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

The Great Seal

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

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

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# November 2017 Medi-Cal Estimate

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

(Dollars in Millions)

Total Medi-Cal local assistance expenditures in the Department of Health Care Services (DHCS) budget in the Current Year as compared to the Appropriation are as follows:

| Medical Care Services | FY 2017-18 Appropriation | Nov 2017 Estimate | Change | |
|---|---|---|---|---|
| | | | Amount | Percent |
| Total Funds | $102,261.1 | $95,163.4 | ($7,097.7) | -6.9% |
| Federal Funds | $65,041.9 | $60,012.0 | ($5,029.9) | -7.7% |
| **General Fund** | **$18,399.7** | **$18,866.7** | **$467.0** | **2.5%** |
| Other Non-Federal Funds | $18,819.5 | $16,284.7 | ($2,534.8) | -13.5% |

| County Administration | FY 2017-18 Appropriation | Nov 2017 Estimate | Change | |
|---|---|---|---|---|
| | | | Amount | Percent |
| Total Funds | $4,574.3 | $4,427.5 | ($146.8) | -3.2% |
| Federal Funds | $3,601.6 | $3,384.5 | ($217.1) | -6.0% |
| **General Fund** | **$960.6** | **$1,031.0** | **$70.4** | **7.3%** |
| Other Non-Federal Funds | $12.1 | $12.0 | ($0.1) | -0.8% |

| Fiscal Intermediary | FY 2017-18 Appropriation | Nov 2017 Estimate | Change | |
|---|---|---|---|---|
| | | | Amount | Percent |
| Total Funds | $423.2 | $449.2 | $26.0 | 6.1% |
| Federal Funds | $268.7 | $288.5 | $19.8 | 7.4% |
| **General Fund** | **$154.5** | **$160.7** | **$6.2** | **4.0%** |
| Other Non-Federal Funds | $0.0 | $0.0 | $0.0 | n/a |

| Total Expenditures | FY 2017-18 Appropriation | Nov 2017 Estimate | Change | |
|---|---|---|---|---|
| | | | Amount | Percent |
| Total Funds | $107,258.7 | $100,040.1 | ($7,218.5) | -6.7% |
| Federal Funds | $68,912.1 | $63,684.9 | ($5,227.2) | -7.6% |
| **General Fund** | **$19,514.8** | **$20,058.4** | **$543.7** | **2.8%** |
| Other Non-Federal Funds | $18,831.6 | $16,296.7 | ($2,534.9) | -13.5% |

Note: Totals may not add due to rounding.

# November 2017 Medi-Cal Estimate

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

(Dollars in Millions)

Total Medi-Cal local assistance expenditures in the Department of Health Care Services (DHCS) budget in the Budget Year as compared to the Current Year are as follows:

| Medical Care Services | FY 2017-18 Estimate | FY 2018-19 Estimate | Change | |
|---|---|---|---|---|
| | | | Amount | Percent |
| Total Funds | $95,163.4 | $96,807.3 | $1,643.9 | 1.7% |
| Federal Funds | $60,012.0 | $63,651.2 | $3,639.2 | 6.1% |
| **General Fund** | **$18,866.7** | **$20,388.7** | **$1,522.0** | **8.1%** |
| Other Non-Federal Funds | $16,284.7 | $12,767.4 | ($3,517.3) | -21.6% |

| County Administration | FY 2017-18 Estimate | FY 2018-19 Estimate | Change | |
|---|---|---|---|---|
| | | | Amount | Percent |
| Total Funds | $4,427.5 | $4,369.3 | ($58.2) | -1.3% |
| Federal Funds | $3,384.5 | $3,280.8 | ($103.7) | -3.1% |
| **General Fund** | **$1,031.0** | **$1,083.6** | **$52.6** | **5.1%** |
| Other Non-Federal Funds | $12.0 | $4.9 | ($7.1) | -59.2% |

| Fiscal Intermediary | FY 2017-18 Estimate | FY 2018-19 Estimate | Change | |
|---|---|---|---|---|
| | | | Amount | Percent |
| Total Funds | $449.2 | $328.1 | ($121.1) | -27.0% |
| Federal Funds | $288.5 | $211.3 | ($77.2) | -26.8% |
| **General Fund** | **$160.7** | **$116.8** | **($43.9)** | **-27.3%** |
| 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 | $100,040.1 | $101,504.7 | $1,464.5 | 1.5% |
| Federal Funds | $63,684.9 | $67,143.2 | $3,458.3 | 5.4% |
| **General Fund** | **$20,058.4** | **$21,589.1** | **$1,530.7** | **7.6%** |
| Other Non-Federal Funds | $16,296.7 | $12,772.3 | ($3,524.4) | -21.6% |

Note: Totals may not add due to rounding.

# November 2017 Medi-Cal Estimate
# Management Summary

Medi-Cal, California's Medicaid program, provides health care to approximately 13.5 million 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.

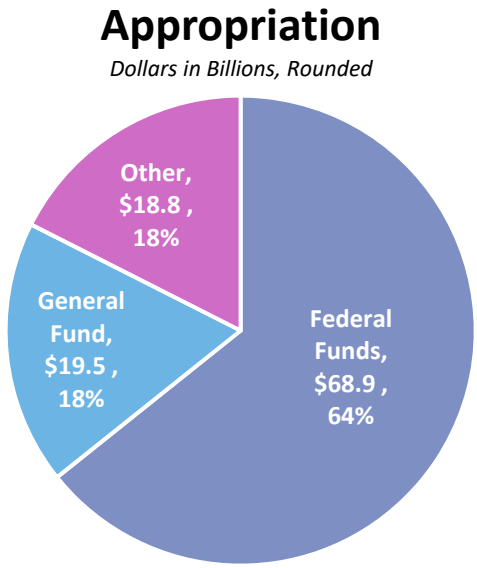
  These estimated expenditures are summarized in the Current Year and Budget Year sections.

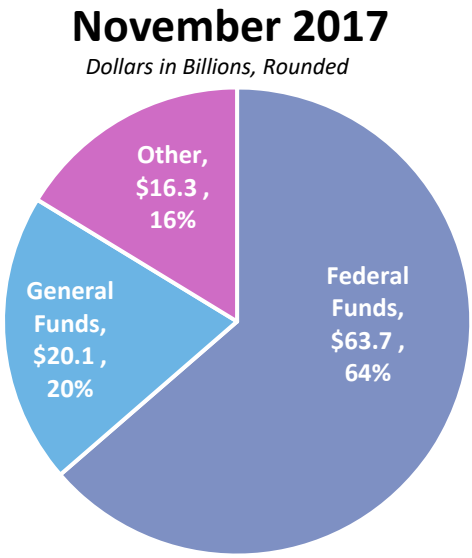
- County Administration: Expenditures for the counties to determine Medi-Cal eligibility, as well as, additional expenditures required to administer the Medi-Cal program. These estimated expenditures can be found in the following sections:
  - County Administration
  - Other Administration

- 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.

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

## FY 2017-18

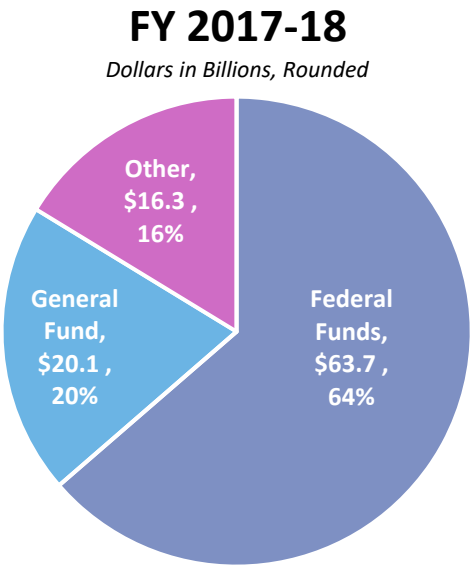


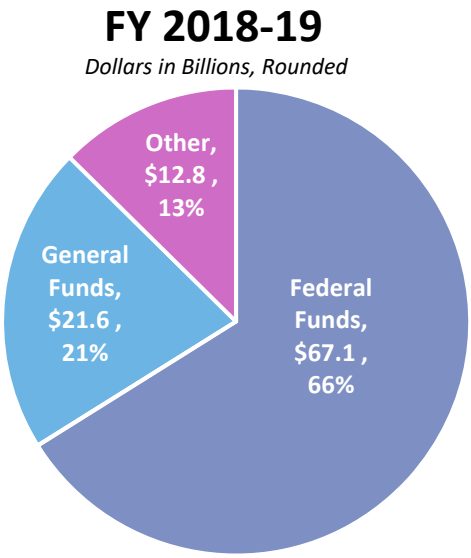




The November 2017 Estimate for FY 2017-18 projects an additional $543.7 million General Fund in expenditures than the FY 2017-18 Budget Appropriation.

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

*(Dollars in Millions, Rounded)*




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

**November 2017 General Fund**

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

*(Dollars in Millions, Rounded)*

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

**Significant Items**

*Dollars in Millions*

| | | Change from Appropriation | | Change from FY 2017-18 | |
|---|---|---|---|---|---|
| | | FY 2017-18 | | FY 2018-19 | |
| **Name** | **PC** | **TF** | **GF** | **TF** | **GF** |
| **Non-OTLICP CHIP** | 9 | ($401.0) | ($38.1) | $0.0 | ($107.6) |
| This policy change (PC) estimates the technical adjustment in funding for the Non-Optional Targeted Low Income Children's Program (OTLICP) population of the Children's Health Insurance Program (CHIP). This PC includes changes to the CS3-Proxy adjustment, expenditures for the Resource Disregard, HPE, and Medicaid Expansion populations. | | | | | |
| **Title XXI Federal Match Reduction** | 24 | ($1.8) | ($97.0) | ($41.7) | $295.0 |
| This policy estimates the funding adjustment for the Children's Health Insurance Program (CHIP) to reflect a reduction of the federal match from 88% to 65% as of January 1, 2018, given the continuing uncertainty regarding full Congressional reauthorization of CHIP. | | | | | |
| **Medi-Cal Inmate Programs** | 1, 3 | ($257.9) | ($29.3) | $122.2 | $10.9 |
| These policy changes estimate the federal funding provided to both the State and Counties for eligible inmates who receive inpatient hospital care. Both State and County inmate costs are estimated based upon actual State claims. Counties will reimbursement the State for the state share of the county inmate expendtiures. | | | | | |
| **MEC Optional Expansion Adjustment** | 16 | $97.0 | ($10.9) | $326.3 | ($120.4) |
| This policy change adjusts the funding from the ACA Optional Expansion funding to the Medi-Cal 50/50 funding for eligibles with Minimum Essential Coverage (MEC) who are not eligible for the ACA Optional Expansion aid category. This PC reflects updated recoupment amounts and timelines. | | | | | |
| **Behavioral Health Treatment** | 27 | $87.1 | $38.3 | ($24.9) | ($10.9) |
| Medi-Cal covers Behavioral Health Treatment (BHT) services for children under age 21. Beginning February 1, 2016, the Department, in collaboration with the Department of Developmental Services (DDS), transitioned responsibility for BHT services provided to existing Medi-Cal eligible DDS Regional Center clients to Medi-Cal. With the November 2017 Estimate, BHT costs for transitioned DDS RC clients are combined in this PC with the costs for others receiving BHT. Additionally, the current BHT estimate updates FFS and managed care costs based on actual payments and estimated managed care capitation rates. | | | | | |
| **Behavioral Health Treatment - BIS DDS Transition** | 44 | ($10.3) | ($4.5) | $93.1 | $40.7 |
| This policy change estimates costs for additional DDS Regional Center (RC) clients with a diagnosis other than Autism Spectrum Disorder (ASD) transitioning to Medi-Cal. The current estimate updates the number of BHT/Behavioral Intervention Services beneficiaries that are estimated to transition to Medi-Cal fee-for-service and managed care. In addition, the transition dates have been shifted to March 2018 and July 2018 for FFS and managed care, respectively. | | | | | |

| | | Change from Appropriation | | Change from FY 2017-18 | |
|---|---|---|---|---|---|
| | | FY 2017-18 | | FY 2018-19 | |
| **Name** | **PC** | **TF** | **GF** | **TF** | **GF** |
| **Diabetes Prevention Program** | 45 | $0.0 | $0.0 | $0.5 | $0.1 |
| This new policy change estimates the costs of the Diabetes Prevention Program (DPP). The DPP is a lifestyle change program designed to prevent or delay Type 2 diabetes among people who have prediabetes and women with a previous diagnosis of gestational diabetes. The program consists of core sessions, core maintenance sessions, and ongoing maintenance sessions. The DPP is projected to begin January 1, 2019. | | | | | |
| **Drug Rebates Prior Year Funding Adjustment** | 48 | ($60.3) | $256.6 | $60.3 | ($256.6) |
| Drug rebate collections are initially recorded as 50% GF/50% FF. The funding for the Affordable Care Act (ACA) optional population, ACA Offset, and Children's Health Insurance Program (CHIP) populations are adjusted once the various funding allocations are determined. Four quarterly funding adjustments are typically made in a fiscal year. This policy change estimates an additional funding adjustment for FY 2016-17 drug rebate collections that was made in FY 2017-18. | | | | | |
| **Drug Rebates** | 51, 52, 54, 55, 116 | ($946.9) | ($280.7) | ($195.0) | ($74.0) |
| Rebate estimates were updated based on actual pharmacy drug rebate collections data through June 2017. | | | | | |
| **Pharmacy Reimbursement & Dispensing Fee** | 49 | N/A | N/A | ($66.0) | ($26.6) |
| This policy change estimates the savings from reimbursing pharmacy drugs based on the Actual Acquisition Cost (AAC) for Covered Outpatient Drugs and the cost associated with adopting the new Professional Dispensing Fee (PDF) methodology. Although the effective date of the new AAC and PDF reimbursement methodology is April 1, 2017, implementation is estimated to begin August 1, 2018. | | | | | |
| **Drug Rebates - Retroactive ACA Adjustments** | 210 | $0.0 | $46.5 | $0.0 | ($46.5) |
| Prior to April 2016, the Rebate Accounting and Information System (RAIS) was not able to identify ACA claims for pharmacy drugs and rebate invoices were blended with non-ACA claims. A system change to allow RAIS to calculate the ACA claims for the blended period, January 2014 to April 2016, has been delayed resulting in additional ACA rebates being owed to the federal government. This adjustment estimates repayments for the additional ACA rebate savings owed for the blended period. | | | | | |
| **New High Cost Treatments for Specific Conditions** | 47 | ($45.5) | ($21.0) | $72.3 | $32.8 |
| This policy change estimates new high cost services and treatments recently approved by the FDA. The updated dollars reflect phase-in changes and the addition of new treatments. | | | | | |

| | | Change from Appropriation | | Change from FY 2017-18 | |
|---|---|---|---|---|---|
| | | FY 2017-18 | | FY 2018-19 | |
| **Name** | **PC** | **TF** | **GF** | **TF** | **GF** |
| **Drug Medi-Cal ODS Waiver** | 56 | ($207.7) | ($48.2) | $666.7 | $133.6 |
| DMC-ODS waiver services include existing DMC treatment modalities and additional new and expanded services. DMC-ODS waiver services for opt-in counties began in February 2017 on a phase-in basis. Five counties implemented the DMC-ODS waiver in FY 2016-17. The Department estimates an additional 15 counties will implement the DMC-ODS waiver in FY 2017-18 and an additional 20 counties in FY 2018-19. The estimated costs reflect changes in phase-in schedule, payment lags, and rates. | | | | | |
| **SMHS Base** | 63 ,64 | $182.8 | ($13.8) | $20.4 | $22.7 |
| The Specialty Mental Health Services (SMHS) base policy changes have been revised based on updated utilization and cost data through June 2017. Due to delayed implementation of a Short Doyle Medi-Cal (SD/MC) system change, a portion of FY 2016-17 claims shifted for payment in FY 2017-18. | | | | | |
| **Managed Care Regulations - Mental Health Parity** | OA 109 | N/A | N/A | $21.3 | $3.0 |
| The federal Parity Final Rule requires parity in access to mental health and substance use disorder services for Medicaid beneficiaries with physical health services. County Mental Health Plans will be required to shorten times for the authorization of treatment plans for both outpatient and inpatient services. The current estimate includes costs related to shortening authorization of outpatient services, beginning July 1, 2018. | | | | | |
| **Medi-Cal 2020 Waiver - Global Payment Program (GPP)** | 73 | ($108.5) | $0.0 | $207.6 | $0.0 |
| The GPP converted Disproportionate Share Hospital (DSH) and Safety Net Care Pool (SNCP) uncompensated care funding from a hospital-focused, cost-based system to one that is focused on value and improved care delivery. Intergovernmental transfers (IGTs) provide the non-federal share of the GPP payments. Estimated expenditures for GPP have been updated for FY 2017-18 and FY 2018-19. | | | | | |
| **Medi-Cal 2020 Waiver - Public Hospital Redesign & Incentives in Medi-Cal (PRIME)** | 74 | $171.0 | $0.0 | ($251.0) | $0.0 |
| The Medi-Cal 2020 demonstration provides up to $1.4 billion TF annually for the Designated Public Hospitals (DPHs) systems and up to $200 TF million annually for the District/Municipal Hospitals (DMPH) systems for the first three years of the demonstration. The funding phases down by 10% in the fourth year of the demonstration and by an additional 15% in the fifth year of the demonstration. The estimate has been updated to pay remaining Demonstration Year (DY) 2016-17 payments and 50% of the annual DY 2017-18 payment in FY 2017-18. The remaining 50% of DY 2017-18 and the first DY 2018-19 payments, which includes the 10% phased down allocation, are estimated to be paid in FY 2018-19. | | | | | |

| | | Change from Appropriation | | Change from FY 2017-18 | |
|---|---|---|---|---|---|
| | | FY 2017-18 | | FY 2018-19 | |
| **Name** | **PC** | **TF** | **GF** | **TF** | **GF** |
| **Medi-Cal 2020 Whole Person Care Pilots** | 75 | ($138.2) | $0.0 | $64.9 | $0.0 |
| Medi-Cal 2020 Waiver Whole Person Care Pilots allow city, county, state, tribal, and federal entities, as well as Medi-Cal Managed care plans, hospitals, and provider organizations, to align communication and integrate services to prevent fragmentation of the delivery system that can result in duplicative or inappropriate care for Medi-Cal beneficiaries. Pilots may also focus on Housing and Supportive Services. This PC includes updates to when various programs will begin. The estimated costs reflect lower amounts allocated to waiver entities through the first application process. | | | | | |
| **Medi-Cal 2020 Waiver - DTI and DSHP** | 76, 83 | ($35.2) | ($17.6) | $52.9 | $26.4 |
| The Dental Transformation Initiative (DTI) in the Medi-Cal 2020 Waiver includes incentive payments for the provision of preventive services, caries risk assessment and disease management, continuity of care and funding for the Local Dental Pilot Programs (LDPPs). Federal claiming of $75 million FFP for Medi-Cal 2020 Designated State Health Program expenditures provides for an offset to the GF costs for the DTI in FY 2017-18 and FY 2018-19. | | | | | |
| **Managed Care Base** | 87, 88, 89, 94 | ($183.1) | $327.5 | $425.8 | $652.6 |
| The four managed care base PCs estimate the managed care capitation costs for managed care health plans. In FY 2017-18, California Healthcare, Research, and Prevention Tobacco Tax Act of 2016 (Proposition 56) funds a portion of the growth as compared to the 2016 Budget Act in the four PCs. In 2018-19, only growth as compared to the 2016 Budget Act in the Two Plan Model base PC will be funded with Proportion 56 revenue. | | | | | |
| **Retro MC Rate Adjustment** | 117 | ($52.2) | $143.6 | $4,188.4 | ($289.6) |
| This policy change estimates retroactive managed care capitation rate adjustments. These dollars reflect updated payment and recoupment timeframes. FY 2017-18 includes significant ACA optional expansion rate recoupments while FY 2018-19 does not. | | | | | |
| **ACA Optional Expansion MLR Risk Corridor** | 25 | ($176.6) | $0.0 | ($88.3) | $0.0 |
| This new policy change budgets additional federally funded payments to and recoveries from managed care health plans (MCPs) related to the Medical Loss Ratio (MLR) risk corridor calculations for ACA Optional Expansion (ACA OE) members. | | | | | |
| **Managed Care Health Care Financing Program** | 105 | N/A | N/A | $1,515.0 | $454.5 |
| This new policy change estimates increased payments to managed care plans (MCPs) designed to support payment levels to counties and/or public entities serving Medi-Cal beneficiaries. | | | | | |
| **Managed Care Public Hospital Directed Payments** | 104 | N/A | N/A | $1,569.0 | $457.6 |
| This new policy change budgets managed care directed payments to fund enhanced managed care capitation payments to managed care plans (MCPs) for Designated Public Hospitals (DPHs) and University of California Health Systems (UCs) to support delivery system reform. | | | | | |

| | | Change from Appropriation | | Change from FY 2017-18 | |
|---|---|---|---|---|---|
| | | FY 2017-18 | | FY 2018-19 | |
| **Name** | **PC** | **TF** | **GF** | **TF** | **GF** |
| **Managed Care Reimbursements to the General Fund** | 113 | $0.0 | ($15.5) | $0.0 | ($1,258.7) |
| This policy change budgets reimbursements to the General Fund (GF) by Intergovernmental Transfer (IGT) from allowable public entities for Medi-Cal payment contributions and administration and processing fees. | | | | | |
| **Mgd. Care Public Hospital Quality Incentive Pool** | 106 | N/A | N/A | $640.0 | $186.7 |
| This new policy change budgets managed care directed payments to fund Quality Incentive Pool (QIP) payments by managed care plans (MCPs) to Designated Public Hospitals (DPHs) and University of California Health Systems (UCs), based on their performance on designated performance metrics. | | | | | |
| **Managed Care Public Hospital IGTs** | 93 | ($1,162.5) | $0.0 | ($1,717.6) | $0.0 |
| This policy change estimates the Intergovernmental Transfer (IGT) from Designated Public Hospitals (DPHs) to the Department that will be used as the non-federal share of capitation rate increases, as well as the related federal match portion of the capitation rate increases. FY 2017-18 is the last year for this item. | | | | | |
| **Managed Care Rate Range IGTs** | 90 | $409.8 | $0.0 | ($3,409.9) | $0.0 |
| This policy change estimates the rate range intergovernmental transfers (IGTs) from the counties or other approved public entities to the Department for providing capitation rate increases to the managed care plans. This program ends in FY 2017-18 but some payments occur in FY 2018-19. | | | | | |
| **Managed Care IGT Admin. & Processing Fee** | 111 | $0.0 | $8.5 | $0.0 | $235.3 |
| This policy change estimates the savings to the General Fund due to the rate range intergovernmental transfers (IGTs) administrative and processing fees assessed to the counties or other approved public entities. The rate range IGT portion of this PC ends in FY 2017-18. | | | | | |
| **HQAF Rate Range Increases** | 96 | $33.3 | $0.0 | ($265.3) | $0.0 |
| This policy change estimates the amount of increased rate range payments to the managed care plans because of the extension of the Hospital Quality Assurance Fee (QAF) program. The decrease in the budget year is due to the completion of payments for this program. | | | | | |
| **CCI Managed Care Payments** | 91 | $44.9 | $22.5 | ($2,212.4) | ($1,106.2) |
| This policy change estimates the capitation payments for Medi-Cal beneficiaries transitioning primarily from fee-for-service into Medi-Cal managed care health plans for their Medi-Cal Long Term Care (LTC) institutional and community based services and supports benefits in seven counties. Effective January 1, 2018, In-Home Supportive Services is no longer included in the managed care plans, resulting in a significant decrease in FY 2018-19 costs. Changes from the prior estimate include an overall decrease in CCI beneficiaries and changes in rates. | | | | | |

| | | Change from Appropriation | | Change from FY 2017-18 | |
|---|---|---|---|---|---|
| | | FY 2017-18 | | FY 2018-19 | |
| **Name** | **PC** | **TF** | **GF** | **TF** | **GF** |
| **Home Health Rate Increase** | 204 | N/A | N/A | $64.5 | $0.0 |
| The new proposal would increase home health agency and private duty nursing rates that are provided by fee-for-service (FFS) and Home and Community-Based Waiver providers by 50%, effective July 1, 2018. California Healthcare, Research, and Prevention Tobacco Tax Act of 2016 (Proposition 56) revenue will be used to fund the non-federal share of the home health agency rate increases. | | | | | |
| **Hospital Quality Assurance Fee Payments** | 138, 139, 163, 196 | ($3,935.6) | $168.7 | ($2,470.7) | ($33.0) |
| The HQAF program assesses a fee on applicable general acute care hospitals and matches the fee with federal financial participation. The fee also provides additional funding for children's health care coverage. The HQAF estimates have been adjusted based on including a new Private Hospital Directed Payments methodology in managed care, conducting an Upper Payment Limit (UPL) review on prior years, and removing prior fee-for-service HQAF payments. | | | | | |
| **Prop. 56 Supplemental Payments** | 141, 147, 148, 156, 160 | ($12.1) | $0.0 | $878.3 | $0.0 |
| Effective April 2017, the California Healthcare, Research, and Prevention Tobacco Tax Act of 2016, or Proposition 56, increases taxes on cigarettes and tobacco. AB 120 appropriates a portion of Proposition 56 revenues to provide supplemental payments for specific physician, dental, women's health, HIV/AIDS and Intermediate Care Facilities for the developmentally disabled (ICF/DD) services. This policy change estimates the expenditures related to providing supplemental payments for specific services. FY 2017-18 includes updated costs with appropriate payment lags and FY 2018-19 includes full year costs. Additionally, FY 2018-19 includes an increase of $232.8 million Prop. 56 revenue for supplemental payments and rate increases approved in the 2017 Budget Act. Of the increased amount, $163 million is for physician payments and $70 million is for dental payments. | | | | | |
| **Dental Retroactive Rate Changes** | 119 | $163.0 | $64.3 | ($186.7) | ($73.4) |
| This policy change for FY 2017-18 only budgets the retroactive adjustments to dental managed care and Fee-for-Service rates affecting prior fiscal years and incorporates shifts in payment timing. | | | | | |
| **Medi-Cal Estate Recoveries** | 185 | ($61.7) | ($30.8) | $18.7 | $9.3 |
| The Medi-Cal ER program is one of several controls to mitigate Medi-Cal costs for care. Upon death of a Medi-Cal beneficiary, the decedent's estate or any recipient of the decedent's estate may have to pay back the costs of services through the ER program. As of January 1, 2017, SB 833 (Chapter 30, Statutes of 2016) limited the ER program to the probated estates of deceased Medi-Cal members 55 years of age and older, for only federally mandated services and also eliminated recovery if a Medi-Cal beneficiary is survived by a spouse/registered domestic partner. The change between years and from appropriation is due to an adjustment to the methodology based on recent experience. | | | | | |

| | | Change from Appropriation | | Change from FY 2017-18 | |
|---|---|---|---|---|---|
| | | FY 2017-18 | | FY 2018-19 | |
| **Name** | **PC** | **TF** | **GF** | **TF** | **GF** |
| **CMS Deferral Payments** | 84 | $0.0 | $59.3 | $0.0 | ($65.3) |
| The Centers for Medicare and Medicaid Services (CMS) reviews claims submitted by Medicaid agencies and may defer payment on claims requiring additional information or claims CMS interprets as not meeting all federal funding requirements. Upon receiving a deferral, the state must immediately return the federal funds to CMS. This policy change estimates the repayment of deferred amounts, issued for Federal Fiscal Year (FFY) 2015 and after, to CMS in FY 2017-18 and FY 2018-19. | | | | | |
| **CMS Deferral and Negative Balance Repayment** | 85 | N/A | N/A | $0.0 | $139.4 |
| As part of the California Medi-Cal 2020 Demonstration Waiver, the Department must settle all outstanding deferrals and negative balances with the Centers for Medicare and Medicaid (CMS). The Department estimates to repay $139.4 million GF, related to negative balances, to CMS in FY 2018-19. | | | | | |
| **School-Based Medi-Cal Administrative Activities (SMAA)** | OA 1 | ($226.4) | $53.2 | ($10.7) | $110.2 |
| The SMAA program reimburses Local Educational Agencies (LEAs), or school districts, for the federal share of certain costs for administering the Medi-Cal program. Under the 2014 CMS agreement, deferred SMAA claims from FY 2009-10 through FY 2014-15 (Quarters 1 and 2) are subject to backcasting, utilizing the newly established Random Moment Time Study (RMTS) methodology. Based on recent RMTS claims data, that backcasting may result in the collection of overpayments to LEAs. Due to the repayment timing agreed upon with CMS, the Department proposes to repay CMS with General Fund (GF) in FY 2017-18 and FY 2018-19. | | | | | |
| **Local Education Agency (LEA) Providers** | 30 | ($10.3) | $5.2 | $4.2 | ($5.2) |
| The LEA Medi-Cal Billing Option Program provides a fee-for-service model for LEAs to claim Title XIX federal funds through the Department for health-related direct services provided by qualified medical practitioners to students who are on Medi-Cal. On February 24, 2016, the independent federal auditor discovered that the LEA Billing Option Program paid out $5.213 million in ineligible Title XXI expenditures. The Department estimates to repay these funds to the Centers of Medicare and Medicaid Services with General Fund (GF) in FY 2017-18. | | | | | |
| **County Administration** | CA 1, 2 | N/A | N/A | $54.8 | $18.5 |
| These policy changes reflect the allocation provided to counties for costs associated with Medi-Cal eligibility determination activities. For FY 2018-19, the separate amount for ACA implementation activities is merged with the main allocation PC. As an interim methodology, the Estimate proposes a funding increase in FY 2018-19 based on an adjustment to the existing funding level using the increase in the Consumer Price Index. | | | | | |

## General Information

This estimate is based on actual payment data through July 2017. Estimates for both fiscal years are on a cash basis and include a two-week hold on weekly Fee-for-Service payments at the end of June and a one-month hold on Managed Care June payments. All held payments are anticipated to be paid in July of the following state fiscal year.

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

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

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

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

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

A 1% variation in total Medi-Cal expenditures would result in an $1 billion TF ($200.1 million General Funds) change in expenditures in FY 2017-18 and $1,015 million TF ($215.9 million General Funds) in FY 2018-19.

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***Medi-Cal Funding Summary***

***November 2017 Estimate Compared to Appropriation***

***Fiscal Year 2017 - 2018***

## TOTAL FUNDS

| MEDI-CAL Benefits: | Total Appropriation | Nov 2017 Estimate | Difference Incr./(Decr.) |
|---|---|---|---|
| 4260-101-0001/0890(3) | $69,136,479,000 | $68,253,118,000 | ($883,361,000) |
| 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 | $7,890,000 | $0 |
| 4260-101-3305 Healthcare Treatment Fund | $1,257,166,000 | $1,070,558,000 | ($186,608,000) |
| 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 | $75,527,000 | ($90,092,000) |
| 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 | $11,772,000 | ($7,724,000) |
| 4260-113-0001/0890 Healthy Families | $3,020,483,000 | $2,389,722,000 | ($630,761,000) |
| 4260-601-0942142 Local Trauma Centers | $44,845,000 | $61,798,000 | $16,953,000 |
| 4260-601-0942 Home Health Program Account | $0 | $0 | $0 |
| 4260-601-0995 Reimbursements | $4,947,529,000 | $3,611,335,000 | ($1,336,194,000) |
| 4260-601-3156 MCO Tax Fund | $328,610,000 | $329,324,000 | $714,000 |
| 4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund | $800,000,000 | $885,500,000 | $85,500,000 |
| 4260-601-3213 LTC QA Fund | $482,975,000 | $539,842,000 | $56,867,000 |
| 4260-601-3293 MCO Tax Fund 2016 | $2,392,507,000 | $2,367,559,000 | ($24,948,000) |
| 4260-601-7502 Demonstration DSH Fund | $148,011,000 | $97,710,000 | ($50,301,000) |
| 4260-601-7503 Health Care Support Fund | $324,393,000 | $113,067,000 | ($211,326,000) |
| 4260-601-8107 Whole Person Care Pilot Fund | $360,000,000 | $290,910,000 | ($69,090,000) |
| 4260-601-8108 Global Payment Program Fund | $1,152,567,000 | $1,044,787,000 | ($107,780,000) |
| 4260-601-8113 DPH GME Special Fund | $0 | $471,791,000 | $471,791,000 |
| 4260-602-0309 Perinatal Insurance Fund | $10,997,000 | $14,140,000 | $3,143,000 |
| 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 | $48,928,000 | $0 |
| 4260-605-3167 SNF Quality & Accountability | $43,122,000 | $43,121,000 | ($1,000) |
| 4260-698-3167 SNF Qual & Acct. (Less Funded by GF) | ($48,928,000) | ($48,928,000) | $0 |
| 4260-606-0834 SB 1100 DSH | $177,411,000 | $220,645,000 | $43,234,000 |
| 4260-611-3158/0890 Hospital Quality Assurance | $16,840,000,000 | $12,802,754,000 | ($4,037,246,000) |
| 4260-611-3201 LIHP MCE Out-of-Network ER Svcs. | $116,250,000 | $0 | ($116,250,000) |
| **TOTAL MEDI-CAL Benefit s** | **$102,261,089,000** | **$95,163,437,000** | **($7,097,652,000)** |
| **COUNTY ADMINISTRATION:** | | | |
| 4260-101-0001/0890(1) | $4,518,300,000 | $4,383,047,000 | ($135,253,000) |
| 4260-106-0890(1) Money Follow Person Fed. Grant | $688,000 | $627,000 | ($61,000) |
| 4260-113-0001/0890 Healthy Families | $32,587,000 | $19,547,000 | ($13,040,000) |
| 4260-117-0001/0890 HIPPA | $10,581,000 | $12,275,000 | $1,694,000 |
| 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 | $630,000 | ($62,000) |
| 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 | $3,907,000 | $0 |
| **TOTAL COUNTY ADMIN .** | **$4,574,347,000** | **$4,427,490,000** | **($146,857,000)** |
| **FISCAL INTERMEDIARY:** | | | |
| 4260-101-0001/0890(2) | $403,121,000 | $428,277,000 | $25,156,000 |
| 4260-113-0001/0890 Healthy Families | $5,816,000 | $6,088,000 | $272,000 |
| 4260-117-0001/0890 HIPAA | $14,293,000 | $14,827,000 | $534,000 |
| 4260-601-0995 Reimbursements | $0 | $0 | $0 |
| **TOTAL FISCAL INTERMEDIAR Y** | **$423,230,000** | **$449,192,000** | **$25,962,000** |
| **GRAND TOTAL - ALL FUND S** | **$107,258,666,000** | **$100,040,119,000** | **($7,218,547,000)** |

Notes:
Proposition 99 funding is from the Cigarette and Tobacco Products Surtax Fund accounts as shown above.

***Medi-Cal Funding Summary***

***November 2017 Estimate Compared to Appropriation***

***Fiscal Year 2017 - 2018***

## STATE FUNDS

| MEDI-CAL Benefits: | State Funds Appropriation | Nov 2017 Estimate | Difference Incr./(Decr.) |
|---|---|---|---|
| 4260-101-0001(3) * | $17,428,661,000 | $18,226,737,000 | $798,076,000 |
| 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 | $7,890,000 | $0 |
| 4260-101-3305 Healthcare Treatment Fund | $1,257,166,000 | $1,070,558,000 | ($186,608,000) |
| 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 | $37,764,000 | ($45,045,000) |
| 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 | $432,965,000 | ($285,994,000) |
| 4260-601-0942142 Local Trauma Centers | $44,845,000 | $61,798,000 | $16,953,000 |
| 4260-601-0942 Home Health Program Account | $0 | $0 | $0 |
| 4260-601-0995 Reimbursements | $4,947,529,000 | $3,611,335,000 | ($1,336,194,000) |
| 4260-601-3156 MCO Tax Fund | $328,610,000 | $329,324,000 | $714,000 |
| 4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund | $800,000,000 | $885,500,000 | $85,500,000 |
| 4260-601-3213 LTC QA Fund | $482,975,000 | $539,842,000 | $56,867,000 |
| 4260-601-3293 MCO Tax Fund 2016 | $2,392,507,000 | $2,367,559,000 | ($24,948,000) |
| 4260-601-8107 Whole Person Care Pilot Fund | $360,000,000 | $290,910,000 | ($69,090,000) |
| 4260-601-8108 Global Payment Program Fund | $1,152,567,000 | $1,044,787,000 | ($107,780,000) |
| 4260-601-8113 DPH GME Special Fund | $0 | $471,791,000 | $471,791,000 |
| 4260-602-0309 Perinatal Insurance Fund | $10,997,000 | $14,140,000 | $3,143,000 |
| 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 | $48,928,000 | $0 |
| 4260-605-3167 SNF Quality & Accountability | $43,122,000 | $43,121,000 | ($1,000) |
| 4260-698-3167 SNF Qual & Acct. (Less Funded by GF) | ($48,928,000) | ($48,928,000) | $0 |
| 4260-606-0834 SB 1100 DSH | $177,411,000 | $220,645,000 | $43,234,000 |
| 4260-611-3158 Hospital Quality Assurance Revenue | $6,382,189,000 | $5,034,239,000 | ($1,347,950,000) |
| 4260-611-3201 LIHP MCE Out-of-Network ER Svcs. | $116,250,000 | $0 | ($116,250,000) |
| **TOTAL MEDI-CAL Benefits** | **$37,219,226,000** | **$35,151,472,000** | **($2,067,754,000)** |
| **Total Benefits General Fund *** | **$18,399,657,000** | **$18,866,694,000** | **$467,037,000** |
| **COUNTY ADMINISTRATION:** | | | |
| 4260-101-0001(1) * | $946,049,000 | $1,016,053,000 | $70,004,000 |
| 4260-113-0001 Healthy Families * | $12,804,000 | $12,740,000 | ($64,000) |
| 4260-117-0001 HIPAA * | $1,708,000 | $2,183,000 | $475,000 |
| 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 | $630,000 | ($62,000) |
| 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 | $3,907,000 | $0 |
| **TOTAL COUNTY ADMIN.** | **$972,752,000** | **$1,042,970,000** | **$70,218,000** |
| **Total Co. Admin. General Fund *** | **$960,561,000** | **$1,030,976,000** | **$70,415,000** |
| **FISCAL INTERMEDIARY:** | | | |
| 4260-101-0001(2) * | $150,157,000 | $156,302,000 | $6,145,000 |
| 4260-113-0001 Healthy Families * | $1,701,000 | $1,700,000 | ($1,000) |
| 4260-117-0001 HIPAA * | $2,681,000 | $2,739,000 | $58,000 |
| 4260-601-0995 Reimbursements | $0 | $0 | $0 |
| **TOTAL FISCAL INTERMEDIARY** | **$154,539,000** | **$160,741,000** | **$6,202,000** |
| **Total FI General Fund *** | **$154,539,000** | **$160,741,000** | **$6,202,000** |
| **GRAND TOTAL - STATE FUNDS** | **$38,346,517,000** | **$36,355,183,000** | **($1,991,334,000)** |
| **Grand Total - General Fund *** | **$19,514,757,000** | **$20,058,411,000** | **$543,654,000** |

Notes:
Proposition 99 funding is from the Cigarette and Tobacco Products Surtax Fund accounts as shown above.

## *Medi-Cal Funding Summary*
## *November 2017 Estimate Compared to Appropriation*
## *Fiscal Year 2017 - 2018*

### FEDERAL FUNDS

| | Federal Funds Appropriation | Nov 2017 Estimate | Difference Incr./(Decr.) |
|---|---|---|---|
| **MEDI-CAL Benefits:** | | | |
| 4260-101-0890(3) | $51,707,818,000 | $50,026,381,000 | ($1,681,437,000) |
| 4260-102-0890 Capital Debt | $82,810,000 | $37,763,000 | ($45,047,000) |
| 4260-106-0890 Money Follows Person Federal Grant | $19,496,000 | $11,772,000 | ($7,724,000) |
| 4260-113-0890 Health Families | $2,301,524,000 | $1,956,757,000 | ($344,767,000) |
| 4260-601-7502 Demonstration DSH Fund | $148,011,000 | $97,710,000 | ($50,301,000) |
| 4260-601-7503 Health Care Support Fund | $324,393,000 | $113,067,000 | ($211,326,000) |
| 4260-611-0890 Hospital Quality Assurance | $10,457,811,000 | $7,768,515,000 | ($2,689,296,000) |
| **TOTAL MEDI-CAL Benefits** | **$65,041,863,000** | **$60,011,965,000** | **($5,029,898,000)** |
| **COUNTY ADMINISTRATION:** | | | |
| 4260-101-0890(1) | $3,572,251,000 | $3,366,994,000 | ($205,257,000) |
| 4260-106-0890(1) Money Follows Person Fed. Grant | $688,000 | $627,000 | ($61,000) |
| 4260-113-0890 Healthy Families | $19,783,000 | $6,807,000 | ($12,976,000) |
| 4260-117-0890 HIPAA | $8,873,000 | $10,092,000 | $1,219,000 |
| **TOTAL COUNTY ADMIN.** | **$3,601,595,000** | **$3,384,520,000** | **($217,075,000)** |
| **FISCAL INTERMEDIARY:** | | | |
| 4260-101-0890(2) | $252,964,000 | $271,975,000 | $19,011,000 |
| 4260-113-0890 Healthy Families | $4,115,000 | $4,388,000 | $273,000 |
| 4260-117-0890 HIPAA | $11,612,000 | $12,088,000 | $476,000 |
| **TOTAL FISCAL INTERMEDIARY** | **$268,691,000** | **$288,451,000** | **$19,760,000** |
| **GRAND TOTAL - FEDERAL FUNDS** | **$68,912,149,000** | **$63,684,936,000** | **($5,227,213,000)** |

## *Medi-Cal Funding Summary*

## *November 2017 Estimate Comparison of FY 2017-18 to FY 2018-19*

### TOTAL FUNDS

| | FY 2017-18 Estimate | FY 2018-19 Estimate | Difference Incr./(Decr.) |
|---|---|---|---|
| **MEDI-CAL Benefits:** | | | |
| 4260-101-0001/0890(3) | $68,253,118,000 | $74,544,924,000 | $6,291,806,000 |
| 4260-101-0080 CLPP Funds | $725,000 | $725,000 | $0 |
| 4260-101-0232 Prop 99 Hospital Srvc. Acct. | $103,682,000 | $75,580,000 | ($28,102,000) |
| 4260-101-0233 Prop 99 Physician Srvc. Acct | $33,320,000 | $21,732,000 | ($11,588,000) |
| 4260-101-0236 Prop 99 Unallocated Account | $45,958,000 | $29,922,000 | ($16,036,000) |
| 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 | $1,070,558,000 | $850,925,000 | ($219,633,000) |
| 4260-101-3311 Healthcare Srvc. Plans Fines and Penalties Fund | $46,633,000 | $0 | ($46,633,000) |
| 4260-102-0001/0890 Capital Debt | $75,527,000 | $82,166,000 | $6,639,000 |
| 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 | $11,772,000 | $6,379,000 | ($5,393,000) |
| 4260-113-0001/0890 Healthy Families | $2,389,722,000 | $3,062,477,000 | $672,755,000 |
| 4260-601-0942142 Local Trauma Centers | $61,798,000 | $64,207,000 | $2,409,000 |
| 4260-601-0942 Home Health Program Account | $0 | $1,338,000 | $1,338,000 |
| 4260-601-0995 Reimbursements | $3,611,335,000 | $1,583,407,000 | ($2,027,928,000) |
| 4260-601-3156 MCO Tax Fund | $329,324,000 | $0 | ($329,324,000) |
| 4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund | $885,500,000 | $760,000,000 | ($125,500,000) |
| 4260-601-3213 LTC QA Fund | $539,842,000 | $504,609,000 | ($35,233,000) |
| 4260-601-3293 MCO Tax Fund 2016 | $2,367,559,000 | $2,519,214,000 | $151,655,000 |
| 4260-601-7502 Demonstration DSH Fund | $97,710,000 | $127,794,000 | $30,084,000 |
| 4260-601-7503 Health Care Support Fund | $113,067,000 | $337,313,000 | $224,246,000 |
| 4260-601-8107 Whole Person Care Pilot Fund | $290,910,000 | $323,365,000 | $32,455,000 |
| 4260-601-8108 Global Payment Program Fund | $1,044,787,000 | $1,066,905,000 | $22,118,000 |
| 4260-601-8113 DPH GME Special Fund | $471,791,000 | $393,337,000 | ($78,454,000) |
| 4260-602-0309 Perinatal Insurance Fund | $14,140,000 | $19,553,000 | $5,413,000 |
| 4260-603-3311 Healthcare Plan Fines and Penalties Fund | $1,392,000 | $0 | ($1,392,000) |
| 4260-605-0001 SNF Quality & Accountability * | $48,928,000 | $48,928,000 | $0 |
| 4260-605-3167 SNF Quality & Accountability | $43,121,000 | $43,121,000 | $0 |
| 4260-698-3167 SNF Qual & Acct. (Less Funded by GF) | ($48,928,000) | ($48,928,000) | $0 |
| 4260-606-0834 SB 1100 DSH | $220,645,000 | $150,386,000 | ($70,259,000) |
| 4260-611-3158/0890 Hospital Quality Assurance | $12,802,754,000 | $10,089,555,000 | ($2,713,199,000) |
| 4260-611-3201 LIHP MCE Out-of-Network ER Svcs. | $0 | $0 | $0 |
| **TOTAL MEDI-CAL Benefit s** | **$95,163,437,000** | **$96,807,259,000** | **$1,643,822,000** |
| **COUNTY ADMINISTRATION:** | | | |
| 4260-101-0001/0890(1) | $4,383,047,000 | $4,296,401,000 | ($86,646,000) |
| 4260-106-0890(1) Money Follow Person Fed. Grant | $627,000 | $682,000 | $55,000 |
| 4260-113-0001/0890 Healthy Families | $19,547,000 | $57,964,000 | $38,417,000 |
| 4260-117-0001/0890 HIPPA | $12,275,000 | $9,268,000 | ($3,007,000) |
| 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 | $630,000 | $736,000 | $106,000 |
| 4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund | $1,419,000 | $0 | ($1,419,000) |
| 4260-605-3167 SNF Quality & Accountability Admin. | $3,907,000 | $3,907,000 | $0 |
| **TOTAL COUNTY ADMIN .** | **$4,427,490,000** | **$4,369,275,000** | **($58,215,000)** |
| **FISCAL INTERMEDIARY:** | | | |
| 4260-101-0001/0890(2) | $428,277,000 | $310,500,000 | ($117,777,000) |
| 4260-113-0001/0890 Healthy Families | $6,088,000 | $3,700,000 | ($2,388,000) |
| 4260-117-0001/0890 HIPAA | $14,827,000 | $13,923,000 | ($904,000) |
| 4260-601-0995 Reimbursements | $0 | $0 | $0 |
| **TOTAL FISCAL INTERMEDIAR Y** | **$449,192,000** | **$328,123,000** | **($121,069,000)** |
| **GRAND TOTAL - ALL FUND S** | **$100,040,119,000** | **$101,504,657,000** | **$1,464,538,000** |

Notes:
Proposition 99 funding is from the Cigarette and Tobacco Products Surtax Fund accounts as shown above.

## *Medi-Cal Funding Summary*

## *November 2017 Estimate Comparison of FY 2017-18 to FY 2018-19*

### STATE FUNDS

| | FY 2017-18 Estimate | FY 2018-19 Estimate | Difference Incr./(Decr.) |
|---|---|---|---|
| **MEDI-CAL Benefits:** | | | |
| 4260-101-0001(3) * | $18,226,737,000 | $19,233,014,000 | $1,006,277,000 |
| 4260-101-0080 CLPP Funds | $725,000 | $725,000 | $0 |
| 4260-101-0232 Prop 99 Hospital Srvc. Acct. | $103,682,000 | $75,580,000 | ($28,102,000) |
| 4260-101-0233 Prop 99 Physician Srvc. Acct | $33,320,000 | $21,732,000 | ($11,588,000) |
| 4260-101-0236 Prop 99 Unallocated Account | $45,958,000 | $29,922,000 | ($16,036,000) |
| 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 | $1,070,558,000 | $850,925,000 | ($219,633,000) |
| 4260-101-3311 Healthcare Srvc. Plans Fines and Penalties Fund | $46,633,000 | $0 | ($46,633,000) |
| 4260-102-0001 Capital Debt * | $37,764,000 | $41,398,000 | $3,634,000 |
| 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 * | $432,965,000 | $945,053,000 | $512,088,000 |
| 4260-601-0942142 Local Trauma Centers | $61,798,000 | $64,207,000 | $2,409,000 |
| 4260-601-0942 Home Health Program Account | $0 | $1,338,000 | $1,338,000 |
| 4260-601-0995 Reimbursements | $3,611,335,000 | $1,583,407,000 | ($2,027,928,000) |
| 4260-601-3156 MCO Tax Fund | $329,324,000 | $0 | ($329,324,000) |
| 4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund | $885,500,000 | $760,000,000 | ($125,500,000) |
| 4260-601-3213 LTC QA Fund | $539,842,000 | $504,609,000 | ($35,233,000) |
| 4260-601-3293 MCO Tax Fund 2016 | $2,367,559,000 | $2,519,214,000 | $151,655,000 |
| 4260-601-8107 Whole Person Care Pilot Fund | $290,910,000 | $323,365,000 | $32,455,000 |
| 4260-601-8108 Global Payment Program Fund | $1,044,787,000 | $1,066,905,000 | $22,118,000 |
| 4260-601-8113 DPH GME Special Fund | $471,791,000 | $393,337,000 | ($78,454,000) |
| 4260-602-0309 Perinatal Insurance Fund | $14,140,000 | $19,553,000 | $5,413,000 |
| 4260-603-3311 Healthcare Plan Fines and Penalties Fund | $1,392,000 | $0 | ($1,392,000) |
| 4260-605-0001 SNF Quality & Accountability * | $48,928,000 | $48,928,000 | $0 |
| 4260-605-3167 SNF Quality & Accountability | $43,121,000 | $43,121,000 | $0 |
| 4260-698-3167 SNF Qual & Acct. (Less Funded by GF) | ($48,928,000) | ($48,928,000) | $0 |
| 4260-606-0834 SB 1100 DSH | $220,645,000 | $150,386,000 | ($70,259,000) |
| 4260-611-3158 Hospital Quality Assurance Revenue | $5,034,239,000 | $4,379,951,000 | ($654,288,000) |
| 4260-611-3201 LIHP MCE Out-of-Network ER Svcs. | $0 | $0 | $0 |
| **TOTAL MEDI-CAL Benefits** | **$35,151,472,000** | **$33,156,067,000** | **($1,995,405,000)** |
| **Total Benefits General Fund *** | **$18,866,694,000** | **$20,388,693,000** | **$1,521,999,000** |
| **COUNTY ADMINISTRATION:** | | | |
| 4260-101-0001(1) * | $1,016,053,000 | $1,066,344,000 | $50,291,000 |
| 4260-113-0001 Healthy Families * | $12,740,000 | $15,549,000 | $2,809,000 |
| 4260-117-0001 HIPAA * | $2,183,000 | $1,660,000 | ($523,000) |
| 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 | $630,000 | $736,000 | $106,000 |
| 4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund | $1,419,000 | $0 | ($1,419,000) |
| 4260-605-3167 SNF Quality & Accountability Admin. | $3,907,000 | $3,907,000 | $0 |
| **TOTAL COUNTY ADMIN.** | **$1,042,970,000** | **$1,088,513,000** | **$45,543,000** |
| **Total Co. Admin. General Fund *** | **$1,030,976,000** | **$1,083,553,000** | **$52,577,000** |
| **FISCAL INTERMEDIARY:** | | | |
| 4260-101-0001(2) * | $156,302,000 | $113,008,000 | ($43,294,000) |
| 4260-113-0001 Healthy Families * | $1,700,000 | $1,295,000 | ($405,000) |
| 4260-117-0001 HIPAA * | $2,739,000 | $2,543,000 | ($196,000) |
| 4260-601-0995 Reimbursements | $0 | $0 | $0 |
| **TOTAL FISCAL INTERMEDIARY** | **$160,741,000** | **$116,846,000** | **($43,895,000)** |
| **Total FI General Fund *** | **$160,741,000** | **$116,846,000** | **($43,895,000)** |
| **GRAND TOTAL - STATE FUNDS** | **$36,355,183,000** | **$34,361,426,000** | **($1,993,757,000)** |
| **Grand Total General Fund *** | **$20,058,411,000** | **$21,589,092,000** | **$1,530,681,000** |

Notes:
Proposition 99 funding is from the Cigarette and Tobacco Products Surtax Fund accounts as shown above.

## *Medi-Cal Funding Summary*

## *November 2017 Estimate Comparison of FY 2017-18 to FY 2018-19*

### FEDERAL FUNDS

| | FY 2017-18 Estimate | FY 2018-19 Estimate | Difference Incr./(Decr.) |
|---|---|---|---|
| **MEDI-CAL Benefits:** | | | |
| 4260-101-0890(3) | $50,026,381,000 | $55,311,910,000 | $5,285,529,000 |
| 4260-102-0890 Capital Debt | $37,763,000 | $40,768,000 | $3,005,000 |
| 4260-106-0890 Money Follows Person Federal Grant | $11,772,000 | $6,379,000 | ($5,393,000) |
| 4260-113-0890 Health Families | $1,956,757,000 | $2,117,424,000 | $160,667,000 |
| 4260-601-7502 Demonstration DSH Fund | $97,710,000 | $127,794,000 | $30,084,000 |
| 4260-601-7503 Health Care Support Fund | $113,067,000 | $337,313,000 | $224,246,000 |
| 4260-611-0890 Hospital Quality Assurance | $7,768,515,000 | $5,709,604,000 | ($2,058,911,000) |
| **TOTAL MEDI-CAL Benefit s** | **$60,011,965,000** | **$63,651,192,000** | **$3,639,227,000** |
| **COUNTY ADMINISTRATION:** | | | |
| 4260-101-0890(1) | $3,366,994,000 | $3,230,057,000 | ($136,937,000) |
| 4260-106-0890(1) Money Follows Person Fed. Grant | $627,000 | $682,000 | $55,000 |
| 4260-113-0890 Healthy Families | $6,807,000 | $42,415,000 | $35,608,000 |
| 4260-117-0890 HIPAA | $10,092,000 | $7,608,000 | ($2,484,000) |
| **TOTAL COUNTY ADMIN.** | **$3,384,520,000** | **$3,280,762,000** | **($103,758,000)** |
| **FISCAL INTERMEDIARY:** | | | |
| 4260-101-0890(2) | $271,975,000 | $197,492,000 | ($74,483,000) |
| 4260-113-0890 Healthy Families | $4,388,000 | $2,405,000 | ($1,983,000) |
| 4260-117-0890 HIPAA | $12,088,000 | $11,380,000 | ($708,000) |
| **TOTAL FISCAL INTERMEDIAR Y** | **$288,451,000** | **$211,277,000** | **($77,174,000)** |
| **GRAND TOTAL - FEDERAL FUND S** | **$63,684,936,000** | **$67,143,231,000** | **$3,458,295,000** |

# 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 | $16,975,737,590 | $8,487,868,790 | $8,487,868,790 | $0 |
| B. C/Y BASE POLICY CHANGES | $46,913,552,700 | $32,032,751,740 | $14,055,121,960 | $825,679,000 |
| C. BASE ADJUSTMENTS | ($147,305,000) | ($183,649,360) | $36,344,360 | $0 |
| **D. ADJUSTED BASE** | **$63,741,985,290** | **$40,336,971,170** | **$22,579,335,120** | **$825,679,000** |
| **II. REGULAR POLICY CHANGES** | | | | |
| A. ELIGIBILITY | ($399,998,970) | ($1,350,790,710) | $944,666,740 | $6,125,000 |
| B. AFFORDABLE CARE ACT | $2,492,316,950 | $2,209,571,940 | $388,611,010 | ($105,866,000) |
| C. BENEFITS | $1,334,130,480 | $1,011,889,380 | $302,352,090 | $19,889,000 |
| D. PHARMACY | ($2,533,428,630) | ($2,045,741,420) | ($487,687,210) | $0 |
| E. DRUG MEDI-CAL | $375,864,990 | $299,593,570 | $76,271,430 | $0 |
| F. MENTAL HEALTH | $287,144,000 | $278,331,000 | $8,613,000 | $200,000 |
| G. WAIVER--MH/UCD & BTR | $4,931,350,000 | $2,515,730,000 | $99,261,000 | $2,316,359,000 |
| H. MANAGED CARE | $6,317,641,360 | $1,891,116,560 | ($591,047,200) | $5,017,572,000 |
| I. PROVIDER RATES | $767,020,640 | $940,682,810 | ($721,394,170) | $547,732,000 |
| J. SUPPLEMENTAL PMNTS. | $16,961,494,000 | $11,140,286,500 | $562,837,500 | $5,258,370,000 |
| K. OTHER | $887,915,560 | $2,784,323,670 | ($4,295,126,110) | $2,398,718,000 |
| **L. TOTAL CHANGES** | **$31,421,450,370** | **$19,674,993,290** | **($3,712,641,920)** | **$15,459,099,000** |
| **III. TOTAL MEDI-CAL ESTIMATE** | **$95,163,435,660** | **$60,011,964,460** | **$18,866,693,190** | **$16,284,778,000** |

# 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 | $108,677,000 | $108,677,000 | $0 | $0 |
| 2 | BREAST AND CERVICAL CANCER TREATMENT | $67,765,000 | $31,133,400 | $36,631,600 | $0 |
| 3 | MEDI-CAL COUNTY INMATE PROGRAMS | $52,316,000 | $44,148,700 | $8,167,300 | $0 |
| 7 | STATE-ONLY BCCTP COVERAGE EXTENSION | $606,290 | $0 | $606,290 | $0 |
| 8 | MEDI-CAL COUNTY INMATE REIMBURSEMENT | $0 | $0 | ($6,125,000) | $6,125,000 |
| 9 | NON-OTLICP CHIP | $0 | $116,863,440 | ($116,863,440) | $0 |
| 10 | NON-EMERGENCY FUNDING ADJUSTMENT | $0 | ($900,963,000) | $900,963,000 | $0 |
| 11 | SCHIP FUNDING FOR PRENATAL CARE | $0 | $67,868,240 | ($67,868,240) | $0 |
| 12 | CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN | $0 | ($14,732,000) | $14,732,000 | $0 |
| 13 | PARIS-VETERANS | ($8,220,360) | ($4,110,180) | ($4,110,180) | $0 |
| 14 | OTLICP PREMIUMS | ($65,731,000) | ($57,843,280) | ($7,887,720) | $0 |
| 15 | MINIMUM WAGE INCREASE - CASELOAD SAVINGS | ($137,086,900) | ($108,523,450) | ($28,563,450) | $0 |
| 16 | MEC OPTIONAL EXPANSION ADJUSTMENT | ($418,325,000) | ($633,309,580) | $214,984,580 | $0 |
| | **ELIGIBILITY SUBTOTAL** | **($399,998,970)** | **($1,350,790,710)** | **$944,666,740** | **$6,125,000** |
| | **AFFORDABLE CARE ACT** | | | | |
| 17 | COMMUNITY FIRST CHOICE OPTION | $2,591,402,000 | $2,591,402,000 | $0 | $0 |
| 18 | HEALTH INSURER FEE | $483,599,000 | $319,848,050 | $163,750,950 | $0 |
| 19 | HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS | $18,210,000 | $18,210,000 | $0 | $0 |
| 20 | PAYMENTS TO PRIMARY CARE PHYSICIANS | $5,339,950 | $5,339,950 | $0 | $0 |
| 21 | HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST. | $0 | $32,229,850 | ($32,229,850) | $0 |
| 22 | 1% FMAP INCREASE FOR PREVENTIVE SERVICES | $0 | $1,055,000 | ($1,055,000) | $0 |
| 23 | ACA MAGI SAVINGS | $0 | $0 | $0 | $0 |
| 24 | TITLE XXI FEDERAL MATCH REDUCTION | ($114,127,000) | ($414,697,910) | $295,162,910 | $5,408,000 |
| 25 | ACA OPTIONAL EXPANSION MLR RISK CORRIDOR | ($176,600,000) | ($176,600,000) | $0 | $0 |
| 26 | ACA DSH REDUCTION | ($315,507,000) | ($167,215,000) | ($37,018,000) | ($111,274,000) |
| | **AFFORDABLE CARE ACT SUBTOTAL** | **$2,492,316,950** | **$2,209,571,940** | **$388,611,010** | **($105,866,000)** |
| | **BENEFITS** | | | | |
| 27 | BEHAVIORAL HEALTH TREATMENT | $402,206,000 | $226,247,600 | $175,958,400 | $0 |
| 28 | FAMILY PACT PROGRAM | $338,916,000 | $257,317,300 | $81,598,700 | $0 |
| 29 | ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS | $321,681,000 | $321,681,000 | $0 | $0 |
| 30 | LOCAL EDUCATION AGENCY (LEA) PROVIDERS | $120,851,000 | $115,638,000 | $5,213,000 | $0 |
| 31 | CCS DEMONSTRATION PROJECT | $40,718,000 | $22,329,680 | $18,388,320 | $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** | | | | |
| 32 | MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA | $39,778,000 | $19,889,000 | $0 | $19,889,000 |
| 33 | ANNUAL CONTRACEPTIVE COVERAGE | $28,303,590 | $21,919,700 | $6,383,880 | $0 |
| 34 | CALIFORNIA COMMUNITY TRANSITIONS COSTS | $12,953,000 | $10,854,000 | $2,099,000 | $0 |
| 35 | DENTAL TRANSFORMATION INITIATIVE UTILIZATION | $9,601,000 | $4,800,500 | $4,800,500 | $0 |
| 36 | FULL RESTORATION OF ADULT DENTAL BENEFITS | $8,473,000 | $4,236,500 | $4,236,500 | $0 |
| 37 | DENTAL BENEFICIARY OUTREACH EFFORTS | $4,314,000 | $2,157,000 | $2,157,000 | $0 |
| 38 | YOUTH REGIONAL TREATMENT CENTERS | $3,233,000 | $3,258,000 | ($25,000) | $0 |
| 39 | PEDIATRIC PALLIATIVE CARE WAIVER | $1,312,010 | $711,620 | $600,390 | $0 |
| 40 | MEDICALLY TAILORED MEALS PILOT PROGRAM | $1,000,000 | $0 | $1,000,000 | $0 |
| 41 | CCT FUND TRANSFER TO CDSS AND CDDS | $918,000 | $918,000 | $0 | $0 |
| 42 | END OF LIFE SERVICES | $65,060 | $0 | $65,060 | $0 |
| 43 | SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER | $53,000 | $53,000 | $0 | $0 |
| 44 | BEHAVIORAL HEALTH TREATMENT - BIS DDS TRANSITION | $911,000 | $512,500 | $398,500 | $0 |
| 46 | PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS | ($1,156,180) | ($634,020) | ($522,160) | $0 |
| | **BENEFITS SUBTOTAL** | **$1,334,130,480** | **$1,011,889,380** | **$302,352,100** | **$19,889,000** |
| | **PHARMACY** | | | | |
| 47 | NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS | $38,629,370 | $21,185,970 | $17,443,400 | $0 |
| 48 | DRUG REBATES PRIOR YEAR FUNDING ADJUSTMENT | ($60,286,000) | ($316,889,830) | $256,603,830 | $0 |
| 50 | LITIGATION SETTLEMENTS | ($2,526,000) | $0 | ($2,526,000) | $0 |
| 51 | BCCTP DRUG REBATES | ($9,172,000) | ($6,287,300) | ($2,884,700) | $0 |
| 52 | FAMILY PACT DRUG REBATES | ($17,503,000) | ($15,326,000) | ($2,177,000) | $0 |
| 53 | MEDICAL SUPPLY REBATES | ($24,916,000) | ($12,458,000) | ($12,458,000) | $0 |
| 54 | STATE SUPPLEMENTAL DRUG REBATES | ($202,948,000) | ($140,164,720) | ($62,783,280) | $0 |
| 55 | FEDERAL DRUG REBATES | ($2,254,707,000) | ($1,529,297,540) | ($725,409,460) | $0 |
| 210 | DRUG REBATES - RETROACTIVE ACA ADJUSTMENTS | $0 | ($46,504,000) | $46,504,000 | $0 |
| | **PHARMACY SUBTOTAL** | **($2,533,428,630)** | **($2,045,741,420)** | **($487,687,210)** | **$0** |
| | **DRUG MEDI-CAL** | | | | |
| 56 | DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER | $372,865,000 | $296,693,570 | $76,171,430 | $0 |
| 61 | DRUG MEDI-CAL PROGRAM COST SETTLEMENT | $3,000,000 | $2,900,000 | $100,000 | $0 |
| | **DRUG MEDI-CAL SUBTOTAL** | **$375,865,000** | **$299,593,570** | **$76,271,430** | **$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 |
|---|---|---|---|---|---|
| | **MENTAL HEALTH** | | | | |
| 65 | SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT | $266,121,000 | $266,121,000 | $0 | $0 |
| 66 | PATHWAYS TO WELL-BEING | $12,982,000 | $12,982,000 | $0 | $0 |
| 67 | MHP COSTS FOR CONTINUUM OF CARE REFORM | $12,305,000 | $5,383,000 | $6,922,000 | $0 |
| 68 | TRANSITIONAL SMHS CLAIMS | $1,510,000 | $0 | $1,510,000 | $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 | ($1,806,000) | ($1,806,000) | $0 | $0 |
| 72 | INTERIM AND FINAL COST SETTLEMENTS - SMHS | ($3,972,000) | ($4,349,000) | $377,000 | $0 |
| | **MENTAL HEALTH SUBTOTAL** | **$287,144,000** | **$278,331,000** | **$8,613,000** | **$200,000** |
| | **WAIVER--MH/UCD & BTR** | | | | |
| 73 | GLOBAL PAYMENT PROGRAM | $2,279,899,000 | $1,139,950,000 | $0 | $1,139,949,000 |
| 74 | PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL | $1,771,000,000 | $885,500,000 | $0 | $885,500,000 |
| 75 | MEDI-CAL 2020 WHOLE PERSON CARE PILOTS | $581,821,000 | $290,911,000 | $0 | $290,910,000 |
| 76 | MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE | $106,752,000 | $53,376,000 | $53,376,000 | $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 | $1,263,000 | $1,263,000 | $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 |
| 84 | CMS DEFERRED CLAIMS | $0 | ($71,690,000) | $71,690,000 | $0 |
| 86 | MH/UCD—SAFETY NET CARE POOL | ($6,723,000) | ($6,723,000) | $0 | $0 |
| | **WAIVER--MH/UCD & BTR SUBTOTAL** | **$4,931,350,000** | **$2,515,730,000** | **$99,261,000** | **$2,316,359,000** |
| | **MANAGED CARE** | | | | |
| 90 | MANAGED CARE RATE RANGE IGTS | $3,553,667,000 | $2,237,319,000 | $0 | $1,316,348,000 |
| 91 | CCI-MANAGED CARE PAYMENTS | $4,612,430,360 | $2,306,215,180 | $2,306,215,180 | $0 |
| 92 | MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES | $2,131,735,000 | $1,521,422,610 | $610,312,390 | $0 |
| 93 | MANAGED CARE PUBLIC HOSPITAL IGTS | $1,717,598,000 | $1,388,340,000 | $0 | $329,258,000 |
| 96 | HQAF RATE RANGE INCREASES | $265,300,000 | $132,650,000 | $0 | $132,650,000 |
| 99 | MCO TAX MGD. CARE PLANS - INCR. CAP. RATES | $22,018,000 | $11,197,000 | $10,821,000 | $0 |
| 101 | CCI-QUALITY WITHHOLD REPAYMENTS | $2,946,000 | $1,473,000 | $1,473,000 | $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 |
|---|---|---|---|---|---|
| | **MANAGED CARE** | | | | |
| 103 | PALLIATIVE CARE SERVICES IMPLEMENTATION | $2,046,000 | $1,084,410 | $961,590 | $0 |
| 109 | MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT | $0 | $0 | ($13,988,000) | $13,988,000 |
| 110 | MCO TAX MANAGED CARE PLANS | $0 | $0 | ($414,743,000) | $414,743,000 |
| 111 | MANAGED CARE IGT ADMIN. & PROCESSING FEE | $0 | $0 | ($267,419,000) | $267,419,000 |
| 112 | GENERAL FUND REIMBURSEMENTS FROM DPHS | $0 | $0 | ($160,090,000) | $160,090,000 |
| 113 | MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND | $0 | $0 | ($15,517,000) | $15,517,000 |
| 114 | MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ. | $0 | $0 | ($585,365,000) | $585,365,000 |
| 115 | MCO ENROLLMENT TAX MANAGED CARE PLANS | $0 | $0 | ($1,782,194,000) | $1,782,194,000 |
| 116 | MANAGED CARE DRUG REBATES | ($1,889,663,000) | ($1,273,125,640) | ($616,537,360) | $0 |
| 117 | RETRO MC RATE ADJUSTMENTS | ($4,100,436,000) | ($4,435,459,000) | $335,023,000 | $0 |
| | **MANAGED CARE SUBTOTAL** | **$6,317,641,360** | **$1,891,116,560** | **($591,047,200)** | **$5,017,572,000** |
| | **PROVIDER RATES** | | | | |
| 118 | DPH INTERIM & FINAL RECONS | $215,065,000 | $215,065,000 | $0 | $0 |
| 119 | DENTAL RETROACTIVE RATE CHANGES | $186,708,000 | $113,333,260 | $73,374,740 | $0 |
| 120 | FQHC/RHC/CBRC RECONCILIATION PROCESS | $204,677,000 | $127,552,200 | $77,124,800 | $0 |
| 121 | AB 1629 ANNUAL RATE ADJUSTMENTS | $69,444,240 | $34,722,120 | $34,722,120 | $0 |
| 122 | RATE INCREASE FOR FQHCS/RHCS/CBRCS | $84,044,300 | $52,375,640 | $31,668,660 | $0 |
| 123 | LTC RATE ADJUSTMENT | $9,726,930 | $4,863,460 | $4,863,460 | $0 |
| 124 | DPH INTERIM RATE GROWTH | $20,964,600 | $10,482,300 | $10,482,300 | $0 |
| 125 | HOSPICE RATE INCREASES | $4,377,320 | $2,188,660 | $2,188,660 | $0 |
| 126 | GDSP NEWBORN SCREENING PROGRAM FEE INCREASE | $17,699,740 | $8,849,870 | $8,849,870 | $0 |
| 127 | EMERGENCY MEDICAL AIR TRANSPORTATION ACT | $10,868,000 | $5,434,000 | ($2,456,000) | $7,890,000 |
| 128 | GDSP PRENATAL SCREENING FEE INCREASE | $4,088,320 | $2,044,160 | $2,044,160 | $0 |
| 129 | ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE | $425,520 | $774,990 | ($349,470) | $0 |
| 130 | ALTERNATIVE BIRTHING CENTER REIMBURSEMENT | $44,930 | $22,470 | $22,470 | $0 |
| 131 | DP/NF-B RETROACTIVE RECOUPMENT FORGIVENESS | $0 | ($744,000) | $744,000 | $0 |
| 133 | LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES | $0 | $0 | ($539,842,000) | $539,842,000 |
| 134 | DPH INTERIM RATE | $0 | $394,275,310 | ($394,275,310) | $0 |
| 135 | LABORATORY RATE METHODOLOGY CHANGE | ($17,457,320) | ($8,728,660) | ($8,728,660) | $0 |
| 136 | REDUCTION TO RADIOLOGY RATES | ($20,250,050) | ($10,125,020) | ($10,125,020) | $0 |
| 137 | 10% PROVIDER PAYMENT REDUCTION | ($23,405,880) | ($11,702,940) | ($11,702,940) | $0 |
| | **PROVIDER RATES SUBTOTAL** | **$767,020,640** | **$940,682,810** | **($721,394,170)** | **$547,732,000** |

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 |
|---|---|---|---|---|---|
| | **SUPPLEMENTAL PMNTS.** | | | | |
| 138 | HOSPITAL QAF - MANAGED CARE PAYMENTS | $6,869,242,000 | $4,946,594,000 | $0 | $1,922,648,000 |
| 139 | HOSPITAL QAF - FFS PAYMENTS | $4,865,095,000 | $2,684,255,000 | $0 | $2,180,840,000 |
| 140 | GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS | $1,207,941,000 | $766,349,000 | $0 | $441,592,000 |
| 141 | PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS | $746,051,000 | $516,295,000 | $0 | $229,756,000 |
| 142 | PRIVATE HOSPITAL DSH REPLACEMENT | $569,419,000 | $284,709,500 | $284,709,500 | $0 |
| 143 | HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS | $433,217,000 | $433,217,000 | $0 | $0 |
| 144 | DSH PAYMENT | $469,970,000 | $293,302,000 | $13,102,000 | $163,566,000 |
| 145 | PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT | $324,086,000 | $196,536,000 | $118,400,000 | $9,150,000 |
| 146 | NDPH IGT SUPPLEMENTAL PAYMENTS | $233,467,000 | $168,466,000 | ($8,190,000) | $73,191,000 |
| 147 | SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES | $223,809,000 | $144,990,000 | $0 | $78,819,000 |
| 148 | WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS | $158,347,000 | $115,739,000 | $0 | $42,608,000 |
| 149 | DPH PHYSICIAN & NON-PHYS. COST | $155,563,000 | $155,563,000 | $0 | $0 |
| 150 | CAPITAL PROJECT DEBT REIMBURSEMENT | $153,994,000 | $116,230,000 | $37,764,000 | $0 |
| 151 | FFP FOR LOCAL TRAUMA CENTERS | $147,634,000 | $85,836,000 | $0 | $61,798,000 |
| 152 | MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS | $137,213,000 | $87,213,000 | $0 | $50,000,000 |
| 153 | QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS | $86,242,000 | $43,121,000 | $48,928,000 | ($5,807,000) |
| 154 | GEMT SUPPLEMENTAL PAYMENT PROGRAM | $70,105,000 | $70,105,000 | $0 | $0 |
| 155 | CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS | $57,392,000 | $57,392,000 | $0 | $0 |
| 156 | ICF/DD SUPPLEMENTAL PAYMENTS | $13,257,000 | $7,785,000 | $0 | $5,472,000 |
| 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 | $5,902,000 | $3,902,000 | $0 | $2,000,000 |
| 160 | AIDS WAIVER SUPPLEMENTAL PAYMENTS | $5,474,000 | $2,737,000 | $0 | $2,737,000 |
| 161 | NDPH SUPPLEMENTAL PAYMENT | $5,410,000 | $3,510,000 | $1,900,000 | $0 |
| 162 | STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS | $4,664,000 | $4,664,000 | $0 | $0 |
| 164 | DP-NF CAPITAL PROJECT DEBT REPAYMENT | $0 | ($57,224,000) | $57,224,000 | $0 |
| | **SUPPLEMENTAL PMNTS. SUBTOTAL** | **$16,961,494,000** | **$11,140,286,500** | **$562,837,500** | **$5,258,370,000** |
| | **OTHER** | | | | |
| 170 | CCI IHSS RECONCILIATION | $339,270,000 | $339,270,000 | $0 | $0 |
| 171 | ARRA HITECH - PROVIDER PAYMENTS | $319,499,000 | $319,499,000 | $0 | $0 |
| 174 | ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS | $117,532,000 | $117,532,000 | $0 | $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** | | | | |
| 178 | INFANT DEVELOPMENT PROGRAM | $42,024,000 | $42,024,000 | $0 | $0 |
| 179 | ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS | $19,472,000 | $10,960,000 | $8,512,000 | $0 |
| 180 | MINIMUM WAGE INCREASE FOR HCBS WAIVERS | $16,823,860 | $8,411,930 | $8,411,930 | $0 |
| 181 | AUDIT SETTLEMENTS | $13,928,000 | $0 | $13,928,000 | $0 |
| 182 | OVERTIME FOR WPCS PROVIDERS | $9,934,000 | $4,967,000 | $4,967,000 | $0 |
| 184 | INDIAN HEALTH SERVICES | $4,104,000 | $25,995,000 | ($21,891,000) | $0 |
| 185 | MEDI-CAL ESTATE RECOVERIES | $3,041,000 | $1,520,500 | $1,520,500 | $0 |
| 186 | WPCS WORKERS' COMPENSATION | $3,026,000 | $1,513,000 | $1,513,000 | $0 |
| 190 | CDDS DENTAL SERVICES | $549,000 | $0 | $0 | $549,000 |
| 191 | FUNDING ADJUST.—OTLICP | $132,000 | $179,525,440 | ($179,393,440) | $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 | ($1,305,870,000) | $1,305,870,000 |
| 196 | HOSPITAL QAF - CHILDREN'S HEALTH CARE | $0 | $0 | ($851,825,000) | $851,825,000 |
| 197 | FUNDING ADJUST.—ACA OPT. EXPANSION | $0 | $1,756,837,450 | ($1,756,837,450) | $0 |
| 198 | COUNTY SHARE OF OTLICP-CCS COSTS | $0 | $0 | ($8,764,000) | $8,764,000 |
| 199 | IMD ANCILLARY SERVICES | $0 | ($23,022,000) | $23,022,000 | $0 |
| 200 | CIGARETTE AND TOBACCO SURTAX FUNDS | $0 | $0 | ($182,960,000) | $182,960,000 |
| 201 | INTEGRATION OF THE SF CLSB INTO THE ALW | ($1,501,910) | ($750,960) | ($750,960) | $0 |
| 202 | MEDI-CAL RECOVERIES SETTLEMENTS AND LEGAL COSTS | ($1,666,160) | ($833,080) | ($833,080) | $0 |
| 211 | ASSISSTED LIVING WAIVER EXPANSION | ($8,680) | ($4,340) | ($4,340) | $0 |
| 212 | HOME & COMMUNITY-BASED ALTERNATIVES WAIVER RENEWAL | $1,757,460 | $878,730 | $878,730 | $0 |
| | **OTHER SUBTOTAL** | **$887,915,560** | **$2,784,323,670** | **($4,295,126,110)** | **$2,398,718,000** |
| | **GRAND TOTAL** | **$31,421,450,380** | **$19,674,993,300** | **($3,712,641,920)** | **$15,459,099,000** |

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** | $7,002,470,410 | $4,354,919,710 | $1,799,277,840 | $848,272,850 |
| PHYSICIANS | $879,824,970 | $579,495,860 | $264,667,410 | $35,661,700 |
| OTHER MEDICAL | $4,091,818,520 | $2,440,542,590 | $1,498,810,060 | $152,465,870 |
| CO. & COMM. OUTPATIENT | $2,030,826,920 | $1,334,881,270 | $35,800,380 | $660,145,280 |
| **PHARMACY** | $1,089,324,180 | $216,164,260 | $831,532,170 | $41,627,740 |
| **HOSPITAL INPATIENT** | $14,493,631,550 | $8,986,267,260 | $1,755,505,490 | $3,751,858,810 |
| COUNTY INPATIENT | $3,398,608,970 | $2,150,646,330 | $28,280,900 | $1,219,681,740 |
| COMMUNITY INPATIENT | $11,095,022,590 | $6,835,620,930 | $1,727,224,590 | $2,532,177,070 |
| **LONG TERM CARE** | $3,073,758,440 | $1,547,920,980 | $1,404,166,020 | $121,671,440 |
| NURSING FACILITIES | $2,649,232,140 | $1,334,390,460 | $1,216,317,260 | $98,524,420 |
| ICF-DD | $424,526,300 | $213,530,520 | $187,848,760 | $23,147,020 |
| **OTHER SERVICES** | $1,118,144,920 | $669,365,270 | $402,481,140 | $46,298,510 |
| MEDICAL TRANSPORTATION | $146,746,480 | $112,821,280 | $25,424,110 | $8,501,090 |
| OTHER SERVICES | $750,174,980 | $443,940,240 | $270,237,750 | $35,996,990 |
| HOME HEALTH | $221,223,470 | $112,603,750 | $106,819,290 | $1,800,430 |
| **TOTAL FEE-FOR-SERVICE** | **$26,777,329,500** | **$15,774,637,490** | **$6,192,962,660** | **$4,809,729,350** |
| **MANAGED CARE** | $48,871,268,880 | $30,191,692,630 | $8,446,412,650 | $10,233,163,600 |
| TWO PLAN MODEL | $30,490,560,630 | $18,820,007,250 | $5,192,913,280 | $6,477,640,100 |
| COUNTY ORGANIZED HEALTH SYSTEMS | $10,717,645,120 | $6,668,740,700 | $1,753,550,520 | $2,295,353,900 |
| GEOGRAPHIC MANAGED CARE | $5,091,575,920 | $3,144,258,540 | $900,321,340 | $1,046,996,040 |
| PHP & OTHER MANAG. CARE | $1,083,938,930 | $617,981,820 | $331,936,940 | $134,020,170 |
| REGIONAL MODEL | $1,487,548,280 | $940,704,320 | $267,690,570 | $279,153,380 |
| **DENTAL** | $1,581,030,040 | $973,442,890 | $493,121,000 | $114,466,150 |
| **MENTAL HEALTH** | $3,016,627,380 | $2,869,044,190 | ($32,699,120) | $180,282,320 |
| **AUDITS/ LAWSUITS** | $50,113,780 | ($52,382,990) | $102,496,770 | $0 |
| **EPSDT SCREENS** | $29,840,690 | $15,757,030 | $13,358,660 | $725,000 |
| **MEDICARE PAYMENTS** | $5,362,487,000 | $1,519,030,000 | $3,843,457,000 | $0 |
| **STATE HOSP./DEVELOPMENTAL CNTRS.** | $207,330,000 | $207,330,000 | $0 | $0 |
| **MISC. SERVICES** | $9,054,686,410 | $8,212,818,390 | ($104,543,560) | $946,411,580 |
| **RECOVERIES** | ($370,434,160) | ($197,349,580) | ($173,084,580) | $0 |
| **DRUG MEDI-CAL** | $583,156,130 | $497,944,420 | $85,211,720 | $0 |
| **GRAND TOTAL MEDI-CAL** | **$95,163,435,660** | **$60,011,964,460** | **$18,866,693,190** | **$16,284,778,000** |

# MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
# NOVEMBER 2017 ESTIMATE COMPARED TO APPROPRIATION
# FISCAL YEAR 2017-18

| SERVICE CATEGORY | 2017-18 APPROPRIATION | NOV. 2017 EST. FOR 2017-18 | DOLLAR DIFFERENCE | % CHANGE |
|---|---|---|---|---|
| **PROFESSIONAL** | $7,756,093,620 | $7,002,470,410 | ($753,623,210) | -9.72% |
| PHYSICIANS | $1,627,897,640 | $879,824,970 | ($748,072,670) | -45.95% |
| OTHER MEDICAL | $4,132,945,240 | $4,091,818,520 | ($41,126,730) | -1.00% |
| CO. & COMM. OUTPATIENT | $1,995,250,730 | $2,030,826,920 | $35,576,190 | 1.78% |
| **PHARMACY** | $1,381,520,530 | $1,089,324,180 | ($292,196,360) | -21.15% |
| **HOSPITAL INPATIENT** | $15,045,885,270 | $14,493,631,550 | ($552,253,710) | -3.67% |
| COUNTY INPATIENT | $1,579,926,680 | $3,398,608,970 | $1,818,682,280 | 115.11% |
| COMMUNITY INPATIENT | $13,465,958,580 | $11,095,022,590 | ($2,370,936,000) | -17.61% |
| **LONG TERM CARE** | $3,381,932,100 | $3,073,758,440 | ($308,173,660) | -9.11% |
| NURSING FACILITIES | $2,920,489,220 | $2,649,232,140 | ($271,257,080) | -9.29% |
| ICF-DD | $461,442,890 | $424,526,300 | ($36,916,580) | -8.00% |
| **OTHER SERVICES** | $1,313,174,820 | $1,118,144,920 | ($195,029,900) | -14.85% |
| MEDICAL TRANSPORTATION | $153,675,280 | $146,746,480 | ($6,928,810) | -4.51% |
| OTHER SERVICES | $939,176,090 | $750,174,980 | ($189,001,110) | -20.12% |
| HOME HEALTH | $220,323,450 | $221,223,470 | $900,020 | 0.41% |
| **TOTAL FEE-FOR-SERVICE** | **$28,878,606,340** | **$26,777,329,500** | **($2,101,276,840)** | **-7.28%** |
| **MANAGED CARE** | $54,006,785,840 | $48,871,268,880 | ($5,135,516,950) | -9.51% |
| TWO PLAN MODEL | $34,465,412,840 | $30,490,560,630 | ($3,974,852,210) | -11.53% |
| COUNTY ORGANIZED HEALTH SYSTEMS | $11,612,574,690 | $10,717,645,120 | ($894,929,570) | -7.71% |
| GEOGRAPHIC MANAGED CARE | $5,417,679,970 | $5,091,575,920 | ($326,104,050) | -6.02% |
| PHP & OTHER MANAG. CARE | $935,840,410 | $1,083,938,930 | $148,098,530 | 15.83% |
| REGIONAL MODEL | $1,575,277,940 | $1,487,548,280 | ($87,729,660) | -5.57% |
| **DENTAL** | $1,655,439,050 | $1,581,030,040 | ($74,409,010) | -4.49% |
| **MENTAL HEALTH** | $2,862,222,770 | $3,016,627,380 | $154,404,610 | 5.39% |
| **AUDITS/ LAWSUITS** | $15,925,040 | $50,113,780 | $34,188,740 | 214.69% |
| **EPSDT SCREENS** | $40,351,300 | $29,840,690 | ($10,510,610) | -26.05% |
| **MEDICARE PAYMENTS** | $5,229,331,000 | $5,362,487,000 | $133,156,000 | 2.55% |
| **STATE HOSP./DEVELOPMENTAL CNTRS.** | $207,330,000 | $207,330,000 | $0 | 0.00% |
| **MISC. SERVICES** | $8,879,518,630 | $9,054,686,410 | $175,167,780 | 1.97% |
| **RECOVERIES** | ($301,486,000) | ($370,434,160) | ($68,948,160) | 22.87% |
| **DRUG MEDI-CAL** | $787,064,800 | $583,156,130 | ($203,908,660) | -25.91% |
| **GRAND TOTAL MEDI-CAL** | **$102,261,088,760** | **$95,163,435,660** | **($7,097,653,110)** | **-6.94%** |
| **GENERAL FUNDS** | **$18,399,657,770** | **$18,866,693,190** | **$467,035,420** | **2.54%** |
| **OTHER STATE FUNDS** | **$18,819,568,500** | **$16,284,778,000** | **($2,534,790,500)** | **-13.47%** |

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

| MAY NO. | NOV. NO. | POLICY CHANGE TITLE | 2017-18 APPROPRIATION | | NOV. 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|---|
| | | | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | | **ELIGIBILITY** | | | | | | |
| 3 | 1 | MEDI-CAL STATE INMATE PROGRAMS | $117,057,000 | $0 | $108,677,000 | $0 | ($8,380,000) | $0 |
| 5 | 2 | BREAST AND CERVICAL CANCER TREATMENT | $69,000,000 | $36,800,000 | $67,765,000 | $36,631,600 | ($1,235,000) | ($168,400) |
| 6 | 3 | MEDI-CAL COUNTY INMATE PROGRAMS | $301,867,000 | $37,477,550 | $52,316,000 | $8,167,300 | ($249,551,000) | ($29,310,250) |
| 9 | 7 | STATE-ONLY BCCTP COVERAGE EXTENSION | $1,696,000 | $1,696,000 | $1,686,000 | $1,686,000 | ($10,000) | ($10,000) |
| 219 | 8 | MEDI-CAL COUNTY INMATE REIMBURSEMENT | $0 | ($37,456,000) | $0 | ($6,125,000) | $0 | $31,331,000 |
| 10 | 9 | NON-OTLICP CHIP | $401,000,000 | ($78,752,490) | $0 | ($116,863,440) | ($401,000,000) | ($38,110,950) |
| 11 | 10 | NON-EMERGENCY FUNDING ADJUSTMENT | $0 | $899,150,000 | $0 | $900,963,000 | $0 | $1,813,000 |
| 12 | 11 | SCHIP FUNDING FOR PRENATAL CARE | $0 | ($68,261,600) | $0 | ($67,868,240) | $0 | $393,360 |
| -- | 12 | CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN | $0 | $0 | $0 | $14,732,000 | $0 | $14,732,000 |
| 14 | 13 | PARIS-VETERANS | ($24,361,990) | ($16,671,840) | ($19,600,290) | ($9,800,150) | $4,761,690 | $6,871,700 |
| 16 | 14 | OTLICP PREMIUMS | ($66,749,000) | ($8,009,880) | ($65,731,000) | ($7,887,720) | $1,018,000 | $122,160 |
| 15 | 15 | MINIMUM WAGE INCREASE - CASELOAD SAVINGS | ($144,192,000) | ($29,866,020) | ($141,385,000) | ($29,459,000) | $2,807,000 | $407,020 |
| 221 | 16 | MEC OPTIONAL EXPANSION ADJUSTMENT | ($515,297,000) | $225,870,970 | ($418,325,000) | $214,984,580 | $96,972,000 | ($10,886,390) |
| | | **ELIGIBILITY SUBTOTAL** | **$140,020,010** | **$961,976,690** | **($414,597,290)** | **$939,160,930** | **($554,617,310)** | **($22,815,750)** |
| | | **AFFORDABLE CARE ACT** | | | | | | |
| 17 | 17 | COMMUNITY FIRST CHOICE OPTION | $2,535,500,000 | $0 | $2,591,402,000 | $0 | $55,902,000 | $0 |
| 19 | 18 | HEALTH INSURER FEE | $502,274,000 | $169,642,060 | $483,599,000 | $163,750,950 | ($18,675,000) | ($5,891,110) |
| 20 | 19 | HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS | $19,463,000 | $0 | $18,210,000 | $0 | ($1,253,000) | $0 |
| 22 | 20 | PAYMENTS TO PRIMARY CARE PHYSICIANS | $2,000,000 | $0 | $5,500,000 | $0 | $3,500,000 | $0 |
| 25 | 21 | HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST. | $0 | ($36,365,640) | $0 | ($32,229,850) | $0 | $4,135,790 |
| 23 | 22 | 1% FMAP INCREASE FOR PREVENTIVE SERVICES | $0 | ($2,026,000) | $0 | ($1,055,000) | $0 | $971,000 |

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

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

| MAY NO. | NOV. NO. | POLICY CHANGE TITLE | 2017-18 APPROPRIATION | | NOV. 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|---|
| | | | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | | **AFFORDABLE CARE ACT** | | | | | | |
| 26 | 23 | ACA MAGI SAVINGS | $0 | $0 | $0 | $0 | $0 | $0 |
| 209 | 24 | TITLE XXI FEDERAL MATCH REDUCTION | ($112,361,000) | $392,156,330 | ($114,127,000) | $295,162,910 | ($1,766,000) | ($96,993,420) |
| -- | 25 | ACA OPTIONAL EXPANSION MLR RISK CORRIDOR | $0 | $0 | ($176,600,000) | $0 | ($176,600,000) | $0 |
| 28 | 26 | ACA DSH REDUCTION | ($137,873,000) | ($16,177,000) | ($315,507,000) | ($37,018,000) | ($177,634,000) | ($20,841,000) |
| | | **AFFORDABLE CARE ACT SUBTOTAL** | **$2,809,003,000** | **$507,229,750** | **$2,492,477,000** | **$388,611,010** | **($316,526,000)** | **($118,618,740)** |
| | | **BENEFITS** | | | | | | |
| 29 | 27 | BEHAVIORAL HEALTH TREATMENT | $213,817,000 | $93,398,740 | $402,206,000 | $175,958,400 | $188,389,000 | $82,559,660 |
| 1 | 28 | FAMILY PACT PROGRAM | $310,264,000 | $74,627,800 | $338,916,000 | $81,598,700 | $28,652,000 | $6,970,900 |
| 30 | 29 | ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS | $245,649,000 | $0 | $321,681,000 | $0 | $76,032,000 | $0 |
| 32 | 30 | LOCAL EDUCATION AGENCY (LEA) PROVIDERS | $131,106,000 | $0 | $120,851,000 | $5,213,000 | ($10,255,000) | $5,213,000 |
| 34 | 31 | CCS DEMONSTRATION PROJECT | $36,847,000 | $16,772,780 | $40,718,000 | $18,388,320 | $3,871,000 | $1,615,540 |
| 33 | 32 | MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA | $39,778,000 | $0 | $39,778,000 | $0 | $0 | $0 |
| 208 | 33 | ANNUAL CONTRACEPTIVE COVERAGE | $36,371,230 | $8,203,280 | $35,637,860 | $8,038,130 | ($733,370) | ($165,150) |
| 35 | 34 | CALIFORNIA COMMUNITY TRANSITIONS COSTS | $19,680,000 | $2,642,000 | $12,953,000 | $2,099,000 | ($6,727,000) | ($543,000) |
| 42 | 35 | DENTAL TRANSFORMATION INITIATIVE UTILIZATION | $6,490,000 | $3,245,000 | $9,601,000 | $4,800,500 | $3,111,000 | $1,555,500 |
| 231 | 36 | FULL RESTORATION OF ADULT DENTAL BENEFITS | $69,458,000 | $34,729,000 | $8,473,000 | $4,236,500 | ($60,985,000) | ($30,492,500) |
| -- | 37 | DENTAL BENEFICIARY OUTREACH EFFORTS | $0 | $0 | $4,314,000 | $2,157,000 | $4,314,000 | $2,157,000 |
| 38 | 38 | YOUTH REGIONAL TREATMENT CENTERS | $5,825,000 | $29,000 | $3,233,000 | ($25,000) | ($2,592,000) | ($54,000) |
| 39 | 39 | PEDIATRIC PALLIATIVE CARE WAIVER | $4,415,140 | $2,062,140 | $2,884,800 | $1,320,110 | ($1,530,340) | ($742,030) |
| 234 | 40 | MEDICALLY TAILORED MEALS PILOT PROGRAM | $2,000,000 | $2,000,000 | $1,000,000 | $1,000,000 | ($1,000,000) | ($1,000,000) |

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

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

| MAY NO. | NOV. NO. | POLICY CHANGE TITLE | 2017-18 APPROPRIATION | | NOV. 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|---|
| | | | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | | **BENEFITS** | | | | | | |
| 41 | 41 | CCT FUND TRANSFER TO CDSS AND CDDS | $2,458,000 | $0 | $918,000 | $0 | ($1,540,000) | $0 |
| 43 | 42 | END OF LIFE SERVICES | $659,980 | $659,980 | $139,230 | $139,230 | ($520,750) | ($520,750) |
| 48 | 43 | SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER | $56,000 | $0 | $53,000 | $0 | ($3,000) | $0 |
| 229 | 44 | BEHAVIORAL HEALTH TREATMENT - BIS DDS TRANSITION | $11,163,000 | $4,912,000 | $911,000 | $398,500 | ($10,252,000) | ($4,513,500) |
| 51 | 46 | PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS | ($4,305,000) | ($1,945,400) | ($1,156,180) | ($522,160) | $3,148,820 | $1,423,240 |
| 31 | -- | BEHAVIORAL HEALTH TREATMENT - DDS TRANSITION | $101,325,000 | $44,260,260 | $0 | $0 | ($101,325,000) | ($44,260,260) |
| 36 | -- | IMPLEMENT AAP BRIGHT FUTURES PERIODICITY FOR EPSDT | $16,372,000 | $7,837,540 | $0 | $0 | ($16,372,000) | ($7,837,540) |
| 40 | -- | DENTAL CHILDREN'S OUTREACH AGES 0-3 | $5,724,000 | $2,862,000 | $0 | $0 | ($5,724,000) | ($2,862,000) |
| 44 | -- | DENTAL BENEFICIARY OUTREACH AND EDUCATION PROGRAM | $725,000 | $362,500 | $0 | $0 | ($725,000) | ($362,500) |
| 45 | -- | MEDICAL MANAGEMENT AND TREATMENT FOR ALD | $440,000 | $198,720 | $0 | $0 | ($440,000) | ($198,720) |
| 46 | -- | ALLIED DENTAL PROFESSIONALS ENROLLMENT | $763,000 | $381,500 | $0 | $0 | ($763,000) | ($381,500) |
| 52 | -- | SRP PRIOR AUTH. & PREVENTIVE DENTAL SERVICES | ($3,201,000) | ($1,600,500) | $0 | $0 | $3,201,000 | $1,600,500 |
| 53 | -- | WOMEN'S HEALTH SERVICES | ($7,932,000) | ($1,787,500) | $0 | $0 | $7,932,000 | $1,787,500 |
| | | **BENEFITS SUBTOTAL** | **$1,245,948,360** | **$293,850,840** | **$1,343,111,720** | **$304,800,240** | **$97,163,360** | **$10,949,390** |
| | | **PHARMACY** | | | | | | |
| 55 | 47 | NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS | $84,331,350 | $38,530,210 | $38,796,190 | $17,518,730 | ($45,535,160) | ($21,011,480) |
| -- | 48 | DRUG REBATES PRIOR YEAR FUNDING ADJUSTMENT | $0 | $0 | ($60,286,000) | $256,603,830 | ($60,286,000) | $256,603,830 |
| -- | 50 | LITIGATION SETTLEMENTS | $0 | $0 | ($2,526,000) | ($2,526,000) | ($2,526,000) | ($2,526,000) |
| 57 | 51 | BCCTP DRUG REBATES | ($11,263,000) | ($3,545,150) | ($9,172,000) | ($2,884,700) | $2,091,000 | $660,450 |
| 58 | 52 | FAMILY PACT DRUG REBATES | ($17,183,000) | ($2,132,400) | ($17,503,000) | ($2,177,000) | ($320,000) | ($44,600) |

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

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

| MAY NO. | NOV. NO. | POLICY CHANGE TITLE | 2017-18 APPROPRIATION | | NOV. 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|---|
| | | | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | | **PHARMACY** | | | | | | |
| 59 | 53 | MEDICAL SUPPLY REBATES | ($24,916,000) | ($12,458,000) | ($24,916,000) | ($12,458,000) | $0 | $0 |
| 61 | 54 | STATE SUPPLEMENTAL DRUG REBATES | ($192,285,000) | ($65,423,790) | ($202,948,000) | ($62,783,280) | ($10,663,000) | $2,640,510 |
| 62 | 55 | FEDERAL DRUG REBATES | ($2,139,644,000) | ($712,018,900) | ($2,254,707,000) | ($725,409,460) | ($115,063,000) | ($13,390,560) |
| -- | 210 | DRUG REBATES - RETROACTIVE ACA ADJUSTMENTS | $0 | $0 | $0 | $46,504,000 | $0 | $46,504,000 |
| 56 | -- | NON FFP DRUGS | $0 | $69,500 | $0 | $0 | $0 | ($69,500) |
| | | **PHARMACY SUBTOTAL** | **($2,300,959,650)** | **($756,978,530)** | **($2,533,261,810)** | **($487,611,880)** | **($232,302,160)** | **$269,366,650** |
| | | **DRUG MEDI-CAL** | | | | | | |
| 64 | 56 | DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER | $580,548,000 | $124,364,740 | $372,865,000 | $76,171,430 | ($207,683,000) | ($48,193,310) |
| -- | 61 | DRUG MEDI-CAL PROGRAM COST SETTLEMENT | $0 | $0 | $3,000,000 | $100,000 | $3,000,000 | $100,000 |
| 69 | -- | DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT | $14,189,000 | $536,900 | $0 | $0 | ($14,189,000) | ($536,900) |
| | | **DRUG MEDI-CAL SUBTOTAL** | **$594,737,000** | **$124,901,640** | **$375,865,000** | **$76,271,430** | **($218,872,000)** | **($48,630,210)** |
| | | **MENTAL HEALTH** | | | | | | |
| 72 | 65 | SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT | $253,505,000 | $0 | $266,121,000 | $0 | $12,616,000 | $0 |
| 74 | 66 | PATHWAYS TO WELL-BEING | $17,201,000 | $0 | $12,982,000 | $0 | ($4,219,000) | $0 |
| 73 | 67 | MHP COSTS FOR CONTINUUM OF CARE REFORM | $23,308,000 | $12,423,500 | $12,305,000 | $6,922,000 | ($11,003,000) | ($5,501,500) |
| 217 | 68 | TRANSITIONAL SMHS CLAIMS | $1,472,000 | $1,472,000 | $1,510,000 | $1,510,000 | $38,000 | $38,000 |
| 75 | 69 | LATE CLAIMS FOR SMHS | $4,000 | $4,000 | $4,000 | $4,000 | $0 | $0 |
| 76 | 70 | SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT | $0 | ($200,000) | $0 | ($200,000) | $0 | $0 |
| 78 | 71 | CHART REVIEW | ($1,485,000) | $0 | ($1,806,000) | $0 | ($321,000) | $0 |
| 79 | 72 | INTERIM AND FINAL COST SETTLEMENTS - SMHS | $20,758,000 | $21,146,000 | ($3,972,000) | $377,000 | ($24,730,000) | ($20,769,000) |
| | | **MENTAL HEALTH SUBTOTAL** | **$314,763,000** | **$34,845,500** | **$287,144,000** | **$8,613,000** | **($27,619,000)** | **($26,232,500)** |

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

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

| MAY NO. | NOV. NO. | POLICY CHANGE TITLE | 2017-18 APPROPRIATION | | NOV. 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|---|
| | | | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | | **WAIVER--MH/UCD & BTR** | | | | | | |
| 81 | 73 | GLOBAL PAYMENT PROGRAM | $2,388,446,000 | $0 | $2,279,899,000 | $0 | ($108,547,000) | $0 |
| 80 | 74 | PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL | $1,600,000,000 | $0 | $1,771,000,000 | $0 | $171,000,000 | $0 |
| 82 | 75 | MEDI-CAL 2020 WHOLE PERSON CARE PILOTS | $720,000,000 | $0 | $581,821,000 | $0 | ($138,179,000) | $0 |
| 86 | 76 | MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE | $141,905,000 | $70,952,500 | $106,752,000 | $53,376,000 | ($35,153,000) | ($17,576,500) |
| 83 | 77 | BTR - LIHP - MCE | $198,363,000 | $0 | $104,616,000 | $0 | ($93,747,000) | $0 |
| 88 | 78 | MH/UCD—STABILIZATION FUNDING | $55,400,000 | $55,400,000 | $55,400,000 | $55,400,000 | $0 | $0 |
| 85 | 79 | BTR - LOW INCOME HEALTH PROGRAM - HCCI | $231,547,000 | $0 | $36,060,000 | $0 | ($195,487,000) | $0 |
| 92 | 80 | UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG | $1,060,000 | $0 | $1,263,000 | $0 | $203,000 | $0 |
| 87 | 81 | MH/UCD—HEALTH CARE COVERAGE INITIATIVE | $23,509,000 | $0 | $1,262,000 | $0 | ($22,247,000) | $0 |
| -- | 82 | MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP | $0 | $0 | $0 | ($6,205,000) | $0 | ($6,205,000) |
| 95 | 83 | MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM | $0 | ($75,000,000) | $0 | ($75,000,000) | $0 | $0 |
| 222 | 84 | CMS DEFERRED CLAIMS | $0 | $12,378,000 | $0 | $71,690,000 | $0 | $59,312,000 |
| 89 | 86 | MH/UCD—SAFETY NET CARE POOL | ($6,723,000) | $0 | ($6,723,000) | $0 | $0 | $0 |
| 84 | -- | LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND | $232,500,000 | $0 | $0 | $0 | ($232,500,000) | $0 |
| | | **WAIVER--MH/UCD & BTR SUBTOTAL** | **$5,586,007,000** | **$63,730,500** | **$4,931,350,000** | **$99,261,000** | **($654,657,000)** | **$35,530,500** |
| | | **MANAGED CARE** | | | | | | |
| 103 | 90 | MANAGED CARE RATE RANGE IGTS | $3,143,888,000 | $0 | $3,553,667,000 | $0 | $409,779,000 | $0 |
| 98 | 91 | CCI-MANAGED CARE PAYMENTS | $9,936,539,000 | $4,968,269,500 | $9,981,455,000 | $4,990,727,500 | $44,916,000 | $22,458,000 |
| 101 | 92 | MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES | $2,131,736,000 | $612,223,010 | $2,131,735,000 | $610,312,390 | ($1,000) | ($1,910,620) |
| 100 | 93 | MANAGED CARE PUBLIC HOSPITAL IGTS | $2,880,095,000 | $0 | $1,717,598,000 | $0 | ($1,162,497,000) | $0 |

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

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

| MAY NO. | NOV. NO. | POLICY CHANGE TITLE | 2017-18 APPROPRIATION | | NOV. 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|---|
| | | | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | | **MANAGED CARE** | | | | | | |
| 105 | 96 | HQAF RATE RANGE INCREASES | $232,000,000 | $0 | $265,300,000 | $0 | $33,300,000 | $0 |
| 122 | 99 | MCO TAX MGD. CARE PLANS - INCR. CAP. RATES | $21,304,000 | $10,464,000 | $22,018,000 | $10,821,000 | $714,000 | $357,000 |
| 220 | 101 | CCI-QUALITY WITHHOLD REPAYMENTS | $9,000,000 | $4,500,000 | $2,946,000 | $1,473,000 | ($6,054,000) | ($3,027,000) |
| 111 | 103 | PALLIATIVE CARE SERVICES IMPLEMENTATION | $2,977,000 | $1,334,530 | $2,046,000 | $961,590 | ($931,000) | ($372,940) |
| 116 | 109 | MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT | $0 | ($13,631,000) | $0 | ($13,988,000) | $0 | ($357,000) |
| 117 | 110 | MCO TAX MANAGED CARE PLANS | $0 | ($414,386,000) | $0 | ($414,743,000) | $0 | ($357,000) |
| 118 | 111 | MANAGED CARE IGT ADMIN. & PROCESSING FEE | $0 | ($275,965,000) | $0 | ($267,419,000) | $0 | $8,546,000 |
| 119 | 112 | GENERAL FUND REIMBURSEMENTS FROM DPHS | $0 | ($253,242,000) | $0 | ($160,090,000) | $0 | $93,152,000 |
| -- | 113 | MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND | $0 | $0 | $0 | ($15,517,000) | $0 | ($15,517,000) |
| 114 | 114 | MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ. | $0 | ($612,223,000) | $0 | ($585,365,000) | $0 | $26,858,000 |
| 115 | 115 | MCO ENROLLMENT TAX MANAGED CARE PLANS | $0 | ($1,780,284,000) | $0 | ($1,782,194,000) | $0 | ($1,910,000) |
| 123 | 116 | MANAGED CARE DRUG REBATES | ($1,066,751,000) | ($345,951,190) | ($1,889,663,000) | ($616,537,360) | ($822,912,000) | ($270,586,170) |
| 124 | 117 | RETRO MC RATE ADJUSTMENTS | ($4,048,269,000) | $191,374,000 | ($4,100,436,000) | $335,023,000 | ($52,167,000) | $143,649,000 |
| 112 | -- | CAPITATED RATE ADJUSTMENT FOR FY 2017-18 | $0 | $0 | $0 | $0 | $0 | $0 |
| 120 | -- | CENCAL HEALTH PLAN-ADDITION OF CHDP | ($3,329,000) | ($1,664,500) | $0 | $0 | $3,329,000 | $1,664,500 |
| 225 | -- | MEDI-CAL NONMEDICAL TRANSPORTATION | $6,000,000 | $1,725,530 | $0 | $0 | ($6,000,000) | ($1,725,530) |
| | | **MANAGED CARE SUBTOTAL** | **$13,245,190,000** | **$2,092,543,880** | **$11,686,666,000** | **$2,093,465,120** | **($1,558,524,000)** | **$921,240** |
| | | **PROVIDER RATES** | | | | | | |
| 130 | 118 | DPH INTERIM & FINAL RECONS | $137,004,000 | $0 | $215,065,000 | $0 | $78,061,000 | $0 |
| 126 | 119 | DENTAL RETROACTIVE RATE CHANGES | $23,693,000 | $9,095,270 | $186,708,000 | $73,374,740 | $163,015,000 | $64,279,470 |

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

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

| MAY NO. | NOV. NO. | POLICY CHANGE TITLE | 2017-18 APPROPRIATION | | NOV. 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|---|
| | | | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | | **PROVIDER RATES** | | | | | | |
| 127 | 120 | FQHC/RHC/CBRC RECONCILIATION PROCESS | $199,430,150 | $75,718,460 | $204,677,000 | $77,124,800 | $5,246,850 | $1,406,340 |
| 128 | 121 | AB 1629 ANNUAL RATE ADJUSTMENTS | $174,846,170 | $87,423,090 | $142,595,970 | $71,297,980 | ($32,250,210) | ($16,125,100) |
| 133 | 122 | RATE INCREASE FOR FQHCS/RHCS/CBRCS | $51,405,790 | $19,517,480 | $152,974,700 | $57,642,270 | $101,568,910 | $38,124,790 |
| 132 | 123 | LTC RATE ADJUSTMENT | $31,718,000 | $15,859,000 | $26,296,090 | $13,148,050 | ($5,421,900) | ($2,710,950) |
| 131 | 124 | DPH INTERIM RATE GROWTH | $37,920,420 | $18,960,210 | $20,964,600 | $10,482,300 | ($16,955,820) | ($8,477,910) |
| 135 | 125 | HOSPICE RATE INCREASES | $21,480,520 | $10,740,260 | $4,441,270 | $2,220,640 | ($17,039,250) | ($8,519,630) |
| 137 | 126 | GDSP NEWBORN SCREENING PROGRAM FEE INCREASE | $19,464,620 | $9,732,310 | $19,493,110 | $9,746,560 | $28,490 | $14,240 |
| 134 | 127 | EMERGENCY MEDICAL AIR TRANSPORTATION ACT | $11,000,000 | ($2,390,000) | $10,868,000 | ($2,456,000) | ($132,000) | ($66,000) |
| 138 | 128 | GDSP PRENATAL SCREENING FEE INCREASE | $4,088,310 | $2,044,150 | $4,088,320 | $2,044,160 | $20 | $10 |
| 139 | 129 | ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE | $1,551,580 | ($1,247,260) | $425,520 | ($349,470) | ($1,126,060) | $897,790 |
| 140 | 130 | ALTERNATIVE BIRTHING CENTER REIMBURSEMENT | $44,390 | $22,190 | $44,930 | $22,470 | $550 | $270 |
| -- | 131 | DP/NF-B RETROACTIVE RECOUPMENT FORGIVENESS | $0 | $0 | $0 | $744,000 | $0 | $744,000 |
| 143 | 133 | LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES | $0 | ($482,975,000) | $0 | ($539,842,000) | $0 | ($56,867,000) |
| 142 | 134 | DPH INTERIM RATE | $0 | ($391,438,740) | $0 | ($394,275,310) | $0 | ($2,836,570) |
| 144 | 135 | LABORATORY RATE METHODOLOGY CHANGE | ($23,980,830) | ($11,990,410) | ($20,994,980) | ($10,497,490) | $2,985,850 | $1,492,930 |
| 145 | 136 | REDUCTION TO RADIOLOGY RATES | ($22,711,270) | ($11,355,630) | ($20,250,050) | ($10,125,020) | $2,461,220 | $1,230,610 |
| 146 | 137 | 10% PROVIDER PAYMENT REDUCTION | ($205,136,000) | ($102,568,000) | ($203,884,000) | ($101,942,000) | $1,252,000 | $626,000 |
| 125 | -- | MEDICARE PART B ADJUSTMENT | ($160,682,000) | ($88,557,500) | $0 | $0 | $160,682,000 | $88,557,500 |
| 136 | -- | DISCONTINUE PHARMACY RATE REDUCTIONS | $22,531,850 | $11,265,920 | $0 | $0 | ($22,531,850) | ($11,265,920) |
| | | **PROVIDER RATES SUBTOTAL** | **$323,668,690** | **($832,144,210)** | **$743,513,490** | **($741,639,330)** | **$419,844,800** | **$90,504,870** |

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

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

| MAY NO. | NOV. NO. | POLICY CHANGE TITLE | 2017-18 APPROPRIATION | | NOV. 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|---|
| | | | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | | **SUPPLEMENTAL PMNTS.** | | | | | | |
| 147 | 138 | HOSPITAL QAF - MANAGED CARE PAYMENTS | $15,569,513,000 | $0 | $6,869,242,000 | $0 | ($8,700,271,000) | $0 |
| 157 | 139 | HOSPITAL QAF - FFS PAYMENTS | $100,398,000 | $0 | $4,865,095,000 | $0 | $4,764,697,000 | $0 |
| 215 | 140 | GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS | $1,187,500,000 | $0 | $1,207,941,000 | $0 | $20,441,000 | $0 |
| 236 | 141 | PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS | $650,000,000 | $0 | $746,051,000 | $0 | $96,051,000 | $0 |
| 148 | 142 | PRIVATE HOSPITAL DSH REPLACEMENT | $573,382,000 | $286,691,000 | $569,419,000 | $284,709,500 | ($3,963,000) | ($1,981,500) |
| 153 | 143 | HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS | $415,351,000 | $0 | $433,217,000 | $0 | $17,866,000 | $0 |
| 149 | 144 | DSH PAYMENT | $444,414,000 | $17,000,000 | $469,970,000 | $13,102,000 | $25,556,000 | ($3,898,000) |
| 150 | 145 | PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT | $300,261,000 | $118,400,000 | $324,086,000 | $118,400,000 | $23,825,000 | $0 |
| 151 | 146 | NDPH IGT SUPPLEMENTAL PAYMENTS | $184,924,000 | ($2,441,000) | $233,467,000 | ($8,190,000) | $48,543,000 | ($5,749,000) |
| 237 | 147 | SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES | $280,000,000 | $0 | $223,809,000 | $0 | ($56,191,000) | $0 |
| 232 | 148 | WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS | $167,000,000 | $0 | $158,347,000 | $0 | ($8,653,000) | $0 |
| 156 | 149 | DPH PHYSICIAN & NON-PHYS. COST | $154,861,000 | $0 | $155,563,000 | $0 | $702,000 | $0 |
| 154 | 150 | CAPITAL PROJECT DEBT REIMBURSEMENT | $186,120,000 | $82,810,000 | $153,994,000 | $37,764,000 | ($32,126,000) | ($45,046,000) |
| 155 | 151 | FFP FOR LOCAL TRAUMA CENTERS | $106,601,000 | $0 | $147,634,000 | $0 | $41,033,000 | $0 |
| 152 | 152 | MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS | $125,117,000 | $2,520,000 | $137,213,000 | $0 | $12,096,000 | ($2,520,000) |
| 129 | 153 | QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS | $86,243,000 | $48,928,000 | $86,242,000 | $48,928,000 | ($1,000) | $0 |
| 159 | 154 | GEMT SUPPLEMENTAL PAYMENT PROGRAM | $76,800,000 | $0 | $70,105,000 | $0 | ($6,695,000) | $0 |
| 158 | 155 | CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS | $73,762,000 | $0 | $57,392,000 | $0 | ($16,370,000) | $0 |
| 233 | 156 | ICF/DD SUPPLEMENTAL PAYMENTS | $54,000,000 | $0 | $13,257,000 | $0 | ($40,743,000) | $0 |
| 160 | 157 | MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH | $10,000,000 | $5,000,000 | $10,000,000 | $5,000,000 | $0 | $0 |

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

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

| MAY NO. | NOV. NO. | POLICY CHANGE TITLE | 2017-18 APPROPRIATION | | NOV. 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|---|
| | | | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | | **SUPPLEMENTAL PMNTS.** | | | | | | |
| 161 | 158 | MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH | $8,000,000 | $4,000,000 | $8,000,000 | $4,000,000 | $0 | $0 |
| 163 | 159 | IGT PAYMENTS FOR HOSPITAL SERVICES | $5,613,000 | $0 | $5,902,000 | $0 | $289,000 | $0 |
| 238 | 160 | AIDS WAIVER SUPPLEMENTAL PAYMENTS | $8,000,000 | $0 | $5,474,000 | $0 | ($2,526,000) | $0 |
| 164 | 161 | NDPH SUPPLEMENTAL PAYMENT | $4,950,000 | $1,900,000 | $5,410,000 | $1,900,000 | $460,000 | $0 |
| 162 | 162 | STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS | $4,631,000 | $0 | $4,664,000 | $0 | $33,000 | $0 |
| 214 | 164 | DP-NF CAPITAL PROJECT DEBT REPAYMENT | $0 | $57,224,000 | $0 | $57,224,000 | $0 | $0 |
| 165 | -- | FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS | $465,948,000 | $0 | $0 | $0 | ($465,948,000) | $0 |
| | | **SUPPLEMENTAL PMNTS. SUBTOTAL** | **$21,243,389,000** | **$622,032,000** | **$16,961,494,000** | **$562,837,500** | **($4,281,895,000)** | **($59,194,500)** |
| | | **OTHER** | | | | | | |
| -- | 170 | CCI IHSS RECONCILIATION | $0 | $0 | $339,270,000 | $0 | $339,270,000 | $0 |
| 174 | 171 | ARRA HITECH - PROVIDER PAYMENTS | $175,130,000 | $0 | $319,499,000 | $0 | $144,369,000 | $0 |
| 176 | 174 | ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS | $110,533,000 | $0 | $117,532,000 | $0 | $6,999,000 | $0 |
| 166 | 178 | INFANT DEVELOPMENT PROGRAM | $26,305,000 | $0 | $42,024,000 | $0 | $15,719,000 | $0 |
| 180 | 179 | ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS | $19,921,000 | $8,339,000 | $19,472,000 | $8,512,000 | ($449,000) | $173,000 |
| 183 | 180 | MINIMUM WAGE INCREASE FOR HCBS WAIVERS | $15,297,260 | $7,648,630 | $16,823,860 | $8,411,930 | $1,526,590 | $763,300 |
| 205 | 181 | AUDIT SETTLEMENTS | $13,928,000 | $13,928,000 | $13,928,000 | $13,928,000 | $0 | $0 |
| 181 | 182 | OVERTIME FOR WPCS PROVIDERS | $14,686,000 | $7,343,000 | $9,934,000 | $4,967,000 | ($4,752,000) | ($2,376,000) |
| 185 | 184 | INDIAN HEALTH SERVICES | $6,239,000 | ($20,795,000) | $4,104,000 | ($21,891,000) | ($2,135,000) | ($1,096,000) |
| 182 | 185 | MEDI-CAL ESTATE RECOVERIES | $64,707,000 | $32,353,500 | $3,041,000 | $1,520,500 | ($61,666,000) | ($30,833,000) |
| 184 | 186 | WPCS WORKERS' COMPENSATION | $3,019,000 | $1,509,500 | $3,026,000 | $1,513,000 | $7,000 | $3,500 |
| 189 | 190 | CDDS DENTAL SERVICES | $984,000 | $0 | $549,000 | $0 | ($435,000) | $0 |

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

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

| MAY NO. | NOV. NO. | POLICY CHANGE TITLE | 2017-18 APPROPRIATION | | NOV. 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|---|
| | | | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | | **OTHER** | | | | | | |
| 194 | 191 | FUNDING ADJUST.—OTLICP | $154,000 | ($176,826,160) | $132,000 | ($179,393,440) | ($22,000) | ($2,567,280) |
| 212 | 193 | HEALTH CARE SVCS. PLANS FINES AND PENALTIES FUND | $0 | ($46,633,000) | $0 | ($48,025,000) | $0 | ($1,392,000) |
| 196 | 194 | CLPP FUND | $0 | ($725,000) | $0 | ($725,000) | $0 | $0 |
| 197 | 195 | CCI-TRANSFER OF IHSS COSTS TO DHCS | $0 | ($1,247,758,000) | $0 | ($1,305,870,000) | $0 | ($58,112,000) |
| 198 | 196 | HOSPITAL QAF - CHILDREN'S HEALTH CARE | $0 | ($1,020,525,000) | $0 | ($851,825,000) | $0 | $168,700,000 |
| 193 | 197 | FUNDING ADJUST.—ACA OPT. EXPANSION | $0 | ($1,764,846,210) | $0 | ($1,756,837,450) | $0 | $8,008,760 |
| 192 | 198 | COUNTY SHARE OF OTLICP-CCS COSTS | $0 | ($8,217,000) | $0 | ($8,764,000) | $0 | ($547,000) |
| 77 | 199 | IMD ANCILLARY SERVICES | $0 | $29,565,000 | $0 | $23,022,000 | $0 | ($6,543,000) |
| 199 | 200 | CIGARETTE AND TOBACCO SURTAX FUNDS | $0 | ($208,524,000) | $0 | ($182,960,000) | $0 | $25,564,000 |
| 206 | 201 | INTEGRATION OF THE SF CLSB INTO THE ALW | ($746,330) | ($373,170) | ($1,501,910) | ($750,960) | ($755,580) | ($377,790) |
| 224 | 202 | MEDI-CAL RECOVERIES SETTLEMENTS AND LEGAL COSTS | ($1,730,000) | ($865,000) | ($1,730,000) | ($865,000) | $0 | $0 |
| -- | 211 | ASSISSTED LIVING WAIVER EXPANSION | $0 | $0 | ($8,680) | ($4,340) | ($8,680) | ($4,340) |
| 190 | 212 | HOME & COMMUNITY-BASED ALTERNATIVES WAIVER RENEWAL | $6,749,700 | $3,374,850 | $1,757,460 | $878,730 | ($4,992,240) | ($2,496,120) |
| 200 | -- | MEDI-CAL RECOVERIES FIFTY PERCENT RULE | ($12,160,000) | ($12,160,000) | $0 | $0 | $12,160,000 | $12,160,000 |
| 201 | -- | MEDICARE BUY-IN QUALITY REVIEW PROJECT RECOVERIES | ($2,000,000) | ($1,000,000) | $0 | $0 | $2,000,000 | $1,000,000 |
| 210 | -- | CCI-FFS SAVINGS FOR ADDITIONAL ENROLLMENT | ($332,853,000) | ($166,426,500) | $0 | $0 | $332,853,000 | $166,426,500 |
| | | **OTHER SUBTOTAL** | **$108,163,630** | **($4,571,612,560)** | **$887,851,720** | **($4,295,158,030)** | **$779,688,090** | **$276,454,520** |
| | | **GRAND TOTAL** | **$43,309,930,040** | **($1,459,624,490)** | **$36,761,613,820** | **($1,051,389,020)** | **($6,548,316,220)** | **$408,235,470** |

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

# FISCAL YEAR 2017-18 COST PER ELIGIBLE BASED ON NOVEMBER 2017 ESTIMATE

| SERVICE CATEGORY | PA-OAS | NEWLY | PA-ATD | PA-AFDC | LT-OAS | H-PE |
|---|---|---|---|---|---|---|
| PHYSICIANS | $9,192,110 | $127,140,380 | $80,224,430 | $36,207,030 | $2,580,870 | $41,384,100 |
| OTHER MEDICAL | $66,699,280 | $1,004,924,410 | $387,095,210 | $315,315,610 | $5,768,440 | $40,179,280 |
| CO. & COMM. OUTPATIENT | $4,619,630 | $130,426,070 | $108,818,150 | $28,880,090 | $740,260 | $45,231,060 |
| PHARMACY | $3,331,360 | $343,754,210 | $437,294,220 | $45,581,720 | $2,207,980 | $20,088,870 |
| COUNTY INPATIENT | $4,781,290 | $497,258,150 | $38,259,820 | $25,457,610 | $2,034,120 | $54,715,030 |
| COMMUNITY INPATIENT | $66,666,960 | $1,243,451,340 | $688,412,810 | $294,256,100 | $19,688,210 | $206,433,000 |
| NURSING FACILITIES | $178,034,910 | $129,452,500 | $481,973,060 | $4,826,560 | $1,102,064,140 | $1,140,000 |
| ICF-DD | $1,209,550 | $4,732,670 | $180,796,850 | $617,590 | $44,558,930 | $0 |
| MEDICAL TRANSPORTATION | $4,685,460 | $13,755,160 | $15,710,920 | $2,295,880 | $2,683,810 | $2,326,690 |
| OTHER SERVICES | $78,565,070 | $26,706,840 | $286,336,530 | $35,833,720 | $48,334,450 | $1,287,770 |
| HOME HEALTH | $1,548,290 | $1,259,030 | $127,839,520 | $5,042,280 | $34,060 | $119,860 |
| **FFS SUBTOTAL** | **$419,333,910** | **$3,522,860,760** | **$2,832,761,520** | **$794,314,170** | **$1,230,695,260** | **$412,905,660** |
| DENTAL | $44,663,400 | $387,082,800 | $119,102,400 | $148,878,000 | $14,887,800 | $0 |
| MENTAL HEALTH | $8,991,350 | $269,141,530 | $1,022,422,300 | $717,110,810 | $735,030 | $0 |
| TWO PLAN MODEL | $1,353,543,720 | $9,451,241,030 | $6,447,591,230 | $1,289,321,230 | $0 | $0 |
| COUNTY ORGANIZED HEALTH SYSTEMS | $305,571,930 | $3,501,974,440 | $1,394,100,660 | $274,226,990 | $749,384,580 | $0 |
| GEOGRAPHIC MANAGED CARE | $194,170,320 | $1,716,787,890 | $1,091,772,410 | $199,509,310 | $0 | $0 |
| PHP & OTHER MANAG. CARE | $232,070,380 | $32,851,780 | $150,042,510 | $22,041,920 | $9,903,840 | $0 |
| EPSDT SCREENS | $0 | $0 | $0 | $5,091,860 | $0 | $0 |
| MEDICARE PAYMENTS | $1,722,913,970 | $0 | $1,622,377,920 | $3,062,560 | $164,778,600 | $0 |
| STATE HOSP./DEVELOPMENTAL CNTRS. | $11,534,150 | $0 | $25,998,000 | $32,714,390 | $1,118,080 | $0 |
| MISC. SERVICES | $550,394,370 | $0 | $4,810,396,450 | $6,158,620 | $0 | $0 |
| DRUG MEDI-CAL | $18,829,380 | $167,165,640 | $42,473,790 | $55,656,480 | $1,825,360 | $0 |
| REGIONAL MODEL | $10,499,270 | $568,044,310 | $288,504,610 | $59,664,060 | $0 | $0 |
| **NON-FFS SUBTOTAL** | **$4,453,182,240** | **$16,094,289,430** | **$17,014,782,270** | **$2,813,436,230** | **$942,633,290** | **$0** |
| **TOTAL DOLLARS (1)** | **$4,872,516,150** | **$19,617,150,190** | **$19,847,543,790** | **$3,607,750,410** | **$2,173,328,560** | **$412,905,660** |
| **ELIGIBLES ***** | **437,400** | **3,863,100** | **985,900** | **1,240,600** | **42,400** | **29,600** |
| **ANNUAL $/ELIGIBLE** | **$11,140** | **$5,078** | **$20,131** | **$2,908** | **$51,258** | **$13,950** |
| **AVG. MO. $/ELIGIBLE** | **$928** | **$423** | **$1,678** | **$242** | **$4,271** | **$1,162** |

(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 NOVEMBER 2017 ESTIMATE

| SERVICE CATEGORY | LT-ATD | POV 250 | MN-OAS | MN-ATD | MN-AFDC | MI-C |
|---|---|---|---|---|---|---|
| PHYSICIANS | $2,351,050 | $17,698,930 | $22,210,580 | $8,905,080 | $131,583,710 | $17,059,950 |
| OTHER MEDICAL | $3,669,230 | $173,723,130 | $128,147,170 | $64,212,200 | $960,738,800 | $84,025,030 |
| CO. & COMM. OUTPATIENT | $647,220 | $23,203,270 | $15,375,700 | $10,023,840 | $111,108,310 | $10,666,730 |
| PHARMACY | $3,388,300 | $27,436,110 | $9,657,080 | $19,976,670 | $102,995,830 | $26,254,910 |
| COUNTY INPATIENT | $5,093,990 | $3,433,730 | $57,202,100 | $19,103,140 | $123,163,110 | $5,438,730 |
| COMMUNITY INPATIENT | $14,459,250 | $104,367,210 | $165,380,390 | $49,617,360 | $784,867,180 | $67,642,550 |
| NURSING FACILITIES | $240,422,270 | $2,258,810 | $226,418,000 | $44,760,970 | $16,704,430 | $3,115,670 |
| ICF-DD | $168,798,490 | $45,520 | $1,220,980 | $9,765,870 | $1,427,640 | $2,146,180 |
| MEDICAL TRANSPORTATION | $987,240 | $589,840 | $8,202,880 | $6,238,730 | $5,254,910 | $849,990 |
| OTHER SERVICES | $9,847,690 | $6,937,920 | $72,425,730 | $49,940,810 | $88,045,170 | $10,684,820 |
| HOME HEALTH | $4,020 | $10,128,110 | $1,172,080 | $47,526,120 | $8,041,310 | $11,808,060 |
| **FFS SUBTOTAL** | **$449,668,730** | **$369,822,570** | **$707,412,700** | **$330,070,780** | **$2,333,930,400** | **$239,692,610** |
| DENTAL | $14,887,800 | $101,822,480 | $44,663,400 | $14,887,800 | $431,746,200 | $29,775,600 |
| MENTAL HEALTH | $2,153,820 | $19,768,370 | $10,427,240 | $104,267,190 | $487,327,710 | $76,855,360 |
| TWO PLAN MODEL | $0 | $754,237,050 | $1,441,308,300 | $614,275,390 | $2,930,949,170 | $38,280,360 |
| COUNTY ORGANIZED HEALTH SYSTEMS | $210,399,040 | $354,703,280 | $438,017,510 | $310,916,130 | $1,004,302,480 | $31,490,680 |
| GEOGRAPHIC MANAGED CARE | $0 | $148,226,050 | $184,162,040 | $113,593,920 | $464,275,700 | $4,620,230 |
| PHP & OTHER MANAG. CARE | $219,270 | $8,705,710 | $221,923,950 | $22,732,470 | $35,140,970 | $2,492,550 |
| EPSDT SCREENS | $0 | $3,877,360 | $0 | $0 | $15,221,760 | $757,180 |
| MEDICARE PAYMENTS | $41,441,500 | $0 | $1,179,887,740 | $523,829,890 | $104,194,810 | $0 |
| STATE HOSP./DEVELOPMENTAL CNTRS. | $303,250 | $0 | $12,604,770 | $4,221,810 | $94,593,790 | $4,696,460 |
| MISC. SERVICES | $0 | ($42,460,900) | $583,865,160 | $791,083,680 | $17,274,340 | $942,440 |
| DRUG MEDI-CAL | $507,520 | $39,701,620 | $19,550,140 | $6,810,990 | $156,111,110 | $8,497,370 |
| REGIONAL MODEL | $0 | $44,909,740 | $31,560,210 | $25,883,370 | $164,833,820 | $927,860 |
| **NON-FFS SUBTOTAL** | **$269,912,200** | **$1,433,490,760** | **$4,167,970,460** | **$2,532,502,640** | **$5,905,971,860** | **$199,336,100** |
| **TOTAL DOLLARS (1)** | **$719,580,930** | **$1,803,313,330** | **$4,875,383,150** | **$2,862,573,420** | **$8,239,902,260** | **$439,028,710** |
| **ELIGIBLES ***** | **11,500** | **917,300** | **486,300** | **165,700** | **3,587,200** | **178,100** |
| **ANNUAL $/ELIGIBLE** | **$62,572** | **$1,966** | **$10,025** | **$17,276** | **$2,297** | **$2,465** |
| **AVG. MO. $/ELIGIBLE** | **$5,214** | **$164** | **$835** | **$1,440** | **$191** | **$205** |

(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 NOVEMBER 2017 ESTIMATE

| SERVICE CATEGORY | MI-A | REFUGEE | OBRA | POV 185 | POV 133 | POV 100 |
|---|---|---|---|---|---|---|
| PHYSICIANS | $253,470 | $222,340 | $79,360 | $88,661,140 | $12,054,080 | $6,180,480 |
| OTHER MEDICAL | $300,460 | $1,288,390 | $281,650 | $211,547,690 | $171,002,180 | $81,046,120 |
| CO. & COMM. OUTPATIENT | $81,540 | $89,590 | $53,670 | $21,596,800 | $12,109,450 | $7,368,070 |
| PHARMACY | $606,720 | $153,700 | $238,550 | $7,227,400 | $7,804,430 | $14,493,760 |
| COUNTY INPATIENT | $58,700 | $9,790 | $306,030 | $61,137,040 | $2,870,850 | $1,719,140 |
| COMMUNITY INPATIENT | $613,360 | $675,830 | $2,596,890 | $777,907,430 | $75,806,140 | $36,383,550 |
| NURSING FACILITIES | $24,127,600 | $20 | $4,992,140 | $2,591,810 | $4,753,090 | $8,450 |
| ICF-DD | $1,082,370 | $0 | $330,070 | $218,730 | $230,990 | $420 |
| MEDICAL TRANSPORTATION | $73,680 | $4,590 | $34,360 | $1,557,210 | $479,310 | $200,240 |
| OTHER SERVICES | $331,310 | $14,400 | $17,210 | $9,569,020 | $15,911,490 | $8,430,790 |
| HOME HEALTH | $20 | $0 | $10 | $2,812,670 | $2,901,980 | $778,620 |
| **FFS SUBTOTAL** | **$27,529,230** | **$2,458,650** | **$8,929,940** | **$1,184,826,940** | **$305,923,980** | **$156,609,650** |
| DENTAL | $14,887,800 | $14,887,800 | $16,753,470 | $49,235,210 | $82,058,680 | $50,260,400 |
| MENTAL HEALTH | $17,090 | $51,320 | $327,750 | $6,969,000 | $6,548,480 | $21,907,650 |
| TWO PLAN MODEL | $24,570 | $1,301,890 | $0 | $179,054,730 | $691,665,980 | $369,707,070 |
| COUNTY ORGANIZED HEALTH SYSTEMS | $84,000 | $159,220 | $29,610 | $74,030,500 | $258,246,540 | $144,500,260 |
| GEOGRAPHIC MANAGED CARE | $4,490 | $568,610 | $0 | $28,487,920 | $108,909,220 | $61,870,310 |
| PHP & OTHER MANAG. CARE | $1,243,270 | $0 | $0 | $3,731,020 | $6,218,370 | $3,731,020 |
| EPSDT SCREENS | $0 | $0 | $0 | $0 | $3,283,090 | $1,609,440 |
| MEDICARE PAYMENTS | $0 | $0 | $0 | $0 | $0 | $0 |
| STATE HOSP./DEVELOPMENTAL CNTRS. | $31,640 | $0 | $23,730 | $9,485,220 | $0 | $10,004,710 |
| MISC. SERVICES | $310 | $0 | $0 | $37,490 | $3,197,360 | $1,582,090 |
| DRUG MEDI-CAL | $68,240 | $106,620 | $0 | $16,151,040 | $32,378,850 | $15,664,850 |
| REGIONAL MODEL | $0 | $16,460 | $0 | $10,918,410 | $37,907,860 | $18,440,190 |
| **NON-FFS SUBTOTAL** | **$16,361,420** | **$17,091,920** | **$17,134,560** | **$378,100,550** | **$1,230,414,440** | **$699,277,980** |
| **TOTAL DOLLARS (1)** | **$43,890,650** | **$19,550,570** | **$26,064,500** | **$1,562,927,490** | **$1,536,338,420** | **$855,887,620** |
| **ELIGIBLES ***** | **1,200** | **2,100** | **900** | **359,700** | **776,700** | **379,400** |
| **ANNUAL $/ELIGIBLE** | **$36,576** | **$9,310** | **$28,961** | **$4,345** | **$1,978** | **$2,256** |
| **AVG. MO. $/ELIGIBLE** | **$3,048** | **$776** | **$2,413** | **$362** | **$165** | **$188** |

(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 NOVEMBER 2017 ESTIMATE

| SERVICE CATEGORY | TOTAL |
|---|---|
| PHYSICIANS | $603,989,080 |
| OTHER MEDICAL | $3,699,964,270 |
| CO. & COMM. OUTPATIENT | $531,039,430 |
| PHARMACY | $1,072,491,830 |
| COUNTY INPATIENT | $902,042,360 |
| COMMUNITY INPATIENT | $4,599,225,560 |
| NURSING FACILITIES | $2,467,644,430 |
| ICF-DD | $417,182,850 |
| MEDICAL TRANSPORTATION | $65,930,880 |
| OTHER SERVICES | $749,220,730 |
| HOME HEALTH | $221,016,040 |
| **FFS SUBTOTAL** | $15,329,747,470 |
| DENTAL | $1,580,481,030 |
| MENTAL HEALTH | $2,755,022,000 |
| TWO PLAN MODEL | $25,562,501,720 |
| COUNTY ORGANIZED HEALTH SYSTEMS | $9,052,137,860 |
| GEOGRAPHIC MANAGED CARE | $4,316,958,430 |
| PHP & OTHER MANAG. CARE | $753,049,020 |
| EPSDT SCREENS | $29,840,690 |
| MEDICARE PAYMENTS | $5,362,487,000 |
| STATE HOSP./DEVELOPMENTAL CNTRS. | $207,330,000 |
| MISC. SERVICES | $6,722,471,410 |
| DRUG MEDI-CAL | $581,499,000 |
| REGIONAL MODEL | $1,262,110,180 |
| **NON-FFS SUBTOTAL** | $58,185,888,340 |
| **TOTAL DOLLARS (1)** | $73,515,635,810 |
| **ELIGIBLES ***** | 13,465,100 |
| **ANNUAL $/ELIGIBLE** | $5,460 |
| **AVG. MO. $/ELIGIBLE** | $455 |

(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 NOVEMBER 2017 ESTIMATE

EXCLUDED POLICY CHANGES: 76

| | |
|---|---|
| 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 | MEC OPTIONAL EXPANSION ADJUSTMENT |
| 22 | 1% FMAP INCREASE FOR PREVENTIVE SERVICES |
| 23 | ACA MAGI SAVINGS |
| 26 | ACA DSH REDUCTION |
| 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 |

# FISCAL YEAR 2017-18 COST PER ELIGIBLE BASED ON NOVEMBER 2017 ESTIMATE

EXCLUDED POLICY CHANGES: 76

| | |
|---|---|
| 112 | GENERAL FUND REIMBURSEMENTS FROM DPHS |
| 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 | 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 | 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 | 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 | AIDS WAIVER SUPPLEMENTAL PAYMENTS |
| 161 | NDPH SUPPLEMENTAL PAYMENT |
| 162 | STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS |
| 163 | MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS |
| 164 | DP-NF CAPITAL PROJECT DEBT REPAYMENT |
| 171 | ARRA HITECH - PROVIDER PAYMENTS |

# FISCAL YEAR 2017-18 COST PER ELIGIBLE BASED ON NOVEMBER 2017 ESTIMATE

EXCLUDED POLICY CHANGES: 76

| | |
|---|---|
| 176 | MEDI-CAL TCM PROGRAM |
| 181 | AUDIT SETTLEMENTS |
| 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 |

# 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 | $17,382,153,180 | $8,691,076,590 | $8,691,076,590 | $0 |
| B. B/Y BASE POLICY CHANGES | $48,381,359,540 | $33,141,138,230 | $14,953,372,300 | $286,849,000 |
| C. BASE ADJUSTMENTS | ($138,956,000) | ($176,522,920) | $37,566,920 | $0 |
| **D. ADJUSTED BASE** | **$65,624,556,720** | **$41,655,691,900** | **$23,682,015,810** | **$286,849,000** |
| **II. REGULAR POLICY CHANGES** | | | | |
| A. ELIGIBILITY | ($178,853,370) | ($844,731,810) | $649,544,440 | $16,334,000 |
| B. AFFORDABLE CARE ACT | $3,169,316,000 | $2,757,171,260 | $604,573,740 | ($192,429,000) |
| C. BENEFITS | $1,452,703,110 | $1,056,183,780 | $376,630,330 | $19,889,000 |
| D. PHARMACY | ($2,635,260,200) | ($1,787,619,880) | ($847,640,330) | $0 |
| E. DRUG MEDI-CAL | $1,039,568,000 | $829,760,470 | $209,807,530 | $0 |
| F. MENTAL HEALTH | $28,168,000 | $19,590,500 | $8,377,500 | $200,000 |
| G. WAIVER--MH/UCD & BTR | $5,330,025,000 | $2,796,836,000 | $206,095,000 | $2,327,094,000 |
| H. MANAGED CARE | $6,887,591,710 | $4,388,541,990 | ($1,367,776,690) | $3,866,826,400 |
| I. PROVIDER RATES | $877,243,820 | $1,018,219,880 | ($685,703,050) | $544,727,000 |
| J. SUPPLEMENTAL PMNTS. | $14,799,044,000 | $9,409,015,500 | $514,296,500 | $4,875,732,000 |
| K. OTHER | $413,155,540 | $2,352,531,870 | ($2,961,528,330) | $1,022,152,000 |
| **L. TOTAL CHANGES** | **$31,182,701,610** | **$21,995,499,560** | **($3,293,323,350)** | **$12,480,525,400** |
| **III. TOTAL MEDI-CAL ESTIMATE** | **$96,807,258,330** | **$63,651,191,470** | **$20,388,692,460** | **$12,767,374,400** |

# 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 | $88,722,000 | $88,722,000 | $0 | $0 |
| 2 | BREAST AND CERVICAL CANCER TREATMENT | $67,765,000 | $31,133,400 | $36,631,600 | $0 |
| 3 | MEDI-CAL COUNTY INMATE PROGRAMS | $194,515,000 | $175,457,800 | $19,057,200 | $0 |
| 7 | STATE-ONLY BCCTP COVERAGE EXTENSION | $274,650 | $0 | $274,650 | $0 |
| 8 | MEDI-CAL COUNTY INMATE REIMBURSEMENT | $0 | $0 | ($16,334,000) | $16,334,000 |
| 9 | NON-OTLICP CHIP | $0 | $224,486,110 | ($224,486,110) | $0 |
| 10 | NON-EMERGENCY FUNDING ADJUSTMENT | $0 | ($895,842,000) | $895,842,000 | $0 |
| 11 | SCHIP FUNDING FOR PRENATAL CARE | $0 | $65,092,720 | ($65,092,720) | $0 |
| 13 | PARIS-VETERANS | ($12,211,770) | ($6,105,890) | ($6,105,890) | $0 |
| 14 | OTLICP PREMIUMS | ($65,750,000) | ($57,860,000) | ($7,890,000) | $0 |
| 15 | MINIMUM WAGE INCREASE - CASELOAD SAVINGS | ($360,183,250) | ($283,205,650) | ($76,977,590) | $0 |
| 16 | MEC OPTIONAL EXPANSION ADJUSTMENT | ($91,985,000) | ($186,610,300) | $94,625,300 | $0 |
| | **ELIGIBILITY SUBTOTAL** | **($178,853,370)** | **($844,731,810)** | **$649,544,440** | **$16,334,000** |
| | **AFFORDABLE CARE ACT** | | | | |
| 17 | COMMUNITY FIRST CHOICE OPTION | $3,814,981,000 | $3,814,981,000 | $0 | $0 |
| 18 | HEALTH INSURER FEE | $308,165,000 | $203,261,180 | $104,903,820 | $0 |
| 19 | HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS | $14,130,000 | $14,130,000 | $0 | $0 |
| 21 | HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST. | $0 | $31,519,250 | ($31,519,250) | $0 |
| 22 | 1% FMAP INCREASE FOR PREVENTIVE SERVICES | $0 | $1,264,000 | ($1,264,000) | $0 |
| 23 | ACA MAGI SAVINGS | $0 | $0 | $0 | $0 |
| 24 | TITLE XXI FEDERAL MATCH REDUCTION | ($155,838,000) | ($755,601,670) | $590,209,670 | $9,554,000 |
| 25 | ACA OPTIONAL EXPANSION MLR RISK CORRIDOR | ($264,900,000) | ($264,900,000) | $0 | $0 |
| 26 | ACA DSH REDUCTION | ($547,222,000) | ($287,482,500) | ($57,756,500) | ($201,983,000) |
| | **AFFORDABLE CARE ACT SUBTOTAL** | **$3,169,316,000** | **$2,757,171,260** | **$604,573,740** | **($192,429,000)** |
| | **BENEFITS** | | | | |
| 27 | BEHAVIORAL HEALTH TREATMENT | $377,323,000 | $212,251,520 | $165,071,480 | $0 |
| 28 | FAMILY PACT PROGRAM | $344,391,000 | $261,474,000 | $82,917,000 | $0 |
| 29 | ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS | $262,906,000 | $262,906,000 | $0 | $0 |
| 30 | LOCAL EDUCATION AGENCY (LEA) PROVIDERS | $125,020,000 | $125,020,000 | $0 | $0 |
| 31 | CCS DEMONSTRATION PROJECT | $78,459,000 | $42,968,320 | $35,490,680 | $0 |
| 32 | MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA | $39,778,000 | $19,889,000 | $0 | $19,889,000 |
| 33 | ANNUAL CONTRACEPTIVE COVERAGE | $29,030,600 | $22,482,740 | $6,547,860 | $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** | | | | |
| 34 | CALIFORNIA COMMUNITY TRANSITIONS COSTS | $8,048,000 | $6,188,000 | $1,860,000 | $0 |
| 35 | DENTAL TRANSFORMATION INITIATIVE UTILIZATION | $9,231,000 | $4,615,500 | $4,615,500 | $0 |
| 36 | FULL RESTORATION OF ADULT DENTAL BENEFITS | $21,224,000 | $10,612,000 | $10,612,000 | $0 |
| 37 | DENTAL BENEFICIARY OUTREACH EFFORTS | $9,228,000 | $4,614,000 | $4,614,000 | $0 |
| 38 | YOUTH REGIONAL TREATMENT CENTERS | $4,853,000 | $4,828,000 | $25,000 | $0 |
| 39 | PEDIATRIC PALLIATIVE CARE WAIVER | $1,815,640 | $994,350 | $821,300 | $0 |
| 40 | MEDICALLY TAILORED MEALS PILOT PROGRAM | $2,000,000 | $0 | $2,000,000 | $0 |
| 41 | CCT FUND TRANSFER TO CDSS AND CDDS | $191,000 | $191,000 | $0 | $0 |
| 42 | END OF LIFE SERVICES | $45,300 | $0 | $45,300 | $0 |
| 44 | BEHAVIORAL HEALTH TREATMENT - BIS DDS TRANSITION | $94,006,000 | $52,880,080 | $41,125,920 | $0 |
| 45 | DIABETES PREVENTION PROGRAM | $315,560 | $192,970 | $122,590 | $0 |
| 46 | PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS | ($4,751,070) | ($2,602,000) | ($2,149,070) | $0 |
| 207 | MEDI-CAL NONMEDICAL TRANSPORTATION | $4,220,070 | $2,600,720 | $1,619,350 | $0 |
| 209 | WHOLE CHILD MODEL IMPLEMENTATION | $45,369,000 | $24,077,580 | $21,291,420 | $0 |
| | **BENEFITS SUBTOTAL** | **$1,452,703,110** | **$1,056,183,780** | **$376,630,330** | **$19,889,000** |
| | **PHARMACY** | | | | |
| 47 | NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS | $111,025,800 | $60,804,550 | $50,221,240 | $0 |
| 49 | PHARMACY REIMBURSEMENT & DISPENSING FEE | ($66,000,000) | ($39,388,270) | ($26,611,730) | $0 |
| 51 | BCCTP DRUG REBATES | ($8,765,000) | ($6,008,400) | ($2,756,600) | $0 |
| 52 | FAMILY PACT DRUG REBATES | ($18,073,000) | ($15,825,100) | ($2,247,900) | $0 |
| 53 | MEDICAL SUPPLY REBATES | ($24,916,000) | ($12,458,000) | ($12,458,000) | $0 |
| 54 | STATE SUPPLEMENTAL DRUG REBATES | ($217,046,000) | ($148,805,500) | ($68,240,500) | $0 |
| 55 | FEDERAL DRUG REBATES | ($2,411,486,000) | ($1,625,939,160) | ($785,546,840) | $0 |
| | **PHARMACY SUBTOTAL** | **($2,635,260,200)** | **($1,787,619,880)** | **($847,640,330)** | **$0** |
| | **DRUG MEDI-CAL** | | | | |
| 56 | DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER | $1,039,568,000 | $829,760,470 | $209,807,530 | $0 |
| | **DRUG MEDI-CAL SUBTOTAL** | **$1,039,568,000** | **$829,760,470** | **$209,807,530** | **$0** |
| | **MENTAL HEALTH** | | | | |
| 66 | PATHWAYS TO WELL-BEING | $13,419,000 | $13,419,000 | $0 | $0 |
| 67 | MHP COSTS FOR CONTINUUM OF CARE REFORM | $15,616,000 | $7,038,500 | $8,577,500 | $0 |
| 70 | SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT | $0 | $0 | ($200,000) | $200,000 |
| 71 | CHART REVIEW | ($867,000) | ($867,000) | $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 |
|---|---|---|---|---|---|
| | **MENTAL HEALTH SUBTOTAL** | **$28,168,000** | **$19,590,500** | **$8,377,500** | **$200,000** |
| | **WAIVER--MH/UCD & BTR** | | | | |
| 73 | GLOBAL PAYMENT PROGRAM | $2,487,459,000 | $1,243,730,000 | $0 | $1,243,729,000 |
| 74 | PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL | $1,520,000,000 | $760,000,000 | $0 | $760,000,000 |
| 75 | MEDI-CAL 2020 WHOLE PERSON CARE PILOTS | $646,730,000 | $323,365,000 | $0 | $323,365,000 |
| 76 | MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE | $159,630,000 | $79,815,000 | $79,815,000 | $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 | $376,000 | $376,000 | $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 |
| 84 | CMS DEFERRED CLAIMS | $0 | ($6,364,000) | $6,364,000 | $0 |
| 85 | CMS DEFERRALS & NEGATIVE BALANCE REPAYMENT | $0 | ($139,386,000) | $139,386,000 | $0 |
| 86 | MH/UCD—SAFETY NET CARE POOL | $9,712,000 | $9,712,000 | $0 | $0 |
| | **WAIVER--MH/UCD & BTR SUBTOTAL** | **$5,330,025,000** | **$2,796,836,000** | **$206,095,000** | **$2,327,094,000** |
| | **MANAGED CARE** | | | | |
| 90 | MANAGED CARE RATE RANGE IGTS | $143,781,000 | $102,459,000 | $0 | $41,322,000 |
| 91 | CCI-MANAGED CARE PAYMENTS | $2,192,430,710 | $1,096,215,350 | $1,096,215,350 | $0 |
| 92 | MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES | $2,246,407,000 | $1,592,065,670 | $654,341,330 | $0 |
| 101 | CCI-QUALITY WITHHOLD REPAYMENTS | $11,412,000 | $5,706,000 | $5,706,000 | $0 |
| 103 | PALLIATIVE CARE SERVICES IMPLEMENTATION | ($122,000) | ($75,790) | ($46,210) | $0 |
| 104 | MANAGED CARE PUBLIC HOSPITAL DIRECTED PAYMENTS | $1,569,000,000 | $1,111,403,600 | $457,596,400 | $0 |
| 105 | MANAGED CARE HEALTH CARE FINANCING PROGRAM | $1,515,011,000 | $1,060,465,740 | $454,545,260 | $0 |
| 106 | MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL | $640,000,000 | $453,345,080 | $186,654,920 | $0 |
| 107 | CAPITATED RATE ADJUSTMENT FOR FY 2018-19 | $381,976,000 | $201,071,760 | $180,904,240 | $0 |
| 108 | HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS | $13,384,000 | $12,045,600 | $1,338,000 | $400 |
| 111 | MANAGED CARE IGT ADMIN. & PROCESSING FEE | $0 | $0 | ($32,103,000) | $32,103,000 |
| 113 | MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND | $0 | $0 | ($1,274,187,000) | $1,274,187,000 |

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 |
|---|---|---|---|---|---|
| | **MANAGED CARE** | | | | |
| 114 | MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ. | $0 | $0 | ($643,334,000) | $643,334,000 |
| 115 | MCO ENROLLMENT TAX MANAGED CARE PLANS | $0 | $0 | ($1,875,880,000) | $1,875,880,000 |
| 116 | MANAGED CARE DRUG REBATES | ($1,913,660,000) | ($1,288,669,020) | ($624,990,980) | $0 |
| 117 | RETRO MC RATE ADJUSTMENTS | $87,972,000 | $42,509,000 | $45,463,000 | $0 |
| | **MANAGED CARE SUBTOTAL** | **$6,887,591,710** | **$4,388,541,990** | **($1,367,776,690)** | **$3,866,826,400** |
| | **PROVIDER RATES** | | | | |
| 118 | DPH INTERIM & FINAL RECONS | $240,730,000 | $240,730,000 | $0 | $0 |
| 120 | FQHC/RHC/CBRC RECONCILIATION PROCESS | $161,794,000 | $100,380,650 | $61,413,350 | $0 |
| 121 | AB 1629 ANNUAL RATE ADJUSTMENTS | $117,343,730 | $58,671,870 | $58,671,870 | $0 |
| 122 | RATE INCREASE FOR FQHCS/RHCS/CBRCS | $200,771,260 | $124,562,540 | $76,208,720 | $0 |
| 123 | LTC RATE ADJUSTMENT | $31,325,170 | $15,662,590 | $15,662,590 | $0 |
| 124 | DPH INTERIM RATE GROWTH | $79,089,610 | $39,544,800 | $39,544,800 | $0 |
| 125 | HOSPICE RATE INCREASES | $43,707,530 | $21,853,770 | $21,853,770 | $0 |
| 126 | GDSP NEWBORN SCREENING PROGRAM FEE INCREASE | $5,754,580 | $2,877,290 | $2,877,290 | $0 |
| 127 | EMERGENCY MEDICAL AIR TRANSPORTATION ACT | $12,138,000 | $6,069,000 | ($2,456,000) | $8,525,000 |
| 128 | GDSP PRENATAL SCREENING FEE INCREASE | $2,749,450 | $1,374,730 | $1,374,730 | $0 |
| 129 | ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE | $4,907,410 | $8,877,100 | ($3,969,690) | $0 |
| 130 | ALTERNATIVE BIRTHING CENTER REIMBURSEMENT | $50,640 | $25,320 | $25,320 | $0 |
| 133 | LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES | $0 | $0 | ($504,609,000) | $504,609,000 |
| 134 | DPH INTERIM RATE | $0 | $408,504,510 | ($408,504,510) | $0 |
| 135 | LABORATORY RATE METHODOLOGY CHANGE | ($18,042,780) | ($9,021,390) | ($9,021,390) | $0 |
| 136 | REDUCTION TO RADIOLOGY RATES | ($50,604,900) | ($25,302,450) | ($25,302,450) | $0 |
| 137 | 10% PROVIDER PAYMENT REDUCTION | ($18,944,900) | ($9,472,450) | ($9,472,450) | $0 |
| 204 | HOME HEALTH RATE INCREASE | $64,475,000 | $32,882,000 | $0 | $31,593,000 |
| | **PROVIDER RATES SUBTOTAL** | **$877,243,820** | **$1,018,219,880** | **($685,703,050)** | **$544,727,000** |
| | **SUPPLEMENTAL PMNTS.** | | | | |
| 138 | HOSPITAL QAF - MANAGED CARE PAYMENTS | $3,636,684,000 | $2,535,861,000 | $0 | $1,100,823,000 |
| 139 | HOSPITAL QAF - FFS PAYMENTS | $3,526,939,000 | $1,706,932,000 | $0 | $1,820,007,000 |
| 140 | GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS | $999,744,000 | $631,401,000 | $0 | $368,343,000 |
| 141 | PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS | $1,338,039,000 | $921,446,000 | $0 | $416,593,000 |
| 142 | PRIVATE HOSPITAL DSH REPLACEMENT | $571,519,000 | $285,759,500 | $285,759,500 | $0 |
| 143 | HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS | $379,083,000 | $379,083,000 | $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 |
|---|---|---|---|---|---|
| | **SUPPLEMENTAL PMNTS.** | | | | |
| 144 | DSH PAYMENT | $425,460,000 | $290,499,000 | $13,554,000 | $121,407,000 |
| 145 | PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT | $297,963,000 | $160,063,000 | $118,400,000 | $19,500,000 |
| 146 | NDPH IGT SUPPLEMENTAL PAYMENTS | $125,874,000 | $76,379,000 | ($4,643,000) | $54,138,000 |
| 147 | SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES | $461,501,000 | $296,982,000 | $0 | $164,519,000 |
| 148 | WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS | $183,259,000 | $134,258,000 | $0 | $49,001,000 |
| 149 | DPH PHYSICIAN & NON-PHYS. COST | $123,573,000 | $123,573,000 | $0 | $0 |
| 150 | CAPITAL PROJECT DEBT REIMBURSEMENT | $123,280,000 | $81,882,000 | $41,398,000 | $0 |
| 151 | FFP FOR LOCAL TRAUMA CENTERS | $135,868,000 | $71,661,000 | $0 | $64,207,000 |
| 152 | MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS | $116,910,000 | $66,910,000 | $0 | $50,000,000 |
| 153 | QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS | $86,242,000 | $43,121,000 | $48,928,000 | ($5,807,000) |
| 154 | GEMT SUPPLEMENTAL PAYMENT PROGRAM | $37,900,000 | $37,900,000 | $0 | $0 |
| 155 | CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS | $59,590,000 | $59,590,000 | $0 | $0 |
| 156 | ICF/DD SUPPLEMENTAL PAYMENTS | $35,616,000 | $19,204,000 | $0 | $16,412,000 |
| 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 | $271,000 | $271,000 | $0 | $0 |
| 160 | AIDS WAIVER SUPPLEMENTAL PAYMENTS | $6,800,000 | $3,400,000 | $0 | $3,400,000 |
| 161 | NDPH SUPPLEMENTAL PAYMENT | $4,315,000 | $2,415,000 | $1,900,000 | $0 |
| 162 | STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS | $4,614,000 | $4,614,000 | $0 | $0 |
| 163 | MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS | $2,100,000,000 | $1,466,811,000 | $0 | $633,189,000 |
| | **SUPPLEMENTAL PMNTS. SUBTOTAL** | **$14,799,044,000** | **$9,409,015,500** | **$514,296,500** | **$4,875,732,000** |
| | **OTHER** | | | | |
| 171 | ARRA HITECH - PROVIDER PAYMENTS | $240,392,000 | $240,392,000 | $0 | $0 |
| 174 | ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS | $63,133,000 | $63,133,000 | $0 | $0 |
| 178 | INFANT DEVELOPMENT PROGRAM | $29,439,000 | $29,439,000 | $0 | $0 |
| 179 | ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS | $11,106,000 | $6,024,000 | $5,082,000 | $0 |
| 180 | MINIMUM WAGE INCREASE FOR HCBS WAIVERS | $42,755,580 | $21,377,790 | $21,377,790 | $0 |
| 182 | OVERTIME FOR WPCS PROVIDERS | $10,128,000 | $5,064,000 | $5,064,000 | $0 |
| 184 | INDIAN HEALTH SERVICES | $5,592,000 | $27,483,000 | ($21,891,000) | $0 |
| 185 | MEDI-CAL ESTATE RECOVERIES | $21,719,000 | $10,859,500 | $10,859,500 | $0 |
| 186 | WPCS WORKERS' COMPENSATION | $3,322,000 | $1,661,000 | $1,661,000 | $0 |
| 191 | FUNDING ADJUST.—OTLICP | $133,000 | $189,368,320 | ($189,235,320) | $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** | | | | |
| 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 | ($884,850,000) | $884,850,000 |
| 197 | FUNDING ADJUST.—ACA OPT. EXPANSION | $0 | $1,777,687,280 | ($1,777,687,280) | $0 |
| 198 | COUNTY SHARE OF OTLICP-CCS COSTS | $0 | $0 | ($9,343,000) | $9,343,000 |
| 199 | IMD ANCILLARY SERVICES | $0 | ($12,675,000) | $12,675,000 | $0 |
| 200 | CIGARETTE AND TOBACCO SURTAX FUNDS | $0 | $0 | ($127,234,000) | $127,234,000 |
| 201 | INTEGRATION OF THE SF CLSB INTO THE ALW | ($1,527,000) | ($763,500) | ($763,500) | $0 |
| 202 | MEDI-CAL RECOVERIES SETTLEMENTS AND LEGAL COSTS | ($1,672,560) | ($836,280) | ($836,280) | $0 |
| 211 | ASSISSTED LIVING WAIVER EXPANSION | ($12,350,520) | ($6,175,260) | ($6,175,260) | $0 |
| 212 | HOME & COMMUNITY-BASED ALTERNATIVES WAIVER RENEWAL | $986,040 | $493,020 | $493,020 | $0 |
| | **OTHER SUBTOTAL** | **$413,155,540** | **$2,352,531,870** | **($2,961,528,330)** | **$1,022,152,000** |
| | **GRAND TOTAL** | **$31,182,701,610** | **$21,995,499,560** | **($3,293,323,350)** | **$12,480,525,400** |

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** | $6,608,380,200 | $4,040,721,580 | $1,827,597,450 | $740,061,160 |
| PHYSICIANS | $834,278,430 | $538,805,650 | $253,961,200 | $41,511,580 |
| OTHER MEDICAL | $4,081,815,280 | $2,425,522,870 | $1,494,706,610 | $161,585,810 |
| CO. & COMM. OUTPATIENT | $1,692,286,490 | $1,076,393,060 | $78,929,650 | $536,963,780 |
| **PHARMACY** | $1,190,935,830 | $621,920,050 | $523,070,040 | $45,945,740 |
| **HOSPITAL INPATIENT** | $13,419,123,280 | $8,182,018,800 | $1,898,051,420 | $3,339,053,060 |
| COUNTY INPATIENT | $3,578,995,880 | $2,264,536,360 | $38,909,780 | $1,275,549,740 |
| COMMUNITY INPATIENT | $9,840,127,400 | $5,917,482,440 | $1,859,141,650 | $2,063,503,320 |
| **LONG TERM CARE** | $3,155,912,760 | $1,643,466,940 | $1,388,892,070 | $123,553,750 |
| NURSING FACILITIES | $2,707,904,310 | $1,418,428,420 | $1,198,018,070 | $91,457,820 |
| ICF-DD | $448,008,450 | $225,038,520 | $190,874,000 | $32,095,930 |
| **OTHER SERVICES** | $1,183,895,510 | $691,992,980 | $412,506,970 | $79,395,550 |
| MEDICAL TRANSPORTATION | $119,322,330 | $83,631,800 | $26,529,360 | $9,161,170 |
| OTHER SERVICES | $782,854,380 | $465,200,600 | $280,896,130 | $36,757,650 |
| HOME HEALTH | $281,718,800 | $143,160,580 | $105,081,490 | $33,476,730 |
| **TOTAL FEE-FOR-SERVICE** | **$25,558,247,570** | **$15,180,120,350** | **$6,050,117,960** | **$4,328,009,250** |
| **MANAGED CARE** | $49,176,558,660 | $32,327,316,110 | $9,573,874,780 | $7,275,367,770 |
| TWO PLAN MODEL | $29,881,172,190 | $19,579,814,530 | $5,754,259,920 | $4,547,097,740 |
| COUNTY ORGANIZED HEALTH SYSTEMS | $11,716,269,090 | $7,803,163,820 | $2,312,828,180 | $1,600,277,080 |
| GEOGRAPHIC MANAGED CARE | $5,136,186,290 | $3,397,180,460 | $971,184,560 | $767,821,270 |
| PHP & OTHER MANAG. CARE | $901,830,930 | $510,981,190 | $271,396,960 | $119,452,780 |
| REGIONAL MODEL | $1,541,100,160 | $1,036,176,100 | $264,205,170 | $240,718,890 |
| **DENTAL** | $2,018,956,460 | $1,230,988,860 | $583,465,020 | $204,502,580 |
| **MENTAL HEALTH** | $2,782,736,470 | $2,612,746,890 | ($14,179,860) | $184,169,440 |
| **AUDITS/ LAWSUITS** | $32,856,240 | ($129,335,270) | $162,191,500 | $0 |
| **EPSDT SCREENS** | $29,832,550 | $16,006,970 | $13,100,580 | $725,000 |
| **MEDICARE PAYMENTS** | $5,569,587,000 | $1,565,079,000 | $4,004,508,000 | $0 |
| **STATE HOSP./DEVELOPMENTAL CNTRS.** | $207,330,000 | $207,330,000 | $0 | $0 |
| **MISC. SERVICES** | $10,519,906,740 | $9,788,934,510 | ($43,628,130) | $774,600,360 |
| **RECOVERIES** | ($347,616,560) | ($185,805,780) | ($161,810,780) | $0 |
| **DRUG MEDI-CAL** | $1,258,863,210 | $1,037,809,820 | $221,053,380 | $0 |
| **GRAND TOTAL MEDI-CAL** | **$96,807,258,330** | **$63,651,191,470** | **$20,388,692,460** | **$12,767,374,400** |

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

| SERVICE CATEGORY | NOV. 2017 EST. FOR 2017-18 | NOV. 2017 EST. FOR 2018-19 | DOLLAR DIFFERENCE | % CHANGE |
|---|---|---|---|---|
| **PROFESSIONAL** | $7,002,470,410 | $6,608,380,200 | ($394,090,210) | -5.63% |
| PHYSICIANS | $879,824,970 | $834,278,430 | ($45,546,540) | -5.18% |
| OTHER MEDICAL | $4,091,818,520 | $4,081,815,280 | ($10,003,230) | -0.24% |
| CO. & COMM. OUTPATIENT | $2,030,826,920 | $1,692,286,490 | ($338,540,430) | -16.67% |
| **PHARMACY** | $1,089,324,180 | $1,190,935,830 | $101,611,650 | 9.33% |
| **HOSPITAL INPATIENT** | $14,493,631,550 | $13,419,123,280 | ($1,074,508,280) | -7.41% |
| COUNTY INPATIENT | $3,398,608,970 | $3,578,995,880 | $180,386,910 | 5.31% |
| COMMUNITY INPATIENT | $11,095,022,590 | $9,840,127,400 | ($1,254,895,190) | -11.31% |
| **LONG TERM CARE** | $3,073,758,440 | $3,155,912,760 | $82,154,320 | 2.67% |
| NURSING FACILITIES | $2,649,232,140 | $2,707,904,310 | $58,672,170 | 2.21% |
| ICF-DD | $424,526,300 | $448,008,450 | $23,482,150 | 5.53% |
| **OTHER SERVICES** | $1,118,144,920 | $1,183,895,510 | $65,750,580 | 5.88% |
| MEDICAL TRANSPORTATION | $146,746,480 | $119,322,330 | ($27,424,150) | -18.69% |
| OTHER SERVICES | $750,174,980 | $782,854,380 | $32,679,400 | 4.36% |
| HOME HEALTH | $221,223,470 | $281,718,800 | $60,495,330 | 27.35% |
| **TOTAL FEE-FOR-SERVICE** | **$26,777,329,500** | **$25,558,247,570** | **($1,219,081,930)** | **-4.55%** |
| **MANAGED CARE** | $48,871,268,880 | $49,176,558,660 | $305,289,780 | 0.62% |
| TWO PLAN MODEL | $30,490,560,630 | $29,881,172,190 | ($609,388,430) | -2.00% |
| COUNTY ORGANIZED HEALTH SYSTEMS | $10,717,645,120 | $11,716,269,090 | $998,623,970 | 9.32% |
| GEOGRAPHIC MANAGED CARE | $5,091,575,920 | $5,136,186,290 | $44,610,370 | 0.88% |
| PHP & OTHER MANAG. CARE | $1,083,938,930 | $901,830,930 | ($182,108,010) | -16.80% |
| REGIONAL MODEL | $1,487,548,280 | $1,541,100,160 | $53,551,880 | 3.60% |
| **DENTAL** | $1,581,030,040 | $2,018,956,460 | $437,926,420 | 27.70% |
| **MENTAL HEALTH** | $3,016,627,380 | $2,782,736,470 | ($233,890,910) | -7.75% |
| **AUDITS/ LAWSUITS** | $50,113,780 | $32,856,240 | ($17,257,550) | -34.44% |
| **EPSDT SCREENS** | $29,840,690 | $29,832,550 | ($8,140) | -0.03% |
| **MEDICARE PAYMENTS** | $5,362,487,000 | $5,569,587,000 | $207,100,000 | 3.86% |
| **STATE HOSP./DEVELOPMENTAL CNTRS.** | $207,330,000 | $207,330,000 | $0 | 0.00% |
| **MISC. SERVICES** | $9,054,686,410 | $10,519,906,740 | $1,465,220,330 | 16.18% |
| **RECOVERIES** | ($370,434,160) | ($347,616,560) | $22,817,600 | -6.16% |
| **DRUG MEDI-CAL** | $583,156,130 | $1,258,863,210 | $675,707,070 | 115.87% |
| **GRAND TOTAL MEDI-CAL** | **$95,163,435,660** | **$96,807,258,330** | **$1,643,822,670** | **1.73%** |
| **GENERAL FUNDS** | **$18,866,693,190** | **$20,388,692,460** | **$1,521,999,270** | **8.07%** |
| **OTHER STATE FUNDS** | **$16,284,778,000** | **$12,767,374,400** | **($3,517,403,600)** | **-21.60%** |

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

| | | NOV. 2017 EST. FOR 2017-18 | | NOV. 2017 EST. FOR 2018-19 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | **ELIGIBILITY** | | | | | | |
| 1 | MEDI-CAL STATE INMATE PROGRAMS | $108,677,000 | $0 | $88,722,000 | $0 | ($19,955,000) | $0 |
| 2 | BREAST AND CERVICAL CANCER TREATMENT | $67,765,000 | $36,631,600 | $67,765,000 | $36,631,600 | $0 | $0 |
| 3 | MEDI-CAL COUNTY INMATE PROGRAMS | $52,316,000 | $8,167,300 | $194,515,000 | $19,057,200 | $142,199,000 | $10,889,900 |
| 7 | STATE-ONLY BCCTP COVERAGE EXTENSION | $1,686,000 | $1,686,000 | $1,686,000 | $1,686,000 | $0 | $0 |
| 8 | MEDI-CAL COUNTY INMATE REIMBURSEMENT | $0 | ($6,125,000) | $0 | ($16,334,000) | $0 | ($10,209,000) |
| 9 | NON-OTLICP CHIP | $0 | ($116,863,440) | $0 | ($224,486,110) | $0 | ($107,622,670) |
| 10 | NON-EMERGENCY FUNDING ADJUSTMENT | $0 | $900,963,000 | $0 | $895,842,000 | $0 | ($5,121,000) |
| 11 | SCHIP FUNDING FOR PRENATAL CARE | $0 | ($67,868,240) | $0 | ($65,092,720) | $0 | $2,775,520 |
| 12 | CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN | $0 | $14,732,000 | $0 | $0 | $0 | ($14,732,000) |
| 13 | PARIS-VETERANS | ($19,600,290) | ($9,800,150) | ($32,119,330) | ($16,059,670) | ($12,519,040) | ($6,259,520) |
| 14 | OTLICP PREMIUMS | ($65,731,000) | ($7,887,720) | ($65,750,000) | ($7,890,000) | ($19,000) | ($2,280) |
| 15 | MINIMUM WAGE INCREASE - CASELOAD SAVINGS | ($141,385,000) | ($29,459,000) | ($363,381,000) | ($77,661,010) | ($221,996,000) | ($48,202,010) |
| 16 | MEC OPTIONAL EXPANSION ADJUSTMENT | ($418,325,000) | $214,984,580 | ($91,985,000) | $94,625,300 | $326,340,000 | ($120,359,280) |
| | **ELIGIBILITY SUBTOTAL** | **($414,597,290)** | **$939,160,930** | **($200,547,330)** | **$640,318,590** | **$214,049,960** | **($298,842,340)** |
| | **AFFORDABLE CARE ACT** | | | | | | |
| 17 | COMMUNITY FIRST CHOICE OPTION | $2,591,402,000 | $0 | $3,814,981,000 | $0 | $1,223,579,000 | $0 |
| 18 | HEALTH INSURER FEE | $483,599,000 | $163,750,950 | $308,165,000 | $104,903,820 | ($175,434,000) | ($58,847,130) |
| 19 | HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS | $18,210,000 | $0 | $14,130,000 | $0 | ($4,080,000) | $0 |
| 20 | PAYMENTS TO PRIMARY CARE PHYSICIANS | $5,500,000 | $0 | $0 | $0 | ($5,500,000) | $0 |
| 21 | HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST. | $0 | ($32,229,850) | $0 | ($31,519,250) | $0 | $710,600 |
| 22 | 1% FMAP INCREASE FOR PREVENTIVE SERVICES | $0 | ($1,055,000) | $0 | ($1,264,000) | $0 | ($209,000) |
| 23 | ACA MAGI SAVINGS | $0 | $0 | $0 | $0 | $0 | $0 |
| 24 | TITLE XXI FEDERAL MATCH REDUCTION | ($114,127,000) | $295,162,910 | ($155,838,000) | $590,209,670 | ($41,711,000) | $295,046,760 |

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

| | | NOV. 2017 EST. FOR 2017-18 | | NOV. 2017 EST. FOR 2018-19 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | **AFFORDABLE CARE ACT** | | | | | | |
| 25 | ACA OPTIONAL EXPANSION MLR RISK CORRIDOR | ($176,600,000) | $0 | ($264,900,000) | $0 | ($88,300,000) | $0 |
| 26 | ACA DSH REDUCTION | ($315,507,000) | ($37,018,000) | ($547,222,000) | ($57,756,500) | ($231,715,000) | ($20,738,500) |
| | **AFFORDABLE CARE ACT SUBTOTAL** | **$2,492,477,000** | **$388,611,010** | **$3,169,316,000** | **$604,573,740** | **$676,839,000** | **$215,962,730** |
| | **BENEFITS** | | | | | | |
| 27 | BEHAVIORAL HEALTH TREATMENT | $402,206,000 | $175,958,400 | $377,323,000 | $165,071,480 | ($24,883,000) | ($10,886,920) |
| 28 | FAMILY PACT PROGRAM | $338,916,000 | $81,598,700 | $344,391,000 | $82,917,000 | $5,475,000 | $1,318,300 |
| 29 | ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS | $321,681,000 | $0 | $262,906,000 | $0 | ($58,775,000) | $0 |
| 30 | LOCAL EDUCATION AGENCY (LEA) PROVIDERS | $120,851,000 | $5,213,000 | $125,020,000 | $0 | $4,169,000 | ($5,213,000) |
| 31 | CCS DEMONSTRATION PROJECT | $40,718,000 | $18,388,320 | $78,459,000 | $35,490,680 | $37,741,000 | $17,102,360 |
| 32 | MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA | $39,778,000 | $0 | $39,778,000 | $0 | $0 | $0 |
| 33 | ANNUAL CONTRACEPTIVE COVERAGE | $35,637,860 | $8,038,130 | $35,637,860 | $8,038,130 | $0 | $0 |
| 34 | CALIFORNIA COMMUNITY TRANSITIONS COSTS | $12,953,000 | $2,099,000 | $8,048,000 | $1,860,000 | ($4,905,000) | ($239,000) |
| 35 | DENTAL TRANSFORMATION INITIATIVE UTILIZATION | $9,601,000 | $4,800,500 | $9,231,000 | $4,615,500 | ($370,000) | ($185,000) |
| 36 | FULL RESTORATION OF ADULT DENTAL BENEFITS | $8,473,000 | $4,236,500 | $21,224,000 | $10,612,000 | $12,751,000 | $6,375,500 |
| 37 | DENTAL BENEFICIARY OUTREACH EFFORTS | $4,314,000 | $2,157,000 | $9,228,000 | $4,614,000 | $4,914,000 | $2,457,000 |
| 38 | YOUTH REGIONAL TREATMENT CENTERS | $3,233,000 | ($25,000) | $4,853,000 | $25,000 | $1,620,000 | $50,000 |
| 39 | PEDIATRIC PALLIATIVE CARE WAIVER | $2,884,800 | $1,320,110 | $3,488,940 | $1,578,210 | $604,140 | $258,100 |
| 40 | MEDICALLY TAILORED MEALS PILOT PROGRAM | $1,000,000 | $1,000,000 | $2,000,000 | $2,000,000 | $1,000,000 | $1,000,000 |
| 41 | CCT FUND TRANSFER TO CDSS AND CDDS | $918,000 | $0 | $191,000 | $0 | ($727,000) | $0 |
| 42 | END OF LIFE SERVICES | $139,230 | $139,230 | $140,000 | $140,000 | $770 | $770 |
| 43 | SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER | $53,000 | $0 | $0 | $0 | ($53,000) | $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

| | | NOV. 2017 EST. FOR 2017-18 | | NOV. 2017 EST. FOR 2018-19 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | **BENEFITS** | | | | | | |
| 44 | BEHAVIORAL HEALTH TREATMENT - BIS DDS TRANSITION | $911,000 | $398,500 | $94,006,000 | $41,125,920 | $93,095,000 | $40,727,420 |
| 45 | DIABETES PREVENTION PROGRAM | $0 | $0 | $315,560 | $122,590 | $315,560 | $122,590 |
| 46 | PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS | ($1,156,180) | ($522,160) | ($4,751,070) | ($2,149,070) | ($3,594,890) | ($1,626,920) |
| 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 | $45,369,000 | $21,291,420 | $45,369,000 | $21,291,420 |
| | **BENEFITS SUBTOTAL** | **$1,343,111,720** | **$304,800,240** | **$1,461,078,360** | **$378,972,210** | **$117,966,640** | **$74,171,970** |
| | **PHARMACY** | | | | | | |
| 47 | NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS | $38,796,190 | $17,518,730 | $111,136,930 | $50,271,520 | $72,340,740 | $32,752,790 |
| 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 | ($66,000,000) | ($26,611,730) | ($66,000,000) | ($26,611,730) |
| 50 | LITIGATION SETTLEMENTS | ($2,526,000) | ($2,526,000) | $0 | $0 | $2,526,000 | $2,526,000 |
| 51 | BCCTP DRUG REBATES | ($9,172,000) | ($2,884,700) | ($8,765,000) | ($2,756,600) | $407,000 | $128,100 |
| 52 | FAMILY PACT DRUG REBATES | ($17,503,000) | ($2,177,000) | ($18,073,000) | ($2,247,900) | ($570,000) | ($70,900) |
| 53 | MEDICAL SUPPLY REBATES | ($24,916,000) | ($12,458,000) | ($24,916,000) | ($12,458,000) | $0 | $0 |
| 54 | STATE SUPPLEMENTAL DRUG REBATES | ($202,948,000) | ($62,783,280) | ($217,046,000) | ($68,240,500) | ($14,098,000) | ($5,457,220) |
| 55 | FEDERAL DRUG REBATES | ($2,254,707,000) | ($725,409,460) | ($2,411,486,000) | ($785,546,840) | ($156,779,000) | ($60,137,380) |
| 210 | DRUG REBATES - RETROACTIVE ACA ADJUSTMENTS | $0 | $46,504,000 | $0 | $0 | $0 | ($46,504,000) |
| | **PHARMACY SUBTOTAL** | **($2,533,261,810)** | **($487,611,880)** | **($2,635,149,070)** | **($847,590,050)** | **($101,887,260)** | **($359,978,170)** |
| | **DRUG MEDI-CAL** | | | | | | |
| 56 | DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER | $372,865,000 | $76,171,430 | $1,039,568,000 | $209,807,530 | $666,703,000 | $133,636,100 |
| 61 | DRUG MEDI-CAL PROGRAM COST SETTLEMENT | $3,000,000 | $100,000 | $0 | $0 | ($3,000,000) | ($100,000) |
| | **DRUG MEDI-CAL SUBTOTAL** | **$375,865,000** | **$76,271,430** | **$1,039,568,000** | **$209,807,530** | **$663,703,000** | **$133,536,100** |

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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

| | | NOV. 2017 EST. FOR 2017-18 | | NOV. 2017 EST. FOR 2018-19 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | **MENTAL HEALTH** | | | | | | |
| 65 | SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT | $266,121,000 | $0 | $0 | $0 | ($266,121,000) | $0 |
| 66 | PATHWAYS TO WELL-BEING | $12,982,000 | $0 | $13,419,000 | $0 | $437,000 | $0 |
| 67 | MHP COSTS FOR CONTINUUM OF CARE REFORM | $12,305,000 | $6,922,000 | $15,616,000 | $8,577,500 | $3,311,000 | $1,655,500 |
| 68 | TRANSITIONAL SMHS CLAIMS | $1,510,000 | $1,510,000 | $0 | $0 | ($1,510,000) | ($1,510,000) |
| 69 | LATE CLAIMS FOR SMHS | $4,000 | $4,000 | $0 | $0 | ($4,000) | ($4,000) |
| 70 | SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT | $0 | ($200,000) | $0 | ($200,000) | $0 | $0 |
| 71 | CHART REVIEW | ($1,806,000) | $0 | ($867,000) | $0 | $939,000 | $0 |
| 72 | INTERIM AND FINAL COST SETTLEMENTS - SMHS | ($3,972,000) | $377,000 | $0 | $0 | $3,972,000 | ($377,000) |
| | **MENTAL HEALTH SUBTOTAL** | **$287,144,000** | **$8,613,000** | **$28,168,000** | **$8,377,500** | **($258,976,000)** | **($235,500)** |
| | **WAIVER--MH/UCD & BTR** | | | | | | |
| 73 | GLOBAL PAYMENT PROGRAM | $2,279,899,000 | $0 | $2,487,459,000 | $0 | $207,560,000 | $0 |
| 74 | PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL | $1,771,000,000 | $0 | $1,520,000,000 | $0 | ($251,000,000) | $0 |
| 75 | MEDI-CAL 2020 WHOLE PERSON CARE PILOTS | $581,821,000 | $0 | $646,730,000 | $0 | $64,909,000 | $0 |
| 76 | MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE | $106,752,000 | $53,376,000 | $159,630,000 | $79,815,000 | $52,878,000 | $26,439,000 |
| 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 | $1,263,000 | $0 | $376,000 | $0 | ($887,000) | $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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# CURRENT YEAR COMPARED TO BUDGET YEAR
# FISCAL YEARS 2017-18 AND 2018-19

| | | NOV. 2017 EST. FOR 2017-18 | | NOV. 2017 EST. FOR 2018-19 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | **WAIVER--MH/UCD & BTR** | | | | | | |
| 83 | MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM | $0 | ($75,000,000) | $0 | ($75,000,000) | $0 | $0 |
| 84 | CMS DEFERRED CLAIMS | $0 | $71,690,000 | $0 | $6,364,000 | $0 | ($65,326,000) |
| 85 | CMS DEFERRALS & NEGATIVE BALANCE REPAYMENT | $0 | $0 | $0 | $139,386,000 | $0 | $139,386,000 |
| 86 | MH/UCD—SAFETY NET CARE POOL | ($6,723,000) | $0 | $9,712,000 | $0 | $16,435,000 | $0 |
| | **WAIVER--MH/UCD & BTR SUBTOTAL** | **$4,931,350,000** | **$99,261,000** | **$5,330,025,000** | **$206,095,000** | **$398,675,000** | **$106,834,000** |
| | **MANAGED CARE** | | | | | | |
| 90 | MANAGED CARE RATE RANGE IGTS | $3,553,667,000 | $0 | $143,781,000 | $0 | ($3,409,886,000) | $0 |
| 91 | CCI-MANAGED CARE PAYMENTS | $9,981,455,000 | $4,990,727,500 | $7,769,067,000 | $3,884,533,500 | ($2,212,388,000) | ($1,106,194,000) |
| 92 | MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES | $2,131,735,000 | $610,312,390 | $2,246,407,000 | $654,341,330 | $114,672,000 | $44,028,940 |
| 93 | MANAGED CARE PUBLIC HOSPITAL IGTS | $1,717,598,000 | $0 | $0 | $0 | ($1,717,598,000) | $0 |
| 96 | HQAF RATE RANGE INCREASES | $265,300,000 | $0 | $0 | $0 | ($265,300,000) | $0 |
| 99 | MCO TAX MGD. CARE PLANS - INCR. CAP. RATES | $22,018,000 | $10,821,000 | $0 | $0 | ($22,018,000) | ($10,821,000) |
| 101 | CCI-QUALITY WITHHOLD REPAYMENTS | $2,946,000 | $1,473,000 | $11,412,000 | $5,706,000 | $8,466,000 | $4,233,000 |
| 103 | PALLIATIVE CARE SERVICES IMPLEMENTATION | $2,046,000 | $961,590 | ($122,000) | ($46,210) | ($2,168,000) | ($1,007,800) |
| 104 | MANAGED CARE PUBLIC HOSPITAL DIRECTED PAYMENTS | $0 | $0 | $1,569,000,000 | $457,596,400 | $1,569,000,000 | $457,596,400 |
| 105 | MANAGED CARE HEALTH CARE FINANCING PROGRAM | $0 | $0 | $1,515,011,000 | $454,545,260 | $1,515,011,000 | $454,545,260 |
| 106 | MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL | $0 | $0 | $640,000,000 | $186,654,920 | $640,000,000 | $186,654,920 |
| 107 | CAPITATED RATE ADJUSTMENT FOR FY 2018-19 | $0 | $0 | $381,976,000 | $180,904,240 | $381,976,000 | $180,904,240 |
| 108 | HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS | $0 | $0 | $13,384,000 | $1,338,000 | $13,384,000 | $1,338,000 |
| 109 | MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT | $0 | ($13,988,000) | $0 | $0 | $0 | $13,988,000 |
| 110 | MCO TAX MANAGED CARE PLANS | $0 | ($414,743,000) | $0 | $0 | $0 | $414,743,000 |

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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

| | | NOV. 2017 EST. FOR 2017-18 | | NOV. 2017 EST. FOR 2018-19 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | **MANAGED CARE** | | | | | | |
| 111 | MANAGED CARE IGT ADMIN. & PROCESSING FEE | $0 | ($267,419,000) | $0 | ($32,103,000) | $0 | $235,316,000 |
| 112 | GENERAL FUND REIMBURSEMENTS FROM DPHS | $0 | ($160,090,000) | $0 | $0 | $0 | $160,090,000 |
| 113 | MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND | $0 | ($15,517,000) | $0 | ($1,274,187,000) | $0 | ($1,258,670,000) |
| 114 | MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ. | $0 | ($585,365,000) | $0 | ($643,334,000) | $0 | ($57,969,000) |
| 115 | MCO ENROLLMENT TAX MANAGED CARE PLANS | $0 | ($1,782,194,000) | $0 | ($1,875,880,000) | $0 | ($93,686,000) |
| 116 | MANAGED CARE DRUG REBATES | ($1,889,663,000) | ($616,537,360) | ($1,913,660,000) | ($624,990,980) | ($23,997,000) | ($8,453,620) |
| 117 | RETRO MC RATE ADJUSTMENTS | ($4,100,436,000) | $335,023,000 | $87,972,000 | $45,463,000 | $4,188,408,000 | ($289,560,000) |
| | **MANAGED CARE SUBTOTAL** | **$11,686,666,000** | **$2,093,465,120** | **$12,464,228,000** | **$1,420,541,460** | **$777,562,000** | **($672,923,660)** |
| | **PROVIDER RATES** | | | | | | |
| 118 | DPH INTERIM & FINAL RECONS | $215,065,000 | $0 | $240,730,000 | $0 | $25,665,000 | $0 |
| 119 | DENTAL RETROACTIVE RATE CHANGES | $186,708,000 | $73,374,740 | $0 | $0 | ($186,708,000) | ($73,374,740) |
| 120 | FQHC/RHC/CBRC RECONCILIATION PROCESS | $204,677,000 | $77,124,800 | $161,794,000 | $61,413,350 | ($42,883,000) | ($15,711,450) |
| 121 | AB 1629 ANNUAL RATE ADJUSTMENTS | $142,595,970 | $71,297,980 | $117,343,730 | $58,671,870 | ($25,252,230) | ($12,626,120) |
| 122 | RATE INCREASE FOR FQHCS/RHCS/CBRCS | $152,974,700 | $57,642,270 | $202,003,490 | $76,676,450 | $49,028,780 | $19,034,180 |
| 123 | LTC RATE ADJUSTMENT | $26,296,090 | $13,148,050 | $31,325,170 | $15,662,590 | $5,029,080 | $2,514,540 |
| 124 | DPH INTERIM RATE GROWTH | $20,964,600 | $10,482,300 | $79,089,610 | $39,544,800 | $58,125,010 | $29,062,500 |
| 125 | HOSPICE RATE INCREASES | $4,441,270 | $2,220,640 | $43,790,730 | $21,895,370 | $39,349,460 | $19,674,730 |
| 126 | GDSP NEWBORN SCREENING PROGRAM FEE INCREASE | $19,493,110 | $9,746,560 | $7,875,440 | $3,937,720 | ($11,617,670) | ($5,808,840) |
| 127 | EMERGENCY MEDICAL AIR TRANSPORTATION ACT | $10,868,000 | ($2,456,000) | $12,138,000 | ($2,456,000) | $1,270,000 | $0 |
| 128 | GDSP PRENATAL SCREENING FEE INCREASE | $4,088,320 | $2,044,160 | $2,749,450 | $1,374,730 | ($1,338,870) | ($669,440) |
| 129 | ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE | $425,520 | ($349,470) | $4,907,410 | ($3,969,690) | $4,481,890 | ($3,620,220) |

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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

| | | NOV. 2017 EST. FOR 2017-18 | | NOV. 2017 EST. FOR 2018-19 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | **PROVIDER RATES** | | | | | | |
| 130 | ALTERNATIVE BIRTHING CENTER REIMBURSEMENT | $44,930 | $22,470 | $50,640 | $25,320 | $5,710 | $2,860 |
| 131 | DP/NF-B RETROACTIVE RECOUPMENT FORGIVENESS | $0 | $744,000 | $0 | $0 | $0 | ($744,000) |
| 133 | LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES | $0 | ($539,842,000) | $0 | ($504,609,000) | $0 | $35,233,000 |
| 134 | DPH INTERIM RATE | $0 | ($394,275,310) | $0 | ($408,504,510) | $0 | ($14,229,200) |
| 135 | LABORATORY RATE METHODOLOGY CHANGE | ($20,994,980) | ($10,497,490) | ($22,610,000) | ($11,305,000) | ($1,615,020) | ($807,510) |
| 136 | REDUCTION TO RADIOLOGY RATES | ($20,250,050) | ($10,125,020) | ($50,604,900) | ($25,302,450) | ($30,354,850) | ($15,177,430) |
| 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 | $64,475,000 | $0 | $64,475,000 | $0 |
| | **PROVIDER RATES SUBTOTAL** | **$743,513,490** | **($741,639,330)** | **$695,637,780** | **($776,654,460)** | **($47,875,710)** | **($35,015,130)** |
| | **SUPPLEMENTAL PMNTS.** | | | | | | |
| 138 | HOSPITAL QAF - MANAGED CARE PAYMENTS | $6,869,242,000 | $0 | $3,636,684,000 | $0 | ($3,232,558,000) | $0 |
| 139 | HOSPITAL QAF - FFS PAYMENTS | $4,865,095,000 | $0 | $3,526,939,000 | $0 | ($1,338,156,000) | $0 |
| 140 | GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS | $1,207,941,000 | $0 | $999,744,000 | $0 | ($208,197,000) | $0 |
| 141 | PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS | $746,051,000 | $0 | $1,338,039,000 | $0 | $591,988,000 | $0 |
| 142 | PRIVATE HOSPITAL DSH REPLACEMENT | $569,419,000 | $284,709,500 | $571,519,000 | $285,759,500 | $2,100,000 | $1,050,000 |
| 143 | HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS | $433,217,000 | $0 | $379,083,000 | $0 | ($54,134,000) | $0 |
| 144 | DSH PAYMENT | $469,970,000 | $13,102,000 | $425,460,000 | $13,554,000 | ($44,510,000) | $452,000 |
| 145 | PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT | $324,086,000 | $118,400,000 | $297,963,000 | $118,400,000 | ($26,123,000) | $0 |
| 146 | NDPH IGT SUPPLEMENTAL PAYMENTS | $233,467,000 | ($8,190,000) | $125,874,000 | ($4,643,000) | ($107,593,000) | $3,547,000 |
| 147 | SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES | $223,809,000 | $0 | $461,501,000 | $0 | $237,692,000 | $0 |
| 148 | WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS | $158,347,000 | $0 | $183,259,000 | $0 | $24,912,000 | $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

| | | NOV. 2017 EST. FOR 2017-18 | | NOV. 2017 EST. FOR 2018-19 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | **SUPPLEMENTAL PMNTS.** | | | | | | |
| 149 | DPH PHYSICIAN & NON-PHYS. COST | $155,563,000 | $0 | $123,573,000 | $0 | ($31,990,000) | $0 |
| 150 | CAPITAL PROJECT DEBT REIMBURSEMENT | $153,994,000 | $37,764,000 | $123,280,000 | $41,398,000 | ($30,714,000) | $3,634,000 |
| 151 | FFP FOR LOCAL TRAUMA CENTERS | $147,634,000 | $0 | $135,868,000 | $0 | ($11,766,000) | $0 |
| 152 | MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS | $137,213,000 | $0 | $116,910,000 | $0 | ($20,303,000) | $0 |
| 153 | QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS | $86,242,000 | $48,928,000 | $86,242,000 | $48,928,000 | $0 | $0 |
| 154 | GEMT SUPPLEMENTAL PAYMENT PROGRAM | $70,105,000 | $0 | $37,900,000 | $0 | ($32,205,000) | $0 |
| 155 | CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS | $57,392,000 | $0 | $59,590,000 | $0 | $2,198,000 | $0 |
| 156 | ICF/DD SUPPLEMENTAL PAYMENTS | $13,257,000 | $0 | $35,616,000 | $0 | $22,359,000 | $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 | $5,902,000 | $0 | $271,000 | $0 | ($5,631,000) | $0 |
| 160 | AIDS WAIVER SUPPLEMENTAL PAYMENTS | $5,474,000 | $0 | $6,800,000 | $0 | $1,326,000 | $0 |
| 161 | NDPH SUPPLEMENTAL PAYMENT | $5,410,000 | $1,900,000 | $4,315,000 | $1,900,000 | ($1,095,000) | $0 |
| 162 | STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS | $4,664,000 | $0 | $4,614,000 | $0 | ($50,000) | $0 |
| 163 | MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS | $0 | $0 | $2,100,000,000 | $0 | $2,100,000,000 | $0 |
| 164 | DP-NF CAPITAL PROJECT DEBT REPAYMENT | $0 | $57,224,000 | $0 | $0 | $0 | ($57,224,000) |
| | **SUPPLEMENTAL PMNTS. SUBTOTAL** | **$16,961,494,000** | **$562,837,500** | **$14,799,044,000** | **$514,296,500** | **($2,162,450,000)** | **($48,541,000)** |
| | **OTHER** | | | | | | |
| 170 | CCI IHSS RECONCILIATION | $339,270,000 | $0 | $0 | $0 | ($339,270,000) | $0 |
| 171 | ARRA HITECH - PROVIDER PAYMENTS | $319,499,000 | $0 | $240,392,000 | $0 | ($79,107,000) | $0 |
| 174 | ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS | $117,532,000 | $0 | $63,133,000 | $0 | ($54,399,000) | $0 |
| 178 | INFANT DEVELOPMENT PROGRAM | $42,024,000 | $0 | $29,439,000 | $0 | ($12,585,000) | $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

| | | NOV. 2017 EST. FOR 2017-18 | | NOV. 2017 EST. FOR 2018-19 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | **OTHER** | | | | | | |
| 179 | ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS | $19,472,000 | $8,512,000 | $11,106,000 | $5,082,000 | ($8,366,000) | ($3,430,000) |
| 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 | $13,928,000 | $13,928,000 | $0 | $0 | ($13,928,000) | ($13,928,000) |
| 182 | OVERTIME FOR WPCS PROVIDERS | $9,934,000 | $4,967,000 | $10,128,000 | $5,064,000 | $194,000 | $97,000 |
| 184 | INDIAN HEALTH SERVICES | $4,104,000 | ($21,891,000) | $5,592,000 | ($21,891,000) | $1,488,000 | $0 |
| 185 | MEDI-CAL ESTATE RECOVERIES | $3,041,000 | $1,520,500 | $21,719,000 | $10,859,500 | $18,678,000 | $9,339,000 |
| 186 | WPCS WORKERS' COMPENSATION | $3,026,000 | $1,513,000 | $3,322,000 | $1,661,000 | $296,000 | $148,000 |
| 190 | CDDS DENTAL SERVICES | $549,000 | $0 | $0 | $0 | ($549,000) | $0 |
| 191 | FUNDING ADJUST.—OTLICP | $132,000 | ($179,393,440) | $133,000 | ($189,235,320) | $1,000 | ($9,841,880) |
| 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 | ($1,305,870,000) | $0 | $0 | $0 | $1,305,870,000 |
| 196 | HOSPITAL QAF - CHILDREN'S HEALTH CARE | $0 | ($851,825,000) | $0 | ($884,850,000) | $0 | ($33,025,000) |
| 197 | FUNDING ADJUST.—ACA OPT. EXPANSION | $0 | ($1,756,837,450) | $0 | ($1,777,687,280) | $0 | ($20,849,830) |
| 198 | COUNTY SHARE OF OTLICP-CCS COSTS | $0 | ($8,764,000) | $0 | ($9,343,000) | $0 | ($579,000) |
| 199 | IMD ANCILLARY SERVICES | $0 | $23,022,000 | $0 | $12,675,000 | $0 | ($10,347,000) |
| 200 | CIGARETTE AND TOBACCO SURTAX FUNDS | $0 | ($182,960,000) | $0 | ($127,234,000) | $0 | $55,726,000 |
| 201 | INTEGRATION OF THE SF CLSB INTO THE ALW | ($1,501,910) | ($750,960) | ($1,527,000) | ($763,500) | ($25,090) | ($12,540) |
| 202 | MEDI-CAL RECOVERIES SETTLEMENTS AND LEGAL COSTS | ($1,730,000) | ($865,000) | ($1,730,000) | ($865,000) | $0 | $0 |
| 211 | ASSISSTED 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 | $1,757,460 | $878,730 | $986,040 | $493,020 | ($771,420) | ($385,710) |
| | **OTHER SUBTOTAL** | **$887,851,720** | **($4,295,158,030)** | **$413,098,100** | **($2,961,557,050)** | **($474,753,620)** | **$1,333,600,980** |
| | **GRAND TOTAL** | **$36,761,613,820** | **($1,051,389,020)** | **$36,564,466,840** | **($602,819,030)** | **($197,146,980)** | **$448,569,990** |

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

# FISCAL YEAR 2018-19 COST PER ELIGIBLE BASED ON NOVEMBER 2017 ESTIMATE

| SERVICE CATEGORY | PA-OAS | NEWLY | PA-ATD | PA-AFDC | LT-OAS | H-PE |
|---|---|---|---|---|---|---|
| PHYSICIANS | $8,604,670 | $120,613,470 | $75,325,900 | $32,913,730 | $2,461,590 | $41,666,500 |
| OTHER MEDICAL | $68,370,050 | $990,846,500 | $393,525,530 | $312,511,440 | $5,926,220 | $40,139,830 |
| CO. & COMM. OUTPATIENT | $4,654,830 | $123,140,930 | $108,089,080 | $27,608,430 | $719,510 | $44,623,760 |
| PHARMACY | $3,541,410 | $401,683,150 | $484,747,010 | $45,714,990 | $2,365,770 | $21,086,260 |
| COUNTY INPATIENT | $5,006,610 | $549,547,020 | $40,255,160 | $26,272,210 | $2,455,140 | $56,346,320 |
| COMMUNITY INPATIENT | $69,312,440 | $1,342,149,420 | $727,563,390 | $297,375,970 | $20,762,150 | $212,449,490 |
| NURSING FACILITIES | $181,462,200 | $132,810,780 | $490,824,000 | $4,912,360 | $1,132,457,290 | $1,144,540 |
| ICF-DD | $1,246,970 | $4,885,390 | $177,035,730 | $619,130 | $47,871,430 | $0 |
| MEDICAL TRANSPORTATION | $4,942,770 | $14,204,620 | $16,548,680 | $2,439,980 | $2,829,650 | $2,297,720 |
| OTHER SERVICES | $82,744,510 | $27,820,480 | $306,677,620 | $35,640,810 | $49,981,980 | $1,242,190 |
| HOME HEALTH | $1,544,810 | $1,631,930 | $166,632,740 | $6,432,390 | $37,190 | $123,030 |
| **FFS SUBTOTAL** | **$431,431,270** | **$3,709,333,680** | **$2,987,224,830** | **$792,441,440** | **$1,267,867,920** | **$421,119,640** |
| DENTAL | $56,731,290 | $491,671,140 | $151,283,430 | $189,104,290 | $18,910,430 | $0 |
| MENTAL HEALTH | $9,300,320 | $277,834,430 | $1,032,038,490 | $723,566,400 | $760,290 | $0 |
| TWO PLAN MODEL | $1,182,468,120 | $10,197,270,880 | $5,469,533,290 | $1,377,426,890 | $0 | $0 |
| COUNTY ORGANIZED HEALTH SYSTEMS | $320,535,120 | $4,060,218,580 | $1,450,050,110 | $336,503,700 | $708,982,840 | $0 |
| GEOGRAPHIC MANAGED CARE | $181,286,790 | $1,849,014,980 | $987,513,190 | $221,575,370 | $0 | $0 |
| PHP & OTHER MANAG. CARE | $239,426,840 | $32,047,740 | $154,240,780 | $22,137,500 | $9,392,890 | $0 |
| EPSDT SCREENS | $0 | $0 | $0 | $5,215,270 | $0 | $0 |
| MEDICARE PAYMENTS | $1,789,519,210 | $0 | $1,685,015,240 | $3,223,230 | $171,129,610 | $0 |
| STATE HOSP./DEVELOPMENTAL CNTRS. | $11,684,060 | $0 | $26,052,660 | $32,779,840 | $1,120,320 | $0 |
| MISC. SERVICES | $832,691,060 | $0 | $5,583,596,250 | $4,931,100 | $0 | $0 |
| DRUG MEDI-CAL | $40,772,050 | $361,970,830 | $91,970,290 | $120,515,340 | $3,952,530 | $0 |
| REGIONAL MODEL | $11,926,450 | $592,654,620 | $310,140,040 | $62,749,820 | $0 | $0 |
| **NON-FFS SUBTOTAL** | **$4,676,341,310** | **$17,862,683,190** | **$16,941,433,780** | **$3,099,728,760** | **$914,248,920** | **$0** |
| **TOTAL DOLLARS (1)** | **$5,107,772,590** | **$21,572,016,870** | **$19,928,658,600** | **$3,892,170,200** | **$2,182,116,840** | **$421,119,640** |
| **ELIGIBLES ***** | **444,200** | **3,882,200** | **986,000** | **1,240,600** | **42,400** | **29,600** |
| **ANNUAL $/ELIGIBLE** | **$11,499** | **$5,557** | **$20,212** | **$3,137** | **$51,465** | **$14,227** |
| **AVG. MO. $/ELIGIBLE** | **$958** | **$463** | **$1,684** | **$261** | **$4,289** | **$1,186** |

(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 NOVEMBER 2017 ESTIMATE

| SERVICE CATEGORY | LT-ATD | POV 250 | MN-OAS | MN-ATD | MN-AFDC | MI-C |
|---|---|---|---|---|---|---|
| PHYSICIANS | $2,218,810 | $12,435,750 | $21,869,310 | $8,028,330 | $121,457,630 | $15,647,680 |
| OTHER MEDICAL | $3,769,200 | $142,233,210 | $131,509,880 | $64,654,750 | $963,753,560 | $86,778,940 |
| CO. & COMM. OUTPATIENT | $624,380 | $17,879,540 | $15,214,190 | $9,600,380 | $106,319,810 | $10,214,660 |
| PHARMACY | $3,702,860 | $4,119,850 | $10,781,700 | $19,050,320 | $98,449,080 | $28,887,320 |
| COUNTY INPATIENT | $5,625,340 | $2,839,770 | $62,730,300 | $21,165,640 | $128,282,910 | $5,951,730 |
| COMMUNITY INPATIENT | $15,454,730 | $90,337,190 | $171,879,450 | $52,441,400 | $787,770,510 | $74,711,990 |
| NURSING FACILITIES | $246,668,870 | $2,380,950 | $242,944,880 | $45,307,180 | $16,838,790 | $3,003,550 |
| ICF-DD | $172,211,670 | $52,220 | $1,174,280 | $8,799,750 | $1,467,200 | $2,146,270 |
| MEDICAL TRANSPORTATION | $1,045,290 | $520,230 | $9,001,800 | $6,384,400 | $5,456,330 | $879,990 |
| OTHER SERVICES | $10,366,410 | $4,804,580 | $78,582,900 | $51,461,030 | $88,456,900 | $11,129,790 |
| HOME HEALTH | $4,300 | $11,132,430 | $1,188,490 | $59,535,790 | $10,374,680 | $15,697,550 |
| **FFS SUBTOTAL** | **$461,691,850** | **$288,735,730** | **$746,877,180** | **$346,428,960** | **$2,328,627,380** | **$255,049,470** |
| DENTAL | $18,910,430 | $129,422,950 | $56,731,290 | $18,910,430 | $548,402,430 | $37,820,860 |
| MENTAL HEALTH | $2,227,830 | $19,346,040 | $10,785,540 | $105,232,390 | $492,121,050 | $75,340,740 |
| TWO PLAN MODEL | $0 | $682,573,450 | $1,263,411,640 | $526,680,690 | $3,152,592,890 | $41,501,880 |
| COUNTY ORGANIZED HEALTH SYSTEMS | $199,034,280 | $381,290,700 | $468,497,500 | $351,334,870 | $1,238,066,170 | $38,800,980 |
| GEOGRAPHIC MANAGED CARE | $0 | $139,198,870 | $171,180,820 | $102,743,290 | $519,295,140 | $5,173,700 |
| PHP & OTHER MANAG. CARE | $207,910 | $8,437,790 | $228,781,320 | $23,338,010 | $34,032,070 | $2,413,600 |
| EPSDT SCREENS | $0 | $3,857,180 | $0 | $0 | $15,140,740 | $753,590 |
| MEDICARE PAYMENTS | $43,044,060 | $0 | $1,225,382,890 | $544,066,520 | $108,206,240 | $0 |
| STATE HOSP./DEVELOPMENTAL CNTRS. | $303,860 | $0 | $13,023,690 | $4,230,250 | $94,170,050 | $4,666,230 |
| MISC. SERVICES | $0 | ($43,233,070) | $883,532,940 | $921,878,320 | $13,831,270 | $754,590 |
| DRUG MEDI-CAL | $1,098,950 | $85,967,610 | $42,332,750 | $14,748,120 | $338,033,990 | $18,421,310 |
| REGIONAL MODEL | $0 | $39,519,780 | $35,146,950 | $27,545,070 | $174,611,190 | $981,370 |
| **NON-FFS SUBTOTAL** | **$264,827,320** | **$1,446,381,300** | **$4,398,807,330** | **$2,640,707,960** | **$6,728,503,230** | **$226,628,840** |
| **TOTAL DOLLARS (1)** | **$726,519,170** | **$1,735,117,030** | **$5,145,684,510** | **$2,987,136,910** | **$9,057,130,610** | **$481,678,300** |
| **ELIGIBLES ***** | **11,500** | **917,500** | **501,200** | **165,700** | **3,564,000** | **176,600** |
| **ANNUAL $/ELIGIBLE** | **$63,176** | **$1,891** | **$10,267** | **$18,027** | **$2,541** | **$2,728** |
| **AVG. MO. $/ELIGIBLE** | **$5,265** | **$158** | **$856** | **$1,502** | **$212** | **$227** |

(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 NOVEMBER 2017 ESTIMATE

| SERVICE CATEGORY | MI-A | REFUGEE | OBRA | POV 185 | POV 133 | POV 100 |
|---|---|---|---|---|---|---|
| PHYSICIANS | $237,280 | $296,770 | $36,240 | $89,305,990 | $8,327,450 | $5,622,300 |
| OTHER MEDICAL | $309,850 | $1,594,540 | $291,120 | $227,127,230 | $138,961,170 | $81,067,870 |
| CO. & COMM. OUTPATIENT | $77,970 | $120,270 | $32,310 | $22,870,250 | $9,417,110 | $6,964,940 |
| PHARMACY | $702,930 | $190,680 | $269,730 | $11,028,530 | $887,180 | $16,809,990 |
| COUNTY INPATIENT | $32,150 | $7,130 | $336,390 | $70,505,030 | $2,388,780 | $1,866,180 |
| COMMUNITY INPATIENT | $549,700 | $691,320 | $2,685,650 | $937,784,950 | $62,790,160 | $39,398,940 |
| NURSING FACILITIES | $24,630,300 | $20 | $4,975,720 | $2,596,720 | $4,597,440 | $10,430 |
| ICF-DD | $1,110,110 | $0 | $350,650 | $202,610 | $232,320 | $490 |
| MEDICAL TRANSPORTATION | $76,890 | $6,670 | $29,900 | $1,890,730 | $427,480 | $219,720 |
| OTHER SERVICES | $355,530 | $20,700 | $17,040 | $9,939,190 | $13,697,160 | $8,561,320 |
| HOME HEALTH | $20 | $0 | $10 | $3,106,370 | $3,099,750 | $958,190 |
| **FFS SUBTOTAL** | **$28,082,740** | **$2,928,110** | **$9,024,750** | **$1,376,357,590** | **$244,825,980** | **$161,480,370** |
| DENTAL | $18,910,430 | $18,910,430 | $22,217,340 | $65,387,730 | $108,979,550 | $66,652,040 |
| MENTAL HEALTH | $17,680 | $53,060 | $339,100 | $7,210,310 | $6,419,430 | $21,475,900 |
| TWO PLAN MODEL | $27,470 | $1,527,720 | $0 | $203,594,050 | $626,033,180 | $397,184,530 |
| COUNTY ORGANIZED HEALTH SYSTEMS | $96,020 | $198,210 | $28,030 | $90,404,760 | $277,478,020 | $177,902,930 |
| GEOGRAPHIC MANAGED CARE | $4,810 | $590,060 | $0 | $32,684,430 | $102,170,740 | $69,076,920 |
| PHP & OTHER MANAG. CARE | $1,204,920 | $0 | $0 | $3,616,200 | $6,026,990 | $3,616,200 |
| EPSDT SCREENS | $0 | $0 | $0 | $0 | $3,265,190 | $1,600,570 |
| MEDICARE PAYMENTS | $0 | $0 | $0 | $0 | $0 | $0 |
| STATE HOSP./DEVELOPMENTAL CNTRS. | $31,710 | $0 | $23,780 | $9,274,320 | $0 | $9,969,240 |
| MISC. SERVICES | $310 | $0 | $0 | $37,360 | $2,489,690 | $1,237,920 |
| DRUG MEDI-CAL | $147,760 | $230,870 | $0 | $34,972,540 | $70,111,300 | $33,919,760 |
| REGIONAL MODEL | $0 | $18,220 | $0 | $12,199,250 | $33,345,840 | $19,491,280 |
| **NON-FFS SUBTOTAL** | **$20,441,100** | **$21,528,570** | **$22,608,260** | **$459,380,940** | **$1,236,319,930** | **$802,127,280** |
| **TOTAL DOLLARS (1)** | **$48,523,840** | **$24,456,680** | **$31,633,010** | **$1,835,738,530** | **$1,481,145,910** | **$963,607,650** |
| **ELIGIBLES ***** | **1,200** | **2,400** | **900** | **351,000** | **776,700** | **377,300** |
| **ANNUAL $/ELIGIBLE** | **$40,437** | **$10,190** | **$35,148** | **$5,230** | **$1,907** | **$2,554** |
| **AVG. MO. $/ELIGIBLE** | **$3,370** | **$849** | **$2,929** | **$436** | **$159** | **$213** |

(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 NOVEMBER 2017 ESTIMATE

| SERVICE CATEGORY | TOTAL |
|---|---|
| PHYSICIANS | $567,069,400 |
| OTHER MEDICAL | $3,653,370,880 |
| CO. & COMM. OUTPATIENT | $508,172,330 |
| PHARMACY | $1,154,018,750 |
| COUNTY INPATIENT | $981,613,800 |
| COMMUNITY INPATIENT | $4,906,108,830 |
| NURSING FACILITIES | $2,537,566,020 |
| ICF-DD | $419,406,210 |
| MEDICAL TRANSPORTATION | $69,202,850 |
| OTHER SERVICES | $781,500,140 |
| HOME HEALTH | $281,499,660 |
| **FFS SUBTOTAL** | **$15,859,528,890** |
| DENTAL | $2,018,956,460 |
| MENTAL HEALTH | $2,784,069,000 |
| TWO PLAN MODEL | $25,121,826,670 |
| COUNTY ORGANIZED HEALTH SYSTEMS | $10,099,422,830 |
| GEOGRAPHIC MANAGED CARE | $4,381,509,110 |
| PHP & OTHER MANAG. CARE | $768,920,760 |
| EPSDT SCREENS | $29,832,550 |
| MEDICARE PAYMENTS | $5,569,587,000 |
| STATE HOSP./DEVELOPMENTAL CNTRS. | $207,330,000 |
| MISC. SERVICES | $8,201,747,740 |
| DRUG MEDI-CAL | $1,259,166,000 |
| REGIONAL MODEL | $1,320,329,890 |
| **NON-FFS SUBTOTAL** | **$61,762,698,010** |
| **TOTAL DOLLARS (1)** | **$77,622,226,900** |
| **ELIGIBLES ***** | **13,471,000** |
| **ANNUAL $/ELIGIBLE** | **$5,762** |
| **AVG. MO. $/ELIGIBLE** | **$480** |

(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 NOVEMBER 2017 ESTIMATE

EXCLUDED POLICY CHANGES: 76

| | |
|---|---|
| 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 | MEC OPTIONAL EXPANSION ADJUSTMENT |
| 22 | 1% FMAP INCREASE FOR PREVENTIVE SERVICES |
| 23 | ACA MAGI SAVINGS |
| 26 | ACA DSH REDUCTION |
| 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 |

# FISCAL YEAR 2018-19 COST PER ELIGIBLE BASED ON NOVEMBER 2017 ESTIMATE

EXCLUDED POLICY CHANGES: 76

| | |
|---|---|
| 112 | GENERAL FUND REIMBURSEMENTS FROM DPHS |
| 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 | 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 | 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 | 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 | AIDS WAIVER SUPPLEMENTAL PAYMENTS |
| 161 | NDPH SUPPLEMENTAL PAYMENT |
| 162 | STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS |
| 163 | MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS |
| 164 | DP-NF CAPITAL PROJECT DEBT REPAYMENT |
| 171 | ARRA HITECH - PROVIDER PAYMENTS |

# FISCAL YEAR 2018-19 COST PER ELIGIBLE BASED ON NOVEMBER 2017 ESTIMATE

EXCLUDED POLICY CHANGES: 76

| | |
|---|---|
| 176 | MEDI-CAL TCM PROGRAM |
| 181 | AUDIT SETTLEMENTS |
| 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 |

## Estimated Average Monthly Certified Eligibles
## November 2017 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** | **2,726,900** | **2,663,900** | **2,670,800** | **-2.31%** | **0.26%** |
| Seniors | 435,000 | 437,400 | 444,200 | 0.55% | 1.55% |
| Persons with Disabilities [6] | 996,300 | 985,900 | 986,000 | -1.04% | 0.01% |
| Families [2] | 1,295,600 | 1,240,600 | 1,240,600 | -4.25% | 0.00% |
| **Long Term** | **54,600** | **53,900** | **53,900** | **-1.28%** | **0.00%** |
| Seniors | 42,600 | 42,400 | 42,400 | -0.47% | 0.00% |
| Persons with Disabilities [6] | 12,000 | 11,500 | 11,500 | -4.17% | 0.00% |
| **Medically Needy [1]** | **4,304,700** | **4,225,300** | **4,217,000** | **-1.84%** | **-0.20%** |
| Seniors | 450,600 | 478,000 | 492,900 | 6.08% | 3.12% |
| Persons with Disabilities [6] | 162,100 | 160,100 | 160,100 | -1.23% | 0.00% |
| Families [2] | 3,692,000 | 3,587,200 | 3,564,000 | -2.84% | -0.65% |
| **Medically Indigent** | **197,800** | **179,300** | **177,800** | **-9.35%** | **-0.84%** |
| Children | 196,300 | 178,100 | 176,600 | -9.27% | -0.84% |
| Adults | 1,500 | 1,200 | 1,200 | -20.00% | 0.00% |
| **Other** | **6,251,600** | **6,347,000** | **6,356,200** | **1.53%** | **0.14%** |
| Refugees | 2,100 | 2,100 | 2,400 | 0.00% | 14.29% |
| OBRA [3] | 2,900 | 900 | 900 | -68.97% | 0.00% |
| 185% Poverty [4] | 371,600 | 359,700 | 351,000 | -3.20% | -2.42% |
| 133% Poverty | 749,700 | 776,700 | 776,700 | 3.60% | 0.00% |
| 100% Poverty | 362,600 | 379,400 | 377,300 | 4.63% | -0.55% |
| Opt. Targeted Low Income Children | 940,300 | 917,300 | 917,500 | -2.45% | 0.02% |
| ACA Optional Expansion | 3,774,100 | 3,863,100 | 3,882,200 | 2.36% | 0.49% |
| Hospital PE | 29,600 | 29,600 | 29,600 | 0.00% | 0.00% |
| Medi-Cal Access Program [7] | 4,400 | 4,300 | 4,700 | -2.27% | 9.30% |
| QMB | 14,300 | 13,900 | 13,900 | -2.80% | 0.00% |
| **GRAND TOTAL [5]** | **13,535,600** | **13,469,400** | **13,475,700** | **-0.49%** | **0.05%** |
| **Seniors and Persons with Disabilities** | **2,098,600** | **2,115,300** | **2,137,100** | 0.80% | 1.03% |
| **Families and Children [8]** | **7,411,800** | **7,260,900** | **7,227,100** | -2.04% | -0.47% |

**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] Includes Medically Needy with No Share-of-Cost and Medically Needy with a Share-of-Cost.

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

[3] 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.

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

| | 2016-2017 | 2017-2018 | 2018-2019 |
|---|---|---|---|
| Presumptive Eligibility | 17,000 | 17,400 | 17,400 |

[5] The following Medi-Cal special program eligibles (average monthly during FY 2013-14 shown in parenthesis) are not included above: BCCTP (12,923), Tuberculosis (622), Dialysis (168), TPN (1). Family PACT eligibles are also not included above.

[6] With the May 2015 Medi-Cal Estimate, the Blind and Disabled programs have been combined for estimating purposes.

[7] Previously, Medi-Cal Access Program Mothers and Infants were included in 185% Poverty and Medically Indigent Children categories.

[8] Includes Public Assistance Families, Medically Needy Families, 185% Poverty, 133% Poverty, 100% Poverty, and Optional Targeted Low Income 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 3 Medi-Cal State Inmates** | LT Seniors | 42 | 15 | 15 |
| | MN Seniors | 22 | 28 | 28 |
| | MN Persons with Disabilities | 4 | 6 | 6 |
| | MI Children | 7 | 11 | 11 |
| | 185% Poverty | 1 | 2 | 2 |
| | ACA Optional Expansion | 259 | 265 | 265 |
| | Total | **336** | **326** | **326** |
| **PC 4 Medi-Cal Access Program Mothers 213-322%** | MCAP Mothers | 3,507 | 3,436 | 3,824 |
| | **Total** | **3,507** | **3,436** | **3,824** |
| **PC 8 Medi-Cal Access Program Infants 266-322%** | MCAP Infants | 852 | 848 | 848 |
| | **Total** | **852** | **848** | **848** |
| **PC 14 PARIS-Veterans** | PA Seniors | | (1) | (1) |
| | PA Persons with Disabilities | | (1) | (1) |
| | PA Families | | (1) | (1) |
| | LT Seniors | | (9) | (9) |
| | MN Seniors | | (15) | (15) |
| | MN Persons with Disabilities | | (12) | (12) |
| | MN Families | | (5) | (5) |
| | MI Adults | | (28) | (28) |
| | **Total** | | **(73)** | **(73)** |
| **PC 15 Minimum Wage Increase - Caseload Savings** | MN Families | | (14,667) | (38,537) |
| | MI Children | | (1,015) | (2,667) |
| | 185% Poverty | | 0 | (8,733) |
| | 133% Poverty | | 0 | 0 |
| | 100% Poverty | | (1,310) | (3,443) |
| | OTLICP | | 0 | 0 |
| | ACA Optional Expansion | | (35,136) | (92,319) |
| | **Total** | | **(52,128)** | **(145,699)** |

## 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 |
|---|---|---|---|---|
| | ***By Aid Category Group*** | | | |
| | PA Seniors | 0 | (1) | (1) |
| | PA Persons with Disabilities | 0 | (1) | (1) |
| ***Total by aid code group*** | PA Families | 0 | (1) | (1) |
| | LT Seniors | 42 | 6 | 6 |
| | LT Persons with Disabilities | 0 | 0 | 0 |
| | MN Seniors | 22 | 13 | 13 |
| | MN Persons with Disabilities | 4 | (7) | (7) |
| | MN Families | 0 | (14,671) | (38,541) |
| | MI Children | 7 | (1,004) | (2,657) |
| | MI Adults | 0 | (28) | (28) |
| | Undocumented Persons | 0 | 0 | 0 |
| | 185% Poverty | 1 | 2 | (8,731) |
| | 133% Poverty | 0 | 0 | 0 |
| | 100% Poverty | 0 | (1,310) | (3,443) |
| | OTLICP | 0 | 0 | 0 |
| | ACA Optional Expansion | 259 | (34,871) | (92,054) |
| | MCAP Infants | 852 | 848 | 848 |
| | MCAP Mothers | 3,507 | 3,436 | 3,824 |
| | Refugees | 0 | 0 | 0 |
| | **Total** | **4,695** | **(47,591)** | **(140,775)** |

# Comparison of Average Monthly Certified Eligibles
## November 2017 Estimate
## Fiscal Year 2017-18

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

| | Appropriaton 2017-2018 | November 2017 2017-2018 | % Change |
|---|---|---|---|
| **Public Assistance** | **2,742,400** | **2,663,900** | **-2.86%** |
| Seniors | 441,500 | 437,400 | -0.93% |
| Persons with Disabilities [2] | 995,900 | 985,900 | -1.00% |
| Families | 1,305,000 | 1,240,600 | -4.93% |
| **Long Term** | **54,700** | **53,900** | **-1.46%** |
| Seniors | 42,800 | 42,400 | -0.93% |
| Persons with Disabilities [2] | 11,900 | 11,500 | -3.36% |
| **Medically Needy [1]** | **4,278,500** | **4,225,300** | **-1.24%** |
| Seniors | 458,400 | 478,000 | 4.28% |
| Persons with Disabilities [2] | 159,700 | 160,100 | 0.25% |
| Families | 3,660,400 | 3,587,200 | -2.00% |
| **Medically Indigent** | **201,300** | **179,300** | **-10.93%** |
| Children | 199,700 | 178,100 | -10.82% |
| Adults | 1,600 | 1,200 | -25.00% |
| **Other** | **6,411,200** | **6,347,000** | **-1.00%** |
| Refugees | 2,500 | 2,100 | -16.00% |
| OBRA | 1,500 | 900 | -40.00% |
| 185% Poverty | 378,700 | 359,700 | -5.02% |
| 133% Poverty | 759,200 | 776,700 | 2.31% |
| 100% Poverty | 367,300 | 379,400 | 3.29% |
| Opt. Targeted Low Income Children | 930,900 | 917,300 | -1.46% |
| ACA Optional Expansion | 3,919,600 | 3,863,100 | -1.44% |
| Hospital PE | 30,400 | 29,600 | -2.63% |
| Medi-Cal Access Program [3] | 5,100 | 4,300 | -15.69% |
| QMB | 16,000 | 13,900 | -13.13% |
| **GRAND TOTAL** | **13,688,100** | **13,469,400** | **-1.60%** |

[1] Includes Medically Needy with No Share-of-Cost and Medically Needy with a Share-of-Cost.

[2] With the May 2015 Medi-Cal Estimate, the Blind and Disabled programs have been combined for estimating

[3] Previously, Medi-Cal Access Program Mothers and Infants were included in 185% Poverty and Medically Inc

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

**Managed Care**
***(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** | **2,329,850** | **2,304,500** | **2,313,480** | **-1.09%** | **0.39%** |
| Seniors | 320,330 | 333,650 | 340,980 | 4.16% | 2.20% |
| Persons with Disabilities [4] | 838,840 | 843,220 | 844,710 | 0.52% | 0.18% |
| Families [2] | 1,170,680 | 1,127,630 | 1,127,790 | -3.68% | 0.01% |
| **Long Term** | **26,600** | **28,650** | **28,660** | **7.71%** | **0.03%** |
| Seniors | 20,980 | 22,850 | 22,860 | 8.91% | 0.04% |
| Persons with Disabilities [4] | 5,620 | 5,800 | 5,800 | 3.20% | 0.00% |
| **Medically Needy [1]** | **3,218,760** | **3,206,370** | **3,201,080** | **-0.38%** | **-0.16%** |
| Seniors | 301,570 | 333,470 | 343,640 | 10.58% | 3.05% |
| Persons with Disabilities [4] | 105,970 | 108,820 | 109,990 | 2.69% | 1.08% |
| Families [2] | 2,811,220 | 2,764,080 | 2,747,450 | -1.68% | -0.60% |
| **Medically Indigent** | **46,080** | **43,880** | **42,840** | **-4.77%** | **-2.37%** |
| Children | 45,990 | 43,830 | 42,790 | -4.70% | -2.37% |
| Adults | 90 | 50 | 50 | -44.44% | 0.00% |
| **Other** | **5,184,780** | **5,327,090** | **5,370,200** | **2.74%** | **0.81%** |
| Refugees | 1,260 | 1,300 | 1,370 | 3.17% | 5.38% |
| OBRA | 50 | 10 | 10 | -80.00% | 0.00% |
| 185% Poverty | 198,710 | 201,620 | 195,450 | 1.46% | -3.06% |
| 133% Poverty | 695,670 | 726,310 | 726,460 | 4.40% | 0.02% |
| 100% Poverty | 341,140 | 360,600 | 359,080 | 5.70% | -0.42% |
| Opt. Targeted Low Income Childrer | 872,630 | 855,370 | 855,650 | -1.98% | 0.03% |
| ACA Optional Expansion | 3,072,170 | 3,178,780 | 3,227,720 | 3.47% | 1.54% |
| Medi-Cal Access Program [5] | 3,150 | 3,100 | 4,460 | -1.59% | 43.87% |
| **GRAND TOTAL [3]** | **10,806,070** | **10,910,490** | **10,956,260** | **0.97%** | **0.42%** |
| **Percent of Statewide** | **79.83%** | **81.00%** | **81.30%** | | |

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

[1] Includes Medically Needy with No Share-of-Cost and Medically Needy with a Share-of-Cost.

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

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

[4] With the May 2015 Medi-Cal Estimate, the Blind and Disabled programs have been combined for estimating purposes.

[5] Previously, Medi-Cal Access Program Mothers and Infants were included in 185% Poverty and Medically Indigent Children categories.

# Estimated Average Monthly Certified Eligibles
## November 2017 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** | **397,050** | **359,400** | **357,320** | **-9.48%** | **-0.58%** |
| Seniors | 114,670 | 103,750 | 103,220 | -9.52% | -0.51% |
| Persons with Disabilities [3] | 157,460 | 142,680 | 141,290 | -9.39% | -0.97% |
| Families [2] | 124,920 | 112,970 | 112,810 | -9.57% | -0.14% |
| **Long Term** | **28,000** | **25,250** | **25,240** | **-9.82%** | **-0.04%** |
| Seniors | 21,620 | 19,550 | 19,540 | -9.57% | -0.05% |
| Persons with Disabilities [3] | 6,380 | 5,700 | 5,700 | -10.66% | 0.00% |
| **Medically Needy [1]** | **1,085,940** | **1,018,930** | **1,015,920** | **-6.17%** | **-0.30%** |
| Seniors | 149,030 | 144,530 | 149,260 | -3.02% | 3.27% |
| Persons with Disabilities [3] | 56,130 | 51,280 | 50,110 | -8.64% | -2.28% |
| Families [2] | 880,780 | 823,120 | 816,550 | -6.55% | -0.80% |
| **Medically Indigent** | **151,720** | **135,420** | **134,960** | **-10.74%** | **-0.34%** |
| Children | 150,310 | 134,270 | 133,810 | -10.67% | -0.34% |
| Adults | 1,410 | 1,150 | 1,150 | -18.44% | 0.00% |
| **Other** | **1,066,820** | **1,019,910** | **986,000** | **-4.40%** | **-3.32%** |
| Refugees | 840 | 800 | 1,030 | -4.76% | 28.75% |
| OBRA | 2,850 | 890 | 890 | -68.77% | 0.00% |
| 185% Poverty | 172,890 | 158,080 | 155,550 | -8.57% | -1.60% |
| 133% Poverty | 54,030 | 50,390 | 50,240 | -6.74% | -0.30% |
| 100% Poverty | 21,460 | 18,800 | 18,220 | -12.40% | -3.09% |
| Opt. Targeted Low Income Children | 67,670 | 61,930 | 61,850 | -8.48% | -0.13% |
| ACA Optional Expansion | 701,930 | 684,320 | 654,480 | -2.51% | -4.36% |
| Hospital PE | 29,600 | 29,600 | 29,600 | 0.00% | 0.00% |
| Medi-Cal Access Program [4] | 1,250 | 1,200 | 240 | -4.00% | -80.00% |
| QMB | 14,300 | 13,900 | 13,900 | -2.80% | 0.00% |
| **GRAND TOTAL** | **2,729,530** | **2,558,910** | **2,519,440** | **-6.25%** | **-1.54%** |
| **Percent of Statewide** | **20.17%** | **19.00%** | **18.70%** | | |

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

[1] Includes Medically Needy with No Share-of-Cost and Medically Needy with a Share-of-Cost.

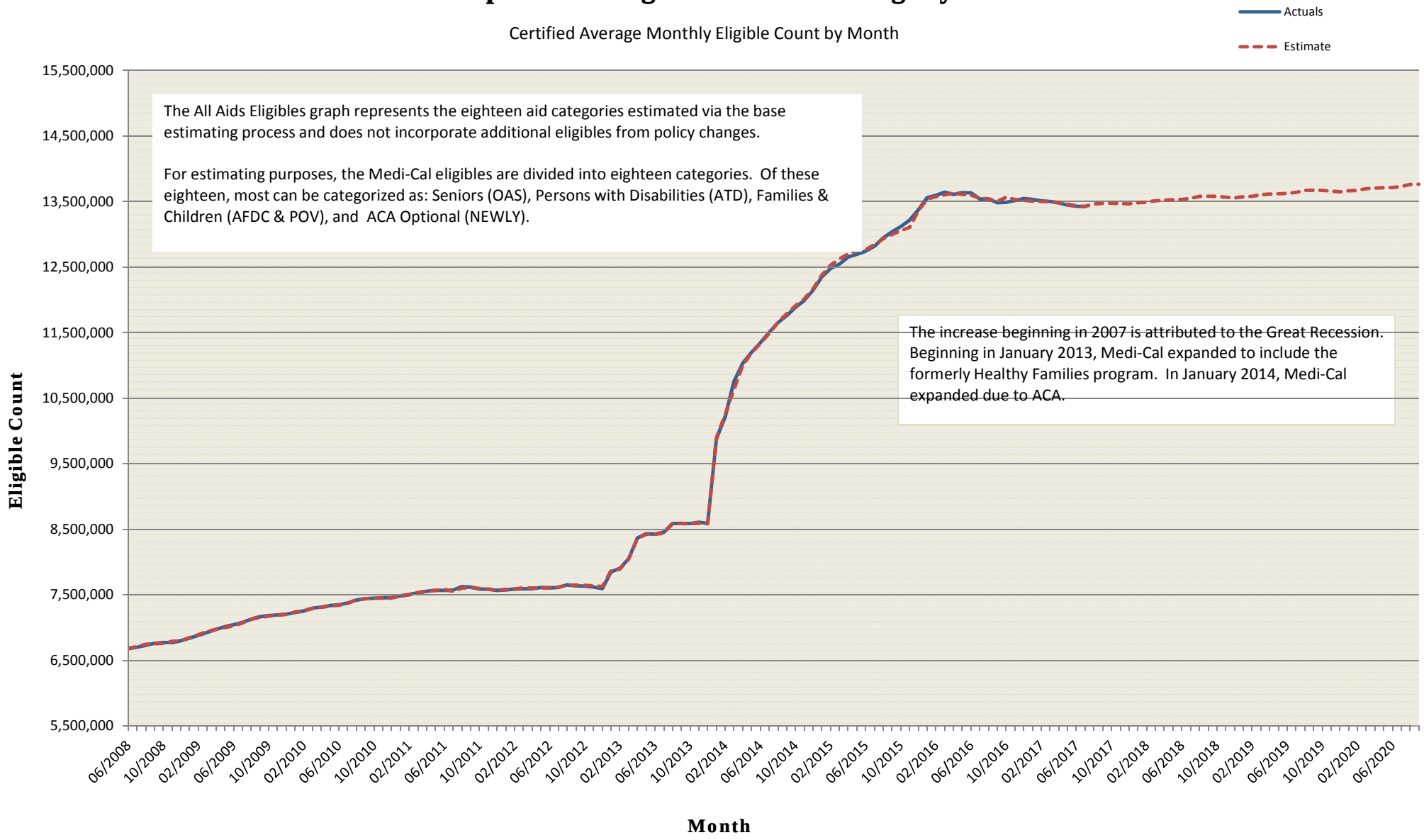
[2] The 1931(b) category of eligibility is included in MN-Families and PA-Families.

[3] With the May 2015 Medi-Cal Estimate, the Blind and Disabled programs have been combined for estimating purposes.

[4] Previously, Medi-Cal Access Program Mothers and Infants were included in 185% Poverty and Medically Indigent Children categories.

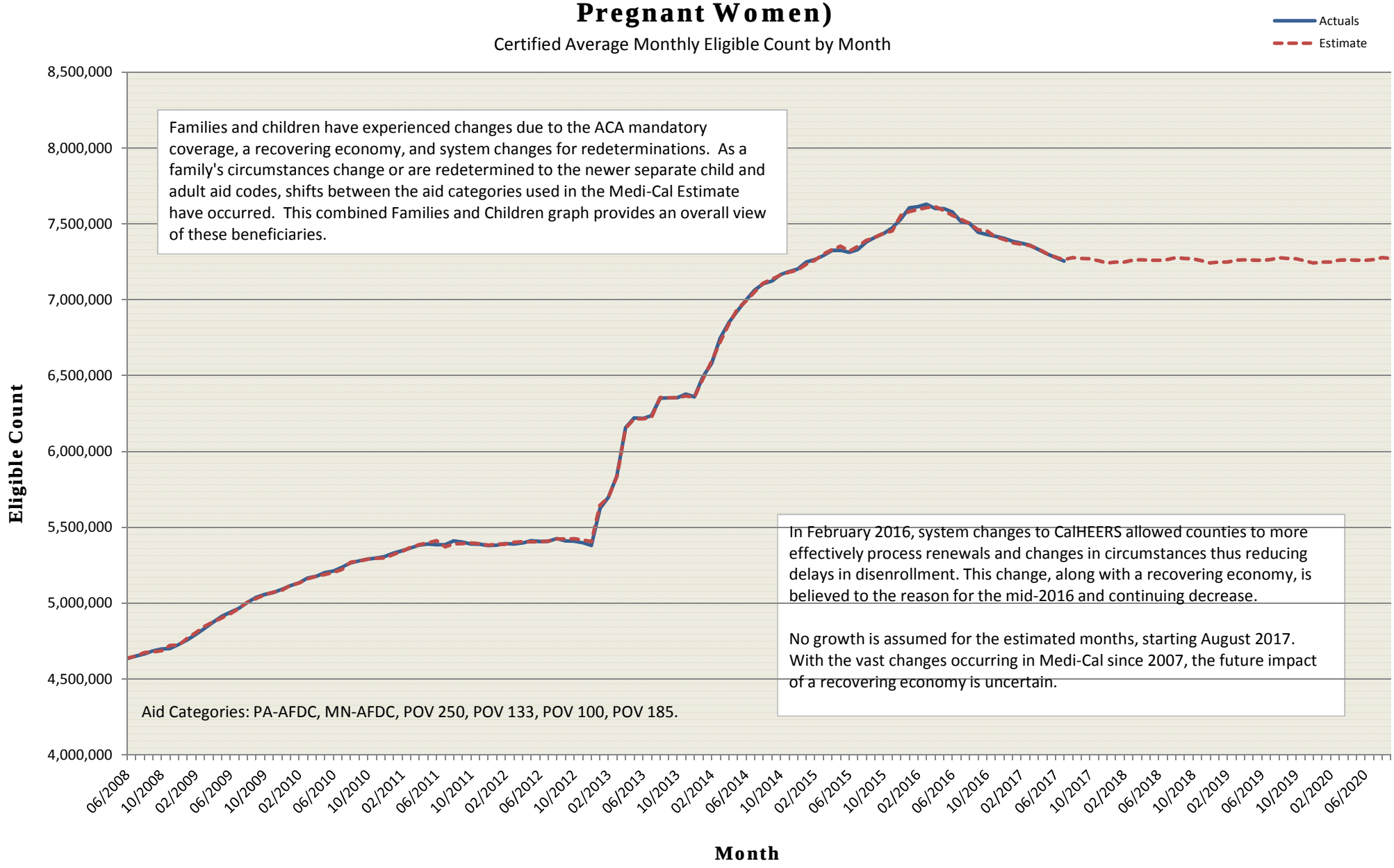
# Statewide Expanded Eligible for Aid Category: All Aids

Certified Average Monthly Eligible Count by Month



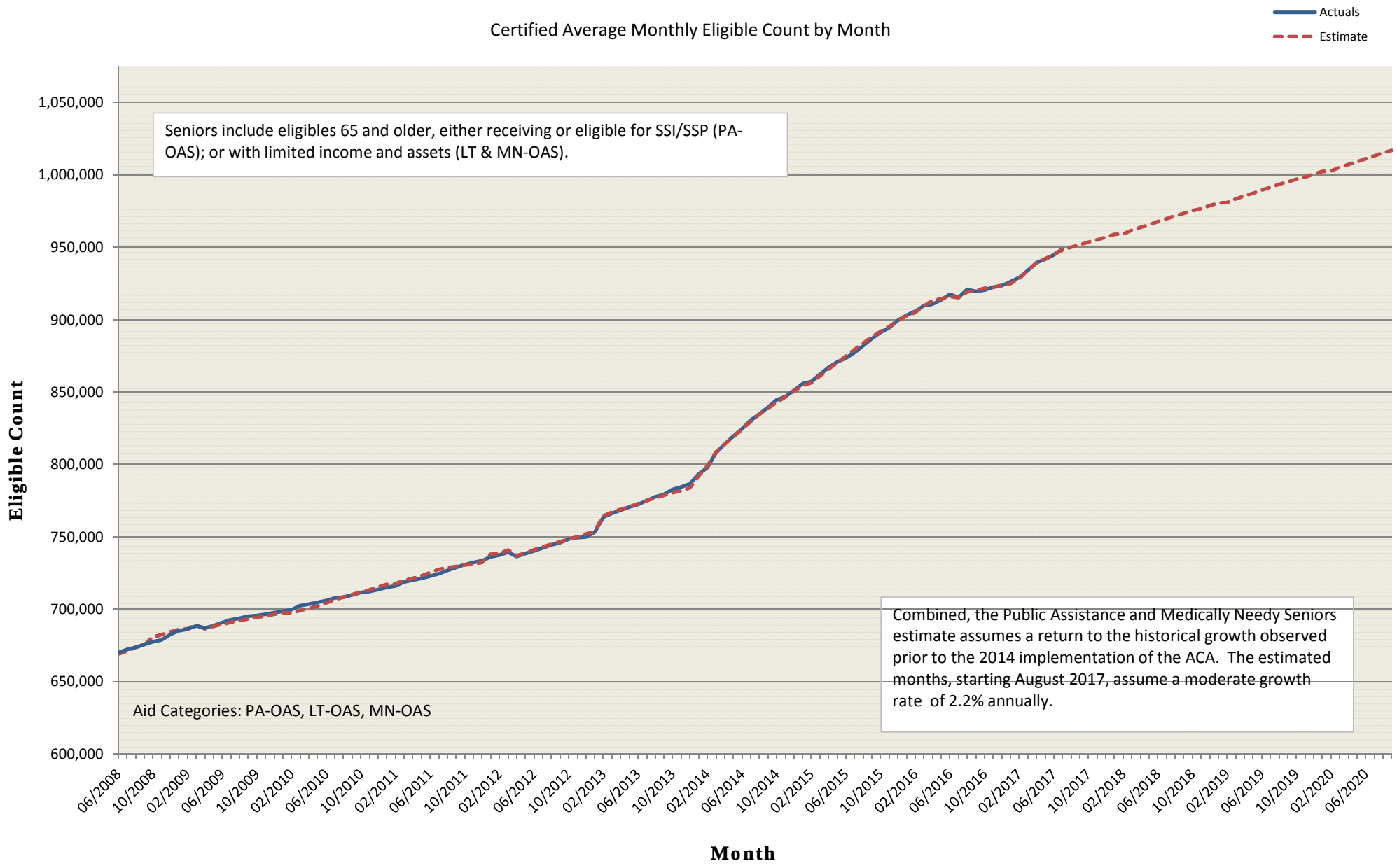
# Statewide Expanded Eligible for Aid Category: Families and Children (including Pregnant Women)

Certified Average Monthly Eligible Count by Month



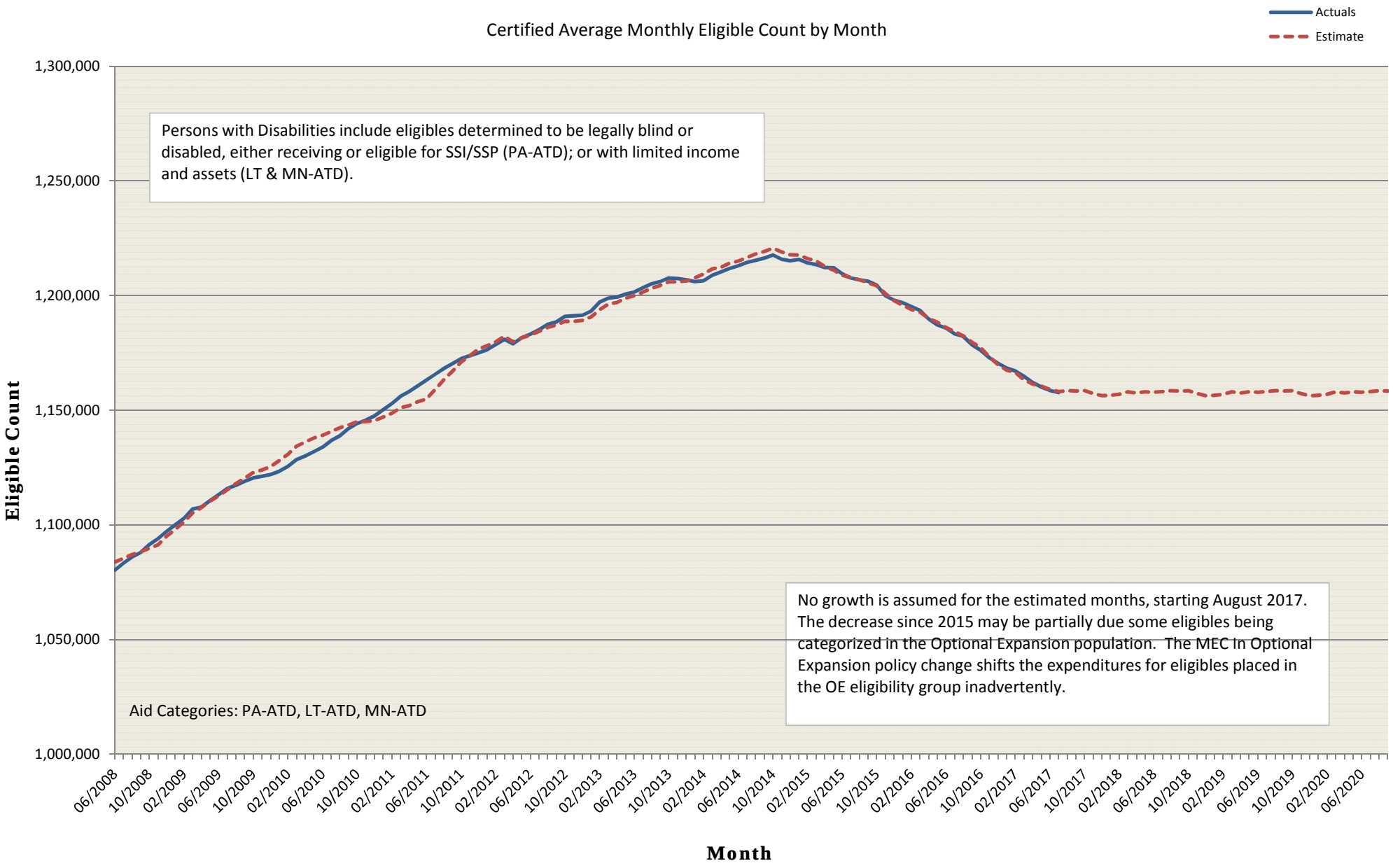
# Statewide Expanded Eligible for Aid Category: Seniors

Certified Average Monthly Eligible Count by Month



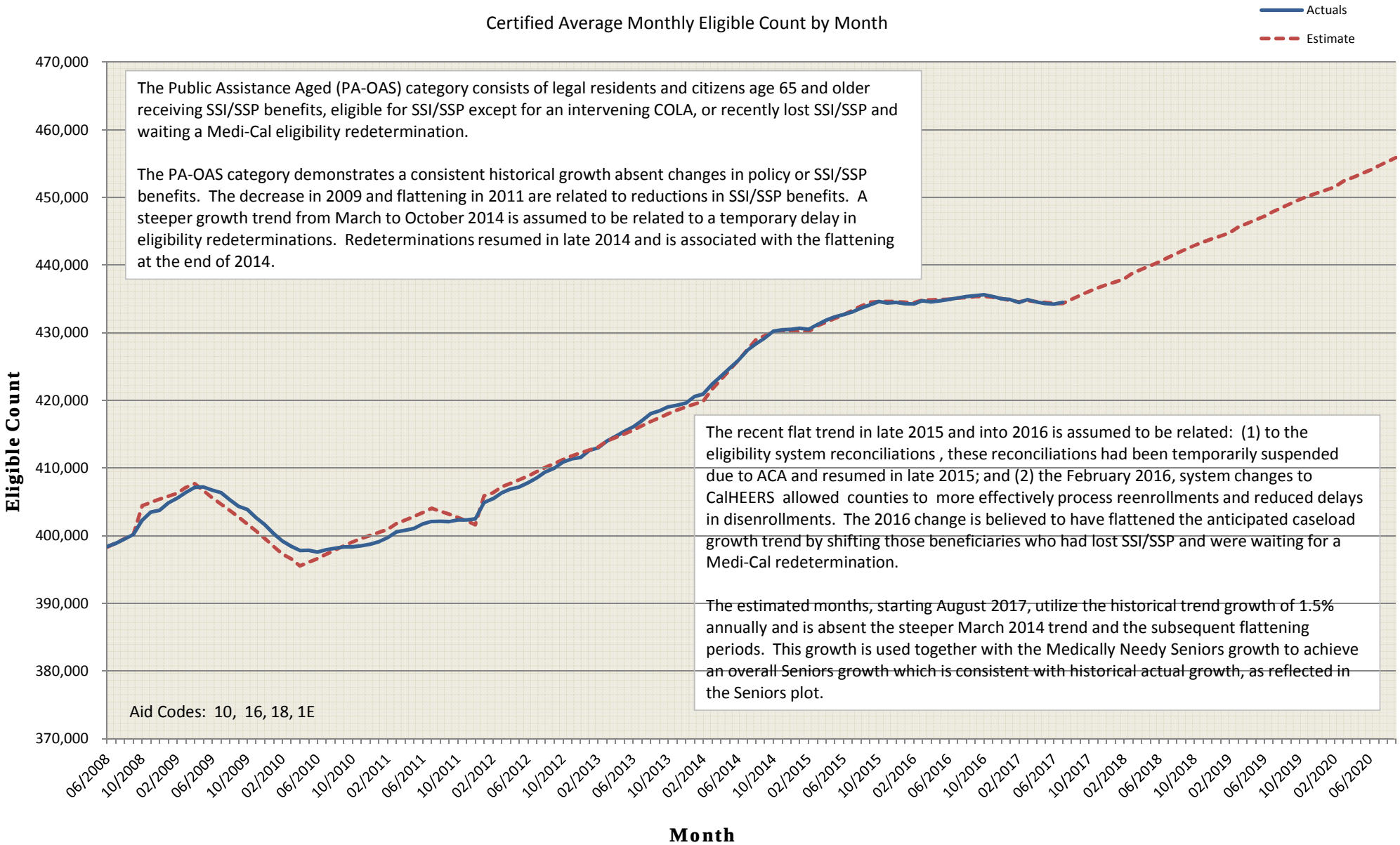
# Statewide Expanded Eligible for Aid Category: Persons with Disabilities

Certified Average Monthly Eligible Count by Month



# 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.

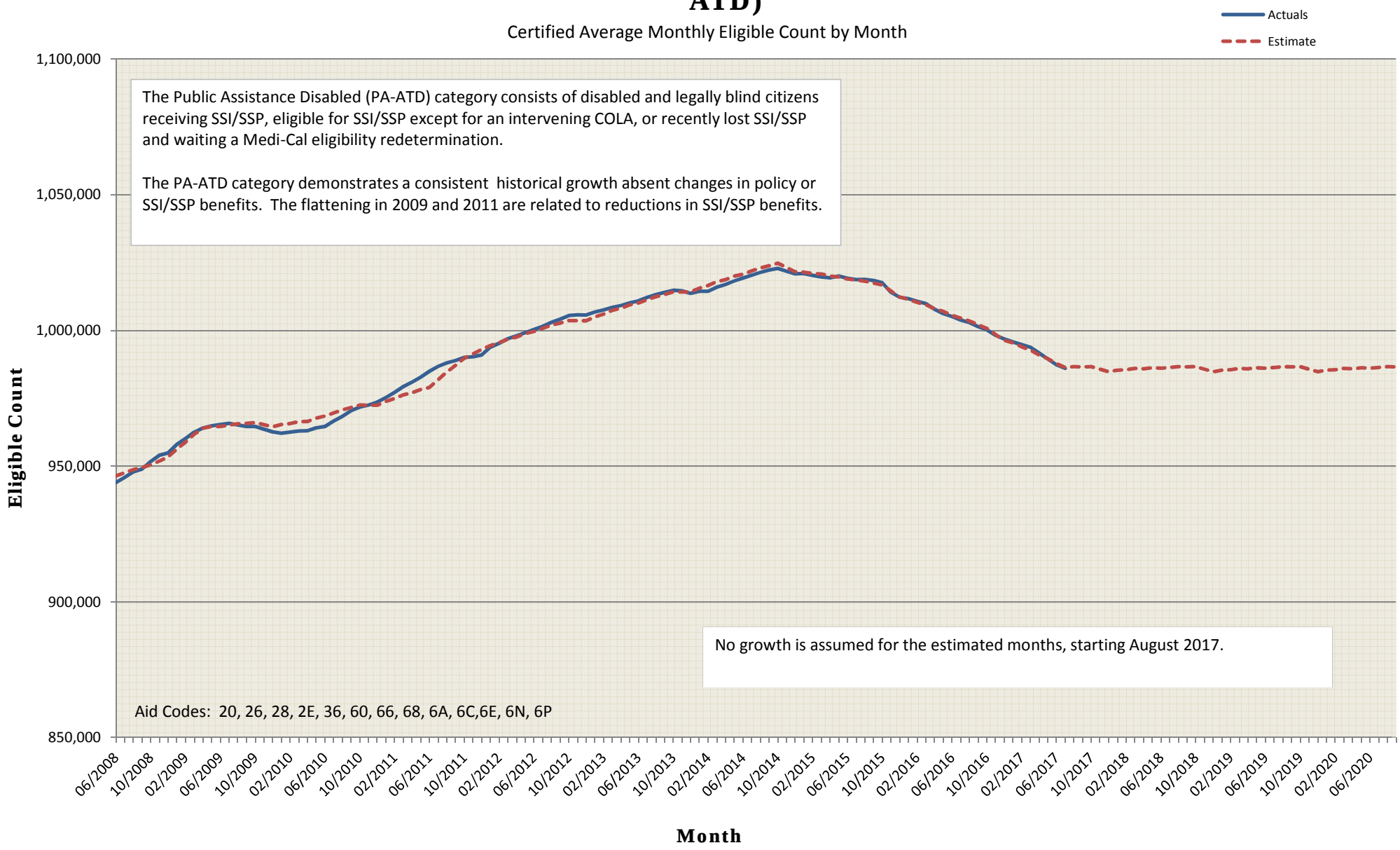
The recent flat trend in late 2015 and into 2016 is assumed to be related: (1) to the eligibility system reconciliations , these reconciliations had been temporarily suspended due to ACA and resumed in late 2015; and (2) the February 2016, system changes to CalHEERS allowed counties to more effectively process reenrollments and reduced delays in disenrollments. The 2016 change is believed to have flattened the anticipated caseload growth trend by shifting those beneficiaries who had lost SSI/SSP and were waiting for a Medi-Cal redetermination.

The estimated months, starting August 2017, utilize the historical trend 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 which is consistent with historical actual growth, as reflected in the Seniors plot.

Aid Codes: 10, 16, 18, 1E

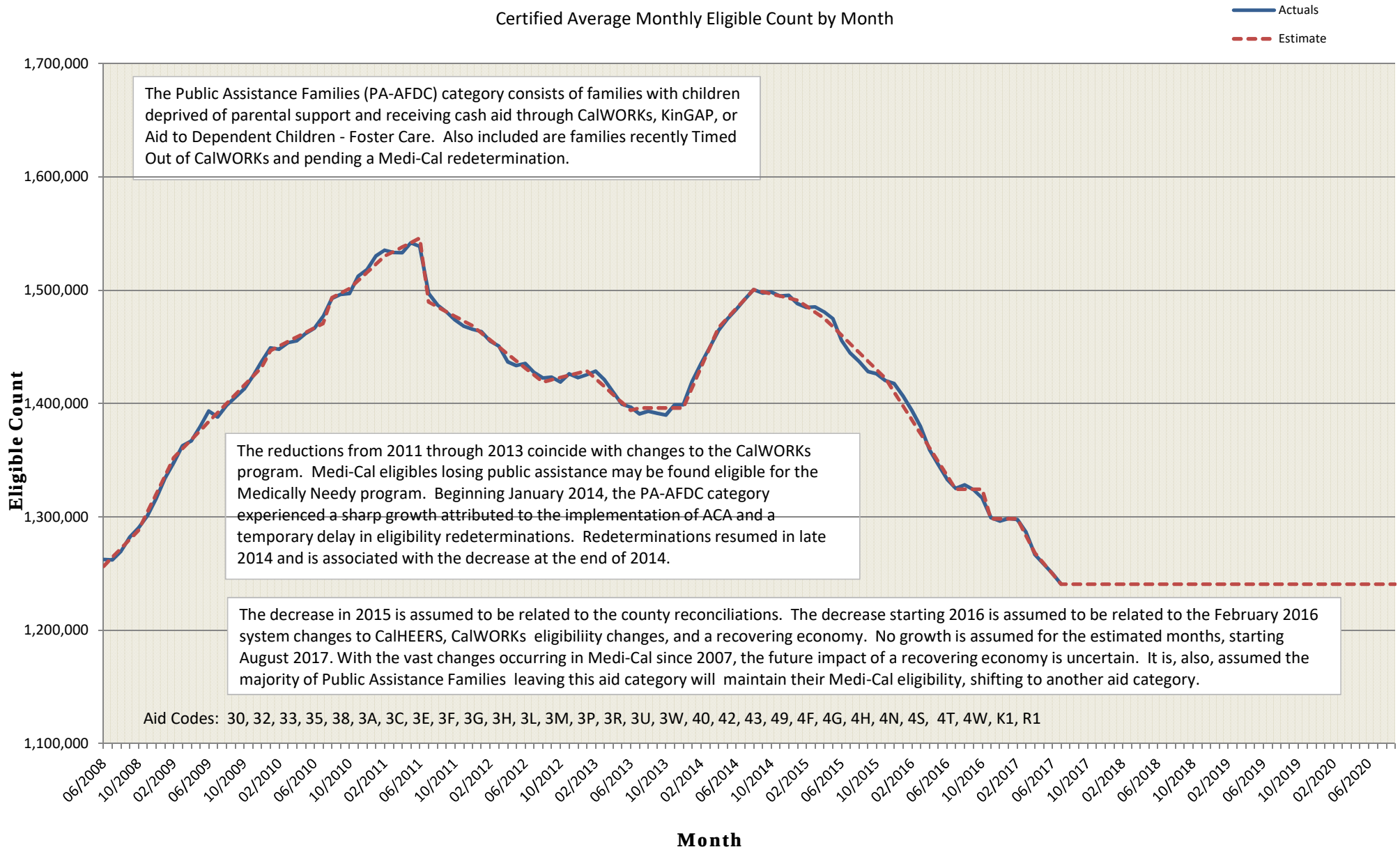
# Statewide Expanded Eligible: Public Assistance Persons with Disabilities (PA-ATD)

Certified Average Monthly Eligible Count by Month



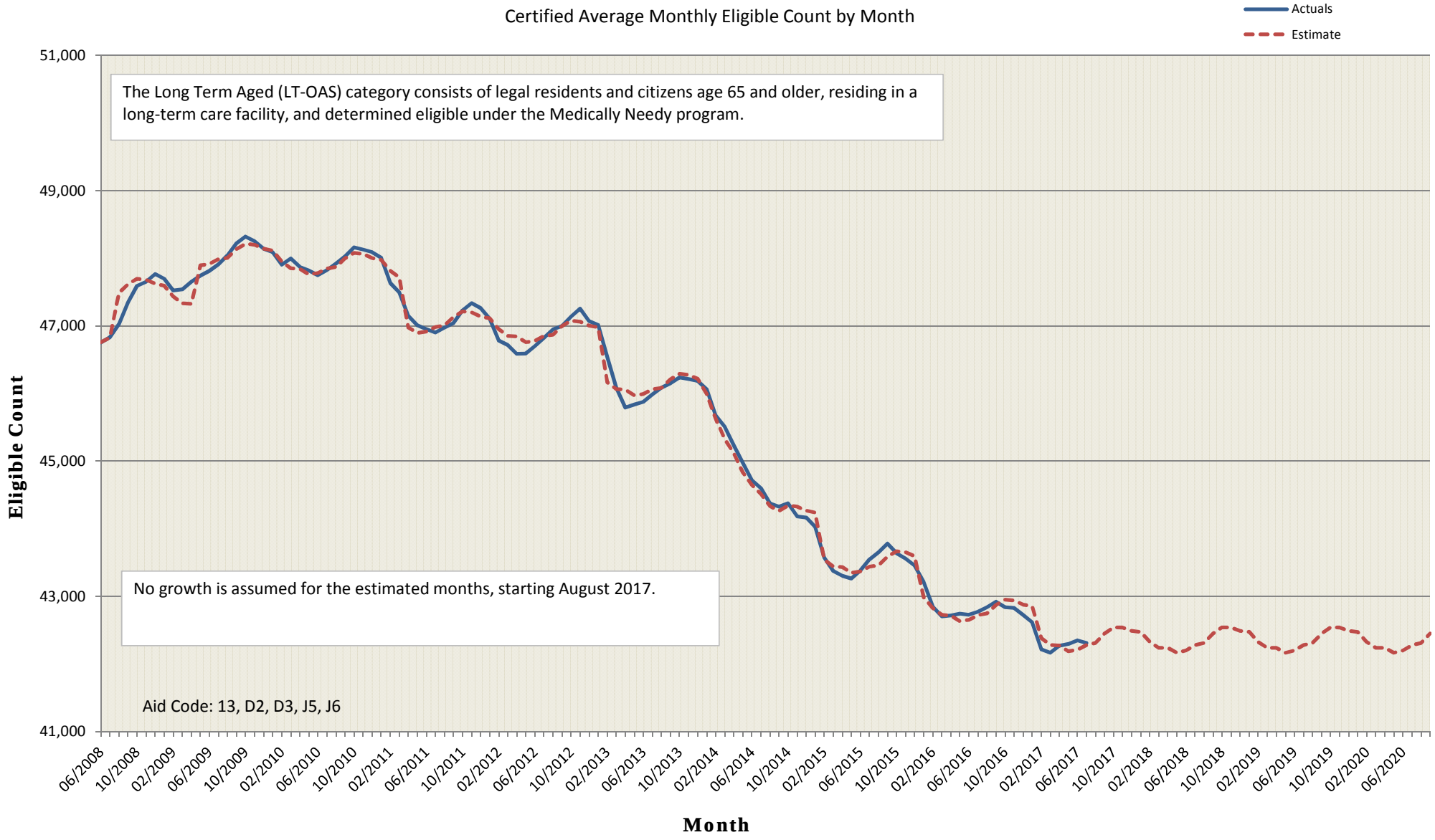
# Statewide Expanded Eligible: Public Assistance Families (PA-AFDC)

Certified Average Monthly Eligible Count by Month



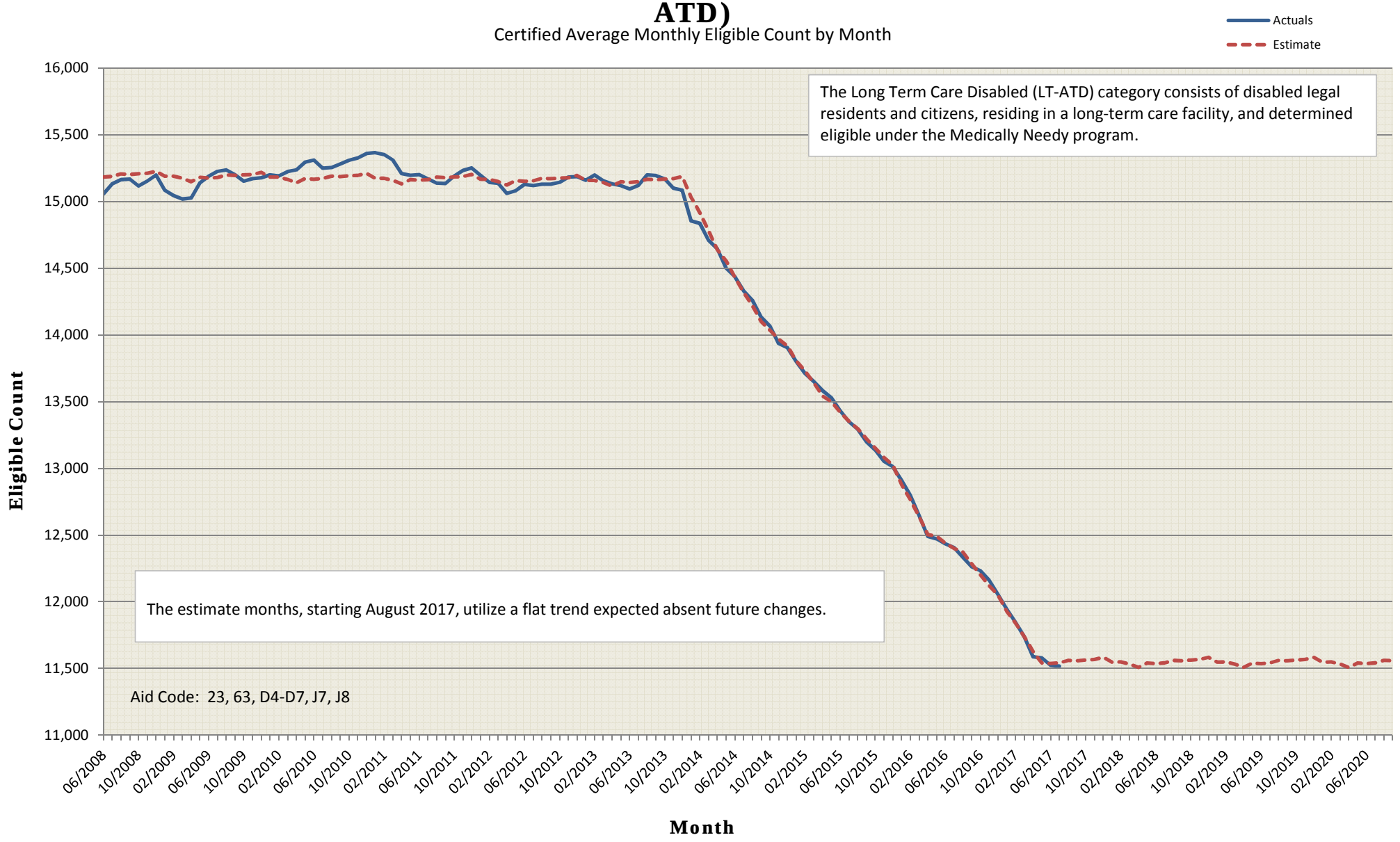
# Statewide Expanded Eligible: Long Term Seniors (LT-OAS)

Certified Average Monthly Eligible Count by Month

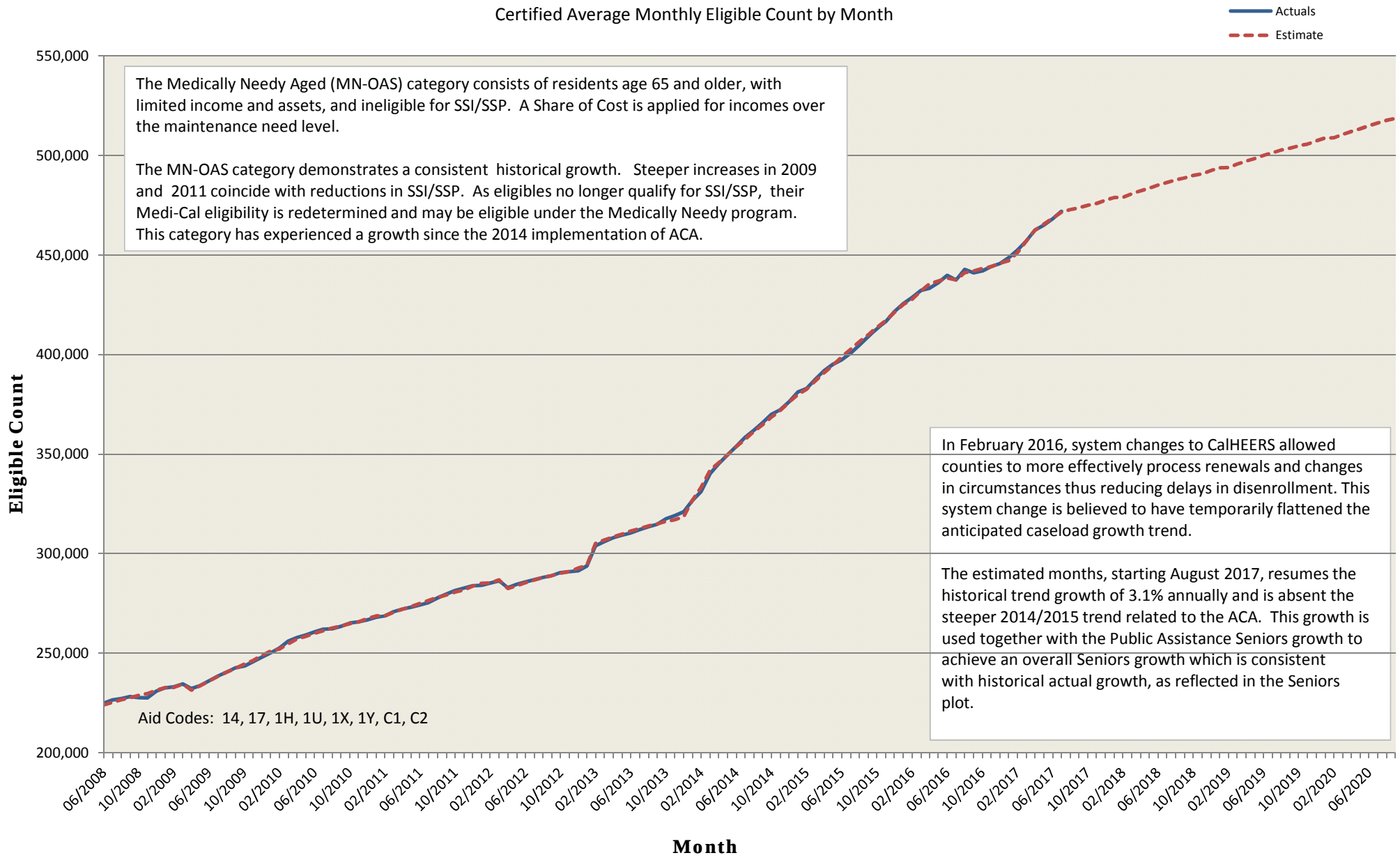


# Statewide Expanded Eligible: Long Term Persons with Disabilities (LT-ATD)

Certified Average Monthly Eligible Count by Month

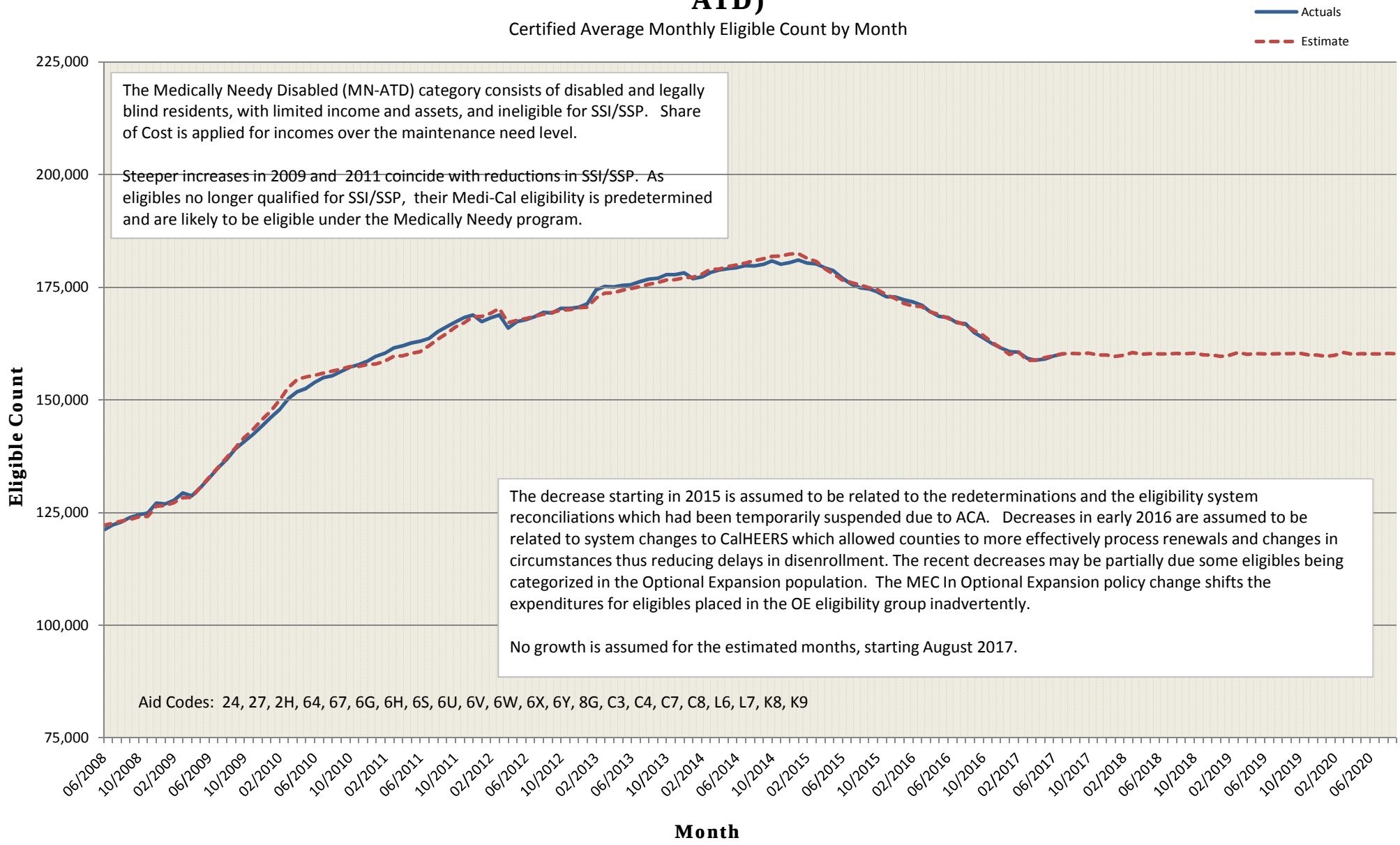


# Statewide Expanded Eligible: Medically Needy Seniors (MN-OAS)

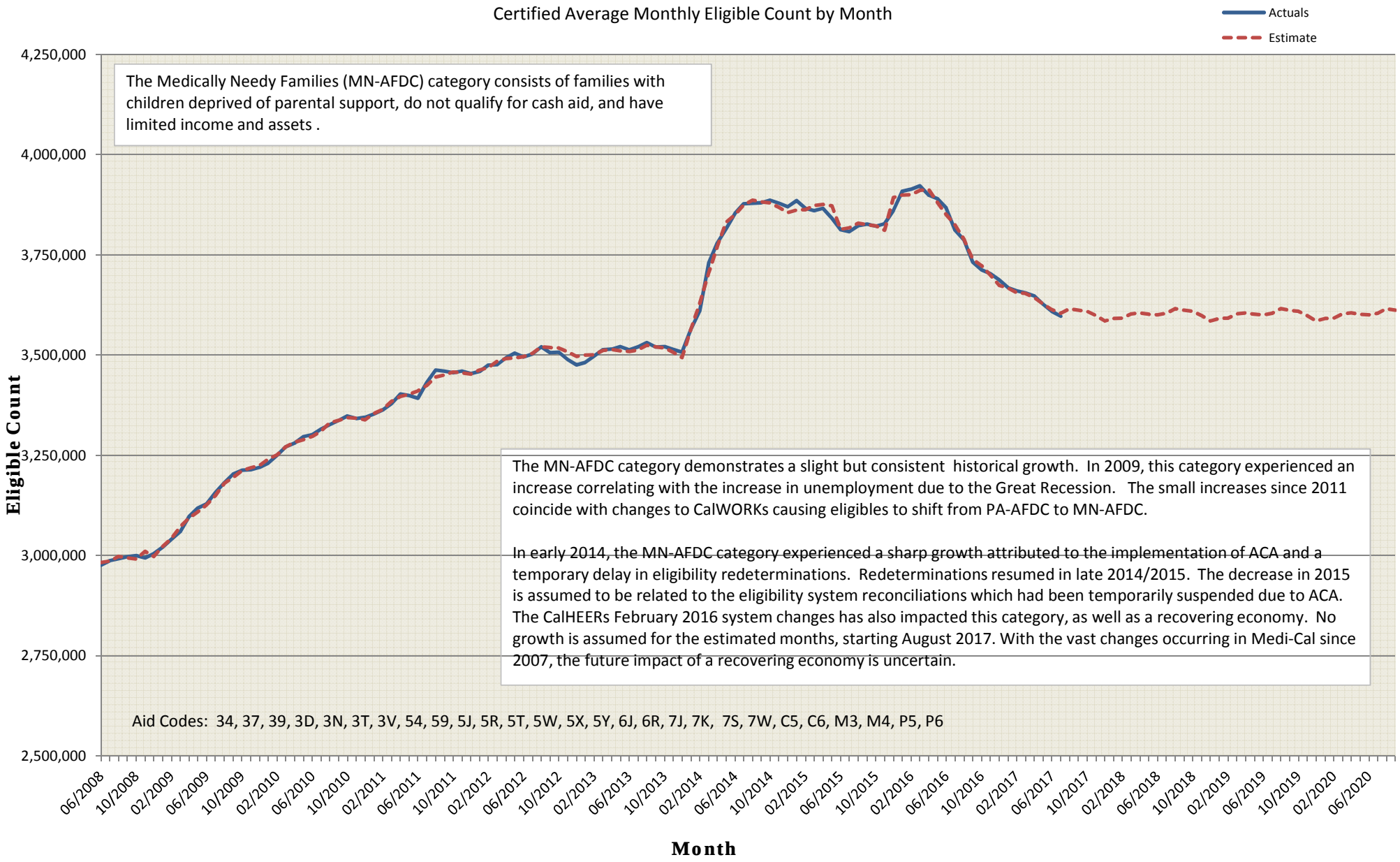


# Statewide Expanded Eligible: Medically Needy Persons with Disabilities (MN-ATD)

Certified Average Monthly Eligible Count by Month

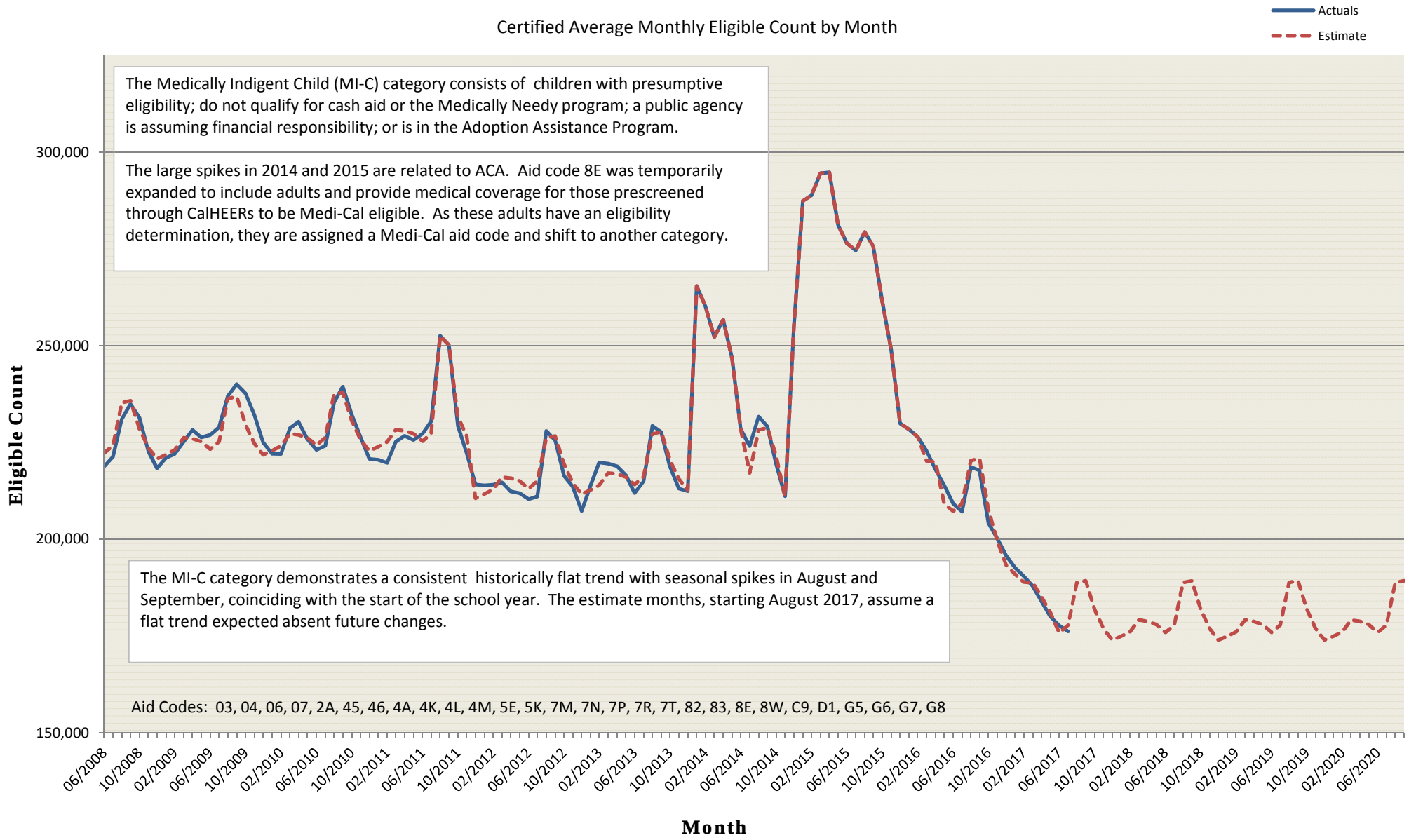


# Statewide Expanded Eligible: Medically Needy Families (MN-AFDC)



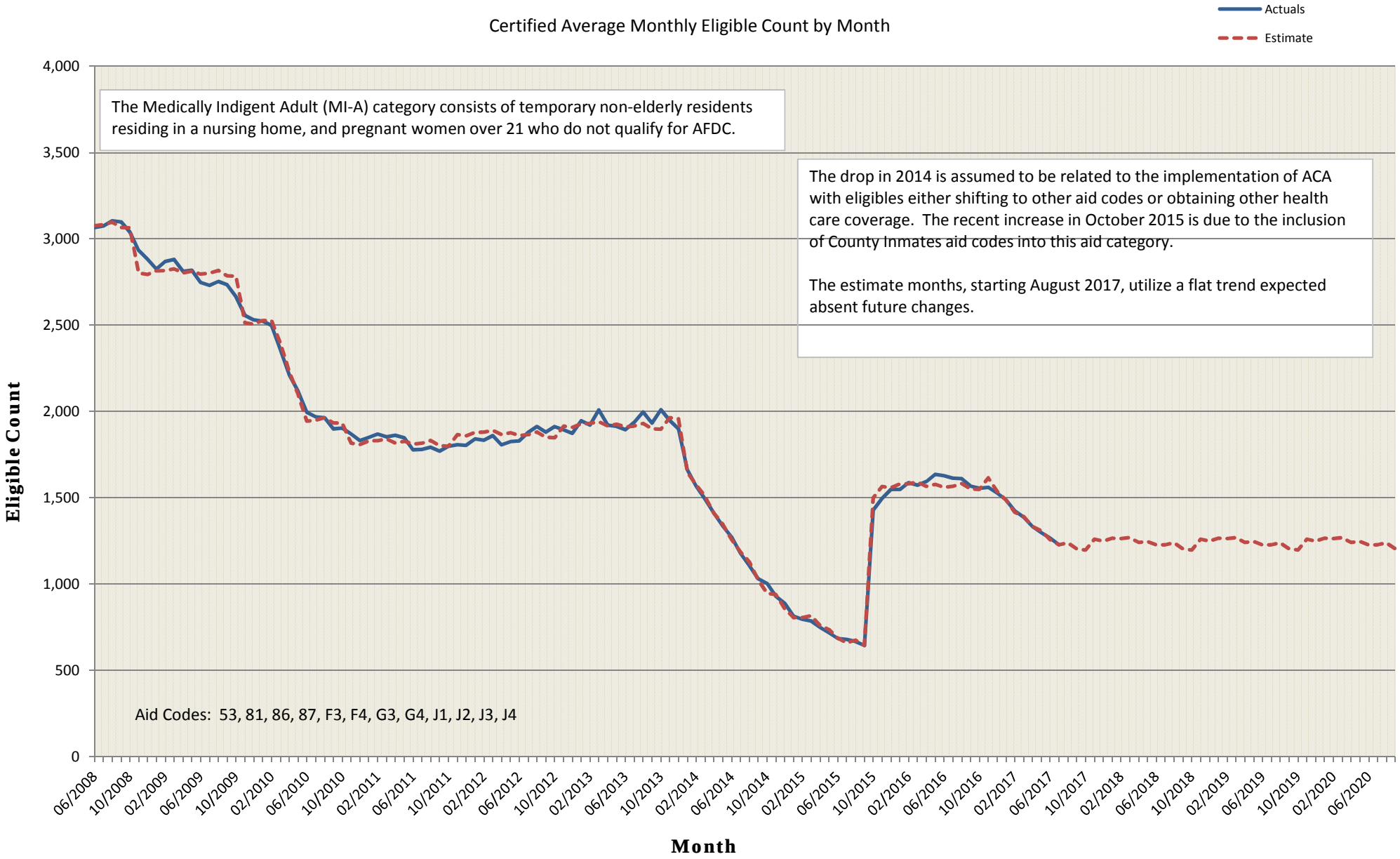
# Statewide Expanded Eligible: Medically Indigent Children (MI-C)

Certified Average Monthly Eligible Count by Month



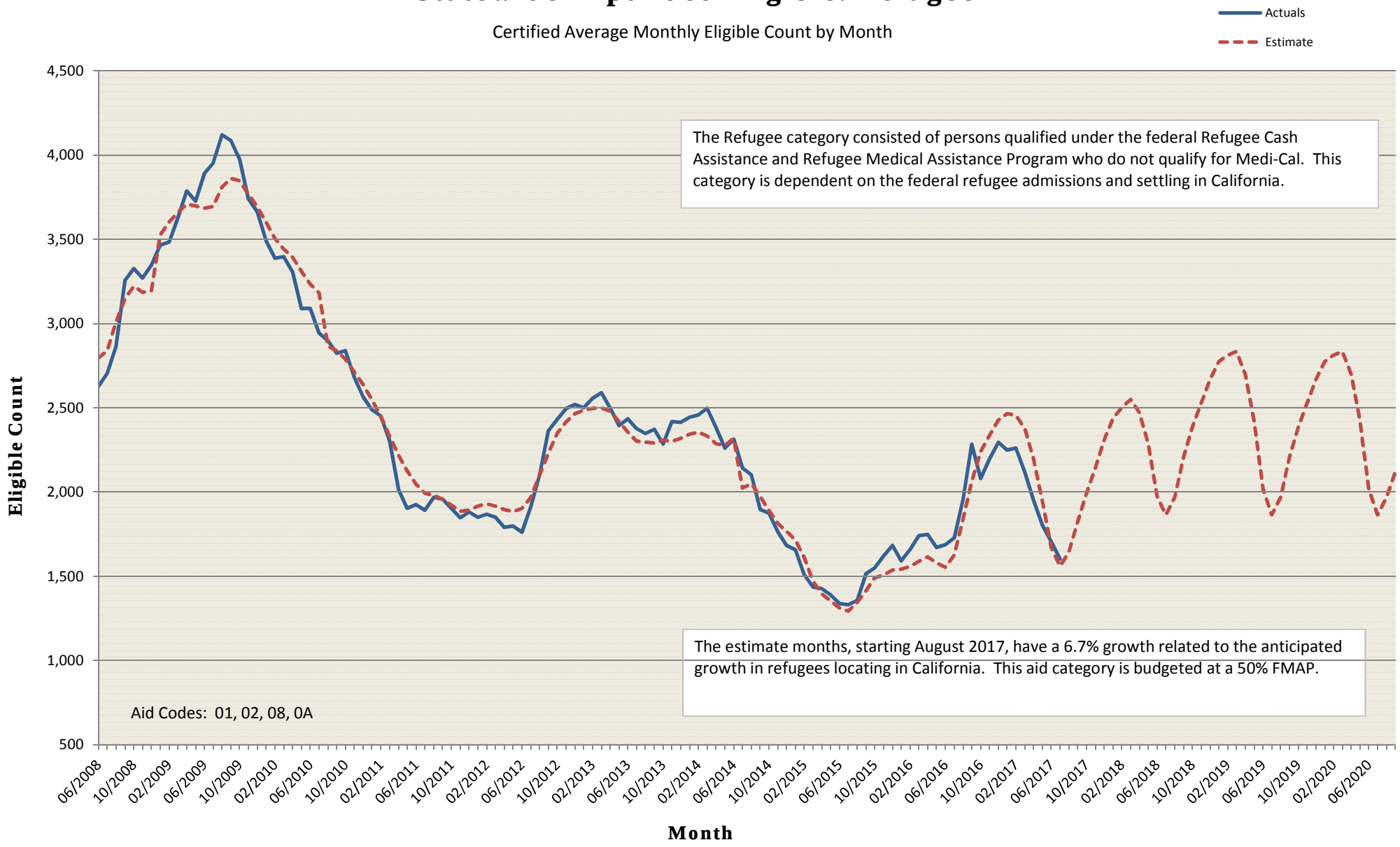
# Statewide Expanded Eligible: Medically Indigent Adults (MI-A)

Certified Average Monthly Eligible Count by Month



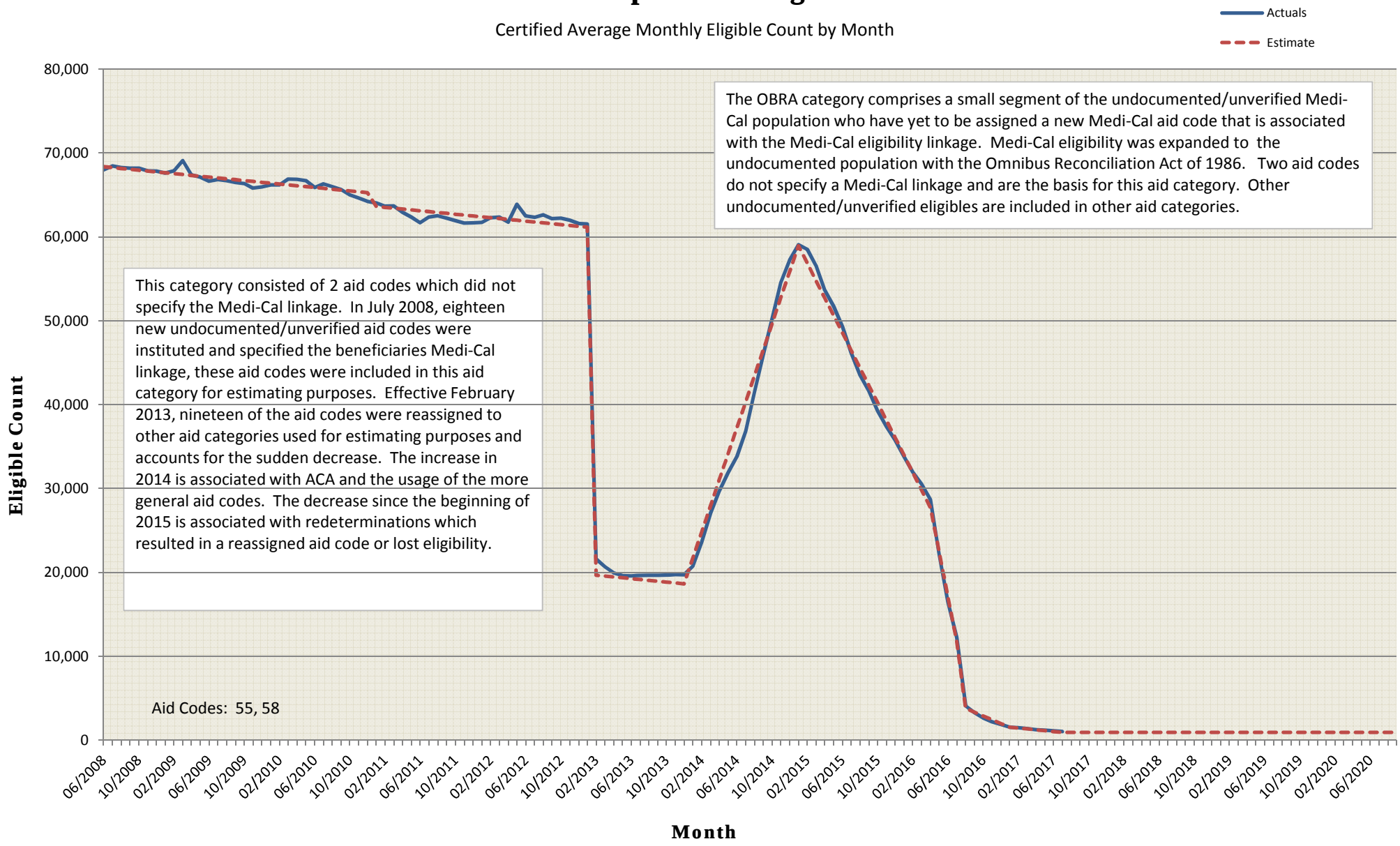
# Statewide Expanded Eligible: Refugee

Certified Average Monthly Eligible Count by Month



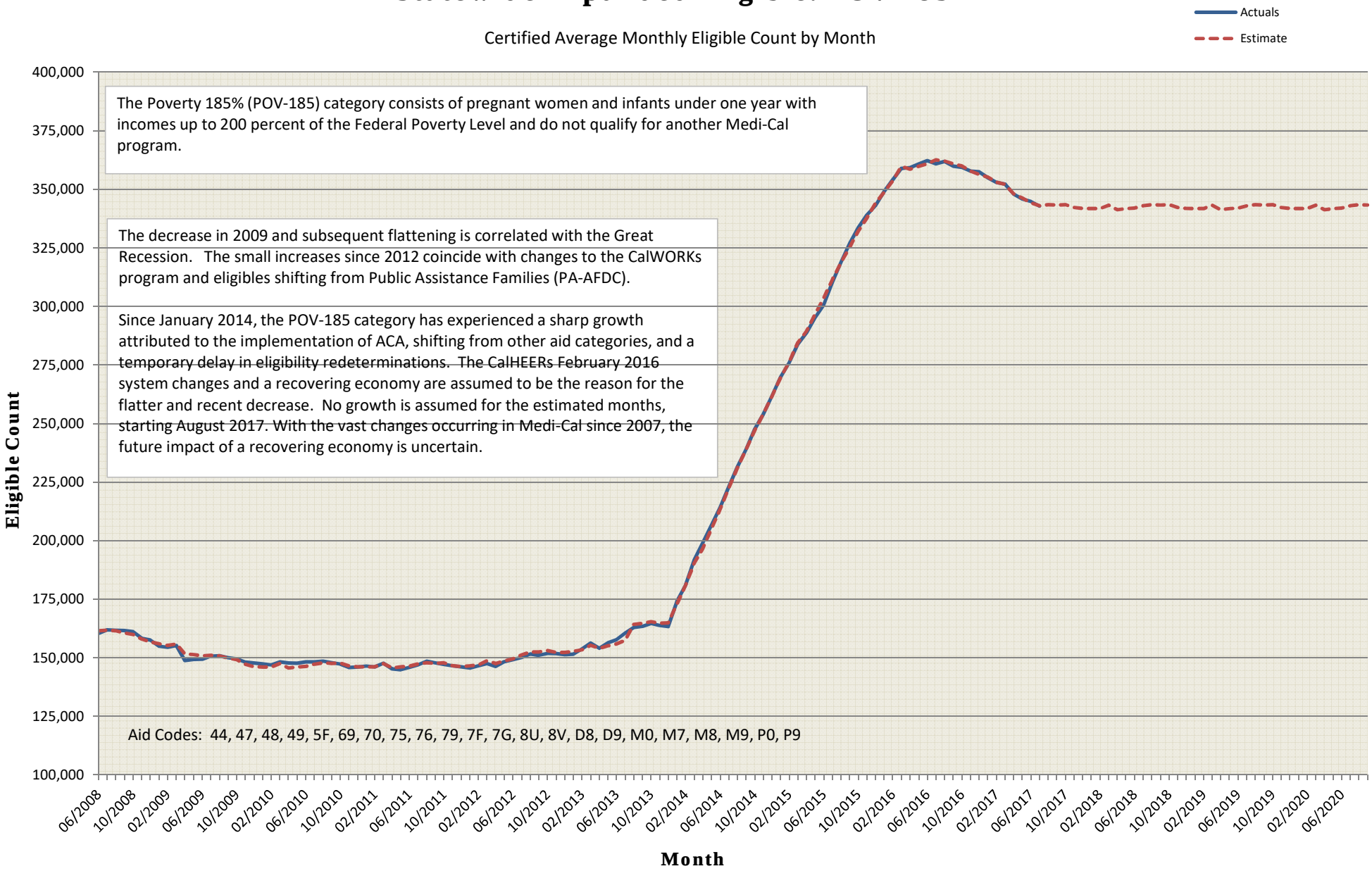
# Statewide Expanded Eligible: OBRA

Certified Average Monthly Eligible Count by Month



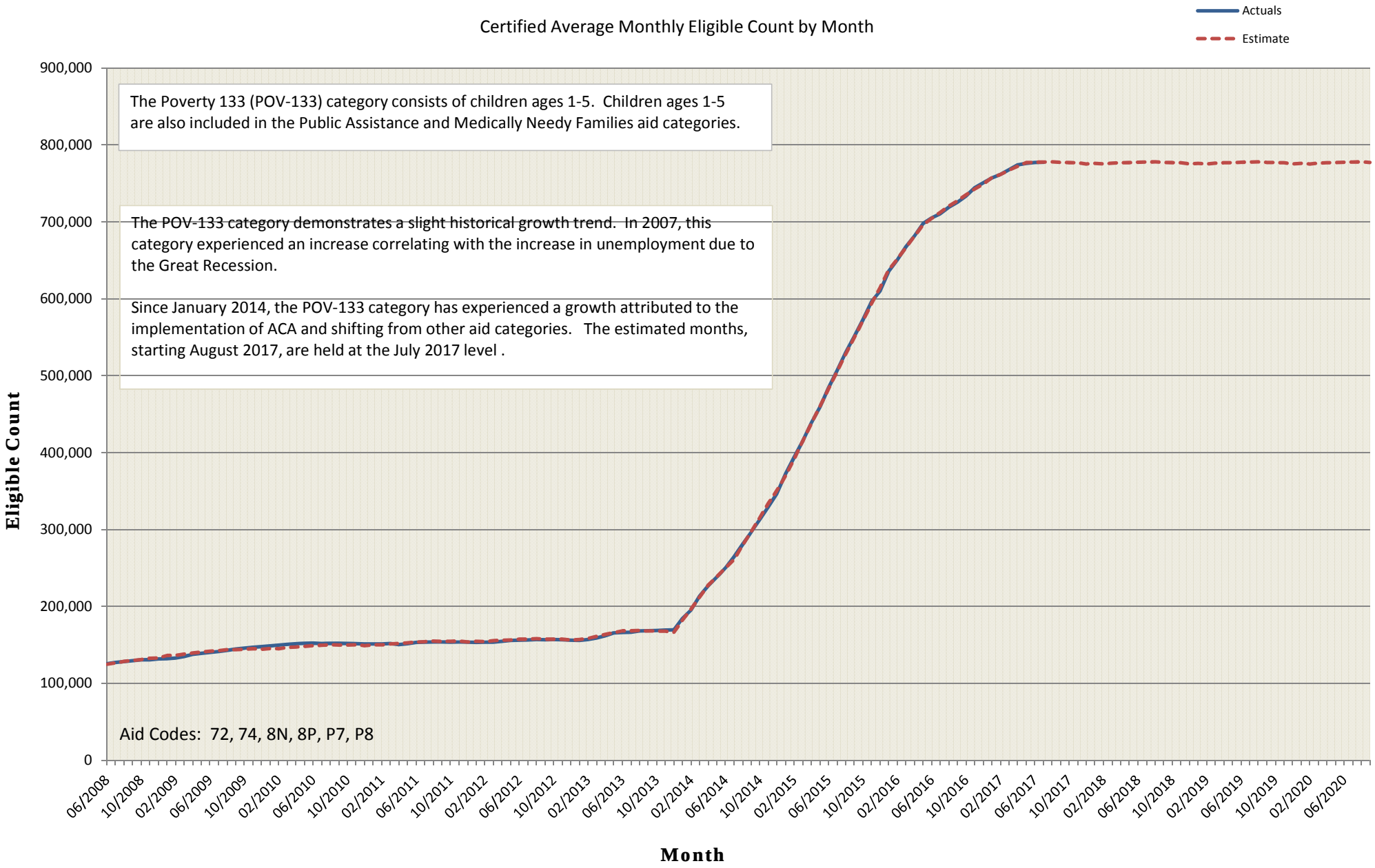
# Statewide Expanded Eligible: POV-185

Certified Average Monthly Eligible Count by Month



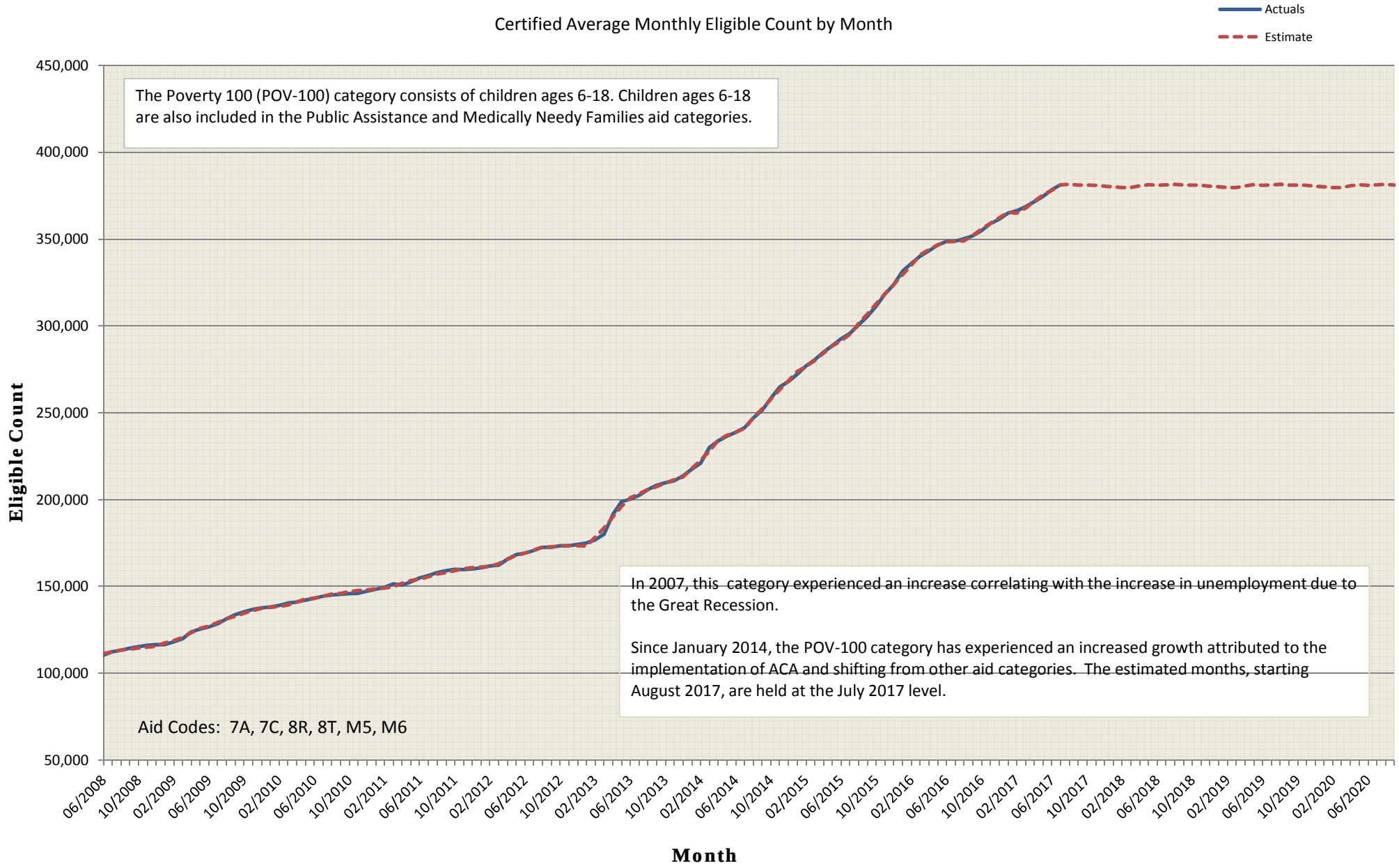
# Statewide Expanded Eligible: POV-133

Certified Average Monthly Eligible Count by Month



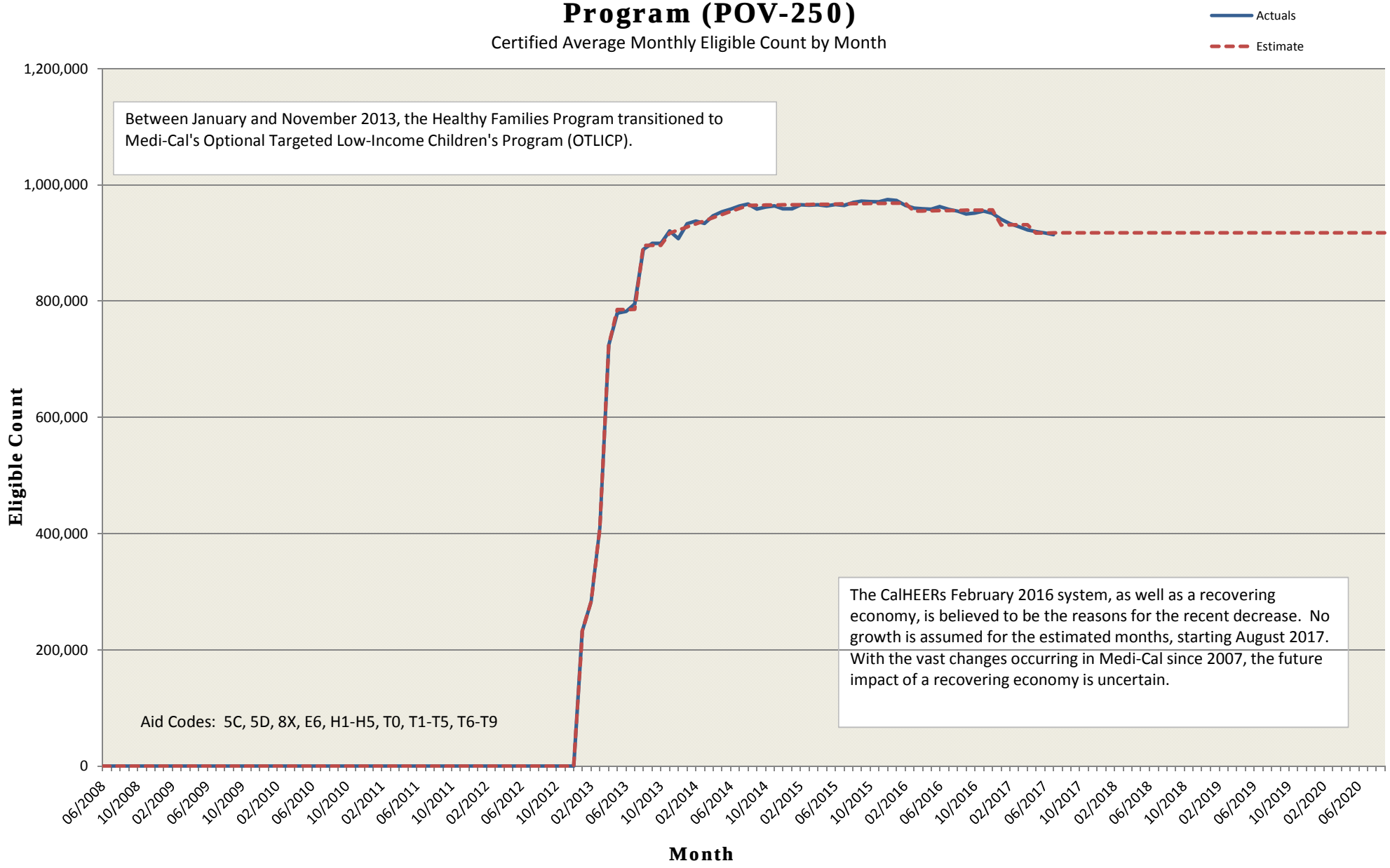
# Statewide Expanded Eligible: POV-100

Certified Average Monthly Eligible Count by Month



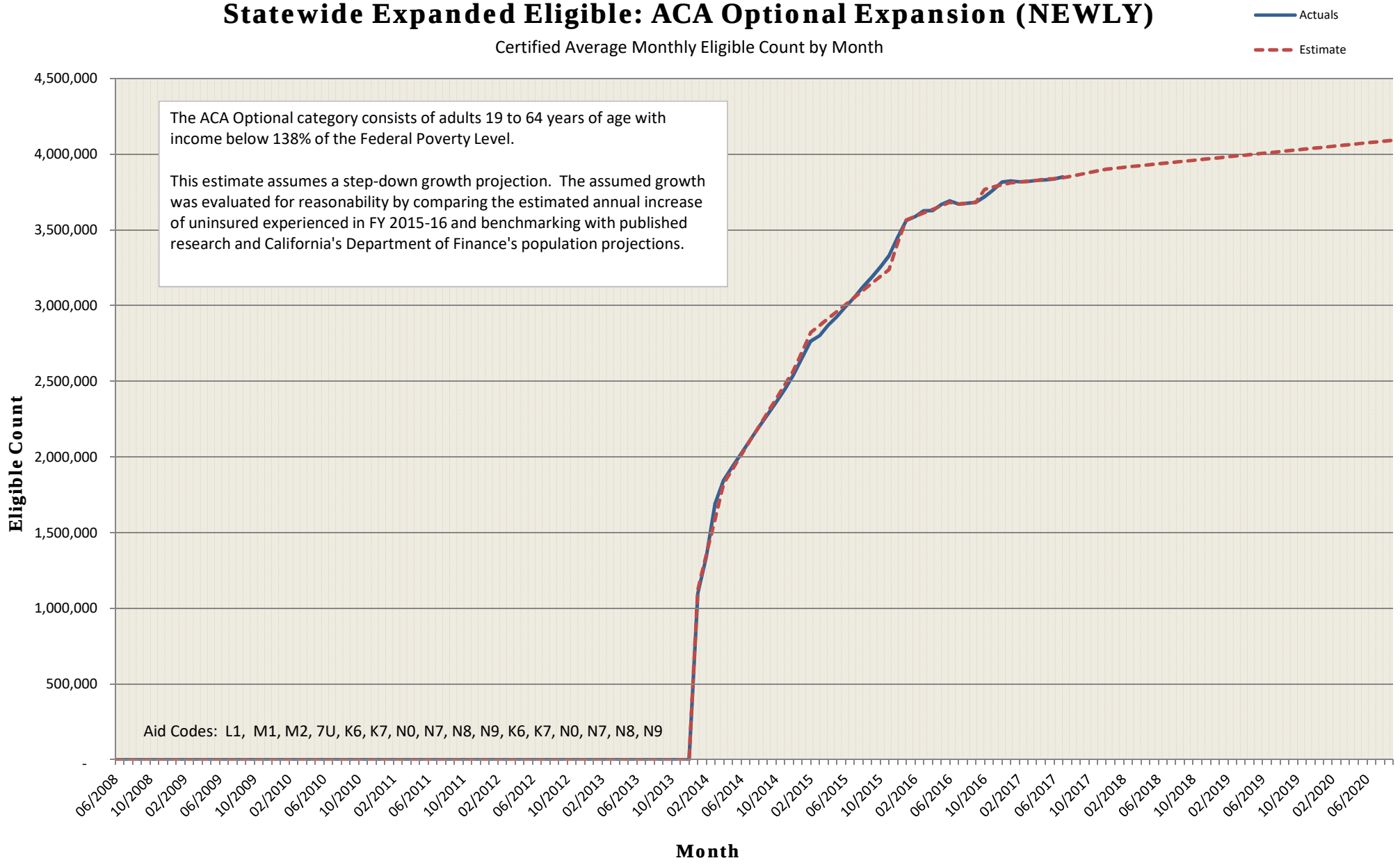
# Statewide Expanded Eligible: Optional Targeted Low-Income Children's Program (POV-250)

Certified Average Monthly Eligible Count by Month



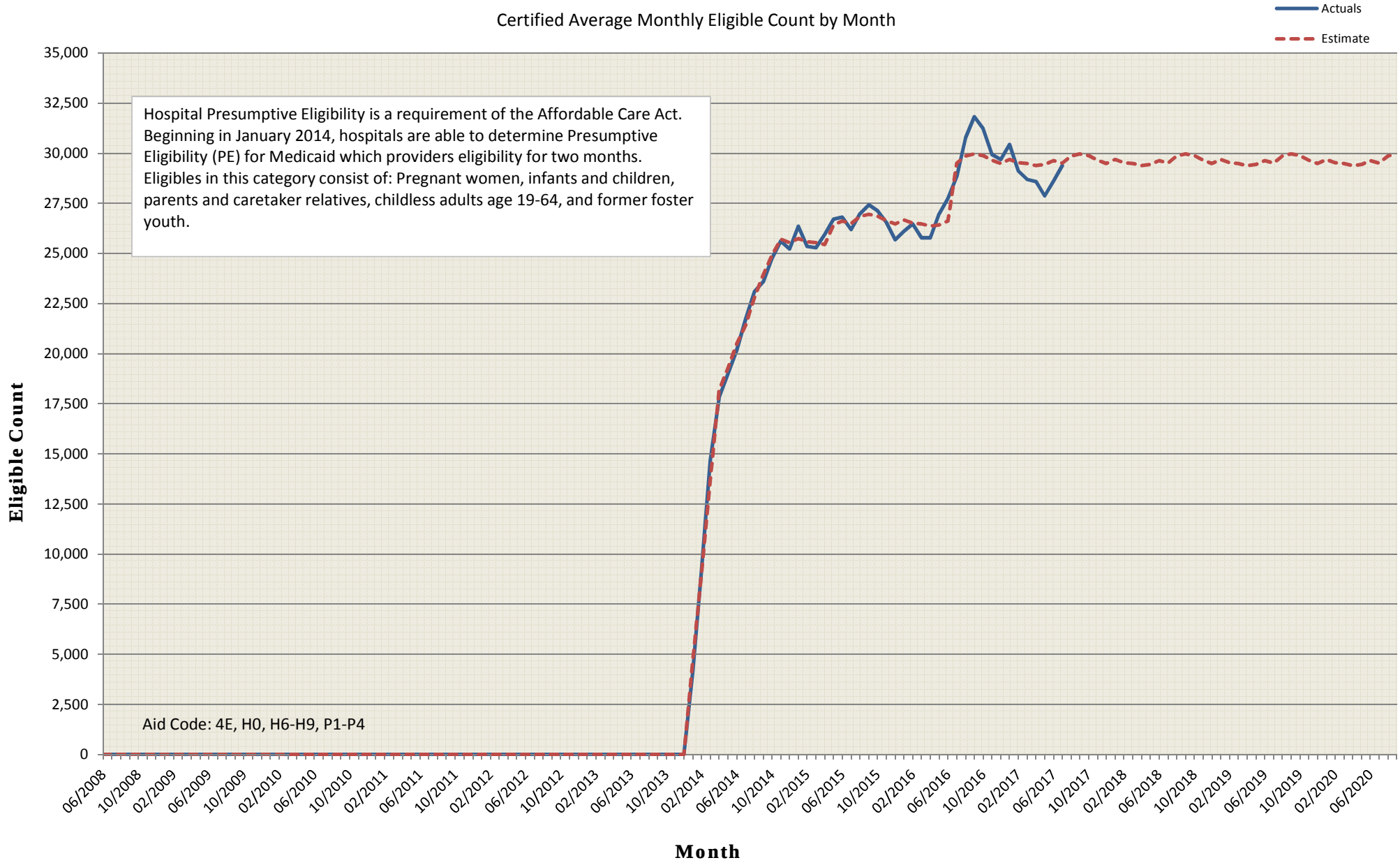
# Statewide Expanded Eligible: ACA Optional Expansion (NEWLY)

Certified Average Monthly Eligible Count by Month



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

Certified Average Monthly Eligible Count by Month



## 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

* With the November 2015 Medi-Cal Estimate, the County Outpatient and Community Outpatient FFS Service Categories were combined into one service category and is now County & Community Outpatient.

## November 2017 FFS Base Estimate

| Fiscal Year | | November 2017 Estimate Total Expenditure | |
|---|---|---|---|
| **PY** | FY 2016-17 | $16,699,569,100 | -- |
| **CY** | FY 2017-18 | $16,975,737,600 | 1.7% |
| **BY** | FY 2018-19 | $17,382,153,100 | 2.4% |

| Fiscal Year | FFS Base Expenditure | | |
|---|---|---|---|
| | May 2017 Estimate | November 2017 Estimate | % Chng |
| FY 2016-17 | $16,880,723,000 | $16,699,569,100 | -1.1% |
| FY 2017-18 | $17,394,766,300 | $16,975,737,600 | -2.4% |

Overall, the November 2017 FFS Base is estimated at $17.0 billion and 17.4 billion, respectively, for FY 2017-18 and FY 2018-19. Compared to the May 2017 Estimate, the November 2017 FFS Base Estimate is lower by 1.1% for FY 2016-17 and 2.4% for FY 2017-18.

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 move 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. The continuing movement of eligibles to the CCI impacts the November 2017 FFS base estimate.

**Overall Caseload Fluctuations:** Overall caseload continues to fluctuate. The Families and Children caseload has continued to decrease since 2016, and is lower than the May 2017 Estimate. The Affordable Care Act (ACA) Optional Expansion caseload continues to grow, but at a lesser rate.

**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 November 2017 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.

# QUARTERLY SUMMARY
# OF
# FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
# (INCLUDES ACTUALS AND NOVEMBER 2017 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 | 2,062,060 | 3.36 | $232.49 | $781.27 | $4,833,099,900 |
| 2017-18 ** | 2 | 1,924,600 | 3.15 | $230.59 | $725.98 | $4,191,681,200 |
| 2017-18 ** | 3 | 1,888,230 | 3.23 | $233.58 | $753.71 | $4,269,545,700 |
| 2017-18 ** | 4 | 1,736,310 | 3.05 | $231.50 | $706.75 | $3,681,410,800 |
| 2017-18 ** | TOTAL | 1,902,800 | 3.20 | $232.08 | $743.45 | $16,975,737,600 |
| 2018-19 ** | 1 | 2,012,440 | 3.42 | $240.38 | $821.06 | $4,957,020,900 |
| 2018-19 ** | 2 | 1,909,850 | 3.16 | $236.05 | $744.93 | $4,268,137,700 |
| 2018-19 ** | 3 | 1,878,350 | 3.22 | $239.14 | $771.10 | $4,345,199,800 |
| 2018-19 ** | 4 | 1,727,840 | 3.11 | $236.49 | $735.37 | $3,811,794,700 |
| 2018-19 ** | TOTAL | 1,882,120 | 3.23 | $238.14 | $769.62 | $17,382,153,100 |

* 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 | 320,600 | -10.4% | 2.34 | 1.3% | $72.71 | -0.5% | $653,608,000 | -9.8% |
| **BY** | FY 2018-19 | 318,080 | -0.8% | 2.35 | 0.4% | $72.67 | -0.1% | $650,842,700 | -0.4% |

**Users:** Users are estimated to decrease by 10.4% from PY to CY due to the lower Families and Children caseload, and the Coordinated Care Initiative (CCI) enrollment increase in January and February 2017 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:** The level of Utilization experienced in PY is estimated to continue in CY and BY, around 2.3 or 2.4 claims per user.

**Rate:** Rate is projected to remain relatively unchanged in CY and BY from PY.

**Total Expenditure:** CY Expenditure is estimated to decrease by 9.8% primarily due to lower Users. BY Expenditure projection is held level with CY.

**Reason for Change from Prior Estimate**

| Fiscal Year | Total Expenditure | | |
|---|---|---|---|
| | M17 | N17 | % Chng |
| FY 2016-17 | $756,877,500 | $724,439,100 | -4.3% |
| FY 2017-18 | $752,170,100 | $653,608,000 | -13.1% |

Compared to the May 2017 Estimate, the November 2017 Estimate is lower by 4.3% and 13.1%, respectively, for FY 2016-17 and FY 2017-18. The decreases are due to the lower Families and Children caseload, and the CCI impact shifting SPDs from FFS to Managed Care.

Fiscal Year 2015-16 Notes:

FFS Physicians base FY 2015-16 data includes a one-time impact of the primary care physician (PCP) incremental increase in rates. ACA required State Medicaid agencies to temporarily increase reimbursement for specific primary care visits to 100% of the Medicare rate for services provided from January 1, 2013 through December 31, 2014. 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 July 2017 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. SB 853 mandates that Medi-Cal rates for radiology services may not exceed 80% of Medicare rate for dates of service on or after October 1, 2010. 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 2016-17 through 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 NOVEMBER 2017 BASE ESTIMATES)

## PHYSICIANS

| | | AVERAGE MONTHLY | | | | |
|---|---|---|---|---|---|---|
| YEAR | QUARTER | USERS | UNIT PER USER | COST PER UNIT | 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 | 350,320 | 2.44 | $73.76 | $180.02 | $189,192,900 |
| 2017-18 ** | 2 | 303,040 | 2.35 | $73.11 | $171.92 | $156,292,200 |
| 2017-18 ** | 3 | 335,330 | 2.30 | $71.52 | $164.68 | $165,671,700 |
| 2017-18 ** | 4 | 293,710 | 2.24 | $72.30 | $161.67 | $142,451,200 |
| 2017-18 ** | TOTAL | 320,600 | 2.34 | $72.71 | $169.89 | $653,608,000 |
| 2018-19 ** | 1 | 345,430 | 2.45 | $73.42 | $179.82 | $186,349,100 |
| 2018-19 ** | 2 | 300,570 | 2.35 | $73.09 | $171.79 | $154,908,400 |
| 2018-19 ** | 3 | 333,840 | 2.29 | $71.51 | $164.03 | $164,285,400 |
| 2018-19 ** | 4 | 292,480 | 2.28 | $72.59 | $165.59 | $145,299,800 |
| 2018-19 ** | TOTAL | 318,080 | 2.35 | $72.67 | $170.51 | $650,842,700 |

* 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 (FQHCs/RHCs) 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 | 1,163,090 | 3.1% | 1.54 | 0.0% | $159.62 | 2.9% | $3,432,545,800 | 5.9% |
| **BY** | FY 2018-19 | 1,152,700 | -0.9% | 1.54 | 0.0% | $159.01 | -0.4% | $3,396,547,200 | -1.0% |

**Users:** Users are estimated to increase by 3.1% in CY. FQHC (the primary provider type in Other Medical) users have been steadily increasing since 2014, as the implementation of ACA and managed care expansions have increased demand on the FQHC network to provide access to primary care services to the beneficiaries. FQHC providers are paid under the prospective payment system (PPS) methodology. For managed care eligibles seeking FQHC service, DHCS is required to reimburse a FQHC for the difference between its per-visit PPS rate and the payment made by the managed care plan. This payment is known as a “wrap-around” payment. Therefore, as Medi-Cal eligibles shift to managed care, their FQHC claims would still be processed through the Fee-For-Service (FFS) system and they would still show as FFS users. Users are estimated to remain relatively unchanged in BY.

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

**Rate:** Rate is estimated to increase by 2.9% from PY to CY, due to PY incorporates a partial year impact of the FY 2016-17 Medicare Economic Index (MEI) rate increase for FQHCs/RHCs, implemented October 2016, while CY incorporates a full year impact of this rate increase. FY 2016-17 MEI rate increase is fully incorporated in the FFS Other Medical base in the November 2017 Estimate. Rates are held level in BY as future rate increases are estimated through policy changes.

**Total Expenditure:** CY Expenditure is estimated to increase by 5.9% due to higher Users and Rates. Total Expenditure is estimated to remain relatively unchanged in BY.

**Reason for Change From Prior Estimate**

| Fiscal Year | Total Expenditure | | |
|---|---|---|---|
| | M17 | N17 | % Chng |
| FY 2016-17 | $3,146,728,600 | $3,240,090,800 | 3.0% |
| FY 2017-18 | $3,159,301,800 | $3,432,545,800 | 8.6% |

Compared to the May 2017 Estimate, the November 2017 Estimate is higher by 3.0% and 8.6%, respectively, for FY 2016-17 and FY 2017-18. The increases are due to higher Users and Rates, as additional later actuals available in the current estimate cycle support the higher levels estimated for Users and Rates.

# QUARTERLY SUMMARY
# OF
# FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
# (INCLUDES ACTUALS AND NOVEMBER 2017 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 | 1,281,550 | 1.59 | $161.48 | $257.29 | $989,196,400 |
| 2017-18 ** | 2 | 1,196,150 | 1.54 | $159.58 | $245.55 | $881,143,400 |
| 2017-18 ** | 3 | 1,141,370 | 1.53 | $159.11 | $244.09 | $835,777,500 |
| 2017-18 ** | 4 | 1,033,290 | 1.49 | $157.78 | $234.34 | $726,428,500 |
| 2017-18 ** | TOTAL | 1,163,090 | 1.54 | $159.62 | $245.93 | $3,432,545,800 |
| 2018-19 ** | 1 | 1,257,400 | 1.59 | $159.39 | $253.89 | $957,737,400 |
| 2018-19 ** | 2 | 1,189,080 | 1.54 | $159.58 | $245.52 | $875,847,100 |
| 2018-19 ** | 3 | 1,135,970 | 1.53 | $159.00 | $243.27 | $829,025,500 |
| 2018-19 ** | 4 | 1,028,350 | 1.51 | $157.85 | $237.90 | $733,937,300 |
| 2018-19 ** | TOTAL | 1,152,700 | 1.54 | $159.01 | $245.55 | $3,396,547,200 |

* 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 | 218,580 | -1.9% | 1.52 | 0.0% | $134.81 | 0.9% | $538,367,100 | -0.8% |
| **BY** | FY 2018-19 | 214,310 | -2.0% | 1.53 | 0.7% | $135.07 | 0.2% | $531,157,700 | -1.3% |

**Users:** Users are projected to decrease by 1.9% in CY and 2.0% in BY related to changes in Caseload.

**Utilization:** Utilization is projected to remain stable from FY 2016-17 through FY 2018-19.

**Rate:** Rate is estimated to remain relatively unchanged from FY 2016-17 through FY 2018-19

**Total Expenditure:** Total expenditure is estimated to decrease by 0.8% in and 1.3% in BY correlated to the changes in Caseload.

**Reason for Change from Prior Estimate**

| Fiscal Year | Total Expenditure | | |
|---|---|---|---|
| | M17 | N17 | % Chng |
| FY 2016-17 | $545,127,100 | $542,747,600 | -0.4% |
| FY 2017-18 | $544,247,800 | $538,367,100 | -1.1% |

Compared to the May 2017 Estimate, the November 2017 Estimate is lower by 0.4% for FY 2016-17 and 1.1% for FY 2017-18. The estimated decreases are correlated to the changes in Caseload.

Note: FY 2015-16 included a one-time adjustment of approximately ($6.0 million) related to the Reduction to Radiology Rate (RRR) recoupment. The recoupments are budgeted in the Radiology Rate Policy Change. The adjusted FY 2015-16 expenditure for County and Community Outpatient was $581,116,900.

# QUARTERLY SUMMARY
# OF
# FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
# (INCLUDES ACTUALS AND NOVEMBER 2017 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 | 256,850 | 1.56 | $139.11 | $216.73 | $167,000,900 |
| 2017-18 ** | 2 | 209,980 | 1.52 | $134.02 | $203.56 | $128,230,200 |
| 2017-18 ** | 3 | 210,410 | 1.52 | $134.13 | $203.41 | $128,397,600 |
| 2017-18 ** | 4 | 197,080 | 1.49 | $130.55 | $194.07 | $114,738,300 |
| 2017-18 ** | TOTAL | 218,580 | 1.52 | $134.81 | $205.25 | $538,367,100 |
| 2018-19 ** | 1 | 243,500 | 1.57 | $140.15 | $219.98 | $160,697,700 |
| 2018-19 ** | 2 | 208,270 | 1.52 | $133.89 | $203.49 | $127,142,400 |
| 2018-19 ** | 3 | 209,300 | 1.51 | $133.78 | $202.39 | $127,080,800 |
| 2018-19 ** | 4 | 196,150 | 1.51 | $131.14 | $197.53 | $116,236,900 |
| 2018-19 ** | TOTAL | 214,310 | 1.53 | $135.07 | $206.54 | $531,157,700 |

* 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 (Dollars per Prescription) | | Total Expenditures | |
|---|---|---|---|---|---|---|---|---|---|
| **PY** | FY 2016-17 | 472,910 | -- | 2.80 | -- | $207.08 | -- | $3,292,285,500 | -- |
| **CY** | FY 2017-18 | 456,280 | -3.5% | 2.77 | -1.1% | $237.10 | 14.5% | $3,597,035,800 | 9.3% |
| **BY** | FY 2018-19 | 453,640 | -0.6% | 2.79 | 0.7% | $251.83 | 6.2% | $3,825,762,300 | 6.4% |

**Users:** Users are estimated to decrease by 3.5% from PY to CY due to the lower Families and Children caseload, and the Coordinated Care Initiative (CCI) enrollment increase in January and February 2017 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:** 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 14.5% from PY to CY, related to discontinuation of FFS 10% pharmacy provider payment reductions for drug products, implemented April 2017. This rate restoration resulted higher rates starting May 2017. PY incorporates a partial year (2 months) impact of the rate restoration, while CY incorporates a full year impact of the rate restoration. The impact of discontinuation of FFS 10% pharmacy provider payment reductions is fully captured in the FFS Pharmacy base in the November 2017 Estimate. In addition, BY Rate is estimated to increase by 6.2%, related to the historical growth experienced in prescription drugs.

**Total Expenditure:** Total expenditure is estimated to increase by 9.3% from PY to CY, due to discontinuation of FFS 10% pharmacy provider payment reductions, partially offset by lower Users; and increase by 6.4% from CY to BY relate to the historical growth experienced in pharmacy rates.

### Reason for Change from Prior Estimate

| Fiscal Year | Total Expenditures | | |
|---|---|---|---|
| | M17 | N17 | % Chng |
| FY 2016-17 | $3,318,243,500 | $3,292,285,500 | -0.8% |
| FY 2017-18 | $3,660,649,400 | $3,597,035,800 | -1.7% |

Compared to the May 2017 Estimate, the November 2017 Estimate is relatively consistent with prior estimate: decreases in Users are partially offset by increases in Rates.

Fiscal Year 2015-16 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 reductions. FY 2015-16 also reflects the implementation of updated federal maximum reimbursements (federal upper limit (FULs) for some generically equivalent drugs dispensed in pharmacies, implemented April 15, 2016. The impact of FUL savings is fully captured in the November 2016 FFS Pharmacy base.

# QUARTERLY SUMMARY
# OF
# FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
# (INCLUDES ACTUALS AND NOVEMBER 2017 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 | 487,470 | 2.94 | $235.91 | $693.31 | $1,013,899,500 |
| 2017-18 ** | 2 | 464,250 | 2.73 | $234.43 | $639.08 | $890,084,100 |
| 2017-18 ** | 3 | 459,980 | 2.76 | $236.35 | $652.63 | $900,602,800 |
| 2017-18 ** | 4 | 413,430 | 2.63 | $242.65 | $638.92 | $792,449,400 |
| 2017-18 ** | TOTAL | 456,280 | 2.77 | $237.10 | $656.94 | $3,597,035,800 |
| 2018-19 ** | 1 | 485,160 | 2.96 | $250.59 | $741.06 | $1,078,602,200 |
| 2018-19 ** | 2 | 461,220 | 2.73 | $249.60 | $681.79 | $943,368,600 |
| 2018-19 ** | 3 | 457,350 | 2.76 | $250.63 | $691.27 | $948,445,500 |
| 2018-19 ** | 4 | 410,840 | 2.70 | $257.32 | $693.99 | $855,345,900 |
| 2018-19 ** | TOTAL | 453,640 | 2.79 | $251.83 | $702.79 | $3,825,762,300 |

* 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 in 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 | 4,460 | -8.0% | 5.52 | 4.2% | $2,754.31 | 3.14% | $812,991,100 | -1.2% |
| **BY** | FY 2018-19 | 4,520 | 1.3% | 5.53 | 0.2% | $2,759.91 | 0.20% | $828,090,400 | 1.9% |

**Users:** Users decreased by -8.0% in CY correlates to changes in Caseload combined with the Coordinated Care Initiative (CCI) enrollment increase in January and February 2017 into Medi-Cal Managed Care plans from FFS. The projected increase of 1.3% in BY corresponds to changes in Caseload.

**Utilization:** Utilization or the number of days stay per user is estimated to increase by 4.2% in CY and remain stable in BY.

**Rate:** The increase in Rate from PY to CY is related to the FY 2016-17 annual rate increases for DPHs, effective July 2016. The DPH Interim Rate Growth policy change estimates the FY 2017-18 DPH rate increase effective July 2017. BY Rate is projected to remain stable.

**Total Expenditures:** Total expenditures are estimated to decrease by -1.2% in CY due to lower Users and offset by an increase in Utilization and Rate. Total expenditures are estimated to increase by 1.9% in BY primarily due to increases in Users.

**Reason for Change from Prior Estimate**

| Fiscal Year | Total Expenditure | | |
|---|---|---|---|
| | **M17** | **N17** | **% Chng** |
| FY 2016-17 | $839,233,800 | $822,995,000 | -1.9% |
| FY 2017-18 | $881,980,600 | $812,991,000 | -7.8% |

Compared to the May 2017 estimate, the November 2017 estimate is lower by -1.9% in FY 2016-17, and FY 2017-18 is lower by -7.8% due to Caseload changes and the Coordinated Care Initiative (CCI) enrollment increase in January and February 2017 into Medi-Cal Managed Care plans from FFS.

# QUARTERLY SUMMARY
# OF
# FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
# (INCLUDES ACTUALS AND NOVEMBER 2017 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 | 4,880 | 5.57 | $2,661.45 | $14,813.46 | $216,731,000 |
| 2017-18 ** | 2 | 4,280 | 5.49 | $2,795.51 | $15,354.18 | $197,201,500 |
| 2017-18 ** | 3 | 4,490 | 5.51 | $2,800.98 | $15,439.72 | $207,741,400 |
| 2017-18 ** | 4 | 4,180 | 5.50 | $2,771.62 | $15,239.27 | $191,317,300 |
| 2017-18 ** | TOTAL | 4,460 | 5.52 | $2,754.31 | $15,200.81 | $812,991,100 |
| 2018-19 ** | 1 | 5,140 | 5.58 | $2,684.40 | $14,989.05 | $231,045,900 |
| 2018-19 ** | 2 | 4,290 | 5.49 | $2,794.98 | $15,347.48 | $197,346,900 |
| 2018-19 ** | 3 | 4,490 | 5.50 | $2,807.69 | $15,441.67 | $207,788,900 |
| 2018-19 ** | 4 | 4,180 | 5.52 | $2,766.95 | $15,287.06 | $191,908,700 |
| 2018-19 ** | TOTAL | 4,520 | 5.53 | $2,759.91 | $15,255.08 | $828,090,400 |

* 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 | 30,840 | -4.4% | 4.75 | 1.9% | $2,383.50 | 6.2% | $4,185,741,600 | 3.5% |
| **BY** | FY 2018-19 | 31,010 | 0.6% | 4.78 | 0.6% | $2,463.96 | 3.4% | $4,383,029,500 | 4.7% |

**Users:** The estimated User decrease of -4.4% in CY correlates to changes in Caseload combined with the Coordinated Care Initiative (CCI) enrollment increase in January and February 2017 into Medi-Cal Managed Care plans from FFS. Users are projected to remain stable for BY.

**Utilization:** Utilization is projected to remain relatively stable at around 4.7 days per user from FY 2016-17 through 2018-19.

**Rate:** The increases in Rate in CY and BY is based on historical growth experienced in this service category. Additionally, CY includes the FY 2016-17 annual rate increases for DPHs. The DPH Interim Rate Growth policy change estimates the FY 2017-18 DPH rate increase effective July 2017.

**Total Expenditures:** Total expenditures is estimated to increase by 3.5% in CY and BY 4.7% due to projected increases in Rates.

### Reason for Change from Prior Estimate

| Fiscal Year | Total Expenditure | | |
|---|---|---|---|
| | M17 | N17 | % Chng |
| FY 2016-17 | $4,163,901,300 | $4,045,885,600 | -2.8% |
| FY 2017-18 | $4,225,013,900 | $4,185,741,600 | -0.9% |

Comparing the May 2017 Estimate to the November 2017 Estimate, FY 2016-17 total expenditures decrease by -2.8% and FY 2017-18 decreases by -0.9% are primarily due to changes in Caseload combined with the Coordinated Care Initiative (CCI) enrollment increase in January and February 2017 into Medi-Cal Managed Care plans from FFS.

# QUARTERLY SUMMARY
# OF
# FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
# (INCLUDES ACTUALS AND NOVEMBER 2017 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 | 34,480 | 4.74 | $2,353.85 | $11,146.62 | $1,153,136,200 |
| 2017-18 ** | 2 | 29,880 | 4.77 | $2,377.79 | $11,340.13 | $1,016,501,600 |
| 2017-18 ** | 3 | 31,670 | 4.80 | $2,389.31 | $11,457.96 | $1,088,523,300 |
| 2017-18 ** | 4 | 27,330 | 4.67 | $2,420.89 | $11,313.92 | $927,580,400 |
| 2017-18 ** | TOTAL | 30,840 | 4.75 | $2,383.50 | $11,310.48 | $4,185,741,600 |
| 2018-19 ** | 1 | 35,170 | 4.82 | $2,435.95 | $11,747.58 | $1,239,484,300 |
| 2018-19 ** | 2 | 29,880 | 4.77 | $2,456.14 | $11,713.54 | $1,050,112,300 |
| 2018-19 ** | 3 | 31,670 | 4.79 | $2,474.21 | $11,863.10 | $1,127,022,900 |
| 2018-19 ** | 4 | 27,330 | 4.72 | $2,497.36 | $11,787.56 | $966,410,000 |
| 2018-19 ** | TOTAL | 31,010 | 4.78 | $2,463.96 | $11,777.68 | $4,383,029,500 |

* 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 | 27,790 | -12.8% | 32.84 | 0.7% | $218.01 | 0.7% | $2,387,305,100 | -11.6% |
| **BY** | FY 2018-19 | 27,740 | -0.2% | 32.99 | 0.5% | $218.14 | 0.1% | $2,395,476,000 | 0.3% |

**Users:** Users are projected to decrease in CY from PY due to the Coordinated Care Initiative (CCI) enrollment increase in January and February 2017 into Medi-Cal Managed Care plans from FFS. 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 2017-18.

**Rate:** The Rate is estimated to increase in CY due to the full incorporation the final 2015-16 & 2016-17 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 Expenditures:** PY expenditures include retroactive payments for the FY 2015-16 rates, thus showing a decrease of 11.6% from PY to CY. The CCI shift of eligibles from FFS to the managed care delivery system also contributes to lower CY expenditures. 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 | | |
|---|---|---|---|
| | M17 | N17 | % Chng |
| FY 2016-17 | $2,684,288,500 | $2,699,223,400 | 0.6% |
| FY 2017-18 | $2,622,081,200 | $2,387,305,100 | -9.0% |

Compared to the May 2017 estimate, the November 2017 estimate for FY 2016-17 remains relatively unchanged. The November 2017 estimate for FY 2017-18 decreased by 9% from the May 2017 estimate due to CCI eligibles shifting to the managed care delivery system.

# QUARTERLY SUMMARY
# OF
# FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
# (INCLUDES ACTUALS AND NOVEMBER 2017 BASE ESTIMATES)

## NURSING FACILITIES

| | | AVERAGE MONTHLY | | | | |
|---|---|---|---|---|---|---|
| YEAR | QUARTER | 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 | 29,700 | 36.03 | $221.87 | $7,995.15 | $712,386,400 |
| 2017-18 ** | 2 | 28,030 | 32.65 | $215.01 | $7,020.77 | $590,390,000 |
| 2017-18 ** | 3 | 27,720 | 32.94 | $217.33 | $7,157.73 | $595,192,200 |
| 2017-18 ** | 4 | 25,710 | 29.24 | $217.00 | $6,344.04 | $489,336,500 |
| 2017-18 ** | TOTAL | 27,790 | 32.84 | $218.01 | $7,158.74 | $2,387,305,100 |
| 2018-19 ** | 1 | 29,580 | 36.19 | $222.37 | $8,048.70 | $714,252,300 |
| 2018-19 ** | 2 | 27,910 | 32.65 | $214.90 | $7,015.69 | $587,491,000 |
| 2018-19 ** | 3 | 27,730 | 32.87 | $217.17 | $7,138.77 | $593,881,000 |
| 2018-19 ** | 4 | 25,740 | 29.80 | $217.22 | $6,473.67 | $499,851,700 |
| 2018-19 ** | TOTAL | 27,740 | 32.99 | $218.14 | $7,196.11 | $2,395,476,000 |

* 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 Expenditures | |
|---|---|---|---|---|---|---|---|---|---|
| **PY** | FY 2016-17 | 4,940 | | 31.85 | | $205.45 | | $388,164,700 | |
| **CY** | FY 2017-18 | 4,940 | 0.0% | 31.59 | -0.8% | $210.00 | 2.2% | $393,177,000 | 1.3% |
| **BY** | FY 2018-19 | 4,970 | 0.6% | 31.69 | 0.3% | $209.93 | -0.03% | $396,893,200 | 0.9% |

**Users:** Users are estimated to remain fairly level in CY and BY from PY.

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

**Rate:** Rate is estimated to increase by 2.2% 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. FY 2016-17 ICF/DD rate increase has fully incorporated in the FFS ICF/DD base since the May 2017 Estimate. FY 2017-18 ICF/DD rate increase is budgeted in the LTC Rate Adjustment policy change. BY is projected at levels consistent with CY.

**Total Expenditure:** Total expenditure is estimated to increase by 1.3% from PY to CY, due to higher rates, partially offset by lower utilizations. Total expenditure is estimated to remain relatively stable from CY to BY.

**Reason for Change from Prior Estimate**

| Fiscal Year | Total Expenditures | | |
|---|---|---|---|
| | **M17** | **N17** | **% Chng** |
| FY 2016-17 | $385,297,400 | $388,164,700 | 0.7% |
| FY 2017-18 | $390,464,500 | $393,177,000 | 0.7% |

Compared to the May 2017 Estimate, the November 2017 Estimate is relatively consistent with prior estimates for FY 2016-17 and FY 2017-18.

# QUARTERLY SUMMARY
# OF
# FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
# (INCLUDES ACTUALS AND NOVEMBER 2017 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 | 5,000 | 36.74 | $208.04 | $7,644.35 | $114,776,600 |
| 2017-18 ** | 2 | 4,970 | 31.12 | $211.75 | $6,590.67 | $98,181,500 |
| 2017-18 ** | 3 | 4,970 | 31.49 | $210.08 | $6,615.26 | $98,629,800 |
| 2017-18 ** | 4 | 4,820 | 26.81 | $210.62 | $5,646.92 | $81,589,200 |
| 2017-18 ** | TOTAL | 4,940 | 31.59 | $210.00 | $6,633.72 | $393,177,000 |
| 2018-19 ** | 1 | 5,040 | 36.94 | $208.06 | $7,685.96 | $116,281,300 |
| 2018-19 ** | 2 | 5,000 | 31.12 | $211.67 | $6,587.98 | $98,739,200 |
| 2018-19 ** | 3 | 5,000 | 31.49 | $210.12 | $6,616.60 | $99,250,100 |
| 2018-19 ** | 4 | 4,850 | 27.02 | $210.29 | $5,682.76 | $82,622,600 |
| 2018-19 ** | TOTAL | 4,970 | 31.69 | $209.93 | $6,653.01 | $396,893,200 |

* 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 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 | 22,400 | 0.0% | 3.24 | 1.9% | $75.74 | -4.3% | $65,880,900 | -2.5% |
| **BY** | FY 2018-19 | 21,770 | -2.8% | 3.28 | 1.2% | $76.31 | 0.8% | $65,392,600 | -0.7% |

**Users:** Users are expected to remain relatively unchanged from FY 2016-17 through FY 2018-19, small adjustments reflect overall Caseload changes.

**Utilization:** The change between PY and CY is related to the Department's updated Healthcare Common Procedure Coding System (HCPCS) for Medical Transpiration in July 2016. While the code conversion is not expected to have an impact of the overall cost of services, the new codes can cause changes affecting the Utilization and Rate for estimating. Overall, as calculated for estimating purposes, Utilization increased and Rates decreased with this code conversion related to billing requirement changes for the new HCPCS codes. The change between the Utilization and Rate is assumed to be offsetting. The increase of 1.2% from CY to BY is due to projected growth due to historical growth experienced in this service category.

**Rate:** The changes in Rate from PY to CY are related to the HCPCS update discussed in Utilization above. BY is held relatively consistent with CY.

**Total Expenditures:** Overall, total expenditures showed slight variation in CY and BY. Total expenditures are estimated to decrease by 2.5%, or $1.7M in CY and decrease by 0.7% or $488K in BY. .

**Reason for Change from Prior Estimate**

| Fiscal Year | Total Expenditure | | |
|---|---|---|---|
| | M17 | N17 | % Chng |
| FY 2016-17 | $69,161,300 | $67,589,800 | -2.3% |
| FY 2017-18 | $66,489,900 | $65,880,900 | -0.9% |

Compared to the May 2017 Estimate, the November 2017 Estimate shows a 2.3%, $1.6 million, decrease in FY 2016-17 and a 0.9%, $609,000, decrease in FY 2017-18. FY 2016-17 and FY 2017-18 remained fairly stable from May 2017 to November 2017 estimate cycles.

# QUARTERLY SUMMARY
# OF
# FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
# (INCLUDES ACTUALS AND NOVEMBER 2017 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 | 26,860 | 3.17 | $75.84 | $240.14 | $19,352,500 |
| 2017-18 ** | 2 | 21,720 | 3.23 | $76.82 | $247.77 | $16,145,000 |
| 2017-18 ** | 3 | 21,890 | 3.41 | $74.40 | $253.88 | $16,669,500 |
| 2017-18 ** | 4 | 19,150 | 3.14 | $75.99 | $238.75 | $13,713,900 |
| 2017-18 ** | TOTAL | 22,400 | 3.24 | $75.74 | $245.05 | $65,880,900 |
| 2018-19 ** | 1 | 24,770 | 3.26 | $77.93 | $253.73 | $18,853,100 |
| 2018-19 ** | 2 | 21,510 | 3.24 | $76.74 | $248.46 | $16,036,600 |
| 2018-19 ** | 3 | 21,750 | 3.42 | $74.29 | $253.85 | $16,563,600 |
| 2018-19 ** | 4 | 19,030 | 3.21 | $76.12 | $244.19 | $13,939,400 |
| 2018-19 ** | TOTAL | 21,770 | 3.28 | $76.31 | $250.37 | $65,392,600 |

* 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 | 202,110 | 4.3% | 3.12 | 1.3% | $90.93 | -1.2% | $687,660,600 | 4.2% |
| **BY** | FY 2018-19 | 201,680 | -0.2% | 3.12 | 0.0% | $90.82 | -0.1% | $686,754,800 | -0.1% |

**Users:** PY Users for LEA services were lower than average for several months and has returned to normal levels. Estimated Users are expected to continue at the historical levels for CY and BY.

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

**Rate:** PY Rate was slightly higher than normal levels, associated with the LEA services. CY and BY are projected to return to the normalized level.

**Total Expenditure:** Total expenditure is estimated to return to the normalized patterned for LEA services from the few unusually low months with occurred in mid-PY.

**Reason for Change from Prior Estimate:**

| Fiscal Year | Total Expenditure | | |
|---|---|---|---|
| | M17 | N17 | % Chng |
| FY 2016-17 | $751,170,600 | $659,915,000 | -12.1% |
| FY 2017-18 | $868,193,500 | $687,660,600 | -20.8% |

Compared to the May 2017 Estimate, the November 2017 Estimate is lower by 12.1% for FY 2016-17 and 20.8% for FY 2017-18. In May 2017 Estimate, the Rate component was overstated. The November 2017 Estimate assumes the LEA expenditures have returned to normalized levels for Users, Utilization, and Rate.

# QUARTERLY SUMMARY
# OF
# FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
# (INCLUDES ACTUALS AND NOVEMBER 2017 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 | 194,370 | 3.35 | $99.08 | $332.41 | $193,830,400 |
| 2017-18 ** | 2 | 200,870 | 2.99 | $90.09 | $269.47 | $162,386,900 |
| 2017-18 ** | 3 | 216,890 | 2.97 | $91.71 | $272.70 | $177,439,600 |
| 2017-18 ** | 4 | 196,330 | 3.17 | $82.40 | $261.48 | $154,003,700 |
| 2017-18 ** | TOTAL | 202,110 | 3.12 | $90.93 | $283.53 | $687,660,600 |
| 2018-19 ** | 1 | 194,810 | 3.36 | $97.29 | $327.33 | $191,296,400 |
| 2018-19 ** | 2 | 199,690 | 2.99 | $90.14 | $269.69 | $161,565,600 |
| 2018-19 ** | 3 | 216,310 | 2.96 | $91.94 | $271.98 | $176,491,900 |
| 2018-19 ** | 4 | 195,930 | 3.20 | $83.58 | $267.78 | $157,400,800 |
| 2018-19 ** | TOTAL | 201,680 | 3.12 | $90.82 | $283.76 | $686,754,800 |

* 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 (Dollars per Claim) | | Total Expenditure | |
|---|---|---|---|---|---|---|---|---|---|
| **PY** | FY 2016-17 | 4,330 | -- | 3.41 | -- | $1,219.92 | -- | $216,232,600 | -- |
| **CY** | FY 2017-18 | 4,350 | 0.5% | 3.50 | 2.6% | $1,212.17 | -0.6% | $221,424,600 | 2.4% |
| **BY** | FY-2018-19 | 4,360 | 0.2% | 3.45 | -1.4% | $1,231.20 | 1.6% | $222,206,700 | 0.4% |

**Users:** Users are estimated to remain fairly level from FY 2016-17 through FY 2018-19.

**Utilization**: Utilization is estimated to increase by 2.6% in CY, mainly due to a higher Utilization level starting August 2016. PY includes a partial impact of this higher Utilization level, while CY includes a full year impact of this higher Utilization level. In addition, CY include an unusually high Utilization in one month of CY (July 2017). These changes seen in Home Health Agencies (HHA) claims coincide with the Healthcare Common Procedure Coding System (HCPCS) code conversion for HHA, effective June 2016. The code conversion is to compliance with the Health Insurance Portability and Accountability Act (HIPAA) requirements. Providers are required to discontinue use of HCPCS Level III Local codes and utilize HCPCS Level II national HIPAA compliance codes for HHA claims. BY is projected to return to a normalized utilization level.

**Rate:** Rate is estimated to remain fairly stable from PY to CY, with the exception of unusually low rates in three months of PY (April to June 2017) and one month of CY (July 2017). These changes seen in HHA claims is attributed to the HCPCS code conversion described above. BY is projected to return to a normalized rate level. In addition, the changes related to the HCPCS code conversion are assumed to be offsetting between Utilization and Rate, as the code conversion is not expected to have an impact on the expenditure levels.

**Total Expenditures:** Total expenditure is estimated to increase by 2.4% or $5 million in CY, due to the estimated higher Utilization level. BY expenditure is projected to remain fairly level.

**Reason for Change from Prior Estimate**

| Fiscal Year | Total Expenditure | | |
|---|---|---|---|
| | M17 | N17 | % Chng |
| FY 2016-17 | $220,693,300 | $216,232,600 | -2.0% |
| FY 2017-18 | $224,173,500 | $221,424,600 | -1.2% |

Compared to the May 2017 estimate, the November 2017 estimate is slightly lower by $4 million and $3 million, respectively, for FY 2016-17 and FY 2017-18. The current estimate is fairly consistent with prior estimate, as the HCPCS code conversion is not expected to have an impact on the expenditure levels.

# QUARTERLY SUMMARY
# OF
# FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
# (INCLUDES ACTUALS AND NOVEMBER 2017 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 | 4,470 | 4.02 | $1,179.51 | $4,746.01 | $63,597,000 |
| 2017-18 ** | 2 | 4,280 | 3.47 | $1,236.01 | $4,294.31 | $55,124,900 |
| 2017-18 ** | 3 | 4,480 | 3.36 | $1,218.02 | $4,087.32 | $54,900,300 |
| 2017-18 ** | 4 | 4,160 | 3.13 | $1,223.29 | $3,825.93 | $47,802,500 |
| 2017-18 ** | TOTAL | 4,350 | 3.50 | $1,212.17 | $4,244.86 | $221,424,600 |
| 2018-19 ** | 1 | 4,500 | 3.71 | $1,243.82 | $4,619.15 | $62,421,200 |
| 2018-19 ** | 2 | 4,280 | 3.50 | $1,236.99 | $4,329.74 | $55,579,600 |
| 2018-19 ** | 3 | 4,480 | 3.38 | $1,220.64 | $4,121.86 | $55,364,200 |
| 2018-19 ** | 4 | 4,160 | 3.20 | $1,220.84 | $3,909.10 | $48,841,600 |
| 2018-19 ** | TOTAL | 4,360 | 3.45 | $1,231.20 | $4,250.60 | $222,206,700 |

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

# QUARTERLY SUMMARY
# OF
# FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
# (INCLUDES ACTUALS AND NOVEMBER 2017 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 | 66,710 | 3.74 | $160.56 | $600.23 | $120,129,500 |
| 2017-18 ** | 2 | 58,350 | 3.52 | $157.25 | $553.50 | $96,894,300 |
| 2017-18 ** | 3 | 61,270 | 3.63 | $152.02 | $551.14 | $101,299,100 |
| 2017-18 ** | 4 | 57,040 | 3.17 | $155.43 | $492.84 | $84,338,100 |
| 2017-18 ** | TOTAL | 60,840 | 3.52 | $156.47 | $551.50 | $402,660,900 |
| 2018-19 ** | 1 | 65,000 | 3.74 | $163.80 | $613.34 | $119,597,900 |
| 2018-19 ** | 2 | 57,850 | 3.52 | $157.98 | $556.00 | $96,494,200 |
| 2018-19 ** | 3 | 60,910 | 3.61 | $152.18 | $549.84 | $100,473,400 |
| 2018-19 ** | 4 | 56,710 | 3.24 | $157.69 | $510.85 | $86,909,900 |
| 2018-19 ** | TOTAL | 60,120 | 3.54 | $158.08 | $559.29 | $403,475,300 |

* 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 NOVEMBER 2017 BASE ESTIMATES)

## NEWLY

| | | AVERAGE MONTHLY | | | | |
|---|---|---|---|---|---|---|
| YEAR | QUARTER | 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 | 496,840 | 2.61 | $288.78 | $752.50 | $1,121,606,300 |
| 2017-18 ** | 2 | 464,390 | 2.42 | $292.00 | $706.84 | $984,736,000 |
| 2017-18 ** | 3 | 428,270 | 2.42 | $308.91 | $746.76 | $959,451,900 |
| 2017-18 ** | 4 | 401,070 | 2.35 | $307.76 | $723.80 | $870,876,000 |
| 2017-18 ** | TOTAL | 447,640 | 2.46 | $298.42 | $732.85 | $3,936,670,300 |
| 2018-19 ** | 1 | 479,140 | 2.61 | $305.85 | $799.75 | $1,149,563,800 |
| 2018-19 ** | 2 | 454,380 | 2.43 | $305.97 | $742.63 | $1,012,307,300 |
| 2018-19 ** | 3 | 420,190 | 2.42 | $323.58 | $781.49 | $985,110,100 |
| 2018-19 ** | 4 | 393,610 | 2.39 | $320.63 | $765.92 | $904,427,100 |
| 2018-19 ** | TOTAL | 436,830 | 2.47 | $313.28 | $772.88 | $4,051,408,400 |

* 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 NOVEMBER 2017 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 | 281,010 | 4.68 | $270.24 | $1,265.65 | $1,066,959,200 |
| 2017-18 ** | 2 | 264,900 | 4.19 | $271.54 | $1,137.74 | $904,149,300 |
| 2017-18 ** | 3 | 265,560 | 4.44 | $270.63 | $1,201.14 | $956,926,000 |
| 2017-18 ** | 4 | 247,530 | 4.21 | $265.75 | $1,117.83 | $830,084,900 |
| 2017-18 ** | TOTAL | 264,750 | 4.39 | $269.64 | $1,182.92 | $3,758,119,400 |
| 2018-19 ** | 1 | 274,780 | 4.79 | $277.94 | $1,330.69 | $1,096,927,100 |
| 2018-19 ** | 2 | 262,170 | 4.20 | $278.29 | $1,168.76 | $919,233,100 |
| 2018-19 ** | 3 | 263,410 | 4.43 | $277.33 | $1,228.34 | $970,664,000 |
| 2018-19 ** | 4 | 245,500 | 4.30 | $272.91 | $1,174.34 | $864,892,300 |
| 2018-19 ** | TOTAL | 261,460 | 4.44 | $276.72 | $1,227.62 | $3,851,716,500 |

* 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 NOVEMBER 2017 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 | 161,080 | 2.36 | $208.08 | $491.51 | $237,520,400 |
| 2017-18 ** | 2 | 154,970 | 2.31 | $200.83 | $464.10 | $215,762,400 |
| 2017-18 ** | 3 | 158,250 | 2.30 | $198.58 | $456.57 | $216,751,100 |
| 2017-18 ** | 4 | 138,880 | 2.22 | $190.16 | $421.83 | $175,754,200 |
| 2017-18 ** | TOTAL | 153,300 | 2.30 | $199.87 | $459.78 | $845,788,000 |
| 2018-19 ** | 1 | 158,460 | 2.39 | $212.81 | $508.66 | $241,810,400 |
| 2018-19 ** | 2 | 154,380 | 2.31 | $204.25 | $472.29 | $218,737,200 |
| 2018-19 ** | 3 | 158,070 | 2.29 | $202.30 | $463.64 | $219,866,600 |
| 2018-19 ** | 4 | 138,840 | 2.25 | $192.86 | $434.47 | $180,968,000 |
| 2018-19 ** | TOTAL | 152,440 | 2.31 | $203.52 | $470.89 | $861,382,200 |

* 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 NOVEMBER 2017 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 | 19,120 | 31.59 | $193.48 | $6,112.36 | $350,686,800 |
| 2017-18 ** | 2 | 18,070 | 28.98 | $188.64 | $5,467.36 | $296,320,300 |
| 2017-18 ** | 3 | 18,660 | 28.31 | $189.49 | $5,365.21 | $300,326,400 |
| 2017-18 ** | 4 | 17,150 | 25.25 | $190.52 | $4,811.26 | $247,539,200 |
| 2017-18 ** | TOTAL | 18,250 | 28.62 | $190.64 | $5,456.09 | $1,194,872,600 |
| 2018-19 ** | 1 | 18,790 | 32.05 | $194.84 | $6,244.22 | $352,047,900 |
| 2018-19 ** | 2 | 18,000 | 28.95 | $188.62 | $5,459.72 | $294,876,500 |
| 2018-19 ** | 3 | 18,650 | 28.34 | $189.43 | $5,369.38 | $300,382,700 |
| 2018-19 ** | 4 | 17,150 | 25.71 | $190.77 | $4,904.08 | $252,276,000 |
| 2018-19 ** | TOTAL | 18,150 | 28.83 | $191.07 | $5,508.36 | $1,199,583,200 |

* 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 NOVEMBER 2017 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 | 44,300 | 3.64 | $241.97 | $879.76 | $116,908,600 |
| 2017-18 ** | 2 | 38,600 | 3.60 | $230.05 | $828.25 | $95,905,500 |
| 2017-18 ** | 3 | 40,260 | 3.55 | $258.38 | $918.49 | $110,939,200 |
| 2017-18 ** | 4 | 35,180 | 3.35 | $252.49 | $844.69 | $89,152,300 |
| 2017-18 ** | TOTAL | 39,580 | 3.54 | $245.41 | $869.26 | $412,905,700 |
| 2018-19 ** | 1 | 43,530 | 3.69 | $252.65 | $931.44 | $121,624,300 |
| 2018-19 ** | 2 | 38,680 | 3.60 | $232.50 | $836.78 | $97,092,100 |
| 2018-19 ** | 3 | 40,290 | 3.55 | $260.41 | $924.68 | $111,756,000 |
| 2018-19 ** | 4 | 35,190 | 3.38 | $253.71 | $858.65 | $90,647,300 |
| 2018-19 ** | TOTAL | 39,420 | 3.56 | $249.86 | $890.25 | $421,119,600 |

* 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 NOVEMBER 2017 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 | 6,450 | 31.61 | $217.37 | $6,871.55 | $132,938,500 |
| 2017-18 ** | 2 | 6,040 | 28.70 | $214.73 | $6,162.70 | $111,698,400 |
| 2017-18 ** | 3 | 6,240 | 27.75 | $212.41 | $5,894.50 | $110,413,400 |
| 2017-18 ** | 4 | 5,880 | 23.93 | $213.40 | $5,106.38 | $90,100,600 |
| 2017-18 ** | TOTAL | 6,150 | 28.08 | $214.66 | $6,027.98 | $445,150,900 |
| 2018-19 ** | 1 | 6,340 | 31.99 | $218.44 | $6,987.26 | $132,943,900 |
| 2018-19 ** | 2 | 6,020 | 28.73 | $214.83 | $6,172.47 | $111,410,800 |
| 2018-19 ** | 3 | 6,240 | 27.71 | $212.90 | $5,898.63 | $110,394,100 |
| 2018-19 ** | 4 | 5,880 | 24.35 | $213.59 | $5,200.70 | $91,755,400 |
| 2018-19 ** | TOTAL | 6,120 | 28.26 | $215.15 | $6,080.32 | $446,504,200 |

* 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 NOVEMBER 2017 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 | 103,060 | 2.23 | $201.62 | $450.22 | $139,197,600 |
| 2017-18 ** | 2 | 98,670 | 2.15 | $193.25 | $415.23 | $122,916,200 |
| 2017-18 ** | 3 | 100,120 | 2.17 | $192.25 | $417.26 | $125,330,100 |
| 2017-18 ** | 4 | 93,230 | 2.19 | $181.49 | $396.62 | $110,927,300 |
| 2017-18 ** | TOTAL | 98,770 | 2.18 | $192.45 | $420.48 | $498,371,200 |
| 2018-19 ** | 1 | 103,200 | 2.26 | $206.57 | $467.11 | $144,614,300 |
| 2018-19 ** | 2 | 98,670 | 2.16 | $198.73 | $428.97 | $126,984,000 |
| 2018-19 ** | 3 | 100,120 | 2.17 | $198.33 | $431.15 | $129,502,900 |
| 2018-19 ** | 4 | 93,230 | 2.22 | $185.99 | $411.98 | $115,221,900 |
| 2018-19 ** | TOTAL | 98,810 | 2.20 | $197.71 | $435.47 | $516,323,100 |

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

# QUARTERLY SUMMARY
# OF
# FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
# (INCLUDES ACTUALS AND NOVEMBER 2017 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 | 81,630 | 4.15 | $193.94 | $804.74 | $197,063,100 |
| 2017-18 ** | 2 | 73,370 | 3.97 | $188.59 | $749.09 | $164,877,100 |
| 2017-18 ** | 3 | 73,740 | 4.05 | $189.60 | $768.42 | $169,989,900 |
| 2017-18 ** | 4 | 69,820 | 3.76 | $187.14 | $703.60 | $147,368,800 |
| 2017-18 ** | TOTAL | 74,640 | 3.99 | $190.04 | $758.44 | $679,298,900 |
| 2018-19 ** | 1 | 82,070 | 4.23 | $194.30 | $821.65 | $202,311,300 |
| 2018-19 ** | 2 | 75,430 | 3.96 | $187.12 | $741.61 | $167,818,400 |
| 2018-19 ** | 3 | 75,980 | 4.03 | $188.01 | $756.89 | $172,514,500 |
| 2018-19 ** | 4 | 72,070 | 3.81 | $185.37 | $706.04 | $152,660,700 |
| 2018-19 ** | TOTAL | 76,390 | 4.01 | $188.98 | $758.52 | $695,304,900 |

* 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 NOVEMBER 2017 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 | 42,180 | 4.52 | $187.42 | $847.36 | $107,232,100 |
| 2017-18 ** | 2 | 37,900 | 3.99 | $188.05 | $751.15 | $85,395,600 |
| 2017-18 ** | 3 | 38,680 | 4.23 | $184.24 | $780.19 | $90,542,700 |
| 2017-18 ** | 4 | 37,060 | 4.04 | $175.59 | $709.88 | $78,913,900 |
| 2017-18 ** | TOTAL | 38,950 | 4.21 | $184.07 | $774.59 | $362,084,400 |
| 2018-19 ** | 1 | 40,600 | 4.61 | $194.66 | $897.65 | $109,341,300 |
| 2018-19 ** | 2 | 36,910 | 4.02 | $190.21 | $764.45 | $84,640,000 |
| 2018-19 ** | 3 | 37,820 | 4.23 | $186.56 | $789.34 | $89,568,500 |
| 2018-19 ** | 4 | 36,190 | 4.15 | $177.85 | $737.49 | $80,078,400 |
| 2018-19 ** | TOTAL | 37,880 | 4.26 | $187.72 | $799.91 | $363,628,300 |

* 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 NOVEMBER 2017 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 | 442,420 | 2.62 | $198.41 | $519.82 | $689,946,900 |
| 2017-18 ** | 2 | 414,140 | 2.56 | $193.64 | $496.01 | $616,251,200 |
| 2017-18 ** | 3 | 405,500 | 2.55 | $193.86 | $495.23 | $602,448,400 |
| 2017-18 ** | 4 | 369,100 | 2.40 | $190.83 | $458.77 | $507,996,100 |
| 2017-18 ** | TOTAL | 407,790 | 2.54 | $194.43 | $493.85 | $2,416,642,600 |
| 2018-19 ** | 1 | 431,710 | 2.68 | $201.27 | $539.25 | $698,401,200 |
| 2018-19 ** | 2 | 413,090 | 2.56 | $195.43 | $500.92 | $620,781,200 |
| 2018-19 ** | 3 | 405,190 | 2.55 | $195.84 | $498.92 | $606,472,500 |
| 2018-19 ** | 4 | 369,060 | 2.45 | $191.93 | $469.40 | $519,700,300 |
| 2018-19 ** | TOTAL | 404,760 | 2.56 | $196.40 | $503.45 | $2,445,355,200 |

* 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 NOVEMBER 2017 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 | 60,810 | 2.68 | $155.68 | $416.73 | $76,025,900 |
| 2017-18 ** | 2 | 57,980 | 2.52 | $155.91 | $392.81 | $68,323,400 |
| 2017-18 ** | 3 | 50,860 | 2.90 | $169.53 | $491.55 | $75,003,700 |
| 2017-18 ** | 4 | 46,760 | 2.67 | $165.75 | $442.40 | $62,059,000 |
| 2017-18 ** | TOTAL | 54,100 | 2.69 | $161.41 | $433.45 | $281,412,000 |
| 2018-19 ** | 1 | 59,760 | 2.76 | $168.11 | $463.78 | $83,149,400 |
| 2018-19 ** | 2 | 57,770 | 2.55 | $162.00 | $412.40 | $71,468,500 |
| 2018-19 ** | 3 | 50,770 | 2.92 | $176.59 | $515.06 | $78,443,600 |
| 2018-19 ** | 4 | 46,700 | 2.74 | $171.25 | $468.52 | $65,642,200 |
| 2018-19 ** | TOTAL | 53,750 | 2.73 | $169.40 | $463.12 | $298,703,600 |

* 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 NOVEMBER 2017 BASE ESTIMATES)

## MI-A

| | | AVERAGE MONTHLY | | | | |
|---|---|---|---|---|---|---|
| YEAR | QUARTER | USERS | UNIT PER USER | COST PER UNIT | 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 | 510 | 25.60 | $203.43 | $5,207.14 | $7,911,600 |
| 2017-18 ** | 2 | 490 | 24.25 | $199.84 | $4,845.76 | $7,092,300 |
| 2017-18 ** | 3 | 470 | 25.23 | $201.11 | $5,073.34 | $7,174,300 |
| 2017-18 ** | 4 | 430 | 22.27 | $203.49 | $4,531.51 | $5,883,900 |
| 2017-18 ** | TOTAL | 470 | 24.40 | $201.93 | $4,927.03 | $28,062,000 |
| 2018-19 ** | 1 | 500 | 25.25 | $203.10 | $5,127.90 | $7,685,100 |
| 2018-19 ** | 2 | 490 | 24.25 | $201.09 | $4,876.07 | $7,136,600 |
| 2018-19 ** | 3 | 470 | 25.21 | $203.03 | $5,118.14 | $7,237,600 |
| 2018-19 ** | 4 | 430 | 22.61 | $205.13 | $4,637.48 | $6,021,500 |
| 2018-19 ** | TOTAL | 470 | 24.38 | $203.00 | $4,948.31 | $28,080,800 |

* 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 NOVEMBER 2017 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 | 660 | 2.16 | $124.11 | $268.63 | $532,800 |
| 2017-18 ** | 2 | 640 | 2.26 | $145.00 | $327.33 | $626,800 |
| 2017-18 ** | 3 | 900 | 2.19 | $142.27 | $311.95 | $845,800 |
| 2017-18 ** | 4 | 950 | 2.07 | $124.70 | $257.83 | $732,600 |
| 2017-18 ** | TOTAL | 790 | 2.16 | $133.98 | $289.71 | $2,738,000 |
| 2018-19 ** | 1 | 780 | 2.27 | $126.99 | $287.90 | $673,100 |
| 2018-19 ** | 2 | 840 | 2.36 | $132.29 | $312.83 | $789,800 |
| 2018-19 ** | 3 | 1,100 | 2.25 | $133.84 | $301.05 | $990,900 |
| 2018-19 ** | 4 | 1,080 | 2.10 | $121.82 | $255.72 | $830,800 |
| 2018-19 ** | TOTAL | 950 | 2.24 | $128.84 | $288.05 | $3,284,600 |

* 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 NOVEMBER 2017 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 | 460 | 7.37 | $239.05 | $1,761.04 | $2,423,300 |
| 2017-18 ** | 2 | 320 | 8.52 | $279.48 | $2,380.05 | $2,256,800 |
| 2017-18 ** | 3 | 300 | 9.48 | $294.16 | $2,789.82 | $2,496,600 |
| 2017-18 ** | 4 | 290 | 7.96 | $288.83 | $2,300.34 | $2,013,500 |
| 2017-18 ** | TOTAL | 340 | 8.22 | $272.95 | $2,244.54 | $9,190,200 |
| 2018-19 ** | 1 | 290 | 9.99 | $281.65 | $2,814.46 | $2,441,600 |
| 2018-19 ** | 2 | 290 | 9.18 | $283.72 | $2,604.75 | $2,259,800 |
| 2018-19 ** | 3 | 290 | 9.76 | $294.42 | $2,873.32 | $2,492,800 |
| 2018-19 ** | 4 | 290 | 8.14 | $290.23 | $2,361.65 | $2,048,900 |
| 2018-19 ** | TOTAL | 290 | 9.27 | $287.41 | $2,663.54 | $9,243,100 |

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

# QUARTERLY SUMMARY
# OF
# FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
# (INCLUDES ACTUALS AND NOVEMBER 2017 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 | 120,680 | 2.95 | $303.66 | $895.47 | $324,202,800 |
| 2017-18 ** | 2 | 103,830 | 2.84 | $324.54 | $922.68 | $287,404,200 |
| 2017-18 ** | 3 | 109,830 | 2.90 | $323.39 | $939.14 | $309,446,000 |
| 2017-18 ** | 4 | 97,470 | 2.71 | $328.84 | $891.71 | $260,737,200 |
| 2017-18 ** | TOTAL | 107,950 | 2.86 | $319.14 | $912.27 | $1,181,790,200 |
| 2018-19 ** | 1 | 116,010 | 3.01 | $332.08 | $998.42 | $347,473,400 |
| 2018-19 ** | 2 | 103,260 | 2.85 | $340.04 | $968.40 | $299,982,400 |
| 2018-19 ** | 3 | 109,680 | 2.90 | $339.59 | $984.54 | $323,939,600 |
| 2018-19 ** | 4 | 97,430 | 2.76 | $341.24 | $942.38 | $275,459,700 |
| 2018-19 ** | TOTAL | 106,590 | 2.88 | $337.93 | $974.77 | $1,246,855,100 |

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

# QUARTERLY SUMMARY
# OF
# FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
# (INCLUDES ACTUALS AND NOVEMBER 2017 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 | 90,270 | 1.97 | $171.39 | $338.01 | $91,537,700 |
| 2017-18 ** | 2 | 87,770 | 1.96 | $165.26 | $323.30 | $85,126,800 |
| 2017-18 ** | 3 | 87,010 | 1.96 | $167.72 | $328.32 | $85,702,900 |
| 2017-18 ** | 4 | 80,500 | 1.93 | $164.83 | $318.66 | $76,953,900 |
| 2017-18 ** | TOTAL | 86,390 | 1.96 | $167.40 | $327.33 | $339,321,300 |
| 2018-19 ** | 1 | 88,060 | 2.00 | $176.95 | $354.60 | $93,679,200 |
| 2018-19 ** | 2 | 87,520 | 1.96 | $169.84 | $333.13 | $87,465,900 |
| 2018-19 ** | 3 | 86,940 | 1.96 | $172.53 | $338.13 | $88,187,900 |
| 2018-19 ** | 4 | 80,480 | 1.95 | $168.82 | $329.29 | $79,504,500 |
| 2018-19 ** | TOTAL | 85,750 | 1.97 | $172.14 | $339.01 | $348,837,500 |

* 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 NOVEMBER 2017 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 | 43,870 | 1.97 | $193.54 | $381.98 | $50,276,900 |
| 2017-18 ** | 2 | 44,190 | 1.84 | $188.50 | $346.54 | $45,944,700 |
| 2017-18 ** | 3 | 42,280 | 1.87 | $187.40 | $350.47 | $44,458,200 |
| 2017-18 ** | 4 | 37,980 | 1.94 | $180.45 | $350.85 | $39,979,300 |
| 2017-18 ** | TOTAL | 42,080 | 1.91 | $187.73 | $357.73 | $180,659,100 |
| 2018-19 ** | 1 | 43,420 | 1.98 | $204.22 | $404.85 | $52,735,500 |
| 2018-19 ** | 2 | 44,110 | 1.84 | $199.71 | $367.68 | $48,660,200 |
| 2018-19 ** | 3 | 42,250 | 1.87 | $199.22 | $372.40 | $47,202,000 |
| 2018-19 ** | 4 | 37,990 | 1.97 | $190.89 | $375.13 | $42,749,700 |
| 2018-19 ** | TOTAL | 41,940 | 1.91 | $198.75 | $380.18 | $191,347,300 |

* 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 | $32,243,000 | $23,511,000 | $0 | $8,732,000 |
| 5 | COUNTY HEALTH INITIATIVE MATCHING (CHIM) | $17,047,000 | $15,001,360 | $2,045,640 | $0 |
| 6 | MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL | $3,399,000 | $2,991,120 | $407,880 | $0 |
| | **ELIGIBILITY SUBTOTAL** | **$52,689,000** | **$41,503,480** | **$2,453,520** | **$8,732,000** |
| | **DRUG MEDI-CAL** | | | | |
| 57 | NARCOTIC TREATMENT PROGRAM | $172,279,000 | $166,312,540 | $5,966,460 | $0 |
| 58 | OUTPATIENT DRUG FREE TREATMENT SERVICES | $25,342,000 | $24,501,260 | $840,740 | $0 |
| 60 | INTENSIVE OUTPATIENT TREATMENT SERVICES | $9,697,000 | $8,292,440 | $1,404,560 | $0 |
| 62 | RESIDENTIAL TREATMENT SERVICES | $1,316,000 | $1,277,590 | $38,410 | $0 |
| | **DRUG MEDI-CAL SUBTOTAL** | **$208,634,000** | **$200,383,830** | **$8,250,170** | **$0** |
| | **MENTAL HEALTH** | | | | |
| 63 | SMHS FOR ADULTS | $1,510,777,000 | $1,413,241,950 | $28,030,050 | $69,505,000 |
| 64 | SMHS FOR CHILDREN | $1,224,732,000 | $1,186,816,430 | $1,639,570 | $36,276,000 |
| | **MENTAL HEALTH SUBTOTAL** | **$2,735,509,000** | **$2,600,058,380** | **$29,669,620** | **$105,781,000** |
| | **MANAGED CARE** | | | | |
| 87 | TWO PLAN MODEL | $20,429,116,000 | $14,066,195,810 | $5,852,920,190 | $510,000,000 |
| 88 | COUNTY ORGANIZED HEALTH SYSTEMS | $7,914,399,000 | $5,520,528,490 | $2,283,870,510 | $110,000,000 |
| 89 | GEOGRAPHIC MANAGED CARE | $3,760,382,000 | $2,641,587,090 | $1,058,794,910 | $60,000,000 |
| 94 | REGIONAL MODEL | $1,195,203,000 | $845,100,140 | $347,702,860 | $2,400,000 |
| 95 | PACE (Other M/C) | $515,861,000 | $257,930,500 | $229,164,500 | $28,766,000 |
| 97 | DENTAL MANAGED CARE (Other M/C) | $118,197,000 | $77,374,380 | $40,822,620 | $0 |
| 98 | SENIOR CARE ACTION NETWORK (Other M/C) | $56,327,000 | $28,163,500 | $28,163,500 | $0 |
| 100 | AIDS HEALTHCARE CENTERS (Other M/C) | $18,930,000 | $9,465,000 | $9,465,000 | $0 |
| 102 | FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C) | $3,051,000 | $1,525,500 | $1,525,500 | $0 |
| | **MANAGED CARE SUBTOTAL** | **$34,011,466,000** | **$23,447,870,410** | **$9,852,429,590** | **$711,166,000** |
| | **OTHER** | | | | |
| 165 | MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS | $3,251,287,000 | $1,519,030,000 | $1,732,257,000 | $0 |
| 166 | MEDICARE PAYMENTS - PART D PHASED-DOWN | $2,111,200,000 | $0 | $2,111,200,000 | $0 |
| 167 | HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.) | $1,741,895,000 | $1,741,895,000 | $0 | $0 |
| 168 | PERSONAL CARE SERVICES (Misc. Svcs.) | $1,353,962,000 | $1,353,962,000 | $0 | $0 |
| 169 | DENTAL SERVICES | $1,232,658,000 | $797,756,950 | $434,901,050 | $0 |
| 172 | DEVELOPMENTAL CENTERS/STATE OP SMALL FAC | $207,330,000 | $207,330,000 | $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.) | $219,679,000 | $219,679,000 | $0 | $0 |
| 175 | WAIVER PERSONAL CARE SERVICES (Misc. Svcs.) | $45,900,000 | $22,950,000 | $22,950,000 | $0 |
| 176 | MEDI-CAL TCM PROGRAM | $41,615,000 | $41,309,000 | $306,000 | $0 |
| 177 | EPSDT SCREENS | $29,840,690 | $15,469,680 | $14,371,010 | $0 |
| 187 | CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.) | $1,485,000 | $1,485,000 | $0 | $0 |
| 188 | HIPP PREMIUM PAYOUTS (Misc. Svcs.) | $1,452,000 | $726,000 | $726,000 | $0 |
| 203 | BASE RECOVERIES | ($371,809,000) | ($198,037,000) | ($173,772,000) | $0 |
| 208 | LAWSUITS/CLAIMS | $38,760,000 | $19,380,000 | $19,380,000 | $0 |
| | **OTHER SUBTOTAL** | **$9,905,254,690** | **$5,742,935,630** | **$4,162,319,060** | **$0** |
| | **GRAND TOTAL** | **$46,913,552,690** | **$32,032,751,730** | **$14,055,121,960** | **$825,679,000** |

# 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 | $46,553,000 | $36,554,000 | $0 | $9,999,000 |
| 5 | COUNTY HEALTH INITIATIVE MATCHING (CHIM) | $16,872,000 | $14,847,360 | $2,024,640 | $0 |
| 6 | MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL | $3,399,000 | $2,991,120 | $407,880 | $0 |
| | **ELIGIBILITY SUBTOTAL** | **$66,824,000** | **$54,392,480** | **$2,432,520** | **$9,999,000** |
| | **DRUG MEDI-CAL** | | | | |
| 57 | NARCOTIC TREATMENT PROGRAM | $181,477,000 | $173,260,750 | $8,216,250 | $0 |
| 58 | OUTPATIENT DRUG FREE TREATMENT SERVICES | $26,848,000 | $25,686,280 | $1,161,720 | $0 |
| 60 | INTENSIVE OUTPATIENT TREATMENT SERVICES | $9,876,000 | $8,373,180 | $1,502,820 | $0 |
| 62 | RESIDENTIAL TREATMENT SERVICES | $1,397,000 | $1,343,420 | $53,580 | $0 |
| | **DRUG MEDI-CAL SUBTOTAL** | **$219,598,000** | **$208,663,630** | **$10,934,370** | **$0** |
| | **MENTAL HEALTH** | | | | |
| 63 | SMHS FOR ADULTS | $1,559,573,000 | $1,440,110,650 | $49,449,350 | $70,013,000 |
| 64 | SMHS FOR CHILDREN | $1,196,328,000 | $1,156,001,950 | $2,896,050 | $37,430,000 |
| | **MENTAL HEALTH SUBTOTAL** | **$2,755,901,000** | **$2,596,112,600** | **$52,345,400** | **$107,443,000** |
| | **MANAGED CARE** | | | | |
| 87 | TWO PLAN MODEL | $20,636,578,000 | $14,171,245,760 | $6,295,925,240 | $169,407,000 |
| 88 | COUNTY ORGANIZED HEALTH SYSTEMS | $8,048,854,000 | $5,653,449,020 | $2,395,404,980 | $0 |
| 89 | GEOGRAPHIC MANAGED CARE | $3,817,381,000 | $2,675,048,700 | $1,142,332,300 | $0 |
| 94 | REGIONAL MODEL | $1,222,082,000 | $859,806,800 | $362,275,200 | $0 |
| 95 | PACE (Other M/C) | $487,954,000 | $243,977,000 | $243,977,000 | $0 |
| 97 | DENTAL MANAGED CARE (Other M/C) | $104,176,000 | $67,155,940 | $37,020,060 | $0 |
| 98 | SENIOR CARE ACTION NETWORK (Other M/C) | $54,439,000 | $27,219,500 | $27,219,500 | $0 |
| 100 | AIDS HEALTHCARE CENTERS (Other M/C) | $19,069,000 | $9,534,500 | $9,534,500 | $0 |
| 102 | FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C) | $1,092,000 | $546,000 | $546,000 | $0 |
| | **MANAGED CARE SUBTOTAL** | **$34,391,625,000** | **$23,707,983,220** | **$10,514,234,780** | **$169,407,000** |
| | **OTHER** | | | | |
| 165 | MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS | $3,347,632,000 | $1,565,079,000 | $1,782,553,000 | $0 |
| 166 | MEDICARE PAYMENTS - PART D PHASED-DOWN | $2,221,955,000 | $0 | $2,221,955,000 | $0 |
| 167 | HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.) | $1,816,555,000 | $1,816,555,000 | $0 | $0 |
| 168 | PERSONAL CARE SERVICES (Misc. Svcs.) | $2,001,165,000 | $2,001,165,000 | $0 | $0 |
| 169 | DENTAL SERVICES | $1,364,464,000 | $879,373,800 | $485,090,200 | $0 |
| 172 | DEVELOPMENTAL CENTERS/STATE OP SMALL FAC | $207,330,000 | $207,330,000 | $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.) | $208,970,000 | $208,970,000 | $0 | $0 |
| 175 | WAIVER PERSONAL CARE SERVICES (Misc. Svcs.) | $48,275,000 | $24,137,500 | $24,137,500 | $0 |
| 176 | MEDI-CAL TCM PROGRAM | $33,555,000 | $33,555,000 | $0 | $0 |
| 177 | EPSDT SCREENS | $29,832,550 | $15,465,510 | $14,367,030 | $0 |
| 187 | CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.) | $1,028,000 | $1,028,000 | $0 | $0 |
| 188 | HIPP PREMIUM PAYOUTS (Misc. Svcs.) | $1,448,000 | $724,000 | $724,000 | $0 |
| 203 | BASE RECOVERIES | ($367,663,000) | ($195,829,000) | ($171,834,000) | $0 |
| 208 | LAWSUITS/CLAIMS | $32,865,000 | $16,432,500 | $16,432,500 | $0 |
| | **OTHER SUBTOTAL** | **$10,947,411,550** | **$6,573,986,310** | **$4,373,425,230** | **$0** |
| | **GRAND TOTAL** | **$48,381,359,550** | **$33,141,138,240** | **$14,953,372,300** | **$286,849,000** |

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

| MAY NO. | NOV. NO. | POLICY CHANGE TITLE | 2017-18 APPROPRIATION | | NOV. 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|---|
| | | | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | | **ELIGIBILITY** | | | | | | |
| 4 | 4 | MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL | $29,170,000 | $0 | $32,243,000 | $0 | $3,073,000 | $0 |
| 7 | 5 | COUNTY HEALTH INITIATIVE MATCHING (CHIM) | $7,144,000 | $857,280 | $17,047,000 | $2,045,640 | $9,903,000 | $1,188,360 |
| 8 | 6 | MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL | $2,755,000 | $330,600 | $3,399,000 | $407,880 | $644,000 | $77,280 |
| | | **ELIGIBILITY SUBTOTAL** | **$39,069,000** | **$1,187,880** | **$52,689,000** | **$2,453,520** | **$13,620,000** | **$1,265,640** |
| | | **DRUG MEDI-CAL** | | | | | | |
| 63 | 57 | NARCOTIC TREATMENT PROGRAM | $158,571,000 | $5,326,150 | $172,279,000 | $5,966,460 | $13,708,000 | $640,310 |
| 65 | 58 | OUTPATIENT DRUG FREE TREATMENT SERVICES | $24,330,000 | $772,510 | $25,342,000 | $840,740 | $1,012,000 | $68,230 |
| 66 | 60 | INTENSIVE OUTPATIENT TREATMENT SERVICES | $9,458,000 | $1,419,370 | $9,697,000 | $1,404,560 | $239,000 | ($14,810) |
| 68 | 62 | RESIDENTIAL TREATMENT SERVICES | $1,505,000 | $49,000 | $1,316,000 | $38,410 | ($189,000) | ($10,590) |
| | | **DRUG MEDI-CAL SUBTOTAL** | **$193,864,000** | **$7,567,030** | **$208,634,000** | **$8,250,170** | **$14,770,000** | **$683,140** |
| | | **MENTAL HEALTH** | | | | | | |
| 70 | 63 | SMHS FOR ADULTS | $1,425,027,000 | $41,156,000 | $1,510,777,000 | $28,030,050 | $85,750,000 | ($13,125,950) |
| 71 | 64 | SMHS FOR CHILDREN | $1,127,659,000 | $2,266,660 | $1,224,732,000 | $1,639,570 | $97,073,000 | ($627,090) |
| | | **MENTAL HEALTH SUBTOTAL** | **$2,552,686,000** | **$43,422,660** | **$2,735,509,000** | **$29,669,620** | **$182,823,000** | **($13,753,040)** |
| | | **MANAGED CARE** | | | | | | |
| 96 | 87 | TWO PLAN MODEL | $20,478,370,000 | $5,606,509,640 | $20,429,116,000 | $5,852,920,190 | ($49,254,000) | $246,410,550 |
| 97 | 88 | COUNTY ORGANIZED HEALTH SYSTEMS | $7,985,671,000 | $2,275,153,800 | $7,914,399,000 | $2,283,870,510 | ($71,272,000) | $8,716,710 |
| 99 | 89 | GEOGRAPHIC MANAGED CARE | $3,798,337,000 | $995,254,430 | $3,760,382,000 | $1,058,794,910 | ($37,955,000) | $63,540,480 |
| 102 | 94 | REGIONAL MODEL | $1,219,782,000 | $338,889,950 | $1,195,203,000 | $347,702,860 | ($24,579,000) | $8,812,910 |
| 104 | 95 | PACE (Other M/C) | $421,796,000 | $182,132,000 | $515,861,000 | $229,164,500 | $94,065,000 | $47,032,500 |
| 106 | 97 | DENTAL MANAGED CARE (Other M/C) | $133,170,000 | $46,959,170 | $118,197,000 | $40,822,620 | ($14,973,000) | ($6,136,550) |

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

| MAY NO. | NOV. NO. | POLICY CHANGE TITLE | 2017-18 APPROPRIATION | | NOV. 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|---|
| | | | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | | **MANAGED CARE** | | | | | | |
| 107 | 98 | SENIOR CARE ACTION NETWORK (Other M/C) | $65,050,000 | $32,525,000 | $56,327,000 | $28,163,500 | ($8,723,000) | ($4,361,500) |
| 108 | 100 | AIDS HEALTHCARE CENTERS (Other M/C) | $19,750,000 | $9,875,000 | $18,930,000 | $9,465,000 | ($820,000) | ($410,000) |
| 110 | 102 | FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C) | $3,117,000 | $1,558,500 | $3,051,000 | $1,525,500 | ($66,000) | ($33,000) |
| | | **MANAGED CARE SUBTOTAL** | **$34,125,043,000** | **$9,488,857,490** | **$34,011,466,000** | **$9,852,429,590** | **($113,577,000)** | **$363,572,100** |
| | | **OTHER** | | | | | | |
| 167 | 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 | ($19,092,000) | ($19,379,500) |
| 168 | 166 | MEDICARE PAYMENTS - PART D PHASED-DOWN | $2,125,280,000 | $2,125,280,000 | $2,111,200,000 | $2,111,200,000 | ($14,080,000) | ($14,080,000) |
| 169 | 167 | HOME & COMMUNITY-BASED SVCS.- CDDS (Misc.) | $1,736,805,000 | $0 | $1,741,895,000 | $0 | $5,090,000 | $0 |
| 170 | 168 | PERSONAL CARE SERVICES (Misc. Svcs.) | $1,464,250,000 | $0 | $1,353,962,000 | $0 | ($110,288,000) | $0 |
| 171 | 169 | DENTAL SERVICES | $1,171,505,000 | $401,821,340 | $1,232,658,000 | $434,901,050 | $61,153,000 | $33,079,710 |
| 173 | 172 | DEVELOPMENTAL CENTERS/STATE OP SMALL FAC | $207,330,000 | $0 | $207,330,000 | $0 | $0 | $0 |
| 175 | 173 | TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.) | $194,996,000 | $0 | $219,679,000 | $0 | $24,683,000 | $0 |
| 177 | 175 | WAIVER PERSONAL CARE SERVICES (Misc. Svcs.) | $46,068,000 | $23,034,000 | $45,900,000 | $22,950,000 | ($168,000) | ($84,000) |
| 178 | 176 | MEDI-CAL TCM PROGRAM | $30,063,000 | $0 | $41,615,000 | $306,000 | $11,552,000 | $306,000 |
| 179 | 177 | EPSDT SCREENS | $34,832,000 | $16,675,000 | $30,984,000 | $14,921,620 | ($3,848,000) | ($1,753,380) |
| 188 | 187 | CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.) | $1,028,000 | $0 | $1,485,000 | $0 | $457,000 | $0 |
| 187 | 188 | HIPP PREMIUM PAYOUTS (Misc. Svcs.) | $1,307,000 | $653,500 | $1,452,000 | $726,000 | $145,000 | $72,500 |
| 203 | 203 | BASE RECOVERIES | ($352,303,000) | ($169,305,000) | ($371,809,000) | ($173,772,000) | ($19,506,000) | ($4,467,000) |
| -- | 208 | LAWSUITS/CLAIMS | $0 | $0 | $38,760,000 | $19,380,000 | $38,760,000 | $19,380,000 |

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

| MAY NO. | NOV. NO. | POLICY CHANGE TITLE | 2017-18 APPROPRIATION | | NOV. 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|---|
| | | | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | | **OTHER** | | | | | | |
| 186 | -- | LAWSUITS/CLAIMS | $2,013,000 | $1,080,500 | $0 | $0 | ($2,013,000) | ($1,080,500) |
| | | **OTHER SUBTOTAL** | **$9,933,553,000** | **$4,150,875,840** | **$9,906,398,000** | **$4,162,869,670** | **($27,155,000)** | **$11,993,830** |
| | | **GRAND TOTAL** | **$46,844,215,000** | **$13,691,910,900** | **$46,914,696,000** | **$14,055,672,570** | **$70,481,000** | **$363,761,670** |

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

| | | NOV. 2017 EST. FOR 2017-18 | | NOV. 2017 EST. FOR 2018-19 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | **ELIGIBILITY** | | | | | | |
| 4 | MEDI-CAL ACCESS PROGRAM MOTHERS 213 -322% FPL | $32,243,000 | $0 | $46,553,000 | $0 | $14,310,000 | $0 |
| 5 | COUNTY HEALTH INITIATIVE MATCHING (CHIM) | $17,047,000 | $2,045,640 | $16,872,000 | $2,024,640 | ($175,000) | ($21,000) |
| 6 | MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL | $3,399,000 | $407,880 | $3,399,000 | $407,880 | $0 | $0 |
| | **ELIGIBILITY SUBTOTAL** | **$52,689,000** | **$2,453,520** | **$66,824,000** | **$2,432,520** | **$14,135,000** | **($21,000)** |
| | **DRUG MEDI-CAL** | | | | | | |
| 57 | NARCOTIC TREATMENT PROGRAM | $172,279,000 | $5,966,460 | $181,477,000 | $8,216,250 | $9,198,000 | $2,249,790 |
| 58 | OUTPATIENT DRUG FREE TREATMENT SERVICES | $25,342,000 | $840,740 | $26,848,000 | $1,161,720 | $1,506,000 | $320,980 |
| 60 | INTENSIVE OUTPATIENT TREATMENT SERVICES | $9,697,000 | $1,404,560 | $9,876,000 | $1,502,820 | $179,000 | $98,260 |
| 62 | RESIDENTIAL TREATMENT SERVICES | $1,316,000 | $38,410 | $1,397,000 | $53,580 | $81,000 | $15,170 |
| | **DRUG MEDI-CAL SUBTOTAL** | **$208,634,000** | **$8,250,170** | **$219,598,000** | **$10,934,370** | **$10,964,000** | **$2,684,200** |
| | **MENTAL HEALTH** | | | | | | |
| 63 | SMHS FOR ADULTS | $1,510,777,000 | $28,030,050 | $1,559,573,000 | $49,449,350 | $48,796,000 | $21,419,300 |
| 64 | SMHS FOR CHILDREN | $1,224,732,000 | $1,639,570 | $1,196,328,000 | $2,896,050 | ($28,404,000) | $1,256,480 |
| | **MENTAL HEALTH SUBTOTAL** | **$2,735,509,000** | **$29,669,620** | **$2,755,901,000** | **$52,345,400** | **$20,392,000** | **$22,675,780** |
| | **MANAGED CARE** | | | | | | |
| 87 | TWO PLAN MODEL | $20,429,116,000 | $5,852,920,190 | $20,636,578,000 | $6,295,925,240 | $207,462,000 | $443,005,050 |
| 88 | COUNTY ORGANIZED HEALTH SYSTEMS | $7,914,399,000 | $2,283,870,510 | $8,048,854,000 | $2,395,404,980 | $134,455,000 | $111,534,470 |
| 89 | GEOGRAPHIC MANAGED CARE | $3,760,382,000 | $1,058,794,910 | $3,817,381,000 | $1,142,332,300 | $56,999,000 | $83,537,390 |
| 94 | REGIONAL MODEL | $1,195,203,000 | $347,702,860 | $1,222,082,000 | $362,275,200 | $26,879,000 | $14,572,340 |
| 95 | PACE (Other M/C) | $515,861,000 | $229,164,500 | $487,954,000 | $243,977,000 | ($27,907,000) | $14,812,500 |
| 97 | DENTAL MANAGED CARE (Other M/C) | $118,197,000 | $40,822,620 | $104,176,000 | $37,020,060 | ($14,021,000) | ($3,802,560) |
| 98 | SENIOR CARE ACTION NETWORK (Other M/C) | $56,327,000 | $28,163,500 | $54,439,000 | $27,219,500 | ($1,888,000) | ($944,000) |

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

| | | NOV. 2017 EST. FOR 2017-18 | | NOV. 2017 EST. FOR 2018-19 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | **MANAGED CARE** | | | | | | |
| 100 | AIDS HEALTHCARE CENTERS (Other M/C) | $18,930,000 | $9,465,000 | $19,069,000 | $9,534,500 | $139,000 | $69,500 |
| 102 | FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C) | $3,051,000 | $1,525,500 | $1,092,000 | $546,000 | ($1,959,000) | ($979,500) |
| | **MANAGED CARE SUBTOTAL** | **$34,011,466,000** | **$9,852,429,590** | **$34,391,625,000** | **$10,514,234,780** | **$380,159,000** | **$661,805,190** |
| | **OTHER** | | | | | | |
| 165 | MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS | $3,251,287,000 | $1,732,257,000 | $3,347,632,000 | $1,782,553,000 | $96,345,000 | $50,296,000 |
| 166 | MEDICARE PAYMENTS - PART D PHASED-DOWN | $2,111,200,000 | $2,111,200,000 | $2,221,955,000 | $2,221,955,000 | $110,755,000 | $110,755,000 |
| 167 | HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.) | $1,741,895,000 | $0 | $1,816,555,000 | $0 | $74,660,000 | $0 |
| 168 | PERSONAL CARE SERVICES (Misc. Svcs.) | $1,353,962,000 | $0 | $2,001,165,000 | $0 | $647,203,000 | $0 |
| 169 | DENTAL SERVICES | $1,232,658,000 | $434,901,050 | $1,364,464,000 | $485,090,200 | $131,806,000 | $50,189,150 |
| 172 | DEVELOPMENTAL CENTERS/STATE OP SMALL FAC | $207,330,000 | $0 | $207,330,000 | $0 | $0 | $0 |
| 173 | TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.) | $219,679,000 | $0 | $208,970,000 | $0 | ($10,709,000) | $0 |
| 175 | WAIVER PERSONAL CARE SERVICES (Misc. Svcs.) | $45,900,000 | $22,950,000 | $48,275,000 | $24,137,500 | $2,375,000 | $1,187,500 |
| 176 | MEDI-CAL TCM PROGRAM | $41,615,000 | $306,000 | $33,555,000 | $0 | ($8,060,000) | ($306,000) |
| 177 | EPSDT SCREENS | $30,984,000 | $14,921,620 | $30,857,000 | $14,860,400 | ($127,000) | ($61,220) |
| 187 | CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.) | $1,485,000 | $0 | $1,028,000 | $0 | ($457,000) | $0 |
| 188 | HIPP PREMIUM PAYOUTS (Misc. Svcs.) | $1,452,000 | $726,000 | $1,448,000 | $724,000 | ($4,000) | ($2,000) |
| 203 | BASE RECOVERIES | ($371,809,000) | ($173,772,000) | ($367,663,000) | ($171,834,000) | $4,146,000 | $1,938,000 |
| 208 | LAWSUITS/CLAIMS | $38,760,000 | $19,380,000 | $32,865,000 | $16,432,500 | ($5,895,000) | ($2,947,500) |
| | **OTHER SUBTOTAL** | **$9,906,398,000** | **$4,162,869,670** | **$10,948,436,000** | **$4,373,918,600** | **$1,042,038,000** | **$211,048,930** |
| | **GRAND TOTAL** | **$46,914,696,000** | **$14,055,672,570** | **$48,382,384,000** | **$14,953,865,670** | **$1,467,688,000** | **$898,193,100** |

# MEDI-CAL PROGRAM BASE
# POLICY CHANGE INDEX

| POLICY CHANGE NUMBER | POLICY CHANGE TITLE |
|---|---|
| | **ELIGIBILITY** |
| 4 | MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL |
| 5 | COUNTY HEALTH INITIATIVE MATCHING (CHIM) |
| 6 | MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL |
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| 88 | COUNTY ORGANIZED HEALTH SYSTEMS |
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| 97 | DENTAL MANAGED CARE (OTHER M/C) |
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| 165 | MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS |
| 166 | MEDICARE PAYMENTS - PART D PHASED-DOWN |
| 167 | HOME & COMMUNITY-BASED SVCS.-CDDS (MISC.) |
| 168 | PERSONAL CARE SERVICES (MISC. SVCS.) |
| 169 | DENTAL SERVICES |
| 172 | DEVELOPMENTAL CENTERS/STATE OP SMALL FAC |
| 173 | TARGETED CASE MGMT. SVCS. - CDDS (MISC. SVCS.) |
| 175 | WAIVER PERSONAL CARE SERVICES (MISC. SVCS.) |
| 176 | MEDI-CAL TCM PROGRAM |
| 177 | EPSDT SCREENS |
| 187 | CLPP CASE MANAGEMENT SERVICES (MISC. SVCS.) |
| 188 | HIPP PREMIUM PAYOUTS (MISC. SVCS.) |

# MEDI-CAL PROGRAM BASE
# POLICY CHANGE INDEX


| POLICY CHANGE NUMBER | POLICY CHANGE TITLE |
|---|---|
| | **OTHER** |
| 203 | BASE RECOVERIES |
| 208 | LAWSUITS/CLAIMS |

# 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 | $32,243,000 | $46,553,000 |
| - STATE FUNDS | $8,732,000 | $9,999,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $32,243,000 | $46,553,000 |
| STATE FUNDS | $8,732,000 | $9,999,000 |
| FEDERAL FUNDS | $23,511,000 | $36,554,000 |

## 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 Department integrated eligibility rules for MCAP into the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) in October, 2015. Currently, the Department maintains a health plan delivery system for MCAP that is separate from the Medi-Cal delivery system. The Department and the plans participating in the separate delivery system renegotiate rates and contracts each year, which is a significant workload.

Effective October 1, 2016, through June 30, 2017, new MCAP beneficiaries were enrolled in the Fee-for-Service (FFS) delivery system. Beginning July 2017, 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 due to $3.6M in retroactive claims shifting from FY 2016-17 to FY 2017-18 in the current estimate.

The change from FY 2017-18 to FY 2018-19, in the current estimate, resulted from the following:

- There are $2M of FFS payments from FY 2017-18 lagged into FY 2018-19.
- There is a per-member per-delivery (PMPD) supplemental capitation payment in MMC, while delivery charges are included in the per-member per-month (PMPM) rate in FFS, resulting in an increase of $16.7M in FY 2018-19.
- The lower PMPM in MMC results in a savings of $3.1M.

**Methodology:**

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

| FY 2017-18 | Average Monthly Caseload | Monthly Deliveries |
|---|---|---|
| MCAP Plan Delivery System | 115 | 1 |
| FFS | 978 | 218 |
| Medi-Cal Managed Care | 2,343 | 248 |
| **Total** | **3,436** | **466** |

The Department anticipates all enrollment to be in MMC in FY 2018-19. The average monthly caseload for 2018-19 will be 3,824 and the monthly deliveries will be 484.

**2.** The Department estimates the following PMPM and PMPD costs:

| FY 2017-18 | PMPM | PMPD |
|---|---|---|
| MCAP Plan Delivery System | $ 506 | $ 11,748 |
| FFS | $ 491 | $ - |
| Medi-Cal Managed Care | $ 233 | $ 6,849 |
| **Weighted Average** | **$ 315** | **$ 6,849** |

The MMC PMPM for 2018-19 is $233 and the PMPD is $6,849.

3. 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 $4,862,000 in FY 2018-19.

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

5. The Department anticipates paying $3,556,000 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

6. 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 | $ 31,010 | $ 3,722 | $ 27,288 |
| 100% Perinatal Insurance Fund | $ 6,002 | $ 6,002 | $ - |
| Premiums | $ (4,769) | $ (992) | $ (3,777) |
| **TOTAL** | **$ 32,243** | **$ 8,732** | **$ 23,511** |

| FY 2018-19 | TF | SF | FF |
|---|---|---|---|
| 88% Title XXI FFP/12% Perinatal Insurance Fund | $ 45,915 | $ 5,510 | $ 40,405 |
| 100% Perinatal Insurance Fund | $ 5,500 | $ 5,500 | $ - |
| Premiums | $ (4,862) | $ (1,011) | $ (3,851) |
| **TOTAL** | **$ 46,553** | **$ 9,999** | **$ 36,554** |

**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 | $17,047,000 | $16,872,000 |
| - STATE FUNDS | $2,045,640 | $2,024,640 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $17,047,000 | $16,872,000 |
| STATE FUNDS | $2,045,640 | $2,024,640 |
| FEDERAL FUNDS | $15,001,360 | $14,847,360 |

## 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 three counties: San Francisco, San Mateo, and Santa Clara.

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

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 FY 2017-18, is an increase due to prior year funds to be paid from FY 2015-16 and FY 2016-17 and a continuous increase in enrollment following the CCHIP integration into CalHEERS. 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. Santa Clara and San Mateo Counties 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 | $2,716,000 | $326,000 | $2,390,000 |
| Benefits Title XXI 88/12 GF | $2,445,000 | $293,000 | $2,152,000 |
| Admin Title XXI 88/12 GF | $271,000 | $33,000 | $238,000 |
| | | | |
| FY 2016-17 | $5,882,000 | $706,000 | $5,176,000 |
| Benefits Title XXI 88/12 GF | $5,294,000 | $635,000 | $4,659,000 |
| Admin Title XXI 88/12 GF | $588,000 | $71,000 | $517,000 |
| | | | |
| FY 2017-18 | $8,449,000 | $1,014,000 | $7,435,000 |
| Benefits Title XXI 88/12 GF | $7,244,000 | $869,000 | $6,375,000 |
| Admin Title XXI 88/12 GF | $1,205,000 | $145,000 | $1,060,000 |
| **Total FY 2017-18** | **$17,047,000** | **$2,046,000** | **$15,001,000** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| FY 2017-18 | $3,602,000 | $432,000 | $3,170,000 |
| Benefits Title XXI 88/12 GF | $3,242,000 | $389,000 | $2,853,000 |
| Admin Title XXI 88/12 GF | $360,000 | $43,000 | $317,000 |
| | | | |
| FY 2018-19 | $13,270,000 | $1,592,000 | $11,678,000 |
| Benefits Title XXI 88/12 GF | $11,943,000 | $1,433,000 | $10,510,000 |
| Admin Title XXI 88/12 GF | $1,327,000 | $159,000 | $1,168,000 |
| **Total FY 2018-19** | **$16,872,000** | **$2,024,000** | **$14,848,000** |

*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 | $3,399,000 | $3,399,000 |
| - STATE FUNDS | $407,880 | $407,880 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $3,399,000 | $3,399,000 |
| STATE FUNDS | $407,880 | $407,880 |
| FEDERAL FUNDS | $2,991,120 | $2,991,120 |

## DESCRIPTION

**Purpose:**
This policy change estimates the fee-for-service (FFS) benefits 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 Department integrated eligibility 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 increase from the prior estimate, for FY 2017-18, resulted from an increase in the Fee-for-Service (FFS) per member per month (PMPM) rate. There is no change from FY 2017-18 to FY2018-19 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** | 210 | 210 |
| **Medi-Cal Managed Care** | 638 | 638 |
| **Total Monthly Enrollment** | **848** | **848** |

2. The Department estimates the weighted average PMPM cost in FY 2017-18 and FY 2018-19 is $950.96 for FFS infants and $148.01 for Medi-Cal Managed Care infants.

3. MCAP subscribers are subject to monthly premiums. Premiums are estimated to total $132,000 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 | $ 3,531 | $ 424 | $ 3,107 |
| Premiums | $ (132) | $ (15) | $ (117) |
| **Net** | **$ 3,399** | **$ 409** | **$ 2,991** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| Benefits | $ 3,531 | $ 423 | $ 3,108 |
| Premiums | $ (132) | $ (16) | $ (116) |
| **Net** | **$ 3,399** | **$ 407** | **$ 2,991** |

**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 | $172,279,000 | $181,477,000 |
| - STATE FUNDS | $5,966,460 | $8,216,250 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $172,279,000 | $181,477,000 |
| STATE FUNDS | $5,966,460 | $8,216,250 |
| FEDERAL FUNDS | $166,312,540 | $173,260,750 |

## 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, is an increase due to the following:

- Increased caseload projections for the regular and perinatal ACA Optional population based on actuals through December 2016,
- Increased units of services (UOS) based on updated FY 2015-16 claims data, and
- Increased FY 2017-18 rates for Dosing, Individual Counseling, and Group Counseling for regular and perinatal clients.

The change in the current estimate, from FY 2017-18 to FY 2018-19, is due to an increase in ACA Optional 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 December 2016.

3. The UOS is based on the total approved units divided by the caseload. Complete data from July 2015 through June 2016 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 | 291.6 | $13.11 | 17,129 | $65,482,000 | 17,129 | $65,482,000 |
| Individual | 125.5 | $15.37 | 17,129 | $33,041,000 | 17,129 | $33,041,000 |
| Group | 0.8 | $3.43 | 17,129 | $47,000 | 17,129 | $47,000 |
| Regular - EPSDT | | | | | | |
| Dosing | 128.5 | $13.11 | 319 | $537,000 | 319 | $537,000 |
| Individual | 61.4 | $15.37 | 319 | $301,000 | 319 | $301,000 |
| Group | 0.0 | $3.43 | 319 | $0 | 319 | $0 |
| Regular - ACA Optional | | | | | | |
| Dosing | 203.1 | $13.11 | 31,312 | $83,373,000 | 32,370 | $86,190,000 |
| Individual | 92.0 | $15.37 | 31,312 | $44,276,000 | 32,370 | $45,772,000 |
| Group | 0.5 | $3.43 | 31,312 | $54,000 | 32,370 | $56,000 |
| Regular Total | | | | $227,111,000 | | $231,426,000 |
| Perinatal - Current | | | | | | |
| Dosing | 129.7 | $14.11 | 92 | $168,000 | 92 | $168,000 |
| Individual | 47.3 | $16.39 | 92 | $71,000 | 92 | $71,000 |
| Group | 0.9 | $4.28 | 92 | $0 | 92 | $0 |
| Perinatal - ACA Optional | | | | | | |
| Dosing | 86.1 | $14.11 | 215 | $261,000 | 223 | $271,000 |
| Individual | 33.5 | $16.39 | 215 | $118,000 | 223 | $122,000 |
| Group | 0.3 | $4.28 | 215 | $0 | 223 | $0 |
| Perinatal Total | | | | $618,000 | | $632,000 |
| Grand Total | | | | $227,729,000 | | $232,058,000 |

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 | $198,401,000 | $49,601,000 | $0 |
| Perinatal | $592,000 | $148,000 | $0 |
| Total for FY 2016-17 | $198,993,000 | $49,749,000 | $0 |
| Regular | $227,111,000 | $170,334,000 | $56,779,000 |
| Perinatal | $618,000 | $463,000 | $155,000 |
| Total for FY 2017-18 | $227,729,000 | $170,797,000 | $56,934,000 |
| Regular | $231,426,000 | $0 | $173,571,000 |
| Perinatal | $632,000 | $0 | $474,000 |
| Total for FY 2018-19 | $232,058,000 | $0 | $174,045,000 |
| Total | | $220,546,000 | $230,979,000 |

# 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 | $96,924,000 | $0 | $48,052,000 | $722,000 | $48,150,000 |
| ACA Optional | $123,011,000 | $5,948,000 | $117,063,000 | $0 | $0 |
| **Perinatal** | | | | | |
| Current | $238,000 | $0 | $117,000 | $4,000 | $117,000 |
| ACA Optional | $373,000 | $18,000 | $355,000 | $0 | $0 |
| **Total** | $220,546,000 | **$5,966,000** | **$165,587,000** | **$726,000** | $48,267,000 |

| FY 2018-19 | TF | GF | FF (Title XIX) | FF (Title XXI) | County |
|---|---|---|---|---|---|
| **Regular** | | | | | |
| Current | $99,410,000 | $0 | $49,286,000 | $739,000 | $49,385,000 |
| ACA Optional | $130,940,000 | $8,192,000 | $122,748,000 | $0 | $0 |
| **Perinatal** | | | | | |
| Current | $239,000 | $0 | $118,000 | $4,000 | $117,000 |
| ACA Optional | $390,000 | $24,000 | $366,000 | $0 | $0 |
| **Total** | $230,979,000 | **$8,216,000** | **$172,518,000** | **$743,000** | $49,502,000 |

**Funding:**
100% Title XIX FF (4260-101-0890)
100% Title XXI FF (4260-113-0890)
100% ACA Title XIX FF (4260-101-0890)
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 | $25,342,000 | $26,848,000 |
| - STATE FUNDS | $840,740 | $1,161,720 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $25,342,000 | $26,848,000 |
| STATE FUNDS | $840,740 | $1,161,720 |
| FEDERAL FUNDS | $24,501,260 | $25,686,280 |

## 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, is a net increase due to:

- Decreased caseload projections for the regular and perinatal population based on actuals through December 2016,
- Updated units of service (UOS) based on updated FY 2015-16 claims data, and
- Updated FY 2017-18 rates for Individual and Group counseling for regular and perinatal clients.

The change in the current estimate, from FY 2017-18 to FY 2018-19, is due to an increase in ACA Optional 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 December 2016.

3. The UOS is based on the total approved units divided by the caseload. Complete data from July 2015 through June 2016 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 | 3.20 | $76.91 | 6,387 | $1,572,000 | 6,387 | $1,572,000 |
| Group | 23.40 | $30.89 | 6,387 | $4,617,000 | 6,387 | $4,617,000 |
| EPSDT | | | | | | |
| Individual | 4.00 | $76.91 | 5,865 | $1,804,000 | 5,865 | $1,804,000 |
| Group | 22.10 | $30.89 | 5,865 | $4,004,000 | 5,865 | $4,004,000 |
| Minor Consent | | | | | | |
| Individual | 4.00 | $76.91 | 613 | $189,000 | 613 | $189,000 |
| Group | 16.30 | $30.89 | 613 | $309,000 | 613 | $309,000 |
| ACA Optional | | | | | | |
| Individual | 2.80 | $76.91 | 22,782 | $4,906,000 | 23,586 | $5,079,000 |
| Group | 18.50 | $30.89 | 22,782 | $13,019,000 | 23,586 | $13,479,000 |
| Perinatal | | | | | | |
| Current | | | | | | |
| Individual | 2.70 | $81.93 | 146 | $32,000 | 146 | $32,000 |
| Group | 19.70 | $38.56 | 146 | $111,000 | 146 | $111,000 |
| ACA Optional | | | | | | |
| Individual | 3.10 | $81.93 | 183 | $46,000 | 187 | $47,000 |
| Group | 16.90 | $38.56 | 183 | $119,000 | 187 | $122,000 |
| | | | | | | |
| Total | | | | $30,728,000 | | $31,365,000 |

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 | $5,234,000 | $1,309,000 | $0 |
| EPSDT | $5,022,000 | $1,256,000 | $0 |
| Minor Consent | $430,000 | $108,000 | $0 |
| ACA Optional | $14,929,000 | $3,732,000 | $0 |
| Perinatal | | | |
| Current | $192,000 | $48,000 | $0 |
| ACA Optional | $192,000 | $48,000 | $0 |
| FY 2016-17 | $25,999,000 | $6,501,000 | $0 |

# OUTPATIENT DRUG FREE TREATMENT SERVICES

**BASE POLICY CHANGE NUMBER: 58**

| | Accrual | FY 2017-18 | FY 2018-19 |
|---|---|---|---|
| Regular | | | |
| Current | $6,189,000 | $4,642,000 | $1,547,000 |
| EPSDT | $5,808,000 | $4,356,000 | $1,452,000 |
| Minor Consent | $498,000 | $374,000 | $124,000 |
| ACA Optional | $17,925,000 | $13,444,000 | $4,481,000 |
| Perinatal | | | |
| Current | $143,000 | $107,000 | $36,000 |
| ACA Optional | $165,000 | $124,000 | $41,000 |
| FY 2017-18 | $30,728,000 | $23,047,000 | $7,681,000 |
| | | | |
| Regular | | | |
| Current | $6,189,000 | $0 | $4,643,000 |
| EPSDT | $5,808,000 | $0 | $4,356,000 |
| Minor Consent | $498,000 | $0 | $374,000 |
| ACA Optional | $18,558,000 | $0 | $13,919,000 |
| Perinatal | | | |
| Current | $143,000 | $0 | $107,000 |
| ACA Optional | $169,000 | $0 | $127,000 |
| FY 2018-19 | $31,365,000 | $0 | $23,526,000 |
| | | | |
| Total | | $29,548,000 | $31,207,000 |

8. Total estimated reimbursements for ODF treatment services are:

| **FY 2017-18** | **TF** | **GF** | **FF (Title XIX)** | **FF (Title XXI)** | **County** |
|---|---|---|---|---|---|
| **Regular** | | | | | |
| Current | $13,911,000 | $0 | $4,842,000 | $4,938,000 | $4,131,000 |
| ACA Optional | $15,310,000 | $833,000 | $14,477,000 | $0 | $0 |
| **Perinatal** | | | | | |
| Current | $179,000 | $0 | $101,000 | $3,000 | $75,000 |
| ACA Optional | $148,000 | $8,000 | $140,000 | $0 | $0 |
| **Total** | $29,548,000 | **$841,000** | **$19,560,000** | **$4,941,000** | $4,206,000 |

# OUTPATIENT DRUG FREE TREATMENT SERVICES

## BASE POLICY CHANGE NUMBER: 58

| FY 2018-19 | TF | GF | FF (Title XIX) | FF (Title XXI) | County |
|---|---|---|---|---|---|
| **Regular** | | | | | |
| Current | $12,496,000 | $0 | $3,095,000 | $5,111,000 | $4,290,000 |
| ACA Optional | $18,400,000 | $1,152,000 | $17,248,000 | $0 | $0 |
| **Perinatal** | | | | | |
| Current | $143,000 | $0 | $71,000 | $3,000 | $69,000 |
| ACA Optional | $168,000 | $10,000 | $158,000 | $0 | $0 |
| **Total** | $31,207,000 | **$1,162,000** | **$20,572,000** | **$5,114,000** | $4,359,000 |

**Funding:**
100%Title XIX FF (4260-101-0890)
100% Title XXI FF (4260-113-0890)
100% ACA Title XIX FF (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)
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 | $9,697,000 | $9,876,000 |
| - STATE FUNDS | $1,404,560 | $1,502,820 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $9,697,000 | $9,876,000 |
| STATE FUNDS | $1,404,560 | $1,502,820 |
| FEDERAL FUNDS | $8,292,440 | $8,373,180 |

## 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, is an increase due to the following:

- Increased caseload projections for the regular ACA Optional population,
- Updated units of service (UOS) based on updated FY 2015-16 claims data, and
- Updated FY 2017-18 rates for regular and perinatal services.

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 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 December 2016.

3. The Units of Service (UOS) is based on the approved units divided by the caseload. Complete data from July 2015 through June 2016 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 | 26.9 | $58.53 | 1,137 | $1,790,000 | 1,142 | $1,798,000 |
| EPSDT | 36.9 | $58.53 | 879 | $1,898,000 | 879 | $1,898,000 |
| ACA Optional | 24.5 | $58.53 | 3,890 | $5,578,000 | 3,948 | $5,661,000 |
| Subtotal | | | 5,906 | $9,266,000 | 5,969 | $9,357,000 |
| Perinatal | | | | | | |
| Current | 27.3 | $84.43 | 136 | $313,000 | 136 | $313,000 |
| ACA Optional | 20.8 | $84.43 | 210 | $369,000 | 218 | $383,000 |
| Subtotal | | | 346 | $682,000 | 354 | $696,000 |
| Total | | | | $9,948,000 | | $10,053,000 |

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 | $8,954,000 | $2,239,000 | $0 |
| Perinatal | $576,000 | $145,000 | $0 |
| Total for FY 2016-17 | $9,530,000 | $2,384,000 | $0 |
| | | | |
| Regular | $9,266,000 | $6,951,000 | $2,318,000 |
| Perinatal | $682,000 | $512,000 | $170,000 |
| Total for FY 2017-18 | $9,948,000 | $7,463,000 | $2,488,000 |
| | | | |
| Regular | $9,357,000 | $0 | $7,019,000 |
| Perinatal | $696,000 | $0 | $522,000 |
| Total for FY 2018-19 | $10,053,000 | $0 | $7,541,000 |
| Total | | $9,847,000 | $10,029,000 |

7. Total estimated reimbursements for IOT services are:

| **FY 2017-18** | **TF** | **GF** | **FF Title XIX** | **FF Title XXI** | **County** |
|---|---|---|---|---|---|
| **Regular** | | | | | |
| Current | $3,693,000 | $1,125,000 | $896,000 | $1,672,000 | $0 |
| ACA Optional | $5,497,000 | $262,000 | $5,235,000 | $0 | $0 |
| **Perinatal** | | | | | |
| Current | $307,000 | $0 | $152,000 | $5,000 | $150,000 |
| ACA Optional | $350,000 | $17,000 | $333,000 | $0 | $0 |
| **Total** | $9,847,000 | **$1,404,000** | **$6,616,000** | **$1,677,000** | $150,000 |

# INTENSIVE OUTPATIENT TREATMENT SERVICES

**BASE POLICY CHANGE NUMBER: 60**

| FY 2018-19 | TF | GF | FF Title XIX | FF Title XXI | County |
|---|---|---|---|---|---|
| **Regular** | | | | | |
| Current | $3,696,000 | $1,127,000 | $898,000 | $1,671,000 | $0 |
| ACA Optional | $5,641,000 | $352,000 | $5,289,000 | $0 | $0 |
| **Perinatal** | | | | | |
| Current | $313,000 | $0 | $155,000 | $5,000 | $153,000 |
| ACA Optional | $379,000 | $24,000 | $355,000 | $0 | $0 |
| **Total** | $10,029,000 | **$1,503,000** | **$6,697,000** | **$1,676,000** | $153,000 |

**Funding:**
100% Title XIX FF (4260-101-0890)
100% Title XXI FF (4260-113-0890)
100% ACA Title XIX FF (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)
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 | $1,316,000 | $1,397,000 |
| - STATE FUNDS | $38,410 | $53,580 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $1,316,000 | $1,397,000 |
| STATE FUNDS | $38,410 | $53,580 |
| FEDERAL FUNDS | $1,277,590 | $1,343,420 |

## 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, is due to decreased caseload projections for the ACA Optional population based on actuals through December 2016. In addition, FY 2017-18 rates were updated based on the required rates.

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 December 2016.

2. The Units of Service (UOS) is based on the approved units divided by the caseload. Complete data from July 2015 through June 2016 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 | 153 | 77.5 | $80.92 | $961,000 |
| ACA Optional | 187 | 44.2 | $80.92 | $669,000 |
| FY 2016-17 | 340 | | | $1,630,000 |
| | | | | |
| Current Perinatal | 153 | 77.5 | $90.14 | $1,068,000 |
| ACA Optional | 208 | 44.2 | $90.14 | $829,000 |
| FY 2017-18 | 361 | | | $1,897,000 |
| | | | | |
| Current Perinatal | 153 | 77.5 | $90.14 | $1,068,000 |
| ACA Optional | 217 | 44.2 | $90.14 | $865,000 |
| FY 2018-19 | 370 | | | $1,933,000 |

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 | $961,000 | $240,000 | $0 |
| ACA Optional | $669,000 | $167,000 | $0 |
| FY 2016-17 | $1,630,000 | $407,000 | $0 |
| | | | |
| Current Perinatal | $1,068,000 | $801,000 | $267,000 |
| ACA Optional | $829,000 | $622,000 | $207,000 |
| FY 2017-18 | $1,897,000 | $1,423,000 | $474,000 |
| | | | |
| Current Perinatal | $1,068,000 | $0 | $801,000 |
| ACA Optional | $865,000 | $0 | $649,000 |
| FY 2018-19 | $1,933,000 | $0 | $1,450,000 |
| Total | | $1,830,000 | $1,924,000 |

6. Total estimated reimbursements for RTS are:

| **FY 2017-18** | **TF** | **GF** | **FF Title XIX** | **FF Title XXI** | **County** |
|---|---|---|---|---|---|
| **Perinatal** | | | | | |
| Current | $1,041,000 | $0 | $512,000 | $15,000 | $514,000 |
| ACA Optional | $789,000 | $39,000 | $750,000 | $0 | $0 |
| **Total** | $1,830,000 | **$39,000** | **$1,262,000** | **$15,000** | $514,000 |

# RESIDENTIAL TREATMENT SERVICES

## BASE POLICY CHANGE NUMBER: 62

| FY 2018-19 | TF | GF | FF Title XIX | FF Title XXI | County |
|---|---|---|---|---|---|
| **Perinatal** | | | | | |
| Current | $1,068,000 | $0 | $526,000 | $15,000 | $527,000 |
| ACA Optional | $856,000 | $53,000 | $803,000 | $0 | $0 |
| **Total** | $1,924,000 | **$53,000** | **$1,329,000** | **$15,000** | $527,000 |

**Funding:**
100% Title XIX FF (4260-101-0890)
100% Title XXI FF (4260-113-0890)
100% ACA Title XIX FF (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)
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 | $1,510,777,000 | $1,559,573,000 |
| - STATE FUNDS | $97,535,050 | $119,462,350 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $1,510,777,000 | $1,559,573,000 |
| STATE FUNDS | $97,535,050 | $119,462,350 |
| FEDERAL FUNDS | $1,413,241,950 | $1,440,110,650 |

## 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, 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 June 2017;
- Increased FY 2016-17 claims expected to be paid in FY 2017-18 due to delayed implementation of Short-Doyle Medi-Cal (SD/MC) system changes to account for ACA Federal Medical Assistance Percentage (FMAP) updates. The SD/MC payment lags applied to FY 2016-17 claims are assumed to be 27% in the same year, 72% in the second year, and 1% in the third year, 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 applied to the FY 2017-18 and FY 2018-19 accrual years.

**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 June 30, 2017, with dates of service from June 2011 through March 2017. The FFS data is current as of June 30, 2017, with dates of service from April 2011 through January 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

# SMHS FOR ADULTS

## BASE POLICY CHANGE NUMBER: 63

projected final claims and client data. The development and application of lag weights is based upon historical reporting trends of the counties.

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 | 226,670 | 227,013 |
| SD/MC ACA | 153,154 | 177,144 |
| FFS | 13,398 | 13,518 |
| FFS ACA | 16,568 | 18,824 |
| Total | 409,790 | 436,499 |

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 | $1,716,893 | $1,486,530 | $230,363 |
| FY 2016-17 | $1,883,336 | $1,633,449 | $249,887 |
| FY 2017-18 | $2,069,571 | $1,798,010 | $271,561 |
| FY 2018-19 | $2,255,806 | $1,962,570 | $293,236 |

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, 56% of FY 2016-17 claims, and 43% 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 | $17,169 | $14,865 | $2,304 |
| FY 2016-17 | $1,316,020 | $1,176,083 | $139,937 |
| FY 2017-18 | $784,020 | $667,249 | $116,771 |
| Total FY 2017-18 | $2,117,209 | $1,858,197 | $259,012 |

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, 56% of FY 2017-18 claims, and 43% 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 | $18,834 | $16,334 | $2,500 |
| FY 2017-18 | $1,266,840 | $1,114,766 | $152,074 |
| FY 2018-19 | $854,409 | $728,318 | $126,091 |
| Total FY 2018-19 | $2,140,083 | $1,859,418 | $280,665 |

# 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 | $2,117,209 | **$675,936** | **$737,306** | **$28,030** | **$69,505** | $606,432 |
| 2018-19 | $2,140,083 | **$650,522** | **$789,589** | **$49,449** | **$70,013** | $580,510 |

**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 | $1,224,732,000 | $1,196,328,000 |
| - STATE FUNDS | $37,915,570 | $40,326,050 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $1,224,732,000 | $1,196,328,000 |
| STATE FUNDS | $37,915,570 | $40,326,050 |
| FEDERAL FUNDS | $1,186,816,430 | $1,156,001,950 |

## 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, 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 June 2017;
- Increased FY 2016-17 claims expected to be paid in FY 2017-18 due to delayed implementation of Short-Doyle Medi-Cal (SD/MC) system changes to account for ACA Federal Medical Assistance Percentage (FMAP) updates. The SD/MC payment lags applied to FY 2016-17 claims are assumed to be 27% in the same year, 72% in the second year, and 1% in the third year, 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 decrease 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 applied to the FY 2017-18 and FY 2018-19 accrual years.

**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 June 30, 2017, with dates of service from June 2011 through March 2017. The FFS data is current as of June 30, 2017, with dates of service from April 2011 through January 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

# SMHS FOR CHILDREN

## BASE POLICY CHANGE NUMBER: 64

projected final claims and client data. The development and application of lag weights is based upon historical reporting trends of the counties.

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 | 274,125 | 281,653 |
| SD/MC ACA | 8,281 | 9,644 |
| FFS | 12,435 | 12,667 |
| FFS ACA | 1,346 | 1,794 |
| Total | 296,187 | 305,758 |

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 | $1,692,497 | $1,605,822 | $86,675 |
| FY 2016-17 | $1,878,062 | $1,786,478 | $91,584 |
| FY 2017-18 | $1,977,930 | $1,880,407 | $97,523 |
| FY 2018-19 | $2,077,797 | $1,974,336 | $103,461 |

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, 56% of FY 2016-17 claims, and 43% 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 | $16,925 | $16,058 | $867 |
| FY 2016-17 | $1,338,647 | $1,286,915 | $51,732 |
| FY 2017-18 | $739,288 | $697,827 | $41,461 |
| Total FY 2017-18 | $2,094,860 | $2,000,800 | $94,060 |

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, 56% of FY 2017-18 claims, and 43% 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 | $18,781 | $17,865 | $916 |
| FY 2017-18 | $1,218,863 | $1,163,776 | $55,087 |
| FY 2018-19 | $776,669 | $732,684 | $43,985 |
| Total FY 2018-19 | $2,014,313 | $1,914,325 | $99,988 |

# 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** | $2,094,860 | **$868,915** | **$274,911** | **$42,990** | **$1,640** | **$36,276** | $870,128 |
| **FY 2018-19** | $2,014,313 | **$815,253** | **$294,527** | **$46,222** | **$2,896** | **$37,430** | $817,985 |

**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 | $20,429,116,000 | $20,636,578,000 |
| - STATE FUNDS | $6,362,920,190 | $6,465,332,240 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $20,429,116,000 | $20,636,578,000 |
| STATE FUNDS | $6,362,920,190 | $6,465,332,240 |
| FEDERAL FUNDS | $14,066,195,810 | $14,171,245,760 |

## 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.

**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,
- Lower Mental Health costs due to updated rates (included in the base rates), and
- Updated FY 2017-18 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, and
- Higher Hepatitis C costs due to higher utilization in FY 2018-19.

# TWO PLAN MODEL

## BASE POLICY CHANGE NUMBER: 87

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.

**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 draft weighted rates have been updated from the previous estimate. FY 2017-18 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 $299,445,000 for FY 2016-17 and FY 2017-18 were included in the rates.

4. The savings from AB 97 are included in the rates. Savings of $262,661,000 for FY 2016-17 and FY 2017-18 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, 2016.

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

9. 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 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, $169.4 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 | 3,954,990 | $1,036,658 |
| Contra Costa | 2,549,817 | $656,974 |
| Kern | 3,943,851 | $824,378 |
| Los Angeles | 36,867,558 | $8,897,395 |
| Riverside | 8,402,319 | $1,906,816 |
| San Bernardino | 8,581,906 | $1,960,354 |
| San Francisco | 1,897,659 | $587,019 |
| San Joaquin | 2,941,852 | $663,068 |
| Santa Clara | 4,093,609 | $949,252 |
| Stanislaus | 2,465,367 | $611,078 |
| Tulare | 2,530,635 | $475,268 |
| Fresno | 5,029,312 | $1,185,816 |
| Kings | 572,857 | $115,035 |
| Madera | 668,620 | $135,416 |
| Total | 84,500,353 | $20,004,527 |
| Hepatitis C Adjustment | | $417,969 |
| **Total FY 2017-18** | | **$20,422,496** |

(Dollars in Thousands)

| Included in the Above Dollars | FY 2017-18 |
|---|---|
| Mental Health | $299,445 |
| AB 97 | ($262,661) |

# TWO PLAN MODEL

## BASE POLICY CHANGE NUMBER: 87

(Dollars in Thousands)

| FY 2018-19 | Eligible Months | Total |
|---|---|---|
| Alameda | 3,992,610 | $1,050,721 |
| Contra Costa | 2,576,143 | $667,481 |
| Kern | 3,980,902 | $836,649 |
| Los Angeles | 37,269,427 | $9,027,048 |
| Riverside | 8,484,058 | $1,935,029 |
| San Bernardino | 8,672,073 | $1,991,833 |
| San Francisco | 1,929,319 | $598,568 |
| San Joaquin | 2,965,059 | $671,019 |
| Santa Clara | 4,142,958 | $964,589 |
| Stanislaus | 2,490,678 | $620,179 |
| Tulare | 2,549,842 | $481,224 |
| Fresno | 5,096,744 | $1,212,218 |
| Kings | 578,293 | $116,684 |
| Madera | 672,310 | $136,702 |
| Total | 85,400,417 | $20,309,944 |
| Hepatitis C Adjustment | | $438,821 |
| **Total FY 2018-19** | | **$20,748,765** |

(Dollars in Thousands)

| Included in the Above Dollars | FY 2018-19 |
|---|---|
| Mental Health | $299,445 |
| AB 97 | ($262,661) |

# 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 | $10,569,571 | $5,284,786 | $5,284,786 | $0 |
| State GF | $40,360 | $40,360 | $0 | $0 |
| ACA 94/6 GF | $3,312,183 | $198,731 | $3,113,452 | $0 |
| ACA 95/5 GF | $4,669,485 | $233,474 | $4,436,011 | $0 |
| Family Planning 90/10 GF | $126,629 | $12,663 | $113,967 | $0 |
| Title XXI 88/12 GF | $690,888 | $82,907 | $607,981 | $0 |
| Healthcare Treatment Fund | $510,000 | $0 | $0 | $510,000 |
| Title XIX 100% | $510,000 | $0 | $510,000 | $0 |
| **Total** | **$20,429,116** | **$5,852,921** | **$14,066,197** | **$510,000** |

(Dollars in Thousands)

| FY 2018-19 | TF | GF | FF | SF |
|---|---|---|---|---|
| Title XIX 50/50 | $11,268,550 | $5,634,275 | $5,634,275 | $0 |
| State GF | $41,537 | $41,537 | $0 | $0 |
| ACA 93/7 GF | $3,411,156 | $238,781 | $3,172,375 | $0 |
| ACA 94/6 GF | $4,755,824 | $285,349 | $4,470,475 | $0 |
| Family Planning 90/10 GF | $125,038 | $12,504 | $112,534 | $0 |
| Title XXI 88/12 GF | $695,659 | $83,479 | $612,180 | $0 |
| Healthcare Treatment Fund | $169,407 | $0 | $0 | $169,407 |
| Title XIX 100% | $169,407 | $0 | $169,407 | $0 |
| **Total** | **$20,636,578** | **$6,295,925** | **$14,171,246** | **$169,407** |

# 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 | $7,914,399,000 | $8,048,854,000 |
| - STATE FUNDS | $2,393,870,510 | $2,395,404,980 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $7,914,399,000 | $8,048,854,000 |
| STATE FUNDS | $2,393,870,510 | $2,395,404,980 |
| FEDERAL FUNDS | $5,520,528,490 | $5,653,449,020 |

## 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.

**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 used in the prior estimate,
- Lower Hepatitis C costs due to lower than previously estimated average monthly utilizers, and
- Lower Mental Health costs due to updated rates (included in base rates).

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

- Higher eligible months,
- Higher Hepatitis C costs due to higher utilization in FY 2018-19 than in FY 2017-18, and
- Higher ACA dollars due to higher ACA eligibles in FY 2018-19.

# COUNTY ORGANIZED HEALTH SYSTEMS

## BASE POLICY CHANGE NUMBER: 88

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.

**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 draft weighted rates have been updated from the previous estimate. Draft FY 2017-18 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 $145,334,000 for FY 2017-18 and $145,334,000 for FY 2018-19 were included in the rates.

6. The savings from AB 97 are included in the rates. Savings of $82,194,000 for FY 2017-18 and $82,194,000 for FY 2018-19 were included in the rates.

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

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

9. 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.

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

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

12. 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.

# COUNTY ORGANIZED HEALTH SYSTEMS

## BASE POLICY CHANGE NUMBER: 88

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

14. COHS dollars on an accrual basis are:

(Dollars in Thousands)

| FY 2017-18 | Eligible Months | Total |
|---|---|---|
| 501- San Luis Obispo | 657,553 | $193,534 |
| 502- Santa Barbara | 1,499,881 | $439,686 |
| 503- San Mateo | 1,354,266 | $409,382 |
| 504- Solano | 1,332,225 | $455,373 |
| 505- Santa Cruz | 836,452 | $246,815 |
| 506-Orange | 9,309,700 | $2,656,358 |
| 507- Napa | 345,499 | $122,561 |
| 508-Monterey | 1,908,730 | $468,765 |
| 509- Yolo | 644,404 | $214,063 |
| 513- Sonoma | 1,364,442 | $446,254 |
| 514- Merced | 1,539,638 | $350,804 |
| 510 - Marin | 478,276 | $182,384 |
| 512 - Mendocino | 457,582 | $141,184 |
| 515 - Ventura | 2,453,191 | $678,853 |
| 523 - Del Norte | 137,601 | $47,275 |
| 517 - Humboldt | 633,452 | $216,309 |
| 511 - Lake | 369,775 | $123,235 |
| 518 - Lassen | 89,865 | $30,906 |
| 519 - Modoc | 36,815 | $14,098 |
| 520 - Shasta | 718,301 | $259,427 |
| 521 - Siskiyou | 214,976 | $69,315 |
| 522 - Trinity | 53,707 | $18,667 |
| Total FY 2017-18 | 26,436,332 | $7,785,248 |
| Hepatitis C Adjustment | | $168,253 |
| **Total with Adjustments** | | **$7,953,501** |

(Dollars in Thousands)

| Included in Above Dollars | FY 2017-18 |
|---|---|
| Mental Health | $145,334 |
| AB 97 | ($82,194) |

# COUNTY ORGANIZED HEALTH SYSTEMS

## BASE POLICY CHANGE NUMBER: 88

(Dollars in Thousands)

| FY 2018-19 | Eligible Months | Total |
|---|---|---|
| 501- San Luis Obispo | 662,889 | $195,436 |
| 502- Santa Barbara | 1,515,322 | $446,137 |
| 503- San Mateo | 1,367,143 | $414,458 |
| 504- Solano | 1,343,839 | $460,372 |
| 505- Santa Cruz | 846,166 | $250,188 |
| 506-Orange | 9,438,068 | $2,707,338 |
| 507- Napa | 350,124 | $124,714 |
| 508-Monterey | 1,922,233 | $477,788 |
| 509- Yolo | 647,508 | $215,330 |
| 513- Sonoma | 1,376,247 | $451,138 |
| 514- Merced | 1,551,727 | $354,304 |
| 510 - Marin | 482,856 | $184,415 |
| 512 - Mendocino | 461,738 | $142,984 |
| 515 - Ventura | 2,475,758 | $687,619 |
| 523 - Del Norte | 138,564 | $47,658 |
| 517 - Humboldt | 641,879 | $219,647 |
| 511 - Lake | 374,086 | $124,858 |
| 518 - Lassen | 90,465 | $31,159 |
| 519 - Modoc | 37,058 | $14,206 |
| 520 - Shasta | 724,764 | $262,074 |
| 521 - Siskiyou | 217,134 | $70,177 |
| 522 - Trinity | 54,261 | $18,879 |
| Total FY 2018-19 | 26,719,828 | $7,900,879 |
| Hepatitis C Adjustment | | $176,647 |
| **Total with Adjustments** | | **$8,077,526** |

(Dollars in Thousands)

| Included in Above Dollars | FY 2018-19 |
|---|---|
| Mental Health | $145,334 |
| AB 97 | ($82,194) |

# 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 | $4,107,232 | $2,053,616 | $2,053,616 | $0 |
| State GF | $10,542 | $10,542 | $0 | $0 |
| Family Planning 90/10 GF | $42,134 | $4,214 | $37,920 | $0 |
| Title XXI 88/12 GF | $362,913 | $43,550 | $319,363 | $0 |
| ACA Optional Expansion 94/6 | $1,337,065 | $80,224 | $1,256,841 | $0 |
| ACA Optional Expansion 95/5 | $1,834,513 | $91,726 | $1,742,787 | $0 |
| Healthcare Treatment Fund | $110,000 | $0 | $0 | $110,000 |
| Title XIX 100% FFP | $110,000 | $0 | $110,000 | $0 |
| **Total** | **$7,914,399** | **$2,283,871** | **$5,520,527** | **$110,000** |

(Dollars in Thousands)

| FY 2018-19 | TF | GF | FF | SF |
|---|---|---|---|---|
| Title XIX 50/50 | $4,238,457 | $2,119,229 | $2,119,229 | $0 |
| State GF | $10,436 | $10,436 | $0 | $0 |
| Family Planning 90/10 GF | $41,549 | $4,155 | $37,395 | $0 |
| Title XXI 88/12 GF | $364,491 | $43,739 | $320,752 | $0 |
| ACA Optional Expansion 93/7 | $1,421,140 | $99,480 | $1,321,660 | $0 |
| ACA Optional Expansion 94/6 | $1,972,781 | $118,367 | $1,854,414 | $0 |
| **Total** | **$8,048,854** | **$2,395,406** | **$5,653,450** | **$0** |

# 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 | $3,760,382,000 | $3,817,381,000 |
| - STATE FUNDS | $1,118,794,910 | $1,142,332,300 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $3,760,382,000 | $3,817,381,000 |
| STATE FUNDS | $1,118,794,910 | $1,142,332,300 |
| FEDERAL FUNDS | $2,641,587,090 | $2,675,048,700 |

## 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 is implementing two new health plans in Sacramento and San Diego, United Healthcare Community Plan of California and Aetna Better Health of California. The Department anticipates United Healthcare Community Plan of California to begin providing services no sooner than October 1, 2017 and Aetna Better Health of California to begin providing services no sooner than January 1, 2018.

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

- Updated FY 2017-18 draft weighted rates used in the prior estimate,
- Lower Hepatitis C costs due to lower than previously expected utilization, and
- Updated Mental Health rates resulting in lower costs (included in the base rates).

# GEOGRAPHIC MANAGED CARE

## BASE POLICY CHANGE NUMBER: 89

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

- Higher Hepatitis C costs, and
- Higher eligible months.

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.

**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 draft weighted rates have been updated from the previous estimate. Draft FY 2017-18 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 $58,410,000 for FY 2017-18 and $58,410,000 for FY 2018-19 were included in the rates.

5. The savings from AB 97 are included in the rates. Savings of $41,855,000 for FY 2017-18 and $41,855,000 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, 2016.

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.

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

# GEOGRAPHIC MANAGED CARE

## BASE POLICY CHANGE NUMBER: 89

12. GMC dollars on an accrual basis are:

(Dollars in Thousands)

| FY 2017-18 | Eligible Months | Total |
|---|---|---|
| Sacramento | 5,349,896 | $1,324,839 |
| San Diego | 8,785,042 | $2,369,907 |
| Total | 14,134,938 | $3,694,746 |
| Hepatitis C Adjustment | | $78,399 |
| **Total FY 2017-18** | | **$3,773,145** |

(Dollars in Thousands)

| Included in Dollars Above | FY 2017-18 |
|---|---|
| Mental Health | $58,410 |
| AB 97 | ($41,855) |

(Dollars in Thousands)

| FY 2018-19 | Eligible Months | Total |
|---|---|---|
| Sacramento | 5,386,324 | $1,341,405 |
| San Diego | 8,865,499 | $2,407,664 |
| Total | 14,251,823 | $3,749,069 |
| Hepatitis C Adjustment | | $82,309 |
| **Total FY 2018-19** | | **$3,831,378** |

(Dollars in Thousands)

| Included in Dollars Above | FY 2018-19 |
|---|---|
| Mental Health | $58,410 |
| AB 97 | ($41,855) |

# 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 | $1,891,815 | $945,907 | $945,907 | $0 |
| State GF | $7,430 | $7,430 | $0 | $0 |
| Family Planning 90/10 GF | $22,790 | $2,279 | $20,511 | $0 |
| Title XXI 88/12 GF | $152,548 | $18,306 | $134,241 | $0 |
| ACA Optional Expansion 94/6 GF | $658,270 | $39,496 | $618,774 | $0 |
| ACA Optional Expansion 95/5 GF | $907,529 | $45,376 | $862,153 | $0 |
| Healthcare Treatment Fund | $60,000 | $0 | $0 | $60,000 |
| Title XIX 100% FFP | $60,000 | $0 | $60,000 | $0 |
| **Total** | **$3,760,382** | **$1,058,795** | **$2,641,586** | **$60,000** |

(Dollars in Thousands)

| FY 2018-19 | TF | GF | FF | SF |
|---|---|---|---|---|
| Title XIX 50/50 | $2,021,178 | $1,010,589 | $1,010,589 | $0 |
| State GF | $7,638 | $7,638 | $0 | $0 |
| Family Planning 90/10 GF | $22,397 | $2,240 | $20,156 | $0 |
| Title XXI 88/12 GF | $152,664 | $18,319 | $134,345 | $0 |
| ACA Optional Expansion 93/7 GF | $673,568 | $47,150 | $626,418 | $0 |
| ACA Optional Expansion 94/6 GF | $939,936 | $56,396 | $883,540 | $0 |
| **Total** | **$3,817,381** | **$1,142,332** | **$2,675,049** | **$0** |

# 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 | $1,195,203,000 | $1,222,082,000 |
| - STATE FUNDS | $350,102,860 | $362,275,200 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $1,195,203,000 | $1,222,082,000 |
| STATE FUNDS | $350,102,860 | $362,275,200 |
| FEDERAL FUNDS | $845,100,140 | $859,806,800 |

## 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.

**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 used in the prior estimate,
- Lower ACA dollars due to lower rates, 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,
- Higher ACA dollars due to higher ACA eligible months, and
- Higher expected Hepatitis C utilization in FY 2018-19.

# REGIONAL MODEL

## BASE POLICY CHANGE NUMBER: 94

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.

**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 draft weighted rates have been updated from the previous estimate. FY 2017-18 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 $26,681,000 for FY 2017-18 and FY 2018-19 were included in the rates.

5. The savings from AB 97 are included in the rates. Savings of $11,465,000 for FY 2017-18 and FY 2018-19 were included in the rates. Rates include the savings for application to the primary care providers effective January 1, 2015.

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

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

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

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

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.

11. 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

12. Regional Model dollars on an accrual basis are:

(Dollars in Thousands)

| FY 2017-18 | Eligible Months | Total |
|---|---|---|
| Alpine | 2,754 | $753 |
| Amador | 78,611 | $19,683 |
| Butte | 799,233 | $229,094 |
| Calaveras | 114,139 | $30,504 |
| Colusa | 87,557 | $17,976 |
| El Dorado | 368,297 | $96,687 |
| Glenn | 119,294 | $27,857 |
| Inyo | 45,571 | $10,746 |
| Mariposa | 45,308 | $12,112 |
| Mono | 33,198 | $7,884 |
| Nevada | 247,258 | $64,482 |
| Placer | 565,377 | $140,397 |
| Plumas | 61,324 | $17,160 |
| Sierra | 7,265 | $1,997 |
| Sutter | 399,492 | $94,168 |
| Tehama | 245,580 | $63,848 |
| Tuolumne | 130,481 | $36,276 |
| Yuba | 307,737 | $78,460 |
| Imperial | 926,407 | $212,268 |
| San Benito | 99,833 | $15,326 |
| Total FY 2017-18 | 4,684,716 | $1,177,678 |
| Hepatitis C Adjustment | | $25,616 |
| **Total with Adjustments** | | **$1,203,294** |

(Dollars in Thousands)

| Included in Dollars Above | FY 2017-18 |
|---|---|
| Mental Health | $26,681 |
| AB 97 | ($11,465) |

# REGIONAL MODEL

## BASE POLICY CHANGE NUMBER: 94

(Dollars in Thousands)

| FY 2018-19 | Eligible Months | Total |
|---|---|---|
| Alpine | 2,755 | $755 |
| Amador | 78,990 | $19,819 |
| Butte | 805,967 | $232,205 |
| Calaveras | 114,701 | $30,660 |
| Colusa | 88,338 | $18,277 |
| El Dorado | 371,154 | $97,804 |
| Glenn | 119,707 | $28,018 |
| Inyo | 45,791 | $10,821 |
| Mariposa | 45,719 | $12,253 |
| Mono | 33,607 | $8,029 |
| Nevada | 250,546 | $65,645 |
| Placer | 573,734 | $144,467 |
| Plumas | 61,973 | $17,388 |
| Sierra | 7,270 | $2,001 |
| Sutter | 404,622 | $96,485 |
| Tehama | 246,095 | $64,182 |
| Tuolumne | 130,861 | $36,568 |
| Yuba | 309,465 | $79,086 |
| Imperial | 936,666 | $217,157 |
| San Benito | 101,032 | $15,711 |
| Total FY 2018-19 | 4,728,993 | $1,197,331 |
| Hepatitis C Adjustment | | $26,893 |
| **Total with Adjustments** | | **$1,224,224** |

(Dollars in Thousands)

| Included in Dollars Above | FY 2018-19 |
|---|---|
| Mental Health | $26,681 |
| AB 97 | ($11,465) |

# 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 | $623,384 | $311,692 | $311,692 | $0 |
| State GF | 4260-101-0001 | $2,170 | $2,170 | $0 | $0 |
| ACA 100% FFP | 4260-101-0890 | $216,032 | $12,962 | $203,070 | $0 |
| ACA 95/5 GF | 4260-101-0890 | $297,456 | $14,873 | $282,583 | $0 |
| Family Planning 90/10 GF | 4260-101-0001/0890 | $7,859 | $786 | $7,073 | $0 |
| OTLICP 88/12 GF | 4260-113-0001/0890 | $43,502 | $5,219 | $38,283 | $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** | | **$1,195,203** | **$347,702** | **$845,101** | **$2,400** |

(Dollars in Thousands)

| FY 2018-19 | | TF | GF | FF |
|---|---|---|---|---|
| Title XIX 50/50 FFP | 4260-101-0001/0890 | $640,326 | $320,163 | $320,163 |
| State GF | 4260-101-0001 | $2,209 | $2,209 | $0 |
| ACA 95/5 GF | 4260-101-0890 | $220,462 | $15,432 | $205,030 |
| ACA 94/6 FFP | 4260-101-0890 | $307,761 | $18,465 | $289,296 |
| Family Planning 90/10 GF | 4260-101-0001/0890 | $7,684 | $768 | $6,916 |
| OTLICP 88/12 GF | 4260-113-0001/0890 | $43,640 | $5,237 | $38,403 |
| **Total** | | **$1,222,082** | **$362,274** | **$859,808** |

# 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 | $515,861,000 | $487,954,000 |
| - STATE FUNDS | $257,930,500 | $243,977,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $515,861,000 | $487,954,000 |
| STATE FUNDS | $257,930,500 | $243,977,000 |
| FEDERAL FUNDS | $257,930,500 | $243,977,000 |

## 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 |

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is an increase due to the delayed implementation of the 2016 PACE rates for all plans that were assumed to be implemented in FY 2016-17 but now will be implemented in October 2017 and 2017 PACE rates for all plans implemented in December 2017. Also, the Innovage plans are still projected to grow and the actual trends have been adjusted to account for the increased growth. The change from FY 2017-18 to FY 2018-19, in the current estimate, is a net decrease due to: 1) no rate repayments in FY 2018-19; 2) a 10% increase in average enrollment; and 3) the Stockton PACE plans (San Joaquin and Stanislaus) beginning in July 2018.

**Methodology:**

1. Assume the January 2016 through June 2017 rates are calculated using the existing comparable population FFS UPL methodology.

2. 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.

3. 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.

4. The Department worked with PACE Organizations to support legislation authorizing changes to current law to transition from an UPL-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

# PACE (Other M/C)

## BASE POLICY CHANGE NUMBER: 95

implementation of the new rate methodology to occur January 1, 2018.

5. The Department received CMS approval of contract amendments implementing 2016 rates in July 2017, retroactive to January 2016. This results in an adjustment of $60,345,000 for the increase of Non-dual and Dual rates that were paid at 2016 PACE rates from January 2016 to August 2017. The adjustment is expected to occur during the October 2017 capitation cycle.

6. The Department anticipates the submission of CY 2017 rates to CMS in 2018. This will result in an adjustment of approximately $19,402,000 to the PACE plans. The adjustment is expected to occur during FY 2017-18.

7. 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) | $45,919,000 | 8,297 | 691 |
| Sutter Senior Care | $15,613,000 | 3,217 | 268 |
| AltaMed Senior BuenaCare | $136,994,000 | 27,768 | 2,314 |
| OnLok (SF, Alameda and Santa Clara) | $98,895,000 | 16,986 | 1,416 |
| St. Paul's PACE | $36,369,000 | 7,616 | 635 |
| Los Angeles Jewish Homes | $10,674,000 | 2,369 | 197 |
| CalOptima PACE | $14,536,000 | 2,822 | 235 |
| InnovAge (San Bernardino and Riverside) | $28,258,000 | 5,586 | 466 |
| Redwood Coast | $7,639,000 | 1,762 | 147 |
| Central Valley Medical Services | $24,837,000 | 5,049 | 421 |
| San Ysidro San Diego | $16,380,000 | 3,012 | 251 |
| **Total Capitation Payments** | $436,114,000 | 84,484 | 7,041 |
| | | | |
| 2016 Rate Adjustment | $60,345,000 | | |
| 2017 Rate Adjustment | $19,402,000 | | |
| **Total FY 2017-18** | **$515,861,000** | | |

*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) | $46,837,000 | 8,297 | 691 |
| Sutter Senior Care | $16,070,000 | 3,247 | 271 |
| AltaMed Senior BuenaCare | $151,261,000 | 30,059 | 2,505 |
| OnLok (SF, Alameda and Santa Clara) | $100,873,000 | 16,986 | 1,416 |
| St. Paul's PACE | $41,303,000 | 8,480 | 707 |
| Los Angeles Jewish Homes | $10,888,000 | 2,369 | 197 |
| CalOptima PACE | $17,764,000 | 3,452 | 288 |
| InnovAge (San Bernardino and Riverside) | $36,114,000 | 7,010 | 584 |
| Redwood Coast | $8,798,000 | 1,996 | 166 |
| Central Valley Medical Services | $29,236,000 | 5,829 | 486 |
| San Ysidro San Diego | $21,369,000 | 3,876 | 323 |
| Stockton PACE (San Joaquin and Stanislaus) | $7,441,000 | 1,248 | 104 |
| **Total Capitation Payments** | $480,513,000 | 92,849 | 7,738 |
| | | | |
| **Total FY 2018-19** | **$487,954,000** | | |

*Totals may differ due to rounding.

**Funding:**

FY 2017-18: 50% Title XIX / 50% GF (4260-101-0001/0890) $458,329,000
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) $487,954,000

# 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 | $118,197,000 | $104,176,000 |
| - STATE FUNDS | $40,822,620 | $37,020,060 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $118,197,000 | $104,176,000 |
| STATE FUNDS | $40,822,620 | $37,020,060 |
| FEDERAL FUNDS | $77,374,380 | $67,155,940 |

## 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,

# DENTAL MANAGED CARE (Other M/C)

## BASE POLICY CHANGE NUMBER: 97

2018, the full restoration of adult dental benefits will include the remaining services which were not restored in 2014, such as restorative services (crowns), prosthodontic services (partial dentures), and endodontic services (root canals). The impact of the restoration of adult dental benefits is included in the capitation rates. 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 primarily due to a decrease in eligibles. The change from FY 2017-18 to FY 2018-19, in the current estimate, is an overall net decrease due to less 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 2016-17 are all expected to pay throughout varying portions or FY 2017-18.

4. Rates for FY 2016-17, FY 2017-18, and FY 2018-19 are all expected to pay throughout varying portions of FY 2018-19

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

# DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 97

| FY 2017-18 | Rating Period | Cap Rate | Ave Monthly Elig | Total Funds |
|---|---|---|---|---|
| **GMC** | | | | |
| For Period July 2017 | FY 2013-14 <21 | $11.30 | 210,861 | $2,382,728 |
| | FY 2013-14 21+ | $3.23 | 215,882 | $697,299 |
| For Period Aug. 2017 | FY 2014-15 <21 | $11.45 | 215,128 | $2,463,212 |
| | FY 2014-15 21+ | $8.42 | 220,250 | $1,854,509 |
| For Period Sept. 2017- Dec 2017 | FY 2015-16 <21 | $11.86 | 216,090 | $12,814,143 |
| | FY 2015-16 21+ | $8.71 | 221,236 | $9,634,821 |
| For Period Jan. 2018 - June 2018 | FY 2016-17 <21 | $12.39 | 218,015 | $13,506,028 |
| | FY 2016-17 21+ | $6.68 | 223,207 | $7,455,099 |
| **GMC Subtotal** | | | | **$50,807,839** |
| | | | | |
| **PHP** | | | | |
| For Period July 2017 | FY 2013-14 <21 | $13.07 | 229,159 | $2,995,105 |
| | FY 2013-14 21+ | $3.42 | 237,108 | $810,910 |
| For Period Aug. 2017 | FY 2014-15 <21 | $12.95 | 240,208 | $3,110,692 |
| | FY 2014-15 21+ | $7.80 | 248,541 | $1,938,617 |
| For Period Sept. 2017- Dec 2017 | FY 2015-16 <21 | $13.50 | 241,552 | $16,304,781 |
| | FY 2015-16 21+ | $9.31 | 249,932 | $11,634,319 |
| For Period Jan. 2018 - June 2018 | FY 2016-17 <21 | $14.17 | 244,241 | $17,304,490 |
| | FY 2016-17 21+ | $6.71 | 252,714 | $8,478,549 |
| **PHP Subtotal** | | | | **$62,577,463** |
| | | | | |
| **HIPF Add-on** | | **Payment Date** | | |
| First half of CY 2015 | | Sept, 2017 | | $1,160,111 |
| Second half of CY 2015 | | Oct. 2017 | | $1,205,640 |
| CY 2016 | | Jan. 2018 | | $2,447,354 |
| **HIPF Subtotal** | | | | **$4,813,105** |
| **Total FY 2017-18** | | | | **$118,198,407** |

# DENTAL MANAGED CARE (Other M/C)

## BASE POLICY CHANGE NUMBER: 97

| FY 2018-19 | Rating Period | Cap Rate | Ave Monthly Elig | Total Funds |
|---|---|---|---|---|
| GMC | | | | |
| For Period July 2018 – Nov. 2018 | FY 2016-17 <21 | $12.80 | 220,132 | $8,453,082 |
| | FY 2016-17 21+ | $7.58 | 225,374 | $5,125,012 |
| For Period Dec. 2018 - June 2019 | FY 2018-19 <21 | $12.80 | 222,442 | $19,930,821 |
| | FY 2018-19 21+ | $7.58 | 227,739 | $12,083,841 |
| **GMC Subtotal** | | | | **$45,592,756** |
| | | | | |
| PHP | | | | |
| For Period July 2018 – Nov. 2018 | FY 2016-17 <21 | $14.67 | 247,199 | $10,879,227 |
| | FY 2016-17 21+ | $7.57 | 255,774 | $5,808,633 |
| For Period Dec. 2018 - June 2019 | FY 2018-19 <21 | $14.67 | 250,426 | $25,716,211 |
| | FY 2018-19 21+ | $7.57 | 259,113 | $13,730,388 |
| **PHP Subtotal** | | | | **$56,134,459** |
| **HIPF Add-on** | | **Payment Date** | | |
| CY 2017 | | March 2019 | | $2,447,354 |
| **HIPF Subtotal** | _ | _ | | $2,447,354 |
| **Total FY 2018-19** | _ | _ | | **$104,174,569** |

**Funding:**

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| Regular FMAP T19 | $75,943,000 | $37,971,500 | $37,971,500 |
| ACA 95% FFP/5% GF (2017) | $17,072,000 | $853,600 | $16,218,400 |
| ACA 94% FFP/6% GF (2018) | $17,072,000 | $1,024,320 | $16,047,400 |
| Title 21 88% FFP/12% GF | $8,110,000 | $486,600 | $7,623,400 |
| **Total** | **$118,197,000** | **$56,383,700** | **$61,813,300** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| Regular FMAP T19 | $68,652,000 | $34,326,000 | $34,326,000 |
| ACA 94% FFP/6% GF (2018) | $14,262,000 | $855,720 | $13,406,280 |
| ACA 93% FFP/7% GF (2019) | $14,262,000 | $998,340 | $13,263,660 |
| Title 21 88% FFP/12% GF | $7,000,000 | $420,000 | $6,580,000 |
| **Total** | **$104,176,000** | **$50,006,340** | **$54,169,660** |

*Totals may differ due to rounding.

# SENIOR CARE ACTION NETWORK (Other M/C)

| | |
|---|---|
| BASE POLICY CHANGE NUMBER: | 98 |
| IMPLEMENTATION DATE: | 2/1985 |
| ANALYST: | Randolph Alarcio |
| FISCAL REFERENCE NUMBER: | 61 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $56,327,000 | $54,439,000 |
| - STATE FUNDS | $28,163,500 | $27,219,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $56,327,000 | $54,439,000 |
| STATE FUNDS | $28,163,500 | $27,219,500 |
| FEDERAL FUNDS | $28,163,500 | $27,219,500 |

## 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, is a decrease due to the delay in implementation of CY 2016 and CY 2017 rates. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to enrollment growth, increases in rates, and elimination of prior year adjustments.

**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 from preliminary CY 2017 rates. Rates in development will be based on SCAN plans' actual experience.

4. The Department anticipates receiving CMS approval of the contract amendment implementing the SCAN 2016 rates, retroactive to January 2016, in January 2018. This will result in a repayment to SCAN of approximately $3,448,000 for the increase in rates for SCAN health plan for the period of January 2016 through January 2018. The repayment is expected to occur during the February 2018 capitation cycle.

5. The Department anticipates receiving CMS approval of the contract amendment implementing the SCAN 2017 rates, retroactive to January 2017, in April 2018. The repayment is projected to occur in May 2017 capitation cycle for an estimate $534,000.

| **FY 2017-18** | **Costs** | **Eligible Months** | **Avg. Monthly Enrollment** |
|---|---|---|---|
| Los Angeles | $34,296,000 | 106,154 | 8,846 |
| Riverside | $11,287,000 | 30,396 | 2,533 |
| San Bernardino | $6,762,000 | 20,076 | 1,673 |
| Total | $52,345,000 | 156,626 | 13,052 |
| | | | |
| 2016 Rate Repayment | $3,448,000 | | |
| 2017 Rate Recoupment | $534,000 | | |
| **Total FY 2017-18** | **$56,327,000** | | |

| **FY 2018-19** | **Costs** | **Eligible Months** | **Avg. Monthly Enrollment** |
|---|---|---|---|
| Los Angeles | $35,668,000 | 106,154 | 8,846 |
| Riverside | $11,738,000 | 30,396 | 2,533 |
| San Bernardino | $7,033,000 | 20,076 | 1,673 |
| Total | $54,439,000 | 156,626 | 13,052 |
| | | | |
| **Total FY 2018-19** | **$54,439,000** | | |

*Totals may differ due to rounding.

**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 | $18,930,000 | $19,069,000 |
| - STATE FUNDS | $9,465,000 | $9,534,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $18,930,000 | $19,069,000 |
| STATE FUNDS | $9,465,000 | $9,534,500 |
| FEDERAL FUNDS | $9,465,000 | $9,534,500 |

## 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 a six-month contract extension with AHF for January 1, 2017 through June 30, 2017, 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.

The Department is currently in discussions with AHF to move to a full-risk managed care plan.

# 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 updated member months and rates.

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

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

| Member Months | Dual | Medi-Cal Only |
|---|---|---|
| January to June 2016 | 2,297 | 2,528 |
| July 2016 to June 2017 | 4,255 | 4,605 |
| July 2017 to December 2017 | 2,181 | 2,360 |
| January 2018 to June 2018 | 2,181 | 2,360 |
| July 2018 to June 2019 | 4,470 | 4,838 |

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 |
| July 2016 to June 2017 | $51.62 | $2,732.76 |
| July 2017 to December 2017 | $55.68 | $2,881.57 |
| January 2018 to June 2018 | $107.95 | $3,676.66 |
| July 2018 to June 2019 | $113.34 | $3,860.49 |

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) | 2,297 | ($511,000) |
| Medi-Cal Only (Retro) | Jan-June 2016 | $1,839.50 | $2,598.57 | $759.07 | 2,528 | $1,919,000 |
| Dual (Retro) | FY 2016-17 | $272.23 | $51.62 | ($220.61) | 4,255 | ($939,000) |
| Medi-Cal Only (Retro) | FY 2016-17 | $1,839.50 | $2,732.76 | $893.26 | 4,605 | $4,113,000 |
| Dual | July-Dec 2017 | N/A | $55.68 | N/A | 2,181 | $122,000 |
| Medi-Cal Only | July-Dec 2017 | N/A | $2,881.57 | N/A | 2,360 | $6,800,000 |
| *Dual | Jan-June 2018 | N/A | $107.95 | N/A | 1,817 | $196,000 |
| *Medi-Cal Only | Jan-June 2018 | N/A | $3,676.66 | N/A | 1,967 | $7,230,000 |
| Total | | | | | | $18,930,000 |

*Assumes five months of capitation payments.

# 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) | Jan-June 2018 | N/A | $107.95 | N/A | 363 | $39,000 |
| **Medi-Cal Only (Retro) | Jan-June 2018 | N/A | $3,676.66 | N/A | 393 | $1,446,000 |
| ***Dual (Retro) | FY 2018-19 | N/A | $113.34 | N/A | 4,098 | $464,000 |
| ***Medi-Cal Only (Retro) | FY 2018-19 | N/A | $3,860.49 | N/A | 4,435 | $17,120,000 |
| Total | | | | | | $19,069,000 |

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

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| Dual | ($1,133,000) | ($567,000) | ($566,000) |
| Medi-Cal Only | $20,063,000 | $10,032,000 | $10,031,000 |
| **Total FY 2017-18** | **$18,930,000** | **$9,465,000** | **$9,465,000** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| Dual | $503,000 | $251,000 | $252,000 |
| Medi-Cal Only | $18,566,000 | $9,283,000 | $9,283,000 |
| **Total FY 2018-19** | **$19,069,000** | **$9,534,000** | **$9,535,000** |

**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: | 1/2018 |
| ANALYST: | Andrew Yoo |
| FISCAL REFERENCE NUMBER: | 66 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $3,051,000 | $1,092,000 |
| - STATE FUNDS | $1,525,500 | $546,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $3,051,000 | $1,092,000 |
| STATE FUNDS | $1,525,500 | $546,000 |
| FEDERAL FUNDS | $1,525,500 | $546,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the cost of the contract with the Family Mosaic Project.

**Authority:**
Welfare & Institutions Code 14087.3

**Interdependent Policy Changes:**
Not Applicable

**Background:**
The Department's contract with the Family Mosaic Project was effective January 1, 2008. The Family Mosaic Project, located in San Francisco, case manages emotionally disturbed children at risk for out-of-home placement.

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is a decrease due to some FY 2017-18 payments shifting to FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to scheduling payments for prior years and some of FY 2017-18. Payments made in FY 2018-19 are related to some FY 2017-18 and FY 2018-19 dates of service.

**Methodology:**
1) Updated FY 2015-16 total member months to 310 based on actuals. Assume the total member months will be 312 in FY 2016-17 and in FY 2017-18.

# 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
- $3,437.89 in FY 2017-18
- $3,506.65 in FY 2018-19

3) FY 2015-16, FY 2016-17, and FY 2017-18 rates were submitted for CMS approval in September 2017.

4) Payments for FY 2015-16, FY 2016-17, and FY 2017-18 are expected to occur in FY 2017-18.

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: $3,437.89 x 312 = $1,072,622 TF

FY 2018-19: $3,506.65 x 312 = $1,094,075 TF

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| FY 2015-16 | $1,019,000 | $509,000 | $510,000 |
| FY 2016-17 | $1,049,000 | $524,000 | $525,000 |
| FY 2017-18* | $983,000 | $492,000 | $491,000 |
| **Total FY 2017-18** | $3,051,000 | $1,525,000 | $1,526,000 |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| FY 2017-18** | $89,000 | $44,000 | $45,000 |
| FY 2018-19* | $1,003,000 | $502,000 | $501,000 |
| **Total FY 2018-19** | $1,092,000 | $546,000 | $546,000 |

*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 | $3,251,287,000 | $3,347,632,000 |
| - STATE FUNDS | $1,732,257,000 | $1,782,553,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $3,251,287,000 | $3,347,632,000 |
| STATE FUNDS | $1,732,257,000 | $1,782,553,000 |
| FEDERAL FUNDS | $1,519,030,000 | $1,565,079,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates Medi-Cal's expenditures for Medicare Part A and Part B premiums.

**Authority:**
Title 22, California Code of Regulations 50777
Social Security Act 1843

**Interdependent Policy Changes:**
PC 125 Medicare Part B Adjustment

**Background:**
This policy change estimates the costs for Part A and Part B premiums for Medi-Cal eligibles that are also eligible for Medicare coverage.

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

1. The estimated 2018 Medicare Part A premium is $4.00 lower than previously projected.
2. Since the May 2017 Estimate, both Part A and Part B eligibles have exhibited slower growth for FY 2017-18.

The change from FY 2017-18 to FY 2018-19 is related to:

1. Projecting a $15 increase in the 2019 premium for Part A.
2. Continued moderate growth expected in both Part A and Part B eligible counts.

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

**BASE POLICY CHANGE NUMBER: 165**

| | 2017 | 2018 | | 2019 |
|---|---|---|---|---|
| | Actual | May 2017 Actual | November 2017 Estimate | November 2017 Estimate |
| | Premiums | | | |
| Part A | $413.00 | $413.00 | $421.00 | $436.00 |
| Part B | $134.00 | $134.00 | $134.00 | $134.00 |
| | Average Estimated Monthly Eligibles | | | |
| Part A | | 179,700 | 178,100 | 180,500 |
| Part B | | 1,411,400 | 1,402,400 | 1,431,300 |

**Methodology:**

1. This policy change also includes adjustments due to reconciliations of state and federal data.

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

| Calendar Year | Part A Premium | Part B Premium |
|---|---|---|
| 2017 | $ 413.00 | $ 134.00 |

3. For 2018 and 2019, the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance, is projecting a 1.94% and 3.56% respective growth in the Medicare Part A premiums. Applying these growths to prior year Part A Premium; $413 x 1.0194 = $421, and $421 x 1.0356 =$ 436 (rounded)

4. For 2018 and 2019, the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance, estimate no change in Medicare Part B premiums from the 2017 level. The Medicare Part B premiums is budgeted at $134.00.

| **FY 2017-18** | **Part A** | **Part B** |
|---|---|---|
| Average Monthly Eligibles | 178,100 | 1,402,400 |
| Rate 07/2017-12/2017 | $413.00 | $134.00 |
| Rate 01/2018-06/2018 | $421.00 | $134.00 |

| **FY 2017-18** | **Part A** | **Part B** |
|---|---|---|
| Average Monthly Eligibles | 180,500 | 1,431,300 |
| Rate 07/2018-12/2018 | $421.00 | $134.00 |
| Rate 01/2019-06/2019 | $436.00 | $134.00 |

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

**BASE POLICY CHANGE NUMBER: 165**

**Funding:**

(Dollars in Thousands)

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| Title XIX 50/50 | $2,952,442 | $1,476,221 | $1,476,221 |
| State GF 100% | $256,036 | $256,036 | $0 |
| Title XIX 100% FFP | $42,809 | $0 | $42,809 |
| **Total** | **$3,251,287** | **$1,732,257** | **$1,519,030** |

(Dollars in Thousands)

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| Title XIX 50/50 | $3,042,836 | $1,521,418 | $1,521,418 |
| State GF 100% | $261,135 | $261,135 | $0 |
| Title XIX 100% FFP | $43,661 | $0 | $43,661 |
| **Total** | **$3,347,632** | **$1,782,553** | **$1,565,079** |

# MEDICARE PAYMENTS - PART D PHASED-DOWN

| | |
|---|---|
| BASE POLICY CHANGE NUMBER: | 166 |
| IMPLEMENTATION DATE: | 1/2006 |
| ANALYST: | Joulia Dib |
| FISCAL REFERENCE NUMBER: | 1019 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $2,111,200,000 | $2,221,955,000 |
| - STATE FUNDS | $2,111,200,000 | $2,221,955,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $2,111,200,000 | $2,221,955,000 |
| STATE FUNDS | $2,111,200,000 | $2,221,955,000 |
| 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 | $132.11 (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 FY 2017-18 is due to a decrease in recent eligible counts of approximately 8,600 average monthly eligibles. Some beneficiaries were incorrectly excluded from the *Centers for Medicare & Medicaid Services* (CMS) auto-enrollment process, thus reducing enrollment. CMS has now corrected this issue. The change between FY 2017-18 and FY 2018-19 is due to an estimated increase of $7.21 PMPM for 2018 and estimated historical growth in eligibles.

**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 5.77% over 2018 amounts based on an average of the annual percentage increase over the prior three years provided by the *Centers for Medicare & Medicaid Services*. Medi-Cal's estimated PMPM for 2019 is $132.11.

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 July 2017.

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 | 1,420,130 | $175,933,300 | **$2,111,200,000** |
| **FY 2018-19** | 12 | 1,454,289 | $185,162,900 | **$2,221,955,000** |

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

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

| | |
|---|---|
| BASE POLICY CHANGE NUMBER: | 167 |
| IMPLEMENTATION DATE: | 7/1990 |
| ANALYST: | Joel Singh |
| FISCAL REFERENCE NUMBER: | 23 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $1,741,895,000 | $1,816,555,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $1,741,895,000 | $1,816,555,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $1,741,895,000 | $1,816,555,000 |

## 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.

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is a net increase due to revising the estimate based on updated prior year expenditures, offset by a decrease in FY 2017-18 expenditure projections and updated HCBS waiver caseload.

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

**BASE POLICY CHANGE NUMBER: 167**

The net change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase in projected FY 2018-19 expenditures and HCBS waiver enrollment, offset by fewer prior year expenditures 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** | $3,483,790 | $1,741,895 | **$1,741,895** |
| **FY 2018-19** | $3,633,110 | $1,816,555 | **$1,816,555** |

**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 | $1,353,962,000 | $2,001,165,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $1,353,962,000 | $2,001,165,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $1,353,962,000 | $2,001,165,000 |

## 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:**
Revised expenditure data is provided by CDSS.

**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** | $2,707,924 | **$1,353,962** | $1,353,962 |
| **FY 2018-19** | $4,002,330 | **$2,001,165** | $2,001,165 |

**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 | $1,232,658,000 | $1,364,464,000 |
| - STATE FUNDS | $434,901,050 | $485,090,200 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $1,232,658,000 | $1,364,464,000 |
| STATE FUNDS | $434,901,050 | $485,090,200 |
| FEDERAL FUNDS | $797,756,950 | $879,373,800 |

## 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. Hewlett Packard Enterprise (HPE) was awarded a multi-year FI contract in 2016. HPE 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 will include 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 an overall increase due to an increase in average monthly eligibles, an increase in the FY 2017-18 rates, and additional costs to be paid in FY 2017-18 for the Health Insurance Provider Fee (HIPF). The change from FY 2017-18 to FY 2018-19, in the current estimate, is an overall increase due to an increase in average monthly eligibles and updated rates to contain dental program changes including, but not limited to, supplemental payments for dental services and the restoration of full adult dental benefits.

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

2. The FY 2016-17 capitation rate is used for the month of January 2018.

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 CY 2016 is $10,180,480
   - HIPF for July through December 2017 is $12,349,089
   - HIPF for January 2018 is $1,171,406

# DENTAL SERVICES

**BASE POLICY CHANGE NUMBER: 169**

| FY 2017-18 | Rating Period | Rate | Average Eligible Months | Total Funds |
|---|---|---|---|---|
| **Regular Capitated** | | | | |
| For Period July 2017 - December 2017 | FY 2015-16 | $8.32 | 11,027,613 | $550,498,441 |
| For Period January 2018 | FY 2016-17 | $7.70 | 11,038,026 | $84,992,800 |
| **Subtotal for Regular Capitated** | | | | **$635,491,241** |
| | | | | |
| **Other FFS - Non Capitated Jul 2017-Jan 2018** | | | | **$3,577,115** |
| | | | | |
| **Straight FFS Payments** | | | | |
| For Period February 2018 - June 2018 | | | 11,067,314 | **$565,881,365** |
| | | | | |
| **HIPF Payments** | | **Payment Date** | | **Amount** |
| For Second Half of CY 2015 | | October 2017 | | $4,006,526 |
| For CY 2016 | | February 2018 | | $10,180,480 |
| For CY 2017 Jul-Dec | | February 2018 | | $12,349,089 |
| For CY 2018 Jan 2018 | | February 2018 | | $1,171,406 |
| **Subtotal HIPF Payments** | | | | **$27,707,501** |
| **Total FY 2017-18** | | | | **$1,232,657,222** |

| FY 2018-19 | Ave Eligible Months | Total Funds |
|---|---|---|
| **Straight FFS Payments** | | |
| For Period July 2018 - June 2018 | 11,119,275 | $1,364,462,831 |
| **Total FY 2018-19** | | **$1,364,462,831** |

# DENTAL SERVICES

**BASE POLICY CHANGE NUMBER: 169**

**Funding (Totals may differ due to rounding):**

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| 88% Title XXI / 12% GF | $87,382,000 | $10,485,840 | $76,896,160 |
| 65% Title XIX / 35% GF | $436,000 | $152,600 | $283,400 |
| 100% GF | $57,000 | $57,000 | $0 |
| 50% Title XIX / 50% GF | $811,781,000 | $405,890,500 | $405,890,500 |
| 94% Title XIX ACA FF/6% GF | $166,501,000 | $9,990,060 | $156,510,940 |
| 95% Title XIX ACA FF / 5% GF | $166,501,000 | $8,325,050 | $158,175,950 |
| **Total** | **$1,232,658,000** | **$434,901,050** | **$797,756,950** |
| | | | |
| **FY 2018-19** | **TF** | **GF** | **FF** |
| 88% Title XXI / 12% GF | $96,725,000 | $11,607,000 | $85,118,000 |
| 65% Title XIX / 35% GF | $483,000 | $169,050 | $313,950 |
| 100% GF | $63,000 | $63,000 | $0 |
| 50% Title XIX / 50% GF | $898,583,000 | $449,291,500 | $449,291,500 |
| 93% Title XIX ACA FF/7% GF | $184,305,000 | $12,901,350 | $171,403,650 |
| 95% Title XIX ACA FF / 5% GF | $184,305,000 | $11,058,300 | $173,246,700 |
| **Total** | **$1,364,464,000** | **$485,090,200** | **$879,373,800** |

# DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

| | |
|---|---|
| BASE POLICY CHANGE NUMBER: | 172 |
| IMPLEMENTATION DATE: | 7/1997 |
| ANALYST: | Joel Singh |
| FISCAL REFERENCE NUMBER: | 77 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $207,330,000 | $207,330,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $207,330,000 | $207,330,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $207,330,000 | $207,330,000 |

## 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:**
There is no change from the prior estimate for FY 2017-18. There is no change from FY 2017-18 to FY 2018-19 in the current estimate.

# 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)

| | Total Funds | CDDS GF | FFP Regular |
|---|---|---|---|
| **FY 2017-18** | $414,660 | $207,330 | **$207,330** |
| **FY 2018-19** | $414,660 | $207,330 | **$207,330** |

**Funding:**

100% Title XIX (4260-101-0890)

# TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)

| | |
|---|---|
| BASE POLICY CHANGE NUMBER: | 173 |
| IMPLEMENTATION DATE: | 7/1991 |
| ANALYST: | Joel Singh |
| FISCAL REFERENCE NUMBER: | 26 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $219,679,000 | $208,970,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $219,679,000 | $208,970,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $219,679,000 | $208,970,000 |

## 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 from the prior estimate, for FY 2017-18, is an increase due to prior year expenditures budgeted in FY 2016-17 shifting to FY 2017-18, increase in the TCM rate, and increase in regional center caseload projections. The net change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase in regional center caseload projections offset by decreased prior year expenditures.

# 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** | $439,358 | $219,679 | **$219,679** |
| **FY 2018-19** | $417,939 | $208,969 | **$208,970** |

**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 | $45,900,000 | $48,275,000 |
| - STATE FUNDS | $22,950,000 | $24,137,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $45,900,000 | $48,275,000 |
| STATE FUNDS | $22,950,000 | $24,137,500 |
| FEDERAL FUNDS | $22,950,000 | $24,137,500 |

## DESCRIPTION

**Purpose:**
This policy change estimates the costs associated with adding personal care services (PCS) to the Nursing Facility (NF) 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 Nursing Facility/Acute Hospital (NF/AH) 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 will increase 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, is a decrease based on estimated expenditures on a cash basis decreasing slightly. 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.

**Methodology:**

1. Assume the number of current NF A/B LOC 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 NF SA LOC 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 for FY 2017-18 and 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 |
|---|---|---|---|---|---|
| NF/AH Waiver | | | | | |
| NF A/B | 2,633,734 | $11.27 | $29,682,000 | $14,841,000 | $14,841,000 |
| NF S/A | 1,368,564 | $11.27 | $15,424,000 | $7,712,000 | $7,712,000 |
| IHO Waiver | | | | | |
| NF A/B | 133,033 | $11.27 | $1,499,000 | $749,500 | $749,500 |
| NF S/A | 16,199 | $11.27 | $183,000 | $91,500 | $91,500 |
| **Total** | | | **$46,788,000** | **$23,394,000** | **$23,394,000** |

| FY 2018-19 | Total Hours | Cost/Hour | TF | GF | FF |
|---|---|---|---|---|---|
| NF/AH Waiver | | | | | |
| NF A/B | 2,656,228 | $11.49 | $30,520,000 | $15,260,000 | $15,260,000 |
| NF S/A | 1,387,815 | $11.49 | $15,946,000 | $7,973,000 | $7,973,000 |
| IHO Waiver | | | | | |
| NF A/B | 133,033 | $11.49 | $1,529,000 | $764,500 | $764,500 |
| NF S/A | 16,199 | $11.49 | $186,000 | $93,000 | $93,000 |
| **Total** | | | **$48,181,000** | **$24,091,000** | **$24,090,000** |

# WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)

**BASE POLICY CHANGE NUMBER: 175**

6. The chart below is adjusted on a cash basis.

| (Dollars in Thousands) | TF | GF | FF |
|---|---|---|---|
| **FY 2017-18** | **$45,900** | **$22,950** | **$22,950** |
| **FY 2018-19** | **$48,275** | **$24,138** | **$24,137** |

**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 | $41,615,000 | $33,555,000 |
| - STATE FUNDS | $306,000 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $41,615,000 | $33,555,000 |
| STATE FUNDS | $306,000 | $0 |
| FEDERAL FUNDS | $41,309,000 | $33,555,000 |

## 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:

- Decreased FY 2017-18 base estimate using more recent fiscal year expenditure data,
- Including General Funds to pay for claims that have exceeded the two-year claiming limit,
- Increased ACA payments,
- Updated reconciliation payments and recoupments,
- Including prior year pending payments for FY 2015-16 and FY 2016-17 in FY 2017-18, and
- Increased payments due to LGA additions.

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

- Lower LGA additions in FY 2018-19, and
- Prior year pending invoices paying out in FY 2017-18. There are no prior year payments expected in FY 2018-19.

# MEDI-CAL TCM PROGRAM

## BASE POLICY CHANGE NUMBER: 176

**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 $31,020,000 for FY 2017-18 and FY 2018-19 is based on average expenditures from FY 2014-15 through FY 2016-17.

3. In FY 2017-18, $2,996,000 will be paid for ACA optional encounters for FY 2015-16 through FY 2017-18. In FY 2018-19, ACA optional encounters are estimated to be $2,996,000 for FY 2016-17 through FY 2018-19.

4. The following reconciliations will occur in FY 2017-18:
   a) The Department will recoup a net of:
      i. $360,000 to complete the FY 2010-11 final reconciliations,
      ii. $4,822,000 to complete the FY 2011-12 final reconciliations,
      iii. $4,822,000 to begin the FY 2012-13 final reconciliations, and
      iv. $93,000 for the FY 2013-14 interim reconciliations.
   b) The Department will pay out a net of:
      i. $177,000 for the FY 2014-15 ACA interim reconciliations, and
      ii. $900,000 for the FY 2014-15 Non-ACA interim reconciliations.

5. In FY 2017-18, the Department will pay pending payments of $5,380,000 for FY 2015-16 and FY 2016-17.

6. 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 $10,933,000 and in FY 2018-19, it is expected to be $5,693,000.

7. 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.

8. Assume that in FY 2018-19 the Department will perform the following reconciliations and recoup the net amounts of:
   a) $492,000 to complete the FY 2013-14 ACA final reconciliations,
   b) $2,585,000 to complete the FY 2013-14 Non-ACA final reconciliations,
   c) $492,000 to complete the FY 2015-16 ACA interim reconciliations, and
   d) $2,585,000 to begin the FY 2015-16 Non-ACA interim reconciliations.

# MEDI-CAL TCM PROGRAM

## BASE POLICY CHANGE NUMBER: 176

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| FY 2017-18 Base (Average Expenditures) | $31,020,000 | | $31,020,000 |
| 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 | $152,000 | | $152,000 |
| FY 2016-17 | $479,000 | | $479,000 |
| FY 2017-18 | $2,365,000 | | $2,365,000 |
| Reconciliations | | | |
| FY 2010-11 (Final) | ($360,000) | | ($360,000) |
| FY 2011-12 (Final) | ($4,822,000) | | ($4,822,000) |
| FY 2012-13 (Final) | ($4,822,000) | | ($4,822,000) |
| FY 2013-14 (Interim) | ($93,000) | | ($93,000) |
| FY 2014-15 ACA (Interim) | $177,000 | | $177,000 |
| FY 2014-15 Non-ACA (Interim) | $900,000 | | $900,000 |
| Pending Payments | | | |
| FY 2015-16 | $191,000 | | $191,000 |
| FY 2016-17 | $5,189,000 | | $5,189,000 |
| LGA Turnover/Additions | $10,933,000 | | $10,933,000 |
| **Total FY 2017-18** | **$41,615,000** | **$306,000** | **$41,309,000** |

| FY 2018-19 | TF | FF |
|---|---|---|
| FY 2017-18 Base (Average Expenditures) | $31,020,000 | $31,020,000 |
| ACA | | |
| FY 2016-17 | $152,000 | $152,000 |
| FY 2017-18 | $1,422,000 | $1,422,000 |
| FY 2018-19 | $1,422,000 | $1,422,000 |
| LGA Turnover/Additions | $5,693,000 | $5,693,000 |
| Reconciliation | | |
| FY 2013-14 ACA (Final) | ($492,000) | ($492,000) |
| FY 2013-14 Non-ACA (Final) | ($2,585,000) | ($2,585,000) |
| FY 2015-16 ACA (Interim) | ($492,000) | ($492,000) |
| FY 2015-16 Non-ACA (Interim) | ($2,585,000) | ($2,585,000) |
| **Total FY 2018-19** | **$33,555,000** | **$33,555,000** |

**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 | $30,984,000 | $30,857,000 |
| - STATE FUNDS | $14,921,620 | $14,860,400 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 3.69 % | 3.32 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $29,840,700 | $29,832,500 |
| STATE FUNDS | $14,371,010 | $14,367,040 |
| FEDERAL FUNDS | $15,469,680 | $15,465,510 |

## 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 claims transitioned on July 1, 2017. Once the transition is complete, EPSDT expenditures will no longer be estimated through this policy change, but instead will be included in the Fee-For-Service Base expenditures.

**Reason for Change:**
The number of screens decreased while the cost per screen increased from the prior estimate for FY 2017-18, -94,208 and $3.35, respectively. The decrease in the number of screens is believed to be related to the decreasing Medi-Cal Families caseload and the transition of clinical laboratory claims to the standard FFS paid claims process.

# EPSDT SCREENS

## BASE POLICY CHANGE NUMBER: 177

**Methodology:**
Costs are determined by multiplying the number of screens by the estimated average cost per screen for FY 2017-18 and FY 2018-19, based on historical trends from July 2012 to April 2017.

**FY 2017-18**
Screens 499,823 x $61.99 (weighted average) = **$30,984,000** (rounded)

**FY 2018-19**
Screens 497,977 x $61.97 (weighted average) = **$30,857,000** (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: | Joel Singh |
| 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 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 Interagency Agreement.

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is an increase due to delayed invoices for FY 2016-17 costs, previously budgeted in FY 2016-17, shifting to FY 2017-18. The change in the current estimate, from FY 2017-18 to FY 2018-19, is due to less 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** | **$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** | **$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 | $1,452,000 | $1,448,000 |
| - STATE FUNDS | $726,000 | $724,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $1,452,000 | $1,448,000 |
| STATE FUNDS | $726,000 | $724,000 |
| FEDERAL FUNDS | $726,000 | $724,000 |

## 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 an increase due to an increase in enrollment of active HIPP members. It was previously estimated that enrollment would decrease in FY 2017-18, however, enrollment is trending upward for FY 2017-18. The estimated premium costs and enrollment were updated in FY 2018-19, but there is no material change from FY 2017-18 to FY 2018-19, in the current estimate.

# HIPP PREMIUM PAYOUTS (Misc. Svcs.)

## BASE POLICY CHANGE NUMBER: 188

**Methodology:**

1. Premium costs are determined by the prior year's average premium expense and include ancillary costs as incurred.

2. In FY 2017-18, based on actual data through December 2016, it is estimated that there will be no change in premium costs and an increase in enrollment for FY 2017-18 compared to the prior estimate.

3. The average monthly premium cost including ancillary costs is estimated to be $605.00 in FY 2017-18 and $635.00 in FY 2018-19.

4. The average monthly HIPP enrollment is estimated to be 200 in FY 2017-18 and 190 in FY 2018-19.

5. Costs for FY 2017-18 and FY 2018-19 are estimated to be:

   **FY 2017-18:** $605.00 x 200 x 12 Months = **$1,452,000 TF ($726,000 GF)**

   **FY 2018-19:** $635.00 x 190 x 12 Months = **$1,448,000 TF ($724,000 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 | -$371,809,000 | -$367,663,000 |
| - STATE FUNDS | -$173,772,000 | -$171,834,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$371,809,000 | -$367,663,000 |
| STATE FUNDS | -$173,772,000 | -$171,834,000 |
| FEDERAL FUNDS | -$198,037,000 | -$195,829,000 |

## 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. These trends will not necessarily mirror one another, reflecting differences in how State staff work WCRP cases as opposed to a contractor.

# 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. FY 2017-18 includes higher than average collections for personal injury – special needs trusts and institutional provider audits. Also, the Department began recovering from third party insurance carriers for mental health expenditures in FY 2017-18. These recoveries are retroactive for three years, increasing FY 2017-18 over FY 2018-19. The FY 2018-19 decrease in recoveries from third party insurance carriers for mental health expenditures is offset by an increase in estate recoveries, based on the historical trend.

(Dollars in Thousands)

| Recovery Type | FY 2017-18 | FY 2018-19 |
|---|---|---|
| Personal Injury Collections | ($106,247) | ($106,616) |
| Workers' Comp. Collections | ($1,500) | ($1,500) |
| Health Insurance Contingency Contract | ($116,255) | ($114,507) |
| General Collections | ($147,807) | ($145,040) |
| **TOTAL** | **($371,809)** | **($367,663)** |

**Methodology:**
1. The recoveries estimate uses the trend in monthly recoveries for July 2014 – July 2017.

2. The General Fund ratio for collections is estimated to be 46.74% in FY 2017-18 and FY 2018-19.

**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 | $38,760,000 | $32,865,000 |
| - STATE FUNDS | $19,380,000 | $16,432,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $38,760,000 | $32,865,000 |
| STATE FUNDS | $19,380,000 | $16,432,500 |
| FEDERAL FUNDS | $19,380,000 | $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 an increase due to updated lawsuit information. 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:**

1. Attorney Fees
   **Total for FY 2017-18** **$0**

2. Provider Settlements of $75,000 or Less Payments
   **Total for FY 2017-18** **$0**

3. Beneficiary Settlements of $2,000 or Less Payments
   **Total for FY 2017-18** **$0**

# LAWSUITS/CLAIMS

**BASE POLICY CHANGE NUMBER: 208**

4. Other Attorney Fees Payments

| | |
|---|---|
| 1. DHCS v. OAHA – Ruderman & Knox, LLP – Sonora Elem School District | $22,400 |
| **Total for FY 2017-18** | **$22,400** |

5. Other Provider Settlements

| | |
|---|---|
| 1. Contra Costa | $6,000,000 |
| 2. LA Care | $31,000,000 |
| 3. AHF | ($600,000) |
| 4. OAHA Appeal No. HA8-0905-391D-JP – Comm Hosp Long Beach | $380,797 |
| 5. Korean Comm Center of the East Bay v. Jennifer Kent, and DHCS | $400,000 |
| 6. Northern Inyo Hospital District | $301,000 |
| 7. Brius Settlement | ($495,043) |
| 8. DaVita Settlement | ($192,760) |
| **Total for FY 2017-18** | **$36,793,995** |
| 1. LA Care | $31,000,000 |
| **Total for FY 2018-19** | **$31,000,000** |

6. Other Beneficiary Settlements

| | |
|---|---|
| 1. DHCS v. OAHA – Ruderman & Knox, LLP – Sonora Elem School District | $120,000 |
| 2. US ex rel Alcaine v. Braden Partners d/b/a PPS | ($41,400) |
| 3. Singleton v. DHCS | $5,000 |
| **Total for FY 2017-18** | **$83,600** |

| | Committed | Balance | Budgeted | Budgeted |
|---|---|---|---|---|
| | **2017-18** | **2017-18** | **2017-18** | **2018-19** |
| Attorney Fees <$5,000 | $0 | $50,000 | $50,000 * | $50,000 * |
| Provider Settlements <$75,000 | $0 | $1,600,000 | $1,600,000 * | $1,600,000 * |
| Beneficiary Settlements <$2,000 | $0 | $10,000 | $10,000 * | $15,000 * |
| Small Claims Court | $0 | $200,000 | $200,000 * | $200,000 * |
| Other Attorney Fees | $22,400 | N/A | $22,400 | $0 |
| Other Provider Settlements | $36,793,995 | N/A | $36,793,995 | $31,000,000 |
| Other Beneficiary Settlements | $83,600 | N/A | $83,600 | $0 |
| Interest if paid by March (4 Mo) | $3,323 | N/A | | |
| | **$36,900,000** | **$1,860,000** | **$38,760,000** | **$32,865,000** |

* Represents potential totals.

**Funding:**
50% Title XIX FF / 50% GF (4260-101-0001/0890)
100% FFP (4260-101-0890)
100% GF (4260-101-0001)

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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 | $108,677,000 | $88,722,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $108,677,000 | $88,722,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $108,677,000 | $88,722,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the federal financial participation (FFP) provided to the California Department of Corrections and Rehabilitation (CDCR) 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 CDCR. Effective April 1, 2011, the Department began accepting Medi-Cal applications from California Correctional Health Care Services (CCHCS) for eligibility determinations for State inmates, retroactive to November 1, 2010. The Department will budget the FFP for services and CDCR administrative costs and CDCR will continue to budget the General Fund (GF). Previously these services were paid by CDCR with 100% 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, CDCR submits a Medi-Cal application to the Department to determine eligibility. Previously these services were funded through CDCR with 100% GF.

# MEDI-CAL STATE INMATE PROGRAMS

## REGULAR POLICY CHANGE NUMBER: 1

AB 396 (Chapter 394, Statutes of 2011) authorizes the Department and the CDCR to:

- Claim FFP for inpatient hospital services provided to Medi-Cal eligible juvenile inmates, in State correctional facilities, when these services are provided off the grounds of the facility. Previously these services were paid by CDCR.

For State inmates, with implementation of the Affordable Care Act (ACA), CDCR utilizes the Single Streamlined Application, currently used by counties, and the Department makes an eligibility determination according to current standard eligibility rules. Federal Medicaid regulations and federal guidance provided to states, allow for coverage of specified services to eligible inmates when provided off the grounds of a correctional facility. The Department currently has an interagency agreement with CDCR in order to claim Title XIX FFP.

These programs require adherence to the utilization review requirements established by the Superior System Waiver.

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is a decrease due to a change in the overall methodology for estimating payments. Assumptions for ongoing costs are now based on FY 2016-17 actual Medi-Cal State Inmate Program payment data. Prior estimates used monthly eligibles and cost per event to determine the estimated payments. The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to less retroactive claim amounts expected to be paid in FY 2018-19.

**Methodology:**

1. The adult State inmate program began in November 2010. Eligibility began in April 2011 with claiming beginning in April 2012. The juvenile State inmate program began in January 2012 with claiming beginning in April 2013.

2. Applications for State inmates in Medi-Cal are processed by the Department if the applicant received off-site inpatient related services.

3. Estimated costs for FY 2017-18 and FY 2018-19 are based on FY 2016-17 claims data.

4. Assume $71,325,000 TF in retroactive payments will be paid in FY 2017-18 and $39,535,000 TF in retroactive payments will be paid in FY 2018-19.

5. 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.

6. Assume a six month lag in ongoing payments.

# 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 | $14,816,000 | $7,408,000 |
| Adults - ACA | $49,269,000 | $47,247,000 |
| Medical Parole | $623,000 | $312,000 |
| Juveniles | $115,000 | $57,000 |
| | | |
| Total Retroactive Payments | $71,325,000 | $53,653,000 |
| ACA | $35,982,000 | $35,982,000 |
| Non-ACA | $35,343,000 | $17,671,000 |
| **Total FY 2017-18** | $136,148,000 | **$108,677,000** |

| FY 2018-19 | TF | FF |
|---|---|---|
| Adults - Non ACA | $16,222,000 | $8,111,000 |
| Adults - ACA | $52,720,000 | $49,556,000 |
| Medical Parole | $698,000 | $349,000 |
| Juveniles | $115,000 | $57,000 |
| | | |
| Total Retroactive Payments | $39,535,000 | $30,649,000 |
| ACA | $22,910,000 | $22,337,000 |
| Non-ACA | $16,625,000 | $8,312,000 |
| **Total FY 2018-19** | $109,290,000 | **$88,722,000** |

*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 | $67,765,000 | $67,765,000 |
| - STATE FUNDS | $36,631,600 | $36,631,600 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $67,765,000 | $67,765,000 |
| STATE FUNDS | $36,631,600 | $36,631,600 |
| FEDERAL FUNDS | $31,133,400 | $31,133,400 |

## 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.

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is a decrease due to a decrease in eligibles. There is no change from FY 2017-18 to FY 2018-19 in the current estimate.

# BREAST AND CERVICAL CANCER TREATMENT

## REGULAR POLICY CHANGE NUMBER: 2

**Methodology:**

1. There were 4,643 FFS and 1,978 managed care eligibles as of March 2017 (total of 6,621). 1,776 of the FFS eligibles were eligible for State-Only services.
2. 116 of the FFS eligibles were in accelerated enrollment as of March 2017.
3. Assume the State will pay Medicare and other health coverage premiums for an average of 477 beneficiaries monthly in FY 2017-18 and FY 2018-19. Assume an average monthly premium cost per beneficiary of $155.12.

   FY 2017-18: 477 x $155.12 x 12 months = $888,000 TF ($888,000 GF)
   FY 2018-19: 477 x $155.12 x 12 months = $888,000 TF ($888,000 GF)

4. FFS costs are estimated as follows:
   (Dollars in Thousands)

| | FY 2017-18 | | FY 2018-19 | |
|---|---|---|---|---|
| **FFS Costs** | **TF** | **GF** | **TF** | **GF** |
| **Full Scope Costs** | $48,279 | $17,146 | $48,279 | $17,146 |
| **State-Only Services** | $18,598 | $18,598 | $18,598 | $18,598 |
| **State-Only Premiums** | $888 | $888 | $888 | $888 |
| **Total** | **$67,765** | **$36,632** | **$67,765** | **$36,632** |

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 are budgeted in the State-Only BCCTP Coverage Extension policy change.

**Funding:**
(Dollars in Thousands)

| **FY 2017-18** | **TF** | **GF** | **FF** |
|---|---|---|---|
| General Fund 4260-101-001 | $ 19,486 | $ 19,486 | $ - |
| 50 Title XIX FFP / 50 GF (4260-101-0001/0890) | $ 1,654 | $ 827 | $ 827 |
| Title XIX 65/35 FFP4260-101-0001/0890 | $ 46,625 | $ 16,319 | $ 30,306 |
| **Total** | **$ 67,765** | **$ 36,632** | **$ 31,133** |

| **FY 2018-19** | **TF** | **GF** | **FF** |
|---|---|---|---|
| General Fund 4260-101-001 | $ 19,486 | $ 19,486 | $ - |
| 50 Title XIX FFP / 50 GF (4260-101-0001/0890) | $ 1,654 | $ 827 | $ 827 |
| Title XIX 65/35 FFP4260-101-0001/0890 | $ 46,625 | $ 16,319 | $ 30,306 |
| **Total** | **$ 67,765** | **$ 36,632** | **$ 31,133** |

# 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 | $52,316,000 | $194,515,000 |
| - STATE FUNDS | $8,167,300 | $19,057,200 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $52,316,000 | $194,515,000 |
| STATE FUNDS | $8,167,300 | $19,057,200 |
| FEDERAL FUNDS | $44,148,700 | $175,457,800 |

## 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, is a decrease due to the shifting of retroactive payments from FY 2017-18 to FY 2018-19 and a change in the overall methodology for estimating MCIP payments. Assumptions for ongoing costs are now based on FY 2016-17 actual Medi-Cal State Inmate Program payment data. Prior estimates used monthly eligibles and cost per event to determine the estimated payments. The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to additional 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 $124,761,000 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. Due to the late execution of the MCIP agreements, there are insufficient county claims data to project future payments; therefore, the Department is assuming county inmate claims will be the same as state inmate claims.

8. Assume a six month lag in ongoing payments.

9. 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 | $12,166 | $6,083 | $6,083 | $16,222 | $8,111 | $8,111 |
| Adult County - ACA | $39,540 | $1,779 | $37,761 | $52,720 | $3,164 | $49,556 |
| Compassionate Release | $524 | $262 | $262 | $698 | $349 | $349 |
| Juvenile | $86 | $43 | $43 | $114 | $57 | $57 |
| | | | | | | |
| Total Retroactive Payments | $0 | $0 | $0 | $124,761 | $7,376 | $117,385 |
| Retro ACA | $0 | $0 | $0 | $70,995 | $988 | $70,007 |
| Retro Non-ACA | $0 | $0 | $0 | $53,766 | $6,388 | $47,378 |
| **Grand Total** | **$52,316** | **$8,167** | **$44,149** | **$194,515** | **$19,057** | **$175,458** |

*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)

# STATE-ONLY BCCTP COVERAGE EXTENSION

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 7 |
| IMPLEMENTATION DATE: | 1/2017 |
| ANALYST: | Shannon Hoerner |
| FISCAL REFERENCE NUMBER: | 2005 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $1,686,000 | $1,686,000 |
| - STATE FUNDS | $1,686,000 | $1,686,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 64.04 % | 83.71 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $606,300 | $274,600 |
| STATE FUNDS | $606,290 | $274,650 |
| FEDERAL FUNDS | $0 | $0 |

## DESCRIPTION

**Purpose:**
This policy change estimates the State-Only Breast and Cervical Cancer Treatment Program (BCCTP) coverage that would be extended for beneficiaries with a recurrence of breast or cervical cancer.

**Authority:**
AB 1795 (Chapter 608, Statutes of 2016)
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.

The State-Only BCCTP 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.

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.

# STATE-ONLY BCCTP COVERAGE EXTENSION

## REGULAR POLICY CHANGE NUMBER: 7

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is a decrease due to a slight decrease in beneficiaries. There is no change from FY 2017-18 to FY 2018-19 in the current estimate.

**Methodology:**

1. Assume that most recurrences happen in the first five years after breast cancer treatment.

2. Assume recurrence rate for breast cancer is 8.1% and 8% for cervical cancer.

3. Assume that there will be only one recurrence and coverage for the full 18-24 months will be necessary for a recurrence.

4. Assume the ratio of breast cancer cases to cervical cancer cases is 95%/5%.

5. Aid codes 0L, 0R, 0T, 0U, 0V, and 0Y had 2,288 beneficiaries in May 2017. Approximately half are in their first year of treatment (1,144) and half are in their second year of treatment.

6. The weighted average per member per month rate is $989.65 for FY 2017-18 and FY 2018-19.

7. Anticipated recurrences for year 1 are estimated as follows:
   - Breast Cancer Recurrences
     (1,144 x 95%) x 8.1% = 88.03
   - Cervical Cancer Recurrences
     (1,144 x 5%) x 8% = 4.58
   - Combined anticipated recurrences = 92.61 (round to 93)
   - FY 2016-17 had six months of implementation, with a recurrence rate of 47

8. Anticipated recurrences for year 2 are estimated as follows:
   - Breast Cancer Recurrences (6 months coverage)
     (1,144 x 95%) x 8.1% x 50% = 44.02
   - Cervical Cancer Recurrences (12 months coverage)
     (1,144 x 5%) x 8% = 4.58
   - Combined anticipated recurrences = 48.59 (round to 49)

# STATE-ONLY BCCTP COVERAGE EXTENSION

## REGULAR POLICY CHANGE NUMBER: 7

9. AB 1795 provides a new coverage period only and does not affect the previously estimated 18 or 24 months of coverage under AB 430. The phase in over four years gives member totals as follows (combined breast and cervical cancer recurrence members shaded):

| | Beneficiaries by Fiscal Year | | | |
|---|---|---|---|---|
| **Treatment Year** | **FY 2015-16** | **FY 2016-17** | **FY 2017-18** | **FY 2018-19** |
| 2016 | 1,144 | 47 | 93 | - |
| 2017 | 1,144 | 1,144 | 49 | 93 |
| 2018 | - | 1,144 | 1,144 | 49 |
| 2019 | - | - | 1,144 | 1,144 |
| 2020 | - | - | - | 1,144 |
| Additional | - | 47 | **142** | **142** |
| **Total** | 2,288 | 2,381 | **2,572** | **2,572** |

10. Using the PMPM and yearly members, additional costs for years 3 & 4 are estimated to be:

    (142 x 12 months) x $989.62 = $1,686,364 GF

11. AB 1795 annual ongoing cost for FY 2017-18 and FY 2018-19 are $1,686,000 GF (rounded).

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

# 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, is a decrease due to a change in the overall methodology for estimating MCIP payments. Assumptions for ongoing costs are now based on FY 2016-17 actual Medi-Cal State Inmate Program payment data. Prior estimates used monthly eligibles and cost per event to determine the estimated payments. The change from FY 2017-18 to FY 2018-

# MEDI-CAL COUNTY INMATE REIMBURSEMENT

## REGULAR POLICY CHANGE NUMBER: 8

19, in the current estimate, is an increase due to additional FY 2016-17 retroactive payments to be paid in 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 $52,316,000 TF ($44,149,000 FF) and $194,515,000 TF ($175,458,000 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:

(Dollars in Thousands)

| FY 2017-18 | GF | Reimbursement |
|---|---|---|
| Non ACA | $4,562 | $4,562 |
| ACA | $1,335 | $1,335 |
| Juvenile | $32 | $32 |
| Compassionate Release | $196 | $196 |
| Retroactive Payments | $0 | $0 |
| **Total** | $6,125 | **$6,125** |

| FY 2018-19 | GF | Reimbursement |
|---|---|---|
| Non ACA | $7,604 | $7,604 |
| ACA | $2,817 | $2,817 |
| Juvenile | $54 | $54 |
| Compassionate Release | $327 | $327 |
| Retroactive Payments | $5,532 | $5,532 |
| **Total** | $16,334 | **$16,334** |

**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 | -$116,863,440 | -$224,486,110 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $0 |
| STATE FUNDS | -$116,863,440 | -$224,486,110 |
| FEDERAL FUNDS | $116,863,440 | $224,486,110 |

## 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 and 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 updated prior year CS3-Proxy adjustments including a draw-down of title XIX FFP, 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 FY 2017-18 to FY 2018-19, in the current estimate, is an increase in GF savings mostly due to not having a CS3-Proxy adjustment repayment in FY 2018-19, but slightly offset by a decrease in estimated expenditures for the Resource Disregard, HPE and the Medicaid Expansion populations.

**Methodology:**
1. It is assumed the estimated costs of the HPE, Medicaid Expansion, and Resource Disregard aid codes will be $485,388,000 TF in FY 2017-18 and $477,377,000 TF in FY 2018-19.

(Dollars in Thousands)

| FY 2017-18 | TF | GF |
|---|---|---|
| Resource Disregard | $12,417 | ($4,718) |
| HPE | $5,790 | ($2,200) |
| Medicaid Expansion | $467,181 | ($177,529) |
| **Total Cost** | **$485,388** | **($184,447)** |

| FY 2018-19 | TF | GF |
|---|---|---|
| Resource Disregard | $12,284 | ($4,668) |
| HPE | $5,555 | ($2,111) |
| Medicaid Expansion | $459,538 | ($174,624) |
| **Total Cost** | **$477,377** | **($181,403)** |

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. Four quarterly adjustments will occur in FY 2017-18 and FY 2018-19 (Ongoing Adjustment).

# NON-OTLICP CHIP

## REGULAR POLICY CHANGE NUMBER: 9

4. The 2014 and the Jan – March 2015 adjustments overdrew Title XXI funding. In FY 2017-18, the Department will repay the Title XXI federal funds and corresponding General Fund (Fund 4260-113-0001) and utilize General Fund (4260-101-0001) and Title XIX federal funds.

**Funding**:
(Dollars in Thousands)

| **FY 2017-18** | | **TF** | **GF** | **FF** |
|---|---|---|---|---|
| 50 % Title XIX /50 % GF | 4260-101-0001/0890 | ($63,808) | ($31,904) | ($31,904) |
| Title XIX FF | 4260-101-0890 | $14,491 | $0 | $14,491 |
| Title XIX GF | 4260-101-0001 | ($14,491) | ($14,491) | $0 |
| 65% Title XXI / 35% GF | 4260-113-0001/0890 | ($421,580) | ($147,553) | ($274,027) |
| Title XXI FF | 4260-113-0890 | ($18,838) | $0 | ($18,838) |
| Title XXI GF | 4260-113-0001 | $18,838 | $18,838 | $0 |
| 88 % Title XXI /12 % GF | 4260-113-0001/0890 | $485,388 | $58,247 | $427,141 |
| **Net Impact** (rounded) | | **$0** | **($116,863)** | **$116,863** |

| **FY 2018-19** | | **TF** | **GF** | **FF** |
|---|---|---|---|---|
| 50 % Title XIX /50 % GF | 4260-101-0001/0890 | ($728,136) | ($364,068) | ($364,068) |
| Title XIX FF | 4260-101-0890 | ($18,230) | $0 | ($18,230) |
| Title XIX GF | 4260-101-0001 | $18,230 | $18,230 | $0 |
| 65% Title XXI / 35% GF | 4260-113-0001/0890 | $250,759 | $87,766 | $162,993 |
| Title XXI FF | 4260-113-0890 | $23,699 | $0 | $23,699 |
| Title XXI GF | 4260-113-0001 | ($23,699) | ($23,699) | $0 |
| 88 % Title XXI /12 % GF | 4260-113-0001/0890 | $477,377 | $57,285 | $420,092 |
| **Net Impact** (rounded) | | **$0** | **($224,486)** | **$224,486** |

*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 | $900,963,000 | $895,842,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $0 |
| STATE FUNDS | $900,963,000 | $895,842,000 |
| FEDERAL FUNDS | -$900,963,000 | -$895,842,000 |

## 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 General Fund.

# NON-EMERGENCY FUNDING ADJUSTMENT

## REGULAR POLICY CHANGE NUMBER: 10

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is an increase due to an increase in non-ACA managed care expenditures. The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to the repayment of the ACA optional expansion population being 95% FFP for FY 2017-18 until January 2018, when FFP changes to 94%. ACA FFP changes to 93% effective January 2019.

**Methodology:**

1. Based on updated July 2016 through June 2017 FFS expenditure reports of non-emergency services provided to this population, the Department estimates non-emergency FFS costs will be $284,726,000 TF in FY 2017-18 and FY 2018-19.

2. Based on July 2016 through June 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 $509,069,000 TF in FY 2017-18 and 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 2016 through June 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 $533,829,000 TF in FY 2017-18 and 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 120,614 undocumented children enrolled in restricted-scope Medi-Cal transitioned to full-scope Medi-Cal. As of June 7, 2017, 77,627 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 198,241.

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 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) | $786,544 | $393,272 | $786,544 | $393,272 |
| All Others (65% FF / 35% GF) | $7,615 | $4,950 | $7,615 | $4,950 |
| All Others (88% FF / 12% GF) | $21,276 | $18,723 | $21,276 | $18,723 |
| ACA | $512,189 | $484,018 | $512,189 | $478,897 |
| **Total** | $1,327,624 | **$900,963** | $1,327,624 | **$895,842** |

# 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 | -$67,868,240 | -$65,092,720 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $0 |
| STATE FUNDS | -$67,868,240 | -$65,092,720 |
| FEDERAL FUNDS | $67,868,240 | $65,092,720 |

## DESCRIPTION

**Purpose:**
This policy change estimates the savings from the State Children's Health Insurance Program's (SCHIP) federal funding for prenatal care for women previously ineligible for federal funding.

**Authority:**
AB 131 (Chapter 80, Statutes of 2005)

**Interdependent Policy Changes:**
Not Applicable

**Background:**
AB 131 required 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 FY 2017-18, is a decrease due to updated expenditure reports reflecting lower prenatal costs for 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 $65,876,000 TF in FY 2017-18 and $62,722,000 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:** | $65,876 TF x .88 = | **$57,971 FFP** |
| | | |
| **FY 2018-19:** | $62,722 TF x .88 = | **$55,195 FFP** |

3. The cost of prenatal care for legal immigrant women is estimated to be $11,247,000 TF in FY 2017-18 and 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:** | $11,247 x .88 = | **$9,897 FFP** |
| | | |
| **FY 2018-19:** | $11,247 x .88 = | **$9,897 FFP** |

5. The federal funding received on a cash basis will be:

(Dollars in Thousands)

| FY | | GF Savings |
|---|---|---|
| **FY 2017-18** | $57,971 + $9,897 = | **$67,868** |
| | | |
| **FY 2018-19:** | $55,195 + $9,897 = | **$65,092** |

**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 | $14,732,000 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $0 |
| STATE FUNDS | $14,732,000 | $0 |
| FEDERAL FUNDS | -$14,732,000 | $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 an increase due to system changes to identify the lawfully present immigrants who are under the age of 21 or pregnant so that FFP for nonemergency services provided for this group can be retained by California under the authority of SPA 09-14. This population is now excluded from repayments to the federal government and the MR-O-151

# CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

## REGULAR POLICY CHANGE NUMBER: 12

reports for each federal fiscal year quarter beginning in July 2011 had to be rerun to identify appropriate repayments. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the cost of the remaining 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 $14,732,000 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 | $14,732,000 | ($14,732,000) |

**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 | -$20,554,000 | -$33,164,000 |
| - STATE FUNDS | -$10,277,000 | -$16,582,000 |
| PAYMENT LAG | 0.9536 | 0.9685 |
| % REFLECTED IN BASE | 58.06 % | 61.98 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$8,220,400 | -$12,211,800 |
| STATE FUNDS | -$4,110,180 | -$6,105,880 |
| FEDERAL FUNDS | -$4,110,180 | -$6,105,890 |

## 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). Currently, CalHEERS does not screen for military history. As a result, these recently enrolled beneficiaries missed their opportunity to become educated on VA benefits and obtain veteran benefit enhancement activities. The military question is scheduled to be added to CalHEERS in FY 2017-18.

# PARIS-VETERANS

## REGULAR POLICY CHANGE NUMBER: 13

**Reason for Change:**
The change from prior estimate, for FY 2017-18, is due to updated managed care (MC) rates and fee-for-service (FFS) per member per month (PMPM) costs, as well as updated discontinued eligibles. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to updated payment lag, percent in base, and dollars in base data for 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 $299.22 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 58.06% of the MC and FFS savings is captured in the base trends. In FY 2018-19, it is estimated that 61.98% of the MC and FFS savings is captured in the base trends.

6. Total estimated savings are $20,554,000 for FY 2017-18 and $33,164,000 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 | -$65,731,000 | -$65,750,000 |
| - STATE FUNDS | -$7,887,720 | -$7,890,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$65,731,000 | -$65,750,000 |
| STATE FUNDS | -$7,887,720 | -$7,890,000 |
| FEDERAL FUNDS | -$57,843,280 | -$57,860,000 |

## 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 FY 2017-18, is a decrease due to a decrease 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 917,286 average monthly OTLICP eligibles and 917,544 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 6,698,022 member months subject to monthly premiums and 6,699,906 in FY 2018-19.
   FY 2017-18: 917,286 x 12 months x 60.85% = **6,698,022** member months
   FY 2018-19: 917,544 x 12 months x 60.85% = **6,699,906** 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 Exempt Member 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 member months:

| Loss of Premiums | FY 2017-18 | FY 2018-19 |
|---|---|---|
| Discount Program | 870,731 | 870,976 |
| Delinquent Premiums | 669,793 | 669,982 |
| **Total Loss of Premium Member Months** | **1,540,524** | **1,540,958** |

5. The net member months for the OTLICP premium calculation are:

| Member Months | FY 2017-18 | FY 2018-19 |
|---|---|---|
| Eligible Member Months | 6,698,022 | 6,699,906 |
| Exempt Member Months | (101,267) | (101,267) |
| Loss Member Months | (1,540,524) | (1,540,958) |
| **Net Member Months** | **5,056,231** | **5,057,681** |

6. Premium requirement for children with incomes between 160-266% FPL is $13 per month.

7. Beginning October 1, 2015, assume estimated costs are eligible for Title XXI 88/12 FMAP. The total estimated premium revenue for OTLICP are:

(Dollars In Thousands)

| Fiscal Year | TF | GF | FF |
|---|---|---|---|
| **FY 2017-18** | **$ 65,731** | **$ 7,888** | **$ 57,843** |
| **FY 2018-19** | **$ 65,750** | **$ 7,890** | **$ 57,860** |

**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 | -$141,385,000 | -$363,381,000 |
| - STATE FUNDS | -$29,459,000 | -$77,661,010 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 3.04 % | 0.88 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$137,086,900 | -$360,183,200 |
| STATE FUNDS | -$28,563,450 | -$76,977,590 |
| FEDERAL FUNDS | -$108,523,450 | -$283,205,650 |

## 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 per hour.

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 for FY 2017-18, from the prior estimate, is a decrease is due to updated caseload and payment lag data. 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 $10.50 as of January 1, 2017. The implementation date for the increase to $11.00 is January 1, 2018.

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 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 24% of each aid category is 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 FFS population is 29% 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 | ($48,820,000) | ($24,410,000) | ($24,410,000) |
| Title XIX ACA 95% FF / 5% GF | ($50,490,000) | ($2,524,500) | ($47,965,500) |
| Title XIX ACA 94% FF / 6% GF | ($42,075,000) | ($2,524,500) | ($39,550,500) |
| **Total Savings** | **($141,385,000)** | **($29,457,000)** | **($111,928,000)** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| Title XIX 50% GF / 50% FF | ($124,444,000) | ($62,222,000) | ($62,222,000) |
| Title XIX ACA 94% FF / 6% GF | ($128,658,000) | ($7,719,500) | ($120,938,500) |
| Title XIX ACA 93% FF / 7% GF | ($110,279,000) | ($7,719,500) | ($102,559,500) |
| **Total Savings** | **($363,381,000)** | **($77,661,000)** | **($285,720,000)** |

*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)

# MEC 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 | -$418,325,000 | -$91,985,000 |
| - STATE FUNDS | $214,984,580 | $94,625,300 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$418,325,000 | -$91,985,000 |
| STATE FUNDS | $214,984,580 | $94,625,300 |
| FEDERAL FUNDS | -$633,309,580 | -$186,610,300 |

## 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 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 Minimum Essential Coverage. A small portion of Optional Expansion eligibles have Medicare Part A or Part B, which qualifies as Minimum Essential Coverage. 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 FY 2017-18, is due to updated actuals and the estimated redetermination dates of eligibles. The change 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.

# MEC 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 FY 2018-19.

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 $357.2 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 policy changes.

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 DPHs from the managed care plans will be needed along with the return of the IGT to the DPHs.

7. Assume Drug Medi-Cal and Specialty Mental Health Services will include County Funds once the adjustment to 50% FMAP occurs. The County Funds (CF) are displayed for informational purposes.

# MEC 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 | ($1,883) | $1,883 | | |
| SMHS/Drug Medi-Cal | ($1,721) | ($1,721) | | | $1,721 |
| Dental | $0 | ($256) | $256 | | |
| Managed Care | $0 | ($7,994) | $7,994 | | |
| Recoup from Plans | ($22,285) | ($22,558) | $0 | $273 | |
| Subtotal FY 2013-14 | ($24,006) | ($34,413) | $10,134 | $273 | $1,721 |
| **FY 2014-15** | | | | | |
| FFS | $0 | ($12,238) | $12,238 | $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 | ($32,788) | $32,788 | $0 | $0 |
| Recoup from Plans | ($120,327) | ($121,800) | $0 | $1,472 | $0 |
| Subtotal FY 2014-15 | ($126,150) | ($174,159) | $46,536 | $1,472 | $5,823 |
| **FY 2015-16** | | | | | |
| FFS | $0 | ($17,577) | $17,577 | $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 | ($52,006) | $52,006 | $0 | $0 |
| Recoup from Plans | ($96,701) | ($98,972) | $0 | $2,271 | $0 |
| Subtotal FY 2015-16 | ($105,335) | ($179,780) | $72,174 | $2,271 | $8,634 |
| **FY 2016-17** | | | | | |
| FFS | $0 | ($18,601) | $18,601 | $0 | $0 |
| SMHS/Drug Medi-Cal | ($9,037) | ($8,585) | ($452) | $0 | $9,037 |
| Dental | $0 | ($2,708) | $2,708 | $0 | $0 |
| Managed Care | $0 | ($52,022) | $52,022 | $0 | $0 |
| Recoup from Plans | ($100,493) | ($98,930) | ($2,562) | $1,000 | $0 |
| Subtotal FY 2016-17 | ($109,530) | ($180,847) | $70,317 | $1,000 | $9,037 |
| **FY 2017-18** | | | | | |
| FFS | $0 | ($17,552) | $17,552 | $0 | $0 |
| SMHS/Drug Medi-Cal | ($9,334) | ($8,308) | ($1,027) | $0 | $9,334 |
| Dental | $0 | ($2,621) | $2,621 | $0 | $0 |
| Managed Care | $0 | ($40,109) | $40,109 | $0 | $0 |
| Recoup from Plans | ($17,393) | ($16,436) | ($957) | $0 | $0 |
| Reduce Managed Care Base Expenditures | ($44,948) | ($42,476) | ($2,472) | $0 | $0 |
| Subtotal FY 2017-18 | ($71,675) | ($127,501) | $55,826 | $0 | $9,334 |

# MEC OPTIONAL EXPANSION ADJUSTMENT

## REGULAR POLICY CHANGE NUMBER: 16

| *(Dollars in Thousands)* | TF | FF | GF | HQAF | CF |
|---|---|---|---|---|---|
| **FY 2018-19** | | | | | |
| FFS | $0 | ($17,101) | $17,101 | $0 | $0 |
| SMHS/Drug Medi-Cal | ($9,517) | ($8,280) | ($1,237) | $0 | $9,517 |
| Dental | $0 | ($2,612) | $2,612 | $0 | $0 |
| Managed Care | $0 | ($40,313) | $40,313 | $0 | $0 |
| Reduce Managed Care Base Expenditures | ($64,097) | ($59,931) | ($4,166) | $0 | $0 |
| Subtotal FY 2018-19 | ($73,614) | ($128,236) | $54,622 | $0 | $9,517 |
| **Total** | | | | | |
| FFS | $0 | ($84,951) | $84,951 | $0 | $0 |
| SMHS/Drug Medi-Cal | ($44,066) | ($41,350) | ($2,716) | $0 | $44,066 |
| Dental | $0 | ($12,299) | $12,299 | $0 | $0 |
| Managed Care | $0 | ($225,233) | $225,233 | $0 | $0 |
| Recoup from Plans | ($357,199) | ($358,697) | ($3,519) | $5,016 | $0 |
| Reduce Managed Care Base Expenditures | ($109,045) | ($102,407) | ($6,638) | $0 | $0 |
| **Subtotal** | **($510,310)** | **($824,936)** | **$309,610** | **$5,016** | $44,066 |

| *(Dollars in Thousands)* | TF | FF | GF | HQAF | CF (Display only) |
|---|---|---|---|---|---|
| **FY 2017-18** | **($418,325)** | ($638,326) | $214,985 | $5,016 | $16,177 |
| **FY 2018-19** | **($91,985)** | ($186,610) | $94,625 | $0 | $27,888 |

### Funding:

*(Dollars in Thousands)*

| FY 2017-18 | Total Funds | Federal Funds | State Funds |
|---|---|---|---|
| 100% ACA Title XIX FF (4260-101-0890) | ($643,396) | ($643,396) | |
| 95% ACA Title XIX FF /5% GF (4260-101-0890/0001) | ($182,244) | ($173,132) | ($9,112) |
| 94% ACA Title XIX FF /6% GF (4260-101-0890/0001) | ($76,237) | ($71,663) | ($4,574) |
| 50 % Title XIX FF / 50% GF (4260-101-0890/0001) | $457,342 | $228,671 | $228,671 |
| 100% Title XIX FF (4260-101-0890) | $21,194 | $21,194 | |
| HQAF Title XIX FF (4260-611-0890) | $5,016 | $5,016 | $0 |
| **Total** | **($418,325)** | **($633,310)** | **$214,985** |

*(Dollars in Thousands)*

| FY 2018-19 | Total Funds | Federal Funds | State Funds |
|---|---|---|---|
| 100% ACA Title XIX FF (4260-101-0890) | ($31,468) | ($31,468) | |
| 95% ACA Title XIX FF /5% GF (4260-101-0890/0001) | ($63,468) | ($60,295) | ($3,173) |
| 94% ACA Title XIX FF /6% GF (4260-101-0890/0001) | ($142,560) | ($134,006) | ($8,554) |
| 93% ACA Title XIX FF /7% GF (4260-101-0890/0001) | ($110,560) | ($102,821) | ($7,739) |
| 50 % Title XIX FF / 50% GF (4260-101-0890/0001) | $228,183 | $114,092 | $114,092 |
| 100% Title XIX FF (4260-101-0890) | $27,888 | $27,888 | |
| **Total** | **($91,985)** | **($186,610)** | **$94,625** |

# 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 | $2,591,402,000 | $3,814,981,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $2,591,402,000 | $3,814,981,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $2,591,402,000 | $3,814,981,000 |

## 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:**
Updated estimates, on a cash basis, as provided by CDSS.

**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 | $483,599,000 | $308,165,000 |
| - STATE FUNDS | $163,750,950 | $104,903,820 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $483,599,000 | $308,165,000 |
| STATE FUNDS | $163,750,950 | $104,903,820 |
| FEDERAL FUNDS | $319,848,050 | $203,261,180 |

## 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 will eliminate the CY 2016 HIPF payments.

# 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:

- A portion of CY 2015 payments decrease due to updated actuals,
- Revising CY 2017 payments on anticipated payments,
- Basing CY 2018 payments on CY 2017 placeholder HIPF dollars plus a 5 percent growth factor, and
- Budgeting five months of CY 2018 payments in FY 2017-18.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to budgeting two years and one month in FY 2017-18 versus one year and seven months 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 will be completed in FY 2017-18.

3. Payments for CY 2016 have been suspended due to federal budget legislation.

4. Due to ongoing efforts to move to a prospective rate setting, CY 2017 estimated payments are expected to occur in FY 2017-18.

5. The estimated payments for CY 2018 are expected to occur in both FY 2017-18 and FY 2018-19.

6. A portion of CY 2019 payments are expected to occur in FY 2018-19.

7. Assume the following amounts:

(Dollars in Thousands)

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| CY 2015 Payments | $70,316 | $0 |
| CY 2017 Payments | $287,501 | $0 |
| CY 2018 Payments | $125,782 | $176,095 |
| CY 2019 Payments | $0 | $132,070 |
| **Total** | **$483,599** | **$308,165** |

8. 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 net premium.

# 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) | $304,088 | $152,044 | $152,044 |
| 100% Title XIX ACA (4260-101-0890) | $20,898 | $0 | $20,898 |
| 95% Title XIX ACA / 5% GF (4260-101-0890) | $85,445 | $4,272 | $81,173 |
| 94% Title XIX ACA / 6% GF (4260-101-0890) | $37,382 | $2,243 | $35,139 |
| 88% Title XXI FF/ 12% GF (4260-101-0001/0890) | $31,884 | $3,826 | $28,058 |
| 65% Title XXI FF / 35% GF (4260-113-0001/0890) | $3,902 | $1,366 | $2,536 |
| **Total** | **$483,599** | **$163,751** | **$319,848** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| 50% Title XIX FF/ 50% GF (4260-101-0001/0890) | $192,409 | $96,205 | $96,205 |
| 94% Title XIX ACA / 6% GF (4260-101-0890) | $53,245 | $3,195 | $50,050 |
| 93% Title XIX ACA / 7% GF (4260-101-0890) | $39,934 | $2,795 | $37,139 |
| 88% Title XXI FF/ 12% GF (4260-101-0001/0890) | $22,577 | $2,709 | $19,868 |
| **Total** | **$308,165** | **$104,904** | **$203,261** |

# 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 | $18,210,000 | $14,130,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $18,210,000 | $14,130,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $18,210,000 | $14,130,000 |

## 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 decrease from the prior estimate for FY 2017-18, is due to updated estimated payment amounts, based on actual data received, as well as an update to the timeline for the availability of data for claiming. The decrease from FY 2017-18 to FY 2018-19, in the current estimate, is due to several factors. First, the Department will pay five quarters of payments in FY 2017-18 and four in FY 2018-19. Second, the estimated payment amounts, based on actual data received, are lower for FY 2018-19.

# HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS

## REGULAR POLICY CHANGE NUMBER: 19

Finally, FY 2018-19 has two quarters of payments for the Calendar Year 2018 ACA FFP of 94%.

**Methodology:**

1. The Department assumes enhanced Title XIX ACA Federal Funding (FF) is available for services provided under the temporary HPE program to those individuals who enroll in temporary HPE at a qualified hospital, then successfully complete the Medi-Cal application process, and are enrolled in the ACA Optional Expansion program.

2. The Department submits claims for beneficiaries receiving services in DPHs and makes payments to DPHs for the enhanced FFP. The Department generates reports six months after the last day of the quarter to allow for lagged claims submission. The estimated average quarterly payment for enhanced Title XIX ACA FFP is $3,823,000 for FY 2017-18 and $3,738,000 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 $18,210,000 in FY 2017-18 and $14,130,000 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 Q2 & Q3 | $ 7,123 | $ 7,123 |
| FY 2016-17 Q4 | $ 3,823 | $ 3,823 |
| FY 2017-18 Q1 | $ 3,632 | $ 3,632 |
| FY 2017-18 Q2 | $ 3,632 | $ 3,632 |
| **Net Impact** | **$ 18,210** | **$ 18,210** |

| FY 2018-19 | TF | FF |
|---|---|---|
| FY 2017-18 Q3 | $ 3,551 | $ 3,551 |
| FY 2017-18 Q4 | $ 3,551 | $ 3,551 |
| FY 2018-19 Q1 | $ 3,514 | $ 3,514 |
| FY 2018-19 Q2 | $ 3,514 | $ 3,514 |
| **Net Impact** | **$ 14,130** | **$ 14,130** |

**Funding:**

(Dollars in Thousands)

| FY 2017-18 | TF | FF |
|---|---|---|
| 50% Title XIX FF (4260-101-0890/0001) | $ - | $ - |
| 100% Title XIX ACA FF (4260-101-0001) | $ 10,946 | $ 10,946 |
| 95% Title XIX ACA FF (4260-101-0890/0001) | $ 7,264 | $ 7,264 |
| **Net Impact** | **$ 18,210** | **$ 18,210** |

# HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS

## REGULAR POLICY CHANGE NUMBER: 19

| FY 2018-19 | TF | FF |
|---|---|---|
| 50% Title XIX FF (4260-101-0890/0001) | $ - | $ - |
| 95% Title XIX ACA FF (4260-101-0890/0001) | $ 7,102 | $ 7,102 |
| 94% Title XIX ACA FF (4260-101-0890/0001) | $ 7,027 | $ 7,027 |
| **Net Impact** | **$ 14,130** | **$ 14,130** |

# PAYMENTS TO PRIMARY CARE PHYSICIANS

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 20 |
| IMPLEMENTATION DATE: | 11/2013 |
| ANALYST: | Joy Oda |
| FISCAL REFERENCE NUMBER: | 1659 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $5,500,000 | $0 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 2.91 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $5,340,000 | $0 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $5,339,950 | $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 occurring in FY 2017-18.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to estimating the completion of the remaining reconciliation payments by March 2018.

**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 estimated remaining payments on a cash basis are expected to be completed by March 2018.

(Dollars in Thousands)

| Fiscal Year | TF | FF |
|---|---|---|
| FY 2017-18 | $5,500 | $5,500 |

**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 | -$32,229,850 | -$31,519,250 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $0 |
| STATE FUNDS | -$32,229,850 | -$31,519,250 |
| FEDERAL FUNDS | $32,229,850 | $31,519,250 |

## 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 decrease in General Fund Savings from the prior estimate, for FY 2017-18, resulted from updated actual claims. 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% in 2019.

# 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 2013-14 Q3 through FY 2016-17 Q3, the estimated average quarterly adjustment for FY 2017-18 is $18,005,000 and $18,011,000 for FY 2018-19.

4. The Department estimates to adjust $72,022,000 TF claims from Title XIX 50/50 FMAP to claim the enhanced Title XIX ACA FMAP in FY 2017-18 and $72,044,000 in 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 | $ (72,022) | $ (36,011) | $ (36,011) |
| 95% Title XIX FF / 5% GF | $ 54,017 | $ 2,701 | $ 51,316 |
| 94% Title XIX FF / 6% GF | $ 18,005 | $ 1,080 | $ 16,925 |
| **Net Impact** | **$ -** | **$ (32,230)** | **$ 32,230** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| 50% Title XIX FF / 50% GF | $ (72,044) | $ (36,022) | $ (36,022) |
| 94% Title XIX FF / 6% GF | $ 54,033 | $ 3,241 | $ 50,791 |
| 93% Title XIX FF / 7% GF | $ 18,011 | $ 1,261 | $ 16,750 |
| **Net Impact** | **$ -** | **$ (31,519)** | **$ 31,519** |

**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 | -$1,055,000 | -$1,264,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $0 |
| STATE FUNDS | -$1,055,000 | -$1,264,000 |
| FEDERAL FUNDS | $1,055,000 | $1,264,000 |

## 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, is due to the following:

FFS

- For FY 2015-16, the savings claimed was greater than the actual savings available. The repayment of the over claimed federal funds for period January 1, 2016 through June 30, 2016, previously budgeted in FY 2016-17, is now included in FY 2017-18.
- Savings for FY 2016-17, has been revised due to updated actual data and the revised savings are slightly lower than previously projected.

Managed care

- Savings for the FY 2016-17, has been revised due to updated data and the revised savings are higher than previously projected.
- Savings for FY 2017-18 will now occur in FY 2018-19.

The change in the current estimate, from FY 2017-18 to FY 2018-19, is primarily due to the federal funds 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 period July 1, 2017 through June 30, 2018.

| FY 2017-18 | FFS | Managed Care | Total Savings |
|---|---|---|---|
| Total for FY 2016-17 | ($205,000) | ($1,032,000) | ($1,237,000) |

| FY 2018-19 | FFS | Managed Care | Total Savings |
|---|---|---|---|
| Total for FY 2017-18 | ($232,000) | ($1,032,000) | ($1,264,000) |

2. The Department will repay 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 |

# 1% FMAP INCREASE FOR PREVENTIVE SERVICES

## REGULAR POLICY CHANGE NUMBER: 22

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 | ($205,000) | $205,000 |
| Total FFS | $0 | ($23,000) | $23,000 |
| 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** | **($1,055,000)** | **$1,055,000** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| FFS: | | | |
| FY 2017-18 Savings | $0 | ($232,000) | $232,000 |
| Total FFS | $0 | ($232,000) | $232,000 |
| 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** | **($1,264,000)** | **$1,264,000** |

**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. 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 will be 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. The change from FY 2017-18 to FY 2018-19 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)** |

# TITLE XXI FEDERAL MATCH REDUCTION

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 24 |
| IMPLEMENTATION DATE: | 1/2018 |
| ANALYST: | Katy Clay |
| FISCAL REFERENCE NUMBER: | 2017 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | -$114,127,000 | -$155,838,000 |
| - STATE FUNDS | $300,570,910 | $599,763,670 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$114,127,000 | -$155,838,000 |
| STATE FUNDS | $300,570,910 | $599,763,670 |
| FEDERAL FUNDS | -$414,697,910 | -$755,601,670 |

## DESCRIPTION

**Purpose**:
This policy change estimates the adjustment to reflect the costs that should be charged to the Children's Health Insurance Program (CHIP) after the reduction of the federal match from 88% to 65%.

**Authority:**
Affordable Care Act (ACA)

**Interdependent Policy Changes:**
Base Adjustments
PC 4 Medi-Cal Access Program Mothers 213-322% FPL
PC 5 County Health Initiative Matching (CHIM)
PC 6 Medi-Cal Access Program Infants 266-322% FPL
PC 9 Non-OTLICP CHIP
PC 10 Non-Emergency Funding Adjustment
PC 11 SCHIP Funding For Prenatal Care
PC 14 OTLICP Premiums
PC 18 Health Insurer Fee
PC 27 Behavioral Health Treatment
PC 31 CCS Demonstration Project
PC 32 Local Education Agency (LEA) Providers
PC 39 Pediatric Palliative Care Waiver
PC 46 Pediatric Palliative Care Expansion and Savings
PC 47 New High Cost Treatments for Specific Conditions
PC 49 Pharmacy Reimbursement & Dispensing Fee
PC 54 State Supplemental Drug Rebates
PC 55 Federal Drug Rebate Program
PC 58 Outpatient Drug Free Treatment Services
PC 60 Intensive Outpatient Treatment Services
PC 62 Residential Treatment Services
PC 64 SMHS for Children
PC 69 Drug Medi-Cal Annual Rate Adjustment

# TITLE XXI FEDERAL MATCH REDUCTION

## REGULAR POLICY CHANGE NUMBER: 24

PC 87 Two Plan Model
PC 88 County Organized Health Systems
PC 89 Geographic Managed Care
PC 92 MCO Enrollment Tax Mgd. Care Plans-Incr. Cap.Rates
PC 94 Regional Model
PC 97 Dental Managed Care (Other M/C)
PC 103 Managed Care Rate Range IGTs
PC 105 Managed Care Health Care Financing Program
PC 116 Managed Care Drug Rebates
PC 126 Dental Retroactive Rate Changes
PC 138 Extended Hospital QAF - Hospital Payments
PC 141 Physician Services Supplemental Payments
PC 169 Dental Services
PC 177 EPSDT Screens
PC 191 Funding Adjust.-OTLICP

**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 and extends the enhanced funding through the end of the Federal Fiscal year of 2017. Effective January 1, 2018, funding for the CHIP program will be exhausted, unless Congress takes action to both reauthorize the program and extend the funding. Given the uncertainty about what Congress will do, it is assumed that the program will be reauthorized but not at the enhanced amount.

**Reason for Change:**
The change from the prior estimate for FY 2017-18 is due to a change in the implementation date from October 1, 2017 to January 1, 2018. The Department removes and adds policy changes (PCs) based on applicable funding sources.

**Methodology:**
1. The Department identified funds allocated to CHIP beneficiaries in Title XXI funding.

2. The total fund after the adjustment of CHIP funding for all PCs is estimated as -$114,127,000 in FY 2017-18 and -$155,838,000 in FY 2018-19.

**Funding:**
50% Title XIX FF / 50% GF (4260-101-0001/0890)
65% Title XXI FF / 12% GF (4260-113-0890/0001)
88% Title XXI FF / 12% GF (4260-113-0890/0001)
Perinatal Insurance Fund (4260-602-0309)

# ACA OPTIONAL EXPANSION MLR RISK CORRIDOR

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 25 |
| IMPLEMENTATION DATE: | 5/2018 |
| ANALYST: | Andrew Yoo |
| FISCAL REFERENCE NUMBER: | 2064 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | -$176,600,000 | -$264,900,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$176,600,000 | -$264,900,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | -$176,600,000 | -$264,900,000 |

## 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.

**Reason for Change:**
This is a new policy change.

# ACA OPTIONAL EXPANSION MLR RISK CORRIDOR

## REGULAR POLICY CHANGE NUMBER: 25

**Methodology**:

1. MCPs will report data for the MLR corridor calculation for the following time periods:
   - 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 2017-18 and 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 of the above calculations. Upon completion and review of these calculations, it is anticipated applicable recoupments and/or paybacks of federal dollars are expect to occur in FY 2019-20.

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 $441.5 million will be recouped from the MCPs for the 18-month period. The Department anticipates $176.6 million to be recouped in FY 2017-18 and $264.9 million to be recouped in FY 2018-19.

7. The 12-month MLR period calculations and dollar estimates are unknown at this time.

(Dollars in Thousands)

| | TF | FF | GF |
|---|---|---|---|
| **FY 2017-18** | **($176,600)** | **($176,600)** | **$0** |
| **FY 2018-19** | **($264,900)** | **($264,900)** | **$0** |

**Funding**:

ACA 100% FFP (2014-2016)Title XIX 100% FF

# ACA DSH REDUCTION

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 26 |
| IMPLEMENTATION DATE: | 10/2017 |
| ANALYST: | Joy Oda |
| FISCAL REFERENCE NUMBER: | 1995 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | -$315,507,000 | -$547,222,000 |
| - STATE FUNDS | -$148,292,000 | -$259,739,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$315,507,000 | -$547,222,000 |
| STATE FUNDS | -$148,292,000 | -$259,739,500 |
| FEDERAL FUNDS | -$167,215,000 | -$287,482,500 |

## DESCRIPTION

**Purpose:**
This policy change estimates the reductions to Disproportionate Share Hospitals (DSHs), as required under the Affordable Care Act (ACA).

**Authority:**
Affordable Care Act (ACA), H.R. 3590, Section 2551 and H.R. 2, Section 412

**Interdependent Policy Changes:**
Not Applicable

**Background:**
The Affordable Care Act (ACA) requires the aggregate, nationwide reduction of the DSH allotments begin in FY 2017-18 in the amount of $2 billion, which represents a 4.65% national reduction. The original effective date was October 1, 2013; however, HR 2 (2015) delayed the start date of these reductions until October 1, 2017. Scheduled reductions for each federal fiscal year are expected to increase through Federal Fiscal Year 2025. The distribution of the aggregate reductions is determined by the Centers for Medicare & Medicaid Services (CMS).

The federal DSH allotment is available for uncompensated Medi-Cal and uninsured costs incurred by DSHs. The non-federal share of the payment is funded via the General Fund, certified public expenditures (CPEs), or intergovernmental transfers (IGTs). However, private hospitals receive Medi-Cal DSH replacement payment adjustments from Title XIX funding, along with $160.00 from the annual DSH allotment. The $160.00 of the annual DSH allotment satisfy the State's payment obligations under the Federal DSH statute. See the Private Hospital DSH Replacement, DSH Payment, and Global Payment Program (GPP) policy changes for more information.

# ACA DSH REDUCTION

## REGULAR POLICY CHANGE NUMBER: 26

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

- The estimated FY 2017-18 DSH allotment was reduced by $7 million based on updated data, and
- Revised assumptions to the California reduction based on the proposed DSH reduction as provided by CMS. The prior estimate reduction was estimated at 3.65% and is now estimated to be an 8.35% reduction.

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

- The DSH allotment for FY 2018-19 is expected increase by 2% over the FY 2017-18 allotment, and
- FY 2017-18 includes one DSH allotment reduction year, while FY 2018-19 includes two DSH allotment reduction years.

**Methodology:**

1. California's DSH allotment for FY 2017-18 is estimated to be $1.232 billion.

2. The FY 2018-19 DSH allotment is estimated to be $1.257 billion, assuming a 2.0% increase over the FY 2017-18 allotment.

3. California's reduction for FY 2017-18 is estimated to be an 8.35% decrease from the anticipated FY 2017-18 DSH allotment, resulting in a total reduction of $166.9 million FF for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs) in FY 2017-18. California's reduction for FY 2018-19 is estimated to be 8.35% with an allotment reduction of $250.3 million FF for NDPHs and DPHs. The DSH allotment reduction will offset DSH payments for NDPHs and DPHs in the DSH Payment (PC 144) and Global Payment Program (PC 73) policy changes.

4. The DSH allotment amount is applied in the DSH payment methodology to determine the reduction amount for the estimated aggregate DSH replacement funding. That amount is estimated to be $77.1 million TF for FY 2017-18 and $113.3 million TF for FY 2018-19. The Private DSH allotment reduction will offset Private DSH replacement payments in the Private Hospital DSH Replacement (PC 142) policy change.

5. The DSH allotment after the estimated 8.35% reduction is estimated to be $1.07 billion for FY 2017-18 and $1.01 billion for FY 2018-19 after an estimated 8.35% reduction.

6. Assume the following DSH reductions on an accrual basis:

(Dollars in Thousands)

| FY 2017-18 | TF | GF | FF | IGT |
|---|---|---|---|---|
| Private DSH (PC 142) | ($77,108) | ($38,554) | ($38,554) | $0 |
| DSH NDPH (PC 144) | ($3,658) | ($1,829) | ($1,829) | $0 |
| DSH UC (PC 144) | ($55,798) | $0 | ($38,221) | ($17,577) |
| GPP (PC 73) | ($253,764) | $0 | ($126,882) | ($126,882) |
| Total Reduction FY 2017-18 | ($390,328) | ($40,383) | ($205,486) | ($144,459) |

# ACA DSH REDUCTION

## REGULAR POLICY CHANGE NUMBER: 26

(Dollars in Thousands)

| FY 2018-19 | TF | GF | FF | IGT |
|---|---|---|---|---|
| Private DSH (PC 142) | ($113,292) | ($56,646) | ($56,646) | $0 |
| DSH NDPH (PC 144) | ($5,379) | ($2,690) | ($2,689) | $0 |
| DSH UC (PC 144) | ($80,087) | $0 | ($54,238) | ($25,849) |
| GPP (PC 73) | ($386,941) | $0 | ($193,470) | ($193,471) |
| Total Reduction FY 2018-19 | ($585,699) | ($59,336) | ($307,043) | ($219,320) |

7. Assume 11/12 of the FY 2017-18 DSH payment reduction will occur in FY 2017-18 and 1/12 will occur in FY 2018-19 for Private Hospital DSH Replacement, DSH NDPH, and DSH UC.

8. Assume 3/4 of the FY 2017-18 DSH payment reduction will occur in FY 2017-18 and 1/4 will occur in FY 2018-19 for GPP.

9. Assume 11/12 of the FY 2018-19 DSH payment reduction will occur in FY 2018-19 for Private Hospital DSH Replacement, DSH NDPH, and DSH UC.

10. Assume 3/4 of the FY 2018-19 payment reduction will occur in FY 2018-19 for GPP.

The aggregate DSH reduction is as follows on a cash basis:

| FY 2017-18 | TF | GF*** | FF | IGT |
|---|---|---|---|---|
| FY 2017-18 Private DSH (PC 142) | ($70,683,000) | ($35,342,000) | ($35,341,000) | $0 |
| FY 2017-18 DSH NDPH (PC 144) | ($3,353,000) | ($1,676,000) | ($1,677,000) | $0 |
| FY 2017-18 DSH UC (PC 144)* | ($51,148,000) | $0 | ($35,036,000) | ($16,112,000) |
| FY 2017-18 GPP (PC 73)** | ($190,323,000) | $0 | ($95,161,000) | ($95,162,000) |
| **Total Reduction FY 2017-18** | **($315,507,000)** | **($37,018,000)** | **($167,215,000)** | **($111,274,000)** |

| FY 2018-19 | TF | GF*** | FF | IGT |
|---|---|---|---|---|
| FY 2017-18 Private DSH (PC 142) | ($6,426,000) | ($3,213,000) | ($3,213,000) | $0 |
| FY 2017-18 DSH NDPH (PC 144) | ($305,000) | ($152,000) | ($153,000) | $0 |
| FY 2017-18 DSH UC (PC 144)* | ($4,650,000) | $0 | ($3,185,000) | ($1,465,000) |
| FY 2017-18 GPP (PC 73)** | ($63,441,000) | $0 | ($31,720,000) | ($31,721,000) |
| FY 2018-19 Private DSH (PC 142) | ($103,851,000) | ($51,926,000) | ($51,925,000) | $0 |
| FY 2018-19 DSH NDPH (PC 144) | ($4,931,000) | ($2,466,000) | ($2,465,000) | $0 |
| FY 2018-19 DSH UC (PC 144)* | ($73,412,000) | $0 | ($49,718,000) | ($23,694,000) |
| FY 2018-19 GPP (PC 73)** | ($290,206,000) | $0 | ($145,103,000) | ($145,103,000) |
| **Total Reduction FY 2018-19** | **($547,222,000)** | **($57,757,000)** | **($287,482,000)** | **($201,983,000)** |

**Funding:**
100% Demonstration DSH Fund (4260-601-7502)*
100% Title XIX FFP (4260-101-0890)
50% MIPA Fund / 50% Title XIX (4260-606-0834/0890)*
100% Global Payment Program Special Fund (4260-601-8108)**
50% GF / 50% Title XIX (4260-101-0001/0890)***

# 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 | $402,206,000 | $377,323,000 |
| - STATE FUNDS | $175,958,400 | $165,071,480 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $402,206,000 | $377,323,000 |
| STATE FUNDS | $175,958,400 | $165,071,480 |
| FEDERAL FUNDS | $226,247,600 | $212,251,520 |

## DESCRIPTION

**Purpose:**
This policy change estimates the costs for providing Behavioral Health Treatment (BHT) services under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) 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

**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 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

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, is an increase due to the following:

- FFS and managed care costs for the DDS transition clients, previously budgeted in a separate policy change titled Behavioral Health Treatment – DDS Transition, are now included in this policy change.
- FFS – The current estimate assumes a higher annual cost based on updated actual data, and more monthly payments to be paid in FY 2017-18 than the prior estimate.
- Managed Care – The number of projected FY 2016-17 and FY 2017-18 supplemental capitation payments have increased based on actual claims data.

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

- For managed care, FY 2017-18 costs include higher supplemental capitation payments for FY 2016-17.
- For FFS, FY 2018-19 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 on July 7, 2017. DDS began submitting claims on a monthly basis in November 2017 and payments began in December 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 $9,001,000 TF, and $9,428,000 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 | $9,001 | $7,501 | $1,500 |
| FY 2018-19 claims | $9,428 | $0 | $7,857 |
| Total | | $7,501 | $9,357 |

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 24,603 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 140,554.

FY 2016-17: 140,554 x $2,152.77 = $302,580,000 TF

9. Assume 25,506 members received 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 145,713.

FY 2017-18: 145,713 x $2,368.05 = $345,056,000 TF

10. Assume 26,442 members received BHT services in FY 2018-19; not all members received BHT services each month. The estimated number of supplemental capitation payments for FY 2018-19 is 151,060.

FY 2018-19: 151,060 x $2,486.45 = $375,603,000 TF

11. Due to the supplemental capitation payment methodology, assume the following payment lags:
    - For FY 2016-17, assume 55.08% of payments was paid in the same fiscal year and 44.92% 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 | $302,580 | $135,913 | $0 |
| FY 2017-18 - FFS | $9,001 | $7,501 | $1,500 |
| FY 2017-18 - MC | $345,056 | $258,792 | $86,264 |
| FY 2018-19 - FFS | $9,428 | $0 | $7,857 |
| FY 2018-19 - MC | $375,603 | $0 | $281,702 |
| Total | $1,041,668 | $402,206 | $377,323 |

# BEHAVIORAL HEALTH TREATMENT

## REGULAR POLICY CHANGE NUMBER: 27

(Dollars in Thousands)

| FY 2017-18 | TF | GF | FF XIX | FF XXI |
|---|---|---|---|---|
| Fee-for-Service | $7,501 | $3,282 | $3,133 | $1,086 |
| Managed Care | $394,705 | $172,676 | $164,885 | $57,144 |
| **Total** | **$402,206** | **$175,958** | **$168,018** | **$58,230** |

| FY 2018-19 | TF | GF | FF XIX | FF XXI |
|---|---|---|---|---|
| Fee-for-Service | $9,357 | $4,093 | $3,909 | $1,355 |
| Managed Care | $367,966 | $160,978 | $153,715 | $53,273 |
| **Total** | **$377,323** | **$165,071** | **$157,624** | **$54,628** |

**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 | $338,916,000 | $344,391,000 |
| - STATE FUNDS | $81,598,700 | $82,917,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $338,916,000 | $344,391,000 |
| STATE FUNDS | $81,598,700 | $82,917,000 |
| FEDERAL FUNDS | $257,317,300 | $261,474,000 |

## 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 increase from the prior estimate, for FY 2017-18, is due to an increase in claims in the Other Medical service category. 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 July 2017 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 TF | FY 2017-18 GF | FY 2018-19 TF | FY 2018-19 GF |
|---|---|---|---|---|
| Physicians | $ 66,459 | $ 16,001 | $ 70,629 | $ 17,005 |
| Other Medical | $ 222,120 | $ 53,478 | $ 221,727 | $ 53,384 |
| Co. & Comm. Outpatient | $ 2,128 | $ 512 | $ 2,146 | $ 517 |
| Pharmacy | $ 48,209 | $ 11,607 | $ 49,889 | $ 12,011 |
| **Total** | **$ 338,916** | **$ 81,598** | **$ 344,391** | **$ 82,917** |

**Funding:**

(Dollars in Thousands)

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| 50% Title XIX / 50% GF (4260-101-0001/0890) | $ 12,890 | $ 6,445 | $ 6,445 |
| 100% GF (4260-101-0001) | $ 47,279 | $ 47,279 | $ - |
| 90% Family Planning / 10% GF (4260-101-0001/0890) | $ 278,747 | $ 27,875 | $ 250,872 |
| **Total** | **$ 338,916** | **$ 81,599** | **$ 257,317** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| 50% Title XIX / 50% GF (4260-101-0001/0890) | $ 13,098 | $ 6,549 | $ 6,549 |
| 100% GF (4260-101-0001) | $ 48,043 | $ 48,043 | $ - |
| 90% Family Planning / 10% GF (4260-101-0001/0890) | $ 283,250 | $ 28,325 | $ 254,925 |
| **Total** | **$ 344,391** | **$ 82,917** | **$ 261,474** |

# ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 29 |
| IMPLEMENTATION DATE: | 5/2013 |
| ANALYST: | Joel Singh |
| FISCAL REFERENCE NUMBER: | 1476 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $321,681,000 | $262,906,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $321,681,000 | $262,906,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $321,681,000 | $262,906,000 |

## 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 from the prior estimate, for FY 2017-18, is an increase based on the revised estimate including a higher number of prior year expenditures. The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to 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** | $643,361 | $321,680 | **$321,681** |
| **FY 2018-19** | $525,811 | $262,905 | **$262,906** |

**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 | $120,851,000 | $125,020,000 |
| - STATE FUNDS | $5,213,000 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $120,851,000 | $125,020,000 |
| STATE FUNDS | $5,213,000 | $0 |
| FEDERAL FUNDS | $115,638,000 | $125,020,000 |

## 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, 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 net decrease due to:

- Updated paid claims data for FY 2017-18,
- Updated FY 2017-18 Rate Inflation,
- Updated Withholds due to LEAs,
- Addition of speech therapy claims,
- Addition of FY 2017-18 Reconciliation due to State,
- Delay of FY 2015-16 Withholds due to LEAs to FY 2018-19, and
- Addition of General Funds (GF) to repay federal funds as a result of an audit.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to the reconciliation in FY 2017-18 and the delay to FY 2018-19 of the FY 2015-16 withholds due to the LEAs.

# 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 will repay CMS with General Fund (GF). 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.

| FY 2017-18 | TF | GF | FF (Title XIX) | FF (Title XXI) |
|---|---|---|---|---|
| FY 2017-18 Interim Payments | $123,197,000 | $0 | $123,197,000 | $0 |
| FY 2017-18 Rate Inflation | $1,332,000 | $0 | $1,332,000 | $0 |
| FY 2014-15 Withholds due to the LEAs | $2,254,000 | $0 | $2,254,000 | $0 |
| FY 2017-18 Speech Therapy EPCs to LEAs | $4,000,000 | $0 | $4,000,000 | $0 |
| FY 2014-15 Withholds due to State | ($79,000) | $0 | ($79,000) | $0 |
| FY 2017-18 Reconciliation due to State | ($9,853,000) | $0 | ($9,853,000) | $0 |
| FY 2017-18 GF Impact-MGO Audit | $0 | $5,213,000 | $0 | ($5,213,000) |
| **FY 2017-18 Total** | **$120,851,000** | **$5,213,000** | **$120,851,000** | **($5,213,000)** |

| FY 2018-19 | TF | FF (Title XIX) |
|---|---|---|
| FY 2018-19 Interim Payments | $123,143,000 | $123,143,000 |
| 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** | **$125,020,000** | **$125,020,00** |

**Funding:**

100% Title XIX FF (4260-101-0890)
100% GF (4260-101-0001)
100% Title XXI FF (4260-113-0890)

# 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 | $78,459,000 |
| - STATE FUNDS | $18,388,320 | $35,490,680 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $40,718,000 | $78,459,000 |
| STATE FUNDS | $18,388,320 | $35,490,680 |
| FEDERAL FUNDS | $22,329,680 | $42,968,320 |

## 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 2018.

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is an increase due to a higher HPSM 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 and a higher HPSM capitation rate.

**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 $1,596.11 and $1,676.92, 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 | $1,596.11 | $3,192,220 | $38,307,000 |
| **FY 2018-19** | 2,000 | $1,676.92 | $3,353,840 | $40,246,000 |

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** | $42,657,000 | $40,246,000 | $ 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 | $7,458.75 | $2,983,499 | $35,802,000 |

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** | $78,459,000 | $35,802,000 | $42,657,000 |

**Funding:**

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| 50% Title XIX / 50% GF (4260-101-0001/0890) | $35,532,000 | $17,766,000 | $17,766,000 |
| 88% Title XXI / 12% GF (4260-113-0001/0890) | $5,186,000 | $622,000 | $4,564,000 |
| **Total** | **$40,718,000** | **$18,388,000** | **$22,330,000** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| 50% Title XIX / 50% GF (4260-101-0001/0890) | $68,620,000 | $34,310,000 | $34,310,000 |
| 88% Title XXI / 12% GF (4260-113-0001/0890) | $9,839,000 | $1,181,000 | $8,658,000 |
| **Total** | **$78,459,000** | **$35,491,000** | **$42,968,000** |

# 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 | $39,778,000 | $39,778,000 |
| - STATE FUNDS | $19,889,000 | $19,889,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $39,778,000 | $39,778,000 |
| STATE FUNDS | $19,889,000 | $19,889,000 |
| FEDERAL FUNDS | $19,889,000 | $19,889,000 |

## 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 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:**
There is no change from the prior estimate for FY 2017-18. 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** | **$39,778** | $19,889 | $19,889 |
| **FY 2018-19** | **$39,778** | $19,889 | $19,889 |

**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 | $37,792,000 | $37,792,000 |
| - STATE FUNDS | $8,524,000 | $8,524,000 |
| PAYMENT LAG | 0.9430 | 0.9430 |
| % REFLECTED IN BASE | 20.58 % | 18.54 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $28,303,600 | $29,030,600 |
| STATE FUNDS | $6,383,880 | $6,547,860 |
| FEDERAL FUNDS | $21,919,700 | $22,482,740 |

## 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 increase from the prior estimate, for FY 2017-18, is due to updated claims data. There is no change in the current estimate from FY 2017-18 to FY 2018-19.

**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.

# ANNUAL CONTRACEPTIVE COVERAGE

## REGULAR POLICY CHANGE NUMBER: 33

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. Total costs for onsite dispensing at 340B clinics is estimated to be $15,500,000 TF ($3,496,000 GF).

Fee-for-Service Pharmacies

7. Pharmacies currently dispense a 90-day supply for oral contraceptives and hormonal patches and rings. Assume all clients will opt-in for a 12-month supply with providers billing at the maximum allowable rate.
8. Total costs for onsite dispensing at pharmacies is estimated to be $63,314,000 TF ($14,280,000 GF).
9. Pharmacy dispensing fee savings as a result of clients getting annual supply of contraceptives instead of every 90 days is estimated to be $6,833,000 TF ($1,541,000 GF).
10. Pharmacy rebate savings due to utilization increase for oral contraceptives, and hormonal patch and ring are $34,189,000 TF ($7,711,000 GF).

11. The net cost impact due to the contraceptive coverage expansion is:

(Dollars in Thousands)

| **Annual Cost** | **TF** | **GF** | **FF** |
|---|---|---|---|
| 340B - Onsite Dispensing | $ 15,500 | $ 3,496 | $ 12,004 |
| Pharmacy Costs | $ 63,314 | $ 14,280 | $ 49,034 |
| Dispensing Fee Savings | $ (6,833) | $ (1,541) | $ (5,292) |
| Rebate Savings | $ (34,189) | $ (7,711) | $ (26,478) |
| **Net Cost** | **$ 37,792** | **$ 8,524** | **$ 29,268** |

**Funding:**

(Dollars in Thousands)

| **FY 2017-18** | **TF** | **GF** | **FF** |
|---|---|---|---|
| 90% Title XIX / 10% GF (4260-101-0890/0001) | $ 32,520 | $ 3,252 | $ 29,268 |
| 100% GF (4260-101-0001) | $ 5,272 | $ 5,272 | $ - |
| **Total** | **$ 37,792** | **$ 8,524** | **$ 29,268** |

| **FY 2018-19** | **TF** | **GF** | **FF** |
|---|---|---|---|
| 90% Title XIX / 10% GF (4260-101-0890/0001) | $ 32,520 | $ 3,252 | $ 29,268 |
| 100% GF (4260-101-0001) | $ 5,272 | $ 5,272 | $ - |
| **Total** | **$ 37,792** | **$ 8,524** | **$ 29,268** |

# 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 | $12,953,000 | $8,048,000 |
| - STATE FUNDS | $2,099,000 | $1,860,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $12,953,000 | $8,048,000 |
| STATE FUNDS | $2,099,000 | $1,860,000 |
| FEDERAL FUNDS | $10,854,000 | $6,188,000 |

## 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 498 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 a decrease due to lower DD beneficiaries transitioning from January through June 2017. 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 $77,183 in FY 2017-18 and $76,373 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 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.

6. 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.

7. 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** | **$12,953,000** | **$2,099,000** | **$10,854,000** |
| | | | |
| CCT Savings: | | | |
| Total Non-DD GF savings and Total FFP* | ($28,828,000) | ($14,414,000) | ($14,414,000) |
| | | | |
| CCT Fund Transfer to CDSS & CDDS (PC 41) | $918,000 | $0 | $918,000 |
| CCT Outreach - Admin costs (OA 44) | $342,000 | $0 | $342,000 |
| | | | |
| Total of CCT PCs including pass through | ($14,615,000) | ($12,315,000) | ($2,300,000) |

*The savings are included in the total, however, they are fully reflected in the base estimates.

# CALIFORNIA COMMUNITY TRANSITIONS COSTS

## REGULAR POLICY CHANGE NUMBER: 34

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| **CCT Costs (PC 34):** | | | |
| **Total Non-DD GF costs and Total FFP** | **$8,048,000** | **$1,860,000** | **$6,188,000** |
| | | | |
| CCT Savings: | | | |
| Total Non-DD GF savings and Total FFP* | ($28,201,000) | ($14,100,000) | ($14,101,000) |
| | | | |
| CCT Fund Transfer to CDSS & CDDS (PC 41) | $191,000 | $0 | $191,000 |
| CCT Outreach - Admin costs (OA 44) | $342,000 | $0 | $342,000 |
| | | | |
| Total of CCT PCs including pass through | ($19,620,000) | ($12,240,000) | ($7,380,000) |

*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 | $9,601,000 | $9,231,000 |
| - STATE FUNDS | $4,800,500 | $4,615,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $9,601,000 | $9,231,000 |
| STATE FUNDS | $4,800,500 | $4,615,500 |
| FEDERAL FUNDS | $4,800,500 | $4,615,500 |

## 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. 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 a net increase due to updated data showing a projected increase in utilization with Domain 4 included. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to estimating that Domain 4 will have less costs in FY 2018-19.

**Methodology:**

1. Domain 1: Assume that utilization will increase by 2% per year for each year of the DTI. The increase in utilization will result in an increase in costs due to additional services being performed. Costs for the base procedure due to the utilization increase will not be absorbed by the DTI incentive payments and will be accounted for based on the number of procedures for each CDT code multiplied by the schedule of maximum allowances.

   Total Domain 1 costs are expected to be $44,611,000 TF in FY 2016-17 and $63,328,000 TF in FY 2017-18.

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 $774,000 TF in FY 2016-17 and $1,568,000 TF in FY 2017-18.

4. Domain 4: Assume a 5% utilization increase within the target population multiplied by the average cost per use.

5. This PC budgets the costs for the non-capitated FFS population. 10% of the overall dental population falls under non-capitated FFS.

| | TF | GF | FF |
|---|---|---|---|
| **Domain 1** | $3,282,000 | $1,641,000 | $1,641,000 |
| **Domain 3** | $284,000 | $142,000 | $142,000 |
| **Domain 4** | $6,035,000 | $3,017,500 | $3,017,500 |
| **FY 2017-18** | **$9,601,000** | **$4,800,500** | **$4,800,500** |

| | TF | GF | FF |
|---|---|---|---|
| **Domain 1** | $4,525,000 | $2,262,500 | $2,262,500 |
| **Domain 3** | $367,000 | $183,500 | $183,500 |
| **Domain 4** | $4,339,000 | $2,169,500 | $2,169,500 |
| **FY 2018-19** | **$9,231,000** | **$4,615,500** | **$4,615,500** |

**Funding:**
50% Title XIX / 50% GF (4260-101-0001/0890)
OTLICP funding identified in PC 194 Funding Adjust.—OTLICP

# 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 | $8,473,000 | $21,224,000 |
| - STATE FUNDS | $4,236,500 | $10,612,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $8,473,000 | $21,224,000 |
| STATE FUNDS | $4,236,500 | $10,612,000 |
| FEDERAL FUNDS | $4,236,500 | $10,612,000 |

## DESCRIPTION

**Purpose:**
The policy change estimates the cost of fully restoring adult dental benefits to the Medi-Cal Dental Program. This proposal would increase 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 will include 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:**
Overall costs increased from the prior estimate; however due to a majority of the beneficiaries receiving a capitated rate, the cost for those beneficiaries is captured in the Dental Services and Dental Managed Care PCs instead. Therefore, the change from the prior estimate, for FY 2017-18, is a net decrease since this PC now only reflects only the costs attributable to the non-capitated population. 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 a full year of expenditures in FY 2018-19.

# FULL RESTORATION OF ADULT DENTAL BENEFITS

## REGULAR POLICY CHANGE NUMBER: 36

**Methodology:**

1. Data regarding the number of incidences, number of users, and total reimbursement rates from January 1, 2008 through December 31, 2008 were pulled and were specific to adult beneficiaries ages 21 and older.

2. A percentage increase was applied to account for population growth and the resultant increased number of users.

3. Assume this policy will be implemented on 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.

| Fiscal Year | TF | GF | FF |
|---|---|---|---|
| FY 2017-18 | $84,730,000 | $31,673,000 | $53,057,000 |
| FY 2018-19 | $212,240,000 | $79,522,000 | $132,718,000 |

Total Cost of the Policy Change

This policy change shows the full cost of the policy, but only budgets the costs for the non-capitated FFS population. 10% of the overall dental population falls under non-capitated FFS.

| Fiscal Year | TF | GF | FF |
|---|---|---|---|
| FY 2017-18 | $8,473,000 | $4,236,500 | $4,236,500 |
| FY 2018-19 | $21,224,000 | $10,612,000 | $10,612,000 |

**Funding:**

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

# DENTAL BENEFICIARY OUTREACH EFFORTS

| | |
|---|---|
| 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 | $4,314,000 | $9,228,000 |
| - STATE FUNDS | $2,157,000 | $4,614,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $4,314,000 | $9,228,000 |
| STATE FUNDS | $2,157,000 | $4,614,000 |
| FEDERAL FUNDS | $2,157,000 | $4,614,000 |

## 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.

The majority of dental fee-for-service (FFS) is 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:**
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 FI contractor to develop an annual dental outreach and education program, as required by the provisions of the current FI contract and WIC Section 14132.91. Outreach activities outlined in the current FI and the future 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,

# DENTAL BENEFICIARY OUTREACH EFFORTS

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- 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,
- 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:**
This is a new policy change. However, this policy change incorporates and combines the outreach efforts as outlined previously in Dental Beneficiary Outreach and Education Program and Dental Children's Outreach Ages 0-3 policy changes. The overall cost for the utilization for these outreach efforts has decreased from the prior estimate primarily due to a change in the focus of the efforts in the Dental Beneficiary Outreach and Education Program to a more targeted approach with a larger emphasis on mailers as opposed to live calls.

The change from FY 2017-18 to FY 2018-19 in the current estimate, is due to a higher utilization rate 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.

2. This PC shows the full cost of the policy, but only budgets the costs for the non-capitated FFS population. 10% of the overall dental population falls under non-capitated FFS. Assume non-capitated payments will occur one month after the utilization increase takes effect.

(Dollars in thousands)

| Fiscal Year | TF | GF | FF |
|---|---|---|---|
| FY 2017-18 | $4,314 | $2,157 | $2,157 |
| FY 2018-19 | $9,228 | $4,614 | $4,614 |

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

# 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 | $3,233,000 | $4,853,000 |
| - STATE FUNDS | -$25,000 | $25,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $3,233,000 | $4,853,000 |
| STATE FUNDS | -$25,000 | $25,000 |
| FEDERAL FUNDS | $3,258,000 | $4,828,000 |

## 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 delay in the implementation of a new YRTC facility. The YRTC facility opened in July 2017 versus March 2017. Also, the estimated enrollment decreased from 20 to 16. The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to an updated federal register rate adjustment which increased the daily rate by about 4%.

**Methodology:**
1. The program was implemented January 2014 with an effective date of September 1, 2013.

2. A new in-state YRTC opened in July 2017 with an estimated average monthly enrollment of 16 Medi-Cal beneficiaries.

# YOUTH REGIONAL TREATMENT CENTERS

## REGULAR POLICY CHANGE NUMBER: 38

3. Assume enrollment will be phased in over a six-month period and payments will begin in August 2017.

4. Assume CY 2017 daily rate per youth is $782, $814 in CY 2018, and $848 in CY 2019.

   CY 2017: $782 daily rate x 365 days ÷ 12 months = $23,786 monthly
   CY 2018: $814 daily rate x 365 days ÷ 12 months = $24,759 monthly
   CY 2019: $848 daily rate x 365 days ÷ 12 months = $25,793 monthly

**FY 2017-18**
CY 2017 enrollee costs:
36 enrollee months phase-in x $23,786 = $856,000
16 enrollees x 6 months x $24,759 = $2,377,000

$856,000 + $2,377,000 = **$3,233,000 TF**

**FY 2018-19**
Monthly enrollee costs:
16 enrollees x 6 months x $24,759 = $2,377,000
16 enrollees x 6 months x $25,793 = $2,476,000

$2,377,000 + $2,476,000 = **$4,853,000 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 $594,000 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 | $343,000 | $0 | $343,000 |
| Oct - Dec 2017 | $514,000 | $0 | $514,000 |
| Jan - Mar 2018 | $1,188,000 | $0 | $1,188,000 |
| **Apr - Jun 2018 | $1,188,000 | $594,000 | $594,000 |
| **Total** | **$3,233,000** | **($25,000)** | **$3,258,000** |

| FY 2018-19 | TF | GF | FFP |
|---|---|---|---|
| *Apr - June 2018 | $0 | ($594,000) | $594,000 |
| Jul - Sep 2018 | $1,189,000 | $0 | $1,189,000 |
| Oct - Dec 2018 | $1,189,000 | $0 | $1,189,000 |
| Jan - Mar 2019 | $1,238,000 | $0 | $1,238,000 |
| **Apr - Jun 2019 | $1,238,000 | $619,000 | $619,000 |
| **Total** | **$4,854,000** | **$25,000** | **$4,829,000** |

*Totals may differ due to rounding

* FFP reimbursement from previous quarter
** FFP to be reimbursed in the following fiscal year

# YOUTH REGIONAL TREATMENT CENTERS

## REGULAR POLICY CHANGE NUMBER: 38

**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: | Matt Wong |
| FISCAL REFERENCE NUMBER: | 1787 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $3,245,000 | $3,692,000 |
| - STATE FUNDS | $1,484,940 | $1,670,060 |
| PAYMENT LAG | 0.8890 | 0.9450 |
| % REFLECTED IN BASE | 54.52 % | 47.96 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $1,312,000 | $1,815,600 |
| STATE FUNDS | $600,390 | $821,300 |
| FEDERAL FUNDS | $711,620 | $994,340 |

## 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 beginning April 1, 2009, through December 26, 2017, 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 2014-15. The Department transferred processing of claims 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 current PPC Waiver term expires on December 26, 2017, and the Department is in the process of completing a waiver renewal application to request a new five year waiver term. As part of the renewal process the Department is proposing to transition the waiver to an Organized Health Care Delivery System (OHCDS) model. The Department will contract with Waiver Agencies for the purpose of performing waiver administration functions and directing the Enhanced Care Management service. The Department and the Counties will maintain an active role in waiver administration by determining waiver participant eligibility, authorizing services, setting enrollment goals, and providing continuous, ongoing monitoring and oversight. These changes will require the Department to develop a per member per month administrative fee and Enhanced Care Management payment to be claimed by waiver agencies, upon the effective date of the new waiver term. The waiver renewal application will not request continuance of the supplemental payment.

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is a decrease due to the reduction in back payments for underpaid claims in the current year 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 210 members were enrolled in PPCW for FY 2017-18 prior to caseload expansion.

   210 members x 12 months = 2,520 member months (MM) prior to caseload expansion.

2. Assume caseload expanding to 332 members incrementally by the end of FY 2017-18 and 382 members incrementally by the end of FY 2018-19.

   For FY 2017-18 caseload expansion includes an additional 554 MM.

   For FY 2018-19 caseload expansion includes an additional 1,189 MM.

3. For FY 2017-18, assume a $300 PMPM cost at 50% FFP for supplemental payments paid through December 30, 2017.

   1,260 MM x $300 PMPM = $378,000 TF (prior to caseload expansion)

   72 MM x $300 PMPM = $22,000 (FY 2016-17 caseload expansion)

   $378,000 + $22,000 = $400,000 TF (rounded)

4. For FY 2017-18, starting January 1, 2018, assume an administrative payment of $165 PMPM will be paid to providers at 50% FFP.

# PEDIATRIC PALLIATIVE CARE WAIVER

## REGULAR POLICY CHANGE NUMBER: 39

1,260 MM x $165 PMPM = $208,000 TF (prior to caseload expansion)

482 MM x $165 PMPM = $79,000 (FY 2017-18 caseload expansion)

$208,000 + $79,000 = $287,000 TF (rounded)

5. For FY 2018-19, assume an administrative payment of $165 PMPM will be paid to providers at 50% FFP.

   2,520 MM x $165 PMPM = $416,000 TF (prior to caseload expansion)

   1,743 MM x $165 PMPM = $288,000 (FY 2018-19 caseload expansion)

   $416,000 + $288,000 = $704,000 TF (rounded)

6. Assume an average claims payment of $701 PMPM.

   For FY 2017-18: (2,520 MM + 554 MM) x $701 = $2,155,000 TF (rounded)

   For FY 2018-19: (2,520 MM + 1,743 MM) x $701 = $2,988,000 TF (rounded)

7. Assume $402,721 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.

8. Total estimated PPCW costs are:

   **FY 2017-18: $3,245,000 TF ($1,484,940 GF)**

   **FY 2018-19: $3,692,000 TF ($1,670,060 GF)**

**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: | 1/2018 |
| ANALYST: | Randolph Alarcio |
| FISCAL REFERENCE NUMBER: | 2046 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $1,000,000 | $2,000,000 |
| - STATE FUNDS | $1,000,000 | $2,000,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $1,000,000 | $2,000,000 |
| STATE FUNDS | $1,000,000 | $2,000,000 |
| 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:**
The change from the prior estimate, for FY 2017-18, is a decrease due to the cost being adjusted for a January 2018 start date. 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:**
1. Assume the Pilot will begin in January 2018.

# MEDICALLY TAILORED MEALS PILOT PROGRAM

## REGULAR POLICY CHANGE NUMBER: 40

2. Assume the cost for FY 2017-18 is $1,000,000 TF and $2,000,000 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 | $918,000 | $191,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $918,000 | $191,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $918,000 | $191,000 |

## 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, is a decrease due to lower DD beneficiaries transitioning from January through June 2017. 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 23% 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 | $238,000 | $116,000 |
| CDDS | $680,000 | $75,000 |
| **Total** | **$918,000** | **$191,000** |

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| CCT Costs (PC 34): | | | |
| Total Non-DD GF costs and Total FFP | $12,953,000 | $2,099,000 | $10,854,000 |
| | | | |
| CCT Savings: | | | |
| Total Non-DD GF savings and Total FFP | ($28,828,000) | ($14,414,000) | ($14,414,000) |
| | | | |
| **CCT Fund Transfer to CDSS & CDDS (PC 41)** | **$918,000** | **$0** | **$918,000** |
| CCT Outreach - Admin costs (OA 44) | $342,000 | $0 | $342,000 |
| | | | |
| Total of CCT PCs including pass through | ($14,615,000) | ($12,315,000) | ($2,300,000) |

*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 | $8,048,000 | $1,860,000 | $6,188,000 |
| | | | |
| CCT Savings: | | | |
| Total Non-DD GF savings and Total FFP | ($28,201,000) | ($14,100,000) | ($14,101,000) |
| | | | |
| **CCT Fund Transfer to CDSS & CDDS (PC 41)** | **$191,000** | **$0** | **$191,000** |
| CCT Outreach - Admin costs (OA 44) | $342,000 | $0 | $342,000 |
| | | | |
| Total of CCT PCs including pass through | ($19,620,000) | ($12,240,000) | ($7,380,000) |

*The savings are included in the total, however, they are fully reflected in the base estimates.

**Funding:**
MFP Federal Grant (4260-106-0890)

# END OF LIFE SERVICES

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 42 |
| IMPLEMENTATION DATE: | 3/2017 |
| ANALYST: | Joel Singh |
| FISCAL REFERENCE NUMBER: | 1943 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $140,000 | $140,000 |
| - STATE FUNDS | $140,000 | $140,000 |
| PAYMENT LAG | 0.9945 | 1.0000 |
| % REFLECTED IN BASE | 53.27 % | 67.64 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $65,100 | $45,300 |
| STATE FUNDS | $65,060 | $45,300 |
| FEDERAL FUNDS | $0 | $0 |

## DESCRIPTION

**Purpose:**
This policy change estimates the cost associated with the End of Life Option Act.

**Authority:**
ABX2 15 (Chapter 1, Statutes of 2015)

**Interdependent Policy Changes:**
Not Applicable

**Background:**
Effective June 9, 2016, ABX2 15 allows terminally-ill adult patients, who meet certain qualifications, and who have been determined by their attending physician to be suffering from a terminal disease, to make a voluntary request for a prescription for an aid-in-dying drug for the purpose of ending their life. Two physicians, attending and consulting, are required to perform various activities, including confirming the terminal diagnosis and prognosis, and determining whether patients have the capacity to make medical decisions. In certain cases, a psychiatrist evaluation will be required. The Act sunsets on January 1, 2026.

**Reason for Change:**
The change from prior estimate, for FY 2017-18, is due to a lower projection of End of Life services utilization based on updated actual data.

There is no change from FY 2017-18 to FY 2018-19 in the current estimate.

**Methodology:**
1. Payments for End of Life services began in March 2017.

2. Assume 24 beneficiaries will request End of Life services in FY 2017-18 and FY 2018-19.

3. Two physician visits are required, per beneficiary, at a cost of $69.59 per visit.

# END OF LIFE SERVICES

## REGULAR POLICY CHANGE NUMBER: 42

4. One consulting physician visit is required, per beneficiary, at a cost of $59.50 per visit.

5. Assume two visits are required for beneficiaries that get referred for mental health evaluations, at a cost of $128.08 per visit. Assume all beneficiaries will receive mental health evaluations.

6. Assume the End of Life drug cost, per beneficiary, is $5,403.

7. Assume all beneficiaries will complete the entire process in order to obtain the End of Life prescription drug, regardless of the final decision to take, or not to take, the medication.

8. Costs for End of Life services are estimated to be:

| End of Life Benefits | FY 2017-18 | | FY 2018-19 | |
|---|---|---|---|---|
| | TF | GF | TF | GF |
| Physician Visit (2 Visits) | $3,000 | $3,000 | $3,000 | $3,000 |
| Consulting Physician (1 Visit) | $1,000 | $1,000 | $1,000 | $1,000 |
| Psychiatrist (2 Visits) | $6,000 | $6,000 | $6,000 | $6,000 |
| Cost for End of Life Drug | $130,000 | $130,000 | $130,000 | $130,000 |
| **Total** | **$140,000** | **$140,000** | **$140,000** | **$140,000** |

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

# 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 | $53,000 | $0 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $53,000 | $0 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $53,000 | $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 (HCBS) 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 (RCFEs), Adult Residential Facilities (ARFs), or in residency units made available by the Direct Access to Housing (DAH) 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 a slight decrease in the average monthly cost per eligible. 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.

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

# BEHAVIORAL HEALTH TREATMENT - BIS DDS TRANSITION

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 44 |
| IMPLEMENTATION DATE: | 5/2018 |
| ANALYST: | Joel Singh |
| FISCAL REFERENCE NUMBER: | 2041 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $911,000 | $94,006,000 |
| - STATE FUNDS | $398,500 | $41,125,920 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $911,000 | $94,006,000 |
| STATE FUNDS | $398,500 | $41,125,920 |
| FEDERAL FUNDS | $512,500 | $52,880,080 |

## DESCRIPTION

**Purpose:**
This policy change estimates the costs for transitioning additional Regional Center (RC) clients, who have been receiving Behavioral Health Treatment (BHT)/ Behavioral Intervention Services (BIS) 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 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

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, began transitioning responsibility for BHT services starting February 1, 2016. The transition was completed in September 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 will start transitioning these additional RC clients to Medi-Cal for BHT/BIS.

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

- The payment date for FFS clients shifted from January 2018 to May 2018.
- The number of FFS clients transitioning was revised from 280 to 602.
- The projected transition date for managed care clients shifted from January 2018 to July 2018.

The change in the current estimate, from FY 2017-18 to FY 2018-19, is due to no BHT/BIS managed care costs in FY 2017-18. Additionally, the number of beneficiaries transitioning for managed care has been revised from 1,720 to 3,947.

**Methodology:**

1. An estimated 4,549 beneficiaries will transition into the Medi-Cal BHT program, of which 602 will transition into fee-for-service (FFS) and 3,947 will transition into managed care.

Fee-for-Service

2. Assume 602 FFS beneficiaries will transition 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 March 2018. DDS will submit claims on a monthly basis and payments are expected to begin in May 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 $1,821,000 TF, and $5,723,000 TF for FY 2018-19.

6. On a cash basis, FFS reimbursements are estimated to be paid as follows:

| Fee-for-Service Claims | Accrual | FY 2017-18 | FY 2018-19 |
|---|---|---|---|
| FY 2017-18 claims | $1,821,000 | $911,000 | $910,000 |
| FY 2018-19 claims | $5,723,000 | $0 | $4,770,000 |
| **Total** | | **$911,000** | **$5,680,000** |

Managed Care

7. Assume 3,947 managed care beneficiaries will transition on July 1, 2018.

8. The estimated monthly capitation rate for BHT/BIS supplemental payments is $2,486.45 for FY 2018-19.

# BEHAVIORAL HEALTH TREATMENT - BIS DDS TRANSITION

## REGULAR POLICY CHANGE NUMBER: 44

9. Assume all 3,947 members will receive BHT/BIS services in FY 2018-19. The estimated number of supplemental capitation payments for FY 2018-19 is 47,364.

   FY 2018-19: 47,364 x $2,486.45 = $117,768,000 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 $88,326,000 TF.

12. Total estimated payments are:

| FY 2017-18 | TF | GF | Title XIX | Title XXI |
|---|---|---|---|---|
| Fee-for-Service | $911,000 | $398,000 | $381,000 | $132,000 |
| **Total** | **$911,000** | **$398,000** | **$381,000** | **$132,000** |

| FY 2018-19 | TF | GF | Title XIX | Title XXI |
|---|---|---|---|---|
| Fee-for-Service | $5,680,000 | $2,485,000 | $2,373,000 | $822,000 |
| Managed Care | $88,326,000 | $38,641,000 | $36,897,000 | $12,788,000 |
| **Total** | **$94,006,000** | **$41,126,000** | **$39,270,000** | **$13,610,000** |

**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 | $458,000 |
| - STATE FUNDS | $0 | $177,930 |
| PAYMENT LAG | 1.0000 | 0.6890 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $315,600 |
| STATE FUNDS | $0 | $122,590 |
| FEDERAL FUNDS | $0 | $192,970 |

## 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 DPP is only available once per lifetime for each Medi-Cal beneficiary. 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 three-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 consecutive 3-month ongoing maintenance session intervals offered during months 13 through 24 of the DPP services period.

# DIABETES PREVENTION PROGRAM

## REGULAR POLICY CHANGE NUMBER: 45

**Reason for Change:**
This is a new policy change.

**Methodology:**
1. Assume the DPP will be implemented January 1, 2019.

2. The total estimated Medi-Cal caseload for FY 2018-19 was assumed to be 13,474,600. Of the total caseload, approximately 38.73% are under the age of 18, 3.19% are between the age of 18 and 21, 36.97% are between the ages of 21 and 50, and the remaining 21.11% are over 50 years old.

| Age Group | Percent in Age Group | Total Medi-Cal Caseload |
|---|---|---|
| Age 0 -18 | 38.73% | 5,218,712 |
| Age 18 - 21 | 3.19% | 429,840 |
| Age 21-50 | 36.97% | 4,981,560 |
| Age 50 and above | 21.11% | 2,844,488 |
| Total | 100.00% | 13,474,600 |

3. According to the 2015 California Health Interview Survey, approximately 2.9% of all children under the age of 21, 7.8% adults between age 21 to 50, and 22.4% adults over 50 years of age have prediabetes. Applying these percentages to Medi-Cal's estimated caseload, it is estimated that approximately 1,038,194 individuals enrolled in Medi-Cal, age 18 and over, have prediabetes.

429,840 x 2.9% = 12,466
4,981,560 x 7.8% = 388,562
2,844,488 x 22.4% = 637,166
1,038,194

4. Assume an estimated 2% of those eligible for DPP will enroll in the program each year. Therefore, of the 1,038,194 estimated Medi-Cal eligibles, 20,763 are estimated to enroll in the DPP.

1,038,194 x 2% = 20,763

Core Sessions
5. Assume the total maximum payments per beneficiary for the Core Sessions include $84.00 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 $2,633,000 TF.

Attendance: (20,763 x 90%) x $84.00 = $1,570,000 TF
Performance: (20,763 x 40%) x $128.00 = $1,063,000 TF

# DIABETES PREVENTION PROGRAM

## REGULAR POLICY CHANGE NUMBER: 45

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 $8.00 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 $1,197,000 TF.

(20,763 x 90%) x 40% x $96.00 = $718,000 TF
(20,763 x 90%) x 40% x ($48.00 + $8.00) = $419,000 TF
(20,763 x 90%) x 20% x $16.00 = $60,000 TF

Ongoing Maintenance Sessions

11. Assume the total maximum payments for the Ongoing Maintenance Sessions include $320.00 ($80.00 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 $1,330,000 TF.

(20,763 x 40%) x 10% x $320.00 = $266,000
(20,763 x 40%) x 20% x $240.00 = $399,000
(20,763 x 40%) x 30% x $160.00 = $399,000
(20,763 x 40%) x 40% x $80.00 = $266,000

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.

15. Performance payments for Core Sessions, Core Maintenance, and Ongoing Maintenance are expected to be paid in FY 2019-20.

16. Total estimated payments are:

| DPP | Annual | FY 2018-19 |
|---|---|---|
| Core Sessions – Attendance | $1,570,000 | $458,000 |
| Core Sessions – Performance | $1,063,000 | $0 |
| Core Maintenance | $1,197,000 | $0 |
| Ongoing Maintenance | $1,330,000 | $0 |
| **Total** | **$5,160,000** | **$458,000** |

# DIABETES PREVENTION PROGRAM

## REGULAR POLICY CHANGE NUMBER: 45

**Funding:**

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| 50% Title XIX / 50% GF (4260-101-0001/0890) | $339,000 | $169,000 | $170,000 |
| 88% Title XXI FF / 12% GF (4260-113-0001/0890) | $2,000 | $1,000 | $1,000 |
| 93% ACA Title XIX FF / 7% GF (4260-101-0001/0890) | $117,000 | $8,000 | $109,000 |
| **Total** | **$458,000** | **$178,000** | **$280,000** |

# PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 46 |
| IMPLEMENTATION DATE: | 10/2017 |
| ANALYST: | Matt Wong |
| FISCAL REFERENCE NUMBER: | 1885 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | -$1,736,000 | -$5,461,000 |
| - STATE FUNDS | -$784,020 | -$2,470,200 |
| PAYMENT LAG | 0.6660 | 0.8700 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$1,156,200 | -$4,751,100 |
| STATE FUNDS | -$522,160 | -$2,149,070 |
| FEDERAL FUNDS | -$634,020 | -$2,602,000 |

## 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, 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 122 additional members; the current level of participants is 210 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 in FY 2017-18, from the prior estimate, is a decrease due to an adjustment in phase-in for the anticipated caseload expansion.

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 332 members enroll in PPCW by the end of FY 2017-18.

2. Assume 382 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 $1,736,000 for FY 2017-18 and $5,461,000 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 | $439,000 | $198,500 | $240,500 |
| **Savings** | **($1,736,000)** | **($784,500)** | **($951,500)** |
| Net Savings | ($1,250,000) | ($574,000) | ($676,000) |

| **FY 2018-19** | **TF** | **GF** | **FF** |
|---|---|---|---|
| OA 2-CCS Case Management | $1,124,000 | $281,000 | $843,000 |
| PC 39-PPCW | $1,509,000 | $696,000 | $813,000 |
| **Savings** | **($5,461,000)** | **($2,470,000)** | **($2,991,000)** |
| Net Savings | ($2,828,000) | ($1,493,000) | ($1,335,000) |

**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 | $43,513,000 | $120,893,000 |
| - STATE FUNDS | $19,648,640 | $54,684,560 |
| PAYMENT LAG | 0.8916 | 0.9193 |
| % REFLECTED IN BASE | 0.43 % | 0.10 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $38,629,400 | $111,025,800 |
| STATE FUNDS | $17,443,400 | $50,221,240 |
| FEDERAL FUNDS | $21,185,970 | $60,804,550 |

## 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).

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.

# NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS

## REGULAR POLICY CHANGE NUMBER: 47

**Reason for Change:**

The change from the prior estimate, for FY 2017-18, is an overall increase due to:

- Distribution and supply issues for the drugs causing the phase-in of the clients to be delayed for SPINRAZA, Exon 51 and DEFLAZACORT.
- The addition of Bineura as a new treatment for CCS-eligible children.
- The CCS removal of the Orkambi FEV threshold and hospitalization authorization criteria for beneficiaries 20 years of age or younger.

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

- Distribution and supply issues for the drugs causing the phase-in of the clients to be delayed for SPINRAZA, Exon 51 and DEFLAZACORT.
- The addition of Bineura as a new treatment for CCS-eligible children.

**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.)
- Due to the CCS removal of the FEV threshold and hospitalization authorization criteria for clients 20 years of age or younger, assume a 30% increase of eligible CCS beneficiaries over a 12 month period starting May 1, 2017.
- Total estimated costs for Orkambi are:

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| CCS Medi-Cal: | $2,511,000 | $3,770,000 |
| CCS OTLICP: | $367,000 | $541,000 |
| Total Orkambi: | $2,878,000 | $4,311,000 |

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 361 beneficiaries beginning July 1, 2017.
- Total estimated costs DEFLAZACORT are:

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| CCS Medi-Cal: | $7,554,000 | $21,558,000 |
| CCS OTLICP: | $1,104,000 | $3,092,000 |
| Total DEFLAZACORT: | $8,658,000 | $24,650,000 |

# NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS

**REGULAR POLICY CHANGE NUMBER: 47**

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 42 beneficiaries beginning July 1, 2017.
- Total estimated costs for Exondys 51 are:

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| CCS Medi-Cal: | $3,206,000 | $8,133,000 |
| CCS OTLICP: | $469,000 | $1,167,000 |
| Total Exondys 51: | $3,675,000 | $9,300,000 |

4. For FY 2017-18 and FY 2018-19, SPINRAZA cost are estimated as follows:

- Assume 64 existing beneficiaries are eligible to receive SPINRAZA as of July 1, 2017.
- Assume a 12-month phase-in of an additional 60 beneficiaries beginning August 1, 2017. Assume a 12-month phase-in of an additional 100 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: | $22,905,000 | $67,453,000 |
| CCS OTLICP: | $3,345,000 | $9,672,000 |
| Total SPINRAZA: | $26,250,000 | $77,125,000 |

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 7 Medi-Cal CCS eligible beneficiaries between August 1, 2017 through June 30, 2018.
- Assume a growth of 2 Medi-Cal CCS eligible beneficiaries in FY 2018-19.

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| CCS Medi-Cal: | $1,790,000 | $4,817,000 |
| CCS OTLICP: | $262,000 | $691,000 |
| Total Brineura: | $2,052,000 | $5,508,000 |

6. County funds will be allocated in the County Share of OTLICP-CCS Costs policy change.

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| CCS-Medi-Cal | $37,966,000 | $18,983,000 | $18,983,000 |
| CCS OTLICP | $5,547,000 | $664,000 | $4,883,000 |
| **Total** | **$43,513,000** | **$19,649,000** | **$23,864,000** |

# NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS

## REGULAR POLICY CHANGE NUMBER: 47

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| CCS-Medi-Cal | $105,731,000 | $52,865,000 | $52,865,000 |
| CCS OTLICP | $15,163,000 | $1,820,000 | $13,343,000 |
| **Total** | **$120,893,000** | **$54,685,000** | **$66,208,000** |

**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: | Cang Ly |
| 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:**
This is a new policy change.

# 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% /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: | 8/2018 |
| ANALYST: | Julie Chan |
| FISCAL REFERENCE NUMBER: | 2070 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | -$66,000,000 |
| - STATE FUNDS | $0 | -$26,611,730 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | -$66,000,000 |
| STATE FUNDS | $0 | -$26,611,730 |
| FEDERAL FUNDS | $0 | -$39,388,270 |

## 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

**Reason for Change:**
This is a new policy change.

**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 August 2018. 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 July 31, 2018. A date for the EPC has yet to be determined.

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 94% beginning January 2018 and 93% beginning January 2019.

# PHARMACY REIMBURSEMENT & DISPENSING FEE

## REGULAR POLICY CHANGE NUMBER: 49

7. On a cash basis, the savings are estimated to be:

(Dollars in Thousands)

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| AAC Savings | ($121,000) | ($48,788) | ($72,212) |
| PDF Costs | $55,000 | $22,177 | $32,823 |
| **Net Savings** | **($66,000)** | **($26,611)** | **($39,389)** |

**Funding:**

(Dollars in Thousands)

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| 50% Title XIX / 50% GF (4260-101-0001/0890) | ($51,038) | ($25,519) | ($25,519) |
| 94% Title XIX / 6% GF (4260-101-0001/0890) | ($5,856) | ($351) | ($5,505) |
| 93% Title XIX / 7% GF (4260-101-0001/0890) | ($7,027) | ($492) | ($6,535) |
| 88% Title XXI/ 12% GF (4260-113-0001/0890) | ($2,079) | ($249) | ($1,830) |
| **Net Savings** | **($66,000)** | **($26,611)** | **($39,389)** |

# 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 | -$2,526,000 | $0 |
| - STATE FUNDS | -$2,526,000 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$2,526,000 | $0 |
| STATE FUNDS | -$2,526,000 | $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. 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 | FY 2017-18 |
|---|---|
| PharMerica #1 | (83,000) |
| Salix, Inc. | (107,000) |
| Maxim | (70,000) |
| Walgreen Company | (176,000) |
| Biocompatibles, Inc. | (268,000) |
| Shire Pharmaceuticals | (399,000) |
| Forest Pharmaceuticals | (70,000) |
| Allergan | (56,000) |
| Novo Nordisk | (36,000) |
| IPC Healthcare, Inc | (90,000) |
| Omnicare-Banigan | (709,000) |
| Omnicare-Corsi | (31,000) |
| Walmart | (431,000) |
| **Total GF Savings** | **($2,526,000)** |

**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 | -$9,172,000 | -$8,765,000 |
| - STATE FUNDS | -$2,884,700 | -$2,756,600 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$9,172,000 | -$8,765,000 |
| STATE FUNDS | -$2,884,700 | -$2,756,600 |
| FEDERAL FUNDS | -$6,287,300 | -$6,008,400 |

## 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, is a decrease due to the result of projecting collections based on:

- The addition of two quarters of actual BCCTP rebate collections from January 2017 through June 2017;
- Decreased BCCTP drug expenditures for the applicable expenditure period;
- Decreased estimated ACA Offset funding based on actuals through June 2017.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to an estimated decline 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 $9,172,000 in FY 2017-18 and $8,765,000 in FY 2018-19.

4. Assume, of the total BCCTP rebates collected, the ACA offset for BCCTP is $930,000 in FY 2017-18 and $889,000 in FY 2018-19.

(Dollars in Thousands)

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| 65% Title XIX / 35% GF | ($8,242) | ($2,885) | ($5,357) |
| ACA Offset | ($930) | $0 | ($930) |
| **Total** | **($9,172)** | **($2,885)** | **($6,287)** |

(Dollars in Thousands)

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| 65% Title XIX / 35% GF | ($7,876) | ($2,757) | ($5,119) |
| ACA Offset | ($889) | $0 | ($889) |
| **Total** | **($8,765)** | **($2,757)** | **($6,008)** |

**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 | -$17,503,000 | -$18,073,000 |
| - STATE FUNDS | -$2,177,000 | -$2,247,900 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$17,503,000 | -$18,073,000 |
| STATE FUNDS | -$2,177,000 | -$2,247,900 |
| FEDERAL FUNDS | -$15,326,000 | -$15,825,100 |

## 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, is slight increase due to the revised collection projections based on:

- Increased average quarterly projections based on the addition of two quarters of actual FPACT rebate collections from January 2017 through June 2017;
- Decreased estimated FPACT drug expenditures for the applicable expenditure period;
- Decreased estimated ACA Offset funding based on actual data through June 2017.

# FAMILY PACT DRUG REBATES

## REGULAR POLICY CHANGE NUMBER: 52

The change between FY 2017-18 and FY 2018-19, in the current estimate, is due to an increase to the projected FPACT pharmacy expenditures applied to FY 2018-19.

**Methodology:**

1. The regular Federal Medical Assistance Percentage (FMAP) percentage is applied to 7.26% of the FPACT rebates to account for the purchase of non-family planning drugs, and the family planning percentage (90% FFP) is applied to 92.74% of the FPACT rebates.

2. Assume the ACA offset is $633,000 for FY 2017-18 and $654,000 for FY 2018-19.

3. Actual data from July 2013 to June 2017 is used to project rebates.

(Dollars in Thousands)

| Fiscal Year | FPACT Drug Expenditures | FPACT Rebate |
|---|---|---|
| FY 2017-18 | $47,504 | ($17,503) |
| FY 2018-19 | $49,049 | ($18,073) |

(Dollars in Thousands)

| **FY 2017-18** | **TF** | **GF** | **FF** |
|---|---|---|---|
| 50% Title XIX /50% GF | ($1,225) | ($612) | ($613) |
| 90% Title XIX / 10% GF | ($15,645) | ($1,565) | ($14,080) |
| ACA Offset | ($633) | $0 | ($633) |
| **Total** | **($17,503)** | **($2,177)** | **($15,326)** |

(Dollars in Thousands)

| **FY 2018-19** | **TF** | **GF** | **FF** |
|---|---|---|---|
| 50% Title XIX /50% GF | ($1,265) | ($632) | ($633) |
| 90% Title XIX / 10% GF | ($16,154) | ($1,616) | ($14,538) |
| ACA Offset | ($654) | $0 | ($654) |
| **Total** | **($18,073)** | **($2,248)** | **($15,825)** |

**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. 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 | -$202,948,000 | -$217,046,000 |
| - STATE FUNDS | -$62,783,280 | -$68,240,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$202,948,000 | -$217,046,000 |
| STATE FUNDS | -$62,783,280 | -$68,240,500 |
| FEDERAL FUNDS | -$140,164,720 | -$148,805,500 |

## 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, is an increase due to the result of revised collection projections based on the net result of the following:

- The addition of two quarters of actual State supplemental rebate collections from January 2017 through June 2017 which were lower than previously estimated;
- Decreased CHIP and Family planning drug rebates based on data through June 2017;
- Increased ACA optional rebates based on data through June 2017; and
- Decreased 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 an increase due to projecting a growth for FY 2018-19 State supplemental drug rebates based on the increased pharmacy expenditures that were applied to the FY 2018-19 projections.

# 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. Family planning drugs account for 0.08% of rebates and are funded with 90% federal funds (FF) and 10% General Fund (GF).

3. Assume CHIP drug rebates are estimated to be $6,694,000 TF for FY 2017-18 and $6,569,000 TF in FY 2018-19, funded at 88% FF and 12% GF.

4. The optional expansion ACA population collections are estimated to be $80,244,000 TF for FY 2017-18, funded at 95% FF and 5% GF. For FY 2018-19, the ACA collections are estimated to be $85,787,000 TF, funded at 94% FF and 6% GF.

(Dollars in Thousands)

| FY 2017-18 | TF | GF | FFP |
|---|---|---|---|
| 50% Title XIX / 50% GF | ($115,917) | ($57,959) | ($57,958) |
| 95% Title XIX/ 5% GF | ($80,244) | ($4,012) | ($76,232) |
| 90% Title XIX / 10% GF | ($93) | ($9) | ($84) |
| 88% Title XXI / 12 % GF | ($6,694) | ($803) | ($5,891) |
| **Total** | **($202,948)** | **($62,783)** | **($140,165)** |

(Dollars in Thousands)

| FY 2018-19 | TF | GF | FFP |
|---|---|---|---|
| 50% Title XIX / 50% GF | ($124,590) | ($62,295) | ($62,295) |
| 94% Title XIX/ 6% GF | ($85,787) | ($5,147) | ($80,640) |
| 90% Title XIX / 10% GF | ($100) | ($10) | ($90) |
| 88% Title XXI / 12 % GF | ($6,569) | ($788) | ($5,781) |
| **Total** | **($217,046)** | **($68,240)** | **($148,806)** |

**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 | -$2,254,707,000 | -$2,411,486,000 |
| - STATE FUNDS | -$725,409,460 | -$785,546,840 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$2,254,707,000 | -$2,411,486,000 |
| STATE FUNDS | -$725,409,460 | -$785,546,840 |
| FEDERAL FUNDS | -$1,529,297,540 | -$1,625,939,160 |

## 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, is an increase, due to the result of revised collection projections based on the net result of the following:

- The addition of two quarters of actual Federal rebate collections from January 2017 through June 2017 which were higher than previously estimated;
- Decreased Family planning and CHIP rebates based on data through June 2017;
- Increased ACA optional and ACA offset rebates based on data through June 2017; and
- Decreased 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 projecting a rise for FY 2018-19 federal drug rebates based on the increased pharmacy expenditures that were applied to the FY 2018-19 projections.

# FEDERAL DRUG REBATES

## REGULAR POLICY CHANGE NUMBER: 55

**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. Family planning drugs account for 0.08% of rebates and are funded with 90% federal funds (FF) and 10% General Fund (GF).

3. Assume CHIP drug rebate collections are estimated to be $80,328,000 TF in FY 2017-18 and $78,830,000 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 $647,694,000 TF for FY 2017-18 at 95% FF / 5% GF and $692,434,000 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 $159,039,000 TF for FY 2017-18 and $170,098,000 TF for FY 2018-19.

(Dollars in Thousands)

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| 50% Title XIX / 50% GF | ($1,366,552) | ($683,276) | ($683,276) |
| 95% Title XIX/ 5% GF | ($647,694) | ($32,385) | ($615,309) |
| 90% Title XIX / 10% GF | ($1,094) | ($109) | ($985) |
| ACA Offset | ($159,039) | $0 | ($159,039) |
| 88% Title XXI / 12 % GF | ($80,328) | ($9,639) | ($70,689) |
| **Total** | **($2,254,707)** | **($725,409)** | **($1,529,298)** |

(Dollars in Thousands)

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| 50% Title XIX / 50% GF | ($1,468,822) | ($734,411) | ($734,411) |
| 94% Title XIX/ 6% GF | ($692,434) | ($41,546) | ($650,888) |
| 90% Title XIX / 10% GF | ($1,302) | ($130) | ($1,172) |
| ACA Offset | ($170,098) | $0 | ($170,098) |
| 88% Title XXI / 12 % GF | ($78,830) | ($9,460) | ($69,370) |
| **Total** | **($2,411,486)** | **($785,547)** | **($1,625,939)** |

**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)

# 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 | $372,865,000 | $1,039,568,000 |
| - STATE FUNDS | $76,171,430 | $209,807,530 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $372,865,000 | $1,039,568,000 |
| STATE FUNDS | $76,171,430 | $209,807,530 |
| FEDERAL FUNDS | $296,693,570 | $829,760,470 |

## DESCRIPTION

**Purpose:**
This policy change estimates the cost of the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver pilot program for opt-in counties to provide Substance Use Disorder (SUD) services.

**Authority:**
Drug Medi-Cal Organized Delivery System Waiver

**Interdependent Policy Changes:**
Not Applicable

**Background:**
Under the State Plan, the Drug Medi-Cal program currently covers the following SUD services: Outpatient Drug-Free Treatment Services (ODF), Intensive Outpatient Treatment Services (IOT), Residential Treatment Services (RTS) for pregnant and postpartum women, and the Narcotic Treatment Program (NTP).

On August 13, 2015, the Department received approval from the Centers for Medicare and Medicaid Services (CMS) to implement the DMC-ODS waiver. The DMC-ODS is a pilot project authorized originally under California's Section 1115 Bridge to Reform Demonstration Waiver and continued in the Medi-Cal 2020 Waiver. The purpose of the pilot program is to test a new paradigm for organized delivery of health care services for Medicaid eligible individuals with a substance use disorder.

DMC-ODS waiver services include the existing treatment modalities (ODF, IOT, NTP, and Perinatal RTS), and additional new and expanded county optional services. Counties that opt-in to participate in the DMC-ODS waiver are required to provide a continuum of care to all eligible beneficiaries modeled after the American Society of Addiction Medicine (ASAM) Criteria. Counties will submit implementation plans and proposed interim rates for all county-covered SUD services, except for the NTP rates, which are set by the State.

Counties currently provide many of the required services (e.g. treatments covered by the current four modalities ODF, IOT, NTP, and Perinatal RTS) under the current DMC program and will continue to

# DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

## REGULAR POLICY CHANGE NUMBER: 56

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, is due to the following:
- Updated county implementation schedule – The prior estimate assumed nine counties to implement the DMC-ODS in FY 2017-18. The current estimate assumes 15 counties to implement the waiver in FY 2017-18.
- Based on updated claims data, the payment lag was revised from two-months to five-months. As a result, 11 counties are projected to be paid in FY 2017-18, and the remaining nine counties payments will be paid in 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 six additional counties, for a total of 14 counties with approved rates.
  - RTS 3.1 – The following county's rates and for RTS 3.1 were updated as follows:
    - Santa Cruz county has revised its waiver plan to remove RTS 3.1 from its list of waiver services.
    - San Francisco county has revised its waiver plan to include RTS 3.1 for waiver implementation.
    - Santa Clara county's RTS 3.1 interim rate was revised and is higher than previously estimated.
    - San Mateo, Marin, and Los Angeles counties RTS 3.1 interim rates were revised and are lower than previously estimated.
  - MAT Expansion – Annual cost projections for all counties increased due to updated caseload data based on FY 2016-17 NTP services utilization.

The change in the current estimate, from FY 2017-18 to FY 2018-19, is primarily due to 20 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. Five counties (San Mateo, Riverside, Marin, Santa Clara, and Contra Costa) implemented the waiver in FY 2016-17. For FY 2017-18 and FY 2018-19, county implementation is expected to phase-in as follows:
   - 15 additional counties will begin providing services in FY 2017-18.
   - 20 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 August 2018.

2. Assume approximately 18 counties will not opt-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.

# DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

## REGULAR POLICY CHANGE NUMBER: 56

DMC-ODS Waiver Costs

4. Costs for the new DMC-ODS waiver services are estimated to be:

| New Waiver Services | Accrual | FY 2017-18 | FY 2018-19 |
|---|---|---|---|
| | | | |
| Required | | | |
| Recovery Services | $1,622,000 | $1,622,000 | $0 |
| Case Mgmt | $2,188,000 | $2,188,000 | $0 |
| Physician Consult. | $300,000 | $300,000 | $0 |
| WM 1.0, 2.0, 3.2 | $632,000 | $632,000 | $0 |
| MAT Expansion | $647,000 | $647,000 | $0 |
| Optional | | | |
| Partial Hospitalization | $90,000 | $90,000 | $0 |
| Additional MAT | $554,000 | $554,000 | $0 |
| WM 3.7 and 4.0 | $0 | $0 | $0 |
| Total for FY 2016-17 | $6,033,000 | $6,033,000 | $0 |
| | | | |
| Required | | | |
| Recovery Services | $51,998,000 | $26,515,000 | $25,483,000 |
| Case Mgmt | $45,770,000 | $22,009,000 | $23,761,000 |
| Physician Consult. | $7,924,000 | $3,995,000 | $3,929,000 |
| WM 1.0, 2.0, 3.2 | $21,216,000 | $10,223,000 | $10,993,000 |
| MAT Expansion | $13,231,000 | $6,446,000 | $6,785,000 |
| Optional | | | |
| Partial Hospitalization | $1,197,000 | $628,000 | $569,000 |
| Additional MAT | $2,976,000 | $1,484,000 | $1,492,000 |
| WM 3.7 and 4.0 | $0 | $0 | $0 |
| Total for FY 2017-18 | $144,312,000 | $71,300,000 | $73,012,000 |
| | | | |
| Required | | | |
| Recovery Services | $92,456,000 | $0 | $53,387,000 |
| Case Mgmt. | $86,816,000 | $0 | $50,130,000 |
| Physician Consult. | $14,006,000 | $0 | $8,088,000 |
| WM 1.0, 2.0, 3.2 | $40,855,000 | $0 | $23,591,000 |
| MAT Expansion | $26,788,000 | $0 | $15,468,000 |
| Optional | | | |
| Partial Hospitalization | $2,027,000 | $0 | $1,171,000 |
| Additional MAT | $5,311,000 | $0 | $3,067,000 |
| WM 3.7 and 4.0 | $0 | $0 | $0 |
| Total for FY 2018-19 | $268,259,000 | $0 | $154,902,000 |
| Total | | $77,333,000 | $227,914,000 |

# DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

## REGULAR POLICY CHANGE NUMBER: 56

5. Costs for the existing modalities for the DMC-ODS waiver services are estimated to be:

| Existing Modalities | Accrual | FY 2017-18 | FY 2018-19 |
|---|---|---|---|
| FY 2016-17 | | | |
| IOT | $14,681,000 | $14,681,000 | $0 |
| RTS 3.1, 3.3, 3.5 | $7,501,000 | $7,501,000 | $0 |
| NTP | $5,978,000 | $5,978,000 | $0 |
| ODF | $8,497,000 | $8,497,000 | $0 |
| Subtotal | $36,657,000 | $36,657,000 | $0 |
| FY 2017-18 | | | |
| IOT | $147,531,000 | $75,971,000 | $71,560,000 |
| RTS 3.1, 3.3, 3.5 | $300,754,000 | $154,119,000 | $146,635,000 |
| NTP | $123,409,000 | $60,987,000 | $62,422,000 |
| ODF | $147,066,000 | $73,812,000 | $73,254,000 |
| Subtotal | $718,760,000 | $364,889,000 | $353,871,000 |
| FY 2018-19 | | | |
| IOT | $257,956,000 | $0 | $148,951,000 |
| RTS 3.1, 3.3, 3.5 | $534,327,000 | $0 | $308,534,000 |
| NTP | $238,319,000 | $0 | $137,611,000 |
| ODF | $271,435,000 | $0 | $156,734,000 |
| Subtotal | $1,302,037,000 | $0 | $751,830,000 |
| | | | |
| Total | | $401,546,000 | $1,105,701,000 |

Base Adjustments for Existing Modalities

6. 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 Adjustment |
|---|---|---|---|
| IOT | $14,681,000 | $139,000 | $14,542,000 |
| RTS 3.1, 3.3, 3.5 | $7,501,000 | $0 | $7,501,000 |
| NTP | $5,978,000 | $610,000 | $5,368,000 |
| ODF | $8,497,000 | $206,000 | $8,291,000 |
| Total for FY 2016-17 | $36,657,000 | $955,000 | $35,702,000 |
| | | | |
| IOT | $75,971,000 | $3,346,000 | $72,625,000 |
| RTS 3.1, 3.3, 3.5 | $154,119,000 | $38,000 | $154,081,000 |
| NTP | $60,987,000 | $42,724,000 | $18,263,000 |
| ODF | $73,812,000 | $5,474,000 | $68,338,000 |
| Total for FY 2017-18 | $364,889,000 | $51,582,000 | $313,307,000 |
| Total | $401,546,000 | $52,537,000 | $349,009,000 |

# DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

## REGULAR POLICY CHANGE NUMBER: 56

| FY 2018-19 | DMC Waiver - Cash Estimate | Less: Cost in Base | Cash Basis Adjustment |
|---|---|---|---|
| IOT | $71,560,000 | $922,000 | $70,638,000 |
| RTS 3.1, 3.3, 3.5 | $146,635,000 | $35,000 | $146,600,000 |
| NTP | $62,422,000 | $14,631,000 | $47,791,000 |
| ODF | $73,254,000 | $2,052,000 | $71,202,000 |
| Total for FY 2017-18 | $353,871,000 | $17,640,000 | $336,231,000 |
| FY 2018-19 | | | |
| IOT | $148,951,000 | $4,367,000 | $144,584,000 |
| RTS 3.1, 3.3, 3.5 | $308,534,000 | $767,000 | $307,767,000 |
| NTP | $137,611,000 | $98,079,000 | $39,532,000 |
| ODF | $156,734,000 | $13,300,000 | $143,434,000 |
| Total for FY 2018-19 | $751,830,000 | $116,513,000 | $635,317,000 |
| Total | $1,105,701,000 | $134,153,000 | $971,548,000 |

Net DMC-ODS Waiver Costs

7. Total net cost for the DMC-ODS waiver services are:

| DMC-ODS Waiver Net Cost | FY 2017-18 | FY 2018-19 |
|---|---|---|
| Required Services | $74,577,000 | $221,615,000 |
| Optional Services | $2,756,000 | $6,299,000 |
| Existing Services | $349,009,000 | $971,548,000 |
| Total | $426,342,000 | $1,199,462,000 |

| **FY 2017-18** | **TF** | **GF** | **FF Title XIX** | **FF Title XXI** | **CF** |
|---|---|---|---|---|---|
| Regular | | | | | |
| Current | $236,713,000 | $68,318,000 | $117,393,000 | $1,694,000 | $49,308,000 |
| ACA Optional | $183,450,000 | $7,786,000 | $173,900,000 | $0 | $1,764,000 |
| Perinatal | | | | | |
| Current | $4,871,000 | $0 | $2,395,000 | $71,000 | $2,405,000 |
| ACA Optional | $1,308,000 | $68,000 | $1,240,000 | $0 | $0 |
| **Total** | $426,342,000 | **$76,172,000** | **$294,928,000** | **$1,765,000** | $53,477,000 |

| **FY 2018-19** | **TF** | **GF** | **FF Title XIX** | **FF Title XXI** | **CF** |
|---|---|---|---|---|---|
| Regular | | | | | |
| Current | $666,104,000 | $183,897,000 | $330,345,000 | $4,764,000 | $147,098,000 |
| ACA Optional | $516,156,000 | $25,685,000 | $484,368,000 | $0 | $6,103,000 |
| Perinatal | | | | | |
| Current | $13,560,000 | $0 | $6,668,000 | $199,000 | $6,693,000 |
| ACA Optional | $3,642,000 | $226,000 | $3,416,000 | $0 | $0 |
| **Total** | $1,199,462,000 | **$209,808,000** | **$824,797,000** | **$4,963,000** | $159,894,000 |

# DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

## REGULAR POLICY CHANGE NUMBER: 56

**Funding:**

| FY 2017-18 | TF | GF | FF | CF |
|---|---|---|---|---|
| 50% Title XIX / 50% GF (4260-101-0001/0890) | $136,367,000 | $68,184,000 | $68,183,000 | $0 |
| 100% Title XIX FF (4260-101-0890) | $103,210,000 | $0 | $51,605,000 | $51,605,000 |
| 100% Title XXI FF (4260-113-0890) | $894,000 | $0 | $786,000 | $108,000 |
| 100% ACA Title XIX FF (4260-101-0890) | $41,248,000 | $0 | $39,484,000 | $1,764,000 |
| 88% Title XXI FF / 12% GF (4260-113-0001/0890) | $1,113,000 | $134,000 | $979,000 | $0 |
| 95% ACA Title XIX FF / 5% GF (4260-101-0001/0890) | $75,623,000 | $3,781,000 | $71,842,000 | $0 |
| 94% ACA Title XIX FF / 6% GF (4260-101-0001/0890) | $67,887,000 | $4,073,000 | $63,814,000 | $0 |
| **Total** | $426,342,000 | **$76,172,000** | **$296,693,000** | $53,477,000 |

| FY 2018-19 | TF | GF | FF | CF |
|---|---|---|---|---|
| 50% Title XIX / 50% GF (4260-101-0001/0890) | $367,077,000 | $183,538,000 | $183,539,000 | $0 |
| 100% Title XIX FF (4260-101-0890) | $306,948,000 | $0 | $153,474,000 | $153,474,000 |
| 100% Title XXI FF (4260-113-0890) | $2,646,000 | $0 | $2,329,000 | $317,000 |
| 88% Title XXI FF / 12% GF (4260-113-0001/0890) | $2,993,000 | $359,000 | $2,634,000 | $0 |
| 100% ACA Title XIX FF (4260-101-0001) | $98,768,000 | $0 | $92,665,000 | $6,103,000 |
| 95% ACA Title XIX FF / 5% GF (4260-101-0001/0890) | $72,854,000 | $3,643,000 | $69,211,000 | $0 |
| 94% ACA Title XIX FF / 6% GF (4260-101-0001/0890) | $210,515,000 | $12,631,000 | $197,884,000 | $0 |
| 93% ACA Title XIX FF / 7% GF (4260-101-0001/0890) | $137,661,000 | $9,637,000 | $128,024,000 | $0 |
| **Total** | $1,199,462,000 | **$209,808,000** | **$829,760,000** | $159,894,000 |

# DRUG MEDI-CAL PROGRAM COST SETTLEMENT

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 61 |
| IMPLEMENTATION DATE: | 1/2013 |
| ANALYST: | Joel Singh |
| FISCAL REFERENCE NUMBER: | 1723 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $3,000,000 | $0 |
| - STATE FUNDS | $100,000 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $3,000,000 | $0 |
| STATE FUNDS | $100,000 | $0 |
| FEDERAL FUNDS | $2,900,000 | $0 |

## 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.

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is due to FY 2014-15 estimated cost settlements included in FY 2017-18.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to no costs allocated to FY 2018-19.

**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 2017-18.

| FY 2017-18 | 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 | $266,121,000 | $0 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $266,121,000 | $0 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $266,121,000 | $0 |

## DESCRIPTION

**Purpose:**
This policy change estimates the supplemental reimbursement based on certified public expenditures for Specialty Mental Health Services (SMHS).

**Authority:**
ABX4 5 (Chapter 5, Statutes of 2009)
Welfare & Institution Code 14723
State Plan Amendment (SPA) 09-004

**Interdependent Policy Changes:**
Not Applicable

**Background:**
State law allows an eligible public agency receiving reimbursement for SMHS provided to Medi-Cal beneficiaries to receive supplemental reimbursement up to 100% of the allowable costs of providing the services. To receive the supplemental payments, the public agency must certify that they incurred the public expenditures.

On February 16, 2016, the Centers for Medicare and Medicaid Services (CMS) approved the supplemental payment SPA 09-004 and Certified Public Expenditure Protocol.

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is an increase due to settling four additional counties for FY 2010-11 payments that will be made in FY 2017-18.

The change from FY 2017-18 to FY 2018-19, in the current estimate, does not anticipate supplemental payments for FY 2018-19.

# 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 based on an average per county. The FY 2010-11 supplemental payments will be paid in FY 2017-18.

5. Assume the FY 2011-12 supplemental payments will increase by 2.4% from the FY 2010-11 regular FFP payment. The FY 2011-12 supplemental payments will be paid in FY 2017-18.

(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 |
| FY 2010-11 | $96,202 | $87,728 | $8,474 |
| FY 2011-12 | $89,833 | $89,833 | $0 |
| **Total for FY 2017-18** | **$266,121** | **$251,719** | **$14,402** |

**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 | $12,982,000 | $13,419,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $12,982,000 | $13,419,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $12,982,000 | $13,419,000 |

## 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 decrease due to:

- The IHBS and ICC claims data was updated and was lower than previously estimated.
- The payment lags applied to FY 2016-17 were updated to 27% paid in the same year, 72% in the second year, and 1% in the third year.
- The payment lags applied to FY 2017-18 were updated to 37% of claims paid in the same year, 62% paid in the second year, and 1% in the third year.
- The percentage of the IHBS and ICC costs estimated to be captured in the SMHS base policy change increased from 22% to 38% for FY 2017-18.

The change between FY 2017-18 and FY 2018-19, in the current estimate, is due to two fiscal years of annual TFC costs being included in FY 2018-19 and resuming the historical 37% in the same year, 62% in the second year, and 1% in the third year, payment lags applied to the FY 2017-18 and FY 2018-19 accrual years.

**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 $18,168,000 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 an annual cost of $15,732,000. Assume the billing for the TFC service model begins April 2018. Assume all 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 | $18,168 | $7,866 | $26,034 |
| 2017-18 | $18,168 | $15,732 | $33,900 |
| 2018-19 | $18,168 | $15,732 | $33,900 |

# PATHWAYS TO WELL-BEING

## REGULAR POLICY CHANGE NUMBER: 66

5. Assume for FY 2016-17, 27% of current year claims will be paid in the year the services occur, 72% is paid in the second year, and 1% is paid in the third year. Based on historical claims received, for FY 2017-18 and FY 2018-19, assume 37% of current year 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 | $18,168 | 0.72 | $13,081 |
| Less: 38% | IHBS & ICC | | | ($4,971) |
| Subtotal | | | | $8,110 |
| 2017-18 | IHBS & ICC | $18,168 | 0.37 | $6,722 |
| Less: 38% | IHBS & ICC | | | ($2,554) |
| Subtotal | | | | $4,168 |
| 2016-17 | TFC | $7,866 | 1.00 | $7,866 |
| 2017-18 | TFC | $15,732 | 0.37 | $5,821 |
| Total 2017-18 Cash Estimate | | | | $25,965 |

(Dollars in Thousands)

| Fiscal Year | Service | Total Accrual | Payment Lag | Cash Estimate TF |
|---|---|---|---|---|
| 2016-17 | IHBS & ICC | $18,168 | 0.01 | $181 |
| Less: 38% | IHBS & ICC | | | ($69) |
| Subtotal | | | | $112 |
| 2017-18 | IHBS & ICC | $18,168 | 0.62 | $11,264 |
| Less: 38% | IHBS & ICC | | | ($4,280) |
| Subtotal | | | | $6,984 |
| 2018-19 | IHBS & ICC | $18,168 | 0.37 | $6,722 |
| Less: 38% | IHBS & ICC | | | ($2,554) |
| Subtotal | | | | $4,168 |
| 2017-18 | TFC | $15,732 | 0.62 | $9,754 |
| 2018-19 | TFC | $15,732 | 0.37 | $5,821 |
| Total 2018-19 Cash Estimate | | | | $26,839 |

(Dollars in Thousands)

| Fiscal Year | TF | FF | CF |
|---|---|---|---|
| **FY 2017-18** | $25,965 | **$12,982** | $12,983 |
| **FY 2018-19** | $26,839 | **$13,419** | $13,420 |

**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 | $12,305,000 | $15,616,000 |
| - STATE FUNDS | $6,922,000 | $8,577,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $12,305,000 | $15,616,000 |
| STATE FUNDS | $6,922,000 | $8,577,500 |
| FEDERAL FUNDS | $5,383,000 | $7,038,500 |

## 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.

- A CFT will be convened for all children or youth who have an open child welfare case. The county mental health department is expected to participate in all CFTs when the child needs SMHS.

# MHP COSTS FOR CONTINUUM OF CARE REFORM

## REGULAR POLICY CHANGE NUMBER: 67

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, is due to:

- Updated caseload figures based on data for CDSS county workload for CFT and placement assessments,
- Updated the FY 2017-18 cost per hour for CFTs from $226.20 to $198.60,
- Decreased open welfare cases estimate from 60% to 42%, 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:

- Updated CDSS caseload assumptions to add costs for FY 2018-19,
- Increased the FY 2018-19 cost per hour for CFTs to $202.77, based on an estimated 2.1% growth factor 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 | |

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, and $3.31 per minute, or $198.60 per hour for FY 2017-18. Assume there is a growth factor of 2.1% applied to the CFT costs, based on the Consumer Price Index (CPI), for an average cost of $202.77 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 | $202.77 | 12 | $1,550,000 |
| Tier 2 | 1,284 | $202.77 | 10 | $2,604,000 |
| Tier 3 | 3,541 | $202.77 | 8 | $5,744,000 |
| Tier 4 | 3,868 | $202.77 | 4 | $3,137,000 |
| Tier 5 | 655 | $202.77 | 4 | $531,000 |
| Total | 9,985 | | | $13,566,000 |

Placement Assessments

1. Based on CDSS' estimated number of children currently in a rate classification level (RCL) 10 to 12 residential group homes, assume 64 children transitioned to an STRTP in FY 2016-17. Assume 514 children would transition in FY 2017-18, and 1,626 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 2016-17: 64 x $226.20 x 4 = $57,907
   FY 2017-18: 514 x $198.60 x 4 = $408,322
   FY 2018-19: 1,626 x $202.77 x 4 = $1,318,820

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 65% 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 0.65 = $1,461,000 (Rounded)
   GF Match: $3,000,000 x (1 – (0.75 x 0.65)) = $1,539,000 (Rounded)

   FY 2018-19: Federal Share: $3,000,000 x 0.75 x 0.65 = $1,461,000 (Rounded)
   GF Match: $3,000,000 x (1 – (0.75 x 0.65)) = $1,539,000 (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 72% of FY 2016-17 claims, and 37% of FY 2017-18 claims. On a cash basis for FY 2018-19, the Department will pay 1% 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 |
|---|---|---|---|---|
| FY 2016-17 | $5,699 | $5,657 | $42 | $0 |
| FY 2017-18 | $6,606 | $4,916 | $151 | $1,539 |
| Total FY 2017-18 | $12,305 | $10,573 | $193 | $1,539 |

(Dollars in Thousands)

| FY 2018-19 | TF | CFT | Placement Assessments | Training |
|---|---|---|---|---|
| FY 2016-17 | $79 | $79 | $0 | $0 |
| FY 2017-18 | $8,491 | $8,238 | $253 | $0 |
| FY 2018-19 | $7,046 | $5,019 | $488 | $1,539 |
| Total FY 2018-19 | $15,616 | $13,336 | $741 | $1,539 |

# MHP COSTS FOR CONTINUUM OF CARE REFORM

## REGULAR POLICY CHANGE NUMBER: 67

2. The FY 2017-18 and FY 2018-19 estimate is:

(Dollars in Thousands)

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| CFT | $10,573 | $5,286 | $5,287 |
| Placement Assessments | $193 | $97 | $96 |
| Training | $1,539 | $1,539 | $0 |
| **Total** | **$12,305** | **$6,922** | **$5,383** |

(Dollars in Thousands)

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| CFT | $13,336 | $6,668 | $6,668 |
| Placement Assessments | $741 | $370 | $371 |
| Training | $1,539 | $1,539 | $0 |
| **Total** | **$15,616** | **$8,577** | **$7,039** |

**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: | 9/2017 |
| ANALYST: | Julie Chan |
| FISCAL REFERENCE NUMBER: | 2026 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $1,510,000 | $0 |
| - STATE FUNDS | $1,510,000 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $1,510,000 | $0 |
| STATE FUNDS | $1,510,000 | $0 |
| FEDERAL FUNDS | $0 | $0 |

## DESCRIPTION

**Purpose:**
This policy change estimates the cost to reimburse San Diego County and Butte 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 and Butte County to be the Mental Health Plan (MHP) for Medi-Cal beneficiaries residing in those counties. San Diego County and Butte 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 and the Butte 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 a slight increase due to corrected reimbursements to the San Diego County MHP.

There are no payments expected to be made to the San Diego and Butte MHPs in FY 2018-19.

# TRANSITIONAL SMHS CLAIMS

## REGULAR POLICY CHANGE NUMBER: 68

**Methodology:**

1. Payments to the San Diego MHP and Butte County MHP are based on actual claims received from the counties.

2. In FY 2017-18, assume General Funds (GF) will be used to pay claims.

(Dollars in Thousands)

| Cash Basis | TF | GF |
|---|---|---|
| **FY 2017-18** | $1,510 | **$1,510** |

**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 | $0 |
| - STATE FUNDS | $4,000 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $4,000 | $0 |
| STATE FUNDS | $4,000 | $0 |
| 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 in FY 2017-18, but the total funds were updated because the claim did not include a county share. There are no claims estimated to be paid in FY 2018-19.

**Methodology:**
1. Late claims are based on actual claims received from the counties.

2. Assume GF will be used to pay claims in FY 2017-18 that exceed the federal claiming limit.

| Cash Basis | TF | GF |
|---|---|---|
| FY 2017-18 | $4,000 | **$4,000** |

**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 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $0 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $0 | $0 |

## DESCRIPTION

**Purpose:**
This policy change estimates the cost of federal fund (FF) repayments made to the Centers for Medicare and Medicaid Services (CMS) for improper claims for Medi-Cal services made by Siskiyou County Mental Health Plan. In addition, Siskiyou County General Fund (GF) reimbursements are also included in this policy change.

**Authority:**
Title 42, United States Code (USC) 1396b (d)(2)(C)

**Interdependent Policy Changes:**
Not Applicable

**Background:**
During the audit and cost settlement processes, the Department identified overpayments to the Siskiyou County Mental Health Plan from improper Medi-Cal billing practices. Pursuant to federal statute, the Department must remit the overpaid FF to CMS within a year of the discovery date. While the county acknowledged its Medi-Cal billing problems, it is unable to repay the amounts owed in a significant or timely manner. Consequently, the County will reimburse the Department 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 $1,000,000.

**Reason for Change:**
There is no change, from the prior estimate, for FY 2017-18. There is no change, from FY 2017-18 to FY 2018-19, in the current estimate.

# 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 2009-10.

2. Siskiyou County will reimburse the GF $200,000 annually. The county has submitted payments totaling $1,000,000.

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. 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 |
| Subtotal | $11,251,000 | $11,251,000 | $0 |
| Repayments | ($1,000,000) | $0 | $0 |
| Recoupments | ($381,000) | $0 | $0 |
| Total | $9,870,000 | $11,251,000 | $0 |

4. The estimate for FY 2017-18 and FY 2018-19 is as follows:

| Fiscal Year | TF | GF | Reimbursement |
|---|---|---|---|
| **FY 2017-18** | $0 | **($200,000)** | **$200,000** |
| **FY 2018-19** | $0 | **($200,000)** | **$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 | -$1,806,000 | -$867,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$1,806,000 | -$867,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | -$1,806,000 | -$867,000 |

## 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, is a net increase due to:

- Increased recoupments from shifting a portion of the FY 2015-16 chart reviews to be paid in FY 2017-18. The FY 2015-16 chart reviews have also been updated to reflect actual inpatient and outpatient recoupments.
- Increased recoupments from updating the estimate to reflect actual recoupments from the FY 2016-17 inpatient chart reviews.
- Decreased recoupments from shifting FY 2017-18 inpatient recoupments to 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 FY 2015-16 that occurred in FY 2017-18. Also, the FY 2017-18 estimate includes both estimated and actual recoupments, whereas the FY 2018-19 estimate includes 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 in FYs 2015-16 and 2016-17.

2. The FY 2018-19 estimate includes estimated recoupments from inpatient and outpatient chart reviews to be conducted in FY 2017-18.

(Dollars in Thousands)

| Fiscal Year | TF | FF |
|---|---|---|
| FY 2017-18 | ($1,806) | ($1,806) |
| FY 2018-19 | ($867) | ($867) |

**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 | -$3,972,000 | $0 |
| - STATE FUNDS | $377,000 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$3,972,000 | $0 |
| STATE FUNDS | $377,000 | $0 |
| FEDERAL FUNDS | -$4,349,000 | $0 |

## 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, is due to the addition of MHP cost settlements for eight counties. There are no settlements anticipated to be paid or recouped for 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 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 Settlement (FY 2010-11) | Underpaid | Overpaid | Net FF |
|---|---|---|---|
| Children and Adults | $152 | ($5,140) | ($4,988) |
| ARRA | $30 | ($996) | ($966) |
| BCCTP | $0 | ($40) | ($40) |
| Pregnancy | $1,150 | $0 | $1,150 |
| Refugees | $0 | ($1) | ($1) |
| M-CHIP* | $74 | ($3) | $71 |
| Healthy Families* | $10 | ($135) | ($125) |
| FY 2010-11 Total | $1,416 | ($6,315) | ($4,899) |

(Dollars in Thousands)

| Interim Settlement (FY 2011-12) | Underpaid | Overpaid | Net FF |
|---|---|---|---|
| Children and Adults | $2,434 | ($2,133) | $301 |
| ARRA | $0 | ($413) | ($413) |
| BCCTP | $0 | ($49) | ($49) |
| Pregnancy | $554 | $0 | $554 |
| M-CHIP* | $18 | ($4) | $14 |
| Healthy Families* | $184 | ($61) | $123 |
| FY 2011-12 Total | $3,190 | ($2,660) | $530 |

# INTERIM AND FINAL COST SETTLEMENTS - SMHS

## REGULAR POLICY CHANGE NUMBER: 72

(Dollars in Thousands)

| Subtotal FF | Underpaid | Overpaid | Net FF |
|---|---|---|---|
| Total FY 2017-18 | $4,637 | ($8,986) | ($4,349) |

5. Cost settlements prior to 2011 Realignment may consist of General Fund (GF).

(Dollars in Thousands)

| Interim Settlement | GF Underpaid | GF Overpaid | Net GF |
|---|---|---|---|
| 2006-07 | $2 | $0 | $2 |
| 2010-11 | $446 | ($72) | $375 |
| Total FY 2017-18 | $448 | ($72) | $377 |

6. The net FF and GF to be paid in FY 2017-18 is:

(Dollars in Thousands)

| **FY 2017-18 Summary** | **TF** | **GF** | **FF** |
|---|---|---|---|
| Children and Adults | ($4,319) | $377 | ($4,696) |
| ARRA | ($1,381) | $0 | ($1,381) |
| BCCTP | ($89) | $0 | ($89) |
| Pregnancy | $1,704 | $0 | $1,704 |
| Refugees | ($1) | $0 | ($1) |
| M-CHIP* | $99 | $0 | $99 |
| Healthy Families* | $15 | $0 | $15 |
| **Total FY 2017-18** | **($3,972)** | **$377** | **($4,349)** |

**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 | $2,279,899,000 | $2,487,459,000 |
| - STATE FUNDS | $1,139,949,000 | $1,243,729,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $2,279,899,000 | $2,487,459,000 |
| STATE FUNDS | $1,139,949,000 | $1,243,729,000 |
| FEDERAL FUNDS | $1,139,950,000 | $1,243,730,000 |

## 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:**
PC 26 ACA DSH Reduction

**Background:**
Since 2005, the Designated Public Hospital and Clinic systems (DPH systems) have received partial support for health expenditures made on behalf of the uninsured through a combination of California's 1115 Waivers' Safety Net Care Pool (SNCP) and Medicaid Disproportionate Share Hospital (DSH) funding. These two funding sources have been provided through a cost-based system. The Medi-Cal 2020's redesigned Global Payment Program (GPP) will include 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

## REGULAR POLICY CHANGE NUMBER: 73

The ACA DSH allotment reduction was previously scheduled to go into effect on October 1, 2013. Instead, HR 2 (2015) was enacted on April 16, 2015, which delays the reduction until October 1, 2017. For the impact of the ACA DSH allotment reduction, see the ACA DSH Reduction policy change for more information.

**Reason for Change:**
The change from the prior estimate for FY 2017-18, is due to updated DSH allotments which reduced the DPH portion for PY 2016-17 and 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 (PY) 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 | $869,667 | $236,000 | $1,105,667 |
| 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 | $1,756,512 | $878,256 | $878,256 |
| **Total** | **$2,279,899** | **$1,139,949** | **$1,139,950** |

| **FY 2018-19** | **TF** | **IGT** | **FF** |
|---|---|---|---|
| PY 2016-17 | $88,250 | $44,125 | $44,125 |
| PY 2017-18 | $588,589 | $294,294 | $294,295 |
| PY 2018-19 | $1,810,620 | $905,310 | $905,310 |
| **Total** | **$2,487,459** | **$1,243,729** | **$1,243,730** |

# GLOBAL PAYMENT PROGRAM

## REGULAR POLICY CHANGE NUMBER: 73

**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 | $1,771,000,000 | $1,520,000,000 |
| - STATE FUNDS | $885,500,000 | $760,000,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $1,771,000,000 | $1,520,000,000 |
| STATE FUNDS | $885,500,000 | $760,000,000 |
| FEDERAL FUNDS | $885,500,000 | $760,000,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the payments to fund the delivery system transformation and alignment incentive program, known as Public Hospital Redesign and Incentives in Medi-Cal (PRIME).

**Authority:**
SB 815 (Chapter 111, Statutes of 2016)
AB 1568 (Chapter 42, Statutes of 2016)
California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)

**Interdependent Policy Changes:**
Not Applicable

**Background:**
California will fund public provider system projects that will change care delivery and strengthen those systems' ability to receive payment under risk-based alternative payment models. Projects will be reported on a broad range of metrics to meet quality benchmark goals. Over the course of the demonstration, payments will increasingly move towards pay for performance. To promote greater stability, 50% of all Medi-Cal managed care beneficiaries assigned to designated public hospital systems in the aggregate will receive all of or a portion of their care under a contracted alternative payment model by January 2018; 55% by January 2019; and 60% by the end of the waiver renewal period in 2020.

Funding for this pool will not exceed $7.464 billion in combined federal and state shares of expenditures over a five-year period for designated public hospital systems (DPH) and district/municipal public hospitals (DMPH) to support reforms to care delivery, provider organization and adoption of alternative payment methodologies. The demonstration will provide up to $1.4 billion annually for the DPH systems and up to $200 million annually for the DMPH systems for the first three years of the demonstration. The pool will then phase down by 10% in the fourth year of the demonstration and by an additional 15% in the fifth year of the demonstration.

# PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL

## REGULAR POLICY CHANGE NUMBER: 74

**Reason for Change:**
The net increase in FY 2017-18, from the prior estimate, is due to:

- Increased DY 2016-17 payments from hospitals not achieving the metrics to claim the full payment in the DY 2016-17 semi-annual payment period in FY 2016-17. The full allocation is expected to be achieved for the DY 2016-17 annual payment in FY 2017-18; and
- Decreased DY 2017-18 payments from updating the payment split for the two annual payments from the historical 64% / 36% split to a 50% / 50% split starting DY 2017-18.

The decrease from FY 2017-18 to FY 2018-19, in the current estimate, is due to including the first semi-annual payment for DY 2018-19 which factors in the 10% phase down 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 remaining DY 2016-17 allocations are estimated to be paid in FY 2017-18.

3. Starting in DY 2017-18 for both DMPHs and DPHs, based on the current hospitals' plans, assume the first semi-annual payment will be 50% of the annual DY allotment. The annual payment will include the remaining 50% of the annual DY allotment plus any unclaimed allotment funds from the first semi-annual payment period, if all metrics are achieved.

4. 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 | $794,000 | $397,000 | $397,000 |
| DMPH | $177,000 | $88,500 | $88,500 |
| Total | $971,000 | $485,500 | $485,500 |
| 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** | **$1,771,000** | **$885,500** | **$885,500** |

# 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 | $700,000 | $350,000 | $350,000 |
| DMPH | $100,000 | $50,000 | $50,000 |
| Total | $800,000 | $400,000 | $400,000 |
| 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** | **$1,520,000** | **$760,000** | **$760,000** |

**Funding:**
50% Title XIX FF (4260-101-0890)
50% Public Hospital Investment, Improvement, and Incentive Fund (4260-601-3172)

# MEDI-CAL 2020 WHOLE PERSON CARE PILOTS

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 75 |
| IMPLEMENTATION DATE: | 7/2016 |
| ANALYST: | Candace Epstein |
| FISCAL REFERENCE NUMBER: | 1953 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $581,821,000 | $646,730,000 |
| - STATE FUNDS | $290,910,000 | $323,365,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $581,821,000 | $646,730,000 |
| STATE FUNDS | $290,910,000 | $323,365,000 |
| FEDERAL FUNDS | $290,911,000 | $323,365,000 |

## 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 from Appropriation for FY 2016-2017 is a decrease of $138 million TF ($0 GF) because the total amount of funds initially allocated to entities through an application process a was less than the annual amount available. A second round of applications was accepted to allocate the remaining funding through the end of the Waiver. The increase from proposed CY 2017-2018 to BY 2018-2019 in the current estimate is an increase of $64 million ($0 GF) due to appropriating the unallocated funds to applicants through 2020.

**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.

# MEDI-CAL 2020 WHOLE PERSON CARE PILOTS

## REGULAR POLICY CHANGE NUMBER: 75

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 and correspond to calendar years. PY 3 begins January 2018.

6. First Round Lead Entity PY 1 payments were made in December 2016 (75%) and in March/April 2017 (25%).

7. Second Round Lead Entity PY 1 payments were made in August 2017 (100%).

8. PY 2 payments will be made in November 2017 (42%) and in May 2018 (58%).

9. PY 3 payments will be made in October/November 2018 (50%) and May 2019 (50%).

(Dollars in Thousands)

| | TF | IGT* | FF |
|---|---|---|---|
| **FY 2017-18** | $581,821 | $290,910 | $290,911 |

(Dollars in Thousands)

| | TF | IGT* | FF |
|---|---|---|---|
| **FY 2018-19** | $646,730 | $323,365 | $323,365 |

**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 | $106,752,000 | $159,630,000 |
| - STATE FUNDS | $53,376,000 | $79,815,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $106,752,000 | $159,630,000 |
| STATE FUNDS | $53,376,000 | $79,815,000 |
| FEDERAL FUNDS | $53,376,000 | $79,815,000 |

## 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 Programs (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

## REGULAR POLICY CHANGE NUMBER: 76

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. 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 a net decrease due to updated data showing an overall decrease in expenses due to the number of expected services based on updated actuals. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to a projected increase in utilization in FY 2018-19.

**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 on a semi-annual basis.

# MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

## REGULAR POLICY CHANGE NUMBER: 76

4. Statewide Medi-Cal eligibles are expected to grow at 1% annually. Expenditures include incentive payments made at the 75% above SMA for the 2% increase of utilization with 1% 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 | $54,472,000 | $27,236,000 | $27,236,000 |
| FY 2018-19 | $61,292,000 | $30,646,000 | $30,646,000 |

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 40% 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 1%. 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 Texas where 16% of children fall under the Low Risk category, 27% fall under the Moderate Risk category and 57% 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.

    Total Domain 2 costs are estimated to be:

| Fiscal Year | TF | GF | FF |
|---|---|---|---|
| FY 2017-18 | $2,889,000 | $1,444,500 | $1,444,500 |
| FY 2018-19 | $28,872,000 | $14,436,000 | $14,436,000 |

# MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

## REGULAR POLICY CHANGE NUMBER: 76

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 twice 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 1% 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 90% 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 | $13,205,000 | $6,602,500 | $6,602,500 |
| FY 2018-19 | $31,015,000 | $15,507,500 | $15,507,500 |

Domain 4: Local Dental Pilot Program

17. The implementation for this domain was April 15, 2017. Payments will be made quarterly beginning FY 2017-18.

18. Fifteen LDPPs were approved.

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 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.

# MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

## REGULAR POLICY CHANGE NUMBER: 76

Total Domain 4 costs are estimated to be:

| Fiscal Year | TF | GF | FF |
|---|---|---|---|
| **FY 2017-18** | **$36,186,000** | **$18,093,000** | **$18,093,000** |
| **FY 2018-19** | **$38,451,000** | **$19,225,500** | **$19,225,500** |

21. On a cash basis, the FY 2017-18 and FY 2018-19 total demonstration costs are:

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| Domain 1 | $54,472,000 | $27,236,000 | $27,236,000 |
| Domain 2 | $2,889,000 | $1,444,500 | $1,444,500 |
| Domain 3 | $13,205,000 | $6,602,500 | $6,602,500 |
| Domain 4 | $36,186,000 | $18,093,000 | $18,093,000 |
| **Total** | **$106,752,000** | **$53,376,000** | **$53,376,000** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| Domain 1 | $61,292,000 | $30,646,000 | $30,646,000 |
| Domain 2 | $28,872,000 | $14,436,000 | $14,436,000 |
| Domain 3 | $31,015,000 | $15,507,500 | $15,507,500 |
| Domain 4 | $38,451,000 | $19,225,500 | $19,225,500 |
| **Total** | **$159,630,000** | **$79,815,000** | **$79,815,000** |

**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:**
The change in FY 2017-18, from the prior estimate, is a decrease due to shifting the remaining final reconciliations for invoice counties to FY 2017-18, and delaying the final reconciliations for the LIHP cost report counties to 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 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:**
The change in FY 2017-18, from the prior estimate, is a decrease due to shifting the remaining final reconciliations for invoice counties to FY 2017-18, and delaying the final reconciliations for the LIHP cost report counties to 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 | $1,263,000 | $376,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $1,263,000 | $376,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $1,263,000 | $376,000 |

## 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 uncompensated care services 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 remaining Calendar Year (CY) 2016 claim was paid in July 2017,
- Revised estimated encounters for CY 2017 based on CY 2017 quarter 1 actuals, and
- Decreased estimated encounters for CY 2018 due to the exclusion of projected dental encounters as a result of the restoration of full adult dental services to Medi-Cal patients, effective January 1, 2018.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to decreased estimated encounters for CY 2018 and CY 2019 as a result of the restoration of full adult dental services.

**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. Assume the rate is $391 for CY 2018 and CY 2019.

7. IHS claims are paid for each encounter. Assume the encounters for CY 2017 are 2,730, CY 2018 are 960, and CY 2019 are 960.

| | | | |
|---|---|---|---|
| Calendar Year 2017 | 2,730 encounters x | $391 = | $1,067,430 FF |
| Calendar Year 2018 | 960 encounters x | $391 = | $375,360 FF |
| Calendar Year 2019 | 960 encounters x | $391 = | $375,360 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 | $1,067,000 | $1,067,000 |
| Calendar Year 2018 | $94,000 | $94,000 |
| **Total** | **$1,263,000** | **$1,263,000** |

| FY 2018-19 | TF | FF |
|---|---|---|
| Calendar Year 2018 | $282,000 | $282,000 |
| Calendar Year 2019 | $94,000 | $94,000 |
| **Total** | **$376,000** | **$376,000** |

**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:**
The change in FY 2017-18, from the prior estimate, is a decrease due to shifting the remaining final reconciliations for invoice counties to FY 2017-18, and delaying the final reconciliations for the HCCI cost report counties to 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 HCCI invoice counties and the HCCI counties that used cost reports. The current estimate reflects reconciliation of HCCI invoice counties occurring in FY 2017-18, and the reconciliation of HCCI 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:**
The change in FY 2017-18, from the prior estimate, is due to delays in receiving final CMHS data resulting in the shift of the final reconciliation from FY 2016-17 to FY 2017-18. 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)<br>• Song-Brown Health Care Workforce Training<br>• Steven M. Thompson Physician Corp Loan Repayment Program (STLRP)<br>• 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 from the prior estimate and from FY 2017-18 to FY 2018-19 in the current estimate. The FY 2017-18 DSHP claiming allocations, however, have 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:

(Dollars in Thousands)

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| CCS | $0 | ($38,000) | $38,000 |
| GHPP | $0 | ($28,000) | $28,000 |
| MIA-LTC | $0 | ($8,000) | $8,000 |
| BCCTP | $0 | ($1,000) | $1,000 |
| **Total** | **$0** | **($75,000)** | **$75,000** |

(Dollars in Thousands)

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| CCS | $0 | ($38,000) | $38,000 |
| GHPP | $0 | ($28,000) | $28,000 |
| MIA-LTC | $0 | ($8,000) | $8,000 |
| BCCTP | $0 | ($1,000) | $1,000 |
| **Total** | **$0** | **($75,000)** | **$75,000** |

**Funding:**
100% GF (4260-101-0001)
100% Health Care Support Fund (4260-601-7503)

# CMS DEFERRED CLAIMS

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 84 |
| IMPLEMENTATION DATE: | 3/2017 |
| ANALYST: | Joy Oda |
| FISCAL REFERENCE NUMBER: | 2034 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $0 |
| - STATE FUNDS | $71,690,000 | $6,364,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $0 |
| STATE FUNDS | $71,690,000 | $6,364,000 |
| FEDERAL FUNDS | -$71,690,000 | -$6,364,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the repayment of deferred claims to the Centers for Medicare and Medicaid Services (CMS).

**Authority:**
California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)
Title 42, Code of Federal Regulations (CFR), 430.40

**Interdependent Policy Changes:**
Not Applicable

**Background:**
CMS reviews claims submitted by state Medicaid agencies to ensure federal financial participation (FFP) eligibility. Claims for which CMS questions the FFP eligibility are deferred and the state Medicaid agency is issued a deferral notice. Upon receipt of the deferral notice, the state Medicaid agency has 120 days to resolve the deferred claim.

When CMS issues a deferral to the state Medicaid agency, in accordance with the timelines set forth in 42 CFR 430.40, the state Medicaid agency must immediately return the deferred FFP to the applicable Payment Management System (PMS) subaccount while the deferral is being resolved. As part of the resolution process, the state Medicaid agency submits documentation in support of the deferred claim to CMS for review. If CMS determines the deferred claim is allowed, then the deferral is released, the funds are returned to the appropriate PMS subaccount, and the state Medicaid agency is notified that the funds are available to be redrawn.

The California Medi-Cal 2020 Demonstration Waiver requires Medi-Cal 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.

# CMS DEFERRED CLAIMS

## REGULAR POLICY CHANGE NUMBER: 84

**Reason for Change:**
The change in FY 2017-18, from the prior estimate, is due to updated data based on actual deferral amounts from CMS.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to lower projected deferral payments in FY 2018-19.

**Methodology:**

1. The Department has received CMS deferrals for Federal Fiscal Year (FFY) 2015 Quarters 1 through 4. The Department has 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 estimates to repay a total of $71.69 million FF for the following:
   - $67.91 million FF for CMS deferrals issued for the FFY 2015 Quarters 3 and 4, and
   - $3.78 million FF for projected hospital per diem deferrals.

3. In FY 2018-19, the Department estimates to repay $6.364 million FF for projected hospital per diem deferrals.

4. The Department will repay the following estimated deferred claims:

| FY 2017-18 | Total Estimated Repayment |
|---|---|
| FFY 2015 Quarter 3 (Apr-June 2015) | $20,357,000 |
| FFY 2015 Quarter 4 (Jul-Sep 2015) | $47,553,000 |
| FFY 2016 Quarter 1 (Oct-Dec 2015) | $2,136,000 |
| FFY 2016 Quarter 2 (Jan-Mar 2016) | $1,644,000 |
| **Total FY 2017-18** | **$71,690,000** |

| FY 2018-19 | Total Estimated Repayment |
|---|---|
| FFY 2016 Quarter 3 (Apr-June 2016) | $2,127,000 |
| FFY 2016 Quarter 4 (Jul-Sep 2016) | $1,489,000 |
| FFY 2017 Quarter 1 (Oct-Dec 2016) | $1,498,000 |
| FFY 2017 Quarter 2 (Jan-Mar 2017) | $1,250,000 |
| **Total FY 2018-19** | **$6,364,000** |

**Funding:**
100% Title XIX FFP (4260-101-0890)
100% GF (4260-101-0001)

# CMS DEFERRALS & NEGATIVE BALANCE REPAYMENT

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 85 |
| IMPLEMENTATION DATE: | 7/2018 |
| ANALYST: | Joy Oda |
| FISCAL REFERENCE NUMBER: | 2035 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $0 |
| - STATE FUNDS | $0 | $139,386,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $0 |
| STATE FUNDS | $0 | $139,386,000 |
| FEDERAL FUNDS | $0 | -$139,386,000 |

## 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.

The California Medi-Cal 2020 Demonstration Waiver requires Medi-Cal 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 which must be resolved by the end of the demonstration waiver, December 31, 2020.

# 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 even, quarterly installments by July 1, 2018.

**Reason for Change:**
There is no change in FY 2017-18, from the prior estimate. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the inclusion of four repayment quarters in FY 2018-19.

**Methodology:**
1. The Department expects to begin the remaining repayments to CMS in July 2018 on a quarterly basis, for a total of 10 installments.

2. Assume four repayments will be made in FY 2018-19 totaling $139,386,000.

(Dollars in Thousands)

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| Repayments | $0 | $139,386 | ($139,386) |

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 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 | $3,553,667,000 | $143,781,000 |
| - STATE FUNDS | $1,316,348,000 | $41,322,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $3,553,667,000 | $143,781,000 |
| STATE FUNDS | $1,316,348,000 | $41,322,000 |
| FEDERAL FUNDS | $2,237,319,000 | $102,459,000 |

## 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
PC 87 Two Plan Model
PC 88 County Organized Health Systems

**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, the managed care rate range IGT program will be discontinued as a result of the Managed Care Final Rule.

# MANAGED CARE RATE RANGE IGTS

## REGULAR POLICY CHANGE NUMBER: 90

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is an increase due to incorporating FY 2015-16 and FY 2016-17 actual participating levels. FY 2017-18 amounts were updated based on anticipated 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 the remaining balance of 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 | $391,761 | $374,663 | $105,001 | $25,015 | $504,679 | $896,440 |
| FY 2016-17 | $470,043 | $449,529 | $125,983 | $30,013 | $605,525 | $1,075,568 |
| FY 2017-18 | $454,544 | $402,428 | $112,783 | $26,869 | $1,127,115 | $1,581,659 |
| **Total FY 2017-18** | **$1,316,348** | $1,226,620 | $343,767 | $81,897 | **$2,237,319** | **$3,553,667** |

(Dollars in Thousands)

| FY 2018-19 | IGT | T19 FF | T21 FF | Family Planning FF | Total FF | TF |
|---|---|---|---|---|---|---|
| FY 2017-18 | $41,322 | $36,584 | $10,253 | $2,443 | $102,459 | $143,781 |
| **Total 2018-19** | **$41,322** | $36,584 | $10,253 | $2,443 | **$102,459** | **$143,781** |

**Funding:**
100% Title XIX FFP (4260-101-0890)
100% Title XXI FFP (4260-113-0890)
Reimbursement (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 | $9,981,455,000 | $7,769,067,000 |
| - STATE FUNDS | $4,990,727,500 | $3,884,533,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 53.79 % | 71.78 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $4,612,430,400 | $2,192,430,700 |
| STATE FUNDS | $2,306,215,180 | $1,096,215,350 |
| FEDERAL FUNDS | $2,306,215,180 | $1,096,215,350 |

## 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 will be removed from capitation rate payments effective January 1, 2018.

**Reason for Change:**
There is an overall net increase in FY 2017-18 from the previous estimate due to the following:

- Overall decrease in all CCI member months – 293,000
  - Increase in CMC – 20,000
  - Decrease in MLTSS Full Dual – 343,000
  - Decrease in MLTSS Non-Full Dual – 4,000
  - Increase in MLTSS Non-Full Dual Institutional – 34,000
- Percent of opt-ins (out of all full duals) increased from 16% to 17%
- Weighted average opt-in rates decreased from $528.50 to $485.10
- The MLTSS Full Dual weighted average rate decreased from $861.42 to $745.00
- IHSS portion of opt-in rates increased from $215.37 to $235.72
- IHSS portion of MLTSS Full Dual rates decreased from $403.43 to $362.54

FY 2018-19 costs decreased from FY 2017-18 in the current estimate. These changes are primarily due to the removal of IHSS from CCI beginning January 1, 2018. Other changes include:

- Overall increase in member months – 118,000
  - No change in CMC
  - Increase in MLTSS Full Dual – 71,000
  - Increase in MLTSS Non-Full Dual – 47,000
  - No change in MLTSS Non-Full Dual Institutional
- Percent of opt-ins (out of all full duals) remained the same at 17%.
- Weighted average opt-in rates increased from $259.83 to $272.82
- The MLTSS weighted average rate increased from $477.89 to $501.72

**Methodology:**

1. All dual eligibles (not including additional enrollment population) 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

# CCI-MANAGED CARE PAYMENTS

## REGULAR POLICY CHANGE NUMBER: 91

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 quarterly depending on the most recently available approved rates. CY 2015 and CY 2017 rates will be paid in FY 2017-18, while CY 2017, CY 2018, and CY 2019 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)

| FY 2017-18 | TF | GF | FFP | Reimb. |
|---|---|---|---|---|
| CCI-Managed Care Payments (PC 91): | | | | |
| Base managed care payments | $7,143,950 | $3,571,975 | $3,571,975 | $0 |
| Base managed care payments for add'l enrollment | $225,765 | $112,882 | $112,882 | |
| Transfer of IHSS Costs to CDSS | $2,474,035 | $1,237,018 | $1,237,018 | $0 |
| Transfer of IHSS Costs to CDSS for add'l enrollment | $137,705 | $68,852 | $68,852 | |
| **Total Managed Care Payments** | **$9,981,455** | **$4,990,727** | **$4,990,727** | **$0** |
| | | | | |
| CCI-Savings and Deferral : | | | | |
| Total Savings (In the Base) | ($7,155,412) | ($3,577,706) | ($3,577,706) | $0 |
| FFS Savings for Additional Enrollment (In the Base): | ($269,705) | ($134,853) | ($134,853) | $0 |
| Defer Managed Care Payment (In the Base) | ($6,719) | ($3,360) | ($3,360) | $0 |
| Total | ($7,431,836) | ($3,715,918) | ($3,715,918) | $0 |
| | | | | |
| IHSS Savings (In the Base) | ($1,305,870) | $0 | ($1,305,870) | $0 |
| Delay 1 Checkwrite (In the Base) | $68,353 | $34,176 | $34,176 | $0 |
| CCI-Transfer of IHSS Costs to DHCS (PC 195) | $0 | ($1,305,870) | $0 | $1,305,870 |
| CCI-Admin Costs, HCO Costs (OA 15, 18, 67) | $27,492 | $13,746 | $13,746 | $0 |
| | | | | |
| Retro MC Rate Adjustments (PC 117) | $1,332,444 | $221,935 | $666,222 | $444,287 |
| CCI-Quality Withhold Repayments (PC 101) | $1,353 | $676 | $677 | $0 |
| Health Insurer Fee (PC 18) | $5,724 | $2,862 | $2,862 | $0 |
| | | | | |
| Total of CCI PCs including pass through | $2,679,115 | $239,473 | $683,761 | $1,750,157 |

# CCI-MANAGED CARE PAYMENTS

## REGULAR POLICY CHANGE NUMBER: 91

(Dollars in Thousands)

| FY 2018-19 | TF | GF | FFP | Reimb. |
|---|---|---|---|---|
| CCI-Managed Care Payments (PC 91): | | | | |
| Base managed care payments | $7,483,438 | $3,741,719 | $3,741,719 | $0 |
| Base managed care payments for add'l enrollment | $285,629 | $142,815 | $142,815 | |
| **Total Managed Care Payments** | **$7,769,067** | **$3,884,534** | **$3,884,534** | **$0** |
| | | | | |
| CCI-Savings and Deferral : | | | | |
| Total Savings (In the Base) | ($7,513,534) | ($3,756,767) | ($3,756,767) | $0 |
| FFS Savings for Additional Enrollment (In the Base): | ($288,675) | ($144,337) | ($144,337) | $0 |
| Defer Managed Care Payment (In the Base) | $71,125 | $35,563 | $35,563 | $0 |
| Total | ($7,731,084) | ($3,865,542) | ($3,865,542) | $0 |
| | | | | |
| Delay 1 Checkwrite (In the Base) | ($19,578) | ($9,789) | ($9,789) | $0 |
| CCI-Admin Costs, HCO Costs (OA 15, 18, 67) | $17,039 | $8,520 | $8,520 | $0 |
| | | | | |
| Retro MC Rate Adjustments (PC 117) | $85,018 | $45,463 | $42,509 | ($2,954) |
| CCI-Quality Withhold Repayments (PC 101) | $9,000 | $4,500 | $4,500 | $0 |
| Health Insurer Fee (PC 18) | $5,724 | $2,862 | $2,862 | $0 |
| | | | | |
| Total of CCI PCs including pass through | $135,186 | $70,547 | $67,593 | ($2,954) |

**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 | $2,131,735,000 | $2,246,407,000 |
| - STATE FUNDS | $610,312,390 | $654,341,330 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $2,131,735,000 | $2,246,407,000 |
| STATE FUNDS | $610,312,390 | $654,341,330 |
| FEDERAL FUNDS | $1,521,422,610 | $1,592,065,670 |

## 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 change from the prior estimate for FY 2017-18.

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.

2. Enrollment for managed care plans are based on the number of Medi-Cal enrollees, alternate health

# MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES

**REGULAR POLICY CHANGE NUMBER: 92**

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** | **$2,131,735** | $610,312 | $1,521,443 |
| **FY 2018-19** | **$2,246,407** | $654,341 | $1,592,066 |

**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 | $1,717,598,000 | $0 |
| - STATE FUNDS | $329,258,000 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $1,717,598,000 | $0 |
| STATE FUNDS | $329,258,000 | $0 |
| FEDERAL FUNDS | $1,388,340,000 | $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 June 30, 2017, the Managed Care Public Hospital IGT program will be discontinued as a result of the Managed Care Final Rule.

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

- Revising FY 2015-16 and FY 2016-17 IGTs to reflect actuals, and
- The removal of FY 2017-18 IGTs.

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 and FY 2016-17 payments are expected to occur in FY 2017-18.

DPH – OE

1. FY 2015-16 payments are expected to occur in FY 2017-18. $0 has been budgeted as the IGT

# MANAGED CARE PUBLIC HOSPITAL IGTS

## REGULAR POLICY CHANGE NUMBER: 93

amount as this rating period is funded solely by federal funds.

2. FY 2016-17 payments are expected to occur in FY 2017-18.

(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 2016-17 | $333,589 | $166,794 | $166,793 | $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** | **$1,717,598** | **$329,258** | **$313,088** | **$1,075,250** |

**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 | $265,300,000 | $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 | $265,300,000 | $0 |
| STATE FUNDS | $132,650,000 | $0 |
| FEDERAL FUNDS | $132,650,000 | $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 December 31, 2016. 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. AB 1607 extends the Hospital QAF program through December 31, 2017. However, the Hospital QAF program rate range increases were discontinued as of December 31, 2016.

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 updated rate range increases for FY 2015-16.

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 | $181,300 | $90,650 | $86,694 | $3,313 | $643 | $90,650 |
| FY 2016-17 Increases (July-Dec 2016) | $84,000 | $42,000 | $40,167 | $1,535 | $298 | $42,000 |
| **Total** | **$265,300** | **$132,650** | **$126,861** | **$4,848** | **$941** | **$132,650** |

**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: | 7/2014 |
| ANALYST: | Andrew Yoo |
| FISCAL REFERENCE NUMBER: | 1781 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $22,018,000 | $0 |
| - STATE FUNDS | $10,821,000 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $22,018,000 | $0 |
| STATE FUNDS | $10,821,000 | $0 |
| FEDERAL FUNDS | $11,197,000 | $0 |

## DESCRIPTION

**Purpose:**
This policy change estimates the cost of capitation rate increases that are offset by Managed Care Organization (MCO) tax proceeds. The tax proceeds will be used for the non-federal share of capitation rate increases.

**Authority:**
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 an increase due to an increase to retro payments from the applicable period scheduled to be paid in FY 2017-18.

The change from FY 2017-18 to FY 2018-19 is due to the completion of all applicable retro-period activity.

# MCO TAX MGD. CARE PLANS - INCR. CAP. RATES

## REGULAR POLICY CHANGE NUMBER: 99

**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:

(Dollars in Thousands)

| | TF | GF (MCO Tax) | FF |
|---|---|---|---|
| **FY 2017-18** | **$22,018** | **$10,821** | **$11,197** |

**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 | $2,946,000 | $11,412,000 |
| - STATE FUNDS | $1,473,000 | $5,706,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $2,946,000 | $11,412,000 |
| STATE FUNDS | $1,473,000 | $5,706,000 |
| FEDERAL FUNDS | $1,473,000 | $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 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.

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 based on performance measures.

# CCI-QUALITY WITHHOLD REPAYMENTS

## REGULAR POLICY CHANGE NUMBER: 101

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.

**Reason for Change:**
For FY 2017-18, the decrease is because CY 2015 repayments that occur in FY 2017-18 were originally budgeted at 100%. Evaluations have been completed, and the amount of quality withhold that the plans will receive has been determined. The repayment ranges between 25% and 100% of the amount withheld. The difference between FY 2017-18 and FY 2018-19 is because FY 2017-18 is budgeting for CY 2015 repayments at 59% due to plans not meeting the benchmarks and FY 2018-19 is budgeting for CY 2015 repayments at 100%. Additionally, withheld amounts and the subsequent repayments are based on the CMC payments for the associated program year.

**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 the second year of CCI (CY 2015) will be repaid in December 2017. Of the amount withheld, only 59% will be repaid because plans did not meet the benchmarks.

4. Assume quality withholds for CY 2016 repaid in FY 2018-19 will be repaid at 100%.

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| Quality Withhold Repayment (CY 2015) | $2,946,000 | $1,473,000 | $1,473,000 |

| 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 | $2,046,000 | -$122,000 |
| - STATE FUNDS | $961,590 | -$46,210 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $2,046,000 | -$122,000 |
| STATE FUNDS | $961,590 | -$46,210 |
| FEDERAL FUNDS | $1,084,410 | -$75,790 |

## 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: Pending contract

**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, is a decrease due to an implementation delay from June 2017 to November 2017 for payment.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease 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 $254,000 TF in FY 2017-18.

3. The Department estimates $1,300,000 TF 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:

| | TF | GF | FF |
|---|---|---|---|
| FY 2017-18 | $2,046,000 | $961,000 | $1,085,000 |
| FY 2018-19 | ($122,000) | ($46,000) | ($76,000) |

**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 PUBLIC HOSPITAL DIRECTED PAYMENTS

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 104 |
| IMPLEMENTATION DATE: | 1/2019 |
| ANALYST: | Andrew Yoo |
| FISCAL REFERENCE NUMBER: | 2060 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $1,569,000,000 |
| - STATE FUNDS | $0 | $457,596,400 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $1,569,000,000 |
| STATE FUNDS | $0 | $457,596,400 |
| FEDERAL FUNDS | $0 | $1,111,403,600 |

## DESCRIPTION

**Purpose:**
This policy change budgets managed care directed payments to fund enhanced managed care capitation payments to managed care plans (MCPs) for Designated Public Hospitals (DPHs) and University of California Health Systems (UCs) based on utilization of network contracted services.

**Authority:**
SB 171 (Legislation Pending)
AB 205 (Legislation Pending)
Code of Federal Regulations (CFR) Section 438.6 9 (c)

**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.

Beginning July 1, 2017, with the FY 2017-18 rating period, the state will direct MCPs to reimburse California's 21 DPHs for network contracted services delivered by DPH systems, enhanced by either a uniform percentage or dollar increment based on actual utilization of network contracted services.

The state will evaluate the extent to which enhanced payments are achieving the goals identified. These may only apply to certain managed care categories of aid. The payments will be enhanced by either a uniform percentage or dollar increment. The total funding available for the enhanced network contracted payments will be limited to a predetermined amount (pool).

# MANAGED CARE PUBLIC HOSPITAL DIRECTED PAYMENTS

## REGULAR POLICY CHANGE NUMBER: 104

Upon determination of actual utilization, the State will direct the MCPs to make enhanced payments to DPHs and UCs for network contracted services. Following the issuance of all enhanced payments, the State will adjust per-member-per-month increments for actual utilization.

**Reason for Change:**
This is a new policy change.

**Methodology:**

1. Assume that estimated total value of the funding for the public hospital directed payment pool is $1,569,000,000 TF for rating period FY 2017-18.

2. Enhanced payment will be issued to MCPs based on actual public hospital utilization for network contracted services.

3. The first payment is anticipated to be made in January 2019.

4. On a cash basis, the estimated payments are:

(Dollars in Thousands)

| FY 2018-19 | TF | GF | FF | ACA |
|---|---|---|---|---|
| FY 2017-18 | | | | |
| Title XIX | $826,008 | $413,004 | $413,004 | $0 |
| ACA 2017 95/5 | $342,823 | $17,141 | $0 | $325,682 |
| ACA 2018 94/6 | $342,823 | $20,569 | $0 | $322,254 |
| Title XXI | $57,345 | $6,881 | $50,464 | $0 |
| **FY 2018-19** | **$1,569,000** | **$457,596** | **$463,468** | **$647,936** |

**Funding:**
100% State GF (4260-101-0001)
100% Title XIX FFP (4260-101-0890)
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)

# MANAGED CARE HEALTH CARE FINANCING PROGRAM

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 105 |
| IMPLEMENTATION DATE: | 5/2019 |
| ANALYST: | Andrew Yoo |
| FISCAL REFERENCE NUMBER: | 2061 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $1,515,011,000 |
| - STATE FUNDS | $0 | $454,545,260 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $1,515,011,000 |
| STATE FUNDS | $0 | $454,545,260 |
| FEDERAL FUNDS | $0 | $1,060,465,740 |

## DESCRIPTION

**Purpose:**
This policy change estimates increased payments to managed care plans (MCPs) designed to support payment levels to counties and/or public entities serving Medi-Cal beneficiaries.

**Authority:**
W&I 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:**
This is a new policy change.

**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 $1,515,011,000 TF.

3. Assume 11 months of payments for FY 2018-19 to occur in FY 2018-19.

4. Anticipated costs on an cash basis are:

# MANAGED CARE HEALTH CARE FINANCING PROGRAM

## REGULAR POLICY CHANGE NUMBER: 105

(Dollars in Thousands)

| FY 2018-19 | TF | Enhanced MC Payment | FF |
|---|---|---|---|
| Title XIX | $807,303 | $403,652 | $403,652 |
| Title XXI | $94,027 | $11,283 | 82,744 |
| ACA 94/6 | $334,734 | $20,084 | 314,651 |
| ACA 93/7 | $278,946 | $19,526 | 259,420 |
| ***Total** | **$1,515,011** | **$454,545** | **$1,060,466** |

*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: | 1/2019 |
| 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 | $186,654,920 |
| 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 | $186,654,920 |
| FEDERAL FUNDS | $0 | $453,345,080 |

## 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 (Legislation Pending)
AB 205 (Legislation Pending)

**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.

Beginning July 1, 2017, with the FY 2017-18 rating period, the Department will implement a managed care DPH and UC QIP. 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).

**Reason for Change:**
This is a new policy change.

# MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL

**REGULAR POLICY CHANGE NUMBER: 106**

**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 | $336,931 | $168,466 | $168,466 | $0 |
| ACA 2017 95/5 | $139,839 | $6,992 | $0 | $132,847 |
| ACA 2018 94/6 | $139,839 | $8,390 | $0 | $131,448 |
| Title XXI | $23,391 | $2,807 | $20,584 | $0 |
| **FY 2018-19** | **$640,000** | **$186,655** | **$189,050** | **$264,295** |

**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 | $381,976,000 |
| - STATE FUNDS | $0 | $180,904,240 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $381,976,000 |
| STATE FUNDS | $0 | $180,904,240 |
| FEDERAL FUNDS | $0 | $201,071,760 |

## 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 2.75% average rate increase, excluding Optional Expansion (OE) rates. OE rates are held constant from FY 2017-18 to FY 2018-19.

# CAPITATED RATE ADJUSTMENT FOR FY 2018-19

## REGULAR POLICY CHANGE NUMBER: 107

**Methodology:**
(Dollars in Thousands)

| | Cost by Plan | Rate Adjustment | Rate Increase (Cash Basis) |
|---|---|---|---|
| COHS | $3,777,919 | 2.75% | $95,243 |
| GMC | $1,629,472 | 2.75% | $41,080 |
| Regional | $693,859 | 2.75% | $17,493 |
| Two Plan | $9,050,231 | 2.75% | $228,160 |
| **Total** | $15,151,481 | | $381,976 |

**Funding:**

| FY 2018-19 | Two Plan | COHS | GMC | Regional | Total |
|---|---|---|---|---|---|
| Title XIX 50/50 FFP (4260-101-0001/0890) | $212,384,000 | $86,722,000 | $37,674,000 | $16,143,000 | $352,923,000 |
| State GF (4260-101-0001) | $760,000 | $214,000 | $142,000 | $56,000 | $1,172,000 |
| Family Planning 90/10 GF (4260-101-0001-0890) | $2,288,000 | $850,000 | $417,000 | $194,000 | $3,749,000 |
| Title XXI 88/12 GF (4260-101-0001/0890) | $12,729,000 | $7,458,000 | $2,846,000 | $1,100,000 | $24,132,000 |
| **Total Funds** | $228,160,000 | $95,243,000 | $41,080,000 | $17,493,000 | **$381,976,000** |
| **GF** | $108,708,000 | $44,554,000 | $19,363,000 | $8,279,000 | **$180,904,000** |
| **FF** | $119,452,000 | $50,689,000 | $21,717,000 | $9,214,000 | **$201,072,000** |

# 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 | $13,384,000 |
| - STATE FUNDS | $0 | $1,338,400 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $13,384,000 |
| STATE FUNDS | $0 | $1,338,400 |
| FEDERAL FUNDS | $0 | $12,045,600 |

## 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 the following counties: Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, San Francisco, Shasta, Solano, Sonoma, and Yolo. Members of this group with eligible chronic physical conditions implement in July 2018. Members of this group with SMIs implement in January 2019.

- Group 2 represents the following counties: Imperial, Lassen, Merced, Monterey, Orange, Riverside, San Bernardino, San Mateo, Santa Clara, Santa Cruz, and Siskiyou. Members of this group with eligible chronic physical conditions implement in January 2019. Members of this group with SMIs implement in July 2019.

- Group 3 represents the following counties: Alameda, Fresno, Kern, Los Angeles, Sacramento, San Diego, and Tulare. Members of this group with eligible chronic physical conditions implement in July 2019. Members of this group with SMIs implement in January 2020.

**Reason for Change:**
This program was not budgeted in the May 2017 estimate.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the program implementation date of September 2018.

**Methodology:**
1. Assume the program begins July 2018. Enrollment will phase-in based on county and condition.

2. The HHP eligibility rate of a given Medi-Cal population is projected to be 2%. It is assumed 25% of the non-dual Targeted Engagement List (TEL) and 12.5% of the dual eligibles will enroll in the HHP for FY 2018-19.

3. Draft capitation rates are assumed to be $370.88 per member per month for FY 2018-19.

4. Assume 48,114 member months for FY 2018-19.

5. Assume a two month payment lag. Payments are estimated to begin in September 2018.

6. The May and June 2019 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.

# HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS

**REGULAR POLICY CHANGE NUMBER: 108**

8. The costs for FY 2018-19 are expected to be:

48,114 x $370.88 = $17,844,733 TF

9. On a cash basis, the costs for FY 2018-19 are expected to be:

$17,844,733 / 12 months x 10 payments in FY 2018-19
**= $13,384,000 TF**

(Dollars in Thousands)

| | TF | FF | HHP Fund* |
|---|---|---|---|
| **FY 2018-19** | **$13,384** | **$12,046** | **$1,338** |

**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 an increase due to retro payments scheduled to be paid and recouped in 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** | **($13,988)** | **$13,988** |

**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 an increase due to retro payments scheduled to be paid in FY 2017-18.

The change from FY 2017-18 to FY 2018-19, is due to the completion of all applicable retro-period activity.

# MCO TAX MANAGED CARE PLANS

## REGULAR POLICY CHANGE NUMBER: 110

**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** | ($414,743) | $414,743 |

**Funding:**

100% State GF (4260-101-0001)
*3156 MCO Tax (Non-GF) (4260-601-3156)
*3156 MCO Tax Fund MRMIB (4260-101-3156)

# 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, the collection of the IGT assessment fees will discontinue as a result of the Managed Care Final Rule.

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 updated managed care rate range IGT totals to reflect actual participation levels for FY 2015-16 and FY 2016-17. FY 2017-18 costs decreased due to a one month shift to FY 2018-19. The FY 2017-18 GME administrative fee increased due to applying a 3% annual growth factor.

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.

**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 | $364,642,000 | $72,928,000 | $251,000 | $72,677,000 |
| FY 2016-17 | $432,959,000 | $86,592,000 | $251,000 | $86,341,000 |
| FY 2017-18 | $392,158,000 | $78,432,000 | $230,000 | $78,202,000 |
| Total FY 2017-18 | $1,189,759,000 | $237,952,000 | $732,000 | $237,220,000 |

| 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 | $35,651,000 | $7,130,000 | $21,000 | $7,109,000 |
| Total FY 2018-19 | $35,651,000 | $7,130,000 | $21,000 | $7,109,000 |

# MANAGED CARE IGT ADMIN. & PROCESSING FEE

**REGULAR POLICY CHANGE NUMBER: 111**

| FY 2017-18 (GME) | IGT amount subject to the fee | 5% GME Admin Fee | Local Assistance Reimbursement to the GF |
|---|---|---|---|
| FY 2016-17 GME | $237,317,000 | $11,866,000 | $11,866,000 |
| FY 2017-18 GME | $366,654,000 | $18,333,000 | $18,333,000 |
| Total FY 2017-18 | $603,971,000 | $30,199,000 | $30,199,000 |

| FY 2018-19 (GME) | IGT amount subject to the fee | 5% GME Admin Fee | Local Assistance Reimbursement to the GF |
|---|---|---|---|
| FY 2017-18 GME | $122,218,000 | $6,111,000 | $6,111,000 |
| FY 2018-19 GME | $377,654,000 | $18,883,000 | $18,883,000 |
| Total FY 2018-19 | $499,872,000 | $24,994,000 | $24,994,000 |

(Dollars in Thousands)

| Fiscal Year | Local Assistance Reimbursement to the GF |
|---|---|
| **FY 2017-18** | **$267,419** |
| **FY 2018-19** | **$32,103** |

**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 | $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 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 a decrease due to:

- The removal of FY 2017-18 GF reimbursements, since the existing DPH reimbursement program will be discontinued on June 30, 2017, and
- Updated FY 2015-16 and FY 2016-17 totals based on actuals.

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:**
<u>DPH – SPD</u>

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.

(Dollars in Thousands)

| | **FY 2017-18** |
|---|---|
| SPD - FY 2014-15 | ($1,263) |
| SPD - FY 2015-16 | $70,282 |
| SPD - FY 2016-17 | $81,746 |
| ACA OE - FY 2016-17 | $9,324 |
| *Total Reimbursement | $160,090 |
| *GF | ($160,090) |
| **Net Impact** | **$0** |

*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: | 5/2018 |
| 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:**
This is a new policy change.

**Methodology:**
1. Data from FY 2016-17 and FY 2017-18 are used to estimate the annual commitment from allowable public entities.

2. Annual administration and processing fees are calculated based on the estimated FY 2017-18 participation.

# MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND

**REGULAR POLICY CHANGE NUMBER: 113**

3. On a cash basis, the estimated reimbursements to the General Fund are:

(Dollars in Thousands)

| | **FY 2017-18** |
|---|---|
| Total Reimbursement | $15,517 |
| GF | ($15,517) |
| **FY 2017-18 Net Impact** | **$0** |

(Dollars in Thousands)

| | **FY 2018-19** |
|---|---|
| FY 2017-18 | $724,535 |
| FY 2018-19 | $549,882 |
| FY 2018-19 Support Cost Reimb. To GF | ($230) |
| Total Reimbursement | $1,274,187 |
| GF | ($1,274,187) |
| **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, is due to:
- An updated funding allocation based on recent payment data, and
- Incorporating a quarter lag for the funds transfer.

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** | ($585,365) | $585,365 |
| **FY 2018-19** | **$0** | ($643,334) | $643,334 |

**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, 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 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** | ($1,782,194) | $1,782,194 |
| **FY 2018-19** | **$0** | ($1,875,880) | $1,875,880 |

**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 | -$1,889,663,000 | -$1,913,660,000 |
| - STATE FUNDS | -$616,537,360 | -$624,990,980 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$1,889,663,000 | -$1,913,660,000 |
| STATE FUNDS | -$616,537,360 | -$624,990,980 |
| FEDERAL FUNDS | -$1,273,125,640 | -$1,288,669,020 |

## 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, is an increase resulting from revised collection projections based on the result of the following:

- An additional quarter of actual Managed Care rebate collections from April 2017 through June 2017 which were significantly higher than previously estimated;
- Increased ACA optional based on data through June 2017;
- Increased ACA Offset rebates and Title XXI rebates based on data through June 2017; and
- Increased 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 projecting higher average quarterly collections.

# 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. Family planning drugs account for 0.08% of rebates and are funded with 90% federal funds (FF) and 10% General Fund (GF).

3. Assume CHIP drug rebate collections are estimated to be $80,328,000 TF in FY 2017-18 and $78,830,000 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 $603,914,000 TF for FY 2017-18, funded with 95% FF and 5% GF and $626,248,000 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 $51,278,000 TF for FY 2017-18 and $51,929,000 TF for FY 2018-19.

(Dollars in Thousands)

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| 50% Title XIX / 50% GF | ($1,153,220) | ($576,610) | ($576,610) |
| 95% Title XIX/ 5% GF | ($603,914) | ($30,196) | ($573,718) |
| 90% Title XIX / 10% GF | ($923) | ($92) | ($831) |
| ACA Offset | ($51,278) | $0 | ($51,278) |
| 88% Title XXI / 12 % GF | ($80,328) | ($9,639) | ($70,689) |
| **Total** | **($1,889,663)** | **($616,537)** | **($1,273,126)** |

(Dollars in Thousands)

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| 50% Title XIX / 50% GF | ($1,155,728) | ($577,864) | ($577,864) |
| 94% Title XIX/ 6% GF | ($626,248) | ($37,575) | ($588,673) |
| 90% Title XIX / 10% GF | ($925) | ($92) | ($833) |
| ACA Offset | ($51,929) | $0 | ($51,929) |
| 88% Title XXI / 12 % GF | ($78,830) | ($9,460) | ($69,370) |
| **Total** | **($1,913,660)** | **($624,991)** | **($1,288,669)** |

**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 | -$4,100,436,000 | $87,972,000 |
| - STATE FUNDS | $335,023,000 | $45,463,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$4,100,436,000 | $87,972,000 |
| STATE FUNDS | $335,023,000 | $45,463,000 |
| FEDERAL FUNDS | -$4,435,459,000 | $42,509,000 |

## 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, and
- Coordinated Care Initiative (CCI) full dual and non-full dual 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, and FY 2017-18, is a increase in recoupments due to:

- Adjusted CCI retro amounts for the following reasons:
  - CY 2016 estimates were updated using more current enrollment for CY 2016,
  - CY 2017 estimates were updated using draft CY 2017 rates,
  - A delay in some FY 2015-16 payments from FY 2016-17 to FY 2017-18, and
  - FY 2016-17 estimates were updated using final FY 2016-17 rates.

- A cost shift of payments previously budgeted to pay in FY 2016-17.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to updating payments and recoupment timeframes.

# RETRO MC RATE ADJUSTMENTS

## REGULAR POLICY CHANGE NUMBER: 117

**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 | $113,088 | $113,088 | |
| CCI Full Duals (CY 2015) | | | | |
| CMC | ($181,976) | ($90,988) | ($90,988) | |
| CMC Reimb. | $26,702 | $26,702 | $0 | |
| MLTSS | $23,498 | $11,749 | $11,749 | |
| MLTSS Reimb. | ($11,053) | ($11,053) | $0 | |
| CCI Full Duals (CY 2016) | | | | |
| CMC | ($91,640) | ($45,820) | ($45,820) | |
| CMC Reimb. | ($19,971) | ($19,971) | $0 | |
| MLTSS | $922,936 | $461,468 | $461,468 | |
| MLTSS Reimb. | ($295,170) | ($295,170) | $0 | |
| CCI Full Duals (CY 2017, 6 mons.) | | | | |
| CMC | $6,956 | $3,478 | $3,478 | |
| CMC Reimb. | ($14,548) | ($14,548) | $0 | |
| MLTSS | $437,844 | $218,922 | $218,922 | |
| MLTSS Reimb. | ($49,035) | ($49,035) | $0 | |
| CCI Non-Full Duals (FY 2015-16) | | | | |
| SFY 2015-16 | $33,212 | $16,606 | $16,606 | |
| SFY 2015-16 Reimb. | ($13,864) | ($13,864) | $0 | |
| CCI Non-Full Duals (FY 2016-17) | | | | |
| SFY 2016-17 | $181,614 | $90,807 | $90,807 | |
| SFY 2016-17 Reimb. | ($67,348) | ($67,348) | $0 | |
| CDSS Reconciliation (CY 2014) | $67,721 | $0 | $0 | $67,721 |
| ACA Optional Recoupment | | | | |
| ACA Optional Recoupment (FY 2015-16) | ($3,115,256) | $0 | ($3,115,256) | |
| ACA Optional Recoupment (July-Dec 2016) | ($2,181,048) | $0 | ($2,181,048) | |
| **Total FY 2017-18** | **($4,100,436)** | **$335,023** | **($4,503,180)** | **$67,721** |

# RETRO MC RATE ADJUSTMENTS

## REGULAR POLICY CHANGE NUMBER: 117

(Dollars in Thousands)

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| CCI Full Duals (CY 2016) | | | |
| CMC | ($4,874) | ($2,437) | ($2,437) |
| CMC Reimb. | $2,954 | $2,954 | $0 |
| CCI Full Duals (CY 2018, 6 mons.) | | | |
| CMC | $8,956 | $4,478 | $4,478 |
| MLTSS | $80,936 | $40,468 | $40,468 |
| **Total FY 2018-19** | $87,972 | $45,463 | $42,509 |

**Funding:**
50% Title XIX FF / 50% GF (4260-101-0001/0890)
ACA 100% FFP (2014-2016) (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 | $215,065,000 | $240,730,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $215,065,000 | $240,730,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $215,065,000 | $240,730,000 |

## 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 the FY 2007-08 and FY 2013-14 final reconciliations which shifted from FY 2016-17. In addition, the FY 2007-08 final reconciliations have been revised based on updated cost reports.

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:

(Dollars in Thousands)

| FY 2017-18 | TF | FF | ACA FF |
|---|---|---|---|
| 2007-08 Final Reconciliation | $82,208 | $82,208 | $0 |
| 2008-09 Final Reconciliation | $137,004 | $137,004 | $0 |
| 2013-14 Final Reconciliation | ($4,147) | ($11,812) | $7,665 |
| **Total** | **$215,065** | **$207,400** | **$7,665** |

| FY 2018-19 | TF | FF | ACA FF |
|---|---|---|---|
| 2009-10 Final Reconciliation | $168,943 | $168,943 | $0 |
| 2014-15 Final Reconciliation | $71,787 | $12,593 | $59,194 |
| **Total** | **$240,730** | **$181,536** | **$59,194** |

**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 | $186,708,000 | $0 |
| - STATE FUNDS | $73,374,740 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $186,708,000 | $0 |
| STATE FUNDS | $73,374,740 | $0 |
| FEDERAL FUNDS | $113,333,260 | $0 |

## DESCRIPTION

**Purpose:**
This policy change budgets the retroactive adjustments to dental managed care and Fee-for-Service 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 an increase due to shifts in payment timing. Payments intended to be made in FY 2016-17 were shifted to FY 2017-18. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to dental rate payments expected to be caught up in FY 2018-19 with no retroactive adjustment payments anticipated in FY 2018-19.

# DENTAL RETROACTIVE RATE CHANGES

## REGULAR POLICY CHANGE NUMBER: 119

**Methodology:**

1. Assume the following retroactive rate adjustments are to be made in FY 2017-18:

| Delta Dental<br>Rate Period | Existing Rate | New Rate | Change | Eligible Months | Dental Retro Rate Adjustment |
|---|---|---|---|---|---|
| Regular | | | | | |
| 07/01/2015 -07/31/2016 | $7.81 | $8.32 | $0.51 | 11,197,242 | $5,710,593 |
| 08/01/2016 - 05/31/2017 | $7.81 | $7.70 | ($0.11) | 111,042,358 | ($12,214,659) |
| 06/01/2017 - 06/30/2017 | $8.32 | $7.70 | ($0.62) | 11,017,589 | ($6,830,905) |
| 07/01/2017 - 12/31/2017 | $8.32 | $10.18 | $1.86 | 66,165,678 | $123,068,162 |
| 01/01/2018 - 01/30/2018 | $7.70 | $10.18 | $2.48 | 11,038,026 | $27,374,304 |
| Total Dental Retroactive Adjustments for Delta Dental (CO 26) | | | | | $137,107,495 |

| FY 2017-18 (cash basis) | Dental Retro Rate Adjustment |
|---|---|
| **Total FY 2017-18** | **$137,107,495** |

2. Assume the following retroactive rate adjustments are to be made in FY 2017-18:

| GMC and PHP Dental Rate Period | Dental Retro Rate Adjustment |
|---|---|
| **GMC <21** | |
| 07/01/2014 - 11/30/2014 | ($6,482) |
| 11/01/2014 - 06/30/2015 | $2,566,506 |
| 07/01/2016 - 07/30/2017 | $3,087,908 |
| 08/01/2017 - 12/31/2017 | $1,102,921 |
| **21+** | |
| 07/01/2014 - 11/30/2014 | $4,625,280 |
| 11/01/2014 - 06/30/2015 | $3,575,104 |
| 07/01/2016 - 07/30/2017 | $9,920,535 |
| 08/01/2017 - 12/31/2017 | ($1,184,996) |
| **PHP <21** | |
| 07/01/2014 - 11/30/2014 | $1,850,766 |
| 11/01/2014 - 06/30/2015 | $2,588,222 |
| 07/01/2016 - 07/30/2017 | $3,524,946 |
| 08/01/2017 - 12/31/2017 | $1,543,622 |
| **21+** | |
| 07/01/2014 - 11/30/2014 | $5,763,143 |
| 11/01/2014 - 06/30/2015 | $1,682,038 |
| 07/01/2016 - 07/30/2017 | $10,757,847 |
| 08/01/2017 - 12/31/2017 | ($1,796,689) |
| **Total Dental Retroactive Adjustments for GMC and PHP** | **$49,600,674** |

# DENTAL RETROACTIVE RATE CHANGES

**REGULAR POLICY CHANGE NUMBER: 119**

| FY 2017-18 (cash basis) | Dental Retro Rate Adjustment |
|---|---|
| **Total FY 2017-18** | **$49,600,674** |

**Funding:**

| FY 2017-18 | | TF | GF | FF |
|---|---|---|---|---|
| 50% Title XIX / 50% GF | 4260-101-0001/0890 | $141,546,000 | $70,773,000 | $70,773,000 |
| 65% Title XIX / 35% GF | 4260-101-0001/0890 | $8,000 | $3,000 | $5,000 |
| 88% Title XXI / 12% GF | 4260-101-0001/0890 | $3,515,000 | $422,000 | $3,093,000 |
| 94% Title XIX ACA FF / 6% GF | 4260-101-0001/0890 | $9,519,000 | $571,000 | $8,948,000 |
| 95% Title XIX ACA FF / 5% GF | 4260-101-0001/0890 | $32,120,000 | $1,606,000 | $30,514,000 |
| **Total** | | **$186,708,000** | **$73,375,000** | **$113,333,000** |

# 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 | $204,677,000 | $161,794,000 |
| - STATE FUNDS | $77,124,800 | $61,413,350 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $204,677,000 | $161,794,000 |
| STATE FUNDS | $77,124,800 | $61,413,350 |
| FEDERAL FUNDS | $127,552,200 | $100,380,650 |

## 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) and the reimbursement to Cost-Based Reimbursement Clinics (CBRCs).

**Authority:**
Welfare & Institutions Code, section 14170 and 14132.100

**Interdependent Policy Changes:**
Not Applicable

**Background:**
For the dual Medicare/Medi-Cal beneficiaries or beneficiaries enrolled in managed care plans, the Department establishes an interim rate paid to the clinics. Annually, each FQHC/RHC submits a reconciliation request for full reimbursement. The Department calculates the difference between each clinic's final PPS rate and the expenditures already reimbursed (interim rate, managed care plans, and Medicare) in order to prepare a 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, with FY 2016-17 audit levels scheduled to be completed in FY 2018-19. The Department did not complete the CBRC reconciliation audits for FY 2012-13 due to completion of another audit to distribute the AB 85 realignment funds. Beginning FY 2018-19, interim rates will be adjusted to the audited levels for the most recent completed audit of any fiscal year subsequent to FY 2014-15. If there are no audited levels available after FY 2014-15, no change will be made to the interim rates beginning in FY 2018-19.

# FQHC/RHC/CBRC RECONCILIATION PROCESS

**REGULAR POLICY CHANGE NUMBER: 120**

Currently, there are 999 active FQHCs, 282 active RHCs, 25 active CBRCs, and 63 active Indian Health Services.

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is an increase due to adjustments from the interim rates to the final rates, and scheduled completion of FY 2012-13 and FY 2013-14 CBRC audits in FY 2017-18. At the same time, LA CBRCs rate adjustments will now be 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 decrease due to less projected FQHC reconciliation settlements.

**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 and based on actual and estimated settlements from July 2016 through June 2018.

2. The estimated FQHC retroactive rate adjustment for FY 2017-18 of $22,383,000 and $20,870,000 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 84.6% of 2015 audited settlements, while the FY 2018-19 reconciliation is based on settlement of 95% of the 2016 reported settlements. Based on reported costs for fiscal years 2011-2016, reconciliations are expected to decrease by 0.19% thereafter. The change from the prior year estimate is due to an increase in reported revenues and reported payments for FY 2015-16.

   Expected completion of the two fiscal year audits in FY 2017-18 compared to expected completion of any one fiscal year audit in FY 2018-19 has contributed to the LA CBRC reconciliation decrease between FY 2017-18 and FY 2018-19.

| (Dollars in Thousands) | **FY 2017-18** | **FY 2018-19** |
|---|---:|---:|
| FQHCs Reconciliation | $86,339 | $72,326 |
| RHCs Reconciliation | $13,234 | $16,311 |
| FQHC Retroactive Rate Adjustment | $22,383 | $20,870 |
| LA CBRCs Reconciliation | $82,721 | $52,287 |
| **Total** | **$204,677** | **$161,794** |

**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: | Davonna McClendon |
| FISCAL REFERENCE NUMBER: | 1508 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $143,399,000 | $134,723,000 |
| - STATE FUNDS | $71,699,500 | $67,361,500 |
| PAYMENT LAG | 0.9944 | 0.8710 |
| % REFLECTED IN BASE | 51.30 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $69,444,200 | $117,343,700 |
| STATE FUNDS | $34,722,120 | $58,671,870 |
| FEDERAL FUNDS | $34,722,120 | $58,671,870 |

## 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 a decrease due to:

- The 2016-17 rates being fully incorporated in the fee-for-service (FFS) base and not budgeted in this policy change,
- Delayed implementation of the 2017-18 rate from December 2017, to February 2018,
- Revised Fee-for-Service (FFS) utilization based on data through July 2017,
- Decreased 2017-18 rates based on a decreased base rate, and QAF rates, and
- A decrease in the 2016-17 retroactive payment amount based on actuals.

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

- Including five months of the 2017-18 rate in FY 2017-18 and 12 months in FY 2018-19,
- The 2017-18 retroactive payment being implemented in FY 2018-19,
- The RY 2016-17 EPCs being paid in FY 2017-18,
- Increased 2018-19 base rates, QAF and add-on amounts, and
- Including 10 months of the managed care costs for the SNF staffing ratio add-on 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 on August 16, 2017.

4. The 2017-18 rates and add-ons will be implemented in February 2018. The 2017-18 retroactive rate payment will cover August 2017, through January 2018, and will be implemented in July 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. However, the FY 2018-19 estimated managed care impact for the SNF Staffing Ratio add-on is included in this policy change.

# 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) | $97,259 | $48,629 | $48,630 |
| RY 2016-17 Retro | $67,718 | $33,859 | $33,859 |
| Add-Ons | ($21,578) | ($10,789) | ($10,789) |
| Managed Care | $0 | $0 | $0 |
| **Total** | **$143,399** | **$71,699** | **$71,700** |

| FY 2018-19 | TF | GF | FFP |
|---|---|---|---|
| FFS (Rate Increase) | $102,639 | $51,319 | $51,320 |
| RY 2017-18 Retro | $3,032 | $1,516 | $1,516 |
| RY 2018-19 Retro | $19,256 | $9,628 | $9,628 |
| Add-Ons | ($9,921) | ($4,961) | ($4,960) |
| Managed Care | $19,717 | $9,859 | $9,858 |
| **Total** | **$134,723** | **$67,361** | **$67,362** |

**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 | $168,289,000 | $216,835,000 |
| - STATE FUNDS | $63,412,840 | $82,306,190 |
| PAYMENT LAG | 0.9090 | 0.9316 |
| % REFLECTED IN BASE | 45.06 % | 0.61 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $84,044,300 | $200,771,300 |
| STATE FUNDS | $31,668,660 | $76,208,720 |
| FEDERAL FUNDS | $52,375,640 | $124,562,540 |

## 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, is an increase due to a change in the estimated rate increase methodology, which represents a closer projection to the actual rate increases and cost. Also, Los Angeles CBRCs rate increases are now included in this estimate, previously budgeted in the FQHC/RHC/CBRC Reconciliation policy change. The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to increased projected rate increase of 2.6% 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 2.43%, 2.75% for calendar year 2017, and 2.59% for calendar year 2018.

| Rate Year | Projected Visits | Current Rate | Rate with Increase |
|---|---|---|---|
| 2016 | 17,828,661 | $156.89 | $156.89 x (1+2.43%) = $160.70 |
| 2017 | 19,028,004 | $160.70 | $160.70 x (1+2.75%) = $165.12 |
| 2018 | 20,346,117 | $165.12 | $165.12 x (1+2.59%) = $169.40 |

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 | $2,797,139 | $2,865,066 | $67,927 |
| 2017 | $3,057,800 | $3,141,904 | $84,104 |
| 2018 | $3,359,551 | $3,446,632 | $87,081 |

4. The July 1, 2017 CBRC rate increase of $37,284,000 is based on the 2014 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 $30,136,000 is based on the 2015 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 | $84,144 | $31,590 | $52,554 |
| CY 2018 Increase | $84,145 | $31,823 | $52,322 |
| **FY 2017-18 Total** | **$168,289** | **$63,414** | **$104,875** |
| | | | |
| **FY 2018-19** | **TF** | **GF** | **FF** |
| CY 2018 Increase | $108,417 | $41,003 | $67,414 |
| CY 2019 Increase | $108,418 | $41,304 | $67,114 |
| **FY 2018-19 Total** | **$216,835** | **$82,307** | **$134,528** |

# RATE INCREASE FOR FQHCS/RHCS/CBRCS

**REGULAR POLICY CHANGE NUMBER: 122**

**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: | Davonna McClendon |
| FISCAL REFERENCE NUMBER: | 1046 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $28,318,000 | $34,127,000 |
| - STATE FUNDS | $14,159,000 | $17,063,500 |
| PAYMENT LAG | 0.9286 | 0.9179 |
| % REFLECTED IN BASE | 63.01 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $9,726,900 | $31,325,200 |
| STATE FUNDS | $4,863,460 | $15,662,590 |
| FEDERAL FUNDS | $4,863,460 | $15,662,590 |

## 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 not to implement the rate freeze for DP Adult Subacute and DP Pediatric Subacute facilities based on its 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 a decrease due to:

- RY 2016-17 rates are fully captured in the Fee-for-Service (FFS) base trends and no longer budgeted in this policy change,
- Revised FFS utilization based on data through July 2017,
- Updated RY 2017-18 add-ons,
- RY 2017-18 retroactive Erroneous Payment Correction (EPC) implementation dates for the LTC facilities, except 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 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,
- Ten months of the RY 2018-19 rate adjustments for DP Pediatric Subacute and FS Pediatric Subacute facilities, and
- RY 2017-18 retroactive EPCs for certain facilities in FY 2018-19.

**Methodology:**

1. The effective date for the rate adjustments is August 1st of each rate year. The implementation dates for 2017-18 and 2018-19 rates, however, are as follows:

| Facility | Rate Year 2017-18 | Rate Year 2018-19 |
|---|---|---|
| DP/NF-B | 11/1/2017 | 11/1/2018 |
| Rural Swing Beds (non-exempt) | 11/1/2017 | 11/1/2018 |
| Rural Swing Beds (exempt) | 11/1/2017 | 11/1/2018 |
| DP Adult Subacute | 11/1/2017 | 11/1/2018 |
| NF-A | 11/1/2017 | 11/1/2018 |
| ICF/DDs | 11/1/2017 | 11/1/2018 |
| DP Pediatric Subacute | 9/1/2017 | 9/1/2018 |
| FS Pediatric Subacute | 9/1/2017 | 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.

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.

# LTC RATE ADJUSTMENT

## REGULAR POLICY CHANGE NUMBER: 123

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.

12. The add-on descriptions are listed below:

# LTC RATE ADJUSTMENT

## REGULAR POLICY CHANGE NUMBER: 123

| 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. | $0.10 - $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 | $1.10 - $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. | | $0.82 - $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 - $0.09 | $0.04 - $0.09 |
| **Emergency Preparedness:** Effective November 15, 2016, CMS established new emergency preparedness requirements for LTC facilities. | $0.06 | $0.06 |

13. The costs below reflect the incremental rate adjustments and add-ons for each facility type:

# LTC RATE ADJUSTMENT

## REGULAR POLICY CHANGE NUMBER: 123

| Fee-for-Service | FY 2017-18 | FY 2018-19 |
|---|---|---|
| Rate Adjustment (16-17) | | |
| DP/NF-B | $15,630,000 | $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 | $23,000 | $0 |
| ICF/DDs | $0 | $0 |
| DP Pediatric Subacute | $404,000 | $0 |
| FS Pediatric Subacute | ($10,000) | $0 |
| Rate Adjustment (17-18) | | |
| DP/NF-B | $5,777,000 | $8,666,000 |
| Rural Swing Beds (non-exempt) | $3,000 | $4,000 |
| Rural Swing Beds (exempt) | ($26,000) | ($38,000) |
| DP Adult Subacute | $833,000 | $1,250,000 |
| NF-A | $25,000 | $37,000 |
| ICF/DDs | $4,220,000 | $6,330,000 |
| DP Pediatric Subacute | $138,000 | $166,000 |
| FS Pediatric Subacute | $22,000 | $26,000 |
| Rate Adjustment (18-19) | | |
| DP/NF-B | $0 | $9,077,000 |
| Rural Swing Beds (non-exempt) | $0 | $9,000 |
| Rural Swing Beds (exempt) | $0 | ($32,000) |
| DP Adult Subacute | $0 | $776,000 |
| NF-A | $0 | $64,000 |
| ICF/DDs | $0 | $3,766,000 |
| DP Pediatric Subacute | $0 | $302,000 |
| FS Pediatric Subacute | $0 | $44,000 |
| Retro Rate Adjustments | | |
| DP/NF-B | $0 | $2,166,000 |
| Rural Swing Beds (non-exempt) | $0 | $0 |
| Rural Swing Beds (exempt) | $0 | ($4,000) |
| DP Adult Subacute | $0 | $312,000 |
| NF-A | $0 | $4,000 |
| ICF/DDs | $0 | $1,168,000 |
| DP Pediatric Subacute | $350,000 | $30,000 |
| FS Pediatric Subacute | $2,000 | $4,000 |
| Total FFS | $28,318,000 | $34,127,000 |
| Managed care | $0 | $0 |
| **Total Cost** | **$28,318,000** | **$34,127,000** |

# 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 | $30,650,000 | $97,389,000 |
| - STATE FUNDS | $15,325,000 | $48,694,500 |
| PAYMENT LAG | 0.6840 | 0.8121 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $20,964,600 | $79,089,600 |
| STATE FUNDS | $10,482,300 | $39,544,800 |
| FEDERAL FUNDS | $10,482,300 | $39,544,800 |

## 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, from the prior estimate, is due to a reduction in the rate growth from 4.37% to 0% for community-based DPHs.

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 July 2017.

# 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.

2. For FY 2017-18:
   - Assume an Erroneous Payment Correction will be issued in March 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 $30,650,000 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 $20,964,000 TF.

3. For FY 2018-19:
   - 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 $97,389,000 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 $79,089,000 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: | Davonna McClendon |
| FISCAL REFERENCE NUMBER: | 96 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $6,243,000 | $44,381,000 |
| - STATE FUNDS | $3,121,500 | $22,190,500 |
| PAYMENT LAG | 0.7114 | 0.9867 |
| % REFLECTED IN BASE | 1.44 % | 0.19 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $4,377,300 | $43,707,500 |
| STATE FUNDS | $2,188,660 | $21,853,760 |
| FEDERAL FUNDS | $2,188,660 | $21,853,760 |

## 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, is a decrease due to:

- The RY 2016-17 hospice room & board rate increase is 100% in the fee-for-service (FFS) base and no longer included in this policy change;
- Updated RY 2016-17 hospice services amounts;
- Delayed implementation of the RY 2017-18 hospice services rates from October 2017 to January 2018. The Erroneous Payment Correction is estimated to occur in March 2018.
- Delayed implementation of the prospective Routine Home Care (RHC) tiered rates and Service Intensity Add-on (SIA) to occur in April 2018, for three months of payments in FY 2017-18. The previous estimate included more payments from assuming RY 2015-16 payments starting December 2017 and RY 2016-17 payments starting March 2018.

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

- The RY 2017-18 EPC occurring in FY 2017-18;
- A full year of the RY 2017-18 hospice services and hospice room & board payments in FY 2018-19;
- Implementation of the RY 2018-19 hospice services payments and EPC in FY 2018-19;
- A full year of the prospective RHC and SIA payments in FY 2018-19; and
- The retroactive payments for the period from January 2016, to March 2018 for RHC and SIA occurring in FY 2018-19.

**Methodology:**

1. The estimated weighted increase for hospice service rates, excluding Routine Home Care, for Rate Year (RY) 2017-18 and RY 2018-19 is 1.43%.

2. RY 2017-18 hospice services rates, excluding Routine Home Care, are assumed to be implemented in January 2018. The EPC for the retroactive period from October 2017 to December 2017 is estimated to occur in March 2018.

3. RY 2018-19 hospice services rates, excluding Routine Home Care, 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 Routine Home Care 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.

# HOSPICE RATE INCREASES

**REGULAR POLICY CHANGE NUMBER: 125**

5. The CMS final hospice rule also establishes a Service Intensity Add-on (SIA) payment for services provided by a registered nurse or social worker during the last seven days of a beneficiary's life for a maximum of four hours a day. It is assumed that the maximum SIA payments will be applied to each hospice beneficiary.

6. The RY 2015-16, RY 2016-17, and RY 2017-18 RHC tiered rates and SIA are expected to be implemented April 2018. Retroactive claims for the period January 2016 to March 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 3.75%.

| Cash Basis | FY 2017-18 | FY 2018-19 |
|---|---|---|
| RY 2016-17 Hospice Services | $102,000 | $102,000 |
| RY 2017-18 RHC & SIA Payments | $3,136,000 | $11,329,000 |
| RY 2017-18 Hospice Services | $14,000 | $29,000 |
| RY 2017-18 Room & Board | $2,984,000 | $3,255,000 |
| RY 2017-18 Retroactive Payments | $7,000 | $0 |
| RY 2018-19 RHC & SIA Payments | $0 | $1,959,000 |
| RY 2018-19 Hospice Services | $0 | $14,000 |
| RY 2018-19 Room & Board | $0 | $3,096,000 |
| RY 2018-19 Retroactive Payments | $0 | $987,000 |
| RHC & SIA Retroactive Payments | $0 | $23,610,000 |
| **TOTAL** | **$6,243,000** | **$44,381,000** |

**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: | Katy Clay |
| FISCAL REFERENCE NUMBER: | 1938 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $19,798,000 | $8,363,000 |
| - STATE FUNDS | $9,899,000 | $4,181,500 |
| PAYMENT LAG | 0.9846 | 0.9417 |
| % REFLECTED IN BASE | 9.20 % | 26.93 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $17,699,700 | $5,754,600 |
| STATE FUNDS | $8,849,870 | $2,877,290 |
| FEDERAL FUNDS | $8,849,870 | $2,877,290 |

## 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
AB 395 (Chapter 461, Statutes of 2011)
AB 1559 (Chapter 565, Statutes of 2014)

**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 material change from the prior estimate for FY 2017-18. The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to the retroactive payments in FY 2017-18 and an increase due to the addition of the $12.00 rate increase in FY 2018-19.

**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 is expected to be implemented in November 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 is expected to be implemented in November 2017. The annual cost is $2,121,000 TF. The EPC is estimated at $11,132,000 TF.

3. CDPH projects a $12.00 fee increase for the GDSP NBS program starting July 1, 2018.

4. The estimated number of births in California is 477,591 in FY 2018-19. GDSP assumes approximately 99.00% of newborns will be screened by the NBS Program each year.

5. Assume approximately 45% of newborns screened are from the Medi-Cal population.

6. Assume 98% of claims submitted are paid.

| Fiscal Year | No. of California Births (A) | % Newborns screened by NBS program (B) | % Medi-Cal Beneficiaries (C) | Collection rate (D) | Fee increase (E) | Annual costs (F = AxBxCxDxE) |
|---|---|---|---|---|---|---|
| FY 2018-19 | 477,591 | 99.00% | 45.00% | 98.00% | $ 12.00 | $ 2,502,000 |

# 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 | $2,502 | $1,251 | $1,251 |
| **Total** | **$8,363** | **$4,182** | **$4,181** |

**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: | Joy Oda |
| 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)
State Plan Amendment (SPA) 16-035

**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 2015-16 was approved on December 10, 2015. The SPA for FY 2016-17 was approved on December 1, 2016. The Department submitted a SPA for FY 2017-18 in September 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 an increase in estimated GF offset amounts and updated augmentation payments.

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 is expected to be $1,228,000, and
   - GF transfer from the first half of FY 2017-18 collections is expected to be $1,228,000.

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 | ($2,456) | $2,456 | $0 |
| Augment Payment | $10,868 | $0 | $5,434 | $5,434 |
| **Total** | **$10,868** | **($2,456)** | **$7,890** | **$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)

# GDSP PRENATAL SCREENING FEE INCREASE

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 128 |
| IMPLEMENTATION DATE: | 7/2017 |
| ANALYST: | Katy Clay |
| FISCAL REFERENCE NUMBER: | 1974 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $4,530,000 | $2,867,000 |
| - STATE FUNDS | $2,265,000 | $1,433,500 |
| PAYMENT LAG | 0.9025 | 0.9590 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $4,088,300 | $2,749,500 |
| STATE FUNDS | $2,044,160 | $1,374,730 |
| FEDERAL FUNDS | $2,044,160 | $1,374,730 |

## DESCRIPTION

**Purpose:**
This policy change estimates the payment to the California Department of Public Health (CDPH) for costs associated with a fee increase for prenatal screening provided to Medi-Cal beneficiaries under the Genetic Disease Screening Program (GDSP).

**Authority:**
Health & Safety Code Section 124977

**Interdependent Policy Changes:**
PC 197 Funding Adjust.—ACA Opt. Expansion

**Background:**
CDPH administers California's GDSP, which includes the Prenatal Screening (PNS) Program and the Newborn Screening (NBS) Program. These programs screen for genetic disorders that are, for the most part, preventable or remediable by early intervention and provide clinical oversight for the follow-up services, which include genetic counseling and confirmatory testing, including ultrasound and diagnostic procedures.

The fee increase is due to the increased expenditures for the maintenance and operation of the computer system for PNS, the Screening Information System (SIS), the transition of SIS from the Department to CDPH, and support for the Accounts Receivable system. In addition, it includes the implementation and the ongoing costs for the new medical billing company (Sutherland) to perform GDSP's patient medical billing.

Effective July 1, 2016, GDSP implemented a $14.60 fee increase for PNS. This increase is in accordance with Health & Safety Code Section 124977, which states the amount of the fee shall be periodically adjusted to fully support the program.

# GDSP PRENATAL SCREENING FEE INCREASE

**REGULAR POLICY CHANGE NUMBER: 128**

GDSP transfers $10 from the Prenatal Screening (PNS) fees collected to the California Birth Defects Monitoring Program (CBDMP). The fee supports the Birth Defects Monitoring Program Fund to provide birth defects monitoring in California to ten counties. With the current $10 fee structure, the Birth Defects Monitoring Program Fund is running an operational deficit and will need a small increase in PNS fees of approximately $4 to continue CBDMP operations at status quo.

Effective July 1, 2018, GDSP will propose to increase the PNS fee by a total of $4. This will increase the fee transfer to the Birth Defects Monitoring Program Fund from $10 to $14 to ensure fund solvency.

**Reason for Change:**
There is no material change from the prior estimate, for FY 2017-18. The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to retroactive payments in FY 2017-18. FY 2018-19 also includes the $4.00 fee increase.

**Methodology:**

1. The Department implemented a $14.60 fee increase for the GDSP PNS program in July 2017, retroactive to July 2016. The annual impact is $2,265,000 TF.

2. The Department expects to implement an Erroneous Payment Correction (EPC) for the period of July 2016 through June 2017 in November 2017 in the amount of $2,265,000 TF.

3. The Department estimates the implementation of a $4.00 fee increase for the GDSP PNS program in July 2018.

4. Assume 341,347 women will have prenatal screening in FY 2018-19. Approximately 45% of them are Medi-Cal beneficiaries.

   341,347 x 45% = 153,606 Medi-Cal caseload in FY 2018-19

5. Assume 98% of claims are paid.

   153,606 x 98% = 150,534 claims paid in FY 2018-19

6. The estimated annual costs are:

   150,534 x $4.00 = $602,000 TF in FY 2018-19 (rounded)

(Dollars in Thousands)

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| $14.60 Rate Increase | $2,265 | $1,132 | $1,133 |
| $14.60 Retro | $2,265 | $1,133 | $1,132 |
| **Rate Increase** | **$4,530** | **$2,265** | **$2,265** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| $14.60 Rate Increase | $2,265 | $1,133 | $1,132 |
| $4.00 Rate Increase | $602 | $301 | $301 |
| **Total** | **$2,867** | **$1,434** | **$1,433** |

# GDSP PRENATAL SCREENING FEE INCREASE

## REGULAR POLICY CHANGE NUMBER: 128

**Funding:**
50% Title XIX / 50% GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in PC 197 Funding Adjust.—ACA Opt. Expansion

# ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 129 |
| IMPLEMENTATION DATE: | 1/2018 |
| ANALYST: | Joy Oda |
| FISCAL REFERENCE NUMBER: | 1996 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $985,000 | $4,963,000 |
| - STATE FUNDS | -$808,960 | -$4,014,650 |
| PAYMENT LAG | 0.4320 | 0.9888 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $425,500 | $4,907,400 |
| STATE FUNDS | -$349,470 | -$3,969,690 |
| FEDERAL FUNDS | $774,990 | $8,877,100 |

## 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 an eight month delay in the expected implementation date from May 2017 to January 2018.

# ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE

## REGULAR POLICY CHANGE NUMBER: 129

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to FY 2017-18 includes six months of payments, while FY 2018-19 includes a full year of payments and an erroneous payment correction.

**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 January 2018. The GF savings as a result of the change in payment methodology is expected to be $992,000 in FY 2017-18. The FY 2018-19 GF savings is expected to be $4,963,000, which includes a $3,005,000 erroneous payment correction for the time period from July 1, 2016 through December 31, 2018 to be implemented in July 2018.

7. The funding adjustment on an annual basis is estimated as follows:

| FY 2017-18 | TF | GF | FF | ACA FF |
|---|---|---|---|---|
| **Alameda Hospital** | | | | |
| DRG | ($723,000) | ($309,000) | ($301,000) | ($113,000) |
| CPE | $1,089,000 | $0 | $736,000 | $353,000 |
| Alameda Hospital Total | $366,000 | ($309,000) | $435,000 | $240,000 |
| **San Leandro Hospital** | | | | |
| DRG | ($1,349,000) | ($500,000) | ($477,000) | ($372,000) |
| CPE | $1,968,000 | $0 | $1,114,000 | $854,000 |
| San Leandro Hospital Total | $619,000 | ($500,000) | $637,000 | $482,000 |
| **FY 2017-18 Total** | **$985,000** | **($809,000)** | **$1,072,000** | **$722,000** |

# ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE

**REGULAR POLICY CHANGE NUMBER: 129**

| FY 2018-19 | TF | GF | FF | ACA FF |
|---|---|---|---|---|
| **Alameda Hospital** | | | | |
| DRG | ($3,619,000) | ($1,537,000) | ($1,508,000) | ($574,000) |
| CPE | $5,467,000 | $0 | $3,689,000 | $1,778,000 |
| Alameda Hospital Total | $1,848,000 | ($1,537,000) | $2,181,000 | $1,204,000 |
| **San Leandro Hospital** | | | | |
| DRG | ($6,750,000) | ($2,478,000) | ($2,385,000) | ($1,887,000) |
| CPE | $9,865,000 | $0 | $5,580,000 | $4,285,000 |
| San Leandro Hospital Total | $3,115,000 | ($2,478,000) | $3,195,000 | $2,398,000 |
| **FY 2018-19 Total** | **$4,963,000** | **($4,015,000)** | **$5,376,000** | **$3,602,000** |

**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: | 12/2017 |
| ANALYST: | Joy Oda |
| FISCAL REFERENCE NUMBER: | 2000 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $51,000 | $51,000 |
| - STATE FUNDS | $25,500 | $25,500 |
| PAYMENT LAG | 0.8810 | 0.9930 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $44,900 | $50,600 |
| STATE FUNDS | $22,460 | $25,320 |
| FEDERAL FUNDS | $22,470 | $25,320 |

## 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)

**Interdependent Policy Changes:**
PC 197 Funding Adjust.—ACA Opt. Expansion

**Background:**
Currently, W&I Code Section 14148.8 requires the Department to provide Medi-Cal reimbursement to ABCs for facility and service related costs. These costs reflect 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 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.

The Department will amend W&I Code Section 14148.8 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, to be effective July 1, 2017.

# ALTERNATIVE BIRTHING CENTER REIMBURSEMENT

**REGULAR POLICY CHANGE NUMBER: 130**

**Reason for Change:**
There is no change for FY 2017-18 from the prior estimate. There is no change from FY 2017-18 to FY 2018-19 in the current estimate.

**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 was assumed to be implemented December 2017.

2. Retroactive payments for the period of July 1, 2017 through November 30, 2017, are expected to be implemented March 2018.

3. On average, there are approximately 200 all-inclusive FFS deliveries in an ABC each year. The incremental increase for the new Medi-Cal rate is $253 per delivery.

   200 deliveries x $253 increase = $51,000 TF (rounded)

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| Rate Increase | $30,000 | $15,000 | $15,000 |
| Retro | $21,000 | $10,500 | $10,500 |
| **Total** | **$51,000** | **$25,500** | **$25,500** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| Rate Increase | $51,000 | $25,500 | $25,500 |
| **Total** | **$51,000** | **$25,500** | **$25,500** |

**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: | Davonna McClendon |
| FISCAL REFERENCE NUMBER: | 1964 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $0 |
| - STATE FUNDS | $744,000 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $0 |
| STATE FUNDS | $744,000 | $0 |
| FEDERAL FUNDS | -$744,000 | $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.

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is an increase in federal fund repayments based on updated retroactive recoupment amounts determined from actual reprocessed claims. In the current estimate, there are no costs estimated in FY 2018-19 due to the completion of the one-time 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 $105.159 million GF. In FY 2016-17, federal fund repayments totaling $104.415 million GF were made to CMS. The remaining $744,000 GF will be paid in FY 2017-18.

| Fiscal Year | TF | GF | FF |
|---|---|---|---|
| **FY 2017-18** | **$0** | **$744,000** | ($744,000) |

**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: | Katy Clay |
| 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.

AB 119 (Chapter 17, Statutes of 2015) extends the AB 1629 facility-specific rate methodology, QAF, and Quality and Accountability Supplemental Payments (QASP) Program through July 31, 2020.

# LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES

**REGULAR POLICY CHANGE NUMBER: 133**

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 (Chapter 30, Statutes of 2016) 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 from FY 2017-18 to FY 2018-19, in the current estimate is due to updated collections and transfer data through July 2017 resulting in higher than expected prior year amounts from FY 2015-16 shifting to FY 2017-18.

**Methodology:**

1. Based on LTC QA fee collection data from July 2013 through July 2017, the average annual LTC QA fee revenue on a cash basis is $487,406,000. Based on the most recent four years of FFS utilization data, the average growth rate for ICF-DDs and nursing facilities is 0.85% and 1.48%, respectively.

2. Based on FY 2014-15, FY 2015-16, and FY 2016-17 actual QA fee transfer data, 96.34% of the current year's fee collection is transferred to the GF in the current year, and 95.11% of the prior year's balance is transferred in the current year. Assume the remaining QA fee balances from prior years will be completely transferred to the GF in the next two fiscal years.

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 2017-18 | $0 | ($476,375) | $476,375 |
| **Total** | **$0** | **($539,842)** | **$539,842** |

| FY 2018-19 | TF | GF | LTCQAF |
|---|---|---|---|
| FY 2015-16 | $0 | ($3,262) | $3,262 |
| FY 2017-18 | $0 | ($18,081) | $18,081 |
| FY 2018-19 | $0 | ($483,266) | $483,266 |
| **Total** | **$0** | **($504,609)** | **$504,609** |

**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 | -$394,275,310 | -$408,504,510 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $0 |
| STATE FUNDS | -$394,275,310 | -$408,504,510 |
| FEDERAL FUNDS | $394,275,310 | $408,504,510 |

## 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, from the prior estimate, is due to a reduction in the rate growth from 4.37% to 0% for community-based DPHs.

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 July 2017.

**Methodology:**
1. The funding adjustment is estimated at:

(Dollars in Thousands)

| | Expenditures | GF to FF Shift |
|---|---|---|
| **FY 2017-18** | **$1,335,323** | **$394,275** |
| **FY 2018-19** | **$1,364,567** | **$408,505** |

**Funding:**
(Dollars in Thousands)

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| 50% Title XIX / 50% GF (4260-101-0890 / 0001) | ($720,972) | ($360,486) | ($360,486) |
| 100% Title XIX FF (4260-101-0890) | $1,335,323 | $0 | $1,335,323 |
| 95% Title XIX ACA / 5% GF (4260-101-0890 / 0001) | ($307,175) | ($15,359) | ($291,816) |
| 94% Title XIX ACA / 6% GF (4260-101-0890 / 0001) | ($307,176) | ($18,431) | ($288,745) |
| ***Total Funds** | **$0** | **($394,275)** | **$394,275** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| 50% Title XIX / 50% GF (4260-101-0890 / 0001) | ($735,190) | ($367,595) | ($367,595) |
| 100% Title XIX FF (4260-101-0890) | $1,364,567 | $0 | $1,364,567 |
| 94% Title XIX ACA / 6% GF (4260-101-0890 / 0001) | ($314,688) | ($18,881) | ($295,807) |
| 93% Title XIX ACA / 7% GF (4260-101-0890 / 0001) | ($314,689) | ($22,029) | ($292,660) |
| ***Total Funds** | **$0** | **($408,505)** | **$408,505** |

*Amounts may differ due to rounding

# LABORATORY RATE METHODOLOGY CHANGE

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 135 |
| IMPLEMENTATION DATE: | 2/2016 |
| ANALYST: | Davonna McClendon |
| FISCAL REFERENCE NUMBER: | 1703 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | -$21,092,000 | -$22,610,000 |
| - STATE FUNDS | -$10,546,000 | -$11,305,000 |
| PAYMENT LAG | 0.9954 | 1.0000 |
| % REFLECTED IN BASE | 16.85 % | 20.20 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$17,457,300 | -$18,042,800 |
| STATE FUNDS | -$8,728,660 | -$9,021,390 |
| FEDERAL FUNDS | -$8,728,660 | -$9,021,390 |

## 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)

**Interdependent Policy Changes:**
PC 197 Funding Adjust.—ACA Opt. Expansion
PC 191 Funding Adjust.—OTLICP

**Background:**
AB 1494 requires 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. The Department will update the reimbursement rates to the applicable clinical and laboratory service codes annually.

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

- Delayed implementation of the 2016-17 rate year retroactive recoupment, based on a revised recoupment schedule beginning November 2017 instead of June 2017 as assumed in the previous estimate; and
- A two-month delay in the prospective 2017-18 rate year adjustment from August 2017 to October 2017, as well as a revised savings amount.

# LABORATORY RATE METHODOLOGY CHANGE

## REGULAR POLICY CHANGE NUMBER: 135

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

- Nine months of the prospective 2017-18 rate year adjustment in FY 2017-18 and 12 months in FY 2018-19;
- Eight months of the 2016-17 rate year retroactive recoupment being budgeted in FY 2017-18, and four months in FY 2018-19; and
- The completion of the 2017-18 rate year retroactive recoupment 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 January 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 January 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 is expected to be implemented in November 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 is expected to be implemented in October 2017. The recoupment of retroactive savings from July 2017 to September 2017 is expected to be implemented in December 2017.

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| New Rate Methodology Savings | ($6,667,000) | ($3,333,000) | ($3,334,000) |
| AB 1494 Retro Savings | ($2,810,000) | ($1,405,000) | ($1,405,000) |
| New Rate Methodology Retro Savings | ($11,615,000) | ($5,807,000) | ($5,808,000) |
| **Total** | **($21,092,000)** | **($10,545,000)** | **($10,547,000)** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| New Rate Methodology Savings | ($6,675,000) | ($3,337,000) | ($3,338,000) |
| AB 1494 Retro Savings | ($5,620,000) | ($2,810,000) | ($2,810,000) |
| New Rate Methodology Retro Savings | ($10,315,000) | ($5,157,000) | ($5,158,000) |
| **Total** | **($22,610,000)** | **($11,304,000)** | **($11,306,000)** |

# LABORATORY RATE METHODOLOGY CHANGE

## REGULAR POLICY CHANGE NUMBER: 135

**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: | Davonna McClendon |
| FISCAL REFERENCE NUMBER: | 1505 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | -$23,790,000 | -$50,895,000 |
| - STATE FUNDS | -$11,895,000 | -$25,447,500 |
| PAYMENT LAG | 0.8512 | 0.9943 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$20,250,000 | -$50,604,900 |
| STATE FUNDS | -$10,125,020 | -$25,302,450 |
| FEDERAL FUNDS | -$10,125,020 | -$25,302,450 |

## 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 December 29, 2016, a SPA was submitted 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.

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

- The removal of the 2016 rate adjustment and associated retroactive recoupment based on the withdrawal of SPA 16-046.

# REDUCTION TO RADIOLOGY RATES

**REGULAR POLICY CHANGE NUMBER: 136**

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

- The completion of the October 2014 retroactive recoupment in FY 2017-18;
- Six months of the prospective 2015 rate adjustment budgeted in FY 2017-18, and 12 months in FY 2018-19; and
- Two months of the 2015 rate adjustment retroactive recoupment being budgeted in FY 2017-18, and ten months 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. Rate adjustment based on the October 2014 Medicare Rates:

   a. The adjusted rates based on the October 2014 Medicare rates are effective October 1, 2012 through September 30, 2015, with an annual FFS savings of $23,045,000 TF. These rates, implemented in August 2015, are fully captured in the FFS base trends and no longer being budgeted in this policy change.

   b. 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. Rate adjustment based on the October 2015 Medicare Rates:

   a. The adjusted rates based on the October 2015 Medicare rates are effective October 1, 2015, through March 31, 2017, with an annual FFS savings of $22,620,000 TF. These rates are expected to be implemented in January 2018.

   b. The total recoupment of retroactive savings from October 1, 2015, through March 31, 2017, is estimated to be $33,930,000 TF and is expected to be implemented in May 2018 over 12 months.

(Dollars in Thousands)

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| Prospective Savings | ($11,310) | ($5,655) | ($5,655) |
| Recoupment of Retro Savings | ($12,480) | ($6,240) | ($6,240) |
| **Total** | **($23,790)** | **($11,895)** | **($11,895)** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| Prospective Savings | ($22,620) | ($11,310) | ($11,310) |
| Recoupment of Retro Savings | ($28,275) | ($14,137) | ($14,138) |
| **Total** | **($50,895)** | **($25,447)** | **($25,448)** |

# REDUCTION TO RADIOLOGY RATES

## REGULAR POLICY CHANGE NUMBER: 136

**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: | Davonna McClendon |
| 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 Assembly Bill (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:**
The change from the prior estimate, for FY 2017-18, is due to a shift in the implementation of the DME/Medical Supplies recoupment from July 2017 to September 2017 based on system delays.

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.

# 10% PROVIDER PAYMENT REDUCTION

## REGULAR POLICY CHANGE NUMBER: 137

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

# HOSPITAL QAF - MANAGED CARE PAYMENTS

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 138 |
| IMPLEMENTATION DATE: | 3/2015 |
| ANALYST: | Jedidiah Warren |
| FISCAL REFERENCE NUMBER: | 1761 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $6,869,242,000 | $3,636,684,000 |
| - STATE FUNDS | $1,922,648,000 | $1,100,823,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $6,869,242,000 | $3,636,684,000 |
| STATE FUNDS | $1,922,648,000 | $1,100,823,000 |
| FEDERAL FUNDS | $4,946,594,000 | $2,535,861,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the Managed Care payments hospitals will receive from the extension of the quality assurance fee (QAF) program. This policy change has been renamed and was previously titled “Extend Hospital QAF – Hospital Payments”.

Refer to the Hospital QAF – FFS Payments policy change for the fee-for-service (FFS) hospital QAF payments.

**Authority:**
SB 239 (Chapter 657, Statutes of 2013)
AB 1607 (Chapter 27, Statutes of 2016)
Proposition 52 (2016)

**Interdependent Policy Changes:**
PC 96 HQAF Rate Range Increases

**Background:**
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.

# 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:

- FFS payments are no longer budgeted in this policy change (refer to the Hospital QAF – FFS Payments policy change for FFS hospital QAF payments),
- FY 2015-16 and FY 2016-17 have been updated based on revised projections, and
- FY 2017-18 payments have been updated and delayed until FY 2018-19.

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

- A portion of HQAF V FY 2017-18 and FY 2018-19 Managed Care payments will shift to a new Directed Payment methodology and the remaining portion will be paid in FY 2018-19, and
- The HQAF V FY 2018-19 Managed Care payments budgeted in this policy change are assumed to be prospective, therefore, 11 months of capitation payments are expected to occur in FY 2018-19.

**Methodology:**

1. Per SB 239, the Hospital QAF program was extended from January 1, 2014, through December 31, 2016.

2. The first SB 239 managed care payment was made in August 2015.

3. On an accrual basis, the following is the total authorized amounts for grants and the managed care rate range increase for the SB 239 HQAF period:

| DOS | Total Authorized | Total Grants Payments | Total Managed Care Rate Increase Authorized |
|---|---|---|---|
| FY 2013-14 | $57,500,000 | $27,000,000 | $30,500,000 |
| FY 2014-15 | $118,000,000 | $55,500,000 | $62,500,000 |
| FY 2015-16 | $140,500,000 | $66,500,000 | $74,000,000 |
| FY 2016-17 | $80,000,000 | $38,000,000 | $42,000,000 |
| Total | $396,000,000 | $187,000,000 | $209,000,000 |

4. On an accrual basis, the following is the total anticipated amounts for grants for the HQAF V period. Managed care rate range increases are not included in HQAF V. These amounts are not yet authorized.

| DOS | Total | Total Grants Payments | Total Managed Care Rate Increase |
|---|---|---|---|
| FY 2016-17 | $46,250,000 | $46,250,000 | $0 |
| FY 2017-18 | $104,900,000 | $104,900,000 | $0 |
| FY 2018-19 | $115,800,000 | $115,800,000 | $0 |
| Total | $266,950,000 | $266,950,000 | $0 |

   - Amounts above for FY 2016-17 are in addition to the amounts in the previous table.
   - Amounts above are based on a draft fee/payment model and subject to change.

5. 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.

# HOSPITAL QAF - MANAGED CARE PAYMENTS

**REGULAR POLICY CHANGE NUMBER: 138**

6. Increased capitation payments under Section 14165.58 are the actuarial equivalent to AB 113 payments previously made to NDPHs. The Department will collect the following amounts from NDPHs:
   - To be collected in FY 2017-18:
     - $25.43 million for FY 2015-16
     - $28.29 million for FY 2016-17
   - To be collected in FY 2018-19:
     - $30.56 million for FY 2017-18
     - $28.36 million for FY 2018-19
7. Payments associated with HQAF V are preliminary estimates at this time. Calculations are based on a draft fee/payment model and subject to change.
8. On a cash basis, the estimated QAF payments are:

(Dollars in Thousands)

| FY 2017-18 | TF | IGT* | SF(HQARF) | FF (TITLE 19) | FF (TITLE 21) | ACA FF |
|---|---|---|---|---|---|---|
| **Managed Care** | | | | | | |
| FY 2015-16 | $3,357,884 | $0 | $894,495 | $809,121 | $114,823 | $1,539,445 |
| FY 2016-17 | $3,318,558 | $0 | $974,429 | $857,665 | $130,220 | $1,356,244 |
| Total MC | $6,676,442 | $0 | $1,868,924 | $1,666,786 | $245,043 | $2,895,689 |
| **NDPH IGT** | | | | | | |
| FY 2015-16 | $95,400 | $25,432 | $0 | $23,003 | $3,265 | $43,700 |
| FY 2016-17 | $97,400 | $28,292 | $0 | $24,876 | $3,777 | $40,455 |
| Total NDPH IGT | $192,800 | $53,724 | $0 | $47,879 | $7,042 | $84,155 |
| **Total FY 2017-18** | **$6,869,242** | **$53,724** | **$1,868,924** | **$1,714,665** | **$252,085** | **$2,979,844** |

(Dollars in Thousands)

| FY 2018-19 | TF | IGT* | SF(HQARF) | FF (TITLE 19) | FF (TITLE 21) | ACA FF |
|---|---|---|---|---|---|---|
| **Managed Care** | | | | | | |
| FY 2017-18 | $1,800,000 | $0 | $544,290 | $458,124 | $69,558 | $728,028 |
| FY 2018-19 | $1,650,000 | $0 | $497,615 | $411,469 | $62,474 | $678,442 |
| Total MC | $3,450,000 | $0 | $1,041,905 | $869,593 | $132,032 | $1,406,470 |
| **NDPH IGT** | | | | | | |
| FY 2017-18 | $97,400 | $30,561 | $0 | $25,931 | $3,937 | $36,971 |
| FY 2018-19 | $89,284 | $28,357 | $0 | $23,770 | $3,609 | $33,548 |
| Total NDPH IGT | $186,684 | $58,918 | $0 | $49,701 | $7,546 | $70,519 |
| **Total FY 2018-19** | **$3,636,684** | **$58,918** | **$1,041,905** | **$919,294** | **$139,578** | **$1,476,989** |

**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 | $4,865,095,000 | $3,526,939,000 |
| - STATE FUNDS | $2,180,840,000 | $1,820,007,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $4,865,095,000 | $3,526,939,000 |
| STATE FUNDS | $2,180,840,000 | $1,820,007,000 |
| FEDERAL FUNDS | $2,684,255,000 | $1,706,932,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the fee-for-service (FFS) payments that hospitals will receive from the hospital quality assurance fee (QAF) program. This policy change has been renamed and was previously titled “Hospital QAF —Hospital Payments.”

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 quality assurance fee (QAF) on applicable general acute care hospitals for the period of April 1, 2009, through December 31, 2010. This QAF program period is referred to as QAF I.

SB 90 extended the Hospital QAF program for the period January 1, 2011, through June 30, 2011, based on a modified amount of payments to hospitals and an increased amount for children’s health care coverage. This QAF program period is referred to as QAF II.

# HOSPITAL QAF - FFS PAYMENTS

## REGULAR POLICY CHANGE NUMBER: 139

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:

- Moving QAF IV and QAF V fee-for-service hospital payments to this policy change from the Hospital QAF – Managed Care Payments policy change,
- Remaining QAF I payments are no longer assumed to be paid,
- QAF II funds will now be rolled into future QAF program periods and paid out at a later date,
- QAF III funds will not be deposited into the LIHP MCE Out-of-Network Emergency Care Services fund due to a denial of federal funding for the LIHP MCE Out-of-Network program from CMS,
- A delay in the second set of FY 2016-17 grant payments from FY 2016-17 to FY 2017-18, and
- Updated Affordable Care Act (ACA) payments to align to the methodology approved by CMS.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to fewer fiscal year payments for QAF IV-QAF V in FY 2018-19.

**Methodology:**
<u>QAF I-QAF III</u>
1. The remaining QAF I through QAF III payments are no longer assumed to be paid.

<u>QAF IV-QAF V</u>
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 are preliminary estimates at this time. Calculations are based on a draft fee/payment model and subject to change

5. Due to implementation delays, QAF V FFS payments are projected for payout beginning in FY 2017-18.

# HOSPITAL QAF - FFS PAYMENTS

**REGULAR POLICY CHANGE NUMBER: 139**

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 will be claimed in FY 2017-18. 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 2013-14 ACA | $244,028 | $0 | ($244,028) | $488,056 | $244,028 |
| FY 2014-15 ACA | $440,437 | $0 | ($440,436) | $880,873 | $440,437 |
| FY 2015-16 | $30,250 | $30,250 | $0 | $0 | $0 |
| FY 2016-17 | $1,603,079 | $837,602 | $765,477 | $0 | $0 |
| FY 2017-18 | $2,547,301 | $1,312,988 | $1,234,313 | $0 | $0 |
| Total FY 2017-18 | **$4,865,095** | **$2,180,840** | **$1,315,326** | **$1,368,929** | $684,465 |

(Dollars in Thousands)

| **FY 2018-19** | **TF** | **SF(HQARF)** | **FF** |
|---|---|---|---|
| QAF IV-QAF V | | | |
| FY 2017-18 | $849,101 | $437,663 | $411,438 |
| FY 2018-19 | $2,677,838 | $1,382,344 | $1,295,494 |
| **Total FY 2018-19** | **$3,526,939** | **$1,820,007** | **$1,706,932** |

*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: | 2/2018 |
| ANALYST: | Joy Oda |
| FISCAL REFERENCE NUMBER: | 2024 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $1,207,941,000 | $999,744,000 |
| - STATE FUNDS | $441,592,000 | $368,343,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $1,207,941,000 | $999,744,000 |
| STATE FUNDS | $441,592,000 | $368,343,000 |
| FEDERAL FUNDS | $766,349,000 | $631,401,000 |

## 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.

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:

# GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

**REGULAR POLICY CHANGE NUMBER: 140**

- Direct GME payments for Medicaid's share of the cost of training new health care providers,
- Indirect GME payments for the additional training time and resources,
- Incentive payments that recognize the importance of training a new workforce generation to help address access to care in California.

Intergovernmental transfers (IGTs) will fund the nonfederal share of the cost. The Department will assess a 5% administrative fee on IGTs related to the GME payments to reimburse the Department for support costs associated with administering the program, 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.

**Reason for Change:**
The change in FY 2017-18, from the prior estimate, is due to an increase in FY 2017-18 payments based on updated inflation-adjusted cost data, and the inclusion of FY 2016-17 and FY 2017-18 Affordable Care Act (ACA) adjustments.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a net decrease due to:
- Fewer quarters estimated to be paid in FY 2018-19, and
- Increased payments for the FY 2018-19 quarters based on a 3% annual inflation update.

**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 $949.26 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 $474.6 million TF.
    - Assume a 3% CPI annual increase for FY 2017-18 and FY 2018-19, which is estimated to provide $977.7 million TF for FY 2017-18, and $1.007 billion TF for FY 2018-19 in annual total computable payments.

4. Payments will be made on a lump-sum quarterly basis throughout the fiscal year and will not be paid as individual increases to current reimbursement rates for specific services.

5. The 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.

# GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

**REGULAR POLICY CHANGE NUMBER: 140**

6. Assume ACA payments will begin in January 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 2017-18.

9. Assume three quarters of FY 2017-18 will be paid in FY 2017-18, and one quarter will be paid in FY 2018-19.

10. Assume three quarters of FY 2018-19 will be paid in FY 2018-19, and one quarter will be paid in a subsequent fiscal year.

(Dollars in Thousands)

| FY 2017-18 | TF | IGT | FF | ACA FF |
|---|---|---|---|---|
| FY 2016-17 | $474,633 | $173,080 | $165,943 | $135,610 |
| FY 2017-18 | $733,308 | $268,512 | $256,382 | $208,414 |
| **Total** | **$1,207,941** | **$441,592** | **$422,325** | **$344,024** |

| FY 2018-19 | TF | IGT | FF | ACA FF |
|---|---|---|---|---|
| FY 2017-18 | $244,436 | $89,504 | $85,461 | $69,471 |
| FY 2018-19 | $755,308 | $278,839 | $264,074 | $212,395 |
| **Total** | **$999,744** | **$368,343** | **$349,535** | **$281,866** |

**Funding:**
Title XIX FFP (4260-101-0890)
DPH Graduate Medical Education Special Fund (4260-601-8113)
Title XIX ACA (4260-101-0890)

# PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 141 |
| IMPLEMENTATION DATE: | 1/2018 |
| ANALYST: | Davonna McClendon |
| FISCAL REFERENCE NUMBER: | 2048 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $746,051,000 | $1,338,039,000 |
| - STATE FUNDS | $229,756,000 | $416,593,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $746,051,000 | $1,338,039,000 |
| STATE FUNDS | $229,756,000 | $416,593,000 |
| FEDERAL FUNDS | $516,295,000 | $921,446,000 |

## 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) 438.6(c)

**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.

# PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS

**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 received 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 will seek approval of an allowable directed plan for the managed care supplemental payments.

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 is seeking federal approval to implement managed care capitation rate increases to fund MCPs to make supplemental payments for 13 CPT codes.

Beginning July 1, 2017 rating period, the state will direct 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 is due to:

- Updated funding splits for the FFS and managed care payments;
- Delayed system implementation of the FFS supplemental payments to February 2018;
- Updating the managed care supplemental payments to a directed payment methodology with 11 months of payments in FY 2017-18; and
- Including the Erroneous Payment Correction (EPC) for FY 2017-18 FFS supplemental payments in May 2018.

# PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS

**REGULAR POLICY CHANGE NUMBER: 141**

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to including one month of FY 2017-18 managed care directed payments and 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; however payments are assumed to begin 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 will be implemented in February 2018.

5. The Erroneous Payment Correction (EPC) for the July 2017 to January 2018 retroactive period is estimated to be implemented in May 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 $789.3 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. 11 months of the FY 2017-18 capitation rate increases are anticipated to occur in FY 2017-18. One month of the MCP FY 2017-18 capitation rate increases are anticipated to be made at the beginning of FY 2018-19.

10. 11 months of the 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.

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) | $8,399 | $3,707 | $210 | $3,633 | $849 |
| Managed Care Directed Payments FY 2017-18 | $723,537 | $219,817 | $22,221 | 202,945 | $278,554 |
| Retro FFS Physician Supplemental FY 2017-18 | $14,115 | $6,232 | $353 | $6,106 | $1,424 |
| **Total** | **$746,051** | **$229,756** | **$22,784** | **$212,684** | **280,827** |

# PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS

**REGULAR POLICY CHANGE NUMBER: 141**

(Dollars in Thousands)

| FY 2018-19 | TF | SF | Title XXI FF | Title XIX FF | ACA FF |
|---|---|---|---|---|---|
| FFS Physician Supplemental FY 2018-19 | $24,198 | $10,718 | $605 | $10,468 | $2,407 |
| Managed Care Directed Payments FY 2017-18 | $65,775 | $20,129 | $2,020 | $18,449 | $25,177 |
| Managed Care Directed Payments FY 2018-19 | $723,537 | $222,763 | $22,221 | $202,945 | $275,608 |
| Additional FY 2018-19 payments | $524,529 | $162,983 | $16,046 | $148,899 | $196,601 |
| **Total** | **$1,338,039** | **$416,593** | **$40,892** | **$380,761** | **$499,793** |

**Funding:**

(Dollars in Thousands)

| FY 2017-18 | TF | SF | FF |
|---|---|---|---|
| Healthcare Treatment Fund Prop. 56 (4260-101-3305) | $229,756 | $229,756 | $0 |
| ACA Title XIX FF (4260-101-0890) | $280,827 | $0 | $280,827 |
| Title XIX FF (4260-101-0890) | $212,684 | $0 | $212,684 |
| Title XXI FF (4260-113-0890) | $22,784 | $0 | $22,784 |
| **Total** | **$746,051** | **$229,756** | **$516,295** |

(Dollars in Thousands)

| FY 2018-19 | TF | SF | FF |
|---|---|---|---|
| Healthcare Treatment Fund Prop. 56 (4260-101-3305) | $416,593 | $416,593 | $0 |
| ACA Title XIX FF (4260-101-0890) | $499,793 | $0 | $499,793 |
| Title XIX FF (4260-101-0890) | $380,761 | $0 | $380,761 |
| Title XXI FF (4260-113-0890) | $40,892 | $0 | $40,892 |
| **Total** | **$1,338,039** | **$416,593** | **$921,446** |

# 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 | $569,419,000 | $571,519,000 |
| - STATE FUNDS | $284,709,500 | $285,759,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $569,419,000 | $571,519,000 |
| STATE FUNDS | $284,709,500 | $285,759,500 |
| FEDERAL FUNDS | $284,709,500 | $285,759,500 |

## DESCRIPTION

**Purpose:**
This policy change estimates the funds for the private Disproportionate Share Hospital (DSH) replacement payments.

**Authority:**
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.11
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
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

**Interdependent Policy Changes:**
PC 26 ACA DSH Reduction

**Background:**
As part of the MH/UCD and BTR, changes were made to hospital inpatient DSH and other supplemental payments. Beginning July 1, 2005, based on SB 1100, private hospitals receive Medi-Cal DSH replacement payment adjustments. The payments are determined using the formulas and methodology that were previously in effect for the 2004-05 fiscal year. These payments along with $160.00 of the annual DSH allotment satisfy the State's payment obligations under the Federal DSH statute.

The federal share of the DSH replacement payments is regular Title XIX funding and will not be claimed from the federal DSH allotment. The non-federal share of these payments is State General Fund.

# PRIVATE HOSPITAL DSH REPLACEMENT

**REGULAR POLICY CHANGE NUMBER: 142**

The Affordable Care Act (ACA) reduction to the DSH allotments was previously scheduled to go into effect on October 1, 2013: instead, HR 2 (2015) was enacted on April 16, 2015, which delays the reduction until October 1, 2017. The private DSH replacement payments are affected because, as required by SB 1100, the methodology to determine the DSH replacement payments is based on the DSH allotment. For the impact of the ACA DSH allotment reduction, see the ACA DSH Reduction policy change.

The Department submitted SPA 16-010 to the Centers for Medicare & Medicaid Services (CMS) in March 2016 to transfer the authority for DSH replacement payments from the BTR to the State Plan. SPA 16-010 is pending CMS approval.

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is due to updated payment data through June 2017, the inclusion of remaining payments for FY 2014-15 and FY 2015-16 which shifted from FY 2016-17, and a reduction in the federal DSH allotment for FY 2017-18.

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 2014-15, FY 2015-16, and FY 2016-17 final payments are assumed to be paid in FY 2017-18.

2. 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:

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| FY 2014-15 | ($450,000) | ($225,000) | ($225,000) |
| FY 2015-16 | $32,304,000 | $16,152,000 | $16,152,000 |
| FY 2016-17 | $15,834,000 | $7,917,000 | $7,917,000 |
| FY 2017-18 | $521,731,000 | $260,865,500 | $260,865,500 |
| **Total FY 2017-18** | **$569,419,000** | **$284,709,500** | **$284,709,500** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| FY2017-18 | $47,430,000 | $23,715,000 | $23,715,000 |
| FY 2018-19 | $524,089,000 | $262,044,500 | $262,044,500 |
| **Total FY 2018-19** | **$571,519,000** | **$285,759,500** | **$285,759,500** |

**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 | $433,217,000 | $379,083,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $433,217,000 | $379,083,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $433,217,000 | $379,083,000 |

## 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:

- Addition of FY 2013-14 Affordable Care Act (ACA) claim payments,
- Updated actual claim/payment information for Dates of Service (DOS) FY 2015-16, which serves as the basis for the DOS FY 2016-17 payment estimate,
- Reduction of estimated FY 2014-15 and FY 2015-16 ACA claim amounts due to a revised calculation methodology, and
- Final reconciliations starting with DOS FY 2005-06. The AB 915 program authorized supplemental payments starting with DOS FY 2002-03. However, due to technical data limitations and currently developing procedures for DOS FY 2002-03 through FY 2004-05, the final reconciliations will begin with DOS FY 2005-06.

# HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

**REGULAR POLICY CHANGE NUMBER: 143**

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to an additional year of ACA payments occurring in FY 2017-18.

**Methodology:**

1. Payments of $433,217,000 and $379,083,000 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 2017-18. 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 2017-18 and FY 2018-19, respectively, 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 2005-06 (Final Reconciliation) | $9,385,000 | $9,385,000 | $0 |
| FY 2012-13 (Adjusted Claims) | ($3,116,000) | ($3,116,000) | $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) | $526,000 | $526,000 | $0 |
| FY 2015-16 (Est. ACA Claims) | $115,938,000 | $0 | $115,938,000 |
| FY 2015-16 (Adjusted Claims) | $880,000 | $880,000 | $0 |
| FY 2015-16 (Untimely Claims) | $872,000 | $872,000 | $0 |
| FY 2016-17 (Est. Payments) | $137,621,000 | $137,621,000 | $0 |
| **Total FY 2017-18** | **$433,217,000** | **$146,168,000** | **$287,049,000** |

| FY 2018-19 | TF | FF | ACA |
|---|---|---|---|
| FY 2006-07 (Final Reconciliation) | $9,385,000 | $9,385,000 | $0 |
| FY 2016-17 (Est. ACA Claims) | $115,866,000 | $0 | $115,866,000 |
| FY 2016-17 (Calendar Year Claims) | $539,000 | $539,000 | $0 |
| FY 2017-18 (Est. ACA Claims) | $112,231,000 | $0 | $112,231,000 |
| FY 2017-18 (Est. Payments) | $141,062,000 | $141,062,000 | $0 |
| **Total FY 2018-19** | **$379,083,000** | **$150,986,000** | **$228,097,000** |

**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 | $469,970,000 | $425,460,000 |
| - STATE FUNDS | $176,668,000 | $134,961,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $469,970,000 | $425,460,000 |
| STATE FUNDS | $176,668,000 | $134,961,000 |
| FEDERAL FUNDS | $293,302,000 | $290,499,000 |

## 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)

**Interdependent Policy Changes:**
PC 26 ACA DSH Reduction

**Background:**
As part of the MH/UCD and BTR, changes were made to hospital inpatient DSH and other supplemental payments. Effective July 1, 2005, based on State Plan Amendment (SPA) 05-022, the federal DSH allotment is available for uncompensated Medi-Cal and uninsured costs incurred by DSHs. Non-emergency services for undocumented individuals are eligible for DSH program funding. The 2017-18 and 2018-19 DSH allotments are estimated to be $1,232,173,502, and $1,256,816,972 respectively.

- 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 nonfederal 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 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 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 State General Fund (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 provides the authority for the Department to implement the new payment methodologies under the successor demonstration project to determine the federal DSH allotment for DPHs.

The Affordable Care Act (ACA) reduction in the DSH allotments was previously scheduled to go into effect on October 1, 2013. Instead, HR 2 (2015) was enacted on April 16, 2015, which delays the reduction until October 1, 2017. For the impact of the ACA DSH allotment reduction, see the ACA DSH Reduction policy change.

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is due to:
- Remaining FY 2014-15 and FY 2015-16 NDPH payments based on updated payment data;
- Decreased FY 2016-17 payments based on updated payment data; and
- Increased FY 2017-18 payments based on updated payment data.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to:
- Differing prior year recoupments 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.

# 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 | $1,946,000 | $973,000 | $973,000 | $0 |
| DSH 2016-17 | $29,849,000 | ($1,248,000) | $20,339,000 | $10,758,000 |
| DSH 2017-18 | $437,351,000 | $12,965,000 | $271,578,000 | $152,808,000 |
| **Total FY 2017-18** | **$469,970,000** | **$13,102,000** | **$293,302,000** | **$163,566,000** |

| 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 | $2,750,000 | $0 | $1,979,000 | $771,000 |
| DSH 2017-18 | $39,760,000 | $1,179,000 | $24,689,000 | $13,892,000 |
| DSH 2018-19 | $386,084,000 | $12,375,000 | $261,925,000 | $111,784,000 |
| **Total FY 2018-19** | **$425,460,000** | **$13,554,000** | **$290,499,000** | **$121,407,000** |

**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 | $324,086,000 | $297,963,000 |
| - 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 | $324,086,000 | $297,963,000 |
| STATE FUNDS | $127,550,000 | $137,900,000 |
| FEDERAL FUNDS | $196,536,000 | $160,063,000 |

## 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 FY 2015-16 ACA claims data, and the addition of the ACA adjustment for FY 2016-17.

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.

    - 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.

# PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

**REGULAR POLICY CHANGE NUMBER: 145**

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 | $5,470,000 |
| FY 2014-15 ACA FFP Adjustment to SF | $14,251,000 |
| FY 2015-16 ACA FFP Adjustment to SF | $22,164,000 |
| FY 2016-17 ACA FFP Adjustment to SF | $21,654,000 |
| Funds Available | $192,537,000 |
| | |
| Less: FY 2017-18 Cash Expenditures to Hospitals | ($127,550,000) |
| | |
| Est. FY 2017-18 Remaining Balance | $64,987,000 |

# PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

## REGULAR POLICY CHANGE NUMBER: 145

| FY 2017-18 | TF | SF | FF | ACA FF | Return to Fund 3097* | 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*** | $5,470,000 | $0 | ($5,470,000) | $10,940,000 | $5,470,000 | $0 |
| FY 2013-14 ACA FF Adjustment to Counties*** | $165,000 | $0 | ($165,000) | $330,000 | $0 | $165,000 |
| FY 2014-15 ACA FF Adjustment to SF*** | $14,251,000 | $0 | ($14,251,000) | $28,502,000 | $14,251,000 | $0 |
| FY 2014-15 ACA FF Adjustment to Counties*** | $1,454,000 | $0 | ($1,454,000) | $2,908,000 | $0 | $1,454,000 |
| FY 2015-16 ACA FF Adjustment to SF*** | $22,164,000 | $0 | ($22,164,000) | $44,328,000 | $22,164,000 | $0 |
| FY 2015-16 ACA FF Adjustment to Counties*** | $1,825,000 | $0 | ($1,825,000) | $3,650,000 | $0 | $1,825,000 |
| FY 2016-17 ACA FF Adjustment to SF*** | $21,654,000 | $0 | ($22,793,000) | $44,447,000 | $21,654,000 | $0 |
| FY 2016-17 ACA FF Adjustment to Counties*** | $2,003,000 | $0 | ($2,108,000) | $4,111,000 | $0 | $2,003,000 |
| **Total** | **$324,086,000** | **$127,550,000** | **$57,320,000** | **$139,216,000** | $63,539,000 | $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 | $64,987,000 |
| Appropriation (GF) | $118,400,000 |
| 2018-19 IGT | $19,500,000 |
| Est. FY 2017-18 Interest Earned | $410,000 |
| FY 2017-18 ACA FFP Adjustment to SF | $20,286,000 |
| | |
| Funds Available | $223,583,000 |
| | |
| Less: FY 2018-19 Cash Expenditures to Hospitals | ($137,900,000) |
| | |
| Est. FY 2018-19 Remaining Balance | $85,683,000 |

| 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*** | $20,286,000 | $0 | ($22,794,000) | $43,080,000 | $20,286,000 | $0 |
| FY 2017-18 ACA FF Adjustment to Counties*** | $1,877,000 | $0 | ($2,108,000) | $3,985,000 | $0 | $1,876,000 |
| **Total** | **$297,963,000** | **$137,900,000** | **$112,998,000** | **$47,065,000** | $20,286,000 | $1,876,000 |

*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 | $233,467,000 | $125,874,000 |
| - STATE FUNDS | $65,001,000 | $49,495,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $233,467,000 | $125,874,000 |
| STATE FUNDS | $65,001,000 | $49,495,000 |
| FEDERAL FUNDS | $168,466,000 | $76,379,000 |

## 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 due to:

- Updated UPL estimates,
- Updated ACA payments and adjustments for FY 2013-14, FY 2014-15 and FY 2015-16,
- Adding the FY 2013-14 Children's Services ACA Adjustment payment as well as updating the FY 2014-15 payment due to the over collection of IGTs of $101,000 and $645,000, respectively,
- The addition of the FY 2016-17 ACA payment and FY 2016-17 regular supplemental payment,
- Updates to the FY 2015-16 Children's Services payment as well as adding the FY 2016-17 Children's Services payment, and
- Updates to the FY 2017-18 regular supplemental payment.

# NDPH IGT SUPPLEMENTAL PAYMENTS

**REGULAR POLICY CHANGE NUMBER: 146**

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

- Additional ACA payments and adjustments occurring in FY 2017-18,
- Additional payments to NDPHs occurring in FY 2017-18, and
- An additional Children's services payment in FY 2017-18.

**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 $127,531,000 TF and the FY 2016-17 tentative UPL amount is $118,672,000 TF. The UPL room for FY 2017-18 and FY 2018-19 are estimated using a trend factor and are $122,719,000 TF and $126,905,000 TF, respectively.

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, FY 2015-16, and FY 2016-17, the ACA supplemental payments will be claimed in FY 2017-18. The 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. 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.

11. 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 Population) | $39,249,000 | $0 | $0 | $0 | $39,249,000 | $0 |
| FY 2015-16 Payments to NDPHs | $13,982,000 | $0 | $6,991,000 | $6,991,000 | $0 | $0 |
| FY 2015-16 Children's Services | $0 | ($4,269,000) | $4,269,000 | $0 | $0 | $0 |
| FY 2016-17 Payments to NDPHs (ACA Population) | $23,533,000 | $0 | $588,000 | $0 | $22,945,000 | $0 |
| FY 2016-17 Payments to NDPHs | $20,838,000 | $0 | $10,419,000 | $10,419,000 | $0 | $0 |
| FY 2016-17 Children's Services | $0 | ($4,667,000) | $4,667,000 | $0 | $0 | $0 |
| FY 2017-18 Payments to NDPHs | $92,514,000 | $0 | $46,257,000 | $46,257,000 | $0 | $0 |
| **Total FY 2017-18** | **$233,467,000** | **($8,190,000)** | **$73,191,000** | **$55,480,000** | **$112,986,000** | $ 8,933,000 |

| FY 2018-19 | TF | GF* | IGT** | FF | ACA |
|---|---|---|---|---|---|
| FY 2017-18 Payments to NDPHs (ACA Population) | $30,206,000 | $0 | $1,661,000 | $0 | $28,545,000 |
| FY 2017-18 Children's Services | $0 | ($4,643,000) | $4,643,000 | $0 | $0 |
| FY 2018-19 Payments to NDPHs | $95,668,000 | $0 | $47,834,000 | $47,834,000 | $0 |
| **Total FY 2018-19** | **$125,874,000** | **($4,643,000)** | **$54,138,000** | **$47,834,000** | $28,545,000 |

***The Return to NDPHs column is for display purposes only (see methodology #5-#7).

# NDPH IGT SUPPLEMENTAL PAYMENTS

## REGULAR POLICY CHANGE NUMBER: 146

**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)

# 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 | $223,809,000 | $461,501,000 |
| - STATE FUNDS | $78,819,000 | $164,519,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $223,809,000 | $461,501,000 |
| STATE FUNDS | $78,819,000 | $164,519,000 |
| FEDERAL FUNDS | $144,990,000 | $296,982,000 |

## 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, increases 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 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 will be 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, is a decrease due to updated projected costs and a payment lag. The increase from FY 2017-18 to FY 2018-19, in the current estimate, is due to a population growth factor for FY 2018-19 as well as the additional dollars in budget year that have been added to allow for other additional supplemental payments.

# SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES

**REGULAR POLICY CHANGE NUMBER: 147**

**Methodology:**

1. Payments will be made via supplemental payments.

2. This policy was effective on July 1, 2017, but payments will not begin until January 2018.

3. Supplemental payments will be 40% of the Dental SMA.

4. Assume Dental Managed Care cost are estimated based on a cost per eligible of the Dental Fee-For-Service population.

5. 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.

6. Funds allocated for the supplemental payments are as follows:

**Funding:**

| FY 2017-18 | TF | GF | FF | SF* |
|---|---|---|---|---|
| 50% Title XIX / 50% GF | $147,081,000 | $0 | $73,540,000 | $73,540,000 |
| 100% State GF | $9,000 | $0 | $0 | $9,000 |
| ACA 95% FFP/5% GF (2017) | $30,412,000 | $0 | $28,892,000 | $1,521,000 |
| ACA 94% FFP/6% GF (2018) | $30,412,000 | $0 | $28,588,000 | $1,825,000 |
| Title 21 88% FFP/12% GF | $15,823,000 | $0 | $13,923,000 | $1,899,000 |
| 65% Title XIX / 35% GF | $72,000 | $0 | $47,000 | $25,000 |
| **Total** | **$223,809,000** | **$0** | **$144,990,000** | **$78,819,000** |

| FY 2018-19 | TF | GF | FF | SF* |
|---|---|---|---|---|
| 50% Title XIX / 50% GF | $304,969,000 | $0 | $152,484,000 | $152,484,000 |
| 100% State GF | $20,000 | $0 | $0 | $20,000 |
| ACA 93% FFP/7% GF (2019) | $61,896,000 | $0 | $57,563,000 | $4,333,000 |
| ACA 94% FFP/6% GF (2018) | $61,776,000 | $0 | $58,070,000 | $3,707,000 |
| Title 21 88% FFP/12% GF | $32,690,000 | $0 | $28,767,000 | $3,923,000 |
| 65% Title XIX / 35% GF | $151,000 | $0 | $98,000 | $53,000 |
| **Total** | **$461,501,000** | **$0** | **$296,982,000** | **$164,519,000** |

*Healthcare Treatment Fund Prop 56

# WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 148 |
| IMPLEMENTATION DATE: | 1/2018 |
| ANALYST: | Katy Clay |
| FISCAL REFERENCE NUMBER: | 2044 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $158,347,000 | $183,259,000 |
| - STATE FUNDS | $42,608,000 | $49,001,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $158,347,000 | $183,259,000 |
| STATE FUNDS | $42,608,000 | $49,001,000 |
| FEDERAL FUNDS | $115,739,000 | $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)

**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 provides $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.

Additionally, the Department allocated $10 million for time-limited supplemental payments for medical pregnancy termination.

# WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS

## REGULAR POLICY CHANGE NUMBER: 148

**Reason for Change:**
The reason for change from the previous estimate, for FY 2017-18, results from updating the implementation date from July 1, 2017, to January 1, 2018. 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 will not begin until 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 | $ 149,447 | $ 33,708 | $ 115,739 |
| Medical Pregnancy Termination | $ 8,900 | $ 8,900 | $ - |
| **Total** | **$ 158,347** | **$ 42,608** | **$ 115,739** |

| FY 2018-19 | TF | SF | FF |
|---|---|---|---|
| E&M Office Visits | $ 173,359 | $ 39,101 | $ 134,258 |
| Medical Pregnancy Termination | $ 9,900 | $ 9,900 | $ - |
| **Total** | **$ 183,259** | **$ 49,001** | **$ 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 | $155,563,000 | $123,573,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $155,563,000 | $123,573,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $155,563,000 | $123,573,000 |

## 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 2007-08 final reconciliation shifted from FY 2016-17,
- FY 2008-09 final reconciliation amounts were updated to include the impact of the American Recovery and Reinvestment Act of 2009 (ARRA) funding and were shifted to FY 2018-19,
- Updated FY 2013-14 final reconciliation and Affordable Care Act (ACA) payment amounts based on finalized cost reports. The estimate no longer includes interim ACA or final ACA reconciliations for FY 2013-14 since the ACA payments for that year are now based on finalized cost reports, and
- Decreased FY 2014-15 ACA payment amounts based on updated data.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to more retroactive ACA payments occurring in FY 2017-18 and the different interim and final reconciliation estimates for the various fiscal years 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 2017-18 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 2007-08 Final Reconciliation | ($3,875,000) | ($3,875,000) |
| FY 2013-14 Final Reconciliation | ($19,769,000) | ($19,769,000) |
| FY 2013-14 Payment ACA | $12,590,000 | $12,590,000 |
| FY 2014-15 Interim Reconciliation | ($4,020,000) | ($4,020,000) |
| FY 2014-15 Interim Payment ACA | $50,137,000 | $50,137,000 |
| FY 2015-16 Interim Payment ACA | $50,500,000 | $50,500,000 |
| FY 2017-18 Interim Payment | $70,000,000 | $70,000,000 |
| **Total** | **$155,563,000** | **$155,563,000** |

| FY 2018-19 | TF | FF | ARRA |
|---|---|---|---|
| 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 2015-16 Interim Reconciliation | $4,000,000 | $4,000,000 | $0 |
| FY 2016-17 Interim Reconciliation | $4,000,000 | $4,000,000 | $0 |
| FY 2016-17 Interim Payment ACA | $50,000,000 | $50,000,000 | $0 |
| FY 2018-19 Interim Payment | $70,000,000 | $70,000,000 | $0 |
| **Total** | **$123,573,000** | **$124,372,000** | **($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 | $153,994,000 | $123,280,000 |
| - STATE FUNDS | $37,764,000 | $41,398,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $153,994,000 | $123,280,000 |
| STATE FUNDS | $37,764,000 | $41,398,000 |
| FEDERAL FUNDS | $116,230,000 | $81,882,000 |

## 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 a net decrease due to:

- SB 1732 – More accurate projections based on updated payment data and actuals paid, partially shifting FY 2016-17 and FY 2017-18 interim payments to FY 2018-19, addition of Affordable Care Act (ACA) adjustments, and shifting FY 2014-15 interim reconciliation to FY 2018-19, and
- SB 1128 – A portion of the FY 2015-16 claims shifted from FY 2016-17 to FY 2017-18.

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

- SB 1732 – Higher portion of interim payments being made in FY 2017-18, and
- SB 1128 – Delayed FY 2015-16 claims processed in FY 2017-18.

**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 2015-16 | $3,966,000 | $1,983,000 | $1,983,000 | $0 |
| FY 2016-17 | $76,752,000 | $38,376,000 | $38,376,000 | $0 |
| FY 2017-18 | $33,336,000 | $16,668,000 | $16,668,000 | $0 |
| ACA Adjustment to GF | | | | |
| FY 2013-14 | $0 | ($4,898,000) | ($4,898,000) | $9,796,000 |
| FY 2014-15 | $0 | ($7,250,000) | ($7,250,000) | $14,500,000 |
| FY 2015-16 | $0 | ($8,704,000) | ($8,705,000) | $17,409,000 |
| Interim Reconciliation | | | | |
| FY 2013-14 | $3,940,000 | $1,589,000 | $1,589,000 | $762,000 |
| **DP-NFs (SB 1128)** | | | | |
| Interim Payment | | | | |
| FY 2015-16 | $15,500,000 | $0 | $15,500,000 | $0 |
| FY 2016-17 | $20,500,000 | $0 | $20,500,000 | $0 |
| **Total FY 2017-18** | **$153,994,000** | **$37,764,000** | **$73,763,000** | **$42,467,000** |

# 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 | ($9,493,000) | ($10,123,000) | $19,616,000 |
| Interim Reconciliation | | | | |
| FY 2014-15 | $5,288,000 | $2,145,000 | $2,145,000 | $998,000 |
| **DP-NFs (SB 1128)** | | | | |
| Interim Payment | | | | |
| FY 2017-18 | $20,500,000 | $0 | $20,500,000 | $0 |
| **Total FY 2018-19** | **$123,280,000** | **$41,398,000** | **$61,268,000** | **$20,614,000** |

**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 | $147,634,000 | $135,868,000 |
| - STATE FUNDS | $61,798,000 | $64,207,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $147,634,000 | $135,868,000 |
| STATE FUNDS | $61,798,000 | $64,207,000 |
| FEDERAL FUNDS | $85,836,000 | $71,661,000 |

## 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 an increase due to:

- The addition of Affordable Care Act (ACA) FY 2016-17 payment adjustments,
- An increase to the estimated Los Angeles County final FY 2016-17 IGT and initial FY 2017-18 IGT, and
- An increase to the Alameda FY 2016-17 IGT.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to fewer retroactive ACA payment adjustments 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 | $5,417 | $0 | ($5,416) | $10,833 | $5,417 |
| FY 2014-15 ACA Adjustment to Counties | $5,364 | $0 | ($5,364) | $10,728 | $5,364 |
| FY 2015-16 ACA Adjustment to Counties | $6,130 | $0 | ($6,130) | $12,260 | $6,130 |
| FY 2016-17 ACA Adjustment to Counties | $7,127 | $0 | ($7,501) | $14,628 | $7,127 |
| FY 2016-17 | $77,828 | $38,914 | $38,914 | $0 | $0 |
| FY 2017-18 | $45,768 | $22,884 | $22,884 | $0 | $0 |
| **Total FY 2017-18** | **$147,634** | **$61,798** | **$37,387** | **$48,449** | $24,038 |

(Dollars in Thousands)

| FY 2018-19 | TF | Special Deposit Fund | FF | ACA FF | *Return to Counties |
|---|---|---|---|---|---|
| FY 2017-18 ACA Adjustment to Counties | $7,454 | $0 | ($8,375) | $15,829 | $7,454 |
| FY 2017-18 | $82,646 | $41,323 | $41,323 | $0 | $0 |
| FY 2018-19 | $45,768 | $22,884 | $22,884 | $0 | $0 |
| **Total FY 2018-19** | **$135,868** | **$64,207** | **$55,832** | **$15,829** | $7,454 |

*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 | $137,213,000 | $116,910,000 |
| - STATE FUNDS | $50,000,000 | $50,000,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $137,213,000 | $116,910,000 |
| STATE FUNDS | $50,000,000 | $50,000,000 |
| FEDERAL FUNDS | $87,213,000 | $66,910,000 |

## 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 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.

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

- The removal of the FY 2015-16 DRG add-on and supplemental payment interim reconciliation amounts, which were completed in FY 2016-17, and
- The inclusion of FY 2016-17 Affordable Care Act (ACA) optional population payments.

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.

**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.

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.

# MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

**REGULAR POLICY CHANGE NUMBER: 152**

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. 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, $38.3 million is attributable to the ACA optional population. Based on updated payment data, $37 million, and $35.9 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.

10. 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.
    - A retroactive payment for FY 2015-16 and FY 2016-17 will be made in FY 2017-18 in PC 117 Retro MC Rate Adjustments.
    - The FY 2017-18 and FY 2018-19 managed care payments are in PC 87 Two Plan Model.

(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 |
| Managed Care 2017-18 (PC 87) | $17,784 |
| Total Managed Care | $31,598 |
| | |
| Total FY 2017-18 | $131,598 |

# MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

## REGULAR POLICY CHANGE NUMBER: 152

(Dollars in Thousands)

| FY 2018-19 | TF |
|---|---|
| Supplemental 2018-19 | $100,000 |
| Total (PC 152) | $100,000 |
| | |
| Managed Care 2018-19 (PC 87) | $20,290 |
| Total Managed Care | $20,290 |
| | |
| Total FY 2018-19 | $120,290 |

11. On a cash basis, costs in FY 2017-18 and FY 2018-19 are expected to be:

(Dollars in Thousands)

| FY 2017-18 | TF | IGT* | FF | ACA FF | Return to County** |
|---|---|---|---|---|---|
| Supplemental 2017-18 | $100,000 | $50,000 | $50,000 | $0 | $0 |
| Supplemental ACA 2015-16 | $19,163 | $0 | ($19,162) | $38,325 | $19,163 |
| Supplemental ACA 2016-17 | $18,050 | $0 | ($19,000) | $37,050 | $18,050 |
| **Total** | **$137,213** | **$50,000** | **$11,838** | **$75,375** | **$37,213** |

(Dollars in Thousands)

| FY 2018-19 | TF | IGT* | FF | ACA FF | Return to County** |
|---|---|---|---|---|---|
| Supplemental 2018-19 | $100,000 | $50,000 | $50,000 | $0 | $0 |
| Supplemental ACA 2017-18 | $16,910 | $0 | ($19,000) | $35,910 | $16,910 |
| **Total** | **$116,910** | **$50,000** | **$31,000** | **$35,910** | **$16,910** |

**The Return to County column is for display purposes only (see methodology #9)

**Funding:**
50% Title XIX / 50% Reimbursement GF (4260-601-0995/4260-101-0890)*
100% Title XIX ACA (4260-101-0890)

# QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 153 |
| IMPLEMENTATION DATE: | 4/2014 |
| ANALYST: | Davonna McClendon |
| FISCAL REFERENCE NUMBER: | 1563 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $86,242,000 | $86,242,000 |
| - STATE FUNDS | $43,121,000 | $43,121,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $86,242,000 | $86,242,000 |
| STATE FUNDS | $43,121,000 | $43,121,000 |
| FEDERAL FUNDS | $43,121,000 | $43,121,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates:

- Transfer from the General Fund (GF) to a Skilled Nursing Facility Quality and Accountability Special Fund (Special Fund), and
- Supplemental payments to freestanding 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:**
There is no material change from the prior estimate, for FY 2017-18.

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 | $210,000 | $210,000 |
| QASP GF Appropriation | $43,236,000 | $43,236,000 |
| PLI savings | $5,692,000 | $5,692,000 |

3. The penalties on nursing facilities will be deposited into the CDPH Skilled Nursing Facility Minimum Staffing Penalty Account and then transferred to the Special Fund. The total amount of supplemental payments may be adjusted in accordance with the amount of administrative penalties deposited into the Special Fund.

4. Estimated CDPH annual administrative costs are $7,814,000 TF ($3,907,000 Special Fund) for FY 2017-18 and FY 2018-19.

5. The 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*** | $86,242 | $0 | $43,121 | $43,121 |
| Transfer from GF* to Special Fund** | $0 | $48,928 | ($48,928) | $0 |
| **Total** | **$86,242** | **$48,928** | **($5,807)** | **$43,121** |

| FY 2018-19 | TF | GF | SF | FF |
|---|---|---|---|---|
| Supplemental Payments*** | $86,242 | $0 | $43,121 | $43,121 |
| Transfer from GF* to Special Fund** | $0 | $48,928 | ($48,928) | $0 |
| **Total** | **$86,242** | **$48,928** | **($5,807)** | **$43,121** |

**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 | $70,105,000 | $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 | $70,105,000 | $37,900,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $70,105,000 | $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 decrease due to:

- The addition of FY 2009-10 through FY 2013-14 interim and final reconciliations,
- The addition of FY 2014-15 interim reconciliations,
- FY 2013-14 through FY 2016-17 ACA payments decreased based on updated cost report data, and
- FY 2016-17 payments are anticipated to be lower than originally estimated based on more recently available data.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is 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 2009-10 Interim Recon. | $13,300,000 | $10,800,000 | $2,500,000 | $0 |
| FY 2010-11 Interim Recon. | $7,900,000 | $6,400,000 | $1,500,000 | $0 |
| FY 2011-12 Interim Recon. | $310,000 | $310,000 | $0 | $0 |
| FY 2012-13 Interim Recon. | $20,000 | $20,000 | $0 | $0 |
| FY 2013-14 Interim Recon. | $2,600,000 | ($3,300,000) | $0 | $5,900,000 |
| FY 2014-15 Interim Recon. | $3,300,000 | ($10,500,000) | $0 | $13,800,000 |
| FY 2009-10 Final Recon. | ($1,000,000) | ($800,000) | ($200,000) | $0 |
| FY 2010-11 Final Recon. | ($2,400,000) | ($2,000,000) | ($400,000) | $0 |
| FY 2011-12 Final Recon. | ($1,500,000) | ($1,500,000) | $0 | $0 |
| FY 2012-13 Final Recon. | ($800,000) | ($800,000) | $0 | $0 |
| FY 2013-14 Final Recon. | ($1,400,000) | ($900,000) | $0 | ($500,000) |
| FY 2015-16 | $16,675,000 | $675,000 | $0 | $16,000,000 |
| FY 2016-17 | $33,100,000 | $14,300,000 | $0 | $18,800,000 |
| **Total FY 2017-18** | **$70,105,000** | **$12,705,000** | **$3,400,000** | **$54,000,000** |

| 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 | $57,392,000 | $59,590,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $57,392,000 | $59,590,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $57,392,000 | $59,590,000 |

## 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 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.

# CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS

**REGULAR POLICY CHANGE NUMBER: 155**

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

- Updated FY 2013-14 payments shifted from FY 2016-17,
- Reduced FY 2014-15 through FY 2017-18 payments based on updated data, and
- Updated ACA payments for FY 2013-14 and FY 2014-15.

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

- Additional Affordable Care Act (ACA) payments occurring in FY 2017-18, and
- Higher regular payments estimated to occur in FY 2018-19.

**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.

| FY 2017-18 | TF | FFP | ACA |
|---|---|---|---|
| FY 2013-14 | $3,268,000 | $3,268,000 | $0 |
| FY 2014-15 | $444,000 | $444,000 | $0 |
| FY 2015-16 | $55,000 | $55,000 | $0 |
| FY 2016-17 | $38,810,000 | $38,810,000 | $0 |
| FY 2017-18 | $2,322,000 | $2,322,000 | $0 |
| FY 2013-14 ACA | $1,278,000 | $0 | $1,278,000 |
| FY 2014-15 ACA | $4,597,000 | $0 | $4,597,000 |
| FY 2015-16 ACA | $6,618,000 | $0 | $6,618,000 |
| **Total FY 2017-18** | **$57,392,000** | **$44,899,000** | **$12,493,000** |

| FY 2018-19 | TF | FFP | ACA |
|---|---|---|---|
| FY 2016-17 | $4,312,000 | $4,312,000 | $0 |
| FY 2017-18 | $44,121,000 | $44,121,000 | $0 |
| FY 2018-19 | $3,005,000 | $3,005,000 | $0 |
| FY 2016-17 ACA | $8,152,000 | $0 | $8,152,000 |
| **Total FY 2018-19** | **$59,590,000** | **$51,438,000** | **$8,152,000** |

**Funding:**
100% Title XIX FF (4260-101-0890)
100% Title XIX ACA FF (4260-101-0890)

# ICF/DD SUPPLEMENTAL PAYMENTS

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 156 |
| IMPLEMENTATION DATE: | 1/2018 |
| ANALYST: | Davonna McClendon |
| FISCAL REFERENCE NUMBER: | 2045 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $13,257,000 | $35,616,000 |
| - STATE FUNDS | $5,472,000 | $16,412,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $13,257,000 | $35,616,000 |
| STATE FUNDS | $5,472,000 | $16,412,000 |
| FEDERAL FUNDS | $7,785,000 | $19,204,000 |

## 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.

In accordance with AB 120 (Chapter 22, Statutes of 2017) the Department of Health Care Services shall develop the structure of the supplemental payments. 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.

# ICF/DD SUPPLEMENTAL PAYMENTS

**REGULAR POLICY CHANGE NUMBER: 156**

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

- Decreased estimated supplemental payments based on the updated Upper Payment Limit;
- Delayed system implementation of the fee-for-service (FFS) supplemental payments to February 2018; and
- Updated managed care implementation with 10 months in FY 2017-18.

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

- Two months of the FY 2017-18 managed care payments 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;
- The Erroneous Payment Correction (EPC) for the retroactive FY 2017-18 FFS payments occurring in FY 2018-19; and
- 10 months of the 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 $26.698 million TF, on an accrual basis. Of that total, the FFS supplemental payments are estimated to be $19.708 million TF and the managed care payments are estimated to be $6.99 million TF, respectively.

4. Assume the FY 2017-18 FFS supplemental payments will be implemented in February 2018 for 5 months in FY 2017-18. The EPC for the retroactive period from July 2017 to January 2018 will be implemented in August 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. Assume 10 months of the FY 2017-18 managed care payments will be paid in FY 2017-18 and 2 months will be paid in FY 2018-19. The managed care payments are expected to begin in January 2018.

7. Assume 10 months of the FY 2018-19 managed care payments will be paid in FY 2018-19.

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) | $7,432 | $3,702 | $0 | $3,701 | $29 |
| Managed Care Payments FY 2017-18 | $5,825 | $1,770 | $179 | $1,634 | $2,242 |
| **Total** | **$13,257** | **$5,472** | **$179** | **$5,335** | **$2,271** |

# ICF/DD SUPPLEMENTAL PAYMENTS

**REGULAR POLICY CHANGE NUMBER: 156**

(Dollars in Thousands)

| FY 2018-19 | TF | SF | Title XXI FF | Title XIX FF | ACA FF |
|---|---|---|---|---|---|
| FFS ICF/DD Supplemental FY 2017-18 | $2,422 | $1,207 | $0 | $1,206 | $9 |
| FFS ICF/DD Supplemental FY 2018-19 (Lagged) | $16,350 | $8,146 | $0 | $8,142 | $62 |
| Managed Care Payments FY 2017-18 | $1,165 | $356 | $36 | $327 | $446 |
| Managed Care Payments FY 2018-19 | $5,825 | $1,794 | $179 | $1,634 | $2,218 |
| FFS ICF/DD Retro 17-18 | $9,854 | $4,909 | $0 | $4,907 | $38 |
| **Total** | **$35,616** | **$16,412** | **$215** | **$16,216** | **$2,773** |

**Funding:**

(Dollars in Thousands)

| FY 2017-18 | TF | SF | FF |
|---|---|---|---|
| Healthcare Treatment Fund Prop. 56 (4260-101-3305) | $5,472 | $5,472 | $0 |
| ACA Title XIX FF (4260-101-0890) | $2,271 | $0 | $2,271 |
| Title XIX FF (4260-101-0890) | $5,335 | $0 | $5,335 |
| Title XXI FF (4260-113-0890) | $179 | $0 | $179 |
| **Total** | **$13,257** | **$5,472** | **$7,785** |

(Dollars in Thousands)

| FY 2018-19 | TF | SF | FF |
|---|---|---|---|
| Healthcare Treatment Fund Prop. 56 (4260-101-3305) | $16,412 | $16,412 | $0 |
| ACA Title XIX FF (4260-101-0890) | $2,773 | $0 | $2,773 |
| Title XIX FF (4260-101-0890) | $16,216 | $0 | $16,216 |
| Title XXI FF (4260-113-0890) | $215 | $0 | $215 |
| **Total** | **$35,616** | **$16,412** | **$19,204** |

# 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 reimburses eligible providers on a quarterly basis through a payment action notice (PAN). The 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 fiscal year will be paid the following fiscal year.

**Reason for Change:**
There is no change from the prior estimate for FY 2017-18 and from FY 2017-18 to FY 2018-19 within the current estimate.

**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** |

# MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH

## REGULAR POLICY CHANGE NUMBER: 157

(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 reimburses eligible providers on a quarterly basis through a payment action notice (PAN). The 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 fiscal year will be paid the following fiscal year.

**Reason for Change:**
There is no change for FY 2017-18 from the prior estimate and from FY 2017-18 to FY 2018-19 within the current estimate.

**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** |

# MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH

## REGULAR POLICY CHANGE NUMBER: 158

(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 | $5,902,000 | $271,000 |
| - STATE FUNDS | $2,000,000 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $5,902,000 | $271,000 |
| STATE FUNDS | $2,000,000 | $0 |
| FEDERAL FUNDS | $3,902,000 | $271,000 |

## 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**

**Reason for Change:**
The change in FY 2017-18, from the prior estimate, is an increase due to the addition of the FY 2016-17 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 IGT 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. Payments are expected to occur in the second quarter of FY 2017-18, 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, FY 2015-16, and FY 2016-17, the ACA supplemental payments will be claimed in 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:

| FY 2017-18 | TF | IGT | FF | ACA FF | *Return to Counties |
|---|---|---|---|---|---|
| FY 2013-14 ACA Adjustment to Counties | $458,000 | $0 | ($458,000) | $916,000 | $458,000 |
| FY 2014-15 ACA Adjustment to Counties | $859,000 | $0 | ($859,000) | $1,718,000 | $859,000 |
| FY 2015-16 ACA Adjustment to Counties | $296,000 | $0 | ($296,000) | $592,000 | $296,000 |
| FY 2016-17 ACA Adjustment to Counties | $289,000 | $0 | ($304,000) | $593,000 | $289,000 |
| FY 2017-18 | $4,000,000 | $2,000,000 | $2,000,000 | $0 | $0 |
| **Total FY 2017-18** | **$5,902,000** | **$2,000,000** | **$83,000** | **$3,819,000** | $1,902,000 |

# IGT PAYMENTS FOR HOSPITAL SERVICES

## REGULAR POLICY CHANGE NUMBER: 159

| FY 2018-19 | TF | IGT | FF | ACA FF | *Return to Counties |
|---|---|---|---|---|---|
| FY 2017-18 ACA Adjustment to Counties | $271,000 | $0 | ($304,000) | $575,000 | $271,000 |
| **Total FY 2018-19** | **$271,000** | **$0** | **($304,000)** | **$575,000** | $271,000 |

*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)

# AIDS WAIVER SUPPLEMENTAL PAYMENTS

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 160 |
| IMPLEMENTATION DATE: | 1/2018 |
| 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)

**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

# 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.

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is a decrease due to prior year data that is lower than previously estimated. 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 will not begin until January 2018.

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 | $3,000 | $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 | $3,000 | $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 | $5,410,000 | $4,315,000 |
| - 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 | $5,410,000 | $4,315,000 |
| STATE FUNDS | $1,900,000 | $1,900,000 |
| FEDERAL FUNDS | $3,510,000 | $2,415,000 |

## 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, and FY 2015-16 Affordable Care Act (ACA) claims data, and the inclusion of the FY 2016-17 ACA adjustments.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the addition of the FY 2017-18 ACA adjustments, and 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.

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 | $204,000 |
| FY 2014-15 ACA FFP Adjustment to SF | $352,000 |
| FY 2015-16 ACA FFP Adjustment to SF | $573,000 |
| FY 2016-17 ACA FFP Adjustment to SF | $481,000 |
| Funds Available | $3,982,000 |
| | |
| Less: FY 2017-18 Cash Expenditures to Hospitals | ($1,900,000) |
| | |
| Est. FY 2017-18 Remaining Balance | $2,082,000 |

# NDPH SUPPLEMENTAL PAYMENT

**REGULAR POLICY CHANGE NUMBER: 161**

| 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*** | $204,000 | $0 | ($204,000) | $408,000 | $204,000 |
| FY 2014-15 ACA FF Adjustment to SF*** | $352,000 | $0 | ($352,000) | $704,000 | $352,000 |
| FY 2015-16 ACA FF Adjustment to SF*** | $573,000 | $0 | ($573,000) | $1,146,000 | $573,000 |
| FY 2016-17 ACA FF Adjustment to SF*** | $481,000 | $0 | ($507,000) | $988,000 | $481,000 |
| **Total** | **$5,410,000** | **$1,900,000** | **$264,000** | **$3,246,000** | **$1,610,000** |

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 | $2,082,000 |
| Appropriation (GF) | $1,900,000 |
| Est. FY 2017-18 Interest Earned | $15,000 |
| FY 2017-18 ACA FFP Adjustment to SF | $515,000 |
| Funds Available | $4,512,000 |
| | |
| Less: FY 2018-19 Cash Expenditures to Hospitals | ($1,900,000) |
| | |
| Est. FY 2018-19 Remaining Balance | $2,612,000 |

| 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*** | $515,000 | $0 | ($579,000) | $1,094,000 | $515,000 |
| **Total** | **$4,315,000** | **$1,900,000** | **$1,321,000** | **$1,094,000** | **$515,000** |

*The Return to Fund 3096 column is for display purposes only (see Methodology #4).

# NDPH SUPPLEMENTAL PAYMENT

## REGULAR POLICY CHANGE NUMBER: 161

**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 | $4,664,000 | $4,614,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $4,664,000 | $4,614,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $4,664,000 | $4,614,000 |

## 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 FY 2017-18, from the prior estimate, is a net increase due to:

- Decreased ACA payment estimates for FY 2013-14, FY 2014-15 and FY 2015-16,
- The addition of an ACA payment for FY 2016-17, and
- Updated payment estimates for FY 2016-17 and 2017-18 based on additional claims.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a net decrease due to higher interim payments for FY 2018-19 and fewer ACA payments occurring in FY 2018-19.

# STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

**REGULAR POLICY CHANGE NUMBER: 162**

**Methodology:**
Supplemental payments for state veterans' homes began in FY 2010-11 and payments are estimated based on actual historical reported certified expenditures.

The estimate is based on:
1. Interim payments,
2. Initial reconciliation payments, and
3. A final reconciliation payment, if necessary.

Program payment amounts are estimated to be:

| FY 2017-18 | FF |
|---|---|
| **ACA Payments** | |
| FY 2013-14 | $20,000 |
| FY 2014-15 | $68,000 |
| FY 2015-16 | $110,000 |
| FY 2016-17 | $143,000 |
| **Interim Payments** | |
| FY 2017-18 | $2,202,000 |
| **Initial Reconciliation Payment** | |
| FY 2016-17 | $2,121,000 |
| **FY 2017-18 Total** | **$4,664,000** |

| FY 2018-19 | FF |
|---|---|
| **ACA Payments** | |
| FY 2017-18 | $154,000 |
| **Interim Payments** | |
| FY 2018-19 | $2,259,000 |
| **Initial Reconciliation Payment** | |
| FY 2017-18 | $2,201,000 |
| **FY 2018-19 Total** | **$4,614,000** |

**Funding:**
100% Title XIX FF (4260-101-0890)
100% Title XIX ACA FF (4260-101-0890)

# MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS

REGULAR POLICY CHANGE NUMBER: 163
IMPLEMENTATION DATE: 1/2019
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2055

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $2,100,000,000 |
| - STATE FUNDS | $0 | $633,189,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $2,100,000,000 |
| STATE FUNDS | $0 | $633,189,000 |
| FEDERAL FUNDS | $0 | $1,466,811,000 |

## DESCRIPTION

**Purpose:**
This policy change budgets managed care directed payments to fund enhanced managed care capitation payments (uniform dollar increments) to managed care plans (MCPs) for private hospitals as defined in Welfare & Institutions Code (WIC) 14169.51, based on utilization of contracted services.

**Authority:**
AB 1607 (Chapter 27, Statutes of 2016)
Proposition 52 (2016)
Title 42, Code of Federal Regulations (CFR) 438.6(c)

**Interdependent Policy Changes:**
Not Applicable

**Background:**
The Centers for Medicare & Medicaid Services (CMS) instituted the final rule which modernized Medicaid managed care regulations. The result is changes in the usage of managed care delivery systems. 42 CFR 438.6(c) provides State's flexibility to implement delivery system and provider payment initiatives under Medicaid managed care plans (MCPs) contracts based on allowable directed payments that focus on delivery system reform.

Beginning with the July 1, 2017, rating period, the state will direct MCPs to reimburse private hospitals as defined in WIC 14169.51, based on actual utilization of contracted services. The enhanced payment is contingent upon hospitals providing adequate access to service, including primary, specialty, and inpatient (both tertiary and quaternary) care.

The state will evaluate the extent to which enhanced payments are achieving the goals identified. These may only apply to certain managed care categories of aid. The payments will be enhanced by either a uniform percentage or dollar increment. The total funding available for the enhanced contracted payments will be limited to a predetermined amount (pool).

# MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS

**REGULAR POLICY CHANGE NUMBER: 163**

Upon determination of actual utilization, the State will direct the MCPs to make enhanced payments to private hospitals for contracted services. Following the issuance of all enhanced payments, the State will adjust per-member-per-month increments for actual utilization.

**Reason for Change:**
This is a new policy change.

**Methodology:**

1. Assume that estimated total value of the funding for the private hospital directed payment pool is $2.1 billion total fund for rating period 2017-18.

2. The non-federal share will be supported by the Hospital Quality Assurance Revenue Fund (HQARF).

3. Enhanced payment will be issued to MCPs based on actual private hospital utilization for contracted services.

4. The first payment is anticipated to be made 6 months following the end of FY 2017-18, in January 2019.

5. On a cash basis, the estimated payments are:

(Dollars in Thousands)

| FY 2018-19 | TF | SF (HQARF) | FF (Title 19) | FF (Title 21) | ACA FF |
|---|---|---|---|---|---|
| FY 2017-18 | $2,100,000 | $633,189 | $532,609 | $80,867 | $853,335 |
| **Total FY 2018-19** | **$2,100,000** | **$633,189** | **$532,609** | **$80,867** | **$853,335** |

**Funding:**
Hospital Quality Assurance Revenue Fund (4260-611-3158)
Title XIX FFP (4260-611-0890)
Title XXI FFP (4260-611-0890)

# DP-NF CAPITAL PROJECT DEBT REPAYMENT

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 164 |
| IMPLEMENTATION DATE: | 2/2018 |
| ANALYST: | Jedidiah Warren |
| FISCAL REFERENCE NUMBER: | 1936 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $0 |
| - STATE FUNDS | $57,224,000 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $0 |
| STATE FUNDS | $57,224,000 | $0 |
| FEDERAL FUNDS | -$57,224,000 | $0 |

## 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 deferring 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. While the repayment to CMS will occur in FY 2017-18, the Department will begin negotiations with the affected entities for a repayment schedule.

**Reason for Change:**
There is no change from the prior estimate for FY 2017-18.

# 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 2017-18.

(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 2017-18** | **$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: | 10/2016 |
| ANALYST: | Randolph Alarcio |
| FISCAL REFERENCE NUMBER: | 1942 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $339,270,000 | $0 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $339,270,000 | $0 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $339,270,000 | $0 |

## 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 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 home or community. LTSS includes both home and community-based services, such as IHSS and institutional long-term care services. Services will be provided through the managed care delivery system for all Medi-Cal beneficiaries who rely on such services. CDSS and the county social service offices provide the administration and payment of IHSS. The cost of IHSS is built into the CCI capitated rates and paid to CDSS to reimburse IHSS providers for personal care services. The Department reconciles the IHSS category of service, which is a component of the capitated rate, to actual IHSS expenditures paid out to providers by CDSS for the same quarter. The Department will determine the overpayments or underpayments to CDSS or the managed care plans during reconciliation. The CDSS reimbursement to the managed care plans is reflected in the Retro MC Rate Adjustments policy change.

# CCI IHSS RECONCILIATION

## REGULAR POLICY CHANGE NUMBER: 170

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.

**Reason for Change:**
There is no change from the prior estimate for FY 2017-18.

**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 that 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 that 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 December 2017.

**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 | $319,499,000 | $240,392,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $319,499,000 | $240,392,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $319,499,000 | $240,392,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the cost of Medicaid incentive payments to qualified health care providers who adopt, implement, or upgrade (AIU) and meaningfully 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 AIU and 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 adoption and meaningful use of EHR technology by providers serving the Medi-Cal population. It is estimated that approximately 22,000 to 24,000 providers, and 320 hospitals, will be eligible for incentive payments. 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 FI Estimate. Administrative costs for the State's Health Information Technology (HIT) program are budgeted separately in the ARRA HITECH Incentive Program policy change.

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is due to two factors. First, the Department rolled over delayed payments from FY 2016-17 to FY 2017-18. Second, pending attestations from FY 2016-17 will be paid in FY 2017-18 due to the extension of the enrollment deadline.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to roll-over payments in FY 2017-18.

**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 payment 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. The year one eligible incentive payments will average $520,000, 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. For FY 2017-18, there is a payment offset for overpayments made.

5. The estimated payments for FY 2017-18 and FY 2018-19 are on a cash-basis.

# ARRA HITECH - PROVIDER PAYMENTS

**REGULAR POLICY CHANGE NUMBER: 171**

FY 2017-18 Incentive Payments:

| Eligibility Year | Professionals | Incentive Payments | FF |
|---|---|---|---|
| 1 | 2,983 | $21,250 | $63,389,000 |
| 2 | 7,173 | $8,500 | $60,971,000 |
| 3 | 2,093 | $8,500 | $17,791,000 |
| 4 | 902 | $8,500 | $7,667,000 |
| 5 | 685 | $8,500 | $5,823,000 |
| 6 | 282 | $8,500 | $2,397,000 |
| **Total FY 2017-18 Professional Payments** | | | **$158,038,000** |

| Eligibility Year | Hospitals | Incentive Payments | FF |
|---|---|---|---|
| 1 | 18 | $520,000 | $9,360,000 |
| 2 | 70 | $950,000 | $66,500,000 |
| 3 | 58 | $1,200,000 | $69,600,000 |
| 4 | 57 | $900,000 | $51,300,000 |
| Payment Offset | | | ($35,299,000) |
| **Total FY 2017-18 Hospital Payments** | | | **$161,461,000** |

FY 2018-19 Incentive Payments:

| Eligibility Year | Professionals | Incentive Payments | FF |
|---|---|---|---|
| 2 | 5,078 | $8,500 | $43,163,000 |
| 3 | 4,887 | $8,500 | $41,540,000 |
| 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** | | | **$109,592,000** |

| 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 | $158,038,000 | $161,461,000 | **$319,499,000** |
| FY 2018-19 | $109,592,000 | $130,800,000 | **$240,392,000** |

**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: | Joel Singh |
| FISCAL REFERENCE NUMBER: | 1232 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $117,532,000 | $63,133,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $117,532,000 | $63,133,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $117,532,000 | $63,133,000 |

## 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.

# ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

**REGULAR POLICY CHANGE NUMBER: 174**

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 from the prior estimate, for FY 2017-18, is an increase due to prior year expenditures previously estimated to be paid in FY 2016-17, shifting to FY 2017-18. The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to FY 2017-18 including ARRA payments and a higher number of prior year expenditures than 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** | $215,064 | $97,532 | $107,532 | $10,000 | **$117,532** |
| **FY 2018-19** | $126,266 | $63,133 | $63,133 | $0 | **$63,133** |

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

# INFANT DEVELOPMENT PROGRAM

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 178 |
| IMPLEMENTATION DATE: | 7/2016 |
| ANALYST: | Joel Singh |
| FISCAL REFERENCE NUMBER: | 2009 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $42,024,000 | $29,439,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $42,024,000 | $29,439,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $42,024,000 | $29,439,000 |

## 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 from the prior estimate, for FY 2017-18, is an increase due to updated caseload data and prior year expenditures including FY 2015-16 and FY 2016-17 costs. The change in the current estimate, from FY 2017-18 to FY 2018-19, is due to fewer prior year expenditures in FY 2018-19.

**Methodology:**

# INFANT DEVELOPMENT PROGRAM

## REGULAR POLICY CHANGE NUMBER: 178

1. The following estimates, on a cash basis, were provided by CDDS.

(Dollars in Thousands)

| | TF | CDDS GF | FF |
|---|---|---|---|
| **FY 2017-18** | $84,048 | $42,024 | **$42,024** |
| **FY 2018-19** | $58,879 | $29,440 | **$29,439** |

**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: | Joel Singh |
| FISCAL REFERENCE NUMBER: | 1526 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $19,472,000 | $11,106,000 |
| - STATE FUNDS | $8,512,000 | $5,082,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $19,472,000 | $11,106,000 |
| STATE FUNDS | $8,512,000 | $5,082,000 |
| FEDERAL FUNDS | $10,960,000 | $6,024,000 |

## 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 from the prior estimate, for FY 2017-18, is a net decrease due to a reduction in the accrual estimate, prior year expenditures previously estimated to be paid in FY 2016-17, shifting to FY 2017-18, and revising the payment lags. General Fund costs have increased due to higher prior year QAF payments estimated in FY 2017-18.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to fewer prior year expenditures in FY 2018-19.

**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 | $1,619 | $8,513 | $21,092 | $1,620 | **$8,512** | **$10,132** | **$828** |
| FY 2018-19 | $941 | $5,083 | $12,048 | $942 | **$5,082** | **$6,024** | **$0** |

**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:**
The change from the prior estimate, for FY 2017-18, is an increase due to updated enrollment counts for CY 2018. 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 | $13,928,000 | $0 |
| - STATE FUNDS | $13,928,000 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $13,928,000 | $0 |
| STATE FUNDS | $13,928,000 | $0 |
| FEDERAL FUNDS | $0 | $0 |

## 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

**Reason for Change:**
There is no change from the prior estimate for FY 2017-18.

**Methodology:**

| FY 2017-18 | Audit | Finding | TF |
|---|---|---|---|
| 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) |
| | | **Total** | **$13,928,000** |

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

# 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 | $9,934,000 | $10,128,000 |
| - STATE FUNDS | $4,967,000 | $5,064,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $9,934,000 | $10,128,000 |
| STATE FUNDS | $4,967,000 | $5,064,000 |
| FEDERAL FUNDS | $4,967,000 | $5,064,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the cost of paying overtime and travel time for Waiver Personal Care Services (WPCS) providers.

**Authority:**
Welfare & Institutions (W&I) Code, Section 12300.4
SB 89 (Chapter 24, Statutes of 2017)

**Interdependent Policy Changes:**
Not Applicable

**Background:**
Federal regulations require In-Home Supportive Services (IHSS) and WPCS providers to be paid overtime. The W&I Code, Section 12300.4 requires overtime and travel time to be paid at time and a half for any hours worked over 40 in a workweek for IHSS/WPCS providers. Based on statute, All-County, and Waiver Policy Letters, an IHSS/WPCS provider who works for one participant only cannot exceed 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 meet 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 a decrease due to a change in methodology where actual data is now acquired and used to project this estimate. The major change that led to a decrease was revising the average amount of providers for each WPCS beneficiary from two providers to one provider. At the same time, more providers were approved under the exemption but overall costs still decreased from the prior estimate. 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 1,794 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 $163,000 and $166,000 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) The estimated cost for overtime, including exemptions, and travel time for WPCS providers is **$9,934,000 TF ($4,967,000 GF)** in FY 2017-18 and **$10,128,000 TF ($5,064,000 GF)** in FY 2018-19.

**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 | $4,104,000 | $5,592,000 |
| - STATE FUNDS | -$21,891,000 | -$21,891,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $4,104,000 | $5,592,000 |
| STATE FUNDS | -$21,891,000 | -$21,891,000 |
| FEDERAL FUNDS | $25,995,000 | $27,483,000 |

## 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. In the May 2017 Estimate, the base expenditures used expenditures from FY 2015-16. Those expenditures were slightly higher than FY 2016-17 expenditures. The decrease from FY 2015-16 to FY 2016-17 cause the current estimate to project fewer claims which decreased the estimate cost. 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 $16.

# INDIAN HEALTH SERVICES

## REGULAR POLICY CHANGE NUMBER: 184

**Methodology:**

1. Currently, there are 66 Indian health clinics participating in Medi-Cal.

2. In FY 2016-17, the Department spent $43,782,000 TF ($21,891,000 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 per visit rate payable to Indian health clinic is estimated to increase by $16, from $391 to $407, based on an average of the last five years.

5. The FY 2017-18 estimate includes an additional $1,368,000 due to the increased rate for the period of January 2017 through June 2017. The annual rate increase for the additional $23 is $2,736,000 TF.

6. The FY 2018-19 estimate includes an additional $952,000 TF due to the anticipated rate increase from $391 to $407 for the period of January 2018 through June 2018. The annual rate increase for the additional $16 is $1,907,000 TF.

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| CY 2017 rate increase | $2,736,000 | $2,736,000 |
| CY 2018 rate increase | $0 | $1,904,000 |
| Retro Jan –June 2017 rate increase | $1,368,000 | $0 |
| Retro Jan –June 2018 rate increase | $0 | $952,000 |
| **Total Rate increase** | **$4,104,000** | **$5,592,000** |
| FY 2016-17 Base expenditures | $43,782,000 | $43,782,000 |
| Total expenditures | $47,886,000 | $49,374,000 |

(Dollars in Thousands)

| **FY 2017-18** | **TF** | **GF** | **FF** |
|---|---|---|---|
| IHS FY 2015-16 Base exp. (50% GF / 50% FF) | ($43,782) | ($21,891) | ($21,891) |
| IHS total expenditures (100% FF) | $47,886 | $0 | $47,886 |
| **FY 2017-18 Total** | **$4,104** | **($21,891)** | **$25,995** |

| **FY 2018-19** | | | |
|---|---|---|---|
| IHS FY 2016-17 Base exp. (50% GF / 50% FF) | ($43,782) | ($21,891) | ($21,891) |
| IHS total expenditures (100% FF) | $49,374 | $0 | $49,374 |
| **FY 2018-19 Total** | **$5,592** | **($21,891)** | **$27,483** |

*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: | 1/2018 |
| ANALYST: | Jedidiah Warren |
| FISCAL REFERENCE NUMBER: | 1991 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $3,041,000 | $21,719,000 |
| - STATE FUNDS | $1,520,500 | $10,859,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $3,041,000 | $21,719,000 |
| STATE FUNDS | $1,520,500 | $10,859,500 |
| FEDERAL FUNDS | $1,520,500 | $10,859,500 |

## 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 FY 2017-18, from the prior estimate, is a decrease due to an adjusted methodology based on the most recent actuals from January 1, 2017, to June 30, 2017. 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 cases established on deaths prior to January 1, 2017, which have accounts receivable balances, decreased approximately 2.5 percent per month from January 1, 2017, to June 30, 2017. Due to the lag between when a case is established and when a settlement is received, ER recoveries are expected to begin decreasing at 2.5 percent per month starting January 1, 2018. The trend is expected to continue monthly, ongoing. As a result, recoveries are expected to decline to approximately $66.459 million in FY 2017-18, compared to FY 2016-17 recoveries. As a result, the savings loss estimated in FY 2017-18 is $3.041 million TF.

   FY 2017-18:
   $69.5 million TF - $66.459 million TF = $3.041 million TF Savings Loss

4. In FY 2018-19, recovery losses are expected to follow the decline in open pre-2017 death cases that have accounts receivables. As a result, recoveries are expected to decline further to approximately $47.781 million in FY 2018-19. As a result, the savings loss estimated in FY 2018-19 is $21.719 million TF.

   FY 2018-19:
   $69.5 million TF - $47.781 million TF = $21.719 million TF Savings Loss

(Dollars in Thousands)

| Uncollectible Estate Recoveries | TF | GF | FF |
|---|---|---|---|
| FY 2017-18 | $3,041 | $1,521 | $1,520 |
| FY 2018-19 | $21,719 | $10,860 | $10,859 |

**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]*

**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 and receive personal care services through the federally funded State Plan Personal Care program in order to be eligible for WPCS benefits. There are approximately 3,400 WPCS providers that are paid via timesheets through the Case Management Information Payroll System (CMIPS II) enrolled in workers' compensation. The California Department of Social Services (CDSS) pays for the insurance claims for the WPCS providers and the Department reimburses CDSS for the costs.

**Reason for Change:**
There is no significant change from the prior estimate for FY 2017-18. 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%.

**Methodology:**
1. Assume the Department pays worker's compensation for providers beginning November 1, 2016, retroactive to October 2014.

# WPCS WORKERS' COMPENSATION

**REGULAR POLICY CHANGE NUMBER: 186**

2. 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 | $549,000 | $0 |
| - STATE FUNDS | $549,000 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $549,000 | $0 |
| STATE FUNDS | $549,000 | $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 Medi-Cal only covers partial dental services for adults 21 years of age and older, CDDS has an IA with the Department where the Medi-Cal dental fiscal intermediary (FI) processes and pays claims for FY 2016-17. For FY 2017-18, the new Administrative Services Organization (ASO) contractor will process claims and the new FI contractor will adjudicate 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 will include 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 a decrease due to a partial year of costs with the implementation of full restoration of adult dental benefits on January 1, 2018, and CDDS no longer needing to cover these services. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to no additional costs are expected in FY 2018-19.

**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.

**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 | $132,000 | $133,000 |
| - STATE FUNDS | -$179,393,440 | -$189,235,320 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $132,000 | $133,000 |
| STATE FUNDS | -$179,393,440 | -$189,235,320 |
| FEDERAL FUNDS | $179,525,440 | $189,368,320 |

## 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:**
Base Adjustments Combined
Fee-For-Service Base Expenditures
PC 24 Title XXI Federal Match Reduction
PC 066 Pathways to Well-Being
PC 123 LTC Rate Adjustment
PC 122 Rate Increase for FQHCs/RHCs/CBRCs
PC 125 Hospice Rate Increases
PC 135 Laboratory Rate Methodology Change
PC 136 Reduction to Radiology Rates
PC 137 10% Provider Payment Reduction
PC 121 AB 1629 Annual Rate Adjustments

**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 and extends the enhanced funding through the end of the Federal Fiscal year of 2015. Effective October 1, 2015, the ACA extended and increased the enhanced federal matching rate for the CHIP program by 23 percent. The California federal funding match was 65 percent through September 30, 2015. Beginning October 1, 2015, the enhanced federal match increased to 88 percent. Authorization for the CHIP program ended on October 1, 2017. Reauthorization of CHIP is pending congressional approval. Due to the uncertainty of reauthorization,

# FUNDING ADJUST.—OTLICP

## REGULAR POLICY CHANGE NUMBER: 191

the Department assumes Congress will reauthorize the program with a reduced federal funding match of 65 percent. Funds in this PC are currently adjusted at the 88 percent federal funding match. PC 24 Title XXI Federal Match Reduction adjusts the funds down to 65 percent beginning January 1, 2018 in anticipation of Congressional action.

**Reason for Change:**
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 $472,088,086 and $497,989,332 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 $179.4M.
   b. In FY 2018-19, the Department estimates the additional CHIP funding will offset general fund spending by $189.2M.

4) The Department estimates the Total Fund after the adjustment of CHIP funding to be $132,000 in FY 2017-18 and $133,000 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 | $ - | $ (179,610) | $ 179,610 |
| PC 66 Pathways To Well-Being | $ 132 | $ - | $ 132 |
| PC 121 AB 1629 Annual Rate Adjustments | $ - | $ (25) | $ 77 |
| PC 122 Rate Increase For FQHCs/RHCs/CBRCs | $ - | $ (730) | $ 730 |
| PC 123 LTC Rate Adjustment | $ - | $ (2) | $ 2 |
| PC 125 Hospice Rate Increases | $ - | $ (79) | $ 79 |
| PC 135 Laboratory Rate Methodology Change | $ - | $ 330 | $ (330) |
| PC 136 Reduction to Radiology Rates | $ - | $ 296 | $ (296) |
| PC 137 10% Provider Payment Reduction | $ - | $ 427 | $ (427) |
| **Total** | **$ 132** | **$ (179,393)** | **$ 179,526** |

# FUNDING ADJUST.—OTLICP

**REGULAR POLICY CHANGE NUMBER: 191**

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| Fee-For-Service Base Expenditures | $ - | $ (187,062) | $ 187,062 |
| PC 66 Pathways To Well-Being | $ 133 | $ - | $ 133 |
| PC 121 AB 1629 Annual Rate Adjustments | $ - | $ (42) | $ 42 |
| PC 122 Rate Increase For FQHCs/RHCs/CBRCs | $ - | $ (2,742) | $ 2,742 |
| PC 123 LTC Rate Adjustment | $ - | $ (8) | $ 8 |
| PC 125 Hospice Rate Increases | $ - | $ (813) | $ 813 |
| PC 135 Laboratory Rate Methodology Change | $ - | $ 342 | $ (342) |
| PC 136 Reduction to Radiology Rates | $ - | $ 741 | $ (741) |
| PC 137 10% Provider Payment Reduction | $ - | $ 349 | $ (349) |
| **Total** | **$ 133** | **$ (189,236)** | **$ 189,369** |

**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:**
The change from the prior estimate, for FY 2017-18, is an increase due to updated MRMIP program funds and expenditures.

# HEALTH CARE SVCS. PLANS FINES AND PENALTIES FUND

## REGULAR POLICY CHANGE NUMBER: 193

**Methodology:**

1. The FY 2017-18 estimate is based on projected administrative fines and penalties assessed by DMHC.

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 appropriates the funding for blood lead tests performed by the Medi-Cal program. It estimates the technical adjustment in funding from 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. This policy change adjusts the CLPP funding.

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 for FY 2017-18. There is no change between fiscal years 2017-18 and 2018-19.

# CLPP FUND

## REGULAR POLICY CHANGE NUMBER: 194

**Methodology:**

1. Funding for Medi-Cal and CHDP Gateway 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 20118-19 is $725,000.

**Funding:**

| | 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 will be 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 will be removed from capitation rate payments effective January 1, 2018.

**Reason for Change:**
FY 2017-18 costs increased from the previous estimate due to a increase in IHSS rates for the CMC population and 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 | $7,143,950 | $3,571,975 | $3,571,975 | $0 |
| Base managed care payments for add'l enrollment | $225,765 | $112,882 | $112,882 | |
| Transfer of IHSS Costs to CDSS | $2,474,035 | $1,237,018 | $1,237,018 | $0 |
| Transfer of IHSS Costs to CDSS for add'l enrollment | $137,705 | $68,852 | $68,852 | |
| Total Managed Care Payments | $9,981,455 | $4,990,727 | $4,990,727 | $0 |
| | | | | |
| CCI-Savings and Deferral : | | | | |
| Total Savings (In the Base) | ($7,155,412) | ($3,577,706) | ($3,577,706) | $0 |
| FFS Savings for Additional Enrollment (In the Base): | ($269,705) | ($134,853) | ($134,853) | $0 |
| Defer Managed Care Payment (In the Base) | ($6,719) | ($3,360) | ($3,360) | $0 |
| Total | ($7,431,836) | ($3,715,918) | ($3,715,918) | $0 |
| | | | | |
| IHSS Savings (In the Base) | ($1,305,870) | $0 | ($1,305,870) | $0 |
| Delay 1 Checkwrite (In the Base) | $68,353 | $34,176 | $34,176 | $0 |
| **CCI-Transfer of IHSS Costs to DHCS (PC 195)** | **$0** | **($1,305,870)** | **$0** | **$1,305,870** |
| CCI-Admin Costs, HCO Costs (OA 15, 18, 67) | $27,492 | $13,746 | $13,746 | $0 |
| | | | | |
| Retro MC Rate Adjustments (PC 117) | $1,332,444 | $221,935 | $666,222 | $444,287 |
| CCI-Quality Withhold Repayments (PC 101) | $1,353 | $676 | $677 | $0 |
| Health Insurer Fee (PC 18) | $5,724 | $2,862 | $2,862 | $0 |
| | | | | |
| Total of CCI PCs including pass through | $2,679,115 | $239,473 | $683,761 | $1,750,157 |

**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. This policy change has been renamed and was previously titled “Extend Hospital QAF – Children’s Health Care”.

**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.

# HOSPITAL QAF - CHILDREN'S HEALTH CARE

**REGULAR POLICY CHANGE NUMBER: 196**

Proposition 52, approved by California voters on November 8, 2016, permanently extends the Hospital QAF program.

**Reason for Change:**
The change from the prior estimate for FY 2017-18, is due to updated Children's payments for FY 2015-16 and FY 2016-17 that were recalculated as a result of annual Upper Payment Limit (UPL) review. The UPL is subject to change, as a result of CMS review.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to FY 2018-19 not including any prior year UPL adjustments and including updated HQAF V payment amounts.

**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 estimated calculations based on the HQAF V, unapproved draft fee/payment model. Amounts are subject to change based on CMS approval of all the required models.

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 | $389,400 |
| FY 2017-18 | AB 1607 (through 12/31/17); Proposition 52 (1/1/18 and forward) | 7/1/17 to 6/30/18 | $841,500 |
| FY 2018-19 | Proposition 52 | 7/1/18 to 6/30/19 | $899,300 |

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 2015-16 | $0 | $105,200 | ($105,200) |
| FY 2016-17 (HQAF IV) | $0 | $63,500 | ($63,500) |
| FY 2016-17 (HQAF V) | $0 | ($389,400) | $389,400 |
| FY 2017-18 | $0 | ($631,125) | $631,125 |
| **Total FY 2017-18** | **$0** | **($851,825)** | **$851,825** |

(Dollars in Thousands)

| FY 2018-19 | TF | GF | Hosp. QA Rev Fund |
|---|---|---|---|
| FY 2017-18 | $0 | ($210,375) | $210,375 |
| FY 2018-19 | $0 | ($674,475) | $674,475 |
| **Total FY 2018-19** | **$0** | **($884,850)** | **$884,850** |

**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 | -$1,756,837,450 | -$1,777,687,280 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $0 |
| STATE FUNDS | -$1,756,837,450 | -$1,777,687,280 |
| FEDERAL FUNDS | $1,756,837,450 | $1,777,687,280 |

## 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 124 DPH Interim Rate Growth
PC 123 LTC Rate Adjustment
PC 125 Hospice Rate Increases
PC 128 GDSP Prenatal Screening Program Fee Increase
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 $3,944,942,227 and $4,083,504,663 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 | $ (1,753,198) | $ 1,753,198 |
| PC 121 AB 1629 Annual Rate Adjustments | $ (1,636) | $ 1,636 |
| PC 124 DPH Interim Rate Growth | $ (5,353) | $ 5,353 |
| PC 123 LTC Rate Adjustment | $ (161) | $ 161 |
| PC 125 Hospice Rate Increases | $ (90) | $ 90 |
| PC 128 GDSP Prenatal Screening Fee Increase | $ (391) | $ 391 |
| PC 130 Alternative Birthing Center Reimbursement | $ (6) | $ 6 |
| PC 135 Laboratory Rate Methodology Change | $ 1,989 | $ (1,989) |
| PC 136 Reduction To Radiology Rates | $ 2,009 | $ (2,009) |
| **Total** | **$ (1,756,838)** | **$ 1,756,838** |

| **FY 2018-19** | **GF** | **FF** |
|---|---|---|
| Fee-For-Service Base Expenditures | $ (1,763,724) | $ 1,763,724 |
| PC 121 AB 1629 Annual Rate Adjustments | $ (2,701) | $ 2,701 |
| PC 124 DPH Interim Rate Growth | $ (16,472) | $ 16,472 |
| PC 123 LTC Rate Adjustment | $ (527) | $ 527 |
| PC 125 Hospice Rate Increases | $ (854) | $ 854 |
| PC 128 GDSP Prenatal Screening Fee Increase | $ (251) | $ 251 |
| PC 130 Alternative Birthing Center Reimbursement | $ (7) | $ 7 |
| PC 135 Laboratory Rate Methodology Change | $ 1,998 | $ (1,998) |
| PC 136 Reduction To Radiology Rates | $ 4,850 | $ (4,850) |
| **Total** | **$ (1,777,687)** | **$ 1,777,687** |

# FUNDING ADJUST.—ACA OPT. EXPANSION

## REGULAR POLICY CHANGE NUMBER: 197

**Funding:**
(Dollars in Thousands)

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| **Title XIX 50/50** | $ (3,944,942) | $ (1,972,471) | $ (1,972,471) |
| **ACA Title XIX 95% FF** | $ 2,106,297 | $ 105,315 | $ 2,000,982 |
| **ACA Title XIX 94% FF** | $ 1,838,645 | $ 110,318 | $ 1,728,327 |
| **Total** | **$ -** | **$ (1,756,838)** | **$ 1,756,838** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| **Title XIX 50/50** | $ (4,083,504) | $ (2,041,752) | $ (2,041,752) |
| **ACA Title XIX 94% FF** | $ 2,178,013 | $ 130,681 | $ 2,047,332 |
| **ACA Title XIX 93% FF** | $ 1,905,491 | $ 133,384 | $ 1,772,107 |
| **Total** | **$ -** | **$ (1,777,687)** | **$ 1,777,687** |

# 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, is an increase due to updated monthly expenditures from July 1, 2016, through June 30, 2017, and the addition of a new treatment and service (Brineura) for CCS beneficiaries.

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, and Brineura 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 $8,764,000 in FY 2017-18 and $9,343,000 in FY 2018-19.

| Fiscal Year | TF | GF | GF Reimbursement |
|---|---|---|---|
| **FY 2017-18** | **$0** | ($8,764,000) | $8,764,000 |
| **FY 2018-19** | **$0** | ($9,343,000) | $9,343,000 |

**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 | $23,022,000 | $12,675,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $0 |
| STATE FUNDS | $23,022,000 | $12,675,000 |
| FEDERAL FUNDS | -$23,022,000 | -$12,675,000 |

## 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:

- Updated IMD FFS repayments based on actual data for dates of service from State Fiscal Year (SFY) 2012-13 Q3 through SFY 2015-16 Q4.
- Resolving IMD FFS deferral repayments in FY 2016-17, for FY 2014-15 Q4 and FY 2015-16 Q1, rather than as previously expected in FY 2017-18.

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

- Resolving IMD FFS deferral repayments for FY 2012-13 Q3 and service periods from October 2015 to June 2016 in FY 2017-18.
- Including FY 2016-17 managed care repayments in FY 2018-19. Managed care repayments from FY 2011-12 to FY 2015-16 are included in FY 2017-18.

**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, and managed care repayments from FY 2011-12 through FY 2015-16.

3. The Department resolved an IMD FFS deferral repayment for FY 2012-13 Q3 and will be paid in FY 2017-18.

4. For FY 2018-19, the Department estimates to repay FFS IMD deferrals from July 2016 through September 2017, and managed care repayments for FY 2016-17.

# IMD ANCILLARY SERVICES

**REGULAR POLICY CHANGE NUMBER: 199**

5. The estimated IMD repayments are:

(Dollars in Thousands)

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| Fee-For-Service | | | |
| FY 2012-13 Q3 (Jan to Mar 13) | $0 | $1,643 | ($1,643) |
| | | | |
| 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 | $5,357 | ($5,357) |
| 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) |
| Subtotal Managed Care | $0 | $17,665 | ($17,665) |
| | | | |
| **Total FY 2017-18** | **$0** | **$23,022** | **($23,022)** |

(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 2016-17 (Jul 16 to Jun 17) | $0 | $3,675 | ($3,675) |
| | | | |
| **Total FY 2018-19** | **$0** | **$12,675** | **($12,675)** |

**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 | $75,580,000 |
| Physicians' Services Account | $21,732,000 |
| Unallocated Account | $29,922,000 |
| **Total CTPS/Prop. 99** | **$127,234,000** |
| **GF** | **($127,234,000)** |
| **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 | -$1,558,000 | -$1,527,000 |
| - STATE FUNDS | -$779,000 | -$763,500 |
| PAYMENT LAG | 0.9640 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$1,501,900 | -$1,527,000 |
| STATE FUNDS | -$750,960 | -$763,500 |
| FEDERAL FUNDS | -$750,960 | -$763,500 |

## 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.

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is an increase in savings due to SF CLSB waiver costs ending June 30, 2017. 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.

# INTEGRATION OF THE SF CLSB INTO THE ALW

## REGULAR POLICY CHANGE NUMBER: 201

**Methodology:**

1. Assume the waiver will be renewed and the SF CLSB beneficiaries will transition into the ALW 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. Assume the 23 beneficiaries that were enrolled in SF CLSB will transition into the ALW in FY 2017-18.

3. Assume the monthly cost for care management is $200 through December 31, 2017 and $320 beginning January 1, 2018.

4. Assume the average monthly cost for wavier services transitioning from institutions is $1,184.

5. 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 | $436,000 | $218,000 | $218,000 |
| Total Savings from SNF Transitions | ($1,994,000) | ($997,000) | ($997,000) |
| **Net Impact Savings** | **($1,558,000)** | **($779,000)** | **($779,000)** |
| | | | |
| **FY 2018-19** | **TF** | **GF** | **FF** |
| Total Cost from Waiver Services | $467,000 | $233,000 | $234,000 |
| Total Savings from SNF Transitions | ($1,994,000) | ($997,000) | ($997,000) |
| **Net Impact Savings** | **($1,527,000)** | **($763,000)** | **($764,000)** |

**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 | 3.69 % | 3.32 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$1,666,200 | -$1,672,600 |
| STATE FUNDS | -$833,080 | -$836,280 |
| FEDERAL FUNDS | -$833,080 | -$836,280 |

## 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, 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: | 7/2018 |
| ANALYST: | Davonna McClendon |
| FISCAL REFERENCE NUMBER: | 2077 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $64,475,000 |
| - STATE FUNDS | $0 | $31,593,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $64,475,000 |
| STATE FUNDS | $0 | $31,593,000 |
| FEDERAL FUNDS | $0 | $32,882,000 |

## 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, pediatric health care facilities, 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) 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:**
This is a new policy change.

**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.

(Dollars in Thousands)

| FY 2018-19 | TF | SF | Title XIX FF | Title XXI FF | ACA FF |
|---|---|---|---|---|---|
| Home Health Rate Increase | $64,475 | $31,593 | $30,077 | $1,889 | $916 |

**Funding:**
Healthcare Treatment Fund Prop. 56 (4260-101-3305)
100% Title XIX FF (4260-101-0890)
100% ACA Title XIX FF (4260-101-0890)
100% Title XXI FF (4260-113-0890)

# 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 through local transportation resources reimbursed through the County-Based Medi-Cal Administrative Activities (CMAA) program or social service office at the county level. 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:**
This change from the prior estimate, for FY 2017-18, is due to managed care costs for NMT now being included in the base capitation rates.

The change in the current estimate, from FY 2017-18 to FY 2018-19, is due to FY 2018-19 including NMT costs only for FFS.

**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 non-pregnant women.

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 | $45,369,000 |
| - STATE FUNDS | $0 | $21,291,420 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $45,369,000 |
| STATE FUNDS | $0 | $21,291,420 |
| FEDERAL FUNDS | $0 | $24,077,580 |

## 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:**
This is a new policy change.

**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. Assume 70% of the CCS Medi-Cal administrative costs for the designated counties will be transferred to the COHS. These payments are applied against the costs in the OA-2 CCS Case Management policy change.

   Annual COHS administrative costs:

   Phase One (12 months): $11,146,000 x 70% = $7,802,000
   Phase Two (6 months): $23,806,000 x 70% x .5 = $8,332,000

   FY 2018-19 Total: $16,134,000 TF (monthly $1,344,500 TF)

3. The payments under capitation are assumed to be equal to the costs under FFS.

4. 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).

5. Total estimate costs for **FY 2018-19** are **$45,369,000 TF ($21,298,000 GF)**.

**Funding:**
50% Title XIX / 50% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890

# DRUG REBATES - RETROACTIVE ACA ADJUSTMENTS

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 210 |
| IMPLEMENTATION DATE: | 12/2016 |
| ANALYST: | Cang Ly |
| FISCAL REFERENCE NUMBER: | 2013 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $0 |
| - STATE FUNDS | $46,504,000 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $0 |
| STATE FUNDS | $46,504,000 | $0 |
| FEDERAL FUNDS | -$46,504,000 | $0 |

## DESCRIPTION

**Purpose:**
This policy change estimates the retroactive adjustments made to the Federal, State Supplemental, and Managed Care drug rebates, for the Affordable Care Act (ACA) newly population.

**Authority:**
Not Applicable

**Interdependent Policy Changes:**
Not Applicable

**Background:**
The capability for the Rebate Accounting and Information System (RAIS) to identify ACA pharmacy drug claims was not established until April 2016. ACA drug rebates were reported in RAIS starting in the quarter beginning July 2016. Prior to this, RAIS was not able to identify ACA claims for pharmacy drugs and rebate invoices were blended with non-ACA claims. The Department made retroactive adjustments to the Federal, State Supplemental, and Managed Care drug rebates.

**Reason for Change:**
The change for FY 2017-18, from the prior estimate, is due to additional ACA claims received for the retroactive period.

**Methodology:**
1. The estimated total ACA adjustment is:

(Dollars in Thousands)

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| Total | $0 | $46,504 | ($46,504) |

**Funding:**

# DRUG REBATES - RETROACTIVE ACA ADJUSTMENTS

**REGULAR POLICY CHANGE NUMBER: 210**

100% GF (4260-101-0001)
100% ACA Title XIX FF (4260-101-0890)

# ASSISSTED 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:**
This is a new policy change. 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.

# ASSISSTED LIVING WAIVER EXPANSION

## REGULAR POLICY CHANGE NUMBER: 211

3. Assume the average annual cost for waiver services it $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 | $2,359,000 | $990,000 |
| - STATE FUNDS | $1,179,500 | $495,000 |
| PAYMENT LAG | 0.7450 | 0.9960 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $1,757,500 | $986,000 |
| STATE FUNDS | $878,730 | $493,020 |
| FEDERAL FUNDS | $878,730 | $493,020 |

## DESCRIPTION

**Purpose:**
This policy change estimates the cost of renewing the Home and Community Based (HCB) Alternatives Waiver (formerly known as the Nursing Facility / Acute Hospital (NF/AH) Waiver).

**Authority:**
Not Applicable

**Interdependent Policy Changes:**
Not Applicable

**Background:**
The HCB Alternatives 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 HCB Alternatives 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 HCB Alternatives 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 increase long-term skilled nursing facility transition;

# HOME & COMMUNITY-BASED ALTERNATIVES WAIVER RENEWAL

**REGULAR POLICY CHANGE NUMBER: 212**

- Localize care management complying 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 (PMPM) based on acuity. The combination of transitions to a Comprehensive Care Management and changing the role of state staff to oversight and monitoring will result in a reduction in health care costs overtime 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 HCB Alternatives 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 the inclusion of a phased-in enrollment for new participants in CY 2017 at an average of 33 per month and 183 per month beginning April 2018. Also, costs decreased due to the delay in implementation of the new 1,100 participants from January 2018 to April 2018. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the increased savings from institutional transitions, which outweigh waiver services, care management, and administration costs.

**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 3,974 waiver participants. Assume 749 new participants will be enrolled in FY 2017-18 and 1,551 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 not begin until April 2018 to allow time to implement the Waiver Agency model.

7. Assume 60% 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** |
|---|---|---|---|
| Administrative Cost | $1,586,000 | $793,000 | $793,000 |
| Care Management | $2,338,000 | $1,169,000 | $1,169,000 |
| Waiver Svcs. - Community | $5,826,000 | $2,913,000 | $2,913,000 |
| Waiver Svcs. - EPSDT | $2,390,000 | $1,195,000 | $1,195,000 |
| Waiver Svcs. – Institutional Tran. | $11,115,000 | $5,558,000 | $5,557,000 |
| Unmet Need | $4,503,000 | $2,251,000 | $2,252,000 |
| Institutional Transitions Savings | ($25,399,000) | ($12,700,000) | ($12,699,000) |
| **Total** | **$2,359,000** | **$1,179,000** | **$1,180,000** |
| | | | |
| **FY 2018-19** | **TF** | **GF** | **FF** |
| Administrative Cost | $7,756,000 | $3,878,000 | $3,878,000 |
| Care Management | $11,433,000 | $5,717,000 | $5,716,000 |
| Waiver Svcs. - Community | $26,267,000 | $13,133,000 | $13,134,000 |
| Waiver Svcs. - EPSDT | $10,148,000 | $5,074,000 | $5,074,000 |
| Waiver Svcs. – Institutional Tran. | $50,739,000 | $25,370,000 | $25,369,000 |
| Unmet Need | $7,749,000 | $3,874,000 | $3,875,000 |
| Institutional Transitions Savings | ($115,946,000) | ($57,973,000) | ($57,973,000) |
| **Total** | **($1,854,000)** | **($927,000)** | **($927,000)** |

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

# 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 | $169,153,000 | $169,153,000 | $0 | $0 |
| 4 | CalWORKS APPLICATIONS | $59,448,000 | $29,724,000 | $29,724,000 | $0 |
| 5 | CASE MANAGEMENT FOR OTLICP | $44,070,000 | $22,035,000 | $22,035,000 | $0 |
| 6 | LOS ANGELES COUNTY HOSPITAL INTAKES | $38,524,000 | $35,851,500 | $2,672,500 | $0 |
| 7 | ENHANCED FEDERAL FUNDING | $0 | $251,247,000 | ($251,247,000) | $0 |
| 8 | SAVE | $0 | $4,000,000 | ($4,000,000) | $0 |
| | **OTHER SUBTOTAL** | **$2,269,188,000** | **$1,491,007,000** | **$778,181,000** | **$0** |
| | **GRAND TOTAL** | **$2,269,188,000** | **$1,491,007,000** | **$778,181,000** | **$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 | $169,153,000 | $0 | $0 | $0 | $169,153,000 | $0 |
| 4 | CalWORKS APPLICATIONS | $0 | $0 | $59,448,000 | $0 | $59,448,000 | $29,724,000 |
| 5 | CASE MANAGEMENT FOR OTLICP | $0 | $0 | $0 | $44,070,000 | $44,070,000 | $22,035,000 |
| 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 | ($251,247,000) |
| 8 | SAVE | $0 | $0 | $0 | $0 | $0 | ($4,000,000) |
| | **OTHER SUBTOTAL** | **$169,153,000** | **$655,310,000** | **$1,362,131,000** | **$82,594,000** | **$2,269,188,000** | **$778,181,000** |
| | **GRAND TOTAL** | **$169,153,000** | **$655,310,000** | **$1,362,131,000** | **$82,594,000** | **$2,269,188,000** | **$778,181,000** |

# 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 | $2,012,817,000 | $1,006,408,500 | $1,006,408,500 | $0 |
| 3 | SAWS | $203,139,000 | $203,139,000 | $0 | $0 |
| 4 | CalWORKS APPLICATIONS | $59,448,000 | $29,724,000 | $29,724,000 | $0 |
| 5 | CASE MANAGEMENT FOR OTLICP | $44,083,000 | $22,041,500 | $22,041,500 | $0 |
| 6 | LOS ANGELES COUNTY HOSPITAL INTAKES | $38,524,000 | $35,851,500 | $2,672,500 | $0 |
| 7 | ENHANCED FEDERAL FUNDING | $0 | $343,907,000 | ($343,907,000) | $0 |
| 8 | SAVE | $0 | $4,000,000 | ($4,000,000) | $0 |
| | **OTHER SUBTOTAL** | **$2,358,011,000** | **$1,645,071,500** | **$712,939,500** | **$0** |
| | **GRAND TOTAL** | **$2,358,011,000** | **$1,645,071,500** | **$712,939,500** | **$0** |

# MEDI-CAL COUNTY ADMINISTRATION
# POLICY CHANGE COST BREAKDOWN
# FISCAL YEAR 2018-19

| NO. | POLICY CHANGE TITLE | ONE-TIME CHANGES PROCEDURAL | ONE-TIME CHANGES CASELOAD | ON-GOING CHANGES PROCEDURAL | ON-GOING CHANGES CASELOAD | TOTAL POLICY CHANGES | GENERAL FUNDS |
|---|---|---|---|---|---|---|---|
| | **OTHER** | | | | | | |
| 1 | COUNTY ADMINISTRATION ALLOCATION | $0 | $0 | $2,012,817,000 | $0 | $2,012,817,000 | $1,006,408,500 |
| 3 | SAWS | $203,139,000 | $0 | $0 | $0 | $203,139,000 | $0 |
| 4 | CalWORKS APPLICATIONS | $0 | $0 | $59,448,000 | $0 | $59,448,000 | $29,724,000 |
| 5 | CASE MANAGEMENT FOR OTLICP | $0 | $0 | $0 | $44,083,000 | $44,083,000 | $22,041,500 |
| 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 | ($343,907,000) |
| 8 | SAVE | $0 | $0 | $0 | $0 | $0 | ($4,000,000) |
| | **OTHER SUBTOTAL** | **$203,139,000** | **$0** | **$2,072,265,000** | **$82,607,000** | **$2,358,011,000** | **$712,939,500** |
| | **GRAND TOTAL** | **$203,139,000** | **$0** | **$2,072,265,000** | **$82,607,000** | **$2,358,011,000** | **$712,939,500** |

# COMPARISON OF FISCAL IMPACTS OF COUNTY ADMINISTRATION POLICY CHANGES
# NOVEMBER 2017 ESTIMATE COMPARED TO APPROPRIATION
# FISCAL YEAR 2017-18

| MAY NO. | NOV. NO. | POLICY CHANGE TITLE | 2017-18 APPROPRIATION | | NOV. 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|---|
| | | | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | | **OTHER** | | | | | | |
| 1 | 1 | COUNTY ADMINISTRATION ALLOCATION | $1,302,683,000 | $651,341,500 | $1,302,683,000 | $651,341,500 | $0 | $0 |
| 2 | 2 | IMPLEMENTATION OF ACA | $655,310,000 | $327,655,000 | $655,310,000 | $327,655,000 | $0 | $0 |
| 3 | 3 | SAWS | $175,828,000 | $0 | $169,153,000 | $0 | ($6,675,000) | $0 |
| 4 | 4 | CalWORKS APPLICATIONS | $59,448,000 | $29,724,000 | $59,448,000 | $29,724,000 | $0 | $0 |
| 5 | 5 | CASE MANAGEMENT FOR OTLICP | $44,683,000 | $22,341,500 | $44,070,000 | $22,035,000 | ($613,000) | ($306,500) |
| 6 | 6 | LOS ANGELES COUNTY HOSPITAL INTAKES | $33,495,000 | $2,382,500 | $38,524,000 | $2,672,500 | $5,029,000 | $290,000 |
| 7 | 7 | ENHANCED FEDERAL FUNDING | $0 | ($266,354,000) | $0 | ($251,247,000) | $0 | $15,107,000 |
| 9 | 8 | SAVE | $0 | ($3,500,000) | $0 | ($4,000,000) | $0 | ($500,000) |
| 8 | -- | PRIOR YEAR RECONCILIATIONS | $0 | $0 | $0 | $0 | $0 | $0 |
| | | **OTHER SUBTOTAL** | **$2,271,447,000** | **$763,590,500** | **$2,269,188,000** | **$778,181,000** | **($2,259,000)** | **$14,590,500** |
| | | **COUNTY ADMINISTRATION GRAND TOTAL** | **$2,271,447,000** | **$763,590,500** | **$2,269,188,000** | **$778,181,000** | **($2,259,000)** | **$14,590,500** |

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

| | | NOV. 2017 EST. FOR 2017-18 | | NOV. 2017 EST. FOR 2018-19 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | **OTHER** | | | | | | |
| 1 | COUNTY ADMINISTRATION ALLOCATION | $1,302,683,000 | $651,341,500 | $2,012,817,000 | $1,006,408,500 | $710,134,000 | $355,067,000 |
| 2 | IMPLEMENTATION OF ACA | $655,310,000 | $327,655,000 | $0 | $0 | ($655,310,000) | ($327,655,000) |
| 3 | SAWS | $169,153,000 | $0 | $203,139,000 | $0 | $33,986,000 | $0 |
| 4 | CalWORKS APPLICATIONS | $59,448,000 | $29,724,000 | $59,448,000 | $29,724,000 | $0 | $0 |
| 5 | CASE MANAGEMENT FOR OTLICP | $44,070,000 | $22,035,000 | $44,083,000 | $22,041,500 | $13,000 | $6,500 |
| 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 | ($251,247,000) | $0 | ($343,907,000) | $0 | ($92,660,000) |
| 8 | SAVE | $0 | ($4,000,000) | $0 | ($4,000,000) | $0 | $0 |
| | **OTHER SUBTOTAL** | **$2,269,188,000** | **$778,181,000** | **$2,358,011,000** | **$712,939,500** | **$88,823,000** | **($65,241,500)** |
| | **COUNTY ADMINISTRATION GRAND TOTAL** | **$2,269,188,000** | **$778,181,000** | **$2,358,011,000** | **$712,939,500** | **$88,823,000** | **($65,241,500)** |

# MEDI-CAL COUNTY ADMINISTRATION
# POLICY CHANGE INDEX


| POLICY CHANGE NUMBER | POLICY CHANGE TITLE |
|---|---|
| | **OTHER** |
| 1 | COUNTY ADMINISTRATION ALLOCATION |
| 2 | IMPLEMENTATION OF ACA |
| 3 | SAWS |
| 4 | CALWORKS APPLICATIONS |
| 5 | CASE MANAGEMENT FOR OTLICP |
| 6 | LOS ANGELES COUNTY HOSPITAL INTAKES |
| 7 | ENHANCED FEDERAL FUNDING |
| 8 | SAVE |

# 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 | $2,012,817,000 |
| CASELOAD - TOT. | $0 | $0 | $0 | $0 |
| TOTAL FUNDS | $0 | $1,302,683,000 | $0 | $2,012,817,000 |
| STATE FUNDS | $0 | $651,341,500 | $0 | $1,006,408,500 |
| % 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 | $2,012,817,000 |
| CASELOAD - TOT. | $0 | $0 | $0 | $0 |
| TOTAL FUNDS | $0 | $1,302,683,000 | $0 | $2,012,817,000 |
| STATE FUNDS | $0 | $651,341,500 | $0 | $1,006,408,500 |

## 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 county administration allocation will be adjusted. The separate funding for implementation of the ACA will be included in this policy change. The projected California Price index (CPI) change will be used to adjust the total dollars available. In addition, the Department will not reallocate unspent funds to counties that overspend their allocation. A similar adjustment will also be applied in FY 2019-20 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.

**Reason for Change:**
There is no change, from the previous estimate, for FY 2017-18. The change in the current estimate, from FY 2017-18 to FY 2018-19, is due to the incorporation of the cost of CA 2 Implementation of the ACA into CA 1 County Administration Allocation. Additionally, the department increased the total cost by 2.8%, the CPI projection, for an increase of $54.8M from FY 2017-18.

**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 | $1,405,487 | $702,744 | $702,744 |
| Support Staff Costs | $577,328 | $288,664 | $288,664 |
| Staff Development Costs | $30,002 | $15,001 | $15,001 |
| **Total Allocation** | **$2,012,817** | **$1,006,408** | **$1,006,408** |

# COUNTY ADMINISTRATION ALLOCATION

## COUNTY ADMIN. POLICY CHANGE NUMBER: 1

2) The funding allocation to counties for FY 2018-19 has not yet been determined so no table is included in this PC.

| Medi-Cal County Administration | | | | |
|---|---|---|---|---|
| FY 2017-18 | | | | |
| County | Total Staff Salary Costs | Support Staff | Staff Development Costs | 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** | **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** |

**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 and imposes a penalty upon the uninsured. 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, 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 Base.

**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 are:

(Dollars in thousands)

| Fiscal Year | TF | GF | FF |
|---|---|---|---|
| **FY 2017-18** | $ 655,310 | $ 327,655 | $ 327,655 |

**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. | $169,153,000 | $0 | $203,139,000 | $0 |
| CASELOAD - TOT. | $0 | $0 | $0 | $0 |
| TOTAL FUNDS | $169,153,000 | $0 | $203,139,000 | $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. | $169,153,000 | $0 | $203,139,000 | $0 |
| CASELOAD - TOT. | $0 | $0 | $0 | $0 |
| TOTAL FUNDS | $169,153,000 | $0 | $203,139,000 | $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 for the Los Angeles Eligibility Automated Determination Evaluation and Reporting System (LEADER) Replacement System (LRS) and the County Expense Claim Reporting Information System (CECRIS) that is paid by the Department.

**Authority:**
Welfare & Institutions Code 14154
Interagency Agreement # 04-35639
Interagency Agreement CalHEERS # 14-90510
Interagency Agreement ACMS # 14-90518
Affordable Care Act (ACA)

**Interdependent Policy Changes:**
Not Applicable

**Background:**
The Statewide Automated Welfare Systems (SAWS) consists of three county consortium systems: LRS, the Consortium-IV (C-IV), and the 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.

# SAWS

## COUNTY ADMIN. POLICY CHANGE NUMBER: 3

LRS is the automated system used in Los Angeles County and seventeen other counties. The implementation of LRS is currently in the final phase.

The CalWIN consortium and C-IV system are currently in the maintenance and operation phase. 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 system to the LRS codebase is scheduled to begin October 2019 and be completed in April 2020. The C-IV Migration will result in a new consortium to replace the LRS and C-IV consortia.

CECRIS will lead to the development and implementation of an automated solution to replace the current County Expense Claim (CEC) and County Assistance Claim (CA 800) systems and manual processes. CECRIS will improve data access, analysis, and the accuracy of administrative and assistance expenditure data for all CDSS public assistance programs. Automating these processes will ensure that costs are reimbursed in accordance with federal cost allocation requirements.

**Reason for Change:**
The decrease from the prior estimate, for FY 2017-18, is due to a decrease in cost for the Consortium IV Migration project. The increase in the current estimate, from FY 2017-18 to FY 2018-19, is due to the addition of $77,860,000 for CECRIS.

**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 | $2,406 | $2,385 |
| SB 1341 Medi-Cal/SAWS | $5,467 | $6,100 |
| LEADER - Replacement | $45,172 | $44,776 |
| WCDS-CalWIN | $48,850 | $46,507 |
| Consortium IV | $38,072 | $0 |
| Consortium IV – Migration | $26,231 | $23,744 |
| State Client Index | $69 | $69 |
| Inter-County Transfer Automation | $603 | $117 |
| Appeals Case Management System (ACMS) | $2,283 | $1,581 |
| CECRIS | $0 | $77,860 |
| **Total** | **$169,153** | **$203,139** |

**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 | $59,448,000 | $0 | $59,448,000 |
| CASELOAD - TOT. | $0 | $0 | $0 | $0 |
| TOTAL FUNDS | $0 | $59,448,000 | $0 | $59,448,000 |
| STATE FUNDS | $0 | $29,724,000 | $0 | $29,724,000 |
| % 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 | $59,448,000 | $0 | $59,448,000 |
| CASELOAD - TOT. | $0 | $0 | $0 | $0 |
| TOTAL FUNDS | $0 | $59,448,000 | $0 | $59,448,000 |
| STATE FUNDS | $0 | $29,724,000 | $0 | $29,724,000 |

## 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:**
There is no change.

# 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 | $59,448 | $29,724 | $29,724 |
| FY 2018-19 | $59,448 | $29,724 | $29,724 |

**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 | $44,070,000 | $0 | $44,083,000 |
| TOTAL FUNDS | $0 | $44,070,000 | $0 | $44,083,000 |
| STATE FUNDS | $0 | $22,035,000 | $0 | $22,041,500 |
| % 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 | $44,070,000 | $0 | $44,083,000 |
| TOTAL FUNDS | $0 | $44,070,000 | $0 | $44,083,000 |
| STATE FUNDS | $0 | $22,035,000 | $0 | $22,041,500 |

## 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, is due to a 1.39% decrease in the updated average monthly caseload data. The change in the current estimate from FY 2017-18 to FY 2018-19 is due to a slight increase in the average monthly 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 is 918,129 for FY 2017-18 and 918,392 for FY 2017-18.

3. The estimated costs are:

(Dollars In Thousands)

| Fiscal Year | TF | GF | FF |
|---|---|---|---|
| FY 2017-18 | $ 44,070 | $ 22,035 | $ 22,035 |
| FY 2018-19 | $ 44,083 | $ 22,042 | $ 22,041 |

**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. The applications processed by the PFSWs are sent 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 federal share for any costs not covered by the DPSS rate is passed through to the county.

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is due to updated actuals from the FY 2015-16 reconciliation. There is no change 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 will complete the FY 2015-16 Los Angeles County Hospital Intakes reconciliation in FY 2017-18. The current FY 2015-16 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 | -$251,247,000 | $0 | -$343,907,000 | $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 | -$251,247,000 | $0 | -$343,907,000 | $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 Base
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, is due to updated estimated amounts in the County Administration Allocation based on claiming reconciliation. Additionally, the Department changed the assumption of the percentage of the allocation eligible for the enhanced federal match from 67.5% to 65% based on actual claims. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to two factors. First, the Department claims three quarters in FY 2017-18 and four quarters in FY 2018-19. The second factor is that funding for CA 1 County Administration Base increased from $1.3M in FY 2017-18 to $2M in FY 2018-19, while the funding for CA 2 Implementation of the ACA is incorporated into CA 1 County Administration Base in FY 2018-19.

**Methodology:**
1. The effective date for the approval for the Department's APD is September 29, 2014, with retroactivity for April-September 2014.

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 | $ 1,004,987 | $ 502,494 | $ 502,494 |
| Title XIX at 75% FFP | $ 1,004,987 | $ 251,247 | $ 753,740 |
| **Total Difference** | **$ -** | **$ (251,247)** | **$ 251,247** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| Title XIX at 50% FFP | $ 1,375,626 | $ 687,813 | $ 687,813 |
| Title XIX at 75% FFP | $ 1,375,626 | $ 343,907 | $ 1,031,720 |
| **Total Difference** | **$ -** | **$ (343,907)** | **$ 343,907** |

**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:**
The change from the previous estimate, for FY 2017-18, is due to an increase in SAVE applications to be processed. There is no change 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)

# November 2017 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 | $2,158,302,000 | $1,893,513,310 | $264,788,690 |
| Fiscal Intermediary | $449,192,000 | $288,451,000 | $160,741,000 |
| **Total Other Administration Tab** | **$2,607,494,000** | **$2,181,964,310** | **$425,529,690** |
| **Management Summary:** | | | |
| **COUNTY ADMINISTRATION** | **$4,427,490,000** | **$3,384,520,000** | **$1,042,970,000** |
| Shown in Other Administration Tab | $2,158,302,000 | $1,893,513,310 | $264,788,690 |
| Shown in County Administration Tab | $2,269,188,000 | $1,491,006,690 | $778,181,310 |
| **FISCAL INTERMEDIARY** | **$449,192,000** | **$288,451,000** | **$160,741,000** |
| Shown in Other Administration Tab | $449,192,000 | $288,451,000 | $160,741,000 |

| FY 2018-2019 ESTIMATE: | Total Funds | Federal Funds | State Funds |
|---|---|---|---|
| **OTHER ADMINISTRATION** | | | |
| County Administration | $2,011,262,000 | $1,635,688,750 | $375,573,250 |
| Fiscal Intermediary | $328,124,000 | $211,278,000 | $116,846,000 |
| **Total Other Administration Tab** | **$2,339,386,000** | **$1,846,966,750** | **$492,419,250** |
| **Management Summary:** | | | |
| **COUNTY ADMINISTRATION** | **$4,369,275,000** | **$3,280,762,000** | **$1,088,513,000** |
| Shown in Other Administration Tab | $2,011,263,000 | $1,635,689,750 | $375,573,250 |
| Shown in County Administration Tab | $2,358,012,000 | $1,645,072,250 | $712,939,750 |
| **FISCAL INTERMEDIARY** | **$328,123,000** | **$211,277,000** | **$116,846,000** |
| Shown in Other Administration Tab | $328,124,000 | $211,278,000 | $116,846,000 |

# 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 | $268,836,000 | $215,594,000 | $53,242,000 | $0 |
| 2 | CCS CASE MANAGEMENT | $194,938,000 | $128,275,540 | $66,662,460 | $0 |
| 3 | MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS | $119,816,000 | $119,816,000 | $0 | $0 |
| 4 | COUNTY SPECIALTY MENTAL HEALTH ADMIN | $103,229,000 | $103,229,000 | $0 | $0 |
| 5 | COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES | $100,730,000 | $100,719,000 | $11,000 | $0 |
| 6 | EPSDT CASE MANAGEMENT | $33,962,000 | $21,846,750 | $12,115,250 | $0 |
| 7 | OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS | $30,197,000 | $23,729,440 | $6,467,560 | $0 |
| 8 | SMH MAA | $29,094,000 | $29,094,000 | $0 | $0 |
| 9 | ARRA HITECH INCENTIVE PROGRAM | $25,525,000 | $23,884,000 | $0 | $1,641,000 |
| 10 | MANAGED CARE REGULATIONS - MENTAL HEALTH | $24,005,000 | $16,005,000 | $8,000,000 | $0 |
| 11 | SMHS COUNTY UR & QA ADMIN | $23,773,000 | $23,425,000 | $348,000 | $0 |
| 12 | PERFORMANCE OUTCOMES SYSTEM | $13,783,000 | $7,556,000 | $6,227,000 | $0 |
| 13 | PAVE SYSTEM | $20,588,000 | $12,708,400 | $7,879,600 | $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 | $12,200,000 | $9,150,000 | $3,050,000 | $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 | $10,790,000 | $8,812,950 | $1,977,050 | $0 |
| 20 | MEDI-CAL RECOVERY CONTRACTS | $10,187,000 | $7,640,250 | $2,546,750 | $0 |
| 21 | LITIGATION RELATED SERVICES | $9,980,000 | $4,990,000 | $4,990,000 | $0 |
| 22 | NEWBORN HEARING SCREENING PROGRAM | $8,845,000 | $4,422,500 | $4,422,500 | $0 |
| 23 | HIPAA CAPITATION PAYMENT REPORTING SYSTEM | $7,094,000 | $5,320,500 | $1,773,500 | $0 |
| 24 | DMC COUNTY UR & QA ADMIN | $6,278,000 | $6,278,000 | $0 | $0 |
| 25 | MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS) | $5,000,000 | $3,325,500 | $1,328,500 | $346,000 |
| 26 | CLINICAL DATA COLLECTION | $3,531,000 | $3,121,650 | $409,350 | $0 |
| 27 | DRUG MEDI-CAL COUNTY ADMINISTRATION | $3,248,000 | $3,248,000 | $0 | $0 |
| 28 | MEDICARE BENEFICIARY IDENTIFIER | $2,618,000 | $2,356,200 | $261,800 | $0 |
| 29 | ELECTRONIC ASSET VERIFICATION PROGRAM | $2,416,000 | $1,208,000 | $1,208,000 | $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-OTHER** | | | | |
| 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 |
| 32 | MITA | $2,206,000 | $1,985,400 | $220,600 | $0 |
| 33 | MEDS MODERNIZATION | $2,015,000 | $1,748,250 | $266,750 | $0 |
| 34 | SSA COSTS FOR HEALTH COVERAGE INFO. | $1,600,000 | $800,000 | $800,000 | $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. | $734,000 | $367,000 | $367,000 | $0 |
| 41 | IRS REPORTING FOR MIN. ESSENTIAL COVERAGE | $592,000 | $296,000 | $296,000 | $0 |
| 42 | ETL DATA SOLUTION | $431,000 | $323,250 | $107,750 | $0 |
| 43 | VENDOR FOR AAC RATE STUDY | $390,000 | $195,000 | $195,000 | $0 |
| 44 | CCT OUTREACH - ADMINISTRATIVE COSTS | $342,000 | $342,000 | $0 | $0 |
| 45 | MEDICARE BUY-IN QUALITY REVIEW PROJECT | $200,000 | $100,000 | $100,000 | $0 |
| 46 | STATE CONTROLLER'S OFFICE INTERAGENCY AGREEMENT | $173,000 | $129,750 | $43,250 | $0 |
| 47 | DENTAL PAPD PROJECT MANAGER | $125,000 | $93,750 | $31,250 | $0 |
| 48 | CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT | $100,000 | $100,000 | $0 | $0 |
| 49 | TAR POSTAGE | $52,000 | $26,000 | $26,000 | $0 |
| 50 | ENROLLMENT ASSIST FOR BHT INSTITUTIONALLY DEEMED | $43,000 | $21,500 | $21,500 | $0 |
| 54 | TITLE XXI FEDERAL MATCH REDUCTION OTHER ADMIN | ($3,099,000) | ($12,863,570) | $9,764,570 | $0 |
| 55 | INTERIM AND FINAL COST SETTLEMENTS-SMHS | ($35,823,000) | ($35,823,000) | $0 | $0 |
| | **DHCS-OTHER SUBTOTAL** | **$1,110,438,000** | **$881,951,260** | **$226,182,740** | **$2,304,000** |
| | **DHCS-MEDICAL FI** | | | | |
| 56 | MEDICAL FI OPERATIONS | $81,248,000 | $55,152,750 | $26,095,250 | $0 |
| 57 | MEDICAL FI COST REIMBURSEMENT | $41,090,000 | $30,259,850 | $10,830,150 | $0 |
| 58 | MEDICAL FI HOURLY REIMBURSEMENT | $27,546,000 | $21,559,500 | $5,986,500 | $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-MEDICAL FI** | | | | |
| 59 | MEDICAL FI OTHER ESTIMATED COSTS | $11,280,000 | $8,010,000 | $3,270,000 | $0 |
| 60 | MEDICAL FI MISCELLANEOUS EXPENSES | $2,440,000 | $1,674,000 | $766,000 | $0 |
| 61 | MEDICAL FI CHANGE ORDERS | $464,000 | $348,000 | $116,000 | $0 |
| 111 | MEDICAL FI SRP RELEASE 1 HOSTING | $7,042,000 | $6,018,300 | $1,023,700 | $0 |
| | **DHCS-MEDICAL FI SUBTOTAL** | **$171,110,000** | **$123,022,400** | **$48,087,600** | **$0** |
| | **DHCS-HEALTH CARE OPT** | | | | |
| 63 | HCO COST REIMBURSEMENT | $44,189,000 | $22,934,680 | $21,254,320 | $0 |
| 64 | HCO OPERATIONS | $44,074,000 | $22,872,620 | $21,201,380 | $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 | $932,000 | $466,000 | $466,000 | $0 |
| | **DHCS-HEALTH CARE OPT SUBTOTAL** | **$140,803,000** | **$72,714,940** | **$68,088,060** | **$0** |
| | **DHCS-DENTAL FI** | | | | |
| 73 | DENTAL FI OPERATIONS | $68,813,000 | $46,057,250 | $22,755,750 | $0 |
| 74 | DENTAL NEW FI TAKEOVER | $23,424,000 | $17,568,000 | $5,856,000 | $0 |
| 75 | DENTAL ASO ADMINISTRATION | $12,700,000 | $8,057,250 | $4,642,750 | $0 |
| 76 | DENTAL FI HOURLY REIMBURSEMENT | $8,748,000 | $6,561,000 | $2,187,000 | $0 |
| 77 | DENTAL FI COST REIMBURSEMENT | $8,016,000 | $4,177,000 | $3,839,000 | $0 |
| 78 | DENTAL NEW FI ADMINISTRATION | $7,300,000 | $5,280,500 | $2,019,500 | $0 |
| 79 | DENTAL ASO TAKEOVER | $4,420,000 | $3,315,000 | $1,105,000 | $0 |
| 80 | DENTAL FI CD-MMIS COSTS | $2,331,000 | $1,748,250 | $582,750 | $0 |
| 81 | DENTAL BENEFICIARY OUTREACH & ED PROGRAM - ADMIN | $1,779,000 | $889,500 | $889,500 | $0 |
| 82 | DENTAL TREATMENT AUTHORIZATION REQUEST PROCESSING | $1,629,000 | $978,750 | $650,250 | $0 |
| 83 | DENTAL FI FEDERAL RULE - REVALIDATION | $254,000 | $127,000 | $127,000 | $0 |
| 84 | DENTAL FI FEDERAL RULE - DATABASE CHECKS | $227,000 | $113,500 | $113,500 | $0 |
| 85 | DENTAL FI CONLAN, SCHWARZMER, STEVENS V. BONTA | $179,000 | $89,500 | $89,500 | $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-DENTAL FI** | | | | |
| 86 | DENTAL FI HIPAA ADDENDUM SECURITY RISK ASSESSMENT | $174,000 | $130,500 | $43,500 | $0 |
| | **DHCS-DENTAL FI SUBTOTAL** | **$139,994,000** | **$95,093,000** | **$44,901,000** | **$0** |
| | **OTHER DEPARTMENTS** | | | | |
| 87 | PERSONAL CARE SERVICES | $421,326,000 | $421,326,000 | $0 | $0 |
| 88 | HEALTH-RELATED ACTIVITIES - CDSS | $299,589,000 | $299,589,000 | $0 | $0 |
| 89 | CALHEERS DEVELOPMENT | $125,682,000 | $99,673,210 | $26,008,790 | $0 |
| 90 | CDDS ADMINISTRATIVE COSTS | $52,239,000 | $52,239,000 | $0 | $0 |
| 91 | MATERNAL AND CHILD HEALTH | $35,201,000 | $35,201,000 | $0 | $0 |
| 92 | HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN | $29,829,000 | $29,829,000 | $0 | $0 |
| 93 | DEPARTMENT OF SOCIAL SERVICES ADMIN COST | $37,029,000 | $37,029,000 | $0 | $0 |
| 94 | FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS | $15,145,000 | $11,238,000 | $0 | $3,907,000 |
| 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 | $1,668,000 | $1,668,000 | $0 | $0 |
| 99 | CALIFORNIA SMOKERS' HELPLINE | $1,321,000 | $1,321,000 | $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 | $752,000 | $752,000 | $0 | $0 |
| 105 | MERIT SYSTEM SERVICES FOR COUNTIES | $194,000 | $97,000 | $97,000 | $0 |
| 106 | CDDS DENTAL SERVICES - ADMIN | $62,000 | $0 | $0 | $62,000 |
| 107 | PIA EYEWEAR COURIER SERVICE | $341,000 | $170,500 | $170,500 | $0 |

# SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
# FISCAL YEAR 2017-18

| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | FEDERAL FUNDS | GENERAL FUNDS | OTHER STATE FUNDS |
|---|---|---|---|---|---|
| | **OTHER DEPARTMENTS SUBTOTAL** | **$1,045,149,000** | **$1,009,182,710** | **$26,276,290** | **$9,690,000** |
| | **GRAND TOTAL** | **$2,607,494,000** | **$2,181,964,310** | **$413,535,690** | **$11,994,000** |

# 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 | $258,096,000 | $94,697,000 | $163,399,000 | $0 |
| 2 | CCS CASE MANAGEMENT | $183,544,000 | $123,406,380 | $60,137,620 | $0 |
| 4 | COUNTY SPECIALTY MENTAL HEALTH ADMIN | $106,250,000 | $106,250,000 | $0 | $0 |
| 5 | COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES | $77,066,000 | $77,066,000 | $0 | $0 |
| 6 | EPSDT CASE MANAGEMENT | $33,962,000 | $21,846,750 | $12,115,250 | $0 |
| 7 | OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS | $35,601,000 | $26,410,160 | $9,190,840 | $0 |
| 8 | SMH MAA | $32,293,000 | $32,293,000 | $0 | $0 |
| 9 | ARRA HITECH INCENTIVE PROGRAM | $11,276,000 | $10,886,000 | $0 | $390,000 |
| 10 | MANAGED CARE REGULATIONS - MENTAL HEALTH | $22,757,000 | $15,173,000 | $7,584,000 | $0 |
| 11 | SMHS COUNTY UR & QA ADMIN | $26,162,000 | $25,214,000 | $948,000 | $0 |
| 12 | PERFORMANCE OUTCOMES SYSTEM | $16,137,000 | $9,183,750 | $6,953,250 | $0 |
| 13 | PAVE SYSTEM | $15,988,000 | $8,858,700 | $7,129,300 | $0 |
| 14 | POSTAGE & PRINTING | $21,586,000 | $10,665,000 | $10,921,000 | $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 | $9,884,000 | $7,413,000 | $2,471,000 | $0 |
| 21 | LITIGATION RELATED SERVICES | $9,980,000 | $4,990,000 | $4,990,000 | $0 |
| 22 | NEWBORN HEARING SCREENING PROGRAM | $7,825,000 | $3,912,500 | $3,912,500 | $0 |
| 23 | HIPAA CAPITATION PAYMENT REPORTING SYSTEM | $5,488,000 | $4,116,000 | $1,372,000 | $0 |
| 24 | DMC COUNTY UR & QA ADMIN | $15,934,000 | $15,934,000 | $0 | $0 |
| 25 | MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS) | $5,000,000 | $3,325,500 | $1,328,500 | $346,000 |
| 26 | CLINICAL DATA COLLECTION | $2,130,000 | $1,842,000 | $288,000 | $0 |
| 27 | DRUG MEDI-CAL COUNTY ADMINISTRATION | $3,248,000 | $3,248,000 | $0 | $0 |
| 28 | MEDICARE BENEFICIARY IDENTIFIER | $1,578,000 | $1,420,200 | $157,800 | $0 |
| 29 | ELECTRONIC ASSET VERIFICATION PROGRAM | $3,328,000 | $1,664,000 | $1,664,000 | $0 |
| 30 | SDMC SYSTEM M&O SUPPORT | $2,325,000 | $1,162,500 | $1,162,500 | $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** | | | | |
| 31 | CA-MMIS MEDCOMPASS SOLUTION | $1,576,000 | $1,346,700 | $229,300 | $0 |
| 32 | MITA | $2,733,000 | $2,459,700 | $273,300 | $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. | $708,000 | $354,000 | $354,000 | $0 |
| 41 | IRS REPORTING FOR MIN. ESSENTIAL COVERAGE | $432,000 | $216,000 | $216,000 | $0 |
| 42 | ETL DATA SOLUTION | $270,000 | $202,500 | $67,500 | $0 |
| 43 | VENDOR FOR AAC RATE STUDY | $327,000 | $163,500 | $163,500 | $0 |
| 44 | CCT OUTREACH - ADMINISTRATIVE COSTS | $342,000 | $342,000 | $0 | $0 |
| 45 | MEDICARE BUY-IN QUALITY REVIEW PROJECT | $200,000 | $100,000 | $100,000 | $0 |
| 48 | CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT | $100,000 | $100,000 | $0 | $0 |
| 49 | TAR POSTAGE | $52,000 | $26,000 | $26,000 | $0 |
| 54 | TITLE XXI FEDERAL MATCH REDUCTION OTHER ADMIN | ($3,574,000) | ($15,860,060) | $12,286,060 | $0 |
| 109 | MANAGED CARE REGULATIONS - MH PARITY | $21,284,000 | $18,244,000 | $3,040,000 | $0 |
| | **DHCS-OTHER SUBTOTAL** | **$999,520,000** | **$660,852,280** | **$337,614,720** | **$1,053,000** |
| | **DHCS-MEDICAL FI** | | | | |
| 56 | MEDICAL FI OPERATIONS | $79,177,000 | $53,807,500 | $25,369,500 | $0 |
| 57 | MEDICAL FI COST REIMBURSEMENT | $36,004,000 | $25,599,250 | $10,404,750 | $0 |
| 58 | MEDICAL FI HOURLY REIMBURSEMENT | $27,546,000 | $21,559,500 | $5,986,500 | $0 |
| 59 | MEDICAL FI OTHER ESTIMATED COSTS | $11,280,000 | $8,010,000 | $3,270,000 | $0 |
| 60 | MEDICAL FI MISCELLANEOUS EXPENSES | $2,440,000 | $1,674,000 | $766,000 | $0 |
| 61 | MEDICAL FI CHANGE ORDERS | $523,000 | $392,250 | $130,750 | $0 |
| 62 | MEDICAL FI OPTIONAL CONTRACTUAL SERVICES | $1,679,000 | $1,511,100 | $167,900 | $0 |
| 111 | MEDICAL FI SRP RELEASE 1 HOSTING | $8,450,000 | $7,221,300 | $1,228,700 | $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 SUBTOTAL** | **$167,099,000** | **$119,774,900** | **$47,324,100** | **$0** |
| | **DHCS-HEALTH CARE OPT** | | | | |
| 63 | HCO COST REIMBURSEMENT | $13,582,000 | $7,049,780 | $6,532,220 | $0 |
| 64 | HCO OPERATIONS | $13,686,000 | $7,102,160 | $6,583,840 | $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 | $2,564,000 | $1,282,000 | $1,282,000 | $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 | $9,248,000 | $4,799,560 | $4,448,440 | $0 |
| | **DHCS-HEALTH CARE OPT SUBTOTAL** | **$114,564,000** | **$59,218,860** | **$55,345,140** | **$0** |
| | **DHCS-DENTAL FI** | | | | |
| 74 | DENTAL NEW FI TAKEOVER | $5,856,000 | $4,392,000 | $1,464,000 | $0 |
| 75 | DENTAL ASO ADMINISTRATION | $35,620,000 | $22,451,500 | $13,168,500 | $0 |
| 78 | DENTAL NEW FI ADMINISTRATION | $18,788,000 | $13,814,500 | $4,973,500 | $0 |
| 79 | DENTAL ASO TAKEOVER | $1,105,000 | $828,750 | $276,250 | $0 |
| 81 | DENTAL BENEFICIARY OUTREACH & ED PROGRAM - ADMIN | $1,781,000 | $890,500 | $890,500 | $0 |
| | **DHCS-DENTAL FI SUBTOTAL** | **$63,150,000** | **$42,377,250** | **$20,772,750** | **$0** |
| | **OTHER DEPARTMENTS** | | | | |
| 87 | PERSONAL CARE SERVICES | $382,359,000 | $382,359,000 | $0 | $0 |
| 88 | HEALTH-RELATED ACTIVITIES - CDSS | $299,700,000 | $299,700,000 | $0 | $0 |
| 89 | CALHEERS DEVELOPMENT | $126,267,000 | $100,131,960 | $26,135,040 | $0 |
| 90 | CDDS ADMINISTRATIVE COSTS | $51,378,000 | $51,378,000 | $0 | $0 |
| 91 | MATERNAL AND CHILD HEALTH | $37,522,000 | $37,522,000 | $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** | | | | |
| 92 | HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN | $29,829,000 | $29,829,000 | $0 | $0 |
| 93 | DEPARTMENT OF SOCIAL SERVICES ADMIN COST | $36,257,000 | $36,257,000 | $0 | $0 |
| 94 | FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS | $14,945,000 | $11,038,000 | $0 | $3,907,000 |
| 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 | $874,000 | $874,000 | $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 | $827,000 | $827,000 | $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** | **$995,053,000** | **$964,743,460** | **$26,402,540** | **$3,907,000** |
| | **GRAND TOTAL** | **$2,339,386,000** | **$1,846,966,750** | **$487,459,250** | **$4,960,000** |

# COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
# NOVEMBER 2017 ESTIMATE COMPARED TO APPROPRIATION
# FISCAL YEAR 2017-18

| MAY NO. | NOV. NO. | POLICY CHANGE TITLE | 2017-18 APPROPRIATION | | NOV. 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|---|
| | | | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | | **DHCS-OTHER** | | | | | | |
| 1 | 1 | SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES | $495,234,000 | $0 | $268,836,000 | $53,242,000 | ($226,398,000) | $53,242,000 |
| 2 | 2 | CCS CASE MANAGEMENT | $196,000,000 | $66,690,000 | $194,938,000 | $66,662,460 | ($1,062,000) | ($27,540) |
| 3 | 3 | MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS | $119,816,000 | $0 | $119,816,000 | $0 | $0 | $0 |
| 4 | 4 | COUNTY SPECIALTY MENTAL HEALTH ADMIN | $115,824,000 | $121,000 | $103,229,000 | $0 | ($12,595,000) | ($121,000) |
| 5 | 5 | COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES | $76,169,000 | $0 | $100,730,000 | $11,000 | $24,561,000 | $11,000 |
| 6 | 6 | EPSDT CASE MANAGEMENT | $33,962,000 | $12,115,250 | $33,962,000 | $12,115,250 | $0 | $0 |
| 7 | 7 | OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS | $33,704,000 | $8,166,720 | $30,197,000 | $6,467,560 | ($3,507,000) | ($1,699,160) |
| 9 | 8 | SMH MAA | $32,512,000 | $0 | $29,094,000 | $0 | ($3,418,000) | $0 |
| 12 | 9 | ARRA HITECH INCENTIVE PROGRAM | $18,729,000 | $0 | $25,525,000 | $0 | $6,796,000 | $0 |
| 112 | 10 | MANAGED CARE REGULATIONS - MENTAL HEALTH | $27,792,000 | $9,264,000 | $24,005,000 | $8,000,000 | ($3,787,000) | ($1,264,000) |
| 11 | 11 | SMHS COUNTY UR & QA ADMIN | $20,876,000 | $415,000 | $23,773,000 | $348,000 | $2,897,000 | ($67,000) |
| 19 | 12 | PERFORMANCE OUTCOMES SYSTEM | $14,952,000 | $6,190,000 | $13,783,000 | $6,227,000 | ($1,169,000) | $37,000 |
| 8 | 13 | PAVE SYSTEM | $18,562,000 | $2,686,150 | $20,588,000 | $7,879,600 | $2,026,000 | $5,193,450 |
| 10 | 14 | POSTAGE & PRINTING | $19,820,000 | $10,002,500 | $20,586,000 | $10,421,000 | $766,000 | $418,500 |
| 13 | 15 | ACTUARIAL COSTS FOR RATE DEVELOPMENT | $16,872,000 | $8,119,000 | $16,872,000 | $8,119,000 | $0 | $0 |
| 18 | 16 | PASRR | $11,699,000 | $2,924,750 | $12,200,000 | $3,050,000 | $501,000 | $125,250 |
| 14 | 17 | MIS/DSS CONTRACT | $11,379,000 | $3,013,750 | $11,379,000 | $3,013,750 | $0 | $0 |
| 17 | 18 | CCI-ADMINISTRATIVE COSTS | $11,213,000 | $5,606,500 | $11,213,000 | $5,606,500 | $0 | $0 |
| 15 | 19 | SURS AND MARS SYSTEM REPLACEMENT | $10,790,000 | $1,977,050 | $10,790,000 | $1,977,050 | $0 | $0 |
| 21 | 20 | MEDI-CAL RECOVERY CONTRACTS | $10,218,000 | $2,554,500 | $10,187,000 | $2,546,750 | ($31,000) | ($7,750) |
| 20 | 21 | LITIGATION RELATED SERVICES | $9,980,000 | $4,990,000 | $9,980,000 | $4,990,000 | $0 | $0 |
| 22 | 22 | NEWBORN HEARING SCREENING PROGRAM | $7,800,000 | $3,900,000 | $8,845,000 | $4,422,500 | $1,045,000 | $522,500 |

# COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
# NOVEMBER 2017 ESTIMATE COMPARED TO APPROPRIATION
# FISCAL YEAR 2017-18

| MAY NO. | NOV. NO. | POLICY CHANGE TITLE | 2017-18 APPROPRIATION | | NOV. 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|---|
| | | | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | | **DHCS-OTHER** | | | | | | |
| 26 | 23 | HIPAA CAPITATION PAYMENT REPORTING SYSTEM | $4,931,000 | $1,232,750 | $7,094,000 | $1,773,500 | $2,163,000 | $540,750 |
| 39 | 24 | DMC COUNTY UR & QA ADMIN | $6,156,000 | $0 | $6,278,000 | $0 | $122,000 | $0 |
| 24 | 25 | MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS) | $5,291,000 | $1,389,750 | $5,000,000 | $1,328,500 | ($291,000) | ($61,250) |
| 46 | 26 | CLINICAL DATA COLLECTION | $4,000,000 | $475,000 | $3,531,000 | $409,350 | ($469,000) | ($65,650) |
| 27 | 27 | DRUG MEDI-CAL COUNTY ADMINISTRATION | $3,310,000 | $0 | $3,248,000 | $0 | ($62,000) | $0 |
| 42 | 28 | MEDICARE BENEFICIARY IDENTIFIER | $1,280,000 | $128,000 | $2,618,000 | $261,800 | $1,338,000 | $133,800 |
| 57 | 29 | ELECTRONIC ASSET VERIFICATION PROGRAM | $2,416,000 | $1,208,000 | $2,416,000 | $1,208,000 | $0 | $0 |
| 29 | 30 | SDMC SYSTEM M&O SUPPORT | $2,325,000 | $1,162,500 | $2,325,000 | $1,162,500 | $0 | $0 |
| 25 | 31 | CA-MMIS MEDCOMPASS SOLUTION | $1,803,000 | $262,500 | $2,252,000 | $327,500 | $449,000 | $65,000 |
| 32 | 32 | MITA | $2,750,000 | $275,000 | $2,206,000 | $220,600 | ($544,000) | ($54,400) |
| -- | 33 | MEDS MODERNIZATION | $0 | $0 | $2,015,000 | $266,750 | $2,015,000 | $266,750 |
| 33 | 34 | SSA COSTS FOR HEALTH COVERAGE INFO. | $1,500,000 | $750,000 | $1,600,000 | $800,000 | $100,000 | $50,000 |
| 36 | 35 | CALIFORNIA HEALTH INTERVIEW SURVEY | $1,000,000 | $0 | $1,272,000 | $0 | $272,000 | $0 |
| 35 | 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 | $899,000 | $449,500 | $888,000 | $444,000 | ($11,000) | ($5,500) |
| 41 | 39 | ENCRYPTION OF PHI DATA | $750,000 | $375,000 | $750,000 | $375,000 | $0 | $0 |
| 44 | 40 | POSTAGE AND PRINTING - THIRD PARTY LIAB. | $740,000 | $370,000 | $734,000 | $367,000 | ($6,000) | ($3,000) |
| 40 | 41 | IRS REPORTING FOR MIN. ESSENTIAL COVERAGE | $1,024,000 | $512,000 | $592,000 | $296,000 | ($432,000) | ($216,000) |
| 47 | 42 | ETL DATA SOLUTION | $334,000 | $83,500 | $431,000 | $107,750 | $97,000 | $24,250 |
| 45 | 43 | VENDOR FOR AAC RATE STUDY | $325,000 | $162,500 | $390,000 | $195,000 | $65,000 | $32,500 |

# COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
# NOVEMBER 2017 ESTIMATE COMPARED TO APPROPRIATION
# FISCAL YEAR 2017-18

| MAY NO. | NOV. NO. | POLICY CHANGE TITLE | 2017-18 APPROPRIATION | | NOV. 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|---|
| | | | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | | **DHCS-OTHER** | | | | | | |
| 48 | 44 | CCT OUTREACH - ADMINISTRATIVE COSTS | $348,000 | $0 | $342,000 | $0 | ($6,000) | $0 |
| 34 | 45 | MEDICARE BUY-IN QUALITY REVIEW PROJECT | $200,000 | $100,000 | $200,000 | $100,000 | $0 | $0 |
| 51 | 46 | STATE CONTROLLER'S OFFICE INTERAGENCY AGREEMENT | $173,000 | $43,250 | $173,000 | $43,250 | $0 | $0 |
| 50 | 47 | DENTAL PAPD PROJECT MANAGER | $125,000 | $31,250 | $125,000 | $31,250 | $0 | $0 |
| 52 | 48 | CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT | $100,000 | $0 | $100,000 | $0 | $0 | $0 |
| 54 | 49 | TAR POSTAGE | $54,000 | $27,000 | $52,000 | $26,000 | ($2,000) | ($1,000) |
| -- | 50 | ENROLLMENT ASSIST FOR BHT INSTITUTIONALLY DEEMED | $0 | $0 | $43,000 | $21,500 | $43,000 | $21,500 |
| 115 | 54 | TITLE XXI FEDERAL MATCH REDUCTION OTHER ADMIN | ($1,927,000) | $9,793,000 | ($3,099,000) | $9,764,570 | ($1,172,000) | ($28,430) |
| 16 | 55 | INTERIM AND FINAL COST SETTLEMENTS-SMHS | ($25,692,000) | $0 | ($35,823,000) | $0 | ($10,131,000) | $0 |
| 58 | -- | MEDICAL INTERPRETERS | $5,205,000 | $2,602,500 | $0 | $0 | ($5,205,000) | ($2,602,500) |
| | | **DHCS-OTHER SUBTOTAL** | **$1,335,480,000** | **$171,722,670** | **$1,110,438,000** | **$226,182,740** | **($225,042,000)** | **$54,460,070** |
| | | **DHCS-MEDICAL FI** | | | | | | |
| 59 | 56 | MEDICAL FI OPERATIONS | $93,135,000 | $30,236,000 | $81,248,000 | $26,095,250 | ($11,887,000) | ($4,140,750) |
| 60 | 57 | MEDICAL FI COST REIMBURSEMENT | $35,664,000 | $10,301,500 | $41,090,000 | $10,830,150 | $5,426,000 | $528,650 |
| 61 | 58 | MEDICAL FI HOURLY REIMBURSEMENT | $27,546,000 | $5,986,500 | $27,546,000 | $5,986,500 | $0 | $0 |
| 62 | 59 | MEDICAL FI OTHER ESTIMATED COSTS | $11,280,000 | $3,270,000 | $11,280,000 | $3,270,000 | $0 | $0 |
| 64 | 60 | MEDICAL FI MISCELLANEOUS EXPENSES | $2,075,000 | $674,750 | $2,440,000 | $766,000 | $365,000 | $91,250 |
| 65 | 61 | MEDICAL FI CHANGE ORDERS | $515,000 | $128,750 | $464,000 | $116,000 | ($51,000) | ($12,750) |
| -- | 111 | MEDICAL FI SRP RELEASE 1 HOSTING | $0 | $0 | $7,042,000 | $1,023,700 | $7,042,000 | $1,023,700 |
| 66 | -- | MEDICAL FI OPTIONAL CONTRACTUAL SERVICES | $804,000 | $80,400 | $0 | $0 | ($804,000) | ($80,400) |
| | | **DHCS-MEDICAL FI SUBTOTAL** | **$171,019,000** | **$50,677,900** | **$171,110,000** | **$48,087,600** | **$91,000** | **($2,590,300)** |

# COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
# NOVEMBER 2017 ESTIMATE COMPARED TO APPROPRIATION
# FISCAL YEAR 2017-18

| MAY NO. | NOV. NO. | POLICY CHANGE TITLE | 2017-18 APPROPRIATION | | NOV. 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|---|
| | | | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | | **DHCS-HEALTH CARE OPT** | | | | | | |
| 68 | 63 | HCO COST REIMBURSEMENT | $44,849,000 | $21,571,400 | $44,189,000 | $21,254,320 | ($660,000) | ($317,080) |
| 69 | 64 | HCO OPERATIONS | $40,650,000 | $19,553,980 | $44,074,000 | $21,201,380 | $3,424,000 | $1,647,400 |
| 70 | 65 | HCO - ENROLLMENT CONTRACTOR COSTS | $16,518,000 | $7,945,120 | $17,990,000 | $8,653,380 | $1,472,000 | $708,260 |
| 71 | 66 | HCO ESR HOURLY REIMBURSEMENT | $14,318,000 | $6,886,920 | $15,580,000 | $7,493,980 | $1,262,000 | $607,060 |
| 72 | 67 | HCO CCI - CAL MEDICONNECT AND MLTSS | $14,200,000 | $7,100,000 | $15,269,000 | $7,634,500 | $1,069,000 | $534,500 |
| 73 | 68 | HCO TAKEOVER | $3,664,000 | $1,832,000 | $2,769,000 | $1,384,500 | ($895,000) | ($447,500) |
| 74 | 69 | HCO TURNOVER | $865,000 | $432,500 | $932,000 | $466,000 | $67,000 | $33,500 |
| | | **DHCS-HEALTH CARE OPT SUBTOTAL** | **$135,064,000** | **$65,321,920** | **$140,803,000** | **$68,088,060** | **$5,739,000** | **$2,766,140** |
| | | **DHCS-DENTAL FI** | | | | | | |
| 75 | 73 | DENTAL FI OPERATIONS | $52,000,000 | $17,250,000 | $68,813,000 | $22,755,750 | $16,813,000 | $5,505,750 |
| 76 | 74 | DENTAL NEW FI TAKEOVER | $15,616,000 | $3,904,000 | $23,424,000 | $5,856,000 | $7,808,000 | $1,952,000 |
| 87 | 75 | DENTAL ASO ADMINISTRATION | $18,953,000 | $6,827,500 | $12,700,000 | $4,642,750 | ($6,253,000) | ($2,184,750) |
| 77 | 76 | DENTAL FI HOURLY REIMBURSEMENT | $8,004,000 | $2,001,000 | $8,748,000 | $2,187,000 | $744,000 | $186,000 |
| 78 | 77 | DENTAL FI COST REIMBURSEMENT | $5,638,000 | $2,625,250 | $8,016,000 | $3,839,000 | $2,378,000 | $1,213,750 |
| 88 | 78 | DENTAL NEW FI ADMINISTRATION | $10,598,000 | $2,977,000 | $7,300,000 | $2,019,500 | ($3,298,000) | ($957,500) |
| 80 | 79 | DENTAL ASO TAKEOVER | $2,947,000 | $736,750 | $4,420,000 | $1,105,000 | $1,473,000 | $368,250 |
| 83 | 80 | DENTAL FI CD-MMIS COSTS | $2,196,000 | $549,000 | $2,331,000 | $582,750 | $135,000 | $33,750 |
| 79 | 81 | DENTAL BENEFICIARY OUTREACH & ED PROGRAM - ADMIN | $4,133,000 | $2,066,500 | $1,779,000 | $889,500 | ($2,354,000) | ($1,177,000) |
| 81 | 82 | DENTAL TREATMENT AUTHORIZATION REQUEST PROCESSING | $2,044,000 | $874,500 | $1,629,000 | $650,250 | ($415,000) | ($224,250) |
| 82 | 83 | DENTAL FI FEDERAL RULE - REVALIDATION | $210,000 | $105,000 | $254,000 | $127,000 | $44,000 | $22,000 |
| 84 | 84 | DENTAL FI FEDERAL RULE - DATABASE CHECKS | $175,000 | $87,500 | $227,000 | $113,500 | $52,000 | $26,000 |
| 86 | 85 | DENTAL FI CONLAN, SCHWARZMER, STEVENS V. BONTA | $134,000 | $67,000 | $179,000 | $89,500 | $45,000 | $22,500 |

# COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
# NOVEMBER 2017 ESTIMATE COMPARED TO APPROPRIATION
# FISCAL YEAR 2017-18

| MAY NO. | NOV. NO. | POLICY CHANGE TITLE | 2017-18 APPROPRIATION | | NOV. 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|---|
| | | | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | | **DHCS-DENTAL FI** | | | | | | |
| 85 | 86 | DENTAL FI HIPAA ADDENDUM SECURITY RISK ASSESSMENT | $137,000 | $34,250 | $174,000 | $43,500 | $37,000 | $9,250 |
| | | **DHCS-DENTAL FI SUBTOTAL** | **$122,785,000** | **$40,105,250** | **$139,994,000** | **$44,901,000** | **$17,209,000** | **$4,795,750** |
| | | **OTHER DEPARTMENTS** | | | | | | |
| 89 | 87 | PERSONAL CARE SERVICES | $371,080,000 | $0 | $421,326,000 | $0 | $50,246,000 | $0 |
| 90 | 88 | HEALTH-RELATED ACTIVITIES - CDSS | $277,756,000 | $0 | $299,589,000 | $0 | $21,833,000 | $0 |
| 91 | 89 | CALHEERS DEVELOPMENT | $120,477,000 | $23,413,020 | $125,682,000 | $26,008,790 | $5,205,000 | $2,595,770 |
| 92 | 90 | CDDS ADMINISTRATIVE COSTS | $57,301,000 | $0 | $52,239,000 | $0 | ($5,062,000) | $0 |
| 94 | 91 | MATERNAL AND CHILD HEALTH | $35,201,000 | $0 | $35,201,000 | $0 | $0 | $0 |
| 95 | 92 | HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN | $29,829,000 | $0 | $29,829,000 | $0 | $0 | $0 |
| 93 | 93 | DEPARTMENT OF SOCIAL SERVICES ADMIN COST | $28,553,000 | $0 | $37,029,000 | $0 | $8,476,000 | $0 |
| 96 | 94 | FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS | $14,645,000 | $0 | $15,145,000 | $0 | $500,000 | $0 |
| 97 | 95 | ACA OUTREACH AND ENROLLMENT COUNSELORS | $11,711,000 | $0 | $11,442,000 | $0 | ($269,000) | $0 |
| 98 | 96 | CLPP CASE MANAGEMENT SERVICES | $4,200,000 | $0 | $5,355,000 | $0 | $1,155,000 | $0 |
| 99 | 97 | DEPARTMENT OF AGING ADMINISTRATIVE COSTS | $4,116,000 | $0 | $4,093,000 | $0 | ($23,000) | $0 |
| 101 | 98 | VITAL RECORDS DATA | $961,000 | $0 | $1,668,000 | $0 | $707,000 | $0 |
| 100 | 99 | CALIFORNIA SMOKERS' HELPLINE | $1,000,000 | $0 | $1,321,000 | $0 | $321,000 | $0 |
| 102 | 100 | KIT FOR NEW PARENTS | $1,119,000 | $0 | $1,119,000 | $0 | $0 | $0 |
| 103 | 101 | VETERANS BENEFITS | $956,000 | $0 | $1,100,000 | $0 | $144,000 | $0 |
| 105 | 102 | CHHS AGENCY HIPAA FUNDING | $849,000 | $0 | $849,000 | $0 | $0 | $0 |
| 106 | 103 | MEDI-CAL INPATIENT SERVICES FOR INMATES | $813,000 | $0 | $813,000 | $0 | $0 | $0 |
| 104 | 104 | CDPH I&E PROGRAM AND EVALUATION | $558,000 | $0 | $752,000 | $0 | $194,000 | $0 |

# COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
# NOVEMBER 2017 ESTIMATE COMPARED TO APPROPRIATION
# FISCAL YEAR 2017-18

| MAY NO. | NOV. NO. | POLICY CHANGE TITLE | 2017-18 APPROPRIATION | | NOV. 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|---|
| | | | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | | **OTHER DEPARTMENTS** | | | | | | |
| 107 | 105 | MERIT SYSTEM SERVICES FOR COUNTIES | $194,000 | $97,000 | $194,000 | $97,000 | $0 | $0 |
| 108 | 106 | CDDS DENTAL SERVICES - ADMIN | $120,000 | $0 | $62,000 | $0 | ($58,000) | $0 |
| 109 | 107 | PIA EYEWEAR COURIER SERVICE | $341,000 | $170,500 | $341,000 | $170,500 | $0 | $0 |
| | | **OTHER DEPARTMENTS SUBTOTAL** | **$961,780,000** | **$23,680,520** | **$1,045,149,000** | **$26,276,290** | **$83,369,000** | **$2,595,770** |
| | | **OTHER ADMINISTRATION TOTAL** | **$2,726,128,000** | **$351,508,260** | **$2,607,494,000** | **$413,535,690** | **($118,634,000)** | **$62,027,430** |
| | | **GRAND TOTAL COUNTY AND OTHER ADMINISTRATION** | **$4,997,575,000** | **$1,115,098,760** | **$4,876,682,000** | **$1,191,716,690** | **($120,893,000)** | **$76,617,930** |

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

| | | NOV. 2017 EST. FOR 2017-18 | | NOV. 2017 EST. FOR 2018-19 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | **DHCS-OTHER** | | | | | | |
| 1 | SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES | $268,836,000 | $53,242,000 | $258,096,000 | $163,399,000 | ($10,740,000) | $110,157,000 |
| 2 | CCS CASE MANAGEMENT | $194,938,000 | $66,662,460 | $183,544,000 | $60,137,620 | ($11,394,000) | ($6,524,840) |
| 3 | MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS | $119,816,000 | $0 | $0 | $0 | ($119,816,000) | $0 |
| 4 | COUNTY SPECIALTY MENTAL HEALTH ADMIN | $103,229,000 | $0 | $106,250,000 | $0 | $3,021,000 | $0 |
| 5 | COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES | $100,730,000 | $11,000 | $77,066,000 | $0 | ($23,664,000) | ($11,000) |
| 6 | EPSDT CASE MANAGEMENT | $33,962,000 | $12,115,250 | $33,962,000 | $12,115,250 | $0 | $0 |
| 7 | OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS | $30,197,000 | $6,467,560 | $35,601,000 | $9,190,840 | $5,404,000 | $2,723,280 |
| 8 | SMH MAA | $29,094,000 | $0 | $32,293,000 | $0 | $3,199,000 | $0 |
| 9 | ARRA HITECH INCENTIVE PROGRAM | $25,525,000 | $0 | $11,276,000 | $0 | ($14,249,000) | $0 |
| 10 | MANAGED CARE REGULATIONS - MENTAL HEALTH | $24,005,000 | $8,000,000 | $22,757,000 | $7,584,000 | ($1,248,000) | ($416,000) |
| 11 | SMHS COUNTY UR & QA ADMIN | $23,773,000 | $348,000 | $26,162,000 | $948,000 | $2,389,000 | $600,000 |
| 12 | PERFORMANCE OUTCOMES SYSTEM | $13,783,000 | $6,227,000 | $16,137,000 | $6,953,250 | $2,354,000 | $726,250 |
| 13 | PAVE SYSTEM | $20,588,000 | $7,879,600 | $15,988,000 | $7,129,300 | ($4,600,000) | ($750,300) |
| 14 | POSTAGE & PRINTING | $20,586,000 | $10,421,000 | $21,586,000 | $10,921,000 | $1,000,000 | $500,000 |
| 15 | ACTUARIAL COSTS FOR RATE DEVELOPMENT | $16,872,000 | $8,119,000 | $16,872,000 | $8,119,000 | $0 | $0 |
| 16 | PASRR | $12,200,000 | $3,050,000 | $12,706,000 | $3,176,500 | $506,000 | $126,500 |
| 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 | $10,790,000 | $1,977,050 | $9,077,000 | $2,086,250 | ($1,713,000) | $109,200 |
| 20 | MEDI-CAL RECOVERY CONTRACTS | $10,187,000 | $2,546,750 | $9,884,000 | $2,471,000 | ($303,000) | ($75,750) |
| 21 | LITIGATION RELATED SERVICES | $9,980,000 | $4,990,000 | $9,980,000 | $4,990,000 | $0 | $0 |
| 22 | NEWBORN HEARING SCREENING PROGRAM | $8,845,000 | $4,422,500 | $7,825,000 | $3,912,500 | ($1,020,000) | ($510,000) |
| 23 | HIPAA CAPITATION PAYMENT REPORTING SYSTEM | $7,094,000 | $1,773,500 | $5,488,000 | $1,372,000 | ($1,606,000) | ($401,500) |

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

| | | NOV. 2017 EST. FOR 2017-18 | | NOV. 2017 EST. FOR 2018-19 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | **DHCS-OTHER** | | | | | | |
| 24 | DMC COUNTY UR & QA ADMIN | $6,278,000 | $0 | $15,934,000 | $0 | $9,656,000 | $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 | $3,531,000 | $409,350 | $2,130,000 | $288,000 | ($1,401,000) | ($121,350) |
| 27 | DRUG MEDI-CAL COUNTY ADMINISTRATION | $3,248,000 | $0 | $3,248,000 | $0 | $0 | $0 |
| 28 | MEDICARE BENEFICIARY IDENTIFIER | $2,618,000 | $261,800 | $1,578,000 | $157,800 | ($1,040,000) | ($104,000) |
| 29 | ELECTRONIC ASSET VERIFICATION PROGRAM | $2,416,000 | $1,208,000 | $3,328,000 | $1,664,000 | $912,000 | $456,000 |
| 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 | $2,206,000 | $220,600 | $2,733,000 | $273,300 | $527,000 | $52,700 |
| 33 | MEDS MODERNIZATION | $2,015,000 | $266,750 | $0 | $0 | ($2,015,000) | ($266,750) |
| 34 | SSA COSTS FOR HEALTH COVERAGE INFO. | $1,600,000 | $800,000 | $1,500,000 | $750,000 | ($100,000) | ($50,000) |
| 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. | $734,000 | $367,000 | $708,000 | $354,000 | ($26,000) | ($13,000) |
| 41 | IRS REPORTING FOR MIN. ESSENTIAL COVERAGE | $592,000 | $296,000 | $432,000 | $216,000 | ($160,000) | ($80,000) |
| 42 | ETL DATA SOLUTION | $431,000 | $107,750 | $270,000 | $67,500 | ($161,000) | ($40,250) |
| 43 | VENDOR FOR AAC RATE STUDY | $390,000 | $195,000 | $327,000 | $163,500 | ($63,000) | ($31,500) |
| 44 | CCT OUTREACH - ADMINISTRATIVE COSTS | $342,000 | $0 | $342,000 | $0 | $0 | $0 |
| 45 | MEDICARE BUY-IN QUALITY REVIEW PROJECT | $200,000 | $100,000 | $200,000 | $100,000 | $0 | $0 |
| 46 | STATE CONTROLLER'S OFFICE INTERAGENCY AGREEMENT | $173,000 | $43,250 | $0 | $0 | ($173,000) | ($43,250) |
| 47 | DENTAL PAPD PROJECT MANAGER | $125,000 | $31,250 | $0 | $0 | ($125,000) | ($31,250) |

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

| | | NOV. 2017 EST. FOR 2017-18 | | NOV. 2017 EST. FOR 2018-19 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | **DHCS-OTHER** | | | | | | |
| 48 | CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT | $100,000 | $0 | $100,000 | $0 | $0 | $0 |
| 49 | TAR POSTAGE | $52,000 | $26,000 | $52,000 | $26,000 | $0 | $0 |
| 50 | ENROLLMENT ASSIST FOR BHT INSTITUTIONALLY DEEMED | $43,000 | $21,500 | $0 | $0 | ($43,000) | ($21,500) |
| 54 | TITLE XXI FEDERAL MATCH REDUCTION OTHER ADMIN | ($3,099,000) | $9,764,570 | ($3,574,000) | $12,286,060 | ($475,000) | $2,521,490 |
| 55 | INTERIM AND FINAL COST SETTLEMENTS-SMHS | ($35,823,000) | $0 | $0 | $0 | $35,823,000 | $0 |
| 109 | MANAGED CARE REGULATIONS - MH PARITY | $0 | $0 | $21,284,000 | $3,040,000 | $21,284,000 | $3,040,000 |
| | **DHCS-OTHER SUBTOTAL** | **$1,110,438,000** | **$226,182,740** | **$999,520,000** | **$337,614,720** | **($110,918,000)** | **$111,431,980** |
| | **DHCS-MEDICAL FI** | | | | | | |
| 56 | MEDICAL FI OPERATIONS | $81,248,000 | $26,095,250 | $79,177,000 | $25,369,500 | ($2,071,000) | ($725,750) |
| 57 | MEDICAL FI COST REIMBURSEMENT | $41,090,000 | $10,830,150 | $36,004,000 | $10,404,750 | ($5,086,000) | ($425,400) |
| 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 | $11,280,000 | $3,270,000 | $11,280,000 | $3,270,000 | $0 | $0 |
| 60 | MEDICAL FI MISCELLANEOUS EXPENSES | $2,440,000 | $766,000 | $2,440,000 | $766,000 | $0 | $0 |
| 61 | MEDICAL FI CHANGE ORDERS | $464,000 | $116,000 | $523,000 | $130,750 | $59,000 | $14,750 |
| 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 |
| | **DHCS-MEDICAL FI SUBTOTAL** | **$171,110,000** | **$48,087,600** | **$167,099,000** | **$47,324,100** | **($4,011,000)** | **($763,500)** |
| | **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 | $44,074,000 | $21,201,380 | $13,686,000 | $6,583,840 | ($30,388,000) | ($14,617,540) |
| 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) |

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

| | | NOV. 2017 EST. FOR 2017-18 | | NOV. 2017 EST. FOR 2018-19 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | **DHCS-HEALTH CARE OPT** | | | | | | |
| 68 | HCO TAKEOVER | $2,769,000 | $1,384,500 | $5,231,000 | $2,615,500 | $2,462,000 | $1,231,000 |
| 69 | HCO TURNOVER | $932,000 | $466,000 | $2,564,000 | $1,282,000 | $1,632,000 | $816,000 |
| 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 | $9,248,000 | $4,448,440 | $9,248,000 | $4,448,440 |
| | **DHCS-HEALTH CARE OPT SUBTOTAL** | **$140,803,000** | **$68,088,060** | **$114,564,000** | **$55,345,140** | **($26,239,000)** | **($12,742,920)** |
| | **DHCS-DENTAL FI** | | | | | | |
| 73 | DENTAL FI OPERATIONS | $68,813,000 | $22,755,750 | $0 | $0 | ($68,813,000) | ($22,755,750) |
| 74 | DENTAL NEW FI TAKEOVER | $23,424,000 | $5,856,000 | $5,856,000 | $1,464,000 | ($17,568,000) | ($4,392,000) |
| 75 | DENTAL ASO ADMINISTRATION | $12,700,000 | $4,642,750 | $35,620,000 | $13,168,500 | $22,920,000 | $8,525,750 |
| 76 | DENTAL FI HOURLY REIMBURSEMENT | $8,748,000 | $2,187,000 | $0 | $0 | ($8,748,000) | ($2,187,000) |
| 77 | DENTAL FI COST REIMBURSEMENT | $8,016,000 | $3,839,000 | $0 | $0 | ($8,016,000) | ($3,839,000) |
| 78 | DENTAL NEW FI ADMINISTRATION | $7,300,000 | $2,019,500 | $18,788,000 | $4,973,500 | $11,488,000 | $2,954,000 |
| 79 | DENTAL ASO TAKEOVER | $4,420,000 | $1,105,000 | $1,105,000 | $276,250 | ($3,315,000) | ($828,750) |
| 80 | DENTAL FI CD-MMIS COSTS | $2,331,000 | $582,750 | $0 | $0 | ($2,331,000) | ($582,750) |
| 81 | DENTAL BENEFICIARY OUTREACH & ED PROGRAM - ADMIN | $1,779,000 | $889,500 | $1,781,000 | $890,500 | $2,000 | $1,000 |
| 82 | DENTAL TREATMENT AUTHORIZATION REQUEST PROCESSING | $1,629,000 | $650,250 | $0 | $0 | ($1,629,000) | ($650,250) |
| 83 | DENTAL FI FEDERAL RULE - REVALIDATION | $254,000 | $127,000 | $0 | $0 | ($254,000) | ($127,000) |
| 84 | DENTAL FI FEDERAL RULE - DATABASE CHECKS | $227,000 | $113,500 | $0 | $0 | ($227,000) | ($113,500) |
| 85 | DENTAL FI CONLAN, SCHWARZMER, STEVENS V. BONTA | $179,000 | $89,500 | $0 | $0 | ($179,000) | ($89,500) |
| 86 | DENTAL FI HIPAA ADDENDUM SECURITY RISK ASSESSMENT | $174,000 | $43,500 | $0 | $0 | ($174,000) | ($43,500) |
| | **DHCS-DENTAL FI SUBTOTAL** | **$139,994,000** | **$44,901,000** | **$63,150,000** | **$20,772,750** | **($76,844,000)** | **($24,128,250)** |

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

| | | NOV. 2017 EST. FOR 2017-18 | | NOV. 2017 EST. FOR 2018-19 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | **OTHER DEPARTMENTS** | | | | | | |
| 87 | PERSONAL CARE SERVICES | $421,326,000 | $0 | $382,359,000 | $0 | ($38,967,000) | $0 |
| 88 | HEALTH-RELATED ACTIVITIES - CDSS | $299,589,000 | $0 | $299,700,000 | $0 | $111,000 | $0 |
| 89 | CALHEERS DEVELOPMENT | $125,682,000 | $26,008,790 | $126,267,000 | $26,135,040 | $585,000 | $126,250 |
| 90 | CDDS ADMINISTRATIVE COSTS | $52,239,000 | $0 | $51,378,000 | $0 | ($861,000) | $0 |
| 91 | MATERNAL AND CHILD HEALTH | $35,201,000 | $0 | $37,522,000 | $0 | $2,321,000 | $0 |
| 92 | HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN | $29,829,000 | $0 | $29,829,000 | $0 | $0 | $0 |
| 93 | DEPARTMENT OF SOCIAL SERVICES ADMIN COST | $37,029,000 | $0 | $36,257,000 | $0 | ($772,000) | $0 |
| 94 | FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS | $15,145,000 | $0 | $14,945,000 | $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 | $1,668,000 | $0 | $874,000 | $0 | ($794,000) | $0 |
| 99 | CALIFORNIA SMOKERS' HELPLINE | $1,321,000 | $0 | $2,200,000 | $0 | $879,000 | $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 | $752,000 | $0 | $827,000 | $0 | $75,000 | $0 |
| 105 | MERIT SYSTEM SERVICES FOR COUNTIES | $194,000 | $97,000 | $194,000 | $97,000 | $0 | $0 |
| 106 | CDDS DENTAL SERVICES - ADMIN | $62,000 | $0 | $0 | $0 | ($62,000) | $0 |
| 107 | PIA EYEWEAR COURIER SERVICE | $341,000 | $170,500 | $341,000 | $170,500 | $0 | $0 |

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

| | | NOV. 2017 EST. FOR 2017-18 | | NOV. 2017 EST. FOR 2018-19 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | OTHER DEPARTMENTS SUBTOTAL | $1,045,149,000 | $26,276,290 | $995,053,000 | $26,402,540 | ($50,096,000) | $126,250 |
| | OTHER ADMINISTRATION TOTAL | $2,607,494,000 | $413,535,690 | $2,339,386,000 | $487,459,250 | ($268,108,000) | $73,923,560 |
| | GRAND TOTAL COUNTY AND OTHER ADMINISTRATION | $4,876,682,000 | $1,191,716,690 | $4,697,397,000 | $1,200,398,750 | ($179,285,000) | $8,682,060 |

# MEDI-CAL OTHER ADMINISTRATION
# POLICY CHANGE INDEX

| POLICY CHANGE NUMBER | POLICY CHANGE TITLE |
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| 2 | CCS CASE MANAGEMENT |
| 3 | MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS |
| 4 | COUNTY 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


| POLICY CHANGE NUMBER | POLICY CHANGE TITLE |
|---|---|
| | **DHCS-OTHER** |
| 39 | ENCRYPTION OF PHI DATA |
| 40 | POSTAGE AND PRINTING - THIRD PARTY LIAB. |
| 41 | IRS REPORTING FOR MIN. ESSENTIAL COVERAGE |
| 42 | ETL DATA SOLUTION |
| 43 | VENDOR FOR AAC RATE STUDY |
| 44 | CCT OUTREACH - ADMINISTRATIVE COSTS |
| 45 | MEDICARE BUY-IN QUALITY REVIEW PROJECT |
| 46 | STATE CONTROLLER'S OFFICE INTERAGENCY AGREEMENT |
| 47 | DENTAL PAPD PROJECT MANAGER |
| 48 | CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT |
| 49 | TAR POSTAGE |
| 50 | ENROLLMENT ASSIST FOR BHT INSTITUTIONALLY DEEMED |
| 54 | TITLE XXI FEDERAL MATCH REDUCTION OTHER ADMIN |
| 55 | INTERIM AND FINAL COST SETTLEMENTS-SMHS |
| 109 | MANAGED CARE REGULATIONS - MH PARITY |
| | **DHCS-MEDICAL FI** |
| 56 | MEDICAL FI OPERATIONS |
| 57 | MEDICAL FI COST REIMBURSEMENT |
| 58 | MEDICAL FI HOURLY REIMBURSEMENT |
| 59 | MEDICAL FI OTHER ESTIMATED COSTS |
| 60 | MEDICAL FI MISCELLANEOUS EXPENSES |
| 61 | MEDICAL FI CHANGE ORDERS |
| 62 | MEDICAL FI OPTIONAL CONTRACTUAL SERVICES |
| 111 | MEDICAL FI SRP RELEASE 1 HOSTING |
| | **DHCS-HEALTH CARE OPT** |
| 63 | HCO COST REIMBURSEMENT |
| 64 | HCO OPERATIONS |
| 65 | HCO - ENROLLMENT CONTRACTOR COSTS |
| 66 | HCO ESR HOURLY REIMBURSEMENT |
| 67 | HCO CCI - CAL MEDICONNECT AND MLTSS |
| 68 | HCO TAKEOVER |
| 69 | HCO TURNOVER |
| 70 | HCO OPERATIONS 2017 CONTRACT |
| 71 | HCO COST REIMBURSEMENT 2017 CONTRACT |
| 72 | HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT |

# MEDI-CAL OTHER ADMINISTRATION
# POLICY CHANGE INDEX


| POLICY CHANGE NUMBER | POLICY CHANGE TITLE |
|---|---|
| | **DHCS-DENTAL FI** |
| 73 | DENTAL FI OPERATIONS |
| 74 | DENTAL NEW FI TAKEOVER |
| 75 | DENTAL ASO ADMINISTRATION |
| 76 | DENTAL FI HOURLY REIMBURSEMENT |
| 77 | DENTAL FI COST REIMBURSEMENT |
| 78 | DENTAL NEW FI ADMINISTRATION |
| 79 | DENTAL ASO TAKEOVER |
| 80 | DENTAL FI CD-MMIS COSTS |
| 81 | DENTAL BENEFICIARY OUTREACH & ED PROGRAM - ADMIN |
| 82 | DENTAL TREATMENT AUTHORIZATION REQUEST PROCESSING |
| 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 | $268,836,000 | $258,096,000 |
| STATE FUNDS | $53,242,000 | $163,399,000 |
| FEDERAL FUNDS | $215,594,000 | $94,697,000 |

## 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 the delay in completing backcasting for FY 2011-12, FY 2012-13, FY 2013-14, and FY 2014-15 to FY 2018-19. In addition, the backcasting payments are now budgeted as federal fund repayments to CMS with a General Fund (GF) impact. Furthermore, the FY 2014-15 recoupments, updated FY 2015-16 payments, and remaining invoice claims were also included in the FY 2017-18 payments.

# SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES

## OTHER ADMIN. POLICY CHANGE NUMBER: 1

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to increased backcasting 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 Q1-Q4 RMTS invoice amounts which are based on FY 2011-12 original invoice amounts, plus an additional increase of a 50% RMTS adjustment factor* added to each quarter;
    - Remaining invoice claims for FY 2009-10 through FY 2011-12; and
    - The backcasting amounts for FY 2009-10 through FY 2010-11, 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.
2. The FY 2018-19 estimate includes:
    - The FY 2016-17 RMTS invoice amounts which are based on FY 2011-12 invoice amounts, plus an additional increase of a 50% RMTS adjustment factor* added to each quarter; and
    - 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.
3. Interim settlement amounts are being used for this estimate because they are the best fiscal representation of backcasted invoice amounts. The SMAA Manual was approved by CMS on October 31, 2016, and includes final approval of all of the codes necessary to complete the coding for backcasting quarters. All four quarters of backcasting invoices will be received by the Department before September 30, 2017 at which time adjustments will be made to the RMTS adjustment factor.

*RMTS adjustment factor – Determining reimbursement under the new RMTS methodology is based on a combination of percentage of time or moments and the total number of personnel and their associated costs included in the cost pool. Although many school districts' invoice claiming amounts will increase due to an increase in the number of eligible personnel that will be included in the cost pools for each district under the new RMTS methodology, some school districts' claiming amounts will not change or will decrease, due to a reduction in the amount of time allocated to the district and/or the

# SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES

**OTHER ADMIN. POLICY CHANGE NUMBER: 1**

limited number of personnel employed at smaller school districts. The Department's experience with the Los Angeles Unified School District (LAUSD), which was the first district to transition to RMTS, indicate that their claim amounts increased by 100% once the district switched from a worker-log based methodology to the RMTS methodology. This was largely the result of the addition of an increased number of eligible personnel (and their associated costs) being added to the cost pool. However, even though LAUSD's claim amounts increased with the implementation of RMTS, other LEA claim amounts will increase or decrease under the RMTS methodology. Currently, there are no identifiable measures of determining whether other LEA claims will increase or decrease until four (4) quarters of RMTS claims data is available and LEAs begin to submit their RMTS claims. Therefore, rather than setting a 100% increase in claiming under RMTS, as occurred for LAUSD, the Department opted to estimate a 50% overall increase.

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| FY 2014-15 Recoupment | ($708,000) | $0 | ($708,000) |
| FY 2015-16 | $258,096,000 | $0 | $258,096,000 |
| FY 2009-10 through FY 2011-12 Remaining Invoice Claims | $11,448,000 | $0 | $11,448,000 |
| Backcasting FY 2009-10 | $0 | $7,643,000 | ($7,643,000) |
| Backcasting FY 2010-11 | $0 | $45,599,000 | ($45,599,000) |
| **Total** | **$268,836,000** | **$53,242,000** | **$215,594,000** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| FY 2016-17 | $258,096,000 | $0 | $258,096,000 |
| Backcasting FY 2011-12 | $0 | $76,905,000 | ($76,905,000) |
| Backcasting FY 2012-13 | $0 | $42,844,000 | ($42,844,000) |
| Backcasting FY 2013-14 | $0 | $29,291,000 | ($29,291,000) |
| Backcasting 2014-15 Q1 and Q2 | $0 | $14,359,000 | ($14,359,000) |
| **Total** | **$258,096,000** | **$163,399,000** | **$94,697,000** |

**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 | $183,544,000 |
| STATE FUNDS | $66,662,460 | $60,137,620 |
| FEDERAL FUNDS | $128,275,540 | $123,406,380 |

## 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.

The Health Plan of San Mateo is paid 70% of the total San Mateo County Case Management Allocation and the County of San Mateo retains 30% of the Case Management allocation for FY 2016-17 and then the County and HPSM both transition into the Whole Child Model participation July 1, 2018.

Starting no sooner that 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:**
The change from the prior estimate, for FY 2017-18, is a decrease due to updated CMS Net amounts and PPC cost adjustments.

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.

Phase One of the implementation process of the Whole-Child Model is scheduled to begin no sooner than July 1, 2018 in five of the twenty designated COHS counties Phase Two is scheduled to begin no

# CCS CASE MANAGEMENT

## OTHER ADMIN. POLICY CHANGE NUMBER: 2

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.

The CCS Medi-Cal administrative costs for the designated COHS counties participating in the Whole-Child Model will reduce to 30% to reflect the reduction in administrative functions moving to the COHS health plans. The remaining 70% will be incorporated into the capitated rate for the health plans participating in the Whole-Child Model

**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 1.79% from FY 2017-18 to FY 2018-19.

   $158,651,000 x (1 + 1.79%) = $161,491,000

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

# CCS CASE MANAGEMENT

## OTHER ADMIN. POLICY CHANGE NUMBER: 2

$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.

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. Both CY and BY payments include a net 12 months of cost.

FY 2017-18: ($2,412,000) TF
FY 2018-19: ($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 the existing managed care COHS. Payments to the COHS under the Whole Child Model will be applied against CCS Case Management. All June payments are made in July. Payments include a net 12 months of cost.

FY 2018-19: ($16,134,000) TF

11. 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.

12. 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.

# CCS CASE MANAGEMENT

## OTHER ADMIN. POLICY CHANGE NUMBER: 2

| 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 | $166,195,000 | $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 |

| FY 2018-19 | | | | |
|---|---|---|---|---|
| CCS Medi-Cal | TF | GF | FF | CF* |
| CCS Case Management | $161,493,000 | $60,839,000 | $100,654,000 | |
| 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 | $170,941,000 | $64,476,000 | $106,465,000 | |
| | | | | |
| 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 | ($2,412,000) | ($1,206,000) | ($1,206,000) | |
| WCM Implementation | ($16,134,000) | ($8,067,000) | ($8,067,000) | |
| **Total** | **$183,544,000** | **$60,138,000** | **$123,406,000** | $966,000 |

* County Funds are not included in the Total Fund

# CCS CASE MANAGEMENT

## OTHER ADMIN. POLICY CHANGE NUMBER: 2

**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) | $65,244,000 | $32,622,000 | $32,622,000 | |
| 75% Title XIX / 25% GF (4260-101-0001/0890) | $101,838,000 | $25,460,000 | $76,378,000 | |
| 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** | **$183,544,000** | **$60,138,000** | **$123,406,000** | $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: | 7/2017 |
| ANALYST: | Jedidiah Warren |
| FISCAL REFERENCE NUMBER: | 1589 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| TOTAL FUNDS | $119,816,000 | $0 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $119,816,000 | $0 |

## DESCRIPTION

**Purpose:**
This policy change estimates federal funds for the administrative costs associated with the Health Care Coverage Initiative (HCCI) under the Medi-Cal/Uninsured Care Demonstration (MH/UCD) and the Low Income Health Program (LIHP) under the California Bridge to Reform (BTR) Demonstration.

**Authority:**
AB 342 (Chapter 723, Statutes of 2010)
AB 1066 (Chapter 86, Statutes of 2011)
California Bridge to Reform Section 1115(a) Medicaid Demonstration

**Interdependent Policy Changes:**
Not Applicable

**Background:**
Under the MH/UCD, $180 million in federal funds was available annually under the Safety Net Care Pool (SNCP) to expand health coverage to eligible low-income, uninsured persons for Demonstration Year (DY) 2007-08 through 2009-10. The federal funds available will reimburse the HCCI. The HCCI was replaced by the LIHP, effective November 1, 2010 through December 31, 2013, which consisted of two components, the Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). The MCE covered eligibles with family incomes at or below 133% of the Federal Poverty Level (FPL). The HCCI covered those with family incomes above 133% through 200% of the FPL. Both were statewide county elective programs. The LIHP HCCI replaced the Coverage Initiative (CI) under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD) which was extended until October 31, 2010. AB 342 and AB 1066 authorized local LIHPs to provide health care services to eligible individuals.

The Centers for Medicare and Medicaid Services (CMS) provided uncapped federal funds to the local LIHPs at an amount equal to the regular Federal Medical Assistance Percentage (50%) for their administrative costs associated with the start-up, implementation, and close out administration of their approved LIHPs. The Department will use Certified Public Expenditures (CPEs) of the local government administrative costs to draw down federal funds and will distribute these funds to the local governments. The Department used the HCCI administrative activities cost claiming protocol for the HCCI under the MH/UCD, as the basis for providing reimbursement for the allowable administrative costs incurred from November 1, 2010 through September 30, 2011, as permitted by the Special Terms and Conditions for the Section 1115(a) BTR Demonstration. The Department received CMS approval of the BTR-LIHP administrative cost claiming protocol and time study on December 12, 2013.

# MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS

## OTHER ADMIN. POLICY CHANGE NUMBER: 3

**Reason for Change:**
There is no change from the prior estimate for FY 2017-18. 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 2018-19.

**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 2017-18 | 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 2017-18** | **$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 | $103,229,000 | $106,250,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $103,229,000 | $106,250,000 |

## 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, is a decrease due to:

- Updated base year expenditures from FY 2013-14 to FY 2014-15,
- Updated growth trends applied to the FY 2016-17 and FY 2017-18 accrual years,
- Updated payment lag factors based on more recent historical claims, and
- Foster Family Agency (FFA) costs were removed from this policy change to the SMHS County UR & QA Admin policy change to correctly categorize FFA costs.

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.

**Methodology:**
1. Mental Health administration costs are based on historical claims payment data. The costs on an accrual basis for MC and CHIP are:

# COUNTY SPECIALTY MENTAL HEALTH ADMIN

## OTHER ADMIN. POLICY CHANGE NUMBER: 4

(Dollars in Thousands)

| Fiscal Year | MC | CHIP | Total |
|---|---|---|---|
| FY 2015-16 | $186,157 | $6,999 | $193,156 |
| FY 2016-17 | $193,418 | $7,272 | $200,690 |
| FY 2017-18 | $198,833 | $7,476 | $206,309 |
| FY 2018-19 | $204,202 | $7,677 | $211,879 |

2. Based on historical claims received, assume 19% of each fiscal year claims will be paid in the year the services occur, 71% is paid in the following year, and 10% in the third year.

(Dollars in Thousands)

| Fiscal Year | Accrual | FY 2017-18 | FY 2018-19 |
|---|---|---|---|
| MC | $186,157 | $18,616 | $0 |
| CHIP | $6,999 | $700 | $0 |
| FY 2015-16 | $193,156 | $19,316 | $0 |
| | | | |
| MC | $193,418 | $137,326 | $19,342 |
| CHIP | $7,272 | $5,163 | $727 |
| FY 2016-17 | $200,690 | $142,489 | $20,069 |
| | | | |
| MC | $198,833 | $37,779 | $141,172 |
| CHIP | $7,476 | $1,420 | $5,308 |
| FY 2017-18 | $206,309 | $39,199 | $146,480 |
| | | | |
| MC | $204,202 | $0 | $38,798 |
| CHIP | $7,677 | $0 | $1,459 |
| FY 2018-19 | $211,879 | $0 | $40,257 |
| Total | | $201,004 | $206,806 |

**3.** 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 | $193,721 | $96,860 | $96,861 | $199,312 | $99,656 | $99,656 |
| CHIP* | $7,283 | $6,369 | $914 | $7,494 | $6,594 | $900 |
| **Total** | $201,004 | **$103,229** | $97,775 | $206,806 | **$106,250** | $100,556 |

**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 | $100,730,000 | $77,066,000 |
| STATE FUNDS | $11,000 | $0 |
| FEDERAL FUNDS | $100,719,000 | $77,066,000 |

## 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 $9,100,000 to $3,522,000 for the resubmitted multiple actual client count/county-wide average percentage FY 2013-14 and FY 2014-15 CMAA invoices.
- Including General Funds to pay for a CMAA FY 2014-15 Q3 invoice,
- An increase in the FY 2015-16 estimated CMAA reimbursement amount,

# COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

## OTHER ADMIN. POLICY CHANGE NUMBER: 5

- The inclusion of FY 2016-17 Q1 CMAA invoice payments, and
- A decrease in the program growth factor from 9% to 6.25%.

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,
- Estimating a greater amount of CMAA backcasting recoupments will be received in FY 2018-19 than in FY 2017-18, and
- Estimating that the total amount of CMAA invoices paid in FY 2018-19 will be lower than in FY 2017-18.

**Methodology:**
**County Medi-Cal Administrative Activities**

1. On September 2016, the Department requested CMS approval to use multiple Medi-Cal discount percentages retroactive to FY 2013-14. Some allowable administrative activities can only be reimbursed based on the number of people served within a group that are Medi-Cal beneficiaries; this number is the Medi-Cal discount percentage. The Department anticipates CMS approval in FY 2017-18. 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 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 General Fund (GF) for $11,000 for a FY 2014-15 Q3 invoice that exceeded the two-year claiming limit;
   - The FY 2015-16 claims estimate are based on claims for FY 2015-16 Q1 and Q2;
   - The FY 2016-17 Q1 claims are estimated to be paid in FY 2017-18;
   - The FY 2016-17 invoice base payments assumes a 6.25% growth factor, based on the average growth from FY 2012-13 to FY 2015-16.

   Estimated CMAA FY 2015-16: $38,010,500 (Q1 and Q2) x 2 = $76,021,000

   Estimated CMAA FY 2016-17: $76,021,000 + 6.25% growth factor = $80,771,000

| CMAA FY 2017-18 Estimated Payments | |
|---|---|
| FY 2010-11 Backcasting Payment | $7,802,000 |
| FY 2010-11 Backcasting Recoupment | ($8,413,000) |
| FY 2011-12 Backcasting Payment | $7,994,000 |
| FY 2011-12 Q1 Backcasting Recoupment | ($1,999,000) |
| FY 2013-14 | $2,393,000 |
| FY 2014-15 | $1,118,000 |
| FY 2014-15 (GF) | $11,000 |
| FY 2015-16 | $70,401,000 |
| FY 2016-17 Q1 | $20,193,000 |
| **Total** | **$99,500,000** |

# 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, and all remaining backcasting claims. In addition, it is estimated that all remaining backcasting recoupments will be received. FY 2017-18 base payments assumes a 6.25% growth factor based on the average growth from FY 2012-13 to FY 2015-16.

   Estimated CMAA FY 2017-18: $80,771,000 + 6.25% growth factor = $85,818,000

| CMAA FY 2018-19 Estimated Payments | |
|---|---|
| FY 2011-12 Q2-Q4 Backcasting Recoupment | ($5,998,000) |
| FY 2012-13 Backcasting Payment | $7,906,000 |
| FY 2012-13 Backcasting Recoupment | ($7,978,000) |
| FY 2016-17 Q2-Q4 | $60,578,000 |
| FY 2017-18 Q1 | $21,455,000 |
| **Total** | **$75,963,000** |

**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-Q3 claims. The FY 2016-17 estimated base payments assumes a 6.25% growth, based on the average growth from FY 2012-13 to FY 2015-16.

   TMAA FY 2016-17: $992,000 x 6.25% growth factor = $1,054,000

| TMAA FY 2017-18 Estimated Payments | |
|---|---|
| FY 2015-16 | $440,000 |
| FY 2016-17 Q1-Q3 | $790,000 |
| **Total** | **$1,230,000** |

5. The TMAA FY 2018-19 estimate includes the remaining FY 2016-17 claims and FY 2017-18 Q1-Q3 claims. The estimated base payments assumes a 6.25% growth, based on the average growth from FY 2012-13 to FY 2015-16.

   TMAA FY 2017-18: $1,054,000 x 6.25% growth factor =$1,119,000

| TMAA FY 2018-19 Estimated Payments | |
|---|---|
| FY 2016-17 Q4 | $263,000 |
| FY 2017-18 Q1-Q3 | $840,000 |
| **Total** | **$1,103,000** |

# COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

## OTHER ADMIN. POLICY CHANGE NUMBER: 5

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 | $99,500,000 | $11,000 | $99,489,000 |
| Tribal MAA | $1,230,000 | $0 | $1,230,000 |
| **Total** | **$100,730,000** | **$11,000** | **$100,719,000** |

| FY 2018-19 | TF | FF |
|---|---|---|
| County MAA | $75,963,000 | $75,963,000 |
| Tribal MAA | $1,103,000 | $1,103,000 |
| **Total** | **$77,066,000** | **$77,066,000** |

**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 | $12,115,250 | $12,115,250 |
| FEDERAL FUNDS | $21,846,750 | $21,846,750 |

## 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 from the prior estimate for FY 2017-18. There is no change between fiscal years 2017-18 and 2018-19.

**Methodology:**
1. The set allocation amount is $33,962,000 ($12,115,250 GF), based on a formula calculated by the CHDP program.

# EPSDT CASE MANAGEMENT

## OTHER ADMIN. POLICY CHANGE NUMBER: 6

**Funding:**

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| Title XIX (50% FF / 50% GF) | $14,973,000 | $7,486,500 | $7,486,500 |
| Title XIX (75% FF / 25% GF) | $17,539,000 | $4,384,750 | $13,154,250 |
| Title XIX (100% FF) | $1,206,000 | $0 | $1,206,000 |
| 100% General Fund | $244,000 | $244,000 | $0 |
| **Total** | **$33,962,000** | **$12,115,250** | **$21,846,750** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| Title XIX (50% FF / 50% GF) | $14,973,000 | $7,486,500 | $7,486,500 |
| Title XIX (75% FF / 25% GF) | $17,539,000 | $4,384,750 | $13,154,250 |
| Title XIX (100% FF) | $1,206,000 | $0 | $1,206,000 |
| 100% General Fund | $244,000 | $244,000 | $0 |
| **Total** | **$33,962,000** | **$12,115,250** | **$21,846,750** |

# 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 | $30,197,000 | $35,601,000 |
| STATE FUNDS | $6,467,560 | $9,190,840 |
| FEDERAL FUNDS | $23,729,440 | $26,410,160 |

## 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

## OTHER ADMIN. POLICY CHANGE NUMBER: 7

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.

The Department integrated eligibility rules for MCAP into the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) in October 2015. This integration resulted in a decrease in applications processed through Maximus.

Administrative vendor services include costs for the following services: applications 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, is due to contract delays for the Medi-Cal Special Populations publication contract resulting in reduced costs in current year. The increase from FY 2017-18 to FY 2018-19, in the current estimate, is primarily due to the costs shifting from FY 2017-18 to FY 2018-19 for the Special Populations publication contract.

**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 | $ 25,988,339 | $ 25,881,241 |
| MCAP | $ 3,904,287 | $ 3,930,841 |
| Medi-Cal Special Populations | $ 303,921 | $ 5,789,321 |

# OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS

## OTHER ADMIN. POLICY CHANGE NUMBER: 7

5. Contract costs and administrative vendor service costs by cost category are as follows:
(Dollars in Thousands)

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| Contract Costs | $ 23,712 | $ 3,225 | $ 20,487 |
| Applications Processing, Printing and Courier Services, Letters and Notices, Transaction Forwarding Fee | $ 443 | $ 222 | $ 221 |
| Call Minute Rate per Minute | $ 1,738 | $ 869 | $ 869 |
| Implementation Costs | $ 4,000 | $ 2,000 | $ 2,000 |
| Special Populations Publications | $ 304 | $ 152 | $ 152 |
| **Total** | **$ 30,197** | **$ 6,468** | **$ 23,729** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| Contract Costs | $ 23,657 | $ 3,219 | $ 20,438 |
| Applications Processing, Printing and Courier Services, Letters and Notices, Transaction Forwarding Fee, Pregnancy Materials | $ 436 | $ 218 | $ 218 |
| Call Minute Rate per Minute | $ 1,718 | $ 859 | $ 859 |
| Implementation Costs | $ 4,000 | $ 2,000 | $ 2,000 |
| Special Populations Publications | $ 5,790 | $ 2,895 | $ 2,895 |
| **Total** | **$ 35,601** | **$ 9,191** | **$ 26,410** |

**Funding:**
(Dollars in Thousands)

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| 50% Title XIX / 50% GF (4260-101-0890/0001) | $ 7,484 | $ 3,742 | $ 3,742 |
| 88% Title XXI / 12% GF (4260-113-0890/0001) | $ 22,713 | $ 2,725 | $ 19,988 |
| **Total** | **$ 30,197** | **$ 6,467** | **$ 23,730** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| 50% Title XIX / 50% GF (4260-101-0890/0001) | $ 12,944 | $ 6,472 | $ 6,472 |
| 88% Title XXI / 12% GF (4260-113-0890/0001) | $ 22,657 | $ 2,719 | $ 19,938 |
| **Total** | **$ 35,601** | **$ 9,191** | **$ 26,410** |

# 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 | $29,094,000 | $32,293,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $29,094,000 | $32,293,000 |

## 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, is a net decrease due to:

- A decreased estimate for the average annual change in mental health (MH) MAA claims from 9.06% to 8.60% based on actuals from FY 2011-12 through FY 2015-16,
- 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 including partial payments to Marin County in FY 2018-19 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 2011-12 through FY 2015-16, the average annual increase in MH MAA FFP reimbursements was 8.60%.

3. Assume total MH MAA claims will increase by 8.60% each fiscal year starting in FY 2016-17.

# SMH MAA

## OTHER ADMIN. POLICY CHANGE NUMBER: 8

4. For FY 2016-17, the Department projects to receive $50,135,000 TF in MH MAA claims on an accrual basis.

(Dollars in Thousands)

| Fiscal Years | Expenditures | Growth | Increase |
|---|---|---|---|
| 2016-17 | $50,135 | 8.60% | $4,312 |
| 2017-18 | $54,447 | 8.60% | $4,682 |
| 2018-19 | $59,129 | 8.60% | $5,085 |

5. Based on historical claims received, assume 3.46% of fiscal year claims will be paid in the year the services occur. The remaining 96.54% will be paid in the following year.

(Dollars in Thousands)

| Fiscal Years | Accrual | FY 2017-18 | FY 2018-19 |
|---|---|---|---|
| 2016-17 | $50,135 | $48,399 | $0 |
| 2017-18 | $54,447 | $1,885 | $52,561 |
| 2018-19 | $59,129 | $0 | $2,048 |
| Total | $163,711 | $50,284 | $54,609 |

6. 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) | $15,808 | $11,856 | $3,952 | $17,167 | $12,875 | $4,292 |
| Other (50/50) | $34,476 | $17,238 | $17,238 | $37,442 | $18,721 | $18,721 |
| Total | $50,284 | $29,094 | $21,190 | $54,609 | $31,596 | $23,013 |

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 2018-19. Marin County's claiming plan has been approved, allowing the claims to be paid.

(Dollars in Thousands)

| Cash Basis Expenditures | FY 2018-19 | | |
|---|---|---|---|
| | TF | FF | CF |
| Medical (75/25) | $481 | $362 | $119 |
| Other (50/50) | $670 | $335 | $335 |
| Total | $1,151 | $697 | $454 |

# SMH MAA

## OTHER ADMIN. POLICY CHANGE NUMBER: 8

8. 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 31.44% of costs are eligible for 75% reimbursement and the remaining 68.56% are eligible for 50% reimbursement.

(Dollars in Thousands)

| | FY 2017-18 | | | FY 2018-19 | | |
|---|---|---|---|---|---|---|
| **Expenditures** | **TF** | **FF** | **CF** | **TF** | **FF** | **CF** |
| Medical (75/25) | $15,808 | $11,856 | $3,952 | $17,648 | $13,237 | $4,411 |
| Other (50/50) | $34,476 | $17,238 | $17,238 | $38,112 | $19,056 | $19,056 |
| **Total** | $50,284 | **$29,094** | $21,190 | $55,760 | **$32,293** | $23,467 |

**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 | $25,525,000 | $11,276,000 |
| STATE FUNDS | $1,641,000 | $390,000 |
| FEDERAL FUNDS | $23,884,000 | $10,886,000 |

## 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 the ARRA, authorizes federal funds for Medicare and Medicaid Incentive Programs from 2011 through 2021. To qualify, health care providers must adopt, implement or upgrade (AIU) and 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

## OTHER ADMIN. POLICY CHANGE NUMBER: 9

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 June 30, 2016 and approved on August 17, 2016. 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 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 conditionsto CalREDIE to improve public health surveillance.

The Department will continue to administer the following projects to support MU of EHRs by eligible Medi-Cal professionals and hospitals:

# ARRA HITECH INCENTIVE PROGRAM

## OTHER ADMIN. POLICY CHANGE NUMBER: 9

- 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 collaborated 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) in November 2015 for FY 2015-16. The Summit will occur in November of 2017. The Summit will help stakeholders understand 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 an increase due to the following:
- Revisions to the EHR Survey project schedule that shifted work from FY 2016-17 to FY 2017-18;
- A change to the California HIT/HIE Summit funding, the non-federal share of which will be provided by outside entities;
- CAIR 2.0 and CalREDIE invoices from FY 2016-17 that will now be paid in FY 2017-18;
- The addition of the HITEMS project;
- The delay of Xerox projects from FY 2017-18 to FY 2018-19;
- And finally Increases to the CAIR Onboarding and CalREDIE eCR project costs.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to:
- CAIR 2.0 and CalREDIE project costs ending in FY 2017-18;
- Decreased costs for CAIR Onboarding and CalREDIE eCR in FY 2018-19 due to lower implementation costs;
- Provider Technical Assistance costs ending in FY 2017-18;
- And the implementation of Xerox projects 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 share is budgeted by CDPH. This policy change budgets the Title XIX 90% FF that will be provided to CDPH per the contracts through an interagency agreement.

3. CTAP project costs are eligible for Title XIX 90% FF. In FY 2016-17, the 10% non-federal share will be provided by the MRMIF. In FY 2017-18, the 10% non-federal share will be provided by the Health Care Services Plans Fines and Penalties Fund.

# ARRA HITECH INCENTIVE PROGRAM

## OTHER ADMIN. POLICY CHANGE NUMBER: 9

4. For the California HIT/HIE Stakeholder Summit, the 10% non-federal share will be provided by outside entities. In FY 2016-17 and FY 2017-18, the 10% non-federal share for the other projects will be provided by outside entities.

5. 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) | $761,000 | $0 | $0 | $761,000 |
| CalREDIE (90% FF/10% GF) | $401,000 | $0 | $0 | $401,000 |
| CAIR Onboarding (90% FF/10% GF) | $1,459,000 | $0 | $0 | $1,459,000 |
| CalREDIE eCR (90% FF/10% GF) | $1,209,000 | $0 | $0 | $1,209,000 |
| HITEMS (90% FF/10% GF) | $5,288,000 | $0 | $0 | $5,288,000 |
| 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) | $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 |
| Sub Total | $25,525,000 | $222,000 | $1,419,000 | $23,884,000 |
| Xerox projects (OA 62) | $0 | $0 | $0 | $0 |
| **Total FY 2017-18** | **$25,525,000** | **$222,000** | **$1,419,000** | **$23,884,000** |

| FY 2018-19 | TF | Reimburs. | SF | FF |
|---|---|---|---|---|
| CAIR Onboarding (90% FF/10% GF) | $1,366,000 | $0 | $0 | $1,366,000 |
| CalREDIE eCR (90% FF/10% GF) | $729,000 | $0 | $0 | $729,000 |
| HITEMS (90% FF/10% GF) | $5,288,000 | $0 | $0 | $5,288,000 |
| Provider Technical Assist. (90% FF/10% SF)* | $0 | $0 | $0 | $0 |
| 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 |
| Sub Total | $9,597,000 | $222,000 | $0 | $9,375,000 |
| Xerox projects (OA 62) | $1,679,000 | $168,000 | $0 | $1,511,000 |
| **Total FY 2018-19** | **$11,276,000** | **$390,000** | **$0** | **$10,886,000** |

**Funding:**
100% Title XIX (4260-101-0890)
100% Reimbursement (4260-601-0995)
100% Health Care Services Plans Fines and Penalties Fund (4260-602-3311)*

# 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 | $24,005,000 | $22,757,000 |
| STATE FUNDS | $8,000,000 | $7,584,000 |
| FEDERAL FUNDS | $16,005,000 | $15,173,000 |

## 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 strengthen 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, is a decrease due to shifting partial year costs for activities related to network adequacy, which was estimated to begin in July 2017 and is now estimated to begin in January 2018.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is net decrease due to incorporating full year costs for network adequacy in FY 2018-19 and the completion of one-time County IT and County Translation costs in FY 2017-18.

**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.

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.

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.

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.

# 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.

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.

8. The estimated total FY 2017-18 and FY 2018-19 costs are:

(Dollars in Thousands)

| **Managed Care Regulations-MH Costs** | **TF** | **GF** | **FF** | **CF** |
|---|---|---|---|---|
| State Monitoring | $5,057 | $1,264 | $2,529 | $1,264 |
| Network Adequacy | $5,057 | $1,264 | $2,529 | $1,264 |
| Quality Measurement & Improvement; External Quality Review | $5,057 | $1,264 | $2,529 | $1,264 |
| Grievances and Appeals System | $5,057 | $1,264 | $2,529 | $1,264 |
| Program Integrity | $5,057 | $1,264 | $2,529 | $1,264 |
| County IT Costs | $5,880 | $1,470 | $2,940 | $1,470 |
| County Translation Costs | $840 | $210 | $420 | $210 |
| **Total FY 2017-18** | $32,005 | **$8,000** | **$16,005** | $8,000 |

(Dollars in Thousands)

| **Managed Care Regulations-MH Costs** | **TF** | **GF** | **FF** | **CF** |
|---|---|---|---|---|
| State Monitoring | $5,057 | $1,264 | $2,529 | $1,264 |
| Network Adequacy | $10,113 | $2,528 | $5,057 | $2,528 |
| Quality Measurement & Improvement; External Quality Review | $5,057 | $1,264 | $2,529 | $1,264 |
| Grievances and Appeals System | $5,057 | $1,264 | $2,529 | $1,264 |
| Program Integrity | $5,057 | $1,264 | $2,529 | $1,264 |
| **Total FY 2018-19** | $30,341 | **$7,584** | **$15,173** | $7,584 |

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 | $23,773,000 | $26,162,000 |
| STATE FUNDS | $348,000 | $948,000 |
| FEDERAL FUNDS | $23,425,000 | $25,214,000 |

## 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 is due to:

- Updated base year expenditures from FY 2013-14 to FY 2014-15,
- Updated growth trends applied to the FY 2016-17 and FY 2017-18 accrual years,
- Updated payment lag factors for UR & QA claims based on more recent historical claims, and
- Foster Family Agency (FFA) costs were moved from the County Specialty Mental Health Admin policy change to this policy change.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to a full year of FFA expenditures expected to occur in FY 2018-19, the payment lags in FY 2018-19, and the growth trends applied for the FY 2017-18 and FY 2018-19 accrual years.

# SMHS COUNTY UR & QA ADMIN

## OTHER ADMIN. POLICY CHANGE NUMBER: 11

**Methodology:**

1. UR and QA expenditures are shared between federal funds (FF) and county funds (CF). Pursuant to Proposition 30, GF funding is provided for levels of service that are provided above those levels mandated by the 2011 Realignment.

2. Based on historical claims received from FY 2011-12 through FY 2014-15, assume 25% of each fiscal year claims will be paid in the year the services occur. Assume 71% is paid in the following year and 4% is paid in the third year.

(Dollars in Thousands)

| Fiscal Year | Accrual | FY 2017-18 | FY 2018-19 |
|---|---|---|---|
| 2015-16 | $31,861 | $1,274 | $0 |
| 2016-17 | $33,104 | $23,504 | $1,324 |
| 2017-18 | $34,030 | $8,508 | $24,162 |
| 2018-19 | $34,949 | $0 | $8,737 |
| Total SPMP & Other | | $33,286 | $34,223 |

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 | $769 | $2,183 |
| FY 2018-19 | $3,075 | $0 | $769 |
| Total for STC | | $769 | $2,952 |

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. Due to a delay in claiming, assume 96% of FY 2016-17 FFA costs will be paid in FY 2017-18 and 4% will be paid in FY 2018-19. 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 2016-17 | $58.12 | $214 | $205 | $9 |
| FY 2017-18 | $58.12 | $428 | $107 | $304 |
| FY 2018-19 | $58.12 | $428 | $0 | $107 |
| Total for FFA | | | $312 | $420 |

# 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 | $24,964 | $0 | $18,723 | $6,241 |
| Other | $8,322 | $0 | $4,161 | $4,161 |
| STC | $769 | $192 | $385 | $192 |
| FFA | $312 | $156 | $156 | $0 |
| **Total** | $34,367 | **$348** | **$23,425** | $10,594 |

(Dollars in Thousands)

| FY 2018-19 | | | | |
|---|---|---|---|---|
| **Personnel** | **TF** | **GF** | **FF** | **CF** |
| SPMP | $25,667 | $0 | $19,250 | $6,417 |
| Other | $8,556 | $0 | $4,278 | $4,278 |
| STC | $2,952 | $738 | $1,476 | $738 |
| FFA | $420 | $210 | $210 | $0 |
| **Total** | $37,595 | **$948** | **$25,214** | $11,433 |

**Funding:**
100% Title XIX FF (4260-101-0890)
100% GF (4260-101-0001)

# PERFORMANCE OUTCOMES SYSTEM

| | |
|---|---|
| OTHER ADMIN. POLICY CHANGE NUMBER: | 12 |
| IMPLEMENTATION DATE: | 3/2018 |
| ANALYST: | Julie Chan |
| FISCAL REFERENCE NUMBER: | 1948 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| TOTAL FUNDS | $13,783,000 | $16,137,000 |
| STATE FUNDS | $6,227,000 | $6,953,250 |
| FEDERAL FUNDS | $7,556,000 | $9,183,750 |

## 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, is a net decrease, due to:

- Adding the 45.296% benefits costs for county personnel for training that was not included in the previous estimate.
- Funding for certain training costs for the Skilled Professional Medical Personnel (SPMP) staff have been updated from 50% FF / 50% GF to 75% FF / 25% GF. The Federal reimbursement is available at 75% for SPMP.
- The cost for clinical staff decreased from the prior estimate based on the reduced number of estimated assessments for FY 2017-18.
- The data entry costs decreased as the number of estimated assessments to be keyed was reduced from the prior estimate.
- The cost of County IT support staff was added for FY 2017-18 and was not included in the previous estimate.
- Partial IT cost are assumed to be paid in FY 2017-18 and the remainder in FY 2018-19.
- Assessments will begin in FY 2018-19 and not in FY 2017-18 as assumed in the previous estimate.

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

- The FY 2018-19 training estimate only includes ongoing training costs.
- The IT contractor costs for the installation of the hardware and software upgrades increase in FY 2018-19.
- The costs for clinical and data entry staff increased based on an increase of beneficiaries being assessed in FY 2018-19.

**Methodology:**

1. Training:
   County personnel costs for training will cost $2,697,000 in FY 2017-18 and $745,000 in 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 in the first year.
   - Assume 794 clinical staff will be trained on the new tools on an ongoing basis.
   - 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 in FY 2017-18 and $495,000 in 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.

# PERFORMANCE OUTCOMES SYSTEM

## OTHER ADMIN. POLICY CHANGE NUMBER: 12

(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 $3,571,000 in FY 2017-18 and $3,641,000 in FY 2018-19.

   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 in FY 2017-18 and $245,000 will be paid in 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 23 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 paid in FY 2017-18 and 50% in 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 | $3,396 | $3,396 |
| Total (rounded) | $3,571 | $3,641 |

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 22 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.

# PERFORMANCE OUTCOMES SYSTEM

## OTHER ADMIN. POLICY CHANGE NUMBER: 12

- 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 in 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 in FY 2018-19.

IT Support Staff:

- Assume 2 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 in FY 2017-18 and FY 2018-19.

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 FY 2017-18 and FY 2018-19 are:

(Dollars in Thousands)

| | FY 2017-18 | | | FY 2018-19 | | |
|---|---|---|---|---|---|---|
| **POS Costs** | **TF** | **GF** | **FF** | **TF** | **GF** | **FF** |
| Training | $2,697 | $684 | $2,013 | $745 | $196 | $549 |
| IT Costs | $3,571 | $1,786 | $1,785 | $3,641 | $1,820 | $1,821 |
| County Staffing Costs | $7,515 | $3,757 | $3,758 | $11,751 | $4,937 | $6,814 |
| **Total** | **$13,783** | **$6,227** | **$7,556** | **$16,137** | **$6,953** | **$9,184** |

**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: | Ila Zapanta |
| FISCAL REFERENCE NUMBER: | 1932 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| TOTAL FUNDS | $20,588,000 | $15,988,000 |
| STATE FUNDS | $7,879,600 | $7,129,300 |
| FEDERAL FUNDS | $12,708,400 | $8,858,700 |

## 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 enterprise-wide 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 a future release which is scheduled for implementation in June 2018. PAVE is expected to enter the certified Maintenance and Operations (M&O) phase in FY 2018-19. In addition, the PAVE system will include planning activities to improve the management, use, data collection, and improved processes for provider information management. Additional system enhancements include a consolidated provider data repository, improving consumer facing provider directories, and collecting provider network information from behavioral health and managed dental programs.

# PAVE SYSTEM

## OTHER ADMIN. POLICY CHANGE NUMBER: 13

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is an increase due to a delay in the project schedule and a shift of payments from the previous year due to the updated project work plan. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to less costs needed in FY 2018-19 as the PAVE system will move from less implementation into more M&O. In addition, the reimbursement to Centers for Medicare & Medicaid Services (CMS) will be made in FY 2018-19 as a result of the improperly claimed enhanced Federal Financial Participation (FFP).

**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) | $12,017,000 | $1,201,700 | $10,815,300 |
| Consultants (90% Title XIX / 10% GF) | $2,535,000 | $253,500 | $2,281,500 |
| Operations (50% Title XIX / 50% GF) | $6,036,000 | $3,018,000 | $3,018,000 |
| **Total** | **$20,588,000** | **$4,473,200** | **$16,114,800** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| Implementation (90% Title XIX / 10% GF) | $4,997,000 | $499,700 | $4,497,300 |
| Consultants (90% Title XIX / 10% GF) | $821,000 | $82,100 | $738,900 |
| Operations (50% Title XIX / 50% GF) | $6,360,000 | $3,180,000 | $3,180,000 |
| M&O Post Certification (75% Title XIX / 25% GF) | $590,000 | $147,500 | $442,500 |
| Improperly Claimed FFP 100% GF (4260-101-0001) | $3,220,000 | $3,220,000 | $0 |
| **Total** | **$15,988,000** | **$7,129,300** | **$8,858,700** |

**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)

# 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 | $21,586,000 |
| STATE FUNDS | $10,421,000 | $10,921,000 |
| FEDERAL FUNDS | $10,165,000 | $10,665,000 |

## 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:**
The change from the prior estimate, for FY 2017-18, is an increase due to an increase in per unit cost for reprinted and corrected 1095-B mailings and an increase in estimated base mass mailing costs. The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to an increase in estimated base mass mailing costs. The increase in base mailing costs, for both FY 2017-18 and FY 2018-19, is based on FY 2016-17 actual invoices and changes in section 1557 of the federal requirements, which prohibits discrimination based on race, color, national origin, sex, age or disability

# POSTAGE & PRINTING

## OTHER ADMIN. POLICY CHANGE NUMBER: 14

in all health programs receiving Federal financial assistance. Section 1557 requirements increase the number of documents that need to be updated and translated, as well as an increase in the number of languages requiring translation.

**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. 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* | $10,000,000 | $5,128,000 | $4,872,000 |
| 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** | **$21,586,000** | **$10,921,000** | **$10,665,000** |

*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: | Andrew Yoo |
| 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. 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 Care Act (ACA) Expansion, and Health Homes Program); however, ongoing actuarial services are

# ACTUARIAL COSTS FOR RATE DEVELOPMENT

## OTHER ADMIN. POLICY CHANGE NUMBER: 15

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: | Julie Chan |
| FISCAL REFERENCE NUMBER: | 1720 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| TOTAL FUNDS | $12,200,000 | $12,706,000 |
| STATE FUNDS | $3,050,000 | $3,176,500 |
| FEDERAL FUNDS | $9,150,000 | $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 was awarded to provide Level II evaluations from January 2, 2015 through December 31, 2017 with two one-year options to renew. A new contract will be awarded in November 2017.

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.
- 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 in the prior estimate, for FY 2017-18, is a net increase due to:

- Shifting the system buildout costs from FY 2017-18 to FY 2018-19,
- The Level II evaluations will reach a higher level than anticipated in the previous estimate.
- Delaying recruitment of the training design contractor from July 2017 to July 2018.

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,
- The new Level II evaluations contractor costs in FY 2017-18 budgets for the initial set-up activities.

**Methodology:**

1. A Level II evaluations contractor payments began in February 2015 with two one-year option to renew. This contract will terminate on October 31, 2017 and a new contract will be executed on November 1, 2017. The Level II evaluation costs is expected to be $11,850,000 in FY 2017-18 and $11,100,000 in FY 2018-19.

2. The PASRR IT system requires ongoing M&O. An M&O contract will be awarded in FY 2017-18 and cost $350,000 per fiscal year.

3. Electronic training costs for the NFs and general acute care hospitals are based on the California Multiple Award Schedule (CMAS) cost 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.

# PASRR

## OTHER ADMIN. POLICY CHANGE NUMBER: 16

5. The PASRR payments on a cash basis are estimated at:

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| Evaluations | $11,850,000 | $2,962,000 | $8,888,000 |
| Ongoing M&O Costs | $350,000 | $88,000 | $262,000 |
| **Total** | **$12,200,000** | **$3,050,000** | **$9,150,000** |

| 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. 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 will be 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 | $10,790,000 | $9,077,000 |
| STATE FUNDS | $1,977,050 | $2,086,250 |
| FEDERAL FUNDS | $8,812,950 | $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 the vendor, 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, 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 April 2018.

**Reason for Change:**
There is no change from the prior estimate for FY 2017-18. 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 | $700,000 | $2,500,000 |
| Total | $4,665,000 | $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 | $481,000 | $4,322,000 |
| Operational Costs (75% FF / 25% GF) | $5,987,000 | $1,497,000 | $4,490,000 |
| **Total FY 2017-18** | **$10,790,000** | **$1,978,000** | **$8,812,000** |

| **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 | $10,187,000 | $9,884,000 |
| STATE FUNDS | $2,546,750 | $2,471,000 |
| FEDERAL FUNDS | $7,640,250 | $7,413,000 |

## 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 – 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 |
| Health Management Systems Inc. (HI) *(Amendment Pending)* | 13-90283 A01 |
| 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 | 16-93355 |
| Lexis-Nexis | 17-94029 |
| Lexis-Nexis | Pending |

**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,
- 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.

**Reason for Change:**
The change in FY 2017-18, from the prior estimate, is a decrease due to a diminishing caseload worked by the HMS WC contractor. The WC contractor will turn over the majority of their high dollar cases to the Department on September 30, 2017, and all remaining cases on December 31, 2017. The Department will be utilizing a variable pricing structure process versus a fixed rate, which will also decrease costs. Also, the pending Lexis-Nexis contract is an extension of the current contract with costs in FY 2017-18 and FY 2018-19.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to the HI recovery program including the mental health population, which was initially added in FY 2017-18 from the prior 3 years of caseload data and is anticipated to normalize in FY 2018-19. The decrease is also due to the WC recovery program insourcing the WC recovery work in FY 2017-18. As of January 1, 2017, there is no plan to resume contracting this WC work. As a result, insourcing the WC work requires a new online database contract (EDEX) in order to facilitate filing liens with the Workers' Compensation Appeals Board.

**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 | $116,255,000 | $114,506,000 | 8.5% | $9,882,000 | $9,733,000 |

# MEDI-CAL RECOVERY CONTRACTS

## OTHER ADMIN. POLICY CHANGE NUMBER: 20

2. The amounts paid to the HMS contractor for WC is contingent upon recoveries. The HMS contract expired April 2017 but the contractor will continue processing recoveries until their applicable Medi-Cal cases deplete. Assume the following recoveries for each fiscal year and the corresponding contingency fee percentage (based on contract year).

   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 | $0 | $0 | 15% | $0 | $0 |
| HMS 07 | $100,000 | $0 | 21% | $21,000 | $0 |
| HMS 12 | $500,000 | $0 | 23.75% | $119,000 | $0 |
| Total | | | | $140,000 | $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 | $126,000 | $112,000 |
| CA Department of Public Health | $17,000 | $17,000 |
| EDEX Information Systems Inc. (WC) | $5,000 | $5,000 |
| Total | $165,000 | $151,000 |

4. The payments shown below include recent recovery activity.

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| Health Insurance | $9,882,000 | $2,471,000 | $7,411,000 |
| Worker's Compensation | $140,000 | $35,000 | $105,000 |
| Online Database Contracts | $165,000 | $41,000 | $124,000 |
| **Total** | **$10,187,000** | **$2,547,000** | **$7,640,000** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| Health Insurance | $9,733,000 | $2,433,000 | $7,300,000 |
| Worker's Compensation | $0 | $0 | $0 |
| Online Database Contracts | $151,000 | $38,000 | $113,000 |
| **Total** | **$9,884,000** | **$2,471,000** | **$7,413,000** |

**Funding:**
75% Title XIX / 25% GF (4260-101-0001/0890)

# LITIGATION RELATED SERVICES

| | |
|---|---|
| OTHER ADMIN. POLICY CHANGE NUMBER: | 21 |
| IMPLEMENTATION DATE: | 7/2009 |
| ANALYST: | Andrew Yoo |
| 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.

Several significant cases, which had previously been inactive awaiting a precedential decision by the United States Supreme Court, continue to be active. Also, 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. 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 | $8,845,000 | $7,825,000 |
| STATE FUNDS | $4,422,500 | $3,912,500 |
| FEDERAL FUNDS | $4,422,500 | $3,912,500 |

## 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 January 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 2017-18 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 an increase for upfront costs in the contract to build a DHCS application and database for the new data management system in the third quarter of FY 2017- 18 and to fund the contract with an IT Project Management contractor.

The decrease from FY 2017-18 to FY 2018-19, in the current estimate, is due to the upfront cost of the data management contract for FY 2017-18.

**Methodology:**
1. The Data Management Contract costs for FY 2017-18 consists of $1,200,000 for the use of the data management system and $1,020,000 one-time upfront cost to build a DHCS application and database.

2. 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 | $2,220,000 | $1,110,000 | $1,110,000 |
| IT Project Management | $125,000 | $62,500 | $62,500 |
| **Total** | **$8,845,000** | **$4,422,500** | **$4,422,500** |

| 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 | $125,000 | $62,500 | $62,500 |
| **Total** | **$7,825,000** | **$3,912,500** | **$3,912,500** |

**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 | $7,094,000 | $5,488,000 |
| STATE FUNDS | $1,773,500 | $1,372,000 |
| FEDERAL FUNDS | $5,320,500 | $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 February 2018 and end January 2020, 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. Three 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 an increase due to new contract and contracted staff costs. 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.

**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 February 1, 2018, will cost $2,083,000 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 | $7,094 | $1,774 | $5,320 |
| 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: | 12/2017 |
| ANALYST: | Joel Singh |
| FISCAL REFERENCE NUMBER: | 1871 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| TOTAL FUNDS | $6,278,000 | $15,934,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $6,278,000 | $15,934,000 |

## 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, is an increase due to the following:

- Invoicing delays will shift FY 2016-17 claims, for Riverside County, to be paid in FY 2017-18.
- The updated DMC-ODS waiver implementation schedule, compared to the prior estimate, has six additional counties (for a total of 15 counties) that will begin providing services in FY 2017-18.
- The UR and QA estimated annual cost was revised, resulting in an increase for FY 2016-17 and FY 2017-18.

# DMC COUNTY UR & QA ADMIN

## OTHER ADMIN. POLICY CHANGE NUMBER: 24

The change in the current estimate, from FY 2017-18 to FY 2018-19, is due to the addition of 20 counties that are projected to implement the waiver in FY 2018-19. Out of the 15 counties implementing the waiver in FY 2017-18, six counties will start services in the fourth quarter. As a result, payments for these six counties will be realized in FY 2018-19.

**Methodology:**

1. DMC-ODS waiver services for opt-in counties began in February 2017 on a phase-in basis. Five counties (San Mateo, Riverside, Marin, Santa Clara, and Contra Costa) implemented the waiver in FY 2016-17. For FY 2017-18 and FY 2018-19, county implementation is expected to phase-in as follows:
    - 15 additional counties will begin providing services in FY 2017-18.
    - 20 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 August 2018.

2. Of the 58 counties, assume 18 counties will 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 December 2017.

4. For counties that implemented DMC-ODS in FY 2016-17, only Riverside County is expected to submit claims for FY 2016-17.

5. For FY 2017-18 and FY 2018-19, counties will submit claims quarterly, no later than 60 days after the end of the quarter. 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. Costs on an accrual basis are as follows:

| | Accrual | FY 2017-18 | FY 2018-19 |
|---|---|---|---|
| FY 2016-17 Claims | $369,000 | $369,000 | $0 |
| FY 2017-18 Claims | $13,082,000 | $8,762,000 | $4,320,000 |
| FY 2018-19 Claims | $25,262,000 | $0 | $18,857,000 |
| Total | | $9,131,000 | $23,177,000 |

6. Assume 75% of the total claims are for SPMP costs and the remaining 25% are for other personnel costs.

7. UR and QA costs for SPMP will receive enhanced federal reimbursement of 75%. All other personnel will receive 50% federal reimbursement.

# DMC COUNTY UR & QA ADMIN

## OTHER ADMIN. POLICY CHANGE NUMBER: 24

8. The estimated UR and QA administrative cost for FY 2017-18 and FY 2018-19 are:

| FY 2017-18 | TF | FF | CF |
|---|---|---|---|
| SPMP | $6,848,000 | $5,136,000 | $1,712,000 |
| Other Personnel | $2,283,000 | $1,142,000 | $1,141,000 |
| **Total** | $9,131,000 | **$6,278,000** | $2,853,000 |
| | | | |
| **FY 2018-19** | **TF** | **FF** | **CF** |
| SPMP | $17,383,000 | $13,037,000 | $4,346,000 |
| Other Personnel | $5,794,000 | $2,897,000 | $2,897,000 |
| **Total** | $23,177,000 | **$15,934,000** | $7,243,000 |

**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:**
The change from the prior estimate, for FY 2017-18, is a decrease due to reduced CDT rates. 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 | $3,531,000 | $2,130,000 |
| STATE FUNDS | $409,350 | $288,000 |
| FEDERAL FUNDS | $3,121,650 | $1,842,000 |

## 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 that 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, 2015 to September 30, 2017. The SSW renewal 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.

A technical contractor, beginning services August 2016 that will last 24 months, costs $500,000. A business contractor, commencing services February 2017 that will last 24 months, costs $500,000. Effective October 2017, a vendor will concurrently provide design, development, and implementation (DD&I) and maintenance and operations (M&O) services.

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is a decrease due to fewer months (nine instead of twelve) of DD&I and M&O expenditures.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to decreased contractor costs and no software and hardware expenditures 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 | $1,031,000 | $103,000 | $928,000 |
| M&O* | $375,000 | $94,000 | $281,000 |
| IV&V Vendor | $125,000 | $12,000 | $113,000 |
| Software | $500,000 | $50,000 | $450,000 |
| Hardware | $1,000,000 | $100,000 | $900,000 |
| **Total FY 2017-18** | **$3,531,000** | **$409,000** | **$3,122,000** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| Technical Contractor | $21,000 | $2,000 | $19,000 |
| Business Contractor | $110,000 | $11,000 | $99,000 |
| DD&I Vendor | $1,374,000 | $137,000 | $1,237,000 |
| M&O* | $500,000 | $125,000 | $375,000 |
| IV&V Vendor | $125,000 | $13,000 | $112,000 |
| **Total FY 2018-19** | **$2,130,000** | **$288,000** | **$1,842,000** |

**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 | $3,248,000 | $3,248,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $3,248,000 | $3,248,000 |

## 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.

# DRUG MEDI-CAL COUNTY ADMINISTRATION

## OTHER ADMIN. POLICY CHANGE NUMBER: 27

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is due to lower payment projections based on the number of county claims received in FY 2016-17.

There is no change in the current estimate, from FY 2017-18 to 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. The estimated DMC county administration costs for FY 2017-18 and FY 2018-19 are:

(Dollars in Thousands)

| FY 2017-18 | County Admin Cost | Title XIX | County Funds |
|---|---|---|---|
| FY 2016-17 Claims, Q4 | $1,624,000 | $812,000 | $812,000 |
| FY 2017-18 Claims, Q1-Q3 | $4,872,000 | $2,436,000 | $2,436,000 |
| **Total for FY 2017-18** | $6,496,000 | **$3,248,000** | $3,248,000 |

(Dollars in Thousands)

| FY 2018-19 | County Admin Cost | Title XIX | County Funds |
|---|---|---|---|
| FY 2017-18 Claims, Q4 | $1,624,000 | $812,000 | $812,000 |
| FY 2018-19 Claims, Q1-Q3 | $4,872,000 | $2,436,000 | $2,436,000 |
| **Total for FY 2018-19** | $6,496,000 | **$3,248,000** | $3,248,000 |

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

# 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 | $2,618,000 | $1,578,000 |
| STATE FUNDS | $261,800 | $157,800 |
| FEDERAL FUNDS | $2,356,200 | $1,420,200 |

## 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 2019.

**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.

CMS has asked state Medicaid programs to make their systems and business processes ready for external integrated system testing with CMS and others by October 2017. CMS has also asked all state Medicaid programs to provide an initial impact assessment. Removal of SSNs from all existing Medicare cards and 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 will allow 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 Social Security Numbers; and
- Reduce the risk of information security breaches.

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is an increase due to revising the estimate based on actual contract costs. 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.

**Methodology:**
1. The state MBI project will allow assessment of the impact of SSN removal from Medicare cards on the Department's systems and business processes in use and remediation efforts 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 | $2,618,000 | $262,000 | $2,356,000 |
| FY 2018-19 | $1,578,000 | $158,000 | $1,420,000 |

**Funding:**
90% Title XIX / 10% GF (4260-101-0001/0890)

# ELECTRONIC ASSET VERIFICATION PROGRAM

| | |
|---|---|
| OTHER ADMIN. POLICY CHANGE NUMBER: | 29 |
| IMPLEMENTATION DATE: | 10/2017 |
| ANALYST: | Shannon Hoerner |
| FISCAL REFERENCE NUMBER: | 2002 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| TOTAL FUNDS | $2,416,000 | $3,328,000 |
| STATE FUNDS | $1,208,000 | $1,664,000 |
| FEDERAL FUNDS | $1,208,000 | $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 reimbursements range between $3.00 and $5.00 per beneficiary, based on volume.

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 full implementation of the AVP occurred in the fall of 2017.

**Reason for Change:**
There is no change from the prior estimate for FY 2017-18. 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 the use of 2016 ABD application data in FY 2018-19.

**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 authorized 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 2015 ABD application data and current enrollment data, assume the estimated number of asset verifications performed in FY 2017-18 will be 604,000, including:

    - 124,000 asset verifications on new applicants,
    - 480,000 asset verifications on beneficiaries.

4. Based on 2016 ABD application data and current enrollment data, assume the estimated number of asset verifications performed in FY 2018-19 will be 832,000, including:

    - 192,000 asset verifications on new applicants,
    - 640,000 asset verifications on beneficiaries.

5. Using an average of $4.00 per beneficiary, the estimated vendor cost are:

    **FY 2017-18:** 604,000 asset verifications x $4.00/beneficiary = **$2,416,000 TF ($1,208,000 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. 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)

**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:**
The change from the prior estimate, for FY 2017-18, is an increase due to revising the estimate based on actual contract amounts.

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 | $2,206,000 | $2,733,000 |
| STATE FUNDS | $220,600 | $273,300 |
| FEDERAL FUNDS | $1,985,400 | $2,459,700 |

## 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)

**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.

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is a decrease due to a delay in the new contract's start date, reducing payments in FY 2017-18.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is an increase due to new contractor costs and a full year of payments in FY 2018-19.

# MITA

## OTHER ADMIN. POLICY CHANGE NUMBER: 32

**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 current contract is effective December 2015 through August 2017.

4. The new contract will be effective November 2017 through November 2019. Payments for the new contract will begin December 2017.

5. There will be a two-month gap between the old and new contract. No MITA project work will be done during this time.

6. The projected costs are:

| Fiscal Year | TF | GF | FF |
|---|---|---|---|
| FY 2017-18 | $2,206,000 | $221,000 | $1,985,000 |
| FY 2018-19 | $2,733,000 | $273,000 | $2,460,000 |

**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. 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 since PAL Stage Gate 2 is scheduled to be completed by October 2017. PAL Stage Gate 3 will begin thereafter.

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is an increase due to outstanding payments from FY 2016-17 being shifted to FY 2017-18. 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 | $1,600,000 | $1,500,000 |
| STATE FUNDS | $800,000 | $750,000 |
| FEDERAL FUNDS | $800,000 | $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 incorporating a higher trend based on historical billing data. The estimate is based on historical data, recent invoices, and the aging population. The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease based on the incorporation of a negative invoice for the FY 2018-19 trend.

**Methodology:**
1. The following projections are based upon the most current actual billings from SSA.

| Fiscal Year | TF | GF | FF |
|---|---|---|---|
| FY 2017-18 | $1,600,000 | $800,000 | $800,000 |
| 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: | Joel Singh |
| 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:**
The change from the prior estimate, for FY 2017-18, is due to a contract amendment to increase the maximum amount reimbursable annually, retroactive to FY 2015-16. As a result of the contract amendment, the amount of the increase for FY 2015-16 and FY 2016-17 claims will be paid in FY 2017-18.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to FY 2017-18 including additional claims for FY 2015-16 and FY 2016-17.

# CALIFORNIA HEALTH INTERVIEW SURVEY

## OTHER ADMIN. POLICY CHANGE NUMBER: 35

**Methodology:**

1. Assume UCLA will submit documentation of CPEs on the CHIS survey. Expenditures will consist of funds received by UCLA from non-federal sources.

2. In July 2017, the CHIS contract was amended to increase the annual reimbursement amount retroactive to FY 2015-16.

3. On an accrual basis, beginning FY 2015-16, the maximum reimbursable amount for California Health Interview Survey is $1,100,000 FF annually.

4. On a cash basis, assume two quarters will be paid in the current fiscal year and the remaining two quarters will be paid in the subsequent fiscal year.

5. 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:

| FY 2017-18 | TF | FF |
|---|---|---|
| FY 2015-16 Claims | $79,000 | $79,000 |
| FY 2016-17 Claims | $643,000 | $643,000 |
| FY 2017-18 Claims | $550,000 | $550,000 |
| **Total for FY 2017-18** | **$1,272,000** | **$1,272,000** |

| FY 2018-19 | TF | FF |
|---|---|---|
| FY 2017-18 Claims | $550,000 | $550,000 |
| FY 2018-19 Claims | $550,000 | $550,000 |
| **Total for FY 2018-19** | **$1,100,000** | **$1,100,000** |

**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: | Andrew Yoo |
| 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. 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:**
The change in FY 2017-18, from the prior estimate, is due to a reduction in the May 2017 and June 2017 invoice payments.

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.

**Reason for Change:**
There is no change from the prior estimate for FY 2017-18. There is no change from FY 2017-18 to FY 2018-19 in the current estimate.

# ENCRYPTION OF PHI DATA

## OTHER ADMIN. POLICY CHANGE NUMBER: 39

**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 | $734,000 | $708,000 |
| STATE FUNDS | $367,000 | $354,000 |
| FEDERAL FUNDS | $367,000 | $354,000 |

## 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 due to a slight increase to Personal Injury postage for the business reply mail. However, the overall estimate decreased as a result of a decrease to printing for Personal Injury and Estate recovery mail outs based on recent trends. The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease due to the one-time cost for a new document folder inserter in FY 2017-18.

**Methodology:**
1. The cost breakdown is shown below:

| FY 2017-18 | Postage | Printing | Other | Total |
|---|---|---|---|---|
| Personal Injury | $201,000 | $24,000 | $0 | $225,000 |
| Estate Recovery | $93,000 | $371,000 | $0 | $464,000 |
| Overpayments | $7,000 | $1,000 | $0 | $8,000 |
| 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 |
| **Total** | $307,000 | $397,000 | $30,000 | **$734,000** |

# POSTAGE AND PRINTING - THIRD PARTY LIAB.

## OTHER ADMIN. POLICY CHANGE NUMBER: 40

| FY 2018-19 | Postage | Printing | Other | Total |
|---|---|---|---|---|
| Personal Injury | $201,000 | $24,000 | $0 | $225,000 |
| Estate Recovery | $93,000 | $371,000 | $0 | $464,000 |
| Overpayments | $7,000 | $1,000 | $0 | $8,000 |
| 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 | $3,000 | $3,000 |
| **Total** | $307,000 | $397,000 | $4,000 | **$708,000** |

*AB 155 requires invoicing for premiums for the 250% Working Disabled Program.
** Cost of maintenance agreement for the current Document Folder Inserter used to process mailings in-house.

2. The estimated costs are:

| Fiscal Year | TF | GF | FF |
|---|---|---|---|
| **FY 2017-18** | **$734,000** | **$367,000** | **$367,000** |
| **FY 2018-19** | **$708,000** | **$354,000** | **$354,000** |

**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 | $592,000 | $432,000 |
| STATE FUNDS | $296,000 | $216,000 |
| FEDERAL FUNDS | $296,000 | $216,000 |

## 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 will end March 2018. The Department will amend or competitively re-procure the M&O contract to address new IRS requirements for a transmission structure change and table structure optimization. The new contract will begin March 2018 and will end February 2019.

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is a decrease due to revising the estimate based on actual contract costs and the removal of hardware and software costs. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to contract payments ending 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 ends March 2018, costs $450,000. Payments for this contract began July 2017.

2. The new M&O contract, begins March 2018 and ends February 2019, will cost $574,000.

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 | $592,000 | $296,000 | $296,000 |
| FY 2018-19 | $432,000 | $216,000 | $216,000 |

**Funding:**

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

# ETL DATA SOLUTION

| | |
|---|---|
| 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 | $431,000 | $270,000 |
| STATE FUNDS | $107,750 | $67,500 |
| FEDERAL FUNDS | $323,250 | $202,500 |

## DESCRIPTION

**Purpose:**
This policy change estimates the cost for the design, development, implementation (DD&I) and maintenance and operations (M&O) of the Extract, Transform, and Load (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 Transformed Medicaid Statistical Information System (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.

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 contracted vendor started in January 2017 and is scheduled to complete services in December 2017. The final payment for the vendor is expected to be made in December 2017. An Implementation Advance Planning Document Update (IAPDU), for federal FY 2017-18, will request funding for software support.

DD&I was completed in August 2016. The project received federal certification and began production on June 1, 2017.

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is an increase due to the shift in M&O expenditures from FY 2016-17 to FY 2017-18 caused by a delay of deliverables for the server environment upgrade. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to increased software costs and no M&O costs in FY 2018-19.

# ETL DATA SOLUTION

## 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. Since no deliverables were completed during FY 2016-17, payment for the contractor has shifted to FY 2017-18.

2. The initial Data Quality software was procured in December 2015. Support and maintenance for Data Quality was procured in February 2017 and will be re-procured in February 2018.

3. The software maintenance renewal for Power Center was procured in December 2016 to meet system requirements. Power Center support and maintenance will be re-procured in December 2017.

4. The Department developed an IAPDU that extended the project to meet the additional CMS requirements and ongoing support for M&O. The project began production in June 2017.

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| M&O (75% FF / 25% GF) | $181,000 | $45,000 | $136,000 |
| Software (75% FF / 25% GF) | $250,000 | $63,000 | $187,000 |
| **Total** | **$431,000** | **$108,000** | **$323,000** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| Software (75% FF / 25% GF) | $270,000 | $67,000 | $203,000 |
| **Total** | **$270,000** | **$67,000** | **$203,000** |

**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 | $390,000 | $327,000 |
| STATE FUNDS | $195,000 | $163,500 |
| FEDERAL FUNDS | $195,000 | $163,500 |

## 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.

**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 to replace the Average Wholesale Price. Additionally, on February 1, 2016, the Centers for Medicare & Medicaid Services (CMS) issued a final rule on Medicaid covered outpatient drugs in the Federal Register. This rule revised requirements pertaining to Medicaid reimbursement for covered outpatient drugs, including a requirement that states implement an Actual Acquisition Cost (AAC) reimbursement methodology, as well as develop a new Professional Dispensing Fee 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 Professional Dispensing Fee, 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 Professional Dispensing Fee.

# 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 Average Wholesale Price reimbursement to a new AAC based methodology. The final payment to Mercer was made in August 2017.

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 August 2017.

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.

Checkbox subscription
Pursuant to the Welfare and Institutions Code 14105.45(b)(2)(B), the Department is adopting a new process in which pharmacy providers must attest annually to total claim volume to be appropriately reimbursed a Professional Dispensing Fee for claims. It is estimated 4,000, of the 5,700 active providers, will attest annually. The Department will purchase a subscription to Checkbox, a professional web-enabled survey software, to efficiently process and store provider attestations.

The Department anticipates a three-year subscription with Checkbox and expects the software to be ready for use by January 1, 2018. The Checkbox subscription and professional services to develop and implement the survey tool are estimated to cost $8,000 and begin October 2017. The subscription, development, and implementation costs will be $4,000 in FY 2017-18. The subscription is anticipated to cost $2,000 on an annual basis.

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is an increase due to making the final payments to Mercer and PCG, beginning the new project management contract with Lucchese Consulting Solutions, LLC, and beginning the Checkbox subscription in FY 2017-18.

The change in the current estimate from FY 2017-18 to FY 2018-19, is due to the completion of the Mercer AAC Rate Study contract and the PCG project management contract in FY 2017-18.

**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.

# VENDOR FOR AAC RATE STUDY

## OTHER ADMIN. POLICY CHANGE NUMBER: 43

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 August 2017.

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 is expected to begin October 2017 and cost $4,000 in FY 2017-18 and $2,000 in FY 2018-19.

| Contractor Costs | TF | GF | FF |
|---|---|---|---|
| FY 2017-18 | $390,000 | $195,000 | $195,000 |
| FY 2018-19 | $327,000 | $163,500 | $163,500 |

**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% federally funded.

CMS granted the Department an extension of the supplemental grant through December 2015 to complete the objectives set forth in the grant.

Beginning January 1, 2016, the Department will allocate MFP grant funding to continue efforts that were initiated under the supplemental grant to increase CCT enrollment. These activities qualify as administrative marketing and outreach activities, which are 100% federally funded through the MFP grant.

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is a decrease due to an update to reflect the actual amounts approved in the Interagency Agreement. There is no change from FY 2017-18 to FY 2018-19 in the current estimate.

**Methodology:**
1. Assume $342,000 from the additional MFP grant funding is expected to be paid in FY 2017-18.

# CCT OUTREACH - ADMINISTRATIVE COSTS

## OTHER ADMIN. POLICY CHANGE NUMBER: 44

2. Assume $342,000 from the additional MFP grant funding is expected to be paid in FY 2018-19.

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 | $12,953,000 | $2,099,000 | $10,854,000 |
| | | | |
| CCT Savings: | | | |
| Total Non-DD GF savings and Total FFP | ($28,828,000) | ($14,414,000) | ($14,414,000) |
| | | | |
| CCT Fund Transfer to CDSS & CDDS (PC 41) | $918,000 | $0 | $918,000 |
| **CCT Outreach - Admin costs (OA 44)** | **$342,000** | **$0** | **$342,000** |
| | | | |
| Total of CCT PCs including pass through | ($14,615,000) | ($12,315,000) | ($2,300,000) |

*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 | $8,048,000 | $1,860,000 | $6,188,000 |
| | | | |
| CCT Savings: | | | |
| Total Non-DD GF savings and Total FFP | ($28,201,000) | ($14,100,000) | ($14,101,000) |
| | | | |
| CCT Fund Transfer to CDSS & CDDS (PC 41) | $191,000 | $0 | $191,000 |
| **CCT Outreach - Admin costs (OA 44)** | **$342,000** | **$0** | **$342,000** |
| | | | |
| Total of CCT PCs including pass through | ($19,620,000) | ($12,240,000) | ($7,380,000) |

*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 | $200,000 | $200,000 |
| STATE FUNDS | $100,000 | $100,000 |
| FEDERAL FUNDS | $100,000 | $100,000 |

## 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 three-year contract with UMass on October 1, 2010, and on May 17, 2012, the Department of General Services approved an extension to June 30, 2015 (Contract 10-87134 A01). After the contract ended, 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 continues to assist 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.

Near the end of the initial contract, UMass submitted additional cases for review of potential overpayment recoveries. These cases needed to be reviewed by the Social Security Administration (SSA) before a final invoice amount could be determined. The final invoice from the initial contract was paid in July 2016. Additional services from UMass on potential overpayment recoveries will continue in the new contract.

**Reason for Change:**
For FY 2017-18, there is no change from the prior estimate. There is no change from FY 2017-18 to FY 2018-19 in the current estimate.

# 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.

2. Assume the estimated amount recovered, in the new contract, will be $2,000,000 in FY 2017-18 and $2,000,000 in FY 2018-19. As a result, the contractor cost is estimated to be $200,000 in FY 2017-18 and $200,000 in FY 2018-19.

   FY 2017-18: $2,000,000 x 10% = $200,000 TF
   FY 2018-19: $2,000,000 x 10% = $200,000 TF

3. The estimated contractor costs are:

| Fiscal Year | TF | GF | FF |
|---|---|---|---|
| FY 2017-18 | $200,000 | $100,000 | $100,000 |
| FY 2018-19 | $200,000 | $100,000 | $100,000 |

**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 | $173,000 | $0 |
| STATE FUNDS | $43,250 | $0 |
| FEDERAL FUNDS | $129,750 | $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:**
There is no change from the prior estimate for FY 2017-18. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to no additional costs in FY 2018-19 because all of the remaining invoices will be paid in FY 2017-18.

**Methodology:**
1. Expenditures for the remaining system changes in the amount of $173,000 TF are anticipated to be invoiced and paid in FY 2017-18.

| Fiscal Year | TF | GF | FF |
|---|---|---|---|
| FY 2017-18 | $173,000 | $43,250 | $129,750 |

**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 | $125,000 | $0 |
| STATE FUNDS | $31,250 | $0 |
| FEDERAL FUNDS | $93,750 | $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 December 31, 2017.

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:**
There is no change from the prior estimate for FY 2017-18. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the contracting ending in December 2017 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 December 31, 2017.

| Fiscal Year | TF | GF | FF |
|---|---|---|---|
| FY 2017-18 | $125,000 | $31,250 | $93,750 |

**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 Management allocations on administrative activities in support of a county'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: | Matt Wong |
| FISCAL REFERENCE NUMBER: | 267 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| TOTAL FUNDS | $52,000 | $52,000 |
| STATE FUNDS | $26,000 | $26,000 |
| FEDERAL FUNDS | $26,000 | $26,000 |

## 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, is a slight decrease due to the increased use of electronic TARs instead of paper TARs. 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 $52,000 for FY 2017-18 and FY 2018-19.

2. Estimates are based on actual expenditures from July 2016 through June 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:**
The change from the prior estimate, for FY 2017-18, is an increase due to a 4-month lag to pay the close out costs associated with the contract.

**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)

# TITLE XXI FEDERAL MATCH REDUCTION OTHER ADMIN

| | |
|---|---|
| OTHER ADMIN. POLICY CHANGE NUMBER: | 54 |
| IMPLEMENTATION DATE: | 10/2017 |
| ANALYST: | Katy Clay |
| FISCAL REFERENCE NUMBER: | 2030 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| TOTAL FUNDS | -$3,099,000 | -$3,574,000 |
| STATE FUNDS | $9,764,570 | $12,286,060 |
| FEDERAL FUNDS | -$12,863,570 | -$15,860,060 |

## DESCRIPTION

**Purpose:**
This policy change estimates the adjustment to reflect the administrative costs charged to the Children's Health Insurance Program (CHIP) after the reduction of the federal match from 88% to 65%.

**Authority:**
Affordable Care Act (ACA)

**Interdependent Policy Changes:**
PC 2 CCS Case Management
PC 4 County Specialty Mental Health Admin
PC 7 OTLICP, MCAP, Special Populations Admin Costs
PC 55 Interim and Final Cost Settlements-SMHS
PC 63 HCO Cost Reimbursement
PC 64 HCO Operations
PC 65 HCO - Enrollment Contractor Costs
PC 66 HCO ESR Hourly Reimbursement
PC 70 HCO Operations for Contract #17-94437
PC 71 HCO Cost Reimbursement for Contract #17-94437
PC 72 HCO ESR Hourly Reimb for Contract #17-94437
PC 89 CalHEERS Development

**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 and extends the enhanced funding through the end of the Federal Fiscal year of 2017. Effective October 1, 2017, funding for the CHIP program will be exhausted, unless Congress takes action to both reauthorize the program and extend the funding. Given the uncertainty about what Congress will do, it is assumed that the program will be reauthorized but not at the enhanced amount.

**Reason for Change:**
The Department removed and added policy changes based on applicable funding sources.

# TITLE XXI FEDERAL MATCH REDUCTION OTHER ADMIN

## OTHER ADMIN. POLICY CHANGE NUMBER: 54

**Methodology:**

1. The Department identified funds allocated to CHIP beneficiaries in Title XXI funding in other administration PCs.

2. The total fund cost of CHIP funding adjusted for other administration policy changes is estimated as -$3,099,000 in FY 2017-18 and -$3,574,000 in FY 2018-19.

**Funding:**

50% Title XIX FF / 50% GF (4260-101-0890/0001)
Title XXI 65% FF / 35% GF (4260-113-0890/0001)
FI 65% Title XXI / 35% GF (4260-113-0001/0890)
Title XXI 88% FF / 12% GF (4260-113-0890/0001)
FI 88% Title XXI / 12% GF (4260-113-0001/0890)
Fed. Share Only 100% Title XXI (4260-113-0890)
100% State GF (4260-101-0001)

# 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 | -$35,823,000 | $0 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | -$35,823,000 | $0 |

## 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, is a net increase due to:

- Payments for county cost settlements for FYs 2006-07 through FY 2010-11 that were scheduled to be made in FY 2016-17 but have shifted to be paid in FY 2017-18, and
- Eight additional cost reports for FY 2010-11 and FY 2011-12 were settled and will be paid in FY 2017-18.

The change from FY 2017-18 to FY 2018-19, in the current estimate, results from no estimated settlements to be paid or overpayments recouped for FY 2018-19.

**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.

# INTERIM AND FINAL COST SETTLEMENTS-SMHS

## OTHER ADMIN. POLICY CHANGE NUMBER: 55

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 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** |
| SMH Admin | $0 | ($5,000) | ($5,000) |
| UR/QA | $296,000 | ($128,000) | $168,000 |
| MH MAA | $132,000 | ($111,000) | $21,000 |
| HFP Admin* | $12,000 | $0 | $12,000 |
| Total FY 2009-10 | $440,000 | ($244,000) | $196,000 |
| | | | |
| FY 2010-11 | **Underpaid** | **Overpaid** | **Net FF** |
| SMH Admin | $0 | ($4,041,000) | ($4,041,000) |
| UR/QA | $4,008,000 | $0 | $4,008,000 |
| MH MAA | $934,000 | ($1,638,000) | ($704,000) |
| MCHIP* | $373,000 | $0 | $373,000 |
| HFP Admin* | $734,000 | $6,000 | $740,000 |
| Total FY 2010-11 | $6,049,000 | ($5,673,000) | $376,000 |
| | | | |
| FY 2011-12 | **Underpaid** | **Overpaid** | **Net FF** |
| SMH Admin | $3,144,000 | ($1,180,000) | $1,964,000 |
| UR/QA | $774,000 | $0 | $774,000 |
| MH MAA | $0 | ($993,000) | ($993,000) |
| MCHIP* | $31,000 | ($2,000) | $29,000 |
| HFP Admin* | $0 | ($38,415,000) | ($38,415,000) |
| Total FY 2011-12 | $3,949,000 | ($40,590,000) | ($36,641,000) |
| | | | |
| **Total FY 2017-18** | $10,684,000 | ($46,507,000) | **($35,823,000)** |

# 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 are shown below:

| FF | FY 2017-18 |
|---|---|
| Title XIX FF | $1,430,000 |
| Title XXI FF* | ($37,253,000) |
| **Total** | **($35,823,000)** |

**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 | $81,248,000 | $79,177,000 |
| STATE FUNDS | $26,095,250 | $25,369,500 |
| FEDERAL FUNDS | $55,152,750 | $53,807,500 |

## 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 to year.

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 a beneficiary.

- Telephone Services Center (TSC) – Claim volume associated with contractor work activity and responsibility to telephone responses to provider and beneficiary inquiries received over telephone lines.

The FI 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, is a net decrease due to reduced costs for General ACLs and CA-EVS/CMS Processing but increased costs for Online ACLS, ECLs, and Retrospective DUR. 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) | $49,565,000 | $17,348,000 | $32,217,000 |
| Online ACLs (75% FF/25% GF, 50% FF/50% GF) | $2,456,000 | $860,000 | $1,596,000 |
| 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) | $890,000 | $223,000 | $667,000 |
| CA-EVS/CMS Processing (75% FF/25% GF) | $4,500,000 | $1,125,000 | $3,375,000 |
| Medicare Drug Discount (100% GF) | $17,000 | $17,000 | $0 |
| TARS (75% FF/25% GF) | $9,900,000 | $2,475,000 | $7,425,000 |
| TSC (75% FF/25% GF, 50% FF/50% GF) | $13,500,000 | $3,918,000 | $9,582,000 |
| **Total** | **$81,248,000** | **$26,096,000** | **$55,152,000** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| General ACLs (75% FF/25% GF, 50% FF/50% GF) | $47,526,000 | $16,634,000 | $30,892,000 |
| Online ACLs (75% FF/25% GF, 50% FF/50% GF) | $2,414,000 | $845,000 | $1,569,000 |
| 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) | $900,000 | $225,000 | $675,000 |
| CA-EVS/CMS Processing (75% FF/25% GF) | $4,500,000 | $1,125,000 | $3,375,000 |
| Medicare Drug Discount (100% GF) | $17,000 | $17,000 | $0 |
| TARS (75% FF/25% GF) | $9,900,000 | $2,475,000 | $7,425,000 |
| TSC (75% FF/25% GF, 50% FF/50% GF) | $13,500,000 | $3,918,000 | $9,582,000 |
| **Total** | **$79,177,000** | **$25,369,000** | **$53,808,000** |

**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 | $41,090,000 | $36,004,000 |
| STATE FUNDS | $10,830,150 | $10,404,750 |
| FEDERAL FUNDS | $30,259,850 | $25,599,250 |

## 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, is an increase due to revising the costs based on actual expenditures instead of projections, and increased costs for consultant contracts, audits & research, and other cost reimbursement items.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is a decrease in other cost reimbursement items, consultant contracts, and equipment.

**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) | $1,815 | $907 | $908 |
| Parcel Services & Common Carriers (50% FF/50% GF) | $115 | $57 | $58 |
| Equipment/Services (75% FF/25% GF) | $4,656 | $1,164 | $3,492 |
| Print/Distr. Center (75% FF/25% GF, 50% FF/50% GF) | $1,136 | $454 | $682 |
| Other Direct Costs (50% FF/50% GF, 75% FF/25% GF) | $1,958 | $734 | $1,224 |
| Facilities Improvement & Modification (50% FF/50% GF) | $557 | $279 | $278 |
| Audits & Research (50% FF/50% GF) | $600 | $300 | $300 |
| Change Orders (50% FF/50% GF) | $51 | $26 | $25 |
| Sales Tax (75% FF/25% GF) | $4,347 | $1,087 | $3,260 |
| Consultant Contracts (75% FF/25% GF, 90% FF/10% GF, 50% FF/50% GF) | $19,880 | $4,828 | $15,052 |
| Telecommunication (75% FF/25% GF) | $1,031 | $258 | $773 |
| Other Cost Reim. Items (50% FF/50% GF, 90% FF/10% GF) | $4,944 | $736 | $4,208 |
| **Total** | **$41,090** | **$10,830** | **$30,260** |

(Dollars in Thousands)

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| Postage (50% FF/50% GF) | $2,178 | $1,089 | $1,089 |
| Parcel Services & Common Carriers (50% FF/50% GF) | $138 | $69 | $69 |
| Equipment/Services (75% FF/25% GF) | $4,561 | $1,140 | $3,421 |
| Print/Distr. Center (75% FF/25% GF, 50% FF/50% GF) | $1,363 | $545 | $818 |
| Other Direct Costs (50% FF/50% GF, 75% FF/25% GF) | $2,350 | $881 | $1,469 |
| Facilities Improvement & Modification (50% FF/50% GF) | $668 | $334 | $334 |
| Audits & Research (50% FF/50% GF) | $600 | $300 | $300 |
| Change Orders (50% FF/50% GF) | $62 | $31 | $31 |
| Sales Tax (75% FF/25% GF) | $4,217 | $1,054 | $3,163 |
| Consultant Contracts (75% FF/25% GF, 90% FF/10% GF, 50% FF/50% GF) | $12,838 | $3,023 | $9,815 |
| Telecommunication (75% FF/25% GF) | $1,237 | $309 | $928 |
| Other Cost Reim. Items (75% FF/25% GF, 50% FF/50% GF) | $5,792 | $1,629 | $4,163 |
| **Total** | **$36,004** | **$10,404** | **$25,600** |

# 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. There is no change from FY 2017-18 to FY 2018-19 in the current estimate.

**Methodology:**
1. SG costs are based on the contract bid price for SG Hourly Reimbursements and the System Replacement Project settlement agreement.

2. Costs are shared between Federal Funds (FF) and General Funds (GF), based on the fixed price Base Volume Method of Payment (BVMP) bid rates.

# 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 | $11,280,000 | $11,280,000 |
| STATE FUNDS | $3,270,000 | $3,270,000 |
| FEDERAL FUNDS | $8,010,000 | $8,010,000 |

## 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 10$^{th}$ Revision (ICD-10).

# MEDICAL FI OTHER ESTIMATED COSTS

## OTHER ADMIN. POLICY CHANGE NUMBER: 59

**Reason for Change:**
There is no change from the prior estimate for FY 2017-18. 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) | $1,200,000 | $300,000 | $900,000 |
| 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** | **$11,280,000** | **$3,270,000** | **$8,010,000** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| Beneficiary ID Cards (75% FF / 25% GF) | $1,200,000 | $300,000 | $900,000 |
| 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** | **$11,280,000** | **$3,270,000** | **$8,010,000** |

**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 | $2,440,000 | $2,440,000 |
| STATE FUNDS | $766,000 | $766,000 |
| FEDERAL FUNDS | $1,674,000 | $1,674,000 |

## 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
Pending IA

**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 is expected to be finalized in October 2017.

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 the inclusion of a staffing IA with OSI. 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).

| 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) | $365,000 | $91,000 | $274,000 |
| FPACT (50% FF / 50% GF) | $180,000 | $90,000 | $90,000 |
| **Total** | **$2,440,000** | **$766,000** | **$1,674,000** |

| FY 2018-19 | 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) | $365,000 | $91,000 | $274,000 |
| FPACT (50% FF / 50% GF) | $180,000 | $90,000 | $90,000 |
| **Total** | **$2,440,000** | **$766,000** | **$1,674,000** |

**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 | $464,000 | $523,000 |
| STATE FUNDS | $116,000 | $130,750 |
| FEDERAL FUNDS | $348,000 | $392,250 |

## DESCRIPTION

**Purpose:**
This policy change estimates the cost of the various active Change Orders (CO), as defined in the Fiscal Medical Intermediary (FI) contract, for the purposes of allowable informal changes to the standard scope of the Medi-Cal FI contract.

**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, is a decrease due to the removal of the Diagnostic Related Groups Change Order and revising the OCC Change Order based on updated expenditure data. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to an increase in costs for the OCC change order.

**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 OA 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 | $464,000 | $116,000 | $348,000 |
| FY 2018-19 | $523,000 | $131,000 | $392,000 |

**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 May 2018, is implemented. The final payment will be issued July 2018.

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is a decrease to zero due to a delay in the completion of work and shifting the final invoice to be paid in 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:**
For FY 2017-18, there is a decrease from the prior estimate due to a correction in payment months and a change to the trending methodology. 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. 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 |
| Development of New Informing Mat. | $198 | $94 | $94 | $1 | $9 |
| Translation Services | $568 | $270 | $269 | $3 | $26 |
| Data Access | $471 | $224 | $223 | $3 | $21 |
| Miscellaneous | $1,043 | $495 | $496 | $6 | $46 |
| Special Training Sessions | $173 | $82 | $82 | $1 | $8 |
| PCs, Printers, Copy Machines | $123 | $58 | $59 | $1 | $5 |
| Additional Systems Group Staff | $4,698 | $2,232 | $2,231 | $28 | $207 |
| Travel and Per Diem | $151 | $72 | $71 | $1 | $7 |
| 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 |
| Development of New Informing Mat. | $61 | $29 | $29 | $0 | $3 |
| Translation Services | $175 | $83 | $82 | $1 | $9 |
| Data Access | $145 | $69 | $69 | $1 | $6 |
| Miscellaneous | $306 | $145 | $146 | $2 | $13 |
| Special Training Sessions | $53 | $25 | $25 | $0 | $3 |
| PCs, Printers, Copy Machines | $38 | $18 | $18 | $0 | $2 |
| Additional Systems Group Staff | $1,446 | $687 | $687 | $9 | $63 |
| Travel and Per Diem | $46 | $22 | $22 | $0 | $2 |
| Temporary Staff | $214 | $101 | $101 | $1 | $11 |
| **Total** | **$13,582** | **$6,540** | **$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 | $44,074,000 | $13,686,000 |
| STATE FUNDS | $21,201,380 | $6,583,840 |
| FEDERAL FUNDS | $22,872,620 | $7,102,160 |

## 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:**
For FY 2017-18, there is an increase from the prior estimate due to a shift in payments from the previous year. 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 |
| Base Volume Increase | $14,895 | $7,075 | $7,075 | $89 | $656 |
| **Total** | **$44,074** | **$20,937** | **$20,938** | **$262** | **$1,937** |

# HCO OPERATIONS

## OTHER ADMIN. POLICY CHANGE NUMBER: 64

(Dollars in Thousands)

| 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 |
| Base Volume Increase | $4,583 | $2,177 | $2,177 | $27 | $202 |
| **Total** | **$13,686** | **$6,502** | **$6,502** | **$81** | **$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 - 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:**
For FY 2017-18, there is an increase from the prior estimate due to a shift in payment months from previous year. 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:**
For FY 2017-18, there is an increase from the prior estimate due to a correction in payment months. 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. 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 would be 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, there is an increase from the prior estimate due to a correction in payment months. 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:**
The decrease in FY 2017-18 costs from the previous estimate is due to a decrease in the total contract amount. 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 | $932,000 | $2,564,000 |
| STATE FUNDS | $466,000 | $1,282,000 |
| FEDERAL FUNDS | $466,000 | $1,282,000 |

## 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 increase in costs for FY 2017-18 from the prior estimate is due to a correction in payment timing. The increase from FY 2017-18 to FY 2018-19 is due to the final payment of $1,748,000 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** | **$932,000** | $466,000 | $466,000 |

| | TF | GF | FF |
|---|---|---|---|
| **FY 2018-19** | **$2,564,000** | $1,282,000 | $1,282,000 |

# HCO TURNOVER

## OTHER ADMIN. POLICY CHANGE NUMBER: 69

**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 assumed operations was on October 1, 2018. Operations for the contractor are based on a fixed price bid.

**Reason for Change:**
This is a new policy change.

**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 | FF | GF | FF |
|---|---|---|---|---|---|
| | | Title XIX | Title XIX | Enhanced Title XXI | 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 was 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:**
This is a new PC.

**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 |
| Translation Services | $349 | $166 | $166 | $2 | $15 |
| Data Access | $290 | $138 | $138 | $2 | $12 |
| Training Sessions | $107 | $51 | $51 | $1 | $4 |
| Independent Contractor Consideration | $427 | $203 | $203 | $3 | $18 |
| PCs, Printers, Copy Machines | $76 | $36 | $36 | $0 | $4 |
| Travel and Per Diem | $93 | $44 | $44 | $1 | $4 |
| 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 | $9,248,000 |
| STATE FUNDS | $0 | $4,448,440 |
| FEDERAL FUNDS | $0 | $4,799,560 |

## 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 was 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:**
This is a new policy change.

**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) | $8,786 | $4,393 | $4,393 |
| Title XXI (88% FF / 12% GF) | $462 | $55 | $407 |
| **Total** | **$9,248** | **$4,448** | **$4,800** |

**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 | $68,813,000 | $0 |
| STATE FUNDS | $22,755,750 | $0 |
| FEDERAL FUNDS | $46,057,250 | $0 |

## DESCRIPTION

**Purpose:**
This policy change estimates the operational costs of the current 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 current FI anticipates the end of operations at the end of January 2018 with the new contractors assuming operational responsibility immediately thereafter. 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 an increase due to updates to payments made and updated projected costs through the end of operations, now estimated to be the end of January 2018. 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 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) | $44,186,000 | $11,046,000 | $33,140,000 |
| Provider Enrollment (50% FF / 50% GF and 75% FF / 25% GF) | $7,798,000 | $3,294,000 | $4,504,000 |
| Total ACSL/TAR | $51,983,000 | $14,341,000 | $37,642,000 |
| TSC – Provider (50% FF / 50% GF) | $12,722,000 | $6,361,500 | $6,361,000 |
| TSC – Beneficiary (50% FF / 50% GF) | $4,108,000 | $2,054,000 | $2,054,000 |
| Total TSC | $16,829,000 | $8,415,000 | $8,414,000 |
| **Total Operations Costs** | **$68,813,000** | **$22,756,000** | **$46,057,000** |

**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 NEW FI TAKEOVER

| | |
|---|---|
| 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, Hewlett-Packard (HPE).

**Authority:**
Contract 16-93286

**Interdependent Policy Changes:**
Not Applicable

**Background:**
HPE 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 will end 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:**
The change from the prior estimate, for FY 2017-18, is an increase due to takeover requirements not being fully met, causing the expected payments from FY 2016-17 to shift to August 2017. 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 that was previously expected to start in March 2017.

3. The remaining 20% ($5,856,000 TF) will be made as a single payment six months after successful

# DENTAL NEW FI TAKEOVER

## OTHER ADMIN. POLICY CHANGE NUMBER: 74

operations, assumed to be in FY 2018-19.

| Fiscal Year | TF | GF | FF |
|---|---|---|---|
| FY 2017-18 | $23,424,000 | $5,856,000 | $17,568,000 |
| FY 2018-19 | $5,586,000 | $1,464,000 | $4,392,000 |

**Funding:**
FI 75% Title XIX / 25% GF (4260-101-0001/0890)

# DENTAL ASO ADMINISTRATION

| | |
|---|---|
| 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 | $12,700,000 | $35,620,000 |
| STATE FUNDS | $4,642,750 | $13,168,500 |
| FEDERAL FUNDS | $8,057,250 | $22,451,500 |

## DESCRIPTION

**Purpose:**
This policy change estimates the total cost for reimbursable items and payment for operations for the 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 are expected to begin 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

## OTHER ADMIN. POLICY CHANGE NUMBER: 75

9. Annual Risk Assessments
10. Miscellaneous
11. Cost Reimbursement Invoices

**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 and a partial year of expenditures due to the assumptions of operations. 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 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) | $6,232,000 | $1,558,000 | $4,674,000 |
| Provider Enrollment (50% FF / 50% GF & 75% FF / 25% GF) | $1,100,000 | $465,000 | $635,000 |
| Total ACSL/TAR | $7,332,000 | $2,023,000 | $5,309,000 |
| TSC – Provider (50% FF / 50% GF) | $1,814,000 | $907,000 | $907,000 |
| TSC – Beneficiary (50% FF / 50% GF) | $2,884,000 | $1,442,000 | $1,442,000 |
| Total TSC | $4,698,000 | $2,349,000 | $2,349,000 |
| **Total Operations Costs** | **$12,030,000** | **$4,372,000** | **$7,658,000** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| Administration/Operations (75% FF / 25% GF) | $16,860,000 | $4,215,000 | $12,645,000 |
| Provider Enrollment (50% FF / 50% GF & 75% FF / 25% GF) | $2,975,000 | $1,257,000 | $1,718,000 |
| Total ACSL/TAR | $19,835,000 | $5,472,000 | $14,363,000 |
| TSC – Provider (50% FF / 50% GF) | $5,684,000 | $2,842,000 | $2,842,000 |
| TSC – Beneficiary (50% FF / 50% GF) | $8,040,000 | $4,020,000 | $4,020,000 |
| Total TSC | $13,724,000 | $6,862,000 | $6,862,000 |
| **Total Operations Costs** | **$33,559,000** | **$12,334,000** | **$21,225,000** |

# DENTAL ASO ADMINISTRATION

## OTHER ADMIN. POLICY CHANGE NUMBER: 75

4. Cost reimbursements are based on actual invoices with a growth factor.

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| Printing and Postage (50% FF / 50% GF) | $78,000 | $39,000 | $39,000 |
| Parcel Service (50% FF / 50% GF) | $68,000 | $34,000 | $34,000 |
| Data Center Access (75% FF / 25% GF) | $300 | $100 | $200 |
| Toll Free Phone Charges (75% FF / 25% GF) | $233,000 | $58,000 | $175,000 |
| Special Training, Conf., Travel (50% FF / 50% GF) | $200 | $100 | $100 |
| Conventions, Fairs, Workshops(50% FF / 50% GF) | $2,000 | $1,000 | $1,000 |
| Facilities Improvement (75% FF / 25% GF) | $11,000 | $3,000 | $8,000 |
| Computer Hardware (75% FF / 25% GF) | $11,000 | $3,000 | $8,000 |
| Audits (50% FF / 50% GF) | $162,000 | $81,000 | $81,000 |
| Indep. Contractor Consideration (75% FF / 25% GF) | $300 | $100 | $200 |
| Annual Risk Assessments (50% FF / 50% GF) | $300 | $100 | $200 |
| Misc. (50% FF / 50% GF) | $104,000 | $52,000 | $52,000 |
| **Total Cost Reimbursable** | **$670,000** | **$271,000** | **$399,000** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| Printing and Postage (50% FF / 50% GF) | $240,000 | $120,000 | $120,000 |
| Parcel Service (50% FF / 50% GF) | $210,000 | $105,000 | $105,000 |
| Data Center Access (75% FF / 25% GF) | $700 | $200 | $500 |
| Toll Free Phone Charges (75% FF / 25% GF) | $719,000 | $180,000 | $539,000 |
| Special Training, Conf., Travel (50% FF / 50% GF) | $600 | $300 | $300 |
| Conventions, Fairs, Workshops (50% FF / 50% GF) | $4,000 | $2,000 | $2,000 |
| Facilities Improvement (75% FF / 25% GF) | $32,000 | $8,000 | $24,000 |
| Computer Hardware (75% FF / 25% GF) | $32,000 | $8,000 | $24,000 |
| Audits (50% FF / 50% GF) | $502,000 | $251,000 | $251,000 |
| Indep. Contractor Consideration (75% FF / 25% GF) | $500 | $100 | $400 |
| Annual Risk Assessments (50% FF / 50% GF) | $600 | $300 | $300 |
| Misc. (50% FF / 50% GF) | $320,000 | $160,000 | $160,000 |
| **Total Cost Reimbursable** | **$2,062,000** | **$835,000** | **$1,227,000** |

5. Total Administration Cost

| | TF | GF | FF |
|---|---|---|---|
| **FY 2017-18*** | **$12,700,000** | **$4,643,000** | **$8,057,000** |
| **FY 2018-19*** | **$35,620,000** | **$13,167,000** | **$22,452,000** |

*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 | $8,748,000 | $0 |
| STATE FUNDS | $2,187,000 | $0 |
| FEDERAL FUNDS | $6,561,000 | $0 |

## DESCRIPTION

**Purpose:**
This policy change estimates the hourly reimbursement costs of the current 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 current FI anticipates the end of operations at the end of January 2018 with the new contractors assuming operational responsibility immediately thereafter. 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 an increase due an extra monthly payment caused by the extended contract operations, updated projected costs with an updated monthly average of hourly reimbursable costs, and a payment from FY 2016-17 being made in FY 2017-18. 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.

# DENTAL FI HOURLY REIMBURSEMENT

## OTHER ADMIN. POLICY CHANGE NUMBER: 76

**Methodology:**

1. SG costs are based on the Contract Bid Price for SG Hourly Reimbursements.

2. SURS costs are based on the Contract Bid Price for SURS Hourly Reimbursements.

3. Costs are shared between federal funds (FF) and General Fund (GF).

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| Systems Group (SG) | $4,880,000 | $1,220,000 | $3,660,000 |
| HIPAA SG* | $589,000 | $147,000 | $442,000 |
| SURS | $3,279,000 | $820,000 | $2,459,000 |
| **Total** | **$8,748,000** | **$2,187,000** | **$6,561,000** |

**Funding:**
*FI HIPAA 75% FF / 25% GF (4260-117-0001/0890)
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 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 | $8,016,000 | $0 |
| STATE FUNDS | $3,839,000 | $0 |
| FEDERAL FUNDS | $4,177,000 | $0 |

## DESCRIPTION

**Purpose:**
This policy change estimates the total cost reimbursement of the current 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 current FI anticipates the end of operations at the end of January 2018 with the new contractors assuming operational responsibility immediately thereafter. 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 increase due to payments made and updated projected costs based on current invoices, noteably the Knox-Keene Annual assessment is inclusive of a full year payment. 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 current 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 |
|---|---|---|---|
| Printing (50% FF / 50% GF) | $518,000 | $259,000 | $259,000 |
| Data Center Access (75% FF / 25% GF) | $59,000 | $15,000 | $44,000 |
| Postage/Parcel Service (50% FF / 50% GF) | $338,000 | $169,000 | $169,000 |
| Special Training, Conf., Travel (50% FF / 50% GF) | $21,000 | $10,000 | $10,000 |
| Audits (50% FF / 50% GF) | $105,000 | $53,000 | $53,000 |
| Facilities Improvement (75% FF / 25% GF) | $338,000 | $85,000 | $254,000 |
| Toll Free Phone Charges (75% FF / 25% GF) | $279,000 | $69,000 | $209,000 |
| Knox-Keene Annual Assess. (50% FF / 50% GF) | $6,036,000 | $3,018,000 | $3,018,000 |
| Misc. (50% FF / 50% GF) | $322,000 | $161,000 | $161,000 |
| **Total** | **$8,016,000** | **$3,839,000** | **$4,177,000** |

**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 NEW FI ADMINISTRATION

| | |
|---|---|
| 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 | $7,300,000 | $18,788,000 |
| STATE FUNDS | $2,019,500 | $4,973,500 |
| FEDERAL FUNDS | $5,280,500 | $13,814,500 |

## DESCRIPTION

**Purpose:**
This policy change estimates the total cost for operations, cost reimbursable items, and hourly reimbursables for the Dental Fiscal Intermediary (FI).

**Authority:**
Contract 16-93286

**Interdependent Policy Changes:**
Not Applicable

**Background:**
Hewlett Packard Enterprise (HPE) was awarded a multi-year contract in 2016. The current FI anticipates the end of operations at the end of January 2018 with the new contractors, HPE, assuming operational responsibility immediately thereafter. HPE 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 NEW FI ADMINISTRATION

## 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 and a partial year of expenditures due to the assumptions of operations now estimated to be at the end of January 2018. 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 | $4,153,000 | $1,038,000 | $3,115,000 |
| Check Write | $82,000 | $20,500 | $61,500 |
| **Total** | **$4,235,000** | **$1,058,500** | **$3,176,500** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| Scanned Claims/TAR | $10,257,000 | $2,564,000 | $7,693,000 |
| Check Write | $247,000 | $62,000 | $185,000 |
| **Total** | **$10,504,000** | **$2,626,000** | **$7,878,000** |

4. Cost reimbursements are based on actual invoices with a growth factor.

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| Printing and Postage (50% FF / 50% GF) | $182,000 | $91,000 | $91,000 |
| Parcel Service (50% FF / 50% GF) | $274,000 | $137,000 | $137,000 |
| Data Center Access (75% FF / 25% GF) | $200 | $100 | $200 |
| Special Training, Conf., Travel (50% FF / 50% GF) | $1,000 | $500 | $500 |
| Facilities Improvement (75% FF / 25% GF) | $10,000 | $2,500 | $7,500 |
| Hardware and Software (75% FF / 25% GF) | $10,000 | $2,500 | $7,500 |
| Audits (50% FF / 50% GF) | $164,000 | $82,000 | $82,000 |
| Ind. Contractor Consideration (75% FF / 25% GF) | $400 | $100 | $300 |
| Annual Risk Assessments (50% FF / 50% GF) | $400 | $100 | $300 |
| Misc. (50% FF / 50% GF) | $156,000 | $78,000 | $78,000 |
| **Total** | **$798,000** | **$393,800** | **$404,300** |

# DENTAL NEW FI ADMINISTRATION

## OTHER ADMIN. POLICY CHANGE NUMBER: 78

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| Printing and Postage (50% FF / 50% GF) | $260,000 | $130,000 | $130,000 |
| Parcel Service (50% FF / 50% GF) | $390,000 | $195,000 | $195,000 |
| Data Center Access (75% FF / 25% GF) | $300 | $100 | $200 |
| Special Training, Conf., Travel (50% FF / 50% GF) | $1,200 | $600 | $600 |
| Facilities Improvement (75% FF / 25% GF) | $15,000 | $4,000 | $11,000 |
| Hardware and Software (75% FF / 25% GF) | $15,000 | $4,000 | $11,000 |
| Audits (50% FF / 50% GF) | $232,000 | $116,000 | $116,000 |
| Ind. Contractor Consideration (75% FF / 25% GF) | $300 | $100 | $200 |
| Annual Risk Assessments (50% FF / 50% GF) | $200 | $100 | $100 |
| Misc. (50% FF / 50% GF) | $222,000 | $111,000 | $111,000 |
| **Total** | **$1,136,000** | **$561,000** | **$575,000** |

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** |

6. Total Administration Cost:

| Fiscal Year | TF | GF | FF |
|---|---|---|---|
| **FY 2017-18*** | **$7,300,000** | **$2,017,000** | **$5,278,000** |
| **FY 2018-19*** | **$18,788,000** | **$4,974,000** | **$13,814,000** |

*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

| | |
|---|---|
| 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 | $4,420,000 | $1,105,000 |
| STATE FUNDS | $1,105,000 | $276,250 |
| FEDERAL FUNDS | $3,315,000 | $828,750 |

## DESCRIPTION

**Purpose:**
This policy change estimates the total cost of Takeover from the current 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 will end at the end of 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, is an increase due to takeover requirements not being fully met, causing the expected payments from FY 2016-17 to shift to September 2017. 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 $5,525,000.

2. Of the contractor's price for takeover, 80% ($4,420,000 TF) will be paid in 12 equal installments starting in September 2017 that was previously expected to start in February 2017.

3. The remaining 20% ($1,105,000 TF) will be made as a single payment six months after successful operations, assumed to be in FY 2018-19.

# DENTAL ASO TAKEOVER

## OTHER ADMIN. POLICY CHANGE NUMBER: 79

| Fiscal Year | TF | GF | FF |
|---|---|---|---|
| FY 2017-18 | $4,420,000 | $1,105,000 | $3,315,000 |
| FY 2018-19 | $1,105,000 | $276,000 | $829,000 |

**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 | $2,331,000 | $0 |
| STATE FUNDS | $582,750 | $0 |
| FEDERAL FUNDS | $1,748,250 | $0 |

## DESCRIPTION

**Purpose:**
This policy change estimates the cost of the base California Dental Medicaid Management Information System's (CD-MMIS) turnover services from the current Dental Fiscal Intermediary (FI), Delta Dental of California (Delta) to the new FI contractor, Hewlett-Packard Enterprise (HPE).

**Authority:**
Contract # 04-35745

**Interdependent Policy Changes:**
Not Applicable

**Background:**
Delta was awarded a multi-year contract in 2004. The current FI anticipates the end of operations at the end of January 2018 with the new contractors assuming operational responsibility immediately thereafter. 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.

The Department has instructed the current 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 current FI is contractually agreed upon. The turnover bid price is paid in nine equal installments. 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 slight increase due to a shift in payment from the prior year. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the completion of all payments in FY 2017-18, and no additional costs are expected in 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 | $2,331,000 | $583,000 | $1,748,000 |

**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 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 | $1,779,000 | $1,781,000 |
| STATE FUNDS | $889,500 | $890,500 |
| FEDERAL FUNDS | $889,500 | $890,500 |

## DESCRIPTION

**Purpose:**
The policy change estimates the administrative cost of implementing strategies to increase utilization for Medi-Cal dental services for the current 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 current FI contractor, Delta Dental (Delta), to develop an annual dental outreach and education program, as required by the provisions of the current FI contract and WIC Section 14132.91. Outreach activities outlined in the current FI and the future 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 a decrease due to changes in the outreach efforts and activities. Previously, the outreach activities for FY 2017-18 included a call campaign reaching approximately 615,130 beneficiaries. However, the updated outreach efforts for both FY 2017-18 and FY 2018-19 include a call campaign targeting only a total of 2,500 beneficiaries combined for both auto-dialers and live calls per each fiscal year.

The change from FY 2017-18 to FY 2018-19 in the current estimate is due to applying the California Consumer Price Index (CCPI) factor into 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 $1,557,600 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 current FI and future ASO contractors. These costs are $11,237 for FY 2017-18 and $7,388 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 | $1,779,000 | $889,500 | $889,500 |
| FY 2018-19 | $1,781,000 | $890,500 | $890,500 |

**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 TREATMENT AUTHORIZATION REQUEST PROCESSING

| | |
|---|---|
| OTHER ADMIN. POLICY CHANGE NUMBER: | 82 |
| IMPLEMENTATION DATE: | 4/2017 |
| ANALYST: | Ila Zapanta |
| FISCAL REFERENCE NUMBER: | 1969 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| TOTAL FUNDS | $1,629,000 | $0 |
| STATE FUNDS | $650,250 | $0 |
| FEDERAL FUNDS | $978,750 | $0 |

## DESCRIPTION

**Purpose:**
This policy change estimates the costs to align the processing of dental Treatment Authorization Requests (TARs) to State regulations.

**Authority:**
Welfare & Institutions Code 14133.9 (d)

**Interdependent Policy Changes:**
Not Applicable

**Background:**
The Department determined that the current contractual requirements for the Dental Fiscal Intermediary (FI), with regards to the processing of TARs, do not align with the requirements delineated in State statute.

Under the current contract, the Dental FI is required to provide a response to a TAR within fifteen (15) calendar days from the time it is received. State statute requires a response within an average of five (5) working days.

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is a decrease due to an updated Dental FI staffing plan resulting in a cost reduction. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to the last payment will be for the March 2018 invoice and no additional costs are expected in FY 2018-19.

**Methodology:**
1. Assume the payments will be made from April 2017 – March 2018 with a one month delay in payment due to invoicing.

2. Assume the Dental FI SG has an hourly rate of $150 for FY 2017-18.

3. Assume system changes will take 3,962 hours to complete in FY 2017-18.
   FY 2017-18: 3,962 hours x $150 = $594,000 TF for system changes

4. In the clinical screening program, certain contracted FI dentists examine patients and report their findings in order to assist the Dental FI in making a final determination regarding the TAR. Assume the cost for expanding the clinical screening program is $459,000 TF in FY 2017-18.

# DENTAL TREATMENT AUTHORIZATION REQUEST PROCESSING

## OTHER ADMIN. POLICY CHANGE NUMBER: 82

5. Assume the change will require additional Dental FI staff to initiate the process of reducing the TAR processing time from 15 days to 5 days at a cost of $346,000 TF in FY 2017-18.

6. Costs are shared between federal funds (FF) and general funds (GF).

| Fiscal Year | TF | GF | FF |
|---|---|---|---|
| FI 50% Title XIX FF / 50% GF | $972,000 | $486,000 | $486,000 |
| FI 75% Title XIX FF / 75% GF | $657,000 | $164,000 | $493,000 |
| **FY 2017-18** | **$1,629,000** | **$650,000** | **$1,629,000** |

**Funding:**
FI 50% Title XIX FF / 50% GF (4260-101-0001/0890)
FI 75% Title XIX FF / 75% GF (4260-101-0001/0890)

# 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 | $254,000 | $0 |
| STATE FUNDS | $127,000 | $0 |
| FEDERAL FUNDS | $127,000 | $0 |

## DESCRIPTION

**Purpose:**
This policy change estimates the cost of additional workload of the current 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 current FI anticipates the end of operations at the end of January 2018 with the new contractors assuming operational responsibility immediately thereafter. 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 net increase due to payments made and updated projected revalidations based on the current average number of monthly revalidations. 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 are expected in FY 2018-19.

**Methodology:**
1. Costs are estimated based on the number of completed packets received from current providers revalidating their enrollment information.

2. The rate per revalidation is $489 for FY 2017-18.

# 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 | $254,000 | $127,000 | $127,000 |

**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 | $227,000 | $0 |
| STATE FUNDS | $113,500 | $0 |
| FEDERAL FUNDS | $113,500 | $0 |

## DESCRIPTION

**Purpose:**
This policy change estimates the cost of additional workload of the current 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 current FI anticipates the end of operations at the end of January 2018 with the new contractors assuming operational responsibility immediately thereafter. 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 an increase due to payments made and updated projected database checks based on the current average number of monthly database checks completed. 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.

# 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. The rate per database check is $1.62 for FY 2017-18.

3. Costs are shared between federal funds (FF) and General Fund (GF).

| Fiscal Year | TF | GF | FF |
|---|---|---|---|
| FY 2017-18 | $227,000 | $113,500 | $113,500 |

**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 | $179,000 | $0 |
| STATE FUNDS | $89,500 | $0 |
| FEDERAL FUNDS | $89,500 | $0 |

## DESCRIPTION

**Purpose:**
This policy change estimates the cost of additional workload of the current 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 current FI anticipates the end of operations at the end of January 2018 with the new contractors assuming operational responsibility immediately thereafter. 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 a net increase due to invoices paid and updated correspondence counts based on the current average number of correspondence counts per month. 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) Costs are estimated based on the number of correspondence counts which include the Conlan Mailed Beneficiary Claim Packets and related documents. These include the initial paperwork that beneficiaries complete and Dental FI's status letters that are sent to beneficiaries and providers.

# DENTAL FI CONLAN, SCHWARZMER, STEVENS V. BONTA

## OTHER ADMIN. POLICY CHANGE NUMBER: 85

2) The rate per correspondence count is $142.39 and based on invoices paid and the projected average monthly number of correspondence counts.

3) Costs are shared between federal funds (FF) and General Fund (GF).

| Fiscal Year | TF | GF | FF |
|---|---|---|---|
| FY 2017-18 | $179,000 | $89,500 | $89,500 |

**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 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 | $174,000 | $0 |
| STATE FUNDS | $43,500 | $0 |
| FEDERAL FUNDS | $130,500 | $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 current FI anticipates the end of operations at the end of January 2018 with the new contractors assuming operational responsibility immediately thereafter. 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 an increase due to invoices paid and updated projected billable hours based on the current average number of billable hours per month. 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. 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. The cost break down of billable hours for the security risk assessment process is projected at a rate of $240 per hour for FY 2017-18.

3. Costs are shared between federal funds (FF) and General Fund (GF).

| Fiscal Year | TF | GF | FF |
|---|---|---|---|
| FY 2017-18 | $174,000 | $43,500 | $130,500 |

**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 | $421,326,000 | $382,359,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $421,326,000 | $382,359,000 |

## 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 | $746,168 | $373,084 | $373,084 |
| CMIPS II | $96,484 | $48,242 | $48,242 |
| **Total** | $842,652 | **$421,326** | $421,326 |
| | | | |
| **FY 2018-19** | **TF** | **DHCS FFP** | **CDSS GF/ County Match** |
| EW Time & Health Related | $673,956 | $336,978 | $336,978 |
| CMIPS II | $90,762 | $45,381 | $45,381 |
| **Total** | $764,718 | **$382,359** | $382,359 |

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 | $299,589,000 | $299,700,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $299,589,000 | $299,700,000 |

## 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); and 4) Adult Protective Services (APS).

**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 | $332,126 | $166,063 | $166,063 |
| CWS/CMS | $8,664 | $4,332 | $4,332 |
| CSBG/APS | $258,388 | $129,194 | $129,194 |
| **TOTAL** | $599,178 | **$299,589** | $299,589 |

| FY 2018-19 | TF | DHCS FFP | CDSS GF/ County Match |
|---|---|---|---|
| CWS | $332,348 | $166,174 | $166,174 |
| CWS/CMS | $8,664 | $4,332 | $4,332 |
| CSBG/APS | $258,388 | $129,194 | $129,194 |
| **TOTAL** | $599,400 | **$299,700** | $299,700 |

**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 | $126,267,000 |
| STATE FUNDS | $26,008,790 | $26,135,040 |
| FEDERAL FUNDS | $99,673,210 | $100,131,960 |

## 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 integrate the Medi-Cal Eligibility Data System (MEDS) into the 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 the technology solutions for 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.

**Reason for Change:**
The change from the prior estimate, for FY 2017-18, is an increase due to a higher shared costs allocation rate for the Department and employee compensation, benefit, and retirement adjustments.

The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to FY 2018-19 being a full year of shared costs for the Department at the increased rate.

**Methodology:**

1. Employee compensation, benefit, and retirement costs increased in July 2017. Since these costs are not currently reflected in the Department's budget, costs are based on the Department of Finance's baseline budget adjustments.

2. Contractors began D&I work in July 2012 with payments beginning in August 2012. M&O started in January 2015.

3. 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.

4. Effective October 1, 2017, FY 2017-18 and 2018-19 costs are based on the estimated enrollment for shared costs at a proposed 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.

5. 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 | $84,768,000 | $21,192,000 | $63,576,000 |
| 88% Title XXI FF / 12% GF | $16,863,000 | $2,024,000 | $14,839,000 |
| 90% Title XIX FF / 10% GF | $21,186,000 | $2,119,000 | $19,067,000 |
| CalHEERS Subtotal | $122,817,000 | $25,335,000 | $97,482,000 |
| | | | |
| 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** | **$126,267,000** | **$26,136,000** | **$100,131,000** |

**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: | Joel Singh |
| FISCAL REFERENCE NUMBER: | 243 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| TOTAL FUNDS | $52,239,000 | $51,378,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $52,239,000 | $51,378,000 |

## 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 from the prior estimate, for FY 2017-18, is a net decrease due to revising the estimate based on updated prior year expenditures and FY 2017-18 expenditure projections. The change from FY 2017-18 to FY 2018-19, in the current estimate, is a net decrease due to fewer prior year expenditures in FY 2018-19.

# 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. | $4,686,000 | $4,686,000 | 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. | $7,277,000 | $7,277,000 | 03-75284 |
| | TCM HIPAA* | $638,000 | $0 | 03-75284 |
| | **Total** | **$52,239,000** | $40,683,000 | |

| FY 2018-19 | | DHCS FFP | CDDS GF | IA # |
|---|---|---|---|---|
| 1 | DC/SOCF Medi-Cal Admin. | $4,659,000 | $4,659,000 | 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. | $6,473,000 | $6,473,000 | 03-75284 |
| | TCM HIPAA* | $638,000 | $0 | 03-75284 |
| | **Total** | **$51,378,000** | $39,822,000 | |

**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: | Joel Singh |
| FISCAL REFERENCE NUMBER: | 234 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| TOTAL FUNDS | $35,201,000 | $37,522,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $35,201,000 | $37,522,000 |

## 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 program 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:**
There is no change from the prior estimate for FY 2017-18.

The change in the current estimate, from FY 2017-18 to FY 2018-19, is due to a higher projection for FY 2018-19 due to an increase in county funds match for anticipated program expansion and outreach.

**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 | $2,861 | $1,196 | $1,152 |
| CPSP & PCG | $31,012 | $0 | $21,961 |
| AFLP | $1,328 | $0 | $1,178 |
| **Total** | **$35,201** | $1,196 | $24,291 |

| FY 2018-19 | DHCS FFP | CDPH GF | County Match |
|---|---|---|---|
| BIH | $4,130 | $2,297 | $1,299 |
| CPSP & PCG | $32,022 | $0 | $22,772 |
| AFLP | $1,370 | $0 | $1,215 |
| **Total** | **$37,522** | $2,297 | $25,286 |

**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 | $29,829,000 | $29,829,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $29,829,000 | $29,829,000 |

## 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)
Interagency Agreement (IA) 17-94267

**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:**
There is no change from the prior estimate for FY 2017-18.
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 $9,943,000 for FY 2017-18 and FY 2018-19.

(Dollars in Thousands)

| Fiscal Year | TF | CDSS GF | DHCS FFP |
|---|---|---|---|
| **FY 2017-18** | $39,772 | $9,943 | **$29,829** |
| **FY 2018-19** | $39,772 | $9,943 | **$29,829** |

**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 | $37,029,000 | $36,257,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $37,029,000 | $36,257,000 |

## 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) 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, is an increase due to revised expenditure data provided by CDSS. 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.

# 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 | $15,570,000 | $7,785,000 | $7,785,000 |
| IHSS Health Related | $162,000 | $81,000 | $81,000 |
| CWS/CMS for Medi-Cal | $598,000 | $299,000 | $299,000 |
| IHSS Plus Option Sec. 1915(j) | $5,860,000 | $2,930,000 | $2,930,000 |
| SAWS | $532,000 | $266,000 | $266,000 |
| Medi-Cal State Hearings | $19,600,000 | $9,800,000 | $9,800,000 |
| Public Inquiry and Response | $630,000 | $315,000 | $315,000 |
| Medicaid Disability Evaluation Services | $31,106,000 | $15,553,000 | $15,553,000 |
| **TOTAL** | $74,058,000 | **$37,029,000** | $37,029,000 |
| | | | |
| **FY 2018-19** | **TF** | **DHCS FFP** | **CDSS GF** |
| IHSS PCSP | $15,482,000 | $7,741,000 | $7,741,000 |
| IHSS Health Related | $111,000 | $56,000 | $56,000 |
| CWS/CMS for Medi-Cal | $789,000 | $394,000 | $394,000 |
| IHSS Plus Option Sec. 1915(j) | $4,185,000 | $2,093,000 | $2,093,000 |
| SAWS | $476,000 | $238,000 | $238,000 |
| Medi-Cal State Hearings | $19,600,000 | $9,800,000 | $9,800,000 |
| Public Inquiry and Response | $764,000 | $382,000 | $382,000 |
| Medicaid Disability Evaluation Services | $31,106,000 | $15,553,000 | $15,553,000 |
| **TOTAL** | $72,513,000 | **$36,257,000** | $36,257,000 |

*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: | Joel Singh |
| FISCAL REFERENCE NUMBER: | 1192 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| TOTAL FUNDS | $15,145,000 | $14,945,000 |
| STATE FUNDS | $3,907,000 | $3,907,000 |
| FEDERAL FUNDS | $11,238,000 | $11,038,000 |

## 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 reason for change from the prior estimate, for FY 2017-18, is an increase due to a higher cost projection for CLPP based on actual billings.

The change in the current estimate, from FY 2017-18 to FY 2018-19, 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 | $2,307,000 | $0 | $0 | $2,307,000 |
| CHCQ | $2,387,000 | $0 | $0 | $2,387,000 |
| Skilled Nursing Facilities | $3,907,000 | $3,907,000 | $0 | $0 |
| **Total** | **$11,238,000** | **$3,907,000** | $2,637,000 | $4,694,000 |

# 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 | $2,107,000 | $0 | $0 | $2,107,000 |
| CHCQ | $2,387,000 | $0 | $0 | $2,387,000 |
| Skilled Nursing Facilities | $3,907,000 | $3,907,000 | $0 | $0 |
| **Total** | **$11,038,000** | **$3,907,000** | $2,637,000 | $4,494,000 |

**Funding:**
100% Title XIX FFP (4260-101-0890)*
SNF Quality & Accountability (non-GF) (4260-605-3167)**
Childhood Lead Poisoning Prevention Fund (non-GF) (4260-001-0080)***

# 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 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 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.

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:**
The decrease from the prior estimate, for FY 2017-18, is due to updated actual funds remaining in the grant after finalization of FY 2016-17 paid invoices. The change 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 | $ 4,167 | $ 4,166 |
| Renewal Assistance | $ 3,609 | $ 1,804 | $ 1,805 |
| 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: | Joel Singh |
| 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:**
The change from the prior estimate, for FY 2017-18, is an increase due to delayed invoices for FY 2016-17 costs, previously budgeted in FY 2016-17, shifting to FY 2017-18. The change in the current estimate, from FY 2017-18 to FY 2018-19, is due to less 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:**
Projections were updated by CDA.

# 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 | $30 | $31 |
| FY 2017-18 DOS | $1,926 | $2,242 | $1,926 | $2,242 |
| FY 2018-19 DOS | | | | |
| **Total CBAS** | $1,956 | $2,273 | $1,956 | $2,273 |
| | | | | |
| **MSSP Support** | | | | |
| FY 2015-16 DOS | $1 | $1 | $1 | $1 |
| FY 2016-17 DOS | $13 | $13 | $13 | $13 |
| FY 2017-18 DOS | $1,318 | $1,521 | $1,318 | $1,521 |
| FY 2018-19 DOS | | | | |
| **Total MSSP** | $1,332 | $1,535 | $1,332 | $1,535 |
| | | | | |
| **ADRC Support*** | | | | |
| FY 2016-17 DOS | | $1 | | $1 |
| FY 2017-18 DOS | | $284 | | $284 |
| FY 2018-19 DOS | | | | |
| **Total ADRC** | | $285 | | $285 |
| | | | | |
| **Grand Total** | **$3,288** | **$4,093** | **$3,288** | **$4,093** |

**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: | Candace Epstein |
| FISCAL REFERENCE NUMBER: | 1774 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| TOTAL FUNDS | $1,668,000 | $874,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $1,668,000 | $874,000 |

## 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.

**Authority:**
Contract 15-92272

**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.

**Reason for Change:**
FY 2017-18 is higher than the prior estimate due to delays in invoicing, resulting in all invoices for FY 2015-16 and FY 2016-17 being paid in FY 2017-18. Costs shown in the prior estimate for data interchange development in FY 2017-18 have been removed. The data interchange was accomplished through modifications to existing data exchange methods. Costs for FY 2018-19 are lower than FY 2017-18 because of the approved contract amount.

**Methodology:**
1. The Department and CDPH will receive 75% FFP for ongoing costs to deliver data in an automated fashion.

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.

# VITAL RECORDS DATA

## OTHER ADMIN. POLICY CHANGE NUMBER: 98

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.

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 | FFP |
|---|---|---|---|
| FY 2015-16 Claims | $184 | $46 | $138 |
| FY 2016-17 Claims | $1,166 | $292 | $874 |
| FY 2017-18 Claims | $874 | $218 | $656 |
| **Total** | $2,224 | $556 | **$1,668** |

(Dollars in thousands)

| FY 2018-19 | TF | HSSF | FFP |
|---|---|---|---|
| FY 2017-18 Claims | $291 | $73 | $218 |
| FY 2018-19 Claims | $874 | $218 | $656 |
| **Total** | $1,165 | $291 | **$874** |

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

# CALIFORNIA SMOKERS' HELPLINE

| | |
|---|---|
| OTHER ADMIN. POLICY CHANGE NUMBER: | 99 |
| IMPLEMENTATION DATE: | 1/2014 |
| ANALYST: | Joel Singh |
| FISCAL REFERENCE NUMBER: | 1680 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| TOTAL FUNDS | $1,321,000 | $2,200,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $1,321,000 | $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 that 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 FY 2016-17, Quarter 3 claims, previously budgeted in FY 2016-17, now budgeted in FY 2017-18 as a result of a delay in claims processing.

The change in the current estimate, from FY 2017-18 to FY 2018-19, 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 FY 2016-17, Q3 claims and FY 2017-18 Q1-Q4 claims. It is assumed that there will be no invoices for FY 2016-17, Q4.

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 2016-17 Claims, Q3 | $321,000 | $321,000 |
| FY 2017-18 Claims | $1,000,000 | $1,000,000 |
| **Total** | **$1,321,000** | **$1,321,000** |

| FY 2018-19 | TF | FF |
|---|---|---|
| FY 2018-19 Claims | $2,200,000 | $2,200,000 |
| **Total** | **$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. 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

**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:**
The change from the prior estimate, for FY 2017-18, is an increase due to the approval of a new outreach program resulting in additional administrative dollars. 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 July 2017. Payments will tentatively begin in October 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. 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) 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 CDCR to:

- Claim federal reimbursement for inpatient hospital services for adult inmates in State correctional facilities when these services are provided off the grounds of the State correctional facility, and the inmates are determined eligible for either the Medi-Cal program or the Low Income Health Program (LIHP) run by counties. As part of these provisions, CDCR is claiming federal financial participation (FFP) for their administrative costs to operate the Inmate Eligibility Program. The federal funds provided to CDCR are included in the Medi-Cal inpatient hospital costs for inmates and LIHP inpatient hospital costs for CDCR inmates policy changes respectively. LIHP ended on December 31, 2013 and all inmates with existing LIHP eligibility were transitioned into Medi-Cal, effective January 1, 2014.

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, CDCR submits a Medi-Cal application to the Department to determine eligibility. Previously these services were funded through 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 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. 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 CDCR's 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: | Joel Singh |
| FISCAL REFERENCE NUMBER: | 261 |

| | FY 2017-18 | FY 2018-19 |
|---|---|---|
| TOTAL FUNDS | $752,000 | $827,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $752,000 | $827,000 |

## 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, is an increase due to more agencies choosing to match funds for the program. The change in the current estimate, from FY 2017-18 to FY 2018-19, is due to delayed invoices for FY 2017-18 shifting to FY 2018-19.

**Methodology:**
1. CDPH budgets the non-federal matching funds.

2. Annual expenditures on an accrual basis are $1,654,000.

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 | $1,158,000 | $579,000 | $579,000 |
| **Total** | $1,504,000 | $752,000 | **$752,000** |

| FY 2018-19 | TF | CDPH GF | DHCS FF |
|---|---|---|---|
| FY 2017-18 | $496,000 | $248,000 | $248,000 |
| FY 2018-19 | $1,158,000 | $579,000 | $579,000 |
| **Total** | $1,654,000 | $827,000 | **$827,000** |

**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 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 | $62,000 | $0 |
| STATE FUNDS | $62,000 | $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 Medi-Cal dental fiscal intermediary (FI) processes and pays claims for FY 2016-17. For FY 2017-18, the new Administrative Services Organization (ASO) contractor will process claims and the new FI contractor will adjudicate 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 will include 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 a decrease due to a partial year of costs with the implementation of full restoration of adult dental benefits on January 1, 2018 and CDSS no longer needing to cover these services. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to no additional costs are expected in FY 2018-19.

# 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 from the current average number of claims processed.

2. All costs are reimbursed by CDDS.

**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.
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 | $21,284,000 |
| STATE FUNDS | $0 | $3,040,000 |
| FEDERAL FUNDS | $0 | $18,244,000 |

## 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
  - timeframes for making authorization decisions within five (5) business days of 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:**
This is a new policy change.

**Methodology:**

1. The estimated costs of Parity Regulations, related to changing authorization of outpatient services, are based on the estimated number of hours county staff would spend performing these authorizations.

2. Service authorizations for SMHS 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. To comply with the Parity Final Rule, MHPs will need to shorten times for the authorization of treatment plans for both outpatient and inpatient services, beginning July 2018.

# MANAGED CARE REGULATIONS - MH PARITY

## OTHER ADMIN. POLICY CHANGE NUMBER: 109

4. Assume each county will need an additional hour per 429,249 SMHS clients to evaluate and authorize treatment plans at a cost of $56.67 per hour, including benefits. The total estimated annual costs are $24,324,000 TF.

5. The estimated total for FY 2018-19 is:

(Dollars in Thousands)

| Treatment Plan Authorizations | TF | GF | FF | CF |
|---|---|---|---|---|
| **FY 2018-19** | $24,324 | **$3,040** | **$18,244** | $3,040 |

**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:**
The change from the prior estimate, for FY 2017-18, is a net increase due to the inclusion of Release I hosting and M&O costs. The change from FY 2017-18 to FY 2018-19, in the current estimate, is due to increased Release I hosting and M&O costs.

# 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 | $642,000 | $5,785,000 |
| 100% GF | $147,000 | $147,000 | $0 |
| **Total** | **$7,042,000** | **$1,023,000** | **$6,019,000** |

| FY 2018-19 | TF | GF | FF |
|---|---|---|---|
| 50% Title XIX / 50% GF | $561,000 | $280,000 | $281,000 |
| 90% Title XIX / 10% GF | $7,712,000 | $771,000 | $6,941,000 |
| 100% GF | $177,000 | $177,000 | $0 |
| **Total** | **$8,450,000** | **$1,228,000** | **$7,222,000** |

**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)

**MEDI-CAL INFORMATION ONLY**
**November 2017**
***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)

## AFFORDABLE CARE ACT

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 to a new group of individuals: primarily adults, age 19-64, without a disability and who do not have minor children.

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.

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 chronic, disabling condition that causes functional impairment expected to last 12 consecutive months or longer or result in death within 12 months and unable to remain safely at home without the services.

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

The four IHSS programs are:

1. Personal Care Services Program (PCSP)
   This program provides personal care services including but not limited to non-medical personal services, paramedical services, domestic services, and protective supervision.
2. IHSS Plus Option (IPO)
   This program provides personal care services but also allows the recipient of services to select a family member as a provider.
3. Community First Choice Option (CFCO)
   This program provides personal care services to those who would otherwise be institutionalized in a nursing facility.
4. Residual (beneficiaries are not full-scope Medi-Cal; State-only program with no FFP)

## HOME AND COMMUNITY BASED SERVICES

Targeted Case Management (TCM)

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

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

**1915(i) HCBS State Plan Services**

The 1915(i) State Plan Services program provides home and community-based services (HCBS) to persons with developmental disabilities (DD) who are Regional Center consumers but do not meet nursing facility level of care criteria required for enrollment in the HCBS Waiver of Persons with DD. As of February 1, 2016, Behavioral Health Treatment (BHT) services for 1915(i) participants under the age of 21 will be a state plan benefit and paid through the managed care delivery system or fee-for-service for members not eligible to enroll into managed care. The 1915(i) state plan amendment is approved from October 1, 2011 through September 30, 2016. The Department initiated the 1915(i) renewal process by submitting a State Plan amendment (SPA) to CMS on 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 ~~are working with CMS to submit~~ **submitted** a SPA reflecting the rate changes~~, retroactive to July 1, 2016~~. **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**, ~~Nursing Facility/Acute Hospital (NF/AH) Waivers,~~ Multipurpose Senior Services Program (MSSP), HCBS Waiver for Persons with (DD~~), Self-Directed Program (SDP) for Persons with Developmental Disabilities, San Francisco Community Living Support Benefit (CLSB)~~, 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.

Assisted Living Waiver (ALW)

The ALW pays for assisted services and supports, care coordination, and community transition in 14 counties (Sacramento, San Joaquin, Los Angeles, Riverside, Sonoma, Fresno, San Bernardino, Alameda, Contra Costa, San Diego, Kern, San Mateo, 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 ~~00~~. 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, retroactive to July March~~ 1, 2017, ~~the Department will expand into San Francisco County and transition~~ **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.

Community-Based Adult Services (CBAS)

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

Home and Community-Based Alternatives (HCB Alternatives) Waiver

The HCB Alternatives 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. ~~This waiver will provide enhanced case management services through a local contracted Care Management Agency (CMA). The participants enrolled in this waiver will receive all medically necessary services as outlined in his/her care plan and approved by the CMA.~~ **The Department will contract with Care Management Contractors (Waiver Agencies) for the purpose of performing waiver**

## HOME AND COMMUNITY BASED SERVICES

**administration functions and directing the Comprehensive Care Management waiver service. The Waiver Agencies are responsible for functions including: participant enrollment, Level of Care (LOC) evaluations, Plan of Treatment (POT) and person-centered care/service plan review and approval, waiver service authorization, utilization management, provider enrollment/network development, quality assurance activities and reporting to ~~DHCS~~ the Department, billing the Fiscal Intermediary (FI), and provider claims adjudication.**

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 ~~is in the process of renewing the NF/AH Waiver which expired on December 31, 2016~~ **received approval of the HCB Alternatives Waiver on May 16, 2017 with a January 1, 2017 effective date. The Department will implement the Waiver Agency model no sooner that January 1, 2018.** ~~To ensure a sufficient review period, CMS approved the extension of the current waiver through March 30, 2017.~~ The waiver renewal ~~was submitted to CMS with a proposed effective date of January 1, 2017 and~~ 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 ~~Nursing Facility/Acute Hospital Waiver~~ **Home and Community Based Alternatives 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~~ **the** Department will **offer the option of transitioning to the HCB Alternatives Waiver.** ~~integrate and close the IHO waiver into the new HCB Waiver as of January 1, 2017.~~ **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

## HOME AND COMMUNITY BASED SERVICES

- 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.

~~The SFDPH has not achieved targeted enrollment due to lack of housing in community care facilities and DAH sites. As a result, CMS approved a waiver amendment on September 23, 2013, which adjusted enrollment estimates.~~ The waiver ~~is~~ **was** approved from July 1, 2012, through June 30, 2017~~. Effective July 1, 2017, the Department will integrate the SF CLSB waiver population into the ALW. As a result of this integration~~ **Due to the similarity of services offered**, **the Department expanded the Assisted Living Waiver (ALW) to San Francisco County effective March 1, 2017.**~~the~~ **The** Department ~~will~~ **did** not renew the SF CLSB waiver upon completion of its ~~current~~ 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

## HOME AND COMMUNITY BASED SERVICES

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.**

~~Approved capacity of unduplicated recipients for this waiver is 4,490 in 2014, 4,570 in 2015 and 4,660 in 2016. The waiver is approved from January 1, 2012 through December 31, 2016. The Department initiated the waiver renewal process and was submitted to CMS for renewal with a proposed effective date of January 1, 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.**

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: ~~12,000~~ **11,684**
- Waiver Year 3: ~~12,000~~ **11,684**
- Waiver Year 4: ~~5,624~~ **11,684**
- Waiver Year 5: ~~5,624~~ **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 than January 1, ~~2018~~ **2020** in the ~~seven~~ **six** CCI counties: Los Angeles,

## HOME AND COMMUNITY BASED SERVICES

Orange, Riverside, San Bernardino, San Diego, ~~San Mateo,~~ and Santa Clara. **The initial reduction for the unduplicated recipients in Waiver Year 2 was a result of the completed CCI implementation 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 the delay of the MSSP transition into managed care to no sooner than January 1, 2020, and slots need to be restored to ensure that services continue to be provided to members. CMS approved the amendment on April 27, 2016, with an effective date of July 1, 2016.**

Home and Community-Based Waiver for Persons with Developmental Disabilities

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. Approved capacity of unduplicated recipients for this waiver is 110,000 in 2013, 115,000 in 2014 and 120,000 in 2015. The waiver is approved from March 29, 2012 through March 28, 2017. 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.

**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.

## HOME AND COMMUNITY BASED SERVICES

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.

**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.**

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.**

**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.

**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.

## 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

## 1115 WAIVER-MH/UCD, BTR, & MEDI-CAL 2020

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

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

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

# MANAGED CARE

## Medi-Cal Managed Care Rates

~~Base Rates are developed through encounter and claims data available for each plan for the most recent 12 months and plans' self-reported utilization and encounters by category of service (i.e., Inpatient, ER, Pharmacy, Primary Care Provider, Specialist, Federally Qualified Health Center (FQHC), etc.) for each rate category for the same period. Medi-Cal eligibility and paid claims data are used to identify all births occurring in each county and health plan. The expenditures associated with labor and delivery services are then removed from the base expenditure data. The delivery events and associated maternity costs are carved out of the Adult and Seniors and Persons with Disabilities (SPDs) Medi-Cal Only aid categories to establish a budget neutral county specific maternity supplemental payment, or appropriate funding built into the rates for plans that do not receive a maternity supplemental payment.~~

~~Trend studies are performed and policy changes are incorporated into the rates. Medi-Cal specific financial statements are gathered for each plan for the last five quarters. Administrative loads are developed based upon a Two-Plan program average. Plan specific rates are established based upon all of the aforementioned steps.~~

~~A financial experience model is developed by trending plan specific financial data to the mid-point of the prospective rate year. The financial experience is then compared to the rate results established through the rate development model. If the result is reasonable, the rates are established from the rate development model. If the result is not reasonable, additional research is performed and the rates are adjusted based upon the research and actuarial judgment.~~

~~The maternity supplemental payments are in addition to the health plan's monthly capitation payment and are paid based on the plan's reporting of a delivery event. Maternity supplemental payment amounts are done in a budget neutral manner so that the cost of the expected deliveries does not exceed the total dollars removed from the Adult and SPD Medi-Cal Only capitation rates. Managed Care County Organized Health Systems (COHS) plans do not receive a maternity supplemental payment; the costs associated with maternity events are included in the COHS health plan's monthly capitation payments. 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.~~

~~Prior to July 1, 2014, rates for the Family category of aid (COA) were paid as one blended rate. Effective July 1, 2014, the department has split the Family COA in 2 groups: "Child (Under 19)" and "Adult/Family (19 and Over)".~~

~~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 Adult/Family and SPD Medi-Cal Only COA.~~

~~Risk Adjustment and County Averaging is prepared with plan- specific pharmacy data (with National Drug Codes) gathered for Managed Care and Fee-for-Service enrollment data for the~~

## MANAGED CARE

~~most recent 12-month period. A cut-off date is established for the enrollment look-back. If a beneficiary is enrolled for at least 6 out of 12 months (not necessarily consecutive), then the beneficiary will be counted in the plan's risk scoring calculation.~~

~~Medicaid RX from UC San Diego is the Risk Adjustment Software used. Medicaid RX classifies risk by 11 age bands, gender, and 45 disease categories. Each member in the Adult/Family or SPD Medi-Cal Only rate category, in a specific plan, that meets the eligibility criteria, is assigned a risk score. Member scores are aggregated to develop two risk scores for each plan operating in a county; a one risk score for the Adult/Family rate and one for the SPD Medi-Cal Only rate. A county-specific rate is then developed for the Adult/Family rate and the SPD Medi-Cal Only rate. The basis for the county specific rate is the aggregate of the plan-specific rates developed and each plan's enrollment for a weighted average county rate. For the FY 2016-17 and FY 2017-18 rates, 65% of this county specific rate was taken and multiplied by each plan's respective risk score and 35% of each plan's plan specific rate was retained and added to the 65% risk adjusted rate to establish a risk adjusted plan specific rate. The risk adjustment policy will be examined in future years and adjusted if determined necessary.~~

~~For COHS, rates continue to be based on the plans' reported expenditures trended in the same manner as for the Two Plan and Geographic Managed Care models.~~

**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**

## MANAGED CARE

**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) ~~projects~~ **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. Based on the lessons learned from the CCI demonstration project, the Budget ~~proposes~~ **proposed** the extension of the Cal MediConnect **(CMC) program** and the mandatory enrollment of dual eligible **beneficiaries** and ~~integrating~~ **the integration** of long-term services and supports, except In-Home Supportive Services (IHSS), into managed care. IHSS would be removed from capitation rate payments effective January 1, 2018.

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

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

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

In addition to managed care carve-outs, the Department is required to provide additional reimbursement through the FFS Medi-Cal program to Federally Qualified Health Center/Rural Health Clinic providers who have rendered care to beneficiaries enrolled in managed care plans. These providers are reimbursed for the difference between their prospective payment

## MANAGED CARE

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.

**~~2016-17 and~~ 2017-18 and 2018-19 Rates**

~~Overall, the FY 2016-17 rates represent a 4.29% increase in classic rates and an 8.85% ACA Optional Expansion rate decrease over the previous fiscal year rates (based on a fiscal year comparison).~~ Rates for FY 2017-18 represent a **1.86%**~~3.69%~~ increase in classic rates over the 2016-17 fiscal year rates and assume the Optional Expansion rates are held constant. **Rates for FY 2018-19 represent a 2.75% increase in classic rates over the 2017-18 fiscal year rates.**

# PROVIDER RATES

Reimbursement Methodology and the Quality Assurance Fee for AB 1629 Facilities

AB 1629 requires the Department to develop a cost-based, facility-specific reimbursement rate methodology for freestanding skilled (level B) nursing facilities, including subacute units which are part of a freestanding skilled nursing facility. Rates are updated annually and are established based on the most recent audited cost report data. AB 1629 also imposed a Quality Assurance Fee (QAF) on these facilities and added requirements for discharge planning and assistance with community transitions.

The rate methodology developed by the Department computes facility-specific, cost-based per diem payments for SNFs based on five cost categories, which are subject to limits. Limits are set based on expenditures within geographic peer groups. Also, costs specific to one category may not be shifted to another cost category.

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

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

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

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

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

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

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

# PROVIDER RATES

Quality and Accountability Supplemental Payment Program

SB 853 (Chapter 717, Statutes of 2010) requires the Department to implement a Quality and Accountability Supplemental Payment (QASP) Program for SNFs by August 1, 2010. The QASP Program will enable SNF reimbursement to be tied to demonstrated quality of care improvements for SNF residents. AB 1489 (Chapter 631, Statutes of 2012) delayed the payments and required the Department to make the payments by April 30, 2014.

AB 119 (Chapter 17, Statutes of 2015) extends the AB 1629 facility-specific rate methodology, QAF, and QASP program through July 31, 2020. Further, beginning rate year 2015-16, the annual weighted average rate increase is 3.62%, and the QASP will continue at FY 2014-15 levels, rather than setting aside a portion of the annual rate increase. Additionally, beginning FY 2015-16, the legislation requires the Department to incorporate direct care staff retention as a performance measure into the QASP Program.

Reimbursement Methodology for Other Long-Term Care Facilities (non-AB 1629)

The reimbursement methodology is based on a prospective flat-rate system, with facilities divided into peer groups by licensure, level of care, bed size and geographic area in some cases. Rates for each category are determined based on data obtained from each facility's annual or fiscal period closing cost report. Audits conducted by the Department result in adjustments to the cost reports on an individual or peer-group basis. Adjusted costs are segregated into four categories:

Fixed Costs (Typically 10.5 percent of total costs). Fixed costs are relatively constant from year to year, and therefore are not updated. Fixed costs include interest on loans, depreciation, leasehold improvements and rent.

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

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

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

**Methodology by Type of LTC Facility**

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

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

## PROVIDER RATES

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

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

Effective August 1, 2016, ABX2 1 (Chapter 3, Statutes of 2016) requires the Department to reimburse ICF/DD, ICF/DD-H, and ICF/DD-N providers the rate in effect in the 2008-09 rate year, increased by 3.7%.

**The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) revenue provided a funding source for supplemental payments to ICF/DD facilities. AB 120 (Chapter 22, Statutes of 2017) appropriated said funds for supplemental payments to ICF/DDs in the 2017-18 Rate Year.**

Subacute Care Facilities are grouped into two statewide peer groups: hospital-based providers and freestanding nursing facility providers. Subacute care providers are reimbursed their projected costs up to the median of their peer group.

Pediatric Subacute Care Units/Facilities are grouped into two peer groups: hospital-based nursing facility providers and freestanding nursing facility providers. There are different rates for ventilator and non-ventilator patients. Reimbursement is based on a model since historical cost data were not previously available.

## INFORMATION ONLY

### REVENUES

1. Revenues

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

| | | |
|---|---|---|
| FY 2016-17: | $ ~~27,208,000~~ **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 | Hospital Quality Assurance Revenue Fund (Item 4260-611-3158) |
| | $ ~~8,000,000~~ **$7,800,000** | Emergency Medical Air Transportation (EMATA) Fund |
| | $ ~~7,180,594,000~~ **7,180,370,000** | Total |
| FY 2017-18: | $ ~~27,644,000~~ **26,351,000** | ICF-DD Quality Assurance Fee |
| | $ ~~539,591,000~~ **503,746,000** | Skilled Nursing Facility Quality Assurance Fee (AB 1629) |
| | $ ~~9,874,000~~ **10,165,000** | ICF-DD Transportation/Day Care Quality Assurance Fee |
| | $ ~~1,267,000~~ **933,000** | Freestanding Pediatric Subacute Quality Assurance Fee |
| | $ 2,428,921,000 | MCO Enrollment Tax |
| | $ 3,790,120,000 | Hospital Quality Assurance Revenue Fund (Item 4260-611-3158) |
| | $ ~~6,000,000~~ **7,008,000** | Emergency Medical Air Transportation (EMATA) Fund |
| | $ ~~6,803,417,000~~ **6,767,244,000** | Total |
| FY 2018-19: | **$ 26,775,000** | ICF-DD Quality Assurance Fee |
| | **$ 533,971,000** | Skilled Nursing Facility Quality Assurance Fee (AB 1629) |
| | **$ 10,165,000** | 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** | Hospital Quality Assurance Revenue Fund (Item 4260-611-3158) |
| | **$ 7,008,000** | Emergency Medical Air Transportation (EMATA) Fund |
| | **$ 7,190,608,000** | Total |

**INFORMATION ONLY**

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.

~~SB 78 (Chapter 33, Statutes of 2013) provides for a statewide tax on the total operating revenue of Medi-Cal Managed Care Plans. Although this tax is effective through June 2016, it has been deemed out of compliance with federal regulations and will be replaced with a new tax beginning July 1, 2016. Proposed legislation~~ **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.

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.

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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.

## ELIGIBILITY

1. ~~County Administration Base~~

~~The Department is in the process of finalizing a Request for Proposal (RFP) for approval to hire a contractor to begin evaluating county processes and time-studies associated with the new budgeting methodology. The Department anticipates the workgroup to begin meeting in FY 2017-18.~~

2. 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.

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3. 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.

**AFFORDABLE CARE ACT**

Optional Expansion Medical Loss Ratio (MLR) Audit Requirement

**This assumption is now a policy change, ACA Optional Expansion MLR Risk Corridor.**

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 ~~$986.2 million~~ **$1.006 billion** for FY 2014-15, $585.9 million for FY 2016-17, ~~and $546.2~~ **$688.8** million for FY 2017-18**, and $530.47 million for FY 2018-19**. ~~Final reconciliation for FY 2013-14 is estimated to cost $164.6 million to be paid in FY 2016-17.~~

**BENEFITS**

California Children's Services (CCS)-Medical Therapy Program (MTP) – Potential Impact of Special Education Litigation

## INFORMATION ONLY

**This item has been deleted because it is currently a policy change in the Family Health Estimate, CCS-MTP – Special Education.**

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.

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

### HOME & COMMUNITY BASED-SERVICES

### 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 pursuing contracts for these rebates.

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

On February 1, 2016, CMS published the Final Rule for Covered Outpatient Drugs, effective April 1, 2016. ~~The Final Rule requires states to 1) reimburse pharmacies based on the Actual Acquisition Cost (AAC) of outpatient drugs; and 2) establish a dispensing fee. In order to comply with the Final Rule by April 1, 2017, the Department contracted with Mercer, who completed a survey on pharmacy acquisition costs and a study for the dispensing fee. To reimburse the pharmacies for drug ingredient costs based on the AAC of outpatient~~

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~~drugs, the Department has chosen to adopt a reimbursement methodology using the National Average Drug Acquisition Cost (NADAC). When a NADAC price is not available, the Wholesale Acquisition Cost (WAC) + 0% will be used. Also, the Department will utilize a two tier approach to the dispensing fee based on a pharmacy provider's total annual prescription volume. The Department will need to make State Plan Amendment (SPA) and legislative changes to adjust the existing pharmacy reimbursement and dispensing fee methodology. Due to required claim system changes, implementation of this new reimbursement methodology is not expected until August 2018. Once implemented, these changes are estimated to result in a net savings to the State of approximately $72 million TF ($36 million GF) annually. The fiscal impact may vary based on actual implementation.~~ **In December 2016, CMS required the Department to change its reimbursement methodology for blood factor products and services. The changes require federal approval via a State Plan Amendment (SPA). Appropriate billing codes and a rate methodology must be determined prior to submission of the SPA and initiation of system changes are necessary to process blood factor claims to meet the directives of CMS. Therefore, implementation of this new reimbursement methodology is expected no sooner than August 2018. The fiscal impact of the change to blood factor reimbursement has yet to be determined.**

~~Additionally, recent direction by CMS requires the Department to change its reimbursement methodology for blood factor products and services and submit these changes for federal approval via a SPA. However, due to the same system changes previously noted, implementation of this new reimbursement methodology is not expected until August 2018. 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.

4. New High Cost Treatments for Specific Conditions

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.

## INFORMATION ONLY

### DRUG MEDI-CAL

1. Naltrexone Treatment Services

Naltrexone Treatment provides outpatient Naltrexone services to detoxified persons with opioid dependency and substance use disorder diagnoses. Naltrexone blocks the euphoric effects of opioids and helps prevent relapse to opioid use. Naltrexone services are not provided to pregnant women. While these benefits are available, beneficiaries are currently not utilizing the service.

### MENTAL HEALTH

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. Mental Health Parity

In March 2016, CMS issued the Medicaid mental health parity final rule. The rule stipulates that treatment limitations, including quantitative treatment limitations, non-quantitative 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 must review such treatment limitations, across the entire Medi-Cal 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 has reviewed all MCP and Mental Health Plan (MHP) contract requirements, APLs, and state guidance regarding potential treatment limitations. In January and February 2017, the Department sent MCP and MHPs a survey to identify any additional plan implemented treatment limitations. The survey focused on six main areas: 1) Prior Authorization and Referral Process; 2) Pharmacy and Drug Formulary; 3) Provider Network, Credentialing and Contracting; 4) Case Management and Care Coordination; 5) Treatment Restriction and/or Exclusions; and 6) Financial Requirements. Depending on the survey

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results and other analytics, the Department may have to implement changes to any treatment limitations not in compliance with Medicaid mental health parity, which could result in a financial impact to the State. The Department must demonstrate compliance by October 2017. **Beginning in FY 2018-19, Mental Health parity costs related to SMHS are budgeted in the Managed Care Regulations — MH Parity policy change.**

3. **Comprehensive Behavioral Health Data Modernization Project**

**A Planning Advanced Planning Document has been submitted to request federal financial participation for planning activities to support the Comprehensive Behavioral Health Data Modernization Project. This project will focus on identifying alternative technical solutions to meet the Department's oversight and accountability needs. A key component of this planning work will be to determine how best to leverage the Department's existing information technology infrastructure. The primary project goals are to:**

- **Develop a consolidated reporting and analysis platform integrating data from 12 existing behavioral health data systems, and**
- **Develop monitoring reports and other data products leveraging the consolidated behavioral health data to address statutory requirements, improve program compliance monitoring, and improve program effectiveness and accountability.**

**Upon completion of this analysis, the Department intends to submit an Implementation Advance Planning Document for the cost of the Design, Development, and Implementation activities of the proposed solution, and the procurement of contractors for ideal technical solutions to fulfill identified business needs and requirements.**

**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 ~~Waiver~~) requires California's resolution of all existing negative ~~federal fund grant account~~ **Payment Management System (PMS) subaccount (federal funding)** balances and deferred claims.

- Negative ~~federal fund grant~~ **PMS subaccount** balances: **Pursuant to STC 160 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 ~~are~~ **continue to** actively **work** toward the resolution of these negative ~~grant account~~ **PMS subaccount** balances**. In June of 2017, due to the progress made to date, the CMS waiver team verbally declared that the STC 160 requirements had been met and that they would be sending written confirmation. As of November 2017, written**

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**confirmation from CMS is still pending. STC 160 required that,** for any negative ~~grant account~~ **PMS subaccount** balances remaining after June 30, 2017, CMS will issue a disallowance and require California to return sufficient funding to bring the ~~grant account~~ **PMS subaccount** balances to $0. ~~To date, DHCS has resolved over $500 million in deferrals. DHCS expects there will be a remaining negative grant account balance by June 30, 2017; however, this resolution process is fluid so the June 30, 2017, negative grant account balance is unknown at this time. Upon disallowance, California will have the right to appeal the disallowance.~~ **California has submitted adjustments to resolve a significant portion of the negative PMS subaccount balances via Quarters 1 and 2 of the 2016 grant year. Approval of these adjustments will not be realized until CMS finalizes these quarters which is expected to occur in December 2017, at the earliest. If CMS disallows adjustments or claims, California will have the right to appeal them. STC 160 further required that,** if the appeal is unsuccessful, California will need to repay CMS, in even quarterly installments, with interest, during the life of the **Medi-Cal** 2020 waiver. **Until California receives the written confirmation from CMS that the requirements of STC 160 have been fulfilled, it is unknown when interest will begin for repayments.**

- Repayment of deferred claims: Claims for which California has drawn down federal funding but CMS has deferred on or before June 30, 2017, CMS will issue a disallowance, triggering the appeal process, after which California will be required to reimburse the remaining federal funding. The deferred claims reimbursement **will** not be subject to interest. Some deferred claims contribute to the negative ~~account~~ **PMS subaccount** balances, mentioned above, and will be liquidated through the negative~~ grant account~~ **PMS subaccount** balance resolution. ~~DHCS~~ **California** is actively working to resolve these deferrals and the total federal funding reimbursement is unknown at this time. ~~DHCS~~ **California** ~~is proposing to~~ **will** begin the federal fiscal year quarterly payments ~~in Fiscal Year 2018-19~~ when the amounts are finalized.

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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**

FQHC Alternative Payment Methodology (APM) Pilot

**This item has been deleted as this has been withdrawn.**

Whole Child Model Implementation

**This item has been deleted as this will be included in the California Children's Services Whole Child Model Implementation policy change.**

Health Homes For Patients With Complex Needs

**This item has been deleted as this will be included in the Health Homes for Patients With Complex Needs policy change.**

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### PROVIDER RATES

Newborn Screening Program Fee Increase

**This item has been deleted as this will be included in the GDSP Newborn Screening Program Fee Increase policy change.**

Revised Federal Regulations for Long-Term Care Facilities

**This item has been deleted as this will be included in the AB 1629 Annual Rate Adjustments and the LTC Rate Adjustment policy changes.**

1. **Ground Emergency Medical Transportation Quality Assurance Fee**

**SB 523 (Chapter 773, Statutes of 2017) requires the Department to impose a Ground Emergency Medical Transportation (GEMT) Quality Assurance Fee (QAF) on all ground emergency medical transports. The QAF revenues will be used to**

- **Pay for Department staffing and administrative costs to implement the QAF program,**
- **Pay for health care coverage in each fiscal year in the amount of 10 percent of the annual QAF collection amount, and**
- **Provide an add-on to the reimbursement rates for base ground emergency transport services, along with a federal match.**

**Effective July 1, 2018, the QAF will be assessed on each GEMT transport for base ground emergency medical services, including Medi-Cal, Medicare, and all other payers. The revenue generated by the QAF collections will be deposited directly into the Emergency Medical Transport Fund.**

**In October 2017, the Department began the process to collect transport and revenue data from GEMT providers in order to calculate FY 2018-19 QAF and add-on amounts. The fiscal impact for this program is indeterminate until data has been collected from all data sources including non Medi-Cal revenue and transport data.**

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### 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 ~~"free care" requirement~~ **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 ~~and "free care"~~, provided they meet specific documentation requirements. In order for the SPA to be implemented, the new services and practitioners~~, as well as the "free care" policy,~~ 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 ~~individualized education plan/individualized family service plan (IEP/IFSP)~~ **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.

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

3. **Freestanding Clinics Supplemental Payments**

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

**CMS approved a revised cost report in June 2017. However, despite the efforts undertaken to date to implement the program, there has been little interest from the provider community. Only two clinics have submitted the required program eligibility documents for participation in FY 2017-18. Due to insufficient interest in the program and not enough participants to reimburse the Department for the cost of 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**

Federal Compliance Audit Report for Fiscal Year Ended June 30, 2015

**This item has been deleted as this will be included in the Local Education Agency (LEA) Providers policy change.**

*LA Care v. Department of Health Care Services*

**This item has been deleted as this will be included in the Lawsuits/Claims policy change.**

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

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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 petition**s** and the hospitals ~~have~~ 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 ~~had~~ **did** not participate~~d~~ in the ***Mission*** litigation and ~~had~~ 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, ~~and~~ 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**,** ~~and~~ Community Hospital of Monterey Peninsula**, and Enloe Medical Center** settlement agreements on November 3, 2016, ~~and~~ November 7, 2016, **and March 21, 2017,** respectively. **Recently, 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. ~~It is estimated that the total value of these settlements may be as high as $3,250,000.~~

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

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

The Plaintiffs in these two state court lawsuits are over 30 hospitals, including the 17 that are Plaintiffs in the federal court *Santa Rosa Memorial Hospital* case. The two lawsuits have been consolidated for litigation purposes. The Plaintiffs contend that the 10% Medi-Cal payment reduction and larger reduction for some hospitals that the Department implemented for non-contract hospital inpatient services, pursuant to ABX 4 5 (Chapter 3, Statutes of 2008) and AB 1183 (Chapter 758, Statutes of 2008) violate various federal Medicaid laws, including 42 U.S.C. sections 1396(a)(8), 1396a(a)(13), and 1396a(a)(30). The Plaintiffs seek retroactive damages of almost $100 million, including interest based on the Department's implementation of the AB 5 and AB 1183 reduced payments.

Litigation in this case had been stayed (i.e., placed on hold), until the federal court ruling dismissing the federal court *Santa Rosa Memorial Hospital* lawsuit. After the parties completed briefing on the Plaintiffs' legal claims, there was a court hearing on April 18, 2016. The court tentatively ruled in favor of the Department on July 19, 2016, and a further hearing was held on December 13, 2016. ~~The parties await the court's final statement of decision.~~ **On April 12, 2017, the trial court issued a judgment in favor of the Department. On April 24, 2017, the plaintiffs appealed the judgment. The appellate court has not set a briefing schedule.**

3. AB 97 Rates Litigation

Four 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

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

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

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

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

- *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

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concerning the 10% reductions, is also named as a co-defendant. Plaintiffs contend the reductions violate 42 U.S.C. section 1396a(a)(30)(A).

On January 31, 2012, the court issued an injunction prohibiting implementation of the payment reductions for physicians, dentists, clinics, non-drug pharmacy services, emergency medical transportation, medical supplies, and durable medical equipment, except for services rendered prior to January 31, 2012, that are not reimbursed at the unreduced rates prior to that date. The Department and Plaintiffs appealed that portion of the district court's order excluding some services from the injunction. On March 22, 2012, the Ninth Circuit denied the Department's request for a stay of the injunction pending appeal. On December 13, 2012, the Ninth Circuit issued a decision reversing the preliminary injunction with respect to the AB 97 rate freeze and reduction for DP/NFs. On May 24, 2013, the Ninth Circuit denied the Plaintiffs' request for rehearing and on June 25, 2013 issued an order formally vacating the four court injunctions. On January 13, 2014, the United States Supreme Court denied the Plaintiffs' petition for certiorari asking it to review the Ninth Circuit decision. Now that the injunction is vacated, the Department will implement the AB 97 payment reductions, as described in the 10% Provider Payment Reduction policy changes. This case has been remanded to the federal district court where the Plaintiffs have indicated they intend to seek a new court order prohibiting the Department from implementing the AB 97 reduced payments. **The parties are having settlement discussions.**

- *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.

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

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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 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 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'

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fees. Plaintiff filed a notice of appeal on February 24, 2016, and filed their opening brief on December 27, 2016**. The Department filed its response brief on April 14, 2017. The plaintiffs' reply brief was filed on May 4, 2017.** Oral arguments have not been set.

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 the final judgment. The plaintiffs also appealed the final judgment because it did not grant relief for admissions July 1, 2013-December 20, 2015, and because it requires the plaintiffs to submit the same information that California hospitals are required to submit to establish eligibility to DSH payments under the Medi-Cal program. Appellate briefing is to begin March 4, 2017 and end on or about May 24, 2017. In addition, the plaintiffs have filed a motion for attorney fees and costs totaling $890,407~~, which the Department has opposed. A hearing on that matter is set for January 12, 2017~~. **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 enforcement of the fee award pending the Department's appeal. The parties are concurrently in the process of preparing and filing briefs related to both the Department's appeal and the plaintiffs' appeal of the final judgment.**

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

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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**.** ~~and therefore the Department requested, and was granted, a continuance of the administrative hearing. A new hearing date has not yet been set.~~ **The hearing on remand occurred on March 9, 2017. 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.

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

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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.**

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

- Declare the Waiver's individual cost limitations unlawful;
- Enjoin the Department from reducing services, discriminating against Plaintiffs, and putting them at risk of institutionalization through the cost and eligibility limitations;
- Order the Department to provide Plaintiffs needed services, and amend policies and procedures to meet Plaintiffs' needs and federal cost neutrality requirements. (By, 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' ~~first two~~ **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.** ~~without~~

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~~prejudice. Plaintiffs filed a third MSJ, and the trial date has been vacated pending the court's ruling on the pending motion. The parties are engaged in settlement negotiations.~~**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. Plaintiffs indicate they will refocus their case to allege insufficient provider rates and may convert the case to a class action. A status conference is set for December 7, 2017, and the parties have been ordered to mediation with a magistrate judge.**

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. ~~of Health Care Services (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 parties are currently negotiating a settlement agreement and attorneys' fees.~~ **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 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,

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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's~~ **Department filed its** reply brief ~~is currently due~~ 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 ~~is~~ engaged in litigation in State and Federal ~~court~~ **courts** with the Department of General Services' Office of Administrative Hearings (OAH) to address a

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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 ~~three~~ **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. ~~The Department prevailed in U.S. District Court in a matter originating in Santa Clara County but lost in State Superior Court in a matter originating in Tuolumne County (however, the U.S. District Court commented that the State court erred in its interpretation of the purpose of the due process-complaint procedure). The Department appealed the Tuolumne decision. The California Fifth Appellate District Court of Appeals upheld the superior court's decision in the Tuolumne case, upholding the OAH decision against the Department. Similarly, the child in the Santa Clara matter appealed to the Ninth Circuit Court of Appeal where the child prevailed. In yet a third case arising from Calaveras County, the Sacramento County Superior Court ruled against the Department. OAH prevailed, which~~ **Three cases were litigated up to the appellate court level, but the Department did not prevail. The Department is currently negotiating the attorney fee award in one case with an adverse trial court ruling and will not appeal further. These cases have** established a precedent that has the potential to obligate the CCS/MTP to provide ongoing educationally necessary OT/PT services statewide at an annual and ongoing cost of many millions of dollars. ~~The Department will not appeal the Sacramento court's decision and is currently in settlement negotiations in the Tuolumne case.~~

15. *MALDEF, et al.* Title VI Administrative Complaints**; *Analina Jimenez Perez, et al., v. Diana 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 DHH~~C~~**S** 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~~, and will contact the Department for any additional information~~. There has been no ~~subsequent~~ **DHHS OCR** activity known to the Department since the **administrative** complaint was filed.

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**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.**

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.

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Plaintiffs' petition for writ of mandate was heard on October 28, 2016. The Court denied the writ petition and complaint, ruling in favor of the Department. On November 16, 2016, Plaintiffs filed a notice of appeal.

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. ~~The Department demurred, and the hearing on the Department's demurrer was scheduled for December 1, 2016. However, on November 7, 2016, Plaintiffs filed an amended petition for writ of mandate, resulting in the hearing being taken off calendar. Instead, a~~

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 ~~have~~ 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, 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

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

19. 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.

20. 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 ~~$22,043,234~~ **$28,361,240** in net overpayments to the 61 hospitals.

Department staff have started auditing the hospitals reviewed by OIG to determine actual overpayment amounts based on adjudicated claims. Subsequently, the Department's initial audit findings suggest the OIG's overpayment findings were significantly overstated.

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

21. 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 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 did not bill for and collect from manufacturer rebates of $69,109,297 ($42,564,416 Federal share).

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

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.

23. Audit of California's Medicaid Inpatient Disproportionate Share Hospital (DSH) Payments to Kern Medical Center, Bakersfield, California, State Fiscal Year 1998

The OIG worked to verify that State Fiscal SFY 1998 DSH Payments to Kern Medical Center (KMC) did not exceed the hospital specific limit as mandated by OBRA of 1993.

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

The overstatement of the KMC limit consisted of the following items:

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

OIG recommended the Department refund to the CMS $14,165,950 representing the federal share of the KMC overpayment associated with the findings for Medicare cost

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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.

24. Audit of California's Claims for Specialty Mental Health Services, Federal Fiscal Year 2014

For federal fiscal year 2014, the OIG reviewed $1.4 billion (Federal share) of specialty mental health services claims. Based on the audit's preliminary draft report, the OIG recommends the Department return up to $230.1 million of Federal Financial Participation (FFP) for claims that did not comply with Federal and State requirements. The final audit report ~~will not be~~ **has not been** released ~~until September 2017~~.

**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.

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4. Payment Deferrals

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

**OTHER: RECOVERIES**

1. 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 ~~is expected to~~ **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**

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**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 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.**

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### 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 ~~two~~ **a** new FI contract~~s~~ by September 30, 2019. The new FI contracts will separate the business operations and maintenance and operations (M&O) functions.
   - ~~The business operations contract will allow the Department to move from oversight to ownership for a majority of the FI tasks. The~~ Takeover for the ~~new FI~~ business operations contract is anticipated to begin in ~~October 2018~~ **February 2019, and operations will be assumed in October 2019. The business operations contract will expire in October 2029.**
   - ~~The new M&O contract will transition the California Medicaid Management Information System (CA-MMIS) M&O functions from the current FI to a new contractor. Contract costs may begin in FY 2017-18.~~ **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.**

   ~~In addition, the Department has started contract negotiations with the current FI on the transitions. Additional funding may be needed for the CA-MMIS Go-Forward Plan as a result of the negotiations.~~

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

### 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

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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**

**AFFORDABLE CARE ACT**

**BENEFITS**
PC 53 Women's Health Services

**HOME & COMMUNITY-BASED SERVICES**

**BREAST AND CERVICAL CANCER**

**PHARMACY**
PC 56 Non FFP Drugs

**DRUG MEDI-CAL**

**MENTAL HEALTH**

**1115 WAIVER—MH/UCD & BTR**

**MANAGED CARE**
PC 210 CCI FFS Savings for Additional Enrollment

**PROVIDER RATES**
PC 120 Cencal Health Plan-Addition of CHDP
PC 136 Discontinue Pharmacy Rate Reductions
PC 216 Border Out-of-State Diagnosis Related Group

**SUPPLEMENTAL PAYMENTS**
PC 202 Noncontract Hosp. Inpatient Cost Settlements

**OTHER: AUDITS AND LAWSUITS**

**OTHER: REIMBURSEMENTS**

**OTHER: RECOVERIES**

**FISCAL INTERMEDIARY: MEDICAL**

**FISCAL INTERMEDIARY: HEALTH CARE OPTIONS**

**FISCAL INTERMEDIARY: DENTAL**
PC 52 SRP Prior Auth. & Preventive Dental Services

## DISCONTINUED POLICY CHANGES

### Fully Incorporated into Base Data/Ongoing

**SYSTEMS OF CARE**
PC 36 Implement AAP Bright Futures Periodicity for EPSDT
PC 45 Medical Management and Treatment for ALD

# DISCONTINUED POLICY CHANGES

## Time Limited/No Longer Available

**COUNTY ADMINISTRATION**
CA 8 Prior Year Reconciliations

**ELIGIBILITY**
PC 24 State-Only Former Foster Care Program

**AFFORDABLE CARE ACT**
OA 55 ACA Expansion Admin Costs

**BENEFITS**
PC 49 Quality of Life Surveys for CCT Participants

**HOME & COMMUNITY-BASED SERVICES**

**BREAST AND CERVICAL CANCER**

**PHARMACY**
OA 56 Epocrates

**DRUG MEDI-CAL**
PC 59 Drug Medi-Cal Annual Rate Adjustment

**MENTAL HEALTH**

**1115 WAIVER—MH/UCD & BTR**
PC 90 MH/UCD & BTR—CCS and GHPP
PC 91 BTR— DPH Delivery System Reform Incentive Pool
PC 93 BTR—Designated State Health Programs

**MANAGED CARE**

**PROVIDER RATES**

**SUPPLEMENTAL PAYMENTS**

**OTHER: AUDITS AND LAWSUITS**

**OTHER: REIMBURSEMENTS**

**OTHER: RECOVERIES**

**OTHER**
OA 53 Prevention of Chronic Disease Grant Project
PC 195 FFP Repayment for CDDS Costs

## DISCONTINUED POLICY CHANGES

### Time Limited/No Longer Available

**FISCAL INTERMEDIARY: MEDICAL**
OA 23 CA-MMIS Go-Forward Oversight
OA 31 CA-MMIS Go-Forward State Transition
OA 43 CA-MMIS Procurement Consultants
OA 67 CA-MMIS Xerox Settlement Agreement

**FISCAL INTERMEDIARY: HEALTH CARE OPTIONS**

**FISCAL INTERMEDIARY: DENTAL**
PC 227 NOD – Settlement Payment to DMC Plans

# DISCONTINUED POLICY CHANGES

## Withdrawn

**ELIGIBILITY**

**AFFORDABLE CARE ACT**

**BENEFITS**
PC 31 Behavioral Health Treatment – DDS Transition
OA 53 Medical Interpreters

**HOME & COMMUNITY-BASED SERVICES**

**BREAST AND CERVICAL CANCER**

**PHARMACY**

**DRUG MEDI-CAL**

**MENTAL HEALTH**

**1115 WAIVER—MH/UCD & BTR**
PC 84 LIHP MCE Out-of-Network Emergency Care Svs Fund

**MANAGED CARE**

**PROVIDER RATES**

**SUPPLEMENTAL PAYMENTS**
PC 165 Freestanding Clinics Supplemental Payments

**OTHER: AUDITS AND LAWSUITS**

**OTHER: REIMBURSEMENTS**

**OTHER: RECOVERIES**
PC 200 Medi-Cal Recoveries Fifty Percent Rule

**FISCAL INTERMEDIARY: MEDICAL**

**FISCAL INTERMEDIARY: HEALTH CARE OPTIONS**

**FISCAL INTERMEDIARY: DENTAL**
PC 46 Allied Dental Professionals Enrollment