beneficiary documents.
   - Assume, on average, each county will need to purchase 300 hours of time for a vendor to translate these documents at a cost of $50 per hour. The total estimated costs are $840,000 TF.
   - Assume 50% of costs will be paid in FY 2017-18 and 50% will be paid in FY 2018-19.

8. On a cash basis for FY 2017-18, the Department will be paying for 27% of FY 2017-18 claims. For FY 2018-19, the Department will be paying 73% of FY 2017-18 claims and 27% of the FY 2018-19 claims.

(Dollars in Thousands)

FY 2017-18	Accrual (TF)	**FY 2017-18 (TF)**	**FY 2018-19 (TF)**
State Monitoring	$5,057	$1,366	$3,691
Network Adequacy	$5,057	$1,366	$3,691
Quality Measurement & Improvement; External Quality Review	$5,057	$1,366	$3,691
Grievances and Appeals	$5,057	$1,366	$3,691
Program Integrity	$5,057	$1,366	$3,691
County IT Costs	$2,940	$792	$2,148
County Translation Costs	$420	$113	$307
Total FY 2017-18	$28,645	$7,735	$20,910
FY 2018-19			
State Monitoring	$5,057	$0	$1,366
Network Adequacy	$10,113	$0	$2,730
Quality Measurement & Improvement; External Quality Review	$5,057	$0	$1,366
Grievances and Appeals	$5,057	$0	$1,366
Program Integrity	$5,057	$0	$1,366
County IT Costs	$2,940	$0	$792
County Translation Costs	$420	$0	$113
Total FY 2018-19	$33,701	$0	$9,099
Grand Total		$7,735	$30,009

MANAGED CARE REGULATIONS - MENTAL HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER: 10

9. The estimated costs in FY 2017-18 and FY 2018-19 are:

(Dollars in Thousands)

FY 2017-18	TF	GF	FF	CF
State Monitoring	$1,366	$341	$683	$342
Network Adequacy	$1,366	$341	$683	$342
Quality Measurement & Improvement; External Quality Review	$1,366	$341	$683	$342
Grievances and Appeals	$1,366	$342	$683	$341
Program Integrity	$1,366	$342	$683	$341
County IT Costs	$792	$198	$396	$198
County Translation Costs	$113	$28	$57	$28
Total	$7,735	**$1,933**	**$3,868**	$1,934

(Dollars in Thousands)

FY 2018-19	TF	GF	FF	CF
State Monitoring	$5,057	$1,265	$2,528	$1,264
Network Adequacy	$6,421	$1,605	$3,210	$1,606
Quality Measurement & Improvement; External Quality Review	$5,057	$1,264	$2,529	$1,264
Grievances and Appeals	$5,057	$1,264	$2,529	$1,264
Program Integrity	$5,057	$1,264	$2,529	$1,264
County IT Costs	$2,940	$735	$1,470	$735
County Translation Costs	$420	$105	$210	$105
Total	$30,009	**$7,502**	**$15,005**	$7,502

Funding:
100% Title XIX FF (4260-101-0890)
100% Title XIX GF (4260-101-0001)

SMHS COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER:	11
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1729

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$25,855,000	$28,667,000
STATE FUNDS	$265,000	$953,000
FEDERAL FUNDS	$25,590,000	$27,714,000

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 2017-18 and FY 2018-19, is due to:

- Updated base year expenditures from FY 2014-15 to FY 2015-16, and
- Updated payment lag factors for UR & QA claims based on more recent historical claims and removed FFA payments for FY 2016-17.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to FFA expenditures expected to occur in FY 2018-19 and revising the payment lags and growth trends applied to the FY 2017-18 and FY 2018-19 accrual years.

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.

SMHS COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 11

2. Based on historical claims received from FY 2012-13 through FY 2015-16, assume 27% of each fiscal year claims will be paid in the year the services occur. Assume 70% is paid in the following year and 3% is paid in the third year.

(Dollars in Thousands)

Fiscal Year	Accrual	FY 2017-18	FY 2018-19
2015-16	$35,130	$1,054	$0
2016-17	$36,184	$25,329	$1,086
2017-18	$37,596	$10,151	$26,317
2018-19	$38,648	$0	$10,435
Total SPMP & Other		$36,534	$37,838

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 2017-18 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 Special Terms and Conditions (STC) related to the SMHS waiver.

(Dollars in Thousands)

STC	Accrual	FY 2017-18	FY 2018-19
FY 2017-18	$3,075	$830	$2,153
FY 2018-19	$3,075	$0	$830
Total for STC		$830	$2,983

6. Beginning in January 2017, counties will incur costs to certify 184 Foster Family Agencies (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. Assume the payment lags in Methodology #2 for the FY 2017-18 and FY 2018-19 accrual year payments. The FFA costs, on a cash basis, are:

(Dollars in Thousands)

FFA	Rate	Accrual	FY 2017-18	FY 2018-19
FY 2017-18	$58.12	$428	$115	$300
FY 2018-19	$58.12	$428	$0	$115
Total for FFA			$115	$415

SMHS COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 11

7. On a cash basis, the estimated payments in FY 2017-18 and FY 2018-19 are:

(Dollars in Thousands)

FY 2017-18				
Personnel	**TF**	**GF**	**FF**	**CF**
SPMP	$27,400	$0	$20,550	$6,850
Other	$9,134	$0	$4,567	$4,567
STC	$830	$208	$415	$207
FFA	$115	$57	$58	$0
Total	$37,479	**$265**	**$25,590**	$11,624

(Dollars in Thousands)

FY 2018-19				
Personnel	**TF**	**GF**	**FF**	**CF**
SPMP	$28,378	$0	$21,284	$7,094
Other	$9,460	$0	$4,730	$4,730
STC	$2,983	$746	$1,492	$745
FFA	$415	$207	$208	$0
Total	$41,236	**$953**	**$27,714**	$12,569

Funding:
100% Title XIX FF (4260-101-0890)
100% GF (4260-101-0001)

PERFORMANCE OUTCOMES SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER:	12
IMPLEMENTATION DATE:	7/2018
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1948

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$0	$14,321,000
STATE FUNDS	$0	$6,414,250
FEDERAL FUNDS	$0	$7,906,750

DESCRIPTION

Purpose:
This policy change estimates the cost to reimburse mental health plans the cost of capturing and reporting new functional assessment data. County mental health plans will collect, manage, use, and report additional functional assessment data 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 POS 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 the POS, 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 POS implementation plan consists 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 POS project milestones, 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: 12

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 funding for the cost increase.

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is a net decrease, due to:

- Shifting FY 2017-18 claims payments to begin in FY 2018-19,
- Updating IT costs, and
- Applying a payment lag of 72% for the reimbursement of FY 2017-18 claims in FY 2018-19, and 24% for the reimbursement of FY 2018-19 claims in FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to:

- POS claims payments are expected to start in FY 2018-19 based on the payment lags listed above.

Methodology:

1. Training:

   County personnel costs for training will cost $2,697,000 for FY 2017-18 and $745,000 for FY 2018-19 and is based on the following assumptions:

   - Assume 3,925 clinical staff will need to be trained on the new functional assessment tools for FY 2017-18.
   - Assume 794 clinical staff will be trained on the new tools on an ongoing basis starting in FY 2018-19.
   - Assume six hours of in-person training is needed for clinical staff.
   - Assume five hours of online self-directed training is needed for clinical staff.
   - Assume clinical staff are paid an average of $39 per hour with 45.296% of salaries and wages in benefits.
   - Assume the clinical staff trained on the new tools will cost $2,447,000 for FY 2017-18 and $495,000 for FY 2018-19 (ongoing).
   - Assume 3,925 clinical staff will need to be registered at a fee of $10 per person annually, resulting in an annual cost of $39,000.
   - Assume 88 training sessions will be needed at $2,400 per session, resulting in an annual cost of $211,000.

(Dollars in Thousands)

Training Costs	FY 2017-18	FY 2018-19
Training (75% FF / 25% GF)	$2,447	$495
Registration Fee (50% FF / 50% GF)	$39	$39
Training Sessions (75% FF / 25% GF)	$211	$211
Total Training Costs	$2,697	$745

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 $4,117,000 for FY 2017-18 and $4,187,000 for FY 2018-19.

PERFORMANCE OUTCOMES SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 12

DHCS costs to install hardware and software:

- Assume it will take 4,000 hours at $105 per hour for an IT contractor to install new hardware and software for the Department. Assume cost to install hardware and software of $175,000 will be paid for FY 2017-18 and $245,000 will be paid for FY 2018-19.

MIS modification:

- Assume each of the 56 counties will need 728 hours of its contractor's time to make modifications to its Pediatric Symptom Checklist (PSC) management information system to extract and report functional assessment data.
- Assume 33 counties will need 1,040 hours of contractor time to make modification to its Child and Adolescent Needs and Strengths (CANS) management information system.
- Assume the IT contractor cost is $105 per hour.
- Assume 50% of MIS modification costs will be incurred for FY 2017-18 and 50% for FY 2018-19.

(Dollars in Thousands)

IT Costs	FY 2017-18	FY 2018-19
DHCS costs to install hardware and software	$175	$245
MIS modifications	$3,942	$3,942
Total (rounded)	$4,117	$4,187

3. Costs to staff county POS:

Clinical Staff:

- Assume 132,526 beneficiaries will be assessed in FY 2018-19:
  - 111,488 beneficiaries will be assessed for the first time,
  - 21,038 beneficiaries will be assessed for the second time.
- For 33 counties: Assume the first group of beneficiaries' assessments will take place from July 2018 through June 2019. The "second time" assessments are the first group of beneficiaries seen a second time within the next six months.
- For 23 counties: Assume the first group of beneficiaries' assessments will take place from October 2018 through June 2019. The "second time" assessments are the first group of beneficiaries and are seen a second time within the next six months.
- For Los Angeles county: Assume the first group of assessments will take place from January 2019 through June 2019. Assume the "second time" assessments will take place in FY 2019-20.
- These beneficiaries will be assessed two times per year, for 30 minutes at each time.
- Assume clinical staff are paid at $39 per hour for assessments with 45.296% of salaries and wages in benefits.
- Assume the clinical staff will cost $3,755,000 for FY 2018-19.

Data Entry Staff:

- Assume data for 132,526 beneficiaries for FY 2018-19 must be keyed into the POS. Assume it takes 10 minutes, at $15 per hour with 45.296% of salaries and wages in benefits. Assume the data entry staff will cost $481,000 for FY 2018-19.

IT Support Staff:

- Assume two full-time staff per 56 counties work 1,776 hours annually at $26 per hour with 45.296% of salaries and wages in benefits. Assume the IT support staff will cost $7,515,000 for FY 2017-18 and FY 2018-19.

PERFORMANCE OUTCOMES SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 12

4. 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	FY 2017-18	FY 2018-19
Clinical Staff (75% FF / 25% GF)	$0	$3,755
Data Entry (50% FF / 50% GF)	$0	$481
IT Staff (50% FF / 50% GF)	$7,515	$7,515
Total	$7,515	$11,751

5. The estimated total costs on an accrual basis for FY 2017-18 and FY 2018-19 are:

(Dollars in Thousands)

Fiscal Year	TF	Training	IT Costs	County Staffing
FY 2017-18	$14,329	$2,697	$4,117	$7,515
FY 2018-19	$16,683	$745	$4,187	$11,751

6. On a cash basis for FY 2018-19, the Department will pay, 72% of FY 2017-18 claims, and 24% of FY 2018-19 claims.

(Dollars in Thousands)

Fiscal Year	TF	Training	IT Costs	County Staffing
FY 2017-18	$10,317	$1,942	$2,964	$5,411
FY 2018-19	$4,004	$179	$1,005	$2,820
Total FY 2018-19	**$14,321**	**$2,121**	**$3,969**	**$8,231**

(Dollars in Thousands)

POS Costs	TF	GF	FF
Training	$2,121	$539	$1,582
IT Costs	$3,969	$1,984	$1,985
County Staffing Costs	$8,231	$3,891	$4,340
Total FY 2018-19	**$14,321**	**$6,414**	**$7,907**

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
75% Title XIX / 25% GF (4260-101-0001/0890)

PAVE SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER:	13
IMPLEMENTATION DATE:	4/2016
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	1932

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$14,587,000	$14,511,000
STATE FUNDS	$3,873,100	$7,675,500
FEDERAL FUNDS	$10,713,900	$6,835,500

DESCRIPTION

Purpose:
This policy change estimates the costs for the implementation and ongoing operations 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 is deploying an enrollment portal and associated business processes to automate provider management activities to comply with provider integrity mandates under the Affordable Care Act (ACA). Some of the requirements are:

- Perform monthly database checks on enrolled providers and associated entities that manage, own, or have a controlling interest;
- Enroll all ordering, referring, or prescribing (ORP) 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.

With the initial implementation of PAVE in November 2016, eighty percent of Medi-Cal Fee-For-Service (FFS) providers have the option to enroll and/or update their enrollment via an intuitive, web-based, interactive, and secure portal. The remaining twenty percent can use PAVE with the next release. Prior to PAVE, provider enrollment utilized a paper-based process.

The remaining provider populations enrolled will be consolidated and included in the release scheduled for implementation in June 2018. PAVE is expected to enter the certified Maintenance and Operations (M&O) phase in FY 2018-19.

The Department will reimburse the Centers for Medicare and Medicaid Services (CMS) in July 2018 as a result of an improperly claimed enhanced Federal Financial Participation (FFP). The Department did not receive pre-approval from CMS to commence activities in preparation for PAVE integration and incorrectly claimed enhanced FFP for design, development, and implementation (DD&I) and M&O activities. Upon CMS' certification of PAVE, the Department will be reimbursed for M&O activities that occurred prior to certification and become eligible for enhanced FFP for M&O.

PAVE SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 13

Reason for Change:
The change from the prior estimate, for FY 2017-18, is a decrease due to updated implementation costs that are also shifting from FY 2017-18 to FY 2018-19 and reducing consultant costs. The net change from the prior estimate, for FY 2018-19, is a net decrease due to updated implementation costs, anticipating higher M&O costs because of increased PAVE use, extending help desk services, and ending some consultant services in FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is a net decrease due to decreased implementation, increased M&O costs, decreased consultant costs, and reimbursement of the improperly claimed FFP to CMS in FY 2018-19.

Methodology:
1. The FY 2017-18 and FY 2018-19 costs are as follows:

FY 2017-18	TF	GF	FF
Implementation (90% Title XIX / 10% GF)	$6,289,000	$629,000	$5,660,000
Consultants (90% Title XIX / 10% GF)	$2,262,000	$226,000	$2,036,000
Operations (50% Title XIX / 50% GF)	$6,036,000	$3,018,000	$3,018,000
Total	**$14,587,000**	**$3,873,000**	**$10,714,000**

FY 2018-19	TF	GF	FF
Implementation (90% Title XIX / 10% GF)	$6,193,000	$619,000	$5,574,000
Consultants (90% Title XIX / 10% GF)	$382,000	$38,000	$344,000
Operations (50% Title XIX / 50% GF)	$7,260,000	$3,630,000	$3,630,000
M&O Post Certification (75% Title XIX / 25% GF)	$676,000	$169,000	$507,000
Improperly Claimed FFP 100% GF (4260-101-0001)	$0	$3,219,000	($3,219,000)
Total	**$14,511,000**	**$7,675,000**	**$6,836,000**

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)
100% GF (4260-101-0001)
100% Title XIX FFP (4260-101-0890)

POSTAGE & PRINTING

OTHER ADMIN. POLICY CHANGE NUMBER:	14
IMPLEMENTATION DATE:	7/1993
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	231

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$20,586,000	$26,786,000
STATE FUNDS	$10,421,000	$13,521,000
FEDERAL FUNDS	$10,165,000	$13,265,000

DESCRIPTION

Purpose:
This policy change budgets postage and printing costs for items sent to or used by Medi-Cal beneficiaries.

Authority:
Welfare & Institutions Code 14124.5 and 10725
Title 42, Code of Federal Regulations (CFR), Section 435.905
Title 45, Code of Federal Regulations (CFR), Section 164.520

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).

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).

Reason for Change:
There is no change from the prior estimate for FY 2017-18. The change from the prior estimate, for FY 2018-19, is an increase in base mass mailing costs as a result of higher postage due to an additional item included in the regular quarterly (JvR) mailings in order to meet HIPPA requirements. The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase in base mass mailing costs as a result of higher postage due to an additional item included in the regular quarterly (JvR) mailings in order to meet HIPPA requirements.

POSTAGE & PRINTING

OTHER ADMIN. POLICY CHANGE NUMBER: 14

Methodology:

1. Based on FY 2016-17 actuals assume that 14,126,000 1095-B mailings are conducted in each fiscal year.

2. Assume that the cost per mailing is $0.581.

   14,126,000 mailings x $0.581 per mailing = $8,207,000 (rounded)

3. 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 $0.633 per unit. The increase in cost per unit is calculated based on non-bulk mailing rates.

   8% x 14,126,000 mailings = 1,130,080 returned mailings

   1,130,080 returned mailings x $0.633 per unit = $715,000 (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 $0.594 per unit. For FY 2017-18 and FY 2018-19, assume the Department will send NFRAs at 50% of FY 2016-17 NFRA totals (215,000 mailings). The attributed decrease in quantity is due to data integrity enhancements from the Medi-Cal Eligibility Data System and the Statewide Automated Welfare System data reconciliation efforts.

   215,000 mailings x 50% = 107,500

   107,500 mailings x $0.594 per mailing = $64,000 (rounded)

5. For FY 2018-19, in order to maintain HIPAA compliance, the JvR will be mailed out as First Class Presort. Currently, the JvR is mailed out as Standard Presort at an average mail cost (per piece) of approximately $0.17. Average mail cost (per piece) for FY 2018-19 base mass mailings are projected to increase to $0.378.

6. The Department estimates the printing and postage costs for FY 2017-18 and FY 2018-19 are:

FY 2017-18	**TF**	**GF**	**FF**
Base Mass Mailing*	$9,000,000	$4,628,000	$4,372,000
1095B			
1095 Mailings	$8,207,000	$4,103,500	$4,103,500
Reprinted/Corrected Form 1095-B	$715,000	$357,500	$357,500
Notice for Requested Action	$64,000	$32,000	$32,000
1095 B Subtotal	$8,986,000	$4,493,000	$4,493,000
Emergency Mailings	$2,600,000	$1,300,000	$1,300,000
Total	**$20,586,000**	**$10,421,000**	**$10,165,000**

POSTAGE & PRINTING

OTHER ADMIN. POLICY CHANGE NUMBER: 14

FY 2018-19	TF	GF	FF
Base Mass Mailing*	$15,200,000	$7,728,000	$7,472,000
1095B			
1095 Mailings	$8,207,000	$4,103,500	$4,103,500
Reprinted/Corrected Form 1095-B	$715,000	$357,500	$357,500
Notice for Requested Action	$64,000	$32,000	$32,000
1095 B Subtotal	$8,986,000	$4,493,000	$4,493,000
Emergency Mailings	$2,600,000	$1,300,000	$1,300,000
Total	**$26,786,000**	**$13,521,000**	**$13,265,000**

***Totals may differ due to rounding.

Funding:
50 % Title XIX FF/ 50 % GF (4260-101-0001/0890)
100 % GF (4260-101-0001)*

ACTUARIAL COSTS FOR RATE DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 15
IMPLEMENTATION DATE: 8/2015
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1937

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$16,872,000	$16,872,000
STATE FUNDS	$8,436,000	$8,436,000
FEDERAL FUNDS	$8,436,000	$8,436,000

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 (FFP) 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 2017-18 or FY 2018-19.

There is no change from FY 2017-18 to FY 2018-19 in the current estimate.

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.

4. Specific costs are identified for existing workloads (Coordinated Care Initiative (CCI), Affordable

ACTUARIAL COSTS FOR RATE DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 15

Care Act (ACA) Expansion, and Health Homes 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.

The FY 2017-18 and FY 2018-19 amounts on an accrual basis are estimated to be:

PC #	PC Title	FY 2017-18	FY 2018-19
OA-17	CCI - Administrative Costs	$1,010,000	$1,010,000
OA-55	ACA Expansion Admin Costs	$517,000	$517,000
N/A	Health Homes Program - Contractor Costs	$650,000	$650,000
N/A	Ongoing Actuarial Services	$15,100,000	$15,100,000
	Total	**$17,277,000**	**$17,277,000**

The FY 2017-18 and FY 2018-19 amounts on a cash basis are estimated to be:

(Dollars in Thousands)

	TF	GF	HHP Fund	FF
FY 2017-18	**$16,872**	$8,119	$317	$8,436
FY 2018-19	**$16,872**	$8,119	$317	$8,436

Funding:
50% Title XIX FF / 50% GF (4260-101-0890/0001)
50% HHP Fund (4260-601-0942)

PASRR

OTHER ADMIN. POLICY CHANGE NUMBER:	16
IMPLEMENTATION DATE:	7/2013
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	1720

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$11,783,000	$12,706,000
STATE FUNDS	$2,945,750	$3,176,500
FEDERAL FUNDS	$8,837,250	$9,529,500

DESCRIPTION

Purpose:
This policy change estimates the contractor costs for the Preadmission Screening and Resident Review (PASRR) Level II evaluations, system build-out, ongoing Maintenance and Operations (M&O), and electronic training 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. The current contractor completes Level II evaluations for the federally mandated PASRR program. 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 contract to provide Level II evaluations from January 2, 2015, through December 31, 2017, was terminated on October 31, 2017. A new contract was awarded in March 2018.

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 and II screening forms and evaluations,
- Significantly reduces processing time for submissions,
- Eliminates paper submissions,
- Reduces the time a contractor takes to return completed evaluations, and
- Increases efficiencies for PASRR clinicians by reducing processing time for determinations.

PASRR

OTHER ADMIN. POLICY CHANGE NUMBER: 16

In July 2018, the Department will award contracts for system build-outs to enhance the existing PASRR system for the following enhancements:

- Reconsideration Letter feature that ensures facilities and the Department have complete records for patient care plans,
- Provide a landing page that allows facilities to activate, deactivate, and reset their user accounts,
- Extend the existing functionality of the system to allow electronic exchange of PASRR information between hospitals and NFs,
- Enhance the determination wizard, and
- Design a new dashboard.

The Department will also provide electronic trainings to NFs and general acute care hospitals on the new automated system. A contract to design the electronic trainings will be awarded in July 2018. The Department plans to have the training available on the PASRR website by June 30, 2019.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is a decrease due to delays in awarding the new Level II evaluations contract and executing the M&O contract. There is no change from the prior estimate for FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a net increase due to:

- Contractor costs for the system build-out and the electronic training beginning in FY 2018-19,
- A full year of M&O costs in FY 2018-19, and
- The new Level II evaluations contractor costs in FY 2017-18 including initial setup costs.

Methodology:

1. Payments for a Level II evaluations contract began in February 2015 and ended in March 2018. Payments for the new Level II evaluations contract began in April 2018.

2. The PASRR IT system requires ongoing M&O. An M&O contract, executed in October 2017, annually costs $350,000.

3. Electronic training costs for the NFs and general acute care hospitals are based on the California Multiple Award Schedule (CMAS) rate of $135.00 per hour. The electronic training contract will be awarded in July 2018 and costs will begin August 2018.

4. Beginning in FY 2018-19, contracts will be awarded to extend the existing functionality and build-out activities for the PASRR system. The contract implements enhancements to the PASRR system that will allow general acute care hospitals and NFs to exchange PASRR information. The contract cost is expected to be $1,150,000 in FY 2018-19.

5. The PASRR payments on a cash basis are estimated at:

FY 2017-18	TF	GF	FF
Evaluations	$11,651,000	$2,913,000	$8,738,000
Ongoing M&O Costs	$132,000	$33,000	$99,000
Total	**$11,783,000**	**$2,946,000**	**$8,837,000**

PASRR

OTHER ADMIN. POLICY CHANGE NUMBER: 16

FY 2018-19	TF	GF	FF
Evaluations	$11,100,000	$2,775,000	$8,325,000
Ongoing M&O Costs	$350,000	$88,000	$262,000
Electronic Training	$106,000	$26,000	$80,000
System Build Out	$1,150,000	$288,000	$862,000
Total	**$12,706,000**	**$3,177,000**	**$9,529,000**

Funding:
75% Title XIX / 25% GF (4260-101-0001/0890)

MIS/DSS CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER:	17
IMPLEMENTATION DATE:	7/2002
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	252

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$11,379,000	$11,331,000
STATE FUNDS	$3,013,750	$3,004,750
FEDERAL FUNDS	$8,365,250	$8,326,250

DESCRIPTION

Purpose:
The policy change estimates the contract costs associated with the Management Information System/Decision Support System (MIS/DSS).

Authority:
Not Applicable

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 the Department and other approved entities. The Department uses the system in various ways, including:

- 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 enhancement, 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.

Reason for Change:
There is no change from the prior estimate for FY 2017-18 and FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the absence of software and hardware refreshes in FY 2018-19.

MIS/DSS CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 17

Methodology:

1. It is estimated that the contractor will be paid the following amounts:

FY 2017-18	TF	GF	FF
Fixed Costs (75% FF / 25% GF)	$8,648,000	$2,162,000	$6,486,000
Additional Fixed Costs (50% FF / 50% GF)	$676,000	$338,000	$338,000
Variable Costs (75% FF / 25% GF)	$2,055,000	$514,000	$1,541,000
Total	**$11,379,000**	**$3,014,000**	**$8,365,000**

FY 2018-19	TF	GF	FF
Fixed Costs (75% FF / 25% GF)	$8,555,000	$2,139,000	$6,416,000
Additional Fixed Costs (50% FF / 50% GF)	$688,000	$344,000	$344,000
Variable Costs (75% FF / 25% GF)	$2,088,000	$522,000	$1,566,000
Total	**$11,331,000**	**$3,005,000**	**$8,326,000**

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
75% Title XIX / 25% GF (4260-101-0001/0890)

CCI-ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	18
IMPLEMENTATION DATE:	7/2012
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1677

	FY 2017-18	FY 2018-19
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)

Interdependent Policy Changes:
Not Applicable

Background:
In coordination with Federal and State Government, the CCI provides benefits of coordinated care models to persons eligible for both Medicare and Medi-Cal (dual eligibles). 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.

CCI-ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 18

Reason for Change:
For FY 2017-18, there is no change from the previous estimate. There is no change from FY 2017-18 to FY 2018-19.

Methodology:
1. The CCI development, implementation and operation costs began July 2012 and will continue through FY 2018-19.

2. All costs for FY 2017-18and FY 2018-19 will be funded at 50/50 FMAP.

FY 2017-18	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 2018-19	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)

SURS AND MARS SYSTEM REPLACEMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	19
IMPLEMENTATION DATE:	7/2016
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	1980

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$10,090,000	$9,077,000
STATE FUNDS	$1,802,050	$2,086,250
FEDERAL FUNDS	$8,287,950	$6,990,750

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:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
System Replacement Project (SRP) constitutes 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, a component 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), ongoing maintenance, and operations 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 system replacement for MARS is scheduled to be implemented by July 2018.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is a decrease due to the removal of operational costs caused by a delay in implementing MARS' system replacement. There is no change from the prior estimate for FY 2018-19. The net change from FY 2017-18 to FY 2018-19, in the current estimate, is decreased DD&I costs offset by increased operational costs in FY 2018-19.

SURS AND MARS SYSTEM REPLACEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 19

Methodology:

1. The estimated breakdown of the SURS costs are:

SURS	FY 2017-18	FY 2018-19
DD&I Costs	$838,000	$0
Operational Costs	$5,287,000	$5,357,000
Total	$6,125,000	$5,357,000

2. The estimated breakdown of the MARS costs are:

MARS	FY 2017-18	FY 2018-19
DD&I Costs	$3,965,000	$1,220,000
Operational Costs	$0	$2,500,000
Total	$3,965,000	$3,720,000

3. The estimated total costs for SURS and MARS are:

SURS and MARS	**TF**	**GF**	**FF**
DD&I Costs (90% FF / 10% GF)	$4,803,000	$480,000	$4,323,000
Operational Costs (75% FF / 25% GF)	$5,287,000	$1,322,000	$3,965,000
Total FY 2017-18	**$10,090,000**	**$1,802,000**	**$8,288,000**

SURS and MARS	**TF**	**GF**	**FF**
DD&I Costs (90% FF / 10% GF)	$1,220,000	$122,000	$1,098,000
Operational Costs (75% FF / 25% GF)	$7,857,000	$1,964,000	$5,893,000
Total FY 2018-19	**$9,077,000**	**$2,086,000**	**$6,991,000**

Funding:

75% Title XIX / 25% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)

MEDI-CAL RECOVERY CONTRACTS

OTHER ADMIN. POLICY CHANGE NUMBER:	20
IMPLEMENTATION DATE:	2/2008
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1551

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$9,475,000	$9,339,000
STATE FUNDS	$2,368,750	$2,334,750
FEDERAL FUNDS	$7,106,250	$7,004,250

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) or workers' compensation (WC) insurance. 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)	14-90133 A01
Department of Public Health	14-90132 A01
Department of Social Services	15-92000
EDEX Information Systems Inc. (WC)	17-94425
EDEX Information Systems Inc. (WC)	18-95016
Health Management Systems Inc. (HI)	13-90283 A01
OHCIR Contract (HI)	Pending
Health Management Systems Inc. (WC)	03-75807 A03
Health Management Systems Inc. (WC)	03-75060 A03
Health Management Systems Inc. (WC)	07-65000 A06
Health Management Systems Inc. (WC)	07-65001 A06
Health Management Systems Inc. (WC)	12-89100
Health Management Systems Inc. (WC)	12-89101
Lexis-Nexis	17-94029
RELX Inc. (Pending Approval)	17-94636

Interdependent Policy Changes:
Not Applicable

MEDI-CAL RECOVERY CONTRACTS

OTHER ADMIN. POLICY CHANGE NUMBER: 20

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 recipient eligibility file and the contractor's policy holder/subscriber file,
- Identification and recovery of Medi-Cal expenditures in WC actions,
- 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 recipients,
- Access to certified copies of birth, death, marriage and divorce records of Medi-Cal recipients,
- Access to disability determinations for applicants requesting an exemption from estate recovery claims on the basis of a disability,
- Cost avoidance activities,
- Electronic access to historical records from the previous WC contractor, and
- Online access to case records, case update notifications, hearing notices, and batch processing of liens.

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 contingency based contracts with Health Management Systems, Inc. for the WC Recovery Program have concluded by request of the contractor, as of December 31, 2017, and agreed by the Department. As such, the entire WC Recovery Program has been in-sourced for all future WC recoveries.

The contingency fee for the new Other Health Coverage Identification and Recovery (OHCIR) contract, which succeeds the HI contract, is unknown at this time. DHCS will not know the contingency rate until a bidder has been awarded the contract. Therefore, invoice payments to the new contractor for recoveries occurring December 2018 onward is unknown at this time. This estimate uses the same 8.5% contingency rate as HMS contract 13-90283 A01 for projection purposes, however, the contingency rate may change.

Reason for Change:
The change in FY 2017-18, from the prior estimate, is a decrease due to:

- A delay in processing a contract amendment for the HMS HI contract which resulted in lower projected recoveries,
- A change in expected recoveries for the HMS WC contract, and
- A decrease in the variable pricing for the Online Database Contracts. Additionally, RELX Inc. is pending a new contract that will be utilizing a fixed rate based on less users which will also decrease costs.

The change in FY 2018-19, from the prior estimate, is a decrease due to:

- Updated HMS HI projections resulting in lower recoveries and continuing the lower recoveries trend for the new HI contract, and
- Utilizing the fixed rate basis for the new RELX Inc. contract.

MEDI-CAL RECOVERY CONTRACTS

OTHER ADMIN. POLICY CHANGE NUMBER: 20

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to continuing the lower projection for the new HMS HI contract as well as not having WC costs due to insourcing the WC cases.

Methodology:

1. The amounts paid to the Health Management Systems Inc. (HMS) contractor for HI is contingent upon recoveries. Assume the following recoveries for each fiscal year at the contracted contingency percentage. Assume the current HMS HI contract expires November 30, 2018, and the new HI recovery contract has an anticipated term date of December 1, 2018, through November 30, 2023.

   Recoveries x Contingency Fee % = Total Contingency Fee

Contractor	FY 2017-18 Recoveries	FY 2018-19 Recoveries	Contingency Fee %	FY 2017-18 Contingency Fee	FY 2018-19 Contingency Fee
HMS 13	$109,375,000	$45,169,000	8.5%	$9,297,000	$3,840,000
Contractor Unknown (OHCIR) (Pending)	$0	$63,236,000	8.5%	$0	$5,375,000

2. The amounts paid to the HMS contractor for WC is contingent upon recoveries. The HMS contract expired April 2017; however, the contractor continued to work their remaining Medi-Cal caseload until December 31, 2017. HMS turned over all remaining cases to the Department as of January 1, 2018. As such, there will be no estimate of recoveries or contingency fees for FY 2018-19.

   Recoveries x Contingency Fee % = Total Contingency Fee

Contractor	FY 2017-18 Recoveries	FY 2018-19 Recoveries	Contingency Fee %	FY 2017-18 Contingency Fee	FY 2018-19 Contingency Fee
HMS 03	$4,500	$0	15%	$1,000	$0
HMS 07	$83,000	$0	21%	$18,000	$0
HMS 12	$96,000	$0	23.75%	$23,000	$0
Total				$42,000	$0

3. The amounts paid to the Online Database contractors is based upon usage:

Online Database Contracts	FY 2017-18	FY 2018-19
Department of Industrial Relations - EAMS	$4,000	$4,000
Department of Industrial Relations – WCIS	$2,000	$2,000
Department of Social Services	$11,000	$11,000
Lexis-Nexis/RELX Inc.	$97,000	$85,000
CA Department of Public Health	$17,000	$17,000
EDEX Information Systems Inc. (WC)	$5,000	$5,000
Total	$136,000	$124,000

MEDI-CAL RECOVERY CONTRACTS

OTHER ADMIN. POLICY CHANGE NUMBER: 20

4. The payments shown below include recent recovery activity.

FY 2017-18	TF	GF	FF
Health Insurance	$9,297,000	$2,324,000	$6,973,000
Worker's Compensation	$42,000	$11,000	$31,000
Online Database Contracts	$136,000	$34,000	$102,000
Total	**$9,475,000**	**$2,369,000**	**$7,106,000**

FY 2018-19	TF	GF	FF
Health Insurance	$9,215,000	$2,304,000	$6,911,000
Worker's Compensation	$0	$0	$0
Online Database Contracts	$124,000	$31,000	$93,000
Total	**$9,339,000**	**$2,335,000**	**$7,004,000**

Funding:
75% Title XIX / 25% GF (4260-101-0001/0890)

LITIGATION RELATED SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 21
IMPLEMENTATION DATE: 7/2009
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1381

	FY 2017-18	FY 2018-19
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 2017-18 or FY 2018-19. There is no change from FY 2017-18 to FY 2018-19 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 FY 2017-18, and $7,880,000 for FY 2018-19.

2. Based on prior actuary costs and the Department's projected workload, costs will be $2,100,000 in FY 2017-18 and $2,100,000 in FY 2018-19.

(Dollars in Thousands)

FY 2017-18	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: 21

(Dollars in Thousands)

FY 2018-19	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 (4260-101-0001/0890)

NEWBORN HEARING SCREENING PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER:	22
IMPLEMENTATION DATE:	7/2014
ANALYST:	Matt Wong
FISCAL REFERENCE NUMBER:	1824

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$7,700,000	$8,225,000
STATE FUNDS	$3,850,000	$4,112,500
FEDERAL FUNDS	$3,850,000	$4,112,500

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

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 contracts breakdowns are as follows:

- Data management contract
  - The data management contract #14-90182 began on December 19, 2014, and expired on November 30, 2016.
  - To remain in compliance with Health & Safety Codes Section 123975 and Sections 124115 through 124120.5 from November 30, 2016 through April 30, 2017, the Department reinstated the use of the Infant Reporting Form through April 30, 2017.
  - Beginning May 1, 2017, the prior vendor's data management service was extended through July 31, 2018, by a no-cost Letter of Intent (LOI) between DHCS and the vendor.
  - The Department will procure an IT Project Management contractor in FY 2018-19 to evaluate automated solution options and to oversee the coding, testing, and implementation of a new automated data management system.

NEWBORN HEARING SCREENING PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 22

- HCC contract #15-92041 began July 1, 2015 and expires May 31, 2020.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is a decrease due to the Project Manager starting in FY 2018-19.

The change from the prior estimate, for FY 2018-19, is an increase due to the role of the Project Manager starting in FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to the addition of an IT project manager and business analyst as well as a test analyst.

Methodology:
1. The Data Management Contract costs for FY 2017-18 consists of $1,200,000 for the use of the prior contractor's data management system.

2. The Data Management Contract costs for FY 2018-19 consists of $1,200,000 for the use of a vendor's data management system, $275,000 for an IT project manager and business analyst to oversee the implementation of the data management system, and $250,000 for a test analyst to ensure the system is ready to be deployed statewide.

3. The estimated costs for FY 2017-18 and FY 2018-19 are as follows:

FY 2017-18	TF	GF	FF
HCC contract	$6,500,000	$3,250,000	$3,250,000
Data Management Contract	$1,200,000	$600,000	$600,000
Total	**$7,700,000**	**$3,850,000**	**$3,850,000**

FY 2018-19	TF	GF	FF
HCC contract	$6,500,000	$3,250,000	$3,250,000
Data Management Contract	$1,200,000	$600,000	$600,000
IT Project Management & Business Analyst	$275,000	$137,500	$137,500
Test Analyst	$250,000	$125,000	$125,000
Total	**$8,225,000**	**$4,112,500**	**$4,112,500**

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

HIPAA CAPITATION PAYMENT REPORTING SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER:	23
IMPLEMENTATION DATE:	10/2012
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	1318

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$6,677,000	$5,488,000
STATE FUNDS	$1,669,250	$1,372,000
FEDERAL FUNDS	$5,007,750	$4,116,000

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 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 effectiveness of monthly reconciliations and supporting research efforts to perform recoveries.

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 are being made to further enhance the system to incorporate a paperless accounting interface and accommodate the Coordinated Care Initiative (CCI) Duals Demonstration project. The accounting interface will increase the Department's efficiency to key the growing number of invoices. The system will have to be maintained on an ongoing basis, as new functionality is required.

A two-year contract was executed in July 2013, and a one-year extension was exercised in April 2014 to address the system enhancements. The contract had an end date of April 30, 2016; however, in April 2016, two one-year optional extensions were exercised to extend the contract to April 30, 2018, in order to continue enhancements to the systems to complete the incorporation of a paperless accounting interface and accommodate the CCI Duals Demonstration Project.

In May 2017, it was determined that additional staffing and a new contract were needed. A new contract for CAPMAN, expected to start March 2018 and end February 2021, will overlap with the existing contract until its expiration. The overlap will allow for a successful transition of operations if a new vendor is awarded the contract. Two one-year optional extensions may be exercised to extend this contract.

HIPAA CAPITATION PAYMENT REPORTING SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 23

Reason for Change:
The change from the prior estimate, for FY 2017-18, is a decrease due to a delay in acquiring the new contract. There is no change from the prior estimate for FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to the assumption of operations for the new contract and the termination of the old contract in FY 2018-19.

Methodology:
1. The old CAPMAN contract, expiring April 30, 2018, will cost $4,931,000 in FY 2017-18.

2. The new CAPMAN contract, beginning March 1, 2018, will cost $1,666,000 in FY 2017-18 and $5,089,000 in FY 2018-19.

3. A project manager (PM) and senior systems engineer (SSE) will be funded through the old CAPMAN contract until April 30, 2018. Starting May 1, 2018, the contracted positions will be funded through a separate contract. Costs are $80,000 in FY 2017-18 and $399,000 in FY 2018-19 for the PM and SSE.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2017-18	$6,677	$1,669	$5,008
FY 2018-19	$5,488	$1,372	$4,116

Funding:
75% HIPAA FFP / 25% HIPAA Fund (4260-117-0001/0890)

DMC COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER:	24
IMPLEMENTATION DATE:	5/2018
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1871

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$190,000	$5,811,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$190,000	$5,811,000

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:
PC 56 Drug Medi-Cal Organized Delivery System Waiver

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 will include the existing treatment modalities (ODF, IOT, NTP, and Perinatal RTS), and the additional new and expanded services. Participation in the waiver is voluntary for counties and implementation is estimated on a phase-in basis beginning February 2017. Counties that opt-in to participate in the DMC-ODS waiver may also opt-in to implement UR and QA activities to safeguard against unnecessary and inappropriate medical care and expenses. Federal funds (FF) reimbursement for these costs is available at 75% for skilled professional medical personnel (SPMP) and 50% for all other personnel.

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is due to the following:

- Due to delays in implementing the DMC-ODS waiver, the total number of counties providing UR and QA activities in FY 2017-18, on an accrual basis, decreased from 20 counties to seven counties. From the seven counties, three counties (Riverside, Marin, and Santa Clara) began UR and QA activities in FY 2016-17.

DMC COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 24

- Invoicing delays will shift all FY 2016-17 and FY 2017-18 claims, except for Riverside County's FY 2016-17 (March 2017 – June 2017) and FY 2017-18 (July 2017 – September 2017) claims, to be paid in FY 2018-19.
- The total number of counties projected to provide UR and QA activities in FY 2018-19, on an accrual basis, decreased from 40 counties to 31 counties. From the 31 counties, a total of 23 counties will incur costs on a cash basis in FY 2018-19.

The change in the current estimate, from FY 2017-18 to FY 2018-19, is due to payments for one county (Riverside) in FY 2017-18, compared to payments to a total of 23 counties in FY 2018-19.

Methodology:

1. DMC-ODS waiver services for opt-in counties began in February 2017 on a phase-in basis.

    - FY 2016-17 - Four counties (San Mateo, Riverside, Marin, and Santa Clara) implemented the waiver in FY 2016-17. From the four counties, three counties, (Riverside, Marin, and Santa Clara) began providing UR and QA activities in the same fiscal year. San Mateo is projected to begin services in July 2018.
    - FY 2017-18 - Seven additional counties (for a total of 11 counties) began providing waiver services in FY 2017-18. Of the seven additional counties, four counties are projected to provide UR and QA activities in the same fiscal year, and three counties will provide UR and QA activities in FY 2018-19.
    - FY 2018-19 - 29 additional counties (for a total of 40 counties) will begin providing waiver services in FY 2018-19. Of the 29 additional counties, 20 counties are projected to provide UR and QA activities in in the same fiscal year. The remaining nine counties are projected to begin the activities in the following fiscal year.

2. Of the 58 counties in California, 18 counties did not opt-in to implement the DMC-ODS waiver.

3. UR and QA expenditures are shared between FF and county funds (CF). Payments are expected to begin in May 2018.

4. For counties that started UR and QA activities in FY 2016-17 and FY 2017-18, payments for only Riverside County is expected to be processed in FY 2017-18. Costs for the remaining counties is estimated to be processed in FY 2018-19. For FY 2018-19, a total of 23 counties are expected to process payments.

5. For FY 2018-19, 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.

6. For counties that submit claims annually, assume claims will be submitted and paid the following fiscal year.

	Accrual	FY 2017-18	FY 2018-19
FY 2016-17 Claims	$274,000	$164,000	$110,000
FY 2017-18 Claims	$4,828,000	$112,000	$4,716,000
FY 2018-19 Claims	$11,553,000	$0	$3,625,000
Total	$16,655,000	$276,000	$8,451,000

DMC COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 24

7. Assume 75% of the total claims are for SPMP costs and the remaining 25% are for other personnel costs.

8. UR and QA costs for SPMP will receive enhanced federal reimbursement of 75%. All other personnel will receive 50% federal reimbursement.

9. The estimated UR and QA administrative cost for FY 2017-18 and FY 2018-19 are:

FY 2017-18	TF	FF	CF
SPMP	$207,000	$155,000	$52,000
Other Personnel	$69,000	$35,000	$34,000
Total	$276,000	**$190,000**	$86,000

FY 2018-19	TF	FF	CF
SPMP	$6,338,000	$4,754,000	$1,584,000
Other Personnel	$2,113,000	$1,057,000	$1,056,000
Total	$8,451,000	**$5,811,000**	$2,640,000

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

MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)

OTHER ADMIN. POLICY CHANGE NUMBER:	25
IMPLEMENTATION DATE:	7/2009
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	1441

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$5,000,000	$5,000,000
STATE FUNDS	$1,674,500	$1,674,500
FEDERAL FUNDS	$3,325,500	$3,325,500

DESCRIPTION

Purpose:
This policy change estimates the system development, maintenance and operations (M&O), and other department reimbursements for the Medi-Cal Eligibility Data System (MEDS).

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
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:

- 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; and
- Supporting eligibility and enrollment functions.

The M&O funding supports MEDS operations and system enhancements. Operations include enabling counties to perform online statistical analysis and MEDS-alert reporting. The system's reporting tools track and report all county worker transactions for MEDS. Some of these system development and M&O costs are offset by reimbursements made from other departments.

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 (TANF), In Home Support Services (IHSS), and Covered California's Advance Premium Tax Credit (APTC).

The Department implements MEDS functionality to support enhancements driven by county consortia and state and county business partners.

MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)

OTHER ADMIN. POLICY CHANGE NUMBER: 25

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.

Reason for Change:
There is no change from the prior estimate for FY 2017-18 and FY 2018-19. There is no change from FY 2017-18 to FY 2018-19 in the current estimate.

Methodology:
1. The projected costs for FY 2017-18 and FY 2018-19 are:

FY 2017-18	TF	GF	FF	Reimbursement
System Development (50% FF / 50% GF)	$660,000	$330,000	$330,000	$0
Maintenance & Operations (75% FF / 25% GF)	$3,994,000	$998,000	$2,996,000	$0
Other Department Reimbursement (100% Reimbursement)	$346,000	$0	$0	$346,000
Total	**$5,000,000**	**$1,328,000**	**$3,326,000**	**$346,000**

FY 2018-19	TF	GF	FF	Reimbursement
System Development (50% FF / 50% GF)	$660,000	$330,000	$330,000	$0
Maintenance & Operations (75% FF / 25% GF)	$3,994,000	$998,000	$2,996,000	$0
Other Department Reimbursement (100% Reimbursement)	$346,000	$0	$0	$346,000
Total	**$5,000,000**	**$1,328,000**	**$3,326,000**	**$346,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
75% Title XIX / 25% GF (4260-101-0001/0890)
100% Reimbursement (4260-601-0995)

CLINICAL DATA COLLECTION

OTHER ADMIN. POLICY CHANGE NUMBER:	26
IMPLEMENTATION DATE:	9/2016
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	1972

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$3,094,000	$2,474,000
STATE FUNDS	$353,200	$322,400
FEDERAL FUNDS	$2,740,800	$2,151,600

DESCRIPTION

Purpose:
This policy change estimates the costs to modify the Department's existing Post-Adjudicated Claims and Encounter System (PACES) to accept an industry standard file that will contain clinical data.

Authority:
Section 1903(i)(4) of the Social Security Act (SSA)

Interdependent Policy Changes:
Not Applicable

Background:
Section 1903(i)(4) of the SSA precludes federal funding under Medicaid, for a hospital or skilled nursing facility that does not have a utilization review plan in effect that meets the requirements set forth in Section 1861(k) of the SSA. Section 1903(i)(4) also provides that these requirements may be waived when a State Medicaid Agency, such as the Department, demonstrates it has a utilization review procedure in place that is superior to the federal requirement.

The Centers for Medicare and Medicaid Services (CMS) has provided clear direction to California to transition from the current Treatment Authorization Request (TAR) model to an approach that allows hospitals to perform their own utilization reviews, while the Department provides monitoring and oversight. Currently, 21 Designated Public Hospitals in California already use this approach. This model will need to be expanded into approximately 350 more hospitals.

The Department received federal approval for renewal of the Superior Systems Waiver (SSW), effective October 1, 2017, to September 30, 2019. The SSW describes how the Department will begin, effective January 1, 2016, collaborating with all District Municipal Public Hospitals (DMPHs) and private hospitals to transition away from the TAR process to performing their own utilization review, followed by monitoring and oversight by the Department. The utilization management systems the hospitals will use (InterQual and MCG, formerly Milliman Care Guidelines) are nationally recognized compilations of evidence-based medical criteria that provide clinical decision support. Hospitals servicing Medicare patients are required to use InterQual.

CLINICAL DATA COLLECTION

OTHER ADMIN. POLICY CHANGE NUMBER: 26

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 (MIS/DSS) Data Warehouse. These efforts will fulfill Medicaid funding requirements and enable the Department to efficiently collect and review clinical medical records.

Effective November 1, 2017, a vendor concurrently provides design, development, and implementation (DD&I) and maintenance and operations (M&O) services. The first phase of implementation is scheduled to be completed by December 2018. A technical contractor, that began services August 2016, and a business contractor, that commenced services February 2017, will provide services until September 30, 2019. Each contractor annually costs $250,000.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is a decrease due to fewer months of DD&I and M&O expenditures, caused by a delay in the vendor's start date, and the removal of independent verification and validation (IV&V) services because of a federal determination that IV&V certification is not required for this project. The net change from the prior estimate, for FY 2018-19, is an increase due to higher contractor costs due to the extension of the contracts through September 2019, new software costs, and no IV&V costs. The net change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to decreased software costs and no hardware expenditures offset by increased DD&I and M&O costs in FY 2018-19.

Methodology:
1. Total costs are estimated to be:

FY 2017-18	TF	GF	FF
Technical Contractor	$250,000	$25,000	$225,000
Business Contractor	$250,000	$25,000	$225,000
DD&I Vendor	$802,000	$80,000	$722,000
M&O*	$292,000	$73,000	$219,000
Software	$500,000	$50,000	$450,000
Hardware	$1,000,000	$100,000	$900,000
Total FY 2017-18	**$3,094,000**	**$353,000**	**$2,741,000**

FY 2018-19	TF	GF	FF
Technical Contractor	$250,000	$25,000	$225,000
Business Contractor	$250,000	$25,000	$225,000
DD&I Vendor	$1,374,000	$137,000	$1,237,000
M&O*	$500,000	$125,000	$375,000
Software	$100,000	$10,000	$90,000
Total FY 2018-19	**$2,474,000**	**$322,000**	**$2,152,000**

Funding:
90% Title XIX / 10% GF (4260-101-0001/0890)
75% Title XIX / 25% GF (4260-101-0001/0890)*

DRUG MEDI-CAL COUNTY ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER:	27
IMPLEMENTATION DATE:	7/2014
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1813

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$6,356,000	$27,767,000
STATE FUNDS	$269,000	$373,000
FEDERAL FUNDS	$6,087,000	$27,394,000

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 costs 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: 27

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is due to higher quarterly interim claims received in FY 2017-18 and increasing the projections for FY 2018-19 based on the actual claims data.

The change in the current estimate, from FY 2017-18 to FY 2018-19 is due to including annual administrative settlement costs in FY 2018-19.

Methodology:
1. Interim claims for the first three quarters (Q1 - Q3) are paid in the same fiscal year. The last quarter claims (Q4) are paid the following fiscal year.

2. ODS waiver county administrative claims are included in the current estimate for counties that submit quarterly interim claims.

3. Annual settlements for county administration claims for FY 2014-15 and FY 2015-16 will be paid in FY 2018-19.

4. The estimated DMC county administration costs for FY 2017-18 and FY 2018-19 are:

FY 2017-18	County Admin Cost	General Fund	Title XIX	County Funds
FY 2016-17 Claims, Q4	$5,795,000	$135,000	$2,898,000	$2,762,000
FY 2017-18 Claims, Q1-Q3	$6,377,000	$134,000	$3,189,000	$3,054,000
Total for FY 2017-18	$12,172,000	**$269,000**	**$6,087,000**	$5,816,000

(Dollars in Thousands)

FY 2018-19	County Admin Cost	General Fund	Title XIX	County Funds
FY 2014-15, Annual Admin Settlement	$20,490,000	$45,000	$10,245,000	$10,200,000
FY 2015-16, Annual Admin Settlement	$21,514,000	$47,000	$10,757,000	$10,710,000
FY 2017-18 Claims, Q4	$3,195,000	$70,000	$1,598,000	$1,527,000
FY 2018-19 Claims, Q1-Q3	$9,585,000	$211,000	$4,794,000	$4,580,000
Total for FY 2018-19	$54,784,000	**$373,000**	**$27,394,000**	$27,017,000

Funding:
100% Title XIX FF (4260-101-0890)
100% GF (4260-101-0001)

MEDICARE BENEFICIARY IDENTIFIER

OTHER ADMIN. POLICY CHANGE NUMBER:	28
IMPLEMENTATION DATE:	7/2017
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	1997

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$1,862,000	$1,636,000
STATE FUNDS	$186,200	$163,600
FEDERAL FUNDS	$1,675,800	$1,472,400

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 April 2018.

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 Department made its systems and business processes ready for external integrated system testing with CMS and others by October 2017. The Department also provided an initial impact assessment to CMS. Removal of SSNs from all existing Medicare cards was completed by April 2018. The issuance of new Medicare cards with MBI will be completed by April 16, 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;

MEDICARE BENEFICIARY IDENTIFIER

OTHER ADMIN. POLICY CHANGE NUMBER: 28

- Support federal efforts to improve information security by limiting the exchange of SSNs; and
- Reduce the risk of information security breaches.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is a decrease due to adding another fiscal year to the project's Advanced Planning Document and spreading contract costs over a four-year period (previously three-year period). The change from the prior estimate, for FY 2018-19, is an increase due to costs from a new System Development Notice, which was not previously budgeted. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to decreased contract costs based on the April 2019 end date in FY 2018-19.

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 2017-18 and FY 2018-19 are:

Fiscal Year	TF	GF	FF
FY 2017-18	$1,862,000	$186,000	$1,676,000
FY 2018-19	$1,636,000	$164,000	$1,472,000

Funding:
90% Title XIX / 10% GF (4260-101-0001/0890)

ELECTRONIC ASSET VERIFICATION PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER:	29
IMPLEMENTATION DATE:	12/2017
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	2002

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$1,164,000	$3,328,000
STATE FUNDS	$582,000	$1,664,000
FEDERAL FUNDS	$582,000	$1,664,000

DESCRIPTION

Purpose:
This policy change estimates the administrative costs associated with implementing a new Asset Verification Program (AVP).

Authority:
Welfare & Institutions Code, Section 14013.5
Title 42 U.S. Code, Sections 1396w and 1383(e)(1)
California Financial Code, Section 293
State Plan Amendment 09-003

Interdependent Policy Changes:
Not Applicable

Background:
Section 1940 of the Social Security Act requires that the State implement an AVP for use in Non-Modified Adjusted Gross Income 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 State Plan Amendment 09-003, Asset Verification System, was approved on April 16, 2009, and State legislation (Welfare and Institutions Code, 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 information on asset amounts for ABD beneficiaries under the AVP. The reimbursement rate is $4.00 per beneficiary.

Program expenditures are reduced when the AVP provides supplemental data that increases the accuracy of eligibility determinations for the ABD population or detects unreported assets that result in the discontinuance of a beneficiary.

ELECTRONIC ASSET VERIFICATION PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 29

The Department conducted a test pilot of the AVP in order to determine the success of the AVP in identifying unreported assets and to assist with the development of the program. The pilot concluded in April, 2017, and the implementation of the AVP occurred in December 2017.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is a decrease due to a two month delay in implementation and a lower than anticipated number of asset verifications performed by the Department. There is no change from the prior estimate for FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to a full year of costs and an increase in the number of asset verifications performed.

Methodology:
1. The policy does not apply to applicants or recipients of federal Supplemental Security Income/State Supplementary Payment (SSI/SSP), 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 291,000 in FY 2017-18 and 832,000 in FY 2018-19.

4. Using the reimbursement rate of $4.00 per beneficiary, the estimated vendor cost are:

   FY 2017-18: 291,000 asset verifications x $4.00/beneficiary = **$1,164,000 TF ($582,000 GF)**
   FY 2018-19: 832,000 asset verifications x $4.00/beneficiary = **$3,328,000 TF ($1,664,000 GF)**

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

SDMC SYSTEM M&O SUPPORT

OTHER ADMIN. POLICY CHANGE NUMBER:	30
IMPLEMENTATION DATE:	7/2013
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	1732

	FY 2017-18	FY 2018-19
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
Pending Contract

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). The Department signed a two-year contract which began on July 1, 2014, and utilized the two one-year optional extensions. 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 is securing a new two-year contract with two one-year optional extensions. The new contract will begin July 1, 2018, and end June 30, 2022.

Reason for Change:
There is no change from the prior estimate for FY 2017-18 and FY 2018-19. There is no change from FY 2017-18 to FY 2018-19 in the current estimate.

Methodology:
1. The estimated contractor cost for the four-year contract, that ends June 2018, is $8,000,000.

2. The contractor cost for the new four-year contract, beginning July 2018, is $8,000,000.

3. Projections include the cost of ongoing M&O to process SMHS and SUDS claims payments.

FY 2017-18	TF	GF	FF
Contractor cost	$2,000,000	$1,000,000	$1,000,000
M&O	$325,000	$162,500	$162,500
Total	**$2,325,000**	**$1,162,500**	**$1,162,500**

SDMC SYSTEM M&O SUPPORT

OTHER ADMIN. POLICY CHANGE NUMBER: 30

FY 2018-19	TF	GF	FF
Contractor cost	$2,000,000	$1,000,000	$1,000,000
M&O	$325,000	$162,500	$162,500
Total	**$2,325,000**	**$1,162,500**	**$1,162,500**

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

CA-MMIS MEDCOMPASS SOLUTION

OTHER ADMIN. POLICY CHANGE NUMBER:	31
IMPLEMENTATION DATE:	7/2017
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	1982

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$2,252,000	$1,576,000
STATE FUNDS	$327,500	$229,300
FEDERAL FUNDS	$1,924,500	$1,346,700

DESCRIPTION

Purpose:
This policy change estimates the MedCompass system replacement costs associated with the California Medicaid Management Information System (CA-MMIS) Medical Fiscal Intermediary (FI) contract.

Authority:
Title XIX of the Federal Social Security Act 1903(a)(3)
Contract # 16-93448

Interdependent Policy Changes:
Not Applicable

Background:
The FI contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The FI contract was awarded on December 8, 2009, and became effective May 3, 2010, which began the takeover phase. The FI contract term runs through March 31, 2020.

MedCompass was a component of the System Replacement Project (SRP). As a result of the SRP vendor not completing all development and implementation, the Department contracted directly with a new vendor to complete the remaining development and implement functionality. The new contract began July 1, 2017, and ends December 31, 2022.

The MedCompass solution is a tool used to bring case data from the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and In-Home Health Operations (IHO) programs into a central database housing all beneficiary information. This central database provides common access to the data needed to transfer services from EPSDT to IHO after a beneficiary turns 21 years of age. MedCompass will also include capabilities for alerts, messaging, tasks, and queues that will provide immediate notifications to caseworkers to reach out to the beneficiaries more efficiently and enhance the services provided to them.

Reason for Change:
There is no change from the prior estimate for FY 2017-18. There is no change from the prior estimate for FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to FY 2017-18 including implementation costs for the new contract.

CA-MMIS MEDCOMPASS SOLUTION

OTHER ADMIN. POLICY CHANGE NUMBER: 31

Methodology:
1. The estimated costs are based upon the contract provisions.

FY 2017-18	TF	GF	FF
50% Title XIX / 50% GF	$150,000	$75,000	$75,000
90% Title XIX / 10% GF	$2,055,000	$205,000	$1,850,000
100% GF	$47,000	$47,000	$0
Total FY 2017-18	**$2,252,000**	**$327,000**	**$1,925,000**

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF	$105,000	$52,000	$53,000
90% Title XIX / 10% GF	$1,438,000	$144,000	$1,294,000
100% GF	$33,000	$33,000	$0
Total FY 2018-19	**$1,576,000**	**$229,000**	**$1,347,000**

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)

MITA

OTHER ADMIN. POLICY CHANGE NUMBER:	32
IMPLEMENTATION DATE:	1/2011
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	1137

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$2,772,000	$5,274,000
STATE FUNDS	$277,200	$527,400
FEDERAL FUNDS	$2,494,800	$4,746,600

DESCRIPTION

Purpose:
This policy change estimates the costs associated with the Medicaid Information Technology Architecture (MITA).

Authority:
MITA Initiative sponsored by Centers for Medicare and Medicaid Services (CMS)
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.

Pursuant to an IA with the Regents of the University of California, Davis (UC Davis), an analyst and programmer will, until December 31, 2018, provide support for data management and analytics to assist the Department in reaching MITA maturity.

MITA

OTHER ADMIN. POLICY CHANGE NUMBER: 32

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 2017-18 and FY 2018-19, is an increase due to revising the estimate based on actual contract costs. Additionally, FY 2018-19 has new IA costs and funding for contracts to support planning for advance MITA maturity of provider management processes.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to new contractor and IA costs, new costs for planning activities related to provider management processes, and a full year of payments in FY 2018-19.

Methodology:
1. The FY 2017-18 and FY 2018-19 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 project will employ contracted positions to continue the implementation phase in FY 2017-18 and FY 2018-19.

3. The old contract was effective December 2015 through August 2017.

4. The new contract is effective December 2017 through December 2019. Payments for the contract began in January 2018.

5. There was a three-month gap between the old and new contract. Some MITA project work was completed during this time by state staff.

6. FY 2018-19 includes costs for an IA with UC Davis to implement analytics as a service to support MITA.

7. FY 2018-19 also includes new costs to support planning for MITA maturity advancement of provider management processes totaling $2,282,000 TF ($228,000 GF).

8. The projected costs are:

Fiscal Year	TF	GF	FF
FY 2017-18	$2,772,000	$277,000	$2,495,000
FY 2018-19	$5,274,000	$527,000	$4,747,000

Funding:
90% Title XIX / 10% GF (4260-101-0001/0890)

MEDS MODERNIZATION

OTHER ADMIN. POLICY CHANGE NUMBER:	33
IMPLEMENTATION DATE:	2/2013
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	1731

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$2,015,000	$0
STATE FUNDS	$266,750	$0
FEDERAL FUNDS	$1,748,250	$0

DESCRIPTION

Purpose:
This policy change estimates the cost to hire contractors to comply with the State's Project Approval Lifecycle (PAL) process, develop Advance Planning Documents (APDs), participate in the project planning efforts, and maintain existing Business Rules Extraction (BRE) software.

Authority:
Title 42, Code of Federal Regulations, Sections 95.611 and 433.110

Interdependent Policy Changes:
Not Applicable

Background:
Medi-Cal Eligibility Data System (MEDS) is a statewide database containing eligibility information for public assistance programs administered by the Department and other departments. The Department is seeking to transition MEDS from an outdated, stand-alone legacy system to a modernized, integrated solution. In addition, the MEDS Modernization Project increases the Department's alignment with the federal Medicaid Information Technology Architecture (MITA).

The Department's Planning APD (PAPD), for the planning phase of the project, was approved by the Centers for Medicare and Medicaid Services (CMS) in September 2014. An updated PAPD was approved by CMS in September 2016. A subsequent PAPD was submitted to CMS in October 2017. As of July 1, 2016, management of the project transitioned to the Office of Systems Integration (OSI) and resource needs were adjusted to reflect the project partnership with the Department, OSI, and the Department of Social Services (CDSS). The Department has secured support funding for PAL Stage Gate 3 and 4 activities. PAL Stage Gate 3 will begin upon approval of Stage Gate 2 by the California Department of Technology (CDT).

Reason for Change:
There is no change from the prior estimate for FY 2017-18 and FY 2018-19. There are no local assistance funds allocated to this project in FY 2018-19.

Methodology:
1. Project planning, alternative analysis, and County Welfare Director's Association consultant costs have been based on standard hourly rates for the specific type of consulting services provided, the estimated number of resources, and hours needed per fiscal year.

2. BRE Software Maintenance fees are based on a percentage of the cost for the associated software licenses that were originally purchased.

MEDS MODERNIZATION

OTHER ADMIN. POLICY CHANGE NUMBER: 33

3. Costs are shared between federal funds (FF) and general funds (GF).

FY 2017-18	TF	GF	FF
BRE Software Maintenance*	$435,000	$109,000	$326,000
Project Planning Consultants	$429,000	$43,000	$386,000
Alternative Analysis Consultants	$1,000,000	$100,000	$900,000
County Welfare Director's Association Consultants	$151,000	$15,000	$136,000
Total	**$2,015,000**	**$267,000**	**$1,748,000**

Funding:
75% Title XIX / 25% GF (4260-101-0001/0890)*
90% Title XIX / 10% GF (4260-101-0001/0890)

SSA COSTS FOR HEALTH COVERAGE INFO.

OTHER ADMIN. POLICY CHANGE NUMBER: 34
IMPLEMENTATION DATE: 1/1989
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 237

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$2,120,000	$1,500,000
STATE FUNDS	$1,060,000	$750,000
FEDERAL FUNDS	$1,060,000	$750,000

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 for FY 2017-18, from the prior estimate, is an increase due to a FY 2017-18 invoice adjustment. In FY 2016-17 there was system error that resulted in an invoice credit, therefore a corrective action was applied to the first quarter invoice in FY 2017-18 which caused a larger than normal invoice for that quarter.

There is no change from the prior estimate for FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease based on the large invoice for FY 2017-18 and assuming the average of historical data from previous quarter invoices for FY 2018-19.

Methodology:
1. The following projections are based upon the most current actual billings from SSA.

Fiscal Year	TF	GF	FF
FY 2017-18	$2,120,000	$1,060,000	$1,060,000
FY 2018-19	$1,500,000	$750,000	$750,000

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

CALIFORNIA HEALTH INTERVIEW SURVEY

OTHER ADMIN. POLICY CHANGE NUMBER:	35
IMPLEMENTATION DATE:	7/2015
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1902

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$1,272,000	$1,100,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,272,000	$1,100,000

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 million to $1,100,000, to align the contract to updated salary costs and operating expenses for the CHIS contractors.

Reason for Change:
There is no change from the prior estimate to FY 2017-18 or FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to FY 2017-18 including retroactive claims for FY 2015-16.

Methodology:
1. Assume UCLA will submit documentation of CPEs on the CHIS survey. Expenditures will consist of funds received by UCLA from non-federal sources.

CALIFORNIA HEALTH INTERVIEW SURVEY

OTHER ADMIN. POLICY CHANGE NUMBER: 35

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. UCLA is expected to submit additional invoices for FY 2015-16 and FY 2016-17 for payment in FY 2017-18.

6. The estimated administrative costs reimbursements for FY 2017-18 and FY 2018-19, on a cash basis are:

(Dollars in Thousands)

FY 2017-18	TF	FF
FY 2015-16 Claims	$79	$79
FY 2016-17 Claims	$643	$643
FY 2017-18 Claims	$550	$550
Total for FY 2017-18	**$1,272**	**$1,272**

FY 2018-19	TF	FF
FY 2017-18 Claims	$550	$550
FY 2018-19 Claims	$550	$550
Total for FY 2018-19	**$1,100**	**$1,100**

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

FAMILY PACT PROGRAM ADMIN.

OTHER ADMIN. POLICY CHANGE NUMBER:	36
IMPLEMENTATION DATE:	7/2012
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1675

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$1,207,000	$1,207,000
STATE FUNDS	$603,500	$603,500
FEDERAL FUNDS	$603,500	$603,500

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. One is to increase access to services for low-income women and men, including adolescents. The other is to increase 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/HIV training and technical assistance services;
- And toll-free referral number.

Reason for Change:
There is no change.

Methodology:
1. The administrative costs for the Family PACT program are estimated in the table below:

Fiscal Year	TF	GF	FF
FY 2017-18	$1,207,000	$603,500	$603,500
FY 2018-19	$1,207,000	$603,500	$603,500

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

SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER:	37
IMPLEMENTATION DATE:	7/2002
ANALYST:	Matt Wong
FISCAL REFERENCE NUMBER:	258

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$950,000	$950,000
STATE FUNDS	$950,000	$950,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of the contract with the County of San Diego for administrative services.

Authority:
Welfare & Institutions Code, sections 14089(g) and 14089.05

Interdependent Policy Changes:
Not Applicable

Background:
The Department contracts with the County of San Diego to provide administrative services for the San Diego Geographic Managed Care program. The Department reimburses the County for staff, postage, printing, data center access, travel, health care options presentations to explain the enrollment and disenrollment process, customer assistance and problem resolution. Effective August 2003, these services are no longer eligible for federal match.

Reason for Change:
There is no change from the prior estimate for FY 2017-18 or FY 2018-19.

There is no change from FY 2017-18 to FY 2018-19 in the current estimate.

Methodology:
1. Based on contract provisions, the administrative activities costs will be $950,000 for FY 2017-18 and FY 2018-19.

Funding:
100% State GF (4260-101-0001)

MMA - DSH ANNUAL INDEPENDENT AUDIT

OTHER ADMIN. POLICY CHANGE NUMBER:	38
IMPLEMENTATION DATE:	7/2009
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	266

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$888,000	$926,000
STATE FUNDS	$444,000	$463,000
FEDERAL FUNDS	$444,000	$463,000

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 (approximately 50 public 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.

The audits will be 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:
There is no change from the prior estimate for FY 2017-18 and FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to an increase in the expected invoice amounts for FY 2018-19, as the contractual amount increased when the contract was extended for two years.

MMA - DSH ANNUAL INDEPENDENT AUDIT

OTHER ADMIN. POLICY CHANGE NUMBER: 38

Methodology:

1. The amended contract amount is $3,623,291 which extended the contract period by two years for a total of four years.

2. The contract has been extended from January 1, 2016 through December 31, 2019.

3. In FY 2017-18, the Department will make the final payment for the FY 2013-14 audit and partial payment for the FY 2014-15 audit.

4. In FY 2018-19, the Department will make the final payment for the FY 2014-15 audit and partial payment for the FY 2015-16 audit.

Fiscal Years	TF	GF	FF
FY 2017-18	$888,000	$444,000	$444,000
FY 2018-19	$926,000	$463,000	$463,000

Funding:

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

ENCRYPTION OF PHI DATA

OTHER ADMIN. POLICY CHANGE NUMBER:	39
IMPLEMENTATION DATE:	5/2010
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	1452

	FY 2017-18	FY 2018-19
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 electronic Protected Health Information (PHI).

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The Department acquired hardware, supplies, and associated maintenance and support services to protect and secure electronic data stored on backup systems. 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 Department information assets from unauthorized disclosure;
- Protect the privacy of Medi-Cal beneficiaries;
- Prevent lawsuits from citizens for privacy violations;
- 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 the backup and recovery methods for the current infrastructure by enhancing infrastructure components. The upgrade is necessary to take advantage of technologies, such as backup to disk, 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 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 management.

ENCRYPTION OF PHI DATA

OTHER ADMIN. POLICY CHANGE NUMBER: 39

Reason for Change:
There is no change from the prior estimate for FY 2017-18 and FY 2018-19. There is no change from FY 2017-18 to FY 2018-19 in the current estimate.

Methodology:
1. The following amounts are based upon the latest projections of cost:

Fiscal Year	TF	GF	FF
FY 2017-18	$750,000	$375,000	$375,000
FY 2018-19	$750,000	$375,000	$375,000

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

POSTAGE AND PRINTING - THIRD PARTY LIAB.

OTHER ADMIN. POLICY CHANGE NUMBER: 40
IMPLEMENTATION DATE: 7/1996
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 240

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$728,000	$696,000
STATE FUNDS	$364,000	$348,000
FEDERAL FUNDS	$364,000	$348,000

DESCRIPTION

Purpose:
This policy change estimates the Third Party Liability postage and printing costs.

Authority:
Government Code 7295.4
AB 155 (Chapter 820, Statutes of 1999)

Interdependent Policy Changes:
Not Applicable

Background:
The Department uses direct mailers and specialized reports to identify Medi-Cal beneficiaries with private health insurance, determine the legal liabilities of third parties to pay for services furnished by Medi-Cal, and ensure that Medi-Cal is the payer of last resort. The number of forms printed and mailed, as well as the number of reports received, correlates to the Medi-Cal caseload. The Department uses a document folder/inserter machine to automate and process the mailings in-house.

Reason for Change:
The change in FY 2017-18, from the prior estimate, is a net decrease due to:

- Moving Worker's Compensation operations in-house resulting in the addition of mail-outs for these cases,
- Purchasing a new copier, and
- Eliminating the need to mail out the Estate Recovery Questionnaire.

The change in FY 2018-19, from the prior estimate, is a net decrease due to adding in-house Worker's Compensation mail-outs and eliminating the need to mail out the Estate Recovery Questionnaire.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to the new purchase of the document folder inserter machine and copier in FY 2017-18.

POSTAGE AND PRINTING - THIRD PARTY LIAB.

OTHER ADMIN. POLICY CHANGE NUMBER: 40

Methodology:

1. The cost breakdown is shown below:

FY 2017-18	Postage	Printing	Other	Total
Personal Injury	$209,000	$26,000	$0	$235,000
Worker's Compensation	$14,000	$1,000	$0	$15,000
Estate Recovery	$64,000	$359,000	$0	$423,000
Overpayments	$7,000	$2,000	$0	$9,000
Cost Avoidance	$5,000	$1,000	$0	$6,000
*AB 155 Invoices	$1,000	$0	$0	$1,000
**Document Folder Inserter	$0	$0	$1,000	$1,000
**New Document Folder Inserter	$0	$0	$29,000	$29,000
**New Copier	$0	$0	$9,000	$9,000
Total	$300,000	$389,000	$39,000	**$728,000**

FY 2018-19	Postage	Printing	Other	Total
Personal Injury	$209,000	$27,000	$0	$236,000
Worker's Compensation	$10,000	$1,000	$0	$11,000
Estate Recovery	$64,000	$359,000	$0	$423,000
Overpayments	$7,000	$2,000	$0	$9,000
Cost Avoidance	$5,000	$1,000	$0	$6,000
*AB 155 Invoices	$1,000	$0	$0	$1,000
**Document Folder Inserter	$0	$0	$1,000	$1,000
**New Document Folder Inserter	$0	$0	$4,000	$4,000
**Copier Maintenance	$0	$0	$5,000	$5,000
Total	$296,000	$390,000	$10,000	**$696,000**

*AB 155 requires invoicing for premiums for the 250% Working Disabled Program.
** Cost of maintenance agreement for equipment used to process mailings in-house.

2. The estimated costs are:

Fiscal Year	TF	GF	FF
FY 2017-18	**$728,000**	**$364,000**	**$364,000**
FY 2018-19	**$696,000**	**$348,000**	**$348,000**

Funding:

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

IRS REPORTING FOR MIN. ESSENTIAL COVERAGE

OTHER ADMIN. POLICY CHANGE NUMBER:	41
IMPLEMENTATION DATE:	7/2017
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	1965

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$340,000	$684,000
STATE FUNDS	$170,000	$342,000
FEDERAL FUNDS	$170,000	$342,000

DESCRIPTION

Purpose:
The policy change estimates the costs associated with the system to communicate with the Internal Revenue Service (IRS) in order to transmit the minimum essential coverage (MEC) data of Medi-Cal recipients.

Authority:
Internal Revenue Code Section 6055
Contract # 16-93508
Pending Contract

Interdependent Policy Changes:
Not Applicable

Background:
As a provider of Medi-Cal MEC, the Department is required to report IRS information comprised of months of coverage for individuals that meet MEC and furnish a statement to those individuals. The Department developed an in-house interface to support the transmission of data from Medi-Cal Eligibility Data System (MEDS) to the IRS Affordable Care Act (ACA) Information Return (AIR) system.

The Department procured a contractor with specialized web-services and data modeling technical skills to assist with the IRS AIR system requirement changes and provide knowledge transfer to the Department. The contractor provides project planning, oversight, scheduling, reporting, and coordination between the mainframe and web services team.

The current maintenance and operations (M&O) contract began May 2017 and ended March 2018. The Department will competitively re-procure the M&O contract to address new IRS requirements for a transmission structure change and table structure optimization. The new contract, beginning June 2018 and ending May 2019, will include a one-year optional extension.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is a decrease due to the current contract ending March 2018, without the option to extend, because of the expiration of the vendor Master Services Agreement certification. The change from the prior estimate, for FY 2018-19, is an increase due to procuring a new contract and contractor costs shifting from FY 2017-18 to FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to higher contractor costs in FY 2018-19.

IRS REPORTING FOR MIN. ESSENTIAL COVERAGE

OTHER ADMIN. POLICY CHANGE NUMBER: 41

Methodology:

1. The current M&O contract, began May 2017 and ended March 2018, costs $340,000. Payments for this contract began July 2017.

2. The new M&O contract, begins June 2018 and ends May 2019, will cost $684,000. Payments for this contract will begin July 2018.

3. Costs are based on the current understanding of the IRS AIR system, the project implementation enhancement to exchange data between the Department and the IRS, and system stabilization.

4. Estimates were developed using analogous cost estimating, known system requirements, and industry standard system development expenses.

M&O Contract Costs	TF	GF	FF
FY 2017-18	$340,000	$170,000	$170,000
FY 2018-19	$684,000	$342,000	$342,000

Funding:

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

T-MSIS

OTHER ADMIN. POLICY CHANGE NUMBER:	42
IMPLEMENTATION DATE:	9/2013
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	1768

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$418,000	$276,000
STATE FUNDS	$104,500	$69,000
FEDERAL FUNDS	$313,500	$207,000

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). This policy change was formerly titled ETL Data Solution.

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.

The Department procured a consulting resource to upgrade the server environment housing the ETL tools and develop an operational recovery plan, systems schema, and documentation. The final payment for the contracted vendor, who started in January 2017, was made in September 2017. In November 2017, CMS approved an Implementation Advance Planning Document Update (IAPDU) for federal FY 2017-18, providing enhanced funding for software support and training costs.

Reason for Change:
The net change from the prior estimate, for FY 2017-18, is a decrease due to reduced software costs offset by new training costs. The net change from the prior estimate, for FY 2018-19, is an increase due to reduced software costs offset by new training costs. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to increased software costs, higher training costs, and no M&O costs in FY 2018-19.

T-MSIS

OTHER ADMIN. POLICY CHANGE NUMBER: 42

Methodology:

1. The M&O contract for server environment upgrade, operational recovery plan development, systems schema development, and documentation work began in January 2017 and ended in September 2017. The final payment for the contractor was made in September 2017.

2. Support and maintenance for Data Quality was procured in February 2017 and will be re-procured annually.

3. The software maintenance renewal for Power Center was re-procured in December 2017 with an optional one-year extension.

4. An IAPDU provides annual funding for training on software and industry data cleansing procedures through federal FY 2020-21.

FY 2017-18	TF	GF	FF
M&O	$181,000	$45,000	$136,000
Software	$226,000	$57,000	$169,000
Training	$11,000	$3,000	$8,000
Total	**$418,000**	**$105,000**	**$313,000**

FY 2018-19	TF	GF	FF
Software	$248,000	$62,000	$186,000
Training	$28,000	$7,000	$21,000
Total	**$276,000**	**$69,000**	**$207,000**

Funding:

75% Title XIX / 25% GF (4260-101-0001/0890)

VENDOR FOR AAC RATE STUDY

OTHER ADMIN. POLICY CHANGE NUMBER:	43
IMPLEMENTATION DATE:	9/2015
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1483

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$386,000	$332,000
STATE FUNDS	$193,000	$166,000
FEDERAL FUNDS	$193,000	$166,000

DESCRIPTION

Purpose:
This policy change estimates the costs related to contractors used for: (1) project management services related to the implementation of the Covered Outpatient Drug Final Rule and (2) a contract to survey drug price information from pharmacies and develop a new Professional Dispensing Fee (PDF).

Authority:
AB 102 (Chapter 29, Statutes of 2011)
CMS Final Rule- 42 CFR Part 447 [CMS-2345-FC]

Interdependent Policy Changes:
Not Applicable

Background:
AB 102 authorized the Department to develop a reimbursement methodology for drugs based on a new benchmark, the Average Acquisition Cost (AAC) to replace the Average Wholesale Price (AWP). Additionally, on February 1, 2016, the Centers for Medicare & Medicaid Services (CMS) issued a final rule on Medicaid Covered Outpatient Drugs (COD) in the Federal Register. This rule revised requirements pertaining to Medicaid reimbursement for COD, including a requirement that states implement an AAC reimbursement methodology, as well as develop a new PDF which will reflect the cost of the pharmacist's professional services and cost to dispense the drug product to a Medicaid beneficiary. Both components of reimbursement are to be effective April 1, 2017. However, due to required system changes, implementation of this new reimbursement methodology is not expected until August 2018.

Additionally, in December 2016, CMS directed the Department to change its reimbursement methodology for blood factor products and services and submit these changes for federal approval via a State Plan Amendment (SPA).

Mercer contract
To obtain information from providers necessary to establish AACs and the PDF, the Department hired a contractor to survey drug acquisition price information from Medi-Cal pharmacy providers as well as to concurrently survey the pharmacy's ancillary costs for acquiring the drug, pharmacist's professional services, and costs to dispense the drug product to a Medicaid beneficiary. The drug acquisition cost survey will be used to examine and evaluate the CMS national pricing benchmark, National Average Drug Acquisition Cost (NADAC), as it compares to prices paid by California pharmacies for all outpatient drugs. The contractor will use relevant information from Medi-Cal pharmacy providers, reflecting the costs of dispensing outside of the actual cost of the drug, in order to calculate a new PDF.

VENDOR FOR AAC RATE STUDY

OTHER ADMIN. POLICY CHANGE NUMBER: 43

In order to obtain the necessary drug pricing information, the Department entered into a contract with Mercer. Mercer conducted a survey of the purchase prices paid by California retail pharmacies for all outpatient drugs and prepared a report comparing the results of that survey to the NADAC and the amount Medi-Cal currently reimburses for each product. The contract with Mercer was from September 2015 to June 2017, which allowed the Department to retain the contractor's services throughout the transition from the current AWP reimbursement to a new AAC based methodology. The final payment to Mercer was made in August2017.

Public Consulting Group contract

Due to the complexity of work, compacted timelines, and need for extensive coordination between the Department, pharmacy stakeholders, and CMS regarding the transition to an AAC reimbursement methodology, the Department entered into a contract with Public Consulting Group, Inc. (PCG), to manage the AAC rate study methodology project. This contract was initiated on July 1, 2014 to meet the AAC related work authorized under AB 102. It was extended in May 2016 to assist in meeting the requirements of the Final Rule for Covered Outpatient Drugs. The contract ended in June 2017 and final payment, to PCG, was made in August2017.

Lucchese Consulting Solutions contract

On July 1, 2017, the Department entered into a contract with Lucchese Consulting Solutions, LLC to continue managing the work previously under way and coordinate the new work related to changes in blood factor product reimbursement. The Lucchese Consulting Solutions, LLC contract has a one-year term with the option for two one-year extensions. As work to implement the AAC reimbursement methodology and new PDF continues, the Department will execute the first one-year extension to maintain contractor services through FY2018-19.

Checkbox subscription

Pursuant to the Welfare and Institutions Code 14105.45(b)(2)(B), the Department adopted a new process where pharmacy providers must attest annually to total claim volume to be appropriately reimbursed a PDF for claims. It is estimated 4,000, of the 5,700 active providers, will attest annually. The Department purchased a subscription to Checkbox, a professional web-enabled survey software, to efficiently process and store provider attestations.

The Checkbox subscription and professional services to develop and implement the survey tool began October 2017. The software was ready for use on January 1, 2018. Based on the three-year subscription, the first year costs (FY 2017-18) of $8,000 will be funded in the support budget. The remaining two years of the subscription are anticipated to cost $7,000 annually and will be budgeted in the Medi-Cal local assistance estimate.

Reason for Change:

The change from the prior estimate, for FY 2017-18 and FY 2018-19, is immaterial.

The change in the current estimate, from FY 2017-18 to FY 2018-19, is immaterial.

Methodology:

1. The Mercer contract for the AAC rate study, for $305,000, was from September 1, 2015 to June 30, 2017. The survey and report aspects of the project is complete and the costs for the AAC contractor concluded on June 30, 2017. The final payment of $36,000 was made to Mercer in August 2017.

2. The PCG project management contract for $325,000 concluded on June 30, 2017. The final payment of $25,000 was made to PCG in August2017.

VENDOR FOR AAC RATE STUDY

OTHER ADMIN. POLICY CHANGE NUMBER: 43

3. On July 1, 2017, the contract with Lucchese Consulting Solutions, LLC began to manage ongoing system changes, continue the AAC implementation efforts, and work on changes associated with the reimbursement of blood factor products. Assume the contract costs are $325,000 for FY 2017-18 and FY 2018-19.

4. The three-year subscription with Checkbox began October 2017. The Medi-Cal local assistance portion of the subscription will cost $7,000 annually starting in FY 2018-19.

Contractor Costs	TF	GF	FF
FY 2017-18	$386,000	$193,000	$193,000
FY 2018-19	$332,000	$166,000	$166,000

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

CCT OUTREACH - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	44
IMPLEMENTATION DATE:	4/2011
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1556

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$342,000	$342,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$342,000	$342,000

DESCRIPTION

Purpose:
This policy change budgets the federal funding to cover administrative costs for increasing the California Community Transitions (CCT) enrollment.

Authority:
Money Follows the Person (MFP) Rebalancing Demonstration (42 USC 1396a)
Deficit Reduction Act of 2005 (P.L. 109-171), Section 6071
Affordable Care Act (ACA) (P.L. 111-148), Section 2403

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 CCT enrollment. This supplemental grant funding does not require matching funds. The costs were 100% federallyfunded.

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 CCT enrollment. These activities qualify as administrative marketing and outreach activities, which are 100% federally funded through the MFP grant.

Reason for Change:
There is no change from the prior estimate for FY 2017-18 and FY 2018-19. There is no change from FY 2017-18 to FY 2018-19 in the currentestimate.

Methodology:
1. Assume $342,000 from the additional MFP grant funding is expected to be paid in FY 2017-18.

2. Assume $342,000 from the additional MFP grant funding is expected to be paid in FY 2018-19.

CCT OUTREACH - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 44

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 2017-18	**TF**	**GF**	**FF**
CCT Costs (PC 34):			
Total Non-DD GF costs and Total FFP	$23,109,000	$2,142,000	$20,967,000
CCT Savings:			
Total Non-DD GF savings and Total FFP	($30,868,000)	($15,434,000)	($15,434,000)
CCT Fund Transfer to CDSS & CDDS (PC 41)	$2,808,000	$0	$2,808,000
CCT Outreach - Admin costs (OA 44)	**$342,000**	**$0**	**$342,000**
Total of CCT PCs including pass through	($4,609,000)	($13,292,000)	$8,683,000

*The savings are included in the total, however, they are fully reflected in the base estimates.

FY 2018-19	**TF**	**GF**	**FF**
CCT Costs (PC 34):			
Total Non-DD GF costs and Total FFP	$10,569,000	$1,679,000	$8,890,000
CCT Savings:			
Total Non-DD GF savings and Total FFP	($26,693,000)	($13,346,000)	($13,347,000)
CCT Fund Transfer to CDSS & CDDS (PC 41)	$1,283,000	$0	$1,283,000
CCT Outreach - Admin costs (OA 44)	**$342,000**	**$0**	**$342,000**
Total of CCT PCs including pass through	($14,499,000)	($11,667,000)	($2,832,000)

*The savings are included in the total, however, they are fully reflected in the base estimates.

Funding:
MFP Federal Grant (4260-106-0890)

MEDICARE BUY-IN QUALITY REVIEW PROJECT

OTHER ADMIN. POLICY CHANGE NUMBER:	45
IMPLEMENTATION DATE:	10/2012
ANALYST:	Jedidiah Warren
FISCAL REFERENCE NUMBER:	1590

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$100,000	$300,000
STATE FUNDS	$50,000	$150,000
FEDERAL FUNDS	$50,000	$150,000

DESCRIPTION

Purpose:
This policy change estimates the cost of contracts with the University of Massachusetts Medical School (UMass) to identify potential overpayments to the Centers for Medicare and Medicaid Services (CMS) and Medicare providers related to the Medicare Buy-In process for Medicare/Medi-Cal dual-eligible members.

Authority:
Welfare & Institutions Code 14124.92
Contract 16-93204

Interdependent Policy Changes:
Not Applicable

Background:
The Department entered into a new three-year contract (16-93204) with the UMass, with an effective date of September 1, 2016, to identify potential overpayments to CMS and Medicare providers related to the Medicare Buy-In process for Medicare/Medi-Cal dual-eligible members. UMass assists the Department in auditing the invoices received from CMS to pay the Medicare premiums. Payments to UMass are contingent upon recovery of overpayments from CMS and Medicare providers. These payments are 10% of the amounts recovered.

Reason for Change:
The change in FY 2017-18, from the prior estimate, is a decrease due to a delay in case corrections which has caused a delay in an invoice payment.

The change in FY 2018-19, from the prior estimate, is an increase due to including the remaining FY 2017-18 payments in FY 2018-19. In addition, the projected recoveries reported by the contractor will continue at the historical level.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due including the remaining payments from FY 2017-18 in FY 2018-19.

MEDICARE BUY-IN QUALITY REVIEW PROJECT

OTHER ADMIN. POLICY CHANGE NUMBER: 45

Methodology:

1. The cost of the contractor is 10% of the amount recovered. Recoveries are estimated to be $2,000,000 TF annually.

2. Assume the estimated amount recovered on a cash basis, in the new contract, will be $1,000,000 in FY 2017-18 and $3,000,000 in FY 2018-19. As a result, the contractor cost is estimated to be $100,000 in FY 2017-18 and $300,000 in FY 2018-19.

   FY 2017-18: $1,000,000 x 10% = $100,000 TF
   FY 2018-19: $3,000,000 x 10% = $300,000 TF

3. The estimated contractor costs are:

Fiscal Year	TF	GF	FF
FY 2017-18	$100,000	$50,000	$50,000
FY 2018-19	$300,000	$150,000	$150,000

Funding:

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

STATE CONTROLLER'S OFFICE INTERAGENCY AGREEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 46
IMPLEMENTATION DATE: 11/2016
ANALYST: Ila Zapanta
FISCAL REFERENCE NUMBER: 2001

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$4,000	$0
STATE FUNDS	$1,000	$0
FEDERAL FUNDS	$3,000	$0

DESCRIPTION

Purpose:
This policy change estimates the costs related to services that have been performed and will be performed by the State Controller's Office (SCO) related to the California Dental Medicaid Management Information (CD-MMIS) system changes needed for check write turnover to SCO.

Authority:
Interagency Agreement 15-92325

Interdependent Policy Changes:
Not Applicable

Background:
Under guidance from the Centers for Medicare and Medicaid Services (CMS), the Department began work with SCO to alter the current check write function where the Fiscal Intermediary (FI) is responsible for processing claims.

The scope of work involves multiple phases in order to alter the current CD-MMIS to allow for SCO takeover of the check write function. Costs included for this agreement pertain to updating the CD-MMIS and enabling the ability to perform the check write function.

Reason for Change:
The change from the prior estimate for FY 2017-18 is a decrease due to actual invoices paid in FY 2017-18 being lower than previously projected. There is no change from the prior estimate for FY 2018-19. The change from FY 2017-18 to FY 2018-19 in the current estimate is due to the current interagency agreement (IA) expiring and no additional services are expected to be rendered under this current IA.

Methodology:
1. Expenditures for the remaining system changes in the amount of $4,000 TF have been invoiced and paid in FY 2017-18.

Fiscal Year	TF	GF	FF
FY 2017-18	$4,000	$1,000	$3,000

Funding:
FI 75% Title XIX FF / 25% GF (4260-101-0001/0890)

DENTAL PAPD PROJECT MANAGER

OTHER ADMIN. POLICY CHANGE NUMBER:	47
IMPLEMENTATION DATE:	7/2016
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1739

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$161,000	$0
STATE FUNDS	$40,250	$0
FEDERAL FUNDS	$120,750	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of a Certified Project Manager (CPM) assisting in the development of a Planning Advanced Planning Document (PAPD) and managing the project to procure a new Medi-Cal Dental Fiscal Intermediary contract.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The CPM works closely with Department staff, CMS, and key stakeholders. The Department and CPM have developed a PAPD to ensure the California Dental Medicaid Management Information System (CD-MMIS) contracts are in compliance with federal regulations and eligible for enhanced federal funding. The PAPD was approved by CMS in September 2014. The Department executed a contract extension amendment to extend the contract with the CPM through February 28, 2018.

The CPM consultant is responsible for performing the full range of project management functions for the duration of this project including:

- Resource planning,
- Contract development and management,
- Risk management,
- Project reporting,
- Fiscal monitoring and reporting,
- Issue management,
- Performing a marketplace analysis of the vendor community and identify procurement alternatives and recommendations for the procurement of a new dental FI contract,
- Developing a complete and thorough PAPD that meets the regulatory criteria and conditions as a MMIS and to ensure the PAPD is developed timely and approval by CMS is obtained, and
- Assisting Department staff in responding to CMS inquiries and provide additional documentation if required.

DENTAL PAPD PROJECT MANAGER

OTHER ADMIN. POLICY CHANGE NUMBER: 47

Reason for Change:
The change from the prior estimate, for FY 2017-18, is an increase due to updated actuals and the updated extension of the contract from December 2017 to February 2018. There is no change from the prior estimate for FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the contracting ending in February 2018 and no additional costs are expected.

Methodology:
1. The CPM was hired in June 2013 with a contract end date of October 31, 2015 and a second contract for the CPM was approved in November 2015, extending the term through May 31, 2017. The Department executed a contract extension amendment to extend the contract with the CPM through February 28, 2018.

Fiscal Year	TF	GF	FF
FY 2017-18	$161,000	$40,000	$121,000

Funding:
FI 75% Title XIX / 25% GF (4260-101-0001/0890)

CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 48
IMPLEMENTATION DATE: 7/2012
ANALYST: Stephanie Hockman
FISCAL REFERENCE NUMBER: 1388

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$100,000	$100,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$100,000	$100,000

DESCRIPTION

Purpose:
This policy change estimates the federal match for county funds expended above the CCS Case Managementallocations on administrative activities in supportofacounty's California Children's Services (CCS) Medi-Cal caseload using Certified Public Expenditures (CPE).

Authority:
California Health & Safety Code § 123955(f)
Code of Federal Regulations, Title 42, 433.51

Interdependent Policy Changes:
Not Applicable

Background:
County costs for determination of CCS Medi-Cal eligibility, care coordination, utilization management and prior authorization of services are reimbursed by Medi-Cal. County funds expended above the allocations on administrative activities in support of a county's CCS Medi-Cal caseload may be used as CPE to draw down Title XIX federal financial participation (FFP).

Reason for Change:
There is no change from the prior estimate or between FY 2017-18 to FY 2018-19.

Methodology:
It is assumed that $100,000 will be drawn down with counties' CPE in FY 2017-18 and FY 2018-19.

Fiscal Year	FFP
FY 2017-18	**$100,000**
FY 2018-19	**$100,000**

Funding:
100% Title XIX (4260-101-0890)

TAR POSTAGE

OTHER ADMIN. POLICY CHANGE NUMBER:	49
IMPLEMENTATION DATE:	7/2003
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	267

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$32,000	$32,000
STATE FUNDS	$16,000	$16,000
FEDERAL FUNDS	$16,000	$16,000

DESCRIPTION

Purpose:
This policy change estimates postage costs for Medi-Cal Treatment Authorization Requests (TAR).

Authority:
Welfare & Institutions Code 14103.6

Interdependent Policy Changes:
Not Applicable

Background:
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 TAR.

TARs are used by Medi-Cal to help ensure that necessary medical or pharmacy services are provided to Medi-Cal recipients and that providers are reimbursed appropriately. TARs are confidential documents and the information included on them is protected by state and federal privacy laws.

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is a decrease due to the removal of courier services. There is no change, from FY 2017-18 to FY 2018-19, in the current estimate.

Methodology:
1. TAR postage costs for Medi-Cal are assumed to be $32,000 for FY 2017-18 and FY 2018-19.

2. Estimates are based on actual expenditures from January 2017 through December 2017.

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

ENROLLMENT ASSIST FOR BHT INSTITUTIONALLY DEEMED

OTHER ADMIN. POLICY CHANGE NUMBER: 50
IMPLEMENTATION DATE: 7/2016
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1983

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$43,000	$0
STATE FUNDS	$21,500	$0
FEDERAL FUNDS	$21,500	$0

DESCRIPTION

Purpose:
The Department provided health insurance application enrollment assistance for the 157 participants on the Home and Community Based Services (HCBS) Developmentally Disabled (DD) Waiver who lost their Medi-Cal eligibility in March 2017. This program allowed case managers to help transition these institutionally certifiable beneficiaries to other health care coverage by March 2017 to avoid gaps in coverage. All 157 participants lost coverage in FY 2016-17 and this policy change estimates the cost to close out the Behavioral Health Treatment (BHT) application enrollment assistance contract.

Authority:
Welfare & Institutions Code 14132.56
Social Security Act Section 1905(a)(13)
SB 870 (Chapter 40, Statutes of 2014)

Interdependent Policy Changes:
Not applicable.

Background:
With the transition of BHT services to a state plan benefit, 157 DD Waiver participants, who only received BHT services through the waiver, lost Medi-Cal eligibility. This population gained Medi-Cal eligibility by waiving Medi-Cal income requirements under institutional deeming. To be institutionally deemed, the beneficiary must be determined to meet a nursing facility level of care, under the age of 21, live at home, receiving at least one HCBS waiver service, and not eligible for zero share-of-cost Medi-Cal. With the transition of BHT services from the waiver to the state plan, these beneficiaries were no longer receiving at least one HCBS waiver service and no longer Medi-Cal eligible under institutional deeming.

Reason for Change:
There is no change from the prior estimate.

Methodology:
1. Assume 157 participants lost coverage in FY 2016-17.

2. Implementation of this program began in July 2016.

3. The close out cost for the BHT application enrollment assistance is estimated to be $43,000 TF ($22,000 GF).

ENROLLMENT ASSIST FOR BHT INSTITUTIONALLY DEEMED

OTHER ADMIN. POLICY CHANGE NUMBER: 50

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

INTERIM AND FINAL COST SETTLEMENTS-SMHS

OTHER ADMIN. POLICY CHANGE NUMBER:	55
IMPLEMENTATION DATE:	7/2016
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1757

	FY 2017-18	FY 2018-19
TOTAL FUNDS	-$2,688,000	$26,745,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$2,688,000	$26,745,000

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 2017-18 and FY 2018-19, is due to:

- Payments for county cost settlements for FYs 2006-07 through FY 2008-09, that were scheduled to be made in FY 2017-18, have shifted to be paid in FY 2018-19,
- Cost reports for FY 2009-10, FY 2010-11, and FY 2011-12 have been updated. These cost settlements were scheduled for payment in FY 2017-18, but a portion of the payments and recoupments have shifted to be paid in FY 2018-19; and
- The settlements for MCHIP administration expenditures, in the previous estimate, were budgeted as Title XXI funding. MCHIP administration settlements were corrected to be Title XIX funding based on federal claiming reports.

INTERIM AND FINAL COST SETTLEMENTS-SMHS

OTHER ADMIN. POLICY CHANGE NUMBER: 55

The change from FY 2017-18 to FY 2018-19, in the current estimate, is the timing of paying cost reports. A portion of the FY 2009-10 through FY 2011-12 cost settlements are scheduled to be paid in FY 2017-18 with the remaining payments and recoupments. FY 2006-07 through FY 2008-09 cost settlement payments are scheduled to be paid in FY2018-19.

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.

Interim Settlements			
FY 2009-10	**Underpaid**	**Overpaid**	**Net FF**
SMH Admin	$0	($5,000)	($5,000)
UR/QA	$198,000	($128,000)	$70,000
MH MAA	$132,000	($111,000)	$21,000
HFP Admin*	$7,000	$0	$7,000
Total FY 2009-10	$337,000	($244,000)	$93,000
FY 2010-11	**Underpaid**	**Overpaid**	**Net FF**
SMH Admin	$8,513,000	($12,611,000)	($4,098,000)
UR/QA	$2,564,000	($299,000)	$2,265,000
MH MAA	$485,000	($2,123,000)	($1,638,000)
MCHIP	$309,000	$0	$309,000
HFP Admin*	$718,000	$0	$718,000
Total FY 2010-11	$12,589,000	($15,033,000)	($2,444,000)
FY 2011-12	**Underpaid**	**Overpaid**	**Net FF**
SMH Admin	$0	($302,000)	($302,000)
MCHIP	$0	($34,000)	($34,000)
HFP Admin*	$0	($1,000)	($1,000)
Total FY 2011-12	$0	($337,000)	($337,000)
Total FY 2017-18	$12,926,000	($15,614,000)	**($2,688,000)**

INTERIM AND FINAL COST SETTLEMENTS-SMHS

OTHER ADMIN. POLICY CHANGE NUMBER: 55

Interim Settlements			
FY 2006-07	**Underpaid**	**Overpaid**	**Net FF**
UR/QA	$86,000	$0	$86,000
HFP Admin*	$2,000	$0	$2,000
Total FY 2006-07	$88,000	$0	$88,000
FY 2007-08	**Underpaid**	**Overpaid**	**Net FF**
UR/QA	$96,000	$0	$96,000
HFP Admin*	$3,000	$0	$3,000
Total FY 2007-08	$99,000	$0	$99,000
FY 2008-09	**Underpaid**	**Overpaid**	**Net FF**
UR/QA	$56,000	$0	$56,000
HFP Admin*	$3,000	$0	$3,000
Total FY 2008-09	$59,000	$0	$59,000
FY 2009-10	**Underpaid**	**Overpaid**	**Net FF**
UR/QA	$98,000	$0	$98,000
HFP Admin*	$5,000	$0	$5,000
Total FY 2009-10	$103,000	$0	$103,000
FY 2010-11	**Underpaid**	**Overpaid**	**Net FF**
SMH Admin	$57,000	($47,000)	$10,000
UR/QA	$2,044,000	$0	$2,044,000
MH MAA	$302,000	$0	$302,000
MCHIP	$984,000	$0	$984,000
HFP Admin*	$52,000	$0	$52,000
Total FY 2010-11	$3,439,000	($47,000)	$3,392,000
FY 2011-12	**Underpaid**	**Overpaid**	**Net FF**
SMH Admin	$19,480,000	($121,000)	$19,359,000
UR/QA	$5,000,000	($212,000)	$4,788,000
MH MAA	$239,000	($1,767,000)	($1,528,000)
MCHIP	$141,000	$0	$141,000
HFP Admin*	$252,000	($8,000)	$244,000
Total FY 2011-12	$25,112,000	($2,108,000)	$23,004,000
Total FY 2018-19	$28,900,000	($2,155,000)	**$26,745,000**

INTERIM AND FINAL COST SETTLEMENTS-SMHS

OTHER ADMIN. POLICY CHANGE NUMBER: 55

4. The net FF to be reimbursed and/or recouped in FY 2017-18 and FY 2018-19 are shown below:

FF	FY 2017-18	FY 2018-19
Title XIX FF	($3,412,000)	$26,436,000
Title XXIFF*	$724,000	$309,000
Total	**($2,668,000)**	**$26,745,000**

Funding:
100% Title XIX FF (4260-101-0890)
100% Title XXI FF (4260-113-0890)*

MEDICAL FI OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER:	56
IMPLEMENTATION DATE:	7/2015
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	1916

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$79,012,000	$77,098,000
STATE FUNDS	$25,401,500	$24,731,750
FEDERAL FUNDS	$53,610,500	$52,366,250

DESCRIPTION

Purpose:
This policy change estimates the operational costs of the Medical Fiscal Intermediary (FI) contract.

Authority:
Contract # 09-86210

Interdependent Policy Changes:
Not Applicable

Background:
The FI contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The FI contract was awarded on December 8, 2009, and became effective May 3, 2010, which began the takeover phase. The FI contract term runs through March 31, 2020.

Many functions of the Medical FI contract services are 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 is paid a fixed rate per transaction. The Department receives a discount when total transactions fall below the base range and pays a premium when total transactions exceed the base range.

- The volume ranges and corresponding bid rates vary from year to year.
- The State Medi-Cal caseload also varies from year toyear.

Operations constitute 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.

- 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.

MEDICAL FI OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 56

- 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 abeneficiary.

- 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 has bid on State-specified volume ranges for each of the above categories. The Department estimates operations costs by applying these bid rates to the projected volumes for the current and budget year.

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is a decrease due to reduced costs for General ACLs, Online ACLs, ECLs, CA-EVS/CMS Processing, and TARS. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to fewer General ACLs and Online ACLs projected in FY 2018-19.

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.

4. Medicare Drug Discount costs are funded at 100%GF.

5. Of the TSC costs, about 16.1% are funded at 50% GF and 83.9% are funded at 25% GF.

MEDICAL FI OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 56

FY 2017-18	TF	GF	FF
General ACLs (75% FF/25% GF, 50% FF/50% GF)	$48,246,000	$16,886,000	$31,360,000
Online ACLs (75% FF/25% GF, 50% FF/50% GF)	$2,429,000	$850,000	$1,579,000
Prospective DUR (75% FF/25% GF)	$320,000	$80,000	$240,000
Retrospective DUR (50% FF/50% GF)	$100,000	$50,000	$50,000
Encounter Claim Lines (75% FF/25% GF)	$800,000	$200,000	$600,000
CA-EVS/CMS Processing (75% FF/25% GF)	$4,000,000	$1,000,000	$3,000,000
Medicare Drug Discount (100% GF)	$17,000	$17,000	$0
TARS (75% FF/25% GF)	$9,600,000	$2,400,000	$7,200,000
TSC (75% FF/25% GF, 50% FF/50% GF)	$13,500,000	$3,918,000	$9,582,000
Total	**$79,012,000**	**$25,401,000**	**$53,611,000**

FY 2018-19	TF	GF	FF
General ACLs (75% FF/25% GF, 50% FF/50% GF)	$46,371,000	$16,231,000	$30,140,000
Online ACLs (75% FF/25% GF, 50% FF/50% GF)	$2,390,000	$836,000	$1,554,000
Prospective DUR (75% FF/25% GF)	$320,000	$80,000	$240,000
Retrospective DUR (50% FF/50% GF)	$100,000	$50,000	$50,000
Encounter Claim Lines (75% FF/25% GF)	$800,000	$200,000	$600,000
CA-EVS/CMS Processing (75% FF/25% GF)	$4,000,000	$1,000,000	$3,000,000
Medicare Drug Discount (100% GF)	$17,000	$17,000	$0
TARS (75% FF/25% GF)	$9,600,000	$2,400,000	$7,200,000
TSC (75% FF/25% GF, 50% FF/50% GF)	$13,500,000	$3,918,000	$9,582,000
Total	**$77,098,000**	**$24,732,000**	**$52,366,000**

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 COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 57
IMPLEMENTATION DATE: 7/2015
ANALYST: DJ Hayer
FISCAL REFERENCE NUMBER: 1917

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$42,390,000	$36,151,000
STATE FUNDS	$11,068,050	$10,319,000
FEDERAL FUNDS	$31,321,950	$25,832,000

DESCRIPTION

Purpose:
This policy change estimates the total cost reimbursement of the Medical Fiscal Intermediary (FI) contract.

Authority:
Contract # 09-86210

Interdependent Policy Changes:
Not Applicable

Background:
The FI contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The FI contract was awarded on December 8, 2009, and became effective May 3, 2010, which began the takeover phase. The FI contract term runs through March 31, 2020.

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.

- Printing – Costs to print the forms, documents, and other State program printing requests as directed by the State.

MEDICAL FI COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 57

- 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.

- Independent Verification & Validation (IV&V) and Consultant Contracts – IV&V and consultant contracts utilized for operational project oversight that are 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.

MEDICAL FI COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 57

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is an increase due to revising the estimate based on actual expenditures instead of projections and including costs for new consultant contracts. The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase in all categories except for equipment, audits & research, sales tax, and consultant contracts in FY 2018-19.

Methodology:
1. Contract costs are shared between Federal Funds (FF) and General Funds (GF).

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
Postage (50% FF/50% GF)	$1,652	$826	$826
Parcel Services & Common Carriers (50% FF/50% GF)	$84	$42	$42
Equipment/Services (75% FF/25% GF)	$3,823	$956	$2,867
Print/Distr. Center (75% FF/25% GF, 50% FF/50% GF)	$775	$310	$465
Other Direct Costs (50% FF/50% GF, 75% FF/25% GF)	$1,835	$688	$1,147
Facilities Improvement & Modification (50% FF/50% GF)	$562	$281	$281
Audits & Research (50% FF/50% GF)	$600	$300	$300
Change Orders (50% FF/50% GF)	$52	$26	$26
Sales Tax (75% FF/25% GF)	$4,218	$1,055	$3,163
Consultant Contracts (75% FF/25% GF, 90% FF/10% GF, 50% FF/50% GF)	$22,703	$5,533	$17,170
Telecommunication (75% FF/25% GF)	$1,185	$296	$889
Other Cost Reim. Items (50% FF/50% GF, 90% FF/10% GF)	$4,901	$755	$4,146
Total	**$42,390**	**$11,068**	**$31,322**

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
Postage (50% FF/50% GF)	$1,982	$991	$991
Parcel Services & Common Carriers (50% FF/50% GF)	$101	$51	$50
Equipment/Services (75% FF/25% GF)	$2,886	$722	$2,164
Print/Distr. Center (75% FF/25% GF, 50% FF/50% GF)	$931	$372	$559
Other Direct Costs (50% FF/50% GF, 75% FF/25% GF)	$2,201	$825	$1,376
Facilities Improvement & Modification (50% FF/50% GF)	$675	$338	$337
Audits & Research (50% FF/50% GF)	$600	$300	$300
Change Orders (50% FF/50% GF)	$62	$31	$31
Sales Tax (75% FF/25% GF)	$4,098	$1,024	$3,074
Consultant Contracts (75% FF/25% GF, 90% FF/10% GF, 50% FF/50% GF)	$15,312	$3,640	$11,672
Telecommunication (75% FF/25% GF)	$1,422	$356	$1,066
Other Cost Reim. Items (75% FF/25% GF, 50% FF/50% GF)	$5,881	$1,669	$4,212
Total	**$36,151**	**$10,319**	**$25,832**

MEDICAL FI COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 57

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 HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	58
IMPLEMENTATION DATE:	7/2015
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	1918

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$27,546,000	$27,546,000
STATE FUNDS	$5,986,500	$5,986,500
FEDERAL FUNDS	$21,559,500	$21,559,500

DESCRIPTION

Purpose:
This policy change estimates the hourly reimbursement costs of the Medical Fiscal Intermediary (FI) contract.

Authority:
Contract # 09-86210

Interdependent Policy Changes:
Not Applicable

Background:
The FI contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The FI contract was awarded on December 8, 2009, and became effective May 3, 2010, which began the takeover phase. The FI contract term runs through March 31, 2020.

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:
There is no change from the prior estimate for FY 2017-18 and FY 2018-19. There is no change, from FY 2017-18 to FY 2018-19, in the currentestimate.

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) bidrates.

MEDICAL FI HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 58

FY 2017-18	TF	GF	FF
Systems Group			
Non-HIPAA (75% FF / 25% GF and 90% FF / 10% GF)	$15,000,000	$3,675,000	$11,325,000
HIPAA (75% FF / 25% GF and 90% FF / 10% GF)	$12,000,000	$2,175,000	$9,825,000
Systems Group Total	$27,000,000	$5,850,000	$21,150,000
FOAG Pharmacists (75% FF / 25% GF)	$546,000	$136,000	$410,000
Total Hourly Reimbursement	**$27,546,000**	**$5,986,000**	**$21,560,000**

FY 2018-19	TF	GF	FF
Systems Group			
Non-HIPAA (75% FF / 25% GF and 90% FF / 10% GF)	$15,500,000	$3,725,000	$11,775,000
HIPAA (75% FF / 25% GF and 90% FF / 10% GF)	$11,500,000	$2,125,000	$9,375,000
Systems Group Total	$27,000,000	$5,850,000	$21,150,000
FOAG Pharmacists (75% FF / 25% GF)	$546,000	$136,000	$410,000
Total Hourly Reimbursement	**$27,546,000**	**$5,986,000**	**$21,560,000**

Funding:
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 HIPAA 90% FF / 10% GF (4260-117-0001/0890)

MEDICAL FI OTHER ESTIMATED COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	59
IMPLEMENTATION DATE:	7/2015
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	1921

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$11,080,000	$11,080,000
STATE FUNDS	$3,220,000	$3,220,000
FEDERAL FUNDS	$7,860,000	$7,860,000

DESCRIPTION

Purpose:
This policy change estimates the total of other estimated costs of the Medical Fiscal Intermediary (FI) contract.

Authority:
Contract # 09-86210

Interdependent Policy Changes:
Not Applicable

Background:
The FI contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The FI contract was awarded on December 8, 2009, and became effective May 3, 2010, which began the takeover phase. The FI contract term runs through March 31, 2020.

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 2017-18 and FY 2018-19, is a decrease due to lower Beneficiary ID Cards costs. There is no change, from FY 2017-18 to FY 2018-19, in the current estimate.

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 2017-18	TF	GF	FF
Beneficiary ID Cards (75% FF / 25% GF)	$1,000,000	$250,000	$750,000
Health Access Program Cards (75% FF / 25% GF)	$280,000	$70,000	$210,000
RAIS Medi-Cal (75% FF / 25% GF)	$1,500,000	$375,000	$1,125,000
RAIS MCO (75% FF / 25% GF)	$6,500,000	$1,625,000	$4,875,000
Cost Containment (50% FF / 50% GF)	$1,800,000	$900,000	$900,000
Total for FY 2017-18	**$11,080,000**	**$3,220,000**	**$7,860,000**

FY 2018-19	TF	GF	FF
Beneficiary ID Cards (75% FF / 25% GF)	$1,000,000	$250,000	$750,000
Health Access Program Cards (75% FF / 25% GF)	$280,000	$70,000	$210,000
RAIS Medi-Cal (75% FF / 25% GF)	$1,500,000	$375,000	$1,125,000
RAIS MCO (75% FF / 25% GF)	$6,500,000	$1,625,000	$4,875,000
Cost Containment (50% FF / 50% GF)	$1,800,000	$900,000	$900,000
Total for FY 2018-19	**$11,080,000**	**$3,220,000**	**$7,860,000**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 75% Title XIX / 25% GF (4260-101-0001/0890)

MEDICAL FI MISCELLANEOUS EXPENSES

OTHER ADMIN. POLICY CHANGE NUMBER:	60
IMPLEMENTATION DATE:	7/2015
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	1922

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$2,445,000	$2,392,000
STATE FUNDS	$767,250	$790,000
FEDERAL FUNDS	$1,677,750	$1,602,000

DESCRIPTION

Purpose:
This policy change estimates the cost of miscellaneous expenses of the Medical Fiscal Intermediary (FI) contract.

Authority:
Contract # 09-86210
Interagency Agreement (IA) # 16-93264, 15-92027, 14-90507, 15-92026 & 17-94428

Interdependent Policy Changes:
Not Applicable

Background:
The FI contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The FI contract was awarded on December 8, 2009, and became effective May 3, 2010, which began the takeover phase. The FI contract term runs through March 31, 2020.

Pursuant to an interagency agreement 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 interagency agreement 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 interagency agreement 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: 60

Reason for Change:
The change from the prior estimate, for FY 2017-18, is an increase due to higher OSI costs. The net change from the prior estimate, for FY 2018-19, is an increase of higher SCO offset by a decrease of FPACT costs and removal of OSI costs. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to increased SCO costs, not including OSI costs, and decreased FPACT costs in FY 2018-19.

Methodology:
1. Costs are shared between Federal Funds (FF) and General Funds (GF).

FY 2017-18	TF	GF	FF
SCO - Warrants and RADs (75% FF / 25% GF)	$1,331,000	$333,000	$998,000
SCO - Postage (50% FF / 50% GF)	$444,000	$222,000	$222,000
SCO - HE Claims - Admin. (75% FF / 25% GF)	$37,000	$9,000	$28,000
CSTO - Warrant Redemption (75% FF / 25% GF)	$81,000	$20,000	$61,000
CDCA - Provider Verification File (75% FF / 25% GF)	$2,000	$1,000	$1,000
OSI - Agency Information Officers (75% FF / 25% GF)	$370,000	$92,000	$278,000
FPACT (50% FF / 50% GF)	$180,000	$90,000	$90,000
Total	**$2,445,000**	**$767,000**	**$1,678,000**

FY 2018-19	TF	GF	FF
SCO - Warrants and RADs (75% FF / 25% GF)	$1,504,000	$376,000	$1,128,000
SCO - Postage (50% FF / 50% GF)	$618,000	$309,000	$309,000
SCO - HE Claims - Admin. (75% FF / 25% GF)	$37,000	$9,000	$28,000
CSTO Warrant Redemption (75% FF / 25% GF)	$81,000	$20,000	$61,000
CDCA -Provider Verification File (75% FF / 25% GF)	$2,000	$1,000	$1,000
FPACT (50% FF / 50% GF)	$150,000	$75,000	$75,000
Total	**$2,392,000**	**$790,000**	**$1,602,000**

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:	61
IMPLEMENTATION DATE:	7/2015
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	1919

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$536,000	$544,000
STATE FUNDS	$134,000	$136,000
FEDERAL FUNDS	$402,000	$408,000

DESCRIPTION

Purpose:
This policy change estimates the cost of Fiscal Medical Intermediary (FI) contract Change Orders (CO).

Authority:
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 FI contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The FI contract was awarded on December 8, 2009, and became effective on May 3, 2010, which began the takeover phase. The FI contract term runs through March 31, 2020.

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.

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.

MEDICAL FI CHANGE ORDERS

OTHER ADMIN. POLICY CHANGE NUMBER: 61

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is an increase due to higher OCC Change Order costs. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to an increase in staffing costs for the OCC Change Order in FY 2018-19.

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 allows for overhead and profit to be included in CO expenses (not to exceed thirty percent).

3. The estimated costs for FY 2017-18 and FY 2018-19 are:

OCC Change Order	TF	GF	FF
FY 2017-18	$536,000	$134,000	$402,000
FY 2018-19	$544,000	$136,000	$408,000

Funding:
FI 75% HIPAA FF/ 25% GF (4260-117-0001/0890)

MEDICAL FI OPTIONAL CONTRACTUAL SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER:	62
IMPLEMENTATION DATE:	7/2018
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	1923

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$0	$1,679,000
STATE FUNDS	$0	$167,900
FEDERAL FUNDS	$0	$1,511,100

DESCRIPTION

Purpose:
This policy change estimates the cost of Optional Contractual Services (OCS) of the Medical Fiscal Intermediary (FI) contract.

Authority:
Contract # 09-86210

Interdependent Policy Changes:
Not Applicable

Background:
The FI contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The FI contract was awarded on December 8, 2009, and became effective on May 3, 2010. The FI contract term runs through March 31, 2020.

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 identified costs are for the implementation of the Medicaid Incentive program, which provide incentives to providers who adopt and use 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 current FI contract end date, the Department intends to take over management of the SLR application from the FI. Remaining OCS costs will be paid to the FI once the System Development Notice, set for June 2018, is implemented. The final payment will be issued July 2018.

Reason for Change:
There is no change from the prior estimate for FY 2018-19.

Methodology:

Fiscal Year	TF	GF	FF
FY 2018-19	$1,679,000	$168,000	$1,511,000

Funding:
FI 90% Title XIX / 10% GF (4260-101-0001/0890)

HCO COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	63
IMPLEMENTATION DATE:	7/2014
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1858

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$44,189,000	$13,582,000
STATE FUNDS	$21,254,320	$6,532,220
FEDERAL FUNDS	$22,934,680	$7,049,780

DESCRIPTION

Purpose:
This policy change estimates the total cost reimbursement of the Health Care Options (HCO) program.

Authority:
HCO contract # 07-65829

Interdependent Policy Changes:
Not Applicable

Background:
MAXIMUS, Inc. has been the enrollment contractor for the HCO program since October 1, 1996. MAXIMUS, Inc. 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. MAXIMUS, Inc. also enrolls beneficiaries into two Dental Managed Care plan models; one in Sacramento County, where enrollment is mandatory, and one in Los Angeles County, where enrollment is voluntary. The contract with Maximus, Inc. is expected to end on September 30, 2018, and a new contract will be in place October 1, 2018, to assume operations.

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 for FY 2017-18 or FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is because there are only 4 payments in FY 2018-19.

Methodology:
1. Contract costs are shared between federal funds (FF) and General Fund (GF).

2. Printing and postage reflect net savings resulting from Personalized Provider Directories (PPD) in the PPD counties of Sacramento and Los Angeles, in lieu of costs for mailing full county-wide provider directories.

HCO COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 63

(Dollars in Thousands)

	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced XXI	Enhanced XXI
FY 2017-18		(50%)	(50%)	(12%)	(88%)
Postage	$22,318	$10,601	$10,601	$134	$982
Printing	$6,567	$3,119	$3,120	$39	$289
Other HCO Informing Materials	$5,455	$2,591	$2,591	$33	$240
Customer Assistance Telephone	$1,729	$821	$822	$10	$76
Miscellaneous	$1,043	$495	$496	$6	$46
Additional Systems Group Staff	$4,698	$2,232	$2,231	$28	$207
Other Cost. Reimb.	$1,684	$800	$798	$10	$76
Temporary Staff	$695	$330	$330	$4	$31
Total	**$44,189**	**$20,989**	**$20,989**	**$264**	**$1,947**

(Dollars in Thousands)

	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced XXI	Enhanced XXI
FY 2018-19		(50%)	(50%)	(12%)	(88%)
Postage	$6,867	$3,262	$3,262	$41	$302
Printing	$2,021	$960	$960	$12	$89
Other HCO Informing Materials	$1,678	$797	$797	$10	$74
Customer Assistance Telephone	$532	$252	$253	$3	$24
Miscellaneous	$306	$145	$146	$2	$13
Additional Systems Group Staff	$1,446	$687	$687	$9	$63
Other Cost Reimb.	$518	$246	$245	$2	$25
Temporary Staff	$214	$101	$101	$1	$11
Total	**$13,582**	**$6,450**	**$6,451**	**$80**	**$601**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 88% Title XXI / 12% GF (4260-113-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER:	64
IMPLEMENTATION DATE:	7/2014
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1856

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$29,179,000	$9,103,000
STATE FUNDS	$14,036,980	$4,379,360
FEDERAL FUNDS	$15,142,020	$4,723,640

DESCRIPTION

Purpose:
This policy change estimates the operational costs of the Health Care Options (HCO) program.

Authority:
HCO contract # 07-65829

Interdependent Policy Changes:
Not Applicable

Background:
MAXIMUS, Inc. has been the enrollment contractor for the HCO program since October 1, 1996. MAXIMUS, Inc. 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. MAXIMUS, Inc. also enrolls beneficiaries into two Dental Managed Care plan models; one in Sacramento County, where enrollment is mandatory, and one in Los Angeles County, where enrollment is voluntary. The contract with Maximus, Inc. is expected to end on September 30, 2018, and a new contract will be in place October 1, 2018, to assume operations.

Operations for the current HCO contract with MAXIMUS began on January 1, 2009, for three years and nine months, and six one-year optional extension years, with current operations ending on December 31, 2018. Funds paid on the contract use a mixture of Federal Funds (FF) and General Funds (GF) (50/50 for Administration; and 65/35 or 88/12 for Medicaid Expansion Children's Health Insurance Program).

Operational costs are the routine expenses incurred by HCO's operations such as:

- Transactions – Enrollment or disenrollment processing activities and transactions with the Department.
- Mailings – Mailings include initial informing, re-informing, monthly reconciliation, and annual re-notification mailings.
- Beneficiary Dental Exception (BDE) Mailings – Mailings to dental beneficiaries in Sacramento County for exception to plan enrollment.
- Beneficiary Direct Assistance/Call Center – Telephone Call Center (TCC) agent informing and enrollment assistance to Medi-Cal applicants/beneficiaries and/or their authorized representatives in understanding, selecting, and using managed care medical and dental plans. In addition, the TCC assists providers, health plans, and counties or other interested parties who request information regarding the HCO program and/or Medi-Cal managed care.
- Personalized Provider Directory (PPD) Project– Fixed price costs for the PPD Project.

HCO OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 64

- Seniors and Persons with Disabilities (SPD) County Inserts – Incremental Costs – Special inserts for SPD informing packets.
- Medi-Cal Publications Management Services – Publication management services for the development, revision, reproduction, and distribution of Medi-Cal publications that do not pertain to HCO informing materials.
- Initial Health Screen Questionnaire - Health Information Form (HIF) - The purpose of the HIF is to ensure applicants/beneficiaries with existing disabilities or with chronic conditions identify themselves to assure timely access to care. The HIFs are distributed and processed to be mailed with the HCO informing packet and are also available at Enrollment Service Representatives presentation sites.
- Base Volume Increase Projection - The estimated cost for the entire infrastructure necessary for HCO Operations for occurrences when current base contract volumes are exceeded from additional and new projects.
- Prior Year Unpaid Invoices - Prior year unpaid invoices will be accrued and paid in the following fiscal year.

Reason for change:
The change for FY 2017-18 and FY 2018-19 is a decrease due to removal of the Base Volume Increase line item. The decrease from FY 2017-18 to FY 2018-19 in the current estimate is because there are only 4 months of payment in FY 2018-19.

Methodology:
1. Operations costs are fixed price rates based on volumes within minimum and maximum ranges under the HCO contract.

(Dollars in Thousands)

FY 2017-18	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced XXI	Enhanced XXI
		50%	50%	12%	88%
Transactions	$12,068	$5,732	$5,733	$72	$531
Packet Mailings	$9,559	$4,541	$4,540	$57	$421
BDE Packet Mailings	$199	$95	$94	$1	$9
BDA/Call Center	$5,724	$2,719	$2,719	$34	$252
PPD	$910	$432	$433	$5	$40
SPD Inserts	$72	$36	$36	$0	$0
Medi-Cal Publications	$449	$213	$214	$3	$19
HIF	$198	$94	$94	$1	$9
Total	**$29,179**	**$13,862**	**$13,863**	**$173**	**$1,281**

(Dollars in Thousands)

HCO OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 64

FY 2018-19	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced XXI	Enhanced XXI
		50%	50%	12%	88%
Transactions	$3,750	$1,781	$1,782	$22	$165
Packet Mailings	$2,998	$1,424	$1,424	$18	$132
BDE Packet Mailings	$61	$29	$29	$0	$3
BDA/Call Center	$1,789	$850	$850	$11	$78
PPD	$283	$135	$134	$2	$12
SPD Inserts	$22	$11	$11	$0	$0
Medi-Cal Publications	$139	$66	$66	$1	$6
HIF	$61	$29	$29	$0	$3
Total	**$9,103**	**$4,325**	**$4,325**	**$54**	**$399**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 88% Title XXI / 12% GF (4260-113-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO - ENROLLMENT CONTRACTOR COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	65
IMPLEMENTATION DATE:	7/2015
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1864

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$17,990,000	$5,638,000
STATE FUNDS	$8,653,380	$2,711,840
FEDERAL FUNDS	$9,336,620	$2,926,160

DESCRIPTION

Purpose:
This policy change estimates the costs for additional resources for the Health Care Options (HCO) program to provide informing and enrollment assistance to beneficiaries eligible for Medi-Cal.

Authority:
HCO contract # 07-65829

Interdependent Policy Changes:
Not Applicable

Background:
MAXIMUS, Inc. has been the enrollment contractor for the HCO program since October 1, 1996. MAXIMUS, Inc. 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. MAXIMUS, Inc. also enrolls beneficiaries in 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 contract with Maximus, Inc. is expected to end on September 30, 2018, and a new contract will be in place October 1, 2018, to assume operations.

The enrollment contractor will require additional resources in its telephone call center to adequately and effectively provide informing and enrollment assistance functions to the increasing numbers of Medi-Cal beneficiaries for the following changes:

- Effective January 1, 2014, the ACA established a new income eligibility standard for Medi-Cal, based upon a Modified Adjusted Gross Income of 133% of the federal poverty level for adults.

- Senate Bill 75 (Statutes of 2015) established eligibility for full scope Medi-Cal benefits for undocumented children under 19 years of age (immigration reform project).

Reason for change:
There is no change for FY 2017-18 or FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is because there are only 4 months of payment in FY 2018-19.

Methodology:
1. Costs are negotiated per agent/person costs through a contract amendment.

2. Contract costs are shared between federal funds (FF) and General Fund (GF).

HCO - ENROLLMENT CONTRACTOR COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 65

	FY 2017-18	FY 2018-19
Telephone Call Center (TCC) Enrollment Operations	$1,555,000	$486,000
System Group Staff	$16,435,000	$5,152,000
Total	**$17,990,000**	**$5,638,000**

(Dollars in Thousands)

FY 2017-18	TF	GF	FF
Title XIX (50% FF / 50% GF)	$17,091	$8,545	$8,546
Enhanced Title XXI (88% FF / 12% GF)	$899	$108	$791
Total	**$17,999**	**$8,653**	**$9,337**

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
Title XIX (50% FF / 50% GF)	$5,356	$2,678	$2,678
Enhanced Title XXI (88% FF / 12% GF)	$282	$34	$248
Total	**$5,638**	**$2,712**	**$2,926**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 88% Title XXI / 12% GF (4260-113-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO ESR HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	66
IMPLEMENTATION DATE:	7/2014
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1857

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$15,580,000	$4,824,000
STATE FUNDS	$7,493,980	$2,320,420
FEDERAL FUNDS	$8,086,020	$2,503,580

DESCRIPTION

Purpose:
This policy change estimates the Enrollment Services Representative's (ESRs) hourly reimbursement for the Health Care Options (HCO) program.

Authority:
HCO contract # 07-65829

Interdependent Policy Changes:
Not Applicable

Background:
MAXIMUS, Inc. has been the enrollment contractor for HCO since October 1, 1996. MAXIMUS, Inc. 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. MAXIMUS, Inc. also enrolls beneficiaries into two Dental Managed Care plan models; one in Sacramento County, where enrollment is mandatory, and one in Los Angeles County, where enrollment is voluntary. The contract with Maximus, Inc. is expected to end on September 30, 2018, and a new contract will be in place October 1, 2018, to assume operations.

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 is no change from the previous estimate for FY 2017-18 or FY 2018-19. The change from FY 2017-18 to FY2018-19 is a decrease because there are only 4 months of payment in FY 2018-19.

Methodology:
1. The hourly reimbursement costs are fixed price hourly rates for full-time equivalent ESR staff at county offices statewide.

HCO ESR HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 66

2. The estimated costs for FY 2017-18 and FY 2018-19 are based on 155 ESRs per year.

(Dollars in thousands)

FY 2017-18	TF	GF	FF
Title XIX (50% FF / 50% GF)	$14,801	$7,400	$7,401
Title XXI (88% FF / 12% GF)	$779	$93	$686
Total	**$15,580**	**$7,493**	**$8,087**

(Dollars in thousands)

FY 2018-19	TF	GF	FF
Title XIX (50% FF / 50% GF)	$4,583	$2,291	$2,292
Title XXI (88% FF / 12% GF)	$241	$29	$212
Total	**$4,824**	**$2,320**	**$2,504**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 88% Title XXI / 12% GF (4260-113-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO CCI - CAL MEDICONNECT AND MLTSS

OTHER ADMIN. POLICY CHANGE NUMBER:	67
IMPLEMENTATION DATE:	7/2014
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1860

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$15,269,000	$4,816,000
STATE FUNDS	$7,634,500	$2,408,000
FEDERAL FUNDS	$7,634,500	$2,408,000

DESCRIPTION

Purpose:
This policy change estimates the costs for the specialized call center and informing materials to transition dually eligible and Medi-Cal only beneficiaries into managed care health plans under the Coordinated Care Initiative (CCI).

Authority:
HCO contract # 07-65829

Interdependent Policy Changes:
Not Applicable

Background:
MAXIMUS, Inc. has been the enrollment contractor for the Health Care Options (HCO) program since October 1, 1996. MAXIMUS, Inc. 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. MAXIMUS, Inc. also enrolls beneficiaries into two Dental Managed Care plan models; one in Sacramento County, where enrollment is mandatory, and one in Los Angeles County, where enrollment is voluntary. The contract with Maximus, Inc. is expected to end on September 30, 2018, and a new contract will be in place October 1, 2018, to assume operations.

The Department will achieve savings from transitioning dually eligible and Medi-Cal only beneficiaries who receive Medi-Cal Long Term Care institutional services, In-Home Supportive Services, Community-Based Adult Services, Multi-Purpose Senior Services Program, and other Home and Community-Based Services from fee-for-service into managed care health plans. Notices and packets were mailed to beneficiaries.

In addition, to ensure a seamless enrollment selection process for beneficiaries impacted by the CCI programs, costs have been included for a beneficiary-centric specialized call center and specialized informing materials. The beneficiaries covered under this project have a dedicated toll free number, which directs them to their own specialized team of CCI experts who guide them through the enrollment process and are able to answer all the Medi-Cal and Medicare questions.

The Governor's Budget estimate of the CCI projects that it 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 In-Home Supportive Services (IHSS), into managed care. IHSS has been removed from capitation rate payments effective January 1, 2018.

HCO CCI - CAL MEDICONNECT AND MLTSS

OTHER ADMIN. POLICY CHANGE NUMBER: 67

Reason for change:
For FY 2017-18 and FY 2018-19, there is no change from the prior estimate. The change from FY 2017-18 to FY 2018-19 in the current estimate is because there are only 4 months of payment in FY 2018-19.

Methodology:
1. Costs include informing materials development and mailing, CCI telephone call center staffing and equipment, and translations of informing materials into Braille and audio formats.

2. The FY 2017-18 and FY 2018-19 costs are below:

	FY 2017-18	FY 2018-19
Printing/Postage	$6,278,000	$2,033,000
Equipment/Non-Equipment	$2,151,000	$783,000
Staffing	$6,840,000	$2,000,000
Total	**$15,269,000**	**$4,816,000**

3. Costs are shared between federal funds (FF) and General Fund (GF).

	TF	GF	FF
FY 2017-18	**$15,269,000**	**$7,634,000**	**$7,635,000**

	TF	GF	FF
FY 2018-19	**$4,816,000**	**$2,408,000**	**$2,408,000**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO TAKEOVER

OTHER ADMIN. POLICY CHANGE NUMBER:	68
IMPLEMENTATION DATE:	10/2017
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1994

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$2,769,000	$5,231,000
STATE FUNDS	$1,384,500	$2,615,500
FEDERAL FUNDS	$1,384,500	$2,615,500

DESCRIPTION

Purpose:
This policy change estimates the takeover costs of the Health Care Options (HCO) program.

Authority:
HCO Contract #17-94437

Interdependent Policy Changes:
Not Applicable

Background:
MAXIMUS, Inc. has been the enrollment contractor for the HCO program since October 1, 1996. MAXIMUS, Inc. 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. MAXIMUS, Inc. 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.

Operations for the current HCO contract with MAXIMUS began on January 1, 2009, for three years and nine months, and six one-year optional extension years, with current operations ending September 30, 2018, with takeover extending through December 31, 2018, including a 12-month turnover period. Funds paid on the contract use a mixture of Federal Funds (FF) and General Funds (GF) 50/50 for Administration.

Reason for change:
There is no change for FY 2017-18 or FY 2018-19. The increase from FY 2017-18 to FY 2018-19 in the current estimate is due to the final payment of $4,000,000 occurring in FY 2018-19.

Methodology:
1. Costs are based on a fixed price bid.

2. Contract costs are shared between Federal Funds and General Funds.

(Dollars in Thousands)

	TF	GF	FF
FY 2017-18	$2,769	$1,384	$1,385

HCO TAKEOVER

OTHER ADMIN. POLICY CHANGE NUMBER: 68

(Dollars in Thousands)

	TF	GF	FF
FY 2018-19	$5,231	$2,615	$2,616

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO TURNOVER

OTHER ADMIN. POLICY CHANGE NUMBER:	69
IMPLEMENTATION DATE:	11/2017
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1993

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$522,000	$1,436,000
STATE FUNDS	$261,000	$718,000
FEDERAL FUNDS	$261,000	$718,000

DESCRIPTION

Purpose:
This policy change estimates the turnover costs of the Health Care Options (HCO) program.

Authority:
HCO contract # 07-65829

Interdependent Policy Changes:
Not Applicable

Background:
MAXIMUS, Inc. has been the enrollment contractor for the HCO program since October 1, 1996. MAXIMUS, Inc. 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. MAXIMUS, Inc. 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.

Operations for the current HCO contract with MAXIMUS began on January 1, 2009, for three years and nine months, and six one-year optional extension years, with current operations ending September 30, 2018, with turnover extending through December 31, 2018. Funds paid on this contract use a mixture of Federal Funds (FF) and General Funds (GF) 50/50 for Administration.

Reason for change:
The change for FY 2017-18 and FY 2018-19 from the previous estimate is a decrease due to the renegotiation of the Turnover bid price. The increase from FY 2017-18 to FY 2018-19 is due to the final payment of $979,000 in FY 2018-19.

Methodology:
1. Costs are based on a fixed price bid.

2. Contract costs are shared between Federal Funds (FF) and General Funds (GF).

	TF	GF	FF
FY 2017-18	**$522,000**	$261,000	$261,000

HCO TURNOVER

OTHER ADMIN. POLICY CHANGE NUMBER: 69

	TF	GF	FF
FY 2018-19	**$1,436,000**	$718,000	$718,000

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO OPERATIONS 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 70
IMPLEMENTATION DATE: 11/2018
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 2051

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$0	$27,935,000
STATE FUNDS	$0	$13,436,640
FEDERAL FUNDS	$0	$14,498,360

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's assumption of operations is 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 2017-18 or FY 2018-19.The change from FY 2017-18 to FY 2018-19 is an increase because operations of the new contract begins in FY 2018-19.

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 2018-19	TF	GF Title XIX	FF Title XIX	GF Enhanced Title XXI	FF Enhanced Title XXI
		50%	50%	12%	88%
Transactions	$6,574	$3,123	$3,122	$39	$290
Packet Mailings	$4,441	$2,109	$2,110	$27	$195
BDA/Call Center	$16,920	$8,037	$8,037	$102	$744
Total	**$27,935**	**$13,269**	**$13,269**	**$168**	**$1,229**

HCO OPERATIONS 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 70

Funding:
FI 50%Title XIX / 50% GF (4260-101-0001/0890)
FI 88% Title XXI / 12% 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:	71
IMPLEMENTATION DATE:	11/2018
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	2052

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$0	$27,040,000
STATE FUNDS	$0	$13,006,240
FEDERAL FUNDS	$0	$14,033,760

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

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 will be 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 for FY 2017-18 or FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase because the contract begins in FY 2018-19.

Methodology:
1. Contract costs are shared between federal funds (FF) and General Fund (GF).

HCO COST REIMBURSEMENT 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 71

(Dollars in Thousands)

	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced Title XXI	Enhanced Title XXI
(FY 2018-19)		**(50%)**	**(50%)**	**(12%)**	**(88%)**
Postage	$13,734	$6,524	$6,523	$82	$605
Printing	$4,041	$1,919	$1,920	$24	$178
Materials Maintenance and Development	$3,357	$1,595	$1,594	$20	$148
Mass Mailings	$1,064	$505	$506	$6	$47
Other Cost. Reimb.	$1,342	$638	$638	$9	$57
Additional Systems Group Staff	$2,891	$1,373	$1,373	$17	$128
Miscellaneous	$611	$290	$290	$4	$27
Total	**$27,040**	**$12,844**	**$12,844**	**$162**	**$1,190**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FY 88% Title XXI / 12% GF (4260-113-0001/0890)

HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER:	72
IMPLEMENTATION DATE:	11/2018
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	2053

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$0	$9,304,000
STATE FUNDS	$0	$4,475,300
FEDERAL FUNDS	$0	$4,828,700

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 will be 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 is no change for FY 2017-18. The change for FY 2018-19, from the prior estimate, is a slight increase due to a revision of the estimated number of working days in FY 2018-19. The change from FY 2017-18 to FY 2018-19 is an increase because the contract begins in 2018-19.

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 2018-19 are based on 200 ESRs per year.

HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 72

(Dollars in thousands)

FY 2018-19	TF	GF	FF
Title XIX (50% FF / 50% GF)	$8,839	$4,419	$4,420
Title XXI (88% FF / 12% GF)	$465	$56	$409
Total	**$9,304**	**$4,475**	**$4,829**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 88% Title XXI / 22% GF (4260-113-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

DENTAL FI OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER:	73
IMPLEMENTATION DATE:	7/2014
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1887

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$57,261,000	$0
STATE FUNDS	$19,912,250	$0
FEDERAL FUNDS	$37,348,750	$0

DESCRIPTION

Purpose:
This policy change estimates the operational costs of the previous 2004 Dental Fiscal Intermediary (FI) contract.

Authority:
Contract # 04-35745

Interdependent Policy Changes:
Not Applicable

Background:
Delta Dental of California (Delta) was awarded a multi-year contract in 2004. The 2004 FI contract with Delta Dental ended in January 2018, with the new Administrative Services Organization (ASO) and FI assuming operational responsibility beginning February 1, 2018. The FI is responsible for FI services related to the Medi-Cal Dental Program.

The terms of the contract require Delta to process and pay claims submitted by Medi-Cal providers for services rendered to Medi-Cal eligibles. There are numerous enhancements to the claims processing system which have been made under the terms of the contract.

Operations constitute all contractual responsibilities required for the Contractor to administer and operate the California Dental Medicaid Management Information System (CD-MMIS). These cost categories consist of:

- General Adjudicated Claim Service Lines (ACSLs) – Lines of service associated with a Medi-Cal dental claim and includes costs related to the Dental Transformation Initiative (DTI) from Federally Qualified Health Centers (FQHC). Payments to FI are based on the number of ACSL's processed.

- Treatment Authorization Requests (TARS) - Prior authorization for treatment in accordance with Medi-Cal dental policy and procedures when prior authorization is required.

- Telephone Service Center (TSC) - Telephone activities to support effective provider and beneficiary service operations and meet all applicable performance standards.

Delta has bid on State-specified volume ranges for each of the above categories. The Department estimates Operations costs by applying these bid rates to the projected volumes for the current and budget year.

DENTAL FI OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 73

Reason for change:
The change from the prior estimate, for FY 2017-18, is a decrease due to updated actuals and updated projected costs based on updated trends through the end of current operations. For FY 2018-19, there is no change from the prior estimate as the 2004 contract ended in CY as anticipated. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the assumption of operations of the new ASO and FI, and no additional costs are expected are expected in FY 2018-19.

Methodology:
1. Operations costs are fixed price rates based on volumes within minimum and maximum ranges under the current Dental FI contract.

2. ACSL/TAR volumes determine the Dental Administration/Operations costs. Provider Enrollment activities account for 15% of the total ACSL/TAR costs.
    a. Provider Enrollment costs:
        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. TSC costs are funded at 50% FF and 50% GF.

FY 2017-18	TF	GF	FF
Administration/Operations (75% FF / 25% GF)	$33,065,000	$8,266,000	$24,799,000
Provider Enrollment (50% FF / 50% GF)	$4,026,000	$2,013,000	$2,013,000
Provider Enrollment (75% FF / 25% GF)	$1,809,000	$452,000	$1,357,000
Total ACSL/TAR	$38,900,000	$10,731,000	$28,169,000
TSC – Provider (50% FF / 50% GF)	$12,414,000	$6,207,000	$6,207,000
TSC – Beneficiary (50% FF / 50% GF)	$5,948,000	$2,974,000	$2,974,000
Total TSC	$18,362,000	$9,181,000	$ 9,181,000
Total Operations Costs	**$57,261,000**	**$19,912,000**	**$37,349,000**

*Slight differences 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:	74
IMPLEMENTATION DATE:	8/2017
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	2004

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$23,424,000	$5,856,000
STATE FUNDS	$5,856,000	$1,464,000
FEDERAL FUNDS	$17,568,000	$4,392,000

DESCRIPTION

Purpose:
This policy change estimates the total cost of Takeover from the current Fiscal Intermediary (FI), Delta Dental of California (Delta), to the new 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 is on a fixed price basis with the exception of those specific work items paid under Cost Reimbursement and Hourly Reimbursed Systems Group. The Treatment Authorization Request (TAR) documents processed during takeover will be paid at the bid rate for phase one of operations and will be counted in the phase one combined claim and TAR document volume. Takeover payment also includes 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 2017-18 or for FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the last payment with the remaining 20% to be made in FY 2018-19, six months after successful operations.

Methodology:
1. The price of takeover is $29,280,000 TF.

2. Of the contractor's price for takeover, 80% ($23,424,000 TF) will be paid in equal installments that began in August 2017.

3. The remaining 20% ($5,856,000 TF) will be made as a single payment six months after successful operations, assumed to be in FY 2018-19.

DENTAL FI TAKEOVER 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 74

Fiscal Year	TF	GF	FF
FY 2017-18	$23,424,000	$5,856,000	$17,568,000
FY 2018-19	$5,856,000	$1,464,000	$4,392,000

Funding:
FI 75% Title XIX / 25% GF (4260-101-0001/0890)

DENTAL ASO ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER:	75
IMPLEMENTATION DATE:	3/2018
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	2007

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$12,303,000	$38,138,000
STATE FUNDS	$4,552,250	$13,832,250
FEDERAL FUNDS	$7,750,750	$24,305,750

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 Services 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

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 and Postage
2. Parcel Services
3. Data Center Access
4. Toll Free Phone Charges
5. Special Training, Conferences, and Travel
6. Facilities Improvement
7. Audits
8. Independent Contractor Consideration

DENTAL ASO ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 75

9. Annual Risk Assessments
10. Miscellaneous
11. Cost Reimbursement Invoices

Reason for Change:
The decrease from the prior estimate, for FY 2017-18, is due to updated projected costs based on actuals. The increase from the prior estimate, for FY 2018-19, is due to updated projected costs based on actual invoices, claims and TSC data. The increase from FY 2017-18 to FY 2018-19, in the current estimate, is due to a partial year of expenditures in FY 2017-18 and a full year of expenditures for FY 2018-19.

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. 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. TSC minutes are based on actual invoices with a growth factor and funded at 50% FF and 50% GF.

FY 2017-18	TF	GF	FF
Administration/Operations (75% FF / 25% GF)	$5,893,000	$1,473,000	$4,420,000
Provider Enrollment (50% FF / 50% GF & 75% FF / 25% GF)	$1,040,000	$439,000	$601,000
Total ACSL/TAR	$6,934,000	$1,913,000	$5,021,000
TSC – Provider (50% FF / 50% GF)	$1,814,000	$907,000	$907,000
TSC – Beneficiary (50% FF / 50% GF)	$3,198,000	$1,599,000	$1,599,000
Total TSC	$5,010,000	$2,505,000	$2,505,000
Total Operations Costs	**$11,944,000**	**$4,418,000**	**$7,526,000**

FY 2018-19	TF	GF	FF
Administration/Operations (75% FF / 25% GF)	$18,089,000	$4,522,000	$13,567,000
Provider Enrollment (50% FF / 50% GF & 75% FF / 25% GF)	$3,192,000	$1,045,000	$2,147,000
Total ACSL/TAR	$21,282,000	$5,568,000	$15,714,000
TSC – Provider (50% FF / 50% GF)	$5,684,000	$2,842,000	$2,842,000
TSC – Beneficiary (50% FF / 50% GF)	$9,972,000	$4,986,000	$4,986,000
Total TSC	$15,656,000	$7,828,000	$7,828,000
Total Operations Costs	**$36,938,000**	**$13,396,000**	**$23,542,000**

DENTAL ASO ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 75

4. Cost reimbursements are based on actual invoices with a growth factor.

FY 2017-18	TF	GF	FF
Total Cost Reimbursable	$359,000	$134,000	$225,000

FY 2018-19	TF	GF	FF
Total Cost Reimbursable	$1,200,000	$436,000	$764,000

5. Total Administration Cost

	TF	GF	FF
FY 2017-18*	$12,303,000	$4,552,000	$7,751,000
FY 2018-19*	$38,138,000	$13,832,000	$24,306,000

*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 HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	76
IMPLEMENTATION DATE:	7/2014
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1888

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$6,604,000	$0
STATE FUNDS	$1,651,000	$0
FEDERAL FUNDS	$4,953,000	$0

DESCRIPTION

Purpose:
This policy change estimates the hourly reimbursement costs of the 2004 Dental Fiscal Intermediary (FI) contract.

Authority:
Contract # 04-35745

Interdependent Policy Changes:
Not Applicable

Background:
Delta Dental of California (Delta) was awarded a multi-year contract in 2004. The Department approved contract extensions with contract runout and closeout activities through September 2019. The 2004 Delta FI contract ended in January 2018 with the new Administrative Services Organization (ASO) and FI contractors assuming operational responsibility beginning February 1, 2018. The FI is responsible for FI services related to the Medi-Cal Dental Program.

The terms of the contract require Delta to process and pay claims submitted by Medi-Cal providers for services rendered to Medi-Cal eligibles. There are numerous enhancements to the claims processing system which have been made under the terms of the contract.

Certain activities are reimbursed on an hourly basis by the State. The rate paid to the Contractor consists of all direct and indirect costs required to support these activities. Hourly reimbursed areas consist of the Systems Group (SG), Surveillance and Utilization Review (SURS) unit, and computer support. 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 Dental Medicaid Management Information Systems. The SURS staff consists of dental consultants, manager/supervisors, liaisons, and analysts that monitor the provider and beneficiary claims to identify potential fraud and abuse.

Reason for change:
The change from the prior estimate, for FY 2017-18, is a decrease due to updated actuals based on paid invoices and assumed payment for work done through completion of the contract. There is no change from the prior estimate for FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the assumption of operations to the new contractors and no additional costs are expected in FY 2018-19.

DENTAL FI HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 76

Methodology:

1. Costs are estimated based on actual paid invoices.

2. Future payments are estimated based on an average of previously paid invoices.

3. Costs are shared between federal funds (FF) and General Fund (GF).

FY 2017-18	TF	GF	FF
Systems Group (SG)	$3,720,000	$930,000	$2,790,000
SURS	$2,884,000	$721,000	$2,163,000
Total	**$6,604,000**	**$1,651,000**	**$4,953,000**

Funding:

FI 75% Title XIX FF / 25% GF (4260-101-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

DENTAL FI COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	77
IMPLEMENTATION DATE:	7/2014
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1889

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$7,492,000	$0
STATE FUNDS	$3,650,000	$0
FEDERAL FUNDS	$3,842,000	$0

DESCRIPTION

Purpose:
This policy change estimates the total cost reimbursement of the 2004 Dental Fiscal Intermediary (FI) contract.

Authority:
Contract # 04-35745

Interdependent Policy Changes:
Not Applicable

Background:
Delta Dental of California (Delta) was awarded a multi-year contract in 2004. The 2004 FI contract with Delta Dental ended January 2018 with the new Administrative Services Organization (ASO) and FI contractors assuming operational responsibility beginning February 1, 2018. The FI is responsible for FI services related to the Medi-Cal Dental Program.

The terms of the contract require Delta to process and pay claims submitted by Medi-Cal providers for services rendered to Medi-Cal eligibles. There are numerous enhancements to the claims processing system which have been made under the terms of the contract.

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 State. 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. Data center access,
3. Postage, parcel services, and common carriers,
4. Special training sessions, convention, and travel,
5. Audits and research,
6. Facilities improvement,
7. Telephone toll charges,
8. Knox-Keene License Annual Assessment, and
9. Miscellaneous.

Costs under these categories consist of direct costs, or a subset thereof, which can be specifically identifiable with the particular cost objective.

DENTAL FI COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 77

Reason for change:
The change from the prior estimate, for FY 2017-18, is a net decrease due to updated costs based on actual paid invoices. There is no change from the prior estimate for FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the assumption of operations to the new FI and no additional costs under the 2004 contract are expected in FY 2018-19.

Methodology:
1. Costs are calculated by projecting with up to date actual invoices.

FY 2017-18	TF	GF	FF
Total	$7,492,000	$3,650,000	$3,842,000

Funding:
FI 50% Title XIX FF / 50% GF (4260-101-0001/0890)
FI 75% Title XIX FF / 25% GF (4260-101-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

DENTAL FI ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER:	78
IMPLEMENTATION DATE:	11/2017
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	2006

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$6,794,000	$20,505,000
STATE FUNDS	$1,800,000	$5,439,000
FEDERAL FUNDS	$4,994,000	$15,066,000

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 and Postage
2. Parcel Services
3. Data Center Access
4. Special Training, Conferences, Travel
5. Facilities Improvement
6. Audits
7. Independent Contractor Consideration
8. Annual Risk Assessments
9. Miscellaneous

DENTAL FI ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 78

10. 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 Systems Group (SG).

Reason for Change:
The change from the prior estimate, for FY 2017-18, is a net decrease due to updated projected costs based on actuals. The change from the prior estimate, for FY 2018-19, is a net increase due to updated projected costs based on actuals. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to a partial year of expenditures in FY 2017-18 and the expected full year of expenditures for FY 2018-19.

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 2015-16 actual document counts and increased by a growth factor.

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 2017-18	TF	GF	FF
Scanned Claims/TAR	$3,949,000	$987,000	$2,962,000
Check Write	$81,000	$20,000	$61,000
Total	**$4,030,000**	**$1,007,000**	**$3,023,000**

FY 2018-19	TF	GF	FF
Scanned Claims/TAR	$11,436,000	$2,859,000	$8,577,000
Check Write	$247,000	$62,000	$185,000
Total	**$11,683,000**	**$2,921,000**	**$8,762,000**

4. Cost reimbursements are based on actual invoices with a growth factor.

FY 2017-18	TF	GF	FF
Total	**$497,000**	**$226,000**	**$271,000**

FY 2018-19	TF	GF	FF
Total	**$1,674,000**	**$731,000**	**$943,000**

5. Hourly Reimbursables:

System Group	TF	GF	FF
FY 2017-18	**$2,267,000**	**$567,000**	**$1,700,000**
FY 2018-19	**$7,148,000**	**$1,787,000**	**$5,361,000**

DENTAL FI ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 78

6. Total Administration Cost:

Fiscal Year	TF	GF	FF
FY 2017-18*	$6,794,000	$1,800,000	$4,994,000
FY 2018-19*	$20,505,000	$5,439,000	$15,066,000

*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 ASO TAKEOVER 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER:	79
IMPLEMENTATION DATE:	9/2017
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	2003

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$3,756,000	$939,000
STATE FUNDS	$939,000	$234,750
FEDERAL FUNDS	$2,817,000	$704,250

DESCRIPTION

Purpose:
This policy change estimates the total cost of Takeover from the 2004 Fiscal Intermediary, Delta Dental of California (Delta), to the new Administrative Services Organization (ASO) contractor.

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 is on a fixed price basis with the exception of those specific work items paid under fixed price per Treatment Authorization Request (TAR) and Cost Reimbursement. Takeover payment also includes 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 2017-18 and FY 2018-19 is a decrease due updated payment timings and values based on actual invoices and updated projections for remaining invoices as well as a decrease to the overall cost based on a revised takeover cost plan. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to only the last payment with the remaining 20% to be made in FY 2018-19.

Methodology:
1. The price of Takeover is $4,695,000 based on the revised takeover cost plan.

2. Of the contractor's price for takeover, 80% ($3,756,000 TF) will be paid in 12 equal installments starting in November 2017 that was previously expected to start in September 2017.

3. The remaining 20% ($939,000 TF) will be made as a single payment six months after successful operations, assumed to be in FY 2018-19.

DENTAL ASO TAKEOVER 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 79

Fiscal Year	TF	GF	FF
FY 2017-18	$3,756,000	$939,000	$2,817,000
FY 2018-19	$939,000	$234,750	$704,250

Funding:
FI 75% Title XIX / 25% GF (4260-101-0001/0890)

DENTAL FI CD-MMIS COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	80
IMPLEMENTATION DATE:	11/2015
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1890

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$656,000	$1,279,000
STATE FUNDS	$164,000	$319,750
FEDERAL FUNDS	$492,000	$959,250

DESCRIPTION

Purpose:
This policy change estimates the cost of the base California Dental Medicaid Management Information System's (CD-MMIS) turnover services from the current Dental Fiscal Intermediary (FI), Delta Dental of California (Delta) to the new FI contractor, DXC Technology Services, LLC (DXC).

Authority:
Contract # 04-35745

Interdependent Policy Changes:
Not Applicable

Background:
Delta was awarded a multi-year contract in 2004. The 2004 FI contract with Delta Dental ended in January 2018, with the new Administrative Services Organization (ASO) and FI contractors assuming operational responsibility beginning February 1, 2018. The 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, the new dental FI began takeover activities. However, the Centers for Medicare and Medicaid Services (CMS) determined the new Medi-Cal Dental FI contract 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 current Dental FI contract for the period of July 1, 2013 through June 30, 2015. The Department instructed the FI contractor to stop all takeover activities. The FI contractor filed a Notification of Claim to recoup costs already expended for takeover activities. The Department has determined that the FI contractor should be reimbursed and five (5) out of the nine (9) equal installments were paid at that time.

The Department has instructed the 2004 Delta FI contractor to resume turnover support services and all activities in accordance with the contract requirements. The turnover period ensures an orderly transfer of the Medi-Cal Dental FI contract from the current contractor to the successor contractor, 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: 80

The schedule of payments for turnover services to the 2004 Delta FI is contractually agreed upon. The turnover bid price is paid in nine equal installments, four (4) of which still remain to be paid, and one final installment of 50% of the Turnover bid price. The final payment is made upon completion of all turnover and runout requirements.

Reason for change:
The change from the prior estimate, for FY 2017-18, is a decrease due to a shift in payments going into FY 2018-19 and that a portion of the payments represented in the prior estimate actually occurred previously. The change from the prior estimate for FY 2018-19, is an increase due to a shift of FY 2017-18 payments going into FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to a shift of FY 2017-18 payments going into FY 2018-19.

Methodology:
1. Costs are based on takeover and turnover contract bid prices, adjusted for CCPI as appropriate.

2. Costs are shared between federal funds (FF) and general funds (GF).

	TF	GF	FF
FY 2017-18	$656,000	$164,000	$492,000
FY 2018-19	$1,279,000	$319,750	$959,250

Funding:
FI 75% Title XIX FF / 25% GF (4260-101-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

DENTAL BENEFICIARY OUTREACH & ED PROGRAM - ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER:	81
IMPLEMENTATION DATE:	4/2016
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1949

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$1,893,000	$1,895,000
STATE FUNDS	$946,500	$947,500
FEDERAL FUNDS	$946,500	$947,500

DESCRIPTION

Purpose:
The policy change estimates the administrative cost of implementing strategies to increase utilization for Medi-Cal dental services for the 2004 Fiscal Intermediary (FI) contractor and the future Administrative Services Organization (ASO) contractor.

Authority:
Welfare & Institutions Code (WIC) Section 14132.91
Contract 04-35745
Contract 16-93287

Interdependent Policy Changes:
PC 37 Dental Beneficiary Outreach Efforts

Background:
In 2014, the California State Auditor (CSA) performed an audit of the Medi-Cal Dental Program. Among the findings/recommendations outlined in CSA's final report was a request that the Department require the 2004 FI contractor, Delta Dental (Delta), to develop an annual dental outreach and education program, as required by the provisions of the 2004 FI contract and WIC Section 14132.91. Outreach activities outlined in the 2004 FI and the 2016 ASO contractors' Outreach and Education Program plan seek to increase utilization of these services, particularly in counties where utilization levels are lowest.

Outreach activities include:
- Informational notices to newly enrolled beneficiaries,
- Targeted auto-dialer calls, calls to beneficiaries who reside in 23 counties with the lowest utilization rates,
- Telephone Service Center (TSC) live calls to targeted beneficiaries who reside in the 23 counties with lowest utilization rates,
- Statewide mailers to beneficiaries who have not utilized services in previous 12 months,
- Direct outreach to State, County, and Community agencies, and
- Website enhancements to the Denti-Cal website.

Outreach and education will help increase beneficiary awareness that they have dental benefits and may access assistance in locating a dentist and scheduling an appointment. Certain administrative activities related to this effort are payable under the contract.

DENTAL BENEFICIARY OUTREACH & ED PROGRAM - ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 81

Reason for Change:
The change from the prior estimate for FY 2017-18 is an increase due to updated actual invoice amounts, and an additional invoice for efforts conducted in the prior fiscal year. The change from the prior estimate for FY 2018-19 is an increase due to updated projections based on actual invoice amounts. The change from FY 2017-18 to FY 2018-19 in the current estimate is due to a full year of operations under the 2016 ASO/FI contracts and applying the California Consumer Price Index (CCPI) factor to the cost reimbursable items in FY 2018-19.

Methodology:

1. The Beneficiary Outreach and Education program began on June 21, 2017. The outreach is an annual cycle that is expected to occur each year.

2. Statewide mailers for both newly enrolled and non-utilizers in the state are funded at 50% FF and 50% GF. These costs are $1,668,268 for both FY 2017-18 and FY 2018-19.

3. Assume costs for the targeted efforts of the auto-dialers and live calls for beneficiaries who reside in the underutilized counties are funded at 50% FF and 50% GF. While targeted efforts for both FY 2017-18 and FY 2018-19 are targeting 2,500 beneficiaries each fiscal year, the cost are different based on the contract terms for 2004 FI and 2016 ASO contractors. An additional invoice for efforts done in FY 2016-17 was also paid in FY 2017-18. These costs are $14,082 in total for FY 2017-18 and $10,233 in total for FY 2018-19.

4. Cost reimbursable items for the statewide efforts are funded at 50% FF and 50% GF. These costs are $210,412 (TF) in FY 2017-18 and $ 216,304 (TF) in FY 2018-19.

5. The administrative costs for FY 2017-18 and FY 2018-19 will be:

Fiscal Year	TF	GF	FF
FY 2017-18	$1,893,000	$946,500	$946,500
FY 2018-19	$1,895,000	$947,500	$947,500

Funding:
FI 50% Title XIX FF / 50% GF (4260-101-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

DENTAL FI FEDERAL RULE - REVALIDATION

OTHER ADMIN. POLICY CHANGE NUMBER:	83
IMPLEMENTATION DATE:	7/2014
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1893

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$200,000	$0
STATE FUNDS	$100,000	$0
FEDERAL FUNDS	$100,000	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of additional workload of the 2004 Delta Dental Fiscal Intermediary (FI) contract as a result of the Centers for Medicare & Medicaid Services (CMS) mandated federal rules that apply to the Medi-Cal Dental Program. The additional workload includes the revalidation of the enrollment of all providers at least once every five years.

Authority:
Contract # 04-35745

Interdependent Policy Changes:
Not Applicable

Background:
Delta Dental of California (Delta) was awarded a multi-year contract in 2004. The Department approved contract extensions with contract runout and closeout activities through September 2019. The 2004 FI contract with Delta Dental ended in January 2018, with the new Administrative Services Organization (ASO) and FI contractors assuming operational responsibility beginning February 1, 2018. The FI is responsible for the FI services related to the Medi-Cal Dental Program.

Effective March 2011, CMS mandated federal rules that apply to the Medi-Cal Dental Program. The current CMS rules establish requirements for the enrollment and screening of Medicare, Medicaid, and Children's Health Insurance Program providers at the federal and state levels.

The Department must revalidate the enrollment of all providers regardless of provider type at least once every 5 years. The Department is allowed to use the results of the provider screening performed by Medicare contractors and has delegated this to the FI. To work towards compliance, Delta hired additional staff to complete the increased workload.

Reason for change:
The change from the prior estimate, for FY 2017-18, is a decrease due to actual invoices paid in FY 2017-2018 being lower than projected. There is no change from the prior estimate for FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the assumption of operations to the new FI and no additional costs are expected in FY 2018-19.

Methodology:
1. Actuals based on invoices are used for months that have already been paid.

2. Future months are estimated using an average of the prior months' actuals.

DENTAL FI FEDERAL RULE - REVALIDATION

OTHER ADMIN. POLICY CHANGE NUMBER: 83

3. Costs are shared between federal funds (FF) and General Fund (GF).

Fiscal Year	TF	GF	FF
FY 2017-18	$200,000	$100,000	$100,000

Funding:
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 FI FEDERAL RULE - DATABASE CHECKS

OTHER ADMIN. POLICY CHANGE NUMBER:	84
IMPLEMENTATION DATE:	7/2014
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1894

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$215,000	$0
STATE FUNDS	$107,500	$0
FEDERAL FUNDS	$107,500	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of additional workload of the 2004 Delta Dental Fiscal Intermediary (FI) contract as a result of the Centers for Medicare & Medicaid Services (CMS) mandated federal rules that apply to the Medi-Cal Dental Program. This additional workload is due to the Department checking specified federal databases for enrollment and reenrollment to confirm the identity and exclusion status of providers and any person with a controlling interest.

Authority:
Contract # 04-35745

Interdependent Policy Changes:
Not Applicable

Background:
Delta Dental of California (Delta) was awarded a multi-year contract in 2004. The Department approved contract extensions with contract runout and closeout activities through September 2019. The 2004 FI contract with Delta Dental ended in January 2018, with the new Administrative Services Organization (ASO) and FI contractors assuming operational responsibility beginning February 1, 2018. The FI is responsible for FI services related to the Medi-Cal Dental Program.

Effective March 2011, CMS mandated federal rules that apply to the Medi-Cal Dental Program. The current CMS rules establish requirements for the enrollment and screening of Medicare, Medicaid, and Children's Health Insurance Program providers at the federal and state levels.

The Department must confirm the identity upon enrollment and reenrollment and determine the exclusion status of providers, and any person with an ownership or controlling interest, or who is an agent or managing employee of the provider through routine database checks. This includes checking specific federal databases and checking at least the List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS) monthly. To work towards compliance, Delta hired additional staff to complete the increased workload.

Reason for change:
The change from the prior estimate, for FY 2017-18, is a decrease due to actual invoices paid in FY 2017-2018 being lower than projected. There is no change from the prior estimate for FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the assumption of operations to the new contractors and no additional costs are expected in FY 2018-19.

DENTAL FI FEDERAL RULE - DATABASE CHECKS

OTHER ADMIN. POLICY CHANGE NUMBER: 84

Methodology:

1. Costs are estimated based on Federal database checks which are required monthly from the LEIE and EPLS databases.

2. Actual invoice values have been used for months already paid.

3. Projections for future months of payment are based upon an average of the previously paid invoices.

4. Costs are shared between federal funds (FF) and General Fund (GF).

Fiscal Year	TF	GF	FF
FY 2017-18	$215,000	$107,500	$107,500

Funding:

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 FI CONLAN, SCHWARZMER, STEVENS V. BONTA

OTHER ADMIN. POLICY CHANGE NUMBER:	85
IMPLEMENTATION DATE:	7/2014
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1891

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$196,000	$0
STATE FUNDS	$98,000	$0
FEDERAL FUNDS	$98,000	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of additional workload of the 2004 Delta Dental Fiscal Intermediary (FI) contract as a result of the *Conlan, Schwarzmer, Stevens v. Bontá* case ruling.

Authority:
Contract # 04-35745

Interdependent Policy Changes:
Not Applicable

Background:
Delta Dental of California (Delta) was awarded a multi-year contract in 2004. The Department approved contract extensions with contract runout and closeout activities through September 2019. The 2004 FI contract with Delta Dental ended in January 2018, with the new Administrative Services Organization (ASO) and FI contractors assuming operational responsibility beginning February 1, 2018. The FI is responsible for FI services related to the Medi-Cal Dental Program.

In the case of *Conlan, Schwarzmer, Stevens v. Bontá,* the Court of Appeals found that the Department failed to provide a procedure whereby Medi-Cal beneficiaries can be reimbursed for their out-of-pocket expenses for health care received during their period of retroactive eligibility and during the period between their application for Medi-Cal and their determination of eligibility. The court held that the Department's system of relying upon the beneficiaries to obtain reimbursement from the providers for these expenses is insufficient because it violates the comparability provisions of the Medicaid law.

The Department has developed and implemented new processes through the Dental FI to ensure prompt reimbursement to beneficiaries. The Dental FI is required to hire, train, and oversee appropriate staff to address this ongoing workload.

Reason for change:
The change from the prior estimate, for FY 2017-18, is due to actual invoices paid FY 2017-18 being higher than projected. There is no change from the prior estimate for FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the assumption of operations to the new contractors and no additional costs are expected in FY 2018-19.

DENTAL FI CONLAN, SCHWARZMER, STEVENS V. BONTA

OTHER ADMIN. POLICY CHANGE NUMBER: 85

Methodology:
1. Costs are estimated based on actual paid invoices.

2. Future payments are estimated based on an average of previously paid invoices.

3. Costs are shared between federal funds (FF) and General Fund (GF).

Fiscal Year	TF	GF	FF
FY 2017-18	$196,000	$98,000	$98,000

Funding:
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 FI HIPAA ADDENDUM SECURITY RISK ASSESSMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	86
IMPLEMENTATION DATE:	7/2014
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1892

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$167,000	$0
STATE FUNDS	$41,750	$0
FEDERAL FUNDS	$125,250	$0

DESCRIPTION

Purpose:
This policy change budgets the cost of establishing the Department's implementation plan designed to comply with the controls required by the National Institute of Standards and Technology (NIST). The Department implements the Health Insurance Portability and Accountability Act's (HIPAA) Security Rule based on the latest NIST guidelines.

Authority:
Contract # 04-35745

Interdependent Policy Changes:
Not Applicable

Background:
Delta Dental of California (Delta) was awarded a multi-year contract in 2004. The Department approved contract extensions with contract runout and closeout activities through September 2019. The 2004 FI contract with Delta Dental ended in January 2018, with the new Administrative Services Organization (ASO) and FI contractors assuming operational responsibility beginning February 1, 2018. The FI is responsible for FI services related to the Medi-Cal Dental Program.

HIPAA's Security Rule covers the steps in the Risk Management Framework that address security control selection for federal information systems in accordance with the security requirements in Federal Information Processing Standard 200. Compliance with the NIST controls will result in increased requirements to the Security and Privacy Laws and regulations required by Contract 04-35745, Exhibit H, the HIPAA Business Associate Addendum. This policy change establishes the Department's implementation plan to comply with NIST to continue the security risk assessment process for all current and future projects.

Reason for change:
The change from the prior estimate, for FY 2017-18, is a decrease due to actual invoices paid FY 2017-2018 being lower than projected. There is no change from the prior estimate for FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the assumption of operations to the new contractors and no additional costs are expected in FY 2018-19.

Methodology:
1. The security risk assessment process costs are based upon the hours required to ensure compliance with the controls required by NIST.

DENTAL FI HIPAA ADDENDUM SECURITY RISK ASSESSMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 86

2. Actual invoice values have been used for months already paid.

3. Projections for future months of payment are based upon an average of the previously paid invoices.

4. Costs are shared between federal funds (FF) and General Fund (GF).

Fiscal Year	TF	GF	FF
FY 2017-18	$167,000	$41,750	$125,250

Funding:
FI HIPAA 75% FF / 25% GF (4260-117-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

PERSONAL CARE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER:	87
IMPLEMENTATION DATE:	4/1993
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	236

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$385,201,000	$393,693,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$385,201,000	$393,693,000

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 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:
Updated expenditure data was provided by CDSS.

Methodology:
The estimates, on a cash basis, were provided by CDSS.

PERSONAL CARE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 87

(Dollars in Thousands)

FY 2017-18	TF	DHCS FFP	CDSS GF/ County Match
EW Time & Health Related	$689,142	$344,571	$344,571
CMIPS II	$81,260	$40,630	$40,630
Total	$770,402	**$385,201**	$385,201
FY 2018-19	**TF**	**DHCS FFP**	**CDSS GF/ County Match**
EW Time & Health Related	$663,680	$331,840	$331,840
CMIPS II	$123,706	$61,853	$61,853
Total	$787,386	**$393,693**	$393,693

Totals may differ due to rounding.

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

HEALTH-RELATED ACTIVITIES - CDSS

OTHER ADMIN. POLICY CHANGE NUMBER:	88
IMPLEMENTATION DATE:	7/1992
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	233

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$274,418,000	$330,365,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$274,418,000	$330,365,000

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:
Interagency Agreements:

CWS	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:
Updated expenditure data received from CDSS.

Methodology:
The estimates, on a cash basis, were provided by CDSS.

HEALTH-RELATED ACTIVITIES - CDSS

OTHER ADMIN. POLICY CHANGE NUMBER: 88

(Dollars in Thousands)

FY 2017-18	TF	DHCS FFP	CDSS GF/ County Match
CWS	$324,562	$162,281	$162,281
CWS/CMS	$7,900	$3,950	$3,950
CSBG/APS	$219,144	$109,572	$109,572
Psychotropic	$480	$240	$240
TOTAL	$548,836	**$274,418**	$274,418

FY 2018-19	TF	DHCS FFP	CDSS GF/ County Match
CWS	$664,696	$187,400	$187,400
CWS/CMS	$8,696	$4,348	$4,348
CSBG/APS	$280,472	$140,236	$140,236
Psychotropic	$480	$240	$240
TOTAL	$660,730	**$330,365**	$330,365

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

CALHEERS DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	89
IMPLEMENTATION DATE:	6/2012
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	1679

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$125,682,000	$126,987,000
STATE FUNDS	$26,008,790	$26,302,170
FEDERAL FUNDS	$99,673,210	$100,684,830

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, Statute of 2010, Chapter 655
SB 900, Statute of 2010, Chapter 659
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.

CALHEERS DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 89

The ACA offers additional enhanced federal funding for developing/upgrading Medicaid eligibility systems and for interactions of such systems with the ACA-required health benefit exchanges. The Department 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 10/90 Federal Financial Participation (FFP) for Title XIX and 12/88 FFP for Title XXI. CalHEERS ongoing maintenance and operations (M&O) cost is 25/75 FFP for Title XIX and 12/88 FFP for Title XXI. 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 November 2017, CMS approved funding through federal FY 2018-19. The Department will submit an IAPDU in 2018, seeking approval for funding through subsequent fiscal years.

Reason for Change:
There is no change from the prior estimate for FY 2017-18. The change from the prior estimate, for FY 2018-19, is an increase due to employee salary and benefit adjustments. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to a full year of shared costs for the Department at the increased rate and employee compensation and benefit increases in FY 2018-19.

Methodology:
1. Contractors began D&I work in July 2012 with payments beginning in August 2012. M&O started in January 2015.

2. Until September 30, 2017, FY 2017-18 costs were based on the estimated enrollment for shared costs at a rate of 13.97% Covered California and 86.03% to the Department. Costs directly attributable to the Department will be 100% the responsibility of the Department.

3. Effective October 1, 2017, FY 2017-18 and 2018-19 costs are based on the estimated enrollment for shared costs at a rate of 12.14% Covered California and 87.86% to the Department. Costs directly attributable to the Department will be 100% the responsibility of the Department.

4. In FY 2017-18 and FY 2018-19, 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

   The M&O period is eligible for:
   - 86.27% at 75% federal reimbursement
   - 13.73% at 88% federal reimbursement

CALHEERS DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 89

FY 2017-18	TF	GF	FF
75% Title XIX FF / 25% GF	$84,327,000	$21,082,000	$63,245,000
88% Title XXI FF / 12% GF	$16,783,000	$2,014,000	$14,769,000
90% Title XIX FF / 10% GF	$21,122,000	$2,112,000	$19,010,000
CalHEERS Subtotal	$122,232,000	$25,208,000	$97,024,000
75% Title XIX FF / 25% GF	$2,976,000	$744,000	$2,232,000
88% Title XXI FF / 12% GF	$474,000	$57,000	$417,000
DHCS EITS Subtotal	$3,450,000	$801,000	$2,649,000
Total	**$125,682,000**	**$26,009,000**	**$99,673,000**

FY 2018-19	TF	GF	FF
75% Title XIX FF / 25% GF	$85,389,000	$21,347,000	$64,042,000
88% Title XXI FF / 12% GF	$16,962,000	$2,035,000	$14,927,000
90% Title XIX FF / 10% GF	$21,186,000	$2,119,000	$19,067,000
CalHEERS Subtotal	$123,537,000	$25,501,000	$98,036,000
75% Title XIX FF / 25% GF	$2,976,000	$744,000	$2,232,000
88% Title XXI FF / 12% GF	$474,000	$57,000	$417,000
DHCS EITS Subtotal	$3,450,000	$801,000	$2,649,000
Total	**$126,987,000**	**$26,302,000**	**$100,685,000**

Funding:
75% Title XIX / 25% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)

CDDS ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	90
IMPLEMENTATION DATE:	7/1997
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	243

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$53,471,000	$52,686,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$53,471,000	$52,686,000

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 2017-18 and FY 2018-19, from the prior estimate, is an increase due to updated DC/SOCF Medi-Cal Admin and TCM RC Admin expenditure data.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a net decrease due to a decrease in expenditures expected in FY 2018-19 and more prior year expenditures in FY 2018-19 than in FY 2017-18.

CDDS ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 90

Methodology:

1. CDDS provides the following cash estimates of its administrative cost components:

FY 2017-18		DHCS FFP	CDDS GF	IA #
1	DC/SOCF Medi-Cal Admin.	$5,090,000	$5,090,000	03-75282/83
	DC/SOCF HIPAA*	$163,000	$0	03-75282/83
2	DC/SOCF Medi-Cal Elig	$525,000	$525,000	01-15378
3	HCBS Waiver Admin.	$21,991,000	$21,991,000	01-15834
4	RC Medicaid Admin.	$16,132,000	$5,377,000	03-75734
5	NHR Admin.	$422,000	$422,000	03-75285
6	TCM Headquarters Admin.	$405,000	$405,000	03-75284
	TCM RC Admin.	$8,105,000	$8,105,000	03-75284
	TCM HIPAA*	$638,000	$0	03-75284
	Total	**$53,471,000**	$41,915,000	

FY 2018-19		DHCS FFP	CDDS GF	IA #
1	DC/SOCF Medi-Cal Admin.	$5,063,000	$5,063,000	03-75282/83
	DC/SOCF HIPAA*	$163,000	$0	03-75282/83
2	DC/SOCF Medi-Cal Elig	$525,000	$525,000	01-15378
3	HCBS Waiver Admin.	$21,843,000	$21,843,000	01-15834
4	RC Medicaid Admin.	$16,132,000	$5,377,000	03-75734
5	NHR Admin.	$595,000	$595,000	03-75285
6	TCM Headquarters Admin.	$350,000	$350,000	03-75284
	TCM RC Admin.	$7,377,000	$7,377,000	03-75284
	TCM HIPAA*	$638,000	$0	03-75284
	Total	**$52,686,000**	$41,130,000	

Funding:

100% Title XIX (4260-101-0890)
100% HIPAA FFP (4260-117-0890)*

MATERNAL AND CHILD HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER:	91
IMPLEMENTATION DATE:	7/1992
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	234

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$36,945,000	$37,555,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$36,945,000	$37,555,000

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. 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.
- Prenatal Care Guidance (PCG): Case management services for improved access to early obstetrical care for Medi-Cal eligible pregnant women.

MATERNAL AND CHILD HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER: 91

- Adolescent Family Life Program (AFLP): Case management services for Medi-Cal eligible pregnant adolescents to address the social, health, educational, and economic consequences of adolescent pregnancy by providing comprehensive case management services to pregnant and parenting adolescents and their children. The AFLP emphasizes promotion of positive youth development, focusing on and building upon the adolescents' strengths and resources to work toward:
    1) Improving the health of the pregnant and parenting adolescent;
    2) Improving graduation rates;
    3) Reducing repeat pregnancies; and
    4) Improving linkages and creating networks for pregnant and parenting adolescents.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is an increase due to additional FY 2016-17 fourth quarter invoices received in FY 2017-18. The change from the prior estimate, for FY 2018-19, is an increase due to revising the estimate based on actual costs and anticipating FY 2017-18 fourth quarter invoices to be received in FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to a higher cost projection for CPSP & PCG offset by a lower cost projection for BIH and AFLP in FY 2018-19.

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 2017-18	DHCS FFP	CDPH GF	County Match
BIH	$3,762	$2,110	$1,127
CPSP & PCG	$31,972	$0	$23,077
AFLP	$1,211	$0	$1,014
Total for FY 2017-18	**$36,945**	$2,110	$25,218

FY 2018-19	DHCS FFP	CDPH GF	County Match
BIH	$3,663	$2,002	$1,199
CPSP & PCG	$32,765	$0	$23,559
AFLP	$1,127	$0	$927
Total for FY 2018-19	**$37,555**	$2,002	$25,685

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

HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN

OTHER ADMIN. POLICY CHANGE NUMBER:	92
IMPLEMENTATION DATE:	7/1999
ANALYST:	Matt Wong
FISCAL REFERENCE NUMBER:	246

	FY 2017-18	FY 2018-19
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) 17-94267 AO1

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 (CHDP) 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: 92

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:
The change from the prior estimate, for FY 2017-18, is an increase due to the addition of $3.85 million ongoing general funds to hire additional Public Health Nurses.
The change from the prior estimate, for FY 2018-19, is an increase due to the addition of $3.85 million ongoing general funds to hire additional Public Health Nurses.
There is no change from FY 2017-18 to FY 2018-19 in the current estimate.

Methodology:
1. CDSS provides the annual Local Revenue Fund of $13,793,000 for FY 2017-18 and FY 2018-19.

(Dollars in Thousands)

Fiscal Year	TF	CDSS GF	DHCS FFP
FY 2017-18	$55,172	$13,793	**$41,379**
FY 2018-19	$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:	93
IMPLEMENTATION DATE:	7/2002
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	256

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$19,640,000	$31,853,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$19,640,000	$31,853,000

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:
Interagency Agreements (IA):

IHSS PCSP	03-75676
IHSS Health Related	01-15931
CWS/CMS for Medi-Cal	06-55834
IHSS Plus Option Sec. 1915(j)	09-86307
SAWS	04-35639
Medi-Cal State Hearings	16-93214
Public Inquiry and Response	16-93215
Medicaid Disability Evaluation Services	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) Inter-agency Agreement (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 2017-18 and FY 2018-19, is a decrease due to updated expenditure data and the Medicaid Disability Evaluation Services IA expiration in June 2016 with a new executed IA in FY 2018-19. This shifted the Medicaid Disability Evaluation Services costs from FY 2016-17 and FY 2017-18 to FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to revised expenditure data provided by CDSS and the shift of costs for Medicaid Disability Evaluation Services from FY 2017-18 to FY 2018-19.

DEPARTMENT OF SOCIAL SERVICES ADMIN COST

OTHER ADMIN. POLICY CHANGE NUMBER: 93

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

FY 2017-18	TF	DHCS FFP	CDSS GF
IHSS PCSP	$15,194,000	$7,597,000	$7,597,000
IHSS Health Related	$54,000	$27,000	$27,000
CWS/CMS for Medi-Cal	$278,000	$139,000	$139,000
IHSS Plus Option Sec. 1915(j)	$3,512,000	$1,756,000	$1,756,000
SAWS	$570,000	$285,000	$285,000
Medi-Cal State Hearings	$18,768,000	$9,384,000	$9,384,000
Public Inquiry and Response	$900,000	$450,000	$450,000
Medicaid Disability Evaluation Services	$4,000	$2,000	$2,000
TOTAL	$39,280,000	**$19,640,000**	$19,640,000
FY 2018-19	**TF**	**DHCS FFP**	**CDSS GF**
IHSS PCSP	$16,340,000	$8,170,000	$8,170,000
IHSS Health Related	$130,000	$65,000	$65,000
CWS/CMS for Medi-Cal	$1,846,000	$923,000	$923,000
IHSS Plus Option Sec. 1915(j)	$5,400,000	$2,700,000	$2,700,000
SAWS	$530,000	$265,000	$265,000
Medi-Cal State Hearings	$19,200,000	$9,600,000	$9,600,000
Public Inquiry and Response	$752,000	$376,000	$376,000
Medicaid Disability Evaluation Services	$19,508,000	$9,754,000	$9,754,000
TOTAL	$63,706,000	**$31,853,000**	$31,853,000

*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:	94
IMPLEMENTATION DATE:	7/2007
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	1192

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$14,395,000	$14,195,000
STATE FUNDS	$3,407,000	$3,407,000
FEDERAL FUNDS	$10,988,000	$10,788,000

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 07-65503 A01
IA 10-10494 A02
IA 13-20463 A02
AB 1559 (Chapter 565, Statutes of 2014)
SB 853 (Chapter 717, Statutes of 2010)

Interdependent Policy Changes:
PC 153 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: 94

The Office of AIDS operates and administers the Human Immunodeficiency Virus (HIV) / Acquired Immune Deficiency 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 public health nurse 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.

Skilled Nursing Facility: 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 2017-18 and FY 2018-19, is a decrease due to a lower cost projection for Skilled Nursing Facilities administrative costs.

The change in the current estimate, from FY 2017-18 to FY 2018-19, in the current estimate, is due to a higher cost projection for CLPP in FY 2017-18.

Methodology:
1. CDPH provides the General Fund match.

2. For Maternal, Child and Adolescent Health, the estimate includes an enhanced FMAP of 75% for Skilled Professional Medical Personnel costs. The estimate also includes funding for the Black Infant Health Program.

3. CDPH provided the following estimates.

FY 2017-18 (Cash Basis)	DHCS FFP*	DHCS SF**	CDPH GF	Other Match
MCAH	$1,900,000	$0	$1,900,000	$0
Office of AIDS	$737,000	$0	$737,000	$0
CLPP	$2,557,000	$0	$0	$2,557,000
CHCQ	$2,387,000	$0	$0	$2,387,000
Skilled Nursing Facilities	$3,407,000	$3,407,000	$0	$0
Total	**$10,988,000**	**$3,407,000**	$2,637,000	$4,944,000

FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 94

FY 2018-19 (Cash Basis)	DHCS FFP*	DHCS SF**	CDPH GF	Other Match
MCAH	$1,900,000	$0	$1,900,000	$0
Office of AIDS	$737,000	$0	$737,000	$0
CLPP	$2,357,000	$0	$0	$2,357,000
CHCQ	$2,387,000	$0	$0	$2,387,000
Skilled Nursing Facilities	$3,407,000	$3,407,000	$0	$0
Total	**$10,788,000**	**$3,407,000**	$2,637,000	$4,744,000

Funding:
100% Title XIX FFP (4260-101-0890)*
SNF Quality & Accountability (non-GF) (4260-605-3167)**

ACA OUTREACH AND ENROLLMENT COUNSELORS

OTHER ADMIN. POLICY CHANGE NUMBER:	95
IMPLEMENTATION DATE:	7/2014
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1820

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$11,442,000	$0
STATE FUNDS	$5,721,000	$0
FEDERAL FUNDS	$5,721,000	$0

DESCRIPTION

Purpose:
This policy change estimates the costs for outreach, enrollment, and renewal activities related to targeted Medi-Cal populations who are eligible as a result of the Affordable Care Act (ACA).

Authority:
SB 101 (Chapter 361, Statutes of 2013)
SB 18 (Chapter 551, Statutes of 2014)
AB 82, Sections 70 and 71 (Chapter 23, Statutes of 2013)
SB 75 (Chapter 18, Statutes of 2015)

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2014, the ACA expands 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. In addition, the ACA requires enrollment simplification for several current coverage groups and imposes a penalty upon the uninsured. Currently eligible but not enrolled beneficiaries who enroll in Medi-Cal as a result of enrollment simplification efforts are considered to be 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 ACA Mandatory expansions.

The Department partnered with Covered California to certify enrollment counselors and provide outreach, enrollment, renewal assistance, and marketing activities related to the ACA. This policy change estimates the costs for the outreach and enrollment of targeted Medi-Cal populations as well as renewal assistance for current Medi-Cal beneficiaries. Also included in this policy change are costs to compensate Medi-Cal enrollment counselors and insurance agents for providing in-person application assistance. There will be special emphasis to target the following populations for outreach and enrollment:

- Persons with mental health disorder needs,
- Persons with substance use disorder needs,
- Persons who are homeless,
- Young men of color,
- Persons who are in county jail, in state prison, on state parole, on county probation, or under post release community supervision,
- Families of mixed-immigration status; and,
- Persons with limited English proficiency.

ACA OUTREACH AND ENROLLMENT COUNSELORS

OTHER ADMIN. POLICY CHANGE NUMBER: 95

The Department established a special Healthcare Outreach and Medi-Cal Enrollment Account within a Special Deposit Fund to collect and allocate public or private grants to fund these activities.

Reason for Change:
There is no change, from the prior estimate, for FY 2017-18 or FY 2018-19. The change in the current estimate, from FY 2017-18 to FY 2018-19, results from the end of the grant in FY 2017-18, with no anticipated invoice activity in FY 2018-19.

Methodology:
1. The Department estimates $11,941,000 (before support adjustment) will be spent on these activities in FY 2017-18.

2. Per SB 75, Section 48(f) (amendment to Section 70 of Chapter 23 of the Statutes of 2013), after all enrollment assistance payments have been made for applications received through June 30, 2015, any remaining funds shall be allocated to the county outreach and enrollment grants under Section 71 of Chapter 23 of the Statutes of 2013.

3. Per SB 101 (Chapter 361, Statutes of 2013) Section 5(d), the Department has authority to expend in aggregate up to $500,000 annually to administer the activities budgeted in this policy change. The Department has included the administrative funding in the Department's support budget (4260-501-0942 (285)).

4. The total amount granted for these projects was $65,000,000, of which the Department will spend the remaining $11,442,000 in FY 2017-18 with no anticipated expenditures in FY 2018-19. The funds will be spent as follows:

(Dollars in Thousands)

FY 2017-18	TF	Special Fund	FF
Enrollment Counselors	$ -	$ -	$ -
Outreach and Enrollment	$ 8,333	$ 4,166	$ 4,167
Renewal Assistance	$ 3,609	$ 1,805	$ 1,804
Support Adjustment	$ (500)	$ (250)	$ (250)
Total	**$ 11,442**	**$ 5,721**	**$ 5,721**

Funding:
50% Healthcare Outreach Fund (4260-501-0942 (285))
50% Title XIX FFP (4260-101-0890)

CLPP CASE MANAGEMENT SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER:	96
IMPLEMENTATION DATE:	7/1997
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	239

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$5,355,000	$4,200,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$5,355,000	$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 public health nurse 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 2017-18 and FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to fewer prior year invoices in FY 2018-19.

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: 96

2. The estimates are provided by CDPH on a cash basis.

(Dollars in Thousands)

FY 2017-18	DHCS FFP	CDPH CLPP Fee Funds
FY 2016-17 Admin. Costs	$2,205	$2,205
FY 2017-18 Admin. Costs	$3,150	$3,150
Total	**$5,355**	$5,355

FY 2018-19	DHCS FFP	CDPH CLPP Fee Funds
FY 2017-18 Admin. Costs	$1,050	$1,050
FY 2018-19 Admin. Costs	$3,150	$3,150
Total	**$4,200**	$4,200

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

DEPARTMENT OF AGING ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	97
IMPLEMENTATION DATE:	7/1984
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	253

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$4,093,000	$4,279,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$4,093,000	$4,279,000

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 eligibles utilizing Aging and Disability Resource Centers (ADRC).

Authority:
Interagency Agreements:
CBAS 03-76137
MSSP 01-15976

Interdependent Policy Changes:
Not Applicable

Background:
The CDA coordinates with the Department to obtain FFP for the administrative costs for services related to Medi-Cal beneficiaries. CDA budgets the matching General Fund (GF).

Reason for Change:
There is no change from the prior estimate for FY 2017-18 and FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to updated invoicing and accounting data.

DEPARTMENT OF AGING ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 97

Methodology:
The estimates below, on a cash basis, were provided by CDA.

(Dollars in Thousands)

	FY 2017-18		FY 2018-19	
CBAS Support	**CDA GF**	**FFP**	**CDA GF**	**FFP**
FY 2016-17 DOS	$30	$31		
FY 2017-18 DOS	$1,926	$2,242	$100	$125
FY 2018-19 DOS			$1,926	$2,242
Total CBAS	$1,956	$2,273	$2,026	$2,367
MSSP Support				
FY 2015-16 DOS	$1	$1	$41	$51
FY 2016-17 DOS	$13	$13	$1,318	$1,521
FY 2017-18 DOS	$1,318	$1,521	$1,360	$1,572
FY 2018-19 DOS				
Total MSSP	$1,332	$1,535		
ADRC Support*				
FY 2016-17 DOS		$1		
FY 2017-18 DOS		$284		$56
FY 2018-19 DOS				$284
Total ADRC		$285		$340
Grand Total	**$3,288**	**$4,093**	**$3,386**	**$4,279**

Funding:
100% Title XIX (4260-101-0890)
100% MFP Federal Grant (4260-106-0890)*

VITAL RECORDS DATA

OTHER ADMIN. POLICY CHANGE NUMBER:	98
IMPLEMENTATION DATE:	5/2016
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1774

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$1,632,000	$922,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,632,000	$922,000

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 (IT) 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.

The Department has entered into a contract with CDPH to provide certified copies of vital records as required for business needs, beginning July 2018.

Reason for Change:
The change in FY 2017-18, from the prior estimate, is due to lower than estimated FY 2016-17 birth and death rates. The change in FY 2018-19 from the prior estimate is due to the addition of the contract with CDPH to provide certified records to the Department. The change from FY 2017-18 to FY 2018-19, in the current estimate, resulted from two factors. First, FY 2017-18 has three years of claims, while FY 2018-19 has only two years of claims. Second, the addition of the contract that allows the Department to request certified copies of vital records from CDPH begins in FY 2018-19.

VITAL RECORDS DATA

OTHER ADMIN. POLICY CHANGE NUMBER: 98

Methodology:

1. The Department and CDPH will receive 75% FFP for ongoing costs to deliver vital records data and certificates.

2. CDPH will provide the match for FFP from the Health Statistics Special Fund (HSSF).

3. On an accrual basis, the maximum reimbursable amount for the cost associated with preparing the records for transfer to the Department is $874,000 per year, and $64,352 per year for certified copies.

4. On a cash basis, assume three quarters will be paid in the current fiscal year and the remaining quarter will be paid in the subsequent fiscal year for each contract.

5. The estimated reimbursements for FY 2017-18 and FY 2018-19 on a cash basis are:

(Dollars in thousands)

FY 2017-18	TF	HSSF	FF
FY 2015-16 Claims	$184	$46	$138
FY 2016-17 Claims	$1,117	$279	$838
FY 2017-18 Claims	$875	$219	$656
	$2,176	**$544**	**$1,632**

FY 2018-19	TF	HSSF	FF
FY 2017-18 Claims	$291	$73	$218
Contract - Certified Copies	$64	$16	$48
FY 2018-19 Claims	$874	$218	$656
	$1,229	**$307**	**$922**

Funding:

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

CALIFORNIA SMOKERS' HELPLINE

OTHER ADMIN. POLICY CHANGE NUMBER:	99
IMPLEMENTATION DATE:	1/2014
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	1680

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$1,373,000	$2,200,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,373,000	$2,200,000

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 quitline 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:
The change from the prior estimate, for FY 2017-18, is an increase due to prior year expenditures being budgeted in FY 2017-18 as a result of a delay in claims processing. There is no change from the prior estimate for FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to a significantly higher cost projection anticipated in FY 2018-19 as a result of CDPH's launch of a new Helpline program for expanded outreach and media expansion.

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.

CALIFORNIA SMOKERS' HELPLINE

OTHER ADMIN. POLICY CHANGE NUMBER: 99

2. On an accrual basis, the reimbursable amount for Helpline services is $1 million FFP in FY 2017-18, and $2.4 million FFP in FY 2018-19.

3. FY 2017-18 costs include prior year expenditures, from FY 2015-16 and FY 2016-17, and FY 2017-18, Q1-Q4 claims.

4. FY 2018-19 costs include FY 2018-19, Q1-Q4 claims; however, a portion of Q4 claims, $200,000, is expected to be paid in the next fiscal year.

5. The estimated administrative cost reimbursements, for FY 2017-18 and FY 2018-19, on a cash basis are:

FY 2017-18	TF	FF
FY 2015-16 Claims	$287,000	$287,000
FY 2016-17 Claims	$86,000	$86,000
FY 2017-18 Claims	$1,000,000	$1,000,000
Total for FY 2017-18	**$1,373,000**	**$1,373,000**

FY 2018-19	TF	FF
FY 2018-19 Claims	$2,200,000	$2,200,000
Total for FY 2018-19	**$2,200,000**	**$2,200,000**

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

KIT FOR NEW PARENTS

OTHER ADMIN. POLICY CHANGE NUMBER:	100
IMPLEMENTATION DATE:	7/2001
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	249

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$1,119,000	$1,119,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,119,000	$1,119,000

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:
There is no change from the prior estimate for FY 2017-18 and FY 2018-19. There is no change, from FY 2017-18 to FY 2018-19, in the current estimate.

Methodology:
1. CCFC will distribute an estimated 370,000 kits in FY 2017-18 and FY 2018-19, of these kits, 46% are expected to be distributed to Medi-Cal eligible newborns.

370,000 kits x 46% = 170,200 Medi-Cal kits

2. Approximately 51% of the kits distributed will be basic kits and 49% will be custom kits. The basic kit costs $13.10 and the custom kit, which contains an additional item specific to the county of birth, costs $13.19.

170,200 Medi-Cal kits x 51% = 86,802 basic kits x $13.10 = $1,137,000
170,200 Medi-Cal kits x 49% = 83,398 custom kits x $13.19 = $1,100,000
Total $2,237,000

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.

KIT FOR NEW PARENTS

OTHER ADMIN. POLICY CHANGE NUMBER: 100

Fiscal Year	Accrual	FY 2017-18	FY 2018-19
FY 2016-17	$2,237,000	$559,000	$0
FY 2017-18	$2,237,000	$1,678,000	$559,000
FY 2018-19	$2,237,000	$0	$1,678,000
Total		$2,237,000	$2,237,000
Total FF (50%)		**$1,119,000**	**$1,119,000**

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

VETERANS BENEFITS

OTHER ADMIN. POLICY CHANGE NUMBER: 101
IMPLEMENTATION DATE: 12/1988
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 232

	FY 2017-18	FY 2018-19
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 17-94270 A01

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 interagency agreement (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, 2017 and was renewed effective July 1, 2017.

Reason for Change:
There is no change from the prior estimate for FY 2017-18 or FY 2018-19.
There is no change from FY 2017-18 to FY 2018-19 in the current estimate.

Methodology:
1. The contract amount is estimated to be $1,100,000 for FY 2017-18 and FY 2018-19. The non-federal match is budgeted by CDVA.

FY	FY 2017-18			FY 2018-19		
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)

CHHS AGENCY HIPAA FUNDING

OTHER ADMIN. POLICY CHANGE NUMBER:	102
IMPLEMENTATION DATE:	7/2001
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	257

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$849,000	$849,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$849,000	$849,000

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) 14-90234; 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.

The final payment for IA 14-90234, which expired June 30, 2017, was made in January 2018. Payments began in December 2017 for IA 17-94031, a three-year IA that became effective July 1, 2017.

Reason for Change:
There is no change from the prior estimate for FY 2017-18 and FY 2018-19. There is no change from FY 2017-18 to FY 2018-19 in the current estimate.

Methodology:
1. The CHHS Agency prioritizes HIPAA projects so that the most critical projects are implemented first.

Cash Basis	DHCS FF	CHHS GF
FY 2017-18	**$849,000**	$849,000
FY 2018-19	**$849,000**	$849,000

Funding:
100% HIPAA (4260-117-0890)

MEDI-CAL INPATIENT SERVICES FOR INMATES

OTHER ADMIN. POLICY CHANGE NUMBER:	103
IMPLEMENTATION DATE:	3/2011
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	1665

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$813,000	$813,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$813,000	$813,000

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. Policy Change CA 1 County Administration Base 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: 103

Reason for Change:
There is no change from the prior estimate for FY 2017-18 or FY 2018-19.
There is no change from FY 2017-18 to FY 2018-19 in the current estimate.

Methodology:
1. Implementation of the Inmate Eligibility Program began April 1, 2011.

2. Reimbursements for administrative costs began in March 2011.

3. The federal share of ongoing administrative costs is $813,000 in FY 2017-18 and FY 2018-19.

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

CDPH I&E PROGRAM AND EVALUATION

OTHER ADMIN. POLICY CHANGE NUMBER:	104
IMPLEMENTATION DATE:	7/2003
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	261

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$566,000	$562,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$566,000	$562,000

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 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 PACT 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.

Reason for Change:
The change from the prior estimate, for FY 2017-18 and FY 2018-19, is a decrease due to revising the estimate based on actual costs. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to fewer prior year expenditures in FY 2018-19.

Methodology:
1. CDPH budgets the non-federal matching funds.

2. Annual expenditures on an accrual basis are $1,124,000.

3. Cash basis expenditures vary from year-to-year based on when claims are actually paid.

CDPH I&E PROGRAM AND EVALUATION

OTHER ADMIN. POLICY CHANGE NUMBER: 104

4. The estimates are provided by CDPH on a cash basis.

FY 2017-18	TF	CDPH GF	DHCS FF
FY 2016-17	$346,000	$173,000	$173,000
FY 2017-18	$786,000	$393,000	$393,000
Total for FY 2017-18	$1,132,000	$566,000	**$566,000**

FY 2018-19	TF	CDPH GF	DHCS FF
FY 2017-18	$338,000	$169,000	$169,000
FY 2018-19	$786,000	$393,000	$393,000
Total for FY 2018-19	$1,124,000	$562,000	**$562,000**

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

MERIT SYSTEM SERVICES FOR COUNTIES

OTHER ADMIN. POLICY CHANGE NUMBER:	105
IMPLEMENTATION DATE:	7/2003
ANALYST:	Shannon Hoerner
FISCAL REFERENCE NUMBER:	263

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$194,000	$194,000
STATE FUNDS	$97,000	$97,000
FEDERAL FUNDS	$97,000	$97,000

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 2017-18.
There is no change from the prior estimate for FY 2018-19.
There is no change from FY 2017-18 to FY 2018-19 in the current estimate.

Methodology:
1. CalHR provided the estimates on a cash basis.

2. The estimated reimbursement is $194,000 TF ($97,000 GF) in FY 2017-18 and FY 2018-19.

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

CDDS DENTAL SERVICES - ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER:	106
IMPLEMENTATION DATE:	11/2011
ANALYST:	Ila Zapanta
FISCAL REFERENCE NUMBER:	1631

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$67,000	$0
STATE FUNDS	$67,000	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the cost related to processing the California Department of Developmental Services (CDDS) dental claims.

Authority:
Interagency Agreement (IA) 16-93167

Interdependent Policy Changes:
Not Applicable

Background:
The Lanterman Act requires the CDDS to provide dental services to its clients. Because Medi-Cal only covers partial dental services for adults 21 years of age and older, CDDS has an IA with the Department where the 2004 Medi-Cal dental fiscal intermediary (FI) processed and paid claims for FY 2016-17. For FY 2017-18, the 2016 Administrative Services Organization (ASO) contractor processes claims and the 2016 FI contractor adjudicates claims for the broader scope of dental services covered by CDDS beginning the thirteenth month after the contract effective date.

The previous IA expired June 30, 2016; however, the Department secured approval on a new IA which will expire on June 30, 2021. The additional costs of processing claims and benefits will be reimbursed by CDDS. Effective May 1, 2014, some adult dental benefits were restored in accordance with Assembly Bill 82. Those services included initial examinations, radiographs, restorations, anterior root canals, complete dentures and complete denture adjustments, repairs and relines. Effective January 1, 2018, the full restoration of adult dental benefits included the remaining services which were not restored in 2014, such as restorative services (crowns), prosthodontic services (partial dentures), and endodontic services (root canals). After the implementation of the full restoration of adult dental benefits, CDSS will no longer need to cover these services.

This policy change estimates the reimbursement of administration costs. The reimbursement of benefit costs is budgeted in the CDDS Dental Services policy change.

Reason for Change:
The change from the prior estimate, for FY 2017-18, is an increase due to updating estimate with actual invoices paid. There is no change from the prior estimate for FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to no additional costs being expected in FY 2018-19. With the implementation of full restoration of adult dental benefits on January 1, 2018, CDSS no longer reimburses DHCS for these services.

CDDS DENTAL SERVICES - ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 106

Methodology:

1. Assume the cost of processing claims is based on actual invoices and projected costs are based on an average of the previously paid invoices.

2. All costs are reimbursed by CDDS.

3. Costs to be reimbursed for FY 2017-18 are in the amount of $67,000.

4. No costs are anticipated to be reimbursed in FY 2018-19 because with the restoration of full adult dental benefits, CDSS no longer reimburses DHCS for these services.

Funding:

Reimbursement GF (4260-610-0995)

PIA EYEWEAR COURIER SERVICE

OTHER ADMIN. POLICY CHANGE NUMBER:	107
IMPLEMENTATION DATE:	7/2003
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1114

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$341,000	$341,000
STATE FUNDS	$170,500	$170,500
FEDERAL FUNDS	$170,500	$170,500

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:
There is no change from the prior estimate for FY 2017-18 and FY 2018-19. There is no change from FY 2017-18 to FY 2018-19 in the current estimate.

Methodology:
1. The contract with United Courier Service charges $1.75 per package and no fuel surcharge.

2. The number of estimated packages to be paid is 195,000 in FY 2017-18. FY 2018-19 payments are estimated to remain stable at 195,000 packages.

   $1.75 x 195,000 = $341,000 (rounded)

Fiscal Year	TF	GF	FF
FY 2017-18	$341,000	$170,500	$170,500
FY 2018-19	$341,000	$170,500	$170,500

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

MANAGED CARE REGULATIONS - MH PARITY

OTHER ADMIN. POLICY CHANGE NUMBER:	109
IMPLEMENTATION DATE:	7/2018
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	2076

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$0	$20,799,000
STATE FUNDS	$0	$2,971,000
FEDERAL FUNDS	$0	$17,828,000

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 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 Final Rule CMS-2333-F (Parity Final Rule), to strengthen access to mental health and substance use disorder services for Medicaid beneficiaries. Final Rule CMS-2333-F (Parity 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: 109

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 Mental Health Plans (MHPs) and Managed Care Plans (MCPs). The inconsistencies identified were for authorization of outpatient and inpatient services. As a result, the Department will need to implement changes to authorization of SMHS policies for compliance with the Parity Final Rule. 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 SMHS:

- The Department will align the requirements for MHP authorizations of psychiatric inpatient hospital 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 and complete the review within five (5) business days upon receipt of request.

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 2018-19, is due to:

- The estimated additional time that counties need for outpatient reviews is shortened, from one hour to 15 minutes, per review;
- The number of pre-authorizations estimated for FY 2018-19 were updated from 429,249 outpatient reviews to 487,243 outpatient reviews; and
- Adding in the costs for inpatient concurrent reviews estimated for FY 2018-19.

MANAGED CARE REGULATIONS - MH PARITY

OTHER ADMIN. POLICY CHANGE NUMBER: 109

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, 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 487,243 reviews at a cost of $56.67 per hour, including benefits. The total estimated annual costs for outpatient pre-authorizations are $6,902,000 TF.

5. For inpatient reviews, assume counties will need an additional 30 minutes for 595,394 reviews at a cost of $56.67 per hour, including benefits. The total estimated annual costs for concurrent inpatient reviews are $16,869,000 TF.

6. The estimated total for FY 2018-19 is:

(Dollars in Thousands)

Treatment Plan Authorizations	**TF**	**GF**	**FF**	**CF**
Outpatient - Pre-Authorizations	$6,902	$863	$5,176	$863
Inpatient – Concurrent Review	$16,869	$2,108	$12,652	$2,109
FY 2018-19	$23,771	**$2,971**	**$17,828**	$2,972

Funding:

100% Title XIX FF (4260-101-0890)
100% Title XIX GF (4260-101-0001)

MEDICAL FI SRP RELEASE 1 HOSTING

OTHER ADMIN. POLICY CHANGE NUMBER:	111
IMPLEMENTATION DATE:	7/2015
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	1924

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$7,042,000	$8,450,000
STATE FUNDS	$1,023,700	$1,228,700
FEDERAL FUNDS	$6,018,300	$7,221,300

DESCRIPTION

Purpose:
This policy change estimates the California Medicaid Management Information System (CA-MMIS) replacement costs.

Authority:
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 Medical Fiscal Intermediary (FI) contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The FI contract was awarded on December 8, 2009, and became effective on May 3, 2010, which began the takeover phase. The FI contract term runs through March 31, 2020.

The System Replacement Project (SRP) constitutes the contractual responsibilities required for the FI to replace the existing CA-MMIS. As a result of the SRP settlement agreement, the contractual responsibilities for the SRP have been removed from the 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 compensates the FI for the continued hosting and M&O of Release I until the expiration of the FI contract.

Reason for Change:
There is no change from the prior estimate for FY 2017-18 and FY 2018-19. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to a full year of costs in FY 2018-19.

MEDICAL FI SRP RELEASE 1 HOSTING

OTHER ADMIN. POLICY CHANGE NUMBER: 111

Methodology:

1. Costs are shared between Federal Funds (FF) and General Funds (GF).

FY 2017-18	TF	GF	FF
50% Title XIX / 50% GF	$468,000	$234,000	$234,000
90% Title XIX / 10% GF	$6,427,000	$643,000	$5,784,000
100% GF	$147,000	$147,000	$0
Total	**$7,042,000**	**$1,024,000**	**$6,018,000**

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF	$561,000	$281,000	$280,000
90% Title XIX / 10% GF	$7,712,000	$771,000	$6,941,000
100% GF	$177,000	$177,000	$0
Total	**$8,450,000**	**$1,229,000**	**$7,221,000**

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 TURNOVER

OTHER ADMIN. POLICY CHANGE NUMBER:	114
IMPLEMENTATION DATE:	12/2017
ANALYST:	DJ Hayer
FISCAL REFERENCE NUMBER:	2085

	FY 2017-18	FY 2018-19
TOTAL FUNDS	$600,000	$0
STATE FUNDS	$193,500	$0
FEDERAL FUNDS	$406,500	$0

DESCRIPTION

Purpose:
This policy change estimates the turnover costs for the California Medicaid Management Information System (CA-MMIS) Medical Fiscal Intermediary (FI) contract.

Authority:
Contract #09-86210

Interdependent Policy Changes:
Not Applicable

Background:
The current FI contract expires March 31, 2020. The Department has initiated turnover activities of the CA-MMIS before the end of operations of the current FI contract.

Turnover activities include, but are not limited to, the transfer of:

- Hardcopy and electronic files;
- Telecommunications;
- Data entry and adjudication; and
- IT services and operations.

The total cost of turnover activities, which began in March 2017 and ends in September 2019, will be $2,500,000. Final payments are expected to be made by March 2020.

Reason for Change:
This is a new policy change.

Methodology:

1. Payments began in December 2017.

2. The estimated costs for FY 2017-18 are:

Fiscal Year	TF	GF	FF
FY 2017-18	$600,000	$193,000	$407,000

MEDICAL FI TURNOVER

OTHER ADMIN. POLICY CHANGE NUMBER: 114

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)

MEDI-CAL INFORMATION ONLY
May 2018
FISCAL YEARS 2017-18 & 2018-19

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

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

AFFORDABLE CARE ACT

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

For those newly eligible adults in the expansion group, the ACA provides California with enhanced FFP at the following rates:

- 100% FFP from calendar years 2014 to 2016,
- 95% FFP in 2017,
- 94% FFP in 2018,
- 93% FFP in 2019,
- 90% FFP in 2020 and beyond.

For those who are currently eligible, but not enrolled in Medi-Cal, enhanced FFP will not be available. Beginning in October 2015, the ACA increased the Children's Health Insurance Program (CHIP) FMAP provided to California by 23 percent, to 88 percent FFP, up from 65 percent.

In response to the federal ACA mandate and State legislative direction, the Department chose the HHS Secretary-approved plan option, which allows the Department to seek approval for the same full scope Medi-Cal benefits received by existing beneficiaries. This option requires the selection of a private market reference plan to define the Essential Health Benefits (EHB) offered in the Alternative Benefit Plan (ABP).

The Standard Blue Cross/Blue Shield PPO (FEHB) Plan was selected as the EHB reference plan, as it allows the Department to provide an ABP package that most closely reflects existing State Plan benefits and thereby avoids disparity between the benefits received by new and existing beneficiaries.

HOME AND COMMUNITY BASED SERVICES

Long-Term Care Alternatives

Medi-Cal includes various Long-Term Services and Supports (LTSS) that allow medically needy, frail seniors, and persons with disabilities to avoid unnecessary institutionalization. The Department administers these alternatives either as State Plan benefits or through various types of waivers.

State Plan Benefits

**In-Home Supportive Services (IHSS) **

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

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

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

The four IHSS programs are:

1. Personal Care Services Program (PCSP)
   This program provides personal care services including but not limited to non-medical personal services, paramedical services, domestic services, and protective supervision.
2. IHSS Plus Option (IPO)
   This program provides personal care services but also allows the recipient of services to select a family member as a provider.
3. Community First Choice Option (CFCO)
   This program provides personal care services to those who would otherwise be institutionalized in a nursing facility.
4. Residual (beneficiaries are not full-scope Medi-Cal; State-only program with no FFP)

HOME AND COMMUNITY BASED SERVICES

**Targeted Case Management (TCM) **

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

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

1915(i) HCBS State Plan Services

The 1915(i) State Plan Services program provides home and community-based services (HCBS) to persons with developmental disabilities (DD) who are Regional Center consumers but do not meet nursing facility level of care criteria required for enrollment in the HCBS Waiver of Persons with DD. As of February 1, 2016, Behavioral Health Treatment (BHT) services for 1915(i) participants under the age of 21 will be a state plan benefit and paid through the managed care delivery system or fee-for-service for members not eligible to enroll into managed care. The 1915(i) ~~*state plan amendmen~~t * ****State Plan Amendment (SPA)** **is approved from October 1, 2011 through September 30, 2016. The Department initiated the 1915(i) renewal process by sub~~mitting a *State Plan amendm~~ent (SPA)* ****SPA renewa~~l~~** **to CMS *on* ~~**~~**in**~~**~~May 2016, *2016, *which became effective on October 1, 2016.

The DD rate increase, as outlined in ABx2 1, was chaptered in October 2015. The Department and CDDS submitted a SPA reflecting the rate changes. CMS approved the SPA on September 29, 2016 with a July 1, 2016 effective date. Rate increases includes several different increase models including a 5% rate increase on services and survey based increases on wages.

Waivers

Medi-Cal operates and administers various HCBS waivers that provide medically needy, frail seniors and persons with disabilities with services that allow them to live in their own homes or community-based settings instead of being cared for in facilities. These waivers require the program to meet federal cost-neutrality requirements so that the total cost of providing waiver services plus medically necessary State Plan services are less than the total cost incurred at the otherwise appropriate facility plus State Plan costs. The following waivers require state cost neutrality: Acquired Immune Deficiency Syndrome (AIDS), Assisted Living Waiver (ALW), In-Home Operations (IHO), Home and Community Based ~~*(HCB) Alternatives Waiver~~ * ****Alternatives (HCBA)****, Multipurpose Senior Services Program (MSSP), HCBS Waiver ~~for~~ Persons with *(DD)* ****DD**,** and Pediatric Palliative Care (PPC). A beneficiary may be enrolled in only one waiver at a time. If a beneficiary is eligible for services from more than one waiver, the beneficiary may choose the waiver that is best suited to his or her needs.

HOME AND COMMUNITY BASED SERVICES

**Assisted Living Waiver (ALW) **

The ALW pays for assisted services and supports, care coordination, and community transition in ~~*14*~~ ****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 *of~~ unduplicated recipients* for this waiver is 3,744. CMS approved a renewal of the ALW on August 28, 2014 effective from March 1, 2014 through February 28, 2019. On May 26, 2017, CMS approved an amendment to expand the ALW into San Francisco County, effective March 1, 2017. This expansion of ALW into San Francisco County allows all San Francisco Community Living Support Benefit (SF CLSB) Waiver participants the option of transitioning into the ALW. ****The Governor's budget released on January 10, 2018 includes funding to add an additional 2,000 slots to the ALW starting June 1, 2018. This funding is contingent upon legislative approval and will also require the Department to submit an amendment to the ALW to CMS for approval.****

****Community-Based Adult Services (CBAS)**

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

Home and Community-Based Alternative~~s *(HCB Alternative~~s)* **(HCBA) Waiver**

The ~~*HCB Alternatives*~~ * ** **HCBA**** Waiver will provide Medi-Cal members with long-term medical conditions, who meet the acute hospital, adult or pediatric subacute or nursing facility (NF) Level of Care (LOC), with the option of returning to and/or remaining in his or her home or home-like setting in the community in lieu of institutionalization. The Department will co~~ntract with *Care Management C~~ontractors* (Waiver Agencies) for the purpose of performing waiver administration functions and directing the Comprehensive Care Management waiver service. The Waiver Agencies are responsible for functions including: participant enrollment, ~~*Level o~~f ~~Care (~~*LOC*)* evaluation~~s, *Plan of Treatment (POT)*~~ and person-centered care/service plan review and approval, waiver service authorization, utilization management, provider enrollment/ network development, quality assurance activities and reporting to the Department, billing the Fiscal Intermediary (FI), and provider claims adjudication.

HOME AND COMMUNITY BASED SERVICES

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

**In-Home Operations (IHO) Waiver **

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

**San Francisco Community Living Support Benefit (CLSB) Waiver **

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

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

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

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

HOME AND COMMUNITY BASED SERVICES

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

**Acquired Immune Deficiency Syndrome (AIDS) Medi-Cal Waiver **

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

Services provided include:

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

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

In 2016, Californians approved Proposition 56, which will generate additional revenue for health care programs. AB 120 (Chapter 22, Statutes of 2017) provides an increase to the AIDS Waiver program of up to $8,000,000 Total Fund ($4,000,000 SF). The Department posted the information to its website in July 2017. ~~*A Waiver amendment addressing these rate increases will be submitted to CMS for approval of the federal match. The proposed effective date for these changes is July 1, 2017, pending CMS approval.~~* ** **The Department received approval of a waiver amendment to incorporate the allocation from AB 120 and increase specific AIDS waiver rates on September 22, 2017, retroactive to July 1, 2017. ****

HOME AND COMMUNITY BASED SERVICES

Multipurpose Senior Services Program (MSSP) Waiver

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

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

The decrease in Waiver capacity is a result of the implementation of the Coordinated Care Initiative (CCI), demonstration program. With the implementation of the CCI program, the total number of MSSP members will be reduced based on the integration of this population into managed care no ~~*later*~~ ** **sooner** **than January 1, 20~~20~~ in *the* six ****of the seven**** CCI counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Santa Clara. The initial reduction for the unduplicated recipients in Waiver Year 2 was a result of ~~*the*~~ completed ~~*CCI implement~~ation* **MSSP transition to managed care** in San Mateo County.

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

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

The DD Waiver provides home and community-based services to persons with developmental disabilities who are Regional Center consumers as an alternative to care provided in a facility that meets the Federal requirement of an intermediate care facility for the mentally retarded; in California, Intermediate Care Facility/Developmentally Disabled-type facilities, or a State Developmental Center. ****As of March 29, 2017, Behavioral Health Treatment (BHT) services for Waiver participants under the age of 21 is a state plan benefit paid through fee-for-service and will implement as a managed care benefit effective July 1, 2018. ****

HOME AND COMMUNITY BASED SERVICES

****The Department submitted a renewal application to CMS on December 22, 2016 and received approval on December 7, 2017. * *** Approved capacity of unduplicated recipients for this waiver is ~~*110,000 in 2013, 115,000 in 2014 and 120,000 in 2015~~* ****130,000 in 2018, 135,000 in 2019, and 140,000 in 2020****. The waiver is appr~~oved from *Marc~~h 29, 2012 * ****January 1, 2018** ~~thr~~ough *March 28, 2017 *~~ **~~**December 31, 2022****~~. *As of March~~ 29, 2017, ~~Behavioral Health Treatment (BHT) services for Waiver participants under the age of 21 will be a state plan benefit and paid through the managed care delivery system or fee-for-service for members not eligible to enro~~ll into managed care. *

~~*The Department is in the process of renewing the DD Waiver which expired on March 29, 2017. To ensure a sufficient review period, CMS approved the extension of the current waiver through June 27, 2017. The Department submitted a second extension for the Waiver through September 24, 2017 in order to resolve issues with the revenue application. The proposed effective date of the Waiver Renewal is October 1, 2017.~~ *

The DD rate increase, as outlined in ABx2 1, was chaptered in October 2015. The Department and CDDS submitted a SPA reflecting the rate changes, retroactive to July 1, 2016.

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

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

As of March 29, 2017, Behavioral Health Treatment (BHT) services for Waiver participants under the age of 21 ~~*will be a state plan benefit and paid through the managed care delivery system or fee-for-service for members not eligible to enroll into managed care~~ * ****is a state plan benefit paid through fee-for-service and will implement as a managed care benefit effective July 1, 2018**. **

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

HOME AND COMMUNITY BASED SERVICES

Pediatric Palliative Care (PPC) Waiver

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

Managed Care Programs

**Program of All Inclusive Care for the Elderly (PACE) **

PACE is a federally defined, comprehensive, and capitated managed care model program that delivers fully integrated services. PACE covered services include all medical long-term services and supports, dental, vision and other specialty services**,** allowing enrolled beneficiaries who would otherwise be in an intermediate care facility or in a skilled nursing facility to maintain independence in their homes and communities. Participants must be 55 years or older and determined by the Department to meet the Medi-Cal regulatory criteria for nursing facility placement. PACE participants receive their services from a nearby PACE Center where clinical services, therapies, and social interaction take place.

SCAN Health Plan

SCAN is a Medicare Advantage Special Needs Plan that contracts with the Department to provide services for the dual eligible Medicare/Medi-Cal population subset residing in Los Angeles, San Bernardino, and Riverside counties. SCAN provides all services in the Medi-Cal State Plan; including home and community based services to SCAN members who are assessed at the Nursing Facility Level of Care and nursing home custodial care. The eligibility criteria for SCAN specifies that a member be at least 65 years of age, have Medicare A and B, have full scope Medi-Cal with no share of cost and live in SCAN's approved service areas of Los Angeles, Riverside, or San Bernardino counties. SCAN does not enroll individuals with End Stage Renal Disease.

HOME AND COMMUNITY BASED SERVICES

Special Grant

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

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

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.

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

- Dental Transformation Initiative (DTI) – For the first time, California's Waiver also includes opportunities for improvements in the Medi-Cal Dental Program. The DTI

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

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

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

MANAGED CARE

Medi-Cal Managed Care Rates

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

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

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

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

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

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

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

~~*The 2017 Governor's Budget estimate of the Coordinated Care Initiative (CCI) projected that it will no longer be cost-effective. Therefore, pursuant to the provisions of current law, the program will discontinue in FY 2017-18.*~~ ** **The 2017 Budget Act discontinued the Coordinated Care Initiative (CCI) program, effective January 1, 2018.**** Based on the lessons learned from the CCI demonstration project, the ~~**~~**2017** ~~**~~ Budget ~~*~~proposed the extension of~~*~~ ****extended**** the Cal MediConnect (CMC) program and the mandatory enrollment of dual eligible beneficiaries and

MANAGED CARE

the integration of long-term services and supports, except In-Home Supportive Services (IHSS), into managed care. IHSS ~~*would be~~* ** **was**** removed from capitation rate payments effective January 1, 2018.

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

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

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

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

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

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

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

PROVIDER RATES

Reimbursement Methodology and the Quality Assurance Fee for AB 1629 Facilities

AB 1629 requires the Department to develop a cost-based, facility-specific reimbursement rate methodology for freestanding skilled (level B) nursing facilities, including subacute units which are part of a freestanding skilled nursing facility. Rates are updated annually and are established based on the most recent audited cost report data. AB 1629 also imposed a Quality Assurance Fee (QAF) on these facilities and added requirements for discharge planning and assistance with community transitions.

The rate methodology developed by the Department computes facility-specific, cost-based per diem payments for SNFs based on five cost categories, which are subject to limits. Limits are set based on expenditures within geographic peer groups. Also, costs specific to one category may not be shifted to another cost category.

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

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

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

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

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

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

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

PROVIDER RATES

Quality and Accountability Supplemental Payment Program

SB 853 (Chapter 717, Statutes of 2010) requires the Department to implement a Quality and Accountability Supplemental Payment (QASP) Program for SNFs by August 1, 2010. The QASP Program will enable SNF reimbursement to be tied to demonstrated quality of care improvements for SNF residents. AB 1489 (Chapter 631, Statutes of 2012) delayed the payments and required the Department to make the payments by April 30, 2014.

AB 119 (Chapter 17, Statutes of 2015) extends the AB 1629 facility-specific rate methodology, QAF, and QASP program through July 31, 2020. Further, beginning rate year 2015-16, the annual weighted average rate increase is 3.62%, and the QASP will continue at FY 2014-15 levels, rather than setting aside a portion of the annual rate increase. Additionally, beginning FY 2015-16, the legislation requires the Department to incorporate direct care staff retention as a performance measure into the QASP Program.

**Reimbursement Methodology for Other Long-Term Care Facilities (non-AB 1629) **

The reimbursement methodology is based on a prospective flat-rate system, with facilities divided into peer groups by licensure, level of care, bed size and geographic area in some cases. Rates for each category are determined based on data obtained from each facility's annual or fiscal period closing cost report. Audits conducted by the Department result in adjustments to the cost reports on an individual or peer-group basis. Adjusted costs are segregated into four categories:

Fixed Costs (Typically 10.5 percent of total costs). Fixed costs are relatively constant from year to year, and therefore are not updated. Fixed costs include interest on loans, depreciation, leasehold improvements and rent.

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

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

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

Methodology by Type of LTC Facility

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

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

PROVIDER RATES

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

Intermediate Care Facilities for the Developmentally Disabled, Developmentally Disabled-Habilitative, and Developmentally Disabled-Nursing (ICF/DD, ICF/DD-H, ICF/DD-N) are peer grouped by level of care and bed size. Effective June 2014, providers of services to developmentally disabled clients have rates set as follows: Each rate year, individual provider costs are rebased using cost data applicable for the rate year. Each ICF/DD, ICF/DD-H or ICF/DD-N will receive the lower of its projected costs plus 5% or the 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 the 2008-09 rate year, increased by 3.7%.

The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) revenue provided a funding source for supplemental payments to ICF/DD facilities. AB 120 (Chapter 22, Statutes of 2017) appropriated said funds for supplemental payments to ICF/DDs in the 2017-18 Rate Year.

Subacute Care Facilities are grouped into two statewide peer groups: hospital-based providers and freestanding nursing facility providers. Subacute care providers are reimbursed their projected costs up to the median of their peer group.

Pediatric Subacute Care Units/Facilities are grouped into two peer groups: hospital-based nursing facility providers and freestanding nursing facility providers. There are different rates for ventilator and non-ventilator patients. Reimbursement is based on a model since historical cost data were not previously available.

INFORMATION ONLY

REVENUES

1. **Revenues**

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

FY 2016-17:	$ 27,184,000	ICF-DD Quality Assurance Fee
	$ 520,740,000	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	$ 9,874,000	ICF-DD Transportation/Day Care Quality Assurance Fee
	$ 1,267,000	Freestanding Pediatric Subacute Quality Assurance Fee
	$ 2,283,263,000	MCO Enrollment Tax
	$ ~~*4,330,242,000~~ * **__**4,262,257,000 ****Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
	$ 7,800,000	Emergency Medical Air Transportation (EMATA) Fund
		$ *7,180,370,000 * **__**7,112,385,000**** Total
FY 2017-18:	$ ~~*26,351,000~~ * **__**26,561,000****	ICF-DD Quality Assurance Fee
	$ 503,746,000	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	$ ~~*10,165,0~~00* ** **__**9,977,000****	ICF-DD Transportation/Day Care Quality Assurance Fee
	$ 933,000	Freestanding Pediatric Subacute Quality Assurance Fee
	$ ~~2,428,921,000~~	MCO Enrollment Tax
	$ *3,790,120,000* ** **__**5,509,435,000 ****Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
	$ ~~7,008,000~~	Emergency Medical Air Transportation (EMATA) Fund
FY 2018-19:	$ ~~*26,775,000~~ * **__**26,890,000****	ICF-DD Quality Assurance Fee $ 6,767,244,000 8,486,581,000** Total
	$ ~~*533,971,000~~**__**521,982,000****	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	$ ~~*10,165,0~~00* ** **__**9,977,000****	ICF-DD Transportation/Day Care Quality Assurance Fee
	$ 933,000	Freestanding Pediatric Subacute Quality Assurance Fee
	$ ~~2,563,988,000~~	MCO Enrollment Tax
	$ *4,047,768,000* ** **__**5,062,836,000****	Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
	$ 7,008,000	Emergency Medical Air Transportation (EMATA) Fund

INFORMATION ONLY

$ 69,189,000 **Medi-Cal Emergency Medical Transport (MEMTF) (Item 4260-601-3323)**

$ ~~*7,190,608,000~~* ** **8,262,803,000** **Total

Effective August 1, 2009, the Department expanded the amount of revenue upon which the quality assurance fee for AB 1629 facilities is assessed, to include Medicare.

Effective January 1, 2012, pursuant to ABX1 19 (Chapter 4, Statutes of 2011), the Department will implement a QA fee from Freestanding Pediatric Subacute Care facilities, pending CMS approval.

SBx2-2 (Chapter 2, Statutes of 2016) provides that the new tax will apply to the Medi-Cal revenue of most managed care plans in the state, with some exemptions. The new tax structure will meet federal requirements while achieving the same GF savings as the previous tax and also providing sufficient funding to restore the 7% reduction in the In-Home Supportive Services Program.

AB 1383 (Chapter 627, Statutes of 2009) authorized the implementation of a quality assurance fee on applicable general acute care hospitals. The fee is deposited into the Hospital Quality Assurance Revenue Fund (Item 4260-601-3158). This fund is used to provide supplemental payments to private and non-designated public hospitals, grants to designated public hospitals, and enhanced payments to managed health care and mental health plans. The fund is also used to pay for health care coverage for children, staff and related administrative expenses required to implement the QAF program. SB 90 (Chapter 19, Statutes of 2011) extended the hospital QAF through June 30, 2011. SB 90 also ties changes in hospital seismic safety standards to the enactment of a new hospital QAF that results in revenue for FY 2011-12 children's services of at least $320 million.

SB 335 (Chapter 286, 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.

INFORMATION ONLY

AB 1607 (Chapter 27, Statutes of 2016) extended the inoperative date of the Hospital QAF program to January 1, 2018, creating a one-year extension of the program.

Proposition 52, approved by California voters on November 8, 2016, permanently extends the Hospital QAF program.

The California Department of Public Health (CDPH) lowered Licensing and Certification (L&C) fees for long-term care providers for FY 2010-11. The aggregate amount of the reductions allowed the QA fee amounts collected from the freestanding NF-Bs and ICF/DDs (including Habilitative and Nursing) to increase by an equal amount. Currently, the QA fee amounts are calculated to be net of the L&C fees in order to be within the federally designated cap, which provides for the maximum amount of QA fees that can be collected. For FY 2011-12, CDPH increased L&C fees which resulted in a reduction in the collection of the QA fee by an equal amount to the L&C fee increase for free-standing NF-Bs, Freestanding Pediatric Subacute Facilities and ICF/DDs (including Habilitative and Nursing).

Effective January 1, 2011, AB 2173 (Chapter 547, Statutes of 2010) imposes an additional penalty of $4 for convictions involving vehicle violations.

AB 119 (Chapter 17, Statutes of 2015) extends the AB 1629 facility-specific rate methodology, QAF, and QASP program through July 31, 2020. Further, beginning rate year 2015-16, the annual weighted average rate increase is 3.62%, and the QASP will continue at FY 2014-15 levels, rather than setting aside a portion of the annual rate increase. Additionally, beginning FY 2015-16, the legislation requires the Department to incorporate direct care staff retention as a performance measure into the QASP Program.

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

ELIGIBILITY

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

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

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

AFFORDABLE CARE ACT

1.**Realignment ****

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

county health care savings that, once determined, will be redirected to fund local human services programs. The 12 public hospital counties and the 12 non-public/non-County Medical Services Program counties have selected one of two mechanisms. Option 1 is a formula that measures health care costs and revenues for the public hospital county Medi-Cal and uninsured population and non-public/non-CMSP county indigent population. Option 2 is redirection of 60% of a county's health realignment allocation plus 60% of the maintenance of effort. Assembly Bill (AB) 85 (Chapter 24, Statutes of 2013) as amended by Senate Bill 98 (Chapter 358, Statutes of 2013) lays out the methodology for the formula in Option 1, and requires the department to perform the calculation. AB 85 also sets targets, and a process to meet the targets, for the number of newly eligible Medi-Cal enrollees who will be default assigned to County Public Hospital health systems as their managed care plan primary care provider. Public hospital health systems will be paid at least cost for their new Medi-Cal population.

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

2. ****Disproportionate Share Hospital Reduction****

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

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

BENEFITS

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

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

INFORMATION ONLY

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

INFORMATION ONLY

HOME & COMMUNITY BASED-SERVICES

1. **Electronic Visit Verification**

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

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

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

BREAST AND CERVICAL CANCER TREATMENT

PHARMACY

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

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

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

On February 1, 2016, CMS published the Final Rule for Covered Outpatient Drugs, effective April 1, 2016. In December 2016, CMS required the Department to change its reimbursement methodology for blood factor products and services. The changes require federal approval via a State Plan Amendment (SPA). Appropriate billing codes and a rate

methodology must be determined prior to submission of the SPA and initiation of system changes are necessary to process blood factor claims to meet the directives of CMS. Therefore, implementation of this new reimbursement methodology is expected ~~*no sooner than Augus~~t 2018* ****in FY 2018-19****. The fiscal impact of the change to blood factor reimbursement has yet to be determined.

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

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

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

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

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

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

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

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

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

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

Axicabtagene ciloleucel (Yescarta) is a one-time treatment for youth and adults, aged 18 and over with refractory or relapsing large B -cell lymphoma. The FDA approved the drug for treatment of individuals with types of refractory or relapsing large B-cell lymphoma (DLBCL), a type of non-Hodgkin lymphoma (NHL) whose cancer has either

not responded to or returned after two or more attempts at standard systemic therapy.

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

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

DRUG MEDI-CAL

**Naltrexone Treatment Services **

****This assumption has been deleted as this has been withdrawn.****

1. **FQHCs and RHCs: DMC and SMHS

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

MENTAL HEALTH

Mental Health Parity

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

Comprehensive Behavioral Health Data Modernization Project

This assumption has been deleted as this has been withdrawn.

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

The Department discovered claim adjudication errors resulting from Short-Doyle/Medi-Cal (SDMC) Phase II system coding that prevented SMHS claims from being adjudicated

correctly and/or completely. System issues include claims with multiple aid codes. Beneficiaries can have up to four approved aid codes. Payments were denied because the SDMC II system adjudicates claims based on the aid code with the highest percentage of FFP. If that aid code was denied, the system did not select another aid code listed on the claim and the claim was denied.

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

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

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

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

1115 WAIVER—MH/UCD & BTR/WAIVER 2020

1. **Waiver 2020 Negative Balance and Deferral Repayment**

The Special Terms and Conditions (STC) of the California Medi-Cal 2020 Demonstration Waiver (Medi-Cal 2020) requires California's resolution of all existing negative Payment Management System (PMS) subaccount (federal funding) balances and deferred claims.

- Negative PMS subaccount balances: Pursuant to STC ~~*160~~* ** **164** **of the Medi-Cal 2020 waiver, negative PMS subaccount balances for federal fiscal year (FFY) 2013 and prior must be resolved by the end of the Medi-Cal 2020 waiver period (December 31, 2020). California and CMS continue to actively work toward the resolution of these negative PMS subaccount balances. In June of 2017, due to the progress made to date, the CMS waiver team verbally decl~~ared~~ that the STC *160* ****164** **requirements had been met and that they would be sending written ~~confi~~rmation. As of *November 2017* ****January 2018****, written confirma~~tion~~ from ~~CMS is s~~till pending. STC *160* ** **164** ****** *required* **requires** that, for any negative PMS subaccount balances rema~~ining after Jun~~e 30, 2017, CMS will issue a *disallowance* ** **demand letter** **and require California to return sufficient funding to bring the PMS subaccount balances to $0. California has submitted adjustments to resolve a significant portion of the negative PMS subaccount balan~~ces via Quarters 1 and 2 of the 2016 grant year. *Approval of these adjustments will not be realized unt~~il ~~CMS finalizes these quarters which is expe~~cted to occur in December 2017, at the earliest.* If CMS disallows adjustments or claims,

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

- Repayment of deferred claims: Claims for which California has drawn down federal funding but CMS has deferred on or before June 30, 2017, CMS will issue a disallowance, triggering the appeal process**.** ~~*after which~~ * ** **However, if the appeal is unsuccessful,**** California will be required to r~~eimburse th~~e *remaining* federal funding. The deferred claims reimbursement will not be subject to interest. Some deferred claims contribute to the negative PMS subaccount balances, mentioned ~~abo~~ve, and *will* ** **may**** be liquidated through the negative PMS subaccount balance resolution. California is actively working to resolve these deferrals and the total federal funding reimbursement is unknown at this time. California will begin the federal fiscal year quarterly payments when the amounts are finalized.

Ongoing deferred claims repayment: In the past, California has not returned federal funding on CMS deferred claims until after the deferred claim was officially disallowed. Pursuant to the Special Terms and Conditions of the Medi-Cal 2020 waiver, California must begin complying with 42 Code of Federal Regulations 430.40, which requires the immediate repayment of federal funding for deferred claims while the deferral is being resolved. Upon its determination that the claim is allowable, CMS will release the funding and allow California to utilize the federal funding. CMS disallowances fluctuate quarter to quarter, resulting in an unpredictable federal fund repayment amount.

2. **BTR Designated State Health Program Reconciliation**

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

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

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

MANAGED CARE

1. ****Managed Care Public and Private Directed Payments****

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

PROVIDER RATES

Ground Emergency Medical Transportation Quality Assurance Fee

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

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**

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

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

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

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

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

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3. **Freestanding Clinics Supplemental Payments**

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

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

OTHER: AUDITS AND LAWSUITS

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

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

1. **SB 1103 Litigation**

- ***OAHA Administrative Appeals and Superior and Appellate Court Actions***
  In 2005, approximately 100 California hospitals sued the Department to challenge the validity of a Medi-Cal reimbursement rate limit for in-patient services provided by non-contract hospitals that was enacted by Senate Bill 1103. During the pendency of this litigation, more than 50 non-contract hospitals filed administrative appeals with the Department's Office of Administrative Hearings and Appeals (OAHA). All challenge SB 1103's validity and, so, seek a retroactive reimbursement rate increase for FY 2004-05, based on SB 1103's alleged invalidity.
  OAHA has been holding these administrative appeals in abeyance during the *Mission Hospital Regional Medical Center v. Douglas* litigation, which finally terminated in early 2014. OAHA dismissed at least 24 of the SB 1103 administrative appeals on the grounds that these appeals are precluded by *res judicata*, that is, by the *Mission* litigation's challenge to SB 1103. In approximately 16 cases, the dismissed hospitals have filed petitions for writ of mandate with the Los Angeles County Superior Court seeking to compel OAHA to order the Department to recalculate their reimbursement rate and pay the increased rate. In three such cases, the superior court denied the writ petitions and the hospitals appealed.
  (*Dignity Health v. Douglas*; *Hi-Desert Med. Center v. Douglas* & *Modoc Med. Center v. Douglas*). In four other cases, the superior court granted the writ petitions and the Department appealed one (*George L. Mee Mem'l Hosp. v. Douglas*). The appellate

court heard these four cases together and, in August 2015, found that each hospital's case was barred by its participation in the *Mission* litigation. The hospitals sought rehearing before the appellate court and filed a petition for review with the Supreme Court, both of which were denied. Since the California Supreme Court denied the petition for review, all remaining superior court petitions were dismissed.

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

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

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

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

The Plaintiffs in these two state court lawsuits are over 30 hospitals, including the 17 that are Plaintiffs in the federal court *Santa Rosa Memorial Hospital* case. The two lawsuits have been consolidated for litigation purposes. The Plaintiffs contend that the 10% Medi-Cal payment reduction and larger reduction for some hospitals that the Department implemented for non-contract hospital inpatient services, pursuant to ABX 4 5 (Chapter 3, Statutes of 2008) and AB 1183 (Chapter 758, Statutes of 2008) violate various federal Medicaid laws, including 42 U.S.C. sections 1396(a)(8), 1396a(a)(13), and 1396a(a)(30). The Plaintiffs seek retroactive damages of almost $100 million, including interest based on the Department's implementation of the AB 5 and AB 1183 reduced payments.

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Litigation in this case had been stayed (i.e., placed on hold), until the federal court ruling dismissing the federal court *Santa Rosa Memorial Hospital* lawsuit. After the parties completed briefing on the Plaintiffs' legal claims, there was a court hearing on April 18, 2016. The court tentatively ruled in favor of the Department on July 19, 2016, and a further hearing was held on December 13, 2016. On April 12, 2017, the trial court issued a judgment in favor of the Department. On April 24, 2017, the plaintiffs appealed the judgment**, **and their opening appellate brief was filed on October 8, 2017. The Department's response brief is due on March 9, 2018.** ** * The appellate court has not set a briefing schedule.*

3. **AB 97 Rates Litigation**

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

- **California Hospital Association v. Douglas, et al.**
  Plaintiffs include the California Hospital Association and Medi-Cal beneficiaries, who contend that payment reductions enacted by AB 97 for nursing facilities that are distinct parts of hospitals (DP/NFs) violate the takings clause of the U.S. Constitution and 42 U.S.C. sections 1396a(a)(8), (19), and (30). AB 97 provides that rates to DP/NFs effective June 1, 2011, shall be the rates paid in the 2008-09 rate year reduced by 10%. The federal government, which approved a State Plan Amendment (SPA) concerning these reductions, has been named as a co-defendant.
  On December 28, 2011, the district court issued a preliminary injunction against the AB 97 reductions for DP/NFs. On March 8, 2012, the district court issued an order modifying the injunction to exclude from its effect services rendered prior to December 28, 2011, that were not reimbursed prior to that date. On December 13, 2012, the Ninth Circuit issued a decision reversing the preliminary *injunction with respect to the AB 97 rate freeze and reduction for DP/NFs. On May 24, 2013, the Ninth Circuit denied the Plaintiffs' request for rehearing and* on *June 25, 2013, issued an order formally vacating the four court injunctions. On January 13, 2014, the United States Supreme Court denied the Plaintiffs' petition for certiorari asking it to review the Ninth Circuit decision. Now that the injunction is vacated, the Department will implement the AB 97 payment reductions (also rate freeze with respect to the *California Hospital Association* case), as described in the 10% Payment Reduction for LTC Facilities and Non-AB 1629 LTC Rate Freeze policy changes. The lawsuit has been remanded to the federal district court where Plaintiffs have indicated they intend to seek a new court order prohibiting the Department from implementing the AB 97 reduced payments for DP/NFs. On March 1, 2016, the Governor signed into law Assembly Bill X2 1, adopting Welfare and Institutions Code section 14105.195, which prohibits the Department from retroactively implementing the AB 97 payment reductions for DP/NFs. Based on this*

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

- ***California Medical Transportation Association v. Douglas, et al.***
  Plaintiffs filed a Complaint for Injunctive and Declaratory Relief challenging the validity of the 10% reduction under AB 97 for reimbursements to providers of NEMT services in the Medi-Cal fee-for-service system. Plaintiffs allege that the implementation of the AB 97 reductions for NEMT services violates 42 U.S.C., section 1396a(a)(30)(A). Additionally, Plaintiffs allege that Defendant Secretary Kathleen Sebelius' approval of the SPA that sets forth the 10% reduction for NEMT services violates 5 U.S.C., sections 701-706.
  On January 10, 2012, the district court issued an injunction enjoining implementation of the reduction on reimbursement for NEMT services on or after June 1, 2011. The court subsequently modified the injunction to allow the Department to implement the 10% reduction for NEMT services rendered prior to January 10, 2012, that had not been reimbursed prior to that date. On December 13, 2012, the Ninth Circuit issued a decision reversing the preliminary injunction with respect to the AB 97 rate freeze and reduction for DP/NFs. On May 24, 2013, the Ninth Circuit denied the Plaintiffs' request for rehearing and on June 25, 2013 issued an order formally vacating the four court injunctions. On January 13, 2014, the United States Supreme Court denied the Plaintiffs' petition for certiorari asking it to review the Ninth Circuit decision. Now that the injunction is vacated, the Department will implement the AB 97 payment reductions, as described in the 10% Provider Payment Reduction policy changes. This case has been remanded to the federal district court where the Plaintiffs have indicated they intend to pursue a new court order that would prohibit the Department from implementing the AB 97 payment reductions for NEMT services. *The parties are having s~~ettlement discussions.* *~~**The parties have agreed to a briefing schedule in federal district court to occur in the first half of 2018.****

- ***California Medical Association et al. v. Douglas,***
  Plaintiffs include the California Medical Association, California Dental Association, and California Pharmacy Association. Plaintiffs challenge the validity of a 10% reduction in Medi-Cal payments for physician, dental, pharmacy, and other services, authorized by AB 97. The federal government, which approved a SPA concerning the 10% reductions, is also named as a co-defendant. Plaintiffs contend the reductions violate 42 U.S.C. section 1396a(a)(30)(A).
  On January 31, 2012, the court issued an injunction prohibiting implementation of the payment reductions for physicians, dentists, clinics, non-drug pharmacy services, emergency medical transportation, medical supplies, and durable medical equipment, except for services rendered prior to January 31, 2012, that are not reimbursed at the unreduced rates prior to that date. The Department and Plaintiffs appealed that portion of the district court's order excluding some services from the injunction. On March 22, 2012, the Ninth Circuit denied the Department's request for

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a stay of the injunction pending appeal. On December 13, 2012, the Ninth Circuit issued a decision reversing the preliminary injunction with respect to the AB 97 rate freeze and reduction for DP/NFs. On May 24, 2013, the Ninth Circuit denied the Plaintiffs' request for rehearing and on June 25, 2013 issued an order formally vacating the four court injunctions. On January 13, 2014, the United States Supreme Court denied the Plaintiffs' petition for certiorari asking it to review the Ninth Circuit decision. Now that the injunction is vacated, the Department will implement the AB 97 payment reductions, as described in the 10% Provider Payment Reduction policy changes. This case has been remanded to the federal district court where the Plaintiffs have indicated they intend to seek a new court order prohibiting the Department from implementing the AB 97 reduced payments. ~~*The parties are having settlement discussions. *~~ ** **The parties have agreed to a briefing schedule in federal district court to occur in the first half of 2018. ****

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

4. ***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 Ninth Circuit decision in *California Association of Rural Health Clinics, et al v. Douglas* (9th Cir. 2013) 738 F.3d 1007. On December 8, 2015, the court granted the Petition for Writ of Mandate. The court further directed Counsel for Petitioners to prepare a formal judgment and writ, submit it to the Department's counsel for approval as to form, and thereafter submit it to the court for signature and entry of judgment. On January 11, 2016, the Court issued the final formal judgment and writ. On February 19, 2016, Counsel for Petitioners sent a letter to Counsel for Respondents; this letter set forth an informal settlement proposal. Counsel for Respondents responded in April 2016, via letter, reflecting the Department's disinterest in pursuing the proposal. The Department appealed the final judgment. ****Appellate briefing was completed in the Fall of 2017 and the parties await**

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scheduling of oral argument. ~~** *and as of December 2016, no briefing schedule has been~~ set.*

5. **Managed Care Potential Legal Damages **

   Three health plans filed lawsuits against the Department challenging the Medi-Cal managed care rate-setting methodology for rate years 2002 through 2005. The cases are referred to as:

   - *Health Net of California, Inc. v. DHCS*
   - *Blue Cross of California, Inc., dba Anthem Blue Cross v. DHCS*
   - *Molina Healthcare of California, Inc., v. DHCS*

   On June 13, 2011, judgment was issued in favor of Plaintiffs in the Health Net, Blue Cross, and Molina Healthcare cases. In all of the cases, the trial court determined that the Department had breached its contract with the managed care plans for the years in question. On November 2, 2012, the Department and Health Net entered into a settlement agreement resolving the Health Net lawsuit. Similarly, the Department has entered into settlement agreements with Blue Cross and Molina in mid/late 2013. The amount of payment due is contingent on each plan's profits, and the settlement accounting **__**is scheduled to occur as follows, subject to applicable run-out periods__ __provided in the settlement~~ terms:~~__ ~~** *will be completed on the following~~ schedule:* *Molina* (January 1, 2018); *Blue Cross* (January 1, 2019); *Health Net* (January 1, 2020).

6. **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 the Department has the duty to review these rates annually. Plaintiffs allege the following causes of action:

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

   The court granted Petitioners' writ on the third cause of action (duty to review rates annually) and ordered the Department to conduct an annual review of reimbursement rates for all physician and dental services. On October 24, 2014, the court found the Department's 2011 rate review report and the analyses of the five third-party payer rates data satisfactory, and discharged the Department's ministerial duty under Welfare and Institutions Code section 14079. The court also found that the Department satisfactorily demonstrated its intention of conducting this rate review on an annual basis. On May 22, 2015, Petitioners filed a motion for attorneys' fees and costs in the amount of $2.5 million. On February 5, 2016, the court denied the plaintiff's motion for attorneys' fees. Plaintiff filed a notice of appeal on February 24, 2016, and filed their opening brief

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on December 27, 2016**.** The Department filed its response brief on April 14, 2017. The plaintiffs' reply brief was filed on May 4, 2017. Oral arguments have not been set.

7. ***Asante, et al. v. Department of Health Care Services, et al.***

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

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

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

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8. ***Riverside Recovery Resources v. Riverside County Department of Mental Health, et al.***

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

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

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

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

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

10. ***Korean Community Center of the East Bay, et al. v. Toby Douglas, et al.* ****

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

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

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

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

11.***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;

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

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

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

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

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

13. ***Rivera v. Douglas, Director of DHCS* **

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

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

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

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

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

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

Costs attributable to the writ are currently unknown. If the Appeal is not successful, the costs attributable to the writ will likely be one or more of the following: (1) for granting

provisional eligibility to applicants whose applications have not been determined within 45 days whenever the Department is unable to timely determine eligibility, and (2) for sending out notices to applicants not granted provisional eligibility and that have not had their eligibility determined within 45 days, with the specific reason(s) for the delay specified in each notice.

14. ~~* Educationally Necessary Statewide Occupational Therapy and Physical Therapy~~ Services

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

15. **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. ~~*DHHS OCR may conducts its own investigation of the Department pursuant in response to the administrative complaint.~~ * There has been no DHHS OCR activity known to the Department since the administrative complaint was filed.

On July 12, 2017, five individuals and three organization filed a class action suit against CHHS and DHCS in Alameda County Superior Court seeking injunctive relief against the same Medi-Cal reimbursement and access policies identified in the above described Title VI Administrative Complaints. Plaintiffs allege that the Department's failure to provide adequate access to providers disparately impacts Latinos. Plaintiffs allege that Medi-Cal

is "disproportionately and majority Latino," and that while all beneficiaries receive poorer treatment than whites covered by other insurance plans (such as Medicare and employer-provided insurance), Latinos are impacted more than other non-Latino Medi-Cal beneficiaries. They also allege that administrative burdens in the Medi-Cal program hinder access to "meaningful" health care. Plaintiffs also contend that the Department fails to monitor Medi-Cal beneficiaries' access to health care services, and fails to ensure managed care plans have adequate networks of providers. Finally, plaintiffs contend that as the percentage of Latino Medi-Cal beneficiaries has increased, the Department has "disinvested" in the Medi-Cal program by reducing Medi-Cal rates relative to Medicare. All of these acts, plaintiffs contend, have disparately impacted Latinos, and constitute purposeful discrimination.

Plaintiffs allege violations of Government Code section 11135 (prohibiting discrimination in state programs), and the California Constitution, Articles I and IV (equal protection, substantive due process). Plaintiffs seek injunctive relief as taxpayers, under California Code of Civil Procedure section 526a, and seek a writ of mandate under Code of Civil Procedure section 1085. Plaintiffs contend that the Department's actions also violate federal Medicaid statutes, including 42 U.S.C. section 1396b(m)(1)(a)(i), and 42 U.S.C. section 1396a(a)(30)(A). Plaintiffs do not seek monetary relief for any of the individual plaintiffs. Rather, they are seeking an order requiring the Department to increase the rates it pays to Medi-Cal providers. ****On November 22, 2017, the Department filed a Demurrer, which was scheduled for hearing on February 9, 2018. ****

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

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

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

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

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

Plaintiffs' petition for writ of mandate was heard on October 28, 2016. The Court denied the writ petition and complaint, ruling in favor of the Department. On November 16, 2016,

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Plaintiffs filed a notice of appeal. **__**Appellate briefing concluded in late 2017 and the parties await scheduling of oral argument.**__**

17.**__*Boothby, et al v. DHCS, et al.*__**

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

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

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

18.**__Dental Managed Care Plans Notifications of Dispute with the Department__**

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

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

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

19. ** **Blue Cross of California v. DHCS, et. al.; *California Physicians' Service DBA Blue Shield of California v. DHCS, et. al.***

Blue Cross of California and Blue Shield of California (Plaintiff) are real parties in interest in a pending California taxpayer action filed in Los Angeles Superior Court captioned Myers v. State Board of Equalization, et al. (Myers), which seeks a writ of mandate directing the appropriate taxing agencies to collect the annual gross premiums tax (GPT) from Plaintiffs as "insurers" under the California Constitution. The Plaintiffs seek reimbursement from the Department for managed care organization (MCO) taxes paid or that will be paid pursuant to SBx2 2 (Chapter 2, Statutes of 2016, 2nd Ex. Sess.) in the event that Myers action results in the Plaintiff being subject to the GPT and exempt from assessment of the SBx2 2 version of the MCO tax. The Blue Cross action has been formally stayed after being designated a related case to Myers, and a status conference has been scheduled for May 29, 2018. The Department awaits the court's ruling on the relatedness of the Blue Shield action to Myers, but it is expected that action will be stayed as well. **

20. **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 Share) for claims for single-source and top-20 multiple-source physician-administered drugs, and $27,349,486 (Federal Share) for other claims, all of which were ineligible for Federal reimbursement.**

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

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

OIG reviewed and reconciled hospital incentive payments reported for the period of October 1, 2011 through December 31, 2015. Although the State made Medicaid EHR incentive payments to eligible hospitals, it did not always make them in accordance with Federal Requirements. The OIG is requesting the Department refund CMS $28,361,240 in net overpayments to the ~~*61~~* ** **64**** hospitals.

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Department staff have started auditing the hospitals reviewed by OIG to determine actual overpayment amounts based on adjudicated claims. Subsequently, the Department's initial audit findings suggest the OIG's overpayment findings were significantly overstated.

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

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

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

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

23. **Audit of California's Medicaid Inpatient Disproportionate Share Hospital (DSH) Payments for University of California, San Diego Medical Center, San Diego, California State ~~Fisc~~al Year *2008* ****1998** **

The Office of the Inspector General (OIG) worked to verify that State Fiscal Year (SFY) 1998 DSH Payments to the University of California, San Diego Medical Center (UCSDMC) did not exceed the hospital specific limit as mandated by Omnibus Reconciliation Act (OBRA) of 1993.

The Department made DSH payments to UCSDMC that exceeded the limit for SFY 1998. The UCSDMC limit determined by the state did not comply with federal statutes and CMS requirements and implementing guidance. The limit determined by the state, based on projected data, was $54,218,316. The state made DSH payments to UCSDMC totaling $50,363,032 ($3,855,284 less than the state determined limit) for SFY 1998. The limit based on audit results, however, was $34,437,864. As a result, UCSDMC received a payment of $15,925,168 ($7,999,212 federal share) in excess of the limit based on the audit.

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

24. **Audit of California's Medicaid Inpatient Disproportionate Share Hospital (DSH) Payments to Kern Medical Center, Bakersfield, California, State Fiscal Year 1998 **

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The OIG worked to verify that State Fiscal SFY 1998 DSH Payments to Kern Medical Center (KMC) did not exceed the hospital specific limit as mandated by OBRA of 1993.

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

The overstatement of the KMC limit consisted of the following items:

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

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

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

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

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

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

not have ordered or prescribed the items or services claimed, Medicaid payments are to be non-excluded.

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

OTHER: REIMBURSEMENTS

1. **Federal Upper Payment Limit**

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

2. **Accrual Costs Under Generally Accepted Accounting Principles**

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

3. **Refund of Recovery**

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

4. **Payment Deferrals**

   The Department issues weekly payments for Fee-For-Service providers. This process is referred to as the checkwrite. Starting in FY 2004-05, the Department implemented (1) an additional week of claim review prior to the release of provider payments starting in July 2004, this shifts the 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.

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OTHER: RECOVERIES

1. **Additional Personal Injury Recoveries**

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

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

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

2. **Refund to Express Scripts**

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

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

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

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

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

****OTHER: INFORMATION MANAGEMENT****

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

FISCAL INTERMEDIARY: MEDICAL

1. **Medical Fiscal Intermediary Contract and Business Operations**
   The current Medical Fiscal Intermediary (FI) contract expires March 31, 2020. In preparation, the Department has begun activities to issue, award, and successfully transition to a new FI contract by September 30, 2019. The new FI contracts will separate the business operations and maintenance and operations (M&O) functions.
   - Takeover for the business operations contract is anticipated to begin in February 2019, and operations will be assumed in October 2019. The business operations contract will expire in October 2029.
   - Takeover for the M&O contract is anticipated to begin in October 2018. Operations will be assumed in October 2019. The M&O contract will expire in October ~~*2026~~* ** **2023****.

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

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

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FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL

1. **Dental Program Utilization Controls Assessment**

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

2. **Allied Dental Professionals Enrollment**

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

DISCONTINUED POLICY CHANGES

Fully Incorporated into Base Data/Ongoing

ELIGIBILITY
PC 7 State-Only BCCTP Coverage Extension

AFFORDABLE CARE ACT

BENEFITS
PC 42 End of Life Services

HOME & COMMUNITY-BASED SERVICES

BREAST AND CERVICAL CANCER

PHARMACY
PC 210 Drug Rebates – Retroactive ACA Adjustments

DRUG MEDI-CAL

MENTAL HEALTH

1115 WAIVER—MH/UCD & BTR

MANAGED CARE

PROVIDER RATES
PC 128 GDSP Prenatal Screening Fee Increase

SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

OTHER: RECOVERIES

FISCAL INTERMEDIARY: MEDICAL

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL

SYSTEMS OF CARE

DISCONTINUED POLICY CHANGES

****Time Limited/No Longer Available****

ELIGIBILITY

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

BENEFITS

HOME & COMMUNITY-BASED SERVICES

BREAST AND CERVICAL CANCER

PHARMACY

DRUG MEDI-CAL

MENTAL HEALTH

1115 WAIVER—MH/UCD & BTR

MANAGED CARE

PROVIDER RATES

SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

OTHER: RECOVERIES

OTHER

FISCAL INTERMEDIARY: MEDICAL

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL

DISCONTINUED POLICY CHANGES

****Withdrawn****

ELIGIBILITY

AFFORDABLE CARE ACT
PC 26 ACA DSH Reduction

BENEFITS

HOME & COMMUNITY-BASED SERVICES

BREAST AND CERVICAL CANCER

PHARMACY

DRUG MEDI-CAL

MENTAL HEALTH

1115 WAIVER—MH/UCD & BTR

MANAGED CARE
PC 104 Managed Care Public Hospital Directed Payments

PROVIDER RATES

SUPPLEMENTAL PAYMENTS
PC 163 Managed Care Private Hospital Directed Payments

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

OTHER: RECOVERIES

FISCAL INTERMEDIARY: MEDICAL

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL
OA 82 Dental Treatment Authorization Request Processing